Technical Note

Gender in Adolescent Mental Health

UNICEF's Gender Action Plan 2018-2021[1] is our road map to ensuring that all children enjoy equal rights, resources, opportunities, and protections. One of the key results expected from this plan is gender-responsive adolescent health with a vision of being gender transformative.

> "UNICEF should be implementing programmes where the effects of gender norms, roles, and inequalities have been examined and measures have been taken to actively address the differentiated needs of all children, regardless of their gender."

This means that UNICEF should be implementing programmes where the effects of gender norms, roles, and inequalities have been examined and measures have been taken to actively address the differentiated needs of all children, regardless of their gender. Ultimately, UNICEF aspires to address underlying power and structural inequalities and eliminate all forms of discrimination to achieve equal outcomes for all children.[2] Building on an earlier White Paper,[3] this technical note is designed to provide information on the relationship between gender and adolescent mental health and how to implement gender-responsive and gender-transformative adolescent-focused mental health and psychosocial programmes.

What is mental health?

According to the WHO, someone has good mental health when they can:

- → **Realize their abilities**
- → **Cope with the normal stresses of life**
- → **Work productively and contribute to their community**

Mental health disorders include a broad range of mental health problems with different symptoms. They are generally characterized by a combination of difficulties with one's thoughts, emotions, behaviours, relationships with others, and capacity to do daily activities.

Mental health and well-being in adolescence

Adolescence (10-19 years) is a critical opportunity for establishing healthy behaviour patterns and social and emotional learning that can increase trajectories of positive growth and lifelong health.[4] During the second decade of life, individuals develop knowledge and social-emotional skills and acquire attributes and abilities that are important for assuming adult roles and actively contributing to society. At the same time, during this transition to adulthood, adolescents also experience major physical, social, and psychological changes. These changes can heighten their risk for developing mental health disorders, such as anxiety and depression, and trigger engagement in health related risk behaviours. Socioeconomic factors, such as poverty, trauma, abuse, and stressful life events, have the greatest effects on mental health and psychosocial well-being.[5] Such life stressors have traditionally included poor living conditions, substance use, gender-based violence, early pregnancy and parenting, and bullying. These threats are often compounded by poor social support or neglect.[6] Without sufficient emotional and economic support, adolescents may be overwhelmed with feelings of helplessness, insecurity, and stress,[7] increasing their risk of developing mental health disorders.[8] This became particularly apparent during the COVID-19 crisis when economic hardship, school closures, gender-based violence, disruption of sexual and reproductive health services, and unpaid care all took a great toll on women and girls, increasing the need for psychosocial support.[9]

Mental health and psychosocial well-being are central to the universal right to the enjoyment of 'the highest attainable standard of health'.[10] However, in 2018 only 35 per cent of the countries in the world had national child/adolescent mental health policies,[11] and evidence suggests that most adolescents and young adults with mental health disorders do not receive care and treatment from health and other professionals.[12]

Two of the 169 established targets for achieving the United Nations Sustainable Development goals specifically mention mental health. Target 3.4: By 2030, reduce by one-third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being. Target 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.[13]

UNICEF has a role to play in achieving these targets.

35%

In 2018 only 35 per cent of the countries in the world had national child/adolescent mental health policies.

Gender differences in prevalence and onset of mental disorders during adolescence

Data are scarce, but it is estimated that one in five adolescents experiences effects of mental disorders,[14] with anxiety and depression being the most common. Globally, girls are more likely than boys to suffer from emotional disorders, such as anxiety and depression, whereas boys suffer more from behavioural disorders, such as attention-deficit hyperactivity disorder (ADHD) and conduct disorder.[15] Prior to puberty, girls and boys experience depression equally, but after puberty girls' risk of depressive disorders increases drastically, and there is a significant gender gap in the prevalence of depressive disorders. Girls are between one-and-a-half and two times more likely than boys to be diagnosed with depression, both during adolescence and throughout their lives.[16]

It is estimated that one in five adolescents experiences effects of mental disorders, with anxiety and depression being the most common.

Recent research shows that adverse childhood experiences (ACEs) related to childhood maltreatment (physical, sexual, or emotional abuse or physical or emotional neglect) and household dysfunction (household substance misuse, domestic violence, intimate partner violence, parental separation or divorce, parental mental health difficulties, or imprisonment), manifest themselves differently in boys and girls. Girls tend to internalize such experiences (resulting in depressive disorder), whereas boys tend to externalize these events, resulting in poorer behavioural regulation and violence.[17] These differing expressions are likely related to gender norms, which are explained more in detail below.

Research suggests that girls are more likely to attempt suicide, whereas boys – who tend to have more access to lethal methods and are less likely to seek help – are more likely to die from self-harm than girls.[18] Masculine norms that support violence and risk-taking and discourage weakness, expression of emotion, and help-seeking likely contribute to the disproportionate burden of suicide borne by adolescent boys.[19] Self-harm is the number one cause of death among boys 10-19 in industrialized countries, but in sub-Saharan Africa, East Asia, and the Pacific it is not in the top five causes of death for this group. While deaths from self-harm are not as prevalent in girls as boys globally, exceptions can be found in some South Asian countries, such as India, Pakistan, and Bangladesh, where more girls than boys die by self-harm. The latter may reflect high levels of gender inequality and gender-based violence in the subregion.[20]

