Young Malawians on the interaction between mental health and HIV/AIDS

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Previous research has identified high levels of mental health problems among people affected by HIV. This study surveys specifically adolescents in southern Malawi on their experience of the impacts of living with HIV or AIDS on one's mental health. At the same time, the study explores the link between mental health problems and subsequent HIV-risk behaviour. Short texts relating everyday scenarios that depicted symptoms of three mental health problems (i.e. depression, anxiety and HIV-related brain impairment) formed the basis of in-depth discussions in 12 existing groups of secondary school students, orphans and vulnerable children, teenage mothers, and out-of-school youths, in both rural and urban settings. The responses show that these young people recognised the mental health sequelae of HIV/AIDS as impacting upon many aspects of one's life. The young people traced these 'interruptions' and 'disruptions' through deteriorating psychological and socio-economic conditions. They showed awareness of a two-way interaction between HIV/AIDS and mental illness, indicating that the latter can increase thoughts of suicide and HIV risk-taking behaviour. More importantly, they identified a number of locally derived community interventions, which if supported by statutory health and education services, can significantly ameliorate their situations. The findings provide avenues for practical integration of mental health provision within HIV prevention, education and care initiatives.

Keywords: community participation, decision-making, health behaviour, HIV prevention, orphans and vulnerable children, participatory research, psychological aspects, social behaviour, socio-economic factors, southern Africa, youth

Introduction

The impact of HIV on the psychological and emotional experiences of people in sub-Saharan Africa is being increasingly acknowledged. Mental trauma affects not only how individuals and communities are able to cope with high levels of illness and suffering, but also how that experience might influence decisions to engage in HIV risk-taking behaviour. The implications for HIV care and prevention in sub-Saharan Africa are considerable.

A number of studies in Africa have identified HIV or AIDS as a source of stress for different groups of young people, including young people in school (Baggaley, Sulwe, Chilala & Mashambe, 1997), orphans (Young & Ansell, 2003) and for those caring for orphans (Tsiwo-Chigubu, 2005). Mast, Kigozi, Wabwire-mangen, Black, Sewankambo, Serwadda, Gray, Waswer & Wu (2004) noted that, apart from the physical effects of HIV infection, patients found that the loss of role and social function, and the emergence of mental health problems were most restricting.

Other studies have reported on the high prevalence of mental illness, particularly depression, within different HIV populations in sub-Saharan Africa, including newly HIV-diagnosed patients (Olley, Gxamza, Seedat, Theron, Taljaard, Reid & Reuter, 2003) and HIV-infected women (Mfusi & Mahabeer, 2000). Olley et al. (2003) also found a high incidence of alcohol abuse and dependence among male HIV-positive patient groups. Studies of orphans in Uganda and Tanzania (Sengendo & Nambi, 1997; Makame, Ani & Grantham-McGregor, 2002) found that orphans had higher rates of depression and were less optimistic about the future than non-orphans. Atwine, Cantor-Graae & Bajunirwe (2005) found higher levels of anxiety and sensitivity to depression among children orphaned by AIDS in Uganda.

Neurological complications of HIV are also prevalent and can have devastating effects on the cognitive function of affected individuals. A recent study in Uganda found the rate of HIV dementia and peripheral neuropathy at 31% and 47%, respectively (Nakasujja, Musisi, Robertson, Wong, Sacktor & Ronald, 2005). However, most attention has focused upon the identification and treatment of neuro-pathologic opportunistic infections and tumours, rather than upon HIV dementia. Bhigjee (2005) comments that until antiretroviral therapy (ART) is widely accessible, all HIV-related neurological complications will persist.

Studies in Western countries have noted that poor mental health also increases people’s HIV-risk through altered...
decision-making and vulnerability, especially around their sexual behaviour (Smith, 2001). In an African context, Bolton & Wilk (2004, p. 127) hypothesised whether persons affected by a ‘loss of hope, worry, pity and other symptoms consistent with depression’ would be less likely to care about their health, including whether or not they contract HIV. They too ventured to ask whether people experiencing severe psychological distress may be resistant to the current HIV control programmes that are predicated upon knowledge and resources using a ‘rational-cognitive’ model (Bolton & Wilk, 2004). Such a relationship has been subsequently explored by Smit, Myer, Middelkoop, Seedat, Wood, Bekker & Stein (2006) who found that the presence of mental illness was associated with forced and transactional sex. It therefore seems plausible that in sub-Saharan Africa, mental health problems not only result from HIV, but may in turn also increase young people’s risk of acquiring HIV. Indeed, given the burden of HIV in sub-Saharan Africa, the implications of such a relationship for HIV prevention, mental health promotion and care provision are very significant.

