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Implications for Mental Health Promotion and Prevention Interventions: Findings From Adolescent Focus Group Discussions in Belize, Kazakhstan, and South Africa

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ABSTRACT

Purpose: This study aimed to understand 10- to 19-year-old adolescents' conceptions of mental health and well-being, and suggestions for appropriate interventions, in three low- and middle-income countries to inform the design of adolescent-responsive preventive and promotive mental health programming.

Methods: Ninety-one adolescents participated in focus group discussions in Belize, Kazakhstan, and South Africa. The discussions were recorded, transcribed, translated, and analyzed using thematic analysis.

Results: Adolescents were active contributors to the discussions and provided important information and solutions for improving adolescents' mental health from interpersonal skills training to interventions in schools and communities. Adolescents identified a need for social emotional skills development, particularly regarding interpersonal relationships and navigating peer pressure and bullying. Furthermore, the discussions highlighted the need for programming to be tailored to the local context regarding language, contextual challenges faced by adolescents, and choice of program facilitators. Adolescents valued supportive interactions with adults in their lives and recommended that programs should include teacher/parent training on interacting with adolescents.

Conclusions: These findings highlight that adolescents are valuable partners in developing adolescent health interventions and show that social emotional skills are key components in such

IMPLICATIONS AND CONTRIBUTION

Mental health promotive and preventive programs have been shown to be effective in improving adolescent health. These programs should be based on adolescents' priorities and culturally and locally adapted. Programs should include social emotional skills, such as interpersonal skills, and components for teachers and parents on

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interventions. These programs should be culturally and locally appropriate and include components for teachers and parents.

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communication and disciplinary practices.

Mental health conditions, including depression and anxiety, account for around 13% of the global burden of disease and injury among the world's 1.2 billion adolescents, and suicide is a leading cause of death among older adolescents [1]. Furthermore, poor mental health in adolescence is associated with self-harm and other risk behaviors, such as substance misuse, inconsistent contraceptive use, aggressive behavior, and bullying, which in turn increase the likelihood of sexually transmitted infections, unsafe abortion, school failure, and delinquency [2,3].

Psychosocial interventions that focus on strengthening adolescents' problem-solving, social and emotional skills, and general life skills have proven to be effective in improving youth's mental health and reducing the occurrence of emotional and behavioral problems and self-harm, especially when they are accompanied by broader actions addressing environmental and contextual factors in the family, school, and community [4]. Furthermore, the psychosocial skills gained are vital for promoting healthy behaviors and preventing or reducing health risk behaviors, such as bullying and risky alcohol and substance use [5,6]. However, studies testing mental health and psychosocial interventions for adolescents in low- and middle-income countries are limited, and few actively incorporate youth feedback and participation in the process of designing, implementing, and adapting the interventions [7].

Although a number of adolescent psychosocial interventions have had a narrow focus, targeting one or two issues [4,8], such as bullying or sexuality, there is a need for multicomponent interventions to address a range of issues in a cost-effective manner [9]. A meta-analysis of 158 randomized controlled trials of universally delivered mental health promotion and prevention interventions revealed seven core program content components with large effect sizes for improving mental health and risky behavior outcomes: mindfulness training, emotional regulation skills, interpersonal skills, problem-solving skills, assertiveness training, stress management, and alcohol and drug education [6].

Based on these findings, United Nations Children's Fund and World Health Organization are partnering on developing a suite of interventions under the Helping Adolescents Thrive (HAT) initiative, to promote positive mental health and prevent mental health conditions and risk behaviors in adolescent populations, specifically in low- and middle-income settings where evidence is most needed. Young people play a central part in the HAT initiative and were consulted on a range of topics relating to prevention programming through focus group discussions (FGDs). The objectives of the FGDs were to (i) explore participants' language use regarding adolescents' experiences of emotions and events in their lives affecting their emotional well-being and (ii) to elicit their opinions regarding priority issues and their suggestions for interventions to mitigate these issues to improve their lives and their communities. This study summarizes the responses of the participants aged 10–19 years as expressed during FGDs in three low- and middle-income countries. These findings are being used to inform the design of adolescent-responsive preventive and promotive mental health programming.

Methods

In this study, we have followed the consolidated criteria for reporting qualitative studies [10]. This study was conducted using qualitative research methodology with a general inductive approach to the data analysis guided by the research objectives [11].

