GENDER AND ADOLESCENT MENTAL HEALTH: AN OPPORTUNITY TO ACHIEVE SUSTAINABLE DEVELOPMENT

USAID El Salvador

BACKGROUND

MENTAL HEALTH AMONG ADOLESCENTS

Suicide is a significant and growing global health problem which has consistently ranked among the leading causes of death for older adolescent girls and boys globally, and approximately 78% of suicides worldwide occurred in low- and middle-income countries (LMIC) in 2015 (WHO, 2018). Suicide and accidental death from self-harm were the third highest cause of adolescent mortality in 2015, resulting in an estimated 67,000 deaths (WHO, 2017a). Mental health can impede all aspects of health, including overall well-being and development, leaving adolescents feeling socially isolated, stigmatized and unable to optimize their social, vocational and interpersonal contributions to society. An estimated three-quarters of adult mental health disorders start before the age of 24 (WHO, 2017b). Poor mental health in adolescence is strongly associated with higher rates of substance use, early pregnancy, school dropout, delinquent behaviors and suicide. It can contribute to more serious mental disorders and overall poor health later in life.
The burden of poor mental health in adolescents spotlights a growing need to identify and implement effective interventions for them. Ensuring adolescents' healthy development requires a focus both on risk factors and protective factors across various health outcomes. Particular focus must be paid to the impacts of harmful gender norms, as well as identifying factors that can protect and enhance their mental health and well-being. The failure to address mental health problems in LMICs has wide-reaching consequences and impedes the achievement of basic development outcomes. The purpose of this brief is to discuss why gender and mental health are important to development and to provide recommendations to the United States Agency for International Development (USAID) on how to address mental health in research and programming.

MENTAL HEALTH AND DEVELOPMENT

Mental health issues cannot be considered in isolation from other areas of development, such as education, employment, sexual and reproductive health, HIV, emergency responses and human rights. Figure 1 illustrates how poor mental health is linked with poor international development outcomes and contextual factors, including stigma and discrimination, lack of educational opportunities, exclusion from income generation and inequities which increase vulnerability to mental health problems (Votruba, Eaton, Prince & Thornicroft, 2014; WHO, 2010).

