MAKERERE UNIVERSITY

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THE POLITICAL ECONOMY OF ADOLESCENT MENTAL HEALTH IN UGANDA: A CASE STUDY AMONG ACTORS AND ADOLESCENTS IN KAMPALA DISTRICT

By

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Declaration

I, Tonny Muwonge, hereby declare that the work submitted in this dissertation is original and a result of own efforts except where otherwise acknowledged. This dissertation has never been submitted for any other award in this or another university or institution.

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Acronyms and abbreviations

AMH – Adolescent Mental Health and wellbeing

CBO – Community-based organization

COVID-19 – Corona virus disease 2019

MoGLSD – Ministry of Gender, Labor, and Social Development

NCDs – Non-communicable diseases

RMNCAH – Reproductive, maternal, new-born, child, adolescent, and healthy aging

SDG – Sustainable Development Goal

UBOS – Uganda National Bureau of Statistics

UCA–Uganda Counselling Association

WHO – World Health Organization

Operational definitions

Actors - Actors are persons, groups, or organisations acting within the adolescent mental health system

Adolescent – an adolescent is an individual aged between 10 and 21 years

Adolescent Mental Health – a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community.

Political economy - "Political economy" covers the broad aspects of how political and economic processes interact in a given society and promote or limit progress towards addressing development problems that require collective action.

Stakeholders – an individual, or any group or organisation that has a concern or interest in adolescent mental health

Abstract

Background: More than half of Uganda's population is below 16 years of age. These children and adolescents have particularly been exposed to increased risk of mental health conditions due to extreme poverty and a history of prolonged armed conflicts. In 2017, Uganda adopted the Child and Adolescent Mental Health Policy to strengthen coordination and collaboration towards promoting mental wellbeing of Ugandan children and adolescents. However, over 5 years later, there is still limited prioritization of mental health services for children and adolescents. Few government agencies and civil society organizations treat AMH as a serious concern, worthy of priority. I embarked on analyzing the political economy of AMH that underpins effective strategies to augment and shift national political priority towards addressing AMH in Uganda.

Objective: To explore the political economy factors affecting adolescent mental health in Uganda.

Methodology: Methods were based on a review of documents including government policy, reports, peer-reviewed articles on AMH systems in Uganda; key-informant interviews with actors; informal observations of national AMH-related events; and a focus group discussion with adolescent advocates. Drawing on network theory in political science, sociology, and published policy frameworks, I examined the internal dynamics of the national networks that seek to address and advance attention on AMH. The analysis was based on a conceptual and an analytical framework.

Results: The findings indicate that actors perceive a major knowledge gap on AMH among stakeholders who have the power to augment political priority towards the issue. Even though many actors agree on the definition of the AMH as a public health problem, coalition building strategies remain weak especially due to gaps in leadership. Even though these were recommended in policy documents, reports and policy briefs, operationalization remains slow.

Conclusion: Current efforts among actors to augment priority towards AMH have had little success due to political economy factors such as limited power, weak coordination, and limited funding.

Recommendation: Proponents of political priority towards AMH in Uganda will need a strong leading entity to coordinate actor efforts, enhance collective action and frame the communication strategies to enable buy-in from external key stakeholders.

CHAPTER ONE: Introduction and Background

1.1 Introduction

Non-communicable diseases (NCDs) including cardiovascular diseases, cancer, chronic respiratory diseases, and diabetes, as well as mental health disorders, are now the dominant cause of death and disability in Uganda (WHO, 2018). The increasing burden of NCDs has led to a dual burden of non-communicable and communicable diseases (WHO, 2018). While national policies on NCDs have been developed, a major gap remains in their operationalization. This gap is particularly visible when it comes to interventions targeted at improving the health and wellbeing of adolescents, especially their mental health and wellbeing (Iversen et al., 2021). This proposal focuses on adolescent mental health and wellbeing (AMH) as a tracer to assess opportunities and challenges in addressing NCDs more broadly.

AMH constitutes an enormous, neglected global problem (Clark et al., 2020; Patel et al., 2018; Patton et al., 2016; UNICEF, 2020; World Health Organization, 2017). Strengthening AMH is required to progress on the Sustainable Development Goals (SDGs), in particular SDG 3 on "Good Health and Wellbeing". SDG target 3.4 specifically includes reduction in premature mortality through prevention and treatment of NCDs and the promotion of mental health and wellbeing. This is also related to the African Union's agenda 2063 under which goal number 3 which hopes to sustain healthy and well-nourished citizens who can achieve Sustainable and inclusive economic growth (African Union, 2015). However, progress is lagging on this critical goal (Patel et al., 2018). Without programming that promotes increasing prevention, diagnosis, treatment and control of AMH disorders, the goals on health remain lagging and given the cascading nature of mental health conditions, unaddressed episodes today are likely to affect productivity of future citizens hence limiting the achievement of sustainable development.

The current generation of adolescents (1.2 billion) is the largest in history (UNICEF, 2019). According to the World Health Organization (WHO), mental health conditions, including depression and anxiety, represent 16% of the global burden of disease among 10-19-year-olds (WHO, 2020a). In addition, suicide was the fourth leading cause of death among young people aged 15 to 29 in 2019 (WHO, 2021a). The burden of mental health morbidity and mortality are likely to have grown during the COVID-19 pandemic (Marques de Miranda et al., 2020). Notably, mental health problems that emerge in adolescence may lead to problems across the

life course, including poor health (Kessler et al., 2005) and negative economic consequences (Suhrcke et al., 2008), and will affect generations to come.

Globally, there is a growing recognition of the importance of addressing adolescent mental health (Bruha et al., 2018). With increasing awareness of the unique challenges and vulnerabilities faced by this population. Governments, international organizations, and advocates worldwide are emphasizing the importance of prioritizing adolescent mental health to promote well-being, reduce stigma, and ensure healthy development for future generations.

In sub-Saharan Africa, adolescent mental health is increasingly becoming an issue of growing concern. The region is home to a large population of young people, with an estimated 226 million adolescents aged 10-19 years living in the region in 2020, according to the United Nations Population Fund (UNFPA) (UNFPA, 2020). Mental health problems are among the leading causes of disability among adolescents globally, and the situation is no different in sub-Saharan Africa.

Several factors contribute to the high prevalence of mental health problems among adolescents in sub-Saharan Africa. These include poverty, conflict and violence, stigma, and a lack of access to mental health services. In addition, cultural beliefs and practices can also influence the way mental health is perceived and addressed in different communities. Unfortunately, many mental health disorders among children and adolescents in sub-Saharan Africa are often underdiagnosed and undertreated (Kessler et al., 2009).

In many sub-Saharan African countries, including Uganda, there are significant barriers to accessing mental health services for adolescents. Stigma, limited resources, and a lack of trained mental health professionals are just a few of the challenges that young people face when seeking mental health support (Molodynski et al., 2017). In Uganda specifically, there is a need for greater investment in adolescent mental health services. According to the WHO, there is only one mental health specialist per 1 million people in Uganda, making it difficult for young people to access the support they need (WHO, 2021a).

1.2 Background

Uganda is a developing country in sub-Saharan Africa that has been through a recent history of unrest and political instability. There has been progress towards peace and economic growth as the world bank report of 2016 showed an over 14% reduction in poverty between 1998 and

2012 (World Bank, 2021). Before the COVID-19 pandemic, Uganda had structural transformation leading to declines in poverty through a reduction in the total workforce employed in agriculture and a take-off in industrial production, especially in agro-processing. These gains would represent an ability to afford better health services, however this has not been significantly felt around mental health services. The WHO reported that Uganda spends only 9.8% of gross domestic product on healthcare (an equivalent of US$146 annually per Ugandan). Less than 1% of this is assigned to mental healthcare, compared with 10% in the United Kingdom (WHO, 2021b). Due to the major gap between demand and supply for mental healthcare, Ugandan mental health services have often been characterised as inadequate. There is limited community care and even in-patient services are not sufficient to satisfy the demand (Molodynski et al., 2017). The mental health workforce in Uganda is significantly inadequate and this is exacerbated by the significant number of medical workers that leave the country in search for better employment opportunities elsewhere (The Observer, 2014). A study by WHO in 2006 showed that 90% of Ugandans with mental health conditions do not receive the treatment they need (WHO & MoH, 2006). A majority share of the mental health funding is used up by the Butabika National Mental Referral Hospital which was established in 1955 and has 550 beds and about 430 staff. Butabika Hospital is also the only mental hospital in the country and manages 850-1000 in patients along with a busy outpatient department with contact of about 350 clients per day in both the general and mental healthcare areas (Butabika Hospital, 2021).

Butabika hospital and a network of 28 out-patient facilities all do not have designated sections for children and adolescents. Notwithstanding the fact that Uganda has very few child and adolescent psychiatrists who have to serve more than half of the entire country's population (20 million children and adolescents) (Iversen et al., 2021).

Adolescents are given the option to access mental health services at primary health care level facilities via adolescent health service sections. The Ministry of Health Policy and Services standards highlights mental health care as one of the services that should be provided as adolescent friendly services integrated within the existing health services at all levels of health service delivery and in the community (MoH, 2012).

Another factor contributing to poor adolescent mental health outcomes in Uganda is social stigma and cultural beliefs about mental illness. Mental illness is often stigmatized and misunderstood, and many Ugandans believe that mental health problems are caused by

supernatural forces or personal weakness. These beliefs can make it difficult for adolescents to seek help and support for their mental health issues.

"Political economy" covers the broad aspects of how political and economic processes interact in a given society and promote or limit progress towards addressing development problems that require collective action. In this study's context, we digest political economy issues in networks working towards AMH in Uganda.

CHAPTER TWO: Literature review

The increasing burden of mental illness

NCDs, are now the leading cause of death globally. According to WHO, NCDs now kill over 41 million people annually thus accounting for 71% of all deaths globally. This increasing burden of NCDs also affects low- and middle-income countries (LMICs) disproportionately because 77% of all NCD-related deaths are reported from these countries (WHO, 2021c). Mental disorders are one of the major categories of NCDs with unique relevance in efforts to control and prevent NCDs. Additionally, mental health and wellbeing also have links to cancers, diabetes, cardiovascular and respiratory diseases and other NCDs (Mental Health Innovation Network, 2018).

Mental health is an essential part of health and well-being as defined by the WHO: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1948)." The global burden of disease that is attributable to mental disorders has grown significantly across all countries. In 2017, the WHO reported a 13% rise in mental health conditions and substance use disorders between 2010 and 2017. The WHO also reports that mental health conditions now account for 1 in 5 years lived with disability globally.

The risk factors for mental disorders go beyond individual attributes like ability to manage one's emotions and interactions to social, cultural, economic, political, and environmental factors such as national policies, social protection, living standards, working conditions, and community social supports (James et al., 2018; WHO, 2019). Factors like these create the need for comprehensive strategies for promotion, prevention, treatment, and recovery in a whole-of-government approach.

Many people in LMICs face daily challenges and experience mental difficulties and unfortunately many who develop mental disorders or psychological problems do not receive the effective treatment or care they need (Semrau et al., 2016).

The Global Burden of Diseases study published in 2017 reported that mental illness accounted for 16.01% of all years lived with disability, making mental disorders a leading cause of morbidity in Uganda (Institute for Health Metrics and Evaluation (IHME, 2017). The report also showed that Depression contributed significantly to disability adjusted life years (DALYs) (234,939.61 DALYs in 2017). This meant that depression alone was responsible for 1.4% of the total disease burden in Uganda in 2017 (Institute for Health Metrics and Evaluation (IHME, 2017).

Why focus on adolescent mental health?

As defined by the United Nations, an adolescent is an individual aged between 10-19 years. Today, this age group makes up for 16% of the world's population (UNICEF, 2019). Adolescence is a crucial and unique stage of development that involves transition from childhood to adulthood. This stage comes with many physical, emotional, and social changes, including exposure to poverty, abuse, or violence, increasing adolescents' risk of experiencing mental health challenges. The WHO global health estimates report between 2000-2019 reported that suicide and self-harm was the fourth leading cause of death among boys and girls aged between 15-19 years (WHO, 2020b). A study by the WHO's World Mental Health Survey Initiative published in 2007 found that nearly half of all mental health conditions start by the age of 14 years but most cases go undetected and untreated (Kessler et al., 2009). And yet children and adolescents' vulnerabilities and mental health needs often remain widely unattended.