Biological differences and adolescents' mental health

Early adolescence is a period of surging hormonal changes. Levels of testosterone rise in boys, while girls experience increases in estradiol. This process, known as 'gondarche', usually occurs in girls between 9-10 years of age and in boys between 11-12 years of age.[21] There is some evidence that these puberty-related changes could have different effects on boys and girls, increasing girls' risk of anxiety while possibly protecting boys. Testosterone surging in boys is associated with increased social aggression and risk-taking, which may result in positive (increased rewards) or negative outcomes depending on the level of threat involved (i.e., bullying).[22] Estradiol surges in girls also relate to increased risk-taking, but changes in estradiol levels during girls' menstrual cycles could also increase anxiety symptoms in girls who are sensitive to hormonal fluctuations.[23] Menstrual problems, including dysmenorrhea (menstruation-related pain), have been linked to increased levels of anxiety and depression in adolescent girls.[24]

Studies in adults have indicated that there are important differences between men and women that should be considered during treatment of mental disorders, such as hormonal fluctuations during menstrual cycles when treating depression.[25] However, overall there is a stunning lack of research of the effects of gender on treatment of mental disorders, which has resulted in a lack of gender-sensitive treatments in practice.[26]

Gender norms and adolescents' mental health

It is impossible to talk about differences in mental health causes and outcomes between boys, girls, and adolescents with diverse SOGIESC (umbrella term for all people whose sexual orientations, gender identities, gender expressions and/or sex characteristics place them outside culturally mainstream categories)[27] without considering social and gender norms. Social norms can be defined as *informal rules about how people should act*. A common social norm is that adolescents should refrain from sexual activity until they are married. Gender norms are a subset of social norms, meaning that they are *informal rules and shared social expectations that distinguish expected behaviour on the basis of gender*[28]. For example, the gender norm that boys and men should not show emotion or seek help results in their being less likely than girls to seek care for mental health issues, such as depression or feelings of low self-worth.[29] Girls, on the other hand, are often expected to care for others and to engage in close relationships, which makes them more sensitive to interpersonal and psychosocial stress.[30] Below we show how gender norms are an important systemic determinant of adolescent exposure to situations or behaviours that can contribute to mental ill-health, and also how societal expectations based on gender can determine how adolescents are diagnosed and treated, both clinically and within the wider social services and justice sectors.

There is some evidence that gender roles become more rigid during adolescence and that discrimination based on gender increases in this period of life.[31] Strict expectations based on gender, including ideals of masculinity and femininity,[32] affect both girls and boys and can profoundly affect their development. For example, adolescent boys are prone to substance use disorders, likely due to in part to masculine norms that encourage peer pressure and risk-taking (such as binge drinking), whereas feminine norms in most cultures often discourage drinking and loss of 'control' among girls. Girls may also be somewhat protected from mental health problems due to their greater likelihood to express their feelings and seek help.[33] However, girls are disproportionately disadvantaged by common norms of femininity, such as service to family, maintaining family honour, and deference to male relations and in-laws.[34]

Girls are also indirectly affected by boys' and men's mental ill-health and substance use, which can manifest through acts of violence towards girls and women. Stressful life events that disproportionately affect agency and choice among girls, such as child marriage and early and unintended childbearing – which are often underpinned by gender norms – are likely drivers of depression and anxiety in adolescent girls. This is especially the case in low- to middle-income countries (LMICs), where child marriage and early childbearing are most prevalent.[35]

Young people of a different sexual orientation or gender identity than local social norms or laws prescribe are particularly at risk of depression and suicidal thoughts and behaviours.[36] According to WHO, people who identify as gay, lesbian, bisexual, transgender, or intersex are among subgroups who may experience 'loss of freedom, rejection, stigmatization, and violence that may evoke severe distress and suicidal behaviour'.[37] The health-care system too often perpetuates such discrimination and stigmatization through assigning outdated medical classifications that pathologize LGBTIQ+ and adolescents with diverse SOGIESC – i.e., label them as ill, disordered, malformed, or abnormal on the basis of their sexual orientation, gender identity/expression, or sex characteristics.[38]

Finally, gender discrimination may be compounded by additional forms of discrimination, such as racial or ethnic discrimination, discrimination based on disabilities, and discrimination against adolescents on the move, which could potentially augment mental ill-health in adolescents.

SOGIESC is the umbrella term for all people whose sexual orientations, gender identities, gender expressions and/or sex characteristics place them outside culturally mainstream categories.

Social norms can be defined as informal rules about how people should act.

Gender norms are a subset of social norms, meaning that they are informal rules and shared social expectations that distinguish expected behaviour on the basis of gender.

Systemic gender bias and adolescents' mental health

Psychiatric diagnoses could be affected by gender biases in providers or standardized diagnosis criteria. For example, in the United States, boys are three times more likely to be diagnosed with ADHD than girls, not necessarily because they are more susceptible to it, but because their symptoms are more external and disruptive. Girls with ADHD tend to internalize their symptoms, making them harder to detect.[39,40] This results in girls being less likely to access therapies, including treatment, and leads to greater depression and anxiety in this population. Men, on the other hand, are less likely to be treated for anxiety with psychotropic medicines than women, despite this regimen's proven efficacy.[41] More research is needed on the role of provider bias and different presentations and manifestations of mental disorders based on gender. These differing manifestations of mental disorders based on gender also likely play a role in the way that youth with mental health disorders are treated by the justice system. The WHO policy brief, 'Health concerns among children deprived of liberty', states that moving from institutional care and justice-related detention to community-based programmes is critical for children's health.[42] However, young men with a mental health disorder or issues with substance use are more likely to be incarcerated in the criminal justice system than young women, even though 'secure' settings are less likely to reduce recidivism and may even increase mental health problems compared to community-based treatment programmes.[43]

Adolescent pregnancy and mental health

Every year, 21 million girls aged 15-19 years in LMICs become pregnant, and 12 million of them give birth.[44] At least 16 per cent of women in low- and middle-income countries experience prenatal mental disorders and 20 per cent experience postnatal mental disorders, with greater risk associated with, among others, being younger or unmarried, having an early pregnancy, and being socioeconomically disadvantaged.[45] While the causal pathway between these social and structural determinants and maternal mental disorders is not clear, the relationship is not surprising.[46] Adolescent girls living in morally repressive societies who become pregnant outside of marriage suffer stigma, social exclusion, economic deprivation, and poorer access to care compared to adult women. In societies where access to sexuality education, contraception, and safe abortion is limited, girls who become pregnant outside of wedlock may believe that self-harm or suicide are their only alternatives to bearing a child.[47] A child who bears a child is woefully unprepared for the severe distress she may experience during childbirth and the responsibility of caring for a newborn infant, especially if she lacks a support network.


