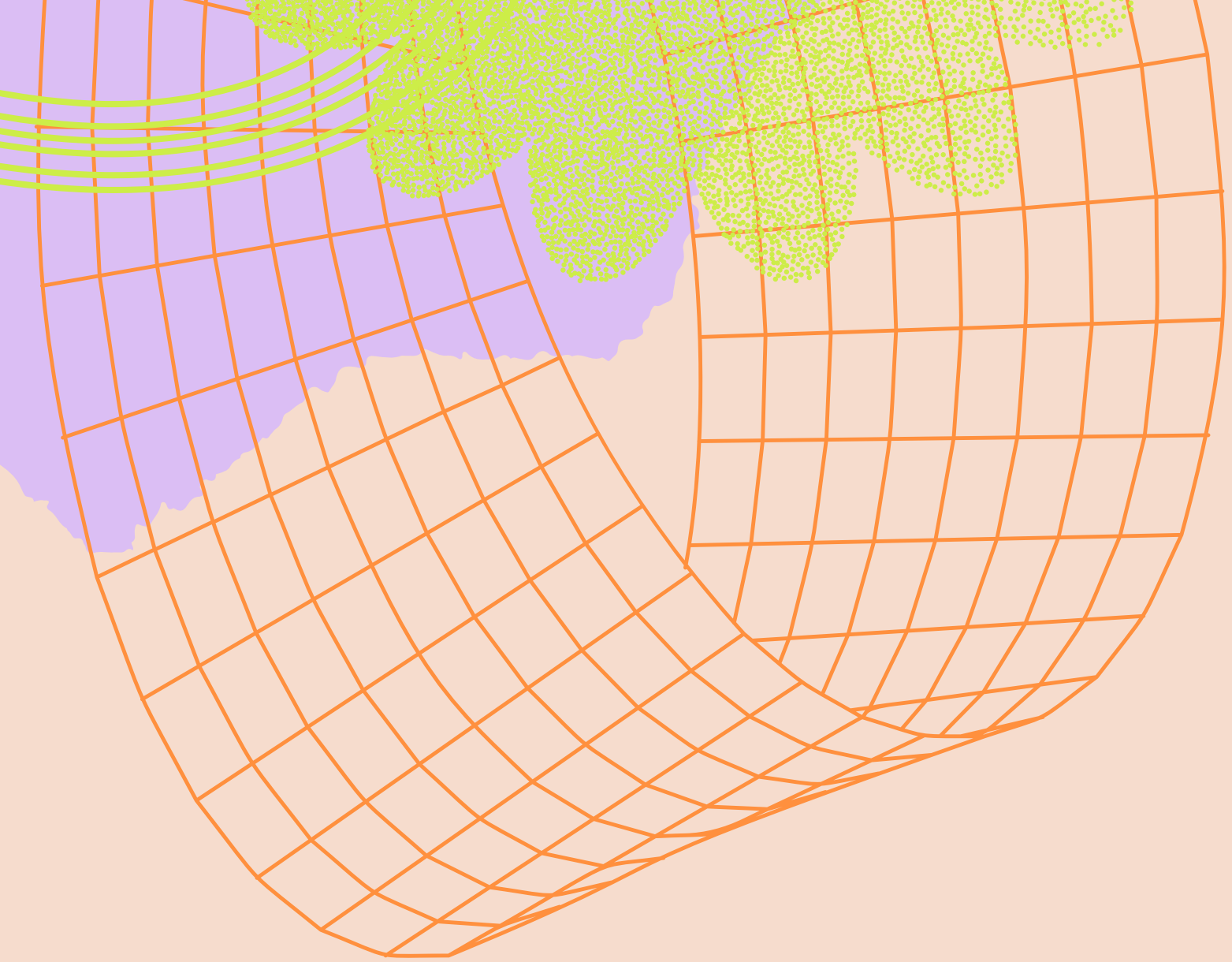
Technical Brief

Understanding the Relationship between Sexual and Reproductive Health and Mental Health for Young People in East and Southern Africa



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This technical brief was authored by Faraaz Mahomed and a team from the United Nations Population Fund (UNFPA) East and Southern Africa Regional Office and the United Nations Children's Fund (UNICEF) Eastern and Southern Africa Regional Office: Renata Tallarico, Alice Armstrong, Isabelle Jost, Joanne Lee, Tamisayi Chinhengo, Jyoti Tewari and Laurie Gulaid.

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Introduction

In East and Southern Africa (ESA), the population of adolescents and young people aged 10 to 24 was estimated at 220 million in 2024; their proportion of the overall population is 32 per cent (UNFPA, 2024). Improving the health and well-being, including the sexual and reproductive health and rights (SRHR), of young people is critical for harnessing demographic, economic, education, gender and climate dividends in the ESA region and on the African continent at large. There is increasing awareness of the significance of mental health, with mental health conditions increasing in prevalence among young people across ESA, affecting their health and well-being (UNICEF, 2021). The purpose of this technical brief is to consider the bidirectional nature of these two health dimensions and how they affect the life and potential of adolescents and young people in the region. This brief will provide recommendations on ways to integrate and harmonize policy and programmatic interventions on SRHR and mental health to improve the health and well-being of adolescents and young people (defined herein as persons between the ages of 10 and 24) in order to address this interdependence.

