Mental Health Disparities among Youth Living in the Slums of Kampala

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1 Introduction

The World Health Organization (WHO) defines mental health as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community and not just the absence of mental disorder (World Health Organization, 2007). Mental illness on the other hand is defined as “collectively all diagnosable mental disorders” or “health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning” (U.S. Department of Health and Human Services, 1999). The Centers for Disease Control and Prevention (CDC) highlights that whereas efforts have been made to screen, diagnose and treat people with mental illness, there has been little effort devoted to protect the mental health of people free from mental illness. Research and efforts to protect the mental health of these people should focus on the realms of social, emotional and psychological well-being which comprise the social determinants of mental health and whose support should be put in place (Centers for Disease Control and Prevention, 2011).

The socio-ecological model which takes into account the multifaceted interaction between individual, relationship, community, and societal factors, helps us to understand the risk factors or determinants of mental health (Centers for Disease Control and Prevention, 2013). They include, but are not limited to the following factors; access to drugs and alcohol, displacement, isolation and alienation, lack of education, transport, housing, neighborhood disorganization, peer rejection, poor social circumstances, poor nutrition, poverty, social disadvantage, urbanization, unemployment, violence and delinquency (WHO, 2004). These are not only individual risk factors that include the capability to manage one's thought process, emotions, or relations with others, but also; social, cultural, economic, political and environmental factors including national policies, social protection, living standards, working conditions, and community social support systems (WHO, 2013).

According to the WHO, 450 million people suffer from mental disorders worldwide with many more having mental problems (WHO, 2010). The WHO Global Burden of Disease Survey estimates that depression and anxiety disorders, including stress-related mental health conditions will become the second-ranked cause of disease burden by the year 2020, accounting for 5.7% of Disability Adjusted Life Years (DALYs), just behind ischemic heart disease (WHO, 2004). Mental health issues, including suicide are estimated to cause approximately 1.2 million deaths and 10-20 times more attempted suicides than that by the year 2020, making this a global public health problem that needs further attention (WHO, 2004).

The higher rates of disproportionate mortality among people with mental disorders are a sound basis for the need for extensive research and support systems for these people. 40%-60% of people with major depression have a greater chance of dying prematurely when compared to the general population because of the increased risk from other opportunistic illness that they acquire such as; cancers, cardiovascular diseases, diabetes and suicide (WHO, 2013). While research has found that certain life stressors are necessary to elicit a sense of competition and survival for people, a high level of adverse experiences especially in childhood is a known risk factor for ill mental health (WHO, 2013).

1.1 Mental Health in Africa

Despite renewed interest in the topic, every year, almost one million people die from suicide (WHO, 2011). Suicide is a particular concern among youth 15 to 19 years of age as it is the fourth leading cause of death globally in this age group (Wasserman, Cheng, & Jiang, 2005). Additionally, suicide attempt and
ideation are also of concern since they are much more common than completed suicides (WHO, 2011). Unfortunately, research on mental health issues and suicidal behavior specifically, is relatively scarce in sub-Saharan Africa (Ovuga, Boardman, & Wassermann, 2005; Bertolote & Fleischmann, 2009; Swahn, Palmier, Kasirye, & Yao, 2012). The limited progress for mental health research in this region stems primarily from the presence of other critical public health issues and because of political and economic instability (Schlebusch, Burrows, & Vawda, 2009).

Advancement has also been limited because of the previously commonly held belief that depressive symptoms and suicidal ideation and behavior in Africa were rare; more recent research, however, indicate quite the contrary and that suicidal behaviors represent a real public health burden (Ovuga et al., 2005; Bertolote & Fleischmann, 2009). Research across countries indicates that suicidal behavior is common but also underscore that patterns vary by countries (Ovuga, et al., 2005; Omigbodun, Dogra, Esan, & Adedokun, 2008; Joe, Stein, Seedat, Herman, & Williams, 2008; Muula, Kazembe, Rudatsikira, & Siziya, 2007; Hjelmeland et al., 2008). Research based on school-attending youth show that self-reported suicidal ideation ranges between 19.6% in Uganda, 23.1% in Botswana, 27.9% in Kenya, and 31.9% in Zambia (Swahn, Bossarte, Eliman, Gaylor, & Jayaraman, 2010). While not empirically examined, it is assumed that the relatively high levels of suicidal ideation and behavior among youth in sub-Saharan Africa may have been exacerbated by the severe psychosocial stress and other adverse health outcomes associated with the high prevalence of HIV/AIDS in Africa (Krug, Dahlberg, Mercy, Zwi & Lozano, 2002) as well as scarce food supply (Food and Agriculture Organization of the United Nations, 2011) and other distressing circumstances.

