

Young people's preferences for Mental Health Intervention in Ghana and Zimbabwe

Moses Kelly Kumwenda

Moses.Kumwenda@lstm.ac.uk

Liverpool School of Tropical Medicine

Rebecca Jopling

King's College London

Rufaro Hamish Mushonga

Kamuzu University of Health Sciences

Suzanne Dodd

King's College London

Franklin Glozah

University of Ghana

Kenneth Adde

University of Ghana

Precious Makiyi

Kamuzu University of Health Sciences

Tiny Tinashe Kamvura

The Friendship Bench

Edith Dambayi

Navrongo Health Research Centre

Raymond Aborigo

Navrongo Health Research Centre

Tarisai Concilia Bere

University of Zimbabwe

Primrose Nyamayaro

University of Zimbabwe

Maria Anyorikeya

University of Ghana

Denford Gudyanga

King's College London

Dixon Chibanda

The Friendship Bench

Benedict Weobong

Research Article

Keywords: adolescents, depression, youth, Ghana, preferences, young people, Zimbabwe

Posted Date: May 25th, 2026

DOI: <https://doi.org/10.21203/rs.3.rs-9380751/v1>

License:  This work is licensed under a Creative Commons Attribution 4.0 International License.
[Read Full License](#)

Additional Declarations: No competing interests reported.

Abstract

Introduction

Common mental disorders (CMDs) are a leading but under-addressed burden among adolescents globally, with prevalence estimates among the 10 to 19 age group reaching up to 52.6% in sub-Saharan Africa. Despite this, health systems across the region remain ill-equipped to meet the mental health needs of young people, contributing to persistent gaps in universal health coverage. This study explored young people's preferences for mental health delivery services in Ghana and Zimbabwe, examining how social contexts, trust and stigma may influence engagement with care.

Methodology

A qualitative cross-sectional design was implemented in Ghana and Zimbabwe during the formative phase of cluster-randomized feasibility trial of the Youth in Mind Consortium. Twenty-two young people exposed to mental health services were purposively selected to participate in semi-structured in-depth interviews and 43 participants naïve of mental health services participated in 4 focus group discussions. The qualitative data was analysed thematically and triangulated across countries and methods by a multidisciplinary, multicounty research team.

Findings

Findings revealed a strong convergence around three key emerging themes: intervention characteristics, attributes of interventionists and characteristics of service delivery. Young people described pervasive unmet mental health needs and openness to a dedicated context-sensitive intervention for young people. Preferences of an ideal intervention centred on services that were trustworthy, confidential, minimally stigmatising. Notably, participants favoured one-on-one, in-person sessions delivered by competent interventionists perceived as trustworthy and culturally resonant.

Conclusion

These findings underscore the urgency of incorporating young people's perspectives into the design of mental health interventions and better still, co-producing these approaches with beneficiaries. Contextually grounded, young people-informed approaches are essential to enhance acceptability, optimise uptake and ensure equity of mental health service delivery in underserved young people within African settings.

Introduction

Adolescents (15–24 years) worldwide experience a rising burden of mental health conditions with an estimated 15% of those aged 15–24 experiencing issues such as depression – a leading risk factor for self-harm and suicide - the fourth most common cause of death in this age group [1]. In sub-Saharan Africa – a home to the fastest growing population globally – the prevalence of common mental disorders (CMD) is both high and contextually variable [2]. For example, in 2021 reported prevalence rates of CMD ranged widely in several conditions including major depression (16.0%-40.8%), depressive symptoms (4.4%-52.6%), anxiety symptoms (2.2%-25%) and anxiety disorder (45.6%) [(3)]. Older adolescents (15–24 years) bear a disproportionate share of this burden [4] with gender differences evident - females more affected by depression, while males frequently report higher experience of physical violence and bullying, which are linked to psychological distress [3–5].

Intersecting and concurrent vulnerabilities intensify this burden. For example, adolescent mothers who are living with HIV experience amplified risk due to stigma and social isolation and these influence their adherence to antiretroviral therapy, by so doing compounding their psychological distress [6, 7]. In Ghana, a study has associated depression in Ghanaian high school students with female gender, age, chronic illness and economic hardship, emphasising the complex nature of determinants of mental health in this group [8].

Despite global commitments to Universal Health Coverage, young people are largely excluded from effective mental health care partly because health systems are usually designed without meaningful consideration of the specific social and structural needs of this sub-population [9]. Consequently, this precipitate low access and disengagement to formal healthcare services. Young people also encounter unique and often invisible barriers to accessing mental health services. The routine standardised models of health care typically fail to recognise the lived realities of adolescents, including the low mental health literacy, unfriendly or stigmatizing health service provision environments, and the absence of adolescent responsive health systems [9]. Structural barriers – such as cost, logistical challenges, and limited availability of professional mental health services providers - further constrain access [10].

Recognising these challenges the Lancet 2019 endorsed investing in adolescent-responsive and evidence-based adolescent-specific interventions to effectively meet the health needs of adolescents [9]. The WHO also called for transformative, community-anchored approaches to mental healthcare for young people to improve accessibility and optimise health outcomes [1]. Community-based mental healthcare approaches offer culturally relevant, accessible and potentially stigma-reducing trajectories to reach underserved young people [11–13]. In alignment to this vision, the African Youth in Mind (Y-MIND) - an NIHR Global Health Research consortium – is advancing the development of tailored interventions for improving treatment of depression and anxiety among young people in Africa. Our study explored young people's preferences for mental health interventions in Ghana and Zimbabwe. The understanding of young people's perspectives is critical to designing interventions that are evidence-based, contextually grounded, culturally meaningful and responsive to the social realities of young people in sub-Saharan Africa.