Key Concepts

According to the United Nations General Assembly (UNGA): "The right to sexual and reproductive health entails a set of freedoms and entitlements. The freedoms include the right to make free and responsible decisions and choices, free of violence, coercion and discrimination, regarding matters concerning one's body and sexual and reproductive health. The entitlements include unhindered access to a whole range of health facilities, goods, services and information, which ensure all people full enjoyment of the right to sexual and reproductive health. Sexual health and reproductive health are distinct from, but closely linked, to each other" (UNGA, 2016).

The working definition of sexual health by the World Health Organization (WHO) is as follows: "A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled" (WHO, 2015).

Reproductive health, as described in the Programme of Action of the International Conference on Population and Development (ICPD), concerns the capability to reproduce and the freedom to make informed, free and responsible decisions. It also includes access to a range of reproductive health information, goods, facilities and services to enable individuals to make informed, free and responsible decisions about their reproductive behaviour (ICPD, 1994).

Mental health is a state in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. Well-being is a psychological, emotional, social and economic construct that encompasses mental health, but recognizes the need for a holistic approach to wellness that is broader than a 'health system'. Mental health and well-being occur on a continuum, from feeling completely well to feeling distressed to the point of experiencing a diagnosable mental health condition. Mental health and well-being are universal phenomena – each person exists at a point along the continuum at any given time of their life. Mental health services consist of promotion, prevention care and treatment (WHO, 2022).

Background

The Sustainable Development Goals (SDGs) aim to do the following: reduce maternal mortality; attain universal access to sexual and reproductive health care services, including family planning, information and education; and improve the prevention, treatment and promotion of mental health and well-being, including strengthening the prevention and treatment of substance abuse (UNGA, 2015).

Between 2000 and 2020, the maternal mortality ratio (MMR) in the ESA region dropped by 49 per cent, but this progress is insufficient to meet SDG targets (WHO, 2023). One of the major contributors to maternal mortality and morbidity in the region is early and unintended pregnancies, including through child marriage. SDG targets for child marriage in the region will likely not be met by 2030, and UNICEF estimates that 20 million girls under the age of 18 will marry in the decade between 2020 to 2030 (UNICEF, 2022). While data on decision-making related to sexual health is difficult to obtain, sub-Saharan Africa ranks lowest of all regions for the abilities and rights of women and girls to make decisions regarding reproduction (UNFPA, 2022a), and ESA has the second-highest adolescent birth rate in the world at 92 per 1,000 girls aged 15–19 (UNFPA, 2024). Adolescent girls and young women aged 15–24 years still accounted for 27 per cent of new HIV infections and were three times as likely to acquire HIV than their male counterparts (UNAIDS, 2024). Laws that prevent parenting adolescents from accessing education or employment remain a considerable barrier to SRHR in ESA (UNFPA, 2020).

From available data, no country in sub-Saharan Africa is on track to meet the SDG targets related to mental health and substance use – a situation that has been worsened as a result of the COVID-19 pandemic (SDGs Center for Africa, 2020). Prevalence data for ESA published by UNICEF indicate that 12.6 per cent of boys aged 10–19 and 11.5 per cent of girls aged 10–19 have a diagnosable mental health condition (UNICEF, 2021). Data also indicates that half of all mental health conditions occur by age 14, but most cases are undetected and untreated, thus contributing heavily to instances of disability throughout the life course (UNICEF, 2021). Prevalence data regarding specific chronic mental health conditions in young people in ESA are difficult to obtain, and further investment in research is needed. Existing prevalence data in the 10–19 age group suggest that depression is a major contributor to overall prevalence, with an aggregated prevalence of 26.9 per cent based on 20 studies across sub-Saharan Africa (Jörns-Presentati et al., 2021).

This is corroborated by a study in Uganda that indicated that 38.5 per cent of adolescents (10–19) screened would qualify for a psychiatric diagnosis, with the largest number indicating a diagnosis of depression (Kinyanda et al., 2011). Another more recent study found a 46 per cent prevalence of depressive symptoms among Ugandan 10- to 19-year-olds living with HIV (Kemigisha et al., 2019). In Kenya, data suggested a 45 per cent prevalence of depression across this age group (Osborn et al., 2020a), while in South Africa data indicated that depression was evident in 19.7 per cent (Strydom et al., 2020) and 41.2 per cent of this age group (Stansfeld et al., 2017), depending on the study and measure. These disparate results indicate the difficulty of obtaining sufficiently robust data regarding young people's mental health.

