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UNDERSTANDING AND TACKLING THE GENDERED DRIVERS OF POOR ADOLESCENT MENTAL HEALTH

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Chisina Kapungu & Suzanne Petroni
International Center for Research on Women

INTRODUCTION

In its most recent and thorough publication on adolescent health, *Global Accelerated Action for the Health of Adolescents (AA-HA!)*, the World Health Organization (WHO) reports that more than 1.2 million adolescents die each year from largely preventable causes, with most deaths occurring in low- and middle-income countries (LMICs) in Africa and South and East Asia (WHO, 2017). Self-harm, which encompasses both suicide and accidental death resulting from self-harm, is among the three leading causes of adolescent mortality, contributing to more than 67,000 deaths each year (WHO, 2017).

Since at least the year 2000, self-harm has consistently been ranked as the world's first or second leading cause of death for older adolescent girls (age 15-19), with particularly high rates among girls living in South and East Asia. Beyond its impact on mortality, however, self-harm and other consequences of poor mental health can put tremendous burdens on adolescents, their families and their communities. Indeed, poor mental health is now the greatest contributor to the non-fatal burden of disease in young people worldwide (Sawyer et al., 2012). But only in recent years has the global health community begun to recognize these factors.

Depression-related illnesses peak in adolescence, just as gender norms are being consolidated (Whiteford, 2013). Adolescent girls are particularly at risk, with a much higher incidence of depression than males, a trend that persists throughout their reproductive lives. While very little is known about the gendered drivers of depression among adolescent girls and boys, self-harm and suicide in LMICs, evidence from neuroscience and social science suggests that the experience of pervasive gender-based discrimination may be a significant contributor to poor mental health, depression and suicide among adolescents and that this deserves further study (Petroni, Patel, & Patton, 2015).

Good mental health is critical to ensuring healthy transitions to adulthood, with implications for overall well-being, growth and development, self-esteem, positive education outcomes, social cohesion and resilience in the face of future health and life changes (UNICEF, 2012). But few programs and policies have effectively addressed the mental health needs of adolescents. Further, programs and policies that do exist rarely take gender differences into account or reach the most marginalized. Marginalized groups include adolescents that are very young; living in poverty; married; out-of-school; or lesbian, gay, bisexual, transgender and intersex; and others. Not appropriately accounting for and addressing the age-specific, gender-specific and context-specific needs of adolescents can harm them by increasing their vulnerability. Ensuring their healthy development requires a focus on alleviating risks, as well as on factors that can offer protection.

Indeed, understanding adolescent girls' and boys' unique and common vulnerabilities to mental health risks, including the impacts of harmful gender norms and the factors that can protect and enhance their mental health and wellbeing, are crucial when considering appropriate policies and interventions. The health and development communities need more research and concrete action

to ensure a collaborative, coordinated and appropriately sized response to the growing burden of poor mental health among adolescents.

This paper attempts to provide a starting point for discussion about what is currently known about the connections among gender, adolescence and mental health, and to provide some initial considerations to help guide a research and program agenda moving forward. It begins with a broad discussion of gender and health during adolescence, then turns more specifically to what is known about gender and mental health in this important life phase. It then highlights some existing interventions, poses imperatives for future work, and draws conclusions for further consideration. We hope readers find it a valuable contribution to a growing conversation.

GENDER AND ADOLESCENT HEALTH

About 1.2 billion adolescents age 10–19 are now alive in the world, nearly 90 percent of them in LMICs (Blakemore & Mills, 2014). Despite the large numbers, adolescence has only recently begun to be taken into account in global health research and programming. Indeed, adolescence has traditionally been viewed as a rather healthy period of the life cycle, requiring less attention than other age periods (Patton et al., 2016). New evidence, however, proves that it is not necessarily free of significant health concerns (Patton et al., 2016).

Sex-differentiated mortality and morbidity patterns begin to emerge during adolescence, with variations in some cases due to differences in biological and environmental risk factors and interactions (Blum, Astone, Decker & Chandra-Mouli, 2014; WHO, 2017). Road injury is the leading cause of death in both young and older adolescent males, but for females the leading cause of death changes from lower respiratory infections among younger girls to maternal conditions among older adolescents (WHO, 2017). Girls and young women are also up to three times more likely than boys to have depressive disorders and to attempt self-harm (WHO, 2014a), which is one of the leading causes of death among adolescent girls. Concurrent mental and physical disorders are linked to higher mortality and morbidity

(Tiihonen et al., 2009), suggesting a need to integrate delivery of currently segmented mental and physical health care and services.

Structural determinants of health— the social, economic and political contexts that contribute to health disparities—can lead to differences in status, power, privilege and access to resources and information (Population Reference Bureau, 2014). Structural factors such as national wealth, income inequality and access to education are strong determinants of adolescent health at the population level (Viner et al., 2012). Gender norms further influence adolescent girls' and boys' susceptibility and exposure to different health risks, as well as access to and use of treatment and diagnosis of health conditions, including mental health. Yet gender, as a key determinant of health, has often been neglected in health research and programming.

Girls living in many LMICs face a variety of social and cultural factors that place them at risk of poor health. Adolescent girls and young women often lack a full range of opportunities and are devalued because of gender bias and low social status. Girls are more likely than boys to be married as children, to drop out of school and to experience forced sexual initiation (UNICEF, 2012). Girls who marry before age 18, as 15 million do each year, face diminished opportunities for education and paid employment, reduced agency and decision-making capacity and increased risk of intimate partner violence. Child brides are also exposed to health risks from early pregnancy, greater maternal and infant mortality and heightened vulnerability to HIV/AIDS and other sexually transmitted diseases (Klugman et al., 2014).

Gender norms can reinforce girls' and young women's unequal position in relationships, which can reduce their ability to refuse sexual advances and to negotiate safer sexual practices, including condom use. Nearly 30% of adolescent girls age 15–19 report lifetime physical and/ or sexual violence by an intimate partner (WHO, 2013) and, in many countries, girls are several times as likely as boys to become infected with HIV. In sub-Saharan Africa, for example, young women age 15–24 are twice as likely as young men to be living with HIV (Joint United Nations Programme on HIV/AIDS, 2014).

Boys and young men also face gendered influences on their health. Cultural expectations of "what it means to be a man" may lead boys to engage in risky and health-harming behaviors, such as early and heavy smoking and use of alcohol and illicit drugs (UNICEF, 2012). They may, for example, be less inclined to wear helmets and seat belts and more inclined to drive fast, engage in risky sexual behaviors and act violently to demonstrate their masculinity.

