

Promoting comprehensive primary health care mental health interventions for young people: A Malawi case study



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Executive summary

This study in Malawi aimed to assess the experiences of 15–24-year-old youth with regard to mental health problems, to evaluate the management of mental health issues and the responses to the issues they face, as well as to recommend interventions to address young people's mental health challenges. The study was implemented under the umbrella of the Regional Network for Equity in Health in East and Southern Africa, in its work to understand equitable health system responses to key health challenges in the region.

The study employed a mixed methods approach. It used qualitative methods such as key informant interviews, focus group discussions, document review, and quantitative methods to obtain and analyse survey data to understand the distribution and determinants of youth mental health challenges. A case study approach was utilised to gain a deeper understanding of the multiple lenses, services and issues involved.

A total of 577 respondents participated in this study. Of these, 304 (53%) were females and 273 (47%) were males. A total of 333 (58%) were within the age-range of 18–19, while 244 (42%) were aged between 20–24. There were no marked differences in the proportions of young people based on their families' assessed wealth index.

As key findings, the prevalence of smoking of both cannabis and tobacco was 6% and was higher in boys than girls, as was the prevalence of harmful alcohol use at 7%. The prevalence of harmful drug use was 4% and again was higher in boys than girls. Depression, heart disease and cancer were low and at similar levels in both boys and girls. These findings have some practical implications in Malawi and other similar settings.

The 7% prevalence of depression identified in the study seems low compared to the 11–14% in youth in several other studies in Africa. It is anticipated that the prevalence of mental and emotional health symptoms will rise among young people given Malawi's levels of poverty, unemployment and inadequate health systems, as well as the lack of accessible, effective interventions for mental health. The impact of poverty and psychosocial risks in youth mental health, emphasizes the need for interventions to address these social determinants.

Challenges identified relating to access to mental health services indicate the need for improved availability and accessibility of mental health services for young people faced with mental health problems. The COVID-19 pandemic impacted youth by increased losses in education, income, employment and food security, as well as increased gender-based violence and sexual abuse.

Respondents emphasized the need for accessible mental health services. According to the study, the only places where young people can get mental health care are schools, Bwaila Hospital, Kamuzu Central Hospital, St John of God hospital, allegedly only accessible by the affluent, and religious clubs.

Given the fact that Malawi has a very high proportion of youth – 46% are under the age of 15, with a further quarter of the population being under 30, youth mental health is an important and urgent issue. The findings make a case for community-based rehabilitation programmes to help young people who are engaged in harmful drug or alcohol use and at risk of high levels of these practices.

Having a guidance and counselling room in schools was praised by students as the best approach in providing mental health services for school students. The guidance and counselling room were felt to help to be useful in relieving stress among students, as it allows them to seek help, advice and counselling as it provides a safe space for students to talk about their problems. Sharing concerns with a trusted adult to confide in helped students to concentrate in class and improved academic performance.

Based on the findings, recommendations are made on areas of primary health care, community, multisectoral, and youth interventions to better support mental health promotion, mental illness prevention, detection, counselling, care and wider responses for young people in Malawi. Although the sample size was small, these may also be relevant across other countries in sub-Saharan Africa.

Community leaders, educational institutions and religious organisations are identified as key in raising awareness and implementing preventive measures in youth mental health. These institutions can advocate for resources, coordinate programmes, and integrate mental health education into curricula, as well identify early signs of mental health issues and ways to address them by providing support services, counselling, and community networks to break down barriers to seeking help. Collaboration among community leaders, educational institutions and religious organisations is crucial for addressing mental health issues at primary health care level.

The study recommends the use of psychoeducation to inform young people about mental health issues and services and issues to reduce stigma and barriers to seeking help. Social support was also identified as an important factor in creating strong relationships such as peer-to-peer support, with family, education, and community networks being important for young people to feel supported. Online resources are another resource recommended that can support young people in dealing with mental health issues, as they provide easy access to certain information and interventions.

1. Background

This pilot study into youth mental health and health services in Malawi aimed to assess the experiences of 15–24-year-old youths with regard to mental health problems and the responses to the issues they face, to evaluate the management of mental health issues, and to recommend interventions to address young people’s mental health challenges. It was implemented under the umbrella of the Regional Network for Equity in Health in East and Southern Africa, in its work to understand equitable health system responses to key health challenges in the region. There is growing evidence of the scale and increasing frequency of substance use among youths in Africa (Olawole-Isaac *et al.*, 2018; Allen *et al.*, 2014; Thern *et al.*, 2017; Jörns-Presentati *et al.*, 2021) and of mental disorders and other mental health symptoms. Recently, suicide among young people has also become a significant source of concern (Quarshie *et al.*, 2020; Thornton, *et al.*, 2019). These already-existing issues for young people are reported to have been aggravated on a national, regional, and international level by COVID-19 (Bauer *et al.*, 2021; Rousseau and Miconi, 2020).

In sub-Saharan Africa (SSA), there is widespread lack of information on how to manage mental health issues, especially in young people (Kutcher *et al.*, 2019), coinciding with epidemic growth in harmful drug use of well-known substances like alcohol and cannabis, and from legally available codeine cough medications. Substance use may be both a symptom and a cause of mental health challenges among the youth. According to a recent systematic review, teenagers in SSA have an overall frequency of 41.6% for ‘any substance use’ (Olawole-Isaac *et al.*, 2018). The dearth of documented information and knowledge on the management of mental health problems has contributed to marginalisation of those affected, while criminalizing the associated behaviours such as substance use further marginalising an already marginalised group (Jumbe *et al.*, 2022).

Malawi, a low-income nation in southern Africa, faces numerous development obstacles (OECD, 2018); the majority of Malawians subsist on agriculture and extremely small-scale businesses. Eighty-six per cent of Malawi’s population live in rural areas where there are few health facilities, with most being concentrated in the cities, resulting in significant inequalities in access to health care. Similarly, the majority of Malawi’s youth (82%) reside in rural areas where they face a variety of disadvantages including low-paying occupations, early marriages and limited access to health care (OECD, 2018).

External funding accounts for 80% of Malawi’s total public sector health expenditure at primary care level. This overdependence on external funding has led to a focus on vertical health programmes concentrating on specific disease conditions that do not align with national health goals, especially in the rural areas, and which have resulted in the neglect of primary health care (PHC) systems and preventive health services (UNICEF, 2018). Yet with more than 46% of the population under 15 years of age and youth aged 15 to 29 years making up a further quarter of the population, the issues facing young people today need particular attention (OECD, 2018).

Depression among the youth is widespread, with a prevalence up to 20% among teenagers (Kim *et al.*, 2014; Msefula and Umar, 2024; Kip *et al.*, 2022), and 30%, in young adults (Udedi, 2014). Studies already conducted in Malawi show a rise in harmful substance use and early initiation of alcohol abuse among teenagers (Hoel *et al.*, 2014; Limaye *et al.*, 2014). Understanding these conditions in Malawi, as in other countries, is complicated by varying cultural conceptions and terminologies used in referring to mental health (Ng’oma *et al.*, 2019; Prajapati and Liebling, 2022; Colucci *et al.*, 2015; Jumbe, 2021). Awareness of mental health and mental illness is very limited among Malawians and people with mental health disorders are stigmatised, mistreated and discriminated against, as many people believe that these are caused by substance addiction or spirit possession (Crabb *et al.*, 2012; Kavalo, 2014). Ignorance of available options and inadequate

access to care, combined with negative attitudes are all exacerbated by the chronic dearth of mental health services and healthcare professionals (Kutcher et al., 2019; Udedi, 2016), as well as limited understanding of and education about mental health.

There is a glaring paucity of published research examining the use of community mental health services in low-income SSA, including in Malawi (Kopinak, 2015; Kutcher et al., 2019; Chibanda et al., 2020). Additionally, because mental health services have not yet been fully incorporated into the primary health care system, it is difficult to access mental health services at local clinics and often, there are no appropriate therapies available in Malawi or in the region at large (Kigozi et al., 2010).