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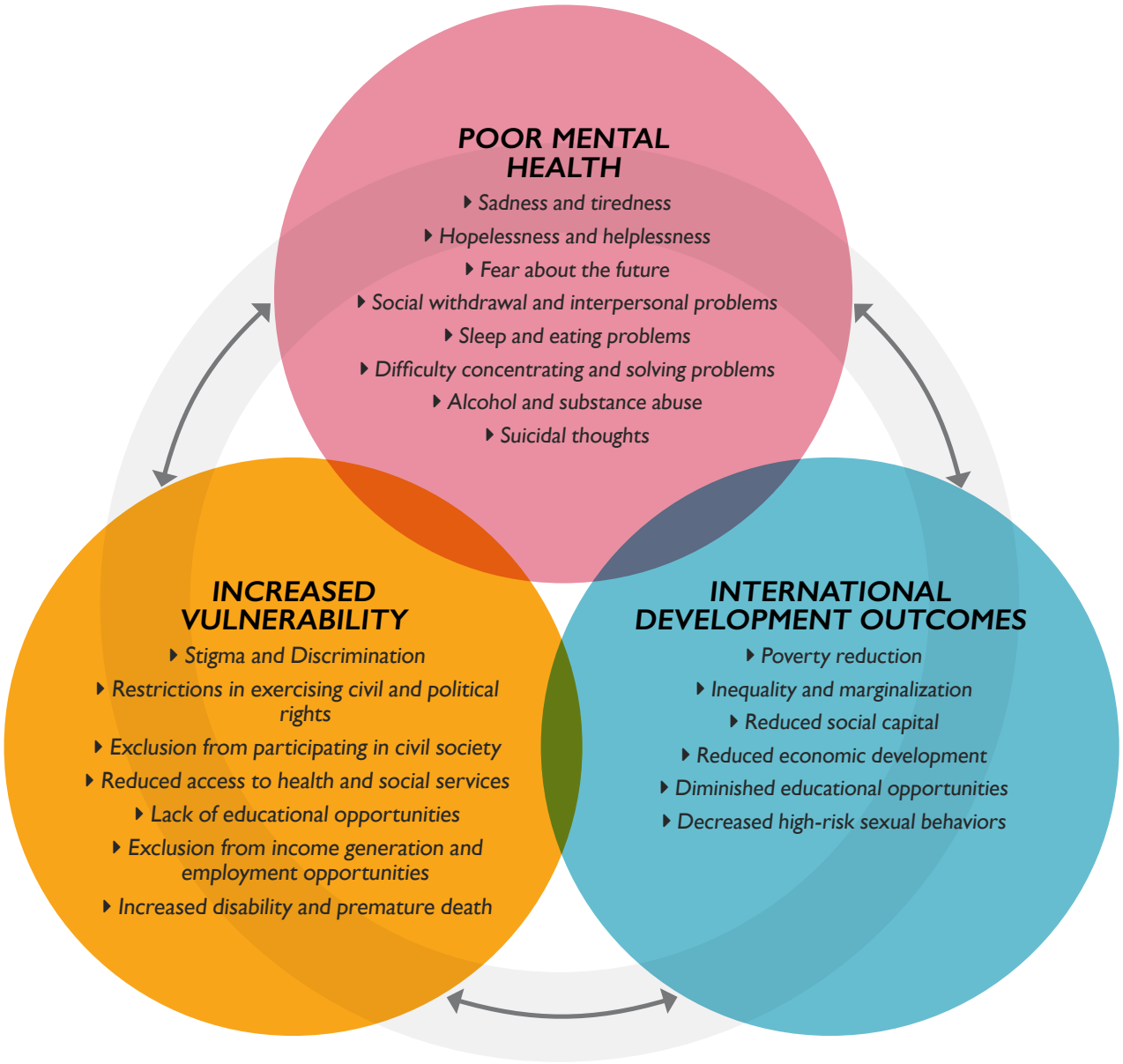
Figure 1: Mental health connected to development outcomes*



* Adapted from the World Health Organization. (2010). Mental health and development: Targeting people with mental health conditions as a vulnerable group. Geneva, Switzerland: World Health Organization.

Good mental health for adolescents 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). At the macro level, mental health impacts country development goals and their ability to take care of their own basic needs. Major strides have been made in increasing life expectancy and reducing child and maternal mortality, increasing access to clean water and sanitation, reducing malaria, tuberculosis, polio and the spread of HIV/AIDS. However, as outlined within the Sustainable Development Goals (SDGs) many more efforts are needed to "ensure healthy lives and promote the well-being for all at all ages" (Goal 3) and "achieve gender equality and empower all women and girls" (Goal 5). The inclusion of mental health and substance abuse in the SDGs is an opportunity to prioritize and strengthen the prevention and treatment of mental health. However, the gendered influences associated with mental health problems need to be better understood, particularly in LMICs, where both evidence and interventions are scarce. A detailed conceptual framework would help to identify the gendered drivers that influence adolescent mental health and inform future programming.