Study setting and participants

This study was approved by the Stellenbosch University Health Research Ethics Committee, the University of Cape Town Human Research Ethics Committee, and the Ethics Committee of the National Centre for Mental Health in the Ministry of Health of Kazakhstan for FGDs conducted in Cape Town, South Africa, Belize City, Belize, and Almaty City and Almaty Oblast, Kazakhstan, during June, July, and September 2019, respectively.

In each country, the research team worked with community organizations in conducting FGDs. A total of 91 participants were included in 12 FGDs across the countries, 28 from Belize, 31 from South Africa, and 32 from Kazakhstan (see Table 1). In Belize and South Africa, FGDs were organized by sex and age, with separate boys' and girls' FGDs held for participants aged 10–14 years and 15–19 years. In South Africa, FGDs were conducted in Khayelitsha, a low-income area on the outskirts of the city of Cape Town which is home to a predominantly black African population of around 400,000 people [12]. Belize City, the largest city in the country, was the location for the Belize FGDs. The city has a population of around 60,000 people [13]. FGDs in Kazakhstan included boys and girls in the same groups and were organized by age and urban or rural residence, with 10- to 14-year-old and 15- to 19-year-old participants in separate FGDs conducted in urban and rural settings in the Almaty region, which has a population of more than two million people [14]. The Kazakhstan investigators decided that the urban/rural and home language/cultural factors were more important to consider in their setting for FGD composition, rather than separating the groups by sex. Rural settings in the country are characterized by lower living standards than urban settings [15]. The urban setting was located in the largest city in Kazakhstan, the multicultural Almaty city in south-eastern Kazakhstan, which has a population of around 1.9 million people. FGDs in the rural area were conducted in Raimbek village in the Karasay rayon district in Almaty Oblast.

Recruitment of participants

In Belize, the recruitment of participants from schools was supported by the Division of Youth Services and the Ministry of Education. The sample of participants was purposively selected to be of diverse socioeconomic backgrounds and ages and for similar numbers of boys and girls. In South Africa, Masiphuhlisane Research Centre, affiliated with Stellenbosch University, recruited youth through their community networks, both face to face and telephonically, also sampling purposively by sex and age. Some of the participants were known to the facilitators, but the majority

Table 1
FGD participantss

Country	Total sample	10–14 years old			15–19 years old		
		Total	F	M	Total	F	M
Belize (English/Creole language)	28 (all school-going)	14	7	7	14	7	7
South Africa (isiXhosa language)	31	16	8 (all school-going)	8 (7 school-going; 1 out of school)	15	7 (5 school-going; 3 out of school)	8 (5 school-going; 3 out of school)
		Total	Urban (Russian language)	Rural (Kazakh language)	Total	Urban (Russian language)	Rural (Kazakh language)
Kazakhstan	32 (all school-going)	16	8 (5 girls and 3 boys)	8 (5 girls and 3 boys)	16	9 (4 girls and 5 boys)	7 (4 girls and 3 boys)

FGD = focus group discussion.

had had no previous contact with the research team. In the other two countries, facilitators had not been in contact with the participants previously. In Kazakhstan, the recruitment of participants was supported by the National Centre for Mental Health in the Ministry of Health, who assisted in liaising with local government authorities to reach school-going adolescent participants both face to face and by telephone. Adolescents were purposively sampled by age, sex, location (urban/rural), and home language. Data were not collected regarding refusal to participate; no participants withdrew from the FGDs during the study.

Information sheets were provided to parents/guardians of participants and to participants outlining the purpose of the study, any benefits and any risks, including potential loss of confidentiality, and the voluntary nature of their participation. Thereafter, written informed consent from parents for their child's participation (if the child was under 18 years of age) and informed consent (and assent where age-appropriate) were obtained from all participants before engaging in any activities.

Data collection

In the three settings, focus group facilitators were selected by the local partners based on their experience working with adolescents and participated in a training workshop beforehand. One of the authors (JS), a clinical social worker and Director of the Maphuhlisane Research Centre, trained facilitators in person in South Africa and Belize. JS and other HAT team members

provided guidance electronically to the Kazakhstan team. [Table 2](#) lists the characteristics of the FGD facilitators in each country. None of the facilitators are currently involved in developing the planned mental health intervention; JS provided initial input on intervention materials but is no longer involved in the project. Of the facilitators, only JS and RS were part of the HAT team at the time of the interviews.

