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Social networks, social participation, and health among youth living in extreme poverty in rural Malawi

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Abstract: Extensive research documents that social network characteristics affect health, but knowledge of peer networks of youth in Malawi and sub-Saharan Africa is limited. We examine the networks and social participation of youth living in extreme poverty in rural Malawi, using in-depth interviews with 32 youth and caregivers. We describe youth's peer networks and assess how gender and the context of extreme poverty influence their networks and participation, and how their networks influence health. In-school youth had larger, more interactive, and more supportive networks than out-of-school youth, and girls described less social participation and more isolation than boys. Youth exchanged social support and influence within their networks that helped cope with poverty-induced stress and sadness, and encouraged protective sexual health practices. However, poverty hampered their involvement in school, religious schools, and community organizations, directly by denying them required material means, and indirectly by reducing time and emotional resources and creating shame and stigma. Poverty alleviation policy holds promise for improving youth's social wellbeing and mental and physical health by increasing their opportunities to form networks, receive social support, and experience positive influence.

1. Introduction

In this paper, we examine the social networks and social participation of youth living in extreme poverty in rural Malawi. We analyzed baseline in-depth interviews conducted with youth (ages 13–19) and their caregivers who are participants in the Government of Malawi's Social Cash Transfer Program (MSCTP), a poverty alleviation program. We provide a rich description of youth participants' peer social networks, and compare network structure (e.g. size), function (e.g. social support) and social participation of girls and boys. We also illuminate how the context of extreme poverty influences their networks, social participation, and their health and wellbeing.

Social wellbeing is conceptualized as an aspect of overall health, along with physical and mental health, in the World Health Organization's 1948 foundational definition (International Health Conference, 2002). Social wellbeing is defined as individuals' perceived quality of their relationships with other people in their social networks, neighborhoods, and communities (Keyes and Shapiro, 2004). Other definitions emphasize people's performance in social roles and their social participation (Larson, 1993). An extensive literature also examines various aspects of social wellbeing, such as social networks, as correlates or predictors of physical and mental health outcomes. Social networks have influence in many health domains, including chronic and infectious disease, mental health, and health-related behaviors (e.g. Kawachi and Berkman, 2001; Smith and Christakis, 2008). In Malawi, a robust literature documents relationships between social networks and HIV outcomes among adults (e.g. Helleringer and Kohler, 2007; Kohler et al., 2015). A smaller body of work examines social participation and physical and mental health (e.g. Myroniuk and Anglewicz, 2015).

Berkman et al. (2000) argue that to comprehend the multiple pathways through which social networks influence health, it is critical to conceptualize them as embedded within broader social

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and structural conditions – such as poverty and gender norms—- that shape network structure and functioning. In high-income countries, measures of individuals' social status level and income predict social networks characteristics, such as size (e.g. Ajrouch et al., 2005). Menjívar (2000) depicted, in an ethnographic study, how a community's lack of material resources threatened social network stability by disabling the exchange of social support. Women have been found to have more intimate social ties than men and to provide more social support through their ties. For women with few resources to share, these relationships can generate rather than alleviate stress (Antonucci et al., 1998; Belle, 1987; Kawachi and Berkman, 2001). Studies also document how contextual factors relate to social participation—in an urban U.S. setting, neighborhood-level socioeconomic disadvantage was positively associated with rates of participation in neighborhood improvement organizations, but this relationship diminished at the highest levels of disadvantage (Swaroop and Morenoff, 2006).

Per Lin et al. (1999), social ties are organized in nested layers around the individual, ranging from participation in community and voluntary organizations within the outermost layer, to network relations within the middle layer, to intimate ties within the innermost layer. Each outer layer of ties affords the opportunity to construct inner layer ties. Empirically, community participation increases the likelihood of "constructing and maintaining interactive ties in social networks." We examine youth's social participation—in which we include involvement in formal and informal institutions such as schools, religious community, and community organizations— in addition to social networks in order to gain a more complete view of their social wellbeing, and deeper understanding of the extent to which their social and structural environment affords opportunities to build and exercise networks.