Little empirical work in Africa has centred on the ways in which young people understand, experience and respond to mental health problems within the community or how this might influence their HIV risk-taking behaviour. While it is clear that the mental health of young people is affected by personal, familial, environmental and structural influences (Richter, 2003), formal mental health and psychiatric care provision in sub-Saharan Africa typically forms part of a centralised system of referrals to scarce psychiatric institutions. Usually, the community is allocated only a limited role in mental health surveillance and care (WHO, 2001). This is in contrast to the sustained and more readily accessible traditional family and community structures that support and manage people with mental health problems through cultural and religious practices (Wilkinson, Mbulumu, Masache & Robins, 1991). Through this lens young people’s perspectives of mental health and mental health problems are shaped and experienced.

Two key principles were intrinsic to the research approach. To start with, we acknowledge an acceptance of Helman’s (2007) ‘combined approach’ to mental health and illness — in that while globally there are broadly common experiences of mental health problems, how each are understood and experienced is different within each specific cultural context. This understanding seeks to avoid the dominance of one particular ‘psychiatric’ discourse (Gilbert, 1999) and is most conducive to a method of enquiry whereby the lived-experience and perceptions of participants are central.

In this way, the study is firmly based within a phenomenological paradigm (Cohen, Kahn & Steeves, 2000), in particular following the interpretation of Cealli (2000) and particularly appropriate for non-Western cultures. The use of scenario-based or vignette-led discussions enabled participants to define the situations in their own terms, clarify their judgements, and in addition provided a less intrusive and less threatening way of exploring this sensitive topic (Wilkinson, 1998).

The second principle adhered to was that of development theory emerging from the notion of participatory rural appraisal (Cornwall, 1996). This includes recognition that communities themselves possess the knowledge and expertise most likely to determine and sustain the best ‘solutions’ to difficulties (see Maalim, 2006). A clearer understanding of how young people view and experience the complex issue of mental health and mental health problems can help to inform what Lwanda (2005, p. 324) has termed “a culturally engaged pragmatic framework for action [for HIV prevention].”

In light of the above, the research addresses the following questions: i) To what extent are young people in Malawi aware of the interaction between HIV infection and mental health? ii) What are the issues perceived by these young people as impacting on the interaction between mental health and HIV? iii) What interventions do these young people suggest to improve or mitigate the impact of mental health problems?

**Methods**

Three life-like and open-ended scenarios (Box 1) were developed, initially from clinical experience and literature on HIV care, and subsequently refined to the local context by a group of Malawian youth workers familiar with the language, mores, life experiences and sensitivities of the young people in the sample. These provisional scenarios were translated independently into Chichewa by at least two youth workers. The draft scenarios were tested in discussions with two pilot groups in order to practice the techniques with the facilitating youth workers, but also to analyse the resulting discourse for three indicators of a mental state (i.e. behaviour, feeling and thoughts). After discussing the scenarios, groups were asked to reflect on their familiarity with the scenario contexts, the clarity of the scenario descriptions, and the influence of gender of the main actors in the scenarios. Only a few modifications to the scenario texts were needed.

The improved scenarios formed the basis for in-depth discussions in six groups of secondary school students and six existing community groups. The latter included groups of orphans and vulnerable children (OVCs), teenage mothers, and groups of out-of-school youths, both in rural and urban settings in southern Malawi. Each group consisted of 6 to 9 participants, usually of mixed sex, and aged between 14 and 20 years. The scenario-based discussions were facilitated by youth workers, with whom the groups normally interacted, thus reducing the impact of the researchers on the data collected. The scenarios described instances with symptoms of depression, anxiety and (HIV-related) brain impairment, respectively, but did not mention these terms explicitly. In this way, responses outside the mental health and HIV discourse could be equally appropriate. The settings of these scenarios were different for the school and community groups in order to reflect an appropriate reality. During the discussions, participants were asked to describe what happens in the scenario, imagine what could have led to this situation, predict what will happen in the near future if no support is offered, and suggest ways of contributing to an improvement of the situation. The
issues were clustered into themes, denoting the perceived qualifying statements (see Lincoln & Gubba, 1985). Similar identified and the data were scrutinised for contradicting or were established. Recurring issues across scenarios were the mental distress that was portrayed in each scenario researchers independently identified the issues relating to health and HIV/AIDS as perceived by the group members.

