Mental health and psychosocial well-being among adolescents in Tanzania

Findings from a mixed-methods baseline study

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Acknowledgements

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Executive summary

This mixed-methods study is part of a project funded by Fondation Botnar to address the mental health needs and psychosocial well-being of adolescents in two very different country contexts, Tanzania and Viet Nam.[1] The summary below outlines the content of the Tanzanian report, core findings and recommendations.

Study aims

This ODI Report is focused on identifying the key drivers of mental ill-health and psychosocial well-being among two subgroups of adolescents (those aged 11–15 years and those aged 16–19 years) in two cities (Morogoro and Mwanza City) in Tanzania.

Subsequent aims of the project are:

- To co-create (with adolescents, teachers and local authorities) and test a range of approaches (digital and non-digital) to support adolescents' mental health and well-being.
- To review and adapt potential approaches based on the monitoring, evaluation and learning (MEL) system, the baseline and endline studies, and ongoing feedback loops.
- To document the effectiveness of both digital and non-digital solutions in addressing adolescents' mental health problems.

In Tanzania – where more than two-thirds of the population are children, adolescents or young adults (aged 0–24) – individuals facing mental health challenges do not receive adequate care. There is poor understanding of mental health and mental illness, while mental health disorders and symptoms are not recognised and remain largely untreated. Traditional healing practices prevail and access to high-quality professional support is limited.

Chapter 2: Methodology

We collected data from adolescents attending primary and secondary schools in both urban study sites.[2] The quantitative survey with 401 adolescents provided a baseline profile to better understand mental health status, literacy and service access, and to inform evaluation of the impact of digital and non-digital interventions. The survey included two key measures of mental health and psychosocial well-being: the Strengths and Difficulties Questionnaire (SDQ, a measure of emotional and behavioural difficulties) and the WHO-5 index (a measure of subjective psychological well-being). The qualitative component included in-depth interviews, focus group discussions, family case studies / intergenerational trios, as well as key informant interviews. Several students who participated in the quantitative survey were selected for the in-depth interviews.

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1   The project consists of six phases: (1) inception; (2) mixed-methods baseline data collection; (3) co-creation/ design of solutions; (4) implementation of solutions; (5) mixed-methods endline data collection; and (6) sharing, dissemination and research uptake. Starting in May 2020, the project will run for a total of 36 months.

2   Mhovu Primary School and SUA Secondary School in Morogoro; and Nyamagana Primary School and Magu Secondary School in Mwanza.

Chapter 3: Overview of mental health policy and services in Tanzania

The lead ministry on health policy is the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) (formerly the Ministry of Health and Social Welfare). Mental healthcare in Tanzania is predominantly government-funded, and is underbudgeted. According to the World Health Organization (WHO) (2017), the government's total expenditure on mental health (as a proportion of total government health expenditure) was just 4%.

While some national health policies address adolescents' needs, these are focused more on HIV, sexual and reproductive health (SRH) or harmful substances than on mental health. Policies on digital health or information and communications technology (ICT) (such as the 2019–2024 Digital Health Strategy) deal with the ICT needs of youths as a means to addressing social inequalities, but they do not link clearly to mental health or psychosocial well-being.

Study respondents described some mental health services available locally, including schools providing counselling services and local clinics providing mental health support through clinical psychiatrists or psychiatric nurses. Local government provides some referral services, and non-governmental organisations and community-based organisations provide some assistance, although not directly dealing with mental health needs.

Chapter 4: Adolescents' mental health and psychosocial well-being status and knowledge

The baseline qualitative research suggests limited understanding (among adolescents and adults in their family and the wider community) of what constitutes mental health and psychosocial well-being, such that people with mental health problems are stigmatised (some young people were more likely to attribute mental health problems to drug use, while adults associated mental ill-health with witchcraft).

In our survey, 70% of respondents reported being knowledgeable about the causes of mental ill-health, and 56% said they would recognise signs of poor mental health. But when probed, emotional literacy appears lacking: 35% believed that 'a mental illness is not a real medical illness', while 68% perceive mental illness as a sign of personal weakness. Nearly half (48%) were unwilling to make friends with someone with a mental illness. Only socioeconomic differences emerged as statistically significant correlates of emotional literacy, with respondents from better-off households showing higher literacy.

