Non-use of Formal Health Services in Malawi: Perceptions from Non-users

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Abstract

Background

The study upon which this paper is based was undertaken to understand users' and non-users' perceptions concerning facilitators and barriers to equitable and universal access to health care in resource-poor countries such as Malawi. In this study, non-users of health services were defined as people who were not in need of health services or those who had stopped using them due to significant barriers.

Methods

A total of 80 interviews with non-users of health services were conducted in Rumphi, Ntchisi, Phalombe and Blantyre Districts of Malawi. Interviews focused on why informants were not using formal health services at the time of data collection. In order to identify non-users, snowballing was used health surveillance assistants, village headmen and community members also helped. One focus group discussion was also conducted with non-users of health services who were members of the Zion Church.

Results

Informants described themselves as non-users of health services due to several reasons: cost of health services; long distances to health facilities; poor attitude of health workers; belief in the effectiveness of traditional medicines; old age and their failure to walk. Others were non-users due to their disability; hence they could not walk over long distances or could not communicate effectively with health providers. Some of these non-users were complete non-users, namely members of the Zion Church and those who believed in traditional medicine, and they stated that nothing could be done to transform them into users of health services. Other non-users stated that they could become users if their challenges were addressed e.g. for those who were non-users of health services due to poor attitudes of health workers, they stated that if these health workers were transferred they would be able to access health services.

Conclusions

Public health education targeting both health workers and non-users, ensuring a functional outreach program and addressing other health system challenges such as shortage of drugs and human resources would assist in transforming non-users into users of health services.

Introduction

The delivery of health services in Malawi is structured into three levels, namely, primary, secondary and tertiary levels. The health posts, health centres and rural or community hospitals constitute the primary level, while district hospitals constitute the secondary level. The tertiary level is made up of central hospitals and specialized hospitals, such as Zomba Mental Hospital. There are four central hospitals in Malawi. A referral mechanism exists from one level of health care to another even though bypassing is common. In 2007 there were 1,059 health facilities in Malawi of which 54% were owned by the Ministry of Health (MoH), 19% by the private sector and 14% by Christian Health Association in Malawi (CHAM). Other facilities were owned by non-governmental organizations (NGOs) (7%), companies (4%) and statutory corporations (2%)[1]. CHAM is a network of health facilities owned by religious organisations and is a non-profit organization.

The responsibility of the MoH at the central level is to formulate policies, standards and guidelines and supervise health service delivery[2]. The delivery of health services at district and community levels is the responsibility of the Ministry of Local Government and Rural Development, following the 1998 National Decentralisation Policy and the 1999 Local Government Act. Tertiary care is, however, the responsibility of the MoH. At national level, the Malawi Health Sector Strategic Plan (HSSP) (2011-2016)[2] guides the implementation of interventions in the health sector to improve the health status of the people of Malawi. The Program of Work, extended up to 2011, guided health sector interventions for the period 2004-2010. The evaluation of the Program of Work showed major improvements in the health status of the people of Malawi, especially in terms of maternal mortality ratio and under-five and infant mortality rates[3]. Challenges, however, still remain in order for Malawi to achieve the targets of the health-related Millennium Development Goals (MDGs) by 2015, and this is especially the case for MDGs 4, 5 and 6[2].

Malawi's Health Sector Strategic Plan 2011-2016 has outlined a set of interventions that will accelerate progress towards achieving the MDGs, one of these being universal access to health care. Studies have shown that cost is a major barrier to accessing health services[4-5]. The achievement of universal access to health care may be affected by prevailing challenges in Malawi's health system such as shortage of human resources; inadequate funding; shortage of medicines; and long distances to health facilities as described in the HSSP[2]. In addition to this, there are certain vulnerable groups whose access to health services may be limited because of their condition e.g. the elderly and persons with disabilities. Universal access to health care will only be achieved if challenges prevailing in the health care system are addressed and the challenges experienced by vulnerable groups in accessing health care are identified and addressed as well.