Among adolescents, research in high-income countries has shown the particular importance of peer social networks for health. Peers can provide critical social support during difficult transitions or life events, and promote prosocial health behaviors (Bernat and Resnick, 2009). However, the peer context also plays an important role in the initiation and maintenance of a range of risky behaviors and negative outcomes, including substance use, obesity, suicidal behaviors, and increased number of sex partners (Abrutyn and Mueller, 2014; Ali and Dwyer, 2011; Bauman and Ennett, 1994; Faris and Ennett, 2012). The strength of the influence of peer ties vary according to network characteristics such as size (Faris and Ennett, 2012), and individual characteristics such as gender (Widman et al., 2016).

Research on social ties and health in youth populations in sub-Saharan Africa, including Malawi, is limited, and predominantly focused on children and adolescents "affected by HIV" and HIV risk behaviors (e.g. Ruiz-Casares, 2010; Sikstrom, 2014; Skovdal et al., 2009). However, the importance of peer networks and social participation for health is clear. In urban Tanzania, Yamanis et al. (2016) found that young men who were members of close knit peer networks, locally referred to as "camps", had an increased likelihood of engaging in concurrency if the majority of their male camp members reported concurrency. Hargreaves et al. (2008) found lower HIV risk among school-attending youth in South Africa than among their non-school-attending peers. School-attending girls were less likely than non-school attending girls to have significantly older sexual partners, suggesting that school offers an environment for developing age-similar – and thus less risky– ties and sexual networks. In this paper, we aim to expand the limited research on peer networks and social participation of youth in sub-Saharan Africa using a gender sensitive lens. We examine how the economic context shapes youth networks and participation, and how networks and participation influence multiple aspects of health. We also consider the implications of our findings for how poverty alleviation policy could improve youth social wellbeing, mental health, and physical health.

2. Methods

2.1. Study setting

Malawi is one of the poorest countries in the world, with an annual GDP per capita of US$250 and a poverty rate of 50 percent. Fifty-four percent of the population is below the age of 18, and life expectancy is 55 largely due to an HIV prevalence rate of 12 percent. The HIV epidemic has resulted in an estimate of over one million orphans in the country. 31 percent of women age 20–24 report at least one live birth before the age of 18 (National Statistical Office, 2015).

The formal education system comprises eight years of primary education (Standard 1–8), four years of secondary (Form 1 – Form 4), and four years of university level education (World Bank, 2010). Nearly all primary school students and three quarters of secondary school students receive education through public institutions (World Bank, 2010). Although free primary education was introduced in 1994, families are often required to pay fees for school operational costs (Kadzamira and Rose, 2003). Three percent of children drop out of school after Standard 1, and 17 percent drop out between Standard 7 and 8. Differences in dropout rates between males and females are not substantial, but rural children are more likely than urban children to drop out at all grades. Attendance rates among males older than age 15 are much higher than rates among females (National Statistical Office and ICF Macro, 2011).

Most people in rural Malawi attend regular religious services and activities (e.g. prayer groups), which foster a sense of community within congregations (Trinitapoli, 2006; Yeatman and Trinitapoli, 2008). Muslim youth commonly attend Madrassa, religious school. Rural villages are typically composed of huts, boreholes, churches and mosques, and spread out to allow for subsistence agriculture (Yeatman and Trinitapoli, 2008). Participation in religious community provides opportunities for interacting with diverse others of diverse experiences and social standing, which are relatively rare in this context, especially for women. While women spend much of their time farming and doing household tasks, usually with women from the same household, compound, or village, many men do paid work and spend time in bars where they meet varied individuals (Yeatman and Trinitapoli, 2008).

The MSCTP– an unconditional cash transfer program to improve the wellbeing of ultra-poor and labor constrained households and to promote investment in nutrition, health, education, shelter, and creation of productive assets— began as a pilot in the district of Mchinji in 2006. It now operates in 18 districts, reaching 750,000 people in 170,000 households. Households are eligible if they are unable to meet their most basic needs, including food, soap, and clothing, and have a high dependency ratio. This demographic targeting criterion effectively captures households who have lost prime-age members due to AIDS and are caring for orphans (UNICEF, 2007). Systematic targeting is used to identify beneficiary households. The Ministry of Gender, Children, Disabilities and Social Welfare administers the program with policy oversight from the Ministry of Finance, Economic Planning and Development and technical support from UNICEF-Malawi. The main financial contributors to the program aside from the Government of Malawi are the German government through KfW, the European Union, the World Bank, and Irish Aid.