GENDER AND MENTAL HEALTH

While roughly as many boys as girls age 15–19 die from suicide each year, girls and boys differ when it comes to risk factors and suicide attempts. Females are between 1.5 to 2 times more likely than males to be diagnosed with clinical depression, both during adolescence and throughout their life course (Patel, 2013). During adolescence, young people learn to navigate relationships with parents, teachers and romantic partners, while at the same time navigating expectations around appropriate gender roles. As outlined in a conceptual framework on the gendered drivers of adolescent mental health, multiple factors shape boys' and girls' risks of poor mental health. Gender role differentiation increases during adolescence and discrimination based on gender also intensifies during this critical phase of development (Petroni, Patel, & Patton, 2015). Gender role conflict evolves whereby adolescents have difficulty with the gender roles that have been traditionally ascribed to their sex. The Global Early Adolescent Study has shown that gender norms reinforce different expectations for boys and girls (Chandra-Mouli et al., 2017). For example, boys were encouraged to be tough, strong and brave and to demonstrate heterosexual prowess. Girls were taught to be polite and submissive and to emphasize their physical beauty while maintaining their modesty. While the evidence base in LMICs is scant, data from high-income countries suggest that gender role conflict serves as a potential risk factor for suicidal behavior in adolescents (Pinhas et al, 2002). Research has also found that the pressure that boys face to conform with harmful masculine norms related to "being a man" is associated with their propensity for violence, with men and boys disproportionately likely both to perpetrate most forms of violence and to die by homicide and suicide (Heilman & Barker, 2018).

Evidence from a range of 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 (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. 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). Gender-specific mental health 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 (Kapungu & Petroni, 2017; Rhodes et al., 2014). For boys, endorsement of stereotypical masculine norms has been associated with substance abuse, delinquency, the perpetuation of interpersonal violence and reduced help-seeking, all of which may also contribute to poor mental health and wellbeing (Rhodes et al., 2014). Further, boys and girls have different likelihoods of being exposed to conflict, such as experiencing gender-based violence, being recruited as a child soldier or being subject to conflict-related sexual violence. Findings show that boys are more vulnerable to externalizing disorders, especially with cumulative exposure to potentially traumatic events. Peer victimization is also a key risk factor for adolescent mental health problems and suicide (Copeland, Wolke, Angold, & Costello, 2013; van Geel, Vedder, & Tanilon, 2014).

Gender and Mental Health

"Gender is a critical determinant of mental health and mental illness. It 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, 2014)

WHAT THE EVIDENCE SHOWS

Working with USAID, YouthPower Learning (www.youthpower.org) led a multi-country analysis of the Global School-based Health Survey (GSHS) to investigate the associations between bullying, violence and other risk and protective factors that contribute to poor mental health among in-school adolescent girls and boys (ages 13–17). The study includes data for in-school adolescents from a six-country analysis from different regions around the world—Cambodia, El Salvador, Ghana, Iraq, Maldives and Swaziland (see Juan, et al, 2018 for more details). Findings indicate that across five countries, in-school adolescent girls reported higher levels of loneliness than boys, as well as problems with sleep due to worrying. In Iraq, Ghana and El Salvador, adolescent girls were between two and six times more likely than boys ever to make a suicide plan.

Across every region, bullying related to someone's appearance or through sexual jokes, gestures and comments increased the risk of poor adolescent mental health. These experiences were tied to gender stereotypes around how girls and boys should look

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or act toward one another. In El Salvador, Iraq, the Maldives and Swaziland, adolescent girls were at least three times more likely to feel lonely if they were bullied based on their appearance. In five of the six countries[1], adolescent girls experienced greater loneliness as a result of bullying due to sexual jokes, gestures and comments. For adolescent boys in El Salvador, Iraq and Swaziland, bullying about appearance increased their likelihood of losing sleep.

The research demonstrates that the harmful mental health effects of bullying and violence disproportionately impact girls due to the socialization, norms, attitudes and perceptions of how they should behave within their society. Overall, the findings illuminate the gendered dimension of bullying. Interventions should take into account gender differences in the type of bullying and violence experienced and perpetrated.

WHY GENDER AND MENTAL HEALTH MATTER FOR USAID

There is growing recognition within the international community that mental health is a neglected, yet essential, lever for achieving the SDGs. Yet, addressing mental health is critical for ensuring countries are on the journey to self-reliance. Target 3.4 under Goal 3 of the Sustainable Development Agenda explicitly aims to "promote mental health and well-being," while the World Health Organization's (WHO) Comprehensive Mental Health Action Plan for 2013-2020 emphasizes the importance of children "having a positive sense of identity, the ability to manage thoughts, emotions, and to build social relationships… enabling their full active participation in society" (WHO, 2013).