Mental health conditions can have a substantial effect on all areas of life, such as school or work performance, relationships with family and friends and ability to participate in the community. Therefore, ensuring strong support towards adolescents' psychological wellbeing and protecting them from risk factors that may affect their ability to thrive is critical in supporting their transition and laying a foundation for healthy and productive adulthoods.

Adolescent mental health in Uganda

Uganda's adolescent population increases by about 225,000 people every year: representing an annual growth rate of 3%. The most recent population census done by the Uganda national Bureau of Statistics (UBOS) in 2014 reported that the age-group 10-19 years constituted 26% of Uganda's total population (UBOS & UNFPA, 2017). These children have particularly been exposed to increased risk of mental health conditions due to extreme poverty and a history of prolonged armed conflicts. The WHO estimates that at least one in five people in post-conflict settings have a mental health condition.

In many LMICs, like Uganda, availability and access to mental health was already very limited before the COVID-19 pandemic. Many people experience a wide range stresses and challenges, and their mental health has further been burdened by the COVID-19 pandemic. The fact that mental health facilities were offered up to be used as COVID-19 treatment units has further limited access to mental health services for young people. In 2017, Uganda adopted the Child and Adolescent Mental Health Policy Guidelines, but this has not resulted in significant changes. There is still limited prioritization of mental health services in terms of allocation of resources for human resources and structures for service provision.

Given the cost-implications of setting up specially designated adolescent mental health units, it has been recommended that strengthening integration of adolescent mental healthcare into primary healthcare settings through adolescent health services also increases access, reach and utilization of care (Brenman et al., 2014; Wesseihoeft et al., 2013).

The gap between knowledge and implementation

Galderisi et al., 2015 proposed a new definition of mental health which described it as an active state of mind which enables a person to use their abilities in coordination with the common human tenets of society. Mental health and wellbeing is a controlling aspect of human life and yet it continues to receive the least priority in Public Health programming.

Increasing research and knowledge on mental health has provided essential information for prevention, treatment, and control of mental disorders, however the utilization and application of such information into meaningful interventions remains slow throughout the world. This is especially true and deeply felt in LMICs, as well as in the poorer groups in developed countries. Despite all the growing evidence, mental health remains among the least prioritized health conditions. The WHO reports that the global median of governments health expenditure remains less than 2% (Institute for Health Metrics and Evaluation (IHME, 2017).

The government of Uganda recognizes the public health importance of mental illness and has made significant strides towards promoting peace, economic development and reducing poverty ultimately resulting in greater investment in healthcare (Molodynski et al., 2017). However, even after recently adopting a Child and Adolescent Mental Health Policy Guidelines, service delivery and positive outcomes remain low in the country(Molodynski et al., 2017; Petersen et al., 2011). Even though there is increased attention paid to the needs of adolescents, they are still left behind. Adolescents are often excluded from decisions that affect their lives.

Political economy drivers of adolescent mental health in Uganda

There are several political economy drivers that can impact adolescent mental health, both directly and indirectly, in Uganda. These drivers may include:

1. Poverty and economic inequality: Poverty and economic inequality can contribute to poor mental health outcomes for adolescents in Uganda. Poverty can limit access to healthcare, education, and other resources that are critical for healthy development. Economic inequality can also create social and economic stressors that can impact mental health. This is often considered a structural driver given how complex it is and how long it may take to address.
2. Political instability and conflict: Uganda has experienced decades of political instability and conflict, which can have a significant impact on adolescent mental health. Conflict can disrupt social networks and support systems, increase exposure to violence and trauma, and create economic instability and insecurity. This aspect relates to the institutions in place and how ultimately determine the country's ability to address AMH.
3. Limited access to mental health services: Uganda has limited resources for mental health services, particularly in rural areas. This lack of access to services can contribute to untreated mental health problems, which can worsen over time and impact overall well-being. Services delivery is related to actors in terms of training and availability of human resources but also in terms of planning and programming for AMH in Uganda.
4. Social stigma and cultural beliefs: Stigma and cultural beliefs surrounding mental illness can impact adolescent mental health outcomes. Negative attitudes towards mental illness can prevent individuals from seeking help and support and can lead

to social isolation and discrimination. Beliefs and practices make part of the issue characteristics and the informal "institution" built around the problem that influences how it is perceived and the actions taken to address it.

5. Education policies and practices: Education policies and practices can impact adolescent mental health outcomes. For example, policies that prioritize academic achievement over mental health and well-being can contribute to stress and anxiety. Similarly, inadequate mental health resources in schools can limit access to support for struggling students. Actor efforts and how they interact with key stakeholders towards addressing AMH yields the policies and influences the practices that get institutionalized to enable the change towards better AMH.

Overall, the political economy drivers of adolescent mental health in Uganda are complex and interconnected. Addressing these drivers will require a comprehensive approach that prioritizes economic development, peace and stability, access to mental health services, and education policies and practices that support mental health and well-being.

CHAPTER THREE: Statement of the problem, Justification and Conceptual framework

3.1 Problem statement

Adolescent mental health is a critical public health concern in Uganda, with high rates of depression and anxiety among this population. While there is a growing recognition of the importance of addressing adolescent mental health, there is a lack of understanding of the political economy drivers that impact mental health outcomes. This knowledge gap limits the ability of policymakers and practitioners to develop effective interventions to address this issue.

Uganda's political economy is shaped by a range of factors, including poverty, conflict, social inequality, and limited resources for mental health services. These factors can have direct and indirect impacts on adolescent mental health outcomes, through their influence on access to resources, social networks, and support systems.

A political economy analysis of adolescent mental health in Uganda is critical to understanding how these drivers intersect and impact mental health outcomes. This an analysis provides insights into the ways in which structural contexts, institutions and stakeholder interactions, social structures, and cultural beliefs contribute to the gap in adolescent mental health programing. I also identify areas for intervention, including policies and programs that can address the root causes of mental health issues and improve access to services.

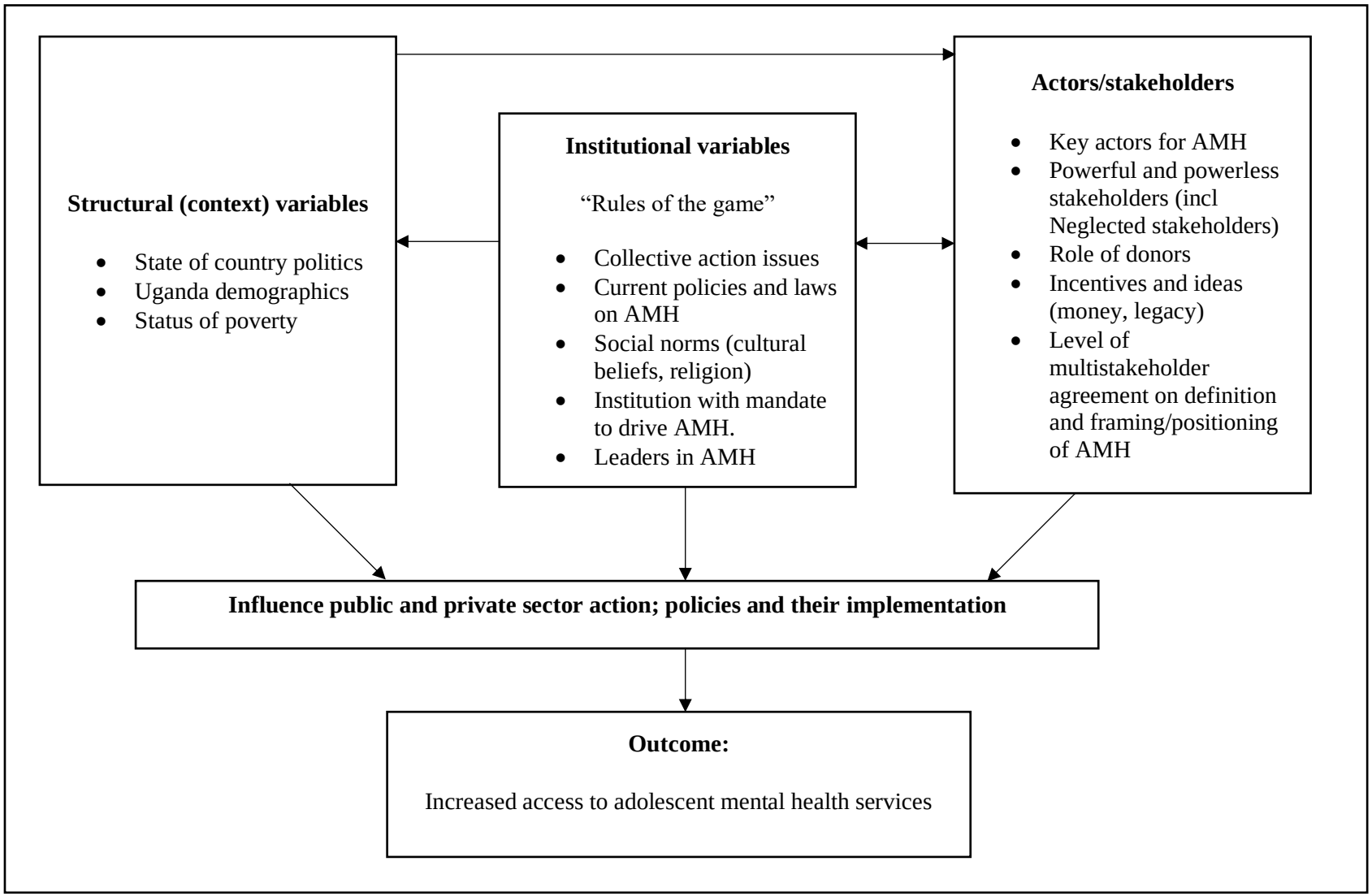
Without a political economy analysis, interventions to address adolescent mental health in Uganda are likely to be piecemeal and ineffective. A comprehensive understanding of the drivers of mental health outcomes is essential to developing sustainable and impactful interventions that can improve the lives of Uganda's adolescents.

3.2 Justification of the problem

Mental health conditions are responsible for a major portion of disease burden among adolescents and nearly three quarters of this burden lies in LMICs like Uganda where there is scarce services and significant shortages in trained mental health staff. New evidence has demonstrated the large burden and linkage of mental and substance disorders with other aspects of sustainable development. However, not much response has been yielded. Uganda has made some progress towards addressing AMH as demonstrated by launching the Child and Adolescent Mental Health Policy Guidelines in 2017, but operationalization of these is still

slow. Worse still, the current COVID-19 pandemic, political stresses, decline in the economy among other societal issues continue to increase the risk of depression, suicide, substance use disorders among other mental health conditions. This therefore creates an urgent need to identify and analyse the systemic factors that impact adolescent mental health in Uganda, with the aim of informing policy and programming interventions to improve mental health outcomes for this population.

3.3 Conceptual Framework



This conceptual framework is adapted from the World Bank tool on governance and political economy analysis. It emphasizes a problem-driven political economy analysis. In the figure, I attempt to visualize how three clusters of political economy drivers interact; the interrelations therein and how they influence program implementation in adolescent mental health. This adapted framework helped to describe the existing institutional and governance arrangements for AMH in Uganda and how these are related to the low traction in bringing attention towards this problem. This was then followed by a deep dive in to the underlying political economy drivers mostly related to the bargaining processes, incentives, power, and consensus within the network of actors.

Guided by the World Bank tool on governance and political economy analysis, I have three major categories of factors or variables considered in this political economy analysis: *structural*, *institutional*, and *actors*. Under *Structural factors*, I include issues beyond the direct control of local actors/stakeholders. These issues often change slowly over time. The *Institutional variables* are associate with 'the rules of the game' which may include things like laws and regulations, even in-house rules such as social obligations. The *Actors or stakeholders* are individuals as well as organized groups or groups with shared interests, such as political parties, the military, business associations, non- governmental organizations (NGOs), traditional associations, and traders in a particular region. In this analysis, the key task was to describe these major categories and to capture how they interact to impact adolescent mental health programming in Uganda.

I used the conceptual framework above to demonstrate how and visualize political economy factors interact to influence public and private sector action on policies and implementation related to adolescent mental health in Uganda. The factors on actors and stakeholders as well as their institutional issues are the ones where change is more likely to occur or be effected as compared to the structural factors which are more stable and difficult to adjust. I further adapted an analytical framework to get a deeper understanding of those two groups of factors: actors and intuitional variables. The analytical framework is described further below.