Between 2009 and 2012 a consortium comprised of Trinity College Dublin, SINTEF in Norway, the University of Namibia, Stellenbosch University and the Secretariat of the African Decade of Persons with Disabilities in South Africa, the Afhad University of Women in the Sudan and the Centre for Social Research of the University of Malawi, with funding from the European Union 7th Framework, implemented a study aimed at exploring access to health services by vulnerable groups (in short the Equitable Project), One of the objectives of the Equitable Project was to undertake research into understanding perceptions of users' and non-users' about the facilitators and barriers to equitable and universal access to health care in Sudan, Namibia, Malawi and South Africa. In each of the chosen countries, the study

investigated the experience of health service users and non-users. In this study, non-users were classified as either those who were not in need of the health care services or those who stopped trying to use these services due to significant barriers. Our focus during fieldwork was on reasons for non-use of health services as well as factors that would prompt the use of health services by those who described themselves as non-users.

Methods

The Equitable Project had both the qualitative and quantitative components. Focus group discussions (FGDs) and in-depth interviews were used to collect data for the qualitative component of the study. This paper is based on the qualitative data which was collected during the study. In Malawi, fieldwork for the Equitable Project was conducted in 4 districts, namely, Rumphi in the northern region, Ntchisi in the central region and Phalombe and Blantyre in the southern region. Blantyre is an urban district while the remaining districts are rural. The choice of districts took into consideration the cultural diversity prevailing in Malawi. In each district, the District Health Office assisted in identifying two health facilities: one belonged to CHAM while the other was a Government facility. CHAM charges user fees while public health facilities provide services free of charge. Interviews and FGDs were conducted in the catchmentareas of the sampled health facilities. A snowball method was used to identify non-users: when one non-user was identified, he or she was asked if he or she knew any other person in the community who was a non-user of formal health services. Health surveillance assistants (who are employees of the MoH based at community level), village headmen and other community members also helped to identify non-users of health services. A total of 80 interviews were conducted with non-users. Two FGDs were conducted with non-users of health services and these participants were members of the Zion Church. In other districts, there were not an adequate number of non-users to constitute an FGD. The inclusion criteria for this study were persons with or without disabilities who were using or not using health formal health services and were aged 18 years and above and were living in the catchment areas of the sampled health facilities. It was only those who consented to participating in this study were interviewed.

Ethical considerations

This study was approved by the National Health Sciences Research Committee (NHSRC) whose secretariat is in the MoH. The NHSRC is an institutional review board that draws membership from different organisations in Malawi and has the responsibility of approving health and related studies. The objectives of the Equitable Project were explained to all participants in this study and their participation was based on informed consent. Verbal consent was obtained from all participants. All participants were assured of the confidentiality of the information they shared with the research team as well as their identify. They were also informed that they were free not to answer any questions they were not comfortable with and they could withdrawal at any time they wanted,

Data analysis

All the transcripts were typed in word soon after the interviews and FGDs were conducted. All the transcripts were read and re-read and major themes emerging were determined. A code book was developed by the Researchers and used to code the data. All the transcripts were then imported into NVIVO, a software for analyzing qualitative data. All analysis was done using this package.

Results

Table 1: Demographic characteristics of the non-users who participated in this study:

Gender	**Percentage**
Male	47.5
Female	52.5
Age	
20-34	25.0
35-49	17.5
50-64	6.3
65-79	21.3
80+	30.0
Educational qualifications	
No formal education	45.0
Standard 1-4	28.8
Standard 5-6	22.5
Form 1-2	0.0
Form 3-4	3.8
Employment status	
Farming	58.8
Unemployed	37.5
Other	3.8
Total	**100.0**

Table 1 shows that more women were interviewed than men an that nearly half of the informants were aged above 65 years of age. Most of the informants either did not have formal education or they went to primary school. Only 4% went to secondary school. Most of the respondents were engaged in farming and nearly 40% said that they were unemployed. Most of the informants who reported that they were unemployed were old men and women and they said that they relied on their children for a livelihood. More than half of the informants were persons with disabilities.

In Malawi, the majority of people will seek health care from health facilities when they are sick. However, through snowballing and with the help of health workers, village headmen and community members, some non-users of health services were identified. A major finding from this study was that some non-users of health services were complete non-users, while others were non-users at the time of data collection for specific reasons; and they would begin using health services once the barriers they were experiencing were addressed. This section describes reasons why some informants described themselves as non-users of formal health services at the time of data collection for this study.

