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GLOBAL MULTISECTORAL OPERATIONAL FRAMEWORK

for Mental Health and
Psychosocial Support of
Children, Adolescents and
Caregivers Across Settings

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Zheng Rong, a barefoot social worker in northern China's Shanxi province, visits five-year-old Xiaoyu at her home. Zheng helped Xiaoyu's family raise money for the young girl's brain surgery and apply for government subsidies. The barefoot social worker programme, supported by the Ministry of Civil Affairs and UNICEF, trains non-professional social workers selected by a community to provide child protection and welfare services. Each person learns essential social work skills, including how to conduct child vulnerability and wellbeing assessments and monitor family situations. Barefoot social workers also spend a great deal of time informing communities on all dimensions of child wellbeing.

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GLOBAL MULTISECTORAL OPERATIONAL FRAMEWORK

for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings

The Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings (MHPSS Framework) supersedes the field-test version of the UNICEF MHPSS Operational Guidelines launched in 2018 and has been developed to operationalize the [UNICEF MHPSS Technical Note \(2019\)](#) that guides UNICEF's approach to mental health and psychosocial support (MHPSS) across sectors and settings.

The MHPSS Framework is designed to support people working in relevant sectors and areas of work – including health, social welfare and child protection, education, adolescent development and participation, early childhood development, disability and nutrition – to become more MHPSS-sensitive and scale up quality MHPSS interventions for children, adolescents, young people and families in development and humanitarian settings. It is intended to help UNICEF staff and partners develop MHPSS programmes across the social ecological model and the mental health continuum of care, which includes prevention, promotion and treatment to improve the mental health and psychosocial wellbeing of children, adolescents and their caregivers globally.

The framework will be assessed for revision at the end of UNICEF's Strategic Plan period in 2025.

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The Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings (MHPSS Framework) is an adaptation and update to the Community-Based Mental Health and Psychosocial Support (CB MHPSS) Operational Guidelines launched in 2018. The adaptation and update were informed by field-testing the CB MHPSS Operational Guidelines through the end of 2020, as well as additional consultations with UNICEF staff at headquarters and regional and country offices. The framework draws upon real-world experiences across settings and input from a range of actors in various fields, including but not limited to MHPSS, education, health and nutrition, and child protection.

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List of acronyms

CB MHPSS	Community-based mental health and psychosocial support	mhGAP	Mental Health Gap Action Plan
CCC	Core commitments for children in humanitarian action	MEAL	Monitoring, evaluation, accountability and learning
CCCM	Camp coordination and camp management	MENA	Middle East and North Africa
CFC	Caring for the caregiver	MENARO	Middle East and North Africa Regional Office
CFS	Child-friendly spaces	MHPSS	Mental health and psychosocial support
CP	Child protection	MoV	Means of verification
DRR	Disaster risk reduction	PFA	Psychological first aid
EAP	East Asia and the Pacific	PHC	Primary health care
EAPRO	East Asia and the Pacific Regional Office	ROSA	Regional Office for South Asia
ECA	Europe and Central Asia	SA	South Asia
ECARO	Europe and Central Asia Regional Office	SBC	Social and behaviour change
ECD	Early childhood development	SDG	Sustainable Development Goal
ECE	Early childhood education	SEL	Social and emotional learning
EQUIP	Ensuring quality in psychological interventions	SP	Strategic plan
ESA	East and Southern Africa	TOC	Theory of change
ESARO	East and Southern Africa Regional Office	UNHCR	United Nations High Commissioner for Refugees
GBV	Gender-based violence	UNICEF	United Nations Children's Fund
HICs	High-income countries	WASH	Water, sanitation and hygiene
HIV	Human immune deficiency virus	WCA	West and Central Africa
IASC	Inter-Agency Standing Committee	WCARO	West and Central Africa Regional Office
LAC	Latin America and the Caribbean	WHO	World Health Organization
LACRO	Latin America and the Caribbean Regional Office		
LGBTQ+	Lesbian, gay, bisexual, transgender, queer/questioning or other		
LMICs	Low- and middle-income countries		
M&E	Monitoring and evaluation		

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Key definitions

Adolescence

Adolescence describes the phase of life between childhood and adulthood, from ages 10 to 18. It is a unique stage of human development, encompassing rapid physical growth and sexual maturation combined with emotional, social and cognitive development. It is also an important time for laying the foundations of good health.¹

Adolescents

Individuals in the 10- to 18-year age group are considered adolescents.²

Advocacy for MHPSS

Advocacy is the deliberate process, based on demonstrated evidence, to directly and indirectly influence decision makers, stakeholders and relevant audiences to support and implement actions that contribute to the mental health and psychosocial wellbeing of children, adolescents, caregivers and communities. This translates to influencing investment and action through policy, legislation and financing to ensure that supportive mechanisms are in place for accessible, affordable and non-stigmatizing quality mental health and psychosocial service delivery for all children, adolescents and their families.

Caregiver

Caregivers are those responsible for the care of children and may include mothers, fathers, grandparents, siblings and others within an extended family network, as well as other professional caregivers specialized in childcare and education, such as teachers, early childhood professionals, childcare workers and other educational staff who engage in the regular care of children.

Child

Child as a term broadly includes all children and adolescents aged 0 to 18 (according to the United Nations Convention on the Rights of the Child).

Community

Community includes all stakeholders in child and family wellbeing, such as children, parents, caregivers, teachers, health workers, legal representatives and religious and governmental leaders. Community can be defined as a network of people who share similar interests, values, goals, culture, religion or history – as well as feelings of social connection and caring among its members.

Community-based approach

A community-based approach is based upon the following core principles as outlined in Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings: Human rights and equity, participation, do no harm, building upon available resources and capacities, integrated support systems, and multilayered supports.³ Guided by these principles, UNICEF suggests all MHPSS interventions be community based, meaning they are designed and implemented as part of a more strategic mental health and psychosocial approach with the aim to build upon existing individual and community resources, capacities and resilience.

Community mobilization and strengthening

“Efforts made from both inside and outside the community to involve its members (groups of people, families, relatives, peers, neighbours or others who have a common interest) in all the discussions, decisions and actions that affect them and their future.”⁴

Community participation

The process by which individuals, families or communities assume responsibility for their own welfare and develop the capacity to contribute to their development. Community participation refers to an active process whereby the beneficiaries influence the direction and execution of projects rather than merely receiving a share of the benefits.⁵

¹ World Health Organization and United Nations Children's Fund, 'Helping Adolescents Thrive Toolkit: Strategies to promote and protect adolescent mental health and reduce self-harm and other risk behaviours', WHO, Geneva, 2021.

² Adolescent age range is aligned with age disaggregation in methodologies for reporting on SMQ indicators in the UNICEF Strategic Plan, 2022–2025. If there are any changes in disaggregation details pertaining to age range of children and adolescents in the launched strategic plan, these will be updated in the MHPSS Framework to maintain alignment.

³ Inter-Agency Standing Committee, 'IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings', IASC, Geneva, 2007, pp. 9–10.

⁴ Ibid., Action Sheet 5.1, p. 93.

⁵ Paul, Samuel, 'Community Participation in Development Projects: The World Bank Experience', Discussion paper, World Bank, Washington, D.C., 1987.

Culture

A set of shared values, beliefs and norms among a society. Culture is dynamic, changing as societies adapt to new information, challenges and circumstances.

Enablers

UNICEF's Strategic Plan (2022–2025) uses this term to refer to its organizational performance, defined as the organizational structures, systems, resources and assets in which UNICEF will continuously invest to become a more agile, values-based, effective and efficient organization that can effectively respond to change and uncertainty. There are five enablers: accelerated resource mobilization; agile, responsive business model; decentralized and empowered internal governance and oversight; dynamic and inclusive people and culture; and strategic internal communication and staff engagement.

Enabling environment

An enabling environment allows good mental health to flourish and reduces risk of mental health and psychosocial problems. It includes all the systems, policies and structures that are necessary for maintaining or restoring children's optimal development, promoting positive social relationships and social and emotional learning, and providing access to quality, affordable and non-stigmatizing mental health care and support. In this MHPSS Framework, the term 'enabling environment' encompasses data and evidence generation, community mobilization and strengthening, workforce development, MHPSS systems-strengthening and the mental health continuum of care, and considers culture, social and gender norms, and other structural determinants of mental health.

Family

Family is a socially constructed concept that may include children who live with one or both biological parents or are cared for in various other arrangements, such as living with grandparents or extended family members, with siblings in child- or youth-led households, or in foster care or alternative care arrangements.

LGBTQ+

LGBTQ+ refers to anyone, including young people, who

identifies as lesbian, gay, bisexual, transgender, queer, questioning or other.

Resilience

Resilience is the ability to overcome adversity and positively adapt after challenging or difficult experiences. Children's resilience relates not only to their innate strengths and coping capacities but also to a pattern of risk and protective factors in their social and cultural environments.⁶

Mental health

Mental health encompasses people's emotional, psychological and social wellbeing. It affects how they think, feel and act, and determines how they handle stress, relate to others and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood. Good mental health is defined as a state of wellbeing in which individuals realize their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and are able to make a contribution to their communities.

Good mental health is related to mental and psychosocial wellbeing. UNICEF's work to improve the mental health of children, adolescents, families and communities includes the promotion of mental health and psychosocial wellbeing; the prevention of mental health conditions; the protection of human rights; and the care and treatment of children, adolescents and caregivers affected by mental health conditions.

Mental health and psychosocial wellbeing⁷

Wellbeing describes a positive state of being when a person thrives. In children and adolescents, it results from the interplay of physical, psychological, cognitive, emotional, social and spiritual aspects that influence a child's or adolescent's ability to grow, learn, socialize, and develop to her or his full potential.

Wellbeing is commonly understood in terms of three domains:

- **Personal wellbeing:** For the individual, this includes positive thoughts and emotions, such as hopefulness, calm, self-esteem and self-confidence. At the community level, personal wellbeing includes strategic actions to raise awareness and change

⁶ United Nations Children's Fund, 'Growing Up in Conflict: The impact on children's mental health and psychosocial well-being; Report on the symposium, 26–28 May 2015, New Babylon Meeting Center, The Hague', UNICEF, New York, 2015, p. 15.

⁷ Adapted from UNICEF's Mental Health and Psychosocial Technical Note's definition of wellbeing to align with the theoretical underpinning of the MHPSS Framework and the social ecological model.

behaviour about mental health and mental disorders and the importance of seeking help that contribute towards individual wellbeing.

- ❑ **Interpersonal wellbeing:** This includes nurturing relationships, responsive caregiving, a sense of belonging, and the ability to be close to others. At the community level, interpersonal wellbeing is about creating the opportunities and space within a local community to develop these relationships and protective factors.
- ❑ **Skills and knowledge:** Skills and knowledge encompass the capacity to learn, make positive decisions, and effectively respond to life challenges and express oneself. They are facilitated through community services that support wellbeing and the ability to learn how to best address MHPSS needs in the community, as well as the capacity to respond to challenges within the community and effectively communicate about mental health and psychosocial wellbeing.

Mental health conditions

Mental health conditions include a wide range of disorders that affect an individual's cognition, emotion or behaviour and interfere with a person's ability to learn and function in the family, at work and in society. In many circumstances, conditions can be successfully prevented or treated. Mental health conditions include mental and substance use problems, severe psychological distress, intellectual disabilities and suicide risk.⁸

Mental health and psychosocial problems

This term refers to the broad spectrum of mental health and psychosocial complaints that are not strictly medical or somatic. These can be psychological or social in nature, affecting an individual's functioning in daily life, her or his environment or life events.

Mental health and psychosocial support (MHPSS)

This is a composite term used to describe any type of local or outside support that aims to protect or promote psychosocial wellbeing or prevent or treat mental disorders. Originally coined by the IASC MHPSS reference group for use in emergency settings, this term is now widely accepted and used by UNICEF and partners across settings to safeguard

the dynamic relationship between psychological aspects of experience (a person's thoughts, emotions, feelings and behaviour), the wider social experience (relationships, traditions), and values and culture.

Persons with disabilities

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others.⁹

MHPSS workforce

The MHPSS workforce includes practitioners who provide MHPSS, either as the central function of their job or as part of a broader range of functions. This includes:

- ❑ Individuals, including community leaders or volunteers
- ❑ MHPSS practitioners, who should have professional, on-the-job training and ongoing supervision, and technical competencies in MHPSS, including teachers and education staff, child and adolescent psychologists, counselling psychologists, psychotherapists, expressive art therapists, family therapists, educational psychologists, social workers, school counsellors, psychiatric care practitioners, psychiatrists, psychiatric nurses, occupational therapists, doctors, primary care physicians and nurses trained in mental health
- ❑ Other MHPSS practitioners who have completed the necessary years of on-the-job training and technical competencies for the services they deliver.

The MHPSS workforce should receive training and supervision specific to each MHPSS intervention.

Transferable skills

MHPSS support can help impart a broad range of skills to children and adolescents, including life skills, twenty-first century skills, soft skills or social-emotional skills that allow young people to become agile, adaptive learners and citizens equipped to navigate personal, academic, social and economic challenges. Transferable skills include problem-solving, negotiation, managing emotions, empathy and communication, and support crisis-affected young people to cope with trauma and build resilience in the face of adversity.¹⁰

⁸ 'Helping Adolescents Thrive Toolkit'.

⁹ United Nations, Convention on the Rights of Persons with Disabilities (CRPD), Article 1, 2022.

¹⁰ Adapted from United Nations Children's Fund, 'The Global Framework on Transferable Skills', UNICEF, New York, 2019.

■ Introduction



Mental health and psychosocial support (MHPSS) is an institutional priority for the United Nations, and for UNICEF.

UNICEF supports mental health as a holistic, life course issue relevant to every sector of development, and embraces all Sustainable Development Goals¹¹ (SDGs) as determinants of mental health and psychosocial wellbeing,¹² reinforcing the prevention, promotion and treatment of mental ill-health. UNICEF's approach aims to be collaborative and multisectoral, spanning health, social welfare and child protection, education, gender and other sectors to be truly effective in addressing the global burden of mental health problems.

Accordingly, UNICEF's commitment to achieve the [2030 Agenda](#) requires an increased understanding of the ways in which social conditions determine health and mental health outcomes. Responses to mental health and psychosocial problems in each population need to be multilayered and multisectoral. Health, education, social welfare and child protection, transport and housing sectors all need to contribute to a 'health in all policies' approach, as reflected in the SDGs.¹³ To deliver the SDGs, and for overall promotion of mental health and psychosocial wellbeing, working together with caregivers and adolescents themselves needs to be a cross-cutting strategy. This should take place across all goal areas, including evidence generation, policy dialogue, service delivery design, intervention (where appropriate) and advocacy. Comprehensive monitoring must be done at global, regional, national and local levels using agreed indicators for SDGs and additional indicators as needed.

The articulation of UNICEF's MHPSS direction in its new strategic plan (2022–2025) is an important step towards strengthening UNICEF institutional capacity and accountability to respond to the MHPSS needs of children, adolescents and families in a way that ensures quality and scalable responses within and across sectors of operation.

This is operationalized in UNICEF's MHPSS Technical Note,¹⁴ which promotes that people who work in relevant sectors and areas of work – including health, social welfare and child protection, education, adolescent development and participation, early childhood

development, disability and nutrition – need to become more MHPSS-sensitive and scale up quality MHPSS interventions for children, adolescents, young people and families in development and humanitarian settings.

UNICEF's field reach and the renewed momentum mean there is no better time to advance the organization's fight against the global burden of mental health problems and contribute to the SDGs by responding to the MHPSS needs of children, adolescents and families in a way that ensures quality and a scalable response within and across sectors and areas of operation.

Aim of the MHPSS Framework

UNICEF's MHPSS Framework is intended to help UNICEF staff and partners develop programmes across the social ecological model and the mental health continuum of care, which includes prevention, promotion and treatment to improve the mental health and psychosocial wellbeing of children, adolescents and their caregivers globally. The strategies and approaches included in the framework will help in accelerating actions for children's, adolescents' and caregivers' mental health and psychosocial wellbeing in national and regional development strategies. The framework can be used in development contexts, humanitarian contexts and within the humanitarian–development–peace nexus.

This framework emphasizes engaging actors in the health, social welfare and child protection and education sectors at all levels of society to design, implement and evaluate MHPSS strategies that are locally relevant, comprehensive and sustainable.

The aim is to more effectively strengthen, promote, protect and mobilize supports and systems within the family and community to support child and family wellbeing and prevent mental health and psychosocial conditions from becoming obstacles to meeting key targets in the SDGs.¹⁵

¹¹ United Nations Children's Fund, 'Mental Health and Psychosocial Technical Note', UNICEF, New York, September 2019, p. 12.

¹² Breuer, Erica, Mary De Silva, and Crick Lund, 'Theory of change for complex mental health interventions: 10 lessons from the programme for improving mental healthcare', *Global Mental Health*, vol. 5, 16 July 2018.

¹³ Patel, Vikram, et al., 'The Lancet Commission on global mental health and sustainable development', *The Lancet*, 10 October 2018.

¹⁴ UNICEF, 'Mental Health and Psychosocial Technical Note', 2019.

¹⁵ UNICEF staff can learn more about mental health as an accelerator for all SDGs in the [Annual SDG Support Package](#) (requires a UNICEF account to access).

The framework accomplishes this by:

- ❑ Providing a foundational understanding of developmental and social needs and how they relate to mental health and psychosocial wellbeing for children and their caregivers
- ❑ Providing intervention tables that present examples of MHPSS interventions and services with recommended programming tools
- ❑ Describing key actions that will build and strengthen MHPSS service delivery across the health, education, social welfare and protection systems, national legislation and policy development, advocacy and financing of MHPSS services
- ❑ Building and strengthening the MHPSS workforce and referral pathways to function across the education, health, social welfare and protection sectors.

The framework will also provide recommendations and tools for developing monitoring and evaluation (M&E) systems for MHPSS programming.

The audience

The MHPSS Framework is an operational document for UNICEF staff and partners on MHPSS programming for children, adolescents, caregivers and families in all contexts, including low- and middle-income countries (LMICs), humanitarian contexts, and high-income countries (HICs) in accordance with UNICEF's guidance on programming in HICs.

The framework is intended to be adapted by UNICEF regional and country offices and other agencies working to improve and strengthen the mental health and psychosocial wellbeing of children, adolescents, caregivers, parents and communities. It is designed to be particularly useful in LMICs, as there is a strong emphasis on the core elements needed to establish and strengthen systems for mental health and psychosocial wellbeing. The framework provides guidance on policy and investment in mental health that is useful across settings, but especially in HICs. MHPSS services are an essential element of response and recovery for humanitarian action across HICs and LMICs.

The framework can be applied in whole or in part, based on contextual needs.

Components of the framework

The MHPSS Framework is designed to support the design and development of MHPSS strategies and action plans at the regional and country levels, as well as field-level MHPSS programming and activities. It is accompanied by a supplementary implementation package (described below).

The MHPSS Framework presents strategies for improving the wellbeing of children and adolescents – as well as their caregivers, including parents and teachers – and for improving the community capacity to deliver MHPSS services and eliminate stigma associated with mental health and psychosocial needs. In this document you can access the following key resources:

❑ **Theoretical underpinnings and approaches:**

Information specific to UNICEF's core approaches for MHPSS programme implementation can be found in this section. This includes the social ecological model; the life course approach for MHPSS; gender, disability and inclusion; the mental health continuum; layering services across an adapted version of the IASC intervention pyramid; and a discussion on multisectoral supports.

- ❑ **Multisectoral theory of change (TOC):** The TOC is structured around the social ecological model, with four outcomes that create an enabling environment for MHPSS across the child/adolescent level, caregiver level, community level, and society and its systems.

- ❑ **Putting it into practice:** The framework includes practical, real-life examples of MHPSS programming from around the globe. Putting it into practice examples have been pulled from case studies, reports and articles available on the UNICEF website, findings from UNICEF's document, [Mental Health and Psychosocial Support for Children in Humanitarian Settings: An Updated Review of Evidence and Practice](#), and case studies that were identified and developed as part of this framework

and are included in the accompanying Putting it into Practice: MHPSS Programming Across Sectors and Settings at UNICEF (forthcoming in 2023).

- **Intervention tables:** The framework includes nine intervention tables that provide examples of MHPSS interventions and services for children, adolescents, caregivers and community members. These tables also link to suggested resources that can be found in [UNICEF's Compendium of Resources](#) for MHPSS. Detailed guidance on how to use the intervention tables is given in the next subsection.
- **MEAL for MHPSS:** Monitoring, evaluation, accountability and learning (MEAL) for MHPSS includes a TOC for MHPSS, log frames across the four outcomes of the framework, suggested indicators, and means of verification. The TOC and log frames are intended to be adapted to reflect your specific programme objectives.

Supplementary implementation package

UNICEF has developed a complementary implementation package that you can use alongside this framework. The implementation package includes the following resources:

- **Assessment and planning toolkit:** The planning and analysis component includes brief guidance and tips on how to assess MHPSS needs and gaps in services at the regional and country levels and how to use that information to guide and inform strategic planning for MHPSS programming across multiple levels (project, district, national and regional levels) and settings (e.g., Humanitarian Response Plan). The purpose of this resource is to provide guidance for conducting a situational analysis for multisectoral MHPSS across sectors and settings. This analysis is the first step taken by a country office when developing its countrywide MHPSS plans and includes:
 - Formulating or adapting a TOC that aligns with the MHPSS Framework's outcomes, the social ecological model, and specific country-level needs
 - Developing a programme, country or regional strategy for MHPSS
 - Developing an M&E framework with clear outputs and indicators informed by the MHPSS Framework.

This toolkit also supports the humanitarian–development nexus by providing core guidance on how to conduct an MHPSS situational analysis that can be used across settings, including establishing a baseline of MHPSS situational needs. At times, humanitarian response programming staff might need to conduct a rapid assessment of MHPSS needs as a result of an emergency context. Examples of rapid assessments are available in this toolkit, with direction to relevant sections in the MHPSS Minimum Services Package.

- **UNICEF's Compendium of Resources:** The Compendium of Resources is an accompaniment to the framework. It provides valuable information about available resources, including guidelines, training manuals and tools. The description of each resource includes a detailed overview of its features and information about how to access documentation, training or publications supporting each resource. The compendium is intended to be used as a reference document to identify available resources for implementing MHPSS programming across sectors and settings. The compendium does not describe how to implement particular interventions but rather provides resources to inspire programme development across a broad spectrum of approaches within a multilayered pyramid of intervention, as well as a map to point users towards additional sources of information. ***The Compendium of Resources is a living document, and UNICEF will release updates periodically.*** The first version was published in 2018, the second in 2021, and a third update is expected in 2022.
- **MHPSS research framework:** This is a comprehensive framework to support research and evidence generation and use efforts for child and adolescent mental health across age groups and at various levels of a child's social ecology.
- **Key MHPSS documents, resources and briefs:** These short sectoral briefing documents and checklists provide additional field-level guidance on mental health and psychosocial programming and activities, with sector-specific considerations and target audiences

- ❑ **MHPSS and innovation package (forthcoming, late 2023):** This package provides practical steps, principles, guidance and tools to support design, implementation, monitoring, evaluation and learning of innovative MHPSS projects and programmes and enhances accountability. The package highlights three pillars on which any innovative MHPSS programme should be built:
- UNICEF Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings (this document)
 - [Matching today's challenges with tomorrow's solutions: UNICEF Global Innovation Strategy and Framework 2.0 – The 'ABCs' of innovation](#)
 - [UNICEF's Human Centred Design: Creating solutions for children using the Human Centred Design approach.](#)

MHPSS principles, standards and approaches

The MHPSS Framework aligns with and draws from multiple international, widely adopted guiding principles, frameworks and conventions related to child protection, child rights, health, education and MHPSS that are critical to safeguarding and promoting enabling environments in which children can reach their full potential. These global principles and standards underpin the framework and should guide MHPSS service delivery.

Global principles and standards that underpin the framework

Four core underpinning documents to the global framework are:

- ❑ [UNICEF Strategic Plan](#) (inclusive of the Convention on the Rights of the Child, gender equality and the 2030 agenda)
- ❑ [UNICEF Core Commitments for Children \(CCCs\)](#)
- ❑ [Declaration of Astana on Primary Health Care](#)
- ❑ [IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.](#)

Fundamental tenets of child wellbeing as enshrined in the Convention on the Rights of the Child¹⁶ are central to both the guiding principles in UNICEF's strategic plan and in the CCCs. These tenets protect the rights of every child – including rights to basic health and welfare, family life, education, leisure and cultural activities, and special protection in certain situations such as humanitarian emergencies – and establish common principles and practices across education, health and social welfare.

The Declaration of Astana, endorsed at the Global Conference on Primary Health Care (PHC) in 2018, aims to ensure that people's physical and mental health problems are addressed through comprehensive promotive, protective, preventive, curative, rehabilitative and palliative care throughout the life course, making PHC about caring for people rather than simply treating specific diseases or conditions. It strategically prioritizes key health system functions aimed at individuals, families and the population as central elements of integrated service delivery across all levels of care. It also systematically addresses the broader determinants of physical and mental health (including social, economic and environmental, as well as people's characteristics and behaviours) through evidence-informed public policies and systems across all sectors. It empowers individuals, families and communities to optimize their physical and mental health as advocates for policies that promote and protect health and wellbeing, as co-developers of health and social services through their participation, and as self-carers and caregivers to others.

The IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings and the associated IASC intervention pyramid, while originally developed for humanitarian settings, have become unifying standards for MHPSS programming across agencies, sectors and contexts (including both development and humanitarian action). The IASC intervention pyramid supports development actors, humanitarian actors, communities and governments to plan, establish and coordinate multisectoral responses to protect and improve people's mental health and psychosocial wellbeing in a wide range of contexts.

¹⁶ Convention on the Rights of the Child, United Nations General Assembly Treaty Series, vol. 1577, 20 November 1989, p. 3.

The IASC guidelines note that MHPSS refers to “any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental

disorder” and is based on the core principles listed in Table 1, which support a community-based approach.

Table 1 Core principles of the IASC guidelines for MHPSS in emergencies

Human rights and equity	Promote the human rights of all affected persons and protect those at heightened risk of human rights violations; ensure equity and non-discrimination in the availability and accessibility of MHPSS supports.
Participation	Maximize the participation of local children, families and communities in assessment, design, implementation and monitoring and evaluation of humanitarian response.
Do no harm	Reduce the potential for MHPSS and other humanitarian interventions to cause harm, for example through effective coordination, adequate understanding of the local context and power relationships, cultural sensitivity and competence, and participatory approaches.
Build on local capacities and resources	Support self-help and identify, mobilize and strengthen existing resources, skills and capacities of children, families, the community, government and civil society.
Integrated support systems	Support activities integrated into wider systems (e.g., community supports, formal or informal school systems, health and social services) to advance the reach and sustainability of interventions and reduce the stigma of stand-alone interventions.
Multilayer supports	Develop a multilayer system of complementary supports to meet the needs of children and families affected in different ways.

Lastly, the MHPSS Framework points to other supporting documents that provide guidance, key strategies and guiding principles for humanitarian response across child protection, education and health programming. These resources can be found in ► [Annex 3](#): UNICEF key commitments, frameworks and minimum standards.

