

ORIGINAL ARTICLE

Self-care practices and mental health of people living with HIV/AIDS in Mogadishu, Somalia

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ABSTRACT

Mental health challenges are prevalent among people living with HIV/AIDS (PLWHA), particularly in conflict-affected and resource-limited settings like Mogadishu, Somalia. While self-care practices have been widely recognized for enhancing psychological well-being in individuals with chronic illnesses, limited research has examined their role in improving mental health outcomes among PLWHA in Somalia. This study investigated the impact of self-care practices on the mental health of PLWHA in Mogadishu. A correlational research design was employed, involving 153 respondents who completed standardized self-care and mental health scales, with Cronbach's alpha reliability coefficients of 0.78 and 0.72, respectively. Anchored on the Health Belief Model (HBM), the study assessed the influence of physical, psychological, and professional self-care practices. Results from correlational and multiple regression analyses revealed that all three forms of self-care were significantly and positively associated with mental health. Psychological self-care demonstrated the strongest individual contribution ($r = 0.625$; $\beta = .404$), followed by physical ($r = 0.622$; $\beta = .370$) and professional self-care ($r = 0.578$; $\beta = .302$). Collectively, the self-care variables explained 65.7% of the variance in mental health ($R^2 = 0.657$), and the model was statistically significant ($F(3,149) = 95.056$, $p < .005$). These findings underscore the importance of holistic self-care strategies in promoting psychological well-being among PLWHA in fragile settings. The study recommends integrating self-care education, psychological support interventions, and physical wellness programs into existing HIV/AIDS care frameworks to enhance mental health outcomes in Somalia and similar contexts.

Keywords: Self-care practices, mental health, HIV/AIDS.

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INTRODUCTION

Mental health is a crucial component of overall well-being, encompassing emotional, psychological, and social aspects of functioning. It influences cognition, mood regulation, interpersonal relationships, stress management, and decision-making [1]. Poor mental health manifests through symptoms such as social withdrawal, loss of interest in routine activities, mood instability, sleep disturbances, substance use, and suicidal ideation. The number of people dealing with the condition of mental illness is also increasing across the globe, with depression and anxiety turning out to be the most prevalent disorders [2-3]. Mental illness is defined as an emotional and behavioural disorder that interferes with day-to-day functioning to a very high degree. Despite the upward trend of mental health programs in the developed world, studies have indicated that there are alarming levels of psychological distress among young adults [4, 5]. Mental health care has become an important element of resilience and prevention of mental health issues, with a focus on self-care gaining prominence.

According to [6], self-care can be defined as the capacity of individuals, families, and communities to promote health, prevent disease, strengthen health, and manage illness and disability, with or without medical support. It incorporates diverse behaviours: nutrition, medication compliance, emotional management, physical exercise, and the use of support services. Self-care has been associated with better health outcomes and minimization of healthcare burdens in the management of chronic illnesses [7]. It is also expected to help address the projected global shortage of 18 million care delivery personnel by 2030 [7,8].

Three specific self-care practices were engaged in this study [physical, psychological, and professional self-care practices]. Physical self-care practices involve activities that improve bodily health and functioning, such as regular exercise, adequate sleep, medical check-ups, and balanced nutrition. The focus is on sustaining energy, preventing illness, and promoting overall physical well-being. Psychological self-care practices are

strategies that nurture an individual's mental and emotional resilience. The aim is to reduce stress, enhance emotional regulation, and support mental clarity and balance. Professional self-care practices are actions taken to maintain effectiveness, satisfaction, and boundaries in one's work life. The emphasis is on preventing burnout, sustaining motivation, fostering career growth, while protecting personal well-being. [9,10].