Being not sick enough

Some respondents in this study stated that they had never had any serious illnesses since they were young or for some years; hence, they never went to a health facility for treatment

as can be seen in the quotes below:

"While some people who visit health facilities when ill experience problems such as long distances to these facilities and a lack of money to pay for services especially at CHAM facilities, I do not experience any such problems because I do not go there as I have never been seriously sick" (a 79year old man, Blantyre).

Another 62 year old man in Blantyre also described himself as a non-user of health services because he had not had any health problems over five years preceding the study, and hence, there was no reason for him to visit the health facility. Such non-users of health services, however, said that they would use health facilities if they suffered from serious illnesses. Some people can, therefore, be described as non-users of health services because they did not need the services at the time.

Poor attitude of health workers

Some of the current non-users of formal health services used to go to health facilities when ill but they stopped because some health care providers do not report for duties on time as required under the rules and regulations of the Malawi Public Service. They report for work at 9:00am or later; they find many clients waiting for them to receive services. Some health workers treat their friends and relatives first and this annoys patients who have been in the queue for a long time. Even after coming to the office late, some health workers will break off at lunch time and never go back to work. According to informants, who described themselves at the time of the study as non-users, such behaviour of health providers discourages people to the extent that they stop availing of health services.

Some people stopped going to the health facility for treatment because some health workers shout at patients or mistreat them. For example, one informant, Jacob, recounted a scenario where, after explaining his health problem, the Medical Assistant asked him:

How did you know? If you already know the problem yourself, why did you come to me here? You should have just gone to the drug store and bought Panado [a pain killer] instead of wasting my time.

This informant stopped going to the health facility to access health care services because of the way he was treated. There were also other informants who explained that a patient should not tell the Medical Assistant the specific disease he or she is suffering from; otherwise he or she will be asked many questions and treated in the same way that Jacob was treated. Such reactions by health workers may annoy patients and some decide not to go again to the health facility to seek health care services until such health workers are transfered.

The official opening hours for health facilities to provide of health services to patients is well known within the communities. It seems that on Saturdays, Sundays and public holidays, the health providers are only supposed to respond to emergencies. When patients go to health facilities on these days, they are told that they will not be treated and in some cases even when there is an emergency, as was cited by one informant, Mabvuto, patients are informed they will not be treated as it is their day off:

"My son wounded himself with a sharp knife on his left leg. I went to the health facility with my son on a Sunday. The Medical Assistant told me and my son that he does not attend to patients on Sunday because it is his day off. I thought this was an emergency and my son needed to be treated immediately but the Medical Assistant still refused. This resulted into an exchange of bad words between myself and the medical assistant and our relationship soured".

After the incident concerning Mabvuto's son who was denied health care services by the Medical Assistant, the relationship was antagonistic. There were also others who stopped going to the hospital for treatment after quarrelling with the Medical Assistant: they thought they might be given poison if they sought health care from the facility. Such informants said that since other public health facilities are far, they resorted to using either traditional medicine or purchasing medicines from shops. They complained that because public health services are free, their alienated relationship with the Medical Assistant had caused them to spend a lot of money on treatment. These people stressed that they would start using the health centre once such health workers were transferred.

Some health workers have also talked harshly to elderly men and women saying that they are old and that medicines are mainly for young people, and blaming them for the stocking out of medicines in facilities, as the case of Chikondi below illustrates:

"I stopped going for health services at the nearest health facility because when I suffered from malaria and went to the nearest health centre to seek treatment, I was disappointed as I was told by the health workers that the medicines are for young people and not for the elderly. Although I received the treatment I, however, decided to stop going to the hospital".

Chikondi was 79 years old and her case and other cases presented here highlight that in some cases health workers do not treat patients effectively, that antagonistic relationships between health workers and clients can ensue, and that patients who have divided relationships with health workers cease going to such facilities because of the fear of being poisoned. The mistreatment of clients by health workers was cited by the majority of informants who described themselves as non-users of formal health care services. There are, however, a lot of health workers doing an excellent job and they treat their clients well and with respect. One male informant aged 20-34, however, stated that *nsomba ikawola yimodzi ndi zonse* meaning that when one fish is rotten, all are rotten. What this implies is that when one health worker mistreats a client, the mistreated client will tell others about his or her experience and others may be afraid of going to the facility for fear of finding themselves in the same predicament. It is evident from cases given that clients can become non-users of health services due to the behavior of health workers and they would resume going to the facility after the transfer of the health workers concerned.