Theoretical underpinnings and approaches

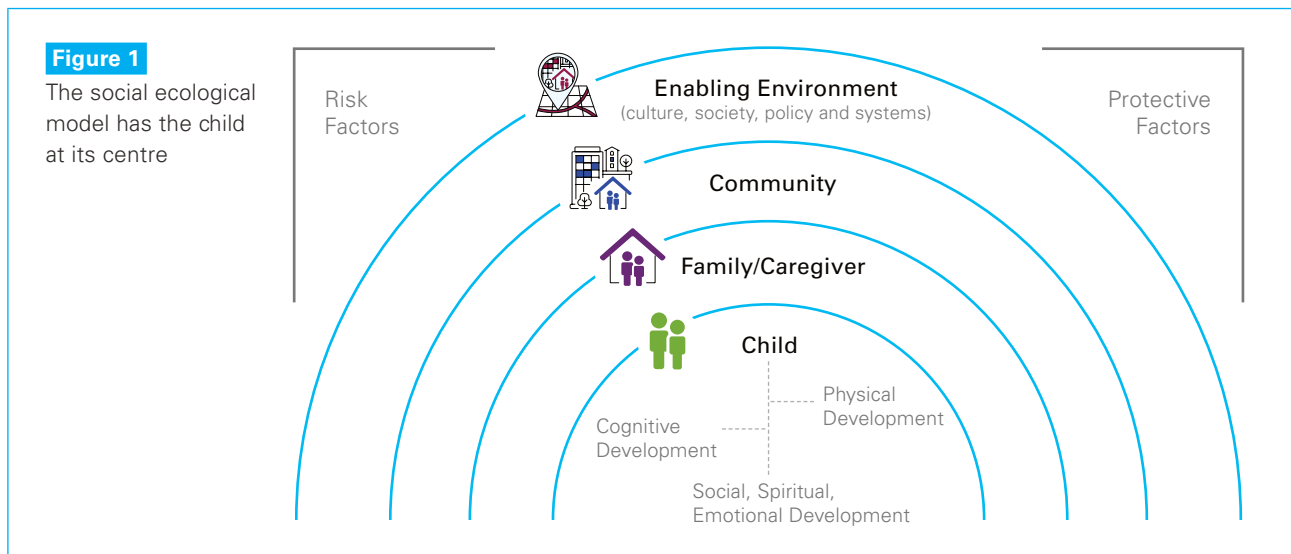
The following theoretical underpinnings and approaches are foundational to UNICEF’s MHPSS TOC (presented in the next section) and should inform all programming that aims to improve a population’s mental health and psychosocial wellbeing. Adopting an MHPSS approach means providing activities in ways that are beneficial to the mental health and psychosocial wellbeing of children, families and communities. This approach should take into consideration how children and the community are engaged in programme development

and delivery of services. An MHPSS approach can be used by any sector to inform how young people, caregivers, families and communities are engaged in the process.¹⁷ MHPSS interventions consist of one or several activities, with the primary goal of improving the mental health and psychosocial wellbeing of children, adolescents or their caregivers.

Social ecological model

The MHPSS Framework is anchored in the [social ecological model](#), with the child at the centre surrounded by family and caregivers, communities and, finally, society with its cultures and norms. MHPSS programmes should apply the social ecological model throughout design and implementation, including understanding the dynamic relationships between children or adolescents and each element of their system and how these dynamics affect children’s mental health and psychosocial needs.

¹⁷ United Nations High Commissioner for Refugees, ‘Operational Guidance: Mental Health and Psychosocial Support Programming for Refugee Operations’, UNHCR, Geneva, 2013.



For more information, see [UNICEF's Brief on the Social Ecological Model](#).

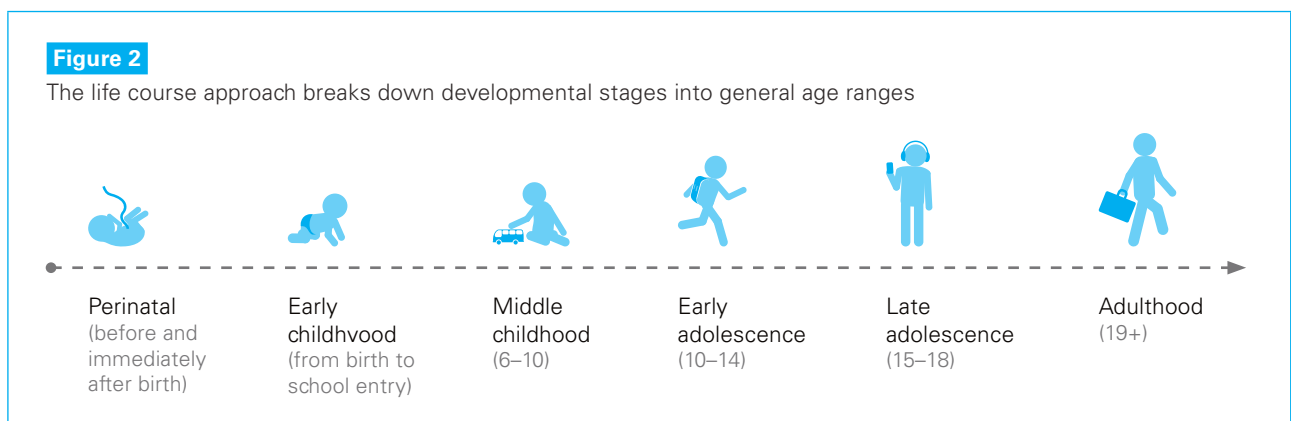
Life course approach

A life course approach to mental health and psychosocial wellbeing acknowledges that child and adolescent wellbeing and resilience are directly linked with the interplay between developmental stage and environmental elements influencing a young person's risk and protective factors.¹⁸

The MHPSS Framework applies general age ranges for each life course stage from perinatal development to adulthood, as reflected in Figure 2. While these categories are useful for designing activities, as mentioned above, it is important to remember that not all children within a particular age group will have the same needs. Children with mental health and psychosocial conditions may experience delays to reach developmental milestones and may require additional

support. Therefore, a life course approach to MHPSS should be adapted to the needs of the children, their families and the community.

All MHPSS programming should ensure the inclusion of children, adolescents and caregivers of all ages, genders, abilities, ethnicities and living situations and actively work to minimize and safeguard against stigma, discrimination and exclusion of at-risk groups in communities.



¹⁸ For more information on UNICEF's life course approach to programming, please contact your UNICEF contact in your country.

Gender

Gender inequalities and harmful social norms based on gender can define roles and responsibilities that limit opportunity, restrict behaviour and constrain expectations and self-expression – all of which can affect mental health. Child marriage, gender-based violence (GBV) and family and cultural expectations can significantly limit opportunity and self-determination. In later adolescence, restrictive stereotypes about work, education and family can get in the way of a young person's ambitions and prospects. In addition, violence against women, including intimate partner violence, can harm health and mental health.

The World Health Organization (WHO) has identified gender, particularly among adolescents, as a critical mental health determinant, noting that "media influence and gender norms can exacerbate the disparity between an adolescent's lived reality and their perceptions or aspirations for the future".¹⁹ [UNICEF's *Mental Health and Psychosocial Support for Children in Humanitarian Settings: An Updated Review of Evidence and Practice*](#) highlights how changing people's attitudes on violence against women and children, and gender norms is an important component of programming.

As such, MHPSS programming needs to be developed based on a clear understanding of the gender-related causes of mental health and psychosocial problems and the barriers to accessing care and support. All MHPSS programming should consider the specific needs of children and adolescents of all genders, including non-binary individuals, to avoid enhancing stigma, discrimination and exclusion of at-risk groups in communities.

UNICEF's [Gender and Adolescent Mental Health and Psychosocial Support Technical Brief](#) provides a more detailed and focused discussion on gender and adolescent mental health.

Disability and inclusion

The need to strengthen programming in realizing the right to mental health and psychosocial wellbeing of children and young people from a rights-based

approach to disability and inclusion is critical. UNICEF's 2019 discussion paper, [A Rights-Based Approach to Disability in the Context of Mental Health](#), provides a detailed and focused discussion on the rights-based approach to disability in the context of mental health and aims to normalize MHPSS across sectors by providing a general overview of how to ensure a rights-based approach to disability in the context of mental health, noting that:

...persons with disabilities are not a homogeneous group and have different layers of identity that comprise a wide range of impairments as well as identity markers, such as age, race, colour, sex, sexual orientation, gender identity, language, religion, national, ethnic, indigenous or social origin, and other status.

– *A Rights-Based Approach to Disability in the Context of Mental Health*, UNICEF, p. 19

Social inequalities affecting persons with disabilities perpetuate inequalities in mental health and wellbeing. Persons with disabilities are disproportionately affected by poverty. Children and adolescents with disabilities are less likely to attend and complete school or to access higher education. Girls and young women with disabilities are disproportionately affected by different forms of GBV. All of these challenges have an enduring impact on the enjoyment of the right to mental health and validate the significance of this framework's community-based approach to MHPSS, which contributes to improved access to services and is associated with continuity of care, better protection of human rights and the prevention of stigmatization.

Further, children with disabilities are particularly vulnerable to multiple and intersectional forms of discrimination, especially in the context of mental health. They may experience discrimination and stigma from peers and in institutional settings, and they are often victims of pervasive practices, such as overmedicalization and institutionalization. While children with disabilities and their families may require different types of disability- and age-appropriate MHPSS services, the understanding of how to provide these from a rights-based perspective is limited. In fact, too often, people with disabilities are perceived as

¹⁹ World Health Organization, 'Adolescent Mental Health', WHO, Geneva, 17 November 2021, <www.who.int/news-room/fact-sheets/detail/adolescent-mental-health>, accessed 10 October 2022.

mere recipients of special care, resulting in widespread segregation, institutionalization and neglect. The human rights approach to disability, in conjunction with the child rights approach, calls for seeing children and adolescents with disabilities as rights-holders who are entitled to exercise their rights and actively participate in all matters that affect them. This approach should guide the design, implementation, evaluation and monitoring of MHPSS policies and programming.

The mental health continuum

Everyone sits somewhere on the mental health continuum, and many, if not most, people move along it at some stage – from experiencing good mental health to anything from short-term distress to a long-term mental health condition. Accordingly, UNICEF addresses

mental health on a continuum of care, focusing on the broad spectrum of mental health issues that affect everyone, from specific mental health conditions to the overall mental wellbeing that every child deserves. The continuum of mental health interventions across promotion, prevention and care (early intervention, treatment and continuing care) is integrated throughout the MHPSS Framework. Programming across development and humanitarian contexts should reflect the mental health continuum of care, with a focus on both mental wellbeing and the treatment and care for those with MHPSS needs across the life course. The framework provides programming examples that demonstrate how to think about MHPSS programming across the continuum of care.

Figure 3

The mental health continuum ranges from positive mental health to severely disabling conditions



More information on the mental health continuum and the continuum of care can be found in the Mental Health Continuum Technical Note (forthcoming).

Community mobilization and strengthening

Mobilizing communities to respond to MHPSS needs will contribute towards improved mental health and wellbeing for children and their families by working with and through a community's natural supports and systems. This contributes to a stronger overall care environment, which promotes inclusion of the most vulnerable children and families in existing supports and reduces the potential for stigma. Mapping and systematically building on local resources, such as community networks, practices and processes, can help build scalable and sustainable programmes. This ensures the most vulnerable and hardest-to-reach members of the community know about the available services and how to access them. Taking a community-based approach in both development and humanitarian contexts helps to establish strong continuity of

services when communities transition from emergency to recovery to development, or in a development context that is suddenly faced with an emergency. Strengthening natural supports and systems also helps to link MHPSS responses to recovery by linking humanitarian and non-humanitarian response programming. Emergency situations focus attention on a population's mental health needs and provide an opportunity to transform MHPSS care for children and families for the long term. This may include specialized psychological and social services for those in need – for example, children and caregivers with mental disorders, protection risks or serious distress. Emergencies may create a demand for systems-strengthening that was not present under development programming. For example, stay-at-home orders, business closures and international travel restrictions were defining characteristics of the 2020–2021 global pandemic and

resulted in a surge in demand for MHPSS services^{20,21} that were easily accessible within one’s community.²²

For more details on strategies for community engagement and participation, please see ► [Annex 1: Strategies for community engagement and participation.](#)

Multilayered MHPSS services

The IASC intervention pyramid (see Figure 4) is widely used to describe the multilayered support that makes up a comprehensive, complementary package of MHPSS interventions for people’s recovery

and wellbeing.²³ Originally developed for use in humanitarian response, the pyramid has since been used in development settings to depict the integrated services that support a given population. The pyramid begins with community foundations and works its way up to specialized care, with fewer people needing services at each layer. The intervention pyramid provides a way to articulate and understand the layering of services and is frequently used and adapted to describe MHPSS services across development and humanitarian contexts. For example, a programme may have interventions that sit at only one layer of the pyramid or multiple interventions across the pyramid.

Figure 4 IASC intervention pyramid

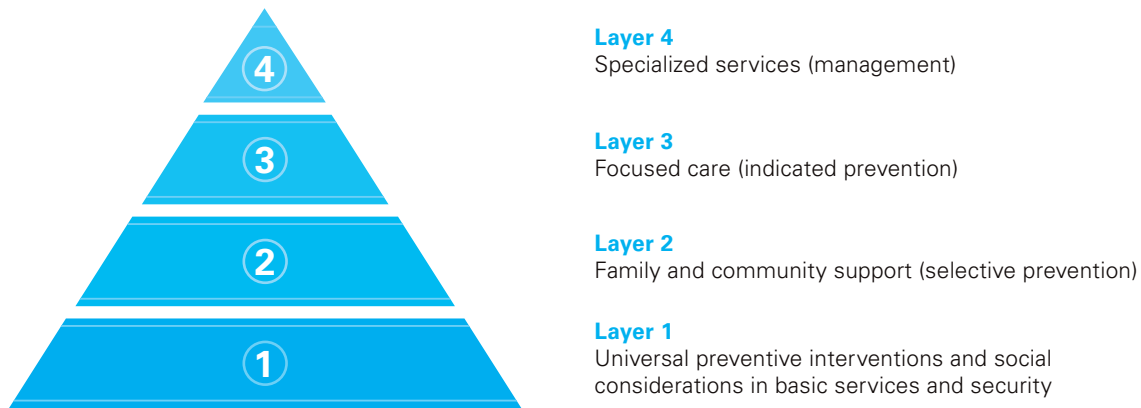




Table 2 IASC intervention pyramid details

Services and interventions	Supervision and staffing
<p>Services provided by mental health clinicians and social service professionals for children and families beyond the scope of general (non-specialized) social and primary health services. Includes interventions that are intended to manage mental health conditions.</p> <p>Examples include individual, family or group psychotherapy for people with mental health conditions.</p>	 <p>Psychiatrists, psychiatric nurses, psychologists, clinical social workers, occupational therapists, primary care physicians and other professionals who are trained in clinical services, including pharmacological treatment and management of mental conditions, are best suited for delivering focused and clinical services at Layer 4. Staff providing services at this layer should be competent in individualized care and able to provide supervision to other staff across layers.</p>
<p>Non-specialized support by trained and supervised workers to children and families, including general (non-specialized) social and primary health services.</p>	 <p>Clinical social workers, psychologists, psychosocial workers, MHPSS providers, nurses, school-based MHPSS providers, and community health workers trained in individualized care, case management and</p>

²⁰ American Psychological Association, ‘Demand for mental health treatment continues to increase, say psychologists’, Press release, APA, 19 October 2021.

²¹ Plewes, Joseph, ‘Analysis: The rise in mental health demand’, NHS Confederation, 13 May 2022.

²² APA, ‘Demand for mental health treatment’.

²³ This is an adaptation of the IASC MHPSS intervention pyramid that continues to benefit from application in the field and further discussion among experts.

Examples include programmes that develop social skills and coping mechanisms for adolescents who are referred to social services due to behavioural challenges.

group work are qualified to undertake most interventions at Layer 3. Paraprofessionals and staff who receive on-the-job training to provide structural MHPSS through case management, family-based interventions, structured group sessions and school-based psychological interventions may help with activities at this layer.

Staff who provide services at this layer should have a strong understanding of individual care and group interventions and be able to provide supervision to staff delivering services for the first two layers.

Family and community supports for recovery, strengthening resilience and maintenance of mental health and psychosocial wellbeing of children and families.



Examples include support groups for marginalized adolescents or children exposed to violence.

Teachers, social workers and community health workers may all provide services at this layer. Community leaders or volunteers who receive training specific to MHPSS in community and family supports, part of multi-disciplinary case management services, may also assist with activities at this layer. Staff working in Layer 2 should have competent skills in leading and facilitating group sessions.

Interventions for members of the general population who are not identified as at risk. These interventions include social considerations in basic services and security in a way that is participatory, safe and socially appropriate to ensure the dignity and wellbeing of all children and community members.



Examples include mental health and substance use awareness programmes and access to basic survival needs, such as food, shelter and disease control.

First responders in basic services across sectors and technical staff working on policy and legislation across education, health and social welfare systems work in this layer. The skill sets for Layer 1 activities will vary dramatically, because interventions can include a wide range of policy- and advocacy-level work in a development context to support accessing basic services during a humanitarian response.

Programmes that include awareness-raising, behaviour change, advocacy and policy efforts should include staff skilled in communications, policy and advocacy.

Multisectoral supports

Multiple entry-points are needed for MHPSS support²⁴ to adequately meet the needs of all children and caregivers, including those with mental health conditions or those exposed to serious protection risks or severely distressing or traumatic events. Just as community health and social workers work in collaboration with formal health and social service systems, MHPSS actors must operate with input from mental health, protection, social services, and other systems that support child and family wellbeing. While the percentage of children and adults who require focused or specialized services may be small, they are often a neglected and vulnerable group.

It is important for actors across all sectors to be aware of the continuum of MHPSS needs of children and

families and to ensure functional referrals up and down the layers of the pyramid. Interventions can best reach children, caregivers, parents and families when they are integrated within existing systems, such as health and social protection structures, rather than conducted as stand-alone programmes (e.g., specialized services without other layers of support).

Other structures also serve as entry-points, such as schools, social service systems, community centres and safe spaces, and community organizations, such as youth clubs, women's cooperatives and religious organizations. MHPSS programmes should avoid over-targeting sensitive groups (e.g., survivors of GBV or children formerly associated with armed forces or groups) in ways that further their discrimination and exclusion in communities. Instead, it is best to work

²⁴ This section intentionally does not describe sectors in detail for two reasons: First, it would duplicate other resources that provide that level of detail, and second, multisectoral support must be inclusive of all sectors, so focusing in detail on a select few would exclude others. Instead, this section focuses on the importance of multisectoral supports, a continuum of supports and needs, and the layering of interventions across sectors.

towards broad support and advocacy to promote the inclusion and wellbeing of all community members, while ensuring that all MHPSS actors are aware of critical referral pathways for sensitive groups.

A multisectoral approach to mental health and psychosocial wellbeing recognizes and builds continuity of services, coordination and communication mechanisms across sectors to avoid gaps and address the continuum of care. More detailed descriptions of these entry-points can be found in [UNICEF's Mental Health Technical Note](#). Another resource that presents these entry-points is the [Minimum Services Package \(MSP\)](#),²⁵ which applies a multisectoral approach to MHPSS service provision but also includes details on key tools and interventions across sectors. The package, while developed for humanitarian contexts, can also be helpful for programme planning in non-emergency contexts.

Innovation and MHPSS

Mental health innovation is a relatively new and emergent field. There are communities of mental health innovators – researchers, practitioners, policymakers, service user advocates and donors from around the world – sharing resources and ideas to promote mental health. The need now is more than ever for innovative solutions that reduce the gap in accessibility to supportive, age-appropriate mental health services globally. But those solutions need and should be co-created with service users, including youth and caregivers. This includes digital and non-digital innovations, which go hand in hand with efforts to build a mental health system and services that protect children and young people's mental health.

Addressing the mental health needs of young people is a major public health concern, which has been impaired by the fact that many children and adolescents do not seek help when they need it. Some of the barriers that young people face in accessing much-needed support include concerns about stigma, confidentiality, shame or embarrassment around discussing personal issues, financial costs, or limited access to services. In many instances, existing efficacious face-to-face interventions can be adapted using digital technology

as a means of addressing these barriers. Digital health interventions (e.g., internet programs, apps, virtual reality environments or robotic systems) have the potential to be effective, with advantages of accessibility, anonymity, prompt feedback and cost-effectiveness. Considering the increased digital literacy and internet use among youth, digital health interventions combined with existing non-digital approaches may serve as a new way to increase accessibility to mental health interventions globally.

Child- and adolescent-focused MHPSS innovation should always reflect on the following areas during innovation design and implementation:

- ❑ Closing the gap in the availability of and accessibility to quality age-appropriate MHPSS services across settings, with particular attention to under-resourced and humanitarian settings, is the collective responsibility of all organizations engaged in MHPSS programming, research and funding (see Box 1).
- ❑ UNICEF and its partners must place greater focus on quality and do-no-harm principles, ensuring that MHPSS innovation is founded on rigorous M&E that captures learning across the programme life cycle.
- ❑ Innovation in any arena brings both success and failure, therefore MHPSS innovations may not always lead to envisaged outcomes. In instances of setbacks or failure, the greatest achievement of innovation is transparency – learning how to stop glossing over failures, allowing them to teach us and inform the improved or next innovation.

²⁵ The MSP is currently being field-tested in multiple settings.

Box 1 Adoption of innovation as an accelerator to develop and deliver age-appropriate digital and non-digital MHPSS services

In 2021, UNICEF's Programme Group and Office of Innovation launched UNICEF's first Mental Health and Psychosocial Wellbeing Portfolio as part of operationalizing UNICEF's Global Innovation Strategy. The portfolio funds promising innovative solutions designed to address the varying and complex mental health and psychosocial needs of children, adolescents and young people and their families.

As part of the MHPSS Framework's implementation package, UNICEF has developed MHPSS and innovation guidelines to better guide country- and regional office-level MHPSS innovations. The information included will help programme staff ensure quality and practise do-no-harm principles, which are especially important given the sensitive nature of mental health. Duty of care must be applied across innovation, in particular with task shifting and digital solutions, and data must be handled properly. The objectives of the package are to:

- Support individual and organizational capacities around design and implementation of innovative MHPSS programmes, field-level monitoring, evaluation, accountability and learning
- Encourage and improve knowledge around innovation, MHPSS and inventive approaches.

More information on global MHPSS innovation:



The Mental Health Innovation Network (MHIN) is a community of mental health innovators – researchers, practitioners, policymakers, service user advocates and donors from around the world – sharing innovative resources and ideas to promote mental health and improve the lives of people with mental, neurological and substance use disorders. The network is jointly led by The Centre for Global Mental Health at the London School of Hygiene and Tropical Medicine and WHO. Expansion of the network has included the launching of regional networks:

- [MHIN Africa](#)
- [MHIN Latin America and Caribbean](#)



Grand Challenges Canada's Global Mental Health programme aims to seed and transition to scale high-impact innovations that support the mental health needs of underserved individuals, in particular young people in LMICs. Learn more:

- [Enhancing Maternal Mental Health and Wellbeing: Adapting 'Thinking Healthy' Intervention in Liberia](#)
- [Global Mental Health announces first cohort of youth mental health seed funding projects](#)



[Uplink Youth Mental Health Challenge](#)

UpLink is a digital platform centred around challenges and digital communities that support the United Nations SDGs. It seeks to source innovative solutions and connect them to influential networks with the resources to scale them. In February 2022, UpLink launched its Youth Mental Health Challenge with [14 top innovators and more than 70 solutions](#). For example,

- [The CETA Approach: Evidence-based, efficient mental health care for all](#)



INVENT²⁶ provides UNICEF staff a one-stop shop to explore, discover, connect and contribute to the landscape of technology for development and innovations across UNICEF, while improving portfolio management and decision-making at all levels. You can access details [here](#) about the current MHPSS funded innovation projects. This resource is limited to UNICEF staff.

²⁶ This link is internal to UNICEF staff. To learn more, please contact your local UNICEF office.

■ Operationalizing the MHPSS Framework



*Together the social ecological model, life course approach and three domains of wellbeing create **UNICEF's MHPSS Framework**.*

Children’s optimal development and wellbeing depend on their interaction with biological or environmental and contextual factors. This includes the children’s or adolescents’ relationships with their caregivers or parents, family and community; the sociocultural and political influences; and the services and structures that surround children, adolescents, their caregivers and communities. These factors have been articulated through various frameworks – child development theories, social ecological models, and studies of children’s resilience in the face of adversity – all of which emphasize that children and families are active agents in their own wellbeing and bring their own skills, assets and resources for coping and building resilience. The MHPSS Framework integrates three of these foundational frameworks: the social ecological model, UNICEF’s life course approach to programming, and adaptation of the IASC intervention pyramid for MHPSS that is relevant across settings.

A functioning MHPSS support system is built around concentric circles of the social ecological model (see *Figure 1*), with children or adolescents in the centre, caregivers in the second circle, and community in the third circle. The child, caregiver and community are then supported and surrounded by the fourth circle of an enabling environment, which includes all the systems, policies and structures necessary for ensuring people’s mental health and psychosocial wellbeing.

The social ecological model engages children as active agents in their ecosystems in dealing with adversity and, in turn, influencing their families and communities. The layers and networks that exist within and between the circles of support provide for children’s social and practical needs,²⁷ protection, learning, belonging and identity, and recovery from critical events.

MHPSS theory of change

A theory of change (TOC) explains how activities produce a series of results that contribute to achieving an intended impact or outcome. The MHPSS TOC is an application of the social ecological model that explains how MHPSS interventions directed at the child, family or caregiver, community, and society and culture can help improve people’s mental health and psychosocial wellbeing. The TOC has also identified common social barriers to mental health and psychosocial wellbeing and key mental health determinants that have a direct impact on a person’s wellbeing. The theory can be adapted and tailored to the specifics of different contexts.

UNICEF’s MHPSS ultimate impact (top box in *Figure 5*) is that the mental health and psychosocial wellbeing of children, adolescents and their caregivers is supported and protected to help them better survive and thrive in their communities and societies. This is achieved when MHPSS systems are mobilized and strengthened to promote child, adolescent and family wellbeing across the domains of wellbeing.²⁸

The outcomes are further elaborated into outputs that contribute to mental health and psychosocial wellbeing by:

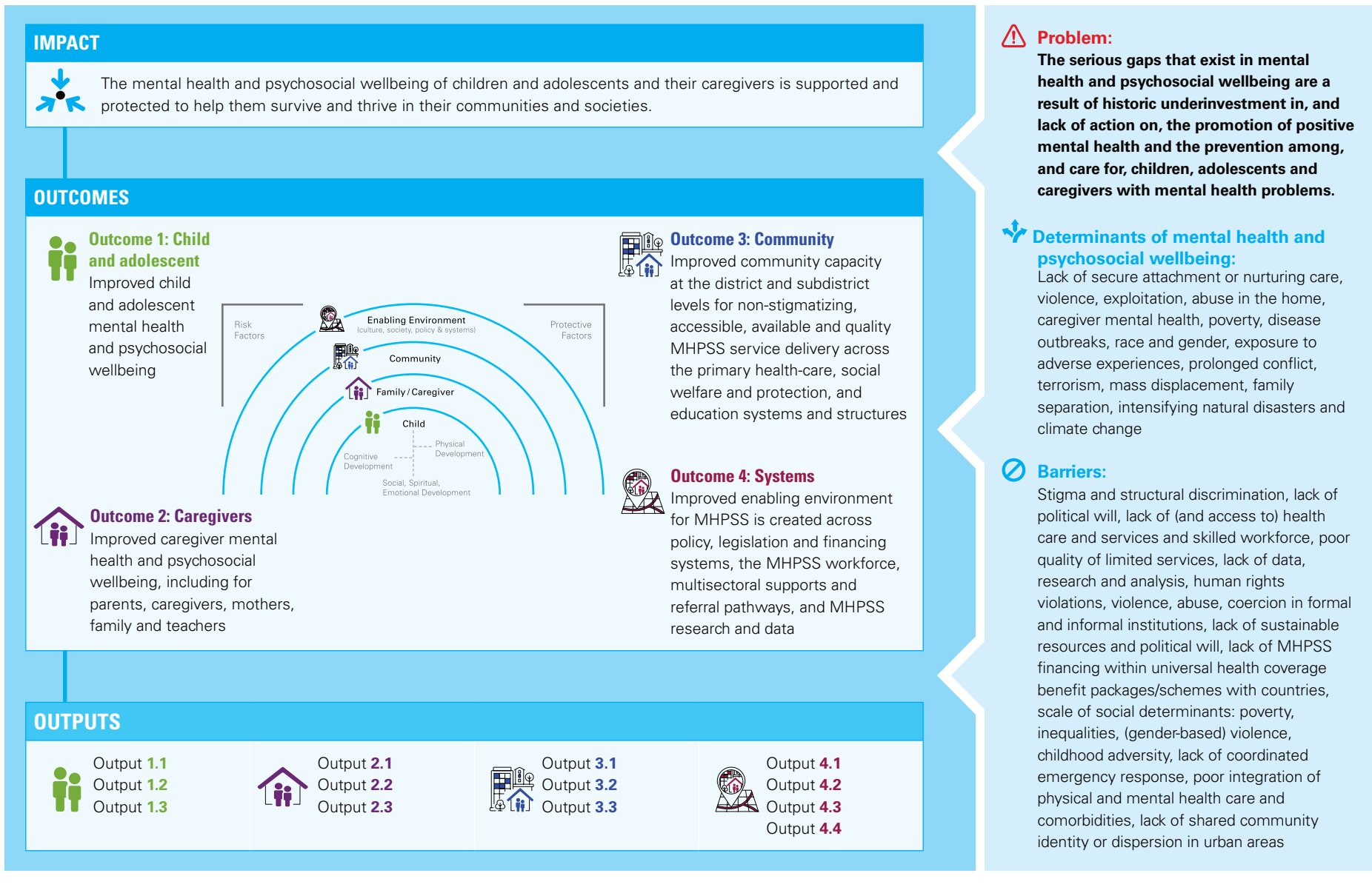
- Addressing the systems and structures central to creating societies that value and respect individual and family mental health and psychosocial wellbeing across the social ecological model by strengthening the MHPSS service delivery infrastructure
- Addressing individuals’ mental health and psychosocial wellbeing by responding to their individual needs (personal wellbeing), relational needs (interpersonal wellbeing), and the skills and knowledge necessary for mental health and psychosocial wellbeing.

