Social Science & Medicine 130 (2015) 69–78

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

What is a good life? Selecting capabilities to assess women's quality of life in rural Malawi

Giulia Greco [a, *], Jolene Skordis-Worrall [b], Bryan Mkandawire [c], Anne Mills [a]

[a] Health Economics and Systems Analysis Group, Department of Global Health and Development, London School of Hygiene and Tropical Medicine, 15-17 Tavistock Place, London WC1H 9SH, UK
[b] UCL Institute for Global Health, 30 Guilford Street, London WC1N 1EH, UK
[c] Parent and Child Health Initiative (PACHI), Amina House, Paul Kagame Road roundabout, P.O. Box 31686, Lilongwe 3, Malawi

A R T I C L E I N F O

Article history:
Available online 27 January 2015

Keywords:
Malawi
Capability approach
Quality of life
Wellbeing
Women
Focus groups
Participatory approach
Multidimensional index

A B S T R A C T

There is growing interest in using Sen's Capability Approach to assess quality of life and to evaluate social policies. This paper describes the formative stages of developing a quality of life measure: the selection of the relevant capabilities. This measure is intended to provide a more comprehensive outcome measure for the evaluation of complex interventions such as Maimwana womens' groups, a community based participatory intervention to improve maternal health in rural Malawi.

Fifteen focus group discussions with 129 women were conducted to explore relevant concepts of quality of life in rural Malawi. Data collection started in October 2009. Findings were elicited based on framework analysis.

The findings portray a complex and highly nuanced perception that women in rural Malawi have of their life and wellbeing. Quality of life was described using a variety of dimensions that are highly interconnected. Quality of life emerges to be not only shaped by the realisation of basic material needs such as being sufficiently nourished and adequately sheltered, but is also highly dependent on complex feelings, relations and social norms. The full exposition of wellbeing with its domains was organised into a framework constituting six different spheres of wellbeing: physical strength, inner wellbeing, household wellbeing, community relations, economic security and happiness.

Despite the list being developed in a specific context and for a specific group of people, the similarities with lists developed in other contexts, with different methods and for different purposes, are considerable. This suggests that there are a number of core aspects of wellbeing considered a minimum requirement for a life of human dignity, that should be included in any attempt to assess quality of life and human development across populations.

© 2015 Elsevier Ltd. All rights reserved.

1. Introduction

MaiMwana Women's Groups (WGs) are a community participatory intervention, organising and mobilising women of reproductive age in rural Malawi (Rosato et al., 2011). During their meetings, women discuss, prioritise, develop and implement local strategies to overcome maternal and neonatal health problems. The intervention emphasises health promotion activities that rely on community engagement and participation aimed at changing behaviour. The groups promote agency, social capital and knowledge. Effectiveness of the MaiMwana WGs was tested with a cluster randomised controlled trial design that estimated a 74 percent reduction in maternal mortality rate, and 41 percent reduction in neonatal mortality rate (Lewycka et al., 2013). However, given the nature of the intervention, its effects are likely to be felt on various aspects of quality of life, and not only on mortality rates. Thus there is a need to develop a more appropriate outcome measure that captures changes in quality of life more broadly defined.

There is growing interest in using Sen's Capability Approach to assess quality of life and to evaluate policies (Sen, 1993; Verkerk et al., 2001; Stiglitz et al., 2009; Gasper, 2010). A crucial normative argument of Sen's approach is that quality of life should not be measured as opulence or utility, and should not be assessed using people's preferences or desires, but it should concern people's capabilities: the abilities to achieve those “beings and doings” that

* Corresponding author.
E-mail address: giulia.greco@lshtm.ac.uk (G. Greco).

http://dx.doi.org/10.1016/j.socscimed.2015.01.042
0277-9536/© 2015 Elsevier Ltd. All rights reserved.

people have reason to value in life (Sen, 1985). These valuable "beings and doings" can range from basic functionings, such as being well nourished and living in a decent house, to more complex functionings such as being in control over personal decisions. The Capability framework distinguishes itself from other conventional approaches, which have a narrower evaluative space, such as utility, income or basic needs.

In order to improve people's quality of life, social and public policy should therefore aim to protect, restore and expand people's capabilities (Sen, 1999, 2003).

The multidimensional nature of quality of life increases the complexity of evaluation and raises a number of methodological challenges that need to be considered when constructing a composite measure (McGillivray, 2012). The different steps for creating a multidimensional measure are (1) development of a theoretical model: selection of dimensions, (2) development of an empirical model: selection of indicators, (3) aggregation of dimensions into one single measure: selection of relative weights and (4) validation of the instrument.

The aim of this paper is to describe the first step for developing a quality of life measure based on Sen's Capability Approach: the selection of the relevant dimensions of quality of life. This measure is intended to provide a more comprehensive outcome measure for the evaluation of complex intervention such as the MaiMwana WGs.

2. Approaches to the selection of capabilities

Sen has deliberately refrained from providing a list of relevant capabilities necessary for policy evaluation, claiming that different capabilities are relevant to different contexts (Sen, 2005). Thus, philosophers, political scientists, and economists have made several attempts to develop sets of dimensions either for a specific context or for universal use.

There are a range of different approaches for the selection of capabilities. Robeyns (2003) proposed a methodological process for selecting capabilities. This includes: to make the selection transparent and sensitive to the context; to justify the method used; to distinguish between different levels of generality; and to aim for the most exhaustive selection possible. The selection should then be scrutinised and endorsed by the general public or by relevant interest groups.

To date, few studies have attempted to directly measure capabilities (or perceived capabilities), (for example: Burchardt et al., 2002; Anand and van Hees, 2006; Grewal et al., 2006; Alkire, 2002b; for a review see Robeyns, 2006). The vast majority of available studies are built upon existing datasets – this might be why they deal mainly with achieved functionings.

In many studies the selection of functionings/capabilities is done by reference to the researchers' own values (Chiappero-Martinetti, 2000; Klasen, 2000). Empirical use of participatory planning processes and public debate for developing a capability list is limited (Alkire, 2002b; White and Pettit, 2004; Grewal et al., 2006; Vizard and Burchardt, 2007; Kinghorn et al., 2014; Al-Janabi et al., 2012).

One programme of work has fully developed and tested a capability index for use in economic evaluation: the ICECAP (ICEpop CAPability) measures (Flynn et al. 2011; Al-Janabi et al., 2012). However, these have not yet been validated for a low-income setting.