Analysis framework

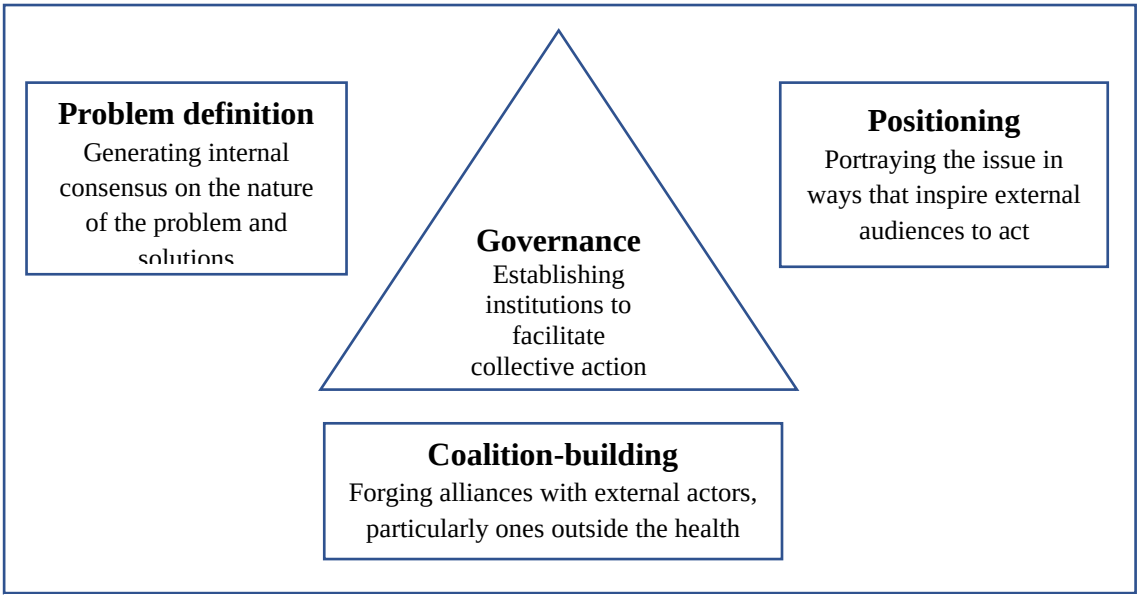


Figure 1: Analysis framework

Since this study majorly focussed on issues around actors/stakeholders and the institutional issues regarding their interaction towards influencing the public and private sector action for AMH, I adapted Professor Jeremy Shiffman's framework, through which I conceptualize political priority as an issue influenced by 4 major constructs. As shown in figure 2 above, I considered the following key factors (among others)

(1) *problem definition* which speaks to how actors understand the problem; within the network of actors, different individuals may have varying conceptualizations of the problem and its resolutions. These conflicts can hinder networks' ability to work together effectively.

(2) *framing;* communication strategies and tools to transfer knowledge from experts to the public about adolescent mental health. Framing/positioning refers to how the actors present the issue to external audiences. Different portrayals of the same issue can exist, but only some will resonate with external actors who possess the necessary resources to address the problem.

(3) *coalition-building*; how actors engage networks concerned with other issues to advance attention and resources and;

(4) *governance* which partians to the quality of institutions actors have established to facilitate collective action (Shiffman, 2017).

CHAPTER FOUR: Research questions and Study objectives

4.1 Research questions

1. What is the structural context of Uganda regarding adolescent mental health?
2. Who are the key actors in adolescent mental health in Uganda?
3. What are the institutional "rules of the game" in adolescent mental health in Uganda?
4. How do the stakeholder issues and "rules of the game" interact, within Uganda's structural context, to influence public and private sector action towards priority setting for adolescent mental health in Uganda?

4.2 Study objectives

4.2.1 General objective

To explore the political economy factors affecting adolescent mental health in Uganda to recommend effective strategies to augment national political priority towards the problem.

4.2.2 Specific objectives

1. To describe the structural context of Uganda, key actors, and institutional issues regarding adolescent mental health in Uganda
2. To describe how the stakeholder issues and institutional issues interact, within Uganda's structural context, to influence public and private sector action towards priority setting for adolescent mental health in Uganda.

CHAPTER FIVE: Methodology

5.1 Study area

This study was conducted in Kampala, Uganda. Kampala is the capital as well as the largest city in Uganda. Kampala being the political and administrative capital, it is home to most of the offices for government ministries, policy makers, civil society organizations and other stakeholders in adolescent mental health throughout Uganda.

Study participants were identified from government ministries, agencies, policy makers and civil society offices. Participants were requested to participate through physical meetings, phone calls, email invitations and via social media.

5.2 Study Population

Policy makers, program implementers and adolescent advocates

5.3 Study Design

A qualitative case study.

5.4 Sample size

a) Document review: The online search for literature yielded a total of 8 recent documents associated with AMH policies and national implementation.

b) Semi-structured individual interviews were conducted with AMH policymakers and program implementers (n=15). A total of 27 individuals were contacted through the different channels and 15 were successfully interviewed. Individuals who were not interviewed were either unavailable for the interview or cancelled the appointment due to time limitations. I was able to achieve information saturation by the 15^{th} interview.

c) Focus group discussion: the focus group discussion included 5 participants aged between 18-21 years

d) AMH-related events: I observed 2 AMH-related events which got to know of happening during the time of the study.

5.5 Sampling procedure

a) Document review: I included all documents identified in the review

b) Semi-structured individual interviews: Purposive sampling was applied to identify policymakers and program implementers in the fields of AMH, mental health and

adolescent health in Uganda. These included Ministry of Health officials, Adolescent Health Clinics, mental health practitioners: psychiatrists, counsellors, training and research institutions like Makerere University College of Health Sciences, civil society organizations or projects in mental health or adolescent mental health.

c) Focus group discussion: We purposively looked for adolescent advocates in Kampala. Adolescent advocates included young people who were involved as volunteers in adolescent health or adolescent mental health programs. Some participants had also been part of mental health programs and had some knowledge on the subject as well as adolescent group leaders among others.
d) AMH-related events: We included every AMH-related event that was publicly advertised happening between January and September 2022.

Inclusion criteria

a) Document review
    i) Policies, programs, and individual reports; explicitly talking about adolescent mental health
    ii) Content in the document had to be published in or about Uganda
    iii) Documents published between the years 2000 and 2022
b) AMH experts
    i) policymakers and program implementers in the fields of AMH, mental health and adolescent health in Uganda
c) Adolescent advocates
    i) Aged between 10-21 years
    ii) Involved in leadership or advocacy related to mental health
    iii) Volunteers at mental health clinic or project
d) AMH-related activities
    i) Any activities related to discussing mental health with major inclusion of adolescent and children's issues.

Exclusion criteria

a) Document review
    i) Documents not directly addressing adolescent mental health; in Uganda
b) AMH actors
    i) Actors without direct link to a mental health organization
c) AMH-related activities

i) Trainings and other treatment-specific activities

5.6 Study variables

This study's primary objective was to describe the political economy factors that underpin effective strategies to augment national political priority for adolescent mental health. To achieve this, the data collection targeted variables arising from a breakdown of the three specific objectives. These variables were;

Structural (context) variables

- Issue characteristics
- State of country politics
- Uganda demographics
- Status of poverty

Actors/stakeholders

- Key actors for AMH
- Leadership: identification of individual AMH "champions" in Uganda
- Community actors (the extent to which adolescents are involve in AMH efforts
- Powerful and powerless stakeholders (incl Neglected stakeholders)
- Role of donors
- Incentives and ideas (money, legacy)
- Level of multistakeholder agreement on definition and framing/positioning of AMH

Institutional variables

1. Problem definition:
    I. How study participants describe the problem (terminologies)
2. Governance and coalition building:
    I. Barriers to effective AMH program implementation
    II. Leadership: AMH coordination institutions and their effectiveness)
    III. Coalition building: the extent to which AMH actors have forged alliances within and outside the field
3. Framing/positioning
    I. Priority setting: how serious a problem AMH is considered

II. Identifying any national actors that have shifted priority towards AMH
III. Available/proposed solutions effectiveness
IV. Rigor in advocacy for priority on AMH by key actors

4. Barriers to collective action
5. Opportunities for generating political priority and attention towards AMH

5.7 Data collection procedures

Data was collected by document review, key-informant interviews, a focus group discussion, and observations.

5.7.1 Data collection methods

a) Document review and Literature review

This helped gather background information and further understand the key issues and operation of the field of AMH in Uganda. This document review also built the basis for the rest of the methodology and analysis.

Assessing existing documents and literature; I compiled a list of available documents (both grey literature and peer-reviewed articles) relevant to answering the research questions. These included policy briefs, reports, published articles and some books sought from Google Scholar, PubMed as well as websites including the Ministry of Health, UNICEF and WHO among others.

Peer-reviewed literature was searched for through google scholar, PubMed and Hinari database. I generated a Boolean search strategy with a document search table summarizing the search components (population, setting (Uganda), Problem definitions, governance on mental health, coalition-building actions, framing and communication) with keywords including "adolescent mental health," "adolescent health," "policies," "rules," "regulations," "young people," in the different search components.

The document counts per search component and combined are summarized in a search table as demonstrated in table 3 below.

Search component	Search words	Results

Population	"adolescent" or Generation Z or teenagers or youth or children or teen or teenager or juvenile or youth or minor or schoolboy or schoolgirl	2,775,197
Setting	Uganda or "Sub-Saharan Africa" or "Low- and middle-income countries" or LMICs or "developing countries"	20,278
Intervention	"intervention" or implementation or project or action or advocacy or resources or law or legislation or policy or treatment or leadership or governance or research or data or mental health or mental health services or psychiatry	17,130,554
Comparator	"attention" or priority or barriers or opportunities or effectiveness	7,785,078
Outcome	"mental disorders" or mental illness or CAMH or depression or suicide	1,194,694
Total		273

Table 1: PubMed result Search table

After filtering for English language and Uganda, I was left with 4 studies, two of which were on evaluating treatment methods. I identified the other documents from Ministry of health, UNICEF, as well as WHO websites.

Compiling documents and literature for the review; selected documents were compiled and gathered in a single database and then reviewed by the principal investigator.

Summarizing information from the reviewed documents and literature; using a guiding data extraction form, information from the documents was summarized before analysis.

b) Semi-structured individual interviews

These were conducted among policy makers and program implementers in the fields of AMH, mental health and adolescent health in Uganda (n=15). These were Ministry of Health officials, Heads of Adolescent Health Clinics, mental health practitioners: psychiatrists, counsellors identified from the Butabika national referral mental hospital, training and research institutions like Makerere University College of Health Sciences, civil society organizations or projects in mental health or adolescent mental health. AMH experts were individuals working in different sectors with broad, multidisciplinary experience working in the field of AMH.

I conducted interviews at Makerere University and in respective offices for some participants while others were done through phone call or Zoom meeting depending on the participants'

preferences. Where participants agreed, I recorded the conversations and transcribed these in verbatim. Interviews lasted between 30 to 65 minutes.

Participants were identified from organization websites, through social media and on recommendation. I contacted them through phone calls, email, and physical invitation. On some occasions, I had to contact the participant multiple times before the interview.

c) Focus group discussions.

A focus group discussion was conducted with adolescent advocates, 18-21 years. The discussion was conducted on a Zoom call. Participants signed consent forms after reading and listening to all necessary information about the study. The focus group discussion lasted roughly 60 minutes. The sound was recorded on participants' agreement.

d) Observation of AMH-related meetings and activities

I looked out for AMH-related meetings and activities happening with in the mental health network through the news, social media and on recommendation. I sought to observe these activities to understand issues related to the study's objectives. I targeted stakeholder meetings, technical working group meetings, campaigns, or conferences organized by the United Nations agencies or other international organizations, government, policy makers or program implementers and hosted within Kampala (or online but intended for Uganda) between January and September 2022. Information was collected in form of written notes using a semi-structured guide.

