results brief

How Common are Depressive Symptoms among Caregivers of Vulnerable Children in Malawi, and What Factors are Associated with Their Occurrence?

The emotional well-being of caregivers of vulnerable children may be affected by a variety of stressors inside and outside of the household. The extent to which caregivers' emotional well-being is compromised may have implications for the children they are caring for, placing them in an even more vulnerable position.

Project SOAR explored the prevalence of and factors associated with depressive symptoms among caregivers of vulnerable children in Malawi. This work is part of Project SOAR's monitoring and evaluation of the Malawi "One Community" project which is supported by the United States Agency for International Development and implemented by Johns Hopkins Center for Communication Programs. The project aims to support the Government of Malawi's effort to reduce new HIV infections and to alleviate the impact of HIV among at-risk populations, including vulnerable children and their caregivers.

The data used for this analysis come from a survey conducted from January to March 2017 among caregivers of vulnerable children aged 0–17 years living in five (Blantyre, Chikwawa, Mangochi, Mulanje, Phalombe) of the eight One Community project districts.

This brief describes the caregivers' characteristics and prevalence of depressive symptoms. It also explores relationships between these symptoms, social support, and stressors such as economic and food insecurity, HIV status, HIV-related stigma. It also explores the relationship between depressive symptoms and antiretroviral therapy (ART) adherence among caregivers living with HIV.

KEY FINDINGS

- Depressive symptoms among caregivers of vulnerable children were not associated with economic or food insecurity in the household.
- Being positive for HIV or never having tested for HIV were associated with a greater reporting of depressive symptoms among caregivers.
- Depressive symptoms were associated with anticipated HIV-related stigma among caregivers who reported testing negative for HIV.
- Social support was protective for depressive symptoms and strengthening social networks should be a pillar of programming for caregivers of vulnerable children.
- Depressive symptoms among caregivers living with HIV were associated with reported lower ART adherence.
- Addressing mental health issues should be a part of adherence counseling for HIV-positive caregivers of vulnerable children.

METHODS

Interviews were conducted with 818 caregivers living in 24 health facility catchment areas in five program districts where One Community is being scaled. Households were identified through a census of households in the One Community areas and selected for the study because they satisfied one or more criteria of being vulnerable (see box on next page).

Multivariable regression analyses was conducted to examine associations between the presence of

PEPFAR USAID FROM THE AMERICAN PEOPLE COLLEGE OF MEDICINE POPULATION COUNCIL Ideas. Evidence. Impact. PROJECT SOAR SUPPORTING OPERATIONAL AIDS RESEARCH

caregiver depressive symptoms and 1) economic insecurity, food insecurity, and HIV and other chronic illness within the household; 2) HIV-related stigma and social support, and 3) ART adherence among caregivers living with HIV. All regressions controlled for caregiver education, age, gender, social support, and household wealth.

MEASURES

Caregiver depressive symptoms: We asked five depression screening questions about whether they have experienced any of the following symptoms in the four weeks prior to the interview: 1) taking little interest or pleasure in things typically enjoyed; 2) feeling down, depressed, or hopeless; 3) having trouble falling or staying asleep; 4) sleeping too much or for too long; and 5) feeling irritable. A summative depressive symptom score was created ranging from 0 to 10.

Social support: Indicators of social support included questions on *emotional social support* (having someone to turn to for suggestions with how to deal with a personal problem), *tangible social support* (help with daily chores if the caregiver is sick), and *social companionship support* (has someone who shows love and affection, and has someone who is available to do something enjoyable with). A summative social support score ranging from 0 to 4 was created.

Perceived and anticipated stigma: These were assessed among caregivers who reported being HIV positive or among caregivers who either reported being HIV negative or have not yet been tested, respectively. Scores were created for each type of stigma based on the number of experiences that they perceived to have occurred since diagnosis or anticipated to occur if they tested positive for HIV. Experiences for both anticipated and perceived stigma consisted of 10 options: loss of job/livelihood, friends, or significant other; rejection or neglect by family, coworkers, or community; difficulty finding sexual partners; negative experiences with health providers; and violence from spouse/partner. Scores had a possible range of 0–10.