Self-care practice has proven to be added value to mental wellness through empirical research. As discovered by [9], physical, psychological, and spiritual self-care were inversely linked to burnout, indicating their preventive nature. On the same note, [11] discussed enhancing emotional well-being related to systematic self-care routines, and [12] underlined the importance of professional support in strengthening psychological resilience. [13], however, state that self-care alone might not be enough to deal with the problem without wider systemic and society-related interventions. Although the body of literature on self-care in chronic conditions is broad enough, with diabetes and heart conditions being the most studied ones, little attention has been given to the role of self-care in the mental health of people living with HIV/AIDS (PLWHA). [14] studied the multidimensionality of self-care among PLWHA and found that successful management of symptoms entails not merely the use of antiretroviral therapy (ART) but also complementary medicine, nutritional, and spiritual regulations, as well as seeking information that relies on individual, family, and structural influence.

Although HIV treatment has greatly improved over the decades, the disease is still a global health emergency with the greatest impact on sub-Saharan Africa. By 2020, an estimated 37.6 million individuals lived with HIV in the world, of which Eastern and Southern Africa boasted 53 percent of the population and 45 percent of new infections [15, 16].

Mental health challenges are common among the population of the PLWHA, particularly young women aged 15 to 24, who are disproportionately exposed to infection because of gender imbalances of power and scarce access to education [15]. Issues

of stigma, discrimination, and internalized shame tend to cause social withdrawal, depression, and anxiety, thus exerting an additional burden on the psychological effects of HIV [17-19]. [20] also refers to the negative result of societal exclusion on the readiness of PLWHA to seek care.

These challenges are particularly pronounced in resource-constrained environments, such as Mogadishu, Somalia, where ongoing conflict, poor infrastructure, and an ineffective health care system exacerbate vulnerabilities [21-24]. Moreover, the stigma surrounding HIV often leads individuals to conceal their medication, avoid health care services, and experience heightened social isolation [25]. Research has indicated that stigma and psychological conditioning problems may have a substantial effect on care compliance and retention [26, 27]. Though accurate HIV data in Somalia are limited, available studies report low but persistent prevalence. For instance, [28] recorded a 0.32% HIV seropositivity rate in Mogadishu, while [29] reported a 0.2% prevalence among pregnant women. [30] estimated that 8,700 people were living with HIV in Somalia in 2020.

A particularly vulnerable group in Somalia and other low-income contexts is housewives. Research suggests that many women contract HIV from their husbands, who engage in high-risk sexual behavior, while the women themselves lack the power to negotiate condom use [31, 32]. Studies found that HIV prevalence among housewives exceeds that of sex workers in some regions, contradicting earlier assumptions about risk distribution. PLWHA in these contexts frequently experience psychosocial burdens such as social isolation, economic vulnerability, and emotional distress, all of which hinder engagement in consistent self-care [17, 18, 33].

Despite these findings, few studies have explored the link between self-care and mental health among PLWHA in Somalia. Notably, [10] conducted a MIMIC model analysis and found that physical self-care had the strongest standardized effect on mental health, while the affective dimension was the most salient indicator of psychological well-being. Yet such data-driven investigations remain scarce, especially in conflict zones such as Mogadishu. The absence of empirical research from

Somalia on this subject limit the development of locally relevant interventions. Although self-care practices have shown promise in managing chronic illnesses and enhancing mental health elsewhere [34-36], their applicability and effectiveness in the Somali context remain underexplored. Addressing this gap is crucial for creating tailored strategies that promote mental health and well-being among PLWHA in Mogadishu.

Purpose of the study

The purpose of the study was to investigate the effect of self-care practices on the mental health of people living with HIV/AIDS in Mogadishu, Somalia. Specifically,

- 1) To examine the relationships between self-care practices (physical, psychological, and professional) and the mental health of people living with HIV/AIDS in Mogadishu, Somalia
- 2) To determine the joint effect of self-care practice (physical, psychological, and professional) on the mental health of people living with HIV/AIDS in Mogadishu, Somalia
- 3) To examine the relative effects of self-care practices (physical, psychological, and professional) on the mental health of people living with HIV/AIDS in Mogadishu, Somalia

Research Questions

- 1) What is the relationship between self-care practices (physical, psychological, and professional) and the mental health of people living with HIV/AIDS in Mogadishu, Somalia?
- 2) What is the joint effect of self-care practices (physical, psychological, and professional) on the mental health of people living with HIV/AIDS in Mogadishu, Somalia?
- 3) What is the relative effect of self-care practices (physical, psychological, and professional) on the mental health of people living with HIV/AIDS in Mogadishu, Somalia?