5.7.2 Data collection tools

a) Literature abstraction guide

This guide gave instructions for the document search, screening, and selection. The exercise targeted examining the internal dynamics of the national networks that seek to address and advance attention on AMH. Among other factors, this guide I considered recording data on: (1) problem definition—the way in which proponents understand the problem and how it should be addressed; (2) governance—the quality of institutions proponents have established to facilitate collective action on the issue; (3) coalition-building strategies—the way in which proponents engage networks concerned with other issues to advance attention and resources for the problem; and (4) framing—the communication strategies and tools employed to transfer knowledge from experts to the public about AMH.

b) Semi-structured key informant interview guide

A semi-structured question guide was developed to guide the key-informant interview. The questions were organized into subsections; each section focusing on answering one of the specific objectives of this study. This is attached in the appendices.

c) Focus group discussion guide

A focus group guide detailing information for the researcher on setting the pace for the discussion as well as guiding questions to elicit responses that satisfy the research questions will be used for the two FGDs. This is also attached in the appendices.

d) Observation guide

A simple guide for writing of notes from observation of AMH-related meetings and activities in Kampala is provided organizing thoughts and observations basing on the key factors; problem definition, governance, coalition-building, and framing. The notes also gathered information on which stakeholder are involved in the engagements, how often these are held, pointed out the organizers as well as level of involvement of key stakeholders.

5.7.3 Pre-testing

Pre-testing (or piloting) of the tools was done with a purposively selected group of individuals (experts and adolescent advocates). The tool was then revised based on results and experiences from the pilot data collection.

5.8 Data management and analysis

5.8.1 Data management

The recordings from the interviews were transcribed verbatim. The transcription was done by the principal investigator Tonny Muwonge. Transcripts were then coded using Microsoft Word software. Transcripts were given unique identifiers to protect participants' anonymity and privacy.

Quality control

Interviews were conducted by the principal investigator himself. The coding process was supported by supervisors, Dr Roy William Mayega and Dr Olivia Biermann. The supervisors were also involved in the themes development process and provided additional views on

choices of allocation and provide insight on aspects the principal investigator could have missed.

For this study, triangulation by use of multiple data sources to develop a comprehensive understanding of the issue but also to increase credibility of the findings. Deviant cases, where found, were examined, and accounted for during the analysis.

5.8.2 Data analysis

- Presentation of data

I summarized the study findings in sub-themes and themes. I also provided a summary of participant characteristics in terms of their field of training and how they were involved in AMH in Uganda.

- Analysis techniques

The data analysis was conducted using thematic analysis technique as described by Braun et al (Braun & Clarke, 2006). I read the transcripts several times before the initial coding. I coded the first 5 transcripts generating as many codes as possible. These were then collapsed, some merged to develop a code book. I then subjected the other 10 interviews to codes generated from the first 5. This was done by coding the other 10 transcripts using codes generated from the initial 5. There a few new codes that were added arising from the other 10 transcripts. And these were added to the pool and included in the subtheme development. Since the transcripts were few, line-by-line coding was done using Microsoft word. During the coding, I aimed to generate as many codes as possible. These were then discussed with the supervisor. I merged similar codes and categorized related codes and then grouped the categories (sub-themes) into themes related to Jeremy Shiffman's framework also allowing for provision of other emergent themes.

The themes were then used to write a narrative presenting key findings of this study supported by quotes and appropriate extracts from the transcripts.

5.9 Ethical considerations

- Ethical review and approval process

I sought for ethical review and approval to conduct this study from the MakSPH High Degrees Research Ethics Committee (HDREC). The committee found the study methodology scientifically sound, ethical and that the study participants' rights would be adequately protected. The study was approved, and the study tools stamped with the HDREC stamp.

- Informed consent

All study participants were given adequate information on the study and its objectives. They were clearly informed of the benefits and risks of participating in the study and that participation was completely voluntary. They were offered a consent form which they had to sign to give their permission to participate in the study and left with a copy.

- Confidentiality

All information collected from study participants, i.e., recordings and transcripts from were handled anonymously and confidentially so that they cannot be identified from the data. Recordings and transcripts were saved in a password-protected local folder on the principal investigator's computer.

- Potential risks and benefits

This study was about getting opinions from participants on the issue of adolescent mental health in Uganda. Participation in the study was completely voluntary and involved very low risks.
Everything the study participants said is anonymous, which means that no one outside the study team can know who said what, or afterwards be able to track or find who was in the interview. I used a unique number code instead of the study participants' names. I also deleted identifying information; and instead, used general categories such as "female youth advocate".
The study participants will not benefit directly or immediately from this study but the information I collected will help improve the understanding of issues around AMH in Uganda. This understanding, I then hope will help generate political priority for adolescent mental health resulting in more resources and efforts for improved mental health wellbeing of adolescents in Uganda.

CHAPTER SIX: Results

Despite making significant progress towards promoting peace, economic development and reducing poverty ultimately resulting in greater investment in healthcare, Uganda still has limited prioritization of adolescent mental health in terms of resource allocation. There is limited knowledge of the key factors pertinent to shifting attention and resources towards AMH. In this study, I perform a political economy analysis of AMH in Uganda giving insight into factors and strategies that could be applied in efforts to motivate political priority in terms of attention and resources towards effective implementation of AMH. The project sought to generate knowledge of the political economy of AMH that can underpin effective strategies to augment national political priority for AMH in Uganda.

In this result section I provide findings from four qualitative methods applied to collect data to enrich the political economy analysis. The findings are presented per data collection method and then summarized according to the three major categories of factors as per the study's conceptual framework.

6.1 Results from the document review

I reviewed literature available online specifically on the issue of addressing adolescent mental health in Uganda. The online search for literature yielded a total of 8 recent documents associated with AMH policies and national implementation. Details of the documents are summarized in the table below. The results from the document review guided discussion questions for both the in-depth interviews and focus group discussion.

Table 2: List of documents analysed.

Title	Main author	Year of publication	Reference
ChildFund Uganda. Child and Adolescent Mental Health services Uganda. 2019	Child Fund Uganda	2019	
PMNCH Adolescent Mental Health: Time for Action. 2019	WHO	2019	
Mental health disparities among youth living on the streets and in the slums of Kampala:	Swahn, Monica (UYDEL)	2013	Swahn, Monica & Palmier, Jane & Kasirye, Rogers & Yao, Huang. (2012). Mental health disparities among youth

Comparisons with representative national and urban school attending youth.			living on the streets and in the slums of Kampala: Comparisons with representative national and urban school attending youth.
Child and Adolescent Mental Health Policy Guidelines. 2017	Ministry of Health	2017	
Adolescent Health Policy and Service Standards. 2012	Ministry of Health	2012	
Situation analysis of children in Uganda. 2015	Ministry of Gender, Labour and Social Development	2015	
Child and adolescent mental health services in Uganda. 2021	Iversen	2021	Iversen et al. Int J Ment Health Syst. Child and adolescent mental health services in Uganda. 2021
WHO Profile on mental health in development (WHO proMIND): Republic of Uganda. Geneva, WHO, 2012	Ministry of Health, World Health Organization	2012	Ndyanabangi S. Funk M. Ssebunnya J. Drew N. Dhillon S. Sugiura K. Skeen S. WHO Profile on mental health in development (WHO proMIND): Republic of Uganda. Geneva, WHO, 2012

The documents highlight importance of investing in AMH due to the cost benefits it provides, but limited priority is given to it, particularly in low- and middle-income countries like Uganda. The lack of knowledge about the cost-effectiveness of interventions and unpreparedness to address the "invisible" problem in LMICs is a challenge. There is mention of the issue of limited research on the specific mental health needs of youth living in slums. The child and adolescent mental health policy guidelines stipulate multisectoral strategies for effective mental health promotion and prevention of mental, neurological, and substance abuse disorders among children and adolescents and their main goal was to mainstream adolescent health concerns in the national development process. Data from these documents showed that despite Uganda's progress towards reducing poverty and improving the lives of children, many children are still deprived of their rights. One of the studies examined the current status of child and

adolescent mental health services in Uganda to make recommendations and inform the implementation of the Uganda Child and Adolescent Mental Health policy guidelines of 2017. A unique finding was that mental health care system in Uganda is largely lacking, particularly at lower service provision levels, and existing programming hardly includes plans for child and adolescent services. Collaboration with the private sector and traditional healers was suggested to address the major human resources gap. Additionally, vulnerable groups such as orphans, HIV/AIDS-affected youth, and former child soldiers should also be mainstreamed into programming.

Problem definition

The literature highlighted several perspectives on how different actors defined the problem of adolescent mental health in Uganda's context. I summarized these as follows:

- High prevalence of mental health conditions among children and adolescents, especially those living in vulnerable conditions such as slums, street youth, and those with chronic conditions and stigmatized due to sexual orientation or gender identity.
- Lack of prioritization and access to mental health services for at-risk groups, particularly young people living in slums and out of school.
- Limited government funding and resources to address the mental health needs of children and adolescents.
- Insufficient workforce and lack of collaboration between different actors in the mental health sector.
- Stigma towards mental illness and negative attitudes towards mental health among health workers.

Overall, the problem definition according to our literature sources revolved around the need for thoughtful policy interventions, guidelines, and resources to address the mental health needs of children and adolescents in Uganda, particularly those living in vulnerable conditions.

Governance

The document review yielded several issues related to governance and leadership in addressing adolescent mental health in Uganda. The authors highlighted gaps in the current effort to address adolescent mental health in Uganda, that is, the lack of necessary adolescent mental health legislation; and limited research and data that limit adolescent mental health programing efforts. The child and adolescent mental health policy guidelines clearly mentioned that

implementation of mental health policies would be led by ministries of government with support from non-governmental partners, each with stipulated roles for performance over a period of 10 years. Three other documents that mentioned leadership also recognized the ministry of health as the key leading entity in mental health (including AMH) issue in Uganda. However, some authors also highlighted the lack of attention given to child and adolescent mental health services in planning and the absence of institutionalized mechanisms to enable child participation in decision-making. The Child Fund Uganda reported that in 2019, the Ministry of Health was in the process of drafting mental health policies, a national strategic plan, and lobbying for a mental health law. They went ahead to recommend that the pending Mental Health Bill be renamed The Mental Health Care Bill to reflect Parliament's commitment to caring for people's needs and to make the language less stigmatizing for people living with mental illness. Iversen et al also recommended the need for strong leadership committed to mainstreaming and addressing mental health issues of adolescents and children in Uganda.

Coalition building

The documents alluded to some efforts made to enhance coalition-building with other key players to address adolescent mental health in Uganda. The Ministry of Health as highlighted earlier is leading a collaboration strategy with other ministries, development partners, faith-based organizations, CBOs, and the National Youth Council for Children, among others concerned with adolescent mental health. The child and adolescent mental health policy guidelines mentioned the existence of a National Steering Committee on Adolescent Health, supported by a Technical Committee for Adolescent Health, and a District Committee on Adolescent Health within local governments. Additionally, the Ministry of Gender, Labour, and Social Development (MoGLSD) also reported working with other ministries, private actors, law enforcement, and funding bodies to promote children and adolescent mental health. Both the ministries reported that partnerships with private-not-for-profit health facilities, faith-based organizations, and NGOs are helping extend services to communities, and some NGOs are also involved in advocacy and providing psychosocial care, particularly in war-afflicted populations. Authors recommended designing of policies that enable early detection of AMH conditions in less stigmatizing settings, such as schools, families, households, and primary healthcare systems. Additionally, Iversen et al and Swahn et al recommended that integration of AMH into existing programs in schools, communities, and healthcare systems is important, and coordinated multisectoral efforts are needed to address other determinants of AMH.

Positioning/framing

Language, initiatives, and research were mentioned as communication strategies and tools to transfer knowledge from experts to the public about adolescent mental health. The WHO-led Mental Health Gap Action Programme and Helping Adolescents Thrive initiative are positioned as important initiatives that are shifting mental health to the center of health and development agendas. In this literature review, I also noticed an emphasis on the challenges of reaching difficult-to-reach groups such as street children. This was highlighted by Swahn et al's study mental health disparities among youth living in slums but is also noted as a point for action by the WHO Adolescent Mental Health; Time for action. The Ministry of Health stood out as the key player and driving force in advocating for driving political priority towards AMH. Key creative solutions suggested included the ministry of health lobbying for the inclusion of AMH services in educational programs and strengthening integration of child and adolescent mental health service provision at the primary health care level to increase access and early detection. Other solutions to the issue included policies that would enable extending mental health services to communities through task-shifting or involving lay workers. Some authors cautioned on the importance of the kind of language that is used in attempting to address issues around mental health. For example, the Child Fund suggested that the Mental Health Bill be renamed to reflect the importance of caring for people's needs and reducing stigma.