An aggregation of 10 studies gauging diagnosable anxiety-related conditions yielded a 29.8 per cent overall prevalence for sub-Saharan Africa (Jörns-Presentati et al., 2021), with an aggregation across 8 studies yielding a 24 per cent prevalence of post-traumatic stress disorder (PTSD) among already identified at-risk youth aged 10 to 19 (Jörns-Presentati et al., 2021). An aggregated prevalence of 20.8 per cent for suicidal behaviour (ideation or attempt) among adolescents aged 10 to 19 was derived from four population-level studies (Jörns-Presentati et al., 2021). Recent data indicate that over 11 per cent of the 15- to 19-year-old females and 7 per cent of the males in the same age group who passed away died from self-harm (Liu et al., 2022).

Data unavailability and inaccuracy as constraints for mental health and psychosocial support programmes in ESA

There is a significant need to invest in more accurate and complete data to gauge the prevalence of mental health challenges among young people in ESA. Disparate rates of prevalence are reported regularly, often as a result of small sample sizes, under-reporting due to stigmatization, or lack of validity of diagnostic instruments (Schneider et al., 2016). These contribute to the difficulties associated with gauging overall prevalence. Moreover, misdiagnosis in the field of mental health remains a key challenge, while the comorbidity of mental health challenges is common. This suggests that, while it is clear that mental health requires greater attention, prevalence data are more complex than several other health areas (Sweetland et al., 2014). Data challenges notwithstanding, studies do demonstrate complex risk profiles for mental health challenges in the region, many of which might be said to co-occur with or be contributors to, or sequelae of, inadequate access to SRHR.

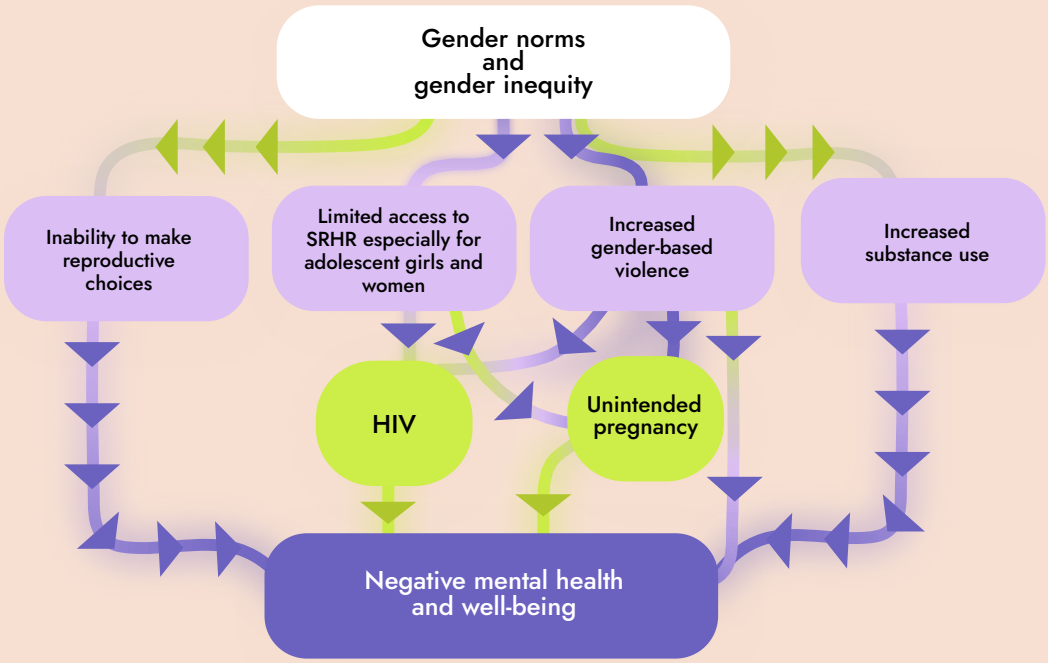
The bidirectional nature of the relationship between SRHR and mental health

While often treated as areas that may require separate interventions, SRHR and mental health are increasingly being shown to have a significant interdependence, and many SRHR and mental health issues are being experienced concurrently by young people. This overlap stems from shared vulnerabilities within the target population, common environmental factors contributing to both issues, and the broad definitions of SRHR and mental health, which encompass similar interventions. Some researchers even suggest that this complex interplay constitutes a 'syndemic' (Duby et al., 2020).

Gender is a particularly important consideration in addressing the relationship between SRHR and mental health. Adolescent girls are subjected to considerable barriers to SRHR, including cultural norms that expose them to heightened levels of exposure to HIV and increased risk of sexual violence. Female respondents in multiple studies across the region exhibit higher rates of depression, anxiety and suicidal behaviour, in some cases directly attributable to exposure to gender-based violence (Bach et al., 2010), and in other cases directly attributable to the experience of unintended pregnancy (Jörns-Presentati et al., 2021) or the trauma associated with termination of pregnancy (Zia et al., 2021). Focusing on gender equality, reduction of gender-based violence (GBV) and increased abilities of adolescent girls and young women to make reproductive choices can have significant mental health benefits (Shinde et al., 2018). The relationship between gender and risk-taking behaviours is complex, with some studies indicating that adolescent girls and young women may be more likely than their male counterparts to engage in unprotected sex or sex with multiple partners when they engage in substance use (Shayo et al., 2019). However, the social norms that contribute to these behaviours are difficult to disentangle from the behaviours themselves, and it is of considerable importance that gendered barriers to mental well-being are seen in context.