Important strides were made with the Millennium Development Goals (MDGs) to reduce maternal and child mortality and malnutrition and combat HIV/AIDS, malaria and tuberculosis, but the MDGs paid little attention to adolescent girls and boys specifically. The more recent inclusion of adolescent health in the United Nations Secretary General's Global Strategy for Women's and Children's Health, as well as targets directly linked to adolescent health in the Sustainable Development Goals (SDGs) represent important opportunities to expand attention to health in this critical age cohort.

It is important to acknowledge that, while the evidence base on adolescent health is growing, tremendous gaps exist. Health interventions for adolescent girls and boys have historically focused on sexual and reproductive health and HIV/AIDS. For this reason, the collection and reporting of data regarding early pregnancy, sexually transmitted infections, maternal health and associated sexual and reproductive health outcomes are relatively strong (Blum, Bastos, Kabiru, & Le, 2012; Patton et al., 2016). Even here, however, scant data exist for very young adolescents (age 10-14), and because of poor records, social norms and other barriers, much of the data that do exist likely do not capture the true scope and scale of their health issues and challenges. Non-communicable diseases are also rapidly rising in LMICs, yet limited attention has been given to this area.

Just as this lack of data poses challenges to health practitioners, planners and policymakers, so too is a lack of information a major barrier for adolescent health, particularly for adolescent girls. Inadequate access to sexuality education and appropriate sexual and reproductive health services, combined with a dearth of information about their own bodies and

sexuality more generally, contributes to a lack of power in girls' relationships and puts them at increased risk of unwanted and high-risk sexual encounters.

The *Lancet Commission on Adolescent Health and Wellbeing* recommends that the global development community adopt a broader concept of adolescent health that includes not only sexual and reproductive health, but also infectious diseases, nutritional deficiencies, injury and violence, non-communicable diseases and their risk factors, as well as mental health and substance misuse (Patton et al., 2016). Addressing this full range of issues requires improved health and social services that better respond to adolescents' health needs, even as they vary by age, cognitive capacity, sexual orientation and gender identity and the diverse contexts in which adolescents grow and develop. Service delivery models must be informed by data on the gender-related barriers that hinder adolescents' use of health services. As adolescent health is often determined by factors beyond the realm of the health sector, strategies should be built on multisectoral action.

GENDER AND MENTAL HEALTH IN ADOLESCENCE

Mental disorders commonly emerge during the adolescent years, influenced both by the biological, emotional and cognitive processes associated with puberty and by the social contexts surrounding adolescents as they mature through this important phase of life (Patton et al., 2016). The existing literature suggests complex and important links among the adolescent developmental phase, gender norms and mental health.

First, we know that adolescence is a period of rapid biological, psychological and social change. Some research has found that puberty, especially early puberty, can trigger psychological stress for both girls and boys (Mensah & Patton, 2013). Pubertal development, brain maturation and increasing sensitivity to social cues (which in themselves can be influenced by gender norms) are all features of adolescence. From neuroscience and genetics, we know that the adolescent brain is highly dynamic, and that environmental and

TABLE 1: DISTRIBUTION OF SUICIDAL THOUGHTS (%) AMONG ADOLESCENTS BY VIOLENCE AGAINST CHILDREN SURVEYS (VACS) COUNTRY

VACS country	Females	Males	Difference (Females-Males)
Cambodia (2013)	5.41	1.28	4.13
Haiti (2012)	23.41	6.27	17.14
Kenya (2010)	13.44	6.29	7.15
Malawi (2013)	4.43	2.50	1.93
Tanzania (2009)	7.30	5.51	1.79
Swaziland (2007)*	14.00	N/A	N/A
Average	11.33	4.37	6.43

% = adjusted; accounts for complex survey design within each dataset
* = females surveyed only

genetic factors interact to influence the probability "that environmental influences (such as gender roles) may influence the specific expression of the phenotypes associated with these pathways" (Patel, 2013).

Pubertal processes, including gonadal hormone changes, may be relevant to understanding sex differences in the pattern of mental and behavioral problems that emerge during adolescence (Goddings, 2015). Girls are no more likely than boys to evidence depression in early childhood, but after puberty, girls' risk of depressive disorders increases drastically, and there is a significant gender gap. Females are between 1.5 and 2 times more likely than males to be diagnosed with depression, both during adolescence and throughout their lives (Patel, 2013). Table 1 illustrates data from the Violence Against Children Surveys (VACS) for six countries, which demonstrate the difference in suicidal ideation (having ever considered killing oneself) between adolescent females and males.

ACCORDING TO THE WORLD HEALTH ORGANIZATION:

Gender is a critical determinant of mental health and mental illness. The morbidity associated with mental illness has received substantially more attention than the gender-specific determinants and mechanisms that promote and protect mental health and foster resilience to stress and adversity. Gender also determines the differential power and control men and women have over the socioeconomic determinants of their mental health and lives, their social position, status and treatment in society, and their susceptibility and exposure to specific mental health risks (WHO, 2014b).

Both girls and boys are affected by social norms and expectations based on their gender and sexuality. Gender role differentiation increases during adolescence, and discrimination based on gender also intensifies during this critical phase of development (Petroni, Patel, & Patton, 2015). Rigid gender norms can profoundly and negatively affect both girls and boys and can particularly constrain girls' aspirations and opportunities. They can influence girls' ability to travel or attend school, the places they can and cannot go in the community, and the nature and types of social interactions they are permitted to engage in. Boys are more able to move freely about and thus have greater opportunities than girls to participate in society and in income-generating activities (Lundgren et al., 2013).

Gender intensification – the increased pressure for adolescents to conform to culturally sanctioned gender roles – has been posited as an explanation for gender differences in depression (Hill & Lynch, 1983). These pressures come from a variety of sources, such as parents, peers, educators and the media. While gender socialization starts at birth, early adolescence (age 10–14) is a critical point, as puberty intensifies social expectations from family members and peers related to gender.

Attitudes that endorse norms perpetuating gender inequality can be harmful to both boys and girls. A mixed-method systematic review suggests that young adolescents in a variety of cultural settings commonly endorse norms that perpetuate gender inequalities, and that parents and peers are central in shaping such attitudes (Kagesten et al., 2016). Also, while the evidence base in low-income countries is scant, data from high-income countries suggest that gender role conflict serves as a potential risk factor for suicidal behavior in adolescents (Pinhas, Weaver, Bryden, Ghabbour, & Toner, 2002).

Evidence from diverse countries demonstrates that exposure to gender discrimination, physical and

emotional abuse, violence, poverty, social exclusion, educational disadvantage, harmful gender norms and psychological stress that accompanies humanitarian crises can all increase mental health problems, including depression (Landstedt, Asplund, & Gillander, 2009; Reiss, 2013; Aggarwal & Berk, 2014; Rhodes et al., 2014; Kagesten et al., 2016). In most countries, girls are at greater risk than boys for all these precursors. Indeed, while gender inequalities affect the lives of both boys and girls, they disproportionately disadvantage girls.