6.2 Results from key informant interviews and the focus group discussion

A total of 15 key stakeholders were interviewed. The characteristics of participants are summarized in table 1 below.

Table 3: Characteristics of interviewees

Participant ID	Field of work	Category	Sex
001	Community psychologist	Advocacy	Female
002	Sexual, reproductive health	Advocacy	Male
003	Adolescent Education & Child Protection	Advocacy	Female
004	Mental health epidemiologist	Researcher	Female
005	Politician	Legislator	Female
006	Community psychologist	Practitioner	Female
007	Youth development	Civil Society	Female
008	Pediatrician	Practitioner/ Academia	Female
009	Community psychologist	Practitioner	Male
010	Clinical psychologist	Private practice owner	Female

011	Clinical psychologist	Civil Society	Female
012	Psychiatrist	Government institution	Male
013	Advocacy	Lived experience	Female
014	Mental health specialist	Government institution	Female
015	Industrial psychologist	Practitioner	Female

A focus group discussion was held with adolescent advocates who were basically 5 young people aged 18-21 years but involved any activities relating to advocacy for mental health promotion.

I sought to understand how experts perceive issues on the prioritization of AMH; their opinions on the developments and implementation of policies for AMH, the best measures to address AMH and motivate collective action, as well as how such efforts can be strengthened. I supplemented these with thoughts from the focus group discussion with adolescents involved in different levels of leadership and advocacy for mental health.

Issue characteristics

All interviewees highlighted that AMH is an issue of low to no national priority in Uganda and that the issue is characterized by widespread neglect across all sectors including government, civil society organizations and even at community level. For example, one participant said,

> *"Uh… when making commitments I have not heard…; I have attended, you know, health conferences in and out of the country and when Uganda is making commitments, we front SDGs of equality health and all, but we have never made a commitment on improvement of mental health of young people." – Participant 002, Male AMH advocate*

Respondents talked about AMH as a complex problem and that despite actors' efforts, very little success had been registered. Throughout the interviews, I identified three major dimensions the interviewees believed made it difficult to motivate collective action to address AMH in Uganda. Firstly, the widespread lack of knowledge and limited understanding of mental health, especially as a problem faced by adolescents. At a social contextual level, there is limited understanding of the unique needs of adolescents and how the different aspects in their development environment could affect their mental health and wellbeing. Many Ugandans do not consider adolescents as people who are at risk of mental health issues. Even where the

need for AMH has been recognized, adolescent needs are often looked at as less important than those of the adults.

> *"Generally, I think young people are taken to be at a lower level than adults. That's a natural phenomenon I think; where people… like decisions are made for them, everything is done for them, ideally. And so, for that matter… and the fact that we are constrained generally in resources, usually adults may want to take on the bigger potion and leaving little for the young ones." – Participant 014, Female Mental Health Specialist, Government institution*

Mental health is still a complex topic in many communities in that even the language to use to describe or express mental illness is very limited. For example, in many Ugandan languages, one can hardly find the right words to clearly describe how they feel in terms of their mental health.

> *"We don't have common terms in societies to refer to mental health. We don't have common terms in societies to describe our feelings. We don't know what depression is in Luganda. We don't know what sadness is in Luganda or Runyakore or Rukiga. Whatever language it is. And for us to see prioritization at a social level we need to have understood do people actually understand this concept in their society" – Participant 009, Male Community psychologist*

The major deficiencies in research and data on AMH and understanding mental health in a local context have also made it more difficult to facilitate social mobilization, as well as policy learning as actors work towards influencing increased political support.

Secondly, the stigma associated with mental health makes it a difficult issue to associate with. This has not only limited the rise of champions but also resulted in general silence about the problem and poor health seeking behavior in communities. This is further worsened by the general suppression of expression of mental health difficulties among children and adolescents by adults. Interviewee 005 alluded to this and even shared her own experience;

> *"Oh, there's a lot of stigma. There's so much stigma that when somebody has got a mental health issue, the family will hide it. The family will not openly say we have a problem, and we need help. People just sneak into Butabika. No one can openly stand up. Even I did not tell anyone I was*

going to Butabika. Because what will people think? That's a family of mad people." – Participant 005, Female Advocate, Politician

Adolescents in the focus group discussion also spoke to this reality of difficulty of openly talking about mental illness due to widespread stigma around the issue.

"Stigma around mental health is a huge issue in most of our places. Many people still believe that mental health problems are a sign of weakness or a moral failing, which makes it hard to seek help when you need it." –Female FGD participant

Thirdly, the lack of funding dedicated towards AMH limits actors' ability to get traction towards addressing the issue. The limited access to funding was reported to be due to the fact that resources are often directed towards other health issues and even when non-communicable diseases are considered, major chunks of the monies are invested in addressing diabetes, cancers and heart conditions.

Human resources are a major pillar in addressing the issue of AMH, but Uganda's AMH workforce remains heavily understaffed. Interviewees often mentioned that the outstanding barriers to addressing this human resource gap included the limited understanding of the field, the low motivation for professionals already in the field, as well as the small funding making it difficult to hire more staff. Some interviewees also emphasized that the lack of recognition of the psychologists in the public health service commission in Uganda makes it difficult for health workers to gain interest in the field.

Despite the mentioned challenges, interviewees and adolescents in the FGD recognized that there are efforts being made by government, CSOs and other stakeholders to support AMH in Uganda. However, interviewees emphasized, that these are currently characterized by major inadequacies such as lack of service access points; limited community support and insufficient efforts to raise awareness on the issue of AMH throughout the country.

According to the interviewees, the COVID-19 pandemic has played a significant role in exposing the significance of the mental health need in Uganda even though this has not necessarily resulted in major advances in political prioritization of AMH. Most interviewees demonstrated how priority for mental health reduced even further when the already few mental

health facilities and staff available were offered up for COVID-19 treatment at the peak of the pandemic, leaving mental illness cases unattended.

> *"Actually, there was research conducted by the school of public health that reported that all the sectors (wards) of mental health were evacuated for COVID19 services. So, you can imagine where all those people who were mentally ill or who needed the admission went to. Where did they go?" – Participant 010, Female Clinical psychologist*

Problem definition

I explored how actors in the field of AMH in Uganda define and describe the problem as well as what they considered the appropriate solutions. Interviewees generally described the lack of priority for AMH as a public health systems problem; sighting that the gross negligence of AMH in policies, planning, research, health promotion and other avenues limits the chances of it making it to the agenda. This negligence was often attributed to the lack of knowledge and understanding of AMH among legislators as this participant describes;

> *"… the political spectrum is ignorant about the challenge. Number 2 is outright neglect of this sector. Since they have no knowledge, they don't understand AMH. But the biggest challenge here now in Uganda is neglect and ignorance or lack of knowledge (to be polite). So, because they are short of knowledge it becomes that challenging to prioritize the issue. Politically it's the lack of will which is brought about by the lack of knowledge." – Participant 007, Female Youth Development Practitioner*

Further explanations on the low political priority of AMH also highlighted the insufficiency of the definition of the stage adolescence as merely a specific age group. For example, one interviewee mentioned that even though UN's definition of adolescence stipulates 10–19-year-olds, some people experience adolescence crises before or beyond this age bracket;

> *"As we are designing and implementing whatever programs, we must clearly define who our target adolescents are because they are very diverse. Our children are not like in one pack, that oh when you are 12 years old, then you are like this… So, as we come up with these words and use this language, we have to put into consideration that children are diverse even beyond their age. And someone may fall in the category of an adolescent, but they still very much believe and act and still very much*

would be categorized more of as a child. You know, they play a lot…" – participant 001, Female Community Psychologist

The interviewees also described AMH as an issue with a with a strong link to all the other adolescent health issues and emphasize that this is the reason it should be given top priority because failure impacts on the success of other interventions.

In terms of solutions, interviews reported awareness creations and mindset change as the most urgent gaps to be addressed if we are to make any progress towards motivating collective action to address AMH in Uganda. Some interviewees also suggested a more holistic approach to addressing adolescent health issues so as to ensure inclusion of mental health services in the care package for adolescents. This was highlighted through propositions like integration of mental healthcare for adolescents into primary healthcare.

Positioning/framing

I sought to understand how the actors in AMH in Uganda portrayed the issue to other stakeholders especially those whose input is key to making progress in addressing the problem. Most interviewees admitted that actors in this field have not had much success in shifting priority towards AMH. Interviewees highlighted that actors have not adequately shown how serious the AMH problem is in Uganda.

"I wouldn't say like in a factual statement but in my opinion, it's to a very less extent. What informs my opinion is the fact that what we are having at this particular time. You have seen a lot of lobbying in increasing budgeting on Sexual and reproductive health but we haven't seen lobbying on increasing mental health budget and yet we have these actors." – Participant 011, Female Psychologist in civil society

Successful efforts mentioned included the writing and launching for 2017 child and adolescent mental health policy and guidelines, but this has since not been adequately implemented. Other innovations like integrating AMH services at primary healthcare points were vaguely attempted and failed because roles were being given to already overwhelmed staff at the health facilities.

"… along the way, we got into the teenage spaces, youth-friendly services came on. But they didn't go far. We talked about them in policies but the actual on ground within health facilities implementation you'd not see it

there… And so, the idea failed because the people who were in there had their roles already." – Participant 014, Female Mental Health specialist, Government institution

According to the interviewees, the AMH problem has been often positioned by actors as a threat to public health and sustainable development. There were noted disagreements on whether AMH should be looked at as a standalone issue rather than in the collective of adolescent health challenges.

Interviewees from CSOs and some others framed AMH as a problem that can best be addressed through the school system given that most adolescents are in school, and it is where spend 60% of their time. The interviewees talked of various school counselling programs including a campaign that is advocating for a national standard of at least one skilled counselor per school. At the Ministry of Health level, the strongest efforts to address AMH have been framed in an alcohol and substance abuse control effort that has attracted some support and partnerships and made strides in that section.

Adolescents in FGD did mention that the closest to mental healthcare most pf them and their peers accessed was through school counsellor even though this was rare and not in all schools.

"For especially the girls, they sometimes they send you see the senior woman when they think that your behavior is not ordinary. She can talk to you about life, and you share with her your experiences at school. The bad thing is that this is usually on grounds of suspicion of pregnancy. Me I think they don't really want to help you mentally. It's nice anyway." – Female FGD participant

Governance and leadership

The community of actors for AMH in Uganda is characterized by fragmented groups with very limited cohesion. Even though the number of these proponents for AMH in Uganda has been gradually increasing over the recent years, interviewees emphasized that their efforts remain weak because of the non-unified nature of their operations.

The interviewees however did note that there have been some efforts to work together, even though these have been limited by the lack of resources to sustain the coalitions. Notably, the two AMH-related events observed for this analysis that occurred between March 2022 and September 2022 demonstrated good effort of mental health actors working together to organize

and successfully implement the first mental health conference and the first mental health run in Uganda. However, these are short-term events that according to the interviewees do not demonstrate a solid long-term commitment to sharing resources and voicing their issues together.

In addition to limited resources, weak leadership was reported as a major reason for limited cohesion among actors. There exists a national body that is mandated with mobilizing resources and coordinating but not much success has been achieved in this.

> *"I have not seen organization that implement in communities coming to a coalition to implement mental health services and information. So again, this goes back to the environment of mental health. Coalitions can easily come together if there is substantial funding that needs to support a coalition." – Participant 002, Male AMH advocate*

Interviewees said that efforts to lead actors towards a unified front have often been spearheaded by individual champions or civil society organizations although these have always partnered with the national coordination body. The limited coordination has also seen the community have very limited involvement of grassroots stakeholders like the community and adolescents for whom interventions are being designed; as well as several other stakeholders who have been neglected.

> *"I haven't seen much of the grassroots movement and champions for this AMH. So, in a political environment. You know, if it were really to intervene with AMH, it's going to cost a lot of money... and it's a big risk with resource allocation issues. So, in the absence of people really wanting it, uhm... it's very hard for the politicians to make it a priority." – Participant 004, Female Mental Health Epidemiologist*

However, some interviewees noted that there are current efforts to remedy this. For example, the ministry of health has a current project called the young people and adolescent peer supporters (YAPS) program through which adolescents are involved in peer-to-peer sensitization on HIV. There is hope that this will be expanded beyond sexual and reproductive health and rights issues to mental health.