The next section of this operational framework discusses each of the outcomes and outputs presented in the TOC. There is a brief discussion about the MHPSS needs related to that outcome, along with recommendations for programme design and development. The framework that follows provides further details of the TOC.

²⁷ Practical needs refer to tangible and immediate needs, such as water, food, shelter, clothing, etc.

²⁸ See ‘Mental health and psychosocial wellbeing’ in the Key definitions section for more information on the domains of wellbeing.

Figure 5 Visual of UNICEF's MHPSS theory of change



UNICEF's MHPSS TOC



IMPACT:

The mental health and psychosocial wellbeing of children and adolescents and their caregivers is supported and protected to help them survive and thrive in their communities and societies.

OUTCOMES

Outcome 1: Child and adolescent

Improved child and adolescent mental health and psychosocial wellbeing

1.1 Children and adolescents have access to safe and nurturing environments and quality services that improve their mental health and psychosocial wellbeing:

- » At home
- » At school
- » In the community

1.2 Children and adolescents have access to support systems that facilitate positive relationships that promote inclusion, belonging and agency

1.3 Children and adolescents have opportunities for stimulation, learning and skills development that contribute to mental health and wellbeing

Outcome 2: Caregivers

Improved caregiver mental health and psychosocial wellbeing, including for parents, caregivers, mothers, family and teachers

2.1 Parents, caregivers, mothers, families and teachers have access to support for developing and maintaining improved mental health and psychosocial wellbeing

2.2 Parents, caregivers, mothers, families and teachers have access to family and community support networks that improve their mental health and psychosocial wellbeing

2.3 Parents, caregivers, mothers, families and teachers develop skills for parenting, teaching, and supporting children and adolescents in distress (MHPSS needs)

Outcome 3: Community


Improved community capacity at the district and subdistrict levels for non-stigmatizing, accessible, available and quality MHPSS service delivery across the primary health care, social welfare and protection, and education systems and structures

3.1 Stigma- and judgement-free environments for mental health and psychosocial wellbeing are established through social and community awareness, acceptance and positive behaviour change for children, adolescents and their parents, caregivers, families and teachers

3.2 Community mental health and psychosocial wellbeing support systems are strengthened across sectors, including community capacities to support children, adolescents, parents, caregivers, families and teachers

3.3 Multisectoral care systems (primary health care, social welfare and protection, education) for children, adolescents, parents, caregivers, families and teachers, including family-friendly policies, are developed and strengthened

OUTPUTS

Outcome 4: Systems An improved enabling environment for MHPSS is created across policy, legislation and financing systems, the MHPSS workforce, multisectoral supports and referral pathways, and MHPSS research and data 

4.1 Policy, legislation and financing: An effective policy, legislative and financing environment is available and accessible by putting supportive mechanisms in place for quality MHPSS service delivery

4.2 Strengthened multisectoral systems and referral pathways: Multilayered support systems and processes within existing structures include functional referral systems across primary health care, social welfare and protection, and education

4.3 Workforce development and capacity: Strengthened capacity among the MHPSS workforce supports the provision of quality age- and gender-responsive MHPSS care across all sectors

4.4 Research, evidence and data: An evidence and data ecosystem for MHPSS informs and drives policy changes around MHPSS

Problem: The serious gaps that exist in mental health and psychosocial wellbeing are a result of historic underinvestment in, and lack of action on, the promotion of positive mental health and the prevention among, and care for, children, adolescents and caregivers with mental health problems.

Determinants of mental health and psychosocial wellbeing:

Lack of secure attachment or nurturing care, violence, exploitation, abuse in the home, caregiver mental health, poverty, disease outbreaks, race and gender, exposure to adverse experiences, prolonged conflict, terrorism, mass displacement, family separation, intensifying natural disasters and climate change

Barriers:

Stigma and structural discrimination, lack of political will, lack of (and access to) health care and services and skilled workforce, poor quality of limited services, lack of data, research and analysis, human rights violations, violence, abuse, coercion in formal and informal institutions, lack of sustainable resources and political will, lack of MHPSS financing within universal health coverage benefit packages/schemes with countries, scale of social determinants: poverty, inequalities, (gender-based) violence, childhood adversity, lack of coordinated emergency response, poor integration of physical and mental health care and comorbidities, lack of shared community identity or dispersion in urban areas



Outcome 1: Child and adolescent Improved child and adolescent mental health and psychosocial wellbeing

In children and adolescents, wellbeing results from the interplay of physical, psychological, cognitive, emotional, social and spiritual aspects that influence their ability to grow, learn and develop to their full potential. Resilience is the capacity to overcome adversity and adapt after difficult experiences. Children's resilience comes from a combination of personal factors (personality, genetic makeup, presence or absence of disabilities); social factors (positive or negative family environments, supportive teachers, positive friendships); and environmental factors (access to essential services and protection, safety of their environment, inclusion and belonging in society). Evidence shows that children and adolescents can develop resilience when:

- ❑ Parents and caregivers are responsive to children's social-emotional, early learning and material needs
- ❑ Children have access to learning opportunities
- ❑ Social cohesion within the community is also strengthened.

Children's vulnerabilities increase with exposure to risks, especially if they lack protective factors, such as problem-solving skills, concerned caregivers or access to basic services and security. Effective MHPSS intervention strategies therefore work to reduce risks and advocate for protective environments and access to services. This includes building the coping capacity of children directly, as well as improving social supports and services within children's care environments. It also involves providing young people with safety, stability and nurturance.

- ❑ **Safety:** The extent to which a child is secure and free from fear and harm (both physical and psychological) in their relationships and their physical environment.
- ❑ **Stability:** The degree of predictability and consistency in children's social, emotional and physical environments.

- ❑ **Nurturance:** The extent to which parents and caregivers are available and able to meet the needs of children and adolescents sensitively and consistently.

In both development and humanitarian contexts, the presence of a stable adult caregiver²⁹ aids children's and adolescents' overall sense of wellbeing. In addition, re-establishing routines during times of personal, familial or external crisis can boost a child's or adolescent's coping and recovery. However, it is important to recognize that caregivers have their own mental health and psychosocial needs that may challenge their ability to offer safety, stability and nurturance to children in their direct care. MHPSS interventions should therefore prioritize the mental health and wellbeing of caregivers, including through preventive and promotive parenting programmes and responsive care as needed.

Children's wellbeing is interconnected with their cognitive, physical, social, spiritual and emotional development and is also directly related to their relationships with caregivers or parents, teachers and the broader community. Programming across Outcome 1 includes strategies across three outputs, which follow the three domains of wellbeing:

- ❑ **Output 1.1** is focused on strategies that contribute towards personal wellbeing, specifically ensuring children and adolescents have safe and nurturing environments at home, at school and in the community.
- ❑ **Output 1.2** is focused on children's interpersonal wellbeing, including the positive relationships that promote inclusion, equality, belonging and agency.
- ❑ **Output 1.3** includes strategies that support the skills and knowledge necessary for positive mental health and psychosocial wellbeing outcomes, including opportunities for stimulation, learning and skills development.

²⁹ 'Caregiver' refers to anyone responsible for the care of children, and may include mothers, fathers, grandparents, siblings and others within an extended family network, as well as other child caregivers outside the family network, such as teachers.

Output 1.1

Children and adolescents have access to safe and nurturing environments and quality services that improve their mental health and psychosocial wellbeing at home, at school and in the community

Safe, nurturing environments at home, at school and in the community ensure that children and adolescents are protected from harm, abuse, neglect and violence, and that they receive nurturing care and support in coping with events in their lives, including the ability

to respond to violence and abuse when it occurs. Considerable research proves the significant role that nurturing plays in the earliest stages of child development, which includes how a mother's health during pregnancy affects a child's development over the life course. Children develop rapidly during their first 1,000 days (about two and a half years), laying a foundation for their growth and development over their life course.³⁰ Interventions and services within Output 1.1 are specifically focused on the environmental and individual needs of children and adolescence.

Box 2 Programming for child and adolescent personal wellbeing

Programming at Output 1.1 is focused on children's and adolescents' personal or individual sense of wellbeing. Personal wellbeing includes a person's positive thoughts and emotions, such as hopefulness, calm, self-esteem and self-confidence. Childhood and adolescence are periods of constant growth and development. A social ecological approach means that programme leaders understand that children's personal mental health and psychosocial wellbeing is directly related to their sense of safety and security at home, at school and in the community, as well as the quality of their relationships with those who engage with them on a daily basis.

Safe and nurturing environments at home are fundamental to the emotional and psychological development of children and adolescents. Support and training for parents and caregivers are therefore important to help them create loving, nurturing relationships within their homes. Children from birth until the age of school entry and beyond depend on nurturing care from their caregivers to help them learn how to express basic needs and wants, recognize emotions in others and express their own emotions. Initially, influential relationships are with children's primary caregivers, who also help shape a child's social skills and teach them how to relate with others, including across gender, disabilities and other minorities. Social interaction becomes increasingly important as children grow and mature. Young children, from ages 5 to 9, learn how to play and interact with other children. During the early adolescent years (ages 10 to 14), peer relationships become influential on young people's thoughts and actions. Positive relationships with caregivers and peers promote young people's sense of inclusion and belonging and help build their sense of agency.

Safe and nurturing environments at school are also important. Support and training for teachers and

others involved in child-focused activities can help ensure that adult caregivers have a positive impact on the mental health and psychosocial wellbeing of all children and are equipped to support children or refer them to others for additional services when necessary. Capacity-building may focus on helping teachers create or adapt learning environments to better meet the learning, mental health and psychosocial wellbeing and safety needs of all young people in schools and learning environments across a variety of development and humanitarian contexts.

Outreach, identification and case management play a strong role in meeting children's mental health and psychosocial wellbeing needs. Community outreach, education and training of gatekeepers are important for early identification of young people who may need mental health and psychosocial services. Children and families with specific health or protection needs may require outreach and case management services to assist with identification of and access to services, follow-up and support.

Effective case management requires trained and supervised staff competent in ethical, best practice standards. Referral resources and coordination

³⁰ World Health Organization, United Nations Children's Fund, and World Bank Group, 'Nurturing care for early childhood development: A framework for helping children survive and thrive to transform health and human potential', WHO, Geneva, 2018.

mechanisms are also needed. Children with protection risks need to be identified quickly, systematically evaluated and referred for appropriate services. Child protection case workers should develop intervention plans that respond to the mental health and psychosocial needs of children and other members of their family. For example, caregivers with a history of addiction will benefit from case management support, follow-up and referrals to services across the health, social welfare and protection systems. Case workers can assist in this process by working with children and families to formulate an action plan that is responsive to each person's support needs. This involves ensuring confidential documentation and information

management, referrals, monitoring and supporting follow-up appointments.

Case management systems in some settings may not be well developed, but they should not be ignored, as this workforce will have culturally relevant knowledge and skills. It is important to find out if there is an existing university-trained workforce with the knowledge and skills for strengthening and building the case management infrastructure across health, education, and social welfare and protection systems. Multisectoral systems-strengthening is essential for establishing strong referral pathways, building capacity, and improving outreach and case management functions for vulnerable children and families.



Putting it into practice for Output 1.1

Practice example from Bhutan:

[Early environments of care: Strengthening the foundation of children's development, mental health and wellbeing](#)

As noted earlier in this document, the mental health and psychosocial wellbeing of young children is directly tied to the physical, psychological and social capacity of their caregivers and families. In Bhutan, UNICEF has supported the Ministry of Education in implementing a national parenting education programme and contextualizing and running a pilot caring for the caregiver (CFC) programme, which helps caregivers build their confidence and strengthen the skills needed to support children's development and wellbeing. The parenting education programme, delivered across 432 community-based Early Childhood Care and Development centres, has reached 8,915 children (4,396 girls and 4,519 boys). Approximately 260 children and 260 caregivers were reached during the CFC pilot. An evaluation of the pilot found that the CFC led to decreased feelings of depression and anxiety and improved self-esteem in caregivers who participated.

Practice example from China:

[Supporting the socio-emotional learning and psychological wellbeing of children through a whole-school approach](#)

According to a recent Chinese national study of mental health, almost 25 per cent of adolescents in China reported experiencing mild or severe depression.³¹ It is estimated that at least 30 million children and adolescents under 17 in China struggle with emotional or behavioural problems. UNICEF is working with health services, the education sector, families and adolescents to ensure adolescents' mental health and wellbeing are promoted and protected. Prevention of mental health problems is more cost-effective and leads to better health and wellbeing outcomes than treatment alone. In the education sector, UNICEF partnered with the Ministry of Education over the past 10 years to develop and implement the [Social and Emotional Learning project](#). The project focuses on improving school culture and environment, enabling student-centred teaching and learning, strengthening school leadership and management, and facilitating school-family collaboration.

Evidence example from Bihar state, India:

[Strengthening the evidence on school-based interventions for promoting adolescent health \(SEHER\)](#)

The SEHER ('dawn' in Hindi) whole-school approach³² to school health promotion interventions was delivered by lay counsellors or teachers in government-run secondary schools in Bihar, India.³³ The Wellcome Trust funded a clustered randomized trial (CRT) of the SEHER programme approach to understand the effects of the intervention over time. The CRT included 75 schools in the Nalanda district of the state of Bihar found that the lay counsellor-delivered intervention, compared with the control group, reported improvements in school climate, depression, violence between peers, attitude towards gender equity, violence victimization and violence perpetration. The effect sizes for these outcomes at end of year two were larger than at the end of year one.³⁴

³¹ United Nations Children's Fund China, 'Adolescent Mental Health: A UNICEF Priority For 2021–2025', UNICEF China, June 2021.

³² United Nations Children's Fund, 'Mental Health and Psychosocial Support for Children in Humanitarian Settings: An updated review of evidence and practice', UNICEF, New York, 2021, p. 57.

³³ Shinde, Sachin, et al., 'A multicomponent secondary school health promotion intervention and adolescent health: An extension of the SEHER cluster randomised controlled trial in Bihar, India', *PLOS Medicine*, vol. 17, no. 2, 11 February 2020.

³⁴ Shinde, Sachin, et al., 'Promoting school climate and health outcomes with the SEHER multi-component secondary school intervention in Bihar, India: A cluster randomised controlled trial', *The Lancet*, vol. 392, no. 10163, 8 December 2018, pp. 2465–2477.

The SEHER whole-school approach has since been included in several publications, including the following:

- CRT findings: [A multi-component secondary school health promotion intervention and adolescent health: An extension of the SEHER cluster randomised controlled trial in Bihar, India](#)
- CRT pilot: [Promoting school climate and health outcomes with the SEHER multi-component secondary school intervention in Bihar, India: A cluster-randomised controlled trial](#)
- [How can schools support whole-school wellbeing? AISNSW Wellbeing Literature Review: A Review of the Research:](#) This report includes a case study focused on the SEHER Adolescent Health Intervention, including a useful table of interventions used in the programme.
- [Building healthy societies: A framework for integrating health and health promotion into education:](#) See Case Study 1: Strengthening the evidence on school-based interventions for promoting adolescent health (SEHER).

Intervention table 1

Interventions and activities for safe and nurturing environments at home, at school and in the community

Intervention table one of nine presents examples of interventions that support the MHPSS needs of children and adolescents at the individual level. UNICEF uses the continuum of care to ensure that all programming includes interventions that promote mental health and psychosocial wellbeing, prevent

mental health conditions, and ensure the care and treatment of children and adolescents.

This list is intended to be illustrative and is not exhaustive. Intervention tables use the terms 'promotion', 'prevention' and 'care' to illustrate an application of the continuum of care. For some users, these terms are helpful; for others they are new and unfamiliar. Users are encouraged to use (or not use) the terms to the extent that they are beneficial to their design and planning processes.

Outcome 1: Child and adolescent

Output 1.1: Children and adolescents have access to safe and nurturing environments and quality services that improve their mental health and psychosocial wellbeing at home, at school and in the community.

Promotion interventions increase protective factors, including healthy behaviours and skills that reduce children's and adolescents' risk of developing mental health and psychosocial conditions. UNICEF programmes may include strategies and interventions that promote mental health and psychosocial wellbeing across all layers of the intervention pyramid and will in turn contribute to the destigmatization of mental health and psychosocial issues. Promotion activities under Output 1.1 include strategies that target the personal wellbeing of children and adolescents.



Build capacity of parents, education personnel and other child caregivers to enable them to provide MHPSS to children. This includes understanding:

- How ensuring access to safe and nurturing environments will have a positive impact on the mental health and psychosocial wellbeing of children and adolescents
- How their own mental health and wellbeing affect that of the child in their care
- What the direct link is between children's and adolescents' mental health and psychosocial wellbeing and the quality of their relationships.



Increase and develop programmes that engage communities and schools in building safe, non-violent, inclusive and effective learning environments that promote all children's and adolescents' mental health and wellbeing.³⁵

- Advocate for multisectoral engagement (across child protection, health and education) with partners and relevant authorities to strengthen an area's capacity to integrate MHPSS in disaster risk reduction and resilience programmes in the education sector.

³⁵ United Nations Children's Fund, 'Learning Brief on Mental Health and Psychosocial Support (MHPSS) in Education', UNICEF, New York, 2022.

Prevention interventions aim to stop mental health and psychosocial problems from developing, getting worse or reoccurring. UNICEF programming may include primary prevention strategies that aim to stop mental health problems before they begin, secondary prevention interventions that provide support to those at high risk of experiencing mental health problems, and tertiary prevention interventions that support people living with mental health and psychosocial problems.³⁶



Provide children with MHPSS and psychoeducation to help them manage and cope with distress, mental health conditions or disabilities. For example:

- Integrating strategies for the prevention of suicide and self-harm across programmes, including hosting suicide prevention programmes at schools, running media campaigns on the radio or TV, or working with parents and caregivers to understand the importance of seeking help when they observe concerning changes and behaviours in their children
- Identifying and referring children who have suffered serious protection risks or severely distressing or traumatic events for specialized care and support as needed (e.g., clinical care by a mental health professional).



Ensure children and adolescents have access to quality learning and skills development in formal and non-formal education settings. This may include:

- Building children's transferable skills, including the capacity to think critically, recognize misinformation, and resist peer pressure (including skills in digital literacy and coping with cyber-violence)
- Supporting initiatives that build safe, gender-responsive and supportive learning environments for children and adolescents and promote positive teacher–student relationships and supportive peer relationships
- Encouraging school management to promote comprehensive school safety efforts that emphasize both physical and psychological safety.

Care and treatment interventions for mental health and psychosocial problems include services that address children's or adolescents' mental health and psychosocial needs through personalized care delivered to individuals or groups. Children and adolescents need access to appropriate mental health and psychosocial care and professional social services. This is particularly important for children with mental health and psychosocial needs and those who have been exposed to serious protection violations. The care and treatment of mental health and psychosocial needs include a wide range of services, including but not limited to counselling and psychotherapy, pharmacology, case management services, hospitalization, support groups, self-help plans and strategies, recovery and rehabilitation approaches, and peer support.

Within the MHPSS Framework, the word 'care' includes the full range of treatment interventions for mental health conditions and psychosocial needs. 'Appropriate care' means that the services provided are responsive to a child's particular MHPSS needs, age and gender. Care should be adapted based upon how a child responds to services. Lastly, it is important not to assume that all children will need additional services. Referrals for additional services should always have the consent of the child.



Provide children and adolescents with individual care and support, which can include the following types of interventions:

- Individual psychological interventions facilitated by a trained provider for the treatment of a mental health condition
- Focused MHPSS for children with mental health conditions and psychosocial needs
- Psychological interventions to support children with gaining autonomy in their daily lives through activities that are meaningful and learning strategies to cope with their mental health conditions.



Case management services for children and adolescents in need of additional services, for example:

- Access to MHPSS, sexual and reproductive health services, and protection services for child and adolescent survivors of GBV
- Case management services that facilitate the management and support of children with mental health conditions or serious protection risks (e.g., helping them access medications and follow-up appointments).

Considerations for adaptation

Continuity of care: Is the child or adolescent in a situation that would make completing the intervention cycle difficult? If so, select approaches and interventions that are not directly dependent on a sequenced treatment.

Remote delivery: Based on the context, activities may need to be adapted for remote delivery or social distancing.

³⁶ Youth.gov, 'Mental Health Promotion and Prevention', <<https://youth.gov/youth-topics/youth-mental-health/mental-health-promotion-prevention>>, accessed 26 October 2022.

Terminology: Adapt terms based upon the needs of the local context. For example, 'educational settings' can be used as an alternative term for schools. The [IASC Guidelines on Mental Health and Psychosocial Support In Emergency Settings](#) provides a list of mental health terms to avoid in non-clinical settings (see p. 10 of the IASC publication).

Consideration for referrals: Avoid referring children to specialized services by default when they have experienced an event that could be defined as traumatic or severely distressing. Everyone, including children, should have agency in the decision to seek additional help and should only be referred if the available services are of high quality, adapted for a child's age, and unlikely to cause more harm. There has been a recent trend to have 'number of referrals' as an M&E target, which may result in inappropriate referrals of children to harmful services.



For **humanitarian response**, check out the following sections and key actions from the [Minimum Services Package](#):

- [MSP 3.5](#) Provide early childhood development (ECD) activities to support young children and their caregivers
- [MSP 3.8](#) Promote the mental health and psychosocial well-being of education personnel and strengthen their capacity to support children
- [MSP 3.9](#) Provide MHPSS through safe spaces for women and girls
- [MSP 3.10](#) Provide mental health care as part of general health services
- [MSP 3.12](#) Initiate or strengthen the provision of psychological interventions
- [MSP 3.13](#) Provide MHPSS through case management services



Recommended resources from the [Compendium of MHPSS Resources](#)

Strategies and approaches

- [INSPIRE website with information to end violence against children](#), Global Partnership and Fund to End Violence Against Children, 2016
- [Helping Adolescents Thrive Toolkit](#), WHO, 2021
- [Global Framework on Transferable Skills](#), UNICEF, 2019

Guidelines

- [Guidelines for Child Friendly Spaces in Emergencies](#), Global Education Cluster and Inter-agency Network for Education in Emergencies (INEE), 2011
- [Interim Briefing Note Addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak](#), IASC, 2020
- [Helping Hands at School and in The Community: Guidance for School-Based Psychosocial Programmes for Teachers, Parents, and Children in Conflict and Postconflict Areas](#), War Trauma Foundation, 2012
- [Promoting rights and community living for children with psychosocial disabilities](#), WHO, 2015
- [Evaluation of Child Friendly Spaces: Tools and guidance](#), World Vision International, 2015
- [MHPSS Assessments in the Context of COVID-19](#), IASC

Programme guidance

- [Move On & Engage: A Mental Health and Psychosocial Resilience Curriculum](#), Terre des hommes, 2020
- [Working with Children and their Environment: Manual of Psychosocial Skills](#), Terre des hommes, 2011
- [The Youth Resilience Programme: Psychosocial support in and out of school](#), Save the Children's Child Rights Resource Centre, 2015
- [The Children's Resilience Programme: Psychosocial support in and out of schools](#), Save the Children's Child Rights Resource Centre, 2012
- [Activity Catalogue for Child Friendly Spaces in Humanitarian Settings](#), IFRC Reference Centre for Psychosocial Support, 2018
- [Safe Healing and Learning Spaces Toolkit](#), International Rescue Committee, 2016
- [Psychosocial Support for Youth in Post-Conflict Situations: A trainer's handbook](#), IFRC Reference Centre for Psychosocial Support, 2014
- [Different. Just like you: A psychosocial approach promoting the inclusion of persons with disabilities](#), IFRC Reference Centre for Psychosocial Support, 2015

- [Broken Links: Psychosocial support for people separated from family members](#), Save the Children's Child Rights Resource Centre, 2014
- [mhGAP Intervention Guide Version 2.0 for mental, neurological and substance use disorders in non-specialized health settings](#), WHO, 2019

Training

- [Child Protection Case Management Training Manual for Caseworkers, Supervisors and Managers](#), Save the Children's Child Rights Resource Centre, 2014

Additional resources

- [UNICEF Technical Note: Gender-Responsive Parenting](#)
- [Early Adolescent Skills for Emotions \(EASE\): A psychological intervention for young adolescents and their caregivers](#), Mental Health Innovation Network
- [Think piece: Social and gender norms and child marriage; A reflection on issues, evidence and areas of inquiry in the field](#), Align Advancing Learning and Innovation on Gender Norms, 2019
- [Social norms, gender norms and adolescent girls: A brief guide](#), Overseas Development Institute, 2015

Output 1.2

Children and adolescents have access to support systems that facilitate positive relationships that promote inclusion, belonging and agency

Positive relationships with caregivers, friends, teachers and others in the community are essential to children's self-esteem and sense of inclusion, supporting their optimal development. Positive relationships also give children opportunities for self-expression and a sense of agency in their lives. Peer-to-peer support helps build social connections, teaches social skills such as reciprocity and empathy, and gives children the opportunity to learn helping and coping skills. Interventions within Output 1.2 are focused on the interpersonal dimensions of wellbeing, which include relationships at home and in the community.

Relationships at home: The primary relationships for children from the prenatal period to birth and early childhood (ages 0–4) are with parents, primary caregivers and other family members. Connection with nurturing, stable caregivers is protective for all children and crucial for the development of positive coping and recovery skills during crises. Loving families provide a foundation for children to develop self-esteem, skills for navigating life challenges, and a sense of structure, stability and predictability in their lives. The mental health and wellbeing of parents and caregivers can shape their ability to provide responsive care to children.³⁷ Thus, strengthening caregiver mental health

and the quality of family relationships has protective effects on children's psychosocial wellbeing and development.

Additionally, emergencies can result in disrupted family and community routines, social networks and community structures through displacement, poverty, loss of family or family separation. In transformed or new environments, children's recovery and wellbeing are enhanced by strengthening the ability of families and communities to re-establish routines and normalcy, supportive social connections, and opportunities for learning, growth and coping with new challenges.

Relationships at school, in the community and with peers: Positive social relationships in the larger community (with peers, family friends, neighbours or teachers) also give children a sense of inclusion, supporting an enabling environment for their growth and development. As children enter middle childhood (ages 5–9), their sphere of relationships expands to include their school environment, particularly teachers and peers. In early adolescence (ages 10–14) and late adolescence (ages 15–18), young people's relationship base expands from home and school to include the wider community. In many cases – especially during adolescence – young people are drawn towards a range of community supports, which can have both positive and negative impacts. Supportive community networks can have a protective function and provide

³⁷ 'Responsive caregiver' refers to the ability of a parent or caregiver to notice, understand and respond to a child's signals in a timely and appropriate manner. For more information, see 'A closer look at the nurturing care components', Nurturing Care Framework, 2020.

opportunities for adolescents to engage with and contribute to their society. They can also provide respite for overstressed parents and caregivers or encourage them to use positive parenting practices. Community engagement often happens spontaneously in spaces such as parks, community centres, places of worship,

shrines, water points or traditional women's gatherings. These natural connections and forums for connecting may be disrupted during emergencies, so programmes may focus on supporting their reactivation.