© UNICEF/Arcos

> "In societies where access to sexuality education, contraception, and safe abortion is limited, girls who become pregnant outside of wedlock may believe that self-harm or suicide are their only alternatives to bearing a child."

Pregnancy in adolescence also interrupts socio-emotional learning and other important biological and psychological changes during adolescence. For example, the disruption of normal adolescent development can influence the development of emotional and cognitive capabilities necessary for maternal behaviours that foster mother-child attachment.[48] This means that the cycle of mental health problems could be perpetuated across generations. Children of depressed mothers are also more likely to suffer from neglect and to be stunted or underweight.[49] Adolescent girls who become pregnant are often forced to leave school, affecting their learning and earnings for the rest of their lives. In humanitarian and fragile settings, pregnant and parenting adolescent girls may already be caring for younger siblings, adding enormous burdens and a lack of opportunity that will follow a girl throughout her life.

Gender-transformative MHPSS programming, advocacy, and policies

The General Comment 20 on the implementation of the Convention on the Rights of the Child During Adolescence exhorts states to implement laws and policies that challenge harmful gender norms.[50] UNICEF programming, advocacy, and policy efforts should strive to be gender responsive and preferably gender transformative.

> "The General Comment 20 on the implementation of the Convention on the Rights of the Child During Adolescence exhorts states to implement laws and policies that challenge harmful gender norms."

That is, we should address the root causes of gender inequality, moving beyond models of self-improvement to redressing power dynamics and structures that reinforce gender inequality.[51] At the very least, UNICEF programming should not reinforce gender discriminatory stereotypes or harmful gender norms that perpetuate ill-health and inequality.

The gender continuum consists of five steps (*see Figure 1*), from gender discriminatory to gender blind to gender aware and finally to gender responsive and gender transformative. Below we define each of these steps and clarify with concrete examples from mental health and psychosocial support (MHPSS).

Figure 1
Examples of MHPSS programming along the gender continuum[47]

Gender discriminatory	Gender blind	Gender aware	Gender responsive	Gender transformative
Favours either boys/men or women/girls, deepening gender inequalities	Ignores gender in programme design, perpetuating the status quo or worsening gender inequalities	Acknowledges but does not robustly address gender inequalities	Identifies and addresses the different needs of girls, boys, women, men, and nonbinary populations to promote equal outcomes	Explicitly seeks to redress gender inequalities and empower the disadvantaged population; requires structural change
Examples				
Programmes or messaging that perpetuate gender norms, i.e., that boys should look tough and girls should only look happy and submissive	Programmes that do not address the specific MHPSS needs of adolescents with diverse SOGIESC MHPSS programmes that do not address behaviours or life events that affect one gender more than others, i.e., alcohol abuse for boys and early pregnancy for girls, or stigma and violence for transgender persons Diagnosis criteria and treatment regimens that do not recognize differing manifestations of mental disorders or treatment needs in boys and girls	MHPSS programmes that address girls' and boys' different lived realities, but do not take a multisectoral and a socio-ecological approach,[52] meaning that an adolescent girl can participate in social-emotional development programmes, but she cannot access contraception when she is sexually active, increasing her likelihood of becoming pregnant and dropping out of school	Targeted messaging strategies for boys and girls to counteract self-harm and suicidality connected to multisectoral programs that address other well-being needs Screening for maternal depression in girls that is developed in conjunction with pregnant and parenting adolescent girls Policies that allow pregnant and parenting adolescent girls to attend school	Programmes that challenge harmful 'masculine' norms that exacerbate mental ill-health, such as dominance, aggressiveness, and risk-taking Training for health-care providers, teachers, and social workers on gender-transformative MHPSS, including recognizing their own biases Convergent, multisectoral social protection programmes (aimed at shifting gender norms) that promote girls' school attendance and complementary programmes, such as life skills and asset-building, including comprehensive sexuality education[53]

GENDER-DISCRIMINATORY

programmes perpetuate negative gender norms, such as using visual communication that only depicts girls as being emotional or boys as being violent and partygoing. Avoiding these stereotypes in communication requires that UNICEF staff and partners become acutely aware of their own gender biases. A checklist for gender responsive communication is provided under Recommendations, below.

GENDER-BLIND

programmes, advocacy, and policies ignore gender differences in their design, such as the needs of special populations like adolescents with diverse SOGIESC, which could be due to stigma or ignorance of the issues facing these populations. Similarly, adolescent health and social protection programmes that do not address harmful models of masculinity ignore the pressures that adolescent boys face and that often lead to violence, substance use, and self-harm. At the very least, these programmes will be less successful for not considering gender differences. At worst, they risk perpetuating gender stereotypes that are harmful and may increase mental ill-health in these populations. Gender-blind psychiatric care can miss differing manifestations of mental disorders in boys and girls or offer treatment that does not consider important biological differences, for example due to hormonal fluctuations in girls or transgender adolescents undergoing hormonal therapy.