Overall, **substance use** – whether among males or females – has been shown to contribute to increased risk-taking behaviours, including unprotected sex and sex with multiple partners (Shayo et al., 2019). Protective factors for adolescent substance misuse include access to information related to substances (Kiambi, 2018), peer group relationships that are not contingent on the use of substances (Sedibe and Hendricks, 2020) and access to alternative coping strategies – such as youth-friendly sports and activity spaces (Mabrouk et al., 2022), group counselling (Osborn et al., 2020b) and life skills training (Bandiera et al., 2020). Importantly,

Gender norms impacting access to SRHR and contributing to increased exposure to psychosocial risk factors



youth-friendly spaces (Denno et al., 2015), group counselling (Senyonyi et al., 2012), life skills training (Madubuike, 2016) and access to information about SRHR (Ninsiima et al., 2021) have also been noted as potential avenues through which sexual risk behaviours can be addressed. Thus, in addressing determinants of good SRHR, it is also important to address antecedent behavioural factors, maximizing protective factors and minimizing risks – potentially with similar intervention strategies.

Adolescent girls and young women are also more likely to be **pregnant or parenting**, and research indicates that this represents a risk factor for poor mental health, both for the parents themselves as well as for their young children, who face a higher likelihood of childhood mental health challenges (Kumar et al., 2017). Research indicates that the demands of parenthood, often coupled with low partner support, compound adolescent mothers' vulnerability to school dropout, poverty, isolation and HIV acquisition, all of which may also contribute to adverse mental health outcomes (Ardington et al., 2015). Parenting adolescents living with HIV experience more mental health difficulties than those without HIV, suggesting a compounded level of stress and adverse mental health (particularly depression and suicidality) due to the dual burden of the disease and the parenting role (Ardington et al., 2015).

Overall, women and girls are at heightened risk for acquiring **HIV**, and evidence suggests that acquiring HIV, the difficulties of managing HIV and the difficulties associated with accessing treatment disproportionately impact women and girls, with higher rates of depression, post-traumatic stress, substance use and anxiety among adolescents living with HIV than without (Di Gennaro et al., 2022) – and higher rates of these conditions among female respondents with HIV-positive status than their male counterparts (Olashore et al., 2022). Stress-related lack of adherence to antiretroviral treatment has also been reported (Tarantino et al., 2020), although there is also emerging evidence that the virus itself may cause mood disorders (Fabrazzo et al., 2023).

Challenges in managing sexual consent can contribute to poor SRHR and mental health outcomes (Myers et al., 2021), including potential HIV acquisition, while research from the region illustrates that childhood trauma is prevalent among adolescents living with HIV and contributes to depression post-infection (Ashaba et al., 2021). This suggests that the relationship between mental health difficulties and acquiring HIV is bidirectional across the life course and is potentially cyclical in nature.

Evidence indicates that **poverty** is a contributing factor to poor mental health, with studies in the region indicating that depression (Zimmerman et al., 2022) and suicidality (Quarshie et al., 2022) are both associated with lack of access to financial resources, and with studies in contexts such as Uganda (Karimli and Ssewamala, 2015) and South Africa (Kilburn et al., 2019) indicating that financial accumulation interventions contribute to improved self-reported well-being, as well as reduced HIV risk. Poverty is a contributing factor to transactional sex, vulnerability to sexual exploitation and abuse (including by intimate partners), and lack of access to treatment for sexually transmitted infections (STIs) such as HIV (Melesse et al., 2020). The aggregated risk of poverty contributing to sexual exploitation and abuse also disproportionately affects women and girls in the region (Melesse et al., 2020).

