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THE SUBJECTIVE WELL-BEING OF YOUTH HEADS OF HOUSEHOLDS IN RURAL SOUTHERN MALAWI

by

Pamela S. Fruechting

A Dissertation Submitted in

Partial Fulfillment of the

Requirements for the Degree of

Doctor of Philosophy

in Nursing

at

The University of Wisconsin-Milwaukee

May 2014

ABSTRACT

THE SUBJECTIVE WELL-BEING OF YOUTH HEADS OF HOUSEHOLDS IN RURAL SOUTHERN MALAWI

by

Pamela S. Fruechting

University of Wisconsin-Milwaukee, 2014

Under the Supervision of Professor Lucy Mkandawire-Valhmu

Youth-headed households in HIV-endemic sub-Saharan Africa face harsh realities of poverty and loss of parental care. Scientific knowledge of these youth is generally limited to socio-economic and psychological indicators of vulnerability while much less is known about youth-centric meanings of well-being. This is the first known study on the subjective well-being of youth heads of households.

The purpose of this exploratory, youth-centric, qualitative study was to identify experiences of subjective well-being, factors for regulating well-being, and meanings of well-being among youth heads of household in the Thyolo and Chiradzulu districts of rural southern Malawi. The theoretical foundation for this study was Diener's model of subjective well-being and a nursing perspective of health.

Semi-structured interviews were conducted across a convenience sample (n=10) of youth ages 10-21 years. Half of the families had at least one child who was a beneficiary of a local, faith-based, non-governmental organization (NGO) that directed a community-based program for vulnerable children. A focus group of NGO administrators was convened to elicit beliefs about the well-being of vulnerable children.

Narrative analysis revealed that youth rely on a referential framework of virtue for appraisal of their subjective well-being. The language of virtue was useful for understanding health, interpersonal relationships, faith, and goals. Three specific findings emerged: (1) *Eight Experiential Contexts of Subjective Well-Being* (provision of basic needs, benevolent belonging, experiencing God, growth through adversity, help, hope, intellectual development, and protection), (2) The regulation of subjective well-being as an interactive social process between the virtue-agency of self, others, and God, and actual or potential opportunities, (3) The *Integrative Virtue Model of Health and Well-Being*, a description of an inferentially-derived meaning of subjective well-being.

This is the first known study to identify virtue as integral to the subjective well-being of youth heads of households. Despite difficult hardships, youth were active agents in promoting their subjective well-being through virtue, maturity of character, and faith. Future research is needed to explore the relationships between virtue, agency, faith, and subjective well-being, among vulnerable youth in low-resource settings of rural Malawi.

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DEDICATION

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للاستشارات المنارة

Chapter 1

Statement of the Problem

Background and Significance of the Problem

It was in the late 1990s when international attention on the HIV-endemic (Human Immunodeficiency Virus) in sub-Saharan Africa began to turn towards the associated increasing orphan population, a phenomena described as the “orphan crisis” (UNICEF, 2011c). Orphan prevalence quickly became a proxy for the severity of the impact of HIV on African communities. In 20 short years, the number of children orphaned worldwide by parents with AIDS-related (Acquired Immunodeficiency Syndrome) illnesses escalated from less than 1 million in 1990 to 16.6 million in 2009, with close to 90% (14.8 million) of these orphans living in sub-Saharan Africa (UNICEF, 2006, 2011c). Worldwide, there are an estimated 153 million children orphans (UNICEF, 2011c). In contrast, worldwide orphan rates from non-AIDS causes have remained constant over the same time period (UNAIDS, 2010).

The Emergence of Youth-Headed Households

Two atypical youth-care structures emerged in response to the HIV/AIDS orphan crisis: grandparent care of orphans and youth-headed households. Societies adapted these new structures of youth-rearing in response to the loss of aunts and uncles who traditionally assumed child-rearing responsibilities for orphaned nieces and nephews (Chirwa, 2002). Though more than 90% of African orphans have been absorbed into the extended family, grandparent care accounts for 50-61% of orphan placement (Bicego, Rutstein, & Johnson, 2003; Floyd et al., 2007; UNAIDS, UNICEF, & USAID, 2004).

Orphans and their siblings who cannot be placed within their extended families may live as a *youth-headed household,* also known as a *child-headed household*. According to UNICEF (2006), youth-headed households are “sibling groups living alone under the care an older adolescent sibling". Factors such as poverty, family placement traditions, potential risk for abuse, relocation of children, and separation of siblings impact the decision for children to reside together as a youth-headed household. This structural definition is somewhat problematic because it does not account for households in which children are *functionally* the head of the household, as in the case of a child caring for a handicapped, chronically ill, or dying, parent (Republic of Malawi, 2003). In both the structural and functional forms of youth-headed households, parental care is absent or minimal, forcing the responsibility for the survival of the family to fall to the oldest child.

The personal, economic, and social challenges facing youth-headed households are daunting. The youth-head of the household must function as parent, provider, and protector, while still in need of parental nurturance themselves. Youth-headed households are considered the most vulnerable sub-group of orphans because of the burden of earning money, providing food, and caring for younger siblings, which exposes these impoverished families to greater risk of hunger, illness, lost educational opportunities, and victimization (Cluver, Gardner, & Operario, 2007; Foster, Levine, & Williamson, 2005).

In response to the critical needs of youth rendered vulnerable by poverty, HIV, and orphaning, humanitarians at the grassroots and global levels sought to develop evidence-based initiatives for the effective care of orphans and vulnerable children

(UNICEF, 2011b). Based on the international consensus that children need families in order to thrive, community-based care programs quickly became the preferred model of care, especially for youth-headed households who have no economic support or adult care (UNICEF Malawi, 2011). By partnering with local and international religious and humanitarian organizations, community-based care programs strive to deliver culturally appropriate material and non-material support to the most vulnerable children, thereby enabling children to remain with extended family in their home communities.

Community-based care is accepted as a "best practice" for safeguarding the welfare of vulnerable children (UNAIDS et al., 2004). The need is great for continued development of sustainable, community-based care programs for the unique needs of children living in youth-headed households. An accurate knowledge of children's situations and experiences is therefore crucial to effective long-term care initiatives. The current knowledge about youth-headed households is largely limited to the concept of vulnerability. A broader view of children's lives is needed to hone program initiatives.

Even though community programs espouse a 'holistic' approach, the literature on youth-headed households is largely limited to measures and narratives of vulnerability. Measures of child vulnerability in quantitative studies include statistical indices of economic status, health status, and educational status. Narratives of youth-headed households in qualitative studies highlight family, personal, and social processes of vulnerability. The implied assumption in both quantitative and qualitative research designs is that vulnerability and well-being are mutually exclusive concepts, such that vulnerability is regarded as a proxy for poor well-being, and that the substance of well-being is the alleviation of vulnerability. Because community-based care programs value children's well-being, there is a pressing need to expand the research agenda from the traditional focus on vulnerability to a broader focus on well-being, with the goal of understanding how vulnerable youth experience well-being within a life of adversity. It is therefore critical that children's ideas and experiences of well-being inform program development.

Significance of the Study

This study is significant in two important regards. First, it reframes the conceptual research paradigm on youth-headed households from one of vulnerability to holistic well-being. Second, it esteems children's narratives as legitimate sources of knowledge about their well-being.

It is critical that the scientific community concerned with the health of vulnerable groups not rely solely on measures of personal deprivation, but also on material and non-material measures of personal capacity, because a proper understanding of holistic well-being cannot be described solely in terms of vulnerability. This study aims to extend the previous scholarly work by investigating how youth-heads of household experience and appraise their subjective well-being, what factors impact their subjective well-being, and what meanings they ascribe to their subjective well-being. *Subjective well-being* is a self-report of well-being and has important positive ramifications for health, morbidity, and mortality. Qualitative analysis is required since no measures for the subjective well-being of Malawian youth have been developed.

Studies of children's health often rely on adult informants as data sources instead of children. The problem with adult surrogates for children’s opinions is that children may hold differing views of well-being than the adults who care for them (Ben-Arieh et al., 2001; Cluver & Gardner, 2007). If adult surrogates are the only source of knowledge about children's well-being, then program development for vulnerable youth may be short-sighted or inadequate for achieving maximal benefit. This study therefore prioritizes a youth-centric methodology of semi-structured interviews because children as young as age 8 are capable of articulating a self-appraisal of their well-being (Huebner, 2004).

Purpose of the Study

The primary purpose of this study was to understand the subjective well-being experiences, factors, and meanings as described by rural southern Malawian youth heads of household (n=10), utilizing semi-structured interviews.

Research Questions

Research question 1. How is the well-being of vulnerable youth heads of households understood through their experiences?

Research question 2. What factors are necessary for the subjective well-being of youth heads of households?

Research question 3. What meanings of subjective well-being can be inferred from the interview data?

Specific Aim

The specific aim of this study was to identify, analyze, and synthesize the experiences, factors, and meanings of youth well-being as narrated by youth heads of household, utilizing qualitative narrative methods, a focus group discussion of NGO administrators, and casual conversations with adult Malawians.

Assumptions

This study rests on three assumptions: (1) subjective well-being is a self-reported appraisal of life satisfaction and is based on both cognitive and emotional judgments, (2) subjective well-being can exist concurrently with life adversity, and (3) youth are reliable informants of their well-being.

Definitions of Terms

Orphan. An orphan is a child under age 18 who has lost one or both parents to death from any cause (UNAIDS, 2010). Nomenclature of orphans is as follows:

> *Single orphan*. A child who has lost one parent.
>
> *Double orphan*. A child who has lost both parents.
>
> *Maternal orphan*. A child whose mother has died (includes double orphans).
>
> *Paternal orphan*. A child whose father has died (includes double orphans).

Youth-headed household**.** Also known as a child-headed household. A sibling group living alone under the care of an older adolescent sibling (UNICEF, 2006).

Summary

Youth-headed households are one of the most vulnerable child populations because of their lack of economic independence and adult protective care. Earlier studies provided understanding of children's vulnerability and the advent of community-based initiatives to meet children's basic needs for physical survival. What remains unknown is *how* youth who are the head of their household experience well-being, what factors they ascribe to their well-being, and what well-being means to them. If, as UNICEF and numerous organizations assert, children's holistic well-being is a desired goal of community-based care, then it follows that a conceptual framework of holistic well-being must inform any well-being research of vulnerable children (UNICEF, 2011a).

Chapter 2

State of the Science: Youth-Headed Households in Malawi

Profile of Malawi

Malawi is an agrarian, sub-Saharan, land-locked country in east Africa, bordered by Tanzania to the north, Mozambique to the east, south and southwest, and Zambia to the west and northwest (Figure 1). Formerly under British rule and known as Nyasaland from 1891 to 1964, Malawi became an independent state in July 1964 and gained republic status in 1966 (Government of Malawi, 2011). With a poverty rate of 53%, Malawi is one of the poorest and least developed countries in the world (Central Intelligence Agency, 2012; Government of Malawi, 2011).

Malawi has a population of 15.91 million and a national adult HIV rate of 12% (The World Bank, 2012; UNAIDS, 2012b). Children under age 19 account for about half (8.565 million) of Malawi's population, and 17.8% (1.3 million) of the children are orphans (UNICEF, 2013; United Nations Department of Social and Economic Affairs: Population Divison, 2013). It is estimated that half of Malawi's orphans (770,000) resulted from AIDS-related illnesses (UNICEF, 2013). The southern region of Malawi, where this dissertation research was conducted, has the highest national rate of HIV (14.5%), though it has declined from 17.6% in 2004 (Government of Malawi, 2005; UNAIDS, 2012a). The southern region also has the highest rate of orphaning (15%) compared to 13% nationally (Government of Malawi, 2011). By the time Malawian children reach 15-17 years old, one in four (27%) is orphaned and an additional 7.6% are vulnerable (UNICEF Malawi, 2006). Poverty inflicts severe material deprivation on children, such that 41% of Malawian orphans and vulnerable children do not even own the three minimum material possessions consisting of a blanket, a pair of shoes, and an extra set of clothes

(UNICEF Malawi, 2011).

In spite of widespread poverty, African kinship care is still the primary care option for orphans. One-third of all Malawian households are caring for foster children or orphans (Government of Malawi, 2011). The vast majority of Malawian orphans (86%) live in rural areas with relatives, and nearly half (49%) live with a grandparent (UNICEF Malawi, 2006).

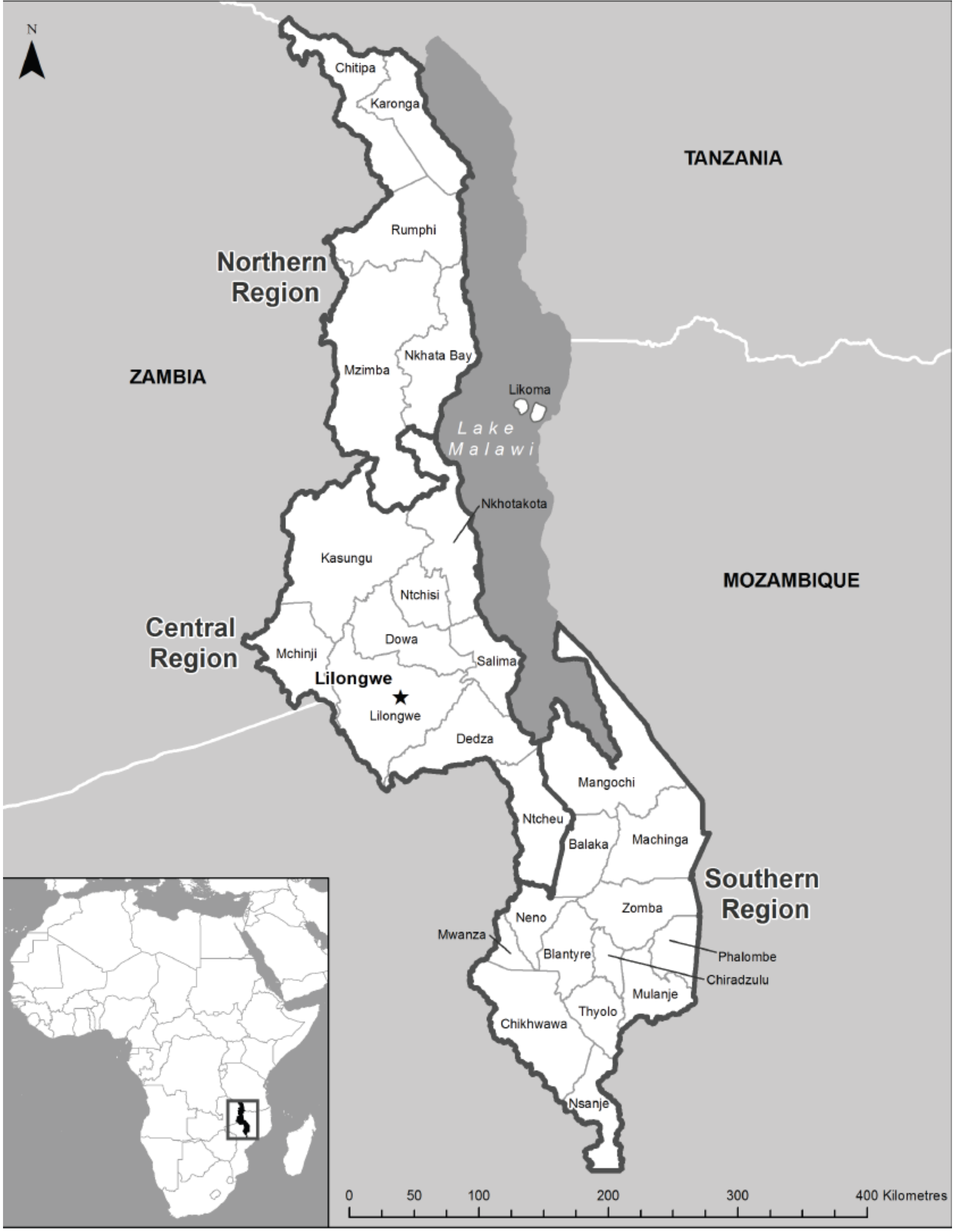
Youth-Headed Households in Malawi

Children who are left without care by the extended family may form a sibling household, also known as a youth-headed or child-headed household. The majority of child-only households are headed by an older teenager between ages 15 and 17 years, and half the children in these households are older than 15 years (Meintjes, Hall, Marera, & Boulle, 2010). In 2010, the number of Malawian orphans living in youth-headed households was approximately 12,000 (1.4% of all orphans), a substantial increase from less than 1% in 2007 (UNICEF Malawi, 2011). For comparison, youth-headed households in other sub-Saharan countries was estimated at less than one percent (UNICEF Malawi, 2011). It is unknown if the increase is due to an absolute increase in households or to improved methods of identifying these households.

The difficulties of enumeration and the vagaries of what constitutes a youth-headed household mean it is likely there are many more youth-headed households than the statistics indicate. The problems of enumeration center on the 18 year age limit that defines orphans. Two examples help explain this. First, when a youth head of household reaches legal adulthood at age 18, the household is no longer enumerated as a youth-headed household, even though the youth may still be the provider and caretaker for younger siblings or an ill parent.

Figure 1. Country of Malawi

Source: Government of Malawi. (2011). Malawi Demographic and Health Survey 2010. Zomba, Malawi.


N
Chitipa
Karonga
TANZANIA
Rumphi
Northern Region
ZAMBIA
Nkhata Bay
Mzimba
Likoma
Lake Malawi
Nkhotakota
Kasungu
MOZAMBIQUE
Ntchisi
Central Region
Dowa
Mchinji
Salima
Lilongwe
Lilongwe
Dedza
Mangochi
Ntcheu
Balaka
Machinga
Southern Region
Zomba
Neno
Mwanza
Blantyre
Phalombe
Chiradzulu
Mulanje
Thyolo
Chikhwawa
Nsanje
0
50
100
200
300
400 Kilometres

For statistical purposes this household would be considered an adult household. Second, children under the age of 18 may be the head of household, providing income and personal care for a disabled or ill parent and younger siblings. but would not be enumerated as a youth-headed household because the parent is present.

Causes of Youth-Headed Households

HIV/AIDS is a major determinant in the formation of youth-headed households since half of orphans were orphaned by HIV/AIDS (Germann, 2005). The economic impact of HIV is the hardest on the poorest families (Bicego et al., 2003). In South Africa, the average monthly per capita income when one person in the household was HIV positive was less than half the income of non-HIV households (Booysen & Bachman, 2002). Medical costs for HIV care are quadruple the non-HIV family's cost of medical care, and more work days are lost due to illness (Bechu, 1998). Nutrition of all members is compromised because food consumption declines by 40% (Bechu, 1998). Loss of income renders school tuition prohibitive, and children that are uneducated are destined to continue in a state of poverty, be at increased risk for HIV, and risk a shorter lifespan (Bechu, 1998; Floyd et al., 2007). Families may experience stigma related to HIV. Stigma isolates families, and they may not feel free to seek support services from community care, church-based care, medical home care, and financial assistance for a proper burial of parents (Earnshaw & Chaudoir, 2009).

The economic effect of HIV is a downward spiraling of deprivation, because as earning power declines, income declines, medical expenses increase, and the income of fewer persons must support more dependents (Williamson, 2005). As families with HIV become more impoverished, children may have to quit school due to the inability to pay school fees, the need to find employment/income, the need to provide care to an ailing adult, or to assist in child-rearing of younger siblings. When HIV/AIDS claims the life of a parent, the oldest child may then assume full responsibility for the family if extended family members are unable to take in the children.

HIV/AIDS is not the only reason for the formation of youth-headed households. Other dynamics leading to a youth-headed household include failure of the family kinship structure, coercive alternatives (wage employment, early marriage, dropping out of school), survival strategies (food security, protecting home and property), personal initiative, and an entrepreneurial spirit (Chirwa, 2002). Also, the prevalence of seasonal migrant labor in Africa may force families to leave children to care for themselves or to be cared for by other kin, such as grandparents (G. Andrews, Skinner, & Zuma, 2006). Relocation of children for the purpose of educational access may be another reason for youth-headed households (Meintjes et al., 2010).

Challenges Facing Youth-Headed Households

Youth-headed households are exposed to multi-dimensional disadvantages: poor socio-economic conditions (Akwara et al., 2010), loss of educational opportunities (UNICEF, 2006), inadequate health knowledge (Amuge et al., 2004), decreased social support (Atwine, Cantor-Graae, & Bajunirwe, 2005), poorer health (C. M. Miller, Gruskin, Subramanian, & Heymann, 2007), depression (Atwine et al., 2005), early sexual debut (Akwara et al., 2010), sibling separation (USAID/SCOPE-OVC/FHI, 2002), and malnutrition (UNICEF, 2006). Poverty tends to narrow the gap between non-orphans and orphans such that nearly half (47%) of all Malawian children do not have their minimal basic needs met (UNICEF Malawi, 2011).

Youth–headed households face numerous daily obstacles. Economic needs for food, work, and housing are so great that only 5% of Mozambique youth-headed households were concerned about access to medical care (Roby & Cochrane, 2007). Yet when given outside support for basic needs, youth-headed households in South Africa were found capable of autonomous household operation (Van Dijk & Van Driel, 2009).

Among youth-headed households in Rwanda, children under age five were likely to have fair to poor health while the household heads were likely to report depression and social isolation (Boris, Thurman, Snider, Spencer, & Brown, 2006). Younger siblings were more likely to be depressed when the household suffered from depression (Boris et al., 2006). Protective factors against depression in orphans included a nurturing caregiver relationship, remaining with siblings, socioeconomic security, peer relationships, and school attendance (Bauman & Germann, 2005; Cluver & Gardner, 2007).

In a study in Mozambique, the majority of youth-headed households were faced with parenting one to four siblings (19% of 111 Mozambique youth-headed households had no siblings to care for), securing food, obtaining money, attending school, adequate shelter, and affordable medical care (Roby & Cochrane, 2007). Roby & Cochrane (2007) found that securing food consumed enormous amounts of time: 20-40 hours for 29% of the child households, and 40-60+ hours for 46% of child households. Rarely did Mozambique children request food from family members. Rather, most children preferred to ask a neighbor/friend (78%) while 11% begged strangers.

Youth heads of households are likely not able to realize their right to attend school, and may have their rights violated through exploitation of employers and abusers (Mogotlane, Chauke, van Rensburg, Human, & Kganagka, 2010; United Nations, 1989).

Economic hardship may lead to risky behavior to ensure mere survival, such as transactional sex and petty crime to attain food or money, which can expose teenagers to HIV infection, pregnancy, or incarceration (Kuhanen, Shemeikka, Notkola, & Nghixulifwa, 2008).

Research Focus on Youth-Headed Households

The well-being of the parentified youth is critical to family health because, for better or worse, the well-being of the household head directly affects the well-being of younger siblings (Boris et al., 2006). Studies on the well-being of youth-headed households have been limited to a specific *aspect* of well-being: psychosocial well-being (Makame & Grantham-Mcgregor, 2002; Meintjes et al., 2010), psychological well-being (Atwine et al., 2005; Delva et al., 2009), or socio-economic well-being (G. Andrews et al., 2006). Researchers generally approach orphan research from a deficit approach to vulnerability, in which alleviation of child vulnerability is equated with child well-being. This is a conceptual error, which is discussed in detail in Chapter 4.

Only one study on youth-headed households was found that explored the concept of well-being. In Germann's study (2005), quality of life of 105 Zimbabwean youth-headed households was the focus of a comprehensive, mixed methods study, which concluded the children were very resilient and creative in developing systems of affection, solidarity, and acceptance, in spite of significant vulnerability. Over 2/3 (69%) of the households reported a medium to satisfactory quality of life despite substantial adversity (Germann, 2005). Quality of life was directly correlated to social support from siblings, peers, and neighborhood members, as measured by the WHOQOL-BY (World Health Organization Quality of Life Assessment-BREF version for Youth) (Germann, 2005). With the exception of Germann (2005), the holistic well-being of youth-headed households has not truly been addressed.

Orphans and Vulnerable Children in Malawian Culture

International Terminology for Vulnerable Children

The criteria for what constitutes an orphan in Malawian culture is essential to understanding how Malawians determine which children are vulnerable and deserving of assistance. The international debate over the semantics of 'orphan' and 'vulnerable child' are highlighted here as a backdrop to the discussion on Malawian orphans.

Recognizing that vulnerability is context-dependent, governments and international health agencies such as UNICEF, WHO, and UNAIDS now subsume ‘orphans’ under the umbrella term of ‘vulnerable children’, even though ‘orphans and vulnerable children’ (OVC) remains the standard term (UNICEF, 2012). For further clarification, the term “highly vulnerable children” was adopted by USAID (2007) for application to *any* child made vulnerable by *any* cause. Under this definition, ‘highly vulnerable children’ includes any child who experiences inadequate adult support, abandonment, economic distress, or chronic illness; has or is suspected of having HIV/AIDS; is directly affected by armed conflict; lives outside of family care; or is otherwise not protected by their community’s traditional social safety nets (USAID, 2007). As will be shown, the USAID definition is congruent with the Malawian understanding of vulnerable children as destitute, abandoned, or unprotected children.

From a policy and programming perspective, the term, ‘highly vulnerable children’, is advantageous in four respects: (1) The tendency to privilege orphans over non-orphans is alleviated, (2) It is equally salient in both global and African discourse,

(3) It is applicable to non-HIV/AIDS contexts of vulnerability (e.g., poverty), and (4) Vulnerability is understood as a systemic process, rather than a typology.

The Malawian Concept of Orphans and Vulnerable Children

For Malawians, the boundaries between orphanhood and vulnerability are indistinct. Foremost, the Malawian idea of 'orphan' is more properly understood as a 'vulnerable' child. While westerners (including global agencies like UNICEF) conceptualize 'orphans' as parentless children without a nuclear family, Africans conceptualize orphans as severely disadvantaged or destitute children, though not necessarily parentless (Bray, 2003). African communities as collectivist cultures place high value on solidarity through extended family ties that are intricately woven into a sense of belonging within the larger community (Mfutso-Bengo & Masiye, 2011). Both western and African cultures consider orphans homeless, yet the concept of 'home' is, for the African, not only loss of a nuclear family, but the loss of extended kin and loss of connection to the wider community. From this perspective, the standard definition of an orphan as a 'parentless child less than age 18' fails to capture the Malawian idea of an orphan as a child who suffers from multi-dimensional destitution, a context that may or may not be primarily due to the loss of a parent.

The collective responsibility of kin and community to care for children frames the Malawian understanding of 'orphan' as a vulnerable child. Chirwa (2002) uses a song to illustrate the Malawian concept of orphans:

> *Mwana wa masiye, mwana wa masiye*
> *Akamalira mperekeze kuli amawo*
>
> When the orphan child cries
> Take/escort him/her where the mother is
> (page 106)

The literal translation of *wa masiye* is one who is an orphan, one who is 'left behind' through parental loss, abandonment, and subsequent physical, social, and material deprivation. The song speaks of the orphan who needs his mother, and in the absence of a mother, the responsibility falls to the community. The Malawian concept of the orphan, then, is a child who has suffered loss, abandonment, or being left behind, because of the destruction of the protection normally afforded by a family (Chirwa, 2002).

The Malawian phrase, *mundilere bwino,* or "bring me up well" is a dominant theme in Malawian folklore that speaks to the special consideration of humane treatment that is due orphans (Chirwa, 2002). Orphanhood in the Malawian context, then, is not merely a *category*, but more importantly, a *process,* of significant disadvantage imposing important negative social and material conditions upon the life of a child while simultaneously imposing ethical mandates upon the community.

The 2010 Malawi Demographic Health Survey reflects these Malawian beliefs in the following definitions of 'orphan' and 'vulnerable child':

> An orphan is defined as a child under age 18 with one or both parents deceased. A vulnerable child is a child under age 18 who has a chronically ill parent (sick for three or more consecutive months during the past 12 months) or who lives in a household where an adult was chronically ill or died during the 12 months preceding the survey (Government of Malawi, 2011, p. 261).

Note that the definition of a vulnerable child does *not* explicitly include orphans. The wording is consistent with cultural norms and the international trend to avoid privileging orphans over equally needy children.

Data findings from a pooled, descriptive analysis of three large surveys in Malawi conducted from 2004 to 2006 further demonstrates that orphanhood cannot be a singular indicator of vulnerability. More specifically, it was poverty, rather than orphan status, that predicted child vulnerability. For example, single orphans who live with their mothers were worse off economically due to loss of the deceased father's income compared to double orphans who tended to be placed with relatives who could provide sufficient economic support (UNICEF Malawi, 2006). Intriguingly, indicators of disadvantage (vaccinations, health card, mosquito bednet, and school attendance) for orphans were the *same* for children who have parents but do not live with them (UNICEF Malawi, 2006).

Structure of the Malawian Family

Equally important to this discussion is the Malawian concept of family and parenthood. The western idea of a nuclear family as a household consisting of parent(s) and child(ren) that is economically and geographically distinct from other relatives is a foreign concept in Malawi. Rather, 'family' in the Malawian sense is an extended family consisting of a collective embodiment of multiple and connected kin, living in geographic proximity, and with ethical and economic obligations to each other (Chirwa, 2002). It is these values and expectations within the extended family that empowers the social capacity of families to respond to orphanhood.

Malawian children periodically migrate to the households of relatives to provide household help to kin, to facilitate school attendance, to care for younger kin, to be cared for when parents must migrate for work, or for economic reasons. In fact, one in five Malawian children does not live with a biological parent (Government of Malawi, 2011).

The older the child, the more likely they are to live with a relative, and for children ages 15-17 the rate is 34% (Government of Malawi, 2011).   The parenting of orphans by the extended family, then, is a natural option and a preferred practice in Malawi. In fact, the 2004 Malawi Demographic and Health Survey queried attitudes related to children affected by HIV. Ninety-four percent of women and 96.7% of men stated they would be willing to take in children orphaned by HIV/AIDS (Government of Malawi, 2005). Furthermore, the success of the family in caring for orphans is reflected in the fact that orphanages are rare in Malawi (UNICEF Malawi, 2011).

Foster Care of Orphans in the Extended Family

African orphans are traditionally cared for, or 'fostered', in the extended family. Foster care in the African sense is an informal process whereby extended family, friends, or community members take in orphans and assume responsibility for their care (Foster, 2007). In Malawi, one-third of all households are caring for foster children or orphans (Government of Malawi, 2011). Formal adoption is rare in Malawi.

The preference for fostering is premised on the assumption that family members are more likely to provide better nurturance of orphans than non-family members. The advantages of fostering include the maintenance of family cohesion, culturally appropriate societal integration, less risk of marginalization, and caregiving assistance to household members (Skovdal, 2010). Successful fostering from the orphans' perspective is in the experience of kindness that is more likely to occur when the orphan is biologically related to the caregiver (Goldberg & Short, 2012).

Orphan placement norms are culturally directed. The preferred primary caregiver for orphans is the surviving parent (especially mothers), followed by older siblings, aunts/uncles, and grandparents. Financial stress is common in families caring for orphans, and may force separation of orphaned siblings into different families (C. M. Miller, Gruskin, Rajaraman, Subramanian, & Heymann, 2006). Financial considerations are now given greater weight in orphan placement decisions and may be partially offset by newly established government-directed financial subsidies to foster families, known as ‘cash transfers’ (Nyamukapa & Gregson, 2005; Skovdal, Mwasiaji, Webale, & Tomkins, 2011). Local and international secular and religious agencies are other sources of potential economic support.

Grandmothers care for 49% of Malawian orphans, and represent the single, largest group caring for orphaned children (UNICEF Malawi, 2006). The prevalence of grandparent care of orphans rapidly increased as AIDS-related illnesses claimed lives of middle generation adults consisting of parents, aunts, and uncles. The caregiving capacity of grandmothers is often severely limited by economic deprivation stemming from exhaustion of resources spent on medical care for their dying adult children, loss of future income from those children, and the economic burden of orphaned grandchildren, especially in meeting educational costs (Casale, 2011). Grandmother care can be beneficial for both children and the elderly. Grandmothers report positive emotional satisfaction in caring for children, even in the face of poverty, and children fare better when cared for by kin (Casale, 2011; Chirwa, 2002; Goldberg & Short, 2012).

Community-Based Orphan Care

The National Plan of Action for Orphans and Vulnerable Children was initiated by the Republic of Malawi in 2005 to strengthen family and community capacities, and to scale up efforts for the well-being of OVC (USAID, 2009). As an effective social response, community-based orphan care is now accepted as a “best practice” and continues to be a crucial safeguard for keeping families together by mitigating against socio-economic causes of family separation. A collaborative response to orphan needs is necessary to meet the five key strategies of *The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World of HIV and AIDS* (UNICEF, 2004). These strategies include (1) strengthening family capacity to care for orphans, (2) supporting community-based orphan care, (3) ensuring essential services like education and health care, (4) guaranteeing legal protection of children, and (5) creating a supportive environment for children affected by HIV/AIDS.

Community-based support acts as a ‘safety net’ through material and non-material assistance to children such as income support, food security, clothing, educational fees, and psychosocial support. Within a defined catchment area, highly vulnerable children are identified by community leaders according to local indices of vulnerability and need (Phiri & Webb, 2002). Priority recipients include children under age 5, child-headed households, children with terminally ill parents or caregivers, and households headed by frail or aged grandparents (Nigeria, 2007).

In principle, the idea of economic support for families makes sense but the sobering reality of poverty means that the majority of needy children are unreached (UNICEF Malawi, 2011). Almost all Malawian orphans and vulnerable children (83%) in 2010 did not receive any kind of support, and only 41% possessed a blanket, a pair of shoes, and more than one set of clothing (Government of Malawi, 2011). Medical care was the most common form of support, especially for children ages 0-4 (12.0%), followed by school assistance (8%) (Government of Malawi, 2011). Feeding programs are a common form of local aid, and for many children this is their only daily meal.

Social cash transfer programs in sub-Saharan Africa have become one way to aid ultra-poor households with high dependency ratios (C. Miller, Tsoka, & Reichert, 2011). Some social cash transfer programs are *conditional cash transfer* programs, the objective of which is to allocate cash to poor households in exchange for a commitment from recipient families to take children to health clinics or enroll them in school, for example (Fiszbein & Schady, 2009). Governments of impoverished nations, such as Malawi, are understandably limited in their capacity to provide financial assistance. The Government of Malawi's Social Cash Transfer scheme began in 2006 and now includes seven districts (Mchinji, Chitipa, Likoma, Machinga, Salima, Mangochi, and Phalombe) (2014). Only two of these districts are at full scale capacity (Mchinga and Likoma). There are no government-sponsored financial assistance programs for the Chiradzulu and Thyolo districts where I conducted my research.

Engagement of non-governmental organizations (NGO) with local volunteers can result in significant cost-effective and sustainable outcomes. One such model of successful community-based orphan care is FOCUS (Families, Orphans and Children Under Stress), located in rural Zimbabwe. Administered by Family AIDS Caring Trust (FACT), the aim of this Christian development initiative was to support and encourage households supporting orphans (FACT ICT Office, 2011). Trained volunteers from churches assessed material, educational, spiritual, and psychological needs. Early identification of essential needs resulted in timely interventions. During the last six months of 1996, FOCUS recorded 9,634 visits by 88 volunteers to 3,192 orphans in 798 families. At an average cost of US$1.55 per visit, the average family received 1.5 visits per month and volunteers averaged 18.2 visits per month. The greatest asset in the program was the volunteers' intimate knowledge of the community, a feat not easily accomplished by an independent foreign NGO.

The Effect of Religion on Orphan Care Programming

Faith-based organizations (FBOs) usually have material provision as their first practical priority in assuring the physical well-being of orphans. The FBOs often partner with indigenous churches to mobilize volunteers for visitation of orphans and surveillance of needy or potentially needy children (Foster & Makufa, 1996). The need for nurturing has been recognized by UNICEF's Convention on the Rights of the Child as well as global health scholars (Phiri & Webb, 2002; United Nations, 1989). In a report on the impact of HIV on orphans and program responses, Phiri & Webb (2002) highlight nurturance as a desperate need of children:

> Addressing the psychosocial welfare elements of orphans and children in affected communities is now a matter of urgency. The cycle of infection will be exacerbated by young people growing up in contexts where mental ill health is rife, combined with feelings of isolation, despair and social disenfranchisement. The responses required are in themselves not complex, but are needed at such an unprecedented scale that we are only starting to comprehend the implications. (p. 1)

Christian Theology of Orphan Care

Faith-based organizations have a doctrinal belief system that informs their humanitarian initiatives. Miqlat USA is a Christian evangelical organization that identified with traditional Christian beliefs. These core beliefs include a Trinitarian view of God the Father, God the Son, and God the Holy Spirit, the incarnate Jesus through the virgin birth, the deity of Jesus Christ, the resurrection of Jesus, that Christ will come again to earth at the end of the ages, the infallibility of Scripture, justification of one's guilt by grace alone, and that the church consists of the fellowship of believers in Christ (Grudem, 2000).

The motivation of Miqlat USA and similar Christian FBOs to provide orphan care stems from beliefs about caring for the poor and the orphaned. The general principle underlying orphan care initiatives is the belief that humankind is made in God's image, *imago Dei*, and as such possess great value, the need to be loved, and the capacity to give love (Bongma, 2007). Christian scripture sets the stage for orphan care by mandating their protection:

> "Pure and undefiled religion in the sight of our God and Father is this: to visit orphans and widows in their distress, and to keep oneself unstained by the world," (James 1:27, New International Version)
>
> "Defend the weak and the fatherless; uphold the cause of the poor and the oppressed. " (Psalm 82:3, New International Version)

Building on this theme further, Moore's (2010) essay on rescuing orphans highlights the integration of belief and action that characterizes Christian missions:

> Orphan care is, by definition, missional…we can show the orphaned universe what it means to belong to a God who welcomes the fatherless. Let's remember that we were orphans once, and that someone came looking for us, someone who taught us to call him "Abba [father]". Let's be ambassadors for the One who loves

> the little children, all the children of the world. Like him, let's welcome children…especially those we are not supposed to want (Moore, 2010).

The concept of Christian missions towards orphans is intricately linked to the ontological ethic of *sanctity of life*. Sanctity is an ontological state in which all human persons are included. Sanctity does not presuppose autonomy or any temporal attainment. Sanctity derives from *sanctitas,* meaning “inviolability, sacredness”. A*gape* love (God's perfect love) is the most basic form of sanctity (Jackson, 2005). Thus, the giving *or* receiving of *agape* love is the purest form of sanctity. Applying the sanctity right to orphans, Jackson (2005) expounds:

> The sanctity of human lives has a claim on us that is utterly unearned and entirely inalienable. I call this claim a “sanctity right,” and it stems from human need and/or potential; it has nothing to do with past merit or demerit, present contract or breach of contract, or future status or lack of status. Moreover, the claim is not merely to inviolability, as in the case of dignity, but also to active assistance. Regardless of whether orphaned or unwanted children have been culpably injured by others, for example, it is the duty of those responsible for the common good (both church and state) to see to it that the children find a loving home. Tragic accident or natural calamity may be responsible for the fate of these children, but the “sanctity rights” to nurturance obtain in any case. (p. 195)

Jackson (2005) echoes other Protestant evangelicals when he says, “The primary motive for Christians however, is not intra-human indebtedness or reciprocity; it stems from the fact that we are loved first by God and are called on, in turn, to incarnate a holy will toward our neighbors," (p. 198). Esteeming the orphan reveres the sanctity of human life, for in nurturing "the least of these", Christians have cared for Christ himself (Matthew 25:45, New International Version).

Religious Health Assets

Faith based organizations as a "religious health asset" have been recognized as a valuable resource worthy of investigative research to examine their scope, scale, nature, and potential (Cochrane, 2006). One of the specific aims of the African Religious Health Assets Programme's (ARHAP) work for the World Health Organization is to understand how FBOs may contribute to best practices in health in their respective socio-political contexts. A second aim of ARHAP is ongoing qualitative analysis of how FBOs function as a religious health asset in the community. Underlying these aims is a "redemptive" framework of health deemed theologically and philosophically relevant to the task. The term "redemptive" invokes strong religious connotations which Cochrane frames against the backdrop of Christ the holistic Healer as the 'Medicine' (*medi sine,* meaning mediator of health) with the foreground filled in by a consumer and capitalist view of health as a commodity (Cochrane, 2006). Invoking the position of the Panos Institute, Cochrane (2006) acknowledges FBOs as a critical entity to provide a "people-centered, socially orientated, and life-world sensitized approach" (p. 113). It is the challenge of life and death in an AIDS-riddled society that FBOs are able to speak of health in redemptive terms. This is not an elitist position, for even African traditional religions have beliefs about the power of faith to bring about physical healing. Cochrane (2006) argues that a redemptive view of health bridges people of all cultures, creeds, and confessions, because of the universal desire for health and well-being. The redemptive view creates discursive space and practice space where faith and health intersect as a focus for developing programs that transcends exclusivities of creed and culture. It is in this sense that Cochrane (2006), situates the FBO as a "religious health asset" to its community.

The true asset value of FBOs as identified by Cochrane (2006) is the invisible and intangible symbolic, relational, and motivational capacities of faith that are rarely explicated in the research on African health and faith:

> Largely missing from most studies on religious health assets is the dimension of religion that is 'internal' to faith-based communities or organizations, that which explains their motivations, commitments, attitudes, actions and relational or associational strengths on the basis of their own self-understandings and world-views. (p. 117)

Unintended Consequences of Faith-Based Organizations

The unintended consequences of Protestant colonialism upon Africa are well-documented (Cooper, 2005). Likewise, the attempt of FBOs to colonialize with religious beliefs may invite adverse unintended consequences for HIV-endemic areas (Bornstein, 2005). Resource-poor countries may perceive an opportunity to withdraw from the governmental responsibility to provide services for the social and economic needs of the poor when NGOs are willing to step in (Farmer, 2005). Failure to examine the effects of Protestant evangelistic practices by FBOs can perpetuate shame-related stigma by gagging the discussion on prevention of sexual transmission of HIV (Bongma, 2007). Orphans need access to such educational initiatives as they are among the least able to make their needs known. If FBOs ignore the discussion on HIV prevention, stigma is perpetuated, risk behaviors by orphans continue, and HIV remains one of the largest public health threats. Public education about HIV remains one of the key venues for reducing stigma, HIV infection rates, orphaning, and improving longevity (Williamson, 2005). It is vital that FBOs examine their religious and moral messages for congruency between values (dignity, sanctity, and love of persons), intention (improvement of quality of life, health, and spirituality), public education initiatives, and programming directives.

Bornstein (2005) elucidates the intricacies of the notion of child sponsorship. This is a common mode of donor fund-raising, including Miqlat USA, in which a monthly stipend from individual donors provides matched children with material support Linking a specific child by a photograph, name, and biographical information, sparks an emotional connection for donors. Donors and children are encouraged to write letters to each other, which often fosters feelings of attachment and belonging. These relationships may lead to resentment by the child's family if the parents perceive they are being bypassed (Bornstein, 2005). In stark contrast to the child sponsorship model, George Muller (1805-1898), Christian pastor, built five stately orphanages in Bristol, England, in the mid-19th century, and raised approximately10, 000 orphans, schooled 122,000 students, and received funds totaling US$7,500,000 for their support (Muller, 1861). Muller attributed the provision to prayer alone - at no time did he ever publicize any needs, solicit funds, assume debt, commence committees, or seek subscribers.

Faith-based organizations have been criticized for religious dogma-driven ineffectiveness in addressing prevention of sexual transmission of HIV (Keikelame, Murphy, Ringheim, & Woldehanna, 2010). A study of Lutheran, Catholic, and

Pentecostal Tanzanians demonstrated that HIV-related shame was prevalent among respondents who believed HIV was a punishment from God or that people with HIV did not follow the Word of God (OR 1.46, $p < 0.01$ and OR 1.92, $p < 0.001$) (Zou et al., 2009). The moral beliefs that linked to religious stigma were that condoms endorse a lack of sexual self-control and the transgression of abstinence (Genrich & Brathwaite, 2005). Positive beliefs from religious leaders in Genrich & Brathwaite's (2005) study included loving people without regard for how HIV was contracted, thinking of HIV as the modern-day version of leprosy in Jesus' day, framing AIDS as "not an academic thing here…it is very concrete", and understanding sexuality as an essence of human nature: "Sexuality is extremely fragile…we talk about it simply as something that we do when in fact it is something that you are." The Pentecostal leader's admonition to "Obey the word, abstain from sex, and avoid HIV," while consistent with "ABC" mantra (abstain, be faithful, use a condom), is grossly insufficient for the person living with HIV. Though it is beyond the scope of this paper, it is critical that FBOs and religious institutions carefully analyze the efficacy and balance of their messages. Genrich & Barthwaite (2005) pose a particularly provocative question to the church at large: "If HIV were not sexually transmitted, would religious organizations respond to the epidemic in the same way?" (p. 10).