GENDER-AWARE

approaches refer to programming, advocacy, and policies that recognize gender differences but do not attempt to change them. An example is providing maternal mental health services to pregnant adolescent girls (recognizing their vulnerability and added disease burden) but ignoring the causes of early and unintended pregnancy, such as lack of information and preventive services, gender-based violence, norms of early childbearing, and poverty. The programme is worthwhile; but without complementary programmes to address the underlying causes of early and unintended pregnancy, the cycle of poverty and negative mental and physical ill-health among adolescent girls caused by harmful gender norms will continue.

GENDER-RESPONSIVE

programmes identify the different needs of boys, girls, and adolescents with diverse SOGIESC to address inequality. An example is designing MHPSS programmes that recognize heightened vulnerabilities for drug use and self-harm in boys and depression and anxiety in girls. Another example is ensuring that perinatal mental health services including social support are available to pregnant and parenting adolescents. Gender-responsive programming requires conducting research and gender analyses and disaggregating data by sex and age. Frequently, qualitative data will need to be collected to understand the MHPSS needs and gender norm challenges of different adolescent populations. Engaging adolescents and young people in the research about themselves is necessary to ensure that their lived realities are reflected.

GENDER-TRANSFORMATIVE

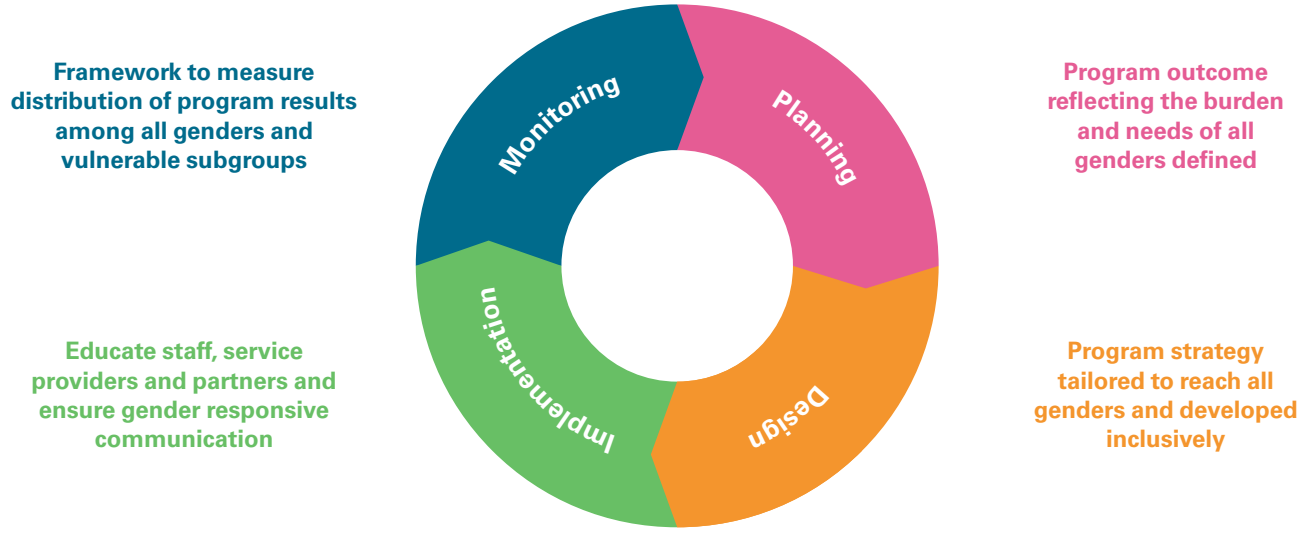
programming seeks to redress gender inequalities and empower discriminated populations. It requires structural change and is therefore a long-term endeavor. Here is a concrete example: A 15-year-old girl becomes pregnant after sexual relations with a teacher who promised her better grades in exchange for sex. Her parents reject her because she has lost her respectability and she can no longer attend school due to her pregnancy. She becomes depressed over her situation and considers suicide. Simply offering the girl counseling will not address the underlying causes of her mental state, which are related to gender norms that value chastity in girls and power structures (teacher-student, parent-child) that perpetuate her situation. The best-case scenario for her would be that she approaches a health-care or social worker about her condition and this person refers her to adolescent-responsive antenatal care, psychosocial counseling and socio-emotional skill-building that will help her to cope with her pregnancy and reduce the risk of post-partum depression or suicide. She is also given support to seek redress from the teacher, and social workers attempt to reunite her with her parents. She is offered post-partum contraceptive counseling, is connected to an early childhood development programme that gives her support in parenting, and is provided with cash transfers that will allow her to go back to school and still support her child. The school uses this example to develop an anti-preying policy with a Code of Discipline that all teachers must sign. A zero-tolerance approach is taken for sex between teachers and students. This example may sound like a dream scenario, but many components of these programmes are already in place in different settings. Rarely are they approached holistically, however. To do so requires putting the adolescent in the centre and working across sectors to address her needs and the root causes of her situation, which in many cases are related to gender norms and structural discrimination.