2.1. Lists of dimensions of quality of life

Five lists of dimensions are presented in web table 1 and discussed here as an illustration of the variety of methodologies adopted for generating them, the types of analysis they are used for and the different disciplines they are rooted in: political science, development studies, social policy, health economics and economics.

2.1.1. Doyal and Gough's needs

Doyal and Gough developed a normative concept of need that would theoretically and practically inform the debates in social policy. They conceptualised universal needs as "preconditions for social participation, which apply to everyone in the same way" (Doyal and Gough, 1991, p.5). They argue that needs can be specified without public consent and because these needs are understood to be the "preconditions" of a fulfilled life, there is a normative duty to satisfy them (Doyal and Gough, 1991).

2.1.2. Nussbaum's Central Human Capabilities

Martha Nussbaum made the first attempt to develop a universal list of capabilities (Nussbaum 2001). While her contribution has its foundation in Sen's capability theory, and they did collaborate on some work, she adopted a more political and normative approach. Her proposed list of ten Central Human Capabilities aimed at establishing a foundation for basic political principles. Although these dimensions were identified and put together by the researcher herself, she argues that her list is open and flexible, and it has since been revised several times. In addition, she notes that the proposed capabilities have a broad cross-cultural consensus (Nussbaum, 2003). However, the list raised questions over the extent of its prescriptiveness (Alkire, 2002), academic legitimacy and lack of consistency with Sen's central idea of pluralism (Robeyns, 2005). Her list is intended for political use since it provides those basic principles that should have constitutional guarantees for all citizens (Nussbaum 2001).

2.1.3. Narayan's voices of the poor

Research led by Deepa Narayan in 2000 for the World Bank's Poverty Reduction Group aimed at eliciting people's values on poverty and ill-being, using a participatory methodology. This is considered pioneering because it is the only cross-country and cross-cultural study of this scale which was based on the active participation of people from poor, low literacy and marginalised backgrounds. The policy implications that result from this work are to design and to implement poverty reduction strategies that can succeed because they are rooted in people's values and expectations.

2.1.4. Al-Janabi and Coast's ICECAP-A measure

The ICECAP measures are an on-going project that aims to develop an outcome measure for use in economic evaluation of health and social care for the general adult population (ICECAP-A), for the older population (ICECAP-O) and for end of life care (ICECAP-SCM) in the UK and other high-income countries. Qualitative methods have been used to develop the ICECAP-A measure descriptive system: in-depth semi-structured interviews to define conceptual attributes in a meaningful terminology for the adult population (Al-Janabi et al., 2012). The attributes are structured into a ready available questionnaire (www.icecap.bham.ac.uk).

2.1.5. Commission on the measurement of economic performance and social progress

The aim of the Commission, chaired by Stiglitz, Sen and Fitoussi, was to identify those objective features that lead to an expansion of people's opportunities and should thus be considered in the assessment of quality of life (Stiglitz et al., 2009). Based on academic research and various concrete initiatives developed around the world, the Commission identified eight key dimensions that are

thought to shape people's wellbeing. These dimensions are meant to guide countries on how to complement the "GDP per capita" measure as a yardstick for their performance, and thus how to monitor more comprehensively the progress of their societies.

As these examples illustrate, the methods that have been used for the selection of dimensions are varied. With the aim of being as consistent with Sen's theory as possible, the selection of capabilities for this study was conducted in a participatory manner with qualitative methods, as done by Narayan and Al-Janabi.

3. Methods

3.1. Study setting

Malawi ranks 174 out of 187 countries in the Human Development Index with a life expectancy at birth of 55 years and 62 percent of the population that live on less than US$1.25 a day (UNDP 2014). The lifetime risk of maternal death is 1 in 34 (Countdown 2014). Mchinji district, in the central region, has a population of 455 000, of which 90 percent live in rural areas, do not have electricity, and are dependent on subsistence farming. 84 percent of the female population have not completed primary education. Total fertility rate in the district is 6.3 (DHS 2010) and maternal mortality ratio is 448 per 100 000 livebirths. Health care is provided by one district hospital, four rural hospitals, nine health centres, and various private clinics. Quality is poor due to lack of clinical staff, low morale, and irregular medical supplies (Lewycka et al., 2013).

3.2. Data collection

A series of focus group discussions (FGDs) were conducted to explore locally relevant concepts of quality of life. The intention was to develop mutually exclusive attributes and to value them in a subsequent valuation task.

In a context such as rural Malawi, FGDs are preferable to one-to-one interviews. The former encourage participation from people reluctant to be interviewed on their own or who feel they do not have much to say, and can help participants to explore and clarify their views in ways that would be less accessible in a one-to-one interview (Barbour and Kitzinger, 1999; Kitzinger 2005). Moreover, by using open ended questions in a participatory setting, focus groups are particularly suitable for investigating the complex and abstract concepts covered in the study.

Data were planned to be gathered with 16 FGDs, formed of 10–12 discussants, in Mchinji district, Malawi, in October–November 2009. From the MaiMwana trial study area, 16 clusters out of 48 were selected at random. Within each cluster, a list of women who delivered during the previous year was obtained from the surveillance database. From the list, 10 to 12 women were chosen at random and invited to participate.

Each group discussion was facilitated by a moderator and a note-taker. A semi-structured topic guide was used to ensure that all groups covered approximately the same topic areas. The discussions were carried out in the informants' local language (Chichewa or Senga).

The topic guide started with an open exploration on the meaning of quality of life (*what does the term good life mean for you?*) and followed by more specific questions about the different dimensions that might constitute a good quality of life (what are those important and valuable dimensions of our lives that make the life good? and what are those dimensions of our lives that make the life bad?). This was followed by an exploration of valued choices in life (*What opportunities, freedoms and choices do you value?*).

Responsive questioning was used to investigate the underlying concepts of quality of life and the factors influencing the quality of life. For example, if a participant said that being able to live in a decent house is essential for a good life, the facilitator asked what is meant by living in a decent house and why living in a decent house is considered valuable and indispensable to achieve a good life. Towards the end of the discussion, the moderator invited participants to reach an agreement on the dimensions of quality of life that had been discussed.