Spirituality as a coping mechanism for people living with HIV/AIDS (PLWHA) has been recognized as a significant factor in creating a personal sense of life purpose (Litwinczuk & Groh, 2007) and well-being (Siegel & Schrimshaw, 2002). Faith-based organizations (FBOs) may reinforce stigma by characterizing people with HIV as unreligious, unvirtuous, and promiscuous. In Uganda, both Christian and Muslim organizations promote the belief that HIV/AIDS is a consequence of sinful behavior by the promiscuous (Monico, Tanga, & Nuwagaba, 2001). Shame-based stigma isolates people from the religious support implicated in the health and well-being of PLWHA (Pargament et al., 2004). Stigma from the religious community reinforces societal stigma. Women have identified barriers to disclosure of HIV status to their husbands: fear of accusation of infidelity, abandonment, discrimination, and violence (Medley, Garcia-Moreno, McGill, & Maman, 2004). When women are abandoned by their spouses they lose economic support, become sicker because they are unable to obtain medication or nutritious food, and are then unable to care for their children. The cycle of youth-headed households are perpetuated in such dismal circumstances, and without medical care or food for the ill mother, these children are soon orphaned.

In summary, western FBOs may unwittingly undermine the cultural structure of individual well-being that is intricately linked to social appraisal and interdependency (Diener, 2009b; Ikuenobe, 2006). While orphan care is a noble cause, an unintended consequence of liberation ideologies and interventions is that the enterprise as a capitalistic western idea carries a risk of marginalizing, even excluding, the community at large as it selects who will benefit from its services and programs (Chirwa, 2002). Institutional ideologies may force beneficiaries to compromise their personal religious beliefs to gain access to services. Bornstein (2005), in her ethnographic study of FBO-based economic development in Zimbabwe wittingly sums up the dilemma: “Faith was used in development as both a controlling discourse of institutional power and a discourse that offered the transformative potential for change,” (p. 65). In an effort to avoid this problem, Miqlat USA, the FBO in my study, strategically works alongside the community to ensure culturally-appropriate forms of support to vulnerable children.

The Role of the African Church in the Care of Vulnerable Children

African churches play a critical role in orphan care and have responded with vigor to uphold theological mandates to help orphans, and to honor the cultural value of civil harmony (Mfutso-Bengo & Masiye, 2011). Congregational responses began proliferating in the 1990s. Religious groups, of which 80% in Malawi are Christian, enlist volunteers to aid the poor, the orphaned, and the sick (Olivier, Cochrane, & Schmid, 2006). Across six sub-Saharan countries, including Malawi, the UNICEF-commissioned report, *Study of the Response by Faith-Based Organizations to Orphans and Vulnerable Children* (Foster, 2006), analyzed the religious activities of 686 faith-based organizations, most of which were local congregations and the Religious Coordinating Bodies (RCBs) that oversee local congregations. Cumulatively, 7,800 volunteers aided over 139,400 OVC, even though local initiatives served fewer than 100 children each. Despite a formal structure, the congregations exhibited remarkably similar helping initiatives, provided significant care without external financial or technical support, and demonstrated fiscal accountability similar to larger NGOs. Benefits to households included increased morale from psychosocial, spiritual, and material support; reduced stigma by regular visitation of households affected by HIV/AIDS; increase in total children attending school; better-adjusted children; reduction of child abuse and exploitation through increased child protection initiatives.

The Relationship of Community Ownership to Sustainability

Community engagement and self-reliance are essential to sustainable orphan care initiatives. Sustainability refers to the continuation of services beyond the funded period (Wessells, 2009). The most critical factor is community ownership is that members are active directors and participants in the program. Other factors include networking capabilities between agencies, support of key stakeholders, positive recognition for efforts, cooperation, and successful goal achievement (Wessells, 2009; World Vision, 2005).

Cultural sensitivity is necessary for sustainability. Success must be framed in Malawian ideals, not western ideals. The terminology surrounding the ‘sustainability’ literature resounds the western ideals of ‘success’: self-reliance, goal achievement, ownership, teamwork, and recognition. By contrast, African moral reasoning values communal harmony above the highly prized western ideal of self-interest (Mfutso-Bengo & Masiye, 2011). The fundamental challenge is how to sustain the African cultural ethic of communal philanthropy in which a high social value is placed on non-material help, such that helping is valued in the act itself, not by the quantity or monetary value (Wilkinson-Maposa, Fowler, Oliver-Evans, & Mulenga, 2005). Community-based orphan care, therefore, must be rooted in the tradition of community philanthropy. Failure to render culturally sensitive community aid to children may result in unintended consequences of robbing citizens of the satisfaction of caring for their own people, as in the case of this resident from Lilongwe, Malawi:

> We appreciate the outsiders taking care of our children, but of course, we always know that it is because they have so much money. They drive around in their

> Land Rovers and we just think, “Of course, if I had that much money, *I* could help my own children.” If we could choose between having outsiders [solve the problem] with their money, and finding a way to get our own money and do it ourselves, I think most of us would rather perform the services ourselves (Zimmerman, 2005, p. 911).

Summary

The response of Malawian impoverished communities to care for increasing numbers of children orphaned from HIV/AIDS demonstrates a remarkable adaptability and resilience. Vulnerability in the Malawian context is associated with the notion of loss of parental care or parental economic provision. Youth-headed households are considered one of the most vulnerable groups of children because of the loss of adult protective care. Successful community-based programs must rely on indigenous ideas of child vulnerability, culturally-acceptable forms of helping children in extreme need, and intrinsic sustainability. Measures of vulnerability remain the norm in the research on youth-headed households, but are too limited in scope for understanding children's holistic well-being. To further the effectiveness of community-based care programs serving youth-headed households, studies of children's ideas and experiences of well-being are needed.

Chapter 3

State of the Science: Health, Well-Being, and Vulnerability

This chapter is devoted to a comparative analysis of vulnerability and well-being from perspectives that are both theoretical and practical. In this chapter, I describe the philosophical and practical advantages of a well-being research framework for the study of orphan well-being. I assert that unquestioned allegiance to the framework of vulnerability ultimately limits-- and undermines-- efforts to improve the well-being of orphans. Vulnerability research frameworks must be complemented with well-being research frameworks if orphan well-being is to be understood as more than just varying degrees of adversity and morbidity.

The vulnerability risks of orphans fall into two broad categories: income risk and social risk. Income risk affects the provision of basic needs (food, shelter, education, health care). Social risks are bounded in interpersonal relationships. The boundary between income risk and social risk is a permeable one, because “wellbeing is not the state of individual bodies but of bodies in society,” (Manderson, 2005, p. 12). Reliance on wealth indicators as a proxy for well-being is problematic because it excludes the social context of well-being and ignores the ontological characteristics of humans as social beings. The holistic complexity of human nature means that well-being is not the absence of vulnerability -- indeed, well-being can and does exist within adversity.

Health and Well-Being

Health and well-being are two different, related concepts, yet no real consensus exists regarding conceptual distinctives (Acton, 1994). A brief overview of the dilemma is presented here as a backdrop to the analysis of vulnerability and well-being research frameworks.

Modern definitions of well-being overlap, and include positive emotions, high quality relationships, physical health, mental health, life satisfaction, and happiness (Astedt-Kurki, Hopia, & Vuori, 1999; Chu, Saucier, & Hafner, 2010; Dirksen, 2000). In general, *health* is subsumed in *well-being*. *Health* is “the state of being free from illness or injury; a person’s mental or physical condition” (Stevenson & Lindberg, 2010b). *Well-being* is the experience of a “good or satisfactory existence” (Dictionary.com, 2012b). The nature of human existence is a holistic one, meaning that the comprehension of the parts of life and health are “intimately interconnected and explicable only by reference to the whole,” (Stevenson & Lindberg, 2010c). Modern definitions of well-being overlap, and include positive emotions, high quality relationships, physical health, mental health, life satisfaction, and happiness (Centers for Disease Control, 2011).

The *Constitution of the World Health Organization* (1946) equates health with well-being: ‘‘Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’’ (p. 2). The profession of nursing values the protection, maintenance, and strengthening of well-being of individuals and populations because nursing recognizes health as a holistic concept that includes physical health, livable environments, and social support (American Nurses Association, 2012; F. M. Andrews & Withey, 1976). The nursing model of health is about ‘optimization’, a word that keenly resounds of well-being:

> Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and

> treatment of human response, and advocacy in the care of individuals, families, communities, and populations. (American Nurses Association, 2012)

The belief that health is consistent with well-being is reflected in many nursing theories (Newman, 1986; Parse, 1992; Watson, 1985). Dorothy Orem (2001), nurse theorist, has developed perhaps the clearest definitions of health and well-being. Orem states, "*Health* is used in the sense of a *state* of a person that is characterized by soundness or wholeness of developed human structures and of bodily and mental functioning," (p. 186). Orem (2001) elaborates on well-being as an experiential state of personal perception:

> *Well-being* is used in the sense of individuals' perceived condition of existence. Well-being is a state characterized by experiences of contentment, pleasure, and kinds of happiness; by spiritual experiences; by movement toward fulfillment of one's self-ideal; and by continuing personalization. Well-being is associated with health, with success in personal endeavors, and with sufficiency of resources. However individuals experience well-being, their human existence may be characterized by features of well-being even under conditions of adversity, including disorders of human structure and functioning. (p. 186)

Demarcation of *health* and *well-being* into conceptually clear constructs is an elusive, difficult task (Acton, 1994). For the World Health Organization (1946), *health* is synonymous with *well-being*, but for Orem, *health* is a state of physiological and anatomical ‘wholeness’ of the mind and body, while *well-being* is an experience that is inclusive of, but not directly dependent upon one's health state. The conceptual ambiguity between *health* and *well-being* rests in the aspect of holism, or 'wholeness', that attends to *both* states. This is most apparent in *The Constitution of the World Health Organization's* (1946) metaphor of *harmony* in child health: "Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development," (p. 2). The phrase, 'healthy development' encompasses Orem's (2001) complementary ideas of health (a state of mind-body functional congruity) and experiential well-being. The phrase, 'the ability to live harmoniously' captures the essence of *resiliency*, in which human responses to stress and adversity are active, not passive, processes (Rutter, 2000). The term, 'development', implies the complex, holistic process of living with, and living in, the world in which children find themselves (Manderson, 2005). As both a social and individual phenomena, the well-being of children is always associated with social support (Chu et al., 2010).

Social support is not the same as attachment to another person. Attachment is a form of belonging to another that invokes a sense of security, trust, and often love (Bowlby, 1969). In child development science, attachment theory is rooted in the idea of belonging meaningfully and in right relationship to a caring adult, usually a parent, who nurtures, protects, and communicates positively with the child (Bowlby, 1969). The landmark research by Rene Spitz in the 1940s demonstrated that attachment deprivation is deadly: 30% of babies up to age 1 year die without emotional nurturing and meaningful interaction from a loving adult, even when food, shelter and medical needs are met. From this discussion, well-being can be stated as an ever-fluid experiential state

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of response processes of the holistic self to available opportunities in the quest to achieve a ‘normalcy’ set point (Costanza et al., 2006).

Quality of Life

The concept of well-being is consistent with *quality of life*, which is defined as “individuals' perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns” (World Health Organization, 1996, p. 5). As an individual perception, *quality of life* does not measure symptoms, disease, or conditions, but may include the *effect* of health on quality of life.

A concept related to *quality of life* is *health-related quality of life.* Research on *health-related quality of life* dominates the nursing literature because health is a holistic experience that is inseparable from quality of life (Watson, 1985). Moons (2004) argues that *health-related quality of life* is used in research to mean a persons’ *self-perceived health status* (or functional ability), and is therefore not a quality of life *resulting from* health status. *Health-related quality of life* implies that *quality of life* may be dichotomized into health-related and non-health related domains of life. The nuanced consequence of this dichotomy is if *health-related quality of life* is interpreted as a measure of quality of life rather than a measure of perceived health status, then the influence of health will be overestimated, and non-health influences will be underestimated, all of which may lead to erroneous conclusions about health states, quality of life, well-being, and patient populations (Moons, 2004).

Health researchers tend to focus on the extent to which a specific intervention contributes to subjective well-being, and use a variety of theoretical assumptions which may or may not be in accordance with the assumptions of subjective well-being as it has been formally posited by Diener (Diener, 2009c; Scorsolini-Comin & dos Santos, 2010). Dedicated research to subjective well-being is needed in health and nursing research but must be based on a consistent theoretical foundation if scientifically rigorous nursing knowledge of well-being is to be advanced. As Scorsolini-Comin & Santos (2010) point out, theoretical and methodological refinement is required to advance the science of subjective well-being within health care. Certainly, a semantically discrete, transdisciplinary, vocabulary would eradicate the confusion surrounding the cornucopia of overlapping terms like *quality of life, health, well-being, health-related quality of life, positive emotion, emotional well-being, self-esteem, satisfaction with life, psychological well-being, spiritual well-being,* and *positive living.* I propose the term, *holistic well-being,* because it is readily understandable in the nursing, health, and psychology domains, and is conceptually consistent with *subjective well-being* and *holistic health,* while escaping the conceptual problems of *health-related quality of life* and *quality of life.*

Physiological Measures of Well-Being

The surge of research on the neurophysiological basis of well-being is supportive of nursing's philosophical assumption that health is holistic, consisting of inseparable, interlinked processes that reciprocally interact with multiple human and non-human environmental phenomena (Newman, 1986; Parse, 1992; Watson, 1985). Orphans, especially institutionalized orphans, may suffer social deprivation resulting in abnormal development and maladaptation across every domain: physical, emotional, cognitive, and social dimensions (St. Petersburg-USA Research Team, 2008). It was only in the last century, that severe social deprivation (lack of physical contact and love) of otherwise healthy children, resulted in early death, usually by age 2 years (Spitz, 1965). The cumulative research on the human brain reveals the true essence of holistic health: the brain is dependent upon positive human interaction for appropriate development, survival, and well-being (Cozolino, 2006).

Nurture deprivation adversely affects DNA. A study of Russian orphans ages 7-10 who were institutionalized since birth display detrimental epigenetic DNA changes of genes that regulate the immune response and of cellular signaling systems that are integral to normal brain development and neurological function (Naumova et al., 2012). These changes were not evident in age-matched controls raised by biological parents. When children are neglected, abused, or traumatized, physiological changes of the brain and body result in malfunction that is inconsistent with well-being and long-term survival (Cozolino, 2006).

A multitude of studies on the health status of African orphans has emerged in response to the AIDS epidemic in sub-Saharan Africa. The child health findings in the following study by Kidman and colleagues (2010) suggest child illness results from major disruption of the parent-child caregiving relationship. Based on a secondary analysis of the Malawi Integrated Household Survey 2004-2005, Malawian children ages 6-17 years, showed no clear association between orphan status (maternal, paternal, or double orphan) and poor health, even after controlling for AIDS-related exposures and socio-demographic variables, but children living with a sick parent were twice as likely to be sick or injured (Kidman, Hanley, Subramanian, Foster, & Heymann, 2010). The pathway for increased health risk of children with sick parents was hypothesized as due to illness exposure, but this was confounded by the finding that orphans living with sick relatives or living in a household with a recent adult death was *not* linked to poorer health. Could it be that a new-onset deficiency of benevolent caregiving between parent and child in the context of parental illness triggers a physiologically-mediated reduced immune response in the child that heightens susceptibility to illness?

Physiological correlates of stress (cortisol, immune, cardiovascular, and sleep parameters) have been extensively studied in the context of disease risk, but have only rarely been considered in relation to well-being. Ryff, Singer, & Love (2004) used physiological correlates to distinguish between eudaimonic (self-development, personal growth, and purposeful engagement) and hedonic (happiness and contentment) types of well-being in aging women. Healthy physiological correlates of well-being (lower body mass index, lower cortisol levels, lower levels of inflammatory marker IL-6, lower hemoglobin A1C, higher good cholesterol, better cholesterol ratios, and better quality sleep) were found for eudaimonic well-being, but not for hedonic well-being, even after controlling for depression. This supports the findings in the psychology literature that happiness is a separate concept from well-being (Diener, Tamir, & Scollon, 2006).

Orphan Research in Vulnerable Population Research

Vulnerability is a complex, negatively valenced concept. An absolute definition is elusive because child vulnerability is context-dependent and socially defined. In the broadest sense, a 'vulnerable' person is at risk for injury of any kind, being 'woundable' in terms of age, sex, gender, income, nutrition, disability, environment, housing, education, personal relationships, or health care access (Dictionary.com, 2011). Vulnerability in children is thus multi-dimensional, cutting across many sectors of a child's life.

The most devastating event for a child, the loss of a parent through death or desertion, potentiates vulnerability to inadequate provision of basic needs, poorer health, psychological stress, and loss of adult protection (G. Andrews et al., 2006; Van der Heijden & Swartz, 2010; Whetten, Ostermann, Whetten, O'Donnell, & Thielman, 2011). In the case of HIV/AIDS, child vulnerability begins with parental illness, not with death (Harms, Jack, Ssebunnya, & Kizza, 2010).

The majority of orphan research is from the perspective of vulnerability. The wide acceptance of morbidity, such as vulnerability, as a proxy measure for well-being severely limits any accurate and meaningful understanding of subjective well-being. Studies that assess vulnerability are generally limited to a quantitative statistical analysis of socio-economic indicators of vulnerability such as income, education, food security, emotional health, physical safety, and shelter. For example, cross-sectional descriptive data indicates Malawian orphans are poorer, less likely to be in school, have fewer basic possessions and less health care access (UNICEF Malawi, 2006). Common psychological vulnerabilities are bereavement and depression (Richter, Foster, & Sherr, 2006). The propensity to evaluate orphans through the vulnerability lens is similar to the emphasis on psychopathology in the child development literature (Huebner & Diener, 2008).

Quantitative socio-economic data on vulnerable children are useful in tracking indicators relative to national economic measures but cannot account for significant positive and negative *experiences* that contribute to one's quality of life (Costanza et al., 2006). For example, protective factors against depression in orphans are related to belonging: a nurturing caregiver relationship, remaining with siblings, socioeconomic security, peer relationships, and school attendance (Bauman & Germann, 2005; Cluver & Gardner, 2007). If researchers rely on socio-economic indicators as a proxy for well-being, the actual quality of life of a vulnerable population is missed entirely, and significant factors for quality of life, like belonging, are never identified. Disturbingly, much of the nursing research on well-being, like the orphan literature, uses depression instruments as a measure of general and psychological well-being (Acton, 1994). A deficit approach of vulnerability or psychopathology usurps any attempt to describe a child as more than their disability or vulnerability status. Methodologically and theoretically, this approach is inconsistent with the philosophy of nursing that esteems wellness and holistic health. Thus, it is a serious scientific error to interpret a negative health state as the measure of overall well-being.

The Conceptual Imperialism of Vulnerability

Deficit approaches in health research (like vulnerability) holds populations captive to their ‘problems’ through taxonomies of illness and deprivation, a phenomena of ‘conceptual imperialism’ (p. 115) (D. Smith, 1990). The labels we assign to groups tends to become a self-fulfilling prophecy (Madsen, 1999). The pervasive conceptualization of orphans as problematic and vulnerable tends to objectify and marginalize them. Madsen (1999) argues that the term, “multi-problem poor” be replaced with “multi-stressed poor” as an acknowledgement of the strengths and knowledge these families employ to address the challenges of their lives. The orientation of the orphan as vulnerable leads to a perpetual, even possibly self-fulfilling, focus on vulnerability. The predominance of negative measures of children’s well-being (for example, depression) leaves no option but to continue descriptions of children in terms of disability, deficiency, or vulnerability (Huebner & Diener, 2008). Just as I have argued for a focus on well-being instead of vulnerability, Madsen (1999) argued for a focus on the 'nonproblematic future', rather than on the problematic present.

Ambiguities of Vulnerability and Well-Being

Ambiguity of the relationship between vulnerability and well-being leads to the erroneous assumption that alleviation of vulnerability is synonymous with well-being. This research abstract is evidence of this line of thinking (G. Andrews et al., 2006):

> A key problem in the literature on the impact of orphanhood on the well-being of children, families and communities, is that the focus of assertions and predictions is often on the negative impact on 'AIDS orphans', or households. There are hardly any studies that compare the experiences of orphans with non-orphans. This paper thus attempts to fill that gap…. data in this paper indicates that orphans in sub-Saharan Africa are more vulnerable than non-orphans. (p. 269)

Andrews, Skinner, & Zuma (2006) begin with an emphasis on their belief that researching orphans from a well-being framework is needed in light of the "key problem" of an emphasis on the negative situation of AIDS orphans. Vulnerability was defined within the article in terms of social and health variables: "Vulnerability to infection with HIV, dropping out of school, development problems through lack of food, social problems due to not being cared for, or being denied a role model," (p. 270). Five variables of orphan vulnerability were examined: orphan status, household structure (such as grandparent or female-head), parental illness, poverty, and access to social services (education, health, and access to grants). Well-being was never defined. One sentence referenced 'health' as an indicator of well-being. In the end, this was a study of orphan vulnerability, not orphan well-being. If well-being is a literal end-point on the vulnerability conceptual spectrum, then one might reasonably argue this was also a well-being study. That would be a false conclusion, though, because well-being is not on the same conceptual spectrum as vulnerability. Rather, well-being is *different* from vulnerability, yet is mediated by vulnerability.

Vulnerability from lack of basic needs is straightforward: Children need food, water, shelter, and safety. Vulnerability from loss of family and loss of belonging is not easily answerable with a 'fix it' strategy. Moving solutions from the family to external sources potentially undermines kinship structures by disengaging the family from the children whose well-being is their responsibility and privilege.

Vulnerable, "at-risk" populations suffer socio-economic deprivation that results in health disparities like poverty and malnutrition (Marmot & Wilkinson, 2006). When vulnerability is considered synonymous with health disparities, then health is never logically achievable as long as health disparities exist. The problem is that the most common measures of 'health' status are actually measures of morbidity and mortality, and not health in the holistic sense of well-being, as per Orem (2001) (Wolfson, 1994).

Summary

Health, vulnerability, and well-being are fraught with conceptual ambiguity, which has led to a focus on morbidity and mortality as the measure of 'health', leaving the psychological effects of well-being on morbidity and mortality virtually untapped. Vulnerability and well-being are not mutually exclusive concepts, but rather interacting concepts (Biswas-Diener & Diener, 2006; Orem, 2001).

If the purpose of nursing is to improve the totality of people’s well-being, and to understand the processes that affect well-being, then the pathognomic model of disease is conceptually inappropriate for the study of well-being. For orphans, the physical, psychological, and social stakes are high, and the response should not be a singular focus on vulnerability, but a wide, panoramic examination of the positive factors of well-being to complement and augment the vulnerability research data. If the well-being of vulnerable children is the desired end-point, then well-being must be the theoretical starting point.

Chapter 4

State of the Science: Subjective Well-Being

The nursing profession has dedicated itself to the optimization of human well-being through the development of theory, research, and practice (American Nurses Association, 2012). As a holistic outcome, well-being cannot logically be equated with the mere absence of negative experiences or conditions, nor purely the presence of positive experiences or conditions, nor related to any one dimension of life, such as health or disability. Well-being is a holistic concept that requires a holistic methodology. The concept of subjective well-being was selected for this study because of the centrality of self-appraisal of one's well-being as the outcome of interest.

The Concept of Subjective Well-Being

Ed Diener (1946 -), the Joseph R. Smiley Distinguished Professor of Psychology at the University of Illinois, is the most prolific researcher on the science of *subjective well-being*. Diener has authored over 325 publications, and is the most-cited psychologist in the world, with 80,557 citations as of May 2, 2014 (Google Scholar, 2014). Sixteen papers are mega-citation classics (over 1,000 citations), including: (1) “Subjective Well-Being,” Diener's landmark paper published in 1984, and (2) “The Satisfaction With Life Scale”, published in 1985, the most widely used assessment instrument in subjective well-being research (Diener, 1984; Diener, Emmons, Larsen, & Griffin, 1985; Larsen & Eid, 2009). In 2012, Diener received the prestigious Distinguished Scientist Lifetime Career Award by the American Psychological Association (American Psychological Association, 2012). As a Senior Scientist with the Gallup Organization, Diener collaborated on the first global poll on well-being, covering

123 countries (Kahneman & Deaton, 2010). The scientific progress on subjective well-being has expanded into cross-cultural population studies across the world, including the poorest people in Calcutta, the Kenyan Maasai, the Amish, and Greenland Inughuit (Biswas-Diener & Diener, 2001; Biswas-Diener, Vitterso, & Diener, 2009).

Subjective well-being is concerned with the individual's global perspective of how satisfied they are with life, and consists of both cognitive and affective judgments. The holistic nature of subjective well-being transcends the pathognomic medical model, and is therefore inherently germane to the philosophy of nursing. The conceptual difficulties with *health-related quality of life* and *quality of life* as proxies for well-being are also overcome with the concept of *subjective well-being*.

The concept of subjective well-being is not a unitary dimension, nor related to a single index of measurement, because it is an overall sense of personal satisfaction with one's life. The science of subjective well-being reflects the intuitive ways people evaluate their lives, the personal satisfaction they experience regarding their lives, and in this sense, represents a broad array of distinct and culturally dependent components. In contrast, *objective well-being* refers to socioeconomic indicators such as income and educational level, and epidemiological health indicators of morbidity and mortality (World Health Organization, 1996).

Subjective well-being is in a sense, a measure of happiness, and has been universally rated by people worldwide as very important to their lives, more so than money (Diener, 2000). Subjective well-being leads to positive life outcomes of longevity, sociability, creativity, healthier immune function, better citizen participation at work, and increased income, suggesting that high subjective well-being at the individual and societal level is extremely desirable (Larsen & Eid, 2009). The extensive research on subjective well-being indicates there is no *single* determinant of subjective well-being, though some conditions like positive social relationships are correlated with well-being (Diener, 1984; Larsen & Eid, 2009). International differences in subjective well-being show positive correlation with income, societal equality, human rights, and individualism (Diener, Diener, & Diener, 1995).

Three Hallmarks of Subjective Well-Being

Three hallmarks characterize subjective well-being: (1) It is subjectively experienced by the individual; (2) It is comprised of positive experiences, and not merely the absence of negative experiences; and (3) It is an overall, global, subjective assessment of one's individual life, not a domain assessment (e.g., health or wealth). These properties interact at the cognitive and affective (emotional) level to produce a mediation effect upon life circumstances (F. M. Andrews & Withey, 1976; Easterlin, 2006).

The Three Components of Subjective Well-Being

Life satisfaction, *positive affect,* and *negative affect* are the three components theorized to constitute subjective well-being. The term, *affect,* as it is used throughout the decades of subjective well-being research and in this dissertation, means 'feelings or emotions', as opposed to the psychiatric meaning of *affect* as an observable expression of emotion (Diener & Iran-Nejad, 1986).

Life satisfaction was first identified as the cognitive component of subjective well-being in the mid-1970s (F. M. Andrews & Withey, 1976). As a cognitive judgment, life satisfaction is different than happiness, which is a feeling (Campbell, Converse, & Rodgers, 1976). Life satisfaction measures are self-reported, and defined as an integrated judgment of one's life over the past few weeks, or one's entire life, depending upon the research question (Schimmack, Diener, & Oishi, 2009). Life satisfaction also includes satisfaction with specific domains of life such as marriage, work, and leisure.

Positive affect refers to frequent pleasant emotion and infrequent unpleasant emotion (Diener, 2009c). Positive emotions are more controllable, more highly subject to socialization effects, and not correlated (in most countries) with positive affect (Diener, 2009c). Subjective well-being takes into account both negative and positive affective judgments. Negative emotions may be related to situational and personality factors. Bradburn (1969), in a landmark breakthrough, showed that positive affect and negative affect are two separate, distinct entities that interact concurrently, and do *not* represent two polar ends of the same spectrum.

Negative affect experiences co-exist with positive affective experiences, such that there is no dichotomy between positive and negative experiences (Biswas-Diener & Diener, 2001; Cluver & Gardner, 2007). Because euphoric happiness is not the goal of subjective well-being, functional aspects of subjective well-being include negative feelings, such as when people sacrifice their happiness for other goals, and when people want to feel happiness and pleasure for the right reasons. In this sense, an ideal form of subjective well-being is found in people's goals, feelings, and values, and how these dimensions function to inform and direct one's subjective well-being.

Subjective Well-Being as an Objective Concept

Subjective assessment of well-being reflects the interests of the persons being assessed, for only if a life is going well, does the individual describe it as positive well-being (Diener, 2009c). Thus, it is the person’s subjective evaluation that is the point of reference, for no one else can describe one’s sense of well-being except the individual.

A person's answer to the question, “How satisfied are you with your life as whole these days?” is indicative of their subjective well-being (Kahneman & Deaton, 2010). Well-being, therefore, exists only when the person (even a child) perceives it as existing, and in that sense, their endorsement becomes an objective statement (Huebner & Diener, 2008). Diener, Lucas, Schimmack, et al., (2009) extends this argument further when he states that economic utility is analogous to the subjective definition of well-being, because utility is defined solely from the individual’s perspective. For example, even basic life needs (food, water, shelter) are subjective by nature because people consider these provisions desirable. When health is understood as just one indicator of many that influence the state of subjective well-being, then health becomes a personal *resource* for achievement of life goals, personal resilience, and meaningful interpersonal relationships rather than a *primary indicator* of well-being, as in *health-related quality of life.*

Temperament and personality may account for a substantial aspect of subjective well-being. Extraverts are more likely to report positive emotions, a finding that extends across cultures (Lucas, Diener, Grob, Suh, & Shao, 2000). Heritability may account for 40% of the variance in positive emotions and 55% of variance of negative emotions, whereas family environments are associated with 22% and 2% of positive and negative emotionality, respectively (Inglehart & Klingemann, 2003).

Cross-Cultural Research on Subjective Well-Being

The explosion of subjective well-being research that was ignited in the 1970s has led to the general finding that most Americans, regardless of race, income, education, sex, or age, are happy (Myers & Diener, 1995). International studies are growing and also indicate that most people are happy, and that life satisfaction and happiness are both ranked in importance well above a neutral level (Diener, 2000). Subjective well-being is pertinent to all cultures, though the factors that inform one's cognitive and emotional appraisal are culture-specific. Cultural differences between nations depend on local cultural norms that govern the regulation of positive emotions and the experience of social appraisal (Eid & Diener, 2001). For example, subjective well-being in western cultures demonstrate an interrelatedness of global self-esteem with global life satisfaction based on the domains of assessment that may be common to both, such as self-evaluation of family life, academics, peer relationships, and oneself (Huebner, Gilman, & Laughlin, 1999). By contrast, cross-cultural studies of subjective well-being in in collectivist, community-oriented, non-western cultures, like Africa, indicate that self-esteem may not be salient to one's subjective well-being (Tov & Diener, 2009).

Collectivist cultures rely more on social appraisal in life satisfaction judgments compared to individualist cultures (Tov & Diener, 2009). Among individualistic countries, strong correlations of self-esteem and global life satisfaction were identified, but collectivist countries showed weak correlations, demonstrating that the magnitude of the relationship between self-esteem and global is culture-dependent (Diener et al., 1995).

Cultural norms influence the affective component, that is, the emotional experiences, of subjective well-being. Emotions are regulated at least in part by cultural norms as far as what emotions are desirable or undesirable (Diener & Tov, 2007). People tend to report greater frequency of emotions they value and fewer of emotions they devalue (Eid & Diener, 2001). It is unclear if the reporting of emotions in children occurs in an attempt to reflect the valued emotions of the culture or if the valued emotions are reported because people are socialized to experience certain preferred emotions and therefore experience valued emotions more frequently (Tsai, Louie, Chen, & Uchida, 2007).

Cultural values exert a normative influence on subjective well-being. In collectivist cultures, the goals of a group may be experienced as one's own, therefore well-being may be as much a collective sense as well as a personal sense of well-being (Mfutso-Bengo & Masiye, 2011; Tov & Diener, 2009). Subjective well-being is enhanced when there is a positive *person-culture match:* that is, when the individual personality matches the aggregate societal personality of a culture by a self-validating effect that one "fits in" with the culture and is similar to other persons that are found in their social contexts (Fulmer et al., 2010). In Fulmer and colleagues (2010) study, robust data from over 7,000 individuals across 28 societies from two multilevel studies using three large-scale multicultural datasets generated consistent positive associations of self-esteem and subjective well-being for person-culture match (Fulmer et al., 2010). When an individual personality trait influences self-esteem/well-being, the relationship for that trait intensifies when the aggregate culture also values the same personality trait (Fulmer et al., 2010). The interplay between culture and subjective well-being means that as cultures shift with time, life satisfaction factors may vary across generations and within individuals (Diener, 2009c). Cross-cultural studies are needed to discover how values and culturally-prescribed activities influence subjective well-being, beginning with qualitative analysis to discover what meanings are attributed to well-being and what factors are associated with well-being (Diener, 2009c).

Subjective Well-Being of Children

Like adults, children as young as age eight are capable of giving a rational account of their own well-being (Biswas-Diener & Diener, 2006; Huebner, 2004). Among American children, life satisfaction reports by children (normal children and children with mild disabilities) have been validated by significant adults like parents and teachers (Huebner, Brantley, Nagle, & Valois, 2002). Qualitative analysis of children's well-being narratives reveals a strong sense of social responsibility and the need for belonging and affection (Chege, 2005; Cluver, Gardner, & Collishaw, 2010; Fattore, Mason, & Watson, 2007). Most children report life satisfaction above the neutral point, but very few report the highest levels of satisfaction. Life satisfaction does not differ significantly as a function of the child's age or gender (Huebner & Diener, 2008). The strongest correlate of life satisfaction of children ages 8-18 is perceived positivity of family relationships, and to a lesser extent, peers, and teachers. Trust is the most salient attachment variable for life satisfaction in both parent and peer interpersonal relationships (Nickerson & Nagle, 2004). Emotional support from parents is perceived as a strong predictor of life satisfaction of adolescents (Suldo & Hubener, 2004). Children who are very unhappy demonstrate pervasive difficulties of behavior, substance abuse, and risk taking (Huebner & Diener, 2008). Not surprisingly, emotional self-efficacy has also been linked to children's life satisfaction (Suldo & Hubener, 2006).

The highest life satisfaction ratings among American children are related to three major individual variables: high self-esteem, emotionally stable temperament, and an internal locus of control (Huebner & Diener, 2008). Huebner, Gilman, & Laughlin (1999) demonstrated the ability of children to differentiate global life satisfaction from global self-esteem, indicating that self-esteem is related to, but different from, life satisfaction. Attribution style, defined as how life events are interpreted as positive or negative, also significantly predicts life satisfaction, while IQ scores do not (Huebner & Diener, 2008). People from poor families or worse environments than average might benefit more from a degree of negative affect if it motivates a personal desire to pursue change (Diener, Nickerson, Lucas, & Sandvik, 2002).

As of this writing, there have been no studies of the subjective well-being of children in African communities. Expansion of the subjective well-being research into vulnerable child populations in the HIV-endemic regions of sub-Saharan Africa would contribute to a fuller understanding of what factors drive African children's subjective well-being.

The Influence of Adverse Life Events on Subjective Well-Being

The bias that less affluent and disadvantaged people are miserable, based on focal attributes (for example, poverty or depressions), is known in psychology and behavioral economics as the 'focusing illusion' (Schkade & Kahneman, 1997). A similar notion is the 'pathetic fallacy' whereby observers see victims of misfortune as more distressed than the victims see themselves (Brickman & Coates, 1978). Both the focusing illusion and pathetic fallacy are forms of bias that may affect the research initiatives on orphans in sub-Saharan Africa. The suspicion for these types of bias is aroused when the majority of the research interest of youth-headed households centers on their vulnerability.

An intriguing study by Brickman, Coates, & Janoff-Bulman (1978) demonstrated the 'focusing illusion' and the 'pathetic fallacy'. Using a mixed methods approach of interviews and Likert scales for self-appraisal of happiness and everyday pleasure, lottery winners were not any happier than paraplegics, suggesting that observers tend to overestimate the duration, generality, and importance of people’s feelings. The 'focusing illusion' and the 'pathetic fallacy' are evident in the public media stereotype of orphans as poor, weak, and miserable. This stereotype of orphans as pitiful victims as objects of charity, when paired with the vulnerability research paradigm, has led to a scarcity of well-being research on orphans.

The popular opinion that poverty is misery was challenged by Biswas-Diener & Diener (2001) who examined life satisfaction among slum dwellers (n=83) in Calcutta to assess the effects of extreme material poverty on subjective well-being. Three groups were sampled: slum dwellers (n=31, mean age 31.9), homeless dwellers (n=32, mean age 43.2), and brothel sex workers (n=20, mean age 30.8). The participants responded to questions about global life satisfaction and 12 specific life domains (material resources, friendship, morality, intelligence, food, romantic relationship, family, physical appearance, self, income, housing, and social life). Global life satisfaction means were less than the control group of college students and slightly less than the neutral value of 2.0 (1.93 vs. 2.43, $p<0.05$). Slum dwellers had the highest life satisfaction of 2.23, sex workers 1.81, and pavement dwellers 1.60, yet positive ratings of satisfaction were found for all specific life domains. The domains of morality, self, physical appearance, family, romantic relationships, and friends were all significant predictors of global life satisfaction. Though this study was limited by small sample size of adults, small geographical area, and cultural homogeneity, it demonstrates that positive aspects of life can and do exist among those in abject poverty and suggests that the poor may not suffer to the degree that outsiders traditionally expect.

Summary

Subjective well-being is a global assessment of well-being and life satisfaction that is determined by cognitive and affective judgments, and is independent of co-existing vulnerability or health disparities. The positive effects of subjective well-being are significant across the lifespan for children and adults: longevity, better physical health, positive mental health, healthy social engagement, and overall life satisfaction (Diener, 2009c). Positive subjective well-being is an important health determinant that cannot be investigated using a vulnerability framework because well-being and vulnerability do not constitute polarities of the same conceptual continuum, just as positive and negative affect are not polarities of the same continuum (Bradburn, 1969; Centers for Disease Control, 2011; World Health Organization, 1946).

The implications of subjective well-being for vulnerable children and orphans, and more specifically, youth-headed households, is three-fold: (1) Subjective well-being is a reliable overall assessment of holistic health, (2) Subjective well-being has adaptive value for life transitions, and (3) Subjective well-being is related to health, social relationships, and resilience. The concept of subjective well-being is a relevant model for orphan research because it translocates the idea of well-being from the deficit orientation of ‘well-being’ as the absence of vulnerability, to within the person's own appraisal of life satisfaction, regardless of circumstances.

Chapter 5

Methodology

The purpose of this exploratory, qualitative study was to describe the subjective well-being experiences, factors for regulating well-being, and meanings of well-being from the perspective of youth heads of households in rural southern Malawi. By analyzing how youth speak about their lives, how they frame their experiences, and what factors they attribute to their well-being, insight is gained into what well-being means to these children, how they promote and protect their well-being, and how well-being is experienced. A narrative approach guided the analysis since the nature of subjective well-being is embedded in one's descriptions and judgments of personal experience.

Theoretical Commitments

Theoretical commitments form the foundation for conceptual refinement within the research design (Bloomberg & Volpe, 2008). Two theoretical constructs were chosen for this study: (1) Diener's model of subjective well-being, and (2) Orem's nursing concept of health and well-being. The complementary nature of these theories rests in the emphasis on the synergistic relationship between health and well-being.

Diener's Model of Subjective Well-Being

Diener's model of subjective well-being was selected as the primary framework for two reasons: (1) Youth-headed households have not yet been studied within a well-being framework, and (2) Diener's work has resulted in application of subjective well-being research across multiple contexts, including children's well-being, intercultural studies of well-being, and national indices of well-being. Subjective well-being means that respondents are capable of rendering an accurate self-appraisal about their well-being. Self-appraisals are consistent with the factors that respondents identify as salient to their well-being (Schimmack et al., 2009). In this sense, subjective well-being is objective, whether measured quantitatively or qualitatively. Diener's model has not yet been implemented in studies of Malawi, and must therefore begin with qualitative inquiry (Diener, 2009a). With so little known about the well-being factors of Malawians, and even less about Malawian orphans, an early commitment to a rigid model of well-being would be a methodological error. By contrast, Diener's model is conceptually open, broad, and sufficient to accommodate cross-cultural qualitative inquiry.

Orem's Nursing Concept of Health and Well-Being

The nursing discipline emphasizes a multi-factorial, multi-disciplinary approach to healthcare, in which health is understood as a complex phenomenon across a variety of populations (individuals, families, social networks, communities, and nations) (Orem, 2001). The primary end of nursing research is to generate evidence-based practice that results in the improved health and welfare of human beings. Ultimately, the judge of health and well-being is the individual person, and it is for this reason, that children's judgments about what experiences constitute well-being and how they understand their own well-being, must, be elicited directly. Orem posited a theory of nursing as meeting the self-care deficits of persons, which is more broadly explicated as the "protection, promotion, and optimization of health and abilities" (American Nurses Association, 2014).

Rationale for Qualitative Approach

The goal of this study was to elicit in-depth understanding of the perceptions and descriptions of children's well-being experiences. Qualitative research methods presume that an experiential understanding of unique groups of persons is best achieved through the solicitation of holistic, subjective content from research participants (Lincoln & Guba, 1985). The objective of qualitative research, then, is to discover previously unnoticed dimensions of phenomena, which in the case of this study, are the characteristics of subjective well-being that children deem salient (Payne, Field, Rolls, Hawker, & Kerr, 2007).

Qualitative methods aim to describe the constitution, rather than the composition, of the social matrix (Packer, 2011). The constitution of a human phenomena is best described as a "radical realism" in which embodied, social human beings are thought to not live in a dualistic world (mental and physical), rather, they are holistic persons engaged with a material world filled with shared public significance (Packer, 2011). In other words, being human is not an isolated, private experience, but a socially formed experience within a myriad of relationships imbued with values, intentions, and meaning (Packer, 2011; Bakhurst, 1991). Qualitative methods permit exploration and examination of socially-informed, yet distinctly individual abstractions of values, morals, and interpretations, phenomena that otherwise cannot be adequately captured in statistical methods (Greene & Hill, 2009-researching children's experiences).

Narrative Method

The narrative method is instrumental for the discovery of the individual perceptions, beliefs, and rationales that attend personal experience (Riessman, 2008). Children's personal perspectives are a meaningful unit of analysis that is best interpreted from their own viewpoint (Mason & Fattore, 2005).

The idea that children are not mere objects to be analyzed, but rather are competent interpreters and contributors to their social world, is a stance upheld by UNICEF’s Convention on the Rights of the Child (1990). The experience of well-being as a socially contingent phenomena implies an experiential difference between adults and children, such that children’s’ experiences will be best understood when they are the principal informant of their experiences. Huebner & Diener's (2008) research on the subjective well-being of children demonstrate that children as young as age eight are capable of giving a rational account of their lives. Though children are reliable informants of their experiences, their narratives must be heard before they can be acknowledged (Fattore, Mason, & Watson, 2009; Huebner & Diener, 2008; Ben-Arieh, 2001).