The data analysis used grounded theory methods (Strauss & Corbin, 1990) to identify issues related to mental health and HIV/AIDS as perceived by the group members. Based on repeated reading of the transcripts, two researchers independently identified the issues relating to mental health or HIV for each scenario. Frequencies of reference to HIV and the apparent level of understanding of the mental distress that was portrayed in each scenario were established. Recurring issues across scenarios were identified and the data were scrutinised for contradicting or qualifying statements (see Lincoln & Gubba, 1985). Similar issues were clustered into themes, denoting the perceived causes of the mental distress, the potential consequences and the suggested interventions. A conceptual model was constructed based on these themes. The reliability of the analysis was high, with agreement on the issues identified between the two researchers at 95%.

Three strategies were used to increase the validity of the analysis. First, the transcripts formed the basis of a workshop with the Malawian youth workers who led the discussions. In pairs, and without seeing the researchers’ analysis, they identified issues relating to mental health and HIV in all transcripts. No new issues arose, although several statements were placed in the local context. Second, the steps from issues to themes and from themes to the conceptual model were confirmed as contextually valid. The third validation method concerned the key phrases used by the respondents. Several English phrases recurred in the transcripts, such as ‘thinking too much’ or ‘discrimination.’

Findings

To what extent are young people in Malawi aware of the interaction between HIV and mental health?

Although no mention was made of HIV in the scenarios, for those describing depression and anxiety, respondents in all groups readily and consistently linked the concerns of the characters in the scenarios to HIV/AIDS (the verbatim quotations include an identifier for the scenario being discussed [see Box 1], followed by the specific group).

This quote denotes recognition of a depression scenario: ‘Salif thinks his mother has AIDS and that she is going to die. This is making him worried that he will soon be an orphan’ (1A, school group 2). For recognition of an anxiety scenario: ‘Jack is worried that maybe the woman infected him with the HI virus’ (2A, school group 1).

Respondents demonstrated their awareness of a relationship between mental health concerns and HIV, since they associated the behaviours described in the depression scenarios with a low mood or bereavement in response to a mother’s sickness or death due to HIV/AIDS. Similarly, the youth recognised the symptoms in the anxiety scenarios as related to the fear of being infected with HIV, becoming ill, or the likelihood of experiencing the effects of HIV-related stigma. Thus, for these scenarios, all groups identified HIV or AIDS among the likely reasons for a character’s trauma.

In contrast, for the scenarios describing the symptoms of HIV-related brain impairment, just two school groups identified HIV by name as a potential cause of the character’s problem. For instance: ‘But if he went to the hospital, they may find him with AIDS because the symptoms of AIDS are the ones that have been outlined’ (3A, school group 6).

Thus, respondents in 10 of the 12 groups suggested other physical or emotional causes for a character’s difficulties, including physical weakness from infections, memory problems due to stress, cognitive impairment and confusion.

### Box 1: Scenarios presented to the discussion groups in the study

1A Depression scenario for school groups:

Your friend Salif is 14 years old. In the past he has always been bright, healthy and enthusiastic about school. Over the past two months his attendance at school has been poor and you notice that in class Salif has stopped taking part in lessons, seems unable to concentrate and keeps getting into trouble. He no longer meets you after school, but returns home to care for his sick mother and to look after his two younger brothers.

1B Depression scenario for community groups:

Rose is 14 years old. She lives with her two younger brothers. In the past she used to be a happy and intelligent girl with lots of friends. But since she left school last year, to take care of her sick mother, she has changed. Now that her mother died three months ago, Rose spends most of her time alone, sitting at home doing nothing, talking very little. She lacks energy and doesn’t cook for her brothers, and most of the times she does not bother to eat. She does not look after her two young brothers, ignoring them even when they get into trouble with other people including their neighbours.