The sessions were audio-recorded and transcribed by the note taker *verbatim* in Chichewa (or Senga in one case). The transcription was translated word for word into English. Local sayings and metaphors, common in Chichewa expressions, were translated literally, and the meaning was explained in brackets. Fifteen minutes of each recording were validated against the Chichewa transcription by an external researcher, who also validated the English translations for the whole length of the records. The note-taker compiled detailed written notes regarding the dynamics, interactions and non-verbal communication of the discussants.

Informed written consent was obtained from the participants prior to the start of the exercise. Ethics approval was granted by the Malawi Health Sciences Research Committee and by the London School of Hygiene and Tropical Medicine Ethics Committee.

3.3. Data analysis

Findings were elicited based on manual framework analysis. Framework analysis uses a thematic approach, but allows themes to develop both from the research questions and from the narratives of the discussions. As recommended by Ritchie and Lewis 2003, five stages were used to construct the framework:

(1) Familiarisation: immersion in the raw data, reading the transcripts several times from beginning to end to get an understanding of the whole session and the possible emerging themes, and reviewing the field notes;
(2) Identification of a thematic framework: identifying all the key concepts, issues and themes that the data can be referenced to;
(3) Indexing: applying the framework systematically to all the data, by writing notes or codes next to the text;
(4) Charting: re-organising the data according to the relevant thematic headings and categories; this involved rephrasing and compacting the text in some cases. A matrix developed in Excel was populated with the text;
(5) Mapping and interpretation: with the help of the matrix, concepts were re-defined, and associations were created between different levels and across themes.

4. Results

By the fifteenth focus group, it became clear – through the repetition of themes and the content and nature of the discussion – that data saturation had been achieved. On this basis, no further focus groups were conducted. A total of 129 women participated. Half of them were younger than 25 years old. The large majority (91 per cent) of participants were married women, and 68 per cent had more than 2 children. 64 and 60 per cent of participants affirmed that they were able to read and write (Table 1). More than half (60 per cent) of the participants had attended at least one women's group meeting before (MaiMwana WG or others).

4.1. Perceptions on the meaning of "good life"

The participants defined somebody living a "good life" as a person that enjoys different states of "beings, havings and doings".

Table 1
Characteristics of participants in the focus group discussions.

Variable	Values	Frequency	%
Age	<= 25	64	
	>25	65	
Marital status	Married	118	91%
	Widowed	1	1%
	Unmarried	6	5%
	Divorced	4	3%
Parity	1 child	41	32%
	2 + children	88	68%
Ethnicity	Chewa	104	81%
	Ngoni	10	8%
	Senga	10	8%
	Others	5	4%
Literacy	Read	82	64%
	Write	78	60%
Housing	Iron sheet roof	13	10%
	Thatched roof	116	90%
Household assets	Bicycle	55	43%
	Mobile phone	28	22%
	Chickens	52	40%
	Pigs/goats	42	33%
	Radio	57	44%
Any Women's Group attended	Yes	78	60%
	No	51	40%
MaiMwana Women's Group attended	1-2 meetings	5	4%
	3-6 meetings	20	16%
	>6	12	9%

These states reflect both material and non-material aspects of a person's living. After mentioning the “basic needs” as valuable dimensions of a good life (e.g. being well-nourished, having money, a decent house, being free of disease), participants explored and articulated in their own words more complex and abstract concepts, such as having a sense of security, being respected and admired, being part of the community, having control over personal decisions, being able to create a united and cooperative household, as these statements illustrate:

> *The goodness of one's life is to have money to buy fertilizer*
>
> *Being in a peaceful marriage and well-fed means that you are a free person*
>
> *One should be nicely [clean] dressed, and should not fall sick often*
>
> *When you are independent, there is nothing that can bother you*
>
> *When the household is united, everything goes smoothly; you decide together how to spend the money, if in buying beer or sugar*
>
> *Being respected is good life because one gets help*
>
> *[Good life is] Having the opportunities to invest in children's future (education)*

As might be expected, aspects of “poor quality life” reflected the opposite of what was defined as a “good life”. The following statement illustrates this:

> *Being beaten, going without food, lacking clothes, yet having ten children you cannot take care of. This is bad life*

4.2. Developing a conceptual model: the list of dimensions

After discussing the general meaning of good life, participants were invited to unpack the different components of a good life. Following the methodological steps described above, the participants' contributions to the conceptualisation of a good life were analysed and grouped by the researcher into a set of six main dimensions, or capabilities, of which each had a set of sub-dimensions. The resulting capability set (Table 2) conceptualises and defines quality of life for women of reproductive age in rural Malawi; it refers to six different dimensions of quality of life: *physical strength, inner wellbeing, household wellbeing, community relations, economic security* and *happiness*.

4.2.1. Physical strength

One of the first components of a good life mentioned in each discussion was having a strong body and a balanced diet. Physical strength included: being able to do physical work, having enough food, being able to avoid diseases and being able to space births.

Participants recognised food as the source of energy essential for survival and needed for carrying out labour-intensive work – the vast majority of women in the study population were subsistence agricultural workers. Hence, having a strong body that does not fall ill often was seen as crucial, allowing women to carry out their farming activities:

> *If you have plenty of food, you are a free person. If one has food, is not getting sick now and again; if you lack food, you cannot work [in the field] … you have no energy. If people are strong, they have no worries; they work properly, and get money to buy other needs*
>
> *A person should be able to go and cultivate, grow crops, dig well. How can a weak person cultivate, is it possible?*

The concept of *health* and *being healthy* was generally expressed in terms of *being able to avoid diseases* and being able to eat enough nutritious food, as described above. Avoiding disease was closely associated with being clean, having access to clean water and sanitary latrines, and being able to avoid HIV and other sexually transmitted infections. On a few occasions, sleeping under a mosquito net was also mentioned as a way of avoiding disease. The

Table 2
Women's capabilities in Malawi.

Physical strength
- being able to do physical work
- having enough food to eat
- being able to avoid diseases
- being able to space births

Inner wellbeing
- having peace of mind
- having control over personal matters
- being free from oppression
- living without shame
- having knowledge
- having good conduct

Household wellbeing
- living free from domestic violence
- having control over money
- living in a decent house
- being able to take care of children and husband
- being able to educate the children

Community relations
- feeling safe and comfortable in the village
- being able to join community groups
- avoiding social exclusion and discrimination
- being respected
- being able to access services

Economic security
- owning assets
- being able to access business opportunities
- being able to rely on safety nets
- being able to cope with shocks

Happiness
- being satisfied with life
- being happy

recurring concept of hygiene and cleanliness encompassed two distinct aspects: the hygienic side, for avoiding diseases, as the next quote suggests; and the social aspect of being nicely and properly dressed, in order to be accepted in the community, which relates to the community wellbeing dimension, discussed later in this section.