Over the years, task shifting and the integration of counselling skills into the training of primary care cadres has been used as a remedy to satisfy the need, because there are not enough skilled mental health staff to go around (Jacobs et al., 2021; Agyapong et al., 2016). Nursing staff, social workers, community health workers and lay persons perform key roles in PHC but have little or no training in dealing with mental health issues; these task shifting experiments have produced mixed results. Research shows that while non-specialist medical personnel may help with issues of alcoholism, post-traumatic stress disorder, dementia, post-natal depression and general depression and anxiety (Van Ginneken *et al.*, 2013; Patel, 2008), other studies concluded that more proof of the efficacy of the management of mental health care by these personnel is required (Kigozi *et al.*, 2010).

Similarly, there is limited research on social relationships and health in young people in SSA, particularly in Malawi. Most with most of it concentrating on young people 'affected by HIV' and engaging in risky behaviours (Ruiz-Casares, 2010; Sikstrom, 2014; Skovdal et al., 2009). Peer networks and social engagement, however, are clearly important for mental health and a prior EQUINET paper noted that young people are seeking support outside the health services sector, through socially provided counselling services, such as: the 'Friendship Bench,' pioneered in Zimbabwe, psycho-education, cognitive behavioural therapy, as well as various forms of art therapy, meditation and online virtual counselling resources that deal with wellbeing and the drivers of stress (Muhia and Nanji, 2021). Still, there is little information available about these mechanisms and youth peer networks in Malawi. However, a study carried out there in 2016 (Rock *et al.*, 2016), discovered that girls reported less social participation and more isolation than boys and that in-school youth had larger, more engaging and supportive networks than out-of-school youth. It also noted that in dealing with the stress and melancholy brought on by poverty, youth traded social support and influence, along with practices promoting protective sexual health practices, in their networks (Rock *et al.*, 2016). However, it was also noted that poverty prevented youth from participating fully in school and religious institutions and community groups, by denying them the necessary resources and, indirectly, by limiting their time and emotional resources and instilling shame and stigma (Rock et al., 2016).

There are significant gaps in terms of mental health interventions developed to fit the needs of youth. A recent review looked at interventions for adolescents living with HIV and mental illness but did not focus on youth in general (Bhana *et al.*, 2020). There are also few recent reviews in the post-COVID-19 pandemic period on the factors affecting young people's mental health in Malawi (Mmanga et al., 2023). EQUINET Information Sheet 8 on COVID-19 explored the experience of the pandemic from a youth lens, noting that young people have been deeply affected by the pandemic's social and economic impacts, with losses in education, income, employment and food security and increased gender violence and sexual abuse. A concurrent rise in stress and anxiety has intensified social and gender inequalities. Service closures and social isolation have deepened pre-pandemic barriers young people face in accessing the services they need.

However, the pandemic also highlighted the roles of youths in creative and solidarity-driven initiatives to provide information, prevention, care and social protection to marginalised and vulnerable groups. It also emphasised the need to include young people in co-deciding, co-creating and co-leading responses that confront inequities (TARSC, EQUINET, 2022). However, there is limited evidence on how the pandemic affected youth mental health in the region and specifically in Malawi.

These conditions are documented in other countries to affect a significant section of the population in terms of both risk factors and mental health outcomes, with implications for equity-oriented interventions, but have not been systematically assessed in Malawi (OECD, 2018). Youth unemployment is known to be both a risk factor and an outcome for mental health issues, as well as being associated with harmful substance use, but other risk factors are not yet well explored (Mafuta, 2015). There are also few services available in Malawi to detect, prevent, counsel or otherwise respond to mental health problems and, as a result, many mental health challenges and their underlying causes go unmanaged (Udedi, 2016; Mafuta, 2015).

1.1 Objectives

The main objective of this study was to use an equity lens to assess the reported and documented experiences of Malawian youth (aged 15–24) with regard to mental health problems, the way in which they have been managed and responded to, the services available to deal with the many reported mental health problems, and to recommend PHC-oriented and other interventions to manage young people’s mental health issues. The study was implemented under the umbrella of the Regional Network for Equity in Health in East and southern Africa (EQUINET), in its work to understand equitable health system responses to key health challenges in the region.

Focusing on young people aged 15–24 years in Malawi, the specific objectives of the study were:

- a. To obtain information on the distribution and determinants of mental health challenges for youth aged 15–24 from literature and from key informant interviews (KIIs) and focus group discussions (FGDs) with youth aged 18–24 years. For ethical reasons, it was not possible to interview youths aged 15–18).
- b. To map and assess existing sources of support among community, peers and various services in selected urban and rural areas, and interventions available to counsel, manage and address mental health issues in people aged 15 to 24 in Malawi.
- c. To determine the alignment of, and any gaps in, current mental health responses and interventions noted in (b.) above, with the mental health needs of people aged 15 to 24 identified in (a.), and to note any equity issues arising.
- d. To use the findings to recommend areas of PHC, community, multisectoral and youth interventions for prevention of mental health challenges and to better support detection, counselling, care and wider responses for people aged 15 to 24.

The study was multisectoral and covered primary health care. It focused not only on biomedical treatment options, but on the inclusion of other sectors and support services that can help youth deal with their mental health issues and that link, or could link, with PHC, as well as with the intersectoral and whole-society action for mental health equity. Other forms of support would include psycho-education which helps inform youth on mental health services and issues, such as social and peer-to-peer support, which have helped create strong relationships for youth, as well as the importance of family, education and community networks in making youth feel supported. Online resources have also been shown to help the mental health of youths and for certain information and interventions, provide ease of access (Muhia and Nanji, 2021).

A case study approach was used, which provided an opportunity to explore this in a manner enabling a deeper understanding of the multiple lenses, services and issues involved.

2. Methods

Study design

This was a cross-sectional study employing a mixed methods approach using both qualitative and quantitative approaches to elicit data and to understand the mental health issues affecting young people aged 15 to 24 years, and enable triangulation. Qualitative interviews were used along with participant observation as a triangulation strategy and to add depth and mitigate interviewer bias. Quantitative methods were employed to determine the burden of mental health issues among the young people in the study setting (See *Table 1*).

Table 1: Methods to meet objectives

Objective	Methods
<p>A. To obtain information on the distribution and determinants of youth mental health challenges for youths aged 15–24 years old from literature and from youth aged 18–24 years old (as opposed to those aged 15–18, for ethical reasons) from KIIs/FGDs.</p>	<ul style="list-style-type: none"> • Document review from NGO, media, scientific and government reports and papers on mental health challenges, risk factors for youth aged 15–24 in Malawi. • Conducting FGDs and interviews to understand the perceptions and experiences of diverse youth aged 18–24 years on their mental health challenges and the causes, and of the responses to existing mental health services among those who have used them.
<p>B. To map and assess existing sources of support in the community, peers and diverse services and interventions to counsel, manage and address mental health problems among people aged 15–24 years in Malawi in selected urban and rural areas.</p>	<ul style="list-style-type: none"> • Document review from NGO, media, scientific and government reports and papers on responses to and support or services for mental health challenges in Malawi for youth aged 15–24. • Conducting FGDs and interviews (see above) to understand youths’ perceptions and experiences of responses to their mental health challenges, from community, peers, organisations and services, including mental health services. • Mapping existing services and other providers of support, and responses to youth mental health in urban and rural areas in Lilongwe district, which covers urban, peri-urban/semi-rural areas. Malawi’s urban townships are primarily agrarian and located at the edge of rural-urban borders (Choi et al., 2016); rural Malawi is extremely varied and includes both peri-urban areas and vast sparsely populated regions with limited infrastructure and road access (Varela et al., 2019; McBride and Moucheraud, 2022).
<p>C. To determine the alignment of and gaps in current mental health responses and interventions from (B.) with the mental health needs (from (A.)) of people aged 15–24 and note any equity issues arising.</p>	<ul style="list-style-type: none"> • Identifying from the above, the distribution of gaps and opportunities in relation to the range of mental health support and services needed. • Interviewing stakeholders (youth and other relevant non-state organisations, professionals, community leaders and PHC and other service providers) to understand the barriers and facilitators to providing the needed support and services for identified mental health needs, as well as any equity issues to address recognitional, distributional, participatory and structural equity. Recognitional equity is a formal recognition of the rights and conditions of social groups; distributional equity refers to the burdens, benefits and mental health outcomes within distribution. Participatory equity involves how influence, power and participation are part of decisions; while structural equity is linked to laws, norms and policies (Loewenson et al., 2023).