Putting it into practice for Output 1.2

Practice example from Brazil:

[Prioritizing children and adolescents' mental health and protection during school reopening \(Brazil\)](#)

Following the onset of the COVID-19 pandemic, UNICEF Brazil supported the development of a cross-sectoral strategy, including the creation of technical guidance and training for education professionals to address students' learning, mental health and protection needs. Training included practical guidance on how to identify, prevent and respond to mental health risks or violence and encompassed how to utilize local referral services. Recommended actions included designating specific actors or groups to lead strategies that ensure a protective environment within schools. For example, some schools have now formed committees for reporting cases of violence. Other suggestions included welcoming students in need, identifying the type of support required and referring cases to appropriate services.

Evaluation example, Colombia and South Sudan:

[War Child Holland's programme evaluation of psychosocial support intervention I DEAL in Colombia and South Sudan \(2013\)³⁸](#)

War Child Holland's psychosocial support intervention I DEAL supports children (aged 11–15 years) to better cope with the aftermath of armed conflict by strengthening their social and emotional coping skills. The intervention addresses the themes of identity, dealing with emotions, relationships with peers and adults, conflict and peace, and the future. Previously published and unpublished evaluations in other countries have shown that I DEAL has positive short-term outcomes for the children participating, particularly mitigating reactions to violence, such as aggression, and improving relations with adults and peers. Key evaluation findings identified in UNICEF's Evidence and Practice Review include:

- Objectives of the I DEAL intervention and the themes it addresses are consistent with children's local perceptions of wellbeing.
- Evaluations in both countries indicated positive results in children's achievement of their personal goals.
- Both evaluations indicate positive outcomes in the development of children's social coping skills, especially conflict resolution skills and improved social relationships with peers and adults.

In addition to I DEAL, War Child Holland also offers Parent DEALS (for parents and caregivers), and She DEALS (for adolescent mothers and survivors of GBV). More information on War Child's I DEAL programmes can be found on War Child Holland's web page dedicated to the [I DEAL approach](#) and in UNICEF's Evidence and Practice Review 'Mental Health and Psychosocial Support for Children in Humanitarian Settings', p. 19.

Intervention table 2

Interventions and activities that facilitate positive relationships that promote inclusion, belonging and agency

Intervention table two of nine presents illustrative examples of interventions that support the MHPSS needs of children and adolescents that facilitate positive relationships. UNICEF uses the continuum of care to ensure all programming includes interventions that promote mental health and psychosocial wellbeing,

prevent mental health conditions, and ensure the care and treatment of children and adolescents.

The terms 'promotion', 'prevention' and 'care' are used to illustrate an application of the continuum of care. For some users, these terms are helpful; for others they are new and unfamiliar. Users are encouraged to use (or not use) the terms to the extent that they are beneficial to their design and planning processes. This list is intended to be illustrative and is not exhaustive.

³⁸ War Child International, Annual Report 'I DEAL Evaluation – South Sudan and Colombia', War Child International, <http://2013.annualreportwarchild.org/read-the-annual-report/S_1018_Children5/a1163_I-DEAL-evaluation-%E2%80%93-South-Sudan-and-Colombia>, accessed 14/12/2022. Additionally, this project was included in 'Mental Health and Psychosocial Support for Children in Humanitarian Settings', p. 19.

Outcome 1: Child and adolescent

Output 1.2: Children and adolescents have access to support systems that facilitate positive relationships that promote inclusion, belonging and agency.

This approach aims to strengthen the network of positive relationships for children and adolescents, which includes relationships with peers, family, teachers and others within the community.

Promotion interventions increase protective factors, including healthy behaviours and skills that reduce children's or adolescents' risk of developing mental health conditions and support their psychosocial needs.³⁹ Promotion activities under Output 1.2 include strategies that target the interpersonal wellbeing of children and adolescents. This may include promoting healthy relationships among peers, with their caregivers, and with others in their community.



Ensure children and adolescents have access to age- and gender-appropriate individual and group activities that support their mental health and psychosocial wellbeing. Some examples include:

- Opportunities for adolescents to contribute to the community; for example, leading activities for younger children, developing or promoting messages about health and coping, and helping in rebuilding efforts
- Youth-organized, -led and -implemented mental health and psychosocial wellbeing promotion campaigns
- Programmes that identify and address harmful behaviours and social and gender norms to reduce violence between peers, abuse, neglect, exploitation and violence against children, and reduce the stigma with mental health and psychosocial problems.

Key considerations

Ensure access to services: MHPSS promotion campaigns should always include information on where to access support, if and when needed, as campaigns often result in an increased number of people seeking help.

Prevention interventions aim to stop mental health and psychosocial problems from developing, getting worse or reoccurring. UNICEF programming under Output 1.2 may include structured group activities facilitated by MHPSS workers trained and supervised in psychosocial support. These may include primary prevention strategies that aim to stop mental health problems before they begin, secondary prevention interventions that provide support to those at high risk of experiencing mental health needs, and tertiary prevention interventions that support people living with mental health and psychosocial problems.⁴⁰



Provide children and adolescents with access to a range of MHPSS interventions that strengthen social connection and healthy relationships with peers and caregivers. For example, interventions can include programmes that:

- Support children based on their specific needs to access services and actively participate in their communities
- Collaborate with children, adolescents and other stakeholders to design, implement and jointly monitor child-friendly, accessible and confidential safeguarding feedback and reporting mechanisms
- Support access to quality structured group activities for children's mental health and psychosocial wellbeing (e.g., creative and expressive activities) within the community (e.g., in child-friendly spaces and learning spaces) and at schools
- Create peer-to-peer groups, youth clubs and group cultural and leisure activities for adolescents, including groups specific to girls' and boys' needs, interests and transferable skills
- Feature creative, cultural and sports activities for children of different ages that also engage their families and community members.

Care and treatment interventions for mental health and psychosocial problems include services that address children's or adolescents' mental health and psychosocial needs through personalized care delivered to individuals or groups. This is particularly important for children with mental health and psychosocial needs and those who have been exposed to serious protection violations. The following examples are focused on care interventions delivered in group settings or on those that strengthen children's and adolescents' interpersonal wellbeing.



Provide group psychological interventions for children and adolescents facilitated by providers trained and supervised in an appropriate evidence-based approach. For example, support access to quality structured group activities for children's mental health and psychosocial wellbeing (e.g., creative and expressive activities) within the community (e.g., in child- and adolescent-friendly spaces and learning spaces) that may run over a period of weeks.

³⁹ Mental Health America, 'Mental Health Treatments'.

⁴⁰ Youth.gov, 'Mental Health Promotion and Prevention'.



Develop programmes that strengthen the quality of the relationships between children or adolescents and their caregivers, such as:

- Support programmes that provide vulnerable families with structured activities to enhance mother, father, caregiver, infant and child positive interaction through play, reading, learning together, etc.⁴¹
- Support groups for adolescent parents (both mothers and fathers) that are responsive to their social and emotional needs, including the need to be included in activities that are responsive to their needs as an adolescent and as a caregiver.



For **humanitarian response**, check out the following sections and key actions from the [Minimum Services Package](#):

[MSP 3.5](#) Provide early childhood development (ECD) activities to support young children and their caregivers

[MSP 3.6](#) Provide group activities for children's mental health and psychosocial well-being

[MSP 3.7](#) Promote caregivers' mental health and psychosocial well-being and strengthen their capacity to support children

Considerations for adaptation

Camp versus host community: Activities that bring together displaced populations and host communities can help promote positive mental health and psychosocial wellbeing. Consider how programmes bring together children and adolescents from different cultural groups and similar cultural groups. Cultural activities are important for promoting mental health and psychosocial wellbeing. It is also essential that children and adolescents from different social groups have opportunities to develop positive relationships with members of different groups.



Recommended resources from the [Compendium of MHPSS Resources](#)

Strategies and approaches

- [INSPIRE website with information to end violence against children](#), Global Partnership and Fund to End Violence Against Children, 2016
- [Helping Adolescents Thrive Toolkit](#), WHO, 2021
- [Global Framework on Transferable Skills](#), UNICEF, 2019

Guidelines

- [Engaged and Heard! Guidelines on Adolescent Participation and Civic Engagement](#), UNICEF, 2020
- [Promoting rights and community living for children with psychosocial disabilities](#), WHO, 2015
- [MHPSS and Participation: Guidance Document to Accompany the MHPSS Compendium of Resources](#), UNICEF, October 2020

Programme guidance

- [The Adolescent Kit for Expression and Innovation](#), UNICEF
- [ARC Foundation Module 4: Participation and Inclusion](#), Save the Children's Child Rights Resource Centre, 2009
- [Boxes of Wonder: Creation of the program with children on the move](#), Save the Children, 2018
- [Care for Child Development](#), UNICEF and WHO, 2012
- [Child Protection Case Management Training Manual for Caseworkers, Supervisors and Managers](#), Save the Children's Child Rights Resource Centre, 2014
- [Move On & Engage: A Mental Health and Psychosocial Resilience Curriculum](#), Terre des hommes, 2020
- [Save the Children Psychological First Aid Training Manual for Child Practitioners](#), Save the Children's Child Rights Resource Centre, 2013
- [mhGAP Intervention Guide Version 2.0 for mental, neurological and substance use disorders in non-specialized health settings](#), WHO, 2019
- [YouCreate Toolkit: Participatory arts-based action research for wellbeing and social change](#)

Training

- [Lay Counselling: A Trainer's Manual](#), IFRC Psychosocial Centre, 2012
- [I Support My Friends: A training for children and adolescents on how to support a friend in distress](#), UNICEF, 2021

⁴¹ 'Learning Brief on Mental Health and Psychosocial Support in Education'.

Output 1.3

Children and adolescents have opportunities for stimulation, learning and skills development that contribute to mental health and psychosocial wellbeing

As children grow, they gain skills and knowledge. Even in the first months of life, responsive parenting helps children develop the capacity to regulate their emotions and manage adversity. Age-appropriate opportunities for learning and stimulation help children develop problem-solving skills and social-emotional skills. Those opportunities come through supportive social interactions with positive role models; safe and supportive learning environments, both formal and non-formal; and participation in play, sports, creative activities, and the cultural and spiritual life of their communities. Opportunities for stimulation, learning and skills development appropriate to age and developmental stage help children develop cognitive and social and emotional skills for life. These include problem-solving, understanding and expressing emotions, self-regulation, and the capacity to form and maintain relationships – all of which are essential for developing and maintaining resilience.⁴²

Quality pre-primary education leads to better intellectual and social-emotional development for children, as a strong start to learning forges neural pathways that later 'catch-up' efforts can never hope to reproduce. Further, children's participation in quality pre-primary education helps children establish healthy behaviours that last a lifetime.⁴³

– From '[A world ready to learn](#)'

Schools and safe spaces: Schools and learning spaces are at the centre of communities, serving as valued institutions and community focal points. Schools and learning environments are a crucial part of a wider

systems approach to promoting mental health and wellbeing, including encouraging gender-equal and inclusive values, preventing mental health problems, and responding to the mental health needs of children and adolescents when required. Schools and learning environments are regarded as the ideal platform for promoting children's mental health and psychosocial wellbeing for several reasons:

- School provides the opportunity for access to a large population of children.
- Children spend most of their time at school or in other learning environments.
- Teachers and other education personnel play a crucial role in equipping children with the knowledge, attitudes and skills needed to maintain healthy lifestyles and develop critical thinking to address unhealthy behaviours and their physical, psychological and social consequences.

Teachers are central to ensuring children's and adolescents' learning, safety, wellbeing and development. In addition to delivering academic content, teachers must provide a safe learning environment, support children's emotional needs, foster social cohesion, stimulate creativity and promote the development of transferable skills.

Ensuring equitable access to education during emergencies is important not only to children but to the community at large. Schools and other learning environments (or other safe spaces that offer educational or creative activities, such as CFS provide children with a safe place to play, learn, socialize with peers, express themselves, develop knowledge and skills, and return to routine and normalcy. Engaging in educational or creative and expressive activities can also potentially foster healing for children affected by adverse events. Also, while children are engaged in education or activities in safe spaces, adults have the time to work on rebuilding and livelihood activities essential to their family's survival and recovery. They can do so knowing that their children are safe and well cared for.

⁴² United Nations Children's Fund, 'Global Framework on Transferable Skills', UNICEF, New York, November 2019.

⁴³ United Nations Children's Fund, 'A world ready to learn: Prioritizing quality early childhood education', UNICEF, New York, April 2019.



Putting it into practice for Output 1.3

Practice example from the State of Palestine:

[*Providing psychosocial support and promoting learning readiness during compounding crises for adolescents in Gaza \(State of Palestine\)*](#)

In response to the needs of adolescents affected by the ongoing violence and school closures in Gaza, UNICEF and partners implemented opportunities for learning and structured activities to foster hope and reduce stress. Two cohorts of adolescents living in conflict-affected Gaza (ages 10–14 and 15–18) attended two-week summer programmes administered across 175 centres. The programmes utilized UNICEF’s Adolescent Kit for Expression and Innovation, a package of guidance, tools, activities and supplies that support life-skills development and community engagement while developing key competencies and skills that help adolescents cope with stressful circumstances in humanitarian and vulnerable development contexts.

Practice example from Colombia:

[*Supporting the learning and socio-emotional development of refugee and migrant children in Colombia*](#)

More than 5.6 million refugees and migrants have left the Bolivarian Republic of Venezuela since 2016, with 30 per cent going to Colombia. The Colombian government provides them with access to the formal education system, but children continue to face many barriers. This case study examines two of UNICEF’s flagship education programmes for refugee and migrant learners: Learning Circles and The Village. The Learning Circles programme is embedded within the national education system and provides a bridge to help refugee students get back into the school system while addressing their social-emotional and learning needs. The Village, with its flexible curriculum, is aimed at building foundational learning (mathematics, language, social sciences, natural sciences) and social-emotional development of refugee and migrant children aged 7 to 12.

Evaluation example from Syria:

[*Insecurity, distress and mental health: experimental and randomized controlled trials of a psychosocial intervention for youth affected by the Syrian crisis*](#)

The Advancing Adolescents programme applies the Mercy Corps proprietary [*Advancing Adolescents Approach*](#) framework developed specifically for use in contexts where there has been prolonged stress. The programme uses structured group activities and mentorship to help adolescents become more aware of their emotions and establish empathy, improve their mental health and psychosocial wellbeing and build multinational social cohesion among adolescents in Jordan, Syria, Lebanon, Iraq and Turkey. Adolescents can choose from a range of group activities, including but not limited to fitness activities, arts and crafts, vocational skills or technical skills. Lay coaches deliver the intervention and are trained to understand how stress physiology affects brain function and how to facilitate experiential learning. The impact evaluation that was done on Advancing Adolescents found that young people who participated in the programme had on average:

- **Improved social connectedness:** Programme participants had 4.8 more friends of other nationalities than the control group.
- **A sense of safety and security for boys:** A greater sense of feeling safe and secure; more likely to have access to safe spaces in the community and to report a sense of feeling safe in their community
- **Future thinking:** Greater confidence in their future, including job prospects
- **Open-mindedness around gender:** Increased tolerance for female leaders in the workplace; higher self-confidence and aspirations for girls.

Research showed that the strongest programme impact was directly related to relationships adolescents established with their coaches – trained volunteers from the community who received training on emotional and behavioural self-regulation, the profound stress attunement model (PSA) and experiential learning. The stronger the relationship, the greater increase in adolescents’ sense of personal wellbeing.

This programme is highlighted in [*UNICEF’s Mental Health and Psychosocial Support for Children in Humanitarian Settings: An Updated Review of Evidence and Practice*](#) (p. 29) as an example of an intervention that promotes resilience among adolescents. The project evaluation found that PSA was effective in regulating stress physiology and reducing the time that adolescents spent experiencing high levels of insecurity. Furthermore, the impact on levels of insecurity was sustained over time, lasting over 11 months of observation. Biological and cognitive outcomes were conducted by measuring stress in the body and brain. The study found that hair cortisol concentrations declined by a third in response to the intervention and determined that programme participation improved regulation of cortisol production – reducing chronically high cortisol levels and upregulating chronically low cortisol levels. There was no impact on prosocial behaviour, post-traumatic stress reactions or resilience levels during the period of study, however. Furthermore, there were no short-term improvements in some of the cognitive skills that underscore learning and social development.⁴⁴

⁴⁴ Panter-Brick, Catherine, et al., ‘Insecurity, distress and mental health: experimental and randomized controlled trials of a psychosocial intervention for youth affected by the Syrian crisis’, *Journal of Child Psychology and Psychiatry*, vol. 59, no. 5, 2 October 2017, pp. 523–541.

You can find more information on this project at the following links:

- [Randomized impact evaluation/RCT](#)
- [Advancing Adolescents Approach](#)
- [Mercy Corps blog entry: Applying a Profound Stress and Attunement Approach](#)
- [Integrating Mental Health And Psychosocial Support Into Youth Programming: A Toolkit; Sector Pullout on Violence Prevention](#)

Intervention table 3

Interventions and activities that provide opportunities for stimulation, learning and skills development

Intervention table three of nine presents illustrative examples of interventions that support the MHPSS needs of children and adolescents that provide opportunities for stimulation, learning and skills development. UNICEF uses the continuum of care to ensure that all programming includes interventions that

promote mental health and psychosocial wellbeing, prevent mental health conditions and ensure the care and treatment of children and adolescents.

The terms 'promotion', 'prevention' and 'care' are used to illustrate an application of the continuum of care. For some users, these terms are helpful; for others they are new and unfamiliar. Users are encouraged to use (or not use) the terms to the extent that they are beneficial to their design and planning processes. This list is intended to be illustrative and is not exhaustive.

Outcome 1: Child and adolescent

Output 1.3: Children and adolescents have opportunities for stimulation, learning and skills development that contribute to mental health and wellbeing.

This approach uses age- and developmentally appropriate activities to help children develop cognitive and social and emotional skills.

Promotion interventions increase protective factors, including healthy behaviours and skills that reduce children's or adolescents' risk of developing mental health and psychosocial conditions.⁴⁵ Interventions within Output 1.3 will most directly relate to the third domain of wellbeing: 'skills and knowledge': the capacity to learn, make positive decisions, effectively respond to life challenges and express oneself, facilitated also through community services that support wellbeing and the ability to learn how to best address the MHPSS needs in the community, the capacity to respond to challenges within the community and how to effectively communicate about mental health and psychosocial wellbeing.



Ensure children and adolescents have access to schools and learning environments that promote their mental health and psychosocial wellbeing through programming focused on ECD and transferable skills. Some examples include programmes that:

- Promote school-age children's and adolescents' mental health by enhancing social-emotional learning and skills-building, as well as substance use prevention⁴⁶
- Include activities that support children's and adolescents' capacity to learn, make positive decisions, effectively respond to life challenges and express themselves; for example:
 - » Group activities for child and adolescent wellbeing that build interpersonal, emotional regulation, problem-solving and stress management skills
 - » Group recreational and sports activities that promote problem-solving skills, emotional regulation, and the capacity to form and maintain relationships.



Raise awareness and support approaches for positive behaviour change around mental health and psychosocial needs within health-care, school and community settings to address stigma and discrimination. This may include:

- Coordinating between sectors to establish or strengthen school-based mental health and psychosocial programmes and services (from promotion to care available within schools or with linkages to other sectors or services)

⁴⁵ Mental Health America, 'Mental Health Treatments'.

⁴⁶ 'Helping Adolescents Thrive Toolkit'.

- Promoting universal access to transferable skills (also called social and emotional learning or life skills) acquisition opportunities for children and adolescents of all ages, genders and abilities in schools and other learning environments, in both development and humanitarian contexts
- Promoting community-based services that support wellbeing and the ability to learn how to best address the MHPSS needs in the community.

Prevention interventions aim to stop mental health and psychosocial problems from developing, getting worse or reoccurring. UNICEF programming may include primary prevention strategies that aim to stop mental health problems before they begin, secondary prevention interventions that provide support to those at high risk of experiencing mental health problems, and tertiary prevention interventions that support people living with mental health and psychosocial problems.⁴⁷



Support interventions that promote mental health and prevent mental health conditions. This may include:

- Responsive infant caregiving through mother–baby interactions (e.g., in feeding centres, baby-friendly spaces)
- Age-appropriate opportunities for learning and stimulation to help children develop problem-solving skills and social-emotional skills
- Interventions that aim to prevent substance use among school-age children and adolescents.

Care and treatment interventions for mental health and psychosocial problems include services that address children's or adolescents' mental health and psychosocial needs through personalized care delivered to individuals or groups. This is particularly important for children with mental health and psychosocial needs and children who have been exposed to serious protection violations.



Support young children's access to and participation in ECD activities and opportunities for early childhood education, and mothers' and babies' access to supportive feeding programmes in baby-friendly spaces.

- Provide children with support and psychoeducation to help them manage and cope with distress, mental health conditions or disabilities.
- Support children's physical and emotional development by building the capacity of caregivers in nurturing and responsive care.



For **humanitarian response**, check out the following sections and key actions from the [Minimum Services Package](#):

- [MSP 3.3](#) Disseminate key messages to promote mental health and psychosocial well-being
- [MSP 3.5](#) Provide early childhood development (ECD) activities to support young children and their caregivers
- [MSP 3.6](#) Provide group activities for children's mental health and psychosocial well-being
- [MSP 3.8](#) Promote the mental health and psychosocial well-being of education personnel and strengthen their capacity to support children

Considerations for adaptation

Children with high levels of distress: Education programmes may need to be adapted for children and adolescents under high levels of distress living in complex emergencies, including conflict, disasters, forced migration, etc. These children may need additional support to improve their psychosocial wellbeing and catch up with learning. Educators need to prioritize children's mental health and wellbeing while working on the most important skills and knowledge required for a student at each grade (covering what they need to know to enter the next grade successfully).



Recommended resources from the [Compendium of MHPSS Resources](#)

Strategies and approaches

- [INSPIRE website with information to end violence against children](#), Global Partnership and Fund to End Violence Against Children, 2016
- [Helping Adolescents Thrive Toolkit](#), WHO, 2021
- [Global Framework on Transferable Skills](#), UNICEF, 2019

⁴⁷ Youth.gov, 'Mental Health Promotion and Prevention'.

Guidelines

- [Guidelines for Child Friendly Spaces in Emergencies](#), Global Education Cluster and Inter-agency Network for Education in Emergencies (INEE), 2011
- [Interim Briefing Note Addressing Mental Health and Psychosocial Aspects Of COVID-19 Outbreak](#), IASC, 2020
- [Helping Hands at School and in the Community: Guidance for School-Based Psychosocial Programmes for Teachers, Parents and Children in Conflict and Postconflict Areas](#), War Trauma Foundation, 2012
- [Integrating Early Childhood Development \(ECD\)](#)
- [Activities into Nutrition Programmes in Emergencies: Why, What and How](#), UNICEF and WHO
- [Evaluation of Child Friendly Spaces: Tools and Guidance](#), World Vision International, 2015

Programme guidance

- [Move on & Engage: A Mental Health and Psychosocial Resilience Curriculum](#), Terre des hommes, 2020
- [Working with Children and Their Environment](#), Terre des hommes, 2011
- [Children's Resilience Programme: Psychosocial support in and out of schools](#), Save the Children's Child Rights Resource Centre, 2012
- [Youth Resilience Programme: Psychosocial support in and out of school](#), Save the Children's Child Rights Resource Centre, 2015
- [Activity Catalogue for Child Friendly Spaces in Humanitarian Settings](#), IFRC Psychosocial Centre, 2018
- [Safe Healing and Learning Spaces Toolkit](#), International Rescue Committee, 2016
- [Psychosocial Support for Youth in Post-Conflict Situations: A trainer's handbook](#), IFRC Psychosocial Centre, 2014
- [Different. Just like you: A psychosocial approach promoting the inclusion of persons with disabilities](#), IFRC Psychosocial Centre, 2015
- [Baby Friendly Spaces: A holistic approach for pregnant, lactating women and their very young children in emergency](#), Action Contre la Faim, 2014
- [Manual for The Integration of Child Care Practices and Mental Health into Nutrition Programs](#), Action Contre la Faim, 2011
- [mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings](#), WHO, 2019
- [Care for Child Development: Orientation materials](#), UNICEF, 2019
- [Caring for the Caregiver](#), UNICEF

Training

- [MHPSS and EIE Toolkit: Training Manual for Teachers](#), AVSI Foundation, 2003
 - [Child Protection Case Management Training Manual for Caseworkers, Supervisors and Managers](#), Save the Children's Child Rights Resource Centre, 2014
-



Outcome 2: Caregivers

Improved caregiver mental health and psychosocial wellbeing, including for parents, caregivers, mothers, family and teachers

The caregiver tier of support encompasses those adults who have responsibility over the different spheres of development for children and adolescents. This includes the family system with parents and primary caregivers; the education system with teachers and other education personnel, such as school counsellors and administrators; and the social welfare and child protection system with case workers and social workers.

Exposure to severely distressing and traumatic experiences, intimate partner violence, extreme poverty, attacks on schools, and violence in the home and community are just some of the risk factors that can affect the mental health and wellbeing of families, caregivers and teachers. Providing support

to parents, teachers and other caregivers focused on their individual needs, coping skills and recovery is necessary for their overall wellbeing and essential to give them the emotional resources necessary to provide children with nurturing care. Achieving this outcome requires strategies that support caregiver wellbeing, coping and recovery; improve interpersonal wellbeing through family and community support networks; and strengthen and build the necessary skills and knowledge for positive caregiving and supporting children in distress. Interventions for caregivers across these three domains equip them to be responsive to both their needs and the needs of the children in their care.



Putting it into practice for Outcome 2

How the Caring for the Caregiver (CFC) training equips front-line workers to support the mental health and psychosocial wellbeing of caregivers in Sierra Leone⁴⁸

Mbalu Turay knew immediately that Kankay Suma was experiencing significant stress. As a trained counsellor, community health worker and facilitator of the local mother's support group (MSG), Mbalu saw the signs as soon as she first met the pregnant mother of three. "I can look at the mothers in the MSG meetings and immediately recognize someone going through a hard time," Mbalu said.

Kankay was indeed going through a hard time. Kankay lives outside town in a rural part of Kambia district in Sierra Leone, a country with high maternal and neonatal mortality rates and a fragile and understaffed health system. Kankay struggled with the 30-minute walk to collect water from a borehole and the task of gathering firewood from the bush. She was isolated from neighbours. And she was experiencing complications with her pregnancy.

Using the skills she learned from CFC training, Mbalu gained Kankay's trust and was able to provide emotional support. She also linked Kankay to a community health supervisor, who made the connection to essential medical and community services. In the weeks after the two women met, Mbalu visited Kankay and her family daily. She counselled Kankay, listened to her concerns, bolstered her confidence and provided practical tips on managing stress. "In our community, when someone is exhibiting signs of sadness, others may chastise them for it," Mbalu said. "However, thanks to the CFC programme, [many of us] are now aware that it's better to be kind and sympathetic to those who are feeling down."

[CFC is a training programme](#) that equips front-line workers, including community health workers such as Mbalu, with the knowledge and skills they need to support the emotional wellbeing of caregivers – the mothers, fathers and others who provide primary care for newborns and young children. The training is founded on a seemingly simple concept: To provide the best start in life, it is essential to care for the caregivers who care for children. And it is essential to focus on vulnerable caregivers, including adolescent parents. At its core, CFC recognizes that caregivers' mental health and emotional wellbeing are the foundation that allows them to nurture and care for their children. This nurturing care, in

⁴⁸ Adapted from United Nations Children's Fund, 'The State of the World's Children 2021: On My Mind; Promoting, protecting and caring for children's mental health', UNICEF, New York, October 2021, pp. 54–55.

turn, builds a child’s lifelong mental health. CFC training builds front-line workers’ interpersonal and counselling skills and offers a package of materials and activities that can be used to strengthen caregivers’ confidence, emotional wellbeing and ability to connect with and support their young children.

CFC trains professional and community health workers so they can help caregivers develop strategies for coping with challenges and stress that arise in daily life. The workers are also trained to help caregivers find support and services if needed. These were the skills that Mbalu put to use when she first met Kankay. And even after Kankay gave birth to her son Mark, Mbalu continued to visit the family, providing support to mother, father, baby and siblings.

“Mbalu wrapped her arms around me and took me to a hospital for the first time in my life,” Kankay said. “She showed me what it means to take care of myself and my family. I am grateful to Mbalu for [the services] she brought to us. Because the services she provided us have helped keep us alive and reminded us we are worthy of being happy.”