Riessman & Quinney (2005) underscore the importance of societal and linguistic contexts of narratives. Taken together, the politics of language, the centrality of the dialogic nature of language, and the structural analysis of rhetoric serve to guard against a reductionist analysis. Riessman’s thematic analysis method is appropriate for two reasons: (1) analysis is an inductive, non-linear process, and (2) discourse is the primary feature of narrative inquiry (Riessman, 1993, 2008). The abstract concept of well-being is communicated not only as a process, but also as a state of being. To analyze a state of being based on narrative transcripts requires sufficient analytical space for concrete details as well as higher abstractions that are informed by the dual *a priori* commitments to Diener's model of subjective well-being and a nursing concept of health (Riessman, 2008). The method permits analytical creativity in how best to position the well-being experiences of vulnerable children within the attendant larger, intangible social structures that are explicit, alluded to, or implied in the narrative. This a noteworthy advantage, because children's narratives of well-being are often directly or indirectly couched in moral terms like 'should' and 'should not', or 'good' and 'bad' (Emond, 2009; Fattore, Mason, & Watson, 2009).

Assumptions of the Study

Four assumptions undergird this study:

1. A youth-centric approach is necessary to discover how children experience and assign meaning to personal well-being (United Nations, 1989).
2. Well-being is conceptually distinct from, but overlaps with, vulnerability (World Health Organization, 1946).
3. Well-being can co-exist with vulnerability (Biswas-Diener & Diener, 2001).
4. Diener's concept of subjective well-being is complementary to the nursing concept of well-being (Diener, 1984; Orem, 2001).

Methods

Purpose of the Study

The objective of this study is to understand the experiences, factors, and meanings of the well-being of vulnerable children who are the heads of their household. The long-term objective is to contribute to the growing body of research on the health and well-being of vulnerable children in HIV-endemic regions of sub-Saharan Africa. This study builds upon the existing service relationship between the University of Wisconsin-Milwaukee College of Nursing and Miqlat Hope Centers of Malawi.

Specific Aim

The specific aim of this study was to identify, analyze, and synthesize the experiences, factors, and meanings of youth well-being as narrated by youth heads of household, utilizing qualitative narrative methods, a focus group discussion of NGO administrators, and casual conversations with adult Malawians.

Research Questions

(1) How do youth-heads of households experience subjective well-being?

(2) What factors do youth-heads of households associate with subjective well-being?

(3) What meanings of well-being can be inferred from youth's narratives?

Research Method

Qualitative narrative study

Primary Data Sources

Four types of data were collected: (1) semi-structured interviews of ten youth-heads of household, (2) focus group with six NGO leaders (3) demographic data of youth households, (4) observation of NGO activities and informal conversations with Malawian adults.

Dissemination of Data Results

This research project is the foundation of a doctoral dissertation. Per the Malawi Ministry of Health National Health Sciences Research Committee protocol, a final report will be submitted, including an abstract, within 3 months of completing the dissertation. The research findings will be further disseminated as follows: (1) Manuscript submissions to international healthcare and nursing journals, (2) Conference presentations, (3) Direct sharing of findings with research participants and their communities, the NGO, Malawi Ministry of Health, and the University of Malawi School of Nursing, and (4) A summary report of data findings for use by the NGO.

Potential Benefits to the Participants and Malawian Society

This study may benefit four groups: (1) Malawian orphans and vulnerable children, (2) Malawian communities, (3) international NGO-directed community-based orphan care programs in Malawi, and (4) the country of Malawi.

Youth may be empowered by participating in this research, knowing they have contributed to the scholarly understanding of vulnerable children. Children feel honored and respected when their stories and opinions are valued (Fattore et al., 2009). The children may benefit directly if the data enhances Miqlat Hope Center program development.

The study has important implications for the health of communities with vulnerable youth. As discussed in Chapter 2, the health benefits of well-being include better physical health, less risk-taking of harmful behaviors, stronger personal relationships with friends, family, and community, helping others, goal-directedness, resiliency through adversity, and healthier lifestyles. An understanding of how youth think of, and experience, well-being may guide community youth development programs. By virtue of strengthening children, the community is also strengthened.

International NGOs operating in Malawi will profit from an expanded knowledge of how vulnerable children experience well-being . As community-based programs seek to broaden their services from material support to non-material support, an understanding of youth well-being will contribute to maximal, long-term impact. Malawi endorses community-based care as the preferred model of care for orphans and vulnerable children, and as such, the study findings may be relevant to Malawi’s ongoing efforts to integrate governmental and non-governmental child protection and well-being initiatives.

Human Subjects Approval

1. University of Wisconsin-Milwaukee Institutional Review Board approval received July 18, 2012, #12.389. Expiration date: July 17, 2013.
2. Malawi Ministry of Health, National Health Services Research Committee approval received June 18, 2012, NHRSC #1029. Expiration date: July 18, 2013.
3. Letter of Support from Miqlat Ministries received April 18, 2012.

Ethical Considerations for Child Subjects

The United Nations Convention on the Rights of the Child has set forth four general principles of children's rights: (1) nondiscrimination (2) the child's best interests (3) the right to benefit from social and economic policies that favor development and survival to adulthood (4) the right to have their opinion heard and duly considered (United Nations, 1989). This research upholds children's rights through adherence to the strict parameters for the protection of child subjects as determined by UNICEF and the United States Department of Health and Human Services (United Nations, 1989; United States Department of Health and Human Services, 2009).

Potential overall risks to children were estimated to be minimal. Safeguards included the multi-level consent process, positively worded open-ended interview questions, and adherence to confidentiality ethics. The interview did not probe sensitive aspects of behavior, sexual behavior, alcohol use, or illegal conduct. If information about the individual youth were to become known outside of the research study, it would pose no significant risk of criminal prosecution, civil liability, damage to financial standing, reputation, or employability.

The interviews were privately conducted at a public facility by the all-female research team. All participants completed the interview. The assent form and interview instructions emphasized to the youth that questions may be declined at will without fear of retribution or forfeiture of the compensation gift. In the case of an adverse event, such as grief reaction, or traumatic responses during the interview, the interview would cease immediately, and the minor will be withdrawn from the study without penalty. The consenting adults of record would be notified, and arrangements made for further assessment and follow-up care as indicated. No youth demonstrated any significant distress, though two shed tears about the loss of a parent. They were offered the option of stopping the interview, but declined. Participants were protected through an ongoing assent process with complete freedom to withdraw at any time.

The social risks were estimated to be minimal, since these risks are reasonably commensurate with those inherent in actual or expected life situations of youth-headed households (United States Department of Health and Human Services, 2009). The effects of these risks depend upon the level of social support, stigma, and personal ability to conduct household activities and care for siblings. Other risks included inadvertent discovery by the public community that the youth is a research participant. Any potential harm from such recognition was considered low and similar to daily encounters.

Compensation to Research Participants

Youth research participants received a modest compensation gift consisting of a pack of sugar, a bar of laundry soap, a bar of bathing soap, a bottle of lotion, a small bag of rice, and a bottle of cooking oil. Miqlat Hope Center provided snacks for the focus group participants and research team.

Protection of Participant Privacy

Privacy of all participants in this study was ensured by strict adherence to confidentiality ethics. Interviews were conducted privately with the Principal Investigator, Research Assistant, and Malawian Research Assistant, all of whom are familiar with research protocols for data control and confidentiality. All interviews and the focus group discussion were digitally audiotaped, and then transferred to a password-protected auxiliary computer hard drive and a portable flash drive. No identifying data was attached to the computer files. Original consent forms and assent forms were kept in a locked file cabinet and will be destroyed after three years, per the Malawi Ministry of Health mandate. Data was conglomerated whenever possible, children's names were redacted, and each child was assigned a random number identifier without reference to gender or location.

Data Collection

Research Team

I had two research assistants for this project: (1) Audrey Tluczek, RN, PhD, University of Wisconsin-Madison, qualitative research consultant and child development specialist, and (2) Carol Beya, Malawian Research Assistant, who translated during interviews, and transcribed all interviews and focus group discussion. Ms. Beya has research experience with qualitative methods and has provided similar services for the University of Wisconsin-Milwaukee College of Nursing's work in Malawi. All researchers had previously completed training on the protection of human subjects.

Research Setting

Duration of study. The research study was conducted during August 8 – August 29, 2012.

Research location. The study was located in rural southern Malawi, one of the most impoverished regions of Malawi. The HIV infection rate is 15%, the highest in the country. Miqlat USA, a faith-based non-governmental organization (NGO), has two community-based care centers, Miqlat Hope Centers, located in Thuchila and Kogoya, each about a 40 minute drive from Miqlat headquarters in Bvumbwe, Malawi, just southeast of Blantyre (MAP). The research team lodged at the NGO headquarters, which enabled ongoing conversations with the administrators and exposure to local culture.

Recruitment Procedures

Written and oral permission for youth to participate in this study was required by 3 adults: (1) the youth's parent/guardian (if available), (2) the local chief, and (3) a Miqlat Hope Center director. The Miqlat Hope Center director notified the chiefs and any guardians of the research opportunity. Miqlat administrators arranged dates for the interviews, and sent word to the youth and guardian, if applicable.

Sample Design

The sampling strategy consisted of a purposive, convenience sample of key participants of ten youth heads of household and six Miqlat Hope Center administrators. During the planning stages, the number of youth-headed households being served by Miqlat was 24 in summer 2011, then by January 2012, the number was 12, and by the time of this study, it was only 6. Miqlat had been able to work with community members to place most of the children in families. Upon my arrival, the administrators, in consultation with the local village chiefs, had recruited 4 additional youth. The age criteria for inclusion was then expanded to accommodate these non-beneficiary households. While some persons were as old as 21 years, they had been the head of their household since mid-adolescence and were able to contribute valuable information to this study. Given the decline in the number of local youth-headed households in the Miqlat program, and given that the research question of well-being of children who act as household head, this change in inclusion criteria was deemed advantageous because it generated a greater variety of experiences. Additionally, the NGO administration felt the older youth provided a substantial benefit to the study in terms of articulating well-being experiences.

Inclusion criteria for research participants.

- Youth between the ages of 8-21 who are the functional head of their household. Initially, the age criterion was 8-17, and then expanded to 21 for the reasons stated above. The lower age limit of 8 years was selected for 2 reasons: (1) It is consistent with the literature demonstrating that children as young as 8 years are capable of a rational appraisal of their well-being (Huebner ***), and (2) young children are known to act as household head, such as in the case of the youngest participant, a ten year old girl, who was found by UWM research professors in 2011, when she was 9 years old girl and caring for her disabled mother and infant sister.
- Households that are headed by a youth means that the youth has assumed the customary adult duties of obtaining food, providing money, caring for siblings, caring for disabled or ill parents, and home maintenance.
- The youth head of household must be fluent in either Chichewa or English.
- The household is not required to be a beneficiary of Miqlat Hope Centers.
- Youth heads of households must be ambulatory and not acutely ill (fever, requiring medical care, unable to attend school, unable pursue usual level of

activity).

- Children with disabilities or chronic, stable illnesses (e.g., HIV) are permitted.
- The youth's parent, guardian, or local chief must give oral and/or written permission for the youth to participate.
- Miqlat Hope Center director must give written permission for the youth to participate.
- Each youth must give oral and/or written assent.

Exclusion criteria for research participants.

- Heads of households over age 21 with no prior history of being the functional head of household.
- Heads of households under age 8.
- Primary language other than English or Chichewa.
- Acutely ill youth.
- Youth for whom permission was denied by the parent, guardian, or local chief.
- Youth for whom permission was denied by the Miqlat Hope Center director.
- Youth who decline to participate.

Consent and Assent Procedures

Consent procedure. In all cases, no parent or guardian gave consent. Since the local chiefs are considered an appropriate proxy for the children in their community, the chief from each district gave verbal and written consent after being advised of the purpose, risks, and benefits of the study. Consent forms were co-signed by a Malawian Miqlat administrator known to the chief and to the child. Dual consent from the chief and Miqlat administrator ensured the children's welfare, in the absence of parents and guardians.

The potential study participants were summoned to Miqlat Hope Center on the designated day by the administrators. After the youth arrived, they met with the research team and administrator, and were offered the opportunity to participate in the study. Risks, benefits, and compensation were presented orally and in writing, questions answered, and assent was confirmed orally and in writing. No youth declined participating in the study.

Assent procedure. In the assent process, the child gives affirmative verbal agreement to participate in the research study, and not merely failure to object (DHHS 45 CFR 46.402 (b)). Assent was documented and witnessed in writing by the child, the Malawian research assistant, a Miqlat administrator, and myself. Regardless of reading ability, the documentation of child assent always reflected witnessed verbal assent. All youth assented to participation in the study.

Interview Guides

Following the lead of other child well-being researchers like Fattore, Mason, & Watson (2007) and Huebner (2008), the first rendition of the interview guide consisted of very broad-based questions about well-being. The first part of the interview guide contained questions about socio-demographic data of the household structure and the family's basic needs. The second part of the interview was structured to elicit descriptions of positive and negative experiences as recommended by Scott Huebner, University of South Carolina psychologist and researcher on children's subjective well-being (Huebner, 2011). Open-ended questions were constructed regarding aspects of subjective well-being: positive and negative experiences, what is good and bad about life, what makes them happy or sad, their perceived strengths, aspirations, the nature of their close interpersonal relationships, and advice they would give to a newly formed youth-headed household. The interview guides focused on the youth's responsibilities, experiences, and interpersonal relationships. Two major revisions of the interview guides were suggested by Dr. Mkandawire-Valhmu: (1) the removal of the term, "well-being" since it has no lexical or conceptual equivalent in the Chichewa language, and (2) adding very specific, concrete questions that could be easily answered by the youth, because Malawian youth are not accustomed to being asked about their opinions. The interview guide was accordingly revised, reviewed, and approved by four members of the dissertation committee and approved by both the University of Wisconsin-Milwaukee IRB and Malawi Ministry of Health (Appendix ?). A similar process was followed for the focus group guide (Appendix ?)

After arrival in Malawi, Dr. Mkandawire-Valhmu, Dr. Tluczek, and I eliminated the interview questions about HIV knowledge and attitudes, because such questions might be too uncomfortable or sensitive for children at a first-time meeting with a foreign researcher. Elimination of the HIV questions did not impact the research objectives or quality of data.

Research Setting

Rural Southern Malawi

This study was conducted in rural southern Malawi, about 30 miles southeast of Blantyre, in two of Malawi's twenty-eight districts, Chiradzulu and Thyolo. It is an impoverished, agricultural region, in which HIV rates approach 15%, the highest in the nation. Twenty-six percent of children ages 15-17 are orphaned. Daily food consists of *nsima*, a staple carbohydrate made from maize flour and water, and if available, beans, vegetables, fruit, and greens are consumed, and less rarely, meat. Malnourishment and stunted growth are common in children. Boreholes (water wells) provide fresh water to the community, but may be located far from home, requiring up to an hour to fetch water.

Local community attitudes about education are mixed, though gaining more widespread positive acceptance (Miqlat USA administrator #2). When children are in school, especially girl children, they are not available for chores, field work, or childcare, which are common reasons for girls to drop out of school (Republic of Malawi, 2012).

In general, southern Malawi is a matrilineal society (Miqlat USA administrator *#2)*. When the mother dies, the children become the responsibility of maternal kin, and the father returns to his home village. Older brothers and sisters are the first option for placement of younger orphans, with girls going to elder sisters, and boys to elder brothers (Chirwa, 2002). The second option is for orphans to be placed with 'junior' and 'senior' mothers and fathers (the English equivalent of aunts and uncles) (Chirwa, 2002). Property inheritance in matrilineal societies of Malawi mean that women own the land, and succession of land goes to daughters only (Peters, 2002). Sons do not inherit their mother's land because men traditionally leave their home village when they marry.

During the 3-week research period, the research team lodged at Miqlat USA headquarters in Bvumbwe, Malawi, a 25-minute drive southeast of Blantyre. Miqlat USA is a Christian charity assisting needy children. Nationally, the majority of Malawians are Protestant Christian (65%), followed by Roman Catholic (21%), and Muslim (13%) (Government of Malawi, 2011).

Miqlat USA, Non-Governmental Organization (NGO), in Rural Southern Malawi

Miqlat USA is an American non-denominational, Christian, evangelical, non-governmental organization that provides services to orphans and vulnerable children through two Hope Centers in rural Malawi (Kogoya village and Thuchila village) (Miqlat USA, 2013). Eight of the ten youth in this sample either had a sibling or were themselves a beneficiary of Miqlat USA's community care program in which children receive a daily meal, educational fees, and healthcare. Miqlat USA is administrated in the United States. In Malawi, the chief administrator is an American who resides at the headquarters in Bvumbwe.

The two Hope Centers serve approximately 650 children from 19 villages between two districts, Thyolo and Chiradzulu (325 at each facility). For each Hope Center there is a Malawian administrator and a Malawian program director. Nutritional support is provided by a daily noon meal to the children, educational support, bi-monthly medical care, a corporate farming enterprise, and Christian instruction are offered to the children. Since Miqlat's inception in 2008, no children have dropped out of school except for pregnancy or relocation.

Miqlat USA's values and activities are predicated on a Christian worldview in which God is the creator of all persons, and all persons are therefore imbued with dignity, value, and worth. While it is Miqlat's goal to alleviate the effects of severe poverty that threatens to destabilize families, it is not their only goal. By providing for children's basic life needs, the community benefits through increased access to safe water boreholes, intact families, and the hope of higher literacy rates in the community.

The goals of Miqlat are reflected in their five main objectives, known as the "Five Pillars":

1. Feeding children daily to counteract widespread food insecurity secondary to poverty and poor crop yields.
2. Supporting early education.
3. Teaching better farming practices through *Foundations For Farming* (Foundations for Farming, 2014) to increase yields, increase income, and increase food security.
4. Health care for the sponsored children. All medical expenses are paid.
5. Mandatory Christian discipleship class to foster social and spiritual responsibility.

Miqlat USA's role in the community. Miqlat's role in the community is both formative and practical. Miqlat USA's goal is for vulnerable children to grow into healthy Malawian children. Orphaned and vulnerable children receive material assistance to remain in their families and their community. Miqlat's community role is to share responsibility for children's welfare by assisting and advising parents so children can thrive. Families are expected to assume primary responsibility for children, and to the best of their ability, to contribute to children's food and school costs.

Family assessment. Miqlat administrators believe that positive community change can be created by sensitizing parents and guardians to:

1. Take children to the hospital when ill.
2. Encourage children to go to school and instill a vision of education.
3. Hold children accountable for their behavior.

4. Consider the adverse effects of girl initiation ceremonies that ritualize puberty by sexual debut with an older man (risk of HIV, pregnancy, and educational loss).
5. Embrace values and practices that protect children and their futures.

Miqlat administrators meet with parents and guardians every two months for routine accountability. Offsite surveillance of families is conducted by *Hope Center* committees, in which community volunteers report to Miqlat pertinent information about children and their families. If a problem arises in a family, such as school absenteeism, illness, or behavioral problems, a committee member meets with the child and their guardians to work towards resolution. If no progress is made, a Miqlat administrator then meets with the child and the guardian.

Instilling the value of child education. Miqlat administrators envision a community changed by educated children. Administrators exhibited a strong commitment to Miqlat's objectives to work towards long-term improvement in children's well-being:

> The other thing is it's my desire as well that we will see them being responsible citizens, that after all these things have happened, I'll be so proud to see them leading the community, to see a changed community, after they have learned through Miqlat. (Miqlat administrator #3)

Community Ownership: Miqlat's Public Scrutiny Recruitment Process

Priority consideration is given to children whose parents are handicapped, as they are the most vulnerable for not having basic needs met. Other vulnerable children include orphans or children who are the head of their household. Double orphans (children who have lost both parents) are regarded as more vulnerable than single orphans due to the loss of all parental care and support. Financial support of children is funded by international donor-directed sponsorship of individual children for $37 US dollars/month.

The recruitment of children into Miqlat's program is a “public scrutiny process”. The public scrutiny process is a critical step to ensure only the most needy children are recruited. The recruitment process begins with obtaining a list of orphans residing in the district from the government’s district social welfare office. Miqlat then consults directly with the community chiefs within each catchment area. The chiefs review the government list and make recommendations regarding which children should be recruited. This is followed by a confirmation process whereby Miqlat staff and community volunteers visit the villages to verify children on the district's social welfare list meet inclusion criteria for the Miqlat program. A final list is compiled, and then a public meeting is called. At the public meeting, all of the children’s names are read out loud, and the community affirms or denies the neediness of each family. The primary advantage of the public scrutiny process is it privileges the voices and decisions of community members, and in so doing, minimizes jealousies and disagreements about which children are finally chosen.

The parameters for a child’s inclusion or exclusion from the Miqlat program is summarized in Table 1. Miqlat’s policies specifically exclude children who are in intimate relationships with the opposite sex, girls who are pregnant, children who are parents, children who do not attend school, and children who do not attend discipleship

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classes. The reason for these exclusions is to motivate children towards healthy habits of mind, body, and spirit.

Miqlat prioritizes the value of community ownership of their program: “It’s not like we are Miqlat and we are here, but this is their (the community’s) own thing,” (Miqlat administrator). Ownership is fostered by community participation in the public scrutiny process for selection of qualified children for the Miqlat program, guardian meetings, accountability of parents/guardians for following Miqlat policies, responsibility of school administrators to report absenteeism of Miqlat beneficiaries, and community responsibility to provide for its own needs such as the repair of homes. Churches are another vital link in securing help for children through the engagement of congregation members. By prioritizing the idea of “help” as coming from within the community, a sense of ownership keeps responsibility for outcomes located with the community itself.

Miqlat’s Mandatory Discipleship Program

Discipleship is derived from the Latin *discipulus,* ‘pupil’ and *discere,* ‘to learn’, and means ‘to follow a teacher or school of thought’ (Dictionary.com, 2013a) . Miqlat requires children to attend discipleship classes after school in which they learn about God, Jesus, and the Bible, but children are not required to be Christian to participate at Miqlat. Failure to attend without sufficient excuse may result in expulsion from the Miqlat program. The discipleship class is intended to form and shape children into responsible citizens who also believe in God.

Table 1

Miqlat Hope Center Beneficiary Criteria with Inclusion and Exclusion Parameters

Criteria for Miqlat Hope Center Program	Inclusion Parameters	Exclusion Parameters
Minimum Age	6 years	Younger than 6 years
Maximum Age	21 years	Older than 21 years
Child Status	Single orphan Double orphan Head of household Child of handicapped parent	Non-orphan
Economic Status	Severe deprivation of basic needs	Adequacy of basic needs
Intimate Relationships with Opposite Sex	Child is not in an intimate relationship	Child is in an intimate relationship
Pregnancy	Child is not pregnant	Child is pregnant
Child as Parent	Child is not a parent	Child is a parent
Religious Affiliation	None required	None required
Community Approval	Child's need is affirmed by the public scrutiny process.	Child's need was not affirmed by the public scrutiny process.
Conformation to Miqlat Policies	Child and parent/guardian agree to abide by Miqlat's policies.	Child and/or parent/guardian refuses to abide by Miqlat's policies.
Educational Status	Attending school	Not attending school
Discipleship Class	Child attends Miqlat discipleship class.	Child refuses to attend Miqlat discipleship class

Data Analysis

Narrative analysis is useful for qualitative inquiries that are informed by *a priori* theory, in this case, Diener's model of subjective well-being and the Orem's concept of well-being (Riessman, 2008). These theoretical commitments directed my focus and construction of the interview guides. Simultaneously, the *a priori* theories constituted a foundation for a structural data analysis of smaller narrative components like clauses. In structural analysis, clauses are analyzed for meaning and logical linkages to other clauses and the narrative as a whole (Riessman, 2008).

Data Analysis Method

Data analysis began on arrival to Malawi. Observations of local Malawian culture, manners, gender roles, and faith were noted in everyday activities and personal interactions. Casual conversations with Miqlat staff and local Malawians (my driver, research assistant, a media producer, and two pastors) were recorded in written notes and transcribed to digital notes while still in Malawi.

Ten transcribed interviews and the focus group transcript were reviewed. Participants' body language, expressions, emotions, rate of speech, tone of speech, and degree of emphasis were notated after the interview. My understanding of the stories were reviewed and corroborated by my research assistant. Field notes were reviewed. Short notes about non-verbal behavior, my impressions at the time of the interview, and any significant situational factors were written in the transcription margins. Early impressions and questions were recorded in written and digital forms.

Audio recordings of the interviews and focus group discussion were listened to and compared against the transcribed reports. No substantive errors were found. Transcripts were randomly assigned an identification number of 1-10. Gender and age were excluded from the evidentiary quotations whenever possible to protect the privacy of the children.

Data analysis was divided into four phases: (1) Demographic Analysis, (2) Final Coding Structure, (3) Factor Mapping, and (4) Inferential Analysis. Preceding the four phases, the first readings of transcribed interviews commenced, and key statements were underlined. Transcripts were read multiple times to develop an understanding of the essence of each participant's story. In keeping with the *a priori* concept of subjective well-being, children's narratives were analyzed with particular attention to statements of judgment and value (e.g., good/bad, right/wrong, happy/sad) within the context of their experiences as the head of their household.

In keeping with the *a priori* theoretical foundation, children's stories were analyzed for experiences that were beneficial or detrimental to their well-being. These were designated as *experiential contexts.* Third, structural aspects and linkages of clauses were analyzed for content and meaning against the broader narrative. This level of data analysis yielded an understanding of how children regulate their well-being, and by induction, the meanings children ascribe to well-being.

Demographic analysis. Demographic analysis, the first phase of data analysis, highlights the socio-economic characteristics of the sample. The demographic analysis permitted comparison with the literature about the prevalent context of a common poverty and the loss of parental care.

Final coding structure. The final coding structure was completed in the second phase of data analysis, was characterized by ever-increasing levels of distillation and clarity of the narratives. This was achieved through multiple iterations until conceptual codes had crystallized into a usable framework. The process was documented in three reports: (1) *narrative interview matrix,* (2) *narrative interview report,* and (3) *conceptual interview scheme* (Dierckx de Casterle, Gastmans, Bryon, & Denier, 2012).

After the first few readings of the interviews, a *narrative interview matrix* was created. This was a one- to two-page synopsis of the participant's story, with emphasis on positive and negative experiences. It highlighted concrete information such as participant experiences, family structure, and material needs. Salient evidentiary quotations were included.

Following more re-readings, a *narrative interview report* was generated. The purpose of the narrative interview report was a brief one-page abstract noting the key story lines followed by a summary impression of the essence of the child's subjective well-being. Using the narrative interview report as a guide, interviews were again re-read at a higher degree of abstraction for the identification of specific, preliminary conceptual codes related to subjective well-being. While it was tempting to foreground vulnerabilities, the research question kept me focused on well-being experiences as the central phenomena.

A *conceptual interview scheme* documented a summary of experiences and meanings of subjective well-being with a delineation of preliminary codes. This step involved distilling the data into the most relevant concepts, categories, and codes for answering the research questions. Concepts were not yet formally interrelated across cases. Notable quotes related to the concepts were marked and recorded in Dedoose.

Preliminary conceptual codes were clarified, modified, and verified within and across participants through multiple iterations to satisfy the twin objectives of ensuring the codes were true to the narratives, and that the codes were logically coherent with the research questions. Preliminary codes were defined and entered into Dedoose, a web-based mixed methods data analysis program. Next, interviews were re-read to identify evidentiary text to support the codes while simultaneously modifying codes for specificity, consistency, and accuracy. Codes were re-defined, some codes collapsed into a larger code, and some codes were truncated into smaller codes. For example, clarification of the code, *help,* was achieved by identification of who it is that helps children (*others* and *God)*, and what kind of help they provide (*material* or *non-material*). More deeply embedded in the narratives was how children's self-agency is a kind of help, albeit self-help, and this observation led to adding "self" as a third person who helped children, thus the sub-codes of *self, others, and God* within the larger code of *help*. An example of collapsing codes for efficient analysis is that the concept of material help was not advanced by my attempts to sub-divide it into categories like food, money, clothing, and the like. Furthermore, the concept of help as described by children was more abstractly understood as deeds by good people, and less defined by types of material goods received from others.

One of the more difficult aspects of coding was deciding which virtues best described the types of goodness children experienced in their relationships with others and God. The rationales for the chosen virtues are explained in Chapters 6 and 7. It was not my intent to enter into complex philosophical distinctions to inform my selection of the relevant virtues in children's narratives. Rather, it was important to me to code virtues simply, in the hope of authentically reflecting how children positioned and described their experiences with others and themselves.

The final coding structure was tested for saliency between the narratives and the three research questions. This stage was the most time-consuming and required multiple revisions. Once the final coding scheme consisting of *Eight Experiential Contexts of Subjective Well-Being* (benevolent belonging, provision of basic needs, experiencing God, growth through adversity, help, hope, intellectual development, and protection) was a good fit with the narratives, the theoretical foundation, and the research questions, I selected pertinent narrative excerpts for inclusion in the data findings and entered them in Dedoose.

Factor mapping. The third phase of data analysis, Factor Mapping, was necessary for answering *Research Question 2*, how children regulate subjective well-being. This phase began with the first readings, and was not completed until the coding structure for *Research Question 1*, the *Eight Experiential Contexts of Subjective Well-Being*, was finalized. Preliminary factor mapping revealed that children's regulation of well-being was a dual function of opportunity and the virtue-agency of self, others, and God. I tested the logic and accuracy of my conclusion by comparing it against the coding structure for the *Eight Experiential Contexts of Subjective Well-Being* as I re-read the narratives. This phase of data analysis was straightforward and did not require major modifications. The simplicity of this phase may be attributed to the lack of interview questions relating to complex processes of decision-making.

Inferential analysis. The fourth phase of data analysis, Inferential Analysis, was for answering *Research Question 3*, the meaning of subjective well being. An inferential, contemplative process was employed to determine how children's subjective well-being experiences, opportunity, and virtue-agency impacted their sense of subjective well-being, as mediated by their perception of health. The nursing model of health, defined loosely, is a modular model of four, interrelated domains: the physical, the psychological, the social, and the spiritual. The data indicated children perceive of health in four slightly different domains: the physical, the psychological, the intellectual, and the spiritual. The findings for all three research questions were interpreted in light of Diener's model of subjective well-being, and the nursing model of health. A meaning of subjective well-being was derived from this inferential strategy, and a model, *The Integrative Virtue Model of Health and Well-Being,* was created to graphically depict the convergence of the data, the conceptual coding framework, and the theoretical foundation. In a very real sense, the legitimacy of the model at both the theoretical and practical level is one confirmation of the scientific rigor of this study.

Reflexive Stance

Dialectical engagement with the data and my personal values was supplemented with a transparent and reflexive stance to reduce bias that might privilege certain groups or analytical processes (Packer, 2011). Reflexivity in cross-cultural research calls for deep deliberation of personal values, because cultural norms are deeply ingrained values that unconsciously guide our expectations of human behavior (Saukko, 2003). I relied on personal reflection, observation, and memos to foster reflexivity, and sharpen my awareness of the impact my values and western experience have on data analysis and interpretation (Vandenberg & Hall, 2011). Taken together, transparency and reflexivity require continual dialectical engagement with the data and one’s personal values to produce a mature and true judgment of the data (Lincoln & Guba, 1985). Where appropriate in this dissertation, I have interjected and discussed my interpretations and preconceptions as a strategy to maintain transparency (Alldred & Burman, 2009).

My capacity for reflexivity was enhanced by two formative experiences. First, a previous trip to Malawi in 2011 as part of a Community Health study abroad trip led by the University of Wisconsin-Milwaukee faculty, including my major professor who is a native Malawian, was key to developing cultural awareness. For example, I learned the customs of respect and employed these during my research. Whenever I was in the villages or at the Hope Centers, all three research team members wore a *chidengi,* and followed the customary forms of respect that included a curtsey on initial introduction, kneeling and speaking in a low voice to the chief, and infusing conversations with humble statements of gratitude. Ms. Beya and a Malawian Miqlat administrator gave positive feedback regarding our sensitivity to Malawian customs.

Second, a reading of Bornstein's (2005) ethnographic study, *The spirit of development: Protestant NGOs, morality, and economics in Zimbabwe,* was another formative experience in my research. Erica Bornstein, PhD, served on my doctoral academic committee. She is an anthropological expert on humanitarianism at the University of Wisconsin-Milwaukee, spent two years in the 1990s in Zimbabwe observing the practices and social effects of a large, American, Christian non-governmental organization. My capacity for reflexivity was expanded by a greater understanding of the complexities of unintended consequences arising from international faith-based development initiatives in Africa. As a result of my sharpened insight, I relied on the principles learned from Bornstein to question my own viewpoint as a Christian American researcher. My heightened awareness of the positive and negative impact NGOs may have on African communities was an asset for developing suggestions for NGO program development for youth-headed households.

For further transparency, I am an American researcher, and as a Christian, many of my beliefs accord with those of Miqlat USA. My affiliation with Miqlat USA arose out the joint ventures between the University of Wisconsin-Milwaukee and Miqlat USA that were established prior to my research. Part of my interest in youth-headed households is related to our Ugandan grandchildren, now ages 6-7 years, all adopted from the same orphanage. The first child, adopted in 2011 at the age of 3 1/2, has a personal history of living in a youth-headed household with five cousins and a grandmother, which partially dispersed after the grandmother's death. Our family supports the now 18 year old cousin, who was, and still remains, the head of the family. My personal association with children orphaned by poverty, peri-natal maternal death, HIV/AIDS, and cultural traditions, strengthens my resolve for the truest analysis possible, in the ultimate interest of the best outcomes possible for Africa's vulnerable, orphaned children. Reflexivity and transparency "...should not replace a 'view from nowhere' with a 'dream of everywhere', but rather it should admit and explore the implications of the view from somewhere quite particular indeed," (Alldred & Burman, 2009, p. 189).

Scientific Rigor

Scientific Rigor of the Research Design

Ensuring *coherence* and *contextual validity* are aspects of scientific rigor that justify the final conclusions of the data while also affirming the cultural relevancy of the data. When research designs are intended to justify, not prove, the conclusions arising from the data, the researcher’s creative effort to craft the best framework for the most coherent explanation conceivable is legitimated (Carter, 2010). Coherence is further enhanced when the researcher's methodology and theoretical commitments dually support the final epistemic claims of the study (Carter, 2010). Coherence, then, is realized when the research design is customized to create the best fit between methodology and the research question (Lincoln & Guba, 1985), because, as Carr (1948) declares, "No body of knowledge can be any more dependable than the method by which it has been obtained," (p. 1). Coherence for this study was strengthened by using multiple data sources and analytical techniques for understanding the well-being of vulnerable children.

Research is an inherently social process that necessitates an intertextualization between the researcher and participant(s) (Packer, 2011). The capability of research to locate the phenomenon of interest within the wider context of its occurrence, ranging from local contexts to global contexts, is known as *contextual validity* (Saukko, 2003). Qualitative contextual validity in this study was anchored in the realism of two factors: (1) the experiences of vulnerable children, (2) the local cultural context of poverty and HIV. Contextual rigor, then, involves validating the data findings for relevancy to its origins in people, time, and space. The cultural aspects of contextual rigor were enhanced by cross-checking my understandings with my Malawian research assistant, NGO administrators, and major professor.

Scientific Rigor and Trustworthiness

Scientific rigor in qualitative studies is a function of contextual validity known as 'trustworthiness' (Lincoln & Guba, 1985). Validity rests at the intersection of epistemology, ontology, disciplinary imperatives, and theoretical assumptions (Riessman, 2008). For Lincoln & Guba (1985), the assurance of trustworthiness is a fourdimensional process consisting of credibility, dependability, confirmability, and transferability. Credibility of the data findings is created by a transparent audit trail that describes the researcher's reflexive and analytical process. A sound research design robust enough to answer the research questions adequately contributes to dependability of the data finding. The helical process of re-reading for code refinement and determination of goodness-of-fit between all three research questions was a necessary process for confirmability of the data findings. Research data that are trustworthy are transferable into real world clinical situations and program development.

Cross-Language Trustworthiness

Cross-language trustworthiness in studies requiring translation of participant interviews is an essential aspect of rigor. Translational rigor ensures accuracy of the translated meanings and requires an accounting of the translational process (Squires, 2009). As an American woman whose primary language is English, the language and cultural differences represented a potential threat to translational rigor. One example of confusion for me was when children referred to a ‘father’ in the household, meaning not a biological father, as I had assumed, but rather a young male relative who was usually a cousin.

My travel guide during the three week trip was Carol Beya, a Malawian woman who was fluent in Chichewa and English, an experienced qualitative research assistant, my translator, and transcriptionist. Her multiple roles enhanced the rigor of the data by minimizing the number of persons involved in the transcription process because she was present at all interviews serving as translator. As a Malawian native, she readily established rapport with the children, and created a warm, non-threatening atmosphere for the children. When one child became tearful, it was Carol who effectively consoled her. The positive relationship between Carol with the children contributed greatly to obtaining relevant data.

Four forms of data checking were employed to establish reliable and valid results: (1) A post-interview conference with the translator to summarize the children's stories and answer any questions ensured an accurate understanding of children's stories, (2) ongoing oversight and review of transcripts by my major professor who is also a native Malawian and experienced qualitative researcher, (3) the presence of a child mental health specialist, Audrey Tluczek, RN, PhD, at all interviews, (4) clarification of children's socio-demographic data by a Miqlat director. The volume, variety, and content of data was confirmed as adequate by the major professor, Dr. Tluczek, and I. Transcription and translation was completed by December 1, 2012.

Data Findings

Description of the Sample

The sample consisted of ten youth, five from Thyolo district and five from Chiradzulu district (Table 2). Ages ranged from 10-21 years. There were eight females and two males, all self-reported as in good health. Five children were maternal orphans, one was a paternal orphan, three were double orphans, and one child was not an orphan. Duration of the youth-headed household ranged from 10 days to six years.

Table 2

Demographic Profile of Participants by District

Home District of Participant	Sex		Age		Orphan Status			
	Female	Male	Range	Average	Maternal Orphan	Paternal Orphan	Double Orphan	Non-Orphan
Chiradzulu	4	1	10-21	15.6	2	1	1	1
Thyolo	4	1	13-19	16.4	3	0	2	0
Totals	8	2	-	16	5	1	3	1

Semi-structured interviews of youth (n=10) were privately conducted in August 2012 in the Miqlat offices at Thuchila (Thyolo district) and Kogoya (Chiradzulu district). Children were interviewed in their choice of English or Chichewa. Nine children were interviewed in Chichewa, and one in English. Consent was obtained from each local chief representing the child participants' communities, and written and oral assent obtained from all children. Every interview was conducted by me, and attended by my research assistant, Ms. Beya, and Dr. Tluczek. As a show of respect, each member of the research team wore a *chidengi*, common female daily attire in rural Malawi consisting of a large piece of fabric worn over regular clothing like a below-knee length skirt.

All children completed the interview, which lasted no more than 2 hours. Interview length was limited because of the translation time and consideration of children’s fatigue as the interview approached two hours. The longest interview was two hours and fifteen minutes. No child suffered identifiable harm. One child wept at the loss of her mother. She declined to discontinue the interview. Another girl escaped an attempted rape a few years prior. Dr. Tluczek questioned her to confirm her current safety and psychological health. After each interview, Dr. Tluczek and I conferred with Ms. Beya to review the interviews for overall meaning and clarified any areas in question.

A focus group consisting of six Miqlat administrators was conducted at headquarters. The discussion topic was the impact of Miqlat Hope Center’s services on the well-being of vulnerable children. The entire discussion was in English, audio-taped, and transcribed by Ms. Beya. Additionally, casual conversations with ten adults, including the six Miqlat administrators, increased my cultural understanding of southern Malawi. The conversations were noted in writing, and then transcribed by me to digital files. Following completion of all data collection, Dr. Tluczek and I reviewed the data, and judged it to be sufficiently saturated and varied to answer the study’s research questions.

Focus Group Discussion Findings

Miqlat administrators conveyed a deep conviction of the spiritual and community ethics involved in the care of orphans. The language of 'transformation' was used to describe profound changes in the attitudes and behaviors of children, a theme that is common in Christian missions organizations and missiology (Miqlat USA; Piper, 2003).

One administrator described how children have a narrow worldview with limited capacity for embracing important human values, especially *dignity.* Building dignity into children's lives positively impacts their present and future achievement:

> Dignity, I think, is a key issue that needs to be addressed, that you value them. We came out of an era of, out of the time of slave trade, colonialism, things like that, that dropped a lot of dignity. And the Christian worldview adds value to someone's life, and you can say to someone, "God loves you so much that he would have sent His one and only Son to die for you", that adds value to someone's life and that value then equips them a lot more than the education side of it and a lot more than the farming side of it. The value of "I'm special, encourages children. I really believe it and I can see it even on an adult level that they can go further, they can do it, that they don't have to wait for some NGO to come around to do it for them. They can do it because God loves them. So that's a very, very crucial aspect of the Five Pillars. (Miqlat administrator #6)

He then explains the relationship between food and dignity as critical for developing a sense of individual value and hope:

> Food is the number one thing children need. If I go home today and I'm hungry and I don't have food that affects my well-being very much so. The most important thing after food is that aspect of dignity. If you don't have well-being

> and food that does affect your dignity it does it robs a major part of who you are like if you find yourself saying, “I don’t have food,” it does steal hope in a big way.
>
> So after basic needs, I believe that dignity in terms of knowing that, “I'm a person of value,” that,”I have some kind of faith that God can use me to do something in this nation,” that, “I can go into government and I can be a leader,” that aspect of dignity, I feel, is the second most important aspect of well-being. From there it's adding the tools as to how one can develop from that premise. (Miqlat administrator #6)

Instilling dignity in children also results in the positive effect of greater daily discipline: “…as you keep on teaching them [children] and as they [others] value them, they [children] respond [with better behavior and less absenteeism].” (Miqlat administrator #6). The positive changes in children’s behavior and spiritual development are valued for both the present day and the future when children are raising their own children:

> There have been so many [good] responses from the parents. We have immediately started getting the feedback from whatever is happening, especially the example we are talking about, the discipleship. Parents will come and make comments. Every two months we have parents and guardian meeting. So one of the things that we call up for these meetings is we want to get the response from the parents. So these are some of the things they say: *“My child has been very naughty at home but today my child is changed all of a sudden.”* So they say this

> because they have been learning about the Bible. So that is a transformation. So there is an immediate result. Their children would pray before eating the food, so there is a change. There is a sense of recognizing God. So that's very important. That's very important. They will be responsible people. Let's say if somebody who does not know God, who would not think stealing is bad, would not think that womanizing is bad, or going with boys is bad. But because he is [learning] the word of God, he will not do those kinds of things. So we have a better community. So those things have been manifesting whilst they are still young, which means they can pass it on to other young people. Even as they grow up, that's a foundation. So they live like that. They'll impact their own children, so they will have a better and clear future for them. (Miqlat administrator #2)

Participants in the focus group were asked how the discipleship program affects children. Two administrators offered their perspective that discipleship is as critical to children's development as is physical food:

> After the child has been helped on the physical side, with the food, with health issues, we are also talking about a spiritual being. So we want that person to be a responsible person spiritually. So remember, Miqlat is a Christian organization, so we want to encourage the children to believe in God, so they can live and be responsible people and even after everything is done, they can also have part and parcel in heaven with Christ. (Miqlat administrator #2)

> Discipleship, it all comes back to discipline.... if we are giving them food but we let them go with their own behaviors and conduct, it means we are feeding them but the food will never accomplish what we are desiring. So it's like these things they have to go together: feed them, disciple them. (Miqlat administrator #6)

One administrator eagerly told her story of the "amazing transformation" of children when children experience genuine love. The narrative was a very emotional moment for the focus group and our research staff, a poignant moment that epitomized the embodiment of Miqlat's commitment to the well-being of children:

> I remember when we first came to the community… before we built the Hope Center. We would gather the children for different things and then we recruited the children that were going to be there and some of the children, none in particular, but in general, the children, they were wild, they were vicious with each other, they would, you know, grab each other and throw each other across the room or whatever, you know. The way they treated each other, the lack of respect they had for everybody and everything around them was just, like, overwhelming sometimes. You know, we'd come in as missionaries, wanting to play games, and, you know, tell stories, and the kids were just like hardly able to focus, especially certain kids. And as we brought them into the program, as we, you know, we brought order and teaching and love and attention to those kids…(voice breaks)…um, I'm going to cry…(voice cracking, other Miqlat staff now have tears in their eyes) … I can pick out certain kids, like (name redacted), who came from these horrible backgrounds. (Regained composure) I know their

> stories, and you think about how they were when they first came into the program and you look at them now and they are sweet,
>
> (another administrator, tearfully interjects): and smiling,
>
> …and smiling, (the entire group chuckles, smiles, and nods in agreement while sniffles are heard) and lovely to the other children, and you know, they just want to come and hang out with you. It's an amazing transformation. (The group continued to smile and nod while some wiped tears from their eyes.) (Miqlat administrator #1)

Miqlat USA's mission, within a framework of Christian theology, is to create an enabling environment to transform the lives of children and, by extension, the community, by educating children, ensuring their health, guiding children to become upstanding citizens, and developing leadership skills, all with the hope of children giving back to their community as they mature into adults. The enforcement of Miqlat policies for discipleship training and membership in the child care program are for the purpose of building discipline and responsibility in the lives of children while simultaneously meeting critical needs of food, education, and healthcare. Miqlat's view is that children are the most promising resource within a community. Drawing on the language of community development, if effective resources are to be mobilized, they must be fit for the task, and the positive development of children is beneficial not only for the children, but the community at large.