MATERIALS AND METHODS

The study used a correlational research design with a cross-sectional survey approach, utilizing validated instruments, correlational analysis, and multiple regression to explore the relationships, combined effects, and relative contributions of self-care practices on the mental health of people living with HIV/AIDS in Mogadishu, Somalia. Due to the

sensitive nature of the study, cluster sampling was employed to select participants based on specific attributes (HIV-positive status), availability, and interest. A total of 153 participants who willingly signed the consent form, completed the scales, and returned them within two weeks were included. The participants comprise 98 males and 55 females. Two standardized scales, the Self-care Practices Scale and the Mental Health Scale, were adapted for the study. These scales were pilot tested before being administered to participants.

The Self-Care Practices Scale was developed by (37). The SCPS is a multidimensional instrument designed to assess the frequency of self-care behaviours across physical, psychological/emotional, and professional domains. The scale uses 5 Likert-style formats ranging from 1 = strongly disagree, 2 = disagree, 3 = not sure, 4 = agree, to 5 = strongly agree; however, the study adopted 4 Likert-style formats (1 = strongly disagree, 2 = disagree, 3 = agree, 4 = strongly agree) to eliminate the neutral midpoint. This is done to avoid indecision and bias, thereby enhancing data clarity and interpretability. The Cronbach's alpha for this study was 0.78 for the overall SCPS.

The Mental Health Scale: The Patient Health Questionnaire-9 (PHQ-9) was developed by (38). The purpose of the scale is to screen for depression, measure severity, and monitor treatment response. It has 9 items, each corresponding to one of the DSM criteria for depression. Responses are rated on a 4-point scale, adjusted to (1 = strongly disagree, 2 = disagree, 3 = agree, 4 = strongly agree). The Cronbach's alpha for this study was 0.72

RESULTS

Research Question 1: What is the relationship between self-care practices (physical, psychological, and professional) and the mental health of people living with HIV/AIDS in Mogadishu, Somalia?

Table 1 results indicate that all three types of self-care practices (physical, psychological, and professional) are positively and significantly associated with mental health. Psychological self-care has the strongest relationship with mental health ($r = 0.625$), followed closely by physical self-

care ($r = 0.622$). Professional self-care also shows a strong, but slightly weaker, connection ($r = 0.578$). These correlations are statistically significant at the 0.01 level, providing strong evidence that these links are not due to chance. Additionally, there are moderate intercorrelations among the three self-care variables, indicating they are related but distinct aspects of behaviour.

Research Question 2: What is the joint effect of self-care practices (physical, psychological, and professional) on the mental health of people living with HIV/AIDS in Mogadishu, Somalia?

Table 2 shows the regression analysis of the combined effects of physical, psychological, and professional self-care practices, which significantly predict mental health outcomes among people living with HIV/AIDS when considered together. It has strong predictive power with an $R^2 = 0.657$; the model explains a large portion (65.7%) of the variation in mental health, indicating a solid combined effect. The ANOVA results, $F_{(3, 149)} = 95.056$, $p < .005$, confirm that the model fits well, showing that the predictors together make a significant contribution to mental health.

Research Question 3: What are the relative effects of self-care practices (physical, psychological, and professional) on the mental health of people living with HIV/AIDS in Mogadishu, Somalia?