For a deeper dive and key resources, please see:

- [Caring for the Caregiver](#)
- [Nurturing Care Framework for Early Childhood Development](#)
- Full case study in the [State of the World’s Children 2021 Report](#), pp. 54–55.

Output 2.1

Parents, caregivers, mothers, families and teachers have access to support for developing and maintaining improved mental health and psychosocial wellbeing

Parents and other caregivers (extended family, foster families, teachers) may require support to cope with distress when it is affecting their own daily lives and wellbeing. Interventions that support caregivers of all genders will fall at all layers of the intervention pyramid and will include universal prevention and promotion support,⁴⁹ focused care for caregivers, specialized MHPSS care for caregivers with mental health and psychosocial conditions, and interventions to develop or strengthen positive coping mechanisms. Caregivers may require additional support during emergencies to cope with the impacts of the emergency on their own daily lives and wellbeing. Activities targeting caregivers should be adapted to respond to the unique mental health needs of adolescent caregivers.

Parents, primary caregivers and family wellbeing:

Parents and primary caregivers of all genders play a leading role in shaping and directing the experiences and opportunities for children’s learning, growth, mental and physical health, psychosocial wellbeing and development.⁵⁰ While the parent–child relationship will change over the life course, it will always be a critical and dynamic relationship. In 2018, WHO published ‘[Nurturing care for early childhood development: A framework for helping children survive and thrive to transform health and human potential](#)’, which emphasized the direct link between child wellbeing and caregiver mental health and noted that responsive care is driven by emotions and motivations. When caregivers struggle with their own mental health and wellbeing, it is difficult for them to provide the nurturing care and support that is essential for children’s development.⁵¹

⁴⁹ Rochat, Tamsen Jean, et al., ‘Caring for the Caregiver: Implementer’s Guide’, UNICEF, New York, 2019.

⁵⁰ United Nations Children’s Fund, ‘UNICEF’s Vision for Elevating Parenting: A Strategic Note’, UNICEF, New York, April 2021.

⁵¹ World Health Organization, ‘Nurturing care for early childhood development’, WHO, Geneva, 2018, <<https://apps.who.int/iris/bitstream/handle/10665/272603/9789241514064-eng.pdf>>, accessed 18 January 2023.

Box 3 Maternal mental health and psychosocial wellbeing

The perinatal period, from conception up to one year post-partum, is a time of huge social, physiological and psychological change for women. Childbirth is generally perceived as a positive event in most cultures; however, research suggests that between 20 and 40 per cent of women experience negative psychological symptoms related to pregnancy and birth.⁵² The prevalence of mental health conditions in the perinatal period is 15–29 per cent,⁵³ with depressive and anxiety disorders being the most common conditions.⁵⁴ In addition, these disorders are more prevalent in LMICs than in HICs, and they might have a strong effect on a new baby and a family's wellbeing, especially other children in the family. Preventative approaches, such as screening for psychosocial risk factors during pregnancy, allow for early identification of MHPSS needs and ensure access to timely provision of psychological care.⁵⁵ The promotion of maternal mental health includes educating and engaging health professionals who deliver health care to women on mental health needs during the perinatal period and can help to improve mother–child attachment and optimize a healthy start in life.⁵⁶

Helping parents understand their own mental health and psychosocial needs, as well as the MHPSS needs of their children, is essential for enhanced parenting across the life course:

- ❑ From prenatal to early childhood (before birth to age of school entry), it is essential to focus on maternal mental health and psychosocial wellbeing. Parental stress management skills and coping skills during pregnancy and early childhood have a direct impact on a child's cognitive and emotional development.⁵⁷
- ❑ Parents of children aged 6 to 10 need support in understanding their children's emotions and social needs, as well as understanding the importance of mental health.⁵⁸
- ❑ Parents of adolescents (10–18) need to continue to nurture their relationships with their children, ensuring an awareness of their children's emotional and social wellbeing. This includes equipping parents with the necessary skills to identify when their children need additional support, awareness of emerging mental health issues, and parenting skills for preventing self-harm.⁵⁹
- ❑ Adolescent parents may need additional support that is responsive to both their developmental needs and their needs as parents.

In emergency situations, the presence of a stable adult caregiver aids children's feelings of wellbeing, and re-establishing routines boosts children's coping ability and recovery. However, caregivers are also affected by emergencies, which may threaten their ability to offer safety, stability and nurturance. MHPSS interventions therefore promote the wellbeing of caregivers so they can provide children with a sense of safety, stability and normalcy, helping to restore or maintain the developmental process.

Teacher wellbeing: The individual wellbeing of teachers is essential for ensuring a nurturing and responsive teacher–student relationship. Teacher stress affects both the quality of teaching and the quality of learning, and it may also have a negative effect on children's wellbeing. A teacher's gender, uncertainty about employment status, level of education, teaching experience, coping mechanisms and displacement are all factors that can influence an individual sense of wellbeing.⁶⁰ These may be compounded by additional factors that cause distress, such as teaching in the aftermath of a natural disaster, in a conflict-affected area, in a poorly resourced school or in areas with high rates of community violence. Teachers may need support in coping with difficult circumstances.

⁵² Creedy, Debra K., Ian M. Shochet, and Jan Horsfall, 'Childbirth and the Development of Acute Trauma Symptoms: Incidence and contributing factors', *Birth: Issues in Perinatal Care*, vol. 27, no. 2, June 2000, pp. 104–111.

⁵³ Vesga-López, Oriana, et al., 'Psychiatric disorders in pregnant and postpartum women in the United States', *Archives of General Psychiatry*, vol. 65, no. 7, July 2008, pp. 805–815.

⁵⁴ National Institute for Health and Care Excellence, 'Antenatal and postnatal mental health: clinical management and service guidance: updated edition', NICE, London, 11 February 2020.

⁵⁵ Spyridou, Andria, Maggie Schauer, and Martina Ruf-Leuschner, 'Prenatal screening for psychosocial risks in a high risk-population in Peru using the KINDEX interview', *BMC Pregnancy and Childbirth*, vol. 16, 6 January 2016.

⁵⁶ Seng, Julia S., et al., 'Childhood Abuse History, Posttraumatic Stress Disorder, Postpartum Mental Health, and bonding: A Prospective Cohort Study', *Journal of Midwifery & Women's Health*, vol. 58, no. 1, January/February 2013, pp. 57–68.

⁵⁷ United Nations Children's Fund, 'UNICEF's Vision for Elevating Parenting: A Strategic Note', UNICEF, New York, April 2021.

⁵⁸ Ibid.

⁵⁹ Ibid.

⁶⁰ Education Equity Research Initiative, 'Landscape Review: Teacher Well-being in Low Resource, Crisis, and Conflict-affected Settings: Task Team on Teachers' Psychosocial and Social-Emotional Well-being', Inter-agency Network for Education in Emergencies and United States Agency for International Development, New York, August 2019.

Efforts to support teacher wellbeing should consider advocating for the inclusion of teacher wellbeing in national education policies and the availability of resources for teachers to receive psychological and social-emotional support. It is also essential to integrate content on mental health and psychosocial wellbeing, including the importance of self-care and staff care in educational institutions, into pre-service and in-service teacher professional development. Training should include practical information on recognizing signs of distress in both staff and learners.

Teaching can be an extremely stressful profession, particularly in low-resource, crisis-affected and conflict-affected contexts. Teachers' stress not only has negative consequences for teachers themselves but also results in lower achievement for students and higher costs for education. Teachers need support to continue teaching, as they are the backbone of keeping children and adolescents learning and thriving.⁶¹ Teacher wellbeing must be a central consideration when developing mental health and psychosocial support policies and systems.



Putting it into practice for Output 2.1

What works for caregivers from the 2020 Review of Evidence and Practice

UNICEF's [Mental Health and Psychosocial Support for Children in Humanitarian Settings: An Updated Review of Evidence and Practice](#) provides practitioners with a review of effective practices and evidence in the field of MHPSS. Section 2 of the review shares evidence and intervention on risk and protective and promotive factors specific to the family and caregivers. Specifically, the review identifies two risk factors: caregiver mental health and compounded stress and alcohol and substance use within the household. The report also identified two protective and promotive factors related to caregivers and families: parent-child relationships and caring for caregivers. Interventions designed to improve mothers' mental health have been found to have a positive impact on infants' health and development.⁶² There are effective interventions for reducing depression and promoting maternal mental health implemented by trained community health workers under professional supervision that have been tested in LMICs.⁶³ Examples of interventions presented in the document include:⁶⁴

- Mercy Corps Palestine implements group sessions using creative activities to help caregivers, mainly mothers of children already engaged in Mercy Corps programmes. The sessions are designed to help mothers better cope with their own stress, and children and caregivers participate in structured sessions together. There are also interventions at the family level to foster positive family interaction and help participants learn about stress management.
- Save the Children Palestine implemented a programme for ex-detainee children and their parents, which included MHPSS components involving MHPSS and counselling for parents and children. The [programme evaluation](#) looks at how the intervention assisted child ex-detainees in individualized services to address severe distress related to their detainment and reintegration back into their families and communities.
- War Child implements a [Caregiver Support Intervention](#) designed to reduce parental stress and distress through an increase in the provision of social support, psychoeducation, and stress management techniques. The programme also teaches parents strategies to reduce harsh parenting and increase positive parenting.
- Action Against Hunger implements [Baby-Friendly Spaces](#) to support mothers and caregivers in taking care of children and infants and preventing child malnutrition. Staff in baby-friendly spaces support parents with psychological distress, help women continue to breastfeed despite distress, and provide a safe space for caregivers to connect with their babies.
- The [Strong Families programme](#),⁶⁵ culturally adapted for Afghanistan, is a brief and light family skills programme that runs over the course of three weeks. The programme worked with female caregivers and children ages 8–12. The programme provided sessions for caregivers, children and family members.⁶⁶ Findings from the pilot and the RCT research on the intervention are published as open access.

⁶¹ Ibid.

⁶² 'Nurturing care for early childhood development'.

⁶³ Rahman, Atif, et al., 'Interventions for common perinatal mental disorders in women in low- and middle-income countries: A systematic review and meta-analysis', *Bulletin of the World Health Organization*, vol. 91, no. 8, 1 August 2013, pp. 593–601.

⁶⁴ 'Mental Health and Psychosocial Support for Children in Humanitarian Settings', pp. 34–57.

⁶⁵ Haar, Karin, et al., 'Strong families: A new family skills training programme for challenged and humanitarian settings; a single-arm intervention tested in Afghanistan', *BMC Public Health*, vol. 20, 7 May 2020.

⁶⁶ Ibid.

Intervention table 4

Interventions and activities for caregivers that help them develop and maintain improved mental health and psychosocial wellbeing

Intervention table four of nine presents illustrative examples of interventions that support the MHPSS needs of caregivers that support their personal mental health and psychosocial wellbeing. UNICEF uses the continuum of care to ensure that all programming includes interventions that promote mental health and

psychosocial wellbeing, prevent mental health conditions, and ensure the care and treatment of caregivers.

The terms 'promotion', 'prevention' and 'care' are used to illustrate an application of the continuum of care. For some users, these terms are helpful; for others they are new and unfamiliar. Users are encouraged to use (or not use) the terms to the extent that they are beneficial to their design and planning processes. This list is intended to be illustrative and is not exhaustive.

Outcome 2: Caregivers

Output 2.1: Parents, caregivers, mothers, families and teachers have access to support for developing and maintaining improved mental health and psychosocial wellbeing.

Promotion interventions increase protective factors, including healthy behaviours and skills that reduce the risk to caregivers of developing mental health and psychosocial conditions. See below for examples of promotion activities that support the personal wellbeing of caregivers.



Promote caregiver mental health and psychosocial wellbeing by integrating the following topics on caregiver mental health into information sessions:

- Maternal mental health and supporting mothers on how to know when to seek additional help
- Parental stress management skills and coping skills during pregnancy and early childhood, which have a direct impact on the cognitive and emotional development of the child
- Social and emotional needs of adolescent parents: their need for additional supports that are responsive to both their developmental needs and their needs as parents
- Teacher stress and strategies that schools can put in place to improve and support healthy behaviours for teachers to reduce their stress levels and improve overall wellbeing.



Promote mental health and psychosocial wellbeing for the education workforce by:⁶⁷

- Advocating for and providing technical support to education authorities and other relevant stakeholders for the inclusion of teacher wellbeing in national education policies, including advocacy and policy support for adequate pay, appropriate working conditions, equity and parental leave
- Supporting policies and programmes to enhance teacher wellbeing.

Develop the capacity and support teachers and other education professionals to better support their own mental health and wellbeing and implement classroom activities to promote their students' mental health and wellbeing.

Prevention interventions aim to stop mental health and psychosocial problems from developing, getting worse or reoccurring. UNICEF programming may include primary prevention strategies that aim to stop mental health problems before they begin, secondary prevention interventions that provide support to those at high risk of experiencing mental health problems, and tertiary prevention interventions that support people living with mental health and psychosocial problems.⁶⁸ The following are examples of interventions that aim to stop mental health problems before they begin, provide support to those at high risk of experiencing mental health problems and interventions that support caregivers living with mental health and psychosocial needs.



Build capacity among community MHPSS workers in identification, referral and case management (e.g., coordination and follow-up support) for caregivers or teachers in need of care. For example:

- Ensure referral and access to clinical MHPSS and professional social services for caregivers and family members with mental health conditions or protection concerns.
- Assist vulnerable families with referral and access to therapeutic interventions (e.g., evidence-based psychological interventions) and specialized social services.

⁶⁷ Annex 8: 'Learning Brief on Mental Health and Psychosocial Support (MHPSS) in Education'

⁶⁸ Youth.gov, 'Mental Health Promotion and Prevention'.

- Equip and train doctors and nurses on maternal mental health during the perinatal period.
- Equip and train those in schools and other educational settings on promoting staff care and teacher wellbeing.

Care and treatment interventions for mental health and psychosocial problems include services that address caregivers' mental health and psychosocial needs through personalized care delivered to individuals or groups. Caregivers need access to appropriate MHPSS care and professional social services. This is particularly important for caregivers with mental health and psychosocial conditions and those who have been exposed to serious protection violations. The care and treatment of mental health and psychosocial problems include a wide range of services, including but not limited to counselling and psychotherapy, pharmacology, case management services, hospitalization, support groups, self-help plans and strategies, recovery and rehabilitation approaches, and peer support. The MHPSS Framework has used the word 'care' to include the full range of treatment interventions for mental health and psychosocial conditions.



Provide specialized and focused MHPSS social services or mental health care for caregivers with mental health conditions or elevated levels of distress or who have been exposed to serious protection violations. Some examples are:

- MHPSS interventions for caregivers in need of additional support within antenatal and postnatal care services, including home visits
- Evidence-based psychological interventions with a trained and supervised mental health provider knowledgeable in the treatment of a mental health condition
- Focused psychosocial care for distressed parents or caregivers, such as scalable psychological interventions or support groups.



Support caregivers with mental health and psychosocial problems or serious protection risks (e.g., helping them access medications and follow-up appointments). Some examples are:

- Support with gaining autonomy in their daily life through activities that are meaningful and learning strategies to cope with their mental health conditions
- Case management services for families and caregivers dealing with mental health and psychosocial conditions in the home, including access to counselling services and protection and welfare services.



For **humanitarian response**, check out the following sections and key actions from the [Minimum Services Package](#):

[MSP 3.10](#) Provide mental health care as part of general health services

[MSP 3.11](#) Provide MHPSS as part of clinical care for survivors of sexual violence and intimate partner violence

[MSP 3.12](#) Initiate or strengthen the provision of psychological interventions

[MSP 3.13](#) Provide MHPSS through case management services

Considerations for adaptation

Adolescent mothers and fathers: Programmes and activities should be adapted to respond to the specific needs of adolescent mothers and fathers. Adolescent parents will benefit from both peer support groups and mentoring relationships with older parents who have demonstrated healthy relationships in their families and communities.



Recommended resources from the [Compendium of MHPSS Resources](#)

Strategies and approaches

- [INSPIRE website with information to end violence against children](#), Global Partnership and Fund to End Violence Against Children, 2016

Programme guidance

- [Broken Links: Psychosocial support for people separated from family members](#), Save the Children's Child Rights Resource Centre, 2014
- [Assessing mental health and psychosocial needs and resources: Toolkit for humanitarian settings](#), WHO-UNHCR, 2012
- [Caring for the Caregiver](#), UNICEF
- [Different. Just like you: A psychosocial approach promoting the inclusion of persons with disabilities](#), IFRC Reference Centre for Psychosocial Support, 2015

Training

- [Child Protection Case Management Training Manual for Caseworkers, Supervisors and Managers](#), Save the Children's Child Rights Resource Centre, 2014
- [MHPSS and EIE Toolkit: Training Manual for Teachers](#), AVSI Foundation, 2003
- [Lay Counselling: A Trainer's Manual](#), IFRC Psychosocial Centre, 2012

Output 2.2

Parents, caregivers, mothers, families and teachers have access to family and community support networks that improve their mental health and psychosocial wellbeing

Access to family and community support networks helps to develop or re-establish networks of support. This aids in strengthening trust, mutual care and self-help to support children and families, including vulnerable families. Interventions that strengthen the interpersonal relationships between caregivers and their children, caregivers and their peers, and caregivers and others in the community help to strengthen support systems. Interventions may include support groups for caregivers or facilitating the inclusion and participation of at-risk families in communal activities. An example could be engaging with local organizations of persons with disabilities to help identify and facilitate access for families caring for persons with disabilities, including participatory discussions on barriers to access, identifying caregiver needs and facilitating access to the identified needs and services for caregivers.

Family and community support networks: Access to and engagement with family and community support networks provide caregivers with relationships that strengthen their interpersonal wellbeing. These relationships and networks are fundamental for child and family safety and wellbeing, providing the conditions for maintaining or restoring children's optimal development. Support groups should be gender-responsive, providing spaces for both mothers and fathers to receive and provide support to their

peers, including groups that are responsive to the needs of adolescent parents.

Support networks are particularly beneficial in emergencies that disrupt family and community routines, social networks and community structures through displacement, poverty, and loss of or separation from key family and community members. In transformed or new environments, caregiver recovery and wellbeing are enhanced by strengthening the ability of families and communities to re-establish routines and normalcy, build supportive social connections and find opportunities for learning, growth and coping with new challenges.

Interpersonal dynamics in the school context should also be considered, as these relationships will affect the overall wellbeing of teachers and students. Positive peer relationships between teachers contribute to improved overall wellbeing, as do relationships between teachers, school leadership and parents. Schools should foster supportive teaching environments that are collaborative, as opposed to competitive and pressure-driven.

MHPSS activities that engage caregivers at this layer can include parent-teacher associations or other local mechanisms to promote parent and caregiver engagement, involve parents and caregivers in coaching or mentoring children, and engage families and caregivers in school events, sports or cultural activities. The community may participate in ensuring that safe structures are developed and maintained for formal and non-formal education.



Putting it into practice for Output 2.2

Responsible, Engaged, and Loving (REAL) Fathers Initiative, northern Uganda

The REAL Fathers initiative was developed by Save the Children and the Institute for Reproductive Health at Georgetown University to prevent intimate partner violence and harsh discipline of young children. The programme uses individual and group mentoring sessions to achieve the following additional aims:

- Improve fathers' use of positive parenting and confidence in using non-violent discipline and couple communication
- Foster acceptance of non-traditional gender roles in parenting by fathers and the wider community
- Increase acceptability and use of voluntary family planning by REAL Fathers couples.⁶⁹

The intervention targets fathers through seven individual mentoring sessions. The final two sessions include the men's wives, and monthly group sessions are conducted with other fathers and mentors in the programme. The intervention aims to change the way fathers relate to their wives and children. In this example, a father is at the centre of the social ecology, with their family (wife and child) and community of other fathers in the programme as their support base. The mentors come from the community and are recognized as loving fathers who never or rarely drink alcohol.

The programme is highlighted in [UNICEF's Review of Evidence and Practice](#) as a promising caregiver intervention. The evaluation (see [evaluation briefing document](#) and the full [research article](#)) found that fathers in the treatment group had positive results across the four domains assessed, including significantly reduced intimate partner violence, increased positive parenting techniques and less likely use of violent or harsh parenting techniques (physical and abusive behaviours, such as shaking or screaming at a child). The programme was also featured in the [Integrating Mental Health and Psychosocial Support into Youth Programming: A Toolkit's](#) sector pull-out on '[Youth Mental Health and Psychosocial Support: Considerations for Gender and Gender-based Violence](#)'.

[REAL Fathers Implementation Guidelines](#): The package has five components: implementation guidelines, mentor training curriculum, mentor discussion guide, mentor resource sheets and women's group sessions.

Intervention table 5

Interventions and activities that facilitate access to family and community support networks

Intervention table five of nine presents illustrative examples of interventions that support the MHPSS needs of caregivers and facilitate access to family and community support networks. UNICEF uses the continuum of care to ensure that all programming includes interventions that promote mental health and

psychosocial wellbeing, prevent mental health conditions, and ensure the care and treatment of caregivers.

The terms 'promotion', 'prevention' and 'care' are used to illustrate an application of the continuum of care. For some users, these terms are helpful; for others they are new and unfamiliar. Users are encouraged to use (or not use) the terms to the extent that they are beneficial to their design and planning processes. This list is intended to be illustrative and is not exhaustive.

Outcome 2: Caregivers

Output 2.2: Parents, caregivers, mothers, families and teachers have access to family and community support networks that improve their mental health and psychosocial wellbeing.

This approach aims to develop or re-establish networks of support and, thereby, strengthen trust, mutual care and self-help to support children and families.

Promotion interventions increase protective factors, including healthy behaviours and skills that reduce the risk to caregivers of developing mental health and psychosocial conditions. The following are examples of promotion activities that support the interpersonal wellbeing of caregivers. Promoting positive peer-to-peer relationships and caregiver-to-child relationships supports mental health and psychosocial wellbeing for the caregiver and their child or adolescent.



Raise awareness of and promote responsive caregiving through national and community-based social behaviour change campaigns. Highlight the benefits of responsive caregiving, such as improving caregiver mental health and psychosocial wellbeing; protecting children against injury and the

⁶⁹ Institute for Reproductive Health, 'Brief: Findings from Scale-Up Evaluation of the REAL Fathers Programme In Uganda', IRH, Georgetown University, Washington, D.C., 2020.

negative effects of adversity; supporting the recognition of and appropriate response to illness; promoting healthy brain, emotional and physical development; and building trust and social relationships.

- Promote learning as something that can happen in everyday moments and through responsive and affectionate interactions between children and their caregivers.
- Facilitate inclusion and participation of families of people with mental health conditions, disabilities or protection risks in communal activities that are responsive to their needs.



Promote effective collaboration between caregivers, the community, school management and teachers to ensure that schools and learning environments are welcoming, inclusive, safe and promote caregiver mental health and psychosocial wellbeing.

- Promote mental health and psychosocial wellbeing through parent–teacher associations or other local mechanisms.
- Support cultural activities that engage caregivers and students around themes related to mental health and psychosocial support.
- Strengthen relationships between school staff (teachers and other educational staff) by fostering supportive teaching environments that are collaborative, as opposed to competitive and pressure-driven.

Prevention interventions aim to stop mental health and psychosocial problems from developing, getting worse or reoccurring. UNICEF programming under Output 2.2 may include structured group activities facilitated by MHPSS workers trained and supervised in psychosocial support. These may include primary prevention strategies that aim to stop mental health problems before they begin, secondary prevention interventions that provide support to those at high risk of experiencing mental health problems, and tertiary prevention interventions that support people living with mental health and psychosocial problems.



Provide teachers, other educational staff and parents with access to a range of mental health and psychosocial support interventions that strengthen social connection and healthy relationships among caregivers. For example:

- Provide routine forums for psychosocial support of teachers and educators, such as support groups for caregivers.
- Engage caregivers in MHPSS activities, including parent–teacher associations or other local mechanisms to promote parent and caregiver engagement.



Provide caregivers with opportunities to strengthen their caregiver-to-child relationships and social connections. For example:

- Strengthen networks of support for parents, teachers, and other caregivers in the community through peer support groups (for parents, mothers or fathers) or safe spaces (for mothers and lactating women, baby-friendly spaces).
- Provide social support to parents and primary caregivers, including through parents' associations and support groups and school- and community-based activities.
- Promote bonding and responsive parenting between infants or young children and parents or primary caregivers through guided ECD sessions.
- Develop mother–infant groups that support responsive caregiving (e.g., providing MHPSS in breastfeeding spaces).
- Provide caregivers with mentors who can support the development of positive and healthy caregiver–child relationships (see [Responsible, Engaged, and Loving \(REAL\) Fathers - Institute for Reproductive Health](#)).

Care and treatment interventions for mental health and psychosocial problems include services that address caregivers' mental health and psychosocial needs through personalized care delivered to individuals or groups. Caregivers need access to appropriate MHPSS care and professional social services. This is particularly important for caregivers with mental health and psychosocial needs and those who have been exposed to serious protection violations. The following examples are focused on care interventions delivered in group settings or are focused on strengthening caregivers' interpersonal wellbeing.



Provide group psychological interventions for caregivers facilitated by an MHPSS provider trained and supervised in an appropriate evidence-based approach (for example, see [Group Problem Management+](#)).



For **humanitarian response**, check out the following sections and key actions from the [Minimum Services Package](#):

[MSP 3.12](#) Initiate or strengthen the provision of psychological interventions

[MSP 3.4](#) Support new and pre-existing group-based community MHPSS activities

[MSP 3.9](#) Provide MHPSS through safe spaces for women and girls

Considerations for adaptation

Age-responsive: Some children may live with elderly caregivers or in child-headed households. Responding to the mental health and psychosocial needs of the primary caregiver should also take into consideration any additional needs based on the caregiver's age.



Recommended resources from the [Compendium of MHPSS Resources](#)

Strategies and approaches

- [INSPIRE website with information to end violence against children](#), Global Partnership and Fund to End Violence Against Children, 2016

Programme guidance

- [Broken Links: Psychosocial support for people separated from family members](#), Save the Children's Child Rights Resource Centre, 2014
- [Caring for the Caregiver](#), UNICEF
- [Responsible, Engaged, and Loving \(REAL\) Fathers](#), Institute for Reproductive Health
- [Different. Just like you: A psychosocial approach promoting the inclusion of persons with disabilities](#), IFRC Psychosocial Centre, 2015
- [Group Problem Management Plus \(Group PM+\): Group psychological help for adults impaired by distress in communities exposed to adversity](#), WHO, 2020

Training

- [Lay Counselling: A Trainer's Manual](#), IFRC Psychosocial Centre, 2012
- [Child Protection Case Management Training Manual for Caseworkers, Supervisors and Managers](#), Save the Children's Child Rights Resource Centre, 2014

Output 2.3

Parents, caregivers, mothers, families and teachers develop skills for parenting, teaching, and supporting children and adolescents in distress (MHPSS needs)

Knowledge, skills and behaviour for supporting children in distress can help improve the quality of caregiver-child relationships and interactions at home and school and in the community. Caregivers may benefit from information and initiatives that build their skills in responsive caregiving. This also helps caregivers to know when a child may need referral for additional support. Information about stress reactions of children at different ages and developmental stages – and strategies to support them – can help parents re-establish a sense of their own effectiveness in challenging situations. Support groups for parents or caregivers of children who are experiencing serious distress or have mental health conditions or developmental disabilities can provide forums for sharing resources, information and strategies. This

can be particularly beneficial for parents of children with disabilities, children affected by armed forces and armed groups, and LGBTQ+ youth, all of whom may deal with stigma and social isolation, poor support systems and limited access to school (including early childhood education) and who need access to a full range of services.

Caregivers can benefit from capacity-building in basic psychosocial skills to support children in their care. Primary caregivers and parents can benefit from positive parenting techniques, gender-responsive parenting and knowledge of how to access additional services for their children. Caregivers of children with disabilities, developmental delays or other mental health and psychosocial needs may need additional support in developing parenting and caregiver skills specific to the needs of their child and family.

Level of education, teaching experience, content knowledge and cultural competence are all factors affecting a teacher's wellbeing. Teachers should be

given training and tools that enable them to help children reduce stress, foster resilience and coping, and build supportive relationships, thereby preventing short- and long-term psychological problems. Formal teacher training (pre-service or in-service) is one strategy to equip teachers and other educators with the knowledge, attitude, behaviour and skills required for supporting distressed children and promoting all learners' mental health through teaching practices.