Methods

This study is sub-analysis of a broader cross-sectional formative qualitative inquiry aimed at understanding young people's preferences for mental health delivery services and the perceived relevance of providing depression and anxiety management to young people Ghana and Zimbabwe. Formative qualitative data were collected in Harare, Zimbabwe and Navrongo, Ghana as part of preparatory phase of the youth in Mind feasibility trials. Figure 1 illustrates the study design, data collection and data analysis process and how the methods data were triangulated to provide a comprehensive picture of young people's perspectives. This analysis sought to uncover preferred modalities of care, and the deeper contextual meanings attached to mental health and help-seeking among young people.

Data Collection

Data collection included semi-structured interviews (SSI) and focus group discussions (FGD) designed to identify local meanings of mental distress, service expectations and sociocultural acceptability of mental health services targeting young people. The FGD technique was specifically suited to explore perceptions of young people without a prior history of mental health issues within a group setting while SIs allowed gaining deeper insights into experiences of young people with a mental health history. In Harare Zimbabwe, data was collected between December 2022 and September 2023. Interactions with young people prioritized youth voices and aimed to decipher how structural, relational and symbolic factors shapes perspectives about mental health care. In Navrongo Ghana data was collected between January and February 2023.

To explore young peoples situated understanding and preferences, focus group discussions and semi-structured guides were employed, containing a pre-defined yet flexible list of open-ended questions. These questions were shaped by Theory of Change and Consolidated Framework for Implementation Research (CFIR), which collectively offered a scaffold for interrogating how multiple contextual factors intersect to shape mental health experiences and expectations of young people [14]. Open-ended questions served as important methodological tool to elicit perspectives on lived realities, values and preferences that young people attach to mental health services. Data collection was undertaken by a locally grounded team of experienced and trained researchers using English and Shona in Zimbabwe, and English, Kasem and Nankani in Ghana to ensure linguistic and cultural resonance. Participants were purposively recruited to ensure representation of the selected groups of people using maximum variation technique (See Table 1).

Study participants

In Ghana, semi-structured interviews were conducted with school-going youth aged 15-18 with embodied experiences of mental illness while FGDs were conducted with young people without prior history of mental health. Young people who had been exposed to mental health services were identified through mental health clinics while treatment naïve participant were purposively identified in secondary schools

with help from school authorities. In Zimbabwe, interviews were conducted with young people aged 18-24 who had previously engaged with care for depression through the Friendship Bench, and adolescents currently enrolled in school. These interactions allowed for the collection of diverse experience narratives, embedded within the local sociocultural context.

Qualitative data collection took place across both countries and was guided by a reflexive approach. During data coding process, thematic saturation became apparent and recognisable through duplication of information [15]. Saturation of information was both a methodological milestone and an indication of the salience and consistency of perspectives across the two contexts.

Data management and analysis

Qualitative data were audiotaped using digital audio recorders and securely uploaded onto a password protected computers for processing. Audio files were transcribed verbatim and translated from Shona (Zimbabwe) and from Nankani/Kasem (Ghana) to English to enable thematic analysis. To safeguard participant confidentiality, all identifying information was removed from transcripts, which were stored under anonymized study ID codes on a secure SharePoint platform accessible only to authorized personnel. A subset of transcripts (10%) was subjected to quality checks by senior qualitative researchers in Ghana and Zimbabwe to ensure fidelity and contextual accuracy in transcription and translation processes.

Multi-country research (Ghana, Zimbabwe, UK, Malawi) team collaboratively conducted inductive and deductive coding, followed by thematic analysis. Thematic data analysis process combined deductive and inductive approaches, reflecting the research team's commitment to both theoretical grounding and emic insights. The analytic analysis was used to unearth nuanced perspectives that shaped care preferences among young preferences. Deductive coding involved using priori codes around young people's preferences (i.e. provider and service characteristics) from the interview guides which were informed by the study's conceptual frameworks [14]. In parallel, inductive coding involving the construction of new codes emerging directly from lived experiences articulated in the data. The initial intercountry codebook was collaboratively developed and refined through an iterative research meeting across the consortium while ensuring that contextual specificity was preserved in cross-national comparisons [14]. Qualitative data were coded in NVivo software (version 14; QSR International, Burlington, Massachusetts, USA) by a group of researchers from each country. Regular analytic meetings among researchers from the United Kingdom, Ghana, Zimbabwe and Malawi allowed consensus-building and reflexivity during data analysis process.

Data analysis was done by MK, and this involved the application of a constant comparison method to identify thematic convergences and divergencies across data sources and sites. Triangulation was used to validate findings and to identify complexities inherent within young people's experiences. In reporting this study, we adhered to the 32-point COnsolidated criteria for REporting Qualitative research (COREQ) checklist to ensure methodological rigor [16].

Ethical considerations

Ethical approvals were obtained from the Medical Research Council of Zimbabwe (Ref: MRCZ/A/2465); Navrongo Health Research Centre Institutional Review Board (Ethics Approval ID: NHRCIRB480), Ghana Health Service Ethics Review Committee (GHS-ERC Number: GHS-ERC:026/07/22) and the Kings College London Research Ethics (Ref: HR/DP-21/22-32917). All participants provided written informed consent prior to their participation. In addition, ascent was obtained for all participants under the age of 18.