The focus groups were conducted at community organization facilities in South Africa (Maphuhlisane Research Centre); and at the Sange Research Centre (urban FGD) and rented premises (rural FGD) in Kazakhstan; and in Belize, the FGDs were conducted in a hotel conference room. Before each FGD, the participants were informed that the data would be used to inform a school-based intervention for adolescents in different countries. The FGDs followed a semi-structured session guide which explored key questions including adolescent perceptions of mental health, factors related to mental health and challenges faced by the adolescents, and their suggestions of strategies and interventions to promote mental health and prevent mental health problems. Sessions were carefully structured to suit younger adolescents (10–14 years old) as well as older adolescents (15–19 years old), regarding timing of breaks and types of icebreaker/energizing activities utilized. FGDs lasted between 90 and 120 minutes.

The format of FGD workshops including only participants and facilitators began with icebreakers and games followed by a review of ground rules to create a space that fostered engagement and open discussion ([Appendix A](#) lists the interview guide and facilitator instructions). The HAT facilitators created a

Table 2
Characteristics of FGD facilitators

Country	Gender of facilitators	Occupation of FGD facilitators at time of groups	Education of facilitators
Belize	2 female lead facilitators and 2 female assistant facilitators	Lead facilitators: (i) communications officer, Department of Youth Services and youth mental health advocate; (ii) Director of the Maphuhlisane Research Centre Other facilitators: school counselors	Lead facilitators: (i) bachelor's degree; (ii) clinical social work, PhD degree Other facilitators: bachelor's degrees
South Africa	2 female and 2 male facilitators working in 2 teams (1 male and 1 female facilitator)	Trained community workers, experienced in qualitative research with adolescents (employees of the Maphuhlisane Research Centre)	All had completed some high school education
Kazakhstan	2 female facilitators	Two facilitators, specialized in conducting focus groups, from a research company: (i) leading analyst (researcher) of SANGE Research Center (ii) analyst (researcher) of SANGE Research Center	(i) PhD degree (ii) Psychology postgraduate degree

FGD = focus group discussion.

nonjudgmental environment and guided adolescents in discussing “healthy” feelings and behaviors based on their own realities, prompting as necessary based on the interview schedule and the discussion. Use of vignettes and a third person point of view were key in exploring perspectives of participants, ranking challenges experienced and brainstorming solutions. For some FGDs, a counselor was available to provide support to participants as needed, and in other FGDs, facilitators experienced in mental health research with youth were trained to provide support and to refer adolescents to mental health services if necessary. Participants were not contacted again regarding the data. FGDs were audio-recorded and transcribed. Field notes were not included.

Data analysis

All transcriptions and translations were performed in each country with a local research team. Focus group data were thematically analyzed using Atlas.ti software, and all transcripts were independently coded by two researchers using a general inductive approach [11]. Open and structural coding was applied to transcripts to identify any patterns or repeating ideas. Researchers did an initial review of the transcripts to identify possibilities for coding. From there, a coding scheme was designed and applied to the remaining transcripts, with modifications to the scheme made throughout the coding process during discussion between the two coders. Data were compared by theme across the three countries.

Results

The overall coding scheme is provided in Table 3.

Describing emotions

Adolescents used a range of words and phrases to speak about their emotions, with some participants using idiomatic culture-specific expressions. Participants were specifically asked about the language that they would use to describe emotions and encouraged to use slang or colloquial terms. For example, adolescents in South Africa illustrated feeling good by saying that the “problems are with my neighbor”, implying that they do not have any problems or being “locked” by life (15- to 19-year-old male,

South Africa). When asked to describe feelings, adolescents volunteered words such as “happy”, “grateful”, “angry”, or “frustrated” but also phrases implying positive or negative circumstances affecting their well-being. For example, adolescents in Belize spoke of “living famous” (10- to 14-year-old male, Belize) or “chaos” (15- to 19-year-old female, Belize). A number of participants described outward manifestations of emotions, such as a teenager smiling and dressing up or being irritable with their friends and withdrawing from social situations. Participants from Kazakhstan mentioned playfulness, joking with friends, and being seen to “chase your own tail a bit” (10- to 14-year-old adolescents, rural Kazakhstan) as indicating positive emotions.

Factors influencing adolescent emotional well-being

A number of themes were identified regarding factors improving or threatening emotional well-being. These were mainly evident at the individual and interpersonal level. While adolescents’ peer group and interpersonal relationships in the home and school environment were foregrounded in the discussions, adolescents also alluded to community factors, such as safety.