Table 3 reveals that the three factors of self-care practices (physical, psychological, and professional) are potent predictors of the mental health of people living with HIV/AIDS. The most potent factor is psychological self-care practices ($\beta = .404$, $t = 7.734$, $p < .001$), followed by physical self-care practices ($\beta = .370$, $t = 6.895$, $p < .001$) and professional self-care practices ($\beta = .302$, $t = 5.629$, $p < .001$). A one standard deviation increase in psychological self-care practices results in a 0.404 standard deviation increase in mental health. Likewise, one standard deviation increase in physical and professional self-care practices leads to 0.370 and 0.302 standard deviation increases in mental health, respectively. All positive beta coefficients indicate that higher engagement in self-care practices predicts better mental health outcomes.

DISCUSSION

This study identified psychological self-care as the strongest predictor of mental health among people living with HIV/AIDS (PLWHA) in Mogadishu. Internal coping strategies such as mindfulness, emotional regulation, and positive thinking were central, aligning with prior evidence that psychological self-care effectively mitigates symptoms of anxiety and depression, particularly in individuals managing chronic stressors like HIV [39-41]. [42] further emphasize that such practices foster a sense of control and self-efficacy, critical components of resilience and mental wellness.

Physical self-care also demonstrated a strong association with mental health outcomes. This is consistent with research by [43], who found that regular physical activity, sufficient sleep, and proper nutrition significantly enhance emotional well-being. Physical health is also observed by [44] psychological well-being, which depends greatly on its basis, most especially for persons with chronic conditions. These results confirm that physical routines serve not only the purpose of ensuring good bodily health but also the purpose of maintaining good mental health, as a buffer against mental discomfort.

Although professional self-care demonstrated a slightly lesser correlation with mental health, it is an appropriate factor. [45] clarify that professional boundaries, supervision, and unending learning may reduce burnout. Similar results about professional self-care were identified by [46], who discovered that during the treatment of clients by healthcare workers who have undertaken professional self-care, the latter are more effective and contribute to the improved state of their mental health. However, the reduced correlation of the current study could probably relate to the contextual barrier in Mogadishu, including scarcity of resources, lack of training infrastructure, and institutional support mechanisms. Excellent systemic enablers, including workplace policies, supportive leaders, and organizational culture, are critical to professional self-care, which, according to [47], may not be well-developed in fragile health systems such as Somalia.

All these findings indicate that professional self-

care in resource-limited settings must be institutionally supported to achieve its full benefits. Investing in workforce development is essential for fostering professional self-care, achieved through robust training infrastructure, comprehensive workplace wellness policies, and sustained attention to employee well-being conditions.

Additionally, the moderate correlations among the three self-care domains support [48] the holistic model, indicating that psychological, physical, and professional practices function as complementary rather than overlapping contributors to mental health. While the findings generally align with previous research, some differences are noteworthy. For example, [49] found that physical self-care had more consistent impacts on mental health than psychological strategies among chronic illness populations. These differences may result from contextual, cultural, or methodological factors. Furthermore, this study did not consider broader socio-ecological influences like stigma or social support, which are known to affect mental health outcomes in PLWHA [50, 51].

Notably, the cumulative contribution of the three self-care dimensions supports a holistic mental health framework, emphasizing the additive value of behavioural, emotional, and occupational practices. This resonates with [9], who found that multidimensional self-care significantly reduced burnout among professional women. The present study expands upon those findings by focusing more broadly on emotional well-being and psychological functioning among PLWHA in a conflict-affected context. Notably, [9] included spiritual self-care, which was not assessed in this study; the similarity in findings across diverse populations emphasizes the universal relevance of self-care practices for mental health. The findings are also consistent with the Indivisible Self Model of Wellness [52], which posits that wellness is a multifaceted construct involving physical, psychological, and professional domains. Likewise, [49] argues that simultaneous engagement in diverse self-care behaviors has synergistic effects on reducing depressive symptoms. [53] further supports this integrated model in its guidelines for comprehensive HIV care, emphasizing the need for psychosocial and behavioural support alongside

biomedical treatment.