The increasing gap between the need for treatment and its provision all over the world is a clear indicator that health systems have not yet adequately responded to the burden of mental health disorders. There is a bigger burden in low and middle income countries with an estimated 76%-85% of people with mental disorders having no treatment. Less than US$2 per person is spent annually on mental health globally and less than US$0.25 per person in low income countries with only 36% of people living in low income countries covered by mental health legislation compared with 92% in high-income countries (WHO, 2013).

1.2 Mental Health in Uganda

Many countries in sub-Saharan Africa do not have appropriate mental health legislation. Uganda in particular has an outdated mental health act which was enacted in 1964 although a new mental health bill has been drafted and are awaiting parliamentary approval since 2010. The new bill addresses community mental health, an urgent need of communities throughout the country (Mental Disability Advocacy Center, 2011).

Although statistics on mental health in the country are very limited, the Uganda Bureau of Statistics report of 2006 revealed that 58% of all households with disabled people had at least one person with a mental disorder, common depression (20%), manic depression (3%), anxiety (4%), Epilepsy (3%) and Schizophrenia (1%); and these account for 20-30% of all hospital outpatient attendance. At least one in five people (approximately 23%) with mental health problems has “suicidal tendencies” and nearly one in four (18%) engage in substance abuse. All in all, an estimated 35% of Ugandans (approximately 9,574,915 people) suffer from some form of psychiatric (mental) disorders; at least 15% of which require treatment. However, these numbers leave out many who are outside the primary care system due to reasons like poverty and lack of appropriate health systems (Chronic Poverty Research Centre, 2007).
1.3 Mental Health of Youth living in the Slums

The United Nations which defines a slum household as a group of individuals living under the same roof in an urban area who lack durable housing, sufficient living space, easy access to safe water, access to adequate sanitation or security of tenure highlights that sub-Saharan Africa’s slums are the most deprived (UN-HABITAT, 2005). It is clear that youth who live on the streets and in the slums of sub-Saharan Africa face much of the burden related to poverty, lack of family support as well as infectious and chronic diseases (Mufune, 2000; Chigunta, 2002). However, to date, there is a dearth of research on the specific mental health needs of these vulnerable youth and their strategies for coping and trying to survive in such a challenging environment (Swahn et al., 2012a). Additionally, it is not clear what the specific disparities may be for these youth compared to their peers who may face fewer disadvantages.

Given the dearth of research of the scope of mental health needs and concerns among youth who live on the streets and in the slums in sub-Saharan Africa, this book chapter examines the prevalence of mental health issues and future aspirations among service-seeking youth living in the slums of Kampala. In particular, we focus on nine indicators including; feeling lonely, feeling so worried that they have not been able to sleep, feeling hopeful about the future, feeling so worried that they have wanted to use drugs and/or alcohol in order to feel better, thought they would never have enough money, thought they would die early (as defined by dying before the age of thirty), thought they would be unhappy, thought bad things would happen to them, and thought they would have a nice family when got older.

This book chapter also compares these service-seeking youth living in the slums of Kampala to urban and nationally representative school-attending youth from Uganda on the mental health indicators of; sadness, loneliness, having no friends, worrying, and suicide ideation. The purpose of this research project is to obtain quantitative data to examine the potential mental health disparities across these population groups in order to inform the identification and implementation of prevention and intervention strategies among vulnerable service-seeking youth.

2 Methods

The current study is based on three cross-sectional surveys: the Global School-based Student Health Survey (GSHS: National); conducted in 2003, of nationally representative students across Uganda, the Global School-based Student Health Survey (GSHS: Urban); conducted in 2003, of nationally representative students in Urban areas in Uganda, and the Kampala Youth Survey of service-seeking youth in Kampala. The GSHS surveys were developed and supported by the WHO with technical support from the CDC (CDC, 2012). The goal of the GSHS is to provide data on health behavior and relevant risk and protective factors among students across regions served by the United Nations. Country-specific questionnaires, fact sheet, public-use data files, documentation, and reports are publicly available from CDC and WHO (CDC, 2012).