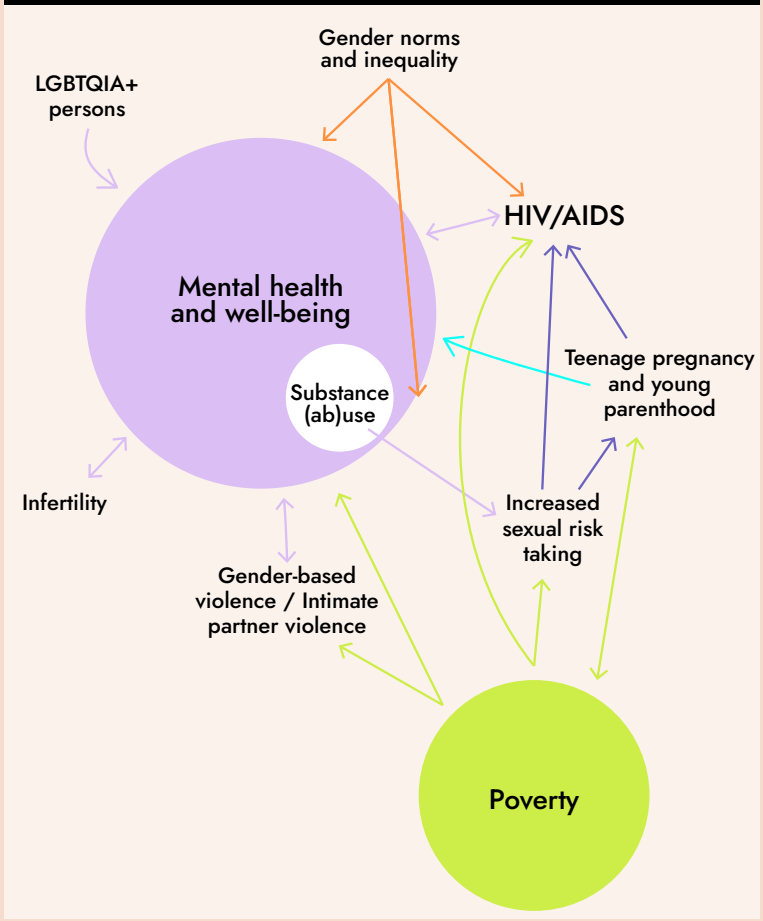
Mental health–related diagnoses may be associated with a lesser likelihood of knowledge related to SRHR among young people, suggesting that interventions tailored for this group may require specific accommodations (Tumwakire et al., 2022). Research also demonstrates that women's experience of intimate partner violence has long been associated with increased depression and suicide attempts, but that women and girls who are depressed also experience higher levels of such violence, indicating a potentially important preventative avenue (Devries et al., 2013). A WHO review illustrates that mental health challenges are more prevalent among women seeking treatment for infertility (WHO, 2009), while cohort studies have demonstrated that stress can have a negative impact on the ability to conceive (Lynch et al., 2014). It is therefore necessary to improve SRHR outcomes, to consider what potential mental health symptomatology is present and to mitigate these symptoms as part of SRHR interventions.

Lesbian, gay, bisexual, transgender, queer, intersex, asexual and gender-fluid individuals (LGBTQIA+) face significant stigma and discrimination in ESA, and research illustrates that this can contribute to poor mental health outcomes (Harper et al., 2021) and inadequate access to SRHR services (Larsson et al., 2016), which in turn can contribute to STIs and thus may potentially lead to further mental health challenges. A study in South Africa demonstrates that LGBTQIA+ adolescents

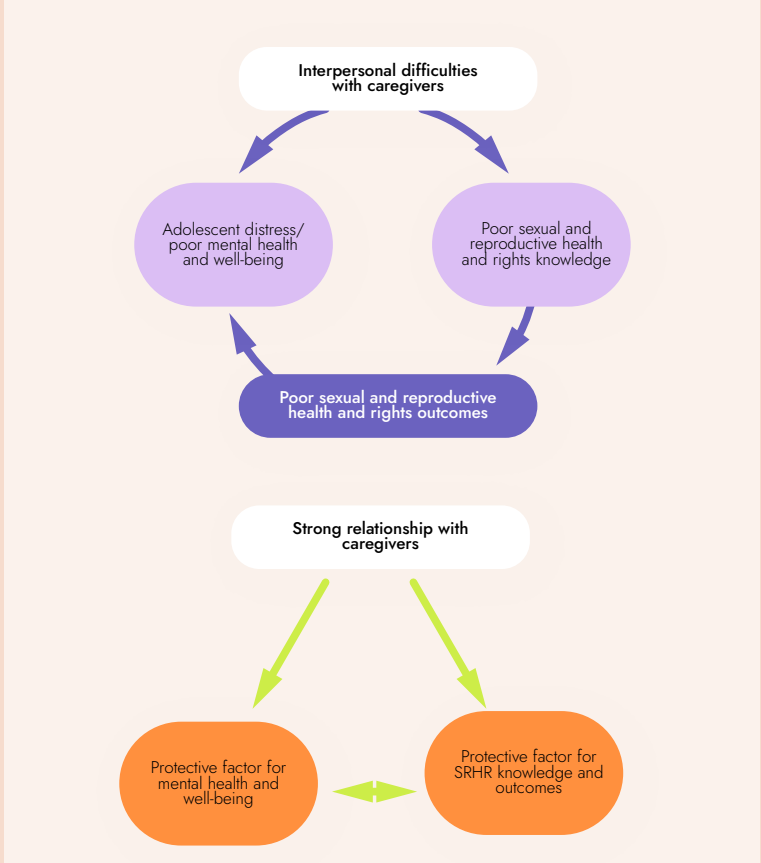
experience higher levels of depression, while a study in Uganda illustrates that – due to the risks associated with discrimination – LGBTQIA+ adolescents are more likely to engage in risk-taking behaviours (unprotected sex in particular) that contribute to the transmission of STIs (Mkhize and Maharaj, 2020). This requires specific intervention to address LGBTQIA+ SRHR needs and the systemic discrimination that can increase the likelihood of mental health challenges.