Demographic Characteristics of the Sample

Demographic characteristics of the sample (n=10) are presented in this section. All children suffered from poverty and loss of parental care, even when adults were residing in the household. As will be shown, it is the loss of parental care, rather than orphan status, that is key to understanding the vulnerability of the children in this sample. The demographic data was limited in that not all children were asked all demographic questions since the interview was open-ended.

Youth Head of Household

The age of the household head ranged from 10-21 years old with a median age of 16.5 years and an average of 16 years. Eight of ten heads were female. Children’s role as the head of household ranged from two weeks to seven years, with an average of four years. Religious affiliation of participants was reported as Protestant (n=7), Roman Catholic (n=2), and Islam (n=1).

Household Composition

Household size, including the head of household, ranged from two to eight persons, with an average of four. Household composition was varied. Each household had an average of 2 (range 0-6) other children in the home who were siblings or cousins. Eight of ten households had at least one adult in the home. The adults were disabled, elderly, or a young male member of the extended family ("uncle" or "father"), and were not considered the head of household.

Basic Needs Data

Basic needs included food, income, water, clothing, blankets, mosquito nets, fertilizer, and shelter. All households suffered from insufficient food and income. All had a safe water source. Temporary jobs like gardening were the main form of employment for children.

Mosquito Nets

Mosquito nets prevent malaria. The net is suspended at the ceiling, and drapes around the person's sleeping space. Four homes did not have mosquito nets for every member, and a total of 5 children from these homes contracted malaria in the last year. In one home with sufficient mosquito nets, 2 children contracted malaria in the last year. It is unknown if the children were not using the nets, or if malaria was acquired in spite of net usage.

Fertilizer

Children lacked money for garden fertilizer. They also lack modern agricultural knowledge about conservation tillage methods that can increase crop yields. No child knew of the local chapter of *Foundations For Farming* (Foundations for Farming, 2014), an organization committed to teaching advanced agricultural skills.

Educational Level

The highest completed educational level ranged from Standard 4 (similar to fourth grade in USA) to Form 4 (similar to 12th grade in USA). The average completed educational level was Three of the household heads were not currently in school due to lack of fees.

Miqlat USA Program Affiliation

Across the ten households there were a total of 30 children, including the youth head of household. Eleven of these children were enrolled in the Miqlat program. Of the ten household heads, half (five) were enrolled in the Miqlat program. Eight households had at least one child in the Miqlat program, and one family had 3 children in the program. Nineteen children were not in the program, usually because the child was a mother, or the child was under age 6 (the minimum age for Miqlat support)

Orphan status. Orphan status was assessed for all participants. Six children were single orphans, three children were double orphans, and one child was a non-orphan (Table 2). Five of the six single orphans were maternal orphans (mother deceased) and one child was a paternal orphan (father deceased). In six cases, children's fathers were living, three of whom live elsewhere and do not support the family, and the reason for the absence of the remaining three fathers is unknown. Two children's mothers are alive, one disabled by HIV and one disabled by stroke.

Cause of Parental Death

The cause of parental death varied. Many times children did not know the cause. In some cases, a Miqlat director clarified the cause of death. Illnesses related to AIDS accounted for three deaths. In six cases the cause of death was unknown.

Maternal causes of death were headache, wounds, mental illness, AIDS-related illnesses, and unknown causes. Paternal causes of death were AIDS-related illnesses, tuberculosis, and unknown causes.

Loss of Parental Care as the Defining Characteristic of Youth-Headed Households

This study makes apparent that it is not only orphan status that contributes to formation of youth-headed households, but it is the *loss of parental care* that is the primary risk factor. Statistical analysis of orphan status in this sample highlighted the difficulties with reconciling traditional definitions of orphan status with a life that is functionally orphan-like by virtue of economic loss and loss of adult protective care.

The status or whereabouts of three fathers was unknown. Though these three children are not paternal orphans since the father is living, the children are living as paternal orphans because the father does not live with them, nor does he support them. Of these three children, one child has also a disabled mother who requires personal care and is unable to generate income. Though this child is not by definition a double orphan, this child functions as if a double orphan, without economic support from either parent.

The orphan status data became clearer when I considered two additional categories of *Loss of Maternal Care* and *Loss of Paternal Care.* The addition of these categories revealed that regardless of orphan status, *all* ten children had suffered the loss of *both* paternal *and* maternal care, despite the fact that some had living parents. The data demonstrates that in this sample, single orphans are no better off than double orphans merely because one parent is living. The data now captured situations like Child #1, who suffered the loss of paternal care at birth when the father left, but the child was not technically a paternal orphan until age 16 when the father died from an AIDS-related illness. Child #4, a non-orphan, has a father elsewhere and a disabled mother, resulting in loss of both maternal and paternal care. The community considers this child to be the head of her household because she is a decision-maker and cares for her mother.

Narrative Evidence and Analysis

The purpose of this section is to posit and explain the evidentiary statements from the narratives as they relate to the three research questions:

(1) How do youth-heads of households experience subjective well-being?

(2) What factors do youth-heads of households associate with subjective well-being?

(3) What meanings of well-being can be inferred from youth's narratives?

The data findings format should be created to coherently reflect the significance and meaning of the data (Bloomberg & Volpe, 2008). For this study, a step-wise, linear approach would have attenuated and obscured the important abstract and interrelated features of the data findings. To avoid this problem, the concepts are first presented together with the evidentiary data, then culminate the findings with the conceptual framework for Research Question 3, and are tested against the extant literature in Chapter 7.

The evidence does not allow drawing discrete boundaries between research questions, especially between children's experiences (*Research Question 1*) and children's interaction of self-agency and opportunities (*Research Question 2*). In the interest of minimizing redundancy, I discuss the data for *Research Questions 1* and *2* together.

Subjective well-being is a self-appraisal of one's well-being. Two factors comprise subjective well-being: (1) a cognitive appraisal of life satisfaction, and (2) an appraisal of positive and negative affect (emotion) related to life experiences. A person's cognitive appraisal of subjective well-being is a reflection of what one values because what one values indicates what one finds important, worthy, and good. If subjective well-being is a measure of life satisfaction, such satisfaction must derive from one's interpretation of what constitutes a good life. Therefore, personal appraisals of experiences relative to one's values is an indicator of what types of experiences contribute to one's subjective well-being.

Despite challenging circumstances of extreme poverty and loss of parental care, this heterogeneous sample of youth heads of households were active, creative, and deliberate in managing the well-being of themselves and their families. The youth relied on a referential framework of virtue for understanding and regulating their well-being experiences. Simply stated, the language of virtue was the language of well-being. In a real sense, children's narratives attested to a "health-value of virtue".

In answer to *Research Question 1* regarding children's subjective well-being experiences, the narrative analysis revealed *Eight Experiential Contexts of Subjective Well-Being,* or common situations in children's lives that impacted their subjective well-being. These experiential contexts were coded as *provision of basic needs, benevolent belonging, experiencing God, growth through adversity, help, hope, intellectual development,* and *protection.* Within each context, children used value-laden language of morality and virtue to ascribe a cognitive or emotional judgment of the situation. These judgment statements formed the basis for the identification and coding of implied or explicit virtues.

In answer to *Research Question 2* regarding the requisite factors for regulation of one's subjective well-being, children's well-being was dependent on a dual requirement of (1) the agency of self, others, or God, to exercise virtue on behalf of the child, and (2) sufficient opportunities in which to exercise said agency. These two factors were contingent on the interaction between personal agency and opportunity at the social interface where children intersect their social world. Opportunities were actual or potential, and could therefore be created. An example of this is when one youth and her sister cut ties with the father and fled, choosing to be a youth-headed household rather than to endure abuse. Such stories demonstrate a certain bravery and resilience of children to reject harmful situations, and to create safe opportunities that increase subjective well-being, even when it means greater economic hardship. Without sufficient opportunity, though, a barrier to well-being will remain, because agency alone is impotent to bring about positive well-being.

In answer to *Research Question 3* on the meaning of well-being, an inferential analysis revealed that the combination of (1) children's referential framework of virtue for judging their subjective well-being, (2) the *Eight Experiential Contexts of Subjective Well-Being,* and (3) the dual interacting factors of virtue-agency and opportunity, could be logically converged into an explanatory and holistic conceptual model of health which I named the *Integrative Virtue Model of Health and Well-Being*. Virtue was both a personal value and an action, both internally experienced and externally experienced, such that subjective well-being was indivisible from both virtue and four domains of children's health: physical, psychological, intellectual, and spiritual. Well-being was therefore inferred from the data analysis as a holistic process:

> *A state of integrated wholeness within and between four health domains (physical, psychological, intellectual, and spiritual), that emerges from, and is contingent on, benevolent virtue-agents who act within the social lifescape to fulfill a child's virtue-informed values within eight experiential contexts (provision of basic needs, benevolent belonging, experiencing God, growth through adversity, help, hope, intellectual development, and protection).*

Definitions of Concepts

Four terms are defined that are found in the discussion of data findings: *virtue, virtue-agent, opportunity, values, lifescape,* and *four domains of holistic health.*

Virtue

Virtue is defined as, "moral excellence, goodness, uprightness" (Dictionary.com, 2012a). The meanings of virtue vary with its grammatical forms. For example, virtue may be used as: (1) a noun to indicate moral excellence or goodness, as in love is a virtue, (2) an adverb to qualify a verb or adjective, as in acting virtuously, or, a behavior showing high moral standards, (3) an adjective to qualify, or attribute a quality to, a noun, as in a virtuous person. Virtuous agency is authenticated by virtuous acts. Adverbs and adjectives constituted the majority of children's use of virtue and moral terms because their narratives contained descriptions and judgments of "good" and "bad" events and people.

Virtues are inherently relational and imbued with social significance of belonging to one another and society. Virtue is necessarily based on a sense of belonging. Where there is no belonging, even in a remote sense, there is no obligation (Gert, 1999). How one belongs to another and to whom, is informed by one's beliefs, cultural traditions, and experiences.

Virtue-Agent

I coined the term, *virtue-agent,* to refer to a person who enacts virtue as a means to help oneself or another. Three kinds of virtue-agents were identified in children's stories: self, others, and God. *Virtue-agency* is the capacity to act virtuously. Because virtues are inherently social and relational, the exercise of virtue is an act of personal agency towards oneself or another.

The children's narratives indicate that the well-being that arises from fulfillment of perceived needs is contingent on two requirements: (1) the active agency of virtuous others, and (2) the existence of a requisite opportunity that when accessed, will fulfill their needs. Taken together, these two requirements constitute the *factors* that regulate well-being. Regulation of well-being is meant here as an interactive process between *active agency* and *accessible opportunities* that results in a positive modification of subjective well-being. *Active agency* refers to children's self-agency, the agency of others, or the agency of God.

Opportunity

Opportunity refers to any actual or potential resource, and may be positive or negative in its benefits. Actual opportunities are opportunities that presently exist. Potential opportunities are opportunities that do not yet exist but might in the future. Positive opportunities for children might include a social program like Miqlat USA, a problem-solving strategy, or a close interpersonal relationship. An example of negative opportunities might be a chance to steal, to engage in substance abuse, or to engage in transactional sex in exchange for food. In general, I have used *opportunity* to mean situations that would provide benefit to children's subjective well-being.

Values

A *value* is defined as "to assign importance, worth, or usefulness; principles, standards of behavior, judgment of what is important," (Dictionary.com, 2013b). Tangible values include food, water, shelter, clothing, and healthcare. Intangible values include values of friendship, learning, and faith. I coined the phrase, *virtue-informed* *values,* describe how children valued what they also deemed morally good. Children's experiences of subjective well-being centered on virtue-informed values that included practical basic needs for daily living as well as the intangible benevolent belonging relationships children establish with virtuous others, including God.

Lifescape

Lifescape is my preferred term to refer to the environmental and social landscape that also includes the higher abstractions of virtue, values, and faith. *Lifescape* implies a dynamic of human life that is ever-changing and never static. As active agents, children act in response to their perceptions of themselves and life around them. The child's perspective, then, is critical to understanding how they view, respond to, and navigate their unique lifescape.

Four Domains of Holistic Health

Four domains of holistic health were identified from the data: physical, psychological, intellectual, and spiritual. For each of the *Eight Experiential Contexts of Subjective Well-Being,* the impact of each context on children's four domains of holistic health is discussed.

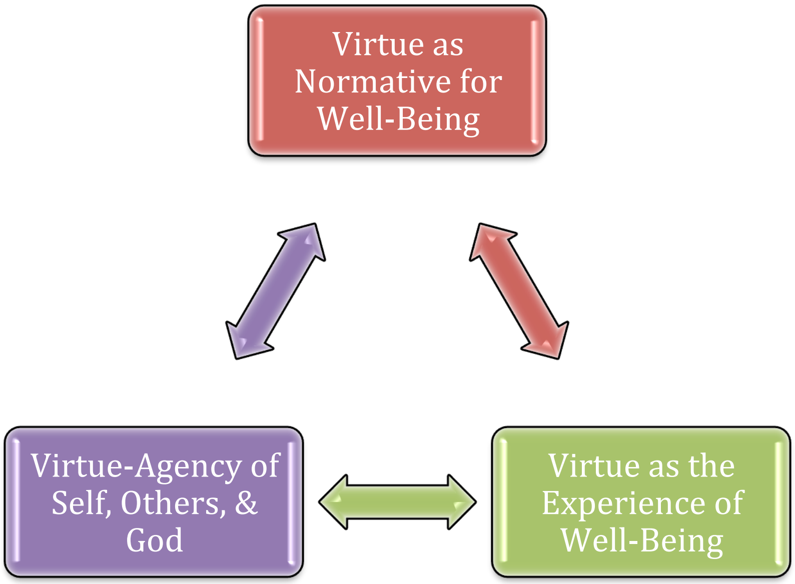
Data Findings for Research Questions 1 and 2

In traditional qualitative research reports, interview excerpts are presented within distinct sections that are dedicated to each individual research question (Bloomberg & Volpe, 2008). This strategy convoluted the results rather than clarified them because of the considerable overlap of data findings between the three research questions. Instead, I begin a presentation of the evidentiary data for *Research Questions 1* and *2*, in which (1) youth appropriate virtue as a referential framework for understanding their well-being, and (2) youth exercise virtue at the social interface to fulfill their values by accessing positive opportunities and avoiding negative opportunities. A summary of the findings for *Research Question 2* follows. The chapter concludes with the findings of *Research Question 3*, in which a statement of the meaning of subjective well-being is depicted in the *Integrative Virtue Model of Health and Well-Being.*

The Referential Framework of Virtue

The *Referential Framework of Virtue* (Figure 3) is a conceptual framework derived from the finding that virtue constituted the means by which children sought to fulfill their values.

Figure 2. The Referential Framework of Virtue.


Virtue as Normative for Well-Being
Virtue-Agency of Self, Others, & God
Virtue as the Experience of Well-Being

The *Referential Framework of Virtue* (Figure 3) is depicted as a triad of good intentions and values, good actions, and good experiences. The goodness of an experience was related to the good actions of a person, and good actions were considered a mirror of a person's good intentions. The inseparability of goodness between intention, action, and experience formed the essence of the *Referential Framework of Virtue*. This finding is consistent with the proposition by Shweder and colleagues (1997) that there are three universal ethics: the ethics of autonomy, community, and divinity. His purpose in this proposition was to bridge the gap between the dichotomy of duty and rights in moral philosophy (Shweder, Much, Mahapatra, & Park, 1997). The elements of the *Referential Framework of Virtue* parallel those of Shweder, et. al (1997): Virtue as normative (divinity), virtue as the experience of well-being (autonomy), and virtue-agency (community).

Virtue as normative for well-being. The normative aspect of virtue was evident in children's appropriation of value-laden language, namely virtue and morality, to assess their life experiences and inform their hopes for the future. Children relied on normative virtues of love, kindness, benevolence, respect, compassion, and helpfulness as a point of reference for judging the moral merits of their experiences and the moral intentions of others. Judgments were both explicit and implied in moral terms like ‘should’, ‘should not’, ‘good’, and ‘bad’. Children judged people’s actions, including their own, from the standpoint that actions imply the merits of one’s intentions.

Virtue-agency of self, others, and God. Virtue-agency arises from the child's understanding that virtue is beneficial and normative for well-being and that these normatives are to be acted upon. The virtue-agency of a person, whether self, others, or God, describes the potential for the person to act virtuously towards the child, even when the child is the self. Through virtuous actions children's values are fulfilled.

Virtue as the experience of well-being. The fulfillment of values constitutes the experience of well-being. Even basic need fulfillment (food, water, shelter) is a function of virtue-agency because it reflects a virtue-informed value that it is good to provide the body with the food and water it needs to survive.

The *Referential Framework of Virtue* provides a background for understanding how children linked intention and agency to their well-being experiences. As the evidentiary data is presented, the three elements of the *Referential Framework of Virtue* will be incorporated in the discussion.

Research Question 1

Research Question 1. What are the experiences of subjective well-being among youth heads of household?

The subjective well-being experiences of children were grounded in the giving and receiving of virtuous acts of the self, others, and God to meet tangible and intangible well-being needs. Virtue was found to be *prescriptive*, *proscriptive*, and *purposeful* for understanding and promoting the subjective well-being of children. Virtue was *prescriptive* because it is a guide for values, intentions, actions, judgment, and appraisal. When virtue was utilized in a *proscriptive* sense, it directed what intentions and actions should be avoided. Virtue was *purposeful* for children's justification of personal values, the means to achieving goals and fulfilling values, the appraisal of one's experiences and relationships, and the criteria of the trustworthiness of another.

Children's subjective well-being experiences occurred across eight, interrelated, life contexts, hereafter known as the *Eight Experiential Contexts of Subjective Well-Being*:

1. Provision of Basic Needs
2. Benevolent Belonging
3. Experiencing God
4. Growth Through Adversity

5. Help
6. Hope
7. Intellectual Development
8. Protection

Definitions of each experiential context are provided in Table 3. The data findings will be presented according to each experiential context.

Table 3

Eight Experiential Contexts of Subjective Well-Being

Experiential Context	Definition
1. Provision of Basic Needs	1. Survival needs consisting of food, water, income, shelter, clothing, blankets, mosquito nets, healthcare access, and fertilizer for crops.
2. Benevolent Belonging	2. Interpersonal connectedness to kind and trustworthy others.
3. Experiencing God	3. Interpersonal connectedness to God.
4. Growth through Adversity	4. The capacity to develop positively through hardship.
5. Help	5. Material (food, money) or non-material (advice, encouragement) help received from others and God.
6. Hope	6. Visions, goals, and desires for the present and the future.
7. Intellectual Development	7. Cognitive development through education, problem-solving, and skill development.
8. Protection	8. Safety from harmful events, persons, or spiritual forces.

The *Eight Experiential Contexts of Subjective Well-Being* delineates areas of children's lives that were important to their well-being, ranging from basic survival needs like food and income, to more abstract needs of personal faith and hope for the future. Furthermore, the *Eight Experiential Contexts of Subjective Well-Being* were daily events of life that affected four domains of children's health: physical health, psychological health, intellectual health, and spiritual health.

These experiential contexts were conveyed with the language of virtue and values. Children spoke of their experiences in terms of good or bad, helpful or unhelpful, acceptance or rejection. From their life experiences, they learned how to maneuver themselves to maximize their subjective well-being, even if it meant hardship for themselves, as in the case of siblings who chose to be a youth-headed household rather than endure parental abuse. It was important for children to align themselves with trustworthy persons, to learn who was good and benevolent, and to avoid those who were detrimental to their well-being. Experiencing God was a foundational experience for children, in which God was a protector, healer, provider, and a source of happiness. The ability to help others was gratifying to children. Helping was not limited by poverty, because helping might mean listening to a friend, giving advice, working in each other's gardens, or even sharing some food during times of plenty. At the core of children's experiences, was a desire to be affiliated with benevolent others, and to be a benevolent person themselves. As harsh as life was for some children, the virtue and experience of benevolence was critical for positive subjective well-being.

In the following sections, evidentiary statements are presented as exemplars of the *Eight Experiential Contexts of Subjective Well-Being*. The ordering of contexts is non-hierarchical, and follows that of Table 3.

Experiential Context 1: Provision of Basic Needs

Basic needs was defined as *the requirements for survival: food, water, income, shelter, clothing, blankets, mosquito nets, healthcare access, and fertilizer for crops*.

Children value life's basic needs because then "that child can grow well" (Child #8). Children's prioritization of the family's basic needs reflected their values of the sanctity of life of self and family. Agency for maintaining the family's sanctity of life by fulfilling their basic needs thus required the exercise of virtues such as responsibility, caring, and discipline. Basic needs were, therefore, a *virtue-informed value* that children prioritized over alternative choices: "The most important thing in families is to have food and clothes. But other things are just supplement" (Child #7).

Children prioritized the care of ill parents and household chores over leisure time:

> You should go and wash clothes for your mother and your sister. You should make sure than when you go to play, remember to come back on time, not later like your mother is not sick. You should go and fetch water for your mother to bathe. Do all the house chores then you can go to play. (Child #2)

Balancing household duties and schooling required a commitment to exercise the virtues of responsibility and discipline. Amid the challenges of finding food, bringing in income, home upkeep, and cooking, Child #9 described her daily life:

> When it is school time, I wake up early in the morning but I don't complete house chores before going to school and I finish them when I get back from school…I make sure that there is always enough water in the house and make sure that the house is clean, not dirty….We go and search at the garden [for food]…When it is school time, I just go and fetch water and clean plates, clean the house, and I cook relish when I get back from school. I normally go and fetch water five times a day but when it is school season I make it half in the morning so that I am not late for my classes. (Child #9)

The prioritization of responsibilities for the family's welfare was a form of virtue-agency captured in the advice one youth imagined he would offer to a friend who just became the head of his household:

"…he should not be playing around but he needs to go and search for food for the family" (Child #8).

The virtue of respect was embodied as an action of obedience to an older sister as a form of family cooperation for accomplishing the daily household work: "Since my sister is the eldest in the house, when she asks me to do something I always obey her and do the work." (Child #5) The opportunity to contribute to the family was expected, and the willingness to do it with a good attitude was the essence of virtue-agency for the well-being of self and others.

The virtue of benevolence, when experienced as family connectedness, had practical import for obtaining basic needs through corporate work opportunities:

> The advantage of the closeness [referring to positive emotional bonds] in the house is that we always get what we need most of the times. Because when I tell them that we should go and do piece work [to earn money], we go and do it. (Child #3)

Provision of food not only required the active virtue-agency for the opportunity of finding food, but such provision was also demonstrative of the virtue of love in this very simple statement about how a father showed love to his children: "He feeds us" (Child #6).

Love was also demonstrated in one family by the withholding of food as a form of discipline:

> They [children/siblings] don't misbehave because they know that we don't have parents. Those children who misbehave know that there is someone to look after them…I just tell them that they are killing themselves if they misbehave…I tell him/her [if they misbehave] that "Today you are not going to eat." [laughs] (Child #3)

The regulation of well-being was the outcome of virtue-agency combined with opportunity. This was evident in Child #4's strategic problem-solving to meet basic needs through an entrepreneurial venture. Self-agency, coupled with creative opportunity, was enacted within the virtues of discipline and responsibility, to start a business that resulted in improved financial well-being: "…we faced a lot of problems like lack of material needs…So with that challenge we started doing a small scale business, we were cooking doughnuts and selling them for us to find money" (Child #4).

The virtue-informed value of providing for family, characterized by virtues of responsibility and discipline, was reinforced by a social expectation that families are to seek opportunities for the provision of the household's basic needs, implying the moral goodness of those who do so: "[The community] expects you to be helping the family with some farming activities…" (Child #8).

Children esteemed those who gave them helpful and well-meaning advice on how to care for the family, and considered such people their friends. Opportunities to show concern to children were actualized through the virtue-agency of others, thereby demonstrating benevolence and care to children:

> I have got a friend and she is an older woman, she is the one who encourages me and gives me advice most of the times. She tells me how to take care of my sister, since she does not walk. “You have to give food to your sick sister and bathe her twice or three times a day so that she can stay healthy. I know that food is a problem, but please, you have to try your best so that your sister and the children should not go to bed with empty stomachs. (Child #7)

Examination of what children said about provision of basic needs for the family can be broadened by considering what was *not* said. It was implied in prior excerpts that a failure of a youth to exercise virtue-agency on behalf of the family’s needs was immoral and detrimental to the family well-being. For Child #5, the father's failure to exercise the virtues of responsibility and parental benevolence resulted in his eventual estrangement from the family, which was a consequence of his moral failure to provide for his children, though he was capable of doing so: "There is no relationship because he doesn’t help us. He is supposed to take care of his children and give them their needs" (Child #5).

The father’s failure to exercise virtue-agency to provide for his children’s basic needs led to the children saving what little money he did give them to build a small business that generated extra money for their basic needs. The adversity that arose out of insufficient parental support was paradoxically an entrepreneurial opportunity for financial gain, and the unfortunate estrangement from the father contributed to the child’s development of the virtues of patience and perseverance:

> He was not giving to us the needs so when he gave us pocket money for school we were keeping it and when it was enough we started a small business, and we were using the profit money and buy necessities like clothes….We were just living a perseverant life, in whatever was happening to us…The money we get [from the business] is not enough, but at least we are able to find food. (Child #5)

By contrast, a ‘good’ father was described as one who exercises virtues of responsibility and unselfishness to provide for his children as he is capable, and as the opportunity arises. The child's perspective was that the father's happiness was the reward of his virtue:

> He [father] supports us but because he is alone it is hard for him to give us everything, like books – it is very difficult for us to have them…He says that if he gets money, he is going to pay for us [education fees]...[He is a good father because] he wants us to finish our school and be educated and he gets happy when he sees us going to school. (Child #9)

The preceding excerpts emphasize how children made a moral distinction between a father’s refusal to provide and a father's inability to provide. In the former case, the father was judged morally culpable for not being a virtue-agent when sufficient opportunity existed. In the latter case, the father was not morally culpable because he had no money, and therefore, no opportunity to exercise his virtue-agency for the financial improvement of his children's welfare. Rather, his child esteemed him as a morally good father for his maximal efforts, regardless of the outcome.

The virtue-agency of others who assist children to meet basic needs are associated with overlapping virtues of generosity, benevolence, and love. For Child #6, the virtue of generosity defined how others can help children meet daily needs: "Give them food, clothes, shoes, lotion, and soap" (Child #6).

The sharing of food with children by others was considered evidence of the virtue-agency of love: "[Regarding how church members show love] Sometimes they give us food" (Child #10).

Likewise, gifts, food, and advice were opportunistic expressions of the virtue of love between siblings:

> [Regarding how a sister shows love to her sibling] She gives me food and encourages me to work hard on my education. [I show love to my sister when] Sometimes when I have money I buy some little snacks for her like biscuits. (Child #1)

The virtues of benevolence and generosity described the types of help given to children by church members, in the form of personal visits and material help for basic needs: "They (church members) come and see my mother and give her some money for her to buy medicine" (Child #2).

Even with children's best efforts, most reported at least one day a week that they were hungry, and daily food was often insufficient in quality and quantity. It was common for children to petition God for provision of basic needs, reflecting their belief that God is a benevolent and generous giver, and therefore, a virtuous God who seizes opportunities to better the lives of children:

"God helps me in the way that when I ask Him He provides to me" (Child #9).

"I ask Him (God) to give us food" (Child #6).

Children believed that God heard their requests just like another person, and they believed God's benevolence was a rational source of provision. Child #1's statement implies a personal history of experiencing God's provision for basic needs:

> I believe that it is good when I need anything I must ask God, because God is the provider…When they [children] can ask God things that they need in their lives, God is able to give them and answer their prayer. (Child #1)

Overall, the hardship of poverty and the attendant deprivation of life's basic needs of food, clothing, and education was the most formidable challenge faced by children:

"We stay in a very hard life" (Child #10).

"The most important thing in families is to have food and clothes. But other things are just supplement" (Child #7).

Poverty was the common denominator impeding a higher quality of life for youth-heads of household:

"My life is fine but only poverty is a problem" (Child #2).

Summary. The realities of poverty and loss of parental care meant children's well-being regarding basic needs was detrimentally affected in multiple ways: food insecurity, lack of income, lack of clothing, blankets, mosquito nets, adequate shelter, and fertilizer for crop production. Children had to conscientiously exercise virtues of discipline and responsibility to provide food and income for the family, often while balancing school and home upkeep. Children associated the virtue of love with those who provide for their basic needs, whether the provider was themselves, others, or God. Poverty may prevent willing persons from helping children in need, but persons lacking virtue will not provide for children, even when they are able.

The impact of basic needs on holistic health. Due to poverty and lack of parental care, children's basic needs for survival were often lacking, which was detrimental to their physical health needs for nourishment, personal hygiene, warmth, adequate rest, adequate clothing, adequate shelter, and protection from malaria. Psychological health was affected adversely as chronic stress when physical health needs were not met. Intellectual health was when there was insufficient income for educational fees, and perhaps adversely affected by insufficient caloric intake. Spiritual health was impacted through a greater reliance of God for provision of physical and psychological needs.

Experiential Context 2: Benevolent Belonging

Benevolent belonging was defined as *interpersonal connectedness to kind and trustworthy others.*

Benevolence was the most frequent virtue identified. Children placed a high value on benevolence. Benevolence is a social virtue that suggests a sense of claiming another as a worthy person, and in this way, benevolence implies a kind of belonging. One may 'belong' to another person in a neutral way, but it is *benevolent belonging* that children attributed to subjective well-being. Importantly, children experienced well-being when they were the ones who were sharing, helping, and loving others, that is, when they were the virtue-agent of benevolence towards another person. Children's need for acceptance and love was the most fundamental form of benevolent belonging.

Children deemed those who love them as morally good and trustworthy people. When asked what kind of people children need in their life to promote their well-being, children articulated their perception that goodness and love were directly correlated, to the point of being synonymous terms:

"When people love you and you also love them, it means they are good people"(Child #7).

"He [grandfather] is a good person and he loves children" (Child #2).

"[One who loves children] I consider him or her as a very good person" (Child #9).

Friends who are loving do good to each other like sharing. Harmful behaviors like fighting are not part of loving relationships:

"[A good friend] loves me and doesn't fight…[A good person] loves their friends and also likes sharing with their friends" (Child #2).

Furthermore, a person who fears [respects] God met children's criteria of a 'good' person:

"A God-fearing person is a good person because he/she knows that God is the creator and also that He is the one who takes care of people" (Child #9).

Behavior is an outward action that indicates moral intention, and therefore, behavior is a measure of one's morals and virtues. For children, a virtuous person was a trustworthy person, that is, a good person. The evidential link between personal virtue, good behavior, and trustworthiness, was apparent in the response to the interview question, "How do you know who to trust?":

"I always see with the behavior of that person" (Child #1).

"People who love their children and are God-fearing" (Child #9).

Virtuous behavior had positive benefits of social acceptance for Child #5:

"People love me because of my behavior. People always say that I have got a good behavior. I don't walk around with boys and I give respect to adults" (Child #5).

Most children described a good friend as one who listens empathetically to their concerns. Child #3 described a good friend as one who not only takes the opportunity to listen, but also heeds the advice given by a friend. To accept and adopt the wisdom of a friend shows trust and requires the virtue of humility:

> A good friend is someone who listens to my advice and not going to repeat the same mistakes the ones I have done. Most of the times I sit down with my friends and encourage them to concentrate on school, not boys, and if they have children they can go back to school. (Child #3)

Children personally experienced love. They were able to immediately identify those who love them, and usually responded with a smile that substantiated their answers:

"Jesus loves me" (Child #1).

"God loves me and my sister, too" (Child #5).

"God loves me… " (Child #4).

"My father" (Child #6).

"The children love me" (Child #7).

"My friends…[and brother and sister]" (Child #10).

In turn, children identified the ones they love, again with a smile:

"I love God and my sister" (Child #5).

"I love my sister" (Child #1).

"I love everyone…" (Child #4).

"I love my friends" (Child #6).

"I love my sister and all the children" (Child #7).

Bad people. "Bad" people, not surprisingly, were problematic for children. Malevolent acts by others (gossip, theft, violence, ridicule) were interpersonal sources of stress that threatened subjective well-being. Some children came from abusive backgrounds, indeed that is what led them to heading their own household. A 'bad' person has intentions to hurt others, as this child notes from personal experiences of being robbed and being ridiculed about being an orphan:

> [A bad person is...] Someone who is a thief and who use swearwords at his/her friends. We regard him/her as a bad person…There are some children they swear to me like 'your mother is dead', and this is one of the problems I faced. (Child #9)

Children's strategy for regulation of well-being in response to both interpersonal and intrapersonal stressors was seeking out benevolent others, and avoiding those who do not act benevolently:

> When we ask them [neighbors or friends] for food, they don't give to us so we stop going to them when we don't have the food. Maybe they just don't like to help and share the food with us. (Child #8)

Subjective well-being, then, was informed by virtue-related values, and the virtue-agency of self, others, and God. For children, the 'goodness' of virtuous others was evidenced by benevolent actions in word and deed. A 'good' person loves children, hence, good people are good for one's well-being, because love is good for one's well-being. Children not only sought out and affiliated themselves with virtuous others, but they also derived well-being benefits through their own virtuous actions. The virtue-agency of others and God was necessary for the subjective well-being of children.

Summary. Belonging to benevolent others was critical to children's well-being. Love and belonging within the family unit was a source of strength for children, both in their giving of love to their siblings and the receiving of love from their siblings. Children's relationships with others who exhibited virtues of love, kindness, and compassion towards them was given the same emphatic value as daily needs for food and income. Close, trusted friends brought a particular comfort and strength to children as they endured daily hardships of food insecurity and inadequate income. Children perceived a special benevolence from God who protected and cared for them, and answered their prayers.

The impact of benevolent belonging on holistic health. Children's physical health was benefitted by association with safe, loving people to provide for their needs and protection. Psychological health was promoted by positive interpersonal relationships of commitment and love. Intellectual development was promoted by children's affiliation with others who could help support them through their education, and who could teach them life skills. Spiritual health was directly related to a belief of belonging to God, and the accessibility of God to children for their needs.

Experiential Context 3: Experiencing God

Experiencing God was defined as *interpersonal connectedness to God*.

Experiencing God was an important element in children's lives. It was not just religious faith that children experienced. Children experienced God as the ultimate virtuous being, one whom they could call on any time for provision, protection, and healing. Children's perception of God was as a personal being characterized by the enactment of the virtue of love. The experience of divine love was simply phrased as a personal experience of love in which children expressed that Jesus loved them and God loved them. In order to honor children's valuation of God as a loving, divine being with whom they communed, trusted, and loved, use of the more ambiguous term, 'faith' was purposely avoided in favor of the more descriptive code, "experiencing God". All the children had a personal faith in God. Seven were Christian, two Roman Catholic, and one was Muslim, which is consistent with Malawi's national data on religious affiliation in which 65% of Malawians are Christian, 20% are Roman Catholic, and 13% are Muslim (Government of Malawi, 2011).

Children learned about God from their family, church or mosque, friends, and Miqlat's mandatory discipleship program. Child #8, a Muslim, had no objection to Miqlat's policy that beneficiaries attend the discipleship program:

> I come here [to Miqlat Hope Center] to eat food like nsima, and also place to worship and to play football. I am a Muslim but I believe God is one, so I don't have any problem with Bible teachings. (Child #8)

Sunday is a good day. Eight of ten children responded that Sunday, the day of worship, met their criteria of a 'good day', because of the hope and happiness that worship imparted to them. All children reported the importance of personal faith and worship in their lives.

In spite of a lack of basic needs, Child #7 described a "good day" in positive experiential terms of personal hope that comes from faith. Sunday is a day of experiencing the virtue of encouragement, and therefore the day is deemed 'good'. The opportunity to engage in worship had a positive effect on children's well-being:

″For me a good day is Sunday when I go to church. It is a good day because when I go to church I receive encouragement message and it gives me hope" (Child #7).

"Sunday is a good day for me because I go to church. [It is good because] I hear the Good News of Jesus Christ" (Child #10).

The experiential 'good' of Sunday arises from the hope-giving encouragement heard in the sermon message. Considering that a 'good day' could be described in any manner, such as a feast of fine food, the statements above from Child #7 and Child #10 highlight the salience of faith for subjective well-being through the development of personal hope.

Children commonly attributed happiness to the experience of hearing about and worshipping God:

"[A good day is…] Hearing the good gospel of Jesus Christ" (Child #2).

"[What I like about my life is] to worship God. I like that I want God to forgive my sin every time" (Child #8).

"They preach about the good gospel of Jesus. I feel very happy when I go to church and also reading the Bible daily" (Child #9).

Communion with God. For children, worship was interpersonal communion with God. For Child #3, well-being was regulated by worshipping God and experiencing God's enacted virtue of forgiveness. Through the child's interpersonal communication with God through prayer, forgiveness was received, subsequently granted to an offended friend, and discordant relationships were restored:

> What is good about life...is to worship God. It makes me very happy because when I have a disagreement with a person or misunderstanding, I pray to God for forgiveness and come the next day I will talk to that person like nothing has happened between us, and I don't keep any grudge and that is why I am a happy person. (Child #3)

Children relied on prayer to commune with God, to make Him aware of their needs, and God answered them:

> I always talk to someone who is closer to me [when I am sad or lonely] that 'I have this problem' and after that I pray to God…[Prayer helps children because] When they can ask God things that they need in their lives, God is able to give them and answer their prayer. (Child #1)

Development of faith required personal motivation and the exercise of virtues like commitment and responsibility: "..and I don't only depend on my church I go also to fellowship with other believers and do fasting" (Child#3). The spiritual discipline of fasting was practiced by Child #3 one week every couple of months. She fasted and prayed during the day, and broke the fast in the evening.

God the Healer. Central to children's understanding of God was His divine benevolence, as the one who will help them in time of need, even for physical healing: "When I get sick, God heals me" (Child #2).

God the Protector. God was also a protector for children:

> If there is something unsafe or we are not comfortable with, we just kneel down and pray to God for protection…My faith in God helps me because whenever I have problems I pray and He answers my prayers. (Child #3)

God's virtuous agency was not only for provision, but also for protection from evil and healing from illness. Child #8 credited God with protection from witchcraft:

> We face a lot of dangers since our mother is sick…like witchcraft. It is more like misfortune and it comes in a spiritual way and sometimes can see a snake in the house and at night we have been experiencing a lot of witches coming to attack and destroy us…We just pray and ask God to protect us. God is my helper. When I am sick He heals me and when I need something He provides to me. (Child #8)

To understand the context of this child's experience of witchcraft, I consulted one of my adult informants who was a pastor. He described witchcraft as a complex phenomena which cannot be seen in action, but only its results can be seen. He explained, "witchcraft is the practice of using supernatural, evil forces to harm others or get wealth through the suffering of other people" (Pastor #1). For example, the pastor knew a man who had an affair, and was immediately rendered a permanent paraplegic after a witch doctor was consulted by the husband of the woman with whom he had an affair. Witch doctors may advise a person to commit evil acts like bestiality, incest or a murderous ritual of one's own child. For failing to fulfill this, one becomes mentally or physically unstable. The pastor believed these powers were real but he is not afraid because, "God has more power than all the witches combined" (Pastor #1)**.**

God the Rescuer. God was credited with empowering children through His virtue-agency of love through opportunities to rescue, comfort, and provide resolution of children's life's problems:

> God loves me and I am here today because of His love….God loves me and when I was in a big problem, He rescued me and He answered my prayer and that is why things are better now…It [faith] helps me a lot and my life has changed from before. These days I put much of my time on church activities than thinking a lot and getting worried over things. Whenever I have problems and when I pray to God, there is solution and my problems are solved. (Child #4)

"…God is the creator and also that He is the one who takes care of people...God helps me in the way that when I ask Him, He provides to me" (Child #9).

God the Comforter. Children's faith comforted them and gave them self-control:

"It [faith] makes me not to get worried too much and also not to do some other bad things" (Child #1).

"It [faith] gives us hope and encouragement that whenever we have problems, we should not get worried" (Child #5).

"[Faith helps because] It encourages me to pray…and I read my Bible" (Child #6).

God our Hope. Encouragement from God was not only obtained through prayer, but also from faith in God's future benevolence found in the Bible verses Child #9 had memorized. The verses speak to the day that earthly existence is over for all of humanity.

For God's people, the belief is that it will be a day of joy when everything hard in life is forever over. The hope in God's future virtue-agency is, for this child, a real and present hope for today:

> I pray to God and I also take my Bible and read, and this is what encourages me most. Like in the book of Psalms it encourages me and it says that "God is going to wipe all your tears", and also Revelation 21:4 says, "God shall wipe away all tears from their eyes, and there shall be no more death, neither sorrow nor crying, neither be any more pain, for the former things are passed away." And John 5:28 says, "Don't be afraid, for the hour is coming in which all that are in the graves shall hear His voice and they shall come forth, they that have done good, unto the resurrection of life, and they that have done evil unto resurrection of damnation", and these verses encourage me very much. (Child #9)

Faith was crucial to building courage and resilience in children: "(The Word of God) gives me courage. It gives me hope in every problem that I am facing" (Child #10).

Summary. The experience of God was a very personal and deep aspect of children's subjective well-being. Their faith was not communicated in terms of religious duty, but in terms of communion with God. God was a source of happiness for children, especially during weekly worship services. The virtues of God as a dependable, benevolent, kind God who hears the prayers of children equipped children for coping with daily life. It was God's personal influence in children's lives that gave meaning and growth through difficult hardships in their lives. God's presence and involvement in children's lives affected every dimension and every need of their lives.

The impact of experiencing God on holistic health. Children's physical health was often dependent on God's provision for food and protection. Prayer to God in times of worry or fear had a calming effect on children's psychological health. Intellectual health was cultivated through reading Scriptures, understanding personal faith, and hearing the message of God on Sundays. Spiritual health was fostered through spiritual disciplines of prayer, fasting, and worship.

Experiential Context 4: Growth through Adversity

Growth through adversity was defined as *the capacity to develop positively through hardship.*

Adversity was cited by older children as an opportunity for personal growth, maturity, wisdom, empathy, and faith, indicating that adversity can, in the long run, be a means to greater subjective well-being.

The harsh reality of poverty. The effects of poverty upon children were real and harsh. Nearly all children stated that their family regularly suffered from hunger due to food insecurity. Surviving poverty required inordinate amounts of physical and emotional energy:

> It is very hard for a young person like me taking care of my own [three]children and my sister’s [three] children, who is right now very sick and she is older than my age…The problem that I face with the children and my [disabled] sister is food shortage. The other problem is that it is hard for me to buy clothes especially for my sister, and as how she doesn’t have spare clothes apart from the one she has dressed [is wearing]. I depend on piece work. (Child #7)

Another child dealt with adversity by facing each challenge as it arose: "We were just living a perseverant life, in whatever was happening to us" (Child #5.)

The demands of poverty constrained opportunities for experiencing happiness found in leisurely family interaction:

> I don’t have time to stay home and relax. Every day I go and look for piece work so that we can find something to eat with the children and my sister. With that there is not any happiness in me every time because of the situation that we are facing. (Child #7)

The hardship of poverty meant that having enough food and being healthy made for a very good day:

> To me a good day is a day when I have found money and we have food to eat in our house. When I am not sick is also a good day to me and when I have played well with my friends without any quarrel. (Child #1)
>
> Simple pleasures also meant worshipping at church: "For me a good day is a day when we have a nice meal in our house or when I go to church” (Child #5).