Relevant topics for MHPSS capacity-building among caregivers include:

- ❑ Becoming aware of their own mental health and psychosocial wellbeing needs

- ❑ Understanding and practising self-care
- ❑ Learning the conditions for optimal child development
- ❑ Knowing how children of different ages respond to and understand distressing events
- ❑ Training in active and empathic listening (i.e., psychological first aid)
- ❑ Knowing one's limits and how and when to refer young people for further help
- ❑ Learning how to create safe and supportive classrooms to strengthen student and adult feelings of being valued and connected to the school.



Putting it into practice for Output 2.3

Learning social and emotional skills in preschool creates brighter futures for children, North Macedonia

Since 2018, UNICEF has provided technical and financial support to the Government of North Macedonia to enhance professional development of teacher competencies for early childhood education. This includes the introduction of a national programme [promoting the social and emotional development of preschool children](#) and developing a dynamic national platform for teacher training, peer support, and mentoring through professional learning communities. To date, UNICEF has trained and supported 70 per cent of the country's preschool teachers to integrate social and emotional learning into their classrooms. Key takeaways from the programme include the following:

- Development of teachers' social and emotional skills is crucial.
- Play and storytelling help preschool children express their feelings.
- Collaboration among teachers and caregivers is paramount.

UNICEF and the North Macedonia Ministry of Education put a call out for teachers to film their lessons for an e-classroom platform. In less than a year, the [Eduino platform](#) became the [single most valuable collective portal](#) for digital content, collaboration and professional development for teachers, students and caregivers. Eduino offers open and free video lessons and over 400 games for parents to stimulate their child's development at home.

Intervention table 6

Interventions and activities that develop caregiver skills for supporting children in distress

Intervention table six of nine presents illustrative examples of interventions that support caregivers in developing skills and knowledge necessary for supporting children in distress. UNICEF uses the continuum of care to ensure that all programming includes interventions that promote mental health and psychosocial wellbeing, prevent mental health conditions, and ensure the care and treatment of caregivers.

The terms 'promotion', 'prevention' and 'care' are used to illustrate an application of the continuum of care. For some users, these terms are helpful; for others they are new and unfamiliar. Users are encouraged to use (or not use) the terms to the extent that they are beneficial to their design and planning processes. This list is intended to be illustrative and is not exhaustive.

Outcome 2: Caregivers

Output 2.3: Parents, caregivers, mothers, families and teachers develop skills for parenting, teaching, and supporting children and adolescents in distress (MHPSS needs).

Caregivers are equipped with the necessary skills and knowledge to be responsive to their own MHPSS needs and those of the children under their care.

Promotion interventions increase protective factors, including healthy behaviours and skills that reduce the risk of developing mental health and psychosocial conditions. Interventions within Output 2.3 will most directly relate to the third domain of wellbeing – skills and knowledge.



Equip providers who work with caregivers with the necessary skills and knowledge to deliver effective, high-quality MHPSS services across the mental health continuum of care, prevention and promotion to:

- Build caregivers' capacity to support their own wellbeing and promote the mental health and psychosocial wellbeing of children
- Provide training and information on positive parenting knowledge, skills and behaviour among caregivers
- Build the capacity of parents and other caregivers (such as teachers) to support distressed children (e.g., psychological first aid or parenting skills training to support children with disabilities)
- Teach parents and other caregivers the basics of self-care.



Build effective collaboration between caregivers, the community, school management and teachers to ensure that schools and learning environments are welcoming, inclusive and safe and promote all children's and adolescents' mental health and psychosocial wellbeing.

- Work with governments and partners to promote the integration of MHPSS literacy and a transferable skills grade-level curriculum into national education curricula (aiming for universal access to transferable skills in preschools, primary and secondary schools, and other learning settings).
- Advocate for the inclusion of MHPSS staff and resources in the national/subnational school system, including a specialized team to intervene in crises (school attacks, natural disasters, other emergencies, etc.).
- Advocate for and provide technical support to design, implement and evaluate pre-service and in-service professional development programmes to develop teachers' MHPSS capacity.
- Support programmes that give teachers MHPSS literacy training, subject matter knowledge and appropriate skills to support transferable skills development, including the use of non-judgemental, child-friendly and normalizing language with children and caregivers exhibiting any sign of distress or mental health issues.
- Ensure managers of schools and learning centres understand and prioritize an inclusive, child-friendly, supportive and gender-equal educational environment where teachers regularly interact with children on an individual level and without discrimination.

Prevention interventions aim to stop mental health and psychosocial problems from developing, getting worse or reoccurring. UNICEF programming may include primary prevention strategies that aim to stop mental health problems before they begin, secondary prevention interventions that provide support to those at high risk of experiencing mental health problems, and tertiary prevention interventions that support people living with mental health and psychosocial problems. This approach improves the quality of caregiver–child interactions at home, at school and in the community and helps caregivers to know when a child may need referral for more specialized support.



Equip teachers and educational staff with the necessary skills and knowledge to be responsive to their own wellbeing and that of the children under their care, which includes:

- Building capacity of teachers and other educators in the knowledge and provision of MHPSS
- Building capacities of teachers in social and emotional learning
- Helping teachers and other education personnel learn how to assist children and adolescents in talking openly about mental health and developing healthy habits
- Connecting students with additional support when needed⁷⁰

⁷⁰ 'Learning Brief on Mental Health and Psychosocial Support in Education'.

- Building teachers' and other educators' capacity to support children's mental health and psychosocial needs and facilitate their meaningful participation
- Supporting teachers by equipping them with the necessary skills for ensuring their own wellbeing, establishing positive coping skills and providing necessary knowledge and skills for each age group and subject they teach
- Providing caregivers with psychoeducation on stress reactions, coping and recovery
- Building capacity and self-care of teachers to create positive, safe classroom environments
- Training teachers to observe children and adolescents' behaviour and identify mental health and psychosocial concerns, provide basic psychosocial support and refer children and adolescents in need of specialized MHPSS services.



Equip primary caregivers, mothers and fathers with the necessary skills and knowledge to be responsive to their own wellbeing and that of the children under their care, for example:

- Strengthening family care and nurturing family environments through positive parenting training (e.g., learning how to help children of different ages and developmental stages cope with an emergency)
- Training parents and other caregivers in how to support children with mental health conditions.



Address basic needs during humanitarian response in a manner that is responsive to the mental health and wellbeing of the affected population.

- Support parents' and caregivers' ability to provide for their family's basic needs (e.g., facilitate access to livelihood strategies).

Care and treatment interventions for mental health and psychosocial problems include services that address mental health and psychosocial needs through direct services delivered to individuals or groups. This is particularly important for caregivers with mental health and psychosocial needs and with children who have mental health and psychosocial needs or who have been exposed to serious protection violations. Under Output 2.3, care and treatment interventions will include those interventions that aim to equip caregivers with the knowledge and skills they need to care for children and adolescents with MHPSS needs.



Build capacity of families and caregivers in self-help and mutual support for specific psychosocial problems (e.g., scalable problem management self-help interventions).

Support distressed caregivers through culturally appropriate models of engagement (e.g., gender-specific support groups, focused support or treatment for caregivers).

Train and supervise non-specialized staff to provide individual and group psychological interventions for vulnerable caregivers and families (e.g., support to mothers with post-partum depression, [Thinking Healthy](#) or interpersonal group therapy).

Build capacity among community MHPSS workers in identification, referral and case management for parents or caregivers in need of specialized care and any other additional support.



For **humanitarian response**, check out the following sections and key actions from the [Minimum Services Package](#):

[MSP 3.7](#) Promote caregivers' mental health and psychosocial well-being and strengthen their capacity to support children

[MSP 3.8](#) Promote the mental health and psychosocial well-being of education personnel and strengthen their capacity to support children

Considerations for adaptation

Caregiver sessions focused on skills and knowledge development should ensure that caregivers have access to information and services that support their mental health and psychosocial needs.



Recommended resources from the [Compendium of MHPSS Resources](#)

Strategies and approaches

- [INSPIRE website with information to end violence against children](#), Global Partnership and Fund to End Violence Against Children, 2016
- [Helping Adolescents Thrive Toolkit](#), WHO, 2020
- [Global Framework on Transferable Skills](#), UNICEF, 2019

Guidelines

- [Interim Briefing Note Addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak](#), Inter-Agency Standing Committee, 2020
- [Helping Hands at School and in the Community: Guidance for School-Based Psychosocial Programmes for Teachers, Parents and Children in Conflict and Postconflict Areas](#), War Trauma Foundation, 2012
- [Integrating Early Childhood Development \(ECD\) Activities into Nutrition Programmes in Emergencies: Why, What and How](#), UNICEF
- [Promoting Rights and Community Living for Children with Psychosocial Disabilities](#), WHO, 2015

Programme guidance

- [Self-Help Plus \(SH+\): A Group-Based Stress Management Course for Adults](#)
- [Thinking Healthy: A manual for psychosocial management of perinatal depression](#), WHO, 2015
- [Caring for the Caregiver](#), UNICEF
- [Care for Child Development Package](#), UNICEF, 2019
- [Working with Children and their Environment: Manual of Psychosocial Skills](#), Terre des hommes, 2011
- [The Children's Resilience Programme: Psychosocial support in and out of schools](#), Save the Children's Child Rights Resource Centre, 2012
- [The Youth Resilience Programme: Psychosocial support in and out of school](#), Save the Children's Child Rights Resource Centre, 2015
- [Safe Healing and Learning Spaces Toolkit](#), International Rescue Committee, 2016
- [Different. Just like you: A psychosocial approach promoting the inclusion of persons with disabilities](#), IFRC Psychosocial Centre, 2012
- [Baby Friendly Spaces: Holistic Approach for Pregnant, Lactating Women and their Very Young Children in Emergencies](#), Action Contre la Faim, 2014
- [Broken Links: Psychosocial support for people separated from family members](#), Save the Children's Child Rights Resource Centre, 2014
- [mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings](#), WHO, 2019
- [Assessing mental health and psychosocial needs and resources: Toolkit for humanitarian settings](#), WHO-UNHCR, 2012

Training

- [Lay Counselling: A Trainer's Manual](#), IFRC Psychosocial Centre, 2012
 - [MHPSS and EIE Toolkit: Training Manual for Teachers](#)
 - [Child Protection Case Management Training Manual for Caseworkers, Supervisors and Managers](#), AVSI Foundation, 2003
-



Outcome 3: Community

Improved community capacity at the district and subdistrict levels for non-stigmatizing, accessible, available and quality MHPSS service delivery across the primary health care, social welfare and protection, and education systems and structures

The community level of support describes an overarching approach to the delivery of MHPSS that is accessible within the community, free or affordable, and rooted in community-led action and response at the district and subdistrict levels. This includes both community-based approaches to MHPSS and community-led interventions and services for MHPSS. Community-based interventions provide psychosocial and mental health approaches with the aim of building upon existing individual and community resources, capacities and resilience. A community-based approach to MHPSS requires time, commitment and a willingness to listen and be open to new ideas and ways of approaching problems. It also requires the ability to effectively and respectfully address harmful practices or historical patterns of exclusion and marginalization of some groups. Because some local practices can cause harm, MHPSS workers must examine and support local practices and resources only if they fit with international standards of human rights. The community level of support includes service providers and structures that surround children and families, including political, economic and social service structures (e.g., health and education), as well as institutions and structures for culture and leisure and spiritual or religious life. UNICEF's community-based approach to MHPSS is at the core of interventions across Outcome 3. A community-based approach:

- ❑ Strengthens natural supports and systems
- ❑ Makes use of community knowledge and capacities
- ❑ Requires skills and a thorough analysis of local practices and resources to carry out MHPSS programmes in line with the principle of 'do no harm'

- ❑ Ensures community engagement in all phases of programming.

Participation is at the heart of a community-based approach to MHPSS. Participation recognizes the important role that children, adolescents, their families and caregivers and the broader community play as drivers of their own mental health and psychosocial wellbeing.⁷¹ Active engagement of communities across the MHPSS programme life cycle can contribute to improved wellbeing by providing a greater sense of control, helping people exercise their sense of agency and ensuring that the needs specific to their lives and communities are driving the MHPSS programme response and delivery. UNICEF's publication, [Mental Health and Psychosocial Support for Children in Humanitarian Settings: An Updated of Evidence and Practice](#), discusses the literature and evidence for community participation and social support in section 4.2 and children's participation in section 5.2. Specifically, the Evidence and Practice Review noted that:⁷²

- ❑ Community participation processes allow greater opportunities to identify and build upon existing informal social support networks and enhance uptake of MHPSS services.
- ❑ Community participation in MHPSS assessments, design, planning and implementation helps to ensure a more holistic understanding of the situation based on local sociocultural contexts and restores the dignity, satisfaction levels, wellbeing and ownership of the target groups.
- ❑ Community participation strengthens people's feelings of self-efficacy and self-determination.

⁷¹ United Nations Children's Fund, 'MHPSS and Participation: Guidance Document to accompany the MHPSS Compendium of Resources', UNICEF, New York, October 2020.

⁷² 'Mental Health and Psychosocial Support for Children in Humanitarian Settings', pp. 68–82.

UNICEF's [guidance document](#) on MHPSS and participation outlines six key reasons why participation is essential for MHPSS:

- ❑ Participation is a right.
- ❑ Meaningful participation enhances children's wellbeing, development and protection.
- ❑ Participation harnesses the agency, assets and strengths of individuals, families and communities for improved wellbeing.
- ❑ Participation supports the shift from treatment to prevention for children's mental health and wellbeing.
- ❑ Participation contributes to more relevant, effective and sustainable decisions, programmes and services.
- ❑ Participation increases accountability.

Participation is the primary vehicle through which community-level interventions and services are delivered, and it will be discussed across Outcome 3.

Actions at the community level are often strategic, building upon existing community resources and creating new ones when there are critical gaps. Interventions may include the involvement of first responders (police, ambulance workers, firefighters) and, in emergency contexts, will also include humanitarian workers across sectors (water, sanitation and hygiene [WASH]; shelter; nutrition; health). In some emergency situations, the political situation or specific dangers may limit community participation. But, to the extent possible, community mobilization and participation are worthy investments that offer substantial returns in terms of appropriateness, acceptability and effective targeting of interventions. Furthermore, any intervention aimed at strengthening the protective environment for children – and promoting inclusion of vulnerable or marginalized children – can only be truly effective through community understanding, will and participation.



Putting it into practice for Outcome 3

What works for child and adolescent participation in MHPSS programming

Programme example: The YouCreate toolkit is designed to strengthen wellbeing, resilience and leadership among youth. It is a participatory action research project that supports adolescents and youth (aged 14–20) to lead their peers in implementing participatory arts-based research projects and art actions to address challenges concerning them with the support of adult allies (see p. 85 in the [Evidence and Practice Review](#)).

Programme example: [Boxes of Wonder](#) is an intervention implemented by Save the Children and local partner C31 with children on the move in Serbia to promote their active participation and ensure MHPSS support. The participatory methodology was piloted with children on the move at country borders and in child-friendly spaces and adolescent corners in drop-in and reception centres. Activities included facilitating child-led tours of the camps, participating in decision-making and implementing video production and the use of other creative tools (see p. 86 in the [Evidence and Practice Review](#)).

Evaluation example: IMC's Urban Soccer Programme Evaluation for children ages 12–22 was implemented in Jordan in 2010 as part of IMC's MHPSS activities. The project was divided into two phases. Phase 1 included the renovation of two urban soccer pitches in Amman and Zarqa, a governorate 30 kilometres northeast of the capital. Renovations were undertaken in collaboration with Greater Amman and Zarqa municipalities. Both Zarqa and Amman municipalities were active in the selection of the urban soccer pitches and provided financial contributions. Positive effects observed on youth included engagement in an organized activity, friendships between Iraqi and Jordanian youth, improved parent engagement, and female participation in sport. Parents benefited from engagement with youth and community, a constructive activity, addressing stereotypes of female participation in sport, and promoting soccer and thus physical health (see p. 81 in the [Evidence and Practice Review](#)).

Output 3.1

Stigma- and judgement-free environments for mental health and psychosocial wellbeing are established through social and community awareness, acceptance and positive behaviour change for children, adolescents and their parents, caregivers, families and teachers

Mental health is a global issue that affects every community and is consistently underfunded regardless of national income levels.⁷³ Perceptions of mental health and psychosocial wellbeing can and do affect how individuals at the community level respond to and cope with mental health and psychosocial problems.

Stigma is often a barrier to seeking support. Actions can be taken at the community level to raise awareness of mental health and psychosocial needs and problems, and the importance of seeking help. These include orienting community members on MHPSS; disseminating key messages to promote mental health and psychosocial wellbeing (e.g., culturally and age-appropriate coping mechanisms, risk factors, protection factors); and conducting stigma-

reduction campaigns. [#OnMyMind: Better mental health for every child](#) is UNICEF's current and ongoing global advocacy campaign to remove stigma around talking about mental health for young people, parents, policymakers and partners.

Children and adolescents have a right to participate in stigma-reduction campaigns, particularly when issues directly concern or interest them. Participation in community-based MHPSS can enhance children's and adolescents' self-confidence and personal development. Participation in raising awareness of mental health and psychosocial wellbeing can result in more meaningful relationships; it also increases self-esteem and provides a sense of mastery and control.⁷⁴ Active participation of children and adolescents helps them build communication, problem-solving and negotiation skills.⁷⁵ In addition, as communities discover how to support and care for one another, the emphasis shifts from treatment to promotion and prevention, resulting in reaching more children, adolescents and families with critical mental health and psychosocial wellbeing messaging.

#OnMyMind: Better mental health for every child

Every child deserves to grow up in a loving, nurturing and safe environment



⁷³ United Nations Children's Fund, 'Mental health for all children and youth people, strategic advocacy framework and global advocacy plan' (draft), UNICEF, New York, March 2021.

⁷⁴ 'Mental health for all children and young people, strategic advocacy framework and global advocacy plan'.

⁷⁵ 'MHPSS and Participation: Guidance Document'.



Putting it into practice for Output 3.1

Understanding stigma as a risk factor for mental health and psychosocial problems⁷⁶

Stigmatization – the social process of exclusion and discrimination arising from local norms – can have complex social and economic consequences, and can be devastating for children in humanitarian settings. Individuals in humanitarian settings may experience stigmatization, rejection and isolation from families and communities for a range of reasons. For example, children have been stigmatized due to experiencing mental distress, sexual violence, association with an armed group, disability, being born out of wedlock, and being from an ethnic or minority group.

Stigma reduces opportunities for participation within a community, may hinder access to vital services, and can have a significant negative impact on an individual's physical and psychosocial wellbeing. Children who experience stigmatization risk being made scapegoats, may be exposed to further violence or may even face exclusion from their communities or family.

Practice example from War Child: *Stigma Reduction Approach (2019)*. Addressing the gap in evidence of interventions aiming to reduce stigma experienced by children in humanitarian settings, War Child is in the process of developing and rigorously evaluating an intervention aiming to reduce the stigmatization of children. The Stigma Reduction Approach (STRETCH) aims for applicability to stigma in any conflict-affected context. Its development is informed by evidence and research to increase the understanding of stigmatization inside communities and to identify the potential resources needed to bring about change. A socio-ecological approach is adopted to help reduce harmful beliefs and practices ingrained within communities. Research has already been undertaken in the Democratic Republic of the Congo and Lebanon and through literature. Lessons learned from this research will serve to further inform the approach. A pilot test of the intervention is planned for 2020–2021 (see p. 66 in the [Evidence and Practice Review](#)).

Practice example from CARE Belgrade (2018): Care Belgrade implemented a programme focused on engaging young men and boys in emergencies that had a significant focus on reducing the stigma associated with being a Syrian refugee in Serbia. The programme encouraged young male members of the Syrian community to work together and look for similarities instead of what separates them. Through a series of workshops and activities, participants were invited to establish the issues that affected them. Workshops included sessions on labelling and similarities and differences between home and various backgrounds. Following initial activities and participatory introductory workshops, participants took part in structured workshops selected on the basis of their specific needs and requests. The programme resulted in the development of a [manual for engaging young men and boys in emergencies](#) (see p. 66 in the [Evidence and Practice Review](#)).

Practice example from Time to Change UK and CBM: Established in 2007 in the United Kingdom, Time to Change UK was dedicated to ending mental health stigma and discrimination. The organization used social behaviour change as the foundation for its stigma-reduction campaigns with over 1,500 employers and 3,500 secondary schools, colleges and youth organizations across the United Kingdom.⁷⁷ Time to Change provided free resources on its website that organizations could download and adapt for their own anti-stigma campaigns. In 2018, Time to Change UK, in partnership with CBM and five country-level partners, launched the programme Time to Change Global, which aimed to counter mental health stigma and discrimination in Ghana, Nigeria, Kenya, Uganda and India. Time to Change Global programme partners developed the resource [Conversations Change Lives: Global anti-stigma toolkit](#), which organizations can use to develop their own anti-stigma campaigns. While the programme has since closed, some of the resources can still be accessed online.

For additional programme examples, see section 4.1 in the [Evidence and Practice Review](#).

⁷⁶ 'Mental Health and Psychosocial Support for Children in Humanitarian Settings', p. 69.

⁷⁷ Time to Change, 'About Us', <www.time-to-change.org.uk/about-us>, accessed 10 July 2022.

Intervention table 7

Interventions and activities for strengthened community awareness and positive behaviour change

Intervention table seven of nine presents illustrative examples of interventions that strengthen community awareness and positive behaviour change. UNICEF uses the continuum of care to ensure that community-based MHPSS programming includes strategies that promote mental health and psychosocial wellbeing, prevent mental health conditions, and ensure the care

and treatment of mental health and psychosocial needs within the community.

The terms 'promotion', 'prevention' and 'care' are used to illustrate an application of the continuum of care. For some users, these terms are helpful; for others they are new and unfamiliar. Users are encouraged to use (or not use) the terms to the extent that they are beneficial to their design and planning processes. This list is intended to be illustrative and is not exhaustive.

Outcome 3: Community

Output 3.1: Stigma- and judgement-free environments for mental health and psychosocial wellbeing are established through social and community awareness, acceptance and positive behaviour change for children, adolescents and their parents, caregivers, families and teachers. This approach aims to mobilize communities to take positive action by providing clear information about the needs of children and their caregivers and how to fulfil them.

Promotion interventions increase protective factors, including healthy behaviours and skills that reduce the risk of developing mental health and psychosocial conditions. Promotion interventions under Output 3.1 include interventions and activities that strengthen community awareness and promote positive behaviour change.



Promote mental health and psychosocial wellbeing within the education sector by advocating for policies and plans that prioritize not only access and learning but also mental health and psychosocial wellbeing of children, adolescents, parents and caregivers, and educators. For example:

- Developing a social behaviour change strategy to address stigma and discrimination, undo prevailing myths regarding mental health and psychosocial problems, and promote support-seeking behaviour among children, adolescents, teachers and other education personnel in schools and learning environments
- Strengthening policies to ensure the design of educational facilities in line with universal design standards that ensure facilities are disaster-resilient, safe, dignified and accessible to all children⁷⁸
- Supporting laws and policies that ban all corporal punishment and create capacity-building programmes for educators in the constructive handling of challenging behaviour
- Creating national strategies, policies and procedures to prevent and address discrimination and peer violence in learning environments
- Ensuring children and adolescents are active participants in the development and implementation of school-based mental health policies and strategies
- Advocating to ensure an enabling legislative environment (e.g., decriminalizing suicide)
- Establishing or strengthening laws, policies and procedures that ensure a safe, supportive learning environment at all levels.



Promote mental health and psychosocial wellbeing within the community through stigma-reduction campaigns for people with mental health and psychosocial needs, including information on unequal gender norms that influence gendered differences in child and adolescent mental health and psychosocial needs. Some examples are:

- Implementing community-wide, targeted awareness-raising activities that combat stigma, discrimination and abuse linked to mental health and psychosocial support problems and promote help-seeking behaviour
- Creating community messaging on children's stress reactions and coping strategies
- Raising awareness of distress reactions of children in emergencies, according to age and developmental stage

⁷⁸ Global Alliance for Disaster Risk Reduction & Resilience in the Education Sector, 'Guidance, Tools, Research & Evidence', <<https://gadrrres.net/resources>>, accessed 27 October 2022.

- Strengthening community-led action and advocacy to promote mental health and psychosocial wellbeing, reduce stigma and increase access to community-based and -led MHPSS services
- Developing stigma-reduction campaigns for people with mental health conditions and child protection messaging, including on unequal gender norms that influence gendered differences in child and adolescent mental health
- Promoting mental health and psychosocial wellbeing, behaviour change and community awareness campaigns about available supports for children, caregivers and families in need
- Working with community leaders and resources to promote stigma reduction and inclusion and participation of children and families with disabilities or MHPSS problems.

Prevention interventions aim to stop mental health and psychosocial problems from developing, getting worse or reoccurring. UNICEF programming may include primary prevention strategies that aim to stop mental health problems before they begin, secondary prevention interventions that provide support to those at high risk of experiencing mental health problems, and tertiary prevention interventions that support people living with mental health and psychosocial problems.



Integrate mental health and psychosocial needs of children and teachers in education sector analysis, planning and monitoring.

- Raise awareness and build capacity in school systems to support children who are experiencing distress, mental health conditions and psychosocial problems or disabilities, including identification and referral of at-risk children, caregivers and families in need.
- Support an enabling legal and policy environment for provision of and access to mental health care, treatment and support.

Care and treatment interventions for mental health and psychosocial problems include services that address mental health and psychosocial needs through personalized care delivered to individuals or in groups. Often the treatment of mental health and psychosocial problems will include a range of complementary services that change the way people think about their problems, interact with their environment or manage their daily activities. The care and treatment of mental health and psychosocial problems include a wide range of services, including but not limited to counselling and psychotherapy, pharmacology, case management services, hospitalization, support groups, self-help plans and strategies, recovery and rehabilitation approaches, and peer support.



Mobilize communities to ensure equitable access to care and treatment interventions for all members of the community.

- Identify and develop functional referral resources and procedures for clinical mental health care and professional social services for children and families in need.
- Establish national crisis helplines that ensure confidential and 24-hour support, with trained hotline employees and volunteers who provide information and critical resources.



For **humanitarian response**, check out the following sections and key actions from the [Minimum Services Package](#):

- [MSP 1.2](#) Assess MHPSS needs and resources to guide programming
- [MSP 2.1](#) Design, plan and coordinate MHPSS programmes
- [MSP 3.1](#) Orient humanitarian actors and community members on MHPSS and advocate for MHPSS considerations and actions
- [MSP 3.3](#) Disseminate key messages to promote mental health and psychosocial well-being
- [MSP 3.4](#) Support new and pre-existing group-based community MHPSS activities

Considerations for adaptation

Referral pathways between development and humanitarian systems can be important. In some instances, countries may have two systems: one for development services and another for humanitarian services. MHPSS systems-building should always focus on creating and strengthening referrals across systems, which may include understanding and adapting programming to complement both development and humanitarian contexts.