Individual factors

The most common individual factors affecting emotional well-being were linked to money and possessions, academic achievements, and risky behaviors. Intrapersonal strengths were only mentioned in one focus group, where a participant suggested that having “a positive mindset” (15- to 19-year-old female, Belize) was vital for well-being. A number of participants mentioned finances and material goods as being key factors influencing a young person’s well-being, particularly in South Africa and Kazakhstan: “when they have a lot of money, their mood is up” (10- to 14-year-old adolescents, rural Kazakhstan). These factors were linked not only to the family’s ability to pay for education and basic needs but also to the family’s standing in the community. Not being able to keep up with others’ “glam” lifestyles (15- to 19-year-old female, Belize) and clothes was a reason for being isolated from their friends: “you cannot stay with them because you are not on style” (15- to 19-year-old male, South Africa). Such comparisons were made based on their face-to-face interactions with peers, as well as on social media. In addition, being given money and material things by family and friends or winning highly prized objects was often mentioned, with positive emotions being linked to “free phones, any freebie” (15- to 19-year-old adolescents, urban Kazakhstan). Academic success or failure was alluded to in every focus group, whereas dropping out of school or being expelled also featured prominently. Older girls in Belize and South Africa were particularly concerned about performing at school and their future work opportunities. One participant described her thoughts about falling behind academically:

“It’s very important school-wise to do my best as we know your parent works very hard for the money to put you in school and you want to show them the progress ... It becomes so much outside, from the inside it becomes like a pressure cooker ...” (15- to 19-year-old female, Belize)

Using alcohol or cannabis was linked to feeling good in Belize and South Africa, but mainly in the context of socializing with

Table 3
Coding scheme overview

Themes
Description of emotions:
<ul style="list-style-type: none"> • ‘Positive’ emotions • ‘Negative’/difficult emotions
Drivers of emotional well-being/emotional difficulties:
<ul style="list-style-type: none"> • Individual, for example, academic achievement or health-related behaviors, such as problem drug use • Interpersonal, for example, friendships or romantic relationships • Environmental, for example, exposure to violence
Suggestions for solutions:
<ul style="list-style-type: none"> • Adolescent social emotional skills interventions, for example, interventions targeting conflict resolution • School- and community-based interventions, for example, educational/vocational programmes, safe spaces for psychosocial support • Teacher- or parent-focused interventions, for example, interventions targeting adolescent-adult communication • Society-level interventions, such as improved law enforcement

friends. However, using substances, particularly drugs other than cannabis, was also cited as a reason for experiencing negative emotions, along with delinquent behaviors, such as committing crimes or drug dealing. In all countries, participants noted that early initiation of sexual activity and teenage pregnancy have a negative impact on well-being.

Interpersonal factors

Across the countries and age groups, support and “acceptance” in interpersonal relationships were the most common drivers of emotional well-being reported by adolescents. The importance of relationships with peers and romantic partners was highlighted as being vital for adolescents’ emotional well-being, with having many loyal friends resulting in positive emotions. Breaking up with a romantic partner, being humiliated or labeled an “outcast” (10- to 14-year-old adolescents, urban Kazakhstan) were often mentioned as causes of unhappiness, and participants in all countries reported that incidents such as bullying, pranks, gossiping, or name-calling were particularly hurtful and in some cases highly dangerous as related by a participant:

“Maybe you see that he is powerful, and you are small ... if he finds you eating chips, he would take them. He won’t even ask because he knows he is [more] powerful than you ... He is known for being the best with a knife. When a person undermines him, he stabs that person. He just stabs and that is the reason you drop out because you are scared of that person” (15- to 19-year-old male, South Africa).

Across all three countries, opportunities to socialize with friends, such as parties or informal gatherings, were described as being largely positive when adolescents felt at ease among their peers, with talking, dancing, drinking, and smoking being desirable activities. However, participants also cited difficulties navigating such situations and other interactions with their peers where adolescents feel pressured by their counterparts to consume alcohol or drugs, miss school, or engage in sexual activity. One young woman explained that “it changes your entire paradise, if your friends are doing something you don’t feel comfortable about” (15- to 19-year-old female, Belize). In general, participants aspired to being independent and resisting peer pressure.

Environmental factors

The adolescents raised additional points related to their immediate environments in homes, schools, or communities. Within homes, experiences of emotional, physical, or sexual abuse were identified by adolescents in all three countries as being major contributors to poor emotional well-being. In addition, adolescents observed that feeling “undermined” (15- to 19-year-old female, South Africa) or neglected by family was an important contributor. Conflict between family members and death in the family were also mentioned as having a negative impact. The reverse of the factors mentioned previously were linked to adolescent emotional well-being, with participants placing a high value on family harmony and receiving love and support from their family.