Opportunities for relaxation and enjoyment constituted a good day: "A good day to me is when there is a football match or any other cultural activities so when I go and attend, I feel good and have fun" (Child #8). A ‘bad day’ in the life of a child was described as a funeral, illness of self or family, or a lack of food.

Comfort through love. Youth-headed families exercised the virtue of benevolence by participating in comforting activities: "When I am sad I just call the children and start singing Gospel Choruses together" (Child #7).

Love, the ultimate virtue, was an interactional experience with family and God: "The children love me…I love my sister and all the children…I feel that love [of God]" (Child #7).

Importantly, poverty did not preclude children's sense of benevolent belonging to family, friends, and God. Children believed that those who practice the virtue of love are morally good: "When people love you and you also love them, it means they are good people" (Child #7).

Yet happiness did not entirely elude Child #7, because of the virtue-agency of the younger nieces and nephews in their disciplined care of their mother:

> What makes me happy about the children is that, whenever I am not home they go to the borehole and fetch water. When they are back they give that water to their mother to drink and bathe. They also cook porridge and give it to the mother. They take care of my sister and I am happy about it…(Child #7)
>
> Harmony in the family contributes to positive subjective well-being of the mother: "What I like about my children is that they don't like fighting each other and they are always together" (Child #7).

Virtue development through adversity. Children attested to the positive personal assets of strength, wisdom, empathy, forgiveness, and kindness that were fostered through personal adversity. Personal inner strength was a positive outcome of successfully enduring life adversity: "I’m very strong because I grew up in problems" (Child #4).

The problems Child #4 endured began in 2005 at age 12 when her mother died the same day that she reported a headache. Child #4 and her sister went to live with grandparents who began "beating her up", attempted to force her to get married, and took some of the parent's property. At age 13, Child #4 reported the problems to the school, and an administrator called the relatives to admonish them. The grandparents continued their ill treatment until Child #4 was age 16, in Form 3 (11th grade). The next year, in Form 4, Child #4 moved away to a boarding school. She is now back home in the village, the head of her home, and caring for a younger sister.

The adversity experienced in interpersonal relationships led Child #4 to develop wisdom and discernment. As a consequence of personal adversity, the virtue of empathy was fostered, which the child perceives as a permanent virtue:

> [Regarding the lack of love from others who are able to help but don’t] It has made me to understand the behaviors of different people and how to have a heart of perseverance and well-discipline to myself. It has made me to know people to trust or not to trust and with the challenges that I have been facing and I now have a heart to help other people when they have problems, as of now or in future. (Child #4)

Adversity, then, for Child #4, became an opportunity to exercise and build personal virtues of wisdom, discipline, perseverance, and empathy, that create empowerment for coping with her present life. Just as importantly, the child’s view is that the well-being capital of personal virtues for the present day also constitutes her well-being capital for the future.

Child #4's story of personal strength in adversity is incomplete without faith in God, because the child ultimately credits God's virtue-agency for her subjective well-being:

> God loves me and I am here today because of His love…God loves me and when I was in a big problem, He rescued me and He answered my prayer and that is why things are better now. (Child #4)

The benevolence of God in adversity. For Child #4, God's ultimate virtue of love included benevolent protection and provision. Importantly, the child's experience of God was an interpersonal interaction that was situated in the interpersonal virtue-language of love. The child exercised self-agency for well-being by petitioning God. The child's pleas were heard, and God responded with active demonstration of love by 'rescuing' the child. God's virtue-agency was credited for Child #4's present experience of subjective well-being.

Children's regulation of well-being often centered on the triadic agency of self, others, and God. Child #1 related how he was denigrated by others to his guardian aunt and found strength in her virtue-agency of encouragement and her wise insight of the maligners' motives of jealousy. Through the child's prayers, God's virtue-agency was accessed, resulting in the child's capacity to forgive the maligners and to exercise kindness towards them:

> Some of the people in my village were telling my aunt that 'Why are you wasting your time and resources sending that child to school. He is not your son, why

> can't you just leave him out of school, and when he is done with his education he is not going to help you at all. I wasn't happy about it and she was encouraging me that I should not be discouraged on what people were talking about. It was more like they were jealous that I should not be educated like their own children. I just forgive them and it was what my aunt told me before she died. I was just praying that God is going to give me a way out. For those people who were talking about bad things, when I have seen them I always greet them even if they are not interested to talk to me. When they have sent me to do something, I was doing because they thought that maybe I was going to refuse. I was doing whatever they told me to do so that I should prove them wrong. (Child #1)

Happiness in adversity. Adverse experiences do not preclude times of happiness. Children attested to experiencing happiness during worship, in the love of friends and family, and the pleasure of observing their siblings caring well for the rest of the family. Children's experiences of happiness also consisted of the everyday events of a healthy childhood, like spending time with friends, receiving gifts, helping others, playing games, doing well with school studies, enjoying a good meal, and having good health. The examples below speak to children's valuing of family bonds, and imply that the opportunities for enjoyable bonding experiences exert a regulatory effect on subjective well-being:

"When it is dark before going to bed, we sit down together and share our different stories that we heard or happened to us during the day. Then we laugh together, then go to bed" (Child #3).

"We [family] like chatting with my brothers and sisters after coming from the garden or school" (Child #10).

Happiness in adversity may seem paradoxical, especially for children who are newly orphaned who perhaps wonder if life will always feel as bad as the present grief. Child #9's answer to the interview question, "What advice would you give another child who just now became the head of their household"? speaks to the healing effect of time:

> Don't worry because your mother has passed away, even us, our mother passed away long time ago but we stay always happy. So don't worry that you are going to stay only children. (Child #9)

Child #9's answer centers on the personal experience that happiness can, indeed, exist in the midst of adversity from grief and loss. The answer implies that Child #9 may have expected chronic sadness or hopelessness after her mother died, yet has lived to see that happy moments are still possible, even as a regular occurrence. Her answer was informed by the virtue of compassion, as her answer reflects feelings of empathy for the newly orphaned child.

Other advice to new youth-headed households prioritized the virtues of love, benevolence, and empathy. Children's advice implied that love mitigates adversity by empowering and encouraging children. The meanings behind children's value-laden language revealed the depth of what children deem necessary for subjective well-being. Virtues of love, compassion, and encouragement were not only expressed by children as a desired goal for well-being, but virtue was also their prescriptive response for another child’s poor well-being from the acute loss of parents, ‘wrong’ behaviors, and the need to be heard:

"I tell him/her to love their siblings…When he/she has done something wrong, you have to discipline him/her [out of love]..I can encourage that person to stay well with his or her siblings" (Child #3).

"I can support her and give her word of encouragement" (Child #4).

"If that person has got a sister, I can advise both of them to listen to each other and also loving each other so that everything can go on well between them" (Child #5).

"I tell him/her to love their siblings…Love includes discipline for wrong" (Child #10).

"I wish I could meet with that person so that we could become friends and start to encourage each other about our situations" (Child #8).

The observation that virtue informs children’s values of what is good and right in life was reinforced by considering what types of advice children would *not* offer to newly formed youth-headed households. Children did not offer advice about strategies for finding food, income, shelter, or educational fees, though these basic needs are, by their own admission, difficult to come by, leaving them hungry, cold at night, and, in some cases, uneducated. Rather, children’s advice was reflective of what contributes to their own subjective well-being experiences, for a child would not advise that which they do not value. The virtue-agency of self and others within the opportunities afforded by interpersonal relationships, particularly within the family, was recognized by children as the greater substance of subjective well-being. This is not to suggest that basic needs are not important, for obviously all children need food, water, and shelter to survive. Rather, the intent here is to draw attention to what children ascribed to a ‘good’ life, and for children, a ‘good’ life was one imbued with the ‘good’ of virtuous others, in addition to having opportunity to have their basic needs fulfilled.

Summary. Daily formidable challenges confront children who live in abject poverty and without the protective care of parents. Multi-dimensional vulnerabilities threatened children's economic, social, psychological, and academic security. Yet even against great odds, children showed remarkable resilience and maturity in finding meaning, even happiness, in their lives. Children were astute about the virtues needed by themselves, from others, and from God, for positive growth: compassion, kindness, love, discipline, and responsibility.

The impact of growth through adversity on holistic health. Physical health may suffer during adversities of poverty, loss of parental care, crop failures, and inadequate income opportunities. Psychological health was compromised during grief, the stress of poverty, interpersonal discord, and victimization. Adversity did not preclude periods of happiness and experiencing love of family and friends. Intellectual health was challenged by educational losses. Spiritual health was often increased as a result of adversity because of faith and reliance on God for physical and psychological sustenance. Virtues of compassion, patience, maturity, and wisdom were positive outcomes of adversity.

Experiential Context 5: Help

Help was defined as *material (food, money, or physical goods) or non-material (advice, encouragement) help received from others and God.*

Help received from others and God, and help given to others was commonly cited by children as a positive experience. The help of God was described in detail in *Experiential Context 3: Experiencing God*. Help was divided into two forms: material help (food, money, or physical goods) and non-material help (encouragement or advice). The virtue-agency of others in the lives of children was most often connected with the concept of help. In acts of helping, a personal relationship was implied, for when one is the recipient of goodness, the giver has likely chosen to be helpful. Actions of help are deliberate expressions derived from a feeling or obligation of benevolence, regardless of whether the helpful other is known to them or not, and thus, children regard these people as virtuous. Help from others is interpreted as the enactment of the virtues of kindness and benevolence, and can fulfill both material and non-material forms of personal need as in Child #4's story that both forms of help are necessary and inseparable in their importance for academic success:

> Both [education and a caring adult] are very important because even if there was people to pay for my school fees, but without anyone to advise me I couldn't have reached Form 4. (Child #4)

Children reported that virtuous people who help children with both non-material and material needs are the kind of people that children need most in their lives:

> "People who can encourage us about school and give them support for their education" (Child #1).

Help to children in many instances did not come from the family, but from friends, and even strangers, as in the case of this youth whose mother was chronically ill and needed assistance to get her to the clinic for medical care:

> We carry her [mother] on the bicycle [to the clinic]. We ask someone to help hold her [if she is not strong enough to ride the bicycle]. Our relatives or neighbors they don't help us, but the people who help us are from far distance, the ones who are just passing by. (Child #8)

The help of advice and encouragement. Advice and encouragement were the most common forms of intangible help since community poverty prohibited others to provide material help to children. Givers of non-material help were family, friends, and God.

Examples of advice include admonitions not to worry, to love, and to behave well:

> "They encourage me not to worry or think too much over my life" (Child #1).
>
> "Some of the relatives encourage us to love each other and that I should always obey and listen to my sister" (Child #5).

"They [people from the village] advise me that I should be careful and safe with my life and also that "since your mother is sick, give her good care" (Child #8).

People who encouraged children's faith were viewed as helpful:

"[Since people cannot give material help] They only encourage us with the word of God. They don't read the Bible to us but they just refer our situation with the stories in the Bible" (Child #5).

Children give help to others. Children exercised the virtues of kindness and empathy to give help in the form of comfort to their siblings:

"I encourage them [siblings] not to worry" (Child #3).

"I take my brothers for a walk [when they are sad]" (Child #8).

Children receive help from friends and family. Conversely, children received comfort from family and friends through listening, playing, and being understood by others when they were troubled:

“I go to play with my friends so that I can get over it [referring to gossip]” (Child #3).

“[Comfort is from the sister] because she is the only person who understands me when I have a problem” (Child #5).

“[I find comfort]…when I chat with my friends with any disappointments” (Child #4).

Help was described by children as an ongoing reciprocation of the virtue of kindness between friends:

"We [friends] listen to each other, when she has asked me to go and help her at their garden I do that and the same with me" (Child #5).

"They [friends] encourage me not to get worried. We play netball and study our books" (Child #8).

Among friends, help was manifested more specifically as mutual encouragement to maintain personal virtues of perseverance in order to do well in school, exhibit responsible personal behavior, and exercising kindness towards friends:

"I am close to my friends…We encourage each other about our education and also how to take care of my siblings" (Child #9).

"We [friends from other youth-headed households] help each other. We discuss issues concerning how dangerous is HIV/AIDS" (Child #8).

"We [friends] encourage each other about education and also to stay away from boys. We teach each other good behaviors" (Child #10, whose best friend is also the head of a household).

"A good friend is someone who listens to my advice and not going to repeat the same mistakes, the ones I have done. Most of the times I sit down with my friends and encourage them to concentrate on school, not boys, and if they have children they can go back to school" (Child #3).

Having a friend was a simple, but intimate, everyday experience for the youngest child (age 10) in the sample:

"We [my friends] just love each other. We like to play, we do jingles [a type of game]" (Child #2).

Judgment of those who do not help children. Children apply the same moral judgment criteria about helping behaviors to the community members as they do their family and peers. When others were incapable of helping, no one was blamed:

"I think since we are orphans, it is very hard for them to assist us because they have got their own children and families to take care of, their own responsibilities again" (Child #1).

Likewise, "Almost everyone in our church is poor, so it is hard to receive [material] help" (Child #7).

Cultural traditions partly determine how virtue was enacted and towards whom. In this next example, Child #4 determined the extended paternal family was not morally culpable for not offering help to the child, because the cultural tradition is that responsibility for child care lies with the maternal kin:

> [The paternal grandmother does not care for children because] she is also taking care of other grandchildren who are orphans, and my grandmother is related on my father's side, so we are not the only people who need her help. (Child #4)

By contrast, the cultural expectation of help from the maternal extended family was the basis of Child #5's three astute moral distinctions about the helping behaviors of relatives: (1) relatives who have the means to help, but do not, (2) relatives who have the means to help and do, and (3) relatives who have the desire to help, but do not have the means to help:

> …those [adult] children they assist her [an older adult maternal relative] but she still doesn't like to share us things. There is our cousin and she is the one whenever we don't have things like flour or soap, she gives us. There is also my older brother…married and has got two children. So he also lacks things in his family and he cannot assist us, too. (Child #5)

Child #4 provided yet a fourth moral distinction about helping, that the ignorant are not guilty of not helping because they cannot understand: "I think [other] people they don’t know what it means to be an orphan and they don’t understand our problems" (Child #4). But for those who rightly understand children’s needs, their refusal to help when they were able was blamed on a lack of the virtue of love: "Sometimes they [others] do [understand problems of orphans], and these people have lack of love in their heart" (Child #4).

Children's ideas of help spanned multiple situations, and included both material and non-material needs. The preeminent findings for the *Experiential Context 6: Help* were (1) virtuous people give help to children in need, (2) virtueless people do not give help to children in need, (3) family members may or may not be reliable sources of help, and (4) God is a virtuous giver of help. Regardless of the form of help, receiving and giving help was necessary for children's subjective well-being for physical health, psychological health of interpersonal connectedness and belonging, intellectual development through formal education and advice, and spiritual health of comfort and help from God.

Summary. Help was the broadest experiential category for understanding children's subjective well-being. Children's needs are great and their capacity limited, leaving them in need of help from benevolent others. Children were willing to help themselves and others, especially siblings and friends, as much as possible, and for this reason desired to continue their education, to learn more effective farming practices, and to advise and encourage other youth-headed households. People who helped children were regarded as good and virtuous. God was a very real help to children for physical, psychological, and spiritual well-being.

The impact of help on holistic health. Physical health was improved through the help of others by provision of food, material needs, and protection from unwanted people. Psychological health of children benefitted from receiving help from others and God, and from children giving help to others in need. Intellectual health and growth was fostered by the financial help of others, and the non-material help of encouragement to persevere through school. Spiritual health was kindled by weekly worship, experiencing God's help, and the friendship of church members.

Experiential Context 6: Hope

Hope was defined as *visions, goals, and desires for the present and the future*.

Impoverished children dream of a life with sufficient food and income. Children connected future material sufficiency with education. In the words of Child #5, the most important thing for children, "Is education and for them to become independent."

Hope was most often linked to completing an education:

"The most important thing for the children is education and to be God-fearing children" (Child #3).

"The very important thing in the life of every child is education, and to have all school resources" (Child #9).

"I would like my siblings to become educated" (Child #7).

"The very important thing that I wanted in my life was my education and by grace I found it" (Child #4.)

Not all children cited education as their future hope. Child #1, who had stressed the importance of education for one's future, qualified his statement further by stressing the importance of living a productive life, accompanied by a dependence on God, both of which require the virtue of personal discipline: "[Children need to] be somebody in the future and a pray-er [a person who prays]" (Child #1).

Children viewed education as a means for greater virtue-agency for opportunities to help others. In this way, education is a path to a career that allows them to exercise compassion and courage:

> I want to become a doctor because I want to help and reduce youth-maternal death which is common in this country. A lot of children and mothers they die while giving birth in hospitals and their communities. (Child #1)

> I would like to be a nurse or soldier. I want to protect my country against enemies. I would like to become a nurse because most of the death cases happen because there are more patients in the hospitals yet the nurses are not enough. Nurse shortage leads to high death rates because those people they lack adequate health care when they go to the hospital, and I am interested to save the lives of other people. (Child #4)

Finishing a post-secondary education was tied to the hope of greater opportunities to exercise compassion and generosity: "First of all, I am interested to help my friends who are just like me, who are orphans. I am also going to help my relatives" (Child #4).

Hope for the future was directly related to the virtue of today and rejecting opportunities for personal ruin:

"I don't like to associate with people at school who drink beer and smoke Indian hemp. I know with those behaviors I can destroy my future" (Child #1).

As discussed in *Experiential Context 3: Experiencing God*, faith in God contributed to the hope of children. God provided for them, protected them, and calmed their worries. God was a source of hope for present and the future well-being.

Summary. Children's future hopes centered on being freed from poverty. They believed education is the path to financial independence. They also desired to financially help their families and other orphans, and to meaningfully contribute to society through their work. Being a good citizen in the future was contingent on being a responsible and virtuous person now.

The impact of hope on holistic health. The future orientation of hope that begins in the present means that physical health now, such that nutrition and health safety practices directly bear on the future health of the body. Psychological health was bolstered by hope in future goodness and life satisfaction. Intellectual health today combined with the discipline for academic achievement positively affect the chances of reaching future career goals. Spiritual health was characterized by hope in God and serving God.

Experiential Context 7: Intellectual Development

Intellectual development was defined as *cognitive development through education, problem-solving, and skill development.*

Education is a prominent value. Education was valued for enabling economic independence to enlarge family resources, the ability to provide for family members, and the pursuit of a vocation that would enable them to help others. Intellectual development included formal education, skills, and problem-solving. The value children placed on education was reflected in responses to “Whom do you most admire?”:

"[I admire] the President because she is educated" (Child #8).

"I admire everyone who has finished their education" (Child #9).

Education was so prized among children, that they judged others as virtuous when others esteemed the value of children’s education:

[Description of a ‘good father’] "He wants us to finish our school and be educated and he gets happy when he sees us going to school" (Child #9.)

[Description of one who loves children] "I consider him or her as a very good person, because he or she is able to encourage the children to go to school because school is very important" (Child #9).

[How the sister shows love] "She gives me food and encourages me to work hard on my education" (Child #1).

Education was not only a prominent value, but a prioritized opportunity that required virtues of discipline and perseverance, as evidenced in this answer to the question, “What do children need most?”:

"The most important thing for the children is education and to be God-fearing children" (Child #3).

"The very important thing in the life of every child is education, and to have all school resources" (Child #9).

"They have to work hard and focus on their education" (Child #1).

Children attested to their enjoyment of school, and each was able to state which academic subjects were their strongest areas. Even with the responsibilities of providing for a family and the requisite discipline required for school studies, this child's happiness about school performance was obvious: "(grinning) As of now, I should not lie – my school is going on well (laughs loudly)" (Child #9).

Intellectual development was not limited to formal education. Skills, talents, and problem-solving were forms of intellectual capital identified in children's narratives. Personal skills included athleticism, housekeeping, cooking, entrepreneurship, academic success, good behavior, resourcefulness in finding jobs, caregiving, house construction, and reading.

According to Child #9, who routinely spent several hours weekly speaking to community members about Jesus, the capacity for skill development and the exercise of personal skills should not be limited by age: "Jesus Christ when he was preaching about the Good News, he was very young, so it's not about age but it's all about your interest" (Child #9).

Education is an investment in the future. Education was a personally important goal for children for three reasons: (1) Children wanted to develop skills of literacy, math, problem-solving strategies, and vocational skills, (2) A completed education was believed to mitigate against a future of poverty for themselves and their family, and (3) Education was viewed as a pathway to helping others in professional careers like nursing, medicine, and the military.

First, children believed education was necessary for one to be prepared for job opportunities: "If you are not educated, you miss a lot of opportunities in life because there are some other things which need someone who knows how to write and read" (Child #7).

Second, education was a prominent value in the lives of youth-heads of household because it was perceived as an investment in future opportunities for a better life:

"School is important because I know when I will finish I am going to find a job and be economically independent, not depending on other people to assist me" (Child #3).

> "I would like to have a future without all of these problems and difficulties everyday and have things we need in the house… I am interested to go back to school" (Child #7).

Third, children valued education because they associated education with an enlarged future capacity of virtue-agency for responsibility, kindness, benevolence, and empathy to be exercised in professional opportunities. The value of education was perhaps no more profound than in children's visionary statements of their future capacity for virtue-agency in a helping profession. Education was related to children's ideas of life purpose, namely, capacity to support their families, and to serve God:

> I want to go back to school. When I finish my school I want to find a good job. I would like to be a doctor. I would like to help the patients because there are some doctors in hospitals who give improper care to their patients. They just look at them without helping the patient with medical support. A good doctor is the one who helps a patient immediately when he or she has come to the hospital. (Child #5)
>
> "[I want to be a] Nurse [because] I want to be helping sick people" (Child #6).

"I want to be selected to go to secondary school. I want to have myself employment so that on the other hand I will serve God" (Child #9).

Poverty threatens educational goals. Poverty was the greatest deterrent to educational opportunities for both primary and secondary school students. Primary school, while free, requires students to pay for uniforms and supplies, a cost that is impossible for impoverished families. Secondary school imposes an even greater financial burden because tuition must be paid by the family, in addition to uniforms and supplies. Children relied on the generosity of others (relatives, politicians, Miqlat USA) to attend school. The economic independence children associated with education may be understood within the virtues of benevolence and discipline as children desired to unburden others by becoming financially self-sufficient themselves.

Children and family members used extra income for school supplies instead of other needs, which testified to the high value of education: "Sometimes when I have done piece work and I have received money, I buy school materials like exercise books for them [children, nieces, nephews] and pencils" (Child #7).

The strong desire to attend school fueled Child #4's clever ingenuity for obtaining school fees when the relatives stopped their financial contribution:

> Then it was time close to elections so a lot of political party leaders were making campaigns, so that people should vote for them. I wrote a letter asking if he can start paying my school fees and he said yes, and he started paying for my school fees and I started my Form I….So because he was busy with some other activities, he didn't pay my school fees for one term and I was chased from school. And I

> stayed at home for two weeks. And after that I came here (to Miqlat)…and they agreed to start giving me support and registered me in this program. (Child #4)

Summary. Intellectual development for children centered on the concept of formal education, and to a lesser extent, included skill development, problem-solving, and pursuit of interests. Education was a highly prized personal value for children's subjective well-being. Poverty was the primary constraint children faced in completing their education. Extra resources were often allocated to school fees rather than to other basic needs. Children believed people who encouraged children in their education were good and trustworthy people.

The impact of intellectual development on holistic health. Physical health improvement is possible through increased knowledge of crop production and income from crops, vocation, or profession. Psychological health from intellectual development arises from the enjoyment of intellectual stimulation, problem-solving skills, and achievement. Intellectual health was directly fostered through formal education and skill acquisition. Spiritual health correlated with intellectual development of reading skills for learning from religious scriptures and articulating one's faith.

Experiential Context 8: Protection

Protection was defined as *safety from harmful events, persons, or spiritual forces*.

Protection of children means they are shielded from the effects of tangible and intangible threats to their well-being. The experiential context of protection was closely related to the experiential context of help. People who helped children were simultaneously protecting children. Personal needs of children implies that fulfillment of said needs will contribute to their subjective well-being. People were motivated to help children when they recognized their need and were willing to actually help. When children were protected by the help of God and others, their well-being was bolstered.

Poverty exposed children to harmful health risks to their minds and bodies, and by extension, to their well-being. No child had adequate housing, enough food, money, clothes, blankets, or mosquito nets. Exposure to the elements, particularly rain and cold, were regular occurrences. Protection was necessary to avoid the harms of poverty, environment, bad people, illness, or witchcraft. Examples of protection included adequate housing, sufficient clothing, avoiding harmful people, seeking healthcare when needed, and prayer. The virtue-agency of others in giving food or money was of great import to children's protection against hunger, but opportunities for practical forms of protective help were lacking because of widespread poverty in their communities.

The virtue-agency of others was crucial for the protection of children’s well-being against bad people. One child who narrowly escaped an attempted rape by a teacher, received no help from her guardian grandmother, but instead was helped by teachers who investigated the matter and the man was brought to justice. The virtue-agency of others was a major factor in children’s subjective well-being, not only for happiness, but as this example shows, for timely protection from additional victimization that can harm well-being.

The virtue-agency of others was also protective of children's emotional well-being when they were suffering the grief of losing a parent. The loss of the emotional stability afforded children by loving parents can leave children emotionally vulnerable. The virtue-agency of benevolent, compassionate adults in the lives of children who are now faced with the task of raising themselves and their siblings was a welcome protective factor.

Conversely, a lack of virtue threatened children's safety and protection. Virtueless others disregarded the needs of children, which led to immoral acts of victimization like stealing food from children at night or while they were away from the home. Such acts sabotaged children's fulfillment of basic needs and threatened their physical and emotional health. The danger of victimization was perpetuated by a lack of legal infrastructure:

The danger that we face is that since our house is not complete and when we have money thieves easily enter into the house and steal our money…and maize flour…There is nowhere we can report [the crime]. (Child #5)

One child was frequently bothered by boys coming around her house. It was her "uncles" who lived nearby whom she could turn to if the boys became too threatening. Having a trusted, benevolent adult to turn to for protection is important, especially for girls.

God was portrayed as a divine protector of children as discussed in *Experiential Context 3: Experiencing God.* Children experienced protection of their bodies through God's provision of food, protection from worries, and protection from spiritual danger like witchcraft. When children were scared, they would kneel and pray, and God would protect and comfort them.

Reciprocity of help between friends was a form of protection through philanthropy. Children knew that when they helped others, then in the future when they themselves needed help, they could count on the friends they helped in the past.

Children recognized that virtue was normative for the protection of their subjective well-being. This was evidenced in their directives about the beneficial effects of good behavior and the detrimental effects of behavior stemming from poor choices:

> They (children/siblings) don't misbehave because they know that we don't have parents. Those children who misbehave know that there is someone to look after them…I just tell them that they are killing themselves if they misbehave…I tell him/her [if they misbehave] that "Today you are not going to eat.' [laughs] (Child #3)

> I like to have friends with good manners but not those who go and drink or smoke, no. I need friends that we should encourage one another about school and not to be sleeping with girls. If one sleep with a girl it is easy maybe to make her pregnant and this can make both of you to stop school. You can also get sexually transmitted diseases like AIDS, syphilis and gonorrhea….sometimes the boys they refuse that they are responsible for that pregnancy. (Child #1)

Summary. The protection of children is important to their subjective well-being, and is closely related to the experiential context of *help.* Helping children was a means to the direct and indirect protection of children. Direct forms of protection included economic and food support, protection against harmful people, and emotional support. Indirect forms of protection included responsible virtue-agency in interpersonal relationships, personal integrity, and nurturing personal faith. Proximity to benevolent people and maintaining a safe distance from unkind people was a deliberate form of self-protection for children, a way of maximizing favorable influences in their lives, and therefore constituted a path to positive subjective well-being.

The impact of protection on holistic health. Physical health was promoted through protection of the body from weather, illness, poverty. Psychological health was benefitted by protection from virtueless people, and by the help of others. Intellectual health was protected when school enrollment was assured. Spiritual health was dependent upon God for protection from physical, psychological or spiritual threats.

Research Question 2

Research Question 2:What are the factors associated with subjective well-being for youth heads of household?

Following identification of the *Eight Experiential Contexts of Subjective Well-Being*, transcripts were examined for clues to what factors impact subjective well-being experiences. The purpose of the *Eight Experiential Contexts of Subjective Well-Being* was to describe what *types* of experiences contribute to subjective well-being, but did not explain what elements were necessary for achieving well-being within each context. The analysis for *Research Question 2* revealed two requisite factors for subjective well-being experiences: (1) the virtue-agency of self, others, and God, and (2) opportunities for value-fulfillment.

The factors of subjective well-being, virtue-agency and opportunity, imply that the promotion of subjective well-being is a *process* between youth and their lifescape (Figure 3). The engagement at the social interface of one's virtue-agency with opportunities is the process whereby children's tangible and intangible values for their subjective well-being are fulfilled, and experienced within the *Eight Experiential Contexts of Subjective Well-Being*. Tangible needs of food and income were as prominent in children's narratives as intangible needs for love, belonging, and faith. For children, virtues not only *informed* self-agency, but also *directed* their self-agency efforts aimed at promotion of well-being.

The virtues of responsibility, discipline, and love, were the means of children's agency for fulfilling basic family needs. Children's *virtue-agency,* that is, their enactment of virtue, was evidence of the value they ascribe to human life. Virtue-agency was a function of opportunity. Virtueless others, such as thieves, child abusers, and people who were capable of helping but refuse, are people who morally failed to act virtuously.

Virtue-Agency of Others

The evidentiary statements for *Research Question 1* highlighted that other people may act as virtue-agents on behalf of children's subjective well-being. Virtue-agents are trustworthy persons who are able to safeguard a child's well-being. Trustworthy persons were cited by children as being both God-fearing people, and people who love children. From a child's perspective, a trustworthy person is one who possesses the virtues of humility and compassion. Given the vulnerability of orphaned children for victimization, the virtue-agency of others was not only necessary for the promotion of their well-being, but also critical to protection of their well-being.

Virtue-Agency of God

Virtue-agency was not only an attribute of self and others, but also an attribute of God. The virtue-agency of God was critically important to children's subjective well-being. Their faith was characterized by an interpersonal relationship with God, who divinely and benevolently acts on their behalf. Children spoke of God in very personal terms, regardless of religion or denomination. They talked with God in prayer, sought comfort from Him when sad, asked Him to provide their daily food, called on Him for healing, ran to Him for protection from evil, requested His help, and experienced His forgiveness. For the majority of children, Sunday, the day of worship, was proclaimed as ‘a good day’. The ‘good news of Jesus Christ’ was a reported source of happiness. Because God is a divine but personal being to children, the relationship with God is imbued with the qualities of interpersonal relationships. The intimate, personal nature that children ascribed to their relationship with God was evident in their perception of a mutual love between them and God.

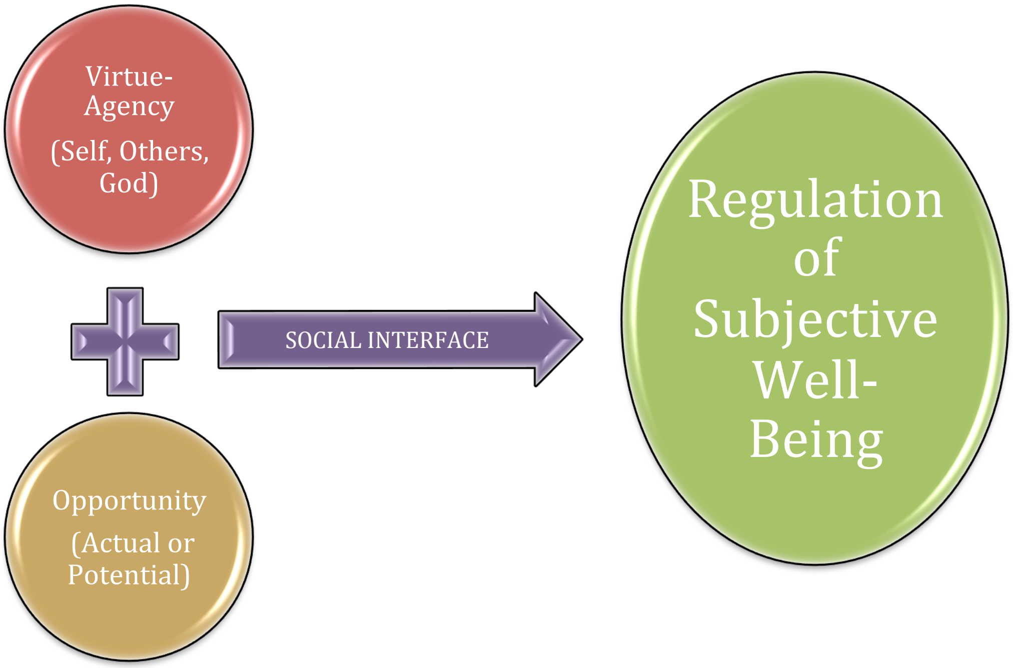
Accessing Opportunities

Opportunities referred to any material resource, program, skill, or interpersonal relationship that may benefit a child’s subjective well-being. In cases where children’s agency for promoting or protecting well-being was hindered for any reason, children may seek other virtue-agents, including God, who can guide them or intervene for them at the social interface. The ability of virtue-agents, including children, to successfully navigate society for the purpose of meeting children’s needs may be limited by poverty, lack of knowledge about existing opportunities, or lack of ability to create new opportunities. The availability or absence of opportunities was a critical mediating factor for well-being, especially regarding opportunities for food security and education.

Poverty affects children directly and indirectly. It was for lack of opportunity, not lack of will, that children have insufficient income. Children were good at capitalizing on opportunities they knew existed, and some entrepreneurial children even created their own income opportunities by starting a business, or in the case of one child, by successfully petitioning a public office candidate to support her education. Living in an impoverished community means that people who might otherwise be willing to help, cannot, because of their own poverty. Family members were not reliable sources of material help partly for this reason. Children's subjective well-being was thus affected by those who were willing to help and engage as virtue-agents, but were themselves constrained by the choke-hold of poverty that would not permit the acquisition of sufficient resources for sharing.

Constraint from accessing opportunity was a common barrier to improving one's subjective well-being. A lack of knowledge of opportunity was a related constraint. An unknown opportunity is, effectively, no opportunity. For example, no child knew of the agricultural program aimed at increasing crop yields called *Foundations for Farming* (2014) and therefore, no child was benefitting from the potential for increased food security and income. After the interviews, I submitted the names of three youth, with their permission, to *Foundations for Farming*.

Figure 3. Two Factors in the Regulation of Subjective Well-Being: Virtue-Agency and Opportunity.


Virtue-Agency
(Self, Others, God)
Opportunity
(Actual or Potential)
SOCIAL INTERFACE
Regulation of Subjective Well-Being

Research Question 3

Research Question 3: What are the meanings of subjective well-being for youth heads of household?

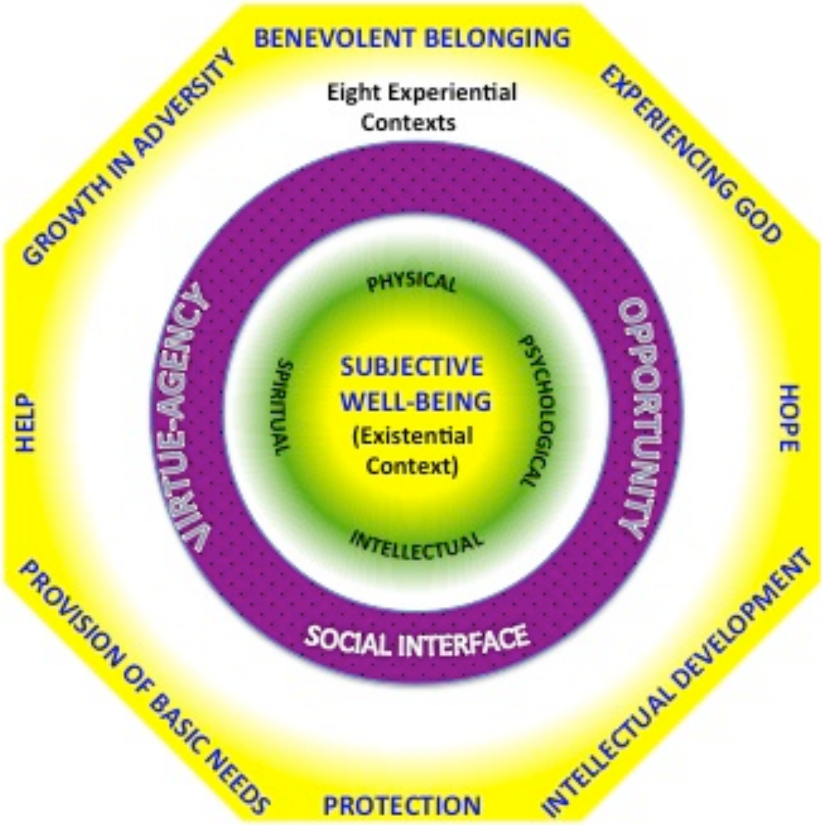
The meaning of subjective well-being was inferentially derived from the interrelatedness of the *Eight Experiential Contexts of Subjective Well-Being* (*Research Question 1*), the two factors for regulating subjective well-being, *virtue-agency* and *opportunity* (*Research Question 2*), and the *Referential Framework of Virtue*. Children's stories of well-being reflected a belief in the centrality of benevolent relationships for a healthy, productive life. These benevolent relationships occurred at three levels: the *material level* (provision of basic survival needs by self and virtuous others), the *interpersonal level* (love, encouragement, and help from others), and the *spiritual level* (experiencing the love of God). Benevolent relationships were directly related to a sense of well-being in four health domains: the *physical*, the *psychological*, the *intellectual*, and the *spiritual*.

The meaning of children's subjective well-being was inferred as,

> *A state of integrated wholeness within and between four health domains (physical, psychological, intellectual, and spiritual), that emerges from, and is contingent on, benevolent virtue-agents who act within the social lifescape to fulfill a child's virtue-informed values within eight experiential contexts (benevolent belonging, help, hope, protection, experiencing God, growth through adversity, intellectual development, and provision of basic needs)*.

The meaning of subjective well-being is depicted graphically in the *Integrative Virtue Model of Health and Well-Being* (Figure 4). Subjective well-being is influenced by an existential state of being (innermost circle) and the actual experiences of daily living (*Eight Experiential Contexts of Subjective Well-Being*). Children's well-being was situated relative to their virtue-informed normative values (yellow center circle) and the ability to fulfill their needs in morally right ways. Two factors were necessary for regulating their well-being and ensuring fulfillment of needs: the virtue-agency of themselves, others, and God, and the existence of actual or potential opportunities at the social interface (purple ring). Need fulfillment occurred within the *Eight Experiential Contexts of Subjective Well-Being* (outer yellow hexagonal ring). The outer experiential contexts and the inner existential context impacted children's health across four domains of health (inner green circle): the physical, psychological, intellectual, and spiritual.

Figure 4. The Integrative Virtue Model of Health and Well-Being.


BENEVOLENT BELONGING
EXPERIENCING GOD
HOPE
INTELLECTUAL DEVELOPMENT
PROTECTION
PROVISION OF BASIC NEEDS
HELP
GROWTH IN ADVERSITY
Eight Experiential Contexts
OPPORTUNITY
SOCIAL INTERFACE
VIRTUE-AGENCY
PHYSICAL
PSYCHOLOGICAL
INTELLECTUAL
SPIRITUAL
SUBJECTIVE WELL-BEING (Existential Context)

Summary of Data Findings

For youth heads of household in rural southern Malawi, the language of virtue was the language of subjective well-being. Virtue was *prescriptive*, *proscriptive*, and *purposeful* for understanding the subjective well-being of youth heads of households. Virtues directed what actions were beneficial (prescriptive) for subjective well-being, what actions were detrimental to subjective well-being and should be avoided (proscriptive), and why virtues were conducive (purposeful) to subjective well-being. Virtue was both a personal attribute and a social skill for achieving positive well-being. *Research Question 1* was answered within the *Referential Framework of Virtue*, in which children judged their *Eight Experiential Contexts of Subjective Well-Being* based on the virtues that constituted each experiential context. The impact of each context on the four domains of holistic health were discussed.

For *Research Question 2*, children interpreted their positive well-being experiences as a consequence of the *virtue-agency of self, others, and God,* combined with the presence or absence of *actual or potential opportunities* that promote subjective well-being. Conversely, negative experiences arose from the lack of virtue by self or others.

In answer to *Research Question 3,* the meaning of subjective well-being was inferentially derived from *Research Questions 1 and 2*, then depicted in the *Integrative Virtue Model of Health and Well-Being.* The model depicts the interrelatedness of the existential aspect of subjective well-being, four domains of health, the social interface of virtue-agency and opportunity, and the external expression of subjective well-being in the *Eight Experiential Contexts of Subjective Well-Being.*

Chapter 7

Discussion of Findings

This exploratory study highlighted three related dimensions of the subjective well-being of youth in rural southern Malawi who are the heads of their household: (1) a youth-centric perspective of the positive and negative subjective well-being experiences, (2) identification of two process factors (virtue-agency and opportunity) necessary for subjective well-being, and (3) an understanding of the meaning of subjective well-being.

Regardless of etiology, structure, or religious commitment, the youth-headed households in this heterogeneous sample shared three common characteristics: (1) A commitment to well-being, in spite of adversity, through their virtue-informed values, and faith; (2) A common poverty that perpetuates barriers to food security, sufficient income, and completion of education; and (3) The loss of parental care.

This study revealed the centrality of virtue as integral to children's subjective well-being. Children relied on value-laden language, in which positive and negative ideas of what is 'good', 'bad', 'right', and 'wrong' about people and events, relative to their ideals of what 'ought' to be. Attentiveness to value language led to the finding that children relied on concepts of virtues and values as a referential basis for their life appraisals.

Virtues were found to serve three main purposes for children's subjective well-being: (1) Virtues were *prescriptive* for a referential framework for what children considered laudable, valuable, and worthy, (2) Virtues were *proscriptive* for delineating what actions and values children consider detrimental to well-being, and, (3) Virtues were *purposeful* for (a) determining personal values, (b) the interpretation and judgment of human behavior and life experiences, and (c) creating socially acceptable pathways for fulfillment of personal values. Virtue informed how children *regulate* their well-being through a process of two interdependent social factors: (1) the presence of actual or potential opportunities, and (2) the virtue-agency of themselves, others, and God.

Children's subjective well-being experiences occurred in eight non-hierarchical contexts as the *Eight Experiential Contexts of Subjective Well-Being*: provision of basic needs, benevolent belonging, experiencing God, growth through adversity, intellectual development, help, hope, and protection. These experiential contexts intersected four health domains (physical, psychological, intellectual, and spiritual). Moreover, children's positive experiences reflected their beliefs about what they value, and in what ways virtue is enacted to achieve well-being.

The meaning of children's well-being was inferred from the data and supporting literature to be a positive interaction of virtue, the existential self, the experiential contexts of well-being, and the domains of health:

> *Well-being is a state of integrated wholeness within and between four health domains (physical, psychological, intellectual, and spiritual), that emerges from, and is contingent on, benevolent virtue-agents who act within the social lifescape to fulfill a child's virtue-informed values within eight experiential contexts (benevolent belonging, help, hope, protection, experiencing God, growth through adversity, intellectual development, and provision of basic needs).*

The purpose of this chapter is to discuss the data findings within nine analytical categories: virtue and morality, subjective well-being, the virtue of benevolence, resilience, agency, religion, poverty, culture, and the *Integrative Virtue Model of Health and Well-Being.* The chapter concludes with implications for nursing, community-based care of vulnerable children, and recommendations for future research.

Analytic Category 1: Virtue and Morality

Virtue and morality are interrelated terms that must be parsed out more fully in order to validate the choice of virtue as the main construct for understanding the data. In favoring the construct of virtue over morality, I do not presume that morality is unrelated to virtue, nor unrelated to well-being, nor that one construct is more prosocial than the other. Indeed, children have attested to morality as important to their personal and social well-being in other studies (Eisenberg, 1992; Fattore et al., 2009; Skovdal & Ogutu, 2009).