Findings

Findings on young people preferences for mental health service delivery mechanisms are grouped into three themes namely: Intervention characteristics, interventionists characteristics and services delivery characteristics (Fig. 1).

Figure 1: Young people's preferences for a mental health intervention

Preferred intervention characteristics

Collective leisure and creative expressions

Findings from Ghana and Zimbabwe revealed that young people's perspectives on key characteristics of effective mental health interventions were shaped by their contextual realities and lived experiences. A recurring theme across both countries was the value of incentivisation as a contextually appropriate strategy for optimising young people's engagement in mental health services. Incentives such as financial support, fun activities, entertainment, and tangible rewards were viewed as both motivational tools and essential mechanisms for enhancing participation and sustaining commitment to mental health care within school contexts. The desire for approaches that incorporated holistic and integrated components reflects how young people's conceptualisation of mental health as complex and socially embedded. Young people favoured multidimensional interventions that extended beyond clinical care to include community-based engagement. This is reflected in young people's call for the establishment of local clubs to foster peer support and therapeutic recreation.

'They can even add clubs in every community for instance a club can be added maybe in Kuwadzana 4 or 2 and a lot of people joining. So, I think people would love that, especially football.' (P09, Adolescent with mental health history, IDI, ZM)

'I see that, football like this, it can help in entertaining them just like entertainment. It even includes a lot of things, like they can sit down and do a play which will be talking about life and those things can help.' (P7, Adolescent with mental health history, IDI, GH)

Mental health literacy and awareness raising

Young people, especially in Ghana, articulated a strong preference for intervention that emphasises mental health literacy and encourage open discussion around psychological conditions. The preference on public education, outreach and normalisation of mental health reflects broader social concerns about stigma and misinformation attached to mental health conditions within communities. Thus, young people advocated for awareness-raising interventions that demystify mental health through relatable mediums such as health talks, visual campaigns and ambassador programs aimed at normalising mental health discussions within everyday social interactions.

'I will say the best way to make the implementation easy and smooth is general education. The students need to be intensively educated on the importance of guidance and counselling and the many misconceptions about it needs to be cleared.' (R7, School Adolescent, Male FGD, GH)

'...you bring in ... this intervention to the needs of students. So maybe, making flyers and pasting them at vantage points for students to see. ... something like a cartoon ... relating to mental health to help them value the importance and to make it more down to earth for it to be easily approachable to the students.' (R6, School Adolescent, Male FGD, GH)

Young people conceptualised mental health literacy not simply as information provision, but as a performative practice that generates safe spaces for discussing sensitive and potentially stigmatising subjects.

Towards contextualised and pluralistic mental health care

Young people further described effective mental health interventions as those that combines biomedical and culturally embedded healing practices to ensure a holistic management of the condition. The biomedical interventions for mental health containing the provision of psychosocial therapy and free mental health medication were broadly viewed as necessary but insufficient if provided without considering the sociocultural aspects. Participants emphasised the integration of spiritual treatments, involving the provision of spiritual support by religious leaders.

'In relation to depression I think that depressed students or young people should be offered free medication at the pharmacies maybe there is someone is prescribed medication maybe depression has gone out of hand and can't be handled.' (P06, Student, IDI, ZM)

'Some people, their depression is not like physical depression. Maybe it is some spiritual attack. So, I think alongside like the social treatment we shall accompany it with some spiritual treatment that is some serious care for the person. So, that God will intervene for the person to be healed or recovered.' (School Adolescent, Male FGD, GH)

Preference for pluralistic healing models reveals how young people in both countries navigates overlapping and often competing systems of mental health care. This underscores the importance of

embedded interventions that are well adapted to the complex interactions between existing healing systems.

Preferred interventionist

Young people in Zimbabwe and Ghana articulated a preference for pluralistic cadre of mental health interventionists. Four main groups were identified: 1) health professionals (school nurses, psychologist, psychiatrist), 2) teachers, 3) peers and 4) religious leaders (pastors and imams). The choices of pluralistic cadre reflect culturally embedded notions of trust, competence and care. Among these interventionists, school nurses emerged as the most trusted providers and were praised for their professional skills and exceptional relational attributes considering that they were already engaged in counselling roles. School nurses, especially in Ghana, were often described in terms of personality as 'cool', 'kind', 'trustworthy', 'mature', 'incredible', in terms of competency as 'educated', 'knowledgeable', 'confident', 'know what they are doing' and in terms of their availability as 'being free', 'a must-go-to individual' and 'are already doing great job'. These descriptions demonstrate that school nurses' credibility emanated from a combination of emotional resonance, institutional authority and social accessibility. The quote below demonstrates how a young person positioned school nurses as essential cadre for engaging young people with mental health interventions.

'I think the school nurse she is cool; she is free, and she is incredible and the health tutor too, she is also doing a great job so maybe if you're considering bringing personnel to come in or take part in your program then she is one of the people ...'. (R3, School Adolescent, Male FGD, GH)

Young people in both countries identified peers such as prefects, ambassadors and student leaders as crucial agents for mental health support. Described as 'best counsellors ever', 'jovial', 'understanding', 'kind', and 'approachable', peers were reckoned as uniquely positioned to identify early signs of mental distress and provide ongoing psychological monitoring post-intervention. Their embeddedness within youth social networks endowed them with both emotional proximity and relational authority. Teachers, especially providing pastoral duties (e.g. guidance and counselling teachers; house/form master's), were profoundly recommended as trusted interventionists. However, young people emphasised the importance of purposively involving teachers perceived as trustworthy and empathetic. Considering the faith healing ecologies of care prevalent in both contexts, especially in Ghana, young people underscored the role of religious leaders in mental health intervention. Their inclusion was perceived as valuable for addressing certain mental health cases perceived to require spiritual attention, illustrating continued salience of religious interpretations of some mental health conditions.