The high explanatory power of the model [$R^2 = 0.657$] mirrors findings by [47], who reported that self-care behaviours accounted for 60% or more of the variance in mental health outcomes. This supports the growing recognition of self-care as a central, not peripheral, component of psychological health. Nevertheless, scholars caution that high R^2 values may overestimate the role of individual behaviours if confounding variables such as socioeconomic status or trauma exposure are not accounted for [51,52]. It is also possible that the estimates can be exaggerated through the use of self-reported measures and not considering the social desirability bias [54]. Cultural and contextual dynamics in Mogadishu may also amplify the importance of self-care, particularly where institutional mental health services are limited. As [55] and [56] argue, in such environments, self-care often substitutes for formal care systems. This may explain the strong association observed between self-care and mental health in this setting, compared to higher-income countries where institutional support is more readily available.

Additional evidence of the predictive strength of psychological self-care can be found in the argumentations of [41], who support the idea that practices like journaling, therapy sessions, and mindfulness can significantly decrease anxiety and depression in chronically ill populations. [42] also, reinforce that internal coping mechanisms are vital for sustaining mental health under chronic stress. Likewise, the role of physical self-care is substantiated by evidence that regular exercise, nutrition, and rest positively influence mood and cognitive functioning [49, 44].

The role of professional self-care, while more limited in this study, remains significant. [45] and [46] show that workplace boundaries, peer support, and supervision mitigate secondary trauma and enhance psychological resilience, particularly for caregivers and professionals within HIV care systems. The moderate beta values (30.2%–40.4%) across all self-care types indicate that no single practice suffices on its own, but all contribute additively to mental well-being, affirming the need for integrative self-care models [52].

However, some literature challenges the primacy of

psychological self-care in resource-constrained environments. [57] found that basic physical needs—rest, food, hygiene—must be addressed before psychological interventions can be effective, particularly in trauma-prone or post-conflict settings. This supports the idea that the relative impact of each self-care type is context dependent. Professional self-care may also be limited where systemic support is absent, as noted by [47], emphasizing the importance of institutional capacity for sustainable self-care. The limitations of this study highlight the need to integrate unmeasured psychosocial variables such as stigma, trauma, or financial hardship in future models. These factors may mediate or moderate the self-care–mental health relationship [50,51], particularly in vulnerable populations.

Theoretically, the findings align with the Health Belief Model (HBM), which posits that individuals are more likely to engage in health-promoting behaviours when they perceive clear benefits and possess the confidence [self-efficacy] to act [58]. The strong predictive power of the model suggests that cues to action—such as counselling, health education, or social networks—may be triggering increased self-care engagement among PLWHA in Mogadishu. The dominance of psychological self-care may also reflect participants' perception of the severity of mental health challenges, reinforcing the link between perceived severity and preventive action [59].

However, the HBM's limitations are evident. It does not fully capture social or systemic barriers to behaviour change. [60] and [61] argue that the model underestimates the influence of structural determinants and emotional or habitual behaviours, particularly relevant in contexts of trauma and poverty. These gaps reinforce the need to complement HBM with socio-ecological frameworks when addressing self-care and mental health in low-resource settings.

Conclusion

This study examined the relationships and predictive effects of physical, psychological, and professional self-care practices on the mental health of people living with HIV/AIDS in Mogadishu, Somalia. The findings reveal that all three types of self-care practices are positively and significantly

associated with mental health. Psychological self-care emerged as the strongest individual predictor, followed closely by physical and professional self-care. Collectively, these self-care domains explained a substantial 65.7% of the variance in mental health, underscoring their critical role in enhancing psychological well-being in this population. The results support a holistic and multidimensional view of self-care, suggesting that mental health outcomes are best promoted through an integrated approach that includes emotional regulation, physical health maintenance, and professional well-being strategies. These findings are consistent with global models of wellness and chronic disease management and highlight the importance of supporting self-care as part of psychosocial interventions in HIV care.

Despite its strengths, the study also highlights contextual barriers, such as limited access to professional development, poor institutional support systems, and widespread stigma, which can hinder the full benefits of self-care. These findings call for integrated, community-based approaches that strengthen self-care capacity while addressing systemic and structural barriers.