For the survey, we coded both the SDQ and WHO-5 such that higher scores indicate a lower risk of mental ill-health. For our survey respondents, the average SDQ score was 47% of the highest possible score, while the average WHO-5 score was 74.5% of the highest possible score. To complement these continuous measures, we categorised the bottom quartile of the SDQ distribution as consisting of students 'at risk' of mental health issues, and the top quartile of the WHO-5 distribution as consisting of students with relatively good psychosocial well-being. We also used the WHO-5 measure to screen for depression; following accepted standards, we designated individuals scoring 50% or less as being at risk of depression.

Slightly more respondents in the qualitative component (adolescents and adults) indicated that adolescent girls were more likely to experience mental health issues than boys, although our survey data did not show statistically

significant differences in our main mental health measures.[3]

School level was the only statistically significant socio-demographic correlate of the SDQ score or of being in the high-risk category. The average score of primary school respondents was 46% of the best possible outcome, compared with 49% for secondary school respondents. We categorised nearly one-third (32.3%) of primary students as at risk of mental ill-health compared with 14.1% of secondary students.

The qualitative research indicates that people perceive mental health challenges as increasing. Reasons include youths being more likely to engage in 'illicit behaviour', poverty, lack of resources to continue studying, or the government's war on drugs. As noted, negative perceptions among community members towards mental health are related to beliefs around witchcraft or curses. According to key informants, these beliefs about people with mental health problems being 'cursed' largely explain why individuals do not feel confident sharing mental health problems or challenges openly, or seeking help for mental ill-health.

Chapter 5: Protective factors for mental health and drivers of mental ill-health

Adolescent study respondents reported a range of factors as driving positive mental health. These include:

- having a positive perception of oneself
- living with both parents in the same household
- having their basic needs met (being able to afford food, healthcare and school materials were mentioned frequently)

- being able to attend school and learn in a positive classroom environment
- having time to play and do other leisure activities such as watch television (TV), sing, or read
- having friendships (most adolescents reported at least one close or special friend)
- having a positive role model(s) (85% of survey respondents reported having a role model, which was positively associated with psychosocial well-being)
- having aspirations for the future (most commonly staying in education up to university level, and getting a good job).

Most survey respondents felt they could rely on one or two people. The number of social support relationships was significantly associated with being male, attending secondary school and higher socioeconomic status (SES). The number of people one could rely on was positively associated with psychosocial well-being. Conversely, respondents with no connections were more likely to be at risk of mental health issues: 40%, compared with 22% of those with at least one supportive relationship.

Adolescent respondents also cited the factors that contribute to or drive mental ill-health. These include:

- having a negative perception of oneself (some adolescent girls described not being heard, not being able to contribute to decisions, or feeling ignored as causing them distress or sadness)
- not having enough time to do the activities they want to, or to rest
- not having enough money to take part in certain leisure activities (or parental disapproval of such activities)
- lack of friends/social networks, leading to isolation.

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3   The only exception was that a higher share of boys than girls were in the top quartile of the WHO-5 index but this difference was only marginally statistically significant (relative risk, 1.46; X^2=3.581, df=1, p<0.01).

Respondents from all categories (adolescents, parents/caregivers and key informants) reported that unhappy/unstable family dynamics were a major stressor in adolescents' lives. Adolescents' family situations were linked to a number of interrelated drivers of mental ill-health:

- not living with one or both parents (for example, the survey showed that while 37% of children living with both parents reported having gone hungry in the past year, the figure was 63% for single parent or other household formations)
- lack of communication between parents and adolescents and lack of parental care, leading to feelings of neglect
- experiencing violence or abuse within the home
- having a parent (typically the father) that abuses alcohol or drugs, which increases the risk of violence.

In our survey, about a quarter (26%) of respondents reported having experienced physical or emotional violence or other maltreatment (such as being denied food) at home within the past year. Experiencing violence is strongly negatively correlated with the WHO-5 score and with a higher SDQ score, and positively associated with being in the WHO-5 at-risk category.