Gender-specific risk factors for girls can include unequal access to resources, decision-making power and education; gender-based violence; and discriminatory practices such as child marriage (Le Strat, Dubertret, & Le Foll, 2011; Rhodes et al., 2014). These risk factors interact with culture and socioeconomic circumstances to elevate exposure and vulnerability to health risks, such as depression, self-harm and suicide. Other research finds that negative, humiliating, or entrapping interpersonal events can join social stress in precipitating women's depression (Broadhead & Abas, 1998; Patel et al., 2001; Brown, 2002; Kessler, 2003). For boys, endorsement of stereotypical masculine norms has been associated with substance abuse, delinquency, perpetuation of interpersonal violence and reduced help-seeking (Rhodes et al., 2014).

While roughly as many boys as girls age 15–19 die from suicide each year, girls and boys face different risk factors and suicide attempts. Data from some countries suggests that girls are more likely to attempt suicide, which causes an unrecognized burden of disability, while boys may have greater access to more lethal methods of self-harm, so they tend to die at higher rates per suicide attempt. Girls are often among the most socially and economically marginalized members of communities, and evidence suggests that such marginalization can contribute to greater risk of suicide (Patton, 2014). To address these challenges, the gendered differences in both motivation and means of self-harm need to be better understood, particularly in developing country settings, where both evidence and interventions are scarce.

Gender-specific risk factors associated with poor mental health

Forms of gender-based discrimination that become exaggerated during adolescence include violence; child, early and forced marriage; sexual abuse and exploitation; limitations on reproductive control; exclusion from education, employment and decision-making; and unequal chore burdens and caretaking responsibilities (Petroni, Patel, & Patton, 2015). Gender-role conflict, defined as psychological or social difficulty arising when individuals have internalized characteristics other than those traditionally ascribed to their sex, can affect adolescents facing contradictory societal and familial role expectations. They may find themselves with conflicting desires, which increase their risk for suicide (Pinhas et al., 2002). Girls' lack of social power also makes them more vulnerable than boys to specific major traumas, particularly sexual abuse. Traumas may contribute directly to depression by making girls feel they are helpless to control their lives, and may also contribute indirectly by increasing girls' reactivity to stress.

Gender-based violence is also associated with a higher prevalence of mental health problems. Sexual assault at any age is closely associated with depression and anxiety disorders, and women who have experienced sexual assault either in childhood or as adults are also more likely to attempt suicide than other women. There are also associations between boys' experience of violence or neglect and their perpetration of violence as adults, suggesting multigenerational impacts of violence and adverse mental health outcomes (Heilman, Herbert, & Paul-Gera, 2014). Far more research needs to be done on how violence or the threat of it affects the mental health of adolescent boys and girls throughout their lives.

Child marriage has been associated in a limited number of studies with increased odds of suicidal thoughts (Gage, 2013). Adolescent girls in South Asia have cited early marriage and intimate partner violence as drivers of self-harm and suicide (UNICEF, 2014). Defined as a legal or customary union between two people, at least one of whom is below age 18, child marriage disproportionately affects girls, who are typically married to older boys and men (Warner et al., 2013). Although child marriage is a

violation of international human rights standards, as well as national law in most countries, it continues to be a pervasive practice throughout the developing world, with one in three women age 20–24 married before age 18 (United Nations Population Fund, 2014). In many parts of the world, a girl's greatest asset is perceived to be her marriageability and fertility. Expectations and control of these perceptions, as well as related social pressures, result in many girls marrying and bearing children young, often before they are physically or emotionally prepared.

Closely related to the phenomenon of child marriage is early and high-risk pregnancy. In societies where access to sexuality education, contraception and safe abortion is limited, girls who become pregnant outside of wedlock may believe that self-harm or suicide are their only alternatives (Petroni, Patel, & Patton, 2015).

Stigma and discrimination increase vulnerability to depression and suicide, and stigma and discrimination can be fueled by gender norms. Girls and boys of a different sexual orientation or gender identity than social norms or laws prescribe face even greater risk of depression and suicide. According to WHO, discrimination experienced by people who identify as gay, lesbian, bisexual, transgender, or intersex are among subgroups who may experience "loss of freedom, rejection, stigmatization and violence that may evoke suicidal behavior" (WHO, 2014c). People living with or affected by HIV—a large proportion of young people in many parts of the developing world—are more vulnerable to poor mental health outcomes as well. For example, a study in South Africa found that adolescents with parents who died or were sickened by HIV had sharply higher rates of suicide behaviors than other adolescents, and that rates were higher among females than among males (Cluver, Sherr, Orkin, & Boyes, 2014).

Critical new evidence points to the need for urgent attention to adolescent mental health in emergency settings. Specific vulnerabilities of women, children and adolescents living in humanitarian crises threaten their health and well-being. The mental health of children who have been forcibly displaced is of particular concern because poverty and exposure to violence in their countries of origin, followed by migration and finally resettlement into a new context, expose them to several and cumulative risks to their physical, emotional and social development.

Exposure to conflict and resettlement stress can vary by sex. Boys and girls in conflict situations, facing loss of property, homes and livelihoods, may join resistance groups or marry early to protect against sexual violence. Boys and girls have different likelihoods of being exposed to events such as gender-based violence or recruitment as child soldiers, and there are differences in family and societal responses to distress in boys and girls (Mels, Derluyn, Broekaert, & Rosseel, 2010).

We hypothesize that rigid social norms and gender-based discrimination limit the perceived control that both girls and boys have over their own lives and futures, and that this perceived lack of control can have deleterious effects on their mental health and overall well-being. Evidence that shows how gender norms and gender-based discrimination may harm the mental health of girls and boys can inform policies and programs that seek to improve their overall well-being. More rigorous evidence of this kind is greatly needed across LMICs.

ADOLESCENT MENTAL HEALTH INTERVENTIONS IN LMICS

The burden of poor mental health in adolescents spotlights a growing need to identify and implement effective interventions for them. Systematic reviews of adolescent mental health interventions from both LMICs and high-income countries demonstrate that comprehensive mental health promotion interventions, delivered in collaboration with families, schools and communities, lead to improved mental health, social functioning and general health behaviors (Barry, Clarke, Jenkins, & Patel, 2013; Das et al., 2016).