Virtue and morality share overlapping definitions and usage, and are sometimes used synonymously. My decision to use the concept of virtue instead of morality as the explanatory framework for the data is based on the distinctions between these terms. In short, I argue that the concept of virtue is better suited as an explanatory concept for this study's data, for philosophical, cultural, and religious reasons, even though the distinctions between morality and virtue are often murky when applied to everyday human interactions. In anthropology, the construct of virtue is being advanced in the sub-field of anthropological ethics to further understand a culture's moral code (Laidlaw, 2014). In this study, virtue was an evaluative concept, not a declarative statement that people are (or are not) inherently good. While *morality* might be the more widely understood term when compared to *virtue,* it was important to choose the concept that best described the data results, and as will be shown, *virtue* was the more salient concept.

Moreover, the concept of virtue has greater discursive relevance to concepts of prosocial behavior, altruism, and well-being (Damon, Lerner, Kuhn, Siegler, & Eisenberg, 2010; Eisenberg & Mussen, 1989; Schwartz, Meisenhelder, Ma, & Reed, 2003). A brief comparison of virtue and morality make this point clearer. In the next section, I outline the basic differences between morality and virtue from perspectives of historical evolution of the terms and theories of children's moral development.

Virtue

The ancient Greek philosophers strived to answer the question of how one ought to live a good life characterize by well-being and human flourishing. Aristotle's idea of eudaimonic happiness, that is, a life well-lived, was identified with virtuous actions, pleasant emotions, and the belief that the virtuous life constituted the pleasant life (Larsen & Eid, 2009). For Aristotle, human flourishing was dependent upon a unity between the cognitive and emotional elements of a person's life experiences. Well-being and virtuous traits became the meaning of the good life, because virtuous character traits could be learned, practiced, reasoned, and cultivated. The life of virtue was synonymous with the life of reason (Rachels & Rachels, 2011).

Virtues as the foundation of moral behavior extended into the rise of Christianity. The theological idea of a virtuous life was epitomized by a congruency between personal possession and expression of virtues, with God understood as the ultimate, perfect, virtuous being and lawgiver. Moral philosophy gradually turned away from a theistic foundation and became increasingly secularized during the Renaissance period (1400-1650). Rules, obligation, and rationality became the accepted basis of morality (Rachels & Rachels, 2011). Though this remains the predominant paradigm for modern moral thought, interest in virtue ethics is growing, a trend often attributed to Elizabeth Anscombe, an analytic philosopher, who was a student of Ludwig Wittgenstein.

It was Anscombe's (1958) landmark article, "Modern Moral Philosophy", originally delivered as a speech to the Voltaire Society in Oxford, that fueled a resurgence of philosophical interest in virtue ethics. Anscombe's main argument was that the obligatory, legalistic language of morality, necessarily required a lawgiver, that is, an authority. Since the modern philosophers had earlier dispensed with the traditional belief that God was the lawgiver, their theories of morality were left without foundation. For Anscombe, the language of morality in virtue ethics does not consist of terms like, "morally good" or "morally bad", but rather are embedded in virtue-language such as "just" or "unjust" (Anscombe, 1958).

Virtuous character traits are both psychological and behavioral in nature (Peterson & Seligman, 2004) The psychological aspect of virtue includes reason, motives, and the aims of virtue. The behavioral aspect concerns specific actions as an outward expression of inner virtue. Virtue is thus an individually possessed, internally experienced, and externally expressed, character trait (Homiak, 2011). Peterson & Seligman (2004) posit virtues as the core characteristics valued within a society's philosophical and religious beliefs. Cultures may vary in the description and expression of specific virtues, but an evolutionary perspective of the utility of virtue, as is assumed by Peterson & Seligman (2004), means that virtue is a form of excellence for addressing problems and thereby ensuring the survival of the species: "The ubiquitous virtues, we believe, are what allow the human animal to struggle against and to triumph over what is darkest within us," (p. 52).

Peterson & Seligman's (2004) psychology research on virtues and character strengths led to the delineation of three conceptual levels of positive traits for well-being: six core universal virtues found in South Asian, Chinese, and Western cultures and their respective moral philosophies (wisdom, courage, humanity, justice, temperance, and transcendence); character strengths as mechanisms that define and display each virtue; and situational themes, that is, habits that manifest character strengths in specific situations. Each of the six virtues is described by three to five character strengths, for a total of twenty-four character strengths across all six virtues. For example, an act of kindness might be abstracted as love, but more broadly belongs to the virtue of humanity (one of the six universal virtues). From this framework, the *Values in Action Inventory of Strengths* (adult and youth versions) assessment tool was created to identify one's personal character strengths (Peterson & Seligman, 2004). Sociocultural differences in how people perceive moral goodness is located at the level of situational themes, such that the manifestation of virtues is dually context-dependent and culturally dependent.

Virtue Ethics

Virtue ethics is the study of how ethics relies on virtues to explain the essence of the 'good life', and motivations for moral behavior. For example, if someone needs help, a virtue ethicist reasons that the virtue of benevolence is the motivation for help, whereas John Mill, the utilitarian ethicist, would say the right action is the one that benefits the most people, and in the Immanuel Kant's deontological view, the expected action would always be in accordance with a moral rule (Hursthouse, 2013).

Virtue ethics is comprised of three features: virtue, practical wisdom (*phronesis)*, and eudaimonia (discussed earlier in this chapter). The concept of virtue is the idea of a trait that makes someone good. Virtue was understood by ancient philosophers as a form of human excellence of character. For this reason, virtue is often used synonymously with 'character trait' (Peterson & Seligman, 2004). Eudaimonia, or flourishing, is the core meaning of well-being and the modern psychological concept of subjective well-being. Eudaimonia is the coalescence of virtue and practical wisdom that produces a sense of personal well-being and a conviction that one has lived well. The complexity of virtue is entrenched in the significance of virtue as descriptive of one's disposition and reputation, and the motivation to do the right thing for the right reason (Hursthouse, 2013).

The good life is the morally meritorious life that is responsive to the socially acceptable demands of the world and is thereby the virtuous life because the virtues are the character traits to which the possessor is responsive (Hursthouse, 2013). The possessor of virtue acts virtuously in moral situations. That is, right choices and right behavior arise from a right character. Virtues can be used to guide action by applying virtue and vice terms, "do what is kind; do not do what is not kind" (Hursthouse, 2013). A good human being is therefore good because of the virtues they possess, a thought that is consistent with both the African ethic of Ubuntu and Judeo-Christian religious thought (Grudem, 2000; Mfutso-Bengo & Masiye, 2011).

The virtuous life, then, is necessarily the moral life. The moral life, however, is not necessarily the virtuous life. One may live a deceitful life of apparent morality, deceiving the public with a mere appearance of virtue, as happens when a serial murderer fits into society so well as a respected community leader that no suspicion of his crimes is aroused for decades (The Associated Press, June 27, 2005). The possibility of dangerous deceit of this magnitude strengthens the justification for virtue as the foundational, analytical concept in the data, rather than morality, in and of itself. Similarly, prosocial behavior can be for selfish gain or for benevolent reasons. The greater morality is embedded in *altruism*, meaning a beneficent intrinsic concern for others that exceeds any concerns about external reward or punishment (Gibbs, 2003)

In summary, virtue ethics asserts that virtue is a beneficial character trait that enables eudaimon, or flourishing. As previously discussed, eudaimon is the essence of life satisfaction in the subjective well-being model. Virtue ethics holds that moral virtues are more fundamental than other moral concepts, such that moral concepts can be reduced to claims about virtues, and moral concepts can likewise be justified on the basis of virtue (Garcia, 1999).

Morality

In comparison to virtue as a character trait, *morality* is a social code of conduct created to avoid and prevent harm (Gert, 2012)A moral code is an informal public system that functions to provide guidance for the actions of a society's members based on moral rules, moral ideals, and moral virtues (Gert, 1999). A moral code may be a *normative* code, meaning that under specific conditions, it is the prescribed action expected of all rational persons, and as a normative code, all rational persons would necessarily endorse it (Gert, 2012). A moral code may, alternatively, be a *descriptive* moral code, meaning the code is accepted by a particular person, group, or community, but not accepted universally. Within the descriptive sense of morality, there may exist a plurality of moralities within one society, each with its own moral content and own moral foundation. But when individuals reference their own morality, they are using the term 'morality' in a universal, normative sense, that is, the moral standard they think all other rational persons would accept (Gert, 2012).

Most societies rely on a tripartite foundation of rationality, tradition, and religion to inform their social morality (Haidt, 2006). Religions may require or restrict behavior that may endorse or contradict social moral codes (Gert, 2012). Religious persons often rely on religious explanations of morality, but whereas morality is a social code, religion is much more (Gert, 2012). Morality within the Christian tradition is situated as virtuous character, for morality without virtue is spiritually worthless (Grudem, 2000). The same is true in African philosophy (Ikuenobe, 2006).

Moral development is bound to the philosophy of personhood (Rachels & Rachels, 2011). Western philosophy for the past 300 years has conceptualized persons as individual, autonomous, and dichotomized into "mind and body". This dualism of mind and body is foreign to African thought. African philosophies of personhood are normative in the metaphysical sense, meaning personal identity is connected to the community in ontological, spiritual, and normative ways (Ikuenobe, 2006). For instance, in the Maasai community of Kenya, the criterion for individual recognition is derived from one's moral and social identity (Ikuenobe, 2006). The autonomy of the African individual is contextualized in the communal nurturing dynamics that encourage social relationships, human flourishing, and the achievement of moral perfection (Ikuenobe, 2006).

The overlap between morality, moral character, and virtue confounds any attempt to finely demarcate boundaries that would permit an easy categorization, and that is not the intent here. Rather, I have presented commonly-accepted, standard definitions, so the reader may distinguish between morality as a system and a code for behavior, and virtue as a morally good character trait. If virtue is a trait, then virtue is foundational to morality. My justification of virtue as the explanatory concept of the data findings was founded on the evidence that children alluded to the character of persons. That is, when children stated how a person should or should not morally act, the implication was a *kind* of person. Though persons can act morally and conform to social moral codes, regardless of character, only persons with virtuous character are truly moral persons in the Ubuntu and Judeo-Christian sense.

Theories of Moral Development

If, as Aristotle asserted, the development of virtue requires practical wisdom, and if virtue is foundational to morality, how much capacity do children actually possess to comprehend the abstractions of morality and virtue? Children's capacity for moral judgment has been theorized to be a function of multiple variables such as age, cognition, emotion, culture, and gender. Three theories of moral development from Piaget, Kohlberg, and Hoffman are briefly reviewed below for the purpose of understanding how different mechanisms driving children's appraisals of moral situations.

Traditional western theories of the moral development of children are grounded in graduating levels of cognitive and emotional development that parallel increasing complexity of moral reasoning. Jean Piaget considered the increasing personal awareness of one's role in social relationships as central to the development of children's sense of morality (Piaget & Inhelder, 2000). Piaget theorized that moral reasoning of children progressed through three stages, ranging from very little cognition of morality between ages 0-3, a more concrete knowledge of external rules and respect for rule-givers, to guide moral behavior in children ages 4-10, and the development of a formal understanding of moral relativism after age 11 (Piaget & Inhelder, 2000).

Building on Piaget's work, Lawrence Kohlberg created a more sophisticated three-level cognitive theory of moral development (Gibbs, 2003). Like Piaget, Kohlberg's moral development levels were age-dependent and cognitive in origin, such that the older the child, the more advanced his moral capacities, all things being equal (Damon et al., 2010). Positive moral actions and emotions exhibited by even young children support the idea that early moral foundations are present in childhood, independent of inhibition of children's natural self-centered impulsivities (Damon et al., 2010).

Each of Kohlberg's three moral levels, the *preconventional*, *conventional*, and *postconventional* levels, consist of two sub-stages each, for a total of six stages. In the preconventional stage, moral reasoning is conceptualized as obedience and sanctions, pleasant and unpleasant consequences of behavior (Rachels & Rachels, 2011). At the conventional level, children seek to please others and maintain accepted social conventions with their morality. The postconventional level consists of higher level abstractions of morality such as incorporating personal and social values into abstract moral reasoning.

Four objections have been raised against Kohlberg. First, Kohlberg's theory, and Piaget's theory as well, relied on children's beliefs about a moral dilemma, not on how children actually responded. Given children's limitations of abstract thinking at young ages, it is possible that moral thinking exists at earlier ages in children (Mathambo & Gibbs, 2009).

Second, despite support for cross-cultural validity for Kohlberg's first two levels, the cross-cultural applicability of Kohlberg's post-conventional level has been called into question because of its strong western, individualistic orientation (Snarey, 1985). More specifically, a moral decision in favor of one's personal goals is more likely to be contradictory in collectivist cultures where one's identity is indivisible from the community identity (Ikuenobe, 2006).

Third, Kohlberg's theory was criticized as being gender-biased toward males (Gilligan, 1982). Kohlberg's methodology included only boys in the sample, and he concluded the moral development of boys exceeded that of girls, which Gilligan contested, and has since been generally disconfirmed (Langford, 1995). Gilligan (1982) claimed Kohlberg's theory was androcentric and favored justice and rights in moral judgments. Gilligan (1982) argued that moral development is gendered, specifically noting that the concept of caring is intrinsic to girl's moral development. Subsequent studies in the field failed to demonstrate appreciable difference of gender on the justification of moral judgments, but substantiated that gender differences exist regarding the content of moral beliefs (Gibbs, 2003). Critics of both Kohlberg and Gilligan acknowledge that gendered styles of moral discourse are a legitimate area for research in moral development (Langford, 1995; Mathambo & Gibbs, 2009)

Fourth, though Kohlberg's theory gained widespread support, his theory fails to account for non-cognitive forms of moral understanding, such as emotion, virtue, or religion (Mathambo & Gibbs, 2009). Martin Hoffman (2001) hypothesized that the emotion of empathy influenced moral development. He demonstrated that even very young children are capable of genuine empathic concern for another, and were therefore capable of genuine moral agency (Hoffman, 2000). Hoffman's findings indicate that the moral development of children is dependent upon a child's capacity for empathy, and this capacity emerges at a younger age than is asserted by cognitive theories of moral reason. Against Kohlberg and Kant, Hoffman disagrees that caring is subordinated to justice because caring is presumably only affective in nature, compared to justice which is presumably only rational. Rather, Hoffman sees no obstacle to both caring and justice, arguing that both caring and justice occur in degrees, and can be compatible concepts in moral situations (Hoffman, 2000).

More recently, Krebs & Denton (2005) published an in-depth critique of the limitations of Kohlberg's model to account for everyday moral judgments, responses, and behavior. Kohlberg's conclusion that people use one or two moral reasoning tactics for moral judgments is overly simplistic, and fails to accommodate the complexity of social, cognitive, and affective processes that facilitate personal goal achievement through moral cooperation with others (Krebs & Denton, 2005). Regarding tacit forms of moral reasoning, Shweder, Turiel, & Much (1981) demonstrated that children as young as four years old possess a moral intuitive competence in how they respond to moral rules and the transgression of moral rules. Children's intuitive forms of moral understanding paralleled adult formal principles of moral reasoning such as importance, generalizability, and obligatoriness (Shweder, Turiel, & Much, 1981). The findings highlight how previous theories of children's moral development, such as Kohlberg's theory, fail to appreciate the intuitive moral understandings of young children by relying on a developmental framework of children's linguistic abilities as a proxy for their moral knowledge.

For Hoffman, empathy can be a strong driver of moral behavior (Hoffman, 2000). Empathy, as Hoffman sees it, is moderated by an interaction of biological, cognitive, and socialization forces that inform one's empathic senses, and terminates in mature prosocial behavior. Empathy is a feeling of human concern, even a vicarious response, to another's situation (Hoffman, 2000). Eisenberg (1992) takes a tangential view to Hoffman by asserting that morality is stimulated by the good feelings attained through prosocial behavior. For Eisenberg (1992) prosocial behavior consists of learned voluntary actions intended to benefit others such as helping and comforting, but may be motivated by either altruism or self-interest. Altruistic prosocial behavior is motivated by sympathy or a desire to act on internalized moral beliefs (Eisenberg, 1992). A child's moral development progresses from a self-centered, "feel good" orientation as a preschooler towards increasing cognition and empathy for those in his social circle. Eisenberg & Mussen (1989) view prosocial behavior as dispositional, meaning a trait state. Unlike Kohlberg's theory in which moral regression is not possible, Eisenberg leaves room for children to move between levels, such as when they do not want to act within their full moral capabilities. Eisenberg & Mussen (1989) proposed five age-related levels of moral reasoning that parallel children's social development that ranges from a self-centered concept of the world to an increasingly abstract sense of duty based on empathy and perspective-taking, culminating in the internalization of principles for living a moral life. The three stages relevant to the sample of youth-heads of households are levels three through five. The third level, *approval-focused orientation*, describes children ages seven to adolescence. Children at this level are motivated by social expectation and the desire to be accepted. Children at this level judge the morality of behavior as 'good' or 'bad'. The fourth level, *self-reflective empathic orientation* (secondary school children), engage in empathic reasoning, perspective-taking, and guilt. At the fifth level, *individualized orientation,* adolescents and adults attain self-respect within the duty to care for others and other internalized principles.

According to Eisenberg & Mussen (1989), one might presume the youth in my sample best fit the *approval-focused orientation* and *self-reflective empathic orientation* levels of moral development. This is a questionable presumption because western models of children's moral development may not be valid for African cultures, though prosocial, altruistic behavior is more common in kin-oriented, interdependent, collectivist societies (Dasen, 1984; Eisenberg, 1992; Mangan, 1978). In this case, the western models that value the development of children's independent morality may not be valid for Malawian children (Ramokgopa, 2001). Western models are usually staged according to children's ages, but African child development is marked by readiness, not age (Ramokgopa, 2001). The moral development of African children is nurtured though teachings by rituals, cooperation, readiness, and interdependence. Physical, cognitive, emotional, and moral development are nested within cultural values and traditions, such that the developmental 'problems' of childhood in Erikson's Psychosocial Stages of Child Development are dealt with as a shared responsibility, not as a crisis (Erikson, 1968; Ikuenobe, 2006). Rites of passage in African cultures promotes pro-social cooperation of children within a paradigm of communal life, as opposed to western ideas of individual competition and success. The self-identity of African children is characterized by Ubuntu, an intersubjectivity of community relationship, not individual achievement (Mkhize, 2008).

Ikuenobe (2006) describes how African moral thought is passed through oral traditions, the content of which reflects descriptive inquiry, normative inquiry, and meta-ethical inquiry of human philosophy. For Ikuenobe (2006), the overriding point of his book, *Philosophical Perspectives on Communalism and Morality in African Traditions,* is that the African communal view of morality presents no inherent conflict between communalism and individualism. Attempts to advance the notion that communal interests are at odds with individualist interests is a "pseudo-problem" that is "fundamentally wrong-headed" (Ikuenobe, 2006, p. 292). It is the very essence of communal African structures that reduce the stress of everyday life within a broad code of social engagement characterized by caring, responsibility, relationships, and expectations.

The modes of teaching African moral thought are embedded in the cultivation, habituation, and acculturation of moral character and virtue. Moral education in the African tradition is never individualistic, private, or autonomous. Rather, it is entrenched and learned in context of the society in which they live and the interpersonal relationships of that society. The goal of moral education in traditional African cultures is to teach principles, beliefs for conduct, attitudes, and habits that are conducive to the everyday well-being of the community and its people (Ikuenobe, 2006). The moral education of African youth comes through oral traditions, dramas, active involvement in the community, and continual connectedness with one another (Ikuenobe, 2006). Traditionally, all adults are responsible for the upbringing of a child, which suggests that adult involvement in the development of children's moral character and virtue may be a culturally-accepted intervention for the well-being of the youth, and by extension, for the well-being of the community.

In light of the foregoing overview of theories of children's moral development and African prosocial moral thought, it would be a methodological error to presume that western models of moral development of the independent personhood of children are valid for understanding the moral development of Malawian children. Malawi's social values of mutual help, community unity, and religiosity, more broadly known as *Ubuntu,* strengthen my defense that children's beliefs about virtue are more likely linked to subjective well-being than morality because of the social appraisal associated with virtuous character (Ikuenobe, 2006; Mfutso-Bengo & Masiye, 2011). Though I did not adopt a formal theory of children's moral development to apply to this study, I do acknowledge and accept the general assumption that children's moral development progresses as they mature cognitively, emotionally, and socially.

Analytic Category 2: Virtue and Subjective Well-Being

Virtues are prosocial, altruistic behaviors "that are consensually recognized and valued and that elevate those who witness them" (Peterson & Seligman, 2004, p. 38). The identification of youth's virtue-informed values in this study suggests these children hold a basic belief that virtue is linked to happiness and well-being. The three-fold importance of virtue as the meaning, process, and criteria of children's well-being experiences indicates that youth value and actively pursue eudaimonic happiness for their subjective well-being, and in this manner, virtue is a form of practical wisdom for optimal interpersonal and intrapersonal functioning (Kesebir & Diener, 2013). The moral agency of youth and their capacity to act morally and freely for one's well-being was a finding also noted by Fattore, Mason, and Watson (2007) in their qualitative study of children's ideas of well-being in New South Wales, Australia. Positive well-being in adolescence is an important goal given that longitudinal studies affirm a continuation of positive well-being into adulthood (Richards & Huppert, 2011).

Youth affirmed the conventional wisdom that chronic hedonic (self-indulgence of human appetites) behavior in the form of bad habits is deleterious to well-being: they strategically avoided persons with hedonic behaviors, and expressed a desire to be affiliated with 'good' people for the purpose of positive relationships and personal growth. Youth's beliefs about well-being were similar to the findings in adult psychology research, in which eudaimonic goals of intimacy, generativity, and spirituality, rather than hedonic goals, correlate with higher subjective well-being (Emmons & McCullough, 2003). Similarly, hedonist pursuits (materialism, sensuality, and the pursuit of wealth beyond basic needs) correlate with lower life satisfaction ratings whereas higher life satisfaction is predictable cross-sectionally and across time for persons who value and are committed to family, friends, and social activities (Headey, 2008). In fact, a dose-response relationship was noted between ratings of daily and global subjective well-being (life satisfaction, positive affect, and perceived meaning of life) and eudaimonic activities (gratitude, volunteering, and perseverance) (Steger, Kashdan, & Oishi, 2008). No such dose-response relationship was found for hedonic activities (materialism, sexual trysts, drunkenness). Furthermore, Steger and colleagues (2008) also found that at the global level, hedonic behavior was not only inversely related to positive affect but also positively related to negative affect. In other words, hedonic behavior increased personal negative affect and decreased positive affect. The research as a whole affirms youth's beliefs that hedonic behavior results in negative feelings and therefore unlikely to be a successful route to subjective well-being.

Youth viewed positive well-being as the outcome of their deliberate engagement of themselves in virtuous behaviors on a momentary, daily, and even lifetime basis, which is consistent with the conclusion that eudaimonic happiness is experienced as frequent positive affect and is a consequence of virtue practice (Proctor, Linley, & Maltby, 2009). The satisfaction youth experienced in enacting virtue to help others is akin to what Kesebir & Diener (2013) call the "virtuous cycle" of happiness and virtue. The "virtuous cycle" refers to the bi-directional relationship between happiness and virtue in which virtue leads to happiness, and happiness in turn, leads to virtue. The happiness of the "virtuous cycle" is a eudaimonic happiness, that is, a happiness achieved by living in accordance with the virtues that one values (Kesebir & Diener, 2013). Eudaimonic happiness, because it reflects personal meaning and purpose for life, requires personal effort for achieving it, including persevering through adversity. Furthermore, Kesebir & Diener's (2013) "virtuous cycle" of virtue and happiness is supported in the finding that youth it is virtuous behavior, not hedonic behavior, that youth associated with future happiness, personal success, and social acceptance. Similar outcomes of optimism, self-reported gratitude, negative emotional feelings, and increased life satisfaction have also been observed in studies testing the positive well-being effects of gratitude interventions for early adolescents (Froh, Sefick, & Emmons, 2008). Grateful people exhibit more prosocial behavior, religiosity, positive emotions, empathy, and less negative emotional experiences of depression, envy, or anxiety (McCullough, Emmons, & Tsang, 2002). Peer approval and support is likely to be stronger when prosocial virtues like kindness are practiced (Layous, Nelson, Oberle, Schonert-Reichl, & Lyubomirsky, 2012).

The foregoing discussion suggests that virtue contributes to subjective well-being, even from a longitudinal perspective. How much of a person's disposition to gratitude is innate or learned is unknown, but the positive effects found in the psychology research should spur consideration of similar studies among vulnerable youth (Skovdal & Ogutu, 2012).

Analytic Category 3: The Primary Virtue of Benevolence

Benevolence, from the Latin, *benevolentia*, from *bene-* good, and *volantem* – to wish, is the ethic of seeking the well-being of another, of acting in the best interests of another (Stevenson & Lindberg, 2010a). Benevolence is the act of being kind, generous, and a disposition to do good to others through charitable acts. Stephen Post (2002), scholar on altruism, defines beneficence as, “love acting for the well-being of another” (p. 51). Benevolence was the most notable virtue in children’s subjective well-being experiences. Benevolence was the qualifying trait of people children wanted in their lives. Belonging to others in benevolent relationships, that is, ‘benevolent belonging’, guided children’s present and future actions of giving and receiving help, experiencing God, and social responsibility.

Benevolent acts may arise from multiple motivations, for example, a sense of justice, duty, kindness, or self-interest (Post, 2002). For example, a child who stated, “*a good father provides for his children*”, was indicting her absent father did not provide physically or emotionally for his children. First, the virtue of benevolence would spawn responsible actions, such that a benevolent father acts as a responsible father. Second, a responsible father is likely also benevolent because he honors the duty to care appropriately for his children. The notion among children that adults are morally “good” when acting for the best welfare of children was also found in Fattore, Mason, & Watson’s (2007) study of western children’s ideas about well-being. The possibility of benevolence as a universal need of children is further developed in Owusu-Bempah's *theory of socio-genealogical connectedness* (see p. 225).

Benevolence was the most frequently occurring virtue in children’s well-being experiences. Each experience was analyzed for the virtue that best fit the children’s description, yet the process was a very subjective one for three reasons. First, children’s descriptions were often very general, especially among younger, less-articulate children. An inferential process was required to determine a range of appropriate underlying virtues. Second, the conceptual overlap of similar virtues made it difficult to narrow the choice to only one or two virtues. In many cases, the decision was made to err on the side of generality and choose a broadly defined virtue like benevolence as the main virtue, compared to similar but more narrowly defined virtues like empathy or compassion. Third, children’s descriptions and judgments were usually in polar terms like, 'good' or 'bad'. The goodness (or not) of interpersonal relationships were important to children and intersected each of the *Eight Experiential Contexts of Subjective Well-Being*. The kindness or love of others and God was often attributed to their personal well-being, and was actively sought as children decided with whom they wanted to be affiliated. The over-arching virtue, benevolence, achieved the best fit with the data within and across cases.

The virtue of benevolence is culturally dependent. Within Malawian culture, the

African ethic of *Ubuntu* is the foundation of group solidarity and community survival (Mfutso-Bengo & Masiye, 2011). *Ubuntu* is a concept of personhood that encompasses the idea of *being,* that is, the interpersonal aspect of human existence that is contingent on the virtues of benevolence, dignity, respect, help, and compassion that are to be practiced without regard to another's social status (Mfutso-Bengo & Masiye, 2011). There is a theological thought in *Ubuntu* that personhood is not only human, but also a trait of God (Battle, 2009). Ideally, each person's individual humanity is known in relationship with others, and it is only in this way that individuality is truly expressed (Battle, 2009). *Ubuntu* is achieved by being good, meaning one acts rightly, justly, and kindly towards others, in which one knows himself by knowing others (Mfutso-Bengo and Masiye, p. 155). Self-promotion is oppositional to the community orientation of interrelatedness and interdependency. The *Ubuntu* concept locates responsibility for the moral development of children within the community. "The greatest compliment among Malawian Chewa (the predominant people group) culture is "*uyu ndi muthu",* which means, "this is a human being," imbued with caring heart, a moral identity, patience, peace, and compassion (Mfutso-Bengo and Masiye, p. 157).

There is evidence suggesting the existence of universal virtues. The potential for universal virtues was the main impetus for Peterson & Seligman's (2004) research which culminated in the book, *Character Strengths and Virtues: A Handbook and Classification,* in which six ubiquitous core virtues are cataloged with their accompanying character strengths. The six virtues, *courage, justice, humanity, temperance, transcendence, and wisdom* were deemed universal because they were identified within each of three major world cultures: China (Confucianism and Taoism), South Asia (Buddhism and Hinduism), and the West (Judeo-Christianity, Islam, and ancient Greece). Using Peterson & Seligman's (2004) classification, benevolence would be considered a *humanity* virtue because benevolence is an interpersonal virtue that relies on the intent to do more than what is fair (as in justice). Acts of *humanity* show generosity, kindness, and understanding when there exists no obvious positive pay-off for the virtue agent (Peterson & Seligman, 2004). Given the interpersonal nature of children's subjective well-being experiences, benevolence is an appropriate fit both with the data and with the theoretical literature on the relationship between altruism and subjective well-being.

God was experienced as a benevolent personal being who helped children, and in particular, protected them from physical, emotional, and spiritual harm. In Christian theology, God's most prominent attribute is love (Grudem, 2000). From a religious and cultural moral perspective of *Ubuntu,* it is not surprising that benevolence is of practical and moral import to youth.

Another common attribute of God is as a father, especially in response to the poor and to orphans (see Chapter 2). Whether the youth in this study, by virtue of being orphans, considered God as a surrogate parent is unknown. The youth did not refer to God as father in the interviews, nor were they were not asked to describe their concept of God. For youth identifying as Christian, it would be expected they would conceive of God as a father, and themselves as God's children, because this image of God permeates the theology and scriptures of Protestant and Roman Catholic faith traditions, regardless of whether one is an orphan or not (Center for Reformed Theology and Apologetics, 2014; Libreria Editrice Vaticana, 2003). The only exception for access to God is in the

Roman Catholic faith, if one commits a 'mortal' sin, that is, a very serious sin that destroys sanctifying grace and results in supernatural death of the soul, then the priest must intercede to restore the relationship with God (White, 1996). In contrast to the Protestant and Roman Catholic imagery of God as a father, a Muslim child would not refer to Allah as father. In Islam, Allah is known by his perfect virtues, and is never named or anthropomorphized as a father, mother, or parent, because Allah is pure and unique, unlike any other, and cannot be compared to any created being (Naik, 2014). Allah has many attributes, including, 'The Loving,' or, 'Al-Wodood' (Naik, 2014).

Benevolence constituted a primary aspect of the process of well-being, that is, how one regulates, interprets, and negotiates subjective well-being over time. Benevolent people were critical to children feeling safe, protected, fed, and emotionally nourished. This finding is consistent with the literature on children’s psychological development in which nurturance is crucial from birth onward (Bowlby, 1969; Chu et al., 2010). Additionally, benevolence towards children reinforces their sense of ‘relational being’ and well-being (Cluver & Gardner, 2007; Gergen, 2009). Not only this, but altruistic behaviors may improve one’s own health (Post, 2007).

In a study of Ugandan and Zambian orphans, children stated that love and attention were their greatest needs, while adults cited basic material provision (food, shelter, clothing) as their greatest need (Chege, 2005). Belonging to others in benevolent ways was purposeful for staying connected to family and society, for garnering emotional or material support when needed, and for creating personal happiness by helping others (Skovdal & Ogutu, 2009). Orphans' negative experiences were often related to the absence of benevolent belonging, as when rejected by another (Cluver et al., 2007). Not surprisingly, having trusted friends is critical form of social capital for coping with adversity (Skovdal & Ogutu, 2012). Spending time together, playing, and singing together constituted a form of bonding and comfort between friends and family. Children recognized that successful interpersonal relationships require a mutual trust imbued with virtues of dignity, respect, kindness, empathy, and forgiveness (Senefeld, Strasser, Campbell, & Perrin, 2013).

Benevolent Kinship Care: Socio-Genealogical Connectedness Theory

A significant work on the importance of the benevolent kinship care of children, *The wellbeing of children in care: A new approach for improving developmental outcomes* (2010), authored by Kwame Owusu-Bempah, Emeritus Reader in Psychology at the University of Leicester in the United Kingdom, highlights the universal need of children, whether orphans or non-orphans, to be reared by kin. Owusu-Bempah draws from the international, interdisciplinary literature to argue that children fostered by kin have no worse psychological outcomes than children raised by their parents; but children fostered by non-kin exhibit a variety of mental health problems and behavior disorders, even though they are raised in their native culture. From the data, Owusu-Bempah (2010) developed the *theory of socio-genealogical connectedness* to explain the positive relationship between a child's identity and self-worth that arises from a sense of belonging and connectedness to biological kin. The socio-genealogical connectedness theory draws no distinction between orphan and non-orphan, because the significance of outcomes is embedded in whether kin or non-kin foster the child. Child vulnerability, then, for Owusu-Bempah (2010), is not contingent on orphan status but on the benevolent capacity of the primary caregiver, and the most benevolent caregiver for an orphan is, all other things being equal, kin.

Owusu-Bempah's theory that the kin relationship of a primary caregiver to a child has significant implications for the child's well-being is evidence in a study of Gambian children by Sear & Mace (2009). Child mortality rates in Gambia were examined in by the kinship relationship of the child’s primary caregiver for children ages 0-2 years. In a sample of 2,294 infants under age 1, infants whose mother died were 6.2 times more likely to die before their first birthday, compared to infants with living mothers. In the sample of toddlers (ages 1-2) (n=1,664), the mortality risk is 5.2 times higher. The death of other female caregivers (grandmothers and older sisters) also imparted increased risk of child mortality. Interestingly, paternal mortality had no significant effect on child mortality. Maternal grandmothers assumed a significant portion of the child’s care at the time of weaning. Elder sisters provided childcare during early childhood. The study results highlight the important nurturing roles that Gambian mothers, maternal grandmothers, and elder sisters have in youth-rearing, suggesting that children’s survival is dependent upon traditional caregiving roles in the Gambian culture (Sear & Mace, 2009).

The *theory of socio-genealogical connectedness* suggests that in some circumstances, the formation of youth-headed households may be the most advantageous living arrangement for unparented children. If, as Owusu-Bempah proposes, that morbidity is decreased when children are cared for by kin in culturally-appropriate ways, then perhaps siblings reared in a child-headed household may have better outcomes than if they are raised by non-kin adults. The parallel findings in the orphan literature that fostering by non-kin can be detrimental to children's well-being, should give pause to any inclination to blanketly pronounce youth-headed households as detrimental and risky to children's well-being, when it might actually be the most protective alternative (Cluver & Gardner, 2007). Even for adults, happiness may be contingent on living near other family members. A study of social networks in a 20-year longitudinal analysis (1983-2003) of the Framingham Heart cohort (n=4739) revealed that groups of happy and unhappy people were evident as separate clusters and the effects extended to three degrees of separation (Fowler & Christakis, 2008). Measures of happiness were strongest between friends and family who lived in geographic proximity to each other, but these were not seen among coworkers (Fowler & Christakis, 2008).

My argument for benevolence as a paradigmatic structure for NGOs unshackles orphans from the vulnerability paradigm, and retains the African community as the most promising asset for the well-being of orphans. Sustainability for lasting social change lies in a participatory approach so that the indigenous people decide for themselves what development programs should be sustained and in what manner. As Wilkinson-Maposa et al. (2005, 2009) demonstrated, the poor are masters at sustaining indigenous systems of help that mobilize resources to those most in need, yet these indigenous forms of philanthropy are rarely evaluated, let alone considered, by NGOs who prefer to implement a system of external resources. Unless development initiatives are integral and compatible with indigenous, organic forms of helping that make up the fiber of African societies, programs to help vulnerable children will not be sustainable. This point applies to youth heads of household, also, for as my study has shown, even children are capable of acting as change agents for themselves and their families through their own virtue-agency for giving and receiving help. The key to sustainability of programs that assist vulnerable children is to identify, then adapt to, a community's structure of indigenous helping, rather than building programs within the traditional form of development in which communities were expected to adapt to the policies of foreign programs (Wilkinson-Maposa & Fowler, 2009).

Benevolence-based well-being in this dissertation research is consistent with four important theoretical domains of benevolent care to orphans: (1) the African ethic of *Ubuntu* (Mfutso-Bengo & Masiye, 2011), (2) the ethics and principles of nursing (American Nurses Association, 2010), (3) the Judeo-Christian concept of a benevolent God (Grudem, 2000), and (4) the benevolent intentions of foreign non-governmental organizations that provide community-based orphan care in Africa (World Vision, 2011).

Community-based care programs must embed programs for vulnerable children within cultural beliefs about who is benevolent, towards whom, and why, because one’s *ideals* of benevolence determine *enacted forms* of benevolence (Sokolowski, 1985). Benevolent actions are culturally mediated, and forms of benevolence that are not culturally understood may create confusion, suspicion, or division in the community (Bornstein, 2005; Lancy, 2008; Leininger & McFarland, 2002). A focus on enacted benevolence between kin and orphan, then, translocates the responsibility and power for orphan well-being from social ‘programs’ to the family.

Placing the outcomes for orphan well-being in the hands of capable families is one of the most benevolent acts an NGO and community can do, because it (1) fortifies the continuity of the socio-genealogical connections of family and ancestry, (2) ensures the psychological well-being of children *and* community, (3) locates sustainability within the ethic and practice of virtues like benevolence, and (4) minimizes dependence upon external agencies (e.g., NGO), thereby contributing to sustainability and a sense of community purpose (Kirmayer, Sehdev, Shitely, Dandeneau, & Isaac, 2009; Owusu-Bempah, 2010). As a shared ethic, benevolence may act as a bond of solidarity between NGOs, vulnerable children, and communities.

Analytic Category 4: Virtue and Resilience

The widely-used modern term, *resilience,* has been used as a framework to study 'at-risk' and 'vulnerable' children. Adverse life experiences of poverty, parental death or other loss of parental care, social isolation, educational loss, and victimization are widely recognized dimensions of child vulnerability among youth-headed households (Foster et al., 2005). The children in this study were well familiar with these adversities which are similar to those delineated in other studies of youth-headed households (see Chapter 2). An important premise in my study was that well-being is not the absence of vulnerability, dysfunction, or adversity, nor does positive development of youth consist merely of the eradication of discomfort and pathology.

The prominent assumption in the resilience research is that a resilient child benefits from traits, relationships, and environments that are commonly considered protective (Peterson & Seligman, 2004). In this paradigm, the focus is on youth outcomes measured as a decreased risk or decreased stress as a function of specific interventions like mentoring programs, skill development, and peer support. The absence of negative outcomes, however, cannot be solely dependent on external interventions, which raises the question of how character strengths and virtues, and in particular, the development of such virtues and strengths, may mitigate the effects of adversity in the lives of vulnerable youth.

When faced with stressors, children not only strategized about how to solve their problems but also sought out benevolent others and God for comfort and resolve of their situation. The data suggest that virtue actions and virtue-agents are one strategy adolescents employ for dealing with adversity. The idea of children's social agency in HIV/AIDS-endemic areas of sub-Saharan Africa has become a more prominent interest to researchers in the last few years, following an increased scholarly interest in youth-centric research designs (Fattore et al., 2009; Skovdal & Ogutu, 2012).

Successful coping was a subjective well-being experience that was informed by youth's beliefs of what 'ought' to be done to bring about a good experience. Being a good person, a virtuous person, while enduring adversity was deemed an essential strategy for coming through adversity as a better, stronger, and wiser person, confirming Peterson & Seligman's (2004) belief that virtues are the key to resilience. When adversity is contextualized as an opportunity to develop resilience, character strengths and virtues that were perhaps not previously relevant, now emerge to contribute to positive outcomes, and not merely to minimize poor outcomes (Peterson & Seligman, 2004).

Adversity for these children seemed not so much about struggling to extinguish a stressful circumstance as it was about how to utilize their skills, personal agency, and the agency of others to effectively and beneficially manage their lives *relative* to the circumstance. For Zimbabwean child caregivers of ill adults, caregiving created a learning process in which children saw positive personal benefits of increased responsibility, skill improvement, and maturity (Robson, Ansell, Huber, Gould, & van

Blerk, 2006). Fattore, Mason, & Watson (2009) noted a similar phenomenon among Australian children: "This idea of integrating sadness into one's life was part of children's conceptualization of a notion of resilience, it was about how they organize their lives so that they are okay and feel strong," (p. 62).

The potential positive effects of persevering through adversity suggests that adversity itself may produce additional protective effects for improved future resilience, a notion that was also highlighted in Rutter's (2012) discussion on the conceptual history of *resilience.* Rutter (2012), who is an expert in the conceptual and empirical research on resilience, offers this definition of resilience:

> Accordingly, resilience can be defined as reduced vulnerability to environmental risk experiences, the overcoming of a stress or adversity, or a relatively good outcome despite risk experiences. Thus, it is an interactive concept in which the presence of resilience has to be inferred from individual variations in outcome among individuals who have experienced significant major stress or adversity…resilience is defined in terms of a better outcome than that seen in other individuals from a similarly adverse background. " (Rutter, 2012, pgs. 336 and 342).

Peterson & Seligman (2004) and Rutter (2012) both caution against understanding resilience as a simplistic unilateral relationship to personality traits, competencies, strengths, or environmental influences. Rutter's (2012) conceptualization of resilience as a dynamic process includes multi-dimensional internal and external protective factors, genetic factors, interactive effects, and 'steeling effects' (brief exposures to stress that increase resistance to future stressors). The presence of the 'steeling effect' was implied in children’s stories of positive growth from adversity. Children in my study who perceived their adversities as beneficial to the development of greater inner strength that fortified them for dealing with future adversity.

Noting a key need for qualitative research on the meaning of experiences, Rutter (2012) leaves room for consideration of personal strengths like virtue for creating positive meaning from adversity. The necessary personal strengths of perseverance and courage for coping with adversity, the requisite substantial personal effort, commitment, and engagement, indicates that growing through adversity is a *process* that may contribute to eudaimonic happiness, and may even overcome the effects of earlier adversities (Rutter, 2012; Scollon & Diener, 2006). In a qualitative study of eighty-nine youth across eleven countries, resolution of seven life tensions was found to characterize resilient, vulnerable youth (Ungar et al., 2007). Ungar and colleagues (2007) did not rely on any specific definition of resiliency, but stated, "resilience is about finding a way to "hit your stride" and live with relative comfort despite contradictions and conflicts; to continue to negotiate and navigate one's way through the challenges one is experiencing," (p. 301). Youth in this sample were deemed resilient according to community adults. Interview data indicated that resilient youth effectively managed seven life tensions of daily life: material resource access, interpersonal relationships, cohesion, power and control, identity, cultural adherence, and social justice. Youth perceived resilience as a continual process of becoming better, and successfully obtaining meaningful material and non-material resources (Ungar et al., 2007).

As a form of social capital, the virtuous relationship between children and adults was an important element of regulating well-being during adversity. Children in this study who testified to positive personal growth through adversity attributed at least part of their positive process to benevolent adults who advised and encouraged them. Similarly, Fattore, Mason, &Watson (2007) noted that Australian children described supportive adults as “managing appropriate exposure to risk, creating a balance between the child feeling secure in learning something new/taking the risk and being able to exert agency within secure parameters. The security provided through strong relationships was seen by children as providing them with the confidence to exert agency,” (p. 21). Likewise, the psychological effects of life adversity faced by AIDS orphans in Kenya was mitigated by perceived social support of a special person and siblings living with the child (Okawa et al., 2011). Similarly, the social capital of altruism can be beneficial for positive post-traumatic growth (Ghafoori & Hierholzer, 2007). Hope is another social process that fosters resilience when children conjoin with ideas of opportunity, competent self-agency, effective social navigation, and development of social support networks (Lee, 2012).