The survey also found strong correlations between witnessing violence and being at risk of depression according to the WHO-5, as well as being in the SDQ high-risk category. A quarter of adolescents reported having witnessed their father commit an act of violence against their mother at least once, while 23% had witnessed another relative hit or beat their mother.

Poverty was also cited as a major driver of mental ill-health among adolescents in the qualitative work, with both adolescents and adults reporting that lack of food and other unmet basic needs (including sanitary pads for girls) caused adolescents to feel worried and sad, and to compare themselves negatively with those from families who could afford these things.

Unemployment and unstable/irregular or precarious employment among parents or caregivers also had negative impacts on adolescents' mental health. The survey found a clear association between psychosocial well-being and SES, with poorer respondents exhibiting lower psychosocial well-being than their wealthier peers, but no clear associations between SES and being at risk of mental ill-health.

Adolescents cited academic pressure (notably fear of failing exams) as another driver of stress and anxiety. This was felt more keenly by students whose parents were unable to afford additional private tuition classes outside school hours. Some adolescents (but mostly older boys) mentioned corporal punishment by teachers (such as being beaten with a stick) as a cause of mental distress, although this was not apparent in the quantitative data. The survey indicates that 64% of students had experienced corporal punishment, and 70% another type of physical punishment (e.g. being forced to run).

Gendered social norms were cited as an important driver of mental ill-health in the qualitative work, particularly for girls. Adolescent boys and girls alike identified girls' greater burden of unpaid care and domestic work responsibilities as detrimental. Norms around son preference also affected girls' mental health, as they were often less likely to be prioritised for education. In qualitative interviews, some adolescents also raised feeling pressure to engage in early sexual encounters, causing mental distress.

Chapter 6: Mental health-seeking behaviours coping strategies and the influence of technology

Awareness and knowledge of services and support

Most adolescents indicated that they do not usually receive information about mental health, from any source. Both adolescents and adults had limited awareness of formal mental health services. The survey showed that knowledge of sources of information is positively correlated with being male, living in Mwanza, being Muslim, secondary school attendance, higher SES, having a role model and having someone on whom they can rely. It is also linked with mental health outcomes; it is positively correlated with psychosocial well-being and inversely with being in both the SDQ and WHO-5 at-risk categories.

Experiences of accessing formal or informal services

Most respondents in the qualitative research had no first-hand experience of accessing mental health services, although adolescents had some limited experience of accessing such services in schools. Adolescents and key informants both indicated limited demand for formal mental health services, partly due to lack of awareness of symptoms but also due to stigma. Some adolescents reported not having approached formal services because their parents/caregivers considered their mental health issues to be driven by 'demons' or 'witchcraft', and so opted to use traditional healers for consultations or treatment.

The survey measured attitudes toward seeking professional psychological help among all survey respondents. Among secondary students, the average score was 23% of the maximum, with higher levels indicating more stigma. Holding stigmatising attitudes is positively associated with being in both the SDQ and WHO-5 at-risk categories.

Coping strategies and behaviour

The survey showed that 65% of respondents used a positive coping mechanism when dealing with a difficulty while 54% used a negative mechanism. Boys and girls were equally likely to use a positive coping mechanism, although boys were more likely than girls to adopt a negative mechanism (56% and 51% respectively).

In the qualitative work too, respondents reported various *positive coping strategies*. These included socialising and engaging in recreational and leisure activities to distract them from feelings of distress. Younger adolescents were more likely to engage in 'play' (as distinct from playing games on a phone, for instance), often with friends. Older adolescents mentioned sitting down quietly and trying to calm down as a way to cope with feelings of sadness or anger. Most young adolescents (boys and girls) reported speaking to a relative (especially their mother), who would listen and offer comfort.

Most adolescents had at least one or two peers – a friend from school or the neighbourhood – with whom they could share their feelings and concerns. Some reported being able to approach supportive teachers to deal with their mental health issues. Others reported that turning to religion could help adolescents find inner strength to deal with problems.