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 well-being, are crucial when considering appropriate policies and interventions. Below are reasons why gender and mental health matters for USAID missions:

1. Specific vulnerabilities of women, children, and adolescents living in fragile and conflict-affected settings threaten their health and well-being. 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. Understanding the debilitating impact of poor mental health on men and women, boys and girls across diverse settings is a critical first step. USAID, currently working in conflict-affected regions like these, can take the lead in addressing the gendered drivers of mental health.

2. USAID's *Youth in Development Policy* is an opportunity to integrate intentionally the gendered drivers of mental health in youth development efforts - be it within USAID activities, projects or country development cooperation strategies. Investments in PYD and mental health have shown to translate to benefits for society, by helping youth successfully transition into adulthood. Across sectors, USAID

[1]El Salvador was the only exception.

missions can proactively and critically think about how gender and mental health impact development outcomes. Programming that targets or involves youth is an important opportunity to address gender norms and the mental health needs of the youth. For example, there is evidence in high-income countries that demonstrates food insecurity is strongly associated with adolescent mental disorders, even after the effects of poverty are accounted for (McLaughlin et al., 2012). The lack of access to reliable and sufficient amounts of food has implications not only for children's physical health, but also their mental health. Therefore, when focusing on young female- and male-headed households through USAID's Feed the Future strategy, there is an opportunity to integrate mental health within programming. Similarly, through USAID's gender-based violence, counter-terrorism, education, health systems strengthening and family planning and reproductive health programming, it is feasible to incorporate the key findings gleaned from the GSHS analysis to understand and address some of the gendered dimensions of bullying, violence and substance use on adolescent mental health.

3. USAID has made substantial investments in youth-focused programming, and the failure to address mental health impedes sector-specific outcomes. In 2010, an estimated US$2.5-8.5 trillion in lost output worldwide was attributed to mental, neurological and substance use disorders. This figure is expected to double by 2030 if concerted efforts are not made at the country and donor level to intervene (Chisolm et. al, 2016). In order to ensure progress towards reaching the SDGs, it is imperative to establish courses of action that will address distinct mental health challenges faced by adolescent girls and boys in a range of contexts. This should be carried out through comprehensive implementation involving research, programming and policy.

GAPS IN RESEARCH AND PROGRAMMING

Data on the prevalence of mental disorders among children and adolescents is exceedingly limited, particularly those disaggregated by age and sex. It is virtually non-existent for many parts of sub-Saharan Africa, Oceania, Latin America and Asia, despite the fact that these regions are home to the majority of the world's youth. Systematic reviews conducted for the Global Burden of Disease (GBD) Study, from 2010 and 2013, indicate that two-thirds of all countries (124 of 187) have no data for any mental disorder (Erskine et al., 2017). Available prevalence data for mental disorders among children and adolescents (ages 5-17 years) is only 6.7 percent. Further, indicators, measures and frameworks for adolescent mental health have, for the most part, been developed and applied in high-income countries (HICs), with very few tested for cross-cultural relevance and utility, and even fewer for their gender sensitivity. There is a lack of standardized measurement for mental health and a lack of measurement of gender roles and attitude in LMICs. Programs are also not factoring gender and mental health into programming across sectors. Mental health of adolescent boys is under-researched. As outlined in a brief commentary, several recommendations have been identified to address the gendered influences on adolescent mental health in LMICs (Kapungu et al, 2018). These recommendations serve as a foundation for creating gender-responsive adolescent mental health research and programs.