2A Anxiety scenario for school groups:

A friend, Jack, tells you that he has learnt that a woman that he had a sexual relationship with last year is sick and in hospital. Her newborn child has also recently died. Jack is looking more and more unkempt and complains that he can’t sleep, eat or work properly. He tells you that he is worried his mother will be angry if she learns of this relationship.

2B Anxiety scenario for community groups:

After class one day, your friend Stella is crying. She tells you that, although no one else knows, she is having a sexual relationship with a 30-year-old married man who lives in the same village. Stella has just learnt that the man’s wife is sick that, although no one else knows, she is having a sexual relationship with a 30-year-old married man who lives in the same village. Stella has just learnt that the man’s wife is sick.

3A Brain-impairment scenario for school groups:

A boy of 19 years in your class has started to become fatigued and breathless. His school work is deteriorating and he has stopped submitting work. When you ask him how he is, he complains that he has constant headaches and can’t see to read properly.

3B Brain-impairment scenario for community groups:

Charles is 20 years old and works with his father as a mechanic and driver. Over the past six months, Charles has become gradually weaker. His father has also noticed that he often forgets to make deliveries at work and appears to care for his sick mother and to look after his two younger brothers.

group discussions in Chichewa were tape recorded, translated and transcribed.

Although no mention was made of HIV in the scenarios, for those describing depression and anxiety, respondents in all groups readily and consistently linked the concerns of the characters in the scenarios to HIV/AIDS (the verbatim quotations include an identifier for the scenario being discussed [see Box 1], followed by the specific group).
due to infections, the abuse of drugs and alcohol, and being bewitched. So, in general, the young people associated the symptoms of HIV-related brain impairment with causes other than HIV or AIDS.

**Issues perceived as impacting on the interaction between mental health and HIV**

**Understanding the cause of the situation**

The respondents appeared to have a clear and compelling understanding of the situations presented in the scenarios as being descriptions of ‘mental health’ incidences. For most of these cases the young people identified HIV or AIDS as a potential cause. HIV/AIDS was seen to impact on mental health through three areas of young people’s lives, i.e. the psychological, socio-economic and physical domains.

The psychological impact of HIV on a person’s mental state was expressed usually as ‘worry.’ The data show three reasons for such worry: feelings of fear, the process of grief and coping with loss, and the challenge of dealing with stigma; each is illustrated by a quotation below:

‘Jack is living in fear that he got infected with HIV from the woman. He is also afraid of his mother’s reaction to this’ (2B, community group 8).

‘The death of her mother has brought worries to Rose because for everything that she was doing, she was relying on her mother. Now that the mother is gone, Rose has no one to rely on’ (1B, community group 12).

‘She is also worried of being stigmatised if her friends know that she went out with an HIV-positive man’ (2A, school group 6).

In addition, the data show two socio-economic reasons for ‘worry’ resulting from HIV and thus threatening young people’s mental health. These reasons centre on orphanhood and increased responsibilities, as illustrated below:

‘She is lacking people to encourage her to deal with the orphanhood that she is experiencing, but also to help her with life skills to deal with the challenges that come with it’ (1B, community group 9).

‘She did not expect her mother to eventually die. She is too worried about how she will provide for her brothers’ (1B, community group 11).

While psychological and socio-economic influences were seen as the main determinants of problems for characters in the depression and anxiety scenarios, respondents in most groups suggested that a physical illness was responsible for the character’s altered thoughts and behaviour in the brain-impairment scenarios. For example:

‘His body immunity will be too weak to fight other infections and he will become a sickly person’ (3A, school group 3).

**Interruption and disrupted lives: the prediction of dire consequences**

Respondents suggested that, if not checked, these mental challenges may result in interrupted lives through psychological deterioration (more fear and grief) and social withdrawal. The potential deterioration in young people’s psychological, socio-economic and physical health, as emerges from the data, is summarised in Table 1.