The main threats to emotional well-being for adolescents across all three countries in the school and other community environments included negative interactions with teachers

in front of their peers, community safety issues, bullying or gossip, and lack of recreational opportunities. Adolescents in all three countries mentioned the impact of community violence on their lives, with one participant relating how they felt unsafe and struggled to enjoy themselves as they were watching “my family so they don’t get drugs or hurt” (15- to 19-year-old female, Belize). In Kazakhstan, road safety concerns were also highlighted. Adolescents spoke of opportunities to engage in various recreational activities in communities as positively influencing their well-being. In Kazakhstan, the staging of community events, particularly in rural areas, was noted as especially exciting.

Proposed solutions

In the focus groups, participants were invited to offer solutions to the most important problems identified by them in their settings. Priority issues raised were violence, including sexual and gang violence, bullying, child abuse as well as academic pressure, peer pressure, and communication with adults in their lives.

Adolescents in all three countries requested social emotional skills training in some form, particularly regarding assertiveness, and decide for themselves when faced with peer pressure and bullying. Participants emphasized the need to address other problems in interpersonal relationships, recommending that adolescents be taught how to cope with loneliness, choose their friends well, and navigate dating relationships and sexuality. Furthermore, adolescents recommended that their parents and teachers be educated on these issues, mostly to be aware of the challenges young people face and also to be able to offer assistance when needed.

Adolescents suggested a range of community- and school-based programs to promote mental health, mitigate the mental health impact of stressors and traumatic events, and provide alternatives to negative life choices, such as gang membership. The programs included educational support and vocational training, programs providing recreational opportunities as well as programs addressing sensitive issues such as sexuality, including discussions on sexual behaviors and substance use and similarly sensitive topics, and access to confidential services. Across the countries, adolescents suggested access to counseling and a “safe haven” for adolescents (15- to 19-year-old male, Belize) who are stressed, facing peer pressure, those who have been abused or bullied, and for adolescents who are violent or bully other children “because there are children who come with their problems from home and take out their anger to children” (10- to 14-year-old female, South Africa). For these programs, adolescents placed emphasis on the idea of being able to talk freely about issues in their lives, access “psychological assistance” (10- to 14-year-old adolescents, urban Kazakhstan), and elicit help without being judged. One participant described the need for such safe spaces:

“The world will never be perfect, so there will always be negative things out there. After all those bad things happen, some place for them to go ...” (10- to 14-year-old female, Belize)

Potential facilitators suggested were school counselors, staff at community organizations, psychologists, and in a few cases, teachers. In two countries, adolescents expressed their preference of not having teachers as facilitators for these processes

given that in many cases, they were identified as being the source of emotional stress. Peer counselors were only mentioned in one focus group, although this was not specifically explored in the groups.

Adolescents noted that the actions of parents and teachers have significant effects on their mental health. Adolescents mentioned that teachers should be held accountable for offering quality teaching, and especially for treating adolescents well, without shaming them in front of their peers. Participants recommended training for the adults in their lives on communicating with adolescents and positive discipline practices. One participant saw some challenges with this approach, but did offer some hope: “Adults are difficult to change ... It’s possible to somehow encourage, teach somehow by training” (15- to 19-year-old adolescents, urban Kazakhstan).

Across the countries, laws and law enforcement solutions were recommended for a range of issues, particularly to address violence in communities, child abuse, and in South Africa, sale of alcohol to minors and drug dealing in communities. Participants were in favor of severe punishment against perpetrators to deter potential offenders. In some cases, participants also recommended police involvement for bullying. Participants called on governments to implement and enforce laws, and improve basic infrastructure for all communities. In two countries, participants highlighted context-specific historical events, namely, colonialism in Belize and apartheid in South Africa, which continue to impact their lives and opportunities. In addition, young people recognized the importance of access to financial support and a range of education opportunities, including training in various trades and employment in preventing violence and crime in their communities, as described by one participant:

“As a president I would open job opportunities because people join gangsterism because they do not have money ... and sometimes children do drop out of schools ... That thing too also causes gangsterism because when those children are out of school, where will they work because they are not educated? There is no place that they will be hired, then they decide to go rob people because it is an easy way that they can get money” (10- to 14-year-old female, South Africa).