RECOMMENDATIONS FOR PROGRAM DESIGN AND IMPLEMENTATION

Recommendations for how program implementers can address the gaps in gender and mental health specifically within USAID programming include:

- **Tailor adolescent programming for vulnerable populations**. Programs should be designed to meet the unique psychosocial needs of boys and girls and ensure that hard-to-reach boys and girls have access to programs and services.
- **Implement gender-responsive mental health interventions**. Develop and implement evidence-based treatments, such as cognitive behavioral therapy and psychosocial support services targeting the mental health of adolescents within education, health governance, countering violent extremism and preventing violent extremism, non-traditional sectors (e.g., Water, Sanitation and Hygiene) and cross-sectoral programs.
- **Develop and adapt materials and curricula**. Integrate gender and mental health into existing adolescent-focused interventions (e.g., sexual and reproductive health, democracy and governance and education). Provide increased attention to harmful gender norms and addressing masculinity in existing or newly designed programs (including with men and boys) across sectors. For example, mental health problems have been found to increase the risk for HIV, and there are gender-related risk factors to HIV acquisition (Brown et al, 2010) Therefore, there are opportunities to adapt curriculum for inclusion including both gender and mental health.

- **Strengthen the capacity for healthcare workers, teachers, school counselors and other frontline professionals**. Training can help professionals, particularly paraprofessionals in mental health psychosocial and support service interventions, to identify and manage mental health disorders among adolescents. Specific attention should include the integration of gender-specific risk factors.

- **Improve coordination and referral networks**. At both the macro-and micro-level, it is critical to work with local health and child protection systems to strengthen referral structures for mental health treatment. Building alliances between the public and private sectors may help to improve identification and treatment of mental health problems.

- **Implement evidence-based Positive Youth Development (PYD) and social-emotional learning strategies**. PYD strategies can help to promote positive mental health by developing skills that can help reducesymptoms of behavior and mental health problems. Programs focused on PYD and social-emotional learning can help strengthen children's life skills and values, including empathy, communication, coping and resilience, decision-making and conflict resolution. For example, promising and evidence-based Blueprints programs for healthy youth development (www.blueprintsprograms.com) in high-income countries prevent problem behaviors and promote healthy youth development. Evidence shows that integrating gender-specific practices into positive youth development programs can improve program outcomes and increase equality between girls and boys and between women and men (Alvarado et al., 2017).

RECOMMENDATIONS FOR MONITORING, EVALUATION, RESEARCH AND LEARNING

- **Incorporate mental health outcomes and measurements into M&E plans of programs**. Including mental health and gender-sensitive indicators in youth-focused programming will help to understand the effects of gender norms and adolescent mental health on sector-specific outcomes. Data can be used to improve program design and implementation.

- **Conduct a programmatic review**. Documenting what is known from existing and previous interventions can help the international community respond effectively to the gendered norms that influence mental health outcomes, as well as more directly addressing the mental health needs of adolescents.

- **Evaluate sectoral programs that have incorporated mental health and gender into interventions**. In LMICs, mental health and psychosocial support programs for adolescents have largely been confined to the humanitarian sphere. Test and rigorously evaluate interventions to understand the impact of gender norms and mental health on development outcomes.

CONCLUSIONS

Mental health has been neglected in LMICs. The SDGs provide an opportunity for renewed attention to addressing the mental health care needs of adolescents. This can be accomplished by strengthening health systems, prioritizing mental health on the global healthcare agenda, improving organization and integration of mental health services into programming, addressing the gendered drivers of mental health and developing policies to inform the design and implementation of gender-responsive interventions in LMICs.

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Additional resources on adolescent mental health can be found at: http://www.youthpower.org/GenDev-mental-health

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USAID YouthPower Learning generates and disseminates knowledge about the implementation and impact of positive youth development (PYD) and cross-sectoral approaches in international development. The project leads research, evaluations and events designed to build the evidence base related to PYD. Concurrently, YouthPower Learning employs expertise in learning and knowledge sharing to promote engagement and inform the global community about how to successfully help transition young people into productive, healthy adults. YouthPower Learning supports the implementation of the 2012 USAID Youth in Development Policy to improve capacity and enable the aspirations of youth so that they can contribute to, and benefit from, more stable, democratic and prosperous communities.

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