<table>
<thead>
<tr>
<th>Psychological impacts:</th>
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<tr>
<td>Increased worry and grief</td>
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<tr>
<td>Withdrawal from life</td>
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<tr>
<td>Mental illness</td>
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<tr>
<td>Suicidal thoughts</td>
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<th>Socio-economic impacts:</th>
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<tr>
<td>Leave home</td>
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<tr>
<td>Reckless sexual behaviour</td>
</tr>
<tr>
<td>Drugs/alcohol abuse</td>
</tr>
<tr>
<td>Begging, stealing</td>
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<tr>
<td>Commercial or transactional sex</td>
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<td>Early marriage</td>
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<th>Physical impacts:</th>
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<tbody>
<tr>
<td>Wasting syndrome</td>
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<tr>
<td>Illness (including high blood pressure, stroke, stomach ulcers)</td>
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<tr>
<td>Acquiring STIs, including HIV</td>
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<tr>
<td>Death</td>
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Respondents from both the school and community groups described how a young person’s mental health may become so severely affected that their thoughts and ability to cope would be undermined. As the quote below indicates, interrupted lives slide into disrupted lives:

‘Sali will drop out of school and he will go into drug abuse and finally will go mad’ (1A, school group 5).

The intensity of the concerns appeared to be strongly related to ‘thinking too much,’ the process by which people are perceived to become mentally ill, and leading to insanity or even death:

‘...She may get insane if she is thinking too much’ (1B, community group 9).

‘Some worries can make you die if you think too much’ (1B, community group 11).

Respondents in 11 groups suggested that suicide was a likely outcome for the characters in one or more of the three scenarios presented to them. All six characters in the scenarios were identified as being at risk of attempting suicide at some stage. However, the characters seen as most ‘at-risk’ were those who suspected they might be HIV-positive in the two anxiety-related scenarios (10 occasions), followed by the characters experiencing bereavement and loss in the two depression scenarios (6 occasions). The resort to such drastic behaviour was seen as an ‘understandable’ reaction by the character to his or her situation and not as a potential consequence of ‘mental illness’ or insanity:

Respondent: …Or he may just kill himself when he can’t cope with life.

Group facilitator: …Is it a common response for people to kill themselves when they have intense problems? All: Yes!

Group facilitator: What happens?

Respondent: You come to a point where you feel so helpless and the shortcut is to just die and leave the world with its problems’ (3B, community group 9).

While heavily criticised and discouraged by respondents, potential suicide was not seen as an irrational act but as an
attempt by the character in the scenario to put an end to their distress:

‘She may take poison to kill herself and forget the issue once and for all’ (2B, community group 4).

For the female characters in the depression and anxiety scenarios, participants identified the risk that their socio-economic difficulties may lead the character to engage in prostitution, with this entailing other risks. This behaviour was primarily seen as an attempt to overcome poverty and as something distinct from ‘reckless sexual behaviour’:

‘She may think of going into sex work to get money for herself and her brothers’ (1B, community group 9).

One leader of an OVC group described how she had witnessed the relationship between bereavement, the burden of responsibility, prostitution and death:

‘I would say it has happened, because in that particular family, the first that died was the father, then the mother followed. They left a number of girls, but the one who was mostly affected was the eldest girl who shouldered the responsibility of caring for his [sic] siblings. She started engaging in transactional sex to get money for support. She contracted a disease, got sick and died’ (1B, community group 7).

Respondents in 9 of the 12 groups highlighted the possibility that as a psychological reaction to their actual or assumed HIV diagnosis, the characters in the two anxiety scenarios might engage in ‘bad’ behaviours such as ‘reckless sexual behaviour.’ This behaviour was recognised as a deliberate attempt to spread the virus and thus was seen as having major consequences to the physical health of the character and all sexual partners:

‘Jack would become more promiscuous in order to share the virus to more people. The problem is that he may be negative and in the process of spreading, he will get it’ (2B, community group 8).

Although respondents employed negative terminology to describe such ‘bad behaviours’ and ‘bad companies,’ they nevertheless recognised that these were attempts by the characters to cope with very real psychological and socio-economic pressures. Nevertheless, the resultant disruption to characters’ lives was also readily seen as increasing the risk of (re)acquiring HIV infection.

These findings are summarised in a conceptual framework showing the interaction between HIV infection and mental health problems (Figure 1). The model encompasses the elements of psychological and social deterioration, the experience of mental illness, suicide, HIV-risk-behaviour and death, as described by the respondents.