Objective	Methods
D. To use the findings to recommend areas of PHC, community, multisectoral and youth interventions for better support of mental health prevention, detection, counselling, care and wider responses, for people aged 15–24 in Malawi.	<ul style="list-style-type: none"> Thematic content analysis of findings using all the above for structured recommendations to fill gaps and address any challenges and equity issues identified.

We had planned to use community engagement workshops to obtain in-depth information on stigma and mental health literacy, and to agree on mental health language and terminology, to avoid misinterpretation/ misunderstanding and misrepresentation. This did not take place for the following reasons:

- 1) There was an unforeseen currency devaluation of 44% in Malawi, which resulted in skyrocketing prices for commodities and goods. This warranted reconfiguration of the budget to cater for price increases, leading to this activity being skipped and funds realigned among the remaining activities, such as vehicle hire and fuel, whose allocations were hugely increased.
- 2) During gatekeeper briefing meetings, the gate keepers in the surrounding areas of the targeted schools expected allowances for their participation, which proved impossible to provide.
- 3) School management allocated very specific and strict times for interviews and refused to release students beyond those times. Since the workshops required longer than the allocated time, it was not possible to conduct the community engagement workshops, which were planned to include both in- and out-of-school young people.

We recognise that terms such as depression, anxiety, harmful use of drugs used in this study might have had a different meaning for the young people involved in this study given socio-cultural perceptions of mental health and different language used to express mental health experiences in Malawi (Kavalo, 2014; Jumbe et al., 2022; Ng’oma et al., 2019; Prajapati and Liebling, 2022). Hence we initiated interactions with efforts to reach a common understanding of any terms used during this study.

Methods for the desk review

The desk review was guided by the methodological framework proposed by Arksey and O’Malley (Arksey and O’Malley, 2005) and further advanced by (Levac et al., 2010), which recommends six stages to be followed in conducting reviews. These include: (i) identifying the research question, (ii) identification of the relevant studies, (iii) selecting the studies, (iv) charting the data, (v) collating, summarizing and reporting the results, and (vi) consultation.

The results have been reported based on identification of relevant studies to capture the full range of mental health interventions targeting young people in eastern and southern Africa. All peer-reviewed and non-journal articles (grey literature) were included. Inclusion of studies and documents depended on their having a component on mental health interventions targeting young people in ESA must have been reported. There were no limits on the dates of publication, but only articles in English were targeted during the search.

The following electronic databases were searched: PubMed, African Index Medicus, PsycINFO, Web of Science and CINAHL. Additionally, we searched the following grey literature databases: Think Tank Search and Open Grey. For this review, the electronic literature search followed the three-step search strategy recommended by the Joanna Briggs Institute (Peters et al., 2020). The first of which was a preliminary search in common online databases – Google Scholar and Google Search engines. The search terms ‘mental health’, ‘mental disorders’, ‘intervention’, ‘tailored interventions’, ‘youth’, ‘East and southern Africa’ and ‘Malawi’ were used in PubMed. The keywords

used in the titles and abstracts of the identified articles were analysed. In the second step, relevant keywords in the titles and abstracts of the identified papers were reviewed to compile a list of terms to guide in undertaking a detailed literature search in all the databases; these included Medical Subject Headings (MeSH) and keywords related to 'mental health', 'mental disorders', 'intervention', 'tailored interventions' and 'youth'. Based on preliminary searches, we combined the seven search terms ('mental health', 'mental disorders', 'intervention', 'tailored interventions', 'youth', 'East and Southern Africa', 'Malawi') with the 'AND' Boolean operator. Respective synonyms for these search terms were combined using the 'OR' Boolean operator.

The refined final search strategy was developed in consultation with NN, JM and an experienced librarian and applied to fit the specifications of each database. Lastly, the reference lists of the selected reports and articles were further explored to identify any additional studies meeting the eligibility criteria. The review's full inclusion criteria were as follows:

- a. Study population: studies were included if the reported age range, and/or mean, and/or median age was between 15 and 24 years.
- b. Outcome measures: studies were included if they reported on an intervention that targeted any mental health problem among youths, such as externalising problems (hyperactivity, attention, aggression and behaviour problems), internalising problems (anxiety, depression, somatisation and withdrawal) and psychological and social wellbeing problems (hopelessness, self-esteem, self-concept, feelings of isolation, lack of social support and resilience).
- c. Geographic location: conducted in East and southern Africa.
- d. Study design: any type of original empirical intervention research such as qualitative studies, quantitative studies, including randomised controlled trials, quasi-experimental designs, pre-post evaluations, open trials and post evaluations, intervention mapping techniques and mixed-method studies.

Exclusion criteria included:

Study types: secondary literature (scoping reviews, literature reviews, systematic reviews and meta-analysis), letters to the editor, protocols and case series.

Outcome measures: studies having interventions that did not target any mental health outcome.

The field work

This study was implemented through an EQUINET consortium involving partners from the following countries, namely Malawi (REACH Trust), South Africa, Kenya (IWG). The Malawi case study will be used as a pilot to inform further case studies in each of the other EQUINET focus countries in ESA. We worked with a diverse team of experts including a: social worker, biostatistician, clinical psychologist, public health specialist and community advocates and health economists, to document the cost effectiveness of the project. Interviews were implemented in the Lilongwe district, the administrative capital of Malawi. A mapping of institutions implementing youth-related mental health programmes was also developed during this study.

To identify the target participants for the study we relied on the Malawi Ministry of Health's structures to collect data from the areas surrounding the schools. The schools selected were those whose students include young people from across the country, making it possible to draw inferences to other districts.

For participants in and around the selected schools and colleges we relied on the heads of institutions to help us identify them; this made them easier to find, reducing the time needed for the study. Nonetheless, the study took an additional five days, to accommodate the timelines and numbers of students allowed to participate, requiring repeated visits to schools.

Around each school young people out of school matched by age and gender were sampled to include data collection from out-of-school youth *Table 2* provides a list of schools and their surroundings that participated in the assessment.

Kamuzu University for Health Sciences (KUHeS) did not respond to our request to collect data despite efforts including going in person, email and phone follow ups. As a result, its surrounding areas were dropped. The management of the Malawi College of Health Sciences (MCHS) had accepted our request to collect data, but unfortunately, on the day data collection was to commence, students were on strike and data collection could not proceed. A follow-up a week later was unsuccessful as the students were writing their examinations and it was only possible to conduct a KII. Similarly, in the two campuses of Lilongwe University of Agriculture and Natural Resources (LUANAR) we could not find agreed times for data collection and only managed a KII at the city campus.

Table 2: Study sites

Name of school	Name of surrounding semi urban and nearly rural areas
Bwaila Secondary School	Area 47, Area 49
Likuni Boys Secondary School	Likuni, Chinsapo 1, Chinsapo 2
Lilongwe Girls Secondary School	Mchesi, Biwi,
Dzenza Secondary School	Area 25, Senti
Lilongwe University of Agriculture and Natural Resources-Main Campus	Mitundu, Bunda
Lilongwe University of Agriculture and Natural Resources-City Campus	Area 36
Malawi College of Health Sciences	

To obtain information on the prevalence of mental health issues we collected data on young people in- and out-of-school, and the sample size was calculated using the WHO prevalence of mental health conditions (WHO, 2021). Ten clusters/schools were targeted for the study. For each cluster, we sampled 57 young persons in- and out-of-school, totalling 570 young people for all 10 clusters; 577 young people were interviewed to allow for a 10% non-response rate in the sample. A design effect of 2.0 (the ratio of the variance of a statistic with a complex sample design to the variance of that statistic with a simple random sample, or an unrestricted sample of the same size) was used, to cater for the effect of clustering the prevalence of mental health by the selected schools/colleges. The formula used to calculate the total sample size for each of the clusters in this study was $n=1.1 \times 2.0 \times [z^2(1-p) p]/e^2$, where, n = the total sample size (the number of households to be interviewed), z = the z value yielding the desired degree of confidence, p = an estimate of population proportion, and e is the absolute size of the error in estimating p. In this case, 1.1= 10% adjustment for non-response, 2.0= design effect, Z=1.96, p=0.13 and e was approximately 0.05.

Defining an a priori sample size was beyond the scope of the qualitative study; qualitative inquiry assumed that information would be collected until redundancy and saturation [the accepted technique used in qualitative research to determine sample size (Patton, 1990)] were reached, i.e. when no new information (categories and themes) emerged from the interviews (in-depth interviews [IDIs] and FGDs and the research team were confident that they understood the issues being expressed.