Lack of a health passport as a barrier to accessing services

Previously, health workers were using pieces of paper to write prescriptions for patients. However, this method presented difficulties in keeping records for patients; hence, the MoH introduced health passports. This has introduced a number of problems resulting in non-access of health care by certain vulnerable groups, such as the elderly and the poor, as some fail to purchase these health passports. Mabvuto, referred to earlier, also gave an example of his niece who got sick and was denied health care service by a Medical Assistant:

"The Medical Assistant did not give my niece treatment because she did not bring her health passport. The Medical Assistant asked me if he was going to write his medical diagnosis and treatment on the child's tongue. My niece failed to access treatment and she died the following

day. The members of the community nearly beat up the Medical Assistant because of anger".

This child would probably not have died if treatment was provided. The absence of the health passport made it impossible for the child to obtain treatment. Another elderly woman, Marita, aged 70+ years old also narrated her experience with health passports, which caused her to be a non-user of health services:

"Sometime back I had malaria and I went to the health facility for treatment. I was asked to buy a health passport but I had no money. I was sent back to look for money first for the health passport before being given treatment. I pleaded with the health worker but I was told to go home and get back to the health facility if only I bought the passport. Without the passport I am failing to access the services and because I am very old and I have difficulties in walking, I do not go to the facility for the services anymore".

Marita uses traditional medicine because traditional healers do not demand health passports. When sick, she just sends a child to the traditional healer and he comes to help her at her home, since she cannot walk as she suffers from severe rheumatism. She says that she can start accessing health services if the health workers stop demanding health passports. The MoH prints health passports that are sold to patients at approximately US$0.31 each. Health workers write the diagnosis and treatment given to a patient in the passport. Patients who do not have passports are sometimes denied treatment, as presented in the above cases, because health workers are without a facility to write the diagnosis and treatment provided. The 70+ year old woman mentioned above ceased accessing health care because she is very poor and cannot afford to purchase the passport.

Non-compatibility with modern medicines

There are people who have the desire to use formal health services, including obtaining the medicines for treatment. They, however, do not make use of such services because they vomit each time they take these medicines as narrated by Tereza, a 75 year old woman:

"I do not use formal healthcare because if I take any type of modern medicines I vomit. This started when I was 64 years old and since then I do not seek treatment from formal health care facilities. The main problem is vomiting and I do not have any interest in using formal healthcare".

While Tereza would wish to access modern medicines, she is failing because once she takes the medicines she vomits. She will only be able to access such services once her problem of vomiting is addressed. A 59 year old woman in Rumphi also said that she does not use modern medicines because when she takes pills they get 'stuck' in her throat. These cases illustrate that the desire to take modern medicines may be present, but some potential clients of formal health services experience problems.

Cost of services

As mentioned earlier, public health services are delivered free of charge in Malawi while CHAM facilities charge user fees. The catchment areas of public and CHAM facilities in most cases do not overlap. People staying in the catchment areas of CHAM facilities are required to pay for services, as free public services might be offered quite far from their places of residence. Some informants resident in catchment areas of CHAM facilities reported that while they would wish to use services offered by CHAM, they do not do so because they are poor and the services are not free. They stated that if CHAM removed the fees, they would be able to go there for treatment. In some cases, even the nearest public health facility does not have medicines, and one 90 year old man, who described himself as a non-user, reported that if he had money, he would have gone to private hospitals for treatment. Being poor, therefore, contributes significantly to people being non-users of health services, especially if they are resident in the catchment areas of private hospitals such as CHAM.

Lack of transport and long distances to health facilities

Distance to health facilities is one of the major determinants of health seeking behavior. A number of respondents mentioned that they were non-users of formal health services because the formal health facilities were located very far from their residential areas. It takes a long time to get there. The most common means of transport people use to get to health facilities is walking and sometimes oxcarts and bicycles. In a poor community only a few people have oxcarts or bicycles. When they get ill, some people do not have transport to get to the health facility e.g. a 70 year old man who described himself as a non-user said:

"The health facility is some 20 km away and there is no public transport; hence, it is difficult for me to access health care".