It is possible for someone to have nothing; she may struggle to get things. But if that person maintains hygiene in the house she doesn't get sick.

Another frequently mentioned component of physical wellbeing was the *opportunity to practise family planning*, being able to choose the number of children freely and being able to space births. This contributed to a "good life" in two ways: first, child spacing allows the body of the mother to recover from the previous pregnancy and to regain strength, as the quote below shows; second, too many children are considered a burden to families where food is already scarce. Whilst the former is related to bodily wellbeing, the latter will be included in the household wellbeing dimension, discussed later in this section.

A couple which practises family planning is regarded as living a good life: such families [where family planning is practised] are enviable because they are able to take good care of their children, and manage them.

The factors that hindered women from spacing births using contraception were multiple. They related to misconceptions about possible side effects, religion, or the husband's authority. The following quotes illustrate this point:

Men claim that sex doesn't feel the same when a woman is using contraception (…) and men can desert them.

Some religions say we should follow the words in the Bible, which is to replenish and fill the earth.

4.2.2. Inner wellbeing

The second dimension of wellbeing identified by the FGD participants refers to the mental and emotional sphere of wellbeing. It comprises peace of mind, control over personal matters, freedom from oppression, living without shame and knowledge.

Complex abstract concepts were brought up during the discussions, often aided by stories and examples of life experiences. The participants described a person with a good life as having no worries. She looks radiant; she walks "free" and "comfortable".

Having peace of mind or peace in the heart (*mtendere*) is a widely used concept in Malawi. It is a state of being in which the person is feeling free from anxiety and preoccupations, at peace with herself. It embraces the self-assuring feeling that nothing is going wrong. In each focus group, discussants reported that having peace of mind is associated with a good life:

A person living a good life has no worries. When you have a peaceful mind everything goes well.

People who practice witchcraft have a defective life. People always talk bad about them, so they lack peace of mind.

As part of the *mtendere*, women stressed the importance of being able to relax and enjoy good things in life:

[I would like the freedom] of having time to rest and take care of my children.

Maybe you spend a lot of time doing casual labour without having some time to have fun.

Another important dimension of a person's life that was discussed is the control over personal matters and being free from oppression. The word *ufulu* in Chichewa means both freedom and right. Being independent, such as being able to travel without the partner's consent (for example for visiting relatives or attending a funeral) or being able to express feelings freely, was considered extremely valuable, as reported in these quotes:

Being free to do what you want, sometime one is forced to do things that you don't want to do, and you really do not have a choice.

A person should be independent because when sick she doesn't wait for someone to tell her what to do, men at times neglect that you are struggling.

If you are independent, then you become responsible, you are then reliable at home, and you become free, you don't wait for someone to help you, and you don't live anxiously.

Women reported that the feeling of *shame* destabilised their mental wellbeing. Shame and inadequacy were generally associated with being poor and marginalised. A person feeling shy, humiliated and inadequate was unanimously considered to be living a poor quality life. In contrast is a person who feels "comfortable" with her being and her appearance.

A person who changes clothes is seen as living a good life. She changes dirty clothes after a bath, and puts on clean ones, and looks good. When she is amongst people, she is not shy. As for me, I may have to wash the few I have to put on when I go in public.

Sometimes people laugh at you; if you are too poor, they avoid you assuming you are there to beg.

Participants mentioned *having knowledge* as a valuable component of their lives. The concept of knowledge comprised being literate (being able to read and write and having numeracy skills), having "wisdom" and having agricultural training. In no cases was knowledge synonymous with formal education, except with reference to the education of children and the problems associated with school fees and dropouts. This dimension of wellbeing was appreciated as important to achieve a good life because a literate person has access to better job opportunities, and, as a result, higher income. Moreover, a person who is able to read and write has a high standing in the community, and is generally associated with being wise.

Education adds to one's natural wisdom, it enlightens one's life.

The educated is able to see what is right and what is wrong.

Closely associated to the concept of inner peace, is *having good conduct* (*khalidwe*). *Khalidwe* can be translated as a righteous person, someone who is behaving virtuously, within the social norms, and who has gained a degree of respect in the community. Someone who is not an honourable person is regarded as unable to live a good life, for several reasons: she will lack inner peace; she will suffer as she will be marginalised, and she will lack the respect and support of the community.

Having good conduct is more important than being healthy, one may have food, and peace (Mtendere), but if he/she is a brute, he/she is good for nothing.

If you have good conduct, people cannot do you evil because you are a respected person.

This dimension is cross-cutting the inner wellbeing and the community wellbeing, and is also discussed at a later stage.

4.2.3. Household wellbeing

Emerging through the focus group discussions was the fact that women's quality of life is not realised in isolation but is to a large extent dependent on the behaviour and wellbeing of other members of the household, in particular on the children's welfare and the husband's conduct.

The dimension related to household wellbeing includes being able to take care of one's children and husband, being free from domestic violence, having control over household money, being able to educate the children and living in a decent house.

The importance of having a harmonious home life and a united family was stressed in the majority of the discussions:

> *When people cooperate [in the household] it becomes easy to develop [prosper]. And you have a good life. You live peacefully in the home.*

> *[Bad life is] being with no husband, divorced, unmarried … especially if you have children. A woman in this situation should go into business [find a job] so that she can share the financial responsibility with a new husband.*

From the discussions it emerged that women feel a high degree of responsibility for the wellbeing of other members of the family. *Being able to take care of the children and the husband* was considered crucial for fulfilling their role as respectable mothers and wives. Failing to do so was expected to enhance their level of anxiety and would ultimately trigger domestic violence. Moreover, their image in the community would deteriorate.

> *One should take good care of the kids and the entire family, so that everyone is healthy and they can work properly and prosper.*

Children's welfare is perceived to depend not only on their health and nutritional status but also on their education. Parents' attitude towards schooling is regarded as being one of the main drivers for keeping children in the school system. Parents are supposed to show support and encourage their children not to drop out of school, while the major obstacles to staying in school are the financial burden associated with schooling costs, including the purchase of uniforms. Additional barriers to schooling, based on the discussions, include the feeling of inadequacy of poor and marginalised children (regarding their clothes and hygienic conditions), the distance to the school, early pregnancy, peer pressure, and child labour (mainly herd-boy and house-girl). No mention was made of poor quality of teaching or school infrastructure as one of the causes of school drop-out.