Negative coping strategies in the qualitative component included keeping a problem to oneself, or self-isolation (some adolescents, particularly girls, said they cut themselves off from others, especially family members). Some

adolescents shared (not necessarily from personal experience) that individuals can turn to harmful substances (cigarettes, alcohol or marijuana) to cope with mental health challenges.

The qualitative component identified that adolescents sometimes bully others as a way of dealing with feelings of anger or to avenge their own experiences of being bullied. The survey showed that 27% of respondents reported having bullied someone at school, boys more so than girls (30.5% compared with 23%). Adolescents who reported bullying someone were more likely to perform worse on the SDQ and to be in the at-risk category for that measure.

Technology use

Perhaps the most striking finding is respondents' lack of access to the internet and technology – most adolescents (63%) had not used a computer (or laptop), tablet or the internet in the past year. Of those who had, most used it less than once a month. Use of a mobile phone with internet access (smartphone) was relatively more common: 53% of respondents had had some access in the past year, with almost a fifth (19%) reporting daily usage. Among adolescents who reported not having their own phone but having occasional access to someone else's, it typically belonged to a parent, older sibling or other caregiver. The qualitative data found that adolescents' use of social media was generally low.

SES is associated with statistically significant differences in computer usage and internet access. Just over a third (36%) of respondents from the highest socioeconomic quartile reported having never used a computer in the past year, compared with 78% of those from the lowest quartile. In terms of gender, differences are only statistically significant for use of the internet: 70%

of girls had never used the internet in the past year, compared with 56% of boys.

Adolescent boys and girls both mentioned that digital technologies can enable them to learn about different health topics, including mental health. Some mentioned that they use digital technologies when they feel sad or stressed. Others perceived the internet as a more 'open' and 'honest' space to get information and talk about mental health (compared with face-to-face interactions) because it offers privacy, allowing them to feel more 'confident' to talk about problems.

Most respondents (adolescents and adults) suggested that a combined approach – using digital and face-to-face methods – should be used to deliver mental health support services. Parents and caregivers also generally approved of adolescents' use of computers as they could increase their children's employment prospects.

Overall impacts of coping factors and technology access on mental health outcomes

The study quantitatively explores the joint impact of all variables (socio-demographic factors, drivers of mental ill-health, protective factors, coping mechanisms/help-seeking behaviours and access to technology) on our key mental health indicators. Overall, it explains around 30% of variation in the SDQ and WHO-5 scores.

Having knowledge of mental health is associated with half the likelihood of being in the high-risk SDQ category, while holding positive attitudes towards mental health is associated with a 70% reduced risk.

Engaging in distraction as a coping mechanism is associated with a much greater likelihood

(9 times) of being in the top quartile of the WHO-5 distribution. Respondents with knowledge of how to seek information about mental illness are twice as likely to be in the top quartile of the WHO-5 while those with access to an internet-capable device are 1.9 times as likely.

Two factors that most influence risk of depression among adolescents (according to the WHO-5 measure) are: being subject to physical violence from parents, and poverty (as measured by having experienced hunger in the previous year). Protective factors include positive attitudes towards accessing psychological help and access to a digital device (both associated with a 60% lower risk).

The relatively low impact of the socio-demographic variables on SDQ and WHO-5 outcomes suggest that they do not principally determine mental health issues and psychosocial well-being. This suggests that the intervention need not devote undue attention to targeting at-risk groups based on these characteristics (with the partial exception of poverty).

Chapter 7: Recommendations

Governments, development partners and civil society organisations or groups working on adolescent mental health in Tanzania should consider the following:

Integrate adolescent mental health into policy frameworks

- Develop new policies and regulations that explicitly address adolescents' mental health and psychosocial support needs. MoHCDGEC should ensure an integrated and coordinated approach to policy and programme implementation, establishing linkages between the Preventive Services Division, the Gender Development Division, the Children Development Unit and the Community Development Division.
- Issue clear guidance and mandates to all relevant agencies on policy implementation to ensure that adolescents' mental health needs are addressed in their respective policies and interventions.