Recommendations

Based on the study's findings, the following recommendations are proposed:

Integration of Self-Care Education into HIV Care Models: Health facilities, NGOs, and policymakers should incorporate structured self-care education—especially on psychological, physical, and emotional strategies—into all HIV/AIDS support services. This includes teaching stress management, mindfulness, nutrition, sleep hygiene, and physical exercise as core components of HIV care. These skills should be made accessible through routine clinical care, support groups, and outreach programs.

Scale Up Psychological and Community-Based Mental Health Interventions: Given the strong predictive power of psychological self-care, HIV programs must prioritize counselling, mindfulness training, and stress-reduction strategies. Where mental health professionals are limited, grassroots solutions—such as peer-led support groups, mobile mental health units, and community counselling—

should be expanded to meet the psychological needs of PLWHA, particularly in underserved and conflict-affected areas like Mogadishu.

Supporting Physical Wellness Through Routine Health Education: Health educators and HIV care providers should consistently promote physical self-care practices, including regular exercise, balanced nutrition, adequate sleep, and routine health monitoring. These wellness behaviours are essential not only for managing HIV symptoms but also for improving mental health and emotional resilience.

Enhancing Institutional and Professional Support Systems: For healthcare workers, caregivers, and PLWHA involved in service delivery, institutions should provide access to supervision, professional development, and workplace wellness programs. Donor agencies and NGOs must invest in long-term workforce capacity-building to enable professional self-care and reduce secondary trauma and burnout.

Addressing Structural and Cultural Barriers Through Policy and Advocacy: Policymakers should work with community leaders, religious institutions, and civil society to combat HIV-related stigma and discrimination. Holistic, culturally appropriate mental health and self-care services must be embedded in national HIV care frameworks, with policies that reflect the psychosocial realities and gender dynamics specific to Somali society.

Expanding Research on Contextual Factors and Long-Term Effects: Future studies should examine how variables such as stigma, social support, income, trauma, and education influence the relationship between self-care and mental health. Mixed-method and longitudinal research designs are encouraged to provide deeper, more actionable insights for intervention design and policy development.

Ethical Considerations

Approval was obtained from Banadir Hospital Mogadishu, Somalia, dated 28th September 2024. Before participating, participants were provided with informed consent, and those who returned the form after two weeks were included in the study. Participation was strictly voluntary, anonymous,

and the confidentiality of all the responses was protected.

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TABLES

Table 1: Zero-order correlation showing relationships among variables

	Variables	$\bar{X}$	St. Dv	1	2	3	4
1	Mental Health	3.15	.65	1.0			
2	Physical Self-care	3.19	.59	.622**	1.0		
3	Psychological Self-care	3.37	.68	.625**	.331**	1.0	
4	Professional Self-care	3.25	.70	.578**	.392**	.327*	1.0

Source: Field Survey, 2024 (** significant at 0.01, * significant at 0.05)

Table 2: Regression summary showing the joint effects of self-care practices (physical, psychological, and professional) on the mental health of people living with HIV/AIDS.

R = .810 Adj.R² = .650

R² = .657 Std. Error = .383

Model	Sum of Squares	Df	Mean Square	F	Sig.
Regression	41.716	3	13.905	95.056	.001
Residual	21.797	149	0.146		
Total	63.513	152			

Source: Field Survey, 2024

Table 3: Multiple Regression summary showing the relative effects of self-care practices (physical, psychological, and professional) on the mental health of people living with HIV/AIDS in Mogadishu, Somalia.

	Unstandardised Coefficients		Standardized Coefficients			
Model	B	Std. Error	Beta (β)	T	Sig.	
(constant)	-.344	0.209		-1.643	<.001	
Physical Self-care Practices	0.404	0.059	0.370	6.895	<.001	
Psychological Self-care Practices	0.385	0.050	0.404	7.734	<.001	
Professional Self-care Practices	0.277	0.049	0.302	5.629	<.001	

Source: Field Survey, 2024