Long distances to health facilities and the absence of appropriate transport causes people, especially old men and women and persons with disabilities, to be non-users of health services. These old men and women and people with disabilities revealed that they would become users of health services if health facilities were constructed within their communities to reduce distance.

Belief in traditional medicine

Some people do not use formal health services because they believe in traditional medicine. One traditional healer in Ntchisi affirmed that his grandfather taught him traditional medicine in order to ensure continuation of tradition and also to please ancestral spirits. He knows medication for different diseases, and he does not opt for formal health services. Some informants preferred traditional medicine because the providers are resident within the community; therefore, they are not required to walk long distances. Traditional healers were also said to treat patients with respect, dissimilar to formal health care providers, as indicated earlier.

In some cases, people opt to use traditional medicine after experiencing failure of modern medicines. For example as narrated by a 42 year old female informant:

"I had a swollen leg and when I visited the hospital, I was not helped as I did not recover. I then started using traditional medicine and there was a significant improvement and I started walking. I have not completely stopped using the hospital but I am on a break to try other things".

Some informants stated that they were using traditional medicines because the traditional healers were within the village and that traditional medicines are cheaper than modern medicines. While modern medicine was introduced in Malawi in the 1800s by the missionaries, there are still people who believe in traditional medicine. As exemplified by the traditional healer, there are people who do not use modern medicine preferring instead to go for traditional medicine.

Running out of drugs

Lack of drugs in health facilities is a factor, as reported

by some participants, which diverts people from obtaining services at health facilities. Some participants cited situations in which they spent a whole morning at a facility, and when their turn came for consultations, they were told that the facility's drug supply was depleted. One informant reported that the last time he accessed formal healthcare, he was given panado for his headache. He was given the same dosage when he suffered from malaria. He decided to stop going there because his healthcare needs were not being met, as he stated that panadol could not be a universal cure. Some patients receive nothing at all and are advised to purchase medicines on their own.

There are also some people who go to a health facility looking for treatment for specific diseases; for example as narrated by a 42 year old man with epilepsy:

"I do not go to the health centre for treatment because at one time in the 1990s, I was told that at the health centre there were no drugs for epilepsy. I am still discouraged from walking a long distance to the health facility in the event that I am told that the drugs are not available. I am also not using health services because I am poor; otherwise, I would have gone to a CHAM facility. I would only start using health facilities if they introduced treatment for epilepsy at his nearest health centre".

The lack of medicines in health facilities, therefore, transforms some people into non-users of formal health services.

Religion

"But he was pierced for our transgressions, he was crushed for our inequities, the punishment that brought us peace was upon him and by his wounds we are healed"

This verse was cited by a 64 year old man explaining why he just prayed when sick rather than going for treatment at health facilities. Religion plays an important role in determining whether one would use formal health care or not. Informants belonging to the Zion Church emphasized that they do not go to the hospital for treatment; they just pray to God, citing for example that Jesus Christ prayed for the sick; he never took them to the hospital for medication. The Zion Church does not allow its members to seek care from health facilities or traditional healers. Members are excommunicated if they are found by the church to be seeking health care from these sources. Within the Zion Church, when one is ill, he or she will consult with his or her church elders and pastors who will pray for them and give them blessed water. If they are not cured, they are referred to a Zion Church Clinic

Some people used to go to mainline churches and health facilities when sick. However, after experiencing healing in the healing churches they stopped going there; for example as reported by Joyce, a woman aged 25-34:

"I suffered from stomachache and used both traditional and modern medicine but I was never healed. My problem was aggravated after eating nsima made from cassava and sorghum flours. Such type of nsima caused my belly to swell. This problem ended in 1995 when I was prayed for by men who visited our village praying for the sick. Since then, I trust in God for healing".

People who believe in faith healing reported that they have never been disappointed. Members of faith groups are complete non-users of health services.

Old age as a barrier to accessing health care

A number of old men and women aged 70+ were interviewed and most of these participants declared that they were old and could not do things that they used to do when they were young, such as walking over long distances. These respondents would, in the past, access formal health services when they were younger, but had stopped accessing such services due to old age and their failure to walk, as illustrated by the case below of a 90 year old woman:

"I used to access formal care without any problems and, when sick, my children took me to the hospital but they are all dead and I live only with my grandchildren who cannot afford to carry me on their backs to the health facility when I am sick. So I stopped accessing formal health care because I have nobody to take me to the health facility".