Respondents were purposively selected using maximum variation purposive sampling, where respondents interviewed were sampled to provide a range of perspectives. This technique ensured inclusion of both male and female participants. The number of interviews carried out depended on the depth and breadth of emerging issues.

For qualitative data, we conducted KIIs with seven heads of schools/colleges and the district medical officer. In-depth interviews were held with twenty young people, to obtain their lived experiences and their associated mental health issues. In addition, five FGDs were held with young persons aged 18–24 in two secondary schools, one tertiary institution and two surrounding areas. Focus group discussions involved bringing together a small group of eight to twelve participants to discuss an

issue related to the research topic. Two researchers conducted each focus group, with one moderating the discussion to ensure it remained focused and that all participants actively contributed, while the other researcher took notes.

Data collection and analysis

Some international tools were adapted to capture mental health issues (PAHO, 2021). We also translated and back-translated the data collection tools into the Chichewa language to cater for those young people who were unable to understand English. For the quantitative data collection tools, we reviewed the programmed tools in Open Data Kit (ODK) – an open-source mobile data collection platform – with data being transmitted to the Kobo Toolbox platform – a free platform for field data collection in challenging environments. The developed databases were loaded on tablets and data collection was done using the ODK Collect Android application. Voice recorders were used to capture qualitative interviews, all of which were transcribed into Microsoft Word; we also confirmed that the ODK Computer-Assisted Personal Interviews (CAPI) was programmed to extract global positioning satellite (GPS) coordinates.

Data validation and completeness

We used the data codes specified in the survey questionnaires to validate the collected data. We checked for example that interviews were not done with anyone less than 15 or above 24 years. The ODK CAPI was able to show both complete and incomplete questionnaires, and for all incomplete questionnaires, supervisors made call-backs or revisits as soon as possible. A batch editing programme was also developed in Stata, a general-purpose statistical software package for data manipulation, visualization, statistics and automated reporting. A batch edit application took an input data file and ran logic on it to generate the report and, optionally, an output data file which was a modified version of the input file. We ran a batch edit programme for the collected data on a daily basis and the data collection team was informed of the most prevalent errors and how to prevent them during the data collection. Similarly, for qualitative data, we generated a table that depicted the workflow during and after the data collection exercise, which was updated daily until the exercise was finished.

The researcher leading this case study is an experienced Malawian health systems researcher who was able to apply his vast interviewing skills and experience to contain any ethical issues. The researcher's positionality is critical to remove threats of bias to the research study (Mays and Pope, 2000). The researcher used a reflective diary to keep researcher bias in check and ensure transparency and reflexivity. Key informant interviews, FGDs and document review were used to triangulate the data obtained from the various data collection methods. Participant checking was applied at the end of each interview by summarising the discussion back to respondents to confirm the concepts, emotions and themes understood from the interview (Schwandt, 2001). Credibility was strengthened by quality transcription that remained true to the interviewee's voice and ensuring that quotes or themes were not taken out of context when analysing. An independent person was engaged to listen to the audios and check the transcripts for credibility.

Quantitative data was managed and analysed using Stata software, and frequencies and proportions were calculated for sociodemographic characteristics and outcome variables. Bivariate analysis was conducted for each outcome with the sociodemographic characteristics, while the qualitative in-depth contextual information captured the actual voices and words of the respondents. Data were analysed using a thematic framework approach (Ritchie and Spencer, 2002) with NVIVO, a software programme used for qualitative and mixed-methods research. This approach has three main sections: data management, descriptive analysis and interpretation of data. Overall, data analysis was iterative (Ritchie and Spencer, 2002), where all the data were analysed by drawing out common agreements and unusual quotes were noted. Both the quantitative and qualitative data were triangulated to give quantitative data context. Data are presented in tables and figures.

Ethical review

Ethical clearance was obtained from the National Committee on Research Ethics in the Social Sciences and Humanities in Malawi as protocol no. P.09/23/796. Written informed consent was obtained from all participants prior to the interviews. Data were anonymised using codes to mitigate confidentiality issues. Participants were made aware that participation was voluntary, and that they could withdraw from the study at any time. In addition to the approval of the research ethics committee, we also sought authorisation from the leadership of the universities, secondary schools and communities for us to conduct interviews with the selected youths. Neither participant responses nor any other information was shared with any other person in the community. Consent was also sought from all individuals before starting each interview and female respondents were interviewed by female research assistants while the male respondents were interviewed by males, since some questions were viewed as too sensitive for a respondent to open up to the opposite sex.

3. Findings

Study participants' characteristics are shown in *Table 3*.

Table 3: Characteristics of study participants

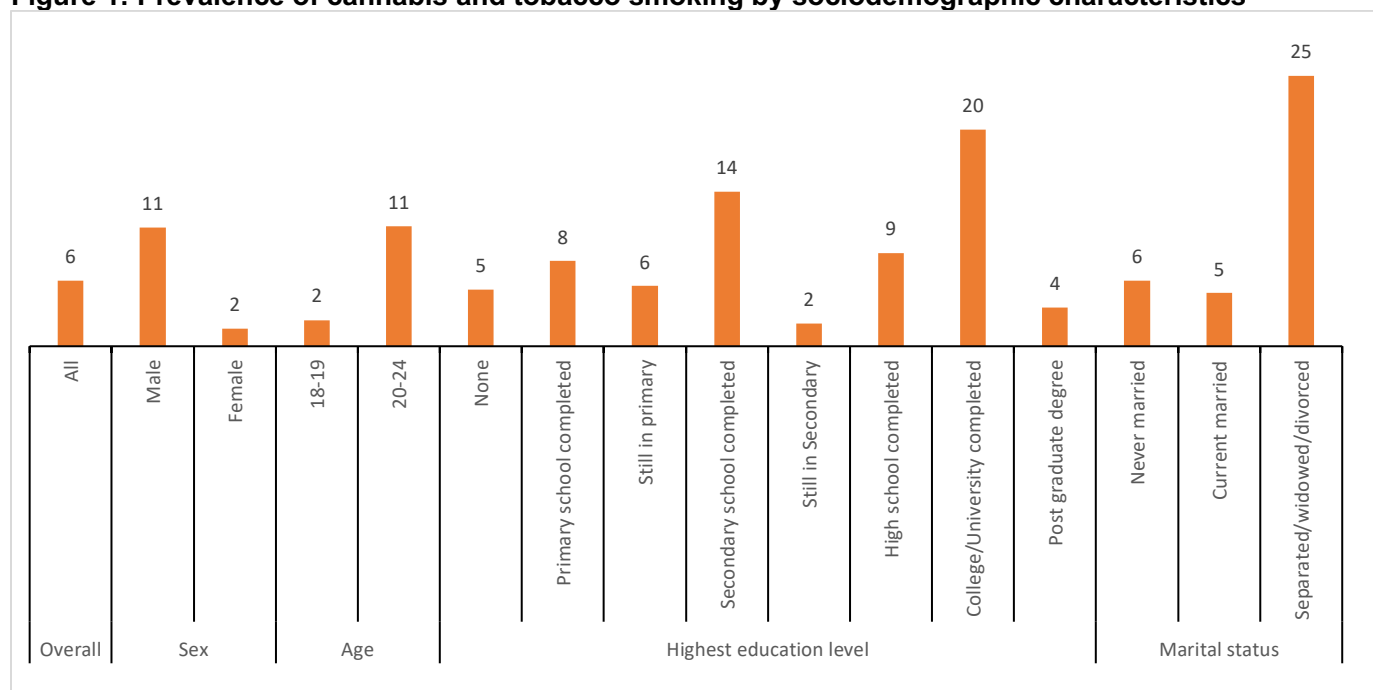
Characteristics	n	%
Total	577	100.0
Sex		
Male	273	47.3
Female	304	52.7
Age group		
18-19	333	57.7
20-24	244	42.3
Highest education level		
No formal schooling - Less than primary	115	19.9
Primary school completed	76	13.2
Still in primary	36	6.2
Secondary school completed	63	10.9
Still in Secondary	191	33.1
High school completed	58	10.1
College/University completed	10	1.7
Post graduate degree	28	4.9
Marital status		
Never married	478	82.8
Current married	82	14.0
Separated/divorced/widowed	17	1.4
Wealth index quintile		
Poorest	118	20.5
Poor	113	19.6
Middle	116	20.1
Rich	115	19.9
Richest	115	19.9

A total of 577 respondents participated. Of these, 304 (53%) were females and 273 (47%) were males. A total of 333 (58%) were within the age-range of 18–19, while 244 (42%) were aged between 20–24. Twenty percent had no formal education, 13% completed primary school, 6% were still in primary school and 11% completed secondary school, while 33% were still in secondary school. Fifty-eight, or 10%, had completed secondary school, while 10 (2%) had completed tertiary education, with 28 (5%) being post-graduates. The majority of the respondents were unmarried, while a few were separated, widowed or divorced (see *Table 3*). There were no marked differences in these proportions based on their families' wealth index, the latter being based on household socioeconomic measures (Poirier, Grépin and Grignon, 2020).