The Kampala Youth Survey, conducted in 2011, was implemented to quantify and describe high-risk behaviors and exposures in a convenience sample of urban service-seeking youth living on the streets or in the slums. These youth were between the ages of 14 and 24 and were participating in a Uganda Youth Development Link (UYDEL); drop-in center for disadvantaged street youth (UYDEL, 2012). The methods of this survey have been described elsewhere (Swahn et al., 2012a; Swahn et al., 2012b; Swahn, Palmier, & Kasirye, 2013). Brief face-to-face surveys lasting about 30 minutes, were administered by social workers/peer educators employed by UYDEL across 8 drop-in centers to youth ages 14-24. Participating youth received snacks and transportation for completing the survey. Surveys were administered in
English or Luganda, to the extent possible, in private settings and rooms, to ensure privacy of survey questions and responses.

Each social worker/peer educator received training on the study methodology, each of the survey questions and its translation into Luganda (local language) if needed, and recruited potential participants among attendants at their specific drop-in Center. Recruitment took place using word-of-mouth, and each attendant was eligible for participation if they were between 14 and 24 years of age. No exclusion criteria were applied beyond the age range. Participants were informed about the study and read (or were read) the consent forms to indicate their willingness to take the survey. The consent process required that emancipated street youth 14 to 17 years of age provide their own consent for participating in the survey. Because youth 14 to 17 years of age who “cater for their own livelihood” are considered emancipated in Uganda, parental permission/consent had been waived. The same consenting process was followed for youth 18 to 24 years of age.

Over the ten-day survey period, 507 youth were approached for participating in the survey. Among these youth, 46 declined and 461 agreed to participate, yielding a participation rate of 90.9%. Four of the surveys were missing substantial numbers of responses and were therefore excluded, yielding 457 completed surveys for the final analytic sample of youth between the ages of 14 and 24 (31.1% boys and 68.5% girls). The mode for age was 17 years (n=81) and 67% of participants were between ages 16 and 20.

2.1 Measures

The Kampala survey questionnaire was modeled from the Global School-based Student Health Survey (CDC, 2012). For this book chapter, nine specific measures were examined with questions asking about if in the past month: the participants felt lonely, had been so worried that they could not sleep, had been so worried that they wanted alcohol or drugs to feel better, felt hopeful about the future, thought that they would never have enough money, thought that they would die early (defined as dying before the age of thirty), thought they would be unhappy, thought that bad things would happen to them and if they thought that they would have a nice family when they get older.

Additionally, five mental health indicators: sadness, loneliness, having no friends, worrying, and suicide ideation, were then compared between these service-seeking youth living in the slums of Kampala to urban and nationally representative youth from Uganda. These measures were compared between the Kampala Youth Survey and Global Student Health Survey (GSHS). See Table 1 for comparison of questions.

2.2 Analysis

Analyses were conducted to examine the percentage of the participants who experienced any of the nine mental health indicators. Analysis was further broken down to examine the prevalence of responses to the nine mental health indicators; sex and age. A z-test was used to test the significance of difference in proportions. The Kampala statistic was compared to Uganda National and Urban statistic respectively. A z-test is used when the sample size is large or when the population variance is known. In our sample, the smallest cell count was five (5). Therefore, no exact test was needed. Also, to conduct comparative analyses across surveys, the ages of participants were restricted to those between 14 and 17 years of age. GSHS: national; N= 2838, GSHS: Urban; N=1524 and the Kampala Youth Survey; N=192. We present the analyses comparing the three studies first followed by a more in-depth examination of the Kampala Youth Survey specifically.
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Loneliness | In the past month, how often have you felt lonely? | During the past 12 months, how often have you felt lonely?
No Friends | How many close friends do you have? | How many close friends do you have?
Worries | In the past month, how often have you been so worried about something that you could not sleep at night? | During the past 12 months, how often have you been so worried about something that you could not sleep at night?
Sadness | In the past year, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing your usual activities? | During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing your usual activities?
Suicide Ideation | In the past year, did you ever think of killing yourself? | During the past 12 months, did you ever seriously consider attempting suicide?