Most of the old men and women also reported that they had problems with their legs and were feeling a lot of pain, with some reporting that they had rheumatism, which made walking over long distances quite a difficult task for them. Accordingly, because of this they were non-users of formal health services at the time. As exemplified by the above case, the absence of children in the homes of old people made these elderly people quite vulnerable as they could no longer access services. This was exacerbated, for example in the area of TA Kuntaja in Blantyre, by the absence of a public transport system of which old men and women could avail to reach the health centre. While in some cases, people could be available to take old men and women to the hospital on a bicycle, some (for example, an 80 year old woman who had a lot of pain in her legs and experienced mobility problems) could not sit on a bicycle; hence, their failure to access health services.

People with disabilities

There were quite a number of informants in this study who reported that they were non-users of health services because they had a disability which prevented them from accessing services. A number of people with disabilities who participated in this study were old men and women and they could not access services because of mobility problems; they had a lot of pain in the legs including suffering from rheumatism. People who cannot speak and who have hearing impairments also experience problems when they visit health facilities as they may try to explain to the doctors their problem but experience communication barriers as explained by a 70 year old man with hearing impairment:

"Although I have a hearing impairment, I am lucky because I have a hearing aid, but that there are others like me who do not have such a device and no guardian; hence, it is difficult for such people to communicate with health workers; and therefore, they may stop availing of health facilities".

One 88 year old man also elucidated that he does not access health services because he is visually impaired and he cannot manage to walk to the hospital and his wife is also too old and has problems with her legs, and therefore cannot manage to escort him. There is no one else who can escort him to the health facility. People with disabilities, especially those with mobility challenges, also reported that it was difficult for them to walk alone to the facility especially in the absence of someone to help them.

Discussion

It is evident from the findings of this study that in Malawi, there are some people who describe themselves as non-users of formal health services for various reasons. This study has illustrated that socio-economic status can transform users of formal health services into non-users. Disparate from some other developing countries, in Malawi, public health services

are delivered free of charge. CHAM and other private facilities charge user fees. Some people residing in catchment areas of CHAM facilities were non-users of health services because they could not afford to pay for services, and they were also living very far from public health facilities. While people might desire to go to health facilities when sick, the cost of treatment may be a major barrier[4-5] and this constitutes one of the factors that lead people to use traditional medicine, which sometimes is considered cheap[10]. In order to increase access to health services, the MoH has signed service level agreements (SLAs) with some CHAM facilities to provide services (especially mother and child services) free of charge to the population in their catchment areas[2]. Under this agreement, the DHO transfers some amount of money to CHAM facilities in order to ensure that Malawians get services free of charge. The implementation of SLAs at St. Anne's Mission Hospital in Nkhotakota District showed that there was an increase of 288% in antenatal admissions, and a considerable increase in hospital deliveries[11].

In addition to cost, this study has also found that some people do not seek care at health facilities due to long distances and the lack of medicines at the facilities. Le Beau[12] argues that recourse to traditional medicine and other forms of therapy may also be as a result of unavailability of, or distance to, health facilities. Distance is therefore an important determinant of health seeking behaviour. Communities situated very far from health facilities are unlikely to seek care from these facilities. While people would like to use health facilities, long distances to these facilities tend to convert these people to non-users. This is also especially true for elderly men and women who, at younger ages, were users but have been transformed into non-users, because of age and unavailability of people who can carry them to health facilities. Therefore, bringing services to the households of elderly people would help to ensure that such elderly people continue to be users of health services.

Some people stopped going to formal health facilities because of persistent shortage of drugs in health facilities. While the availability of drugs in public facilities has improved significantly during the implementation of the Program of Work 2004-2010[3], reports of drug shortages in health facilities are not uncommon. Some studies have shown that if drugs are not available, patients are given prescriptions to purchase drugs from elsewhere. The persistent shortage of drugs in health facilities, as has been demonstrated in this study, can transform users into non-users of formal health services. Some informants questioned the rationale for health workers to give the same drugs (e.g. panadol) for a wide range of diseases.