Resiliency of vulnerable youth in low-resource areas may be enhanced by culturally relevant storying interventions. Based on bibiliotherapy techniques to enhance coping responses of children, Wood, Theron & Mayabe (2012) investigated the effectiveness of a cultural story intervention to foster the well-being and resilience of thirty-two South African children orphaned by AIDS-related illnesses. Narrative inquiry and drawings pre-and post-intervention were qualitatively analyzed using an a priori coding method based on a seven-themed model of resilience (Ungar et al., 2007). Storying was effective at developing resilience by increasing positive self-image and increasing security of relationships with caregivers (Wood, Theron & Mayabe, 2012).

Children were coincidentally observed acting out, on their own initiative, the culturally-relevant stories they heard about moral role models in the stories, indicating children continued to internalize what they had learned.

Resilience and Helping Relationships

The proximity of a relative or neighbor does not determine the “use-value” of the relationship for receiving help that may contribute to children’s resilience (Van Dijk & Van Driel, 2012). An important aspect of help is that children’s well-being was enhanced when they were able to help others, such as when listening to and sharing a friend’s suffering, sharing food, or working in friends’ gardens (Erickson & Abelson, 2012). Receiving and giving help may foster resilience by affirming personal dignity (Post, 2002).

The close relationship between the experiential context of help and the other seven contexts is evident of children’s valuing of, and reliance on, interdependence with others that may reflect cultural social values of interdependence. In a qualitative study of helping practices among the poor in four countries of southern Africa (Zimbabwe, Mozambique, Namibia, and South Africa), material and non-material helping behaviors were guided by transactional principles of reciprocity and mutual support (Wilkinson-Maposa et al., 2005). The 'philanthropic impulse' (to use Bornstein's phrase) among the poor was driven by a belief rooted in *Ubuntu* that "my humanity is tainted if your humanity is not recognized and assisted when in need" (Bornstein, 2009); Wilkinson-Maposa, et al., 2005, p. xi). It was the act of helping, not the monetary value of helping, that was valued. In keeping with this maxim, non-material help was highly valued. More specifically, the study concluded, "Help follows a cardinal rule: 'If you have you must give, no matter how little' (Wilkinson-Maposa, et al., 2005, p. xi). The predominant theme of the transactional aspect of helping one another as an investment in tomorrow's well-being implies that helping is a form of ensuring one another's daily survival.

A good reputation enables Malawian youth to receive help. Youth-heads of household were keenly aware of their reputation, a finding that parallels Eisenberg & Mussen's (1989) third stage of moral development in which children respond to social expectations. The motivation for a good reputation may also be explained by the desire to strategically position oneself to receive help, and in this way, contribute to resilience. Wilkinson-Maposa et al. (2005) found that personal reputation was a strong determinant for receiving help from others. By contrast, virtueless people, namely those who are untrustworthy, mistreat others, refuse to help, 'bad' people, the ungrateful, and the selfish, were not worthy of help (Wilkinson-Maposa et al., 2005). For youth-headed households to receive help, they must be worthy, and worthiness is judged by reputation. When youth have their needs met, their subjective well-being is increased, and one way to ensure needs are met is to guard one's reputation so that the social criteria for receiving help are met.

Miqlat USA takes a long view of education as a form of indirect help to a community in achieving a resilient and productive society. Children embraced this ideal, and even if they were not attending school, they deeply desired that their siblings and own children complete school. Global discourses and policies that promote education as a public “vaccine” against poverty are argued by Kendall (2008) as potentially destructive because they fail to critically consider the negative economic and social ramifications, such as the eroding of traditional Malawian cultural values and community infrastructure that has historically sustained them economically. Whether widespread education actually will enable communities for greater resilience remains to be seen (Kirmayer et al., 2009).

Analytic Category 5: Virtue and Agency

The regulation of subjective well-being is a highly social process because of the importance of interdependent personal relationships for well-being. Youth's agency for managing their well-being has typically been overlooked in the research, which may reflect the western tendency to view children as dependents, victims, and powerless. Only in recent years has there been a visible emphasis on children's agency in the youth-headed household literature (Robson et al., 2006; Skovdal & Ogutu, 2012). The literature emphasizes youth's active agency as a uni-directional source of personal control and competency, but employs a more passive tone when speaking of other-agents and social influences that impact children's capacity as agents (Lee, 2012). Research is needed to clarify the agency force of those who help vulnerable children and how cultural factors mediate these relationships.

The data demonstrated that children's life experiences were framed by their moral evaluations of their experience, such that good experiences were associated with virtuous actions and positive moral value. Because children used virtue as the criteria for appraising the intents and actions of others, then virtue is necessarily a defining characteristic of their well-being experiences. Furthermore, if virtue is the defining characteristic of well-being experiences, then virtue must also be embedded in the meaning of well-being, because what one values, one desires to experience. Another way to say this is that what one values is what one has decided is good for oneself, and well-being then derives from the experiential context where personal values are fulfilled. An active personal agency for virtue is then required to achieve subjective well-being.

Life is social, and social spaces must be safe for children. The safety of children's social spaces is an interactive function of social trust, social cohesion, and social control (Almedom & Glandon, 2010). Children in this study generally reported feeling safe, indicating adequate social trust. Social trust, cohesion, and control implies that safe societies adhere to certain values, morals, and beliefs. The well-being of children, therefore, cannot be disaggregated from the larger social spaces of economic and social policy (Kirmayer et al., 2009).

Only virtuous persons, or *virtue-agents*, are capable of conducting their relationships with children in a manner that creates an enabling environment of safety, acceptance, and freedom for children's thriving. This benevolent environment formed the social context for children's positive well-being experiences. Importantly, children differentiated people on the basis of virtuous behavior in an effort to minimize negative experiences and maximize positive experiences. Children purposely avoided virtueless persons because of the threat to their physical, emotional, and spiritual safety. Avoidance can thus be interpreted as personal agency arising from virtues like self-respect and dignity, because children are intentionally protecting themselves from negative, even dangerous, experiences that threaten their well-being. This type of avoidance might also be categorized as a moral act, in that morals are codes of behavior created to prevent harm to others, in this case, youth are protecting themselves (Gert, 2012).

Strong peer groups constitute a protective social space for psychological well-being (Cluver & Gardner, 2007). Children commonly exercised their virtue-agency in pursuing friendship opportunities, which Skovdal & Ogutu (2012) refer to as ‘bonding social capital’. School environments can be instrumental for developing friendships that foster the positive well-being of HIV-affected children, but may represent a lost social opportunity for children who can’t afford school (Skovdal & Ogutu, 2012). On the other hand, educational goals may erode traditional forms of family cohesion fostered by working together (Abebe & Bessell, 2011).

Children’s inclination to seek positive forms of well-being through the virtue-agency of others may be considered a form of “asset-based coping”, which is the ability of low-resource communities to fulfill their needs within existing resources (Ferreira, 2013). What is less well understood is how impoverished communities help each other utilizing socially acceptable strategies (Wilkinson-Maposa et al., 2005). Social and religious norms of reciprocity in helping others is lacking in the literature on vulnerable children, which may partly explain the continued prevalence of western individualistic and donor-driven paradigms for community resiliency initiatives in sub-Saharan Africa . What is left out of the discourse on the agency of vulnerable children is how ideological, structural, and economic changes in the collective community in the name of ‘development’ may alter the tactical agency of children as well as the agency of others who would respond to children's needs (Kirmayer et al., 2009).

Analytic Category 6: Virtue and Religious Beliefs

Another perspective deserving mention is the relationship between virtue and religious beliefs. While the complexity of distinguishing between religious beliefs, values, and personal virtues has not been unraveled, the religious-health literature widely affirms that religiosity is conducive to subjective well-being, though a causal link between religiosity and adolescent well-being has not been established (Yonker, Schnabelrauch, & DeHaan, 2012). Religion may contribute to health and well-being through the promotion of self-control, positive goal selection, and self-regulatory behavior (McCullough & Willoughby, 2009).

Religiousness may moderate depression, lower substance use, increase social support, provide a positive framework for appraising life events, and facilitate coping with stress (T. B. Smith, McCullough, & Poll, 2003). It is estimated that only 35-50% of the relationship between religiousness and indicators of health/well-being can be attributed to explanatory variables like social support, coping, and health behaviors (George, Larson, Koenig, & McCullough, 2000). Levin (2001) agrees that the link between religion and health is vague, and may be a function of adherence to a particular worldview that may delineate what personality traits, behaviors, or psychological states contribute to, or prevent, illness. Schwartz, Meisenhelder, Ma, & Reed (2003) demonstrated that altruistic behaviors are positively associated with better mental health, which suggests that religious-based altruistic beliefs may be indirectly tied to altruistic behaviors, which in turn contribute to subjective well-being from a religious as well as a moral virtues perspective.

Everyday life in Malawian culture is imbued with faith narratives, where 82% of the population identify as Christian, 13% as Muslim, and 5% claiming other or no religion (Central Intelligence Agency, 2012). Casual conversation among Malawians is commonly sprinkled with religious references to God's blessings and help. The fusion of faith, health, and well-being among people living and coping with HIV/AIDS in Sub-Saharan Africa has been well-documented (Keikelame et al., 2010; Mkandawire-Valhmu, Kako, & Kibicho, 2012; Olivier et al., 2006). The proliferation of faith-based responses to HIV/AIDS and OVC reflect the African paradigm of spiritual and physical unity:

> For the majority of Africans, their interpretations of life and health would be

> powerfully religious...This is a comprehensive understanding of health, a far richer description, one that encompasses the spiritual elements of health that the biomedical model tends to ignore, and one that is linguistically embedded in a non-Cartesian unity of subject and object, of religion and health. (Olivier, Cochrane, & Schmid, 2006, p. 9, 16).

Children’s religious understandings may inform their personal understanding of virtue and morality, and partially contribute to subjective well-being, but until culture-specific studies are completed, the strength and direction of this relationship remains speculative.

Religion, Virtue, and Social Desirability Response Bias

A possible limitation in this study is the *social desirability response bias,* resulting in children crafting interview responses to appease me directly, or Miqlat USA indirectly (Fisher & Katz, 2000). An understanding of cultural norms is salient to the idea of social desirability response bias (Middleton & Jones, 2000). Since collectivist cultures experience greater subjective well-being when they achieve social goals to please others and contribute to group harmony, children’s virtue-laced answers may be mirroring a cultural norm. Furthermore, cultural norms for experiencing positive emotions are associated with more frequent reports of such experiences compared to negative emotions (Eid & Diener, 2001; Mfutso-Bengo & Masiye, 2011). Children's reports, then of virtue, faith, and morality may be cultural reflections, or conveyance of their ideals, rather than response bias. Nevertheless, authenticity of children’s answers to interview questions was validated by consistent responses within and across cases, suggesting a shared similarity of experiences, rather than a sample-wide operative of social desirability response bias.

Two strategies were used to minimize response bias during the interview process: (1) a deliberate, ongoing, assent process throughout the interview by offering youth multiple opportunities to ask questions and voice concerns, and (2) the use of a Malawian research assistant who noted no concerns regarding verbal and non-verbal behavioral cues.

Signs of response bias and unintended coercion were not found during an analytical comparison of the data between the seven households who were Miqlat USA beneficiaries and the three non-beneficiary households. First, the four open-ended questions on spirituality in the interview guide was compared to the actual interview questions for all ten participants. None of these questions were asked of any participant because the topic of God and faith arose spontaneously in response to other interview questions. Only the youngest participant was asked an unplanned, direct question about spirituality, "Does your family have faith?", which was answered affirmatively. Later in the interview this same participant volunteered more information about personal faith, which was then probed. Given the pervasive element of religion in everyday Malawian life, children's narratives about God and faith are likely more evident of the cultural and religious norms, and much less likely about bias or coercion. Importantly, no forms of appeasement were volunteered by youth, such as self-proclamations of personal goodness.

As an American Christian researcher who understands virtue from a multi-dimensional perspective of secularism, religiosity, western culture, and individualism, I relied on three methods to minimize cultural and religious bias when analyzing the data. First, my five-member academic committee each provided input for the interview guide from their culturally, professionally, and religiously diverse perspectives. Second, an iterative, multi-stage process was utilized to arrive at a fair weighting and valid interpretation of the data, and then defended with appropriate literature. Third, the data findings and analytical conclusions were confirmed with my major professor and academic committee, and then clarified where necessary.

Analytic Category 7: Poverty and Subjective Well-Being

If virtue is about living well and flourishing, what meaning does this have within the context of poverty? This is an important consideration to explore, given that my demographic data substantiated prior studies linking poverty, loss of parental care, food insecurity, and high rates of adult HIV, to the formation of youth-headed households (Foster et al., 2005).

Two studies that examined the relationship between basic needs, poverty, and subjective well-being are worth mentioning. In the first study, Lyubomirsky, Sheldon, & Schkade (2005) identified three major determinants of happiness, based on a literature review: (1) a genetically-based set point for happiness, (2) personal life circumstances (such as income, personal history, culture, educational level, and gender), and (3) factors and activities under one’s voluntary control. The variation in personal happiness was most explained by genetics (50%) and deliberate activities (40%). Life circumstances comprised only 10% of the variance in overall happiness as long as basic needs were met.

Three major limitations of this survey are apparent. First, most of the studies reviewed were from western industrialized nations, and not impoverished nations

(Lyubomirsky, Sheldon, & Schkade, 2005). Second, the category of ‘life circumstances’ included many variables, not just income or basic needs, which results in a dilution of the effect of income and basic needs on personal subjective well-being. In rural Malawi, where poverty is rampant, it seems that improvement in life circumstances, particularly with regard to basic needs of food and shelter would be more highly correlated with happiness than would other life circumstance variables. Third, this study did not include any research on children, which limits its generalizability to youth-headed households in Malawi.

To answer the question of how one’s subjective well-being is dependent upon fulfillment of basic needs, I turned to a study by Tay & Diener (2011), “Needs and subjective well-being around the world”. The study utilized Gallup World Poll data to experimentally examine the association between basic needs and subjective well-being across 123 countries (n=60,865), representing 66% of the world’s population, including Africa (n=14,748). The study examined the relationship between life needs (basic needs, safety/security, social support/love, respect/pride, mastery, and self-direction/autonomy) and the three components of subjective well-being (life evaluation, positive feelings, and negative feelings). The category of basic needs, which included food and shelter, was considered satisfied if in the past 12 months the respondent had enough money for food, had enough money for shelter, and did not go hungry.

For all countries, basic needs was most strongly associated with life evaluation (0.31) with Africa slightly lower at 0.25 (Tay & Diener, 2011). The variance between basic needs fulfillment and life evaluation was 63% for the world, and 62% for Africans. Negative emotions were predicted by lack of basic needs, but less so for Africa (14%)

compared to the world (23%). Tay & Diener's (2011) analysis contains three important conclusions germane to the question of the relationship between basic needs and subjective well-being:

(1) Different types of needs (basic needs, social needs, etc.) independently influence subjective well-being, such that a person with unmet basic needs may still experience subjective well-being when other social needs are fulfilled. This conclusion is supported in my data in which all children reported hunger and inadequate shelter, yet they identified positive well-being experiences, primarily from social relationships. The low variance (-0.14) between Africans' negative emotions and lack of basic needs may be due to the influence of cultural norms for experiencing positive and negative emotion, societal norms for material wealth, and collectivist values (Diener, Oishi, & Ryan, 2013).

(2) When basic needs were met, income did not contribute significant variance for higher subjective well-being, which suggests that basic need fulfillment is more closely related to subjective well-being than is income. Children's narratives attested to this as well, in they did not express desire for material wealth beyond basic needs and educational fees.

(3) Fulfillment of basic needs lessens negative emotions, but having all needs fulfilled is alone insufficient to achieve high life evaluations. This is corroborated in my study by the *Eight Experiential Contexts* of subjective well-being, in which psychosocial well-being constituted a large dimension of children's well-being experiences. It is certain that if children's basic needs were fulfilled, their subjective well-being could be expected to improve.

Taken together, what the experimental data from Tay & Diener (2009) and Lyubomirsky et al (2005) demonstrate is that subjective well-being is not purely fate. It is directly related to both basic need fulfillment, and equally important, psychosocial well-being need fulfillment that can be met by intentional activities. Even though some life factors like temperament and poverty are generally unchangeable in their immediate state, there is otherwise ample room for personal agency in the regulation of subjective well-being.

For severely impoverished children like those in my study, the situation is different in that these children spend a disproportionate amount of time on basic need fulfillment, sometimes at the expense of psychosocial needs for friendship and educational losses (Kendall, 2008). Basic need fulfillment has multi-dimensional benefits that not only facilitate physical survival and health, but also has significantly positive effects on how individuals evaluate their lives (Diener et al., 2013). If children's basic needs were more easily and readily met, they would have a greater bank of time and effort available for elective, intentional activities that could potentially increase their subjective well-being. In summary, basic needs are necessary, but not sufficient, for positive subjective well-being. Yet virtue practices may help mitigate against the negative psychological effects of deprivation, through social support systems and effective personal agency (Froh et al., 2008; Ungar et al., 2007).

Analytic Category 8: Culture and Subjective Well-Being

The relevance of subjective well-being must be centralized within the culture being studied (Diener, 2009b). A culture consists of a dynamic set of beliefs as opposed to a static, unchanging rigidity. How a culture experiences subjective well-being, the

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correlates associated with well-being, what factors are specific to a culture, and what factors are universal, remain important questions in the international subjective well-being research. A growing body of cross-cultural evidence on subjective well-being supports the present conceptual structure of subjective well-being (a triad of life satisfaction, frequent positive affect, and infrequent negative affect) as globally valid, though individualistic cultures rely more on emotional feelings while collectivist cultures rely more on perceived normative standards due to the high value placed on community harmony (Diener et al., 2013). The finding that children's hardship was partially linked to the arduous work of resourcing their basic needs, while their positive emotional experiences were primarily interpersonal experiences, is corroborated by Tay & Diener's (2011) finding that across 123 countries, life satisfaction is most strongly predicted by basic need fulfillment, and positive affect is best predicted by social needs fulfillment.

The idea that virtues may be ubiquitously related to well-being opens the door for finding common ground between cultures within the context of global health initiatives. A comparison of my data with Fattore, Mason, and Watson's data (2009) on the well-being of Australian children hints at this possibility. The two studies were conducted in markedly different cultures: Australia, an individualistic, industrial society, and Malawi, a collectivist, agrarian society. In both studies, two similar findings were noted: (1) children understood their well-being in moralistic terms that permeated across life domains, personal relationships, and emotional experiences; and (2) the emotional well-being of children was described as an interaction between personal agency, a positive sense of self, and society (Fattore et al., 2009).

Miqlat USA's role in the local community and culture is viewed by the administration as a 'brotherly' relationship in which the NGO assists the community in the care of its most vulnerable children. Beyond material support, Miqlat USA, acts as a kind of 'gatekeeper' of the children through its surveillance of children's family situations. In circumstances of serious misbehavior, missed school days, or poor parenting, Miqlat USA administrators will intervene to rectify the situation, much as an uncle would. Whether families respond out of fear of loss of support for their child, or whether they respond out of respect and appreciation, I do not know. From a purely speculative standpoint, the complexities of the collectivist interdependent accountability may conceivably extend from the community to Miqlat USA in a positive sense, but as Bornstein (2005) made clear, gatekeeper roles of foreign NGOs may run counter to the culture, to the point of intrusion, when their actions challenge, even threaten, culturally accepted forms of child-rearing.

The importance of cultural distinctions and the need for culturally-relevant research designs cannot be underestimated. Subjective well-being data on cultural differences indicates individualistic nations are more adversely affected by negative feelings than collectivist cultures (Diener et al., 2013). Assuming this is true, we should question if the reliance of western researchers on western ideas of depression, use of western-developed measurements of depression, and western analyses for depression in qualitative methods, have conflated the prevalence and/or severity of depression noted in the research on youth-headed households of sub-Saharan Africa. In a world of limited resources, accurate research conclusions are necessary to ensure resources are directed into maximally beneficial initiatives.

Analytic Category 9: The *Integrative Virtue Model of Health and Well-Being*

A singular, universal definition of well-being does not exist, yet there is consensus across the historical and interdisciplinary literature that well-being is synonymous with 'human flourishing' and 'life satisfaction', and usually incorporates elements widely recognized in the health literature such as the physical, psychological, cognitive, and spiritual domains of life (Kiefer, 2008; Orem, 2001; Seligman, 2011). In the well-being literature, taxonomies consist of life dimensions (domains), such as body, mind, and spirit. A variety of taxonomies of child well-being exist because no standardized set of domains of adolescent well-being has been established. Taxonomies are tools that simplify the conceptual aspects of data findings by classifying like data into topical categories. In Pollard & Lee's (2003) review of the child well-being literature (n=415) five categorical domains of well-being were identified: physical, psychological, cognitive, social, and economic. Huebner's model of adolescent subjective well-being is described by five social domains: family, friends, school, living environment, and self (Gilman & Huebner, 2003). In a study of young caregivers (children caring for an ill adult relative) in Zimbabwe, five categorical domains of child well-being were recognized: education, personal, emotional, income, and reproductive (referring to domestic household work) (Robson et al., 2006). For all three of the afore-mentioned studies, a domain of spirituality, religiosity, or morality was not included (Gilman & Huebner, 2003; Pollard & Lee, 2003; Robson et al., 2006). It is ironic that given the human universal attribute of morality, explicit inclusion is rare in well-being models, and when present, are usually subsumed in a spiritual, psychological, or metaphysical domain (Kirsten, van der Walt, & Viljoen, 2009).

In the present study, the *Eight Experiential Contexts of Subjective Well-Being* denote *types* of well-being experiences that arise out of a process of agency and opportunity, rather than discrete *domains* or *categories* of well-being experiences. A taxonomy of experiential contexts permitted analytical overlap and interaction between contexts, and was a better conceptual fit with the abstractions of children's value judgments than could be achieved with a boundaried categorical taxonomy.

Children's sense-making strategies to create a sense of coherence and life meaning, consisted of moral evaluations of their experiences based on their ideas of what determines the 'well' of well-being (Wissing & van Eeden, 2002). Valuations of their experiences intersected four categorical health domains: physical, psychological, intellectual, and spiritual. It was not uncommon for one experiential context to concurrently affect multiple health domains. For instance, if in the experiential context of *help* a child received food from another, the food itself contributes to their physical health, the act of being helped positively impacts their psychological health, the gift of food may free up time for school studies that would otherwise be spent searching for food, and the provision of food may represent an answer to prayer that sustains their faith in God.

Youth believed in the necessity of inner virtue of themselves and anyone who purports to help them, including God, for positive subjective well-being. People who help children are virtue-agents with positive moral character, whose virtuous acts contribute to children's well-being by assisting and creating situations that positively impact children. But without sufficient opportunity for such experiences, virtue-agency is impotent. These two factors, virtue-agency and opportunity, were identified as the required elements for children to actually realize positive well-being experiences. The opposite is also true: Without virtue-agency and/or opportunity, well-being experiences remain a dream, and not a reality. The interaction of virtue-agency and opportunity takes place at the social interface, where virtue-agents and opportunity converge to create well-being experiences.

The *Integrative Virtue Model of Health and Well-Being* (Figure 4) is a graphic schema of this study's data analysis. The model depicts the open and dynamic interrelationships between virtue, experiential and existential subjective-well being, health, and the social interface. The justification of the elements and their relationships was discussed throughout this thesis. The advantage to conceptualizing health and subjective well-being together as a function of virtue is the capacity of the model to accommodate and converge these concepts and attend to situational heuristics like 'vulnerability'.

The *Integrative Virtue Model of Health and Well-Being* is a summary framework of the study's data of children's experiences and meaning of well-being:

> *Well-being is a dynamic state of integrated wholeness within and between four health domains (physical, psychological, intellectual, spiritual), that emerges from, and is contingent on, benevolent virtue-agents (self, others, God) who access actual or potential opportunities at the social interface to fulfill a child's virtue-informed values within eight experiential contexts (provision of basic needs, benevolent belonging, experiencing God, growth through adversity, help, hope, intellectual development, protection)***.**

The *Integrative Virtue Model of Health and Well-Being* differs from other systems-based health models such as Bronfenbrenner's *Ecological Systems Theory* (Bronfenbrenner, 2005) and the *Eco-Systemic Model* (Kirsten et al., 2009) in four ways:

1. The centrality of Diener's concept of subjective well-being.
2. The governing function of virtue for appraising and regulating well-being.
3. The placement of traditional categorical health domains (physical, psychological, intellectual, spiritual) *between* the experiential and existential level, instead of at the experiential level.
4. The experiential level is a taxonomy of types of experiences important to children's subjective well-being.

There is considerable overlap and interaction among the model's elements as was demonstrated in this chapter. This is not to say, though, that virtue equates to health or well-being. Rather, virtue is related to socially acceptable forms of personal agency, healthy relationships, and personal responsibility, all of which contribute to positive health and well-being (Martin, 2006).

Three related objections might be raised about the model: (1) It reifies the human condition, (2) It oversimplifies the attainment of well-being, or (3) It romanticizes the children in this study who face severe daily hardship. The objections of reification, oversimplification, and romanticization have in common the idea of that the model is unrealistic and nonrepresentational of human well-being. However, the objections are overcome by understanding the primary purpose of a model. The purpose of a model is to simplify the logical ideas and relationships between components known or hypothesized to influence well-being. A model is therefore an *ideological* depiction of well-being in perfect circumstances that can be legitimately derived from data as well as philosophical thinking. The utility of a model is a function of its ideology and its legitimacy for explaining and guiding our thinking about the well-being of vulnerable children. Models are meant to inform ideas of health, and are useful for theorizing about health, framing research designs, interpreting data, and directing interventions. The inclusion of virtue in the *Integrative Virtue Model of Health and Well-Being* is meant to draw attention to the idea that virtue is an important, yet rarely incorporated, element of well-being. The model exemplifies how virtue may be related to well-being and health, but it is in no way nullified by the reality of an imperfect, suffering humanity.

The literature on virtue has declined in the last century (Kesebir & Kesebir, 2012), indicating less scholarly attention to the salience of virtue for human thriving. However, the experimental and longitudinal studies in the health and psychology literature highlights the correlative relationship of virtue, health, and happiness, suggesting that societal health is contingent on virtuous human actions, for both individualist and collectivist societies. Though the *Integrative Virtue Model of Health and Well-Being* is in nascent form and admittedly limited to this study, there is need for further philosophical, nursing, and cultural studies to determine its validity as a model of health and well-being. Irrespective of cultural or religious affiliation, the findings of this study imply that the absence of domains of morality, virtue, spirituality, and religiosity in studies of children's health and well-being is a clear indication that new questions need to be asked (Gilman & Huebner, 2003; Pollard & Lee, 2003; Robson et al., 2006).

Turning attention to the field of research in nursing ethics, a certain paradox of ideas is evident in that the virtues of nurses are critical to the health and well-being of patients, but the virtues of patients for their own health and well-being are not explicitly considered. Given the wealth of research on well-being, virtue, character development, and health presented here, nursing research must expand its philosophical and research horizons to explore how patients' own virtues impact their health to overcome the myopic view of virtue as a unidirectional phenomena from nurse to patient.

Research is needed to elucidate the cultural aspects of subjective well-being, such as how culturally-prescribed activities affect subjective well-being and understanding the influence of cultural values on personal feelings and how one pursues well-being within a particular culture (Diener, 2009a). Developing an understanding of Malawian cultural meanings, constructs of virtue, and socially-appraised acts of virtue, as they relate to adolescent subjective well-being and health is critical for guiding how to think about and act on health inequalities (Carlisle & Hanlon, 2003). The social nature of virtue and the Malawian collectivist value of the social appraisal of virtue within *Ubuntu,* suggests that virtue development may be a culturally-appropriate intervention for Malawian youth.

Conclusion

Originating in the field of positive psychology, research on subjective well-being now spans nearly four decades and intersects multiple disciplines, including health. Subjective well-being is a concept consisting of three constructs: global life satisfaction, frequent positive affect, and infrequent negative affect. Importantly, the holistic nature of subjective well-being as a complex interaction of life events, temperament, and human needs makes it an appropriate concept for understanding health as more than just eradication of inequities and illness.

This study is one of the first studies in nursing on the topic of subjective well-being. It is also the first study to explore the subjective well-being of youth-headed households. This study extends the literature on vulnerable children by challenging the popular notion that adolescent positive well-being is antithetical to vulnerability. The research findings effectively translocate the scholarly dialogue from a discourse of the vulnerability and passivity of orphaned youth, to the broader discourse of the active, competent, and even creative, agency of youth to regulate their subjective well-being across the physical, psychological, intellectual, and spiritual domains of health. Importantly, the analytical focus on virtue does not subrogate the primacy of children's basic health needs, nor does it diminish the harsh reality of adversity, nor does it exaggerate the positive effects of religious faith.

The saliency of virtue for children's holistic well-being was represented in the *Integrative Virtue Model of Health and Well-Being*. The advantage of using a virtue-based paradigm is the foundational emphasis on virtuous character traits as integral to the dual holistic imperative to improve well-being and decrease ill-being. A virtue-based model overcomes the tendency to artificially separate the physical, psychological, intellectual, and spiritual health domains, by unifying these domains of health, and this unity is consistent with the African ethic of *Ubuntu,* Judeo-Christian theology, African moral philosophy, and a nursing philosophy of holistic health. Virtue development at the personal and community levels, as a means to improve health and decrease pathology, may be a cost-effective, culturally appropriate intervention for low-resource settings like rural southern Malawi. Indeed, this idea is embraced in Miqlat USA's strategies for ensuring family-based care of orphans through community agreement about what constitutes the healthy development of children.

Packer (2011) reminds us the researcher is neither a participant nor an observer, but a "stranger from another form of life…to make evident…the 'regional ontology' of a form of life…whose goal in writing data results is "a matter of making things show up: writing to have an effect on one's readers, so they will see in a new and different way," (p. 242). It is my hope that this study will provoke thoughtful consideration of virtue as a lens for understanding subjective well-being and illuminate the moral, religious, and indigenous philosophical spaces that impact the lives of vulnerable Malawian youth.

Limitations

Four limitations to this study are noted:

(1) Malawian children are not accustomed to being asked about their lives and their opinions, and this may have limited a fuller articulation of their life experiences to achieve a nuanced understanding beyond this exploratory study. Future studies are suggested for follow-up, including a program of longitudinal research.

(2) The cross-cultural nature of this study warrants consideration that the individualistic orientation of the data and the time constraints of the research design may have diminished salient contextual elements of community and culture (Ungar et al., 2007). While these elements are important considerations in the holistic care of vulnerable children, an in-depth analysis of ethnographic features would have exceeded the scope of this study. Nevertheless, a broad array of literature was used to overcome

this limitation, and all aspects of the research process were reviewed with my Malawian professor for cultural relevancy, appropriate methodology, and analytical validity.

(3) None of the youth admitted to a current abusive or an acutely traumatic situation, though at least three relayed a history of past abuse, and one experienced a recent loss of a caretaker. The apparent relative safety of this sample may have skewed the results towards a more optimistic analysis than might be found among children suffering from acute trauma or abuse. Follow-up studies are needed to determine specific risks and pathways of adolescent risk.

(4) The small sample and predominance of participant households with at least one member receiving support from Miqlat USA obscures direct knowledge of the impact of external support on subjective well-being. Comparison studies of youth pre- and post-beneficiary status, and between types of support organizations (secular NGO, FBO, or no NGO) would elucidate this aspect. The answer, it seems, would hinge less on the presence or absence of an NGO or FBO, and more on the dynamic complexities of how the community itself contextualizes religion and morality, the religious beliefs of the child, religious meanings of health and illness, community well-being, and community cohesion (Schmid, Thomas, Olivier, & Cochrane, 2008).

Implications for Nursing

The theory of 'positive health' hypothesizes that subjective well-being is correlated with delayed morbidity, properly functioning biological systems, and quality of life (Ryff, Singer, & Love, 2004). The paradigm of positive health inverts the traditional medical paradigm of illness by turning the focus of attention from psychological adversity and correlated elevated biological risk to a focus on how subjective well-being is correlated with reduced biological risk. The protective benefits of positive well-being in terms of longevity, decreased illness, and decreased disability point to the importance of developing national measures of subjective well-being and health determinants in all countries (Diener & Chan, 2011). Certainly, a beneficial research objective in global health is to find effective interventions for improving subjective well-being in low-resource settings like Malawi.

Studies are needed to understand how to enhance youth's prosocial altruistic beliefs and behaviors, and how culture (family, peers, elders) and institutions (education, religion, community-based care programs) affect the development of prosocial values, virtues, and behaviors (Eisenberg, 1992). Concrete knowledge about prosocial behavior and altruism could be applied to policies that affect community values and resource allocation.

From a philosophical standpoint, incorporation of the subjective well-being model may be one avenue to reconstructing research paradigms of vulnerability in a way that complements, but does not diminish, personal motivation, strengths, and agency. Along the same line, further exploration of the utility of the *Integrative Virtue Model for Health and Well-Being* may contribute to a broader understanding of holistic health.

Spiritual experiences of youth and the bearing of these experiences on prosocial behavior and subjective well-being deserve scholarly attention. Children's spiritual experiences are generally ignored in the vulnerability literature, and as I have shown, spirituality is a very real part of children's daily lives, and should not be restricted to extraordinary accounts of miracles or near-death experiences (Burpo, 2010). Qualitative studies to generate narrative accounts of children's faith beliefs and experiences are a first step toward building a body of research on children's health and spirituality, given the literature on the health benefits of religiosity for adults (Levin, 2001). I propose a comparative, cross-sectional, qualitative study of the faith and subjective well-being of youth who are considered resilient by their community, with further delineation of the sample into NGO and non-NGO affiliation.

Another proposal for future nursing research arising from this dissertation is a qualitative examination of the relationship between virtue development and resilience. Building on Ungar and colleagues' (2007) research on resiliency of vulnerable children, I recommend a two-stage qualitative research program. The objectives of the first stage would be to (1) identify specific personal virtues in a sample of vulnerable children who are considered resilient by community peers and adults, and (2) understand how youth use virtue to create enabling environments for themselves and their families. The second stage would consist of a virtue development program for vulnerable children created from the first stage data. Pre-and post-outcome qualitative assessments of the subjective well-being and resiliency of vulnerable children would be conducted. This study could also be designed as a comparative study between two or more settings for the purpose of determining if the relationship of subjective well-being and virtue varies by NGO presence and/or affiliation.

Implications for Community-Based Care of Vulnerable Children

Understanding who and what children regard as ‘good’ for their well-being is a clue to the types of effective program initiatives for children’s well-being. Organizations that assist vulnerable children should consider how to implement children’s perspectives of virtue, faith, and agency as part of their holistic program initiatives. The *Integrative*

Virtue Model of Health and Well-Being suggests that program initiatives should target personal virtue development at multiple levels by incorporating virtue when teaching strategies for achieving life goals, creating guidelines for mentor programs, planning activities to help others, and in forming peer-support groups.

A recommended intervention to increase resilience of African youth is the use of story techniques to foster development of moral character among children ages 9-14 years (Wood, Theron, & Mayaba, 2012). Generational stories passed through families, religions, and cultures are a form of moral education about building virtuous character and attaining wisdom from community elders (Ikuenobe, 2006). A program of story-telling for passing cultural and religious traditions of morality and virtue to youth may foster resilience through moral character development, build mentoring relationships between adults and children, and strengthen community cohesion through the corporate remembrance of their people's history and values. If Owusu-Bempah (2010) is correct about the psychological importance of the social and genealogical connectedness for the well-being of orphaned children, such an intervention may serve a protective function for children by creating and establishing a deeper connection between themselves and their community while strengthening their personal agency.

The strength of children’s active agency for their well-being suggests that children may benefit from additional programs that increase their knowledge of, and strategies for, accessing existing community resources, and building entrepreneurial skills for income opportunities. *Foundations for Farming* (2014) is one such resource for improving agricultural skills, increasing income, and increasing food security, that could be mobilized in partnership with Miqlat USA.

The prominent importance of children's faith in God as a divine and interpersonal experience, indivisible from their subjective well-being, is strongly suggestive of the need to include faith development in children's programs. Since virtues are the lifeblood of theistic religions, FBOs and NGOs might consider ways to directly incorporate virtue development within spiritual development. Both secular and faith-based organizations may partner with the local churches to create complementary programming. This type of partnering is not a foreign concept in Malawi, as the local churches have historically served as significant sources of support for vulnerable populations like orphans and people affected by HIV (Foster, 2006; Olivier et al., 2006).

Directions for Future Research

There is a dearth of literature on Malawian orphans and youth-headed households, and specifically, there is no nursing literature. Furthermore, there are very few studies of the holistic well-being of these children. Four broad objectives for orphan and vulnerable child research are offered to fill these voids. First, research to understand how children's faith impacts their subjective well-being and resiliency is an important area that remains unexplored. Second, robust research models are needed to accommodate the salutogenic factors of well-being in vulnerable populations. Third, researchers should partner with smaller NGOs for the express purpose of research and development of evidence-based practice to inform practitioners, develop programming, and facilitate grant funding. Fourth, there is perplexing *absence* of nursing scholarship in the orphan literature. This is antithetical to our professional nursing heritage as advocates for the health of vulnerable children. Until orphan care becomes a concern of nursing scholars, orphans and their communities will remain invisible to the wider nursing profession. The challenge to the international nursing community to create a formal body of research on the health and well-being of orphans, particularly in HIV-endemic areas, is a laudable and necessary goal.

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Appendix A: Narrative Interview Matrix

Narrative Interview Matrix Subjective Well-Being	
File ID: #3-10 Random ID: Child #3 Participant #10 Elizabeth Age 18	
Age	18
Sex	F
Miqlat (M) Non-Miqlat (NM)	NM Younger sister in M.
Experiences of SWB	Work together as a family. Share stories before bedtime, then laugh and go to bed. Encouraging others as a good friend, to not repeat her mistakes, encourage school, and that they can return to school even if have children. Favorite subject: Math To worship God. For siblings to get education and become independent. Playing with friends to get over worries. Eats at least once daily Garden of maize, pumpkins, pigeon peas, mustard, rape and tomatoes. Garden close to river so irrigates. Working together Talking/sharing/laughing together Closeness in family, unity, happiness
Notes	16F, 9 F, 2 yr. old child, 2 maternal uncles, (brother stays with GrMa who's caring for orphans…"related on my father's side so we are not the only people who need her help." Division of work is by duty roster. All share. She is decision-maker about work, piecework, gardening, duties. She is disciplinarian…no work, no food. Had to drop out of school because social welfare committee didn't continue fees, but well-wishers paying her fees now and she is repeating form 1 since didn't pass form 2 exams bc had to drop out due to fees. No help from church. Goal is to finish school and become a mechanic and a driver. Most important thing for children: education and be God-fearing Would advise others to "love their siblings." Love includes discipline for wrong. And "Stay well with siblings".

Quotes	“They don’t misbehave because they know that we don’t have parents, those children who misbehave knows that there is someone to look after them.” “My faith in God helps me because whenever I have problems I pray and He answers my prayers, and I don’t only depend on my church, I go also to fellowship with other believers, and do fasting (for one week every couple of months – fasts during day, eats at night). “To worship God” is good thing about her life “…because if I have a disagreement for a person or misunderstanding, I pray to God for forgiveness and come the next day I will talk to that person like nothing has happened between us, and I don’t keep any grudge and that is why I am a happy person.” Miqlat: “They should continue..pay school fees…Miqlat has also done a great job because children were tested their blood here and some were found HIV positive. Because of Miqlat some of the children are receiving medicine in hospitals and this is a very great achievement.”
Risks to Subjective Well-Being	
Experiences of Risk	Both parents deceased. 8 children total, 4 died, now 2F, 3M. Died at ages 18, 10, 8, unknown cause….Both parents deceased (father, TB. 2003; mother uterus, 2005….???doesn’t reckon with story, so father died 2005, mother 2003). Mother first, then moved to father’s village. She cares for 5 siblings. Insufficient income – piecework, all children People gossip about appearance.
Quotes	Copes with danger, unsafe, not comfortable, “…we just kneel down and pray to God for protection.”

Appendix B: Narrative Interview Report

March 26, 2013

NARRATIVE INTERVIEW REPORT

File ID: #3-10
Random ID: Child #3
Participant #10
Elizabeth
Age 18

BRIEF ABSTRACT

18 yr. old female, double orphan, lives with sister, age 16, 2 ‘uncles’, and her 2 yr. old daughter, and 9 yr. old niece. Paternal grandmother caring for orphans so she cannot help. Piece work for income, sometimes without food. All children help with chores. She is primary decision-maker. If children misbehave, they will not eat. Not treated any differently in village. She knows other CHH, but they are not her friends (reason not ascertained – I think she just knows of them, but not personally).

Well-wishers supporting her for school, Form 2 about to start.

Family is close to each other which enables cooperation for all to work to get what they need most times. All in family are happy. At night, share stories, laugh, then go to bed. She enjoys chatting with brothers and sisters on the way home from garden or school.

Dangers: If something unsafe or not comfortable with, “we just kneel down and pray to God for protection”.

Fears/Worries: Play with my friends to get over it. Example: Gossip about the way she looks. Encourages children not to worry.

What children need most in life: Education and to be God-fearing.

Help from others: Friends, family – chores, fun, listen, advise, encourage. Miqlat has done a great job, helping HIV+ children, pay school fees. Supporters paying her school fees.

Help from church: None.

Help from faith: “My faith in God helps me because whenever I have problems I pray and He answers my prayers, and I don’t only depend on my church I go also to fellowship with other believers and do fasting." (One week/month – Chores, pray about 2 pm, and pray at dark before breaking fast). God is love, protection, forgiveness.

What is good about life: To worship God. Makes her very happy. If disagreements with others, pray to God for forgiveness, and no grudges, and unity with other. This makes her happy.

Good friend: Listens to my advices, does not repeat my mistakes, encourage them to concentrate on school and not boys, and if they have children they can go back to school.

Education important because you can be independent.

Aspiration: Finish school and become a car mechanic and driver through vocational school. Children to finish school and become independent.

Advice to another CHH: "I tell him/her to love their siblings." Love includes discipline for wrong. "Stay well with his/her siblings."

SUMMARY IMPRESSION

Well-being is realized in love of family and friends and faith. God is a source of love and protection, and worship on Sunday is a very happy time. Faith is integral to well-being. Poverty affects ability to attain material and food needs, and education. Well-being beliefs include completion of education so that one may become independent, and in this way, well-being is improved through emancipation from deprivation. Education and God-fearing faith are what children need most, and sufficient opportunity is needed to achieve education and grow personal faith. Within the day to day events and relationships, though, is a language of love and help and positive virtues (responsibility, discipline, work ethic, forgiveness, love, help) and values (discipline, family unity, happiness). Good relationships are relationships of benevolence, listening, and encouragement. Therefore, well-being, a type of 'good-being', will necessarily include benevolent relationships.

Good relationships with God and friends are the source for resolve of worries. Good people love. Good people are virtuous. Good relationships are benevolent relationships, and are corrective, supportive, protective, and provisionary to deal with life. It is not a 'relationship' per se, but the enactment of love and perception of love that arises out of the interpersonal interaction, that is the active relational catalyst that creates a sense of well-being. In this way, the reciprocal enactment of her love towards others is simultaneously an active catalyst for her personal well-being. Therefore, giving and receiving love and help, in both material and non-material ways is integral to well-being. This required enactment of love in benevolent relationships is why mere mentor programs may not deliver high impact. If learning skills and methods were the catalyst for well-being, teachers would be esteemed more than those who exhibit love (family, friends, God). Mentors, to be effective, therefore, must enter into a benevolent interpersonal relationship with the mentee.

Appendix C: Conceptual Interview Scheme

Conceptual Interview Scheme
File ID: #3-10
Random ID: Child #3
Participant #10
Elizabeth
Age 18

Summary of Subjective Well-Being
Well-being is anchored in her faith in God. She describes worship as very happy, she is able to forgive others during disagreements, and this makes her happy. She describes family as happy, they laugh, work together, chat together, plays with friends. Vision is for economic independence through completing education and becoming a mechanic.
Concepts Associated with Subjective Well-Being: Faith, happiness, forgiveness, benevolent others

Well-being is realized in contentment and happiness, anchored in faith in God, and lived out in positive relationships with friends and family. Well-being is a type of 'good-being', in a language of love and help and other virtues. Benevolent relationships with God and others is a source for resolve of worries, a corrective to adversity or difficulties. Well-being is catalyzed by active relational love, in both giving love, and receiving love.