© UNICEF/Naram

Recommendations

Below are six recommendations to begin your journey of gender transformative adolescent MHPSS programming. (*See Figure 2.*)

Figure 2
Key steps in the programming cycle



Planning

Assess the mental health burden and MHPSS needs of girls, boys, and SOGIESC diverse adolescents and their causes. The UNICEF Adolescent Health Dashboard is a good place to start to look at death and disability data for adolescent girls and boys 10-14 and 15-19 years. Conduct qualitative research with adolescents to uncover the sources of stress and psychosocial burdens for girls, boys, and adolescents with diverse SOGIESC. The Gender Programmatic Review Toolkit can be used to distinguish between immediate, underlying, and structural causes of disparities in MHPSS issues. [54]

Design

Using data collected in the planning phase, design adolescent MHPSS programmes and policies that equally meet the needs of girls, boys, and adolescents with diverse SOGIESC. Gender differences in needs and access to MHPSS programming, many of which are based in gender norms that dictate male and female behaviour, must be addressed from the design stage. For example, if a school-based MHPSS programme is planned for secondary school students, and it is known that fewer girls attend secondary school, then the programme must be complemented to reach girls from this age group. A programme to prevent and respond to violence in boys through the creation of youth centres that does not address harmful models of masculinity will not reach the root causes of violence. Programmes must be tailored to the differing needs and causes of gender disparities if they are to be successful.

Recognizing that gender norms can prevent the participation of adolescents of different genders for different reasons, ensure that girls, boys, and adolescents with diverse SOGIESC are equally represented, heard, and involved during design and engagement initiatives. Make additional efforts to reach out to diverse and underrepresented adolescents, including LGBTIQ+ adolescents and pregnant and parenting adolescents. A number of resources can help: 'Engaged and Heard! Guidelines on Adolescent Participation and Civic Engagement' provides in-depth information on engaging adolescents in programmes; 'Skills4Girls: Girl-Centered Skills Development' provides tools for engaging girls, in particular. 'Innovation and Technology for Gender Equality GenderTech Toolkit: Building digital solutions for, with, and by girls' helps you involve girls in developing digital solutions to ensure their relevance beyond the male population.

Implementation

Educate and train UNICEF staff, partners, and service providers to improve their capacity to implement gender-responsive MHPSS programmes and services for adolescents. Gender norms are ensconced in every level of society, including in UNICEF staff. UNICEF and its partners cannot deliver gender-responsive or -transformative programmes if we ourselves are gender blind.

Ensure that communication materials on adolescent mental health do not perpetuate or exacerbate harmful gender norms or stereotypes. Show girls, boys, women, and men proactively taking care of their mental and emotional well-being, tackling mental health and emotional challenges, and demonstrating mental health–seeking behaviours. 'Gender Responsive Communication for Development', designed by ROSA, can help ensure that communication is gender responsive. 'Gender Responsive Content Creation on COVID-19' provides an example of a checklist for that you can use for other topic areas, as well.

Monitoring

Develop a monitoring framework to measure the distribution of mental health outcomes among all genders and vulnerable subgroups. Collect and disaggregate data on depression, anxiety, suicidality, and functional impairment by sex and age in order to ensure progress towards equitable MHPSS outcomes. Programme and service data should be disaggregated by age (10-14 and 15-19) and sex.

If possible, collect data on nonbinary persons (identify first how they are referred to in your context).[55] The IASC Recommendations for Conducting Ethical Mental Health and Psychosocial Research in Emergency Settings provides more advice on collecting sensitive data on mental health from children and adolescents.

Conclusion

UNICEF and its partners can take key steps to mitigate harmful gender norms around mental health and address gender-specific adolescent mental health risks. More research is also needed to understand gendered protective and risk factors for mental health in adolescents and effective MHPSS approaches to address adolescents' gender-specific MHPSS needs.

MHPSS programming needs to be developed with adolescent involvement, irrespective of the service delivery platform (social sector, schools, or health sector), based on a clear understanding of the gender-related causes of mental ill-health and the barriers to accessing care and support.

We must explore and address the social determinants of ill health, including gender norms and biases, to ensure that all adolescents have access to support and care related to their mental health and psychosocial well-being. This also means that all UNICEF staff and partners need to examine their own stereotypes and biases when developing materials that are gender sensitive and, in the long run, gender transformative.

UNICEF has a mandate and duty to protect the rights of all children. This requires us to consider the needs of children at different ages through a gender lens. Applying such a lens to adolescent mental health and well-being will help to ensure that every child survives and thrives.

Case studies

Conducting a gender and mental health analysis in Mongolia

Mongolia has some of the highest rates of suicide in East Asia and the Pacific, with adolescent boys' rates being three times higher than girls, although girls are more likely to experience anxiety or depression. UNICEF undertook a gender analysis to determine the underlying causes of mental ill-health in Mongolia, and found they were grounded in harmful norms around masculinity and femininity. Some strategies identified for addressing these issues were awareness raising on the effects of gender norms on mental health, information and education on gender norms, gender identity and gendered stereotypes in comprehensive sexuality education curricula and adaptation of a life skills curriculum to be more gender responsive.

Surveying adolescents to identify gendered MHPSS needs during COVID-19

A recent UNICEF paper in Cote D'Ivoire, Ethiopia, and Lebanon revealed the multilayered impact of lockdowns due to COVID-19, poverty, and gender on adolescent psycho-emotional well-being. Sources of stress for adolescent girls included lack of access to menstrual hygiene supplies as family incomes contract, increased time poverty due to unequal household responsibilities, and heightened exposure to sexual- and gender-based violence risks. Adolescent boys, on the other hand, were found to be at greater risk of exploitative forms of labour and sometimes early marriage. The paper also revealed common coping strategies (e.g., relying on faith, volunteering, and escapism) and divergent strategies employed by adolescent girls (e.g., taking up new hobbies) and boys (e.g., playing online games, substance abuse). The authors recommend school-based psychosocial support (when schools reopen); social protection services, including cash transfers for the most vulnerable; community-based programmes to address sexual- and gender-based violence, including child marriage; and virtual platforms to provide preventive and promotive services.[56]