**Interventions suggested to improve or mitigate the impact of mental health problems**

The respondents were asked to suggest ways to halt the deteriorating mental health of the character in each scenario. The interventions they suggested are listed in Table 2 and span psychological, socio-economic, physical and spiritual domains of life.

The intervention most frequently suggested was to give advice and encouragement to maintain one’s normal life, including at school and work, and through friendships:

‘Help her by encouraging her to go back to school, because it holds her future’ (1B, community group 10).
by invoking direct spiritual intervention and by guiding characters towards appropriate or healthy behaviours, was repeatedly suggested:

‘Keep praying for them’ (1B, community group 8).

‘Encourage him to go to church and become a good Christian so that he keeps away from bad behaviours’ (2B, community group 10).

When applied to the conceptual framework (see Figure 1), the suggested community interventions, mainly of a psychological and socio-economic nature, were aimed most prominently at junctures 2 and 3 depicted in Table 2, and indicate awareness that, if offered at an early stage, such interventions may reduce the likelihood of further disruption to a young person’s psychological health and socio-economic wellbeing.

Discussion

The young people in this study clearly identified the immense psychological and emotional toll of HIV or AIDS, consistent with the findings of previous studies, and they went on to describe the potential impact of this upon young people’s subsequent psychological health and socio-economic wellbeing.

Figure 1 models the perceived relationship between HIV infection, mental and social adjustment, deteriorating physical or mental illness, and potential suicide or premature death, and it incorporates the young people’s own descriptors of altered thoughts, feelings and behaviours. Although the term mental health or specific psychiatric diagnoses were not used, the psychological and social impacts of HIV/AIDS upon young people and the influence of poor mental health upon their sexual risk-taking behaviour were emphasised throughout the discussions. Indeed, the model portrays a dynamic such that ‘disrupted’ lives lead to increased HIV-risk-taking-behaviour and lends support to Bolton & Wilk’s (2004) suggestion of the link between low mood and higher-risk sexual behaviour and Smit et al.’s (2006) association between mental health problems and transactional sex.

The alarming frequency with which suicide was cited by the young people as a ‘common’ occurrence in reaction to having a positive HIV status is of particular concern. This suggests not only the need for further research, but also indicates an urgent requirement for suicide risk-reduction awareness to be highlighted within traditional and community networks and for the recognition of suicidal thoughts and planning, plus effective interventions, to be incorporated into all education and health-sector services.

Another significant concern arises from the issue of HIV-risk-behaviour, described by the young people as ‘reckless sexual behaviour.’ The respondents indicated that this behaviour was seen as a deliberate act (or omission) resulting from feelings of anger, alienation and fatalism. Although a number of researchers have attempted to provide a cultural and social context for this form of alteration (Forster, 2001; Lwanda, 2005), respondents in this study clearly recognised such behaviour as part of a deteriorating psychological state. It would therefore follow that increased awareness of this phenomenon and access to appropriate mental health support, particularly from VCT facilities, may reduce the instance of young people resorting to such a coping strategy.

Psychological changes were more easily recognised than the cognitive changes that may result directly from HIV or opportunistic infections. As a result, potential cognitive changes were not included in the model of the interaction between HIV/AIDS and mental health problems (Figure 1). The majority of respondents recognised a physical cause for the problems implied in the brain-impairment scenario; however, this was not collectively attributed to HIV/AIDS. There may be a number of explanations for this result. First, the scenario may have made too oblique reference to HIV-related cognitive impairment and as a result respondents did not recognise the experience. Alternatively, limited