'... my peers they have the ability ... to counsel and guide peers cause these young people they are part of the environment in which all these situations are going. So, they may even come with solutions of how to deal with these problems.' (P05, Student, IDI, ZM)

'There should be a spiritually matured person in the project so that somebody like that will go through a spiritual process to free the person from that depression.' (R5, School Adolescent, Male FGD, GH)

Preferred qualities of interventionists

Young people in Ghana and Zimbabwe articulated preferred attributes of mental health interventionist and these emerged within four domains: training, gender, attitude, and trust. Clinical training was perceived as essential, with young people expressing preference for interventionist equipped with skills to navigate complexities of adolescent mental health conditions. At the same time, they recognised the significance of capacitating lay providers, indicating their openness to task-shifted approaches which are accompanied by sufficient training. To ensure the responsiveness of interventions to unique needs of young people, gender congruence between interventionist and client emerged as a critical consideration. This was particularly important for girls in both countries who expressed preference for female interventionist with the ability of dealing with gender specific experiences of vulnerability and stigma. This reflects the moral and social sensitivities surrounding adolescent mental health care in context of amplified gendered power relationships.

'I think we need a large number of trained personnel. ... Cause if we have children, children can be deceitful if haven't got training yet.' (P04, Student, IDI, ZM)

'If it is a man, I can't go to him and say things like, if my mensuration is coming, it's always paining me. I can't go to him and be talking about those things, but I can go to the woman and the woman will help me with those kinds of things. ...the counsellor must be a woman.' (R7. School Adolescent, Female FGD, GH)

Young people emphasised the importance of relational qualities in mental health care, valuing interventionists who are friendly, approachable, patient and open to discuss a broad range of young people concerns. Empathy and non-judgemental attitude towards young people were critical for ensuring comfort during talk therapies. The moral duty of maintaining privacy particularly for stigmatising issues – such as poverty, sexual violence, teenage pregnancy and relationship problems – underscored their demand for respecting and maintain confidentiality. Interestingly, there was notable distrust of digital interventions ability to maintain privacy and discretions, reflecting broader ambivalence about virtual nature of online mental health care.

'... also ... get ... guidance and counselling ambassadors among the students. ... they should be trained or given some form of training so that if they could at least identify some depressed people in the school then ... encourage them ... to go for counselling' (School Adolescent, Male FGD, GH)

Additionally, young people expressed preference for youth-friendly interventions that aligned with their contextual needs and aspirations.

'I think that with the confidentiality and privacy; you can get it from most of the councillors So, like you can be assured of that but the place where you should go to for the counselling maybe there can be an improvement or maybe just a block for us to going for the counselling will do a good job.' (School Adolescent, Male FGD, GH)

Service delivery preferences: Spatial and social dimensions

Young people expressed clear preferences regarding the location and mode of mental health intervention.

Preferred place of service delivery

Three options emerged as model of service delivery across both contexts namely school-based, community-based and facility-based. The spatial positioning of services demonstrates strong preference for school-based interventions. This illustrates the value that young people placed on convenience and familiarity of mental health services. Facility-based intervention was often conceptualised as secondary or referral service delivery points, primarily for cases requiring specialized care. This stratified service delivery model reflects considerations given to logistical concerns but also the broader interpretation of care seeking in young people and institution management of complex cases. Schools were viewed as important not merely because of convenience, but also for their capacity for relational continuity, reduced stigma and attrition within the mental healthcare cascades. The perceived distance of facility-based services was perceived to be associated with potential access barriers to health seeking including disengagement and hesitancy.

'I think it should be in the school because if it outside, we will find challenges going there. Sometimes you might not even be granted the permission to go, other times you may not have money transportation to get there.' (R2, School Adolescent, Female FGD, GH)

Young people emphasised the importance of relational qualities in mental health care, valuing interventionists who are friendly, approachable, patient and open.

'I am a scholar so I think that it must be implemented in schools but not knowing whether some older women will be able to gain access into school. So, it should then also be implemented in health centres and schools.' (P11, Adolescent with mental health history, IDI, ZM)

Within school premises, young people favoured sessions to take place in private and familiar places such as counsellor's/teacher's offices, school clinics, and infirmaries. Adolescents with lived experience of depression emphasised the importance of privacy and emotional safety during sessions, highlighting the value of environments in shaping therapeutic engagement. Crucially, participants valued the need for well-defined referral pathways for school-based mental health interventions to prevent loss to follow-up and ensure continuity of care.

'... inside the school, in a room at a hiding place is better. Outside too is good but let's say as we are here right now, after here people will be asking me a lot....' (P73, Adolescent with mental health history, IDI, GH)

'And concerning the referral to a professional, sometimes depression is not just because of one issue. It might be sort of like maybe an illness or a chronic disease or something like that, that is causing it. So, I

think the referral is a wonderful idea.' (R7, School Adolescent, Male FGD, GH)

Access to therapy sessions

Young people in both countries highlighted that the need for more flexible and less cumbersome system for scheduling appointments for talk therapies. They emphasised the importance of minimizing bureaucratic bottlenecks to allow timely access to mental health services. They recommended scheduling in-person sessions at convenient time and locations with preferences for afternoons, evenings, during weekends, or after classes to ensure to avoid interferences with educational commitments. Participants also emphasised implementing a simpler follow-up system for missed appointments.