In LMICs, mental health and psychosocial support programs for adolescents (see box 1 on page 7) have largely been confined to the humanitarian sphere. Populations affected by humanitarian crises have multiple and complex needs and require a comprehensive mental health and case management approach that identifies, supports and protects those who are vulnerable, while promoting stability and recovery.

School-based programs incorporating life skills and social and emotional learning, along with early interventions to address emotional and behavioral problems, can improve social and emotional functioning, health behaviors and academic performance. Robust evidence from a systematic review of mental health promotion programs in LMICs found that school-based interventions can also reduce depression and anxiety while improving coping skills (Barry et al., 2013).

Key barriers to the sustainable delivery of mental health or psychosocial interventions in LMICs include limited funding and infrastructure, chronic shortage of mental health professionals, lack of treatment adapted to the local context and challenges associated with training and supervision. Further, without specific attention to gender differences and the social norms that may be influencing poor mental outcomes, clinical interventions are likely inadequate to address the many challenges.

Indeed, it is likely that programs addressing the impact of gender norms on adolescent mental health will not necessarily have an explicit mental health focus. Programs that promote more equitable gender norms and aim to empower adolescent girls may not only shift social norms but also have the consequence, intended or not, of improving mental health outcomes for both boys and girls.

For example, adolescent girl-focused programs that take a comprehensive approach to addressing girls' multiple vulnerabilities, such as social isolation, economic insecurity, lack of access to health services and sexual and gender-based violence (Erulkar, Ferede, Girma, & Ambelu, 2013), may be excellent springboards from which to build the evidence base on adolescent mental health outcomes. Programs that build the assets of girls or address masculinity in boys can similarly provide opportunities to measure mental health or psychological well-being outcomes. Such programs must be paired with efforts to shift norms at the family and community level to create an enabling environment for change.

A growing evidence base suggests that efforts to engage men and boys to promote health, prevent violence and advance gender equality can also serve as opportunities to address and improve gender norms (Namy, Barker and Dworkin, 2014), though much more needs to be done to

Gender and age considerations appear to be reflected in the way the humanitarian community assesses needs and implements emergency response and recovery operations (Mazurana, Benelli, Gupta, & Walker, 2011; DARA, 2011; Plan International, 2013).

For example, the *I'm Here* approach outlines a roadmap for mainstreaming adolescent girls into emergency response programs and for collecting information that can inform the design of targeted humanitarian interventions that address girls' vulnerabilities (Women's Refugee Commission, 2014). However, few programs specifically address gender norms, and scientific evidence on the mental health and psychosocial supports that prove most effective in emergency settings is still thin (see Annex).

Schools are one of the most important settings for promoting the mental health of adolescents, as they provide a forum for advancing social and emotional competence as well as academic learning. Mental health promotion and universal prevention interventions designed for school-going adolescents range in focus from the development of social, emotional, problem-solving and coping skills to mental health promotion, combined with sexuality education or physical fitness programs (Barry et al., 2013). Most of the school-based life skills and resilience programs in LMICs indicate positive effects on students' self-esteem, motivation and self-efficacy, though there are differential effects for gender and age groups (Mason-Jones et al., 2012).

understand the most effective ways to change harmful norms related to masculinity. An important step in gender-based programming for men and boys seems to be acknowledging explicitly that prevailing gender-inequitable definitions of manhood are part of the problem.

IMPERATIVES FOR THE FUTURE

The global development community is beginning to recognize the importance of mental health and well-being. The inclusion of mental health in the SDGs and the WHO Comprehensive Mental Health Action Plan for 2013–2020 are major steps toward recognizing and addressing the magnitude of the problem, but mental health disorders remain largely undertreated, particularly in LMICs. Investments in mental health programs in LMICs are also not proportionate to the burden of these disorders, with most countries investing less than one percent of their health budgets in mental health services (WHO, 2015).

In addition to inadequate funding, a dearth of appropriately trained human resources, lack of effective policies, competition with other basic health priorities and gender-irrelevant programming all suggest limited capacity on the part of most LMICs to prevent and respond to the mental health needs of adolescents. Also, a tremendous challenge to progress in this area is an inadequate evidence base, particularly around the influence of gender norms as a driver of poor mental health.

Mental health policies and programs in LMICs must incorporate a far greater understanding of gender dynamics to be most effective. Further, they should be developed in consultation with adolescent girls and boys to increase their relevance and effectiveness. Qualitative and quantitative research can generate a deeper understanding of the intersections between gender, adolescence and mental health in LMICs, including among hard-to-reach adolescent populations.

Qualitative research can focus on understanding the ways adolescents perceive gender roles and expectations and how these perceptions affect their psychosocial stress and mental health outcomes, including depression and suicide. Quantitative research, in the form of household surveys, can help to determine the prevalence and psychosocial correlates of mental

health problems among both in-school and out-of-school adolescents and identify context-specific risk and protective factors, including gender-specific risk factors. More implementation or operations research can help to identify some of the factors that promote mental health and reduce the risk of depression and suicide while building the resiliency of adolescent girls and boys. Results from such studies could be used to design suitable intervention programs at the school, community and primary-care levels.

School health services may be a priority area for strategic mental health interventions, given the growing retention of adolescents in secondary education and the health services' responsiveness to adolescents' needs. In many contexts, community-based interventions may also be effective and likely to remain important in places where harmful gender norms prevail and where rates of secondary school attendance are low.

The magnitude of the public health problem of suicidal behaviors creates an urgent need for governments to develop comprehensive national suicide prevention strategies that give context to the problem and outline specific actions to take at multiple levels. Without such a strategy, governments cannot put in place mechanisms to address this issue in a sustained manner. Health care services also need to incorporate suicide prevention as a core component, including mental health care training for health workers and community outreach workers, so they can serve in the frontline of suicide prevention (Devries et al., 2011; García-Moreno et al., 2015; WHO, 2014c).

The provision of clinical or medical services alone is clearly inadequate to address the negative impacts that gender norms may have on mental health. If gender discrimination, gender-based violence, gendered barriers to care and gender-role stereotyping underlie mental health problems, these must be addressed through policies, programs and interventions that can be offered by medical professionals and clinicians.

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CONCLUSION

There is growing recognition within the international community that mental health improvement is a neglected yet essential lever for achieving the SDGs. Despite this recognition, few donors have prioritized the issue, and a mental health program gap continues among LMICs. Failure to invest in the mental health care of adolescents, in particular, will negatively influence not only the health of this generation but also that of future generations. It is therefore imperative to identify ways in which to improve adolescent mental health.

To better understand the intersection between gender, adolescence and mental health, the International Center for Research on Women, a U.S.-based research institute, together with UNICEF, convened 32 experts from academia, civil society and bilateral, multilateral and private donor institutions for a consultation. The convening aimed to bring experts from diverse disciplines to discuss immediate research and programmatic priorities for designing and implementing gender transformative mental health programs.