HOUSEHOLD VULNERABILITY CRITERIA

- Economic insecurity (e.g., inability to pay for unexpected household expense, household head or spouse unable to work due to disability or illness, or no one in the household had consistent work that generated money for the household)
- Food insecurity (e.g., lack of food in the household, a household member were to sleep hungry, a household member went a whole day and night without eating)
- Chronic illness (e.g., Having one or more members in the house living with HIV, sick for at least 3 of previous 12 months, or on long-term medication)

RESULTS

Who are the caregivers of vulnerable children?

- Median age: 38 years
- 24% never attended school and 51% partially completed primary
- 87% female
- Caring for a median of 3 children, including biological and non-biological children
- 37% caregiving without a spouse or live-in partner
- 94% had ever been tested for HIV; 39% in the last 6 months
  - 40% HIV positive

Depressive symptoms

- 87%: At least one depressive symptom sometimes or often
- 62%: Three or more depressive symptoms sometimes or often
- Depressive symptoms score (range 0–10): mean 3.5, SD 2.5

Household stressors

- 61%: Economically insecure
- 32%: Food insecure
- 43%: Member in the household with a chronic illness

Relationships between depressive symptoms and stressors

Depressive symptoms among caregivers were not associated with economic or food insecurity in the household.

Although many households reported experiencing these stressors, they were not associated with more depressive symptoms. This suggests that despite significant resource deprivation, caregivers are emotionally coping and resilient given their circumstance.

Reporting being HIV positive or never having tested were associated with a greater experience of depressive symptoms compared to those testing negative.

There is a significant relationship between testing positive for HIV and depression symptoms in our sample. This finding echoes other studies which have found that individuals living with HIV are more likely to be diagnosed with depression compared to individuals who are HIV negative.[1] Never having been tested for HIV is also associated with depressive symptoms compared to testing negative for HIV. This may be due to underlying characteristics that are unique to the group of caregivers who have never been tested that are not captured in our analysis.

Depressive symptoms were associated with anticipated HIV-related stigma among caregivers who reported testing negative for HIV.

Mental health may suffer due to stigma,[2] and it is not uncommon for people living with HIV to encounter stigma due to their status.[3] The average level of HIV-related stigma among caregivers in this sample—for both perceived and anticipated stigma—was 2.5 on a range of 0–10, with a standard deviation of 2.6. This average suggests relatively low perceived and anticipated stigma in this setting and suggests significant progress in addressing stigma in generalized HIV epidemics.

The results indicate that anticipated stigma by those who are HIV negative is significantly associated with the caregivers' depressive symptom score. A 1-standard deviation (SD) increase in anticipated HIV-related anticipated stigma score is associated with a 0.17-SD higher depressive symptom score among caregivers who tested negative for HIV. We did not find an association between depressive symptoms and perceived HIV-related stigma among caregivers living with HIV.

Social support was protective for depressive symptoms.

Previous studies have shown that social support may moderate the path between stigma and depression and play a protective role.[4] Our analysis finds that social support is protective against depressive symptoms among caregivers; a 1-SD increase of social support score is associated with a 0.12-SD lower depressive symptoms score.

Depressive symptoms among caregivers living with HIV were associated with reported lower ART adherence.

Emotional wellbeing can have implications for ART adherence. ART nonadherence increases the chances of treatment failure, experiencing co-morbidities, developing ART resistance, and continuing to be infectious to others.[5-7] A large body of literature has found a relationship between depressive symptoms and ART nonadherence and has shown this association to be consistent across settings and time.[8,9]

Nearly all (98 percent, n=303) caregivers who knew of their HIV-positive status reported currently using antiretroviral medication. Of those on treatment, 85 percent (n=259) reported never forgetting to take their medication in the past six months. In a multivariable regression of adherence on depressive symptoms, a 1-SD increase in depressive symptoms score was significantly associated with 29 percent lower odds of reported ART adherence. A limitation of our analysis was that ART adherence was self-reported and did not use pill counts or viral load testing to capture adherence.