<table>
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<tr>
<th>Personal domain</th>
<th>Supportive intervention</th>
<th>Juncture in model of interaction between HIV and mental health (see Figure 1)</th>
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<tbody>
<tr>
<td>Psychological:</td>
<td>Give HIV/AIDS counselling</td>
<td>√ √ √ √ √ √</td>
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<tr>
<td></td>
<td>Encourage to join youth group</td>
<td>√ √ √ √</td>
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<td></td>
<td>Encourage to join sports group</td>
<td>√ √ √ √</td>
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<td></td>
<td>Invite to join church group</td>
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<td></td>
<td>Befriend/include in social group</td>
<td>√ √ √ √</td>
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<td></td>
<td>Encourage HIV status disclosure to family/relatives</td>
<td>√ √ √ √</td>
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<td></td>
<td>Encourage to talk about worries</td>
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<td></td>
<td>Encourage to abstain from drugs/alcohol</td>
<td>√ √ √ √</td>
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<td></td>
<td>Encourage to abstain from transactional sex</td>
<td>√ √ √ √</td>
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<tr>
<td>Socio-economic:</td>
<td>Advise on orphan care</td>
<td>√ √ √ √</td>
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<tr>
<td></td>
<td>Provide school fees</td>
<td>√ √ √ √</td>
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<tr>
<td></td>
<td>Provide clothes/food/shelter</td>
<td>√ √ √ √</td>
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<tr>
<td></td>
<td>Transport/accompany to hospital</td>
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<td></td>
<td>Share income-generating skills (e.g. gardening)</td>
<td>√ √ √ √</td>
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<tr>
<td>Physical:</td>
<td>Encourage to go to VCT</td>
<td>√ √ √ √</td>
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<td></td>
<td>Encourage to consult health clinic</td>
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<tr>
<td>Spiritual:</td>
<td>Pray for people</td>
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knowledge and awareness may have led respondents to recognise the experience in the scenario but not link it to HIV. Indeed, since HIV-related impairment occurs most prominently in late-stage HIV disease, it would not be surprising for such a diagnosis to be overlooked since it would usually be accompanied by other serious physical conditions. Nevertheless, this perhaps indicates the need for a stronger emphasis within HIV education on the effects of HIV on cognitive functioning, particularly in view of the potential health improvements brought by ARVs.

Despite the severity and extent of the mental health challenge discussed, respondents in this study identified a range of interventions at different junctures within the model where the disruption to young people’s lives might be arrested and reversed. This may be seen as a source of some optimism and an indication of potential for change — not least because of respondents’ level of community awareness and motivation to support their peers. Most frequently suggested were interventions aimed at improving the psychological and socio-economic domains, such as through increased community-based involvement and activity, including the expansion of youth group activities and by offering practical and emotional support. Interventions from the psychological and spiritual domains (see Table 2) illustrate some realistic community-based interventions that would greatly affect young peoples’ lives (early in the model, Figure 1, junctures 1 and 2), including building up mental health support in existing youth groups, sport and church groups, and in so doing, strengthen young people's opportunity and ability to communicate their feelings and thoughts to peers and loved ones. The identification and development of these localised support systems and networks derive genuinely from the strong participatory and collectivist culture of African society (Arihinenbuwa & Collins, 2000). Indeed, the respondents’ focus on giving social support rather than physical support through medication indicates what is most likely to deliver creative and sustainable improvement in mental health. Such improvements in turn need to be informed by locally generated knowledge and awareness concerning the nature and effects of mental health problems.

In addition to suggesting local community action, these young Malawians also offered reminders of the interrelated nature of psychological and socio-economic factors, as they made suggestions about where statutory health, education and welfare and faith-based organisations might intervene with practical or financial support to mitigate or resolve an individual’s problems.

Conclusions

The implications of these findings for organisations are considerable. The perceptions of the close link between HIV and mental health emerging in this study need to be reinforced through public awareness campaigns. Acknowledgement of the two-way links between HIV and mental health should be included in training programmes for community leaders, health professionals and teachers. Mental-health support initiatives in schools, such as anti-bullying policy and anti-discrimination initiatives, need to be re-energised with this in mind. In particular, primary-health-caregivers in the community need training to increase their skills in the early recognition of mental distress, including suicidal thoughts, and, where needed, they should know appropriate referral routes. Extending the expertise and confidence of VCT-centre staff in mental health assessment, including assessment of suicidal risk, mental health promotion and care, is also a significant priority.

This study does emphasise that, in providing such awareness-raising, community-based support and professional education, care must be taken to ensure that the terms and language used reflect that understood within communities. While psychiatric terminology was not used by the young respondents in this study, they nevertheless held strong, meaningful and culturally-based notions of mental health problems and their impact; it is from these understandings that culturally appropriate and accessible mental health services and support need to be developed for young people in mental distress.

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