Recommendations from the convening will be available in a forthcoming publication.

An enhanced understanding of the distinct mental health challenges that face adolescent girls and boys in different contexts, and of the ways these challenges are affected by gender-based discrimination, can help to identify gaps and establish a course of action for generating new evidence on risks and protective factors.

The SDGs provide an opportunity for renewed attention to meeting the health care needs of adolescents through strengthening health systems, focusing on mental health in the global health care agenda, improving the organization of and integrating mental health services into general health care, addressing the gendered drivers of mental health and developing policies to inform the design and implementation of gender-transformative interventions in LMICs. Prioritizing research and action can help on all these fronts.

ANNEX

This annex provides examples of interventions in low- and middle-income countries (LMICs) that work to improve mental health outcomes for adolescents. While some do not have an explicit gender focus, they could be considered for future adaptation with more focus on gender.

PROGRAMS IN HUMANITARIAN SETTINGS

International Medical Corps

In 2015, the International Medical Corps (IMC) set up mental health and psychosocial support programs in 24 countries (https://internationalmedicalcorps.org/mentalhealth). IMC also launched a regional initiative that provides mental health and psychosocial support in five countries: Syria, Iraq, Jordan, Lebanon and Turkey. IMC's Mental Health and Psychosocial Support team works with local partners to assist children and their families with child-friendly safe spaces and activities in urban and refugee camp settings (IMC, 2015).

The program uses a comprehensive mental health and case management approach that identifies, supports and protects the vulnerable and promotes stability and recovery. The program also strengthens national health systems by training medical and nonmedical professionals to detect and address mental health problems. Case managers then follow up to ensure that those with mental health issues are put in touch with any additional services they need.

IMC also integrates innovative strategies into its core programs to address gender-based violence in Africa, Asia, the Middle East and Russia in areas of armed conflict and post-conflict. They are part of more stable community-based development and capacity-building projects and are also a component of integrated health programs related to human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), nutrition, or reproductive health.

In Jordan, IMC conducted a *Youth Empowerment Program* (IMC & United Children's Fund, 2013) involving Iraqi refugee and vulnerable Jordanian young people in learning life skills and participating in community restoration projects. Participants reported decreased depression and anxiety and improved social support and community connectedness. IMC Jordan also organized a photo camp for vulnerable children and young people in partnership with National Geographic, resulting in building skills among the young people as well as in international exhibitions. IMC's projects for children and young people are not only recreational but also aim to build key life skills, involve families and community leaders, strengthen social support networks and make important contributions to community building.

Mercy Corps

Syrian refugee children and adolescents are experiencing a variety of hardships, including isolation and insecurity, psychological distress, extended disruptions of education and exploitative employment (United Nations High Commissioner for Refugees, 2013). In 2013, Mercy Corps, along with UNICEF, Save the Children and World Vision, spearheaded the *No Lost Generation campaign* to mitigate the devastating impact of the Syrian crisis in various countries. The Advancing Adolescents program, funded by the government of Canada, was designed to strengthen the resilience of young people and enable them to cope with stresses they face and to master practical skills essential to leading healthy lives (Mercy Corps, 2014).

The program, called *Busma* in Jordan and *Nubader* in Lebanon, targets the most vulnerable and isolated refugee and host-community adolescents age 13 to 17 and aims to improve their psychosocial well-being, enhance their ability to develop goals and learn life skills and increase social cohesion among Syrians and host communities. Community-based organizations serve as safe hubs that are led by trained local coaches to foster enriching interactions among community members. Mentors offer educational and skills-building training in safe and familiar locations in the community.

Young people, community leaders, elders and recognized safe people from the community are recruited to form Community-Based Protection Networks (CBPNs), which

are first-response mechanisms for child protection in these isolated areas. By building the capacity of the team, the networks, community-based organizations, coaches and mentors to deal with gender issues and gender-based violence (GBV), the program aims to influence change in young people's traditional perceptions. Through the CBPNs it also responds to and prevents gender-based violence. Activities specifically address boys' and girls' different needs and priorities, as identified in the situational assessment.

International Rescue Committee

The International Rescue Committee's *Women's Protection & Empowerment* program in Jordan focuses on interventions that address GBV, specifically violence against Syrian and Jordanian women and girls. The prevention component focuses on raising awareness of the program's services and decreasing the risks of GBV by offering activities for adolescent girls, working with parents and promoting socioeconomic empowerment.

The response component involves providing comprehensive psychosocial support services, including case management and counseling. Recognizing the gendered impacts of this conflict on Syrian refugees, the IRC has established adolescent girl groups in urban areas to help girls connect with one another, develop life skills and discuss issues they face during adolescence. These groups follow the IRC Jordan's 12-week adolescent girl curriculum, which covers issues such as decision-making, communication, early marriage and menstruation.

The IRC's Girl Empower (GE) program in Nimba County, Liberia, is an innovative program to equip girls age 13-14 with the skills and experiences necessary to make healthy, strategic life choices and to stay safe from sexual and abuse and exploitation. The program offers a combination of mentorship, asset-building, discussion groups and local capacity-building. As part of the program, the IRC invites adolescent girls in rural communities to join groups led by trained local mentors. During weekly meetings, the girls learn about life skills and financial literacy and open savings accounts with seed money from the program.

The program also holds monthly discussion groups for caregivers of participants and trains local health and psychosocial care providers on ways to improve services for GBV survivors. The Population Council, Innovations for Poverty Action and the World Bank are evaluating the program's efficacy in preventing GBV via a randomized control trial featuring a control group, a standard GE group and a GE+ group, where girls and their families experience everything offered by the GE group but are also given small cash incentives to encourage regular meeting attendance.

CARE's Young Men Initiative

The Young Men Initiative (YMI) is a promising, evidence-based strategy for engaging young men in the Western Balkans in promotion of gender equality and prevention of violence. Formative research first identified and explored gender norms and expectations that influence and contribute to young men's discriminatory and violent behaviors. The results informed development of an intervention, which is comprised of social media campaigns and a school-based curriculum (adapted from Promundo's "Program H" model). The goal is to help young men age 13-19 to deconstruct masculinity and reflect on ways that unhealthy gender norms lead to inequitable treatment of women and girls.

The Program H activities have been shown in rigorous studies to lead to positive changes in young men's gender attitudes and behaviors related to violence and HIV prevention (http://www.promundo.org.br/en/activities/activities-posts/program-h/). Preliminary results suggest the project led to an increased uptake of gender-equitable attitudes on violence, homophobia, family dynamics and sexual and reproductive health (CARE International, 2012).