'...maybe after class around 3:30 pm. We close at three o'clock, So maybe around 3:30 to maybe 4:00 or 5:00, would be the best time. Because during the day we will be having classes or if it's the weekend then any time will be okay.' (P50, Adolescent with mental health history, IDI, GH)

Mode of service delivery

Young people in both Zimbabwe and Ghana expressed a strong preference for one-on-one sessions over group sessions for privacy reasons and to enhance attentiveness. One-on-one sessions were valued for their ability to foster privacy, ensure open discussions, and tailor session content to unique needs of the client. Group sessions were often perceived as compromising confidentiality and increasing the risk of stigma, while also posing challenges for young people less comfortable in expressing themselves in collective context.

'There are a lot of people who need this help. So maybe a group would do, but it would also be nice if people individual problems are known because challenges are unique to individuals. If these services were to be given as a group, you then wouldn't know if the advice is applicable to all the unique challenges that each individual is experiencing.' (P12, Adolescent with mental health history, IDI, ZM)

'I think meeting the counsellor one-on-one is better than you going in a group to go and meet him because some people are shy to express their views when they're many. So, you go in person to meet the counsellor will give you the chance or the confidence in order to express yourself in a good position in which the counsellor can help you.' (School Adolescent, Male FGD, GH)

In terms of delivery formats, there was overwhelming preference for in-person interactions. Participants associated face-to-face sessions with trustworthiness, professionalism, and greater feeling of therapeutic commitment. Concerns about online sessions included limited access to online technologies, lack of privacy and the risk for data breaches and cyberbullying. Many participants question the effectiveness of online sessions in addressing serious mental health concerns, especially in settings where digital literacy and access to digital devices is limited.

... not everyone is financially capable of conducting an online lesson, not everybody is internet illiterate. So not everybody knows how to get the access to online platforms (P4, School Adolescent, IDI, ZM)

'I think using the Internet is not all that private because now technology is advancing, we have more hackers in the system. So, let's say you using the Internet, it can end up leaking and people will get to know what you were talking and communicating with the counsellor. So, I think the Internet will not be that effective.' (R1, School Adolescent, Male FGD, GH)

Nonetheless, some young people acknowledged that online interventions could address access barriers and reduce self-stigma. Online interventions were further deemed as useful emergency alternatives, especially in moments of acute distress or where in-person access is not feasible. However, these benefits were framed as conditional, with clear emphasis on superiority of in person engagement for sustained and meaningful mental health support.

'I believe that the online one should be used only where meeting the counsellor face to face would be like difficult or almost impossible or maybe it should be used as a kind of first aid. So, in a sense that if the depression just sets in and going to the counsellor at that moment will not be feasible, you can now just log online and still talk to him....' (R7, School Adolescent, Male FGD, GH)

'I think sitting face-to-face and talking to one another is better than online. This is because online you are not able to see the person's face. So, you wouldn't know whether he/she is serious or not. but when you are sitting in front of the counsellor and watching his/ her face you would know that he/she is serious. The person wants your betterment that is why he/she is talking that way.' (P72, Adolescent with mental health history, IDI, GH)

Discussion

This study represents the first multi-country exploration of young people's preferences for mental health services in Zimbabwe and Ghana. Conducted within the broader research landscape of rejuvenated interest for youth mental health, this work contributes to critical debates on the localization of mental health services in persistently underserved settings - even in high income countries [17]. Our inquiry into young people's preferences must be situated within the epidemiological contexts of sub-Saharan Africa, where the burden of undiagnosed and untreated mental health conditions is both profound and under-acknowledged [18]. The findings underscore a compelling theme about the importance of localised and youth-friendly mental health interventions, which were viewed in both countries as acceptable, accessible, and amenable to the specific needs of young people. Places where young people are usually found such as schools were viewed not simply educational institutions, but as safe environments enabling young people to engage in mental health services. Across the countries, young people articulated a strong preference for private, in person interactions with trusted service providers. Importantly, they recognised the critical need for effective referral mechanisms - demonstrating a nuanced awareness of health systems barriers and the importance of continuity of care across institutional cascade. These findings align with existing scholarship that emphasises the importance of linkages between community healthcare and primary health facility for sustaining health care access [19, 20].

While the efficacy and acceptability of mental health interventions targeting young people provided in schools have been documented in several sub-Saharan African countries [21–23], many of such studies have not sufficiently explored the granular preferences for an ideal intervention for young people. This research offers insights into the specific attributes young people associate with ideal mental health intervention. These include the preference for incentives, effective publicity, and thematic alignment with real-world psychosocial challenges that young people's experience. Young people were especially receptive to interventions incorporating elements of psychoeducation, cognitive and behavioural skills, and activities that fosters peer social networks and help seeking behaviour, reflecting findings from elsewhere [24, 25].

A particularly salient and unanticipated finding was the value young people placed on spiritual elements within mental health care. While translation of this suggestion or integrating it within biomedical therapies may be problematic, the finding speaks to a wider sociocultural ontology of health and illness within African contexts – where spiritual, ancestral, and religious domains are integral to the understanding of health and wellbeing. Recent reviews echo this call for culturally sensitive mental health interventions for young people in Sub-Saharan Africa [26, 27]. Similarly, a scoping review across six African countries identified alternative and complementary treatments as points of friction between traditional and biomedical healing systems by children and adolescents [28]. Thus, the findings of this study support a pluralistic approach – advocating for mental health interventions that are not only scientifically sound but also culturally in alignment with local values, cultural practices and religious culture.

