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African Population and Health Research Center
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Strengthening Adolescent Well-being

A Call for Integrated Mental Health and Sexual Reproductive Health Policies in East and Southern Africa

POLICY BRIEF
JUNE 2025

Introduction

Adolescence, a period between 10 to 19 years, is a crucial stage of life representing the transition from childhood to adulthood. This period is a unique stage of human development characterized by physiological, emotional, and sexual development, shaping a sense of identity and individuality[1]. During this period, adolescents have unique health, social, emotional, and developmental needs that must be met to help them acquire knowledge and skills, to manage and cope with their emotional, biological, and physical changes. It is a period vital for the development of sexual and reproductive capacities, characterized by rapid growth of reproductive organs, onset of menstruation, and beginning of sexual activity. For some adolescents, this phase also marks the onset of several mental health disorders, with available evidence suggesting that half of all such conditions begin before the age of 15[2]. Globally, one in seven adolescents aged 10 to 19 suffer from a mental disorder, with depression, anxiety, and behavioral disorders being the most pervasive causes of illness and disability in this age group. Sexual and reproductive behavior significantly impacts adolescents' mental health. For instance, exposure to sexual violence, unintended pregnancy, and sexually transmitted infections, including HIV infection, have all been linked to poor mental health in adolescents[3] [4]. Additionally, evidence suggests that young people with depression and other mental disorders often engage in risky sexual behaviors. These may include having multiple sexual partners and inconsistent use of contraceptives or condoms, which can lead to a higher incidence of unintended pregnancies and an increased risk of sexually transmitted infections, including HIV[5]. Mental disorders can elevate adolescents' risk of adverse sexual and reproductive health (SRH) outcomes.

Given the bidirectional relationship between adolescent sexual reproductive health (ASRH) and mental health, addressing both areas through integrated services can broaden service provision and access, which will in turn enhance ASRH and mental health outcomes. Integrating sexual and reproductive health and rights (SRHR) and mental health means leveraging opportunities within the overall healthcare system to offer SRHR services and mental health and psychosocial support (MHPSS) services. It also involves incorporating SRHR into MHPSS policies on or related to adolescents and young people. Providing clear policy direction is essential for the successful integration of MHPSS into SRHR and vice versa. However, there is limited evidence of the extent to which MHPSS and SRHR policies address service integration.

[1] Sawyer SM, Azzopardi PS, Wickremarathne D, Patton GC. The age of adolescence. The Lancet Child & Adolescent Health. 2018;2(3):223-8.

[2] Liu L, Villavicencio F, Yeung D, Perin J, Lopez G, Strong KL, et al. National, regional, and global causes of mortality in 5–19-year-olds from 2000 to 2019: a systematic analysis. The Lancet Global Health. 2022;10(3):e337-e47.

[3] Hodgkinson S, Beers L, Southammakosane C, Lewin A. Addressing the mental health needs of pregnant and parenting adolescents. Pediatrics. 2014;133(1):114-22.

[4] Recto P, Champion JD. Psychosocial risk factors for perinatal depression among female adolescents: a systematic review. Issues in mental health nursing. 2017;38(8):633-42.

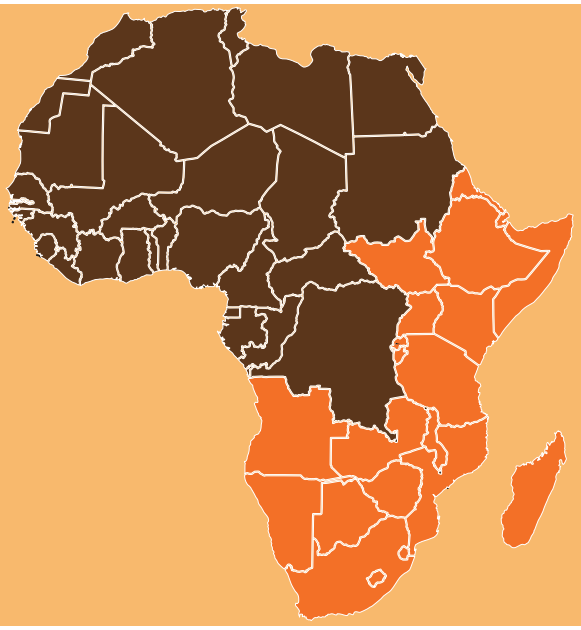
[5] Matevosyan NR. Reproductive Health in Women with Serious Mental Illnesses: A Review. Sexuality and Disability. 2009;27(2):109-18.

Objectives

This policy brief draws from findings of a review of SRHR and MHPSS policies in the Eastern and Southern Africa (ESA) region that assesses the extent of services integration, identifies gaps and opportunities, and provides recommendations for policy and programmatic improvements with respect to adolescent health. The policy brief seeks to inform advocacy efforts aimed at creating a supportive policy environment for integrated services that can address ASRH and mental health and psychological needs more holistically, thereby contributing to better health outcomes and well-being.