Coalition building

All interviewees emphasized the need for building coalitions with stakeholders outside their field mentioning actors like the ministry of education and sports, the ministry of gender, labor and social development and the ministry of internal affairs among other stakeholders whose resources would be needed in successfully implementing AMH improvement efforts. Even though some interviewees noted that current efforts to address AMH in Uganda have been multisectoral, such as the technical working committee on adolescent health and the ministry of health division for mental health, others argued that in their work and other actors around them, there was limited partnerships with players outside the field of mental health.

> *"Yes indeed! And like I said, at the ministry of health level, it's always the 3 key line ministries working together; ministry of health, ministry of gender and the ministry of education and sports. And then obviously the finance, the budget has to support them" – Participant 008, Female Paediatrician*

Recommendations

Additionally, the interviewees made suggested best measures for the improvement of AMH programing and service delivery in Uganda. Most interviewees emphasized the need for strengthening and enforcement of AMH legislations, this also including ensuring the decriminalization of suicide to be more supportive and less punitive to sufferers. Interviewees proposed that actors design creative ways to motivate interest of policy makers to increase resources allocated to AMH. This can be done, they said, through awareness creation among members of parliament. Some interviewees also encouraged the adoption of high-level champions for AMH such as was seen in HIV control where the president spearheaded efforts and sickle cell anemia where the Kabaka of Buganda has been a champion. Both efforts have realized significant rise in priority.

Interviewees emphasized the need to create a supportive environment for adolescents to thrive. This including respecting adolescents' autonomy, ensuring their safety in homes and encourage their open communication on issues concerning their mental health. This should then be followed with increasing access to services through offering subsidies on treatment costs and increasing the number of service delivery points at all levels.

In summary, the prioritization of AMH in Uganda is low at all levels including national, organizational and community. And this is especially due to the limited knowledge and understanding of the issue. Actors working towards promoting AMH in Uganda describe the

problem as a health systems policy issue that is yet to be addressed. In their efforts to motivate collective action, actors have framed the AMH problem as a threat to public health and a threat to sustainable development because adolescents make up the biggest proportion of Uganda's population. The lack of clear leadership in the community of actors and limited building of coalitions with external stakeholders have limited progress towards achieving set goals for AMH improvement in Uganda.

6.3 Results from the observations

I observed two major mental health related events that happened in Kampala during the time of data collection (January to September 2022). Only two AMH-related activities were conducted within Kampala during the study period.

i) The National Mental Health conference, May 2022

This was organized by the Uganda Counselling Association with the Ministry of Health mental health department and the national mental health technical working group. The conference included individuals and organizations different sectors representing government, civil society, for-profit organizations, academia, and security agencies among others.

ii) The Mental Health run, September 2022

This was organized by an advocacy organization called Heart-to-heart spaces which collaborated with other key players in the mental health network in Uganda, held on world suicide prevention day under the theme "creating hope through action." The event provided a platform for advocacy, collaboration and building coalitions for multisectoral action towards improving mental health in Uganda. The run included individuals and organizations different sectors representing government, civil society, for-profit organizations, academia, and security agencies among others.

Both the two events observed for this analysis had strong participation of external stakeholders through provision of funding, mobilization of participants and other resources pertinent to the success of these events.

Issue characteristics

The two events had a related general focus on mental health of Uganda and adolescent mental health was only mentioned as a subtopic.

The two key guest speakers at these events highlighted the major knowledge gap on mental health issues countrywide and emphasized the need for awareness campaigns such was done with the mental health run.

A key issue on the limited opportunities for dissemination of research and work related to mental health in Uganda emerged during the mental health conference and a resolution was made to make improvements in this regard.

Organizers of both events talked about how restrictions due to the COVID-19 pandemic limited mental health promotion efforts as well as any activities that would enable actors continue to pursue strengthening of the provision of mental health services.

Even though, issues regarding mental health school going children especially due to the sudden changes in their school schedules, sometimes having to stay locked in doors and having to tend to sick loved ones were widely discussed, mainstreaming children and adolescent mental health as a sector of its own that would need specific strategies and funding hardly occurred at these events.

Problem definition

I sought to understand how organizers and speakers at these events defined the problem of adolescent mental health in Uganda, when they did mention it through the advertisements, speeches, and other communication formats about the events.

On one of the days leading to the mental health run, part of the mobilization communication quoted statistics on the number of children and adolescents affected by the limited understanding of their mental health needs Uganda. The organizers followed this with a message that more advocacy and awareness creation through an event like the mental health run and they therefore defined the issue as a public health problem that needed to be tackled through collective action. One of the participants called on everyone to engage even more;

"I am thrilled to see so many stakeholders here today, but our work is not done. I encourage all of you to continue to engage with us in mental health advocacy and to promote access to quality mental health services in your communities. Together, we can create a brighter future for mental health in Uganda." –Male Participant at the Mental health run

Positioning/framing

To understand how the actors involved in these events portrayed AMH to other stakeholders attending and outside these events, I paid attention to speeches and how AMH was framed as an issue when it was. An outstanding observation was that actors still lacked a unified way of framing adolescent mental health effectively: Framing it in a way that resonates with policymakers and the public is crucial to rallying collective action. Actors made some effort to frame adolescent mental health as an issue of public concern that requires public participation to address. The discordance surfaced when other speakers insisted the policy gaps were more pertinent in the moment.

Governance and leadership

The organization and execution of the mental health run was spearheaded by two mental health champions and supported by several other private service providers as well as civil society organizations. The ministry of health and the national referral hospital for mental health, Butabika were involved through their heads who graced the occasion. Therefore, leadership was mostly by non-government players.

Throughout the event, there was no display or mention of a single leader or entity to coordinate efforts by the whole mental health movement collectively including all partners, but the stakeholders demonstrated a case of rising to action when need arose. For example, one of the key speakers thanked the organizers for their efforts;

"I want to take this opportunity to thank the organizers of this mental health run for their leadership in bringing together stakeholders to raise awareness about mental health. Your efforts do go a long way in teaching people about stigma and advocating for access to mental health services for all Ugandans. Let us continue to work together towards a healthier, more resilient society." –Female Speaker at Mental Health run

In their speeches, both the head of the mental health department at the Ministry of Health and the executive director of the Butabika national referral hospital appreciated the efforts of such young players joining forces and mobilizing different players to make louder calls to action on mental health in Uganda.

The organization of the mental health conference was done by the Uganda Counselling Association (UCA) with support from the Ministry of Health and other actors. By the time of this conference, this association had only been recently formed to guide and support psychologists countrywide. The UCA too is a non-governmental organization. Even though the

effort to set up this association is a step in the right direction, the association's mandate does not strongly cover the mobilization and coordination of other mental health players that are not practitioners.

Coalition building

Overall, the mental health run welcomed a more diverse group of stakeholders which stretched across practitioners both public and private; mental health institutions; service providers; education sector; gender support programs across to well-wishers.

In both events, the organizers embarked on identifying and mobilizing actors with shared interests: mobilizing stakeholders who share a common interest in addressing mental health issues in Uganda. These included, mental health advocates, substance use disorder advocates, health care providers, insurance companies, and policymakers all had a stake in ensuring equal coverage for mental health and substance use disorder treatments including children and adolescents.

6.4 Results by structural, institutional and actor factors

Here, I present the summary of findings organized by the three major categories of factors or variables considered in this political economy analysis: structural, institutional, and actors; linking the insights from the different data collection methods that fed the analysis.

Structural contextual factors

Uganda is a low-income country in East Africa with a population of over 42 million people. Adolescents (aged 10-19 years) make up a significant proportion of the population, with over 9 million young people in this age group. Despite the high prevalence of mental health problems among young people in Uganda, mental health is not prioritized in national health policies or budget allocations.

As highlighted in results from the different data sources, several structural factors contribute to the state of adolescent mental health in Uganda. Poverty is a major issue, with over 20% of the population living below the national poverty line. Poverty is linked to poor mental health outcomes, as it limits access to resources such as healthcare, education, and employment opportunities. This can lead to stress, anxiety, and depression, particularly among young people.

Gender and cultural norms also play a role in adolescent mental health in Uganda. Traditional gender roles can put pressure on young people to conform to certain expectations, which can be stressful and lead to poor mental health outcomes. Stigma around mental health is also a significant barrier to care, with many young people and their families feeling ashamed or embarrassed to seek help.

The lack of resources for mental health services is a major structural barrier to improving adolescent mental health in Uganda. There is a shortage of trained mental health professionals, and the few available services are concentrated in urban areas. This limits access to care for young people in rural areas, where the majority of the population lives.

Additionally, political instability and corruption have contributed to a lack of investment in mental health services, as well as a lack of accountability for the provision of care. The government has made some efforts to improve adolescent mental health services, but progress has been slow, with limited funding and a shortage of trained professionals.

In conclusion, Uganda's structural context regarding adolescent mental health is shaped by poverty, gender and cultural norms, stigma, and a lack of resources and investment in mental health services. Addressing these structural factors will require a multi-sectoral approach that includes increased funding for mental health, investment in education and employment opportunities, and reducing stigma and improving awareness of mental health issues.

Actors/stakeholder factors

In general, stakeholders involved in adolescent mental health in Uganda included government agencies, non-governmental organizations (NGOs), mental health professionals, community leaders, and individuals and families affected by mental illness. During mental health events, these stakeholders worked together in various ways to achieve their set objectives in regard to promoting adolescent mental health in Uganda.

For example, in response to the reported increase in deaths by suicide among adolescents, civil society organizations convened as many relevant partners as possible to raise awareness on suicide prevention. The government through the mental health department at the ministry of health takes on the overall coordination role; while NGOs may work to provide mental health education and outreach to affected communities, and mental health professionals may provide

counseling and treatment services. Community leaders also work to reduce stigma and promote awareness of mental health issues, and individuals and families may seek support and care.

In some cases, stakeholders worked together to advocate for policy changes or increased funding for mental health services. They also collaborated on research projects to better understand the causes and prevalence of mental health conditions among children and adolescents in Uganda.

Overall, effective stakeholder interaction is essential for addressing mental health issues in Uganda and promoting the well-being of children and adolescents and their communities. It requires collaboration, coordination, and a commitment to reducing stigma and improving access to care.

Institutional factors

Here I describe issues related to "rules of the game", the existing policies as well as informal rules by which actors operate. For example, where some of the actors were motivated to take on mental health advocacy as a social obligation being leaders in their communities. The following paragraphs describe the major issues on institutional variables from the data.

Regulatory Frameworks: Uganda has a national mental health policy that outlines the regulatory framework for mental health services in the country. This policy is supported by the Mental Health Act of 2019, which provides a legal framework for the delivery of mental health services. The act establishes the National Mental Health Policy Council, which is responsible for developing, monitoring, and evaluating mental health policies and services in the country.

Human Resource Constraints: Uganda faces significant human resource constraints in the mental health sector, including a shortage of mental health professionals such as psychiatrists, psychologists, and psychiatric nurses. The shortage is even more significant for specialists in child and adolescent mental health care. This shortage is due in part to the low number of training programs for mental health professionals, as well as inadequate funding for mental health services.

Financing: Financing for mental health services in Uganda is limited, and mental health services are often not prioritized in budget allocations. This lack of funding has limited the availability and quality of mental health services for adolescents, particularly in rural areas.

Stigma and Discrimination: Stigma and discrimination surrounding mental health issues are highly prevalent, which discourages adolescents from seeking help. Traditional beliefs about mental health and the role of family in providing care also influence the utilization of mental health services.

Service Delivery Models: The service delivery models for mental health services throughout the country are primarily centered around hospital-based care. This model can limit access to mental health services for adolescents, particularly those in rural areas who may not have access to transportation to reach urban centers.

Coordination and Collaboration: Coordination and collaboration among adolescent mental health actors, including government agencies, civil society organizations, and international partners, is critical to improving mental health outcomes for adolescents in Uganda; but this is still majorly lacking. Effective coordination can help to address the human resource constraints and financing challenges facing mental health services in the country.