The role of mental health literacy emerged as another key component of effective service delivery. Participants consistently linked limited awareness and knowledge of mental health conditions to low service uptake – an issue widely acknowledged in the literature [28, 19, 29].

Privacy and confidentiality were dominant themes throughout our study as young people in both countries expressed profound unease with mental health interventions that failed to safeguard privacy, which is consistent earlier research [29, 30]. They emphasized preference for one-on-one sessions and in person delivery engagement with health providers, citing fears around stigma and exposure of private information when group or digital approaches are used. These findings suggest the need for an intervention design approach that is informed by contextual factors and lived experiences of young people to ensure that young people's concerns are fully accommodated.

Gender dimension also surfaced as an important determinant in mental health service delivery. Participants, especially females, articulated that some mental health challenges were more effectively communicated to interventionists of the same gender – implying a need for gender sensitive matching between young clients and providers. This is reflective of broader debates on the gendered nature of emotional expressions and mental health care in diverse sociocultural contexts within sub-Saharan Africa.

Finally, the preference for school nurses and peers as service providers highlights the importance of relational trust and embeddedness in intervention delivery. Youth emphasised that any involvement of

teachers must be contingent on pre-existing trust relationship with students. Echoing a study from South Africa, young people preferred lay mental health providers within a primary health care setting, pointing towards the viability of task-shifting models in contexts with limited mental health human resources [31]. Such findings align with calls to strengthen the capacity of non-specialist providers to effectively recognize, diagnose, and manage young people [19].

Study limitations

There were several methodological limitations to this analysis. There were more data from Ghana than Zimbabwe and this may have a bearing on our findings. The age group of young people included in the study were different between Ghana (16–19 years) and Zimbabwe (16–24 years). Furthermore, young people included in the Ghana study were identified in schools while those in Zimbabwe were included because of their involvement in the Friendship Bench intervention. Despite these limitations, the findings of the current study were triangulated between the two countries and are consistent with findings that have been reported elsewhere.

Conclusions

In sum, this study contributes to the emerging discourses and empirical evidence on preferences of young people for mental health interventions in sub-Saharan Africa context, offering a nuanced understanding of how social context, cultural norms and lived experiences shape young people's preference for mental health interventions. The paper calls for locally anchored, youth informed, and culturally integrative approach to designing and implementing mental health services for young people. These findings were important for informing the design of a mental health intervention in Ghana and Zimbabwe within the Y-Mind consortium. Findings have potential implications for global efforts for implementing evidence-based adolescent-specific interventions to effectively meet the mental health needs of young people.

Declarations

Authors' Contributions

MKK, RJ, DC, BW, and MA contributed to the study conception and design. Material preparation, data collection, and analysis were performed by MKK, RJ, RHM, TB, SD, FG, KA, PM, TTK, ED, RA, PN, MA, and DG. The first draft of the manuscript was written by MKK, and all authors commented on previous versions of the manuscript. DC, MA and BW supervised the project and provided critical revisions. All authors read and approved the final manuscript.

Competing Interests (Conflict of Interest)

I declare that the authors have no competing interests as defined by Discover, or other interests that might be perceived to influence the results and/or discussion reported in this paper.

Authorship

I confirm the corresponding author has read the journal policies and submit this manuscript in accordance with those policies.

Ethics Approval

Ethical approvals were obtained from the Medical Research Council of Zimbabwe (Ref: MRCZ/A/2465); Navrongo Health Research Centre Institutional Review Board (Ethics Approval ID: NHRCIRB480), Ghana Health Service Ethics Review Committee (GHS-ERC Number: GHS-ERC:026/07/22) and the Kings College London Research Ethics (Ref: HR/DP-21/22-32917).

Consent to Participate

A freely-given, informed consent to participate in the study was obtained from all participants (or their parent or legal guardian in the case of children under 18). All procedures involving human participants were conducted in accordance with relevant institutional and national ethical guidelines and regulations, including the principles outlined in the Declaration of Helsinki.

Consent for Publication

A freely-given, informed consent to (Consent to Participant and Publish) were obtained from all participants (or their parent or legal guardian in the case of participants under 18). All participants were informed that findings would be published in aggregate form.

Funding

This research was funded by the National Institute for Health and Care Research (NIHR133384). The funders had no role in the study design, data collection and analysis, decision to publish, or preparation of the manuscript.

Data Availability

The datasets generated during and/or analysed during the current study are not publicly available because participant consent/assent were not obtained for data sharing beyond the study team, but are available from the corresponding author or the Institute of Psychiatry, Psychology & Neuroscience at King's College London on reasonable request. Data access requests should be directed to research.data@kcl.ac.uk.

Clinical trial number: not applicable.