Appendix D: Interview Guide

Youth Head of Household
Mwana wa mkulu pakhomo

Principal Investigator: Pamela Fruechting, MSN, APRN

Title of Research Study: The well-being of vulnerable children: Reconciling perspectives of well-being between youth heads of households and a community-based international non-governmental organization in rural Malawi.

Semi-Structured Format
Meeting Place: Miqlat Ministries
Malo okomanila – ma ofesi aMiqlat

Greetings & Introduction to the Youth Malonjerano
Good morning, (name). I am very glad to meet you. My name is Ms. Pamela Fruechting. I am a student at University of Wisconsin-Milwaukee. Audrey and Carol are assisting me. Carol is our translator.

Thank you very much for coming. I am here to understand how young people who are the family caretaker describe and experience well-being in daily life. I will use the information to advise communities, healthcare professionals, and organizations like Miqlat Hope Center on what young people say is important for well-being. No one will know what each of you said but I will present your responses in a group format. You will receive a small gift as an expression of appreciation for participation in this study.

Moni. Ine ndakondwera kudziwana nanu. Ine dzina langa ndine Pamela Fruechting. Ndine mwana wa sukulu ku univesite yotchedwa University of Wisconsin-Milwaukee. Pamodzi nane ndi mayi Audrey Tluczek ndi Carol Beya amene ali otanthauzira. Zikomo kwambiri chifukwa cha kubwera kwanu. Ndiri pano kufuna kumva za mmene achinyamata amene amadziyan'ganira okha komanso amene amayan'ganira abale awo pa khomo amakhalira pa umoyo wa tsiku ndi tsiku. Ndigwiritsa ntchito mayankho anu podziwitsa anthu ammudzi, ogwira ntchito ya chipatala ndinso mabungwe ngati Miqlat za mfunso zimene mwapereka ngati achinyamata. Palibe atadziwe kuti uje anayankha mwakuti koma mayankho anu ndidzapereka monga mwa gulu. Mudzalandira mphatso yosonyeza kuthokoza kwanga pondithandiza ndi kafukufuku ameneyu

Qualifying Criteria: Are you healthy today? (If 'no', reschedule interview)
Kodi muli bwino lero kapena mwadwala?

Demographic Information
Participant Information
Sex: (M/F) *Mwamuna kapena mkazi*

Age: *Zaka*
Grade level: *kalasi yanji pa sukulu*

Mosquito net? (yes/no) *Mumagona mmasikito kapena mu neti?*

Do you have a garden? (yes/no) *Muli ndi munda?*
What do you grow? *Mumalima chani?*

List everything you ate yesterday: What did you eat in the morning after waking up? What are other things you ate at school? What other things did you eat during the day? What did you eat before you went to bed last night? *Dzulo mutadzuka munadya chani? Kusukulu munadya chani? Zina ndi zina zimene munadya ndi chani? Masana munadya chani? Madzulo musanagone, munadya chani?*

Are you employed? (yes/no) *Muli pa ntchito?*
Where? *Mumagwira ntchito kuti?*
How many hours a day? What is your work schedule like every week? *Pa tsiku mumagwira ma ola angati? Sabata ili yonse, magwiridwe anu antchito amakhala otani?*

For Each Household Member: *Munthu wina ali yense amene amakhala pa khomo panu*
Sex: (M/F) *Mwamuna kapena mkazi*
Age: *Zaka*
Grade level: *Kalasi yanji pa sukulu*
How is he or she today: (yes/no) *Ameneyu lero wadzuka bwanji?*
Mosquito net: (yes/no) *Amagona mmasikito kapena muneti?*

END of DEMOGRAPHIC SURVEY

Interview Instructions to the Youth

Please answer my questions as thoroughly as you can. There is no right or wrong answer. Researchers are obligated to maintain privacy of people's stories. In my report, I do not use your name. I use a code, like 'Girl #4' or 'Boy #12'. If you tell me you are in danger, then I must tell a responsible adult for your protection. Do you have any questions?

Chonde yankhani mafunso anga mwatsatanetsatane. Palibe yankho lolakwika. Ife ngati opanga kafukufuku timayenera kusunga chinsinsi cha anthu amene amatiuza za moyo wawo. Muzolemba zanga, sindidzagwiritsa ntchito dzina lanu ayi. Ndidzalemba mwachitsanzo, "Mtsikana nambala folo kapena mnyamata nambala 12. Ngati mungandiuze kuti muli pachipsyinjo kapena wina akuopsyeza moyo wanu, ndiyenera kuulula kwa munthu wa mkulu amene angapereke chitetezo kwa inu. Muli ndi mafunso?

I will be audio recording our visit. You may respond in English or Chichewa. Do you have any questions for me before we begin?
Ndizayamba kujambula kapena kutepa kucheza kwathu. Khalani omasuka kuyankhula mu chizungu kapena Chichewa. Muli ndi mafunso ena ali onse tisanayambe?

Probes for Clarification
Please explain. *Chonde fotokozani mwatsatanetsatane*
What is that like? *Zili choncho chifukwa chani?*
Why is that important? *Izi ndi zofunikira chifukwa chani?*
How did you learn that? *Zimenezi inu munaphunzira bwanji kapena munaphunzira kuti kapena kwa ndani?*
What do you do in that case? *Zikakhala choncho inu mumatani?*
Who helps you? *Amakuthandizani ndi ndani?*
How does one cope positively? *Mumadzithandiza bwanji moyenerera?*

INTERVIEW QUESTIONS
Mafunso

FAMILY
Who lives with you?
Why are you the caretaker of your family? *Zinakhala bwanji kuti inu mukhale oyan'ganira abale anu pa khomo kapena titi wamkulu wa pa khomo?*

Where did you learn how to care for a family?
Munaphunzira kuti kuyan'ganira ana pa khomo kapena kuyan'ganira anthu pakhomo?
What is it like to be the head of the family?
Tandifotokozereni mmene zimakhalila kukhala ndi udindo wa mutu wa pa khomo kapena mkulu wa pa khomo.
Tell me about each of your siblings' personalities.

Tandiuzani za wina ali yense mwa abale anu amene mumakhala nawo. Ana amenewa ndi otani?
What are the joys in your family?
Ndi zosangalatsa zanji zimene inu mumaziona pa khomo panu?
What are the difficulties?
Ndi mabvuto anji amene mumawaona pa khomo panu?
    Who helps you?
    Amakuthandizani ndi ndani?
    How do they help you?
    Amakuthandizani bwanji?
How do you help others?
Mumathandiza anthu ena mu njira zanji?
    Whom do you help?
Mumathandiza ndani?
What encourages you?
Chimakulimbikitsani ndi chain?
    How?
Mumalimbikitsidwa mu njira zanji?
What does a good sister do?
Nchemwali wa bwino amakhala otani?
What does a good brother do?
Nchimwene wa bwino amakhala otani?
What is most important for families?
Chofunikila kwambiri mmakomo ndi chain?

ACTIVITIES
What do you do each day of the week? *Tandiuzeni za mmene moyo wanu umakhalira pa sabata ili yonse*

Describe a typical day, from when you wake up until you go to sleep. *Tandiuzeni za tsiku lanu mmene limakhalira kuyambira mukadzuka mpakana kupita kukagona*

When do you and your siblings play?
Inu ndi abale anu mumasewera liti?
    How do you play?
    Mumasewera bwanji?
When do you and your siblings relax?
Mumapuma liti inu ndi azibale anu?
    How do you relax?
    Mumapuma bwanji?

RESPONSIBILITIES
What kinds of decisions do you make?
Mumapanga bwanji ganizo loti muchite?
Who else makes decisions?
Ndi ndani amene amanena zoyenera kuchita pa khomo?
    What decisions do they make?

Amapanga bwanji maganizo okhudzana ndi zimene zikuyenera kuchitika?
Who makes sure chores and school work are done?
Ndi ndani amene amaonetsetsa kuti ntchito za pakhomo zagwiridwa? Nanga ndi ndani amene amaonetsetsa kuti zolemba za kusukulu zachitidwa?
What happens if one does not do their work?
Chimachitika ndi chain wina akapanda kugwira ntchito yake ya pa khomo?

ECONOMICS

What is your source of income?
Ndalama mumazipeza bwanji?
If employed:
Ngati muli pa ntchito
Where do you work?
Mumagwira ntchito kuti?
How many hours each day do you work?
Mumagwira ntchito ma ola anagati tsiku lili lonse?
How much do you earn?
Mumalandira ndalama zingati?
What do you do when there is not enough money?
Mukapanda kukhala ndi ndalama zokwanira mumapanga bwanji?

FOOD Chakudya

What foods do you usually eat?
Mumadya zakudya zanji tsiku lili lonse
Where do you get it?
Mumachitenga kuti chakudya chimenechi?
Who prepares it?
Amaphika ndi ndani?
Is there enough?
Chimakhala chokwanira?

WATER Madzi

What is your water source?
Madzi mumakatunga kuti?
Where is it?
Malo otungira madzi ali kuti?
How far away is it?
Malo otungira madzi ali kutali bwanji?
Who gets it?
Amakatunga madzi ndi ndani?

CLOTHING Zovala

How many sets of clothes does each person have?
Wina ali yense mwa ana apakhomo pano ali ndi zovala zingati?
Does each person have shoes?
Ali yense ali ndi nsapato
Who washes the clothes?

Amachapa zovala ndi ndani?

How often?

Amachapa kangati pa tsiku kapena pa sabata

Do you have soap? How do you find soap?

Muli ndi sopo. Sopo mumamupeza bwani?

HOUSEHOLD GOODS

What do you sleep on?

Mumagona pa chain?

Do you have blankets?

Muli ndi ma bulengete?

Does everyone use a mosquito net?

Ali yense ali ndi masikito kapena neti?

SAFETY

What dangers exist?

Zoopsya zimene mumaziona ndi zotani?

How do you protect your family?

Azibale anu mumawateteza bwanji?

HEALTH

How is your health?

Thanzi lanu ndi lotani?

How is the health of your siblings?

Thanzi la azibale anu ndi lotani?

What do you do to stay healthy?

Mumatani kuti mukhale ndi thanzi la bwino?

What do you do when one is sick?

Wina akadwala mumapanga bwanji?

How do you know if someone has malaria?

Mumadziwa bwanji wina akakhala ndi malungo?

What time do you go to bed and what time do you wake up? (yes/no) *Mumagona nthawi yanji ndipo mumadzuka nthawi yanji?*

When does your family bathe?

Mumasamba liti?

Do you have soap? How do you find bathing soap

Muli ndi sopo? Sopo osambira mumamupeza bwanji?

Do you clean your teeth?

Kodi mumatsuka mano?

How? When?

Mano mumatsuka bwanji? Mumatsuka liti mano?

HIV/AIDS

Many people these days have HIV.

Have you known someone with HIV?

Mumadziwapo wina ali yense amene ali ndi kachirombo koyambitsa matenda a edzi?

Why do people get HIV?
Kachirombo kameneka anthu amapezeka nako chifukwa chani?
How do people get HIV?
Kachirombo kameneka anthu amapezeka nako bwanji?
Can a person get HIV from food?
Kodi anthu akhoza kupatsirana kachirombo pogawana chakudya?
From sharing plates?
Pogawana mbale?
Can children get HIV by playing together?
Ana posewerera limodzi?
How does one avoid getting HIV?
Kodi kachirombo kameneka tingakapewe bwanji?
Can you tell by looking if someone has HIV?
Kodi munthu ukhoza kudziwa ngati munthu ali ndi kachirombo koyambitsa matenda a edzi?
How does one cope when they find out they have HIV?
Munthu akakhala ndi kachirombo amathandizika bwanji?
How does HIV change someone's life?
Kachirombo kamasintha bwanji moyo wa muthu?
What do you think is the hardest thing for people with HIV?
Ndi chovuta chanji chenicheni chimene amaona anthu oti ali ndi kachirombo?
Why do some people reject people with HIV?
Ndi chifukwa chain anthu ena amasala anthu amene ali ndi kachirombo?
Why do some people accept people with HIV?
Anthu ena amavomera bwanji anthu oti ali ndi kachirombo?
Is it different if a child or baby has HIV? Why/why not?
Ndi zosiyana mwana kapena khanda akakhala ndi kachirombo? Chifukwa chain?
Kusiyana kwake ndi kotani?
Do adults with HIV have friends? Why/why not?
Akuluakulu amene ali ndi kachirombo ali ndi anzawo? Chifukwa?
Do children with HIV have friends? Why/why not?
Ana amene ali ndi kachirombo ali ndi anzawo? Chifukwa
Should people with HIV keep it a secret? Why/why not?
Anthu amene ali ndi kachirombo akuyenera kubisa? Chifukwa?
What do you think people with HIV need the most?
Anthu amene ali ndi kachirombo afunika chani makamaka?
What is the best way to help people with HIV?
Anthu amene ali ndi kachirombo tingawathandize bwanji?
Where do youth learn about HIV and how to prevent it?
Achinyamata amaphunzira kuti za kachirombo ndi mmene angadzitetezere?

SCHOOL Sukulu
How are you doing in school?
Maphunziro anu akuyenda bwanji kusukulu?
How are your siblings doing in school?

Azibale anu akuchita bwanji ku sukulu?
What is your favorite subject?
Phunziro limene mumalikondwa koposa kusukulu ndi phunziro lanji?
What do you like best about school?
Chimene mumakondetsetsa ku sukulu ndi chani?
What do you like least about school?
Chimene simukonda ku sukulu ndi chani?
What is hard about school?
Chovutitsitsa ku sukulu ndi chani?
What is easy about school?
Chophweketsetsa ku sukulu ndi chani?
What do you like about your teacher?
Chimene mumakondwa mwa aphunzitsi anu ndi chani?

FRIENDS

What is a good friend like?
Mnzako wabwino amakhala otani?
Do you have close friends?
Muli ndi anzanu amene mumagwirizana nawo kwambiri?
    How long have you been friends?
    Anzanu amenewa mwakhala nawo pa chinzake nthawi yaitali bwanji?
    What are your friends like?
    Anzanu amenewa ndi otani?
    What do you do together?
    Mumapanga zotani mukakhala limodzi?
Do you know other children who live alone?
Mukudziwa ana ena amene amadzilera okha?
    Are they your friends?
Ana amenewa ndi anzanu?
    Do you help each other?
    Mumathandizana?
What do people like about you?
Chimene anthu amakondwa mwa inu ndi chani?
What do you like about other people?
Inu mumakonda chani mwa anthu ena?
Are you treated any differently than other youth?
Anthu amakusalani kapena kukuonani mosiyana ndi ana ena?
    Why/Why not?
Chifukwa?

SPIRITUAL

How does one take care of his spirit?
Kodi munthu mzimu wake amauyan'ganira bwanji?
Do you have religious or spiritual beliefs?
Muli ndi chipembedzo kapena chikhulupiriro cha uzimu?
    What are they?

Tandifotokozereni
Where did you learn this?
Chipembedzo chimenechi munaphunzira kuti?
What does this mean for you?
Chipembedzo chimenechi chitanthauza chani kwa inu?
How important is this to you?
Chipembedzo chimenechi ndi chofunikira bwanji pa moyo wanu?
Why or why not?
Chifukwa?
Do you attend worship services?
Mumapita kopemphera?
Where?
Kuti?
How often?
Mumapemphera kangati pa sabata?
How long have you been attending?
Mwakhala mukupita kopemphera kumeneku nthawi yaitali bwanji?
What do you do there?
Kopemphera kumeneko mumapangako chani?
How does one increase their faith or spirituality?
Kodi munthu angaonjezere bwanji chikhulupiriro kapena moyo wa uzimu?

POSITIVE EMOTIONS

What do you like about your life?
Chimene mumakonda za moyo wanu ndi chani?
What are your strengths?
Mphamvu zanu ndi zotani?
What do you do well?
Chimene mumachita bwino koposa ndi chani?
What makes you happy?
Chimene chimakusangalatsani ndi chani?
What are your hopes for the future?
Chiyembekezo chanu chapatsogolo ndi chani?
How will you accomplish that?
Mudzakwaniritsa bwanji zolinga zanu?
Who do you admire and why?
Munthu amene mumamusirira ndi ndani?
Who helps you to live well?
Amakuthandizani kuti mudzikhala moyo wa bwino ndi ndani?
How?
Bwanji?
How does one live a good life?
Kodi kuti munthu akhale ndi moyo wa bwino akuyenera kutani?
How does one keep a good perspective of life?
Kodi kuti munthu adzikhala ndi chikhulupiriro akuyenera kutani?
How does one keep going during hard times?

Kodi kuti munthu adzitha kupirira mu nthawi ya mabvuto akuyenera kutani?
What is most important to you?
Chofunikira kwambiri kwa inu ndi chani?
What hopes do you have for your siblings?
Muli ndi chiyembekezo chanji kwa azibale anu?
What hopes do you have for yourself?
Muli ndi chiyembekezo chotani cha inuyo?

NEGATIVE EMOTIONS
When are you worried?
Chimakudandaulitsani ndi chani?
    How do you cope?
    Mumapirira bwanji?
    Who helps you?
    Amakuthnadizani ndi ndani?
When are you afraid?
Chimakuchititsani mantha ndi chani?
    What do you do?
    Mumapanga chani mukakhala ndi mantha?
    Who helps you?
    Amakuthandizani ndi ndani?
When are you sad?
Ndi chani chimene chimakudandaulitsani?
    What do you do?
    Mumapanga chani?
    Who helps you?
    Amakuthandizani ndi ndani?
When are you angry?
Chimakukwiitsani ndi chani?
    What do you do?
Mukakhala okwiya mumatani?
    Who helps you?
Amakuthandizani ndi ndani?
When are you lonely?
Chimakupangitsani kuti muone ngati muli nokha ndi chani?
    What do you do?
Mumapanga chani?
    Who helps you?
Amakuthandizani ndi ndani?
What comforts you the most?
Ndi chani chimene chimakuthandizani?
How do you comfort your siblings when they are worried, afraid, sad, angry, or lonely?
Azibale anu mumawathandiza bwanji akakhala kuti ndi odandaula kapena amantha, okhumudwa kapena ankwiyo?

COMMUNITY

Are you considered a child or an adult in your community?
Pa mudzi pano amakuonani ngati mwana kapena wa mkulu?
Why?
Chifukwa?
What is a youth's responsibility to the community?
Ntchito yaw a chinyamata pa mudzi ndi chani?
How does a youth act responsibly?
Wachinyamata angakwaniritse bwanji kukhala okwaniritsa ntchito yake pa mudzi?
How do you teach this to your siblings?
Azibale anu mumawaphunzitsa bwanji kuti adzikhala okwaniritsa ntchito?
How do you and your community help each other? *Tandiuzeni za mmene inu ndi anthu apamudzi pano mumagwirira ntchito limodzi pothandizana*

MIQLAT HOPE CENTER

How did you get involved with Miqlat Hope Center? *Chinachitika ndi chani kuti mudziwane ndi aMiqlat?*
Who is your contact person at Miqlat Hope Center?
Munthu amene mumalumikizana naye ku Miqlat ndi ndani?
What do you do there?
Ku Miqlat mumapangako chani?
Do you have friends that do not go to Miqlat Hope Center?
Muli ndi anzanu amene sapita ku Miqlat?
How do you think Miqlat Hope Center could help children and the community better?
Mukuganiza kuti aMiqlat angapange chani kuti adzithandiza ana koposa?

FINAL QUESTIONS

What do youth and children need most in life?
Ndi chani chimene achinyamata ndi ana akufunikira koposa pa moyo wawo?
What do you wish people knew about you or your family?
Ndi chani chimene inu mungakonde kuti anthu adzidziwa za inu ndi ana apa khomo panu?
What else is important for me to know about your life?
Ndi chani china chimene ine ndikuyenera kudziwa zokhudzana ndi moyo wanu?
What advice would you give a friend who is now the head of the family?
Ndi malangizo anji amene mungapereke kwa mwana amene amayan'ganira abale ake pa khomo?
What other questions would you ask if you were doing this project?
Mafunso ena amene inu mungafunse mutakhala kuti mukupanga kafukufukuyu ndi inuyo angakhale otani?

Closing Remarks

We are at the end of the interview. Thank you very much for telling me about your life. We have a gift for your family to express our thanks.

Kutsiriza

Tafika pamathero akucheza kwathu. Zikomo kwambiri chifukwa chondiuza za umoyo wanu. Tiri ndi kamphatso aka koti mukagawane ndi anthu apakhomo panu mongothokoza chifukwa cha kucheza nafe.

Appendix E: Discussion Guide for Miqlat Hope Center Administrators Focus Group

Location: Miqlat Hope Center
Attendees: Administrative Staff

(Greetings to the participants): Good morning. My name is Ms. Pamela Fruechting. Thank you very much for coming today to participate in this important discussion about child-headed households. I am an American nurse attending the University of Wisconsin-Milwaukee. I am visiting here for my PhD research on child-headed households that are served by Hope Center. I first visited Malawi and Hope Center in January 2011 with my professor, Lucy Mkandawire-Valhmu. I will use the information I find out from you to better understand how their well-being might be enhanced. With me are Audrey Tluczek, from the University of Wisconsin-Madison. (Audrey introduces herself and her area of expertise in children's mental health). Carol Beya is our translator, transcriber, and guide.

(Instructions to the group): Your real names will not be used in my report. I will not report negatively about any information you give. I will ask you a few questions about your opinions, and you may answer however you want. This is an open discussion for the purpose of improving my understanding, so please offer whatever remarks you feel are important. Do you have any questions before we begin?

(Interview commences)

Introductions: I would like to know who you are. Please state your name and position with Miqlat.

(Thank you. Now I would like to ask that as a group we begin discussing the role of Miqlat and its impact on children and the community. I will ask some questions to generate discussion. I welcome any and all remarks you have. I may ask specific questions as we discuss.)

1. Tell me about the history of Miqlat in this community.

- How did Miqlat begin?
- How and when did Miqlat first come to Malawi?
- What are Miqlat's values, goals, and purpose?
- How many employees/volunteers work at Hope Center?
- How many children have you served over the years?

- How have services evolved over the years?
- How does Hope Center work with the community and villages?
- How are needy children identified for Hope Center services?
- How does Hope Center help children?
- What are the challenges Hope Center faces?
- What does it cost to run Hope Center on a monthly or annual basis?
    - How is MHC funded?
    - If child sponsorship, how does that impact the immediate family and community?

2. **Miqlat is a faith-based organization.**
    - What does “Miqlat” mean?
    - What are Miqlat’s religious beliefs?
    - How do these beliefs direct the program agenda?
    - Are children required to adhere to Miqlat’s religious ideals?
    - What are the religious beliefs of the community?
        - How does Miqlat’s religious values fit with the community’s values?
        - Is there ever a clash of ideals?
            - If so, how are differences reconciled?
    - What challenges does a religious organization like Miqlat face?
3. **Regarding programming, what programs have been most successful and why?**
    - What are your plans for the future?
    - What will be required to fulfill future goals?
4. **I’d like to talk about the children now.**

- What circumstances led to children living by themselves? Is that sometimes favorable?
- Is stigma ever a problem for these children? Please explain.
- How does the community feel about these children?
- What is the role of the community in the lives of these children?

- What are some of the challenges that the children face?
- What do the children need most for positive well-being?

- What is your role in the lives of these children?
- What are some of the challenges that you face in helping them?

5. What other information would help me understand the situation better?

(Closing Remarks)

[Summarize meeting].
Thank you very much for your time and sharing this information with me.

Appendix F: University of Wisconsin-Milwaukee Institutional Review Board Approval

UNIVERSITY of WISCONSIN
UWMILWAUKEE
Department of University Safety & Assurances

Melissa Spadanuda
IRB Manager
Institutional Review Board
Engelmann 270
P. O. Box 413
Milwaukee, WI 53201-0413
(414) 229-3173 *phone*
(414) 229-6729 *fax*

http://www.irb.uwm.edu
spadanud@uwm.edu

New Study - Notice of IRB Expedited Approval

Date: July 18, 2012

To: Lucy Mkandawire-Valhmu, PhD
Dept: Nursing

Cc: Pamela Fruetching, MSN

IRB#: 12.389
Title: The well-being of vulnerable children: Reconciling perspectives between youth heads of households and a community-based international non-governmental organization in rural Malawi

After review of your research protocol by the University of Wisconsin – Milwaukee Institutional Review Board, your protocol has been approved as minimal risk Expedited under Category 6 and 7 as governed by 45 CFR 46.110 and 45 CFR 46.404.

This protocol has been approved on **July 18, 2012** for one year. IRB approval will expire on **July 17, 2013**. If you plan to continue any research related activities (e.g., enrollment of subjects, study interventions, data analysis, etc.) past the date of IRB expiration, a continuation for IRB approval must be filed by the submission deadline. If the study is closed or completed before the IRB expiration date, please notify the IRB by completing and submitting the Continuing Review form found on the IRB website.

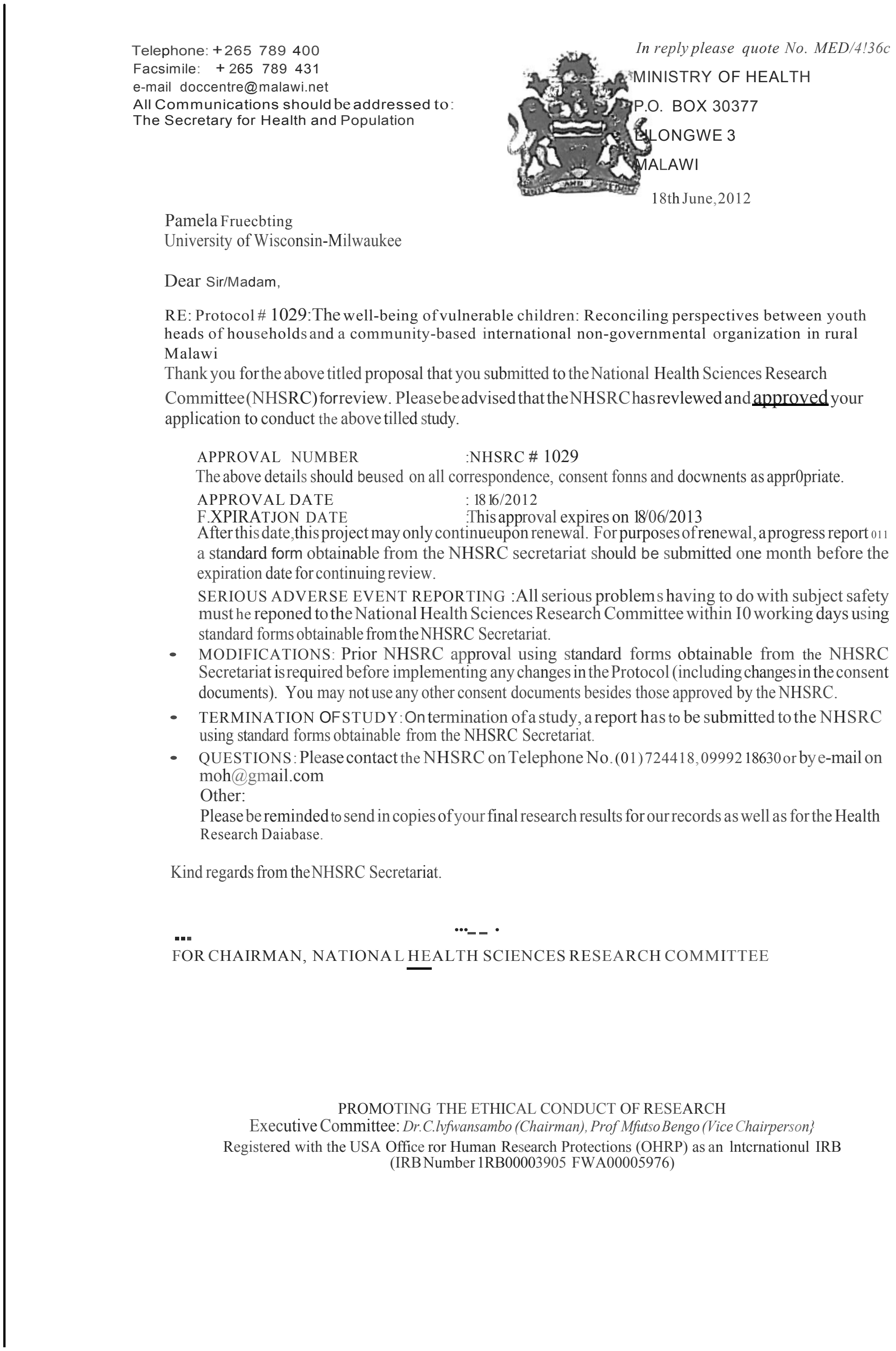
Unless specifically where the change is necessary to eliminate apparent immediate hazards to the subjects, any proposed changes to the protocol must be reviewed by the IRB before implementation. It is the principal investigator's responsibility to adhere to the policies and guidelines set forth by the UWM IRB and maintain proper documentation of its records and promptly report to the IRB any adverse events which require reporting.

It is the principal investigator's responsibility to adhere to UWM and UW System Policies, and any applicable state and federal laws governing activities the principal investigator may seek to employ (e.g., FERPA, Radiation Safety, UWM Data Security, UW System policy on Prizes, Awards and Gifts, state gambling laws, etc.) which are independent of IRB review/approval.

Contact the IRB office if you have any further questions. Thank you for your cooperation and best wishes for a successful project

Respectfully,
Melissa C Spadanuda
Melissa C. Spadanuda
IRB Manager

Appendix G: Malawi Ministry of Health Approval for Research



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All Communications should be addressed to:
The Secretary for Health and Population

In reply please quote No. MED/4!36c
MINISTRY OF HEALTH
P.O. BOX 30377
LILONGWE 3
MALAWI

18th June, 2012

Pamela Fruecbting
University of Wisconsin-Milwaukee

Dear Sir/Madam,

RE: Protocol # 1029: The well-being of vulnerable children: Reconciling perspectives between youth heads of households and a community-based international non-governmental organization in rural Malawi

Thank you for the above titled proposal that you submitted to the National Health Sciences Research Committee (NHSRC) for review. Please be advised that the NHSRC has revlewed and approved your application to conduct the above tilled study.

APPROVAL NUMBER :NHSRC # 1029

The above details should be used on all correspondence, consent fonns and docwnents as appr0priate.

APPROVAL DATE : 18 16/2012
F.XPIRATJON DATE :This approval expires on 18/06/2013

After this date, this project may only continue upon renewal. For purposes of renewal, a progress report 011 a standard form obtainable from the NHSRC secretariat should be submitted one month before the expiration date for continuing review.

SERIOUS ADVERSE EVENT REPORTING :All serious problems having to do with subject safety must he reponed to the National Health Sciences Research Committee within I0 working days using standard forms obtainable from the NHSRC Secretariat.

- MODIFICATIONS: Prior NHSRC approval using standard forms obtainable from the NHSRC Secretariat is required before implementing any changes in the Protocol (including changes in the consent documents). You may not use any other consent documents besides those approved by the NHSRC.
- TERMINATION OF STUDY: On termination of a study, a report has to be submitted to the NHSRC using standard forms obtainable from the NHSRC Secretariat.
- QUESTIONS: Please contact the NHSRC on Telephone No. (01) 724418, 09992 18630 or by e-mail on moh@gmail.com

Other:

Please be reminded to send in copies of your final research results for our records as well as for the Health Research Daiabase.

Kind regards from the NHSRC Secretariat.

FOR CHAIRMAN, NATIONAL HEALTH SCIENCES RESEARCH COMMITTEE

PROMOTING THE ETHICAL CONDUCT OF RESEARCH
Executive Committee: *Dr. C. lvfwansambo (Chairman), Prof Mfutso Bengo (Vice Chairperson}*
Registered with the USA Office ror Human Research Protections (OHRP) as an Intcrnationul IRB
(IRB Number 1RB00003905 FWA00005976)

Appendix H: Letter of Approval from Miqlat USA

Miqlat
PLACE OF REFUGE & HOPE

November 29, 2011

TO: Sigma Theta Tau International Grant Reviewers

RE: Pamela Fruechting, MSN, APRN

Dear Sir/Madam,

Miqlat Ministries is a Christian, non-denominational American organization that operates two Miqlat Hope Centers in Malawi, Africa. Miqlat Hope Centers exist to provide nutritional, educational, medical, spiritual, and vocational support to ~650 orphans and vulnerable children in a rural HIV-endemic area of Malawi.

The University of Wisconsin-Milwaukee has been involved in ongoing service projects with Miqlat Hope Centers to provide material assistance and medical care to the children. The HIV-endemic has resulted in the loss of parents of families, and some of these families have become child-headed households.

Miqlat Ministries would be pleased to have Pamela Fruechting, doctoral candidate at UWM College of Nursing, conducts her dissertation research on child-headed households that are affiliated with our Hope Centers. We will consult with her on the project, help identify child-headed households for interviews, discuss our faith-based care program with her, introduce her to community leaders, and arrange for her to participate in our orphan care program.

Pam was part of a UWM study abroad class on Malawian community health that visited Miqlat Hope Center in January 2011. We look forward to having her with us again as she returns to Malawi in summer 2012 for her dissertation research. Please accept this letter of support in consideration of her grant application for travel funding.

Sincerely,

D.S. Gillespie
Co-Founder/Director
Miqlat, Inc.

CURRICULUM VITAE

Pamela S. Fruechting, PhD, FNP-C, ONP-C

Certified Orthopedic Nurse Practitioner
Family Nurse Practitioner

Updated May 3, 2014

CURRENT PROFESSIONAL WORK

- Advanced practice registered nurse (APRN). Wichita Medical Associates, Wichita, KS. Adult and geriatric medicine, including clinical and post-operative orthopedic care (April 2010-present).
- Adjunct graduate faculty, Georgetown University, School of Nursing and Health Studies, Washington, D.C. (January 2012-present). Courses: *Professional Aspects of Advanced Practice Nursing; Research Methods and Biostatistics for Healthcare Professionals*.
- Medical-legal consultant and expert witness. Fruechting Consulting, LLC (January 2010-present).
- Free tutoring by email in nursing philosophy & theory, via personal blog, *Nursing Philosophy…It Matters*. www.nursing-philosophy.com (2009-present).
- April 2014: Appointed to the American Academy of Nurse Practitioners Certification Program 2014 Item Writing Workshop, June 22, 2014, Nashville, TN.
- May 2014: Appointed to the American Nurses Association's Nursing Scope and Standards Advisory Group to review and revise the book, *Nursing: Scope and Standards of Practice (2nd edition)*, 2010, published by the American Nurses Association.

ACADEMIC HISTORY

2014: Doctor of Philosophy in Nursing (PhD), University of Wisconsin-Milwaukee. Dissertation: *The subjective well-being of youth heads of households in rural southern Malawi.* GPA 3.916.

2012: Graduate Certificate in Philosophy, Trinity Theological Seminary, Newburgh, IN. GPA 4.0.

1997: Master of Science in Nursing, University of Kansas, Kansas City, KS. GPA 3.93.

1995: Bachelor of Science in Nursing, Fort Hays State University, Fort Hays, KS. GPA 3.95.

1994: Associate Degree in Nursing, Seward County Community College, Liberal, KS.

1980: Bachelor of Science, Consumer Economics, Kansas State University, Manhattan, KS.

LICENSURE & CERTIFICATION

Kansas APRN license (1997): 53-44646-062 (Expires 06-30-14)
Kansas RN license (1994): 13-70624-062 (Expires 06-30-14)
District of Columbia APRN license (2012): RN1025503 (Expires 06-30-14)
Orthopedic Nurse Practitioner-Certified (ONP-C) (2006), National Association of Orthopedic Nurses (Expires 06-30-17).
Drug Enforcement Administration Registration (1997): MF0558746 (Expires 09-2015)
Family Nurse Practitioner (1997), American Nurses Credentialing Center: 0306449-22 (Expires 02-28-18)
Oklahoma ARNP license: R0069716 (Expired 06-30-10; Reason: No longer practicing in Oklahoma as part of South Central Kansas Bone & Joint Center, Pratt, KS)
Oklahoma Bureau of Narcotics Certification: 31108 (Expired 06-30-10; Reason: No longer practicing in Oklahoma as part of South Central Kansas Bone & Joint Center, Pratt, KS)

Previous Certifications held 1995 -1999:
Advanced Cardiac Life Support
Pediatric Advanced Life Support
Trauma Nurse Core Course

ORTHOPEDIC AND TRAUMA MANAGEMENT EXPERIENCE

- Adult Medical Practice, Wichita Medical Associates, Wichita, KS (April 2010-present):
    - General medical care, including acute and chronic clinical orthopedics, for adults in long-term care, skilled care, and assisted living.

- Surgical/Clinical Orthopedic Experience (September 1997-December 2009):
    - Clinical and surgical management of general orthopedic, trauma, and joint reconstruction practice, including, but not limited to:
        - Joint aspiration, steroid injections, orthopedic radiographic interpretation, MRI interpretation, emergency orthopedics, reduction of dislocations and fractures, casting, management of antibiotic therapies for septic joints, and anticoagulation management.

    - Surgical first assistant (joint replacement and revision, trauma, general orthopedics)

    - Comprehensive perioperative care
        - Directly responsible for preoperative, intraoperative, and postoperative management of all orthopedic surgery patients.
        - About 1000 total cases annually.

- Extensive experience in adult joint reconstruction and revision
    - Primary joint reconstruction
    - Complex cases including surgical management of periprosthetic fractures, septic prosthetic joints, proximal femoral allografts, massive acetabular defects, tumor implants, extensor mechanism allografts, and prosthetic joint resections and revisions.
    - Approximately 325+ joint reconstruction cases annually.
    - Mentored by Ian S. Kovach, MD, PhD, past Harris Hip Fellow (South Central Kansas Bone & Joint Center, Pratt, KS).

- Workers Compensation Experience
    - Constructed approximately 500 orthopedic impairment ratings per the American Medical Association Guides to the Evaluation of Permanent Impairment.
    - Attended “Evaluating Impairment – Use of the AMA Guides: A Case Study Approach” in 2000. Conducted by C. Brigham, MD, 15 hrs. CME.
    - Consultations with attorneys, case workers, and employers, regarding case review, medical record interpretation, explanation of clinical decision processes, and expected prognosis.
    - Pre-employment and Department of Transportation physical examinations for determination of fitness for duty.

EMERGENCY MEDICAL EXPERIENCE

- Nurse practitioner experience in emergency medical and orthopedic evaluation, diagnosis, and management (1997-present).
- Registered nurse experience in hospital and pre-hospital emergency nursing (1994-1997).

ACADEMIC EXPERIENCE

- January 2012-Present: Adjunct graduate faculty, Georgetown University School of Health Sciences.
- 1999-2009: Clinical preceptor for orthopedic rotations of 14 physician assistant & nurse practitioner students (South Central Kansas Bone & Joint Center).
- 1999-2009: Supervised and trained 3 full-time orthopedic physician assistants (South Central Kansas Bone & Joint Center).
- April 2009: Guest lecturer for Wichita State University Physician Assistant program. Created and conducted a workshop on orthopedic examination of shoulder, hip, and knee.
- 1995-1997: Nursing faculty for orthopedics, trauma, emergency medicine, legal issues, ethics, and general nursing. Seward County Community College, Liberal, KS.
- 1997: Elected “Teacher of the Year”, Seward County Community College, Department of Nursing, Liberal, KS.

PUBLICATIONS

1. Fruechting, P. (2014). (*In press, July 2014)* The common ground of a holistic humanity. *Journal of Christian Nursing.*
2. Fruechting, P. (2010). Strengthening ontologic foundations. *Nursing Philosophy (11)*3, 224.
3. Fruechting, P. (1995). The surprise gift. *Journal of Emergency Nursing21*(2), 145.

PROFESSIONAL WEB SITE PUBLICATIONS

1. Fruechting, P. (2013). Fruechting Consulting, LLC. http://www.PamelaFruechting.com
2. Fruechting, P. (2011). The Orphan Health Project. http://www.orphanhealthproject.com
3. Fruechting, P. (2008). Nursing Philosophy…It Matters. http://www.nursing-philosophy.com

PRESENTATIONS

1. (2013). Fruechting, P. The integral relationship between virtue and the self-appraised subjective well-being of vulnerable youth heads of households in rural southern Malawi. Oral presentation. Sigma Theta Tau International Biennial Congress, November 16, 2013, Indianapolis, IN.

PROFESSIONAL AFFILIATIONS

American Association of Nurse Practitioners (#0702216, exp. 06/15/14)
Sigma Theta Tau International (Nursing Honor Society) (#0262186, exp. 12/31/14)
American Nurses Association (#1370409, exp. 01/31/15)
National Association of Orthopedic Nurses (#32792, exp. 12/31/14)
American Association of Legal Nurse Consultants (#62941, exp. 12/31/14)
Nurses Christian Fellowship (#2159, exp. 12/31/14)

ACADEMIC AND PROFESSIONAL AWARDS

- 2009: Chancellor's Award recipient, University of Wisconsin-Milwaukee, for exemplary academic record and high potential for future success in doctoral studies.
- 2002: Ember Award recipient for exemplary professionalism (Pratt Regional Medical Center).
- 1997: Nursing Teacher of the Year, Seward County Community College.

SPECIAL PROFESSIONAL INTERESTS

- Utilization of MRI of the knee by primary care providers
- Septic prosthetic joint pathology and treatment
- Health philosophy, ethics, well-being, and altruism
- Global orphan health care
- Public perceptions and attitudes regarding healthcare & technology

PROFESSIONAL EMPLOYMENT HISTORY

January 2012-Present: *Georgetown University*, School of Nursing & Health Studies, Washington, D.C.
Adjunct Graduate Faculty. Course: *Research Methods and Biostatistics for Healthcare Professionals* and *Professional Aspects of Advanced Nursing Practice.*

April 2010-Present: Advanced Practice Registered Nurse (APRN). *Wichita Medical Associates*, 347 S. Laura, Wichita, KS, 67211. R. Kevin Bryant, MD.

January 2010-Present: Medical Legal Consultant, *Fruechting Consulting, LLC*, 4601 E. Douglas, Suite 206, Wichita, KS, 67218.

December 6, 1999-December 31, 2009: Advanced Practice Registered Nurse (APRN) and Occupational Health Department Head (December 1999-2002).*South Central Kansas Bone & Joint Center*, 203 Watson, Suite 300, Pratt, KS, 67124. Ian S. Kovach, MD, PhD. Resigned to complete PhD.

November 1997-December 1999: Advanced Practice Registered Nurse (APRN) Orthopedic Nurse Practitioner. *Orthopaedic Specialists & Rehab*, 121 E. 11th St., Liberal, KS, 67901. Marc-Andre Bergeron, MD. Resigned due to husband's employment/relocation.

September 1997-November 1997: Advanced Practice Registered Nurse (APRN). Emergency Department, Inpatient, and Outpatient Care. *Satanta District Hospital*, Satanta, KS, 67870. Juvenal Jabel, MD. Resigned after 3 month contract to join orthopedic specialty practice.

January 1997-August 1997: Registered Nurse, BSN. Emergency Department and Intensive Care Unit. *St. Catherine Hospital*, Garden City, KS, 67846. Resigned to continue master's degree/nurse practitioner certification.

August 1995-December 1997: Nursing Faculty, *Seward County Community College*, Department of Nursing, Liberal, KS, 67901. Resigned to pursue master's degree/nurse practitioner certification.

June 1994-August 1995: Registered Nurse. Medical/surgical, emergency, and intensive care nursing. *Meade District Hospital*, Meade, KS, 67864. Resigned to accept nurse faculty position.

1992-1997: *Meade County Emergency Medical Services*, Meade, KS, 67864. Resigned to continue master's degree.
1994-1997: Registered Nurse/Emergency Medical Technician-Intermediate.
1992-1994: Emergency Medical Technician-Basic & Intermediate.

HOSPITAL PRIVILEGES

Pratt Regional Medical Center, Pratt, KS (1999-2010).
Share Medical Center, Alva, OK (2001-2005).
Southwest Medical Center, Liberal, KS (1997-1999).
Satanta District Hospital, Satanta, KS (1997).