#CopingWithCOVID: Analysing the mental well-being of LGBTIQ+ adolescents in EAPRO

Five hundred forty-three LGBTIQ adolescents and youth responded to the #COVID19: Impact on LGBTIQ Adolescents and Youth in Southeast Asia & East Asia survey launched by UNICEF East Asia & Pacific, Youth Voices Count, Equal Asia Foundation, and Prism Chat in April-May 2020. Two-thirds (62 per cent) of the respondents reported being concerned about their mental health. Other concerns included their identity being disclosed; escalating familial hostility; domestic violence; social isolation; potential human rights violations; physical health; and getting COVID-19. Almost all (91 per cent) currently received mental health information from social media, but 45 per cent reported wanting online learning resources and mental health support. Recommendations included ensuring gender-sensitive, youth-friendly mental health, sexual and reproductive health, and HIV services for LGBTIQ+ persons through multiple platforms with adequate referrals and linkages to other services.[57,58]

Endnotes

1 United Nations Children's Fund, 'Gender Action Plan, 2018 – 2021', UNICEF, New York, 2017, <www.unicef.org/gender/files/Gender_Action_Plan_brochure-web.pdf>.

2 United Nations Children's Fund, 'Current Issues: Eliminating Discrimination Against Children and Parents Base on Sexual Orientation and/or Gender Identity', UNICEF Current Issues, No. 9, UNICEF, November 2014, <https://www.unicef.org/media/91126/file>.

3 Kapungu, Chisina and Suzanne Petroni, 'Understanding and Tackling the Gendered Drivers of Poor Adolescent Mental Health', International Center for Research on Women, June 2017, <www.icrw.org/wp-content/uploads/2017/09/ICRW_Unicef_MentalHealth_WhitePaper_FINAL.pdf >.

4 Balvin, Nikola and Prerna Banati, 'The Adolescent Brain: A second window of opportunity - A compendium', Miscellanea, UNICEF Office of Research, 2017, Innocenti, Florence, <www.unicef-irc.org/publications/933-the-adolescent-brain-a-second-window-of-opportunity-a-compendium.html>.

5 Patel, Vikram, et al., 'The Lancet Commission on global mental health and sustainable development', The Lancet Commissions, vol. 392, issue 10157, 09 October 2018, pp. 1553-1598. <www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31612-X>.

6 Walsh, Sophie, et al., 'Clusters of Contemporary Risk and Their Relationship to Mental Well-Being Among 15-Year-Old Adolescents Across 37 Countries', Journal of Adolescent Health, vol. 66, issue 6, 01 June 2020, pp. S40 – S49. <www.sciencedirect.com/science/article/pii/S1054139X20300811>.

7 Bilsen, Johan, 'Suicide and Youth: Risk Factors', Frontiers in Psychiatry – Public Mental Health, Brussels, 30 October 2018, <www.frontiersin.org/articles/10.3389/fpsyt.2018.00540>.

8 Hinton, Rachel, et al., 'Adolescent Mental Health Knowledge Summary: Time for Action', UNICEF, 2019, <www.unicef.org/documents/adolescent-mental-health-knowledge-summary-time-action>.

9 The United Nations Entity for Gender Equality and the Empowerment of Women, 'Policy Brief: The Impact of COVID-19 on Women', 2020, <www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/policy-brief-the-impact-of-covid-19-on-women-en.pdf>.

10 United Nations, International Covenant on Economic, Social and Cultural Rights, 1966. <https://www.ohchr.org/Documents/ProfessionalInterest/cescr.pdf>

11 United Nations Children's Fund, 'Adolescent Health Dashboard', 2019, <https://data.unicef.org/resources/test-adolescent-health-dashboard-regional-profiles>, accessed 31 May 2021.

12 United Nation's Children's Fund, 'Adolescent Mental Health Knowledge Summary', UNICEF, <www.unicef.org/documents/adolescent-mental-health-knowledge-summary-time-action>.

13 <https://www.un.org/sustainabledevelopment/health/>, Accessed July 14, 2021.

14 Erksine, HE, et al., 'The global coverage of prevalence data for mental disorders in children and adolescents', Epidemiology and Psychiatric Sciences, vol. 26, no.4, August 2017, pp. 395-402, <https://pubmed.ncbi.nlm.nih.gov/26786507>.

15 'Adolescent Health Dashboard', <https://data.unicef.org/resources/adolescent-health-dashboard-regional-profiles>, accessed July 15, 2021.

16 Patel, Vikram, 'Reducing the Burden of Depression in Youth: What Are the Implications of Neuroscience and Genetics on Policies and Programs?', Journal of Adolescent Health, vol. 52, issue 2, suppl. 2, 01 February 2013, pp. S36-S38, <www.jahonline.org/article/S1054-139X(12)00178-4/fulltext>.

17 Blum, Robert W., Mengmeng Li, and Gia Naranjo-Rivera, 'Measuring Adverse Child Experiences Among Young Adolescents Globally: Relationships with Depressive Symptoms and Violence Perpetration', Journal of Adolescent Health, vol. 65, 15 January 2019, pp. 86-93, <https://static1.squarespace.com/static/54431bbee4b0ba652295db6e/t/5d0bf12dade1940001ad051e/1561063726290/ACES+Paper.pdf>.

18 Miranda-Mendizabal, Andrea, et al., 'Gender differences in suicidal behavior in adolescents and young adults: systematic review and meta-analysis of longitudinal studies', International Journal of Public Health, vol. 64, 2019, pp. 265-283, <https://link.springer.com/content/pdf/10.1007/s00038-018-1196-1.pdf>.