> *If his [child] body is healthy, he is never absent from school … when a child is healthy parents have no worries.*

> *The children themselves sometime due to peer pressure start bad conducts such as drinking and smoking which makes them fail in school … Girls might get impregnated … They do not adhere to parents' advice. Some young girls sleep with sugar daddies to top up their pocket money which unfortunately gets them impregnated and they fail to go further with education. (…) We should advise them and inspire them.*

Data suggest that domestic violence was perceived to be a frequent and widely spread occurrence within the communities, and was not considered socially acceptable. Participants reported anecdotes about friends or family, or stories they had heard about. Verbal and physical abuses were thought to be triggered mainly by alcohol abuse and other so-called "misunderstandings" such as discussion about extra-marital affairs, and use (or misuse) of household money. Extramarital relations were seen as undermining the stability of the family because, together with breaking the bond of trust, they were also a vehicle for the spread of sexually transmitted diseases. In order to enjoy a good life, women stressed the importance of a loving and caring husband, who respects his wife and children, and contributes to the flourishing of the household (for example supporting the construction of a proper house or doing a cash-earning job).

> *Men are cunning at times, they give a woman a lot of children, elsewhere off they go (…) We are not on good terms with men here because they always squander their money on beers. They even spend it on extra-marital affairs. They bring AIDS home (…) It is hard, they are just used to, they cannot stop. We cannot stop them and you cannot follow them wherever they go. (…) There is no solution, only love, unity and respect.*

> *Men sometimes are just violent. You have done nothing wrong and they will just come to you and beat you up. This is lack of respect. (…) Everybody deserves to be respected.*

Another important factor contributing to the wellbeing of the household is living in a decent, clean and disease-free environment and *good housing*. This is achieved mainly with good hygiene practices and a solid structured house (for example a house with a pit latrine and a waterproof corrugated roof):

> *A house should have a toilet, a bathing shelter, there should be a rubbish pit, and the house should be well taken care of. Even if you have all these things but they are not put to good use, diseases will be there.*

4.2.4. Community relations

The community dimension evokes the concept of social capital. It comprises the following sub-dimensions: feeling safe and comfortable in the village, being able to join community groups, avoiding discrimination, being respected and admired in the community, and not being isolated from basic services.

During all but one of the group discussions, participants affirmed that "bonding" social capital (networks among homogenous groups) is an essential aspect in their life for achieving a higher standard of living. As the following quotes suggest, a person who holds strong ties with other people in the village is confident that she will be helped if in need and will be more able to cope with risks and shocks, compared with more vulnerable and isolated people.

> *[Good life means] someone who when you meet on the way, can help you.*

The reciprocal nature of the relationship was also brought up in the discussions (being able to support others, financially, or in kind, or emotionally). It was referred to as a "well-off" condition because if a person is in a position where she can assist other people, it implies that she can financially afford it and feels psychologically able to do so because, for example, she is not burdened with anxiety and worries.

> *I wish I had wealth so that I could assist those who are in need.*

> *When one is free [from worries], he is generous, he is helpful.*

Social networks are also precious because they foster trust and safety in the village. Women described it as being free from assaults in the village and being able to walk without fear.

It emerged that the mechanism that holds together and reinforces social networks is the respect for social norms, or having

good conduct, a concept mentioned previously in the inner wellbeing section. Having socially acceptable behaviour (e.g. avoiding laziness and theft, alcoholism, extra marital affairs, practising witchcraft), being admired and respected, appear to be essential components of good community living, as these quotes show:

> *Sometimes there are people who are in need, but they do not steal. They work hard and we look at them as living a good life. We regard those who steal as living a bad life.*

> *It is better to have good conduct because when you are sick there is someone who will take you to the hospital.*

> *People gossip because they are ignorant, gossiping is not good, you are jealous of what people have, you don't relate well with others, people do not share with you any good things.*

What can be termed "bridging" social capital (social networks among heterogeneous groups) was a recurrent theme mentioned in reference to living in a united and cooperative community. Being able to join associations (e.g. community groups, church groups), gives women the opportunity to learn something, in particular about farming (technology adoption and innovation dissemination), as the quotes describe:

> *If there is unity in the village, you share ideas. You learn something from people; you may get lessons on farming.*

> *Associating with others such as in an organisation makes people lead to good life because you learn one or two new important things for living a good life. Living in isolation doesn't help.*

There was no mention of "linking" social capital (links between people outside of the community, e.g. political ties). However, being able to access basic services was brought up in a number of group discussions in relation to lack of transport, bad road connections and distance to clinics, and safe water pumps.

4.2.5. Economic security

The Economic security dimension relates to financial security and access to economic resources. It comprises owning assets, being able to access business opportunities, having strong safety nets and being able to cope with shocks. Being able to cope with risks through established social networks has already been discussed in the section of *community wellbeing.*

Asset ownership and business opportunities were brought up in the discussions as strategies for reaching and maintaining a good living standard.

> *Whenever she lacks money, she can sell excess [farm] produce, gets money out of it, and solves her problems.*

> *If one rears animals, she doesn't struggle; if she is broke, she can sell some.*

Most women in our sample argued that initiatives promoting their capacity to earn an income independent of their spouses are to be encouraged. The opportunities that were mentioned were access to microcredit schemes, cash-earning jobs (e.g. seasonal work in tobacco estates), agricultural skills development courses, and subsidised fertilizers and seeds.

> *Bad life is lacking a starting point [for business].*

> *There are some men who forbid a wife to do business yet they don't even buy her a piece of cloth.*

> *If I am doing some business, I will buy whatever for my children with my own means.*

4.2.6. Happiness

Women described a sense of contentment and achievement as something to aim for in life. They stressed the need for living a life that is worth living, a meaningful life that should not be wasted with actions or feelings that do not make people prosper. They referred to "prosper" in the sense of developing as a person and being satisfied as the quotes below illustrate. These concepts may be referred to as subjective wellbeing: life satisfaction, and happiness. They are a step ahead of being free from worries; they are more closely related to self-fulfilment. Women expressed a close link between happiness and health: you cannot be happy if you are not healthy and vice versa.