HealthNet TPO

HealthNet TPO (http://www.healthnettpo.org/en/), a Dutch aid agency, delivers a multitiered psychosocial care package combining promotion of mental health, prevention and treatment to address the needs of

at-risk children and adolescents in conflict-affected settings, including Afghanistan, Burundi, Cambodia, Democratic Republic of Congo, Iraq, Lesotho and Nepal. Health promotion activities include peer support groups, community sensitization and psycho-education to increase awareness of the mental health needs of children and promote community resilience.

Prevention activities target subgroups of children with psychosocial distress, as identified by a brief screening tool in schools. A structured group intervention addresses symptoms of distress and strengthens factors to protect children against developing mental health problems. Treatment is provided in the form of individual counseling, parental support and referral to a psychiatrist when necessary. Throughout the programs, HealthNet TPO is sensitive to gender inequity and violence in relations on all levels.

School-Based Mental Health Interventions

Promising school-based mental health interventions include the *Resourceful Adolescent Program* in Mauritius, an evidence-based intervention using cognitive behavioral and interpersonal therapy delivered by teachers to secondary school students age 12–16 (Rivet-Duval, Heriot, & Hunt, 2011). A randomized clinical trial demonstrated significant improvements in depressive symptoms, hopelessness, self-esteem and coping skills. Classroom-based psychosocial interventions among children age 6–11 and adolescents age 13–16 in armed conflict settings also have had significant positive effects on social and emotional well-being and communication skills, reducing problems with conduct and peers (Khamis, Macy, & Coignez, 2004).

Community-Based Mental Health Interventions

Evidence from community-based mental health delivery programs specifically targeting young people in LMICs suggests positive impacts. A review identified eight studies evaluating out-of-school community interventions for adolescents in five countries (Barry, Clarke, Jenkins, & Patel, 2013). Four studies were conducted in South Africa and one each in India, Honduras, Egypt and Uganda.

Interventions included a multicomponent school- and community based-intervention for young people age 16–24 (Balaji, Andrews, Andrew & Patel, 2011); a family-based strengthening program (*Familias Fuertas*) for parents and their adolescent children (Vasquez et al., 2010); a multidimensional program (*Ishraq*) aimed at improving life skills, literacy, recreational activities and health knowledge for girls age 13-15 in Egypt (Brady et al., 2007); and combined HIV prevention and life skills intervention (*Stepping Stones and Collaborative HIV Adolescent Mental Health Program [CHAMPSA]*) for adolescents in South Africa (Bell et al., 2008; Jewkes et al., 2008).

Balaji et al. (2011) found that the community-based youth health intervention in India resulted in significant improvements in participants' depression scores, reported levels of suicide behavior and knowledge and attitudes about mental health. Long-term findings from the Stepping Stones intervention include reduced physical and sexual partner violence at two years' follow-up and reduced substance abuse at one-year follow-up (Jewkes et al., 2008).

The Friendship Bench aims to reduce the mental health treatment gap by training lay health workers to recognize mental illness using a locally validated assessment tool, and to offer evidence-based problem-solving therapy in Zimbabwe (Chibanda, 2015). It consists of up to six structured 45-minute sessions delivered on a wooden bench within the grounds of the clinic. Health workers train and supervise grandmother health providers to use problem-solving therapy with clients over age 18. The Friendship Bench Program has been scaled up to 72 clinics in the cities of Harare, Gweru and Chitungwiza, with over 27,500 people now receiving treatment.

A cognitive behavioral treatment (CBT) intervention for adolescents age 12-18 with a history of suicide attempts has been implemented in psychiatric inpatient units in Iran (Alavi et al, 2013). Participants receive 12 sessions of therapy involving safety planning, psycho-education, reasons for living, case conceptualizing, mood monitoring, problem solving, goal setting, using social supports and improving family communications.

Participants' parents attend some of the sessions with their children. The intervention has led to a significant decrease in adolescent suicidal ideation and behaviors. Mental health interventions for HIV-positive young people have demonstrated promise when delivered by lay counselors (Donenberg et al., 2015). The Kigali Impereheza Project in Rwanda is trauma-focused cognitive behavioral therapy delivered by HIV-positive youth leaders. It has demonstrated reduced depression, anxiety and trauma after six months of treatment. The Indigenous Leader Outreach Model has demonstrated high potential to strengthen local capacity to improve mental health among adolescents.

The Family Strengthening Intervention (FSI) aims to reduce mental health problems among HIV-affected children through improved child-caregiver relationships, family communication and parenting skills, HIV psycho-education and connections to resources (Betancourt et al., 2014). Findings indicate that caregiver-reported improvements in family connectedness, good parenting, social support and children's pro-social behavior were sustained and strengthened over six months. Significant improvements were found in caregiver-reported child perseverance/self-esteem, depression, anxiety and irritability. Significant decreases in child-reported harsh punishment were observed at post-intervention and follow-up, and decreases in caregiver-reported harsh punishment were also recorded. The FSI is a feasible and acceptable intervention that shows promise for improving mental health symptoms and strengthening protective factors among children and families affected by HIV in low-resource settings.

A series of programs attempting to address inequitable gender norms have engaged boys and men and demonstrated that these gender-focused interventions can lead to reductions in violence and to other positive health outcomes (Barker et al., 2010; De Koker et al., 2014; Dworkin, Treves-Kagan & Lippman, 2013; Jewkes et al., 2008). However, rigorous evaluations of only a small number of these programs have been documented in the scientific literature, and recent literature reviews have revealed that existing evaluations have various limitations, including a lack of comparison groups and standardized or validated measures, no exploration of effects across

types of interpersonal violence (IPV), inadequate follow-up rates and limited use of theoretical frameworks (De Koker et al., 2014;.Dworkin, Treves-Kagan & Lippman, 2013). The Male Norms Initiative, a community based project in Ethiopia has demonstrated support for gender-equitable norms and reductions in IPV among young men. The 2 main intervention components were interactive group education (GE) and community mobilization and engagement activities (CE) aimed at raising awareness and promoting community dialogue. The interventions focused on promoting critical reflection regarding common gender norms that might increase the risk of violence or HIV and other STIs (e.g., support for multiple sexual partners and acceptance of partner violence). Through this reflection, the participants were able to identify the potential negative outcomes of enacting these norms and the potential positive aspects of more gender-equitable behavior. In addition, the activities engaged the wider community in supporting a shift in specific harmful norms. Engaging Boys and Men in Gender Transformation, a manual based on EngenderHealth and Promundo's gender-transformative programming, was used to facilitate the reflection process (ACQUIRE Project, 2008)