FIGURE 1: LIST OF ESA COUNTRIES

Angola
Botswana
Burundi
Comoros
Democratic Republic of Congo
Djibouti
Eritrea
Eswatini
Ethiopia
Kenya
Lesotho
Madagascar



Malawi
Mauritius
Mozambique
Namibia
Rwanda
Seychelles
Somalia
South Africa
South Sudan
Tanzania
Uganda
Zambia
ZImbabwe

Methods

The process employed in carrying out the scoping review is depicted in Figure 1. We reviewed the most recent policy documents, laws, guidelines, and strategies related to MHPSS and SRHR in the ESA region. We identified these documents through a Google search, and searches of regional bodies and national health ministries' websites. We also searched the World Health Organization (WHO)'s national policy document repository[6]. We contacted state ministries and civil society organizations working on SRHR and MHPSS for additional documents. A total of 120 SRHR and 14 MHPSS policies were identified. We also held a validation workshop with key stakeholders and their insights were incorporated into the study report.

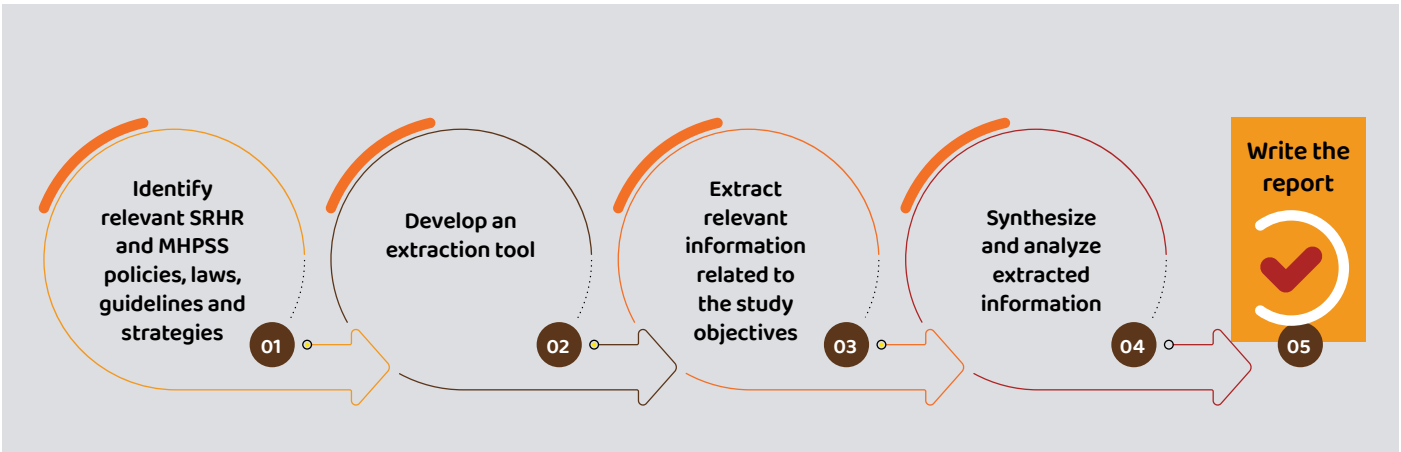


FIGURE 1: OVERVIEW OF OUR APPROACH TO THE POLICY REVIEW

[6] WHO National policies [Internet]. Available from: https://platform.who.int/data/maternal-newborn-child-adolescent-ageing/national-policies?selectedTabName=National+policy+document+repository

Key Findings

1. There were notable differences in the availability of mental health policies compared to SRHR policies. Every country had at least one SRHR policy, but only 12 out of 25 had mental health policies (Figure 1).
2. There were no mental health policies and strategies in the East African Community (EAC) and Southern African Development Community (SADC) regions.
3. While reproductive health and HIV policies and strategies were available in most countries in the region (21 of the 25 countries), standalone ASRH policies were not available in 11 countries. Additionally, gender-based violence (GBV) policies were unavailable in seven countries.

TABLE 1: LIST OF ESA COUNTRIES WITH(OUT) POLICY DOCUMENTS PER THEMATIC AREAS

	Sexual and Reproductive Health and Rights (SRHR)	Adolescent Sexual and Reproductive Health (ASRH)	HIV/AIDS	Gender-Based Violence (GBV)	Family Planning	Mental Health
Angola						
Botswana						
Burundi						
Comoros						
Democratic Republic of Congo						
Djibouti						
Eritrea						
Eswatini						
Ethiopia						
Kenya						
Lesotho						
Madagascar						
Malawi						
Mauritius						
Mozambique						
Namibia						
Rwanda						
Seychelles						
Somalia						
South Africa						
South Sudan						
Tanzania						
Uganda						
Zambia						
Zimbabwe						

Note: Yellow indicates countries where specific policy documents are available, while brown indicates countries where specific policy documents are unavailable.