> *A happy person becomes healthy and if you want to be happy, you have to be healthy.*

> *When you are a happy person you do forget problems, you are also loved by people and they usually like to come to your house.*

5. Discussion

5.1. Results

The study's findings portray complex and highly nuanced perceptions that women in rural Malawi have of their life and wellbeing. Quality of life was described using a variety of dimensions that are highly interconnected. Even in this resource constrained setting, quality of life emerges to be not only shaped by the realisation of basic material needs such as being sufficiently nourished and adequately sheltered, but is also highly dependent on complex feelings, relations and social norms. Abstract concepts were elicited through detailed recounts of everyday living that were described in a thorough and vivid manner.

Within the findings, the full exposition of wellbeing with its domains was organised into a framework constituting six different spheres of wellbeing: physical strength, inner wellbeing, household wellbeing, community relations, economic security and happiness.

Physical and mental wellbeing generally occupy a prime position in the majority of health-related quality of life measures (Hawthorne et al., 2001) and welfare indices (McGillivray, 2012). In the context of this study however, physical wellbeing was reported not only as valuable in itself but also, and possibly more significantly, as enabling a person to perform her daily chores and farming activities. Health was not only referred to as the absence of illness, but mainly as the capacity to work and produce resources to sustain the family. The complexity and multidimensionality of the concept of "health" amongst local populations in Sub-Saharan Africa has been noted in other studies, for example in the KENQOL study (Fox-Rushby, 2000).

Women's lack of control over reproductive choices has been widely recognised as an impediment to achieve a good life as it poses a significant burden on women's bodies; moreover, it limits women's participation in many aspects of society. Women in many developing countries are deprived of the freedom to do things in life because of the health threats that repeated pregnancies pose in the form of high maternal mortality and morbidity (Sen, 1994; Dejong, 2006). Reductions in fertility rates have often been associated with improvement in women's quality of life such as expanded opportunities for education, employment and community activity (Dreze and Sen, 2002). In this study, women recognised the danger of frequent deliveries and thus the need for child spacing to allow the body to recover between births. Having control over reproductive choices was classified as part of the bodily strength dimension as primarily it affects the health of the mothers. However, it was also recognised as an issue that crosscuts quality of life dimensions (e.g. household wellbeing and inner wellbeing).

The wellbeing of other members of the household had a great influence on how a woman assessed her standard of living. A woman did not regard herself as living a good life if her children or her husband were not doing well. Participants believed that children should be well-fed, healthy, and should go to school. Husbands should be respected and respectful, and the house should be kept clean and comfortable. This might be partially dictated by social expectations regarding gender behaviour, where the woman is expected to be responsible for the family welfare, as an appreciated wife and conscientious mother. However, the impediments to reach a better level of living conditions in the household were seen to be those same people whom the mother and wife needed to care for.

During the group discussions, women denounced verbal and physical abuse as a recurrent act in their communities. The violence was often generated by alcohol consumption or other forms of “misunderstanding”: for example, when a woman refused to have sexual intercourse with her husband, or when she questioned him about extra marital affairs.

The World Health Organisation has identified marital violence as a major health threat (WHO, 2013) as it has been found to cause severe physical and mental injuries to women. Domestic violence undermines women's capabilities and functionings since it can erode her employment opportunities and social relations (Agarwal and Panda, 2007). As the Commission on the Measurement of Economic Performance and Social progress reports, freedom from domestic violence needs to be a significant aspect for evaluating wellbeing and for expanding people's capabilities (Stiglitz et al., 2009). The findings in this study are aligned with the conclusion that the Commission draws on this aspect of quality of life.

A rich literature from several disciplines stresses the value of social connections and social trustworthiness for economic and human development (Putnam, 2000). A strong sense of belonging to one group or association can enhance a sense of unique personal identity (Stiglitz et al., 2009). There is also much evidence that social networks are very robust predictors of subjective measures of quality of life such as life satisfaction (Helliwell and Putnam, 2004). The participants in this study brought up in the discussions that their quality of life, in addition to personal and family wellbeing, was shaped by the interactions with the environment and the community. Women relied on bonding and bridging social capital as a strategy for increasing security in the village, coping with shocks and risks, and for disseminating knowledge, as happens with farming groups or community loan schemes. Social networks were reinforced with the principles of “good conduct”: avoiding anti-social behaviour such as stealing, begging, gossiping, witchcraft. Social exclusion, marginalisation and the feeling of inadequacy and shame were widely associated with poverty and deprivation.

One dimension of the framework was related to economic security, understood as the access to economic resources and the ability to cope with shocks. In addition to social networks, which can provide an “emergency fund” in case of need, the ownership of assets such as livestock and the opportunity for cash-earning work such as contracted farming were crucial for achieving and maintaining a degree of independence and control over decisions on financial matters.

The last dimension refers to subjective wellbeing: how happy people are overall, how satisfied they are with the kind of life they are living. A long philosophical tradition starting from Aristotle views people as the best judges of their own condition (Diener and Suh 1997). Subjective wellbeing is closely linked to the utilitarian tradition but has a wider application due to the strong presumption that enabling people to be “happy” and “satisfied” with their life is a universal goal of human existence (Stiglitz et al., 2009).

The dimensions of a good life that emerged through the focus group discussions are a combination of factors influencing quality of life and components of quality of life. It was not possible to make a distinction between these two elements. It is clear, though, that the dimensions were all valuable and important aspects of these women's lives because they enabled women to prosper and flourish and to conduct a life of human dignity that it is worth living. For these reasons, the dimensions can be considered capabilities as defined by Sen.

5.2. Comparing the list with other sets of dimensions

It is interesting and instructive to compare the set of capabilities developed in this study with lists related to quality of life generated by other studies for different purposes and following different methodologies. The five sets of dimensions summarised in the second section have been considered for this exercise.

5.2.1. Doyal and Gough's needs

Despite major conceptual and methodological differences, their list of needs is reflected in the set of dimensions elicited in Malawi. Nutrition, housing, physical and economic security, reproductive health rights, and relationships all feature in the list developed here. However, *community relations, happiness* and *inner wellbeing* do not feature in Doyal and Gough's framework.