The poor attitude of health workers can transform users of health services to non-users as has been demonstrated in this study, and also illustrated by Dennis and Harrison[13]:

Western medicine practitioners get angry too easily and are too impatient. They do not understand the villager, then the villager gets angry and does not cooperate. Thus the western medical practitioners do not gain his confidence and the villager turns to his zo (meaning medicine man).

As can be seen from the above quotation and from the results of this study, people stop using formal health services because they have been treated harshly by health workers. People may bypass health facilities because of the poor attitude of health workers[10]. Studies have shown that traditional healers are in some cases preferred because they treat their patients respectfully and they give them individualized care, there are no long queues and they satisfy their requirement[14]. Strategic interventions are therefore required to improve the attitude of health workers; improving staffing levels being one of the interventions as contained in the current HSSP, which extends up to 2016.

Over the years religion has played an important role in determining health seeking behavior. While people are free to choose therapy, in some cases religion restricts the choices that people make during illness episodes. As early as the 1970s, scholars such as Daneel[15] highlighted that certain African Independent Churches were popular because they were involved in healing. Such an activity attracted many Africans because it was in line with traditional religion[15]. Other studies have specifically mentioned the Zion Church as forbidding their members from accessing formal health services. Members of the Zion Church are therefore non-users of health services as they believe in prayer for healing purposes. In 2010, there was an outbreak of measles in Malawi, and the Ministry of Health instituted a nationwide measles immunisation campaign targeting children aged below 15 years. Members of the Zion Church still refused the vaccination of their children; and some of these children had to be vaccinated at gun point. The use of medicines by Zionists is not allowed and visits to the hospital for medication are considered a lapse in the spiritual life[15]; such members are excommunicated. In 2010, the outbreak of measles in Malawi showed that there are certain population groups, for example, members of the Zion Church, who do not access health services including immunisation[7-9]. There is little that can be done immediately to change the attitude of the members of the Zion Church and other churches that prohibit their members from utilising formal health services. However, religion is dynamic and, with more national campaigns, there is a possibility that gradually, more members of these churches will recognise the health benefits of utilising formal health services, and the churches may begin to adopt a different viewpoint on the matter.

Malawi's National Policy on Equalization of Opportunities for People with Disabilities highlights the need to address the special challenges that persons with disabilities experience when accessing health services[6]. Just like the current study, other studies have also generally demonstrated that persons with disabilities have problems in terms of accessing health services. The 2003 Living conditions study showed that the majority of persons with disabilities were aware of the services available and that a significant proportion needed the services. However, a considerably lower proportion of persons with disabilities actually received the services they needed. For example 84% of the persons with disabilities were aware of the health services available, 83% required these services but only 64% received the services. This demonstrates that there exist gaps between what services persons with disabilities need and what they receive[16].

While the majority of PWDs would want to access health care from health facilities they however experience problems in accessing modern health services and these include: the lack of money for them to get to health centres[17]; communication barriers between health workers and people with hearing impairments[18] as health workers do not know sign language; and long distances to health facilities[19]. These are some of the problems that this current study has also highlighted. While the majority of people in Malawi go to health facilities

for treatment during illness episodes, there are various groups of people that for various reasons do not utilize these services. Achieving universal access to treatment may only be realised if non-users of health services, for whatever reasons, are identified and their concerns addressed.

Conclusions

This paper explored reasons for the self-description of certain populations in Malawi as non-users of formal health services. Studies have been conducted that examine non-use of specific health care services such as family planning, HIV testing and counseling and antenatal services. This study differentiated however in its examination of reasons for non-use concerning non-users of formal health services, and those factors that would transfer non-users to users of health services. This study has generally illustrated that there are two groups of non-users: some are complete non-users such that there may be little that can be done to initiate their use of formal health services. The first of such groups are the members of the Zion Church who believe in the power of God for their healing as is written in the Bible. While in other countries Zionists use herbal medicines, in members of the Zion Church stated that they do not use such medicines but rely on prayer. There are also others who reported that they use traditional medicines and it has never failed them and they are accustomed to using such traditional medicines. There were others, however, who were non-users of health services due to contextual factors; they would start using services so long as these factors were addressed. Participants talked about bad attitudes of health workers, which gave rise to their standing as non-users of health services and would only become users if such health workers were transferred.

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