EXAMPLES FROM UNICEF COUNTRY OFFICE PROGRAMS

Adolescent mental health, within the broader scope of adolescent health, is a "learning" agenda for UNICEF, and as such is included in the agency's new Strategic Plan for 2018-2021. The following are examples of work in this area by some of UNICEF's regional and country offices:

UNICEF LATIN AMERICA AND THE CARIBBEAN OFFICE (LACRO)

In 2016, LACRO began analyzing the key issues for adolescent health in Latin America and the Caribbean (LAC), and how UNICEF can contribute to ensuring adolescent wellbeing. A framework for Gender-Responsive Adolescent Health (GRAH) for LAC was developed, where mental health is one of the six pillars of action. The framework is in its final stages and will be disseminated to Country Offices in the region in mid-2017. One of the key priority issues identified by LACRO is data gaps in the

areas of both strategic advocacy and programming, be it in relation to disaggregated information for the 10-14 and 15-19 age groups, existing policies and programs and whether they are adolescents and gender-responsive, determinants of adolescent health, stakeholder mapping, influencers of adolescent choices and of adolescents' perceptions of mental health; and the impacts that gender, sexual orientation and ethnic origin may have on adolescent mental health. In this regard, LACRO is planning a study to examine the exposure of adolescents to and their use of social media and its impact on their mental health.

UNICEF Argentina has recently started working on a series of new approaches related to adolescent health. This includes a study on adolescent suicide; experiences with community mobilization and creation of "centros de escucha" (listening spaces); linkages between health and education services and the creation of health advisories in secondary schools; and forums for adolescent with multisectoral participation where adolescents can discuss adolescent pregnancy and mental health. The main concept beyond this work is the need to create an "egalitarian" environment that respects differences; supports adolescents in the construction of identity and autonomy; promotes the non-judgmental listening of adolescents by parents, and the generation of safe space for adolescent participation.

UNICEF Brazil has been working on adolescent development and has supported the development of a national policy on adolescent mental health, including the establishment of child and adolescent psychosocial support centers.

UNICEF Jamaica conducted a study on youth suicidality in 2014, and prepared three case studies on suicide among indigenous adolescents in 2012 that highlighted difficulties with the exposure to different cultural norms when living outside of indigenous communities.

UNICEF Kazakhstan

In early 2015, three Kazakhstan ministries (Health, Education and Internal Affairs) and UNICEF joined efforts to develop a two-year inter-sectoral project on prevention of suicides among adolescents in Kyzylorda province. The pilot model is evidence-based, combining recognized approaches. It has three components: raising adolescents' awareness with interactive lessons and program communication material promoting mental health and health-seeking behavior and referral services; equipping school psychologists with tools (psychometric instruments) and skills to identify and follow up on high-risk cases, and building capacity of school staff to act as suicide-prevention gatekeepers; and promoting referral and follow-up by medical and mental health specialists.

In its first year (school year 2015–2016), the project reached over 35,000 adolescents and 23,630 staff in 312 educational organizations. Adolescents identified at high risk of suicidal behavior (997 adolescents, or 3% of participants) were referred to the trained health professionals and mentored by school psychologists. An interim assessment of first-year results showed that capacity-building helped reduce stigma and prejudice among education and health professionals and convinced service providers that suicide can be prevented. Awareness-raising and mentoring also promoted health-seeking behavior among adolescents and parents.

Following the intervention, use of the youth hotline increased fivefold. Importantly, trust greatly increased between adolescents and school psychologists, who are now recognized by colleagues and parents as key in suicide prevention. In 2016, a second region (Mangistau Oblast) started large-scale piloting of the project, and seven more regions have indicated readiness to launch similar interventions. Kazakhstan's efforts have resulted in improved mental health among young people, and the last four years have seen a gradual decrease in both numbers and rates of suicides among adolescents nationwide.

In recent years, donors have supported an increasing number of mental health research initiatives, with a special focus on generating evidence in LMICs. These donors include, for example, the United Kingdom's Department for International Development, the Wellcome Trust, the United States National Institute for Mental Health, and the European Union, as well as Grand Challenges Canada.

UNICEF China

UNICEF China is conducting a range of activities with a gender-specific focus. They include development of an adolescent health services package, with gender-based interventions targeting higher rates of suicide in girls and substance abuse in boys; the collection of sex-differentiated data on adolescent health through the National Health Service Survey; the creation of gender-specific materials and core messages and organization of gender-specific health promotion activities through a hotline, in schools, and through other channels; and advocacy for gender-differentiated social emotional learning.

Based on the different development characteristics of adolescent boys and girls, and findings from the baseline survey conducted in project areas in 2014, UNICEF China is piloting and testing a social and emotional learning course through strengthening knowledge about gender-differentiated social and emotional learning needs of adolescents for school principals and teachers. A social and emotional learning element is being incorporated into the life skills-based education curriculum being developed with the Ministry of Education. The curriculum is focused on building a supportive environment for psychological health in vocational schools through strengthening the related teacher posts and links with other local social service providers. UNICEF China also advocates for greater recognition of gender-differentiated social and emotional learning needs with education policy-makers, administrators, and related stakeholders.

UNICEF Mongolia

UNICEF Mongolia is supporting a Youth Innovation Challenge on adolescent mental health and prevention of sexually transmitted infections, an effort to develop nontraditional, gender-responsive solutions to challenges in these areas. Workshops among government and private sector stakeholders and parents identify key barriers to delivering services. Selected adolescent girls and boys from urban, suburban, and rural areas who participate in a Youth Forum have contributed to the development of problem statements, assessed the issues from a gender perspective and proposed possible adolescent-centered solutions.

UNICEF Mongolia also implemented some new practices in providing primary-level mental health counseling in schools in geographically-focused areas (GFAs) in the 2012–2016 country program. The program promoted capacity-building for school doctors and social workers in all GFA schools using a UNICEF-supported module on psychological counseling. The module was also embedded into the In-Service Teacher Training Institute in 2016, benefiting 61 first-year school social workers. It was also adapted into an interactive training module, to be used for on-the-job training of school social workers in providing primary-level mental health counseling to adolescents. In addition, UNICEF Mongolia supported programs to improve school extracurricular activities and adolescent life skills-development. The program collaborated with the Ministry of Education, Culture, Science and Sports and nongovernmental organizations to help schools establish and maintain Child Development Centers in all 40 schools within GFAs. These centers then offered programs promoting adolescent personal development and participation in school life through activities such as student publications, debate clubs, student councils, peer education on prevention of sexually transmitted infections, and eco-clubs.