3.1 Prevalence of smoking and harmful alcohol and drug use

The overall prevalence of cannabis and tobacco smoking was 6% and the sociodemographic characteristics are shown in *Figure 1*. The prevalence was higher in boys than girls (11% versus 2%), with older boys being more likely to smoke compared to younger ones. There is an increasing trend in the proportion of smokers from completion of primary school to completion of secondary school and again from completion of tertiary education. Those respondents separated, widowed or divorced had the highest prevalence.

Figure 1: Prevalence of cannabis and tobacco smoking by sociodemographic characteristics



In line with findings from the questionnaires, our qualitative interviews showed that both boys and girls were indulging in alcohol and substance use. Across all respondent types, i.e., key informant interviewees, in-depth interview interviewees and from the FGDs, respondents mentioned that students often felt pressured to engage in activities like smoking *chamba* (cannabis), binge drinking, or bullying others, as illustrated by the following quotes:

“...for boys, many of them are engaged in smoking chamba (cannabis) as a solution to their problems, which results in many boys to drop out of school completely, thinking that this was real life because their thinking capability was affected.” ID1 young girl

“The age range of 14 to 25 years old is the most vulnerable group in secondary education, based on my own experience. Additionally, the presence of a forest makes this school particularly vulnerable since while some people visit it for prayer, others only come to smoke chamba. There was a tree in the area directly behind our blocks that people nicknamed the ‘tree of sin’ (mtengo wamachimo). Students go there and smoke.” KII Secondary

“We know that out there, youth are smoking cannabis and whether it is a tradition or something that we people we are just careless, but we need to sensitise more young people on mental health issues so that we assist the youth.” KII Secondary

While respondents often referred to cannabis smoking, we included both cannabis and tobacco in our survey.

Prevalence of alcohol abuse

The prevalence of alcohol use at harmful levels (abuse) across sociodemographic characteristics is shown in *Figure 2*. Overall, 7% of young people took harmful levels of alcohol, higher in boys than in girls (11% versus 4%). Older boys were more likely to use alcohol than younger ones. There is a clear trend in increasing use of alcohol from completion of primary education to completion of secondary school and a further increase from completion of secondary school to completion of a postgraduate degree. Those separated, widowed, or divorced had the highest prevalence of alcohol consumption, while those in the poorest category had the highest prevalence of alcohol consumption compared to those in the middle class and the rich.

In the qualitative interviews, some respondents mentioned that peer pressure and societal expectations also influence the mental health of young people in relation to alcohol abuse, as stated in the examples below.

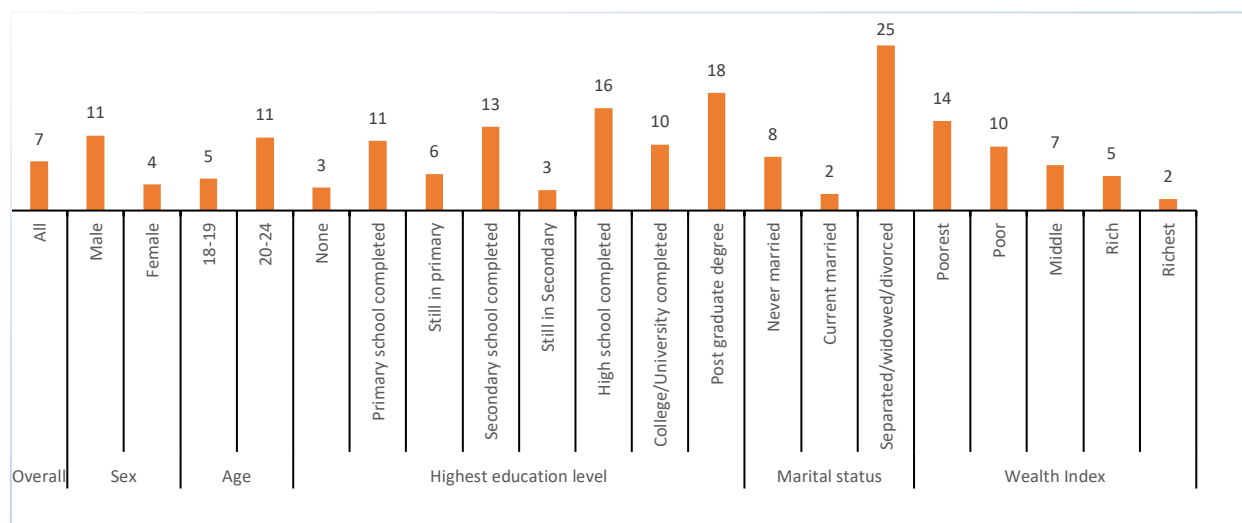
“There are certain guys at school who engage in certain behaviours to be seen by others, and this influences other students to think that they can enjoy life and gain attention by doing the same things. This indicates that peer pressure plays a role in the boys’ involvement in alcohol abuse.” IDI Young boy

“Young people in the school react to peer pressure and engage in issues like alcohol abuse. These challenges lead to a lack of concentration in class and an increased use of harmful substances like binge drinking and harmful drug use, ultimately is leading to deaths of young people due to overdosing. Normally, particular groups of young people who commonly use substances in harmful ways or are at risk of substance use in the school are those in years 2, 3 and 4... During the first year, most young people hide their true colours and so [you] wouldn’t get more cases from that group...” KII University

Another respondent indicated that alcohol abuse among young people was one contributing factor to cases of suicide both at their school as well as in the general society.

“We had a case whereby one of the former learners here hang[ed] himself with the same issue of taking alcohol. Apparently, his parents advised him against binge drinking and he just hang[ed] himself... Another example is that when that student committed suicide, his friends here started threatening teachers including their parents that if we continue giving strict rules against alcoholism, they will also hang themselves... We had to invite counsellors and therapists to offer counselling to assist the learners to survive.” KII Secondary school

Figure 2: Prevalence of alcohol abuse by sociodemographic characteristics



Prevalence of harmful drug use

The prevalence of harmful drug use by sociodemographic characteristics is shown in *Figure 3*. The overall prevalence of harmful drug use was 2% and higher in boys than in girls (4% vs 0%). The older boys were more likely to use such drugs compared to the younger ones (see *Figure 3*). There is an increasing trend in the proportion using harmful drugs by education level. The poorest and the middle-class youth also had higher prevalence of harmful drug use. Those that never married had slightly higher proportion than those with other marital status.

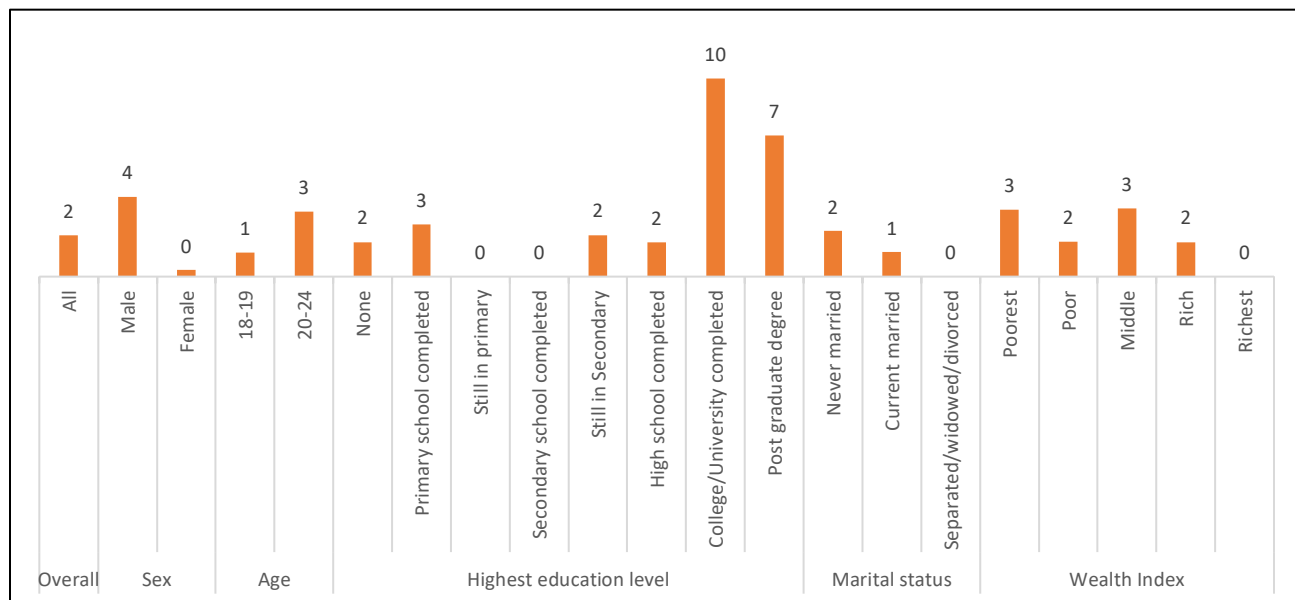
Figure 3, overleaf, shows the prevalence of harmful drug use identified by the study.

From our IDIs and KIIs, we obtained some sentiments on harmful drug use shown below.

“Influence of peers and friends on mental health is real. At school, I think, as students, we should be choosing friends who have good behaviours. We should not make friendship with those who use drugs” FGD Boys

“Our young people, both those in school and in the community are abusing substances very dangerously, so much so that it has reduced most of our educated young men and women into being useless, like more or less zombies... I have scenarios like a 22 year--old girl who ran away from home and got involved in drug abuse. She ran away from Blantyre and came to Lilongwe and got involved in gangs that use such drugs and later on her organs were negatively affected. Fortunately, she was redeemed probably two months before she died. But after redemption we sent her back home, where she stayed for a month or so and was taken to hospital. However, because all her organs were destroyed and she died... Another young man was a former student and during the time I was a teacher in that school, he got selected to the university, completed his degree and started working, and his contract was not renewed due to COVID-19. So, after losing his contract, he lost it, started drinking and started using drugs; the time I met him he was in a very bad state. So, these are just examples, but there are so many that I can share with you” KII Secondary

Figure 3: Prevalence of harmful drug use by sociodemographic characteristics



3.2 Prevalence of depression

The prevalence of depression is shown in *Figure 4*. The overall prevalence of depression was 7%, with both boys and girls reporting the same level. Older boys and girls were more likely to get depressed compared to younger ones and there is an increasing trend among all young people who have completed primary, secondary and tertiary education, including vocational/technical education. Those who were separated, widowed or divorced reported a higher proportion of depression compared to those who were married or unmarried. Those who never married had slightly higher rates of depression than those currently married and those who were separated or widowed or divorced.

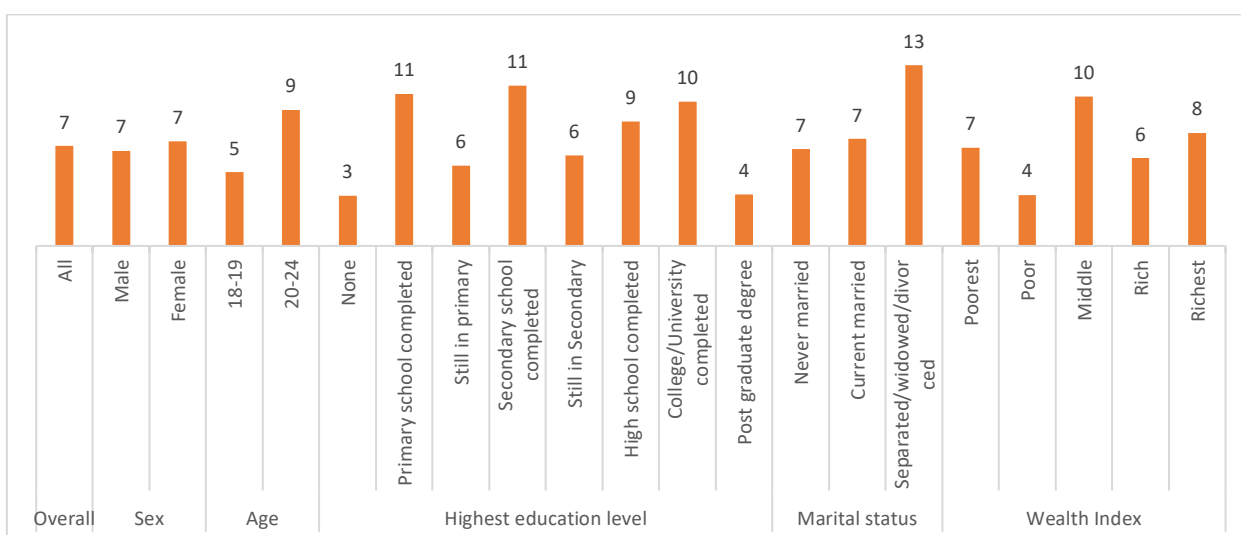
A similar trend was observed in those from middle-class families, followed by the richest and rich. Our qualitative interviews corroborated with quantitative findings. For example, most respondents in our qualitative interviews mentioned that young people who were depressed ended up binge drinking and using drugs. This resulted in increased cases of depression and suicide, as demonstrated in these quotes:

“...Also, drug and substance abuse, a lot of people especially the youth are engaging themselves in drug and substance abuse, drinking alcohol and smoking [cannabis and tobacco, so it disturbs the way people behave, so when a small issue happens, they resort to killing themselves due to drug overdose.” FGD Girls

“Teasing and bullying – you find that all the times people are saying bad things about you than minding their own. This affects the person’s esteem which may result in committing suicide.” IDI Young boy

“Social media is also contributing [to depression in young people]. For example, when you have done something wrong and you see people have posted on Facebook, you see no reason to live because everyone will be pointing at you and this kind of pressure may result in suicidal thoughts.” FGD Girls

Figure 4: Prevalence of depression by sociodemographic characteristics



Note: In the graph, the discrepancy in bar size arises because all labels were rounded to the nearest whole number.

“...I can think of a lot of issues like heart break from relationships, you don’t see a reason of staying alive... Similarly, when you have lost parents who were supporting you, you feel there is no hope anymore and you decide to simply join them...” IDI Young girl

“Staying with relatives who are not giving you a fair treatment, not giving you required needs. Getting raped, when all these happen to you, as a person you become stressed out of what has happened to them. Also, divorce of parents results in stress because others may be talking about them, so you tend to overthink on different things...” FGD Girls

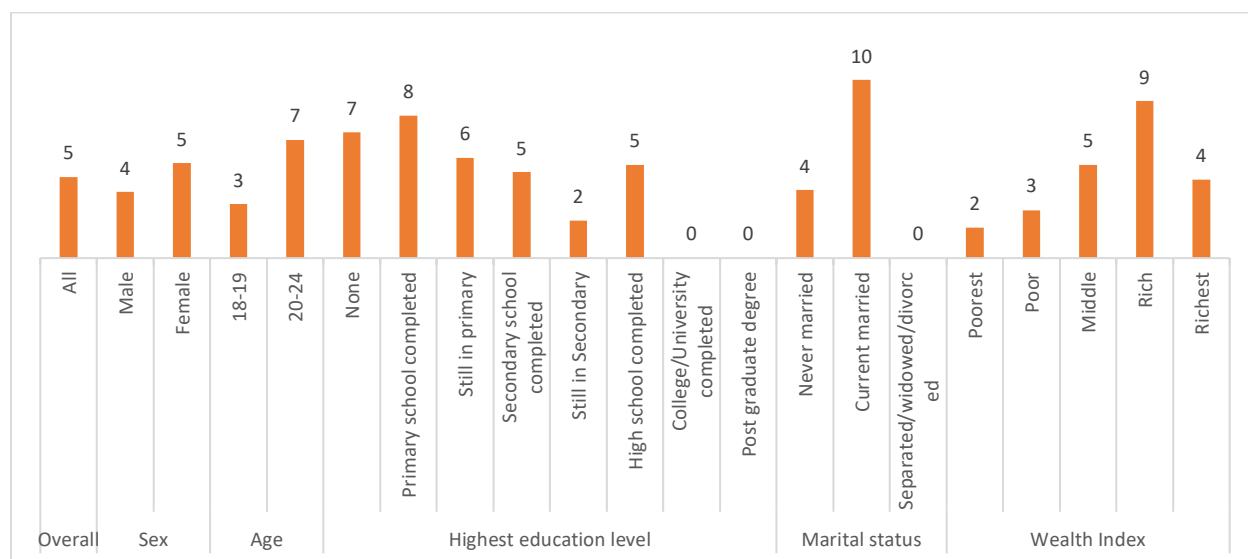
“Some mental issues come in because of peer pressure, our students think that the pattern of behaviour at a particular time, everyone else must behave like that so at the end of the day you find that those that can cope are the ones that survive, but there are other ones that cannot cope because they have too many people to please: teachers, parents as well as please their friends. So, it brings in stress in their lives. Those are the majority, of course we have other factors that they are being affected because of loss of loved ones.” KII Secondary

3.3 Prevalence of high blood-pressure

Figure 5 shows the prevalence of high blood pressure, which was 5%, and was higher in girls than in boys (5% vs 4%), and in older girls than in younger ones. There is an increasing trend in the development of hypertension between those still in primary school and those who completed primary education and again to those who had completed high school. The proportion experiencing high blood pressure was higher in those who were married than in those who were not (10% versus 4%). A similar trend was observed in the wealth index.

Overall prevalence for heart disease, lung disease and cancer were at 1%, with a higher proportion of heart disease recorded in young married people (2%) and in those from the richest families (2%). A somewhat interesting finding was on lung disease, where young people who had completed primary education recorded a higher proportion (3%) compared to all other groups. Young people with no education also had a higher prevalence of cancer (3%), while the prevalence in those from the richest families was 2%.

Figure 5: Prevalence of high blood pressure by sociodemographic characteristics



Our qualitative interviewees spoke in general terms when referring to issues such as high blood pressure, heart disease and other chronic illnesses. Respondents mainly suggested the need for health care workers to conduct awareness around these issues among students, as illustrated in the following interview with a key informant.

“Maybe if the hospital personnel can be coming here at school and talk to our students because we cannot take all the students to them. But one or two hospital personnel can come and talk to our students periodically, maybe once or twice in a term. As we start the school and in the middle of the term before we write the examinations, to talk to our students on mental health, that can help. Because as we are talking right now most of boarding schools have closed: it’s either they have burned it or they have vandalized. That is a psychological issue... We also hear a lot of students complaining of high blood pressure and heart diseases... There is just a lot happening when we talk of mental health and the general non-communicable diseases. So, if health workers can be coming as we start the school and as we come to the closure of the school and talk to our students on mental health, I think that can help.” KII Secondary

3.4 Further qualitative findings

In addition to the above illustrated themes which complemented each other in terms of issues that emerged from the quantitative and qualitative interviews, several other important issues surfaced solely from our qualitative interviews; these are summarised here.

Our qualitative interviews showed that there were a number of contextual issues affecting the mental health of young people, both within the school and in the community. The interviews revealed that poverty, moral challenges, peer pressure and loss of loved ones were major factors contributing to mental health issues among young people. Additionally, the interviews highlighted the prevalence of harmful behaviours such as stealing, young girls engaging in sexual relationships with older men, as well as alcohol abuse and harmful drug use among the students. The interviewees emphasized the need for counselling services, rehabilitation programmes and educational initiatives to address these mental health challenges effectively.

The interviews revealed that poverty had a significant impact on the mental health of young people.

"Lack, meaning poverty. So, the first thing that the young people think about is to find their necessities, and a lot of them get into stress because they find that the parents are unable to provide." KII Secondary school

The interviewees also highlighted the influence of moral decadence and societal changes on youth mental health. The quote supporting this theme is:

"The upbringing of the children of today and the way our generation was raised are totally different. We were told to be resilient; we were told to be satisfied with what we were given, but the youth of today are not told how to survive. The mentality of saying that whatever I want I can get is what also is troubling a lot of them. So, they join groups which has brought a lot of competition and comparison amongst them..." KII University

Access to mental health services

The need for accessible mental health services was emphasized by respondents:

"We need rehabilitation services where the young men and women should go into rehabs for them to stop drugs and alcohol abuse" FGD Boys.

"I can say that there are no adequate and well-known places where young people can go to access mental health services. I am answering like that because I hear there is St John of Hope but it is only for those that are affluent, or those that have the ability and also have the knowledge that they can send their children to that facility. The majority don't even know about those services. Some are only exposed to Bwaila hospital down here and mostly, people go there [till] the situation is beyond, that's when they go to Bwaila for treatment. But as for services, we don't have services in the community, yeah... Of course in the school what we have done is to set up a guidance and counselling club for mental health... We had an opportunity to be trained by UNICEF through the Ministry of Education. That training – we trained teachers and 40 students – that guidance and counselling training that we had and the activities that we have in the community are the ones that fill in the gap..." KII Secondary

"In this school we already have mental health services that the youth need. First of all, I should say that I am the only psychotherapy counsellor they have full time. I asked the school to send me to a counselling school so that I could have the expertise to be counselling students well because the students used to come to my office with different problems. So it can be that others do not come to me when they need counselling services since I work here and they are not comfortable, that's just my thinking. So, I feel there is need to hire special counsellors to be visiting this school at least once a week so that those that are not free with me can be meeting them in order to reach out all the students that need counselling." KII University

The advantages of having a guidance and counselling room in school were praised by students as the best approach in supporting school pupils with mental health services. Five issues emerged from interviews including:

1. Stress relief: The guidance and counselling room helps to relieve stress among students.
2. Support for mental health: Students can seek help, advice and counselling from teachers in the guidance and counselling room.
3. Prevention of suicide: The room provides a safe space for students to talk about their problems and helps them refrain from acting on thoughts of committing suicide.
4. Parent-like support: Sharing with the teacher in the guidance and counselling room is like talking to a parent, providing students with a trusted adult to confide in.

5. Improved performance: The support provided in the guidance and counselling room helps students to concentrate in class, leading to improved academic performance.

Challenges during the COVID-19 pandemic

The impact of the COVID-19 pandemic on the students' mental health was also discussed.

"To us we had issues; first of all we had parents who came to pick their children out of the school. We had two problems; that is, the parents thought that the children are going to die in the school, while the students thought if they are kept indoors then they will die here without seeing their parents, so it was a challenge." KII Secondary

Challenges in disclosure and identification of mental health issues

The challenge of young people not disclosing their mental health issues was also apparent in the interviews.

"We have a counselling and guidance club here... Teachers are not the biggest barrier because some teachers you can talk to, they cannot disclose to others, the barrier is us students, because once you are seen attending those counselling sessions you will become the talk of the day. I think the importance of guidance and counselling is not well understood amongst the student; it is more associated with negativity and there is need for awareness... Because once you are seen, people will be saying she wanted to commit suicide. Others say she just go there for the food. As a result many students are put off to come out and disclose the issues they are grappling with mentally..." FGD Girls

4. Discussion

This was the third assessment to examine the mental health and other factors amongst school-going young adults aged 18–24 years in Malawi, with the first two conducted in 2008 and 2010 respectively (Zverev, 2008; Kasapila and Mkandawire, 2010).

As key findings, the prevalence of tobacco and cannabis smoking was 6% and was higher in boys than girls; the prevalence of alcohol abuse was 7% and was higher in boys than girls, while the prevalence of harmful drug use was 4% and was also higher in boys than in girls. Depression, heart disease and cancer were low and at similar levels in both boys and girls. These findings have some practical implications in the Malawi and other similar settings.

The prevalence of depression, at 7% from our study, seems low compared to 11–14% in youth in several other studies carried out in Africa (Osborn et al., 2022; Haroz et al., 2017). The other studies focused on multiple issues including HIV and AIDS, chronic illnesses, student performance, high-risk factors, early life trauma, or child-headed households, and these risk factors could also contribute to increased prevalence of depression.

In this study, it was found that youth, particularly in schools, reported counselling, guidance clubs, confiding in trusted teachers, social activities and social support as elements contributing to healthy lives. This is consistent with findings from other general population studies in finding that relationships and confiding in others have the largest protective effect on depression across all demographic categories (Choi et al., 2020). This suggests that social contact may be essential in lowering risk of depression and other mental ill-health in young people. However, it should also be noted that most studies noting high levels of depression were conducted during COVID-19 (Osborn et al., 2022) and COVID-19 measures were also associated with depression.

Despite the low prevalence of depression identified in this study, it is anticipated that the prevalence

of mental and emotional health issues in young people will rise, given Malawi's current circumstances of poverty, unemployment and inadequate health systems, as well as the lack of accessible, efficient mental health interventions (Mayston *et al.*, 2020). This result aligns with evidence that shows that most people are more concerned about how societal changes affect their financial and psychological well-being, than about being sick (Holmes *et al.*, 2020). It is therefore necessary to carry out preventative measures like mental health and emotional disorders screenings and psychoeducation targeted at the youth populations identified as being at risk for negative psychosocial consequences (Pfefferbaum and North, 2020).

The prevalence of high blood pressure, although quite low (4-5%) in this study, was an interesting and very significant finding given that hypertension is not generally associated with youth (Kawałko *et al.*, 2023). However, more recent meta-analyses have begun to demonstrate a similar pattern, with body-mass index (BMI) in children and adolescents being significantly linked to high blood pressure (Noubiap *et al.*, 2017; Reuter *et al.*, 2019). Given this, there is a need for greater public awareness of paediatric hypertension as a public health concern in order to facilitate early detection and treatment of the illness and therefore lessen its detrimental effects. (Robinson and Chanchlani, 2022).

The prevalence of tobacco and cannabis use in this study is consistent with that observed in other studies, where more males than females have been found to be smoking both (Ng'ambi *et al.*, 2022; Zyambo *et al.*, 2023a; Reitsma *et al.*, 2021). The observed prevalence was, however, lower than what was observed in South Sudan (Reitsma *et al.*, 2021; Jarelnape *et al.*, 2023), where the prevalence was 70% higher than in Malawi. The observed differences may be due to cultural differences between the two settings, with culture in South Sudan more pro-smoking than in Malawi. This calls for the need to implement smoking cessation interventions (Zyambo *et al.*, 2023b) through utilisation of health care providers and psychosocial counsellors in order to reduce the burden of resulting disease such as high blood pressure and cancers in the population.

This study found higher alcohol uptake than observed in the 2017 Malawi STEPS survey, because, in this study, we looked only at consumption of alcohol, while in the study utilising STEPS data, they focused on harmful alcohol abuse. However, we also found that the males had higher alcohol consumption than females, which is consistent with the Malawian cultural context, where alcohol consumption is male dominated (Eide *et al.*, 2013; Msyamboza *et al.*, 2012). Although the standard analysis was to utilise the Alcohol Use Disorders Identification Test (AUDIT C) in the youthful population we could argue that any alcohol use is deemed harmful because the brain continues to develop until around 25 years of age (Haas *et al.*, 2020; Bonnie, 2004). Although the prevalence of harmful drug use is lower than reported in other analyses focusing on SSA, there is consistency in that it was found that more males than females abuse drugs (Fentaw, *et al.*, 2022). This calls for the urgent need to target the male population with interventions aimed at curbing harmful substance abuse.

From this study, depression was higher than the other chronic illnesses such as high blood pressure among both males and females. This is consistent with other studies conducted in Malawi and similar settings where chronic conditions are low in the 15–24-year-olds (Ng'ambi *et al.*, 2020). nonetheless, there is still a need to focus on interventions aimed at reducing depression among those aged 18–24 years by providing counselling and health care.

According to the study, the only places where young people can get mental health care are schools, Bwaila Hospital, Kamuzu Central Hospital, St John of God hospital (which participants alleged was mainly accessible by the affluent), and religious clubs. Thus, the findings make a case for the need for community-based rehabilitation programmes by providing accessible and tailored support within the community to help effectively support young people who are using harmful drugs or alcohol, in

the absence of dedicated mental health facilities. Suggested services include structured programmes in local churches, mosques and health centres, as well as programmes during vacation periods to provide mental health awareness and alternative solutions to young people in and out of school.

5. Recommendations

This study highlights the need for educational institutions to address the escalation of alcohol, tobacco and cannabis smoking, harmful drug use, depression and growing chronic illness among the youth. It also has highlighted the impact that poverty, careless pleasure-seeking and peer pressure have on youth mental health. Educational institutions need to deliberate and take specific measures to offer counselling services and guidance, as seen in schools like Lilongwe Girls Secondary School, Bwaila Secondary School, Likuni Boys' Secondary School and LUANAR University. Clubs and counsellor support in these institutions are improving student behaviour and performance, motivating more young people to disclose mental health issues and addressing stress from exam pressure, bullying, poverty and overindulgence.

Schools should also establish rehabilitation programmes and mental health services to foster resilience. They should also offer skills-building programmes during school holidays to steer students away from negative influences. Open communication and awareness on mental health issues in schools and communities can help address peer pressure, high use of drugs and alcohol and other factors affecting students' mental well-being. Online resources should also be explored and utilised in communication and awareness as these can support young people's mental health and provide easier access to certain information and interventions. Implementing these measures can significantly improve students' mental health by addressing issues like exam pressure, bullying, poverty, overindulgence and peer pressure.

Furthermore, we suggest the introduction of cluster-based counselling services in schools and communities. These have the potential to guarantee regular visits to schools and community centres by counsellors who are already working in the schools mentioned above, thus offering ongoing mental health support for young people. This approach emphasizes leveraging existing community resources and creating intentional spaces for young people to receive support, guidance and emotional skills-building opportunities. Overall, through these community-based initiatives and partnerships, young people struggling with substance abuse can interact with community leaders and receive quality support, guidance and education, even in the absence of dedicated mental health facilities.

Roles of community leaders, educational institutions and religious organisations

Community leaders, educational institutions and religious organisations are key in raising awareness and implementing preventive measures for mental health among the youth. They can advocate for resources and coordinate programmes to integrate mental health education into curricula. Educational institutions and religious organisations can support the early identification and addressing of mental health issues, providing support services, counselling and the creation of community networks to break down barriers to seeking help. Collaboration among these groups is crucial for addressing mental health issues at primary health care level, and ensures young people have access to resources and support services that address stress and depression and promote awareness of the common symptoms.

This study highlights the need for young people to understand common symptoms of stress and to learn how to effectively manage stress and depression by addressing both the symptoms and the root cause. The combined efforts of the suggested institutions can help remove barriers to seeking help, reduce stigma and provide a safe and supportive environment in which young people can

address their mental health concerns. This collaborative approach can make a significant contribution to improving the mental health and well-being of young people in schools and in the community at large.

While these recommendations are based on the study findings and the Malawi context, they may also be relevant in other similar sociocultural contexts. Equally important is the role of community stakeholders in various organisations and, in the process, the establishment of a public health approach to mental health across SSA. However, due to the study's small sample size a larger scale study throughout ESA may be necessary to generate more generalisable conclusions from a quantitative survey.

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Acronyms

CAPI	Computer-Assisted Personal Interviews
ESA	Eastern and Southern Africa
FGD	Focus Group Discussion
IDI	In Depth Interview
KII	Key Informant Interview
NGO	Non-Governmental Organization
ODK	Open Data Kit
OECD	Organization for Economic Co-operation and Development
PHC	Primary Health Care
SSA	Sub-Saharan Africa

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity-oriented interventions. EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in east and southern Africa, including

- Protecting health in economic and trade policy, in extractives
- Local production of health technologies
- Urban health and wellbeing
- Building universal, participatory, primary health care oriented health systems
- Equitable, health systems strengthening responses to pandemics
- Fair Financing of health systems
- Promoting public health law and health rights
- Social empowerment and action for health
- Monitoring progress on equity and equity analysis

EQUINET is governed by a steering committee involving institutions and individuals co-ordinating theme, country or process work in EQUINET from the following institutions:

TARSC, Zimbabwe; CWGH, Zimbabwe; CEHURD Uganda; SEATINI, Zimbabwe; REACH Trust Malawi; IWGSS South Africa and Kenya, TJNA Kenya, I4D Uganda, and SATUCC

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