**Table 1**: Description of mental health indicator questions in the Kampala Survey and the GSHS (national/urban).

### 3 Results

Among the youth in the Kampala Youth Survey, the most frequently reported mental health indicator was loneliness (81.8%) followed by worrying (77.7%) and sadness (75.0%). In the GSHS: National, the two most frequently reported mental health indicators were sadness (43.1%) and suicide ideation (20.1%). In the GSHS: Urban, the two most frequently reported mental health indicators were sadness (43.3%) and suicide ideation (18.5%). Statistical differences were noted across surveys with respect to loneliness, worrying and sadness which were all more prevalent among youth in the Kampala Youth Survey than in either the GSHS: National or the GSHS: Urban. The prevalence of each mental health indicator stratified by sex is presented in Table 2.

The patterns noted overall were also observed for specific gender analyses. Boys and girls in the GSHS National and Urban samples were less likely to report loneliness, worrying (losing sleep) and sadness than were boys and girls in the Kampala Youth Survey.

For the nine mental health indicators, the prevalence for each is presented in Table 3. Analyses for the nine indicators show that 83.3% (N = 373) of the overall respondents said they experienced loneliness, 82.9% (N = 375) of the overall respondents said they were so worried that they have or had lost sleep, 35.2% (N = 159) of the overall respondents said that they were so worried that they wanted to use drugs or alcohol to feel better, 92.9% (N = 419) of the respondents felt hopeful about the future, 70.58% (N = 319) of the respondents thought they would never have enough money, 44.3% (N = 199) of the overall respondents thought they would die early (defined as dying before the age of 30), 66.3% (N = 295) of the overall respondents thought they would be unhappy, 77.6% (N = 346) of the respondents thought they would have bad things happen to them, and 92.2% (N = 413) of the overall respondents thought they would have a nice family when they got older.

The prevalence of the nine mental health indicators broken down by sex is presented in Figure 1. Analyses were computed for responses by sex for the different mental health status indicators. There were no significant differences between boys and girls based on being lonely, having worried, having no money, being unhappy, thinking bad things will happen to them and expecting to have a nice family in the
future. However, significant differences were found between boys and girls in their responses to being so worried that they used drugs. Higher number of boys reported that they were worried and used drugs (46.8% boys and 30.1% girls) and this difference was significant with a p-value of 0.0006.

Kampala Youth Survey (Age 14 - 17) %
Overall Boys Girls
Loneliness 153 (81.8) 61 (87.1) 92 (78.6)
No Friends 16 (8.7) 5 (7.5) 11 (9.3)
Worries 146 (77.7) 57 (82.6) 89 (74.78)
Sadness 141 (75.0) 59 (84.3) 82 (69.5)
Suicide Ideation 51 (26.8) 14 (19.7) 37 (31.1)

GSHS National (Age 14 - 16+) %
Overall Boys Girls
Loneliness 329 (11.9)*** 168 (12.1)*** 161 (11.7)***
No Friends 281 (10.3) 131 (9.4) 150 (11.3)
Worries 328 (12.1)*** 158 (11.3)*** 170 (13.0)***
Sadness 1179 (43.1)*** 572 (40.6)*** 607 (45.7)***
Suicide Ideation 534 (20.1) 249 (17.9) 285 (22.8)

GSHS Urban (Age 14 - 16+) %
Overall Boys Girls
Loneliness 191 (13.0)*** 78 (11.0)*** 113 (15.0)***
No Friends 155 (10.9) 60 (8.5) 95 (13.1)
Worries 152 (10.3)*** 59 (7.8)*** 93 (12.7)***
Sadness 641 (43.3)*** 279 (38.5)*** 362 (48.0)***
Suicide Ideation 256 (18.5) 109 (16.0) 147 (20.8)

*** p < 0.05, All comparisons are made against the Kampala Youth Survey.

Table 2: Prevalence and Comparisons of Mental Health Factors across Three Surveys.

Significant differences were also found between boys and girls based on their responses of expecting to die early. More boys reported thinking that they would die early (52.1% boys and 40.7% girls) and this was a significant difference with a p-value of 0.0241.