19 Rice, Simon, Rosemary Purcell, and Patrick McGorry, 'Adolescent and Young Adult Male Mental Health: Transforming System Failures Into Proactive Models of Engagement', Journal of Adolescent Health, vol. 62, issue 3, 01 March 2018, pp. S9-S17, <www.jahonline.org/article/S1054-139X(17)30407-X/fulltext>.

20 United Nation's Children's Fund, United Nations Population Fund, and The United Nations Entity for Gender Equality and the Empowerment of Women, 'Gender Counts: South Asia', 2019, UNICEF, <www.unicef.org/rosa/reports/gender-counts-south-asia>.

21 Ikegami, Saiko, et al., 'An ultrasensitive assay revealed age-related changes in serum oestradiol at low concentrations in both sexes from infancy to puberty', Clinical Endocrinology, vol. 55, issue 6, 12 January 2002, pp. 789-795. <https://onlinelibrary.wiley.com/doi/abs/10.1046/j.1365-2265.2001.01416.x>.

22 Peper, Jiska S. and Ronald E. Dahl, 'The Teenage Brain: Surging Hormones—Brain-Behavior Interactions During Puberty', Current Directions in Psychological Science, vol. 22, no. 2, 16 April 2013, pp. 134-139, <https://journals.sagepub.com/doi/10.1177/0963721412473755>.

23 Nillni, Yael I., Kelly J. Rohan, and Michael J. Zvolensky, 'The role of menstrual phase and anxiety sensitivity in catastrophic misinterpretation of physical symptoms during a CO2 challenge', Archives of Women's Mental Health,, vol. 15, 25 August 2012, pp. 413-422, <https://link.springer.com/article/10.1007/s00737-012-0302-2>.

24 Sahin, Nilfer, et al., 'Assessment of anxiety-depression levels and perceptions of quality of life in adolescents with dysmenorrhea', Reproductive Health, vol. 15, 26 January 2018, article no. 13, <https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-018-0453-3>.

25 Kornstein, Susan G., Diane M.E. Sloan, and Michael E. Thase, 'Gender-Specific Differences in Depression and Treatment Response', Psychopharmacology Bulletin, vol. 36, suppl. 3, Autumn 2002, pp. 99-112, <https://medworksmedia.com/wp-content/uploads/2017/10/099-112_PBAut%E2%80%A6sup_Kornstein.pdf>

26 Howard, Louise M., et al, 'Gender-neutral mental health research is sex- and gender-biased', The Lancet Psychiatry, Vol. 4, issue 1, Jan. 1, 2017, pp. 9-11, <https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(16)30209-7/fulltext>

27 International Organization for Migration, 'Full Glossary of Terms', IOM, 2020, <https://migrationnetwork.un.org/resources/iom-full-glossary-terms-describe-sexual-orientation-gender-identity-gender-expression-and>.

28 United Nations Children's Fund, 'Technical Note on Gender Norms', UNICEF, New York, 2020, <http://www.unicef.org/media/65381/file/GP-2020-Technical-Note-Gender-Norms.pdf>.

29 Rickwood, Debra J., Frank P. Deane, and Coralie J. Wilson, 'When and how do young people seek professional help for mental health problems', Medical Journal of Australia, vol. 187, issue S7, 01 October 2007, pp. S35-S39, <https://onlinelibrary.wiley.com/doi/abs/10.5694/j.1326-5377.2007.tb01334.x>.

30 Rutter, Michael, Avshalom Caspi, and Terrie E. Moffitt, 'Using sex differences in psychopathology to study causal mechanisms: unifying issues and research strategies', Journal of Child Psychology and Psychiatry, vol. 44, issue 8, 16 October 2003, pp. 1092-1115, <https://acamh.onlinelibrary.wiley.com/doi/abs/10.1111/1469-7610.00194>.

31 International Center for Research on Women, 'Understanding and Tackling the Gendered Drivers of Poor Adolescent Mental Health', 2017, <www.icrw.org/publications/understanding-tackling-gendered-drivers-poor-adolescent-mental-health>.

32 Landstedt, Evelina, Kenneth Asplund, and Katja Gillander Gadin, 'Understanding adolescent mental health: the influence of social processes, doing gender and gendered power relations', Sociology of Health & Illness, vol. 31, issue 7, 22 October 2009, pp. 962-978, <https://pubmed.ncbi.nlm.nih.gov/19659740>.

33 Van Droogenbroeck, Filip, Bram Spruyt, and Gil Keppens, 'Gender differences in mental health problems among adolescents and the role of social support: Results from the Belgian health interview surveys 2008 and 2013', BioMed Central (BMC) Psychiatry, vol. 18, 10 January 2018, article number 6, <https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-018-1591-4>.

34 United Nations Children's Fund, 'Technical Note on Gender Norms,' <https://www.unicef.org/media/65381/file/GP-2020-Technical-Note-Gender-Norms.pdf>

35 Laurenzi, Christina A., et al., 'Psychosocial interventions targeting mental health in pregnant adolescents and adolescent parents: a systematic review', Reproductive Health, vol. 17, 14 May 2020, article number 65, <https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-020-00913-y>.

36 International Center for Research on Women, 'Understanding and Tackling the Gendered Drivers of Poor Adolescent Mental Health'.

37 World Health Organization, Preventing suicide: A global imperative, WHO, Geneva, 2014, p. 36, <www.who.int/publications/i/item/9789241564779>.

38 United Nations Human Rights Office of the High Commissioner, Born Free and Equal: Sexual Orientation, Gender Identity, and Sex Characteristics in International Human Rights Law, Second Edition, OHCHR, New York and Geneva, 2019, <www.ohchr.org/Documents/Publications/Born_Free_and_Equal_WEB.pdf>.