CHAPTER SEVEN: Discussion

AMH generally has low political priority in Uganda. This issue is characterized by a small community of actors who operate in fragmented groups with little to no cohesion. These actors' efforts to shift priority towards AMH in Uganda have not had much success partly because of general lack of understanding of AMH right from community to the policy makers. Actors have pointed out some dimensions of AMH that have made it so difficult to motivate collective action to include the widespread stigma associated with mental health.

The low national priority of AMH in Uganda reported by our study participants is consistent with findings from other studies done in Uganda and the region (Akol et al., 2015; Iversen et al., 2021). It has also been reported in other studies that there is major stigma and discrimination associated with mental illness in Uganda.

Contrary to the findings from a study by Angella Akol and colleagues (Akol et al., 2015), interviewees in this study mostly reported that we lacked adequate legislation to support improvement of adolescent mental health. Interviewees emphasized that the existing policies and laws were outdated and required revision and strengthening. This difference in findings could be due to the differences in priority levels to wards AMH between 2015 and 2022. Additionally, the COVD-19 pandemic and current economic crisis could have exposed major limitations in the current policies and their implementation to support improvement of AMH.

The limited knowledge on AMH emerged as a crosscutting issue associated with the low prioritization of the problem, gaps in service provision, limiting of actor cohesion and even coalition building. The limited knowledge on AMH also appears to not only be an external issue but also constitutes some grey areas in how within the actors' networks the problem of AMH is defined. I can relate this with the very limited research and learning within this field.

Also, the lack of funding was reported to affect all the four major dimensions; that is problem definition, governance, coalition building and framing/positioning of the issue. To explain this, the interviewees reported that the lack of funding limited their ability to do research and have continuous medical education trainings; this ultimately keeps the problem definition myopic. In terms of governance, the lack of funding as well as competition for business limited actors' ability to work together more often. Coalition-building requires many knowledge sharing platforms such as conferences and other stakeholder mapping efforts which are difficult without dedicated resources. And finally, in the pursuit for resources, actors were more likely

to frame the issue towards directions where funding was accessible. Take for example the strong efforts towards alcohol and substance control which was influenced by availability of partners and resources.

This study brought to light key issues to leverage upon to make effort towards motivating increased political priority for AMH in Uganda. These findings demonstrate the need for bigger national studies to describe the network of actors for AMH in Uganda. I also demonstrate the key role data has to play in motivating buy-in from policy makers hence necessitating more inquiries into the magnitude of the AMH problem in Uganda.

I also identified the unique gap of limited ability for Ugandans to express themselves in regard to their mental health. There is very limited understanding of mental health issues described in a local context and the lack of the appropriate words of expressions. This presents a unique opportunity to study the issue further and describe or even quantify how much this expression limitation impacts access to mental health services for adolescents.

These findings have broader implications beyond Uganda. Mental health issues among adolescents are a global concern, and the challenges identified in Uganda resonate with many other countries. Lack of prioritization, stigma, inadequate funding, and fragmented governance structures are common challenges faced globally. It is crucial to recognize that addressing AMH requires a holistic approach that integrates mental health into broader health and development agendas.

In terms of current strategies and policies, the analysis suggests that while efforts have been made in Uganda, they remain insufficient. The existing policies and programs have major inadequacies, including limited service access, inadequate community support, and insufficient awareness-raising efforts. The COVID-19 pandemic has further exposed the need for prioritizing AMH, but it has not necessarily resulted in significant advances in political support. New strategies like the new Reproductive, Maternal, Newborn, Child, Adolescent and Healthy Aging Sharpened Plan for Uganda recently launched by the Ministry of Health highlight solutions that are in line with recommendations made from this study. In this sharpened plan, targeted areas for improvement of AMH were listed to include the provision of sexuality education; applying improved service delivery models including incorporating peer-led approaches and community-based counselling; strengthening service provider competencies; shifting from a “treatment, prevention and risk-reduction” approach to a “strengths-and-

resilience-building" approach; and enhancing school health promotion. Overall, this sharpened plan suggests a comprehensive and integrated approach to address adolescent mental health issues (Ministry of Health, 2022).

Globally, there is an increasing recognition of the importance of adolescent mental health, and efforts are being made to address this issue. International frameworks such as the United Nations Sustainable Development Goals (SDGs) and the World Health Organization's Mental Health Action Plan emphasize the importance of mental health promotion and service provision, including for adolescents. However, translating these global commitments into effective policies and programs at the national level remains a challenge.

To improve AMH programming and service delivery in Uganda and globally, several recommendations emerge from the analysis. These include strengthening and enforcing AMH legislation, destigmatizing mental health, increasing funding allocations, improving coordination and leadership, and building coalitions with stakeholders outside the mental health sector. Additionally, the adoption of high-level champions and the involvement of grassroots stakeholders, including adolescents themselves, can help drive the prioritization of AMH. These are detailed in a subsequent section.

Overall, these findings underscore the urgent need for increased attention and investment in adolescent mental health.

Strengths and limitations of the study

This study had unique strengths in that I included insights from observing some actor efforts but also that I included a wide variety of players in the AMH field in Uganda.

The study had just two interviewees representing funders. The analysis would have probably benefitted from more insight from funding partners since we found that funding shaped the course of action among actors.

The focus group of adolescents did not include younger adolescents who may potentially have some unique experiences in this regard.

The frameworks used in this study were also borrowed from other uses. That is, the conceptual framework from World Bank Group was primarily designed for the World Bank audience. The framework by Professor Shiffman was primarily designed for global-level priority setting so I

had to make adjustments to include issues unique to national contexts as described in the methodology.

This study should be perceived as an initial stage in exploration of why AMH has low priority in Uganda and I recommend that future studies could aim to understand the comparative weight of different factors in shaping this priority level.

Implications of this study

Findings from this study have implications on the development of new policies and AMH initiatives by actors trying to promote AMH in Uganda. As proponents for AMH in Uganda look to attract more attention and resources towards this issue, they will need to consider means to strengthen collaborations amongst themselves as well as establishing means to shape building coalitions with external players whose resources are needed for the success of their efforts. There is a need to invest in mindset change in communities, through major social and behavior change communication campaigns to motivate adults to prioritize mental health needs of adolescents. This should be followed by efforts to enable policy learning for legislators, so they are able to support the agenda during national budget allocation because limited funding represents a major barrier to AMH programming at Ministry of Health.

CHAPTER EIGHT: Conclusions

In Uganda, AMH is recognized as a multisectoral issue, requiring collaboration among various government sectors. The Ministry of Health, the primary custodian has made efforts to integrate mental health education into school curricula and provide training to healthcare providers to address adolescent mental health needs. Other key players include the Ministry of Gender, Labor, and Social Development which focuses on creating supportive environments and providing counselling and psychosocial support services, while the Ministry of Justice and Constitutional Affairs addresses legal and policy frameworks related to mental health. The problem has been that the commitments have not translated into action on the issue.

Priority levels for addressing AMH in Uganda have been dwindling over the years. The COVID-19 pandemic has exposed the urgent need for improvements but also demonstrated the huge magnitude of the issue. There is increasing social attention towards mental health and wellbeing of adolescents in Uganda. However, key stakeholders such as political leaders and major funding bodies have not yet demonstrated actual commitment to addressing the issue. Even though the number of actors in the field of AMH is increasing, their power and ability to effect significant change remains limited. The network of actors is still majorly fragmented and so the lack of a unified front and strong leadership to unite actors towards lobbying for attention and resources for AMH has resulted in slow progress.

Within Uganda's context and structural factors of poverty, gender, and cultural norms as well as certain national political difficulties, the institutions available to support AMH programming remain insufficient and even the good policies designed hardly get implemented. The data also shows that progress is further impeded by the disorganization in the network of proponents for AMH in Uganda.

Future research should consider unpacking the institutional issues within networks working to promote AMH in Uganda. In light of the plans in the new sharpened RMNCAH strategy, researchers may also want to assess the capacity and readiness of the healthcare system to provide the comprehensive integrated mental health services for adolescents; identifying gaps in infrastructure, human resources, training and additional service delivery models.

CHAPTER NINE: Recommendations

Actors in AMH in Uganda may have a window of opportunity (because of gaps in adolescent mental health programming exposed by the COVID-19 pandemic) to motivate increased political priority and resources towards addressing AMH in Uganda. However, they will need to work on improving cohesion among themselves to create plausible solutions and voice their concerns louder to the policy makers. Actors will also need to enhance their coalition building efforts to enable partnerships with other stakeholders whose resources are needed for the success of AMH promotion efforts in Uganda.

Schools play a unique role in making and breaking the mental health and wellbeing of adolescents. And this is also highlighted the new Reproductive, Maternal, Newborn, Child, Adolescent, and healthy aging sharpened plan II. Therefore, the involvement of school owners and staff should be streamlined and strengthened. The ministry of education and sports should also consider including aspects of mental health and wellbeing of children and adolescents in school staff trainings. Policies that support mental health and wellbeing of adolescents in schools, such as the standard of at least one trained counselor for every school, should be supported and implemented.

Legislators in health committees and mental health committees of the parliament of Uganda should spearhead policy learning among members of parliament to motivate more support towards increasing national budgetary allocation to addressing AMH in Uganda. This can be achieved, first by clearly defining and framing the issue in ways the other politicians can easily understand. They may also consider use of a policy champion as this has been applied in other sectors like HIV/AIDS.

More exploratory research needs to be conducted to understand the unique aspects of Uganda's cultural context and beliefs towards mental health especially as is experienced by adolescents and adults' response and handling of cases. The unique finding of how lacking mental health diction is in Uganda as well as the one how most adults are very dismissive of adolescents' reports of mental illness demonstrates deeply rooted traditions that proponents need to unpack to find effective ways to get communities to prioritize adolescent mental health in ways that are unique to their context.

Future efforts for AMH programming should be inclusive of communities, especially the adolescents and without excluding adolescents living with disabilities including mental illness. The new sharpened RMNCAH plan calls to action all key stake holders to play a role in promoting adolescent health and wellbeing.

Researchers should do more robust research into understanding and describing the network that makes up actors in AMH in Uganda to provide actionable knowledge on rallying collective action towards addressing AMH. This is because most respondents among actors reported not knowing of or operating under any specific network but showed that there existed some vague form of operation on how interventions were designed, communicated and who was involved.

The ministry of health should consider taking a more active role in coordinating all actors for AMH in Uganda. This way they can guide planning, record actor grievances, and provide an opportunity for adopting of innovative solutions towards addressing AMH in Uganda.

AMH actors should consider more dissemination workshops and events to enable lesson sharing and working towards a common understanding and definition of the AMH problem in Uganda.

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APPENDICES

Appendix I: Guide for Interviews with key stakeholders/ "AMH Experts"

(The questions will be adapted based on the previous literature review.)

Broad introductory questions - level and development of priority

1. Priority level: In your opinion, to what extent is adolescent mental health and well-being (AMH) a global / national priority?
2. History: How has the global / national priority for AMH changed over time, especially in the last 10-20 years? Have you observed any change in the last 1-2 years?

Actors / networks worried about AMH

I. Problem definition

3. I use the term "AMH" during this interview, although I realize that others use different words to describe this problem. What terminology do you use? How do you define the problem?
4. Who are the main actors engaged in AMH globally / nationally?
5. To what extent do these actors speak with one voice about the problem and its solutions?
6. What do you think is the best measure to strengthen AMH? In you view, what should we focus on to reduce trends in depression, self-harm, and suicide?

II. Governance and coalition building

7. Community of actors (i.e., stakeholders with an interest in improving AMH across sectors) / networks: What does the group(s) / network(s) of actors working with or engaging in AMH globally / nationally look like? Which individuals and organizations make up this/these group(s) / network(s)?
8. Grassroots involvement: To what extent are grassroots actors involved? Specifically, to what extent are adolescents at community level involved?
9. Opposition: Which actors, if any, show the greatest opposition to promoting the AMH agenda? How well have actors responded to this opposition?
10. Cohesion of society: To what extent do those involved in AMH constitute a cohesive group / network, globally / nationally?
11. Leadership

a. Individuals: Are there individual "champions" / leaders who have been able to bring together actors to strengthen AMH globally / nationally? If yes, how did the succeed, in your view?
b. Organizations / Units: In your opinion, are there organizations that are leading the fight on this issue at the global / national level? If yes, what is their strength and/or value added?
c. Governance / Coordination: What global / national guidance institutions are in place to coordinate collective action to promote the AMH agenda? How effective have these institutions been?