CONCLUSION AND RECOMMENDATIONS

This study found that depressive symptoms among caregivers of vulnerable children were not associated with economic and food insecurity in the household, suggesting that caregivers were emotionally resilient to these stressors. Not surprisingly we did find a relationship between depression and a positive HIV status. Yet depression was associated with anticipated stigma among HIV-negative caregivers and not perceived stigma among HIV-positive caregivers. There could be many explanations for why this association exists for anticipated stigma. Caregivers reporting high anticipated stigma scores may feel that their community is not tolerant or supportive, which may affect their mental health even if they are not experiencing the stigma firsthand. Caregivers may have even experienced stigma from something other than HIV, affecting their feelings of connectedness and self-worth. It is also important to acknowledge that the relationship between depression and stigma may be bidirectional; individuals who are depressed may anticipate more stigma because they are depressed.

Our analysis highlights the importance of social support as a protective factor for depression. Strengthening social support through, for example, care group models, should be a central pillar of programming for caregivers of vulnerable children.

Finally, we did observe a relationship between depressive symptoms and missed doses of ART among caregivers living with HIV. As the lack of adherence to treatment has cascading health and well-being impacts, it is critical to explore this relationship further. Evidence presented here suggests the importance of addressing mental health issues with caregivers as part of adherence counseling.

REFERENCES

1. Ciesla, JA and JE Roberts. 2001. "Meta-analysis of the relationship between HIV infection and risk for depressive disorders," *The American Journal of Psychiatry*. 158(5): 725–730.
2. Major, B and LT O'Brien. 2005. "The social psychology of stigma," *Annual Review of Psychology*. 56: 393–421.
3. Dos Santos, MML et al. 2014. "An exploratory survey measuring stigma and discrimination experienced by people living with HIV/AIDS in South Africa: the People Living with HIV Stigma Index," *BMC Public Health.* 14: 80. doi: 10.1186/1471-2458-14-80
4. Takada, S et al. 2014. "The dynamic relationship between social support and HIV-related stigma in rural Uganda," *Annals of Behavioral Medicine.* 48(1): 26–37. doi: 10.1007/s12160-013-9576-5
5. Bangsberg, DR et al. 2000. "Adherence to protease inhibitors, HIV-1 viral load, and development of drug resistance in an indigent population," *AIDS.* 14(4): 357–66.
6. Paterson, DL et al. 2000. "Adherence to protease inhibitor therapy and outcomes in patients with HIV infection," *Annals of Internal Medicine.* 133(1): 21–30.
7. Cohen, MS et al. 2011. "Prevention of HIV-1 infection with early antiretroviral therapy," *The New England Journal of Medicine*. 365(6): 493–505. doi: 10.1056/NEJMoa1105243
8. Uthman, OA. et al. 2014. "Depression and adherence to antiretroviral therapy in low-, middle- and high-income countries: a systematic review and meta-analysis," *Current HIV/AIDS Reports.* 11(3): 291–307. doi: 10.1007/s11904-014-0220-1
9. Gonzalez, JS. et al. 2011. "Depression and HIV/AIDS treatment nonadherence: A Review and meta-analysis," *Journal of Acquired Immune Deficiency Syndromes.* 58(2): 181–187. doi: 10.1097/QAI.0b013e31822d490a

Suggested citation: Project SOAR. 2018. "How common are depressive symptoms among caregivers of vulnerable children in Malawi, and what factors are associated with their occurrence?," *Project SOAR Results Brief*. Washington, DC: Population Council.

Project SOAR is a five-year (September 2014–September 2019) cooperative agreement funded by the President's Emergency Plan for AIDS Relief and the U. S. Agency for International Development (Agreement No. AID-OAA-A-14-00060). The contents of this brief are the sole responsibility of Project SOAR and Population Council and do not necessarily reflect the views of PEPFAR, USAID, or the United States Government.

Population Council leads the Project SOAR consortium in collaboration with Avenir Health, Elizabeth Glaser Pediatric AIDS Foundation, the Johns Hopkins University, Palladium, and The University of North Carolina at Chapel Hill.

Project SOAR/Population Council
4301 Connecticut Avenue, NW, Suite 280
Washington, DC 20008
Tel: +1 202 237 9400
e-mail: ProjectSOAR@popcouncil.org
projsoar.org