The **caregiver relationship** is increasingly recognized as a crucial vector of adolescent mental health (Shenderovich et al., 2021), and research indicates that interpersonal difficulties between a young person and their caregiver may contribute to both adolescent distress and the absence of important SRHR knowledge, with the potential for risk behaviours and unintended pregnancies as a result (Mbachu et al., 2020). This remains an underexplored phenomenon, but it illustrates that interpersonal difficulties may contribute to poor SRHR outcomes. Similarly, protective factors related to adolescent mental health include strong relationships with caregivers (Betancourt et al., 2014) and with peers (Kumakech et al., 2009), both of which have also been noted to be protective factors for SRHR (Duby et al., 2021; Thurman et al., 2020).

Risk factors for mental health and bi-directional relationships



Poor and positive relationships with caregivers contributing to mental health and SRHR outcomes



Promising interventions and programmes

Regardless of which occurs first – whether SRHR affects mental health or vice versa – it is essential to integrate these two areas if the related SDG targets are to be met in ESA and if the best possible health and well-being outcomes for young people are to be realized. The bidirectional relationship between SRHR and mental health must be taken into account in health policy, planning, financing and delivery, particularly for young people who are especially susceptible because of the natural impacts of rapid brain development, along with rapid sexual development and potential initiation of consensual sexual activity or subjection to unwanted sexual activity (Victor and Hariri, 2016). Such interventions should be inherently intersectoral, given the myriad socioeconomic determinants of mental health and SRHR globally and in ESA. An intersectoral approach, utilizing schools and other community-based platforms, is necessary for promotive and preventive efforts in particular.

The use of digital technologies can also be a driver of change, given that young people are particularly likely to engage with the digital environment and given that there is vast potential for information to be delivered at low cost and in a manner that is safe and confidential (World Economic Forum, 2021). However, the digital divide needs to be considered when developing such solutions, and offline usage options provided where possible. Meaningful youth participation and involvement in decision-making processes is essential to ensure relevance and participatory programming (UNFPA and Restless Development, 2019). Similarly, programming should take into account the needs of specific risk groups – such as young people affected by poverty, orphans, youth with disabilities (including intellectual impairments), youth living with HIV, young people with pre-existing mental health needs and LGBTQIA+ youth – who may require adapted interventions that suit their circumstances and should recognize the inherent risks those circumstances might pose to their well-being.

Below is a summary of a few identified promising programmes and interventions.

- The Safeguard Young People Programme, UNFPA's flagship youth programme currently implemented in 11 countries, aims to empower young people and improve their SRHR, but it also focuses on a broader set of topics, including GBV and safety. Relevantly, the programme encourages youth participation and engages men and boys who are critical partners in the advancement of SRHR and the mental health of women and girls. The integration of mental health into adolescent SRHR policies, programmes and interventions and the generation of additional evidence have been identified as important areas, which the SYP programme has started to address (UNFPA, 2022b).

- Right Here Right Now 2 is an advocacy and programmatic initiative in several countries, including Kenya, Burundi and Uganda, that aims to ensure access to youth-friendly SRHR information and services for LGBTQIA+ youth. The Right Here Right Now 2 initiative is supported by Rutgers and partners with local non-governmental organizations, several of

whom provide counselling, life skills or mental health support tailored to the needs of LGBTQIA+ youth (Rutgers, 2021).

- In Zimbabwe, peer supporters serve as a key source of support for adolescents living with HIV and struggling with mental health needs. The peer support programme, known as Zvandiri, deploys community adolescent treatment supporters (CATS) as peer counsellors. Trial data indicate that the Zvandiri model – which makes use of support groups, counselling, digital reminders and caregiver-directed interventions – can significantly improve adherence to treatment (and, in turn, lead to suppression of viral load) and can reduce mental distress and common mental health disorders (Chinoda et al., 2020). CATS are provided with ongoing training and supervised by health workers and Zvandiri mentors. They are also provided with a standard package of care to look after their own health and well-being, including viral load monitoring, tuberculosis screening, mental health screening, SRHR, counselling and support. The approach uses 'differentiated service delivery', meaning it simplifies and decentralizes HIV services across the care cascade, and peer counsellors focus on the individual preferences, expectations and needs of young people living with HIV (Mavhu et al., 2020). Research indicates that the model can also improve the CATS' well-being, sense of self-worth and adherence to treatment of peer supporters (Bernays et al., 2020). This is especially important because the peer supporters are themselves young people living with HIV who experience social stigma and potentially may also struggle with the burden of their disease, including the psychological burden. Recognizing the considerable challenges pregnant and parenting adolescents face, Zvandiri incorporated an emphasis on pregnant and parenting adolescents through its Young Mentor Mothers programme, launched in 2018. Through a peer support model that focused specifically on pregnant and parenting adolescents, mentor mothers were trained to provide psychosocial support to young mothers in their communities. The Young Mentor Mothers programme was successful in reducing the rate of mother-to-child transmission of HIV to less than 1 per cent, compared to the national rate of 7.66 per cent, while also substantially improving mental health outcomes (Angell et al., 2022).