Provide sufficient budget allocations

- The MoHCDGEC, the National Council for Mental Health and other ministries responsible for youth affairs will need sufficient budget allocations for targeted investments in services and other resources to meet adolescents' mental health and psychosocial support needs. It is worth nothing that the Abuja Declaration (2001) recommended at least 15% of national budgets go to health.
- Additional funding is needed to pay for more mental health professionals, and community and school-based counsellors, with tailored training to ensure that these professionals are equipped to support adolescents' mental health.
- As schools play a key role in adolescent mental health (promotion, prevention and care), they should receive more funding to develop strategies to prevent and identify mental health disorders among children and adolescents.
- Budget allocations should also tackle the broader drivers of adolescent mental ill-health, principally poverty and experiences of violence within or beyond the home.
- Ensure sufficient investment in appropriate physical infrastructure (e.g. equipped hospitals and health clinics, a capable and qualified workforce, up-to-date data and information systems) to provide adequate and specialised care for adolescents experiencing mental ill-health.

Use digital technologies effectively to support adolescents' mental health and psychosocial well-being

- Government and development partners should pilot digital or 'blended' solutions (a combination of digital and face-to-face approaches) to address adolescents' mental health needs. Content should be codeveloped by adolescents along with teachers, mental health and technology experts, and solutions tailored to the needs of adolescents in different contexts (urban, rural, semi-urban, etc.).
- Local governments, working with development partners, should make online information available for adolescents through mobile phones or computers, with adequate safeguards to protect children from addictive behaviours or inappropriate social media.
- Programme content and materials should help participants explore what constitutes mental ill-health, the drivers and risk factors, and facilitate discussions about stigma, social norms and other context-specific factors that can challenge mental health.
- Adolescents need strategies to help them prevent and cope with mental ill-health, along with information about services they can access when experiencing distress, or when symptoms become sufficiently severe to require professional support.

Improve mental health services and human resources

- There is an urgent need to improve the quality of mental healthcare service providers (including nurses, doctors, other healthcare workers, counsellors, social workers, psychiatrists and psychologists). There should be a training package on how best to support adolescents with the most common mental health disorders.

- The content and modalities of training programmes should directly reflect Tanzanian realities. They should be co-developed by mental health professionals with experience of working with adolescents, and those who will use the training (including mental healthcare workers and community organisations offering mental health support to youths).
- Teachers are often the 'first responders' for adolescents experiencing mental health challenges, so need more training in how to provide support. Schools should have dedicated (trained) psychologists and counsellors, with adequate infrastructure for them to provide services in confidence (for example, counselling centres).
- Organisations should pilot different models of support through schools (different kinds of counsellors, staff delivering after-school clubs, collaboration with local health clinics or hospitals, etc.).

Increase awareness of mental health and support services for adolescents, including among those most at risk

- Local government, schools and service providers should prioritise adolescents who are most at risk of mental ill-health: adolescents from poor households; those who live in unstable family situations; those who face challenges at school (linked to poverty or violence, for example); and those who face stigma, for whatever reason.
- Government, community leaders, health workers and other stakeholders should work together to raise awareness of mental ill-health, its drivers and symptoms, and the support services available, and to break down stigma. Awareness-raising should target adolescents, their parents/caregivers, support networks (teachers, care workers, after-school

club staff, etc.) and the wider community. It should also highlight the role of discriminatory gendered norms and their impact on adolescent boys' and girls' mental health.

Invest in skills development for parents, teachers and adolescents

- Support parents, caregivers and teachers to identify mental ill-health symptoms and develop strategies to build their confidence to discuss mental health with adolescents.
- Provide adolescents (through the curriculum or in extra-curricular sessions) with information and strategies to prevent or cope with mental ill-health.

Improve coordination among stakeholders

- Local government needs to promote coordination on mental health issues among key stakeholders working with adolescents. There should be effective mechanisms to link parents/ caregivers of adolescents experiencing mental ill-health to the services that can provide support. As parents/caregivers typically go to traditional healers if their adolescent child displays symptoms of mental ill-health, authorities (national and district level) need to strengthen collaboration between traditional healers and formal service providers.