The prevalence of the nine mental health indicators broken down by age is presented in Figure 2. Analyses were also computed to assess mental health status indicators by age dichotomized as those under 18 years of age and those 18 years of age and older (<18 and ≥ 18). Respondents did not significantly differ by age group in their responses to being lonely, being hopeful, thinking they will die early, thinking they will have no money, thinking bad things will happen to them, being unhappy or thinking they will have a nice family. There were, however, significant differences based on their age according to the responses for worrying resulting in sleep loss and being so worried that they used drugs. Older youth reported worrying that impacted sleep more often (77.8% < 18 and 86.6% ≥ 18) and this was significant with a p-value of 0.0143 while older youth also reported using drugs more than younger youth because of being so worried (23.7% < 18 and 43.6% ≥ 18) and this was significant with a p-value of 0.0001.

4 Discussion

This book chapter sought to determine whether youth, primarily non-school-attending, living in the slums of Kampala, had greater mental health needs than nationally representative school-attending youth living across Uganda or living in urban areas. In the comparisons, even when restricted to youth living in urban areas specifically, those who live in the slums are at particular disadvantage with respect to sadness, worrying and loneliness indicating that the mental health needs in this vulnerable population are of grave concerns. This is in accordance with previous research among girls and young women living on the streets and in the slums of Kampala (Swahn et al., 2012b).
### Indicators of Mental Health Status

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Yes %</th>
<th>No %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lonely</td>
<td>373 (83.3)</td>
<td>75 (16.7)</td>
</tr>
<tr>
<td>Worried No Sleep</td>
<td>375 (82.8)</td>
<td>78 (17.2)</td>
</tr>
<tr>
<td>Worried Using Drugs</td>
<td>159 (35.2)</td>
<td>293 (64.8)</td>
</tr>
<tr>
<td>Hopeful</td>
<td>419 (92.9)</td>
<td>32 (7.1)</td>
</tr>
<tr>
<td>No Money</td>
<td>319 (70.6)</td>
<td>133 (29.4)</td>
</tr>
<tr>
<td>Die Early</td>
<td>199 (44.3)</td>
<td>250 (55.7)</td>
</tr>
<tr>
<td>Unhappy</td>
<td>295 (66.3)</td>
<td>150 (33.7)</td>
</tr>
<tr>
<td>Bad Things</td>
<td>346 (77.6)</td>
<td>100 (22.4)</td>
</tr>
<tr>
<td>Nice Family</td>
<td>413 (92.8)</td>
<td>32 (7.2)</td>
</tr>
</tbody>
</table>

**Table 3:** Nine Mental Health Status Indicators Examined in Kampala Youth Survey (2011).

This research revealed that there is a high prevalence of youth expecting to be unhappy in the future which is of great concern and highlights the need for interventions to reduce the impact of social disadvantage in their lives through interventions at various levels (Swahn *et al.*, 2012b). These recommendations build on previous research which also proposes that socially-disadvantaged youth have lower levels of collective cognitive and social resources upon which to encourage them to have high hopes for the future (Clinkinbeard & Zohra, 2012; Foster & Spencer, 2011). In the current study we also found no significant differences between boys and girls for the most part with respect to the mental health indicators, a finding that is consistent with previous research examining adolescents' conceptions of the past, the present, and the future which found that females and males reported relatively similar ideas about the past, present, and future (Mello *et al.*, 2009).
These findings, while preliminary, demonstrate very high levels of sadness, worry and loneliness among youth living in the slums and reflect great social isolation and despair. As has been suggested previously (Swahn et al., 2012a), while street youth may appear to have higher levels of adaptability and flexibility when faced with adversity than do other youth populations (Ayuku, Devries, Mengech, & Kaplan, 2004), there may still be limits of flexibility that these vulnerable youths can express because of the possible cumulative effect of victimizations (Swahn et al., 2012b) and other adverse health factors that subsequently may be expressed as sadness and isolation as noted in this study. This may be a particular salient issue in the absence of a social network available for support (Swahn et al., 2012a) which is also noted as a disparity among these vulnerable youth.