- In South Africa, the Perinatal Mental Health Project (PMHP), a stepped care intervention based at the University of Cape Town, was integrated into antenatal health services in an urban secondary-level maternal health facility. The PMHP offered screening and referral services for all patients. Over three years, 90 per cent of all women attending antenatal care in the maternity clinic were offered mental health screening, with 95 per cent uptake. Of those screened who qualified for referral, 47 per cent received counselling through the programme. The PMHP model involves training maternity health workers on mental health and on-site counselling, as well as establishing a referral pathway for those requiring referral (Cooper et al., 2009).

- The non-governmental organization BRAC Uganda runs Empowerment and Livelihood for Adolescents (ELA) clubs, primarily for girls aged between 13 and 21. The nationwide programme targets in-school and out-of-school adolescent girls (BRAC, 2022). The clubs are safe spaces for the girls to interact with peers and mentors and learn about issues such as SRHR, early marriage, GBV and drug misuse. The clubs also provide vocational training suited to the local labour market. BRAC began a collaboration with StrongMinds,

which has been providing group therapy for women and girls at scale in Uganda and Zambia. The BRAC ELA mentors have been trained to provide a group-based, culturally adapted and locally validated type of interpersonal therapy for depression. StrongMinds provides technical assistance and supervision to facilitators and groups, and monitors and evaluates the groups. The BRAC–StrongMinds collaborative approach is currently being evaluated in a cluster-randomized controlled trial (Center for Effective Global Action, 2022).

- Ask–Boost–Connect–Discuss (ABCD) is a mobile-based care tool that can be delivered by peer supporters based at HIV facilities. The ABCD package of care was co-developed by the non-governmental organization PATA (Paediatric AIDS Treatment for Africa) and end-users and comprises the following: screening for the psychosocial needs of young mothers ('Ask'); mental health support through structured, evidence-based sessions ('Boost'); help with accessing services ('Connect'); and ongoing supervision and self-care ('Discuss'). ABCD content was adapted from the WHO Thinking Healthy Programme. Use of the peer-delivered tool has been piloted in Malawi, Tanzania, Uganda and Zambia (PATA, 2022).

- Task-sharing in the field of mental health includes the training of non-specialized frontline health workers on mental health–related content. This serves the purpose of destigmatizing mental health at the primary health care level and enables counselling for health-care users who may use other health services at the primary health care level or through community health workers (CHWs). The Programme on the Improvement of Mental Health Care (PRIME), a consortium of research institutions and ministries of health in five countries, has examined acceptability and multiple modalities for using this model, including among perinatal health-care workers, and the acceptability of this model – contingent upon training in mental health – has been established in countries such as Uganda and South Africa (Mendenhall et al., 2014). A 2022 study showed that a task-sharing approach, in which a group mental health intervention (group interpersonal therapy) for parenting adolescents living with HIV in Kenya was delivered by trained CHWs, had a positive effect on both the enhancement of the skills and core work of the CHWs as well as management of stress and improving interpersonal relationships for the parenting adolescents (Yator et al., 2022). Supervision by specialist staff is a necessary component of all task-sharing models. In the Kenyan example, in addition to weekly face-to-face continuous supportive supervision for the CHWs, the researchers also utilized phone calls, SMS and WhatsApp for supervisory purposes (Yator et al., 2022).

- ERSAE-Stress-Prosocial Skills in Tanzania (Berger et al., 2018), the programme titled An Integrated Approach to Addressing the Challenge of Depression among the Youth in Malawi and Tanzania (Kutcher et al., 2019), Shamiri in Kenya (Osborn et al., 2021), and prolonged exposure for adolescents and supportive counselling in South Africa (Rossouw et al., 2018) are school-based interventions that concentrate on mental health outcomes. They have elicited significant reductions in symptoms, including depression, anxiety, aggressive or violent behaviours, and PTSD symptoms. There is less evidence of the effectiveness of school-based SRHR interventions – many of which have been committed to but not appropriately implemented in the region – but research in South Africa has illustrated that

delivering integrated SRHR information in school (Shaikh et al., 2021) or through after-school interventions (Letsela et al., 2021) can significantly improve knowledge about HIV transmission, boost usage of contraception and reduce risk behaviours. At the curriculum level, these two areas of health do not yet overlap sufficiently, but there is scope for the development of such an intervention. The UNICEF and WHO Helping Adolescents Thrive Toolkit is an adolescent mental health promotion and prevention intervention to be delivered in schools and community-based settings.

Among the skills practiced are stress management, emotional regulation, problem solving and SRHR-related skills, including decision-making, alternatives to risk behaviours and consent in interpersonal relationships. Because the programme is delivered universally, it also targets men and boys and thus engages them on the interdependence between SRHR and mental health (WHO and UNICEF, 2021).