UNICEF also supported the National Authority for Children in designing and implementing life skills programs, which reached about 80% of all adolescents in GFAs. In developing this program, UNICEF supported a 2015 national survey of Strengths and Supports in Lives of Mongolian Youth, which assessed adolescents' life skills and their ability to manage themselves at home, in school, and in public.

OTHER SPECIALIZED PROGRAMS

Population Council

The Population Council, in partnership with the Ethiopian Ministry of Health and its Regional Bureaus of Women, Children and Youth Affairs, operated the Biruh Tesfa program in urban areas of Addis Ababa, Ethiopia. Biruh Tesfa (Amharic for "bright future") engaged mentors to offer education, life skills-training, and mentoring to young women as well as referral services to counselors, psychologists and medical staff as needed (Jani et al, 2016).

Biruh Tesfa partnered with a local NGO, the Organization for the Prevention, Rehabilitation and Integration of Female Street Children (OPRIFS), to offer medical care, reproductive health services, and shelter to young women age 7–24 who are victims of violence (Jani & Schenk, 2014). The intervention delivered client-driven, psychosocial counseling, administered by counselors trained in adolescent development, psychological well-being, mental health problems, and factors increasing vulnerability of marginalized adolescents. It included both individual and group counseling sessions, such as creative art therapies and music, drama, and dance (MDD), to participants from two Addis-based service delivery organizations, Biruh Tesfa and Retrak.

The counseling also covered sexual health and HIV/AIDS (risk behavior, knowledge, and prevention strategies, including HIV testing and counseling), alcohol and drug abuse, and experience with violence, as appropriate, with each participant. Significant reductions in attention problems and aggressive behavior were found among female participants, resulting in an overall decrease in mental health problems. No statistically significant reductions were seen in mental health outcomes among young men. Female participants with a mental health issue were less likely to report comprehensive HIV knowledge or perceived HIV risk. For male participants, no significant associations were found between mental health status and HIV-related outcomes.

Mental Health Innovation Network

The Mental Health Innovation Network (MHIN), funded by Grand Challenges Canada, brings together researchers working across projects providing comprehensive treatment and care for adolescent mental health problems in community settings. MHIN is led by the Centre for Global Mental Health at the London School of Hygiene & Tropical Medicine and the WHO Department for Mental Health and Substance Abuse.

Following are some examples of projects it supports.

◆ *Farm Radio International* is an innovative radio-based approach to improving adolescent mental health, part of a larger project called *An Integrated Approach to Addressing the Issue of Youth Depression in Malawi*

and Tanzania. It addresses adolescent depression by combining empirically validated methods in school-based mental health literacy, training of community-based health care providers, and behavior change communications (Gilberds, Brown, Leclair, Thadzi, & Burnham, 2016).

◆ The intervention incorporates interactive weekly radio programs for adolescents, offering serialized soap operas, quizzes, and polls that young listeners can participate in free of charge through mobile phones. Teachers deliver an evidence-based mental health curriculum along with school-based radio listening clubs, where students listen to and discuss the radio program together. Teachers are also trained to identify students at risk, and students learn how to identify mental disorders and self-care skills. Concurrently, schools develop links with local community health care clinics so that students can be directly referred to them. Also, community health care workers who have never been trained to identify, diagnose, or treat adolescent depression undergo training. Program results include improved knowledge about depression, decreased stigma, increased help-seeking, and improvements in access to mental health care, community mental health care provision, and young people's mental health (Gilberds et al., 2016).

◆ *Giving LIFE A Chance* (http://www.mhinnovation.net/innovations/giving-life-chance) aims to reduce the prevalence of suicide in the Embera community of Chocó, Colombia. It uses a psychosocial intervention for adolescents and young adults delivered by paraprofessionals, combined with culturally appropriate suicide education and prevention work for indigenous communities in the region. The project will evaluate the mental health status of young people who have attempted suicide or who are identified as being at imminent risk of suicide, and it will investigate the community response.

◆ *The Equilibrium Project* (http://www.mhinnovation.net/innovations/equilibrium) is an interdisciplinary intervention program designed to promote the social and family reintegration of maltreated children and adolescents in Brazil. Its participants are referred by the juvenile court system for intensive treatment, as most had been living on the streets

before placement in group shelters with supervision. The project offers comprehensive mental and physical health care along with social services in an urban community center where participants can receive specialized services and support for school attendance while participating in social and recreational activities with their peers. Goals of treatment are to decrease symptoms, promote adequate education and social development, and ultimately enable social and family reintegration.

◆ *Classroom-Based Intervention* has been shown effective in several clinical trials in Indonesia (Tol et al., 2008), Nepal (Jordans et al., 2010), and Sri Lanka (Tol et al., 2012). A series of non-randomized evaluation studies rolled out across Burundi, Indonesia, Nepal, Sri Lanka, and Sudan showed that it improved case detection and made effective care available to over 96,000 children in the five countries (Jordans et al., 2013).

◆ An innovative mental health care treatment program in the Philippines operates a model clinic for young people with mood disorders, using mindfulness-based cognitive therapy delivered by paraprofessionals (http://www.mhinnovation.net/innovations). The intervention will also create a center of excellence for mindfulness and conduct a randomized clinical trial that will test whether paraprofessionals can deliver mindfulness-based cognitive therapy effectively.

The Mental Health Gap Action Programme (mhGAP)

Recognizing the need to provide services for people with mental, neurological and substance abuse (MNS) disorders, the WHO Department of Mental Health and Substance Abuse launched the Mental Health Gap Action Programme (mhGAP) in 2008. The interventions are typically modified from existing evidence-based psychological interventions, with the aim of reducing the burden on scarce available specialists.

These interventions can be delivered over fewer sessions by a non-specialist or provided as self-help. They include group and individual face-to-face non-specialist-delivered meetings, electronic mental health interventions and a multimedia approach involving both audio recording and self-help reading materials. The key objectives of mhGAP are to increase the allocation of financial and human resources for care of MNS disorders and to achieve higher coverage with key interventions in LMICs. Through these objectives, mhGAP provides evidence-based guidance and tools toward achieving the targets of the Comprehensive Mental Health Action Plan 2013–2020. The intervention guides are targeted to non-specialized health care providers, including primary care doctors, nurses, and other health care providers.

WHO has also developed a model describing the optimal mix of mental health services, which proposes the integration of mental health services with general health care (Funk et al., 2004). Services integrated into primary care include the identification and treatment of mental disorders, referral to other levels where required, attention to the mental health needs of people with physical health problems, and mental health promotion and prevention. WHO also has developed a toolkit in collaboration with the Mental Health Commission of Canada to help communities identify, prioritize, and implement suicide prevention activities as appropriate to the context.

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