12. Coalition building: To what extent have AMH actors forged alliances with actors outside the field?

III. Framing / positioning

13. How have actors / networks highlighted the problem for decision-makers in government, international institutions and agencies, donors, and other key stakeholders?
    a. How effective have they been in shifting priorities within these institutions and key national governments? Do you have examples of stakeholders that have shifted priorities towards AMH?
    b. How well have the actors shown how serious the problem is?
    c. How convincing are the solutions that the actors have proposed? How effectively have they communicated solutions to attract political support?

<u>Additional questions</u>

14. Which dimensions of the problem of AMH make it more difficult to motivate and achieve collective action? What features of the problem facilitate attention to the problem?
15. To what extent are there data/research deficiencies or measurement problems in this area?
16. Who would you recommend I talk to in order to learn more?
17. Would you have any additional comments?

Appendix II: Guide for Focus groups with adolescent advocates

(The questions will be adapted based on the previous literature review and expert interviews.)

Broad introductory questions - level and development of priority

1. Priority level: Do you think that your mental health and well-being is a global / national priority? Why / why not?

Actors / networks worried about AMH

I. Problem definition

2. I use the term 'adolescent mental health and well-being (AMH)' during this discussion, but I understand that others use different words to describe this problem. How would you describe the problem?
3. How do you think others would describe the problem (e.g., parents, teachers, politicians)?
4. What do you think is the best measure to strengthen your mental health and well-being?

II. Governance and coalition building

5. Stakeholder community / network: Who is committed to your mental health and well-being? What does their commitment look like?
6. Opposition: Is there anyone who opposes or hinders the promotion of your mental health and well-being (e.g., in family, school, society)? How well has this resistance been handled?
7. Cohesion of society: How much cohesion is there among those who are committed to your mental health and well-being?
8. Leadership
    a. Individuals: Who do you consider as individual "champions" who are committed to your mental health and well-being?
    b. Organizations / units: Which organizations do you think are “champions” in the field?
    c. Governance / Coordination: What global / national institutions are there to coordinate collective action to promote your mental health and well-being? How effective have these institutions been?

9. Coalition building: How much have those who are committed to your mental health and well-being collaborated with external actors (e.g., from other sectors)?

III. Framing / positioning

10. How have those involved in your mental health and well-being highlighted the problem for leaders of international institutions and others?
    d. How effective have they been in shifting priorities within these institutions and national governments?
    e. How well have they shown how serious the problem is? How would you explain the seriousness of the problem?
    f. How convincing are the solutions they have proposed? How effectively have they communicated solutions to attract political support? What solutions do you see, and how would you make the case to attract more political support?

<u>Additional questions</u>

1. What dimensions of the problem make it more difficult to motivate and create action? What features of the problem facilitate attention to the problem?
2. To what extent are there data/research deficiencies or measurement problems in this area?
3. Who would you recommend I talk to, to learn more for this research?
4. Would you have any additional comments?

Appendix III: Information Letters and Consent Forms

A) EXPERTS

Information for the researcher participant.

We would like to ask you if you want to participate in a research project. In this document, we provide you with information about the project and what it means to participate.

What kind of project are you and why do you want me to participate?

This is a research project based on interviews. The project aims to understand the political economy for adolescent mental health in Uganda, i.e. why adolescent's mental health is not a priority topic globally and nationally in Uganda when it comes to funding and attention, even when the burden is great and there is evidence from research.

We would like to request you to participate because we would like to know how you perceive the problem of adolescent mental health, as well as governance and coalition building in the area. We will use this information to increase knowledge about the political economy of adolescent mental health and well-being.

The principal researcher for the project is Makerere University School of Public Health. Research principal means the organization that is responsible for the project. The application is approved by the Makerere University School of Public Health Institutional Review Board.

How is the study done?

This is a qualitative survey with data collection through interviews. An interview takes about 30-60 minutes and is recorded.

Possible consequences and risks of participating in the study.

In this study, we would like to ask you about your experiences of working in the field of adolescent mental health. We would like to ask questions about how you define and position the problem, as well as about governance and coalition building in the area.

Participation in the study is completely voluntary and involves very low risks. If you feel uncomfortable or do not want to answer an individual question, you have the right to refrain from answering. If you choose not to respond, you do not have to state why, and you can cancel your participation at any time.

In qualitative research in very specific subject areas with relatively few experts, such as adolescent mental health, it may be possible to identify a person based on their position or their speech patterns. We will therefore use a unique number code instead of your name. We will also delete potentially identifying information such as your workplace if you mention it; instead, we will use general categories such as "expert in an international organization". With very specific word choices, we will paraphrase instead of quoting you verbatim. The content of your interview therefore remains completely confidential and makes identification impossible.

We are happy to share the transcript of your interview with you if you are interested in it. If you believe that certain sections should not be published or included in reports, we will remove these sections. There is also the opportunity for follow-up conversations.

What happens to my information?

The project will collect and record information about you, i.e., recordings and transcripts from interviews. This data will be handled anonymously and confidentially so that you cannot be identified from the data. Recordings and transcripts will be saved in a password-protected folder on Makerere University School of Public Health's "MakSPH Cloud" (approved for secure data storage). The consent forms will also be saved in a password-protected folder on MakSPH Cloud and in a locked cabinet at the department. After the study is completed, the data will be stored for 10 years and according to the department's rules and processes.
Your answers will be processed so that unauthorized persons cannot access them. The person responsible for your personal information is Tonny Muwonge.

How do I get information about the results of the study?

You can contact Tonny Muwonge (tonny.muwonge@mak.ac.ug) if you are interested in your individual data (recordings and transcripts), or the results of the entire project.

Compensation

No insurance cover applies, and you will not be reimbursed for the time given in the interview.

Participation is voluntary.

Your participation is voluntary, and you can choose to cancel your participation at any time. If you choose not to participate or want to cancel your participation, you do not need to state why. If you wish to cancel your participation, please contact the person responsible for the study (see below).

Who is responsible for the study?

The principal researcher for the study is Tonny Muwonge, a Master of Public Health finalist, Makerere University School of Public Health, New Mulago Hill Road, Mulago, Kampala, mobile: 0753414942, email: tonny.muwonge@mak.ac.ug. This study is also supervised by Dr Roy William Mayega , email: rmayega@musph.ac.ug and Dr Olivia Biermann, email: olivia.biermann@ki.se You may also contact the chairperson of the institutional review board, Dr Suzanne Kiwanuka on skiwanuka@musph.ac.ug, 0772 886 377/ 0393-291-397 in case you have any questions or complaints concerning you rights while they participate in this study.

Consent to participate in the project.

I have received oral and written information about the study and have had the opportunity to ask questions. I have been offered a copy of the written information.

☐ I agree to participate in the study "THE POLITICAL ECONOMY OF ADOLESCENT MENTAL HEALTH IN UGANDA: A CASE STUDY AMONG ACTORS AND ADOLESCENTS IN KAMPALA DISTRICT".

☐ I agree that information about me is processed in the manner described in the research participant's information.

Place and date	Signature
	Full names

B) Adolescents

Information for the research participant

We would like to ask you if you want to participate in a research project. In this document we provide you with information about the project and what it means to participate.

What kind of project are you and why do you want me to participate?

This is a research project based on focus group discussions. The project aims to understand why adolescent mental health is not a priority topic globally and nationally in Uganda when it comes to funding and attention, even when the burden is great and knowledge from research is available.

We would like to request you to participate because we are interested in how you as a youth advocate perceive the problem of adolescent mental health. We will use this information to increase knowledge for adolescents' mental health and well-being.

The principal researcher for the project is Makerere University School of Public Health. Research principal means the organization that is responsible for the project. The application is approved by the Makerere University School of Public Health Institutional Review Board and the Uganda National Council of Science and Technology (registration number: xxx).

How is the study done?

This is a qualitative study with data collection through focus group discussions. A focus group discussion takes approximately 60 minutes and is recorded.

Possible consequences and risks of participating in the study.

In this study, we want to ask you how you as a youth advocate think about adolescent mental health. Participation in the study is completely voluntary and involves very low risks. If you feel uncomfortable or do not want to answer an individual question, you have the right to refrain from answering. If you choose not to respond, you do not have to state why, and you can cancel your participation at any time.

Everything you say is anonymous, which means that no one outside this room can know who said what, or afterwards be able to track down or find who was in this discussion. We will use a unique number code instead of your name. We will also delete potentially identifying

information; instead, we will use general categories such as "female youth advocate". The content of the focus group therefore remains completely confidential and makes identification impossible.

It is also very important that everyone here today agrees not to share with outsiders what was said or who was present. We cannot guarantee that other participants will not spread what has been said here today. We hope we can trust each other.

We are happy to share the transcript of the focus group with you if you are interested in it. If you believe that certain sections should not be published or included in reports, we will remove these sections. There is also the opportunity for follow-up conversations.

What happens to my information?

The project will collect and record information about you, i.e. recordings and transcripts from focus group discussion. This data will be handled anonymously and confidentially so that you cannot be identified from the data. Recordings and transcripts will be saved in a password-protected folder on Makerere University School of Public Health's "MakSPH Cloud" (approved for secure data storage). The consent forms will also be saved in a password-protected folder on MakSPH Cloud and in a locked cabinet at the department. After the study is completed, the data will be stored for 10 years and according to the department's rules and processes. Your answers will be processed so that unauthorized persons cannot access them. The person responsible for your personal information is Tonny Muwonge.

How do I get information about the results of the study?

You can contact Tonny Muwonge (tonny.muwonge@mak.ac.ug) if you are interested in your data (recordings and transcripts), or the results of the entire project.

Compensation

No insurance cover applies and you will not be reimbursed for the time given in the focus group discussion.

Participation is voluntary

Your participation is voluntary, and you can choose to cancel your participation at any time. If you choose not to participate or want to cancel your participation, you do not need to state why.

If you wish to cancel your participation, please contact the person responsible for the study (see below).

Who is responsible for the study?

The principal researcher for the study is Tonny Muwonge, a Master of Public Health finalist, Makerere University School of Public Health, New Mulago Hill Road, Mulago, Kampala, mobile: 0753414942, email: tonny.muwonge@mak.ac.ug. This study is also supervised by Dr Roy William Mayega , email: rmayega@musph.ac.ug and Dr Olivia Biermann, email: olivia.biermann@ki.se You may also contact the chairperson of the institutional review board, Dr Suzanne Kiwanuka on skiwanuka@musph.ac.ug, 0772 886 377/ 0393-291-397 in case you have any questions or complaints concerning you rights while they participate in this study.

Consent to participate in the project

I have received oral and written information about the study and have had the opportunity to ask questions. I have been offered a copy of the written information.

☐ I agree to participate in the study " THE POLITICAL ECONOMY OF ADOLESCENT MENTAL HEALTH IN UGANDA: A CASE STUDY AMONG ACTORS AND ADOLESCENTS IN KAMPALA DISTRICT"

☐ I agree that information about me is processed in the manner described in the research participant's information.

Place and date	Signature
	Full names

Appendix IV: Literature and document review guide

Literature and document review/critical appraisal form

Reviewer notes	
Document ID	
Type of document (journal article, report, news article, website, plan, policy, or law and other)	
Title of document	
Author(s)	
Institution	
Year of publication	
Setting and scope (Description of the key message of the document)	
Clear statement of study/activity objective	
Problem definition: How do the authors describe the problem? How do the authors think the problem should be addressed?	
Governance: What does the document say about the quality of institutions established to facilitate collective action on the issue?	
Coalition-building strategies: In what ways do the authors or institutions engage networks concerned with other issues to advance attention and resources for the problem?	

Appendix V: Observation guide

Observation guide for Adolescent Mental Health-related activities in Kampala

Name of reviewer	Reviewer's notes
Type of activity	Date
Organizer of activity	Venue
Objective/theme of the activity	
Target audience	
List of participating stakeholders	
What information is being given to participants?	
Problem definition: How do the speakers describe the problem? How do the speakers think the problem should be addressed?	
Governance: What consensus do the participants make about the quality of institutions established to facilitate collective action on the issue?	
Coalition-building strategies: In what ways do the speakers, participants or institutions engage networks concerned with other issues to advance attention and resources for the problem?	
Any other discussion issues on AMH	
What are the key action decisions made at the end of the activity?	