Recommendations

Advocacy recommendations

- Advocacy for legislative reform banning child marriage, female genital mutilation and coercive sexual practices across ESA and beyond should also urge duty bearers to consider the mental health implications of these practices and urge the inclusion in legislation of mental health assessment, management and preventive actions for persons subjected to these practices.

- Include mental health in regional and continental SRHR campaigns such as the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA Plus) by the African Union Commission to strengthen political commitments on adolescent SRHR and mental health.

- Mental health and SRHR advocates should lobby for greater resource allocation for human rights–based, people-centred integrated SRHR and mental health responses. Evidence-based programming that has demonstrated efficacy, such as Zvandiri (Mavhu et al., 2020), should be given priority as part of an overall strategic emphasis on mental health and SRHR at national and regional levels.

Programming recommendations

- Existing programming on HIV and other SRHR information and services in the region should include an emphasis on mental health, both as a sequel and as an antecedent factor. Emphasis should be placed on universally delivered promotive and preventive interventions (including stress management, emotional regulation, problem solving and interpersonal relationship skills), targeting not only women and girls, but also men, boys and non-binary individuals. Special attention should be paid to ensuring youth participation in design and delivery, along with review by experts on sensitivity with regard to gender, sexual orientation, disability, migration, socioeconomic status and other potential sources of vulnerability. The BRAC-StrongMinds partnership model demonstrates new modalities for programming (Center for Effective Global Action, 2022).

- Existing SRHR, including HIV programming, should include self-care and in-person care (if necessary) for mental health issues, including referral pathways.

- Training frontline health workers at the primary health care level on mental health screening, counselling, referral and information provision is an important adjunct to improving SRHR service provision and outcomes. The Perinatal Mental Health Project (PMHP) in South Africa demonstrates the considerable uptake of mental health–associated information and services at perinatal points of service, and the Programme on the Improvement of Mental Health Care (Mendenhall et al., 2014) illustrates the significance of mental health stigma reduction among SRHR providers in improving mental health outcomes. Similarly, frontline workers who are not trained on mental health may also require training on SRHR and its interdependence with mental health – which may serve the dual purpose of improving SRHR and mental health outcomes.

- Peer provider support models – with the assistance and facilitation of trained professionals – can be a significant asset. Replication of integrated approaches to mental health and SRHR through peer provider support models should be encouraged. Peer support topics of interest will likely include stress management, emotional regulation, problem solving, interpersonal relationship skills, decision-making and consent, sexual health information, and identity formation. The Zvandiri (Mavhu et al., 2020) and Right Here Right Now 2 (Rutgers, 2021) models illustrate how pregnant and parenting adolescents, adolescents living with HIV, and LGBTQIA+ adolescents could benefit from peer provider support interventions, and these can be implemented with significant promise. The Ask–Boost–Connect–Discuss or ABCD model (PATA, 2022) offers an example of digitized content for peer support, and this too is an avenue that demonstrates promise.

- Explicit recognition in programming of the social, economic, cultural and political determinants of health and well-being is needed to ensure that greater attention is paid to the complex causal mechanisms that contribute to the region's SRHR and mental health outcomes. A regional strategic framework to improve SRHR and mental health outcomes could be developed by taking into account the proven causal pathways and proven human rights–based integrated approaches, with the full and equal participation of youth from all backgrounds, paying particular attention to a gendered approach and to the needs of youth living with HIV, LGBTQIA+ youth, youth affected by poverty and other marginalized groups. Emphasis should also be placed on the particular significance of caregivers and the need to incorporate their voices and their impact in the lives of youth into programming.

- Digital information regarding SRHR and mental health and the bidirectional relationship between the two can supplement in-person activities. The use of existing infrastructure on platforms such as Facebook and WhatsApp has dramatically improved the usability and scalability of digital tools (Osamuyi, 2016), thus suggesting that a digital platform need not be developed anew, but instead that the feasibility of mental health–specific content delivered through existing channels should be explored as a first option. The use of already validated tools would be ideal but may not be practically possible due to intellectual property constraints. Scientific validation – preferably through a trial or at the very least a technical advisory group – as well as population validation – through a youth advisory council – should be incorporated into any digital programming.

- The ongoing SRHR and HIV programmes, should pay specific attention to the bidirectional relationship between SRHR and mental health, incorporating mental health promotion and prevention content while also offering avenues for self-care and referral for young people requiring care and treatment.

Conclusion

It is clear that emphasis needs to be placed on the interdependence of SRHR and mental health if SDG targets in both of these areas are to be met in ESA. The social, cultural and economic determinants of both mental health and SRHR will also require consideration, given the importance that environmental factors play in their relationship. Innovative approaches to integration are already taking hold in the region, demonstrating both the viability and the efficacy of integrated intervention for SRHR and mental health among adolescents and young adults in ESA. As a region with a fast-growing young population, it is essential that the opportunities mentioned above are taken advantage of. Young people continue to face myriad barriers to their SRHR and mental health, but a future that emphasizes integrated intervention is a promising one.

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