Recommended resources from the [Compendium of MHPSS Resources](#)

Strategies and approaches

- [INSPIRE website with information to end violence against children](#), Global Partnership and Fund to End Violence Against Children, 2016
- [Helping Adolescents Thrive Toolkit](#), WHO, 2021
- [Early Childhood Accelerator, Analysis and Planning Toolkit](#), UNICEF

Guidelines

- [Engaged and Heard! Guidelines on Adolescent Participation and Civic Engagement](#), UNICEF, 2020
- [Evaluation of Child Friendly Spaces: Tools and guidance](#)
- [Guidelines for Child Friendly Spaces in Emergencies](#), World Vision International, 2015
- [Helping Hands at School and in the Community: Guidance for School-Based Psychosocial Programmes for Teachers, Parents, and Children in Conflict and Postconflict areas](#), War Trauma Foundation, 2012
- [Interim Briefing Note Addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak](#), Inter-Agency Standing Committee, 2020
- [MHPSS and Participation: Guidance Document to accompany the MHPSS Compendium of Resources](#), UNICEF, 2020
- [Mainstreaming Psychosocial Care and Support through Child Participation: For programmes working with children and families affected by HIV and AIDS, poverty and conflict](#), REPSSI, 2009
- [Promoting Rights and Community Living for Children with Psychosocial Disabilities](#), WHO, 2015

Programme guidance

- [ARC: Foundation Module 4; Children's Participation and Inclusion](#), Save the Children's Child Rights Resource Centre, 2009
- [Different. Just like you: A psychosocial approach promoting the inclusion of persons with disabilities](#), IFRC Psychosocial Centre, 2015
- [I Support My Friends: A training for children and adolescents on how to support a friend in distress](#), UNICEF, 2021
- [Move On & Engage: A Mental Health and Psychosocial Resilience Curriculum](#), Terre des hommes, 2020
- [Working with Children and their Environment: Manual of Psychosocial Skills](#), Terre des hommes, 2011
- [Safe Healing and Learning Spaces Toolkit](#), International Rescue Committee, 2016
- [Activity Catalogue for Child Friendly Spaces in Humanitarian Settings](#), IFRC Psychosocial Centre, 2018
- [mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings](#), WHO, 2019

Training

- [Save the Children Psychological First Aid Training Manual for Child Practitioners](#), Save the Children's Child Rights Resource Centre, 2013

Output 3.2

Community mental health and psychosocial wellbeing support systems are strengthened across sectors, including community capacities to support children, adolescents, parents, caregivers, families and teachers

Community-led MHPSS activities help activate and restore natural supports⁷⁹ within community and family care systems when they have been weakened by external factors or mental health and psychosocial problems within the family. High levels of distress occur in all contexts and can be caused by a wide range of factors, such as extreme poverty, violence in the home, conflict or natural disasters, and even global pandemics – all of which can sometimes make it hard for children and families to access support

systems or utilize positive coping mechanisms.

Interventions and services at the community level can help strengthen a person's interpersonal wellbeing by creating opportunities within their local community to develop supportive nurturing relationships, responsive caregiving, and relationships with those they did not know before but with whom they share commonalities, thereby creating a sense of belonging.

Activation of natural community supports for child and family wellbeing acknowledges and strengthens community resources to support children and families. Community support will look different from one context to another, as it will reflect local needs and available resources, which may be part of a formalized or professional care system or community-led and -mobilized activities.

⁷⁹ Natural supports refer to all supports that existed prior to any outside or external supports being established.

Formalized supports and professional care systems may include interventions hosted at local health clinics, places of worship or schools that bring together community members to provide support around a shared need or issue. These supports may be organized by a local ministry of social welfare, health authority or school system, and may focus on specific MHPSS needs that have been identified in the community.

[Social and behaviour change](#)⁸⁰ (SBC) activities aim to build the capacity of local community organizations, such as women’s groups or organizations of persons with disabilities, to conduct outreach to vulnerable families on issues specific to mental health and psychosocial wellbeing. SBC involves understanding people, their beliefs and values, and the social and cultural norms that shape people’s lives. It involves engaging communities and listening to adults and children as they identify problems, propose solutions and act upon them. SBC is a two-way process for sharing ideas and knowledge using a range of communication tools and approaches that empower individuals and communities to take actions to improve their lives. It can be useful in working with communities on topics that vary greatly from one culture to the next and in some cases from one community to the next. An example could be a community group for people who need support following the death of a loved one held at a place of worship, in a community hall, at a health centre or even outside under a tree.

Strengthening a community’s MHPSS systems includes providing technical support to increase the mental health and psychosocial workforce in schools and learning environments. School mental health and psychosocial professional staff should include school psychologists, counsellors, social workers, educational personnel trained in MHPSS, and other qualified MHPSS service providers. Professionals can work with students, families, educators and the broad school community to provide a comprehensive range of services within the school context, including the universal promotion of mental health, identification and referral for services, and crisis intervention.

For example, in locations where a counsellor or psychologist is part of the school system, students and education personnel may have access to psychological interventions, while their caregivers may have opportunities to attend orientation or other sessions on mental health and psychosocial support.

During emergencies where there are significant displacements, humanitarian actors should provide support in mobilizing communities to identify activities and interventions that can activate local supports. Examples include group-based activities, such as cooking clubs, parenting support groups, cultural dance clubs, and other club-based activities that bring members of the community together around a shared interest. Community mobilization and support to community organizations may also include support to community leaders in promoting mental health and psychosocial wellbeing through the promotion of positive gender and social norms on child and family wellbeing and stigma reduction against at-risk children. The [Evidence and Practice Review](#) identifies community engagement as essential for supporting the successful implementation and uptake of MHPSS programmes in humanitarian settings. It found that:

- ❑ Mental health sensitization, mobilization strategies and the need to develop effective partnerships with local communities and government were understood as pivotal in increasing programme accessibility and reach.
- ❑ Establishing good relationships with parents may also be important when there is a need to communicate the value of children and young people participating in MHPSS programmes.⁸¹

Community mobilization and engagement strengthen the networks of support for children and families and help rebuild community capacity for longer-term recovery and care. They support self-help on individual and communal levels, capitalizing on existing resources. Furthermore, engaging people with local knowledge provides important information about how best to deliver services so they are acceptable to beneficiaries and appropriate to local understandings of child development, wellbeing and rearing.

⁸⁰ Social and behaviour change (SBC) is a set of approaches that promote positive and measurable changes towards the fulfilment of children’s rights. SBC involves working with communities and authorities to understand and influence the cognitive, social and structural drivers of change. It relies on social and behavioural evidence, as well as participatory approaches, to co-design solutions that address development and humanitarian challenges.

⁸¹ Kohrt, Brandon A., et al., ‘The Role of Communities in Mental Health Care in Low- And Middle-Income Countries: A Meta-Review of Components and Competencies’, *International Journal of Environmental Research and Public Health*, vol. 15, no. 6, June 2018.



Putting it into practice for Output 3.2

Community components are vital to addressing mental health needs⁸²

A meta-review published in the International Journal of Environmental Research and Public Health found that community components are vital to addressing global mental health needs and rectifying the stark gap between the burden of mental disorders and access to appropriate evidence-based interventions in LMICs. The review's authors identified that:

- Community platforms were an alternative to primary care to enhance the reach of services.
- Community components could augment clinical services, such as by enhancing medication adherence.
- Community programmes were also implemented to increase the likelihood of family involvement, which would in turn improve quality of life, functioning and inclusion.
- Community platforms had economic benefits not observed in primary care and specialty settings.
- Community platforms are used to promote social inclusion.

The authors also found that community-based services enhanced the delivery of care that was easily accessible to persons with mental illness. Furthermore, community services (including school-based services) can promote social inclusion because community-based settings can be less stigmatizing than visiting a mental health-care facility. A recent study on the psychosocial wellbeing of Rohingya refugees emphasized the importance of the community in supporting MHPSS needs. Qualitative data from focus group discussions indicated that male and female adults and older persons with MHPSS needs were primarily seeking treatment services from traditional healers and that Rohingya men, women, boys and girls only entered the formal health-care system to access mental health care if there was a physical problem associated with their condition. Adolescent boys and girls reported rarely (if ever) using health clinics in the camp, preferring to seek MHPSS from their peers and parents. The research further identified the crucial role of local community members and training of outreach workers who were able to support referrals to relevant services, particularly in project areas where humanitarian staff are not permitted to visit due to insecurity or other political factors.

For more information on these community elements, see Section 4.2: 'Community Participation and Social Support' in the [Evidence and Practice Review](#).

Intervention table 8

Interventions and activities for strengthened community mental health and psychosocial wellbeing support systems across sectors

Intervention table eight of nine presents illustrative examples of interventions for strengthened community MHPSS systems across sectors. UNICEF uses the continuum of care to ensure that community-based MHPSS programming includes strategies that promote mental health and psychosocial wellbeing, prevent

mental health conditions, and ensure the care and treatment of mental health and psychosocial needs within the community.

The terms 'promotion', 'prevention' and 'care' are used to illustrate an application of the continuum of care. For some users, these terms are helpful; for others they are new and unfamiliar. Users are encouraged to use (or not use) the terms to the extent that they are beneficial to their design and planning processes. This list is intended to be illustrative and is not exhaustive.

⁸² 'Mental Health and Psychosocial Support for Children in Humanitarian Settings', p. 78.

Outcome 3: Community

Output 3.2: Community mental health and psychosocial wellbeing support systems are strengthened across sectors, including community capacities to support children, adolescents, parents, caregivers, families and teachers.

This approach acknowledges and strengthens community resources to support children and families.

Promotion interventions increase protective factors, including healthy behaviours and skills that reduce the risk of developing mental health and psychosocial conditions. This approach acknowledges and strengthens community resources to support children and families.



Build MHPSS programmes across sectors that promote mental health and psychosocial wellbeing through community engagement on MHPSS topics. Some possible examples include the following:

- Support community leaders (e.g., faith leaders) in promoting child protection and mental health and psychosocial wellbeing.
- Ensure children and families have access to important information about services that are available to support mental health and psychosocial needs, legal rights and positive coping strategies.
- Disseminate key messages to promote mental health and psychosocial wellbeing (e.g., how and where to access MHPSS and other relevant services, learning coping strategies).
- Conduct national and community-based awareness-raising campaigns to promote learning that starts at birth and takes place within and outside formal educational settings.
- Develop participatory approaches and community-based mechanisms that support the participation of children, families and community members in school management.
- Build the capacity of health-care workers in child-friendly communication and supporting children's and adolescents' participation in health-care decisions.
- Ensure collaboration between health and child protection sectors to ensure health-care services are child- and family-friendly, including in the times, spaces and methods used in service delivery.
- Hold community information sessions on topics related to MHPSS, such as the importance of supporting caregivers and training to provide infant and young child learning and how active play can support the development of important skills and stimulation that is essential for child development.

Prevention interventions aim to stop mental health and psychosocial problems from developing, getting worse or reoccurring. UNICEF programming may include primary prevention strategies that aim to stop mental health problems before they begin, secondary prevention interventions that provide support to those at high risk of experiencing mental health problems, and tertiary prevention interventions that support people living with mental health and psychosocial problems.



Create opportunities for community members to come together and respond to the range of mental health and psychosocial needs within the community. Some examples may include:

- Working with and through women's groups to strengthen outreach to vulnerable families and reduce their risk of mental health and psychosocial problems
- Conducting peer-led support groups and education programmes that strengthen the community-based response to mental health and psychosocial problems
- Promoting community-led efforts to strengthen and promote family unity through prevention of family separation, identification and care of separated children, and family tracing and reunification
- Facilitating opportunities for children and adolescents to contribute to community improvement and service activities, which allows children to feel effective, positive belonging, positive identity, transcendence
- Ensuring strong referral networks and promoting collaborative working with social services, education and child protection to support health and mental health and psychosocial wellbeing cross-sectorally.

Care and treatment interventions for mental health and psychosocial problems include services that address mental health and psychosocial needs through personalized care delivered to individuals or in groups. Often treatment of mental health and psychosocial problems will include a range of complementary services that change the way people think about their problems, interact with their environment or manage their daily activities. The care and treatment of mental health and psychosocial problems include a wide range of services, including but not limited to counselling and psychotherapy, pharmacology, case management services, hospitalization, support groups, self-help plans and strategies, recovery and rehabilitation approaches, and peer support.



Strengthen services and systems within the community to increase access to mental health and psychosocial support of children, adolescents and their caregivers.

- Set up or promote existing national crisis helplines that ensure confidential and 24-hour support through trained and supported hotline employees and volunteers. Volunteers can provide information and critical resources to persons in distress or their loved ones and are able to make referrals to specialized services, support groups and legal support, if needed.
- Build capacity and ensure ongoing support and supervision to MHPSS workers in scalable evidence-based individual or group psychological interventions.



For **humanitarian response**, check out the following sections and key actions from the [Minimum Services Package](#):

[MSP 1.1](#) Coordinate MHPSS within and across sectors

[MSP 3.1](#) Orient humanitarian actors and community members on MHPSS and advocate for MHPSS considerations and actions

[MSP 3.3](#) Disseminate key messages to promote mental health and psychosocial well-being

[MSP 3.4](#) Support new and pre-existing group-based community MHPSS activities

[MSP 3.8](#) Promote the mental health and psychosocial well-being of education personnel and strengthen their capacity to support children

[MSP 3.10](#) Provide mental health care as part of general health services

[MSP 3.12](#) Provide MHPSS through case management services

Considerations for adaptation

Participation and community engagement are core elements of quality MHPSS programming. Building strong programmes with good community engagement and participation – including children, adolescents and caregivers – will help ensure that activities are tailored to each community's unique needs, thus leading to needs-based and age- and gender-responsive approaches that are inclusive and can address the varying and often complex needs of different groups or individuals.



Recommended resources from the [Compendium of MHPSS Resources](#)

Strategies and approaches

- [Early Childhood Accelerator, Analysis and Planning Toolkit](#), UNICEF

Guidelines

- [Engaged and Heard! Guidelines on Adolescent Participation and Civic Engagement](#), UNICEF, 2020
- [Guidelines for Child Friendly Spaces in Emergencies](#), Inter-agency Network for Education in Emergencies, 2011
- [Guidelines for the provision of remote psychosocial support services for GBV survivors](#), United Nations Population Fund
- [Helping Hands at School and in the Community: Guidance for School-Based Psychosocial Programmes for Teachers, Parents, And Children in Conflict and Postconflict Areas](#), War Trauma Foundation, 2012
- [MHPSS and Participation: Guidance Document to accompany the MHPSS Compendium of Resources](#), UNICEF, 2020
- [Mainstreaming psychosocial care and support through child participation](#), REPSSI, 2009
- [Promoting Rights and Community Living for Children with Psychosocial Disabilities](#), WHO, 2015

Programme guidance

- [ARC Foundation Module 4: Participation and Inclusion](#), Save the Children's Child Rights Resource Centre, 2009

- [Different. Just like you: A psychosocial approach promoting the inclusion of persons with disabilities](#), IFRC Psychosocial Centre, 2015
- [mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings](#), WHO, 2019
- [Preventing Suicide: A resource for establishing a crisis line](#), WHO, 2018
- [Working with Children and Their Environment](#), Terre des hommes, 2011
- [The Behavioural Drivers Model: A conceptual framework for social and behaviour change programming](#), UNICEF, 2019

Training

- [Save the Children Psychological First Aid Training Manual for Child Practitioners](#), Save the Children's Child Rights Resource Centre, 2013
- [Training Volunteers to Answer Helpline for Patients In COVID-19 Isolation Units – Egypt](#), Terre des hommes, 2020

Output 3.3

Multisectoral care systems (primary health care, social welfare and protection, education) for children, adolescents, parents, caregivers, families and teachers, including family-friendly policies, are developed and strengthened

MHPSS programming needs to support and strengthen care systems at local, regional and national levels. Interventions that engage the community are more likely to be meaningful and sustainable and help restore people's sense of competence and agency to meet new challenges and become hopeful about the future. Strengthening resources and capacities for self-help makes best use of people's knowledge and capacities to recover and to help their children do the same.

Strengthening formal care systems includes improving promotive, preventive and responsive MHPSS services within health, education and social welfare and protection systems for coordinated care, case management and referrals for children and families with MHPSS and protection needs. Social workers, health-care workers and teachers are all part of the care system that delivers MHPSS services at the community level. A strong care system links these services together and makes them accessible within the community. For example, MHPSS services could be provided in the community by MHPSS practitioners or members of the community who have been trained in specific approaches and who receive supervision from the local health system or social welfare and education system. Ensuring that these services are provided in the community, while also linked to a

formal system, increases accessibility of services and ensures ongoing quality oversight of service delivery. It is important that interventions work to support existing community resources (parents, teachers, health and social service workers, religious leaders) and help re-establish community support structures that may have been disrupted by emergencies, while ensuring that these supports are inclusive and work towards the best interests of all children.

Intervention table 9

Interventions and activities for strengthened care systems across PHC, social welfare and protection, and education

Intervention table nine of nine presents illustrative examples of interventions for strengthened care systems across PHC, social welfare and protection, and education. UNICEF uses the continuum of care to ensure that community-based MHPSS programming includes strategies that promote mental health and psychosocial wellbeing, prevent mental health conditions, and ensure the care and treatment of mental health and psychosocial needs within the community.

The terms 'promotion', 'prevention' and 'care' are used to illustrate an application of the continuum of care. For some users, these terms are helpful; for others they are new and unfamiliar. Users are encouraged to use (or not use) the terms to the extent that they are beneficial to their design and planning processes. This list is intended to be illustrative and is not exhaustive.

Outcome 3: Community

Output 3.3: Multisectoral care systems (primary health care, social welfare and protection, education) for children, adolescents, parents, caregivers, families and teachers, including family-friendly policies, are developed and strengthened.

This approach includes capacity-building in the social services, education, protection and health systems, which protect children and families and promote their mental health and psychosocial wellbeing.

Promotion interventions increase protective factors, including healthy behaviours and skills that reduce the risk of developing mental health and psychosocial conditions.



Build capacity and support the work of education, health and social service professionals, protection actors and community volunteers on mental health and psychosocial wellbeing for vulnerable and at-risk children and families. Some examples are:

- Building the capacity of health service staff to become age- and gender-sensitive while delivering care and to challenge stigma and discrimination
- Strengthening the capacity of the health sector in providing child-friendly services, including through age-appropriate, child-friendly communication techniques and supporting children's and adolescents' meaningful participation in health-care decisions.



Ensure children and families have access to essential information about basic services, legal rights and positive coping strategies.

- Disseminate information on mental health and psychosocial wellbeing across multiple platforms, including social media, TV and the radio. Messaging should always include information on where to go to access services or help.
- Establish information access points with pamphlets and other materials on MHPSS and where to access services. These can be located in the community anywhere people gather, including but not limited to schools, health centres or clinics, shopping centres and parks.

Prevention interventions aim to stop mental health and psychosocial problems from developing, getting worse or reoccurring. UNICEF programming may include primary prevention strategies that aim to stop mental health problems before they begin, secondary prevention interventions that provide support to those at high risk of experiencing mental health problems, and tertiary prevention interventions that support people living with mental health and psychosocial problems.



Support health-care providers and nutrition actors to identify and refer parents with mental health concerns, including new mothers and infants and young children at risk due to protection concerns, poor growth or developmental disabilities. This includes building the capacity of health-care providers and nutrition actors to provide basic psychosocial support and positive parenting support to parents and caregivers.



Ensure basic needs (shelter, food, WASH) are provided in ways that respect the culture, dignity and agency of children and families and are sensitive to children's developmental needs.

Care and treatment interventions for mental health and psychosocial problems include services that address mental health and psychosocial needs through personalized care delivered to individuals or groups. Often the treatment of mental health and psychosocial problems will include a range of complementary services that change the way people think about their problems, interact with their environment or manage their daily activities. The care and treatment of mental health and psychosocial problems include a wide range of services, including but not limited to counselling and psychotherapy, pharmacology, case management services, hospitalization, support groups, self-help plans and strategies, recovery and rehabilitation approaches, and peer support.



Strengthen social service systems for coordinated care, case management and referral for children and families with MHPSS and protection needs.

- Provide outreach services to vulnerable families for MHPSS, protection services and referral to specialized care and other sector services as needed.
- Equip community leaders and local service providers with the necessary skills and knowledge to be responsive to the MHPSS needs in their community.
- Work with community and intersectoral actors to appropriately identify and reach out to vulnerable parents or caregivers (with mental health conditions, disability or serious distress) for care and referral to relevant support and services.

- Build the capacity of community health workers, educators and community volunteers to appropriately identify, support and refer vulnerable children, adolescents and families to child protection or MHPSS services.
- Improve the capacity of PHC staff to provide quality mental health services.



For **humanitarian response**, check out the following sections and key actions from the [Minimum Services Package](#):

- [MSP 1.1](#) Coordinate MHPSS within and across sectors
- [MSP 3.3](#) Disseminate key messages to promote mental health and psychosocial well-being
- [MSP 3.4](#) Support new and pre-existing group-based community MHPSS activities
- [MSP 3.10](#) Provide mental health care as part of general health services

Considerations for adaptation

Emergencies can provide strategic opportunities to strengthen or establish critical MHPSS systems. Development and humanitarian actors need to ensure that strong communication and collaboration exist across and within national health, education, social welfare and child protection service structures to reduce duplication or the establishment of parallel systems.



Recommended resources from the [Compendium of MHPSS Resources](#)

Strategies and approaches

- [Helping Adolescents Thrive Toolkit](#), WHO, 2021
- [Early Childhood Accelerator, Analysis and Planning Toolkit](#), UNICEF

Guidelines

- [Engaged and Heard! Guidelines on Adolescent Participation and Civic Engagement](#), UNICEF, 2020
- [Helping Hands at School and in the Community: Guidance for School-Based Psychosocial Programmes for Teachers, Parents, and Children in Conflict and Postconflict areas](#), War Trauma Foundation, 2012
- [Interim Briefing Note Addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak](#), Inter-Agency Standing Committee, 2020
- [MHPSS and Participation: Guidance Document to accompany the MHPSS Compendium of Resources](#), UNICEF, 2020
- [Mainstreaming psychosocial care and support through child participation](#), REPSSI, 2009
- [Promoting Rights and Community Living for Children with Psychosocial Disabilities](#), WHO, 2015

Programme guidance

- [ARC Foundation Module 4: Participation and Inclusion](#), Save the Children's Child Rights Resource Centre, 2009
- [Different. Just like you: A psychosocial approach promoting the inclusion of persons with disabilities](#), IFRC Psychosocial Centre, 2015
- [Guidance and technical packages on community mental health services: Promoting person-centred and rights-based approaches](#), WHO, 2021
- [Working with Children and their Environment: Manual of psychosocial skills](#), Terre des hommes, 2011

Training

- [Save the Children Psychological First Aid Training Manual for Child Practitioners](#), Save the Children's Child Rights Resource Centre, 2013



Outcome 4: Systems

An improved enabling environment for MHPSS is created across policy, legislation and financing systems, the MHPSS workforce, multisectoral supports and referral pathways, and MHPSS research and data

UNICEF's MHPSS Framework promotes a multisectoral support system that integrates service delivery at the child/adolescent level, the family/caregiver level and the community level. This system recognizes that everyone sits somewhere on the mental health continuum – from experiencing good mental health to anything from short-term distress to long-term disabling conditions – and many, if not most, people move along it at some stage. Accordingly, UNICEF addresses mental health on a continuum of care, which includes prevention, promotion and treatment focusing on the broad spectrum of mental health issues that affect everyone, from specific mental health conditions to the overall mental wellbeing that we would want for every child. The enabling environment underpins and reinforces the circles of support and is shaped by the financing and budget allocations, policies, laws, institutions, culture, and social and gender norms creating a system that moderates access to mental health and psychosocial services. The enabling environment is made up of four areas: data and evidence generation, community mobilization, MHPSS systems-strengthening and the continuum of care.

In the absence of a strategy that clearly defines UNICEF's role within the broader global ecosystem of Outcome 4, this outcome will be further explored through a new component (developed throughout the Strategic Plan period to 2025) in the supplemental MHPSS Framework implementation package, which includes:

- ❑ Guidance and tools (including fact sheets and tip sheets) to support the design, implementation, monitoring, evaluation, documentation and learning of mental health legislative, policy, financing and advocacy work that enhances accountability across all settings, including HICs
- ❑ Guidance for mental health and psychosocial wellbeing and inventive approaches relevant to

Outcome 4 informed by desk reviews and findings from consultations

- ❑ Training materials/activities to improve capacity and knowledge around mental health legislative, policy, financing and advocacy approaches.

Output 4.1

Policy, legislation and financing: An effective policy, legislative and financing environment is available and accessible by putting supportive mechanisms in place for quality MHPSS service delivery

The first step in developing a multisectoral strategy for MHPSS is to conduct a comprehensive analysis of the current enabling environment. National legislation, policies and financing across health, social welfare and education systems determine what kinds of MHPSS services are available and accessible across the other three outcomes listed in this framework – child and adolescent, caregiver and community. These systems are essential for creating an environment that is responsive to the MHPSS needs of any given population. An examination of the enabling environment for each context will determine which services are needed, who the primary service providers are, and where the biggest gaps are in service provision. It is also crucial to ensure that any analysis captures children's and adolescents' perceptions of their mental health and psychosocial needs and the services necessary to meet those needs.

This information will help programme planners develop comprehensive and coordinated multisectoral MHPSS responses at the national, regional and local levels. The analysis should look at the mixture of policies, laws, institutions, culture and social norms (related to gender, disabilities and other characteristics prone to stigma and exclusion, including LGBTQ+) that influence access to and availability of MHPSS services for all children, adolescents, their families and communities.

The role of advocacy

Advocating for the policy, legislative and financing environment necessary for efficient MHPSS service delivery includes policies, laws, institutions, culture and social and gender norms that create:

- ❑ A system that facilitates access to affordable and non-stigmatizing MHPSS for all children, adolescents, their families and communities
- ❑ A supportive environment for the voice, agency and action of advocates and users of MHPSS, including youth and caregivers.

UNICEF defines advocacy as “...the deliberate process, based on demonstrated evidence, to directly and indirectly influence decision makers, stakeholders and relevant audiences to support and implement actions that contribute to the fulfilment of children’s and women’s rights”.⁸³ In the context of mental health, UNICEF defines advocacy as influencing investment and action through policy, legislation and financing to ensure that supportive mechanisms are in place for accessible, affordable, non-stigmatizing, quality MHPSS service delivery for all children, adolescents and their families.

Advocacy relates to but differs from the following:

- ❑ Communication plays a critical role in advocacy strategies but is never a stand-alone tactic. It also supports other objectives, such as brand strengthening or resource mobilization.
- ❑ Technical assistance to governments supports the capacity of decision makers. Advocacy focuses on influencing decision makers and building political will for action. Technical assistance supports decision makers’ capacities.

Table 3 depicts strategic actions across policy, legislation and financing for MHPSS. The recommended key actions are reinforced by UNICEF’s global advocacy priority on mental health 2021–2025 and its four accelerator areas.⁸⁴

- 1. Investment for all:** Secure greater and better investment in inclusive and gender-responsive MHPSS services across all sectors and community

services and structures for all children, adolescents, caregivers, parents and families, from high-, low- and middle-income countries and humanitarian settings. Services must be appropriate for and adapted to specific cultural contexts.

- 2. Promotion and prevention in the family:** Support caregivers, parents and families by rolling out parenting programmes⁸⁵ to promote positive parenting and nurturing caregiving and support caregiver wellbeing and mental health.
- 3. Response in the school and community:** Ensure that all children and adolescents learn and interact in safe, supportive and secure environments, both online and offline, and have supportive relationships with teachers and peers and access to mental health services for all who need them.
- 4. Changing the public conversation on mental health:** Ensure key actions around legislation, policy, services and investment are directly related to changing the global conversation and public perception on mental health and mental ill-health and related issues of abuse and neglect. This will likely involve strategic communications and behaviour change strategies that engage service users, tackle stigma and discrimination, promote positive parenting practices, and equip mental health-informed and resilient communities and societies with respect and attention to local nuances and contexts.

The four accelerator areas reflect different aspects of the prevention, promotion and treatment continuum and the various actions required in the short, medium and long terms to truly transform children’s and adolescents’ mental health and wellbeing. While UNICEF will prioritize these accelerators at global, regional and national levels, colleagues will also need to advocate on broader issues to support implementation of the MHPSS Framework.

For a detailed overview of UNICEF’s Global Mental Health Advocacy Blueprint, please see ► [Annex 7](#).

⁸³ United Nations Children’s Fund, ‘Advocacy Toolkit: A guide to influencing decisions that improve children’s lives’ (internal resource), UNICEF, New York, 2010.

⁸⁴ United Nations Children’s Fund, ‘Mental Health and Global Advocacy Strategy April 2021’ (internal resource), UNICEF, New York, 2021. For more information about UNICEF’s Global Advocacy Strategy, please contact UNICEF staff in your local country office.

⁸⁵ United Nations Children’s Fund, ‘Universal parenting support to prevent abuse and neglect: A policy call for national governments’, UNICEF, New York.