39 Rucklidge, Julia J., 'Gender differences in attention-deficit/hyperactivity disorder', Psychiatric Clinics of North America, vol. 33, issue 2, June 2010, pp. 357-373, <https://pubmed.ncbi.nlm.nih.gov/20385342>.

40 Quinn, Patricia O. and Madoo, Manisha, 'A review of attention-deficit/hyperactivity disorder in women and girls: Uncovering this hidden diagnosis', Prim Care Companion CNS Discord, vol 16, issue 3, 2014, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4195638/>

41 Pigott, T.A., 'Gender differences in the epidemiology and treatment of anxiety disorders', Journal of Clinical Psychiatry, vol. 60, suppl 18, 1999, <https://pubmed.ncbi.nlm.nih.gov/10487250>.

42 World Health Organization, 'Health Concerns Among Children Deprived of Liberty: Policy Brief', 2021, <https://apps.who.int/iris/handle/10665/341885>.

43 Kempker, Samantha M., Adam T. Schmidt, and Erin M. Espinosa, 'Understanding the Influence of Mental Health Diagnosis and Gender on Placement Decisions for Justice-Involved Youth', Journal of Youth and Adolescence, vol. 46, 26 September 2016, pp. 1562-1581, <https://pubmed.ncbi.nlm.nih.gov/27670664>.

44 World Health Organization, 'Adolescent Pregnancy', 2020, <www.who.int/en/news-room/fact-sheets/detail/adolescent-pregnancy>, accessed 31 May 2021.

45 Fisher, Jane, et al., 'Prevalence and determinants of common perinatal mental disorders in women in low- and lower-middle-income countries: a systematic review', Bulletin of the World Health Organization, vol. 90, 1 February 2012, pp. 139G-149G, <www.ncbi.nlm.nih.gov/pmc/articles/PMC3302553/pdf/BLT.11.091850.pdf>.

46 Hodgkinson, Stacy, Lee Beers, and Amy Lewin, 'Addressing the Mental Health Needs of Pregnant and Parenting Adolescents', Pediatrics, vol. 133(1), January 2014, pp. 114-122, <www.ncbi.nlm.nih.gov/pmc/articles/PMC3876179>.

47 International Center for Research on Women, 'Understanding and Tackling the Gendered Drivers of Poor Adolescent Mental Health'.

48 Flaherty, Serena C, and Lois S Sadler, 'A Review of Attachment Theory in the Context of Adolescent Parenting', Journal of Pediatric Health Care, vol. 25(2), March-April 2011, pp. 114-121, <www.ncbi.nlm.nih.gov/pmc/articles/PMC3051370>.

49 Surkan, Pamela J., et al., 'Maternal depression and early childhood growth in developing countries: systematic review and meta-analysis', Bulletin of the World Health Organization, vol. 89, 26 May 2011, pp. 608-615E, <https://apps.who.int/iris/handle/10665/270961>.

50 United Nations Human Rights Office of the High Commissioner, 'General comment No. 20 (2016) on the implementation of the rights of the child during adolescence', United Nations Convention on the Rights of the Child, Committee on the Rights of the Child, OHCHR, 6 December 2016, <https://digitallibrary.un.org/record/855544>.

51 United Nations Children's Fund, 'What is gender-transformative programming?', UNICEF Gender Section PDHQ, June 2020. Internal document.

52 United Nations Children's Fund, 'Technical Note on Gender Norms.'

53 United Nations Children's Fund, 'Technical Note on Gender Norms'.

54 For a more in-depth instrument: United Nations Children's Fund, 'Gender Toolkit: Integrating Gender in Programming for Every Child in South Asia', UNICEF Regional Office for South Asia, Kathmandu, 2018, <www.unicef.org/rosa/reports/regional-office-south-asia-gender-toolkit-2018>.

55 International Organization for Migration, 'Full Glossary of Terms'.

56 Banati, Prerna, Nicola Jones, and Sally Youssef, 'Intersecting Vulnerabilities: The Impacts of COVID-19 on the Psycho-emotional Lives of Young People in Low- and Middle-Income Countries', The European Journal of Development Research, vol. 32, 09 November 2020, pp. 1613-1638, <https://link.springer.com/article/10.1057/s41287-020-00325-5>.

57 Youth Voices Count, 'Coping With COVID: The Well-Being of LGBTIQ Adolescents and Youth during the COVID-19 Pandemic in Asia and the Pacific', Youth Voices Count, Iloilo City, Philippines, June 2020, <https://drive.google.com/file/d/1Ct93mF3g3YOyiRFd4DC0aGH3IznMmsXx/view>.

58 United Nations Children's Fund, Webinar: 'Reflections from #CopingWithCOVID: Lives of LGBTIQ youth during the lockdowns', UNICEF, 28 May 2020, <https://blogs.unicef.org/east-asia-pacific/reflections-from-copingwithcovid-lives-of-lgbtiq-youth-during-the-lockdowns>.

Technical Note developed by Sarah Thomsen, in collaboration with Prerna Banati, Helen Belachew, Roshni Basu, Gerda Binder, Fatima Gohar, Jennifer Groves, Rachel Harvey, Zeinab Hijazi, Karen Humphries-Waa, Tanvi Jain, Indeep Janda, Joanna Lai, Luula Mariano, Shirley Prabu, Sagri Singh, Manel Stambouli, Ticiana Garcia Tapia, and Alexandra Yuster.

Contact: Joanna Lai jlai@unicef.org

unicef | for every child