5.2.2. Nussbaum's Central Human Capabilities

Despite the fact that the aim of Nussbaum's list and the methodology used to develop it differ substantially from those in this study, considerable areas of commonality are noted. Nussbaum describes *bodily health* and *bodily integrity* as being able to have good health, including reproductive health; to be adequately nourished; to have adequate shelter, being able to move freely from place to place; to be secure against violent assault, including sexual assault and domestic violence; having choice in matters of reproduction. These are all present in the Malawi framework, although not under the same category but distributed across the *physical, inner* and *household wellbeing* dimensions.

The *inner wellbeing* dimension is articulated in Nussbaum's list across three different capabilities: *Emotions*; *Senses, Imagination, and Thought;* and *Play*. The Malawian concept of *good conduct* is associated with Nussbaum's *Practical Reason*: being able to form a conception of the good. The *community relations* dimension here is very similar to her idea of *Affiliation*.

The main differences are that the Malawi set does not include any dimensions associated to *Other Species* or to *Control over one's Environment* (e.g. political participation). However, the participants in the focus groups did mention being able to hold property, which is part of this last capability.

Finally, in the Ten Central Human Capabilities there is no mention of strategies for coping with shocks and risks, which was a highly valued element of the *economic security* dimensions.

5.2.3. Narayan's voices of the poor

The aim and methodology used in Narayan's work are equivalent to the approach used here. Both studies used participatory methods to elicit people's values and perceptions of well-being and ill-being.

The similarities in the findings between Narayan's list of dimensions and the framework developed here are extensive. The majority of capabilities and functionings are present in both lists, are grouped under matching headings, and in many cases are described with the same or similar expressions, for example *Peace of mind*. The only dimension that does not explicitly overlap is *Security* (with the exception of personal physical security). In *Voices of*

the Poor, the concept of *Security* includes civil peace and lawfulness, which were not mentioned in the Malawian context. This may be because Malawi has not experienced unrest or armed conflict in recent history, and because access to formal justice in remote rural areas is unfamiliar. Finally, in the Malawian context the capability to practise family planning was highly valued although it does not explicitly appear in the *Voices of the Poor*.

5.2.4. Al-Janabi and Coast's ICECAP-A measure

The ICECAP-A project and this work share many similarities in terms of aim, objectives and methods. However, the two sets of dimensions of wellbeing have substantial differences. In the ICECAP-A, basic capabilities such as having adequate nourishment are absent, probably because in a developed nation these aspects of quality of life are taken for granted. *Community relations,* which is a highly valued component in Malawi, is also not explicitly present in the ICECAP-A, although it could be part of the *Love, friendship and support* dimension. The *Achievement and progress* dimension listed in ICECAP-A, is not mentioned here. The results of the two studies appear to reflect their specific cultural contexts.

5.2.5. Commission on the measurement of economic performance and social progress

Although the list proposed by the Commission was drawn from academic literature and targeted at the country level, there is a significant degree of overlap between the Commission's list of wellbeing dimensions and the quality of life for Malawian women. Although *education* is not mentioned directly here, nor *political voice* and *environment*; *social connections and relationship* matches with the *community relations* dimension, and the last dimension (*insecurity*) includes both the economic security dimension and the freedom from domestic violence sub-dimension. The dimensions of health and material wellbeing feature in both lists. The Commission's list misses a mental wellbeing dimension.

5.3. Limitations

While developing the framework, great care was given to produce mutually exclusive attributes of life, however this was not always possible as some sub-dimensions were cross-cutting the main dimension. For example, domestic violence not only was regarded as having an impact on the wellbeing of the family but also on the victim's mental state and it might also affect her physical health. Also, having a good conduct is part of the inner aspect of wellbeing, however it has an impact on the individual's social life as well. Social networks are one feature of the community relations, however the economic aspect of the safety nets (for example being able to cope with shocks thanks to the financial or in-kind support from family and friends) are part of the economic security dimension.

6. Conclusion

This paper has reviewed existing methods for selecting dimensions of quality of life. A participatory approach was chosen for eliciting women's perceptions of what a ‘good life’ means in Mchinji District, Malawi. A conceptual framework of quality of life was developed from women's expressed contributions. This framework included six dimensions of quality of life, which represent women's capabilities: bodily strength, inner wellbeing, household wellbeing, community relations, economic security and happiness, and a number of sub-dimensions. The challenges of operationalising the capability approach have been widely recognised to the extent that it was defined as “an unworkable idea” (Rawls 1999). This study is one of the few that applies the capability approach empirically with the specific purpose of creating a metrics to assess quality of life. It provides evidence of the feasibility of developing a list of capabilities directly from people' voices, and it shows that group dynamics are appropriate participatory methods for defining and measuring challenging concepts in a setting that is economically deprived and geographically remote. It demonstrates that it is possible to collect meaningful and reliable information on capabilities, desires, choices and freedoms, reaching beyond people's economic, material and health conditions. The core dimensions were expressed according to women's values and in their own words, hence they may not be generalisable beyond this population group or geographical area. However, the framework could be extended to women living in other areas of rural Malawi, or parts of neighbouring Zambia and Mozambique, where the majority of the population belongs to the same ethnic group (Chewa) and shares values, norms and traditions. Further adjustments and validation tests would be needed if the list is used in different contexts.

Despite the list being developed in a specific context and for a specific group of people, the similarities with lists developed in other contexts, with different methods and for different purposes, are considerable. This suggests that there are a number of core aspects of quality of life that are considered a minimum requirement for a life of human dignity that goes beyond survival and includes more sophisticated components of what makes a life worth living. These core components should be included in any attempt to assess quality of life and human development across populations.

The methodological challenges tackled in this study represent an important step towards the development of a multidimensional index of wellbeing based on the capability framework that can be used to assess and monitor quality of life, and to evaluate policies aimed at improving people's lives.

Acknowledgements

The authors would like to thank the collaborators at MaiMwana Project and UCL Institute for Global Health for guidance and access to the site: Tambosi Phiri, Sonia Lewycka, Mikey Rosato, and Anthony Costello; Henry Nthani for fantastic fieldwork assistance, transcription and translation; and three anonymous reviewers. GG acknowledges financial support from the UK Medical Research Council, Doctoral Training Award the University of London Central Research Fund and the British Fund for Women Graduates. The authors are very grateful to the women who took part in this study.

Appendix A. Supplementary data

Supplementary data related to this article can be found at http://dx.doi.org/10.1016/j.socscimed.2015.01.042.