Given the stark differences with respect to sadness, loneliness and worrying, it was surprising that levels of suicide ideation also did not differ between the groups. However, there may be religious and other contextual and cultural factors that serve to protect these vulnerable youth against suicide ideation even though they have very high levels of sadness and loneliness. Alternatively, it is also highly recognized that the level of stigma and cultural disapproval of suicide may result in under reporting of any suicide-related questions. Additional exploration and research on this topic would be very beneficial in particular for the service provision to these youths. Moreover, the prevalence of reporting sadness varied by sex in the Kampala youth survey indicating that boys had higher levels than girls (84% and 69%, respectively). This observation was not made for either of the GSHS surveys.

4.1 Limitations

The Kampala study is comprised of a relatively small number of participants and included limited measures related to mental health indicators and future aspirations. As such, results of this study should be viewed in the context of several important limitations. Most importantly, the surveys compared herein used very different study methodologies, included questions which were not always worded exactly the same and also did not capture the same time period. The different data collection years could have impacted the findings in multiple and unknown ways. Both surveys also included very brief measures on
mental health symptomatology. Moreover, the surveys were also conducted several years apart. These important discrepancies and limitations could have impacted the findings in multiple and unknown ways. Also, the study participants in the Kampala youth survey were not randomly selected, but were youth who self-selected to attend the drop-in centers and to take part of the study. Therefore, the findings may not be representative of street and slum youth in Kampala and may not be generalizable to populations elsewhere. Despite these important limitations, the findings clearly underscore significant mental health disparities among vulnerable urban youth living in the slums compared with urban school-attending youth. However, additional research is needed to replicate these findings and expand comparisons that seek to elucidate the significant and modifiable mental health disparities that may be better addressed in the future to improve the lives and health outcomes of vulnerable youth.

4.2 Further Research

Future research is also needed to better determine strategies for providing additional services and treatment to these youths who may be difficult to reach but who are already service-seeking. Several reports have outlined the dire situation of mental health needs and the acute shortage of psychiatrists, psychologists, nurses, and social workers in Africa (Saxena, Thornicroft, Knapp, & Whiteford, 2007) and in Uganda, more specifically (Swahn et al., 2012a; Ovuga, Boardman, & Wasserman, 2007). However, new strategies have been suggested for the development of child mental health services in low income countries (Omigbodun, 2008) including school based mental health programs (Ibeziako, Omigbodun, & Bella, 2008) that may also be promising for adaptation to be delivered to youth who seek services in drop-in centers. However, these would most ideally involve lay workers but will need to be implemented and evaluated in these informal drop-in centers.

4.3 Implications and Recommendations

The health concerns of street children in Kampala is a particularly pressing issue because they are expected to substantially increase in numbers as Uganda is projected to have the world’s highest population growth over the next couple of decades (Swahn et al., 2012a; World watch Institute, 2011). Unfortunately, there is a dearth of information regarding the specific mental health needs and concerns among street youth in sub-Saharan Africa (Ovuga et al., 2005; Bertolote & Fleischmann, 2009; Swahn et al., 2012a; Schlebusch et al., 2009). As such, our findings indicate that there is a significant unmet need among these youths, and given the rapid population growth, these unmet needs will continue to increase and exacerbate the already compromised living situation for these youth. This concern of these youth based on their responses is consistent with findings from a study on self-schemas and possible selves as predictors and outcomes of risky behaviors in adolescents which suggested that the self-concept could be one means through which the behaviors become structuralized into actually enduring parts of the self in the future (Stein, Roeser, & Markus, 1998).

The findings from these youth are worthy of attention and although challenging to address, they can be met through multisectoral collaborations. This is emphasized in the WHO’s mental health action plan 2013-2020 which is a fundamental resource for improving mental health globally. It gives background and insight for nations and communities to improve their mental health outcomes through its major objectives to; strengthen effective leadership and governance for mental health, provide comprehensive, integrated and responsive mental health and social care services in community-based settings, implement strategies for promotion and prevention in mental health and to strengthen information systems, evidence and research for mental health. It lays a foundation for mental health prioritization through six
cross cutting principles of Universal health coverage, Human rights, Evidence-based practice, Life course approach, Multi-sectoral approach and Empowerment of persons with mental disorders and psychosocial disabilities (WHO, 2013). This is an exciting advancement for mental health research and priority setting and hopefully these initiatives will reach youth in underserved communities with high need for services, particularly in sub-Saharan Africa.

References