Table 3 Key actions within the enabling environment

Legislation
<ul style="list-style-type: none"> • Legislation secures the rights of people with mental health conditions.⁸⁶ This may include supporting law reform processes to abolish laws and regulations that permit coercion and discriminate against service users and persons with disabilities receiving mental health care. • Legislation ensures children are protected and have access to quality MHPSS services. • Legislation ensures access to mental health care for all, including establishing policies and financing for the delivery of MHPSS services within the community. • Legislation establishes guidelines and standards for promotive, preventive and responsive mental health and wellbeing policies in schools.⁸⁷ • The legislative and policy environment secures public financing for parenting support programmes that promote positive parenting and nurturing caregiving and support caregiver wellbeing.⁸⁸ Legislation supports the development of community-based and community-led MHPSS services. • National, regional and local legislation supports access to MHPSS services across PHC, education and social welfare and protection services. • Development and implementation of mental health-related laws and policies ensure active consultation with and the involvement of target groups of direct or indirect impact, including children and adolescents with disabilities.
Policies
<ul style="list-style-type: none"> • Ministries and departments develop policies that promote mental health and psychosocial wellbeing for all, including gender-responsive and gender-inclusive family-friendly policies (such as paid parental leave, breastfeeding support, access to affordable quality childcare and child benefits) and access to care and treatment that provide parents and caregivers with time, resources and services. • Mental health considerations are integrated into health policies that focus on specific populations at higher risk of mental health challenges, such as people with HIV, pregnant adolescents, and humanitarian and migrant populations. • Ministries or departments of education include policies and financing supporting the integration of school-based MHPSS services for children, adolescents and teachers. • MHPSS needs of children and teachers are integrated to education sector analysis, planning, budgeting and monitoring. • Policies promote high-quality, community-based care for people with mental health conditions and ensure safe, dignified, evidence-based treatment for people in residential care. • Ministries or departments of social welfare include policies that facilitate access to MHPSS services when necessary. • The legislative and policy environment secures public financing for parenting support programmes that promote positive parenting and nurturing caregiving and support caregiver wellbeing.⁸⁹ • A human rights-based approach to disability is promoted in the process of policy formulation, implementation and evaluation of mental health programmes and services.
Financing
<ul style="list-style-type: none"> • Financing of MHPSS services across government ministries is prioritized. • Financing supports community participation in MHPSS needs assessment and analysis. • Financing is distributed for MHPSS services across sectors. Necessary actions are taken to increase funding for core services. • A local evidence base and critical gaps for mental health and psychosocial wellbeing are identified. • Legislation ensures funding for MHPSS data and evidence. • The legislative and policy environment secures public financing for parenting support programmes that promote positive parenting and nurturing caregiving and support caregiver wellbeing.⁹⁰ • Resources are mobilized for community-based, peer-led and human rights-based responses, and services are inclusive of persons with disabilities. • Resources are mobilized for outreach activities for individuals who are institutionalized, live in confinement or are restricted or deprived of liberty at home or within their community. These efforts should not be stand-alone and should run in parallel with policy efforts to deinstitutionalize mental health services and promote high-quality, community-based care for people with mental health conditions.

⁸⁶ United Nations Children's Fund and Burnet Institute, 'Strengthening Mental Health and Psychosocial Support Systems and Services for Children and Adolescents in East Asia and the Pacific Region; Regional Report 2022', UNICEF East Asia and the Pacific Regional Office, Bangkok, 2022.

⁸⁷ 'Mental Health and Global Advocacy Strategy April 2021' (internal resource).

⁸⁸ Ibid.

⁸⁹ Ibid.

⁹⁰ Ibid.



Putting it into practice for Output 4.1

Advocating for child and adolescent mental health policy and legislative changes around the globe

Country example: Advocating for policy and legislative changes in Viet Nam

The study on '[Mental health and psychosocial wellbeing of children and young people in selected provinces and cities in Viet Nam](#)' was carried out as part of a broader collaboration between UNICEF Viet Nam and the Ministry of Labour, Invalids and Social Affairs, with research and technical expertise provided by the Overseas Development Institute. The study aims to provide an overview of the situation of mental health and psychosocial wellbeing of children and young people in Viet Nam. The resource package includes the following documents: the full study, an executive summary, two focused reports on suicide, two briefing documents on suicide and policy recommendations.

Country example: Advocating for policy reform in Kazakhstan

For over a decade, UNICEF Kazakhstan has been working to influence government policy on mental health, with a particular focus on reducing adolescent suicide. In 2011, it launched a report titled '[Child Suicide in Kazakhstan](#)',⁹¹ which helped lay the foundation for developing a nationwide response to prevent adolescent suicide in Kazakhstan. UNICEF Kazakhstan subsequently worked closely with government ministries and agencies to develop the Adolescent Mental Health and Suicide Prevention (AMHSP) programme in two regions, which aimed to lower adolescent suicide risk over a three-year period and provided learning and evidence for how the government could scale the programme nationwide. The generation and use of data, good collaboration with government, and evidence generated on the value of a proactive response to adolescent mental health and suicide prevention were key factors that accelerated national efforts to integrate mental health into the public health-care system in the 2018 policy reform. As a result, the Ministry of Health formally shifted the prevention, management and treatment of select mental health issues from only being offered at dedicated mental health clinics to being offered as outpatient services at general practice offices. This greatly helped improve accessibility of mental health services for adolescents and the whole population and helped alleviate stigma associated with using mental health clinics.

Country example: Advocating for child- and adolescent-focused mental health policies in Spain

In May 2020, UNICEF Spain identified MHPSS as a priority advocacy area after the onset of COVID-19. The office published a comprehensive [policy briefing with recommendations on how the government could strengthen the whole MHPSS system for children and adolescents in Spain](#). There were many reports on youth mental health, but UNICEF's became a reference for government as it offered a clear policy narrative, road map and tangible recommendations. UNICEF established a bimonthly meeting with the Ministry of Health for the first time and used its convening power to create an informal network of non-governmental organizations and medical and professional associations to more strategically advocate together for children's and adolescents' mental health policies in Spain. Initial advocacy successes include UNICEF's inclusion as a key stakeholder in the national mental health strategy consultation process (the only child rights organization included), and the creation of a permanent children's and adolescents' mental health group in the Ministry of Health, which UNICEF has been asked to play a key role in running.



Recommended resources from the [Compendium of MHPSS Resources](#)

- [The State of the World's Children 2021](#) examines child, adolescent and caregiver mental health. It focuses on risks and protective factors at critical moments in the life course and delves into the social determinants that shape mental health and wellbeing. Components of the report include: a companion report for adolescents; the full report in Arabic, English, French and Spanish; an executive summary in English; and regional briefs for Europe, Latin America and the Caribbean, and Africa. It calls for commitment, communication and action as part of a comprehensive approach to promote good mental health for every child, protect vulnerable children and care for children facing the greatest challenges. For more information please see:
 - » An [interactive view](#) of data from the report
 - » A [companion report](#) titled 'On My Mind: How adolescents experience and perceive mental health around the world'.
- [Universal parenting support to prevent abuse and neglect: A policy call for national governments](#) by the Office of the Special Representative of the Secretary-General on Violence against Children, UNICEF and WHO describes how a minimum package of well-evidenced parenting support can significantly prevent abuse and neglect of children. Parenting is a wide and multifaceted policy issue upon which many aspects of the social, emotional and physical development of children are dependent. This note recommends a universal approach or primary prevention through a basic package of interventions to every parent or caregiver.

⁹¹ United Nations Children's Fund in the Republic of Kazakhstan, 'Child Suicide in Kazakhstan: Special report', UNICEF Kazakhstan, Astana, the Republic of Kazakhstan.

- [Financing Child, Adolescent and Youth Mental Health Briefing](#) by the Global Mental Health Action Network's Child & Youth and Financing Mental Health working groups explores the need for greater investment, current levels of investment, what great investment can achieve, and what needs to be done to increase and improve investment in child, adolescent and young people's mental health. Children, adolescents and young people are particularly vulnerable to mental ill-health, yet investment in their mental health remains low and disproportionate to the disease burden.
- **United for Global Mental Health's** [Knowledge Hub page](#) provides more than 120 articles specific to global mental health. The topics can be filtered by the following categories: Countdown Global Mental Health 2030, education, financing, HIV and tuberculosis, news, publications, rights, suicide decriminalization, systems and universal health coverage. Of particular interest is [Brief: Financing Mental Health for All](#).
- [Advocacy package: IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings](#) is part of a campaign to encourage all humanitarian actors and United Nations Member States affected by or at risk of emergencies to embrace and implement the [IASC MHPSS guidelines](#). It also highlights the progress made by countries that have already implemented these guidelines.
- [Follow the Money: Global Funding of Child and Family MHPSS Activities in Development and Humanitarian Assistance](#) includes findings from a study conducted by the MHPSS Collaborative on private development finance for the years 2018–2019, which reveal that, despite small increases, child and family MHPSS remains severely underfunded. Even with small increases in funding over the past years, the small fraction of funding for child and family MHPSS is woefully insufficient to offset the high demand for MHPSS services across the globe. The reality in 2019 is that only 0.31 per cent of Official Development Assistance funding and 1 per cent of private sector funding went to child and family MHPSS.
- [Promoting rights-based policy & law for mental health](#) by WHO discusses its work with countries to develop and implement progressive mental health and related policies and laws in line with international best practice and human rights standards, including the United Nations Convention on the Rights of Persons with Disabilities. Policies and laws are the cornerstones for a coordinated government effort to promote the rights of people with psychosocial, intellectual and cognitive disabilities and put in place services and supports to meet their needs and promote their recovery. Examples of key resources on this page include:
 - » [Guidance and technical package on community mental health services](#)
 - » [The WHO mental health policy and service guidance package](#)
 - » [Comprehensive Mental Health Action Plan 2013–2030](#).
- The [Mental Health Atlas](#), released every three years, is a compilation of data provided by countries around the world on mental health policies, legislation, financing, human resources, availability and utilization of services, and data collection systems. It serves as a guide for countries for the development and planning of mental health services. The Mental Health Atlas 2020 includes information and data on the progress made towards achieving mental health targets for 2020 set by the global health community and included in WHO's Comprehensive Mental Health Action Plan. The atlas includes data on newly added indicators on service coverage, mental health integration into PHC, preparedness for the provision of MHPSS in emergencies, and research on mental health. It also includes new targets for 2030.

Output 4.2

Strengthened multisectoral systems and referral pathways: Multilayered support systems and processes within existing structures include functional referral systems across primary health care, social welfare and protection, and education

An MHPSS system comprises the government ministries, institutions and implementing agencies that are legally responsible for the delivery of services for MHPSS, including both community-based MHPSS services and facility-based mental health services. This requires identifying which government ministries have mandates and budgets for the delivery of MHPSS services and how accessible these services are to the local population. In most contexts the relevant

government ministries will include health, education and social welfare, but other government agencies might share responsibility depending on the location, laws and policies.

Multisectoral supports are essential in providing comprehensive MHPSS for children, adolescents, families and communities. These supports may be provided through sector-specific interventions, be part of a larger multisectoral programme or belong to a system of wrap-around services. Regardless of the format, it is essential for agencies to recognize that they are one part of a child's or adolescent's ecosystem that includes supports from multiple sectors and systems and that each of these systems is dependent upon legislation and available financing.

Box 4 Types of multisectoral supports

Multisectoral programme: An MHPSS programme implemented across more than one sector to respond to MHPSS needs. For example:

- Collaboration between child protection and education programming to train and equip teachers to understand referral pathways for children with MHPSS needs and protection risks
- A school mental health programme that engages both the education and health sectors.

Sector-specific intervention: A specific intervention intended to respond to a specific MHPSS need. For example:

- Mental health treatment by a PHC provider under a health programme
- Social-emotional learning activities provided in an education programme.

System of wrap-around services: Programmes that provide services or interventions across multiple systems, such as school, home and community, and include a variety of targeted interventions for the child and family. For example:

- Social workers or trained case workers from the social welfare and protection sectors trained in case management and referral services
- Case workers support client access to services across multiple sectors.

Services may be provided by government ministries, local organizations and other key partners at the local, national, regional and international levels. Participation from individuals, families, communities and civil society in the development and implementation of MHPSS policies and plans is critical, particularly for services that directly affect the availability, affordability, access and quality of mental health services. This includes key local and international non-governmental agencies.

Universal health care reaffirms the right of every human being, without distinction of any kind, to the highest attainable standard of physical and mental health.⁹² It implies that all people have access, without discrimination, to necessary promotive, preventive, curative, rehabilitative and palliative essential health services, with special emphasis on the poor, vulnerable and marginalized segments of the population.

Strengthening MHPSS service delivery within PHC is an inclusive, effective and efficient approach to enhance people's physical and mental health. MHPSS service delivery through PHC includes ensuring that those with mental health conditions receive appropriate screening, diagnosis, treatment, and medication when necessary

Strengthening the ability of the education sector to deliver quality MHPSS services ensures that all children and teachers benefit from the integration of mental health and psychosocial services in the school systems. This may include the delivery of social-emotional learning curricula, access to school-based counselling

services, and the delivery of peer-to-peer support. The education system is an ideal platform for supporting and promoting the development of mental health and psychosocial wellbeing (see ► [Annex 8: MHPSS in Education Learning Brief](#)). In emergency contexts, education gives students a sense of normalcy and stability, which can help improve their mental health and psychosocial wellbeing. The education system is also integral in shaping and defining social norms and can play a vital role in addressing stigma and attitudes towards mental health and psychosocial wellbeing.

Social welfare systems, including child protection services, provide children and their families with the supportive interventions needed to adapt and cope with mental health and psychosocial needs in the home and the community. Those working on the front line of social welfare are often supporting children and families in distressing circumstances. Social welfare service providers need to be equipped to counsel families and children in distress, which may include providing referrals to additional services.

Referral pathways are a core aspect of MHPSS service delivery and should be established across service providers. Referrals between health services, social welfare and education systems should be clearly documented, agreed upon between government authorities and agencies, and regularly updated and validated.⁹³ Strengthening referral pathways between providers is central to strengthening the MHPSS system.

⁹² Resolution adopted by the United Nations General Assembly, 'Political Declaration of the High-level Meeting on Universal Health Coverage. Universal health coverage: moving together to build a healthier world resolution', A/RES/74/2, 10 October 2019.

⁹³ Contact details should be regularly updated and validated due to potentially high turnover rates across the MHPSS workforce.

Box 5 How we work together – from building blocks to a multisectoral framework

UNICEF's MHPSS Framework promotes a multisectoral integration of the social ecological model, UNICEF's life course approach to programming, and the IASC intervention pyramid for MHPSS. These frameworks come together to create a system that responds to the MHPSS needs of children and their families across UNICEF's three domains of wellbeing. The response system depends on a multisectoral support system that delivers services across all layers of the intervention pyramid across the life course. It is essential for agencies to recognize that they are one part of a child's or adolescent's ecosystem that includes supports from multiple sectors, systems and institutions.

MHPSS services are most effective when they are designed to work together with other sectors, rather than being separate pillars of interventions. For this reason, the MHPSS Framework promotes the integration and collaboration of MHPSS interventions across sectors as being essential for building and strengthening mental health and psychosocial wellbeing. Within the social ecological framework, services and service providers are reflected in the outer layer as part of the enabling environment, providing the support needed to help children, adolescents, caregivers, parents, families and communities improve their mental health and psychosocial wellbeing. Multiple agencies may be a part of a child's enabling environment, providing complementary and overlapping services. When there is a lack of coordination, these services may at times conflict with each other – decreasing the overall benefit to children.

Lastly, integrated support across the layers of the pyramid is represented in the circles of support. These address the needs of children and families for wellbeing and safety in their context – from the delivery of basic services in culturally appropriate ways, to strengthening family and community social networks, to focused or specialized care when needed. The intervention pyramid serves as a guide and a reminder that comprehensive multisectoral programming should include activities focused on the general population, interventions to strengthen family and community bonds, structured and focused interventions, and interventions delivered by trained specialists.



Putting it into practice for Output 4.2

Country example:

[Mainstreaming adolescent mental health and suicide prevention in Kazakhstan's education and health systems](#)

In 2010, the Republic of Kazakhstan recognized that young people in the country were facing a public health crisis: rising suicide rates in the adolescent population. The following year, suicide was identified as the leading cause of mortality of those aged 15–19. UNICEF, in partnership with Kazakhstan's education and health system, responded to this crisis by:

- **Prioritizing research for an effective response**

UNICEF Kazakhstan, the Ministry of Health and the University of Molise in Italy conducted joint research to obtain evidence and data for developing early detection, prevention and response measures to adolescent suicide. This research, [Study on Prevalence, Underlying Causes, Risk and Protective Factors in Respect to Suicides and Attempted Suicides in Kazakhstan](#), was used to drive programme design and influence policy change.

- **Developing an adolescent mental health and suicide prevention programme**

The report provided policy and programming recommendations that were used in the development of the 2015–2018 Adolescent Mental Health and Suicide Prevention (AMHSP) programme implemented in two regions, Kyzylorda (2015–2017) and Mangistau (2016–2018).

- **Affecting legislation**

The generation and use of data, collaborative processes, and sharing of information and evidence generated by the AMHSP programme on the value of a proactive response to adolescent mental health and suicide prevention were key factors that acted as a catalyst to accelerate national efforts to integrate mental health into the public health-care system in the 2018 policy reform. This was not only for adolescent mental health but for the wider population. The Ministry of Health formally shifted the prevention, management and treatment of select mental health issues from only being offered at dedicated mental health clinics to being offered as outpatient services at general practitioners. This greatly helped improve accessibility of mental health services for adolescents and the whole population and helped alleviate the stigma associated with using mental health clinics.

More information on this programming can be found in the following case studies and research reports:

- Research: [Study on Prevalence Underlying Causes, Risk and Protective Factors in respect to Suicide and attempted Suicides in Kazakhstan](#)
- Case Study 1: [Mainstreaming Adolescent Mental Health and Suicide Prevention in Kazakhstan's Education and Health Systems](#)
- Case Study 2: [Mental Health Promotion and Suicide Prevention in Schools](#)

Myanmar's multisectoral MHPSS strategy: Laying the foundations for sustained quality MHPSS service delivery in the midst of a complex humanitarian crisis

Since February 2021, Myanmar has shifted into an increasingly deteriorating and complex humanitarian crisis, driving the need to increase access to quality MHPSS services across the country. The economic and political crisis of 2021 and onset of countrywide armed conflict combined with the impact of COVID-19 has driven almost half the population (25 million people) into poverty. People are facing daily protection risks, limited access to services and increased food insecurity, leading to extreme stress.

The current crisis calls for innovative MHPSS interventions and a mainstreaming of MHPSS activities into multisectoral response to maximize reach and modalities to support the psychosocial wellbeing of the most vulnerable populations. In response, UNICEF Myanmar prioritized the development of a Multisectoral MHPSS Strategy for 2022–2025.

The multisectoral strategy was developed using the Minimum Service Package (MSP) for MHPSS in humanitarian settings to identify prioritized MHPSS multisectoral activities that will be implemented in the first year of the strategy through identified relevant sectors. The MHPSS Framework provided the strategic and technical guidance for the prioritized MHPSS activities of the MSP, with the oversight of the UNICEF approach and focus of supporting children and caregivers.

To learn more about how UNICEF Myanmar developed its Multisectoral MHPSS Strategy, see the case study and the strategy in ► [Annex 9](#).



Recommended resources from the [Compendium of MHPSS Resources](#)

- [The IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings \(2007\)](#) were developed through an inclusive process, with input from United Nations agencies, non-governmental organizations and universities. The guidelines help people plan, establish and coordinate a set of minimum multisectoral responses to protect, support and improve people's mental health and psychosocial wellbeing in the midst of an emergency. UNICEF has adapted action sheets from the IASC guidelines in ► [Annex 2](#) of this document, which include recommendations for protection, health, nutrition, education, camp coordination and WASH actors.
- IMC's [Toolkit for the Integration of Mental Health into General Healthcare in Humanitarian Settings](#) aims to support the understanding and implementation of integrated mental health programmes in humanitarian settings. It provides a framework for essential steps and components, with associated key guidance and resources, that strengthen the integration process. It is primarily intended for implementing agencies but may also be useful for donors and government actors. Users can access the three steps and three cross-cutting components relevant to current programme needs or stages of programming.
- [Integrating Mental Health and Psychosocial Support into Youth Programming: A Toolkit](#) provides strategies and tools for designing, implementing and evaluating MHPSS programmes and activities for youth in LMICs and conflict-affected contexts. The toolkit includes [Sector Pullouts](#) to give more in-depth information about possible interventions in education; gender and GBV; health; violence prevention, peace and security; and youth employment.

Output 4.3

Workforce development and capacity: Strengthened capacity among the MHPSS workforce supports the provision of quality age- and gender-responsive MHPSS care across all sectors

As the term 'mental health and psychosocial support' implies, there is a close relationship between the psychological and social aspects of a child's development and wellbeing. Various personal, social and environmental factors influence the wellbeing of children and families and their ability to recover from adversity. A strong MHPSS workforce spans the health, education, social welfare and child protection sectors and is essential for providing services that are

responsive to the psychological and social aspects of a child's development and wellbeing. The MHPSS workforce should be equipped to provide social and psychological interventions at all layers of the IASC intervention pyramid.

The MHPSS workforce includes practitioners who provide MHPSS, either as the central function of their job or as part of a broader range of functions. This includes community leaders or volunteers with professional or on-the-job training and technical competencies in MHPSS. This workforce and any project staff should receive training and supervision on technical competencies specific to each MHPSS intervention.

Conducting a multisectoral situational analysis and capacity needs assessment is the first step in developing plans for strengthening, building and capacitating a national or local MHPSS workforce. Some countries might have only one psychiatrist in the entire country or a psychologist who is trained in counselling but who has not developed competencies needed for a particular intervention.

Any programme aiming to implement MHPSS activities should include guidance and technical oversight from an MHPSS technical adviser or specialist. This should be someone with training in MHPSS, which can include the following backgrounds: child and adolescent psychology, psychiatric care, counselling psychology, clinical social work or educational psychology. This adviser might also be a staff member who has the necessary years of on-the-job training and technical competencies. For some interventions, this individual may need to provide clinical supervision, training and oversight to programmes where UNICEF is directly involved in clinical or lower-level case management work. Depending on the size of the MHPSS response or programme, staff members might need to provide technical assistance at multiple levels or at just one level of an organization, programme or response.

MHPSS programme activities should include a competent national and local MHPSS workforce across the health, social welfare and education sectors. Assessing the qualifications and training needs of the national and local workforce for carrying out the planned activities is essential to develop clear staffing and development plans. Professional certifications will vary considerably between countries and should be assessed to determine which competencies and levels of education meet the necessary qualifications of proposed interventions. The workforce can include a combination of the following:

- ❑ Mental health professionals providing clinical services (e.g., psychological or psychiatric services, including pharmacological treatment of mental conditions)
- ❑ General health professionals, such as nurses, clinical officers and physicians providing management of mental health conditions

- ❑ Social service professionals providing MHPSS through protection and social services (e.g., case management, outreach to vulnerable families)⁹⁴
- ❑ Community leaders and community members trained in MHPSS interventions (e.g., community-led support groups, group Problem Management+, etc.).

Trained workers who demonstrate the appropriate competencies and receive proper training and regular supervision by mental health clinicians can provide scalable interventions to support adults and children experiencing common mental disorders. With training and supervision, workers can provide non-clinical MHPSS to children and families, such as:

- ❑ Peer support
- ❑ Cultural and recreational activities for children
- ❑ Group activities for children's mental health and psychosocial wellbeing
- ❑ Identification of vulnerable families for referral to specialized supports
- ❑ Basic support, such as assessing needs and concerns; helping people address basic needs; listening to and comforting people and helping them feel calm; helping connect to information, services and social support; and protecting people from further harm (e.g., through training in psychological first aid).⁹⁵

Staffing and supervision across the intervention pyramid

In a comprehensive MHPSS approach, a wide range of actors work together across the intervention pyramid to meet a community's needs (see Figure 4, 'Supervision and staffing'). Establishing minimum competencies, qualifications and standards for MHPSS workers is an important aspect of a community-based approach. Organizations implementing activities at low levels of the pyramid (e.g., Layers 1 and 2) should have technical oversight from an MHPSS specialist. At a minimum, a programme should be able to provide referrals to services at all levels of the pyramid. Where high-quality services at all levels are not available at a given location (for example,

⁹⁴ UNICEF staff may work through credible partners in the field to provide specialized services, such as clinical mental health care. Partners should be familiar with and comply with international quality standards for specialized services, such as the IASC MHPSS Guidelines and mhGAP in Humanitarian Settings Guidelines.

⁹⁵ World Health Organization, War Trauma Foundation and World Vision International, 'Psychological First Aid: Guide for field workers', WHO, Geneva, 2011.

safe and accessible psychiatric services for children and adolescents), programme staff should advocate with donors, government agencies and implementing agencies to make them available. All MHPSS programming should have systems for supervision, coaching, competency assessment and in-service training included in the programme design (see [MHPSS MSP Section 2](#) for checklists of essential components of all MHPSS programmes). MHPSS supervision supports MHPSS workers' technical competence and practice, promotes wellbeing, and enables effective and supportive monitoring of MHPSS work.⁹⁶

Maintaining quality standards in MHPSS capacity-building

UNICEF covers both immediate and long-term MHPSS needs, with the goal of sustainability. The global lack of child and adolescent mental health services and human resources means UNICEF often begins work in an environment with limited formal MHPSS capacity.

Accordingly, UNICEF works to strengthen local capacity by training and mentoring the MHPSS workforce, covering the entire spectrum of MHPSS, ranging from psychological first aid and community services designed to meet basic needs of an entire population to mental health services for individuals needing more specialized care.

All project staff and front-line workers should have adequate competencies in basic psychosocial support skills,⁹⁷ which include but are not limited to listening carefully, assessing basic needs, promoting social support, protecting people from further harm, and connecting people with services and resources.

MHPSS planning should always include a workforce development and capacity-building strategy (see [MSP Activity 2.4](#): Support MHPSS competencies of staff and volunteers). Table 4 can be used to provide guidance on core considerations for workforce development and capacity-building programme strategies.

Table 4 Core areas for workforce development and capacity-building guidance⁹⁸

Domain	Humanitarian	Foundational	Comprehensive
Competency and needs assessment	Conduct training needs assessment through multiple methods, including questionnaires on knowledge and perceived competencies. See IMC's Toolkit for more guidance on why this is important in humanitarian setting.	Conduct training needs assessment through multiple methods, including questionnaires on knowledge and perceived competencies, pre-training competency assessments using role play or the Ensuring Quality in Psychological Support (EQUIP) platform, focus group discussions with trainees and (where possible) on-the-job observations and site visits.	Carry out quarterly capacity and training needs assessments and formative evaluations through interviews, EQUIP platform competency assessment role plays, surveys or focus group discussions to inform ongoing refresher trainings or on-the-job training and supervision. Assess for training of trainers (ToT) potential among trainees or local mental health staff or professionals.

⁹⁶ Alliance for Child Protection in Humanitarian action, 'Case Management Supervision and Coaching Training Package', <www.alliancecpha.org/en/child-protection-online-library/case-management-supervision-and-coaching-training-package-0>, accessed 27 October 2022.

⁹⁷ [Key consideration 21: Guidance on psychosocial support skills for specific groups or types of emergency](#) - MHPSS MSP foundational helping skills, basic psychosocial competencies, basic helping skills, foundational helping skills or core clinical skills.

⁹⁸ Adapted from Murray, Laura K., et al., 'Building capacity in mental health interventions in low resource countries: An apprenticeship model for training local providers', *International Journal of Mental Health Systems*, vol. 5, no. 1, December 2011.

Domain	Humanitarian	Foundational	Comprehensive
Curriculum	Develop a curriculum training document that is clearly based on competencies and training needs assessment.	Develop a curriculum training document that is clearly based on competencies and training needs assessment. In non-humanitarian contexts, the EQUIP platform can be used to establish a baseline competency assessment and repeated over time intervals to measure improvement or current training needs. This can be used to develop customized training curricula, which include learning objectives, topics to be covered, time needed for each topic and trainee requirements to pass. EQUIP can be used alongside knowledge assessments such as pre- and post-tests that are developed or adapted to correspond to the customized training curriculum.	Develop UNICEF training materials in compliance with global guidelines and best practices. Develop and implement ToT training through training candidates, co-training with candidates and observing candidates while training. EQUIP competency-based assessment role plays can be integrated into ToT to ensure ToT trainer competency as well as building the capacity of ToT