References

1. WHO. Mental health of children and young people Service guidance [Internet]. Geneva. 2004 [cited 2024 Dec 2]. Available from: <https://www.who.int/health-topics/mental-health>
2. Gu D, Andreev K, Dupre ME. Major Trends in Population Growth Around the World. *China CDC Wkly*. 2019;3(28):604–13.
3. Too EK, Abubakar A, Nasambu C, Koot HM, Cuijpers P, Newton CR et al. Prevalence and factors associated with common mental disorders in young people living with HIV in sub-Saharan Africa: a systematic review. *J Int AIDS Soc* [Internet]. 2021;24(e25705):58–76. Available from: <http://onlinelibrary.wiley.com/doi/10.1002/jia2.25705/full>
4. Berhane Y, Canavan CR, Darling AM, Sudfeld CR, Vuai S, Adanu R, et al. The age of opportunity: prevalence of key risk factors among adolescents 10–19 years of age in nine communities in sub-Saharan Africa. *Trop Med Int Health*. 2020;25(1):15–32.
5. Silva SA, Silva SU, Ronca DB, Gonçalves VSS, Dutra ES, Carvalho KMB. Common mental disorders prevalence in adolescents: A systematic review and metaanalyses. *PLoS ONE*. 2020;15(4).
6. Nyongesa MK, Mwangi P, Kinuthia M, Hassan AS, Koot HM, Cuijpers P et al. Prevalence, risk and protective indicators of common mental disorders among young people living with HIV compared to their uninfected peers from the Kenyan coast: a cross-sectional study. *BMC Psychiatry*. 2021;21(1).
7. Simms V, Bernays S, Chibanda D, Chinoda S, Mutsinze A, Beji-Chauke R et al. Risk factors for HIV virological non-suppression among adolescents with common mental disorder symptoms in Zimbabwe: a cross-sectional study. *J Int AIDS Soc* [Internet]. 2021;24(e25773):1–11. Available from: <http://onlinelibrary.wiley.com/doi/10.1002/jia2.25773/full>
8. Obeng-Onkon NAS, Opoku DA, Ayisi-Boateng NK, Osarfo J, Amponsah OKO, Ashilevi J et al. Prevalence and correlates of depression among students in a senior high school in Ghana: A school-based cross-sectional study. *SAGE Open Med*. 2024;12.
9. The Lancet Child & Adolescent Health. Universal health coverage and the forgotten generation. *The Lancet Child and Adolescent Health*. Volume 3. Elsevier B.V.; 2019. p. 749.
10. Radez J, Reardon T, Creswell C, Lawrence PJ, Evdoka-Burton G, Waite P. Why do children and adolescents (not) seek and access professional help for their mental health problems? A systematic review of quantitative and qualitative studies. *European Child and Adolescent Psychiatry*. Volume 30. Springer Science and Business Media Deutschland GmbH; 2021. pp. 183–211.
11. Mabrouk A, Mbithi G, Chongwo E, Too E, Sarki A, Namuguzi M, et al. Mental health interventions for adolescents in sub-Saharan Africa: A scoping review. *Front Psychiatry*. 2022;13(937723):1–13.
12. Garcia-Carrion R, Villarejo BC, Villardón-Gallego L. Children and adolescents mental health: A systematic review of interaction-based interventions in schools and communities. *Frontiers in Psychology*. Volume 10. Frontiers Media S.A.; 2019.
13. Barry MM, Clarke AM, Jenkins R, Patel V. A systematic review of the effectiveness of mental health promotion interventions for young people in low and middle income countries. *BMC Public Health*. 2013;13(1).

14. Breimaier HE, Heckemann B, Halfens RJG, Lohrmann C. The Consolidated Framework for Implementation Research (CFIR): A useful theoretical framework for guiding and evaluating a guideline implementation process in a hospital-based nursing practice. *BMC Nurs.* 2015;14(1).
15. Saunders B, Sim J, Kingstone T, Baker S, Waterfield J, Bartlam B, et al. Saturation in qualitative research: exploring its conceptualization and operationalization. *Qual Quant.* 2018;52(4):1893–907.
16. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care* [Internet]. 2007;19(6):349–57. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/17872937>
17. Duong MT, Bruns EJ, Lee K, Cox S, Coifman J, Mayworm A, et al. Rates of Mental Health Service Utilization by Children and Adolescents in Schools and Other Common Service Settings: A Systematic Review and Meta-Analysis. *Adm Policy Mental Health Mental Health Serv Res.* 2021;48(3):420–39.
18. Jorns-Presentati A, Napp AK, Dessauvagie AS, Stein DJ, Jonker D, Breet E et al. The prevalence of mental health problems in sub-Saharan adolescents: A systematic review. *PLoS ONE.* 2021;16(5 May).
19. Kutcher S, Perkins K, Gilberds H, Udedi M, Ubuguyu O, Njau T et al. Creating Evidence-Based Youth Mental Health Policy in Sub-Saharan Africa: A Description of the Integrated Approach to Addressing the Issue of Youth Depression in Malawi and Tanzania. *Front Psychiatry.* 2019;10.
20. MacDonald K, Ferrari M, Fainman-Adelman N, Iyer SN. Experiences of pathways to mental health services for young people and their carers: a qualitative meta-synthesis review. *Social Psychiatry and Psychiatric Epidemiology.* Volume 56. Springer Science and Business Media Deutschland GmbH; 2021. pp. 339–61.
21. Tareke M, Yirdaw BA, Gebeyehu A, Gelaye B, Azale T. Effectiveness of school-based psychological interventions for the treatment of depression, anxiety and post-traumatic stress disorder among adolescents in sub-Saharan Africa: A systematic review of randomized controlled trials. *PLoS ONE.* 2023;18(11 November).
22. Coetzee BJ, Gericke H, Human S, Stallard P, Loades M. What should a Universal School-Based Psychoeducational Programme to Support Psychological Well-Being amongst Children and Young People in South Africa Focus on and how should it be Delivered? A Multi-Stakeholder Perspective. *School Ment Health.* 2022;14(1):189–200.
23. Coetzee B, Loades M, Human S, Gericke H, Laning G, Kidd M, et al. Four Steps To My Future (4STMF): acceptability, feasibility and exploratory outcomes of a universal school-based mental health and well-being programme, delivered to young adolescents in South Africa. *Child Adolesc Ment Health.* 2024;29(1):22–32.
24. Gimba SM, Harris P, Saito A, Udah H, Martin A, Wheeler AJ. The modules of mental health programs implemented in schools in low- and middle-income countries: findings from a systematic literature review. *BMC Public Health.* 2020;20(1).