References

Agarwal, B., Panda, P., 2007. Toward freedom from domestic violence. J. Hum. Dev. 8 (3).
Al-Janabi, H., Flynn, T.N., et al., 2012. Development of a self-report measure of capability wellbeing for adults: the ICECAP-A. Qual. Life Res. 21 (1), 167–176.
Alkire, S., 2002a. Dimensions of human development. World Dev. 30 (2), 181–205.
Alkire, S., 2002b. Valuing Freedoms: Sen's Capability Approach and Poverty Reduction. Oxford University Press, USA.
Anand, P., van Hees, M., 2006. Capabilities and achievements: an empirical study. J. Socio-Economics 35 (2), 268–284.
Barbour, R.S., Kitzinger, J., 1999. Developing Focus Group Research: Politics, Theory and Practice. Sage.
Burchardt, T., Le Grand, J., et al., 2002. Constraint and Opportunity: Identifying Voluntary Non-employment. London School of Economics and Political Science, Centre for Analysis of Social Exclusion.
Chiappero-Martinetti, E., 2000. A multi-dimensional assessment of well-being

based on Sen's functioning theory. Rev. Internazionale Sci. Sociali 58, 207–239.
Dejong, J., 2006. Capabilities, reproductive health and well-being. J. Dev. Stud. 42 (7), 1158–1179.
Doyal, L., Gough, I., 1991. A Theory of Human Need. Palgrave Macmillan.
Dreze, J., Sen, A., 2002. India: Development and Participation. Oxford University Press, USA.
Flynn, T.N., Chan, P., et al., 2011. Assessing quality of life among British older people using the ICEPOP capability (ICECAP-O) measure. Appl. Health Econ. Health Policy 9 (5), 317–329.
Fox-Rushby, J.A., 2000. Operationalising conceptions of 'Health' Amongst the Wakamba and Maragoli of Kenya: the basis of the KENQOL instrument. Qual. Life Res. 9 (3), 316–316.
Gasper, D., 2010. Understanding the diversity of conceptions of well-being and quality of life. J. Socio-Economics 39 (3), 351–360.
Grewal, I., Lewis, J., et al., 2006. Developing attributes for a generic quality of life measure for older people: preferences or capabilities? Soc. Sci. Med. 62 (8), 1891–1901.
Hawthorne, G., Richardson, J., et al., 2001. A comparison of the Assessment of Quality of Life (AQoL) with four other generic utility instruments: health-related quality of life in clinical studies. Ann. Med. 33 (5), 358–370.
Helliwell, J.F., Putnam, R.D., 2004. The social context of wellbeing. Philos. Transac. R. Soc. Lond. Biol. Sci. 1435–1446 (London).
Kinghorn, P., Robinson, A., Smith, R.D., 2014. Developing a capability-based questionnaire for assessing well-being in patients with chronic pain. Soc. Indic. Res. 1–20.
Kitzinger, J., 2005. Qualitative research: introducing focus groups. BMJ 311 (7000), 299–302.
Klasen, S., 2000. Measuring poverty and deprivation in South Africa. Rev. Income & Wealth 46 (1), 33–58.
Lewycka, S., Mwansambo, C., et al., 2013. Effect of women's groups and volunteer peer counsellors on mortality, morbidity and health behaviours among mothers and children in rural Malawi: the MaiMwana factorial cluster randomised controlled trial. Lancet 381 (9879), 1721–1735.
McGillivray, M., 2012. Human Well-being: Concept and Measurement. Palgrave-Macmillan.
Narayan, D., 2000. Voices of the Poor: Can Anyone Hear Us? Oxford University Press for the World Bank, New York.
Nussbaum, M.C, 2001. Women and Human Development: The capabilities Approach. Cambridge University Press.
Nussbaum, M., 2003. Capabilities as fundamental entitlements: Sen and social justice. Fem. Econ. 9 (2), 33–59.
Putnam, R.D., 2000. Bowling Alone: The Collapse and Revival of American Community. Simon & Schuster, New York.
Rawls, J, 1999. The Law of Peoples. Massachusetts: Harvard University Press, Cambridge.
Ritchie, J., Lewis, J., 2003. Qualitative Research Practice: A Guide for Social Science Students and Researchers. Sage Publications Limited.
Robeyns, I., 2003. Sen's capability approach and gender inequality: selecting relevant capabilities. Fem. Econ. 9 (2), 61–92.
Robeyns, I., 2005. Selecting capabilities for quality of life measurement. Soc. Indic. Res. 74 (1), 191–215.
Robeyns, I., 2006. The capability approach in practice. J. Political Philosophy 14 (3), 351–376.
Rosato, M., Mwansambo, C., et al., 2011. MaiMwana women's groups: a community mobilisation intervention to improve mother and child health and reduce mortality in rural Malawi. Malawi Med. J. 22 (4).
Sen, A., 1985. Commodities and Capabilities. Oxford University Press, Oxford.
Sen, A., 1993. Capability and well-being. In: Nussbaum, M., Sen, A. (Eds.), The Quality of Life, vol. 453. Claredon Press, Oxford, pp. 30–54.
Sen, A., 1994. Population: delusion and Reality. N. Y. Rev. Books 41 (15).
Sen, A., 1999. Development as Freedom. Alfred A. Knopf, New York.
Sen, A., 2003. Development as capability expansion. In: Fukuda–Parr, S., Shiva Kumar, A.K. (Eds.), Foreword to "Readings in Human Development. Concepts, Measures and Policies for a Development Paradigm. Oxford University Press, Oxford.
Sen, A., 2005. Human rights and capabilities. J. Hum. Dev. 6 (2), 151–166.
Stiglitz, J.E., Sen, A., et al., 2009. Report by the commission on the measurement of economic performance and social progress. In: Commission on the Measurement of Economic Performance and Social Progress.
Verkerk, M.A., Busschbach, J.J.V., et al., 2001. Health-related quality of life research and the capability approach of Amartya Sen. Qual. Life Res. 10 (1), 49–55.
Vizard, P., Burchardt, T., 2007. Developing a Capability List: Final Recommendations of the Equalities Review Steering Group on Measurement. CASE Paper 121. Centre for Analysis of Social Exclusion, London School of Economics and Political Science, London.
White, S., Pettit, J., 2004. Participatory Approaches and the Measurement of Human Well-being. Research Paper. UNU-WIDER, United Nations University (UNU).
WHO, 2013. Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-partner Sexual Violence. WHO, Geneva.