Discussion

In this study, several important findings emerged. First, adolescents’ participation in the FGDs underscored that adolescents should be seen as active contributors with important information and solutions for developing and implementing mental health promotion and prevention programming, as well as for providing input on broader society and community level interventions. Second, adolescents identified a need for social emotional skills development, particularly regarding interpersonal relationships, navigating peer pressure and bullying. Third, the discussions highlighted the need for programming to be tailored to the local context regarding language used, contextual issues, and choice of program facilitators. Fourth, to create mental health–promoting environments for adolescents, adults in these contexts should be equipped to interact with adolescents.

In the focus groups, adolescents actively engaged in discussions, providing rich data on factors affecting their mental health and putting forward solutions which ranged from adolescents’ skills training needs to laws and policies. The adolescents’ awareness of the social determinants of their mental health and

well-being led to suggestions around creating safer communities, with regard to violence and road safety, and the provision of economic, educational, and recreational opportunities for young people. Globally, stakeholders are increasingly recognizing the need to collaborate with adolescents in promoting and intervening for health. These principles are articulated in the Global Accelerated Action for the Health of Adolescents (AA-HA!) Guidance to Support Country Implementation GLOBAL AA-HA and the HAT initiative activities [16]. Youth consultation events, such as these FGDs, are a first step toward integrating adolescents and youth into initiatives to create meaningful collaborations for improving adolescent well-being. When adolescents lead in developing solutions rather than being told what to think, feel, and do, programs are tailored to young people’s priorities and more effective in engaging young people and improving outcomes [17,18].

Regarding social emotional learning, the most pressing need articulated by adolescents across the countries was development of the interpersonal skills required to navigate friendship and dating relationships and cope with bullying and peer pressure. In addition, handling loneliness and stress emerged as a key factor in adolescents’ emotional well-being. Social emotional or life skills training—including components such as interpersonal skills, emotion regulation, and stress management—is commonly included in school-based programs and has been found to lead to a range of benefits, including improved mental health and academic performance and decreased risky behaviors and school dropout [6,19,20]. This study suggests that these components would be important to include in mental health promotion and prevention programming, based on adolescents’ priorities.

The importance of tailoring programming to local culture and needs was evident in the diverse language used by adolescents when speaking about mental health and their realities, as well as in some differences in challenges faced by young people in different settings, and in adolescents’ views of which adults they would choose to engage with them around their emotional well-being and sensitive issues. Overall cultural adaptation of prevention programs has been shown to increase the feasibility, acceptability, and effectiveness of interventions; yet, an additional step of reviewing and revising a program for each local setting allows for additional tailoring to improve the intervention ‘fit’ with the setting, encourage ongoing improvements, and promote program sustainability [21]. These considerations are particularly salient in selecting facilitators for adolescent health programming given that, although teachers were seen as likely facilitators in most FGDs in this study, adolescents in some settings preferred engaging with counselors or community organization staff. In a recent evidence review, lay workers were as effective as other cadres of facilitators in delivering adolescent mental health promotion and prevention interventions [7]. Such task-sharing approaches, whereby nonspecialist workers provide services, have been used successfully in a range of health interventions in low-resourced settings [22,23].

Adolescents in this study valued support from adults in their homes, schools, and communities and suggested strategies to facilitate healthy adolescent-adult interactions, such as educating adults on adolescents’ challenges and needs, and training parents and teachers in effective communication and discipline. These findings are supported by evidence that training adults on disciplinary practices and adult-adolescent communication improves adolescent health, reduces risky behaviors, and has a beneficial effect on other outcomes, such as retention in

education [24–27]. In addition, promotion of parental and teacher well-being is also important in promoting adolescent well-being as teachers and parents with higher levels of stress often have difficulty understanding the needs of their children and are less able to respond in a sensitive way [28,29].

The findings of this study have implications for planning adolescent programs but should be considered with the following study limitations in mind. First, the FGDs only took place in three countries in certain locations within those countries and may not be generalizable to other settings, further underscoring the need to adapt programming for new contexts. Second, the transcripts were translated into English, and some meaning may have been lost in this process. To mitigate this, local partners in each country supported the analysis and data interpretation.

Conclusion

The FGDs to inform the HAT intervention have demonstrated that such a process of engaging adolescents in a safe and meaningful way can elicit valuable data that can effectively inform programs and create a collaborative space for joint problem-solving and solution development. The findings suggest that social emotional skills training should be included in culturally and locally appropriate adolescent programs, with components aimed at awareness building, skills training, and well-being for parents and teachers.

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Supplementary Data

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