25. Bradshaw M, Gericke H, Coetzee BJ, Stallard P, Human S, Loades M. Universal school-based mental health programmes in low- and middle-income countries: A systematic review and narrative synthesis. Volume 143. Preventive Medicine: Academic Press Inc.; 2021.
26. Seekles M, Twagira F, Alam A, Obasi A. Promotive and preventive interventions for adolescent mental health in Sub-Saharan Africa: a combined scoping and systematic review. *BMJ Public Health*. 2023;1(1):e000037.
27. Aggarwal S, Wright J, Morgan A, Patton G, Reavley N. Religiosity and spirituality in the prevention and management of depression and anxiety in young people: a systematic review and meta-analysis. *BMC Psychiatry*. 2023;23(1).
28. Saade S, Lamarche AP, Khalaf T, Makke S, Legg A. What barriers could impede access to mental health services for children and adolescents in Africa? A scoping review. *BMC Health Serv Res*. 2023;23(1).
29. Gulliver A, Griffiths KM, Christensen H. Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry*. 2010;10.
30. Field S, Abrahams Z, Honikman S. Adolescent mothers: A qualitative study on barriers and facilitators to mental health in a low-resource setting in Cape Town, South Africa. *Afr J Prim Health Care Fam Med [Internet]*. 2020;12(1):1–9. Available from: <http://www.phcfm.org>
31. Myers B, Joska JA, Lund C, Levitt NS, Butler CC, Naledi T, et al. Patient preferences for the integration of mental health counseling and chronic disease care in South Africa. *Patient Prefer Adherence*. 2018;12:1797–803.

Table

Table 1 Socio-demographic profile of participants

Data collection approach	Study participants	Zimbabwe			Ghana			Total
		N	Gender		N	Gender		
			F	M		F	M	
FGD	Young People naïve of mental health services	10	5	5	33	17	16	43
SII	Young People exposed to mental health services	15	7	8	7	5	2	22
	Young people’s caregivers/guardians	10	9	1	4	3	1	14
	Total	35	21	14	44	25	19	79

Figures

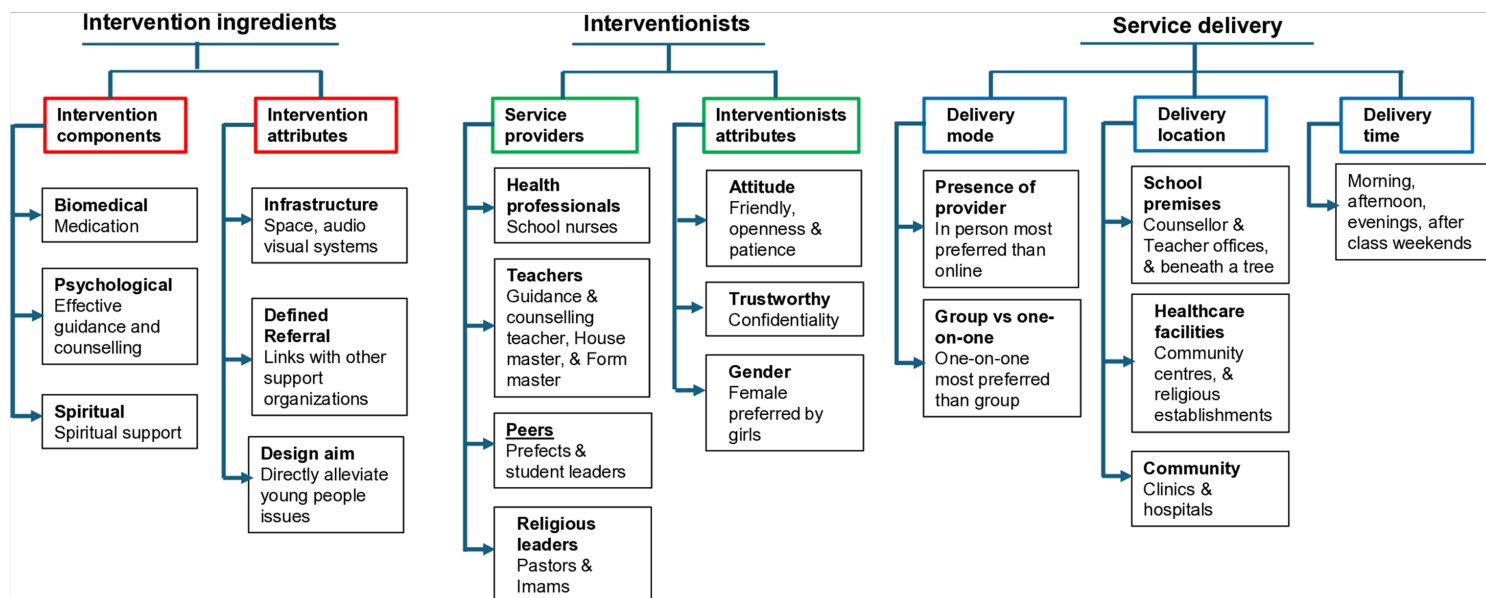


Figure 1

Young people's preferences for a mental health intervention