Key Findings

1. Several of the policy documents were outdated and are up for review. Only about one-third (33.3%) of policies addressing GBV, one-quarter of SRHR (25.8%), and HIV/AIDS (25%) policies, and one-fifth (21.4%) of family planning policies are operational, with less than one-fifth of ASRH (18.7%) policies being active.
2. The policy direction for service integration was more evident in HIV and GBV policy documents. Many SRHR policies (64.5%) and policies on HIV/AIDS (86.1%), GBV (76.2%), ASRH (68.8%), and family planning (50%) included guidelines for integrating MHPSS. However, only 28.6% of mental health policies incorporated SRHR.
3. Involvement of adolescents and young people in the policy formulation process was lacking.
4. The involvement of SRHR experts in the MHPSS policy development process, and mental health experts in the SRHR policy development process was not documented in any of the documents we reviewed. Only Kenya and Seychelles included mental health experts in their HIV/AIDS strategies development.
5. Countries that have set clear targets for integrating SRHR and MHPSS services include Djibouti, Malawi, Namibia, Seychelles, Somalia, and South Africa.
6. Service integration was most strongly prioritized in policies and strategies on GBV and HIV, while receiving comparatively limited attention in frameworks for reproductive health, ASRH, family planning, and mental health.
7. Integrated service delivery was specifically recommended for adolescents living with HIV, child survivors of sexual and GBV, adolescents affected by harmful traditional practices (e.g., child marriage, female genital mutilation), orphans and child-headed households, and adolescents with disabilities.
8. Community-based approaches, capacity building for non-MHPSS health providers, and strengthening referral systems were recommended to bolster service integration.

Limitations

The desk review has some limitations, including:

1. Despite our attempts to reach out to country partners for policy documents and online searches, there is still a possibility that we may have missed some existing policy documents in our search.
2. The finding that only 12 countries have mental health policies should not be viewed as an absence of progress in enhancing mental health in nations without such policies. Although 13 countries in the region have yet to establish mental health policies, the presence of Mental Health Acts signifies substantial advancements in improving access to mental health services within these nations.
3. The findings regarding the limited involvement of young people and mental health experts warrant careful interpretation. It is essential to recognize that while some countries may have engaged with these groups in the development of their policies, such consultations might not be explicitly documented in the policy documents. This lack of mention could lead to an underestimation of the actual engagement and input from these critical stakeholders, thereby affecting the overall understanding of the policy's inclusivity and effectiveness. Future studies should investigate the participation of youth and mental health professionals in the development of SRHR policies through qualitative research methodologies.

Conclusion

We examined the existing and relevant policies on SRHR and MHPSS in the ESA region, focusing on their integration at both regional and national levels. Our findings revealed that only a few policies, implementation frameworks, and guidelines are actively in use.

While most publications indicate a policy direction favouring service integration, only a limited number of countries have established specific targets. Many countries suggested community-based approaches, capacity building for non-MHPSS health providers, and the strengthening of referral systems as additional strategies to enhance service integration.

Recommendations

The findings from the review lead to the following recommendations:

1. **Advocate for the development of mental health policies:** CSOs need to advocate for the development of mental health policies, strategies, and guidelines in the EAC, SADC, and the 13 ESA countries where none currently exist.
2. **Promote the consistent review and revision of policies once their duration has expired:** Numerous policy documents featured in this study are no longer current and require review. It is essential to review and update policy documents to integrate new evidence, strategies, and realities.
3. **Advocate for the involvement of adolescents and young people in policy processes:** To ensure policies address the needs and priorities of adolescents and young people, there is a need to build their capacity and involve them in the policy development process. This is critical to ensure that policies are holistically responsive to their needs and aspirations.
4. **Promote the involvement of MHPSS experts in SRHR policy development processes and SRHR experts in MHPSS policy development:** Due to the interlinkages between MHPSS and SRHR, experts from both sides must be involved in policy development processes. Their specialized knowledge will extensively inform decision-making processes and policy directions, ensuring that these issues are adequately addressed. Mental health policy drafters should involve SRHR technical experts in the policy development process to craft how SRHR can be integrated with mental health services and how to leverage SRH services to expand access to MHPSS services and vice versa.
5. **Set measurable targets for service integration:** Countries should not only provide policy directions but also set specific, measurable, and actionable service integration targets to ensure rapid progress in expanding access to MHPSS and improving the mental health and well-being of young people.

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