Building Resilient Youth: Sport-Based Mental Health and Addiction Prevention Systems – The MIK Health & Wellness Experience

Shummu-Ê-L Mulenga Bukata Chanda gives us an insight into the problem of addiction among the youth in Zambia and how an organisation he founded is tackling it.



Shummu Ê-L Mulenga Bukata Chanda giving a mental health talk at the University of Lusaka in Lusaka Zambia

Introduction

Across sub-Saharan Africa the health community is increasingly aware that adolescent and young-adult mental health problems and substance use are not isolated clinical concerns: they undermine education, reduce employability and productivity, strain families, and contribute to social unrest. In Zambia the stakes are high: youth form a large proportion of the population and early prevention of addiction and psychosocial distress would deliver outsized returns for national development. This article argues for a systems-first approach, building low-cost, community-owned preventive platforms that reach children and adolescents before problems become clinical crises. It describes MIK Health & Wellness's Sport for Mental Resilience (SMR) pilot in Kanchibiya as a practical example of how sport, combined with deliberate psychosocial content and referral pathways, can become a scalable public-health intervention. The article closes with concrete recommendations for health services, education authorities and development partners.

The problem: youth mental health, substance use and development risk

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Zambia's demographic structure concentrates risk and opportunity: a large youth cohort can power rapid development if healthy and engaged, or magnify social and economic fragility if psychosocial needs go unmet.[1] Across Southern Africa, studies have documented alarmingly high rates of depressive symptoms among adolescents: many surveys report prevalences in the 25–30% range for school-aged youth, and several syntheses point to an even higher pooled burden for depression across the continent. These mental-health burdens are tightly associated with risky behaviours, including early initiation of alcohol and tobacco use, and increased vulnerability to sexual health risks.

Tobacco and alcohol remain important entry points to longer-term addiction. Country profiles and policy analyses estimate adult current smoking prevalence in Zambia at roughly 10% (with wide gender disparities), and the economic cost of tobacco has been estimated in policy briefs at ZMW 2.8 billion annually (about 1.2% of GDP), including health expenditures and productivity losses.[2,3] Meanwhile, regional reviews find current alcohol use among adolescents ranges widely but is significant (reported pooled estimates often in the low double digits), underlining the need for preventive measures during school and pre-school years.

Taken together, these facts make clear that mental-health and addiction risks among youth are not only



The young boys of MIK–CYS football team!

clinical but developmental problems: they degrade school performance, erode human capital, and, when unaddressed, feed social instability. Treating illness is necessary, but insufficient. Prevention delivered at scale through community and education systems must become the strategic priority.

Why prevention must be systems-driven

Health systems and education systems in many low- and middle-income countries (LMICs) are structured around episodic care and crisis management. For adolescent mental health and addiction, the evidence points to three realities:

1. Most harmful trajectories begin early; by the time young people present to clinical services, problems are often entrenched.
2. Social and behavioural drivers (poverty, idleness, weak school linkages, peer influence) are central; clinical services alone cannot change those determinants.
3. Low-cost, structured, frequent contact, delivered through trusted community platforms, is the most feasible prevention strategy at scale.

Therefore, the logical public-health answer is to build systems that (a) create routine, protective contact for children and adolescents, (b) embed brief psychosocial curricula and gatekeeper training into those contacts, and (c) ensure simple referral and data loops that connect community practice to district health and education authorities.

MIK's operational thesis: sport, research and ultimately policy reform as preventive infrastructure

MIK Health & Wellness is a Zambian-born, youth-led organization formed to convert lived experience and community credibility into scalable prevention platforms. Our core thesis is that sport — particularly organised football in many communities — is not merely recreation. It is existing, culturally resonant infrastructure for routine engagement with boys and young men. If training sessions are intentionally redesigned to include brief psychosocial components, mentorship, attendance discipline and referral pathways, they can function as a low-cost, repeatable prevention system.

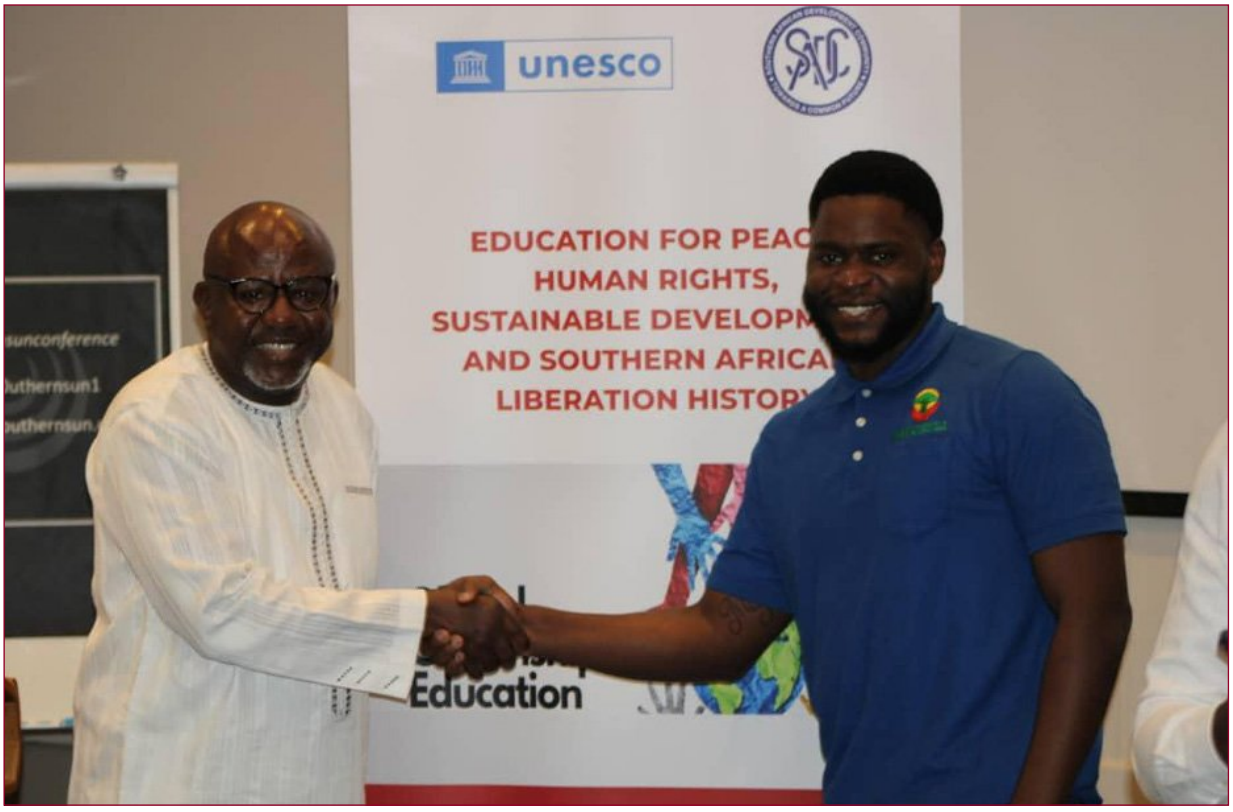
Key design features of the Sport for Mental Resilience (SMR) model are:

- **Routine and predictability**. 4 times-weekly practices establish habit and reduce idle time; a key risk factor for substance initiation.
- **Mental-resilience moments**. Each session begins and ends with a 5–10 minute facilitator-led discussion on discipline, anger management, stress, and refusal skills.
- **Earned incentives**. Equipment and recognition are tied to attendance, behaviour and school performance (rewarding responsibility rather than creating dependency).
- **Data and referrals**. Simple attendance registers, 3-question wellbeing checklists, and escalation SOPs link coaches to district health or MIK referral partners when risk is detected.

This systems design recognises that behaviour change is incremental and context-bound: sport provides the cadence; psychosocial briefings provide the content; and referral pathways ensure safety nets for higher levels of need.

Kanchibiya pilot: from idea to practice

In Kanchibiya District (MIK's legacy site), we launched MIK Chalabesa Youth Football Club (MIK-CYFC) for boys aged approximately 8–17. The programme started with minimal equipment but clear rules: consistent attendance, respectful behaviour, and an agreement to stay alcohol and tobacco-free. Coach Jerry Simfukwe (a respected community coach) leads sessions that integrate short resilience modules and weekly reflections. The headmaster of the local school has offered institutional support, and MIK maintains attendance and basic self-reported wellbeing metrics.



Dr Abdul Rahman Lamin head of social and health sciences UNESCO ROSA and self during our annual meeting in Johannesburg South Africa.

Early operational lessons are instructive. First, community leadership matters more than equipment: local ownership by school and coach creates stability. Second, repetition matters: consistent sessions established routine and gradually shifted norms around alcohol use and idleness. Third, evidence matters to scale: keeping simple, verifiable records (attendance, school performance, basic wellbeing items) allowed MIK to produce rapid "impact snapshots" used to attract in-kind donors and local government interest.

Kanchibiya's model intentionally treats sport as entry point, not end: the goal is to produce a cohort of young people with greater school retention, fewer early initiations into substance use, and improved psychosocial coping.

Partnerships, research and policy alignment

MIK has pursued partnerships to anchor practice in evidence and policy. We are engaged with UNESCO's Regional Office for Southern Africa (ROSA) under the Youth As Researchers (YAR) Initiative and are aligning pilot learning with UNESCO-MGIEP (Mahatma Gandhi Institute of Education for Peace) research frameworks; a step that strengthens the model's legitimacy for education sectors and donors. These partnerships allow us to embed youth-led research methodologies, co-design wellbeing modules for schools (GCED aligned), and plan regional dissemination. Close links with district education and health offices ensure referral and sustainability pathways.

Why this model is cost-sensible and scalable

Prevention through sport is cost-sensible for several reasons. First, the incremental cost of adding short psychosocial content, coach training (psychological first aid basics), and basic monitoring tools is low compared with recurrent clinical costs for established substance use disorders and severe mental illness. Second, sport facilities and gatherings already exist informally in most districts; formalising them requires modest in-kind support (balls, bibs, cones) rather than large capital investments. Third, the model's built-in metrics (attendance, school linkage, self-reported wellbeing) provide donors and ministries with rapid, policy-relevant indicators that can justify modest investment and scale.

A recent national tobacco investment case (Zambia) suggested that investing in FCTC-aligned interventions yields large returns in saved lives and averted economic losses, an economic logic that equally supports upstream addiction prevention through community platforms.

Implementation considerations and safeguards

A community-based sport model must prioritise safeguarding, ethics and measurement:

- **Safeguarding & child protection**. All adults in contact with children must be vetted; coaches must receive child-protection training and clear referral SOPs must be established with district health and social services.
- **Trauma-informed practice**. Resilience conversations

must avoid re-traumatisation; coaches should be trained to identify distress and use simple, safe supportive language.

- **Monitoring & evaluation**. Indicators must be simple and feasible: attendance, school attendance linkage, a 3-item wellbeing screener, and incident/referral logs. Rigorous randomized evaluation is desirable but not required for early scale; pragmatic implementation research can produce the needed policy evidence.
- **Gender and inclusion**. Football can engage boys effectively, but parallel, culturally appropriate platforms are needed for girls and out-of-school adolescents. Inclusion plans should be explicit at the outset.

Policy recommendations for health and education leaders

For Ministries of Health, Education and Youth, and development partners, the following actions would accelerate prevention at scale:

1. Recognize prevention platforms (sport, schools, faith settings) as part of the national mental-health strategy; allocate modest seed funding for coach training and monitoring tools.
2. Adopt simple, harmonized indicators for youth wellbeing and school engagement that community programmes can report into district dashboards.
3. Invest in coach/teacher mental-health literacy (brief trainings on PFA, referral pathways and psychosocial support).
4. Prioritize child protection protocols within all community youth interventions, including background checks and clear complaint mechanisms.
5. Fund implementation research and operational learning to adapt models to urban, peri-urban and girls' programmes.

Conclusion: from prevention to national resilience

Zambia and the region face a pivotal choice: continue to invest disproportionately in treatment and crisis response, or rebalance resources toward upstream, community-based prevention that keeps young people on healthy life trajectories. The Sport for Mental Resilience model is not a panacea; it is a strategic, evidence-aligned way to use existing community infrastructure to protect youth mental wellbeing, reduce early substance use, and deliver measurable development returns. By combining routine engagement, simple psychosocial content, and accountable referral systems, we can make the healthier and more productive choice the easiest choice for our children. MIK Health & Wellness stands ready to partner with government, universities and development agencies to test, learn and scale this approach; because prevention is not only public health good practice; it is nation building.

Acknowledgements

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A young man vaping courtesy of FREEPIK

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