



Young people

“They are already dead”: how outdated knowledge and cruel stereotypes contribute to depression and suicide in Malawi teens with HIV

Gus Cairns | 16 April 2026

Estimated reading time 11 minutes



Image: Greg Chimitris. Image is for illustrative purposes only. CC BY 2.0

A qualitative study of adolescents living with HIV in Malawi has found that outdated beliefs about HIV, and stereotypes of people with it, contribute to pervasive and persistent stigma against young people living with the virus. This does not only have adverse psychological effects but disadvantages them in practical ways, damaging their educational and employment prospects.

Deaths from AIDS have decreased fivefold in Malawi since their peak in 2004 and the country had **achieved the UNAIDS 95-95-95 target by 2021**, with 87% of people with HIV on antiretroviral therapy and virally suppressed.

Despite this, the researchers found, nearly all the respondents in the study – the only exception being HIV care providers – agreed that the most common stereotype about HIV infection was still that it was an inevitable death sentence.

Glossary

stigma

depression

qualitative

focus group

exclusion criteria

“This response – ‘they are already dead’ – reflects how deeply this stereotype is engrained in Malawian society,” the researchers comment. “This belief, phrased in various ways, (‘Dead person’, ‘Finished’, ‘Close to dying’,...‘Moving around while already dead’, ‘time is running out’),” speaks to the presumed imminent death of an adolescent living with HIV (ALWH).”

The researchers refer to these as ‘death-centric stereotypes’ and propose that they are the root cause of a whole variety of downstream adverse consequences. The psychological consequences include low self-esteem, social self-isolation, depression and suicidality.

But they also reveal how death-centric stereotypes reinforce existing aspects of Malawian social and educational culture, especially due to its position as a lower-income country, that already contribute to reduced opportunities in life for young people if they have HIV.

The study

The qualitative study was co-ordinated by Maria Faidas and colleagues at the University of North Carolina in the US, collaborating with Blantyre University in Malawi, and was conducted at three health centres in Malawi’s capital, Lilongwe. The centres run quarterly “teen clubs” for adolescents with HIV, providing antiretroviral therapy (ART), viral load testing, and many other physical and educational activities.

The 13 ALWH study participants were aged 13 to 19, with an average age of 16.3 years. Six were below 16. They were selected from Teen Club attendees in October 2023 and January 2024.

Each teenager took part in an in-depth semi-structured interview, with questions based on “[What Matters Most](#)”, an analysis of how stigma works in specific cultures. This has been used in numerous settings ranging from [Chinese immigrants in New York](#) to [HIV-affected men in Botswana](#). It conceives of stigma as preventing people from achieving ‘full personhood’ and being able to function as a valued, contributing member of society.

As well as the 13 ALWH, the study enrolled 55 people involved in their lives: 12 HIV-negative adolescent peers also aged 13-19; 10 carers such as parents, step-parents and siblings; 12 teachers; 12 HIV care providers including clinicians and nurses; and nine mental health service providers including psychiatric nurses and counsellors. They took part in ten focus groups; both in-depth interviews and focus groups lasted one to two hours.

One important aspect of this study was that the ALWH participants were screened for depression and only those with some degree of it took part in the study. In contrast, the HIV-negative peers were

also screened for depression and were *excluded* if they were positive for it.

The reason for this was that the study’s object, as a qualitative one, was not to examine the prevalence of depression and stigma in ALWH but to understand *how* stigma contributes to negative life experience and self-concept. In the event, out of 118 ALWH attending the Teen Clubs, 26 (22%) screened positive for depression and half of those joined the study. Using a separate screening test, eight (nearly 7%) screened positive for suicidal ideation and three of those took part in the study.

The screening tool used was the **Beck Depression Inventory mark 2** (BDI-II), where a score of 13 or more has an 80% sensitivity to identifying depression. The five male participants had a BDI-II score of 17.5, indicating mild depression, and the eight female participants 19.6, indicating moderate depression.

Experiences and effects of stigma

As already noted above, the study’s most striking finding was how firmly entrenched were stereotypes of people with HIV as being moribund and sickly. As one 15-year-old boy with HIV said:

“It is difficult for a child like me to work hard...when you are at school, you think about what they say about you: ‘What can a person with HIV, like you, achieve?’”

One important finding was that school curricula, developed during the AIDS years, were still perpetuating the idea that HIV was a death sentence. A teacher said:

“We have youth clubs in our schools where we sing some songs such as ‘AIDS is a killer, that’s why people die’. That is what we

teach them. We need to highlight that though such is the case, [with] counselling and guidance...they can live long.”

Thus, songs initially devised to raise awareness of the consequences of HIV are now perpetuating stigma.

Even if people with HIV are not regarded as near death, they can still be seen as not having a viable future. One 15-year-old girl with HIV said this:

“The belief that a lot of people use against a person with HIV is that a person with HIV cannot get educated, a person with HIV cannot work, a person with HIV cannot get married and that a person with HIV cannot do anything, even run a business.”

This has several severe practical impacts on young people with HIV. In a country like Malawi, the researchers note, “poverty is pervasive, and many families must make difficult decisions about finances.” This often means that HIV-positive children miss out on chances for education, in a country where school fees have to be paid. One counsellor said:

“In a family of four children [where] one is HIV positive...what happens is that, when resources are scarce, they don’t prioritise the resources on the child who is HIV positive. They still feel that his or her future is uncertain because of the HIV status.”

One male caregiver recounted a situation where a mother of three children refused to enrol her only HIV-positive child into school, even when he had moved to his grandparents, saying, “I don’t have time to request a transfer letter for that child.” In the end the grandmother had to pay the child’s school fees.

Reduced opportunities for education can translate into reduced employment opportunities, which can also derive from stereotypes taught at school. An HIV-negative 13-year old said:

“According to what we learnt...they taught us that when a person with HIV wants to expand his or her business by getting a loan, people say, ‘Don’t give him or her a loan. He has HIV and can die soon’.”

This also shows how parents can directly stigmatise a child who has HIV – even when they are the natural parents and are also living with HIV. One caregiver recounted how the child may internalise this stigma:

“The real parents think the child is finished and is not important. They pioneer the discrimination. Ordinary people copy from what the parents say and do the same...[and] when an ordinary person says the same words that parents say, the child thinks he or she is not worthy.”

Internalised stigma can combine with stereotypes of people with HIV as weak or incapable, to create social isolation. Lingering assumptions about what people with HIV look like (such as being thin, having thinning hair, lightened skin and rashes) may be attributed to the young person, even when they are in fact healthy. They are then excluded from social activities partly out of fear of transmission and partly out of false beliefs that the young person is unable to ‘keep up’ with normal activities.

A mental health provider said:

“When [a boy] went out to play, his friends were telling him that you are a ‘sickling’, hence cannot play. If the adolescent’s talent

was football, this would destroy his talent, and the adolescent wouldn't have the desire to go and play with friends.”

This can have a particularly strong impact in countries like Malawi, which rely on people volunteering for activities such as maintaining roads, digging drainage systems, and preparing food for funerals. As the researchers comment, “Non-participation in community development works is particularly damaging in a community-oriented society like Malawi where individuals are expected to contribute to their community through physical labour. This exclusion from community activities prevents ALWH from feeling connected to fellow peers and community members, and sends a message that ALWH are not valuable to society, which reinforces low self-esteem.”

It is easy to see how this can reinforce feelings of low self-worth, especially in a society where having a family and children is highly valued. An 18-year-old ALWH said:

“[People] believe that if someone has HIV, the person cannot do anything or take care of a family...that's the end of life. They believe the person cannot do anything because they are close to dying.”

In other words, what the researchers call the ‘death-centric stereotypes’ can be self-fulfilling, leading to a sense among young people with HIV, in a powerful phrase, that they had “failed at life”.

Three study participants described thinking of suicide, either in the present or the past. The method of suicide most often mentioned by participants was what the researchers called “passive suicide” – stopping treatment and letting HIV take its course. One 15-year-old boy described his feelings thus:

“When you have HIV you ask yourself ‘If I take the medicine, will I be healed? Will they stop mocking me?’ You just stop taking your medicine because you feel like you will not be able to play or chat with your friends even if you do. You feel like it’s better to just die’.”

However, some reported active suicide attempts. The precipitating factor most strongly associated with such attempts was fights and bullying by other family members. One boy aged 15 recounted a fight where his brother called him ‘a dead person’. This escalated to violence, with his brother stoning him.

“I said ‘If you want me dead you can just go ahead and kill me’, and I went to the bedroom, opened my ART medicine, and as I was about to take them all, my mother came and stopped me.”

It’s notable in this story that a suicide attempt induced by one family member was prevented by another. Perhaps conscious of the burden of stigma the teenagers interviewed in this study relate, the researchers end with a quote from the mother of a young woman with HIV:

“I encourage the child I gave birth to so that the child should be independent and realise that one day, she is going to be a woman too... Love, motivation, and care is what is needed to help the child understand that HIV is not the end of life.”

Conclusions and recommendations

The researchers recommend further studies, such as ones to investigate internalised stigma more closely, ones to develop interventions which challenge false and outdated beliefs and stereotypes about HIV, and research to investigate the value of

psychotherapeutic support. But some of their findings already point strongly to recommendations.

Firstly, Malawi is one of 25 countries worldwide, 10 of them in Africa, that still criminalise suicide. This is obviously a huge disincentive to talking about suicidal feelings and attempts. “Involving policy makers and advocating for the decriminalization of suicide will allow for meaningful change on a systemic level,” the authors comment.

Secondly, “this study identified school curriculums as a potential area where stigmatization is perpetuated against ALWH”. They need to be replaced with “a multi-faceted stigma-reduction approach”.

Thirdly, awareness that poor adherence to ART may be an indicator of depression and suicidality needs to be raised among HIV service providers as well as carers and family. “Suicide assessment for ALWH should be particularly attentive to the motivation behind ART non-adherence,” they comment.

Fourthly, the authors note that stigmatisation within the family home emerged as a particularly important risk factor for suicide. “Family members' treatment can influence suicide risk, exerting either protective or harmful effects,” they say. “These findings highlight the need to develop multi-level stigma reduction interventions... particularly within the home.”

References

Faidas MF et al. *‘You feel like it’s better to just die’: Death-centric stereotypes and stigma contribute to suicide risk for adolescents living with HIV in Malawi*. PLoS Global Public Health, 29 December 2025.

<https://doi.org/10.1371/journal.pgph.0005655>

Image credit: Photo by Greg Chimitris. Available at [malawi pt 1 227 | Greg Chimitris | Flickr](#) under [Creative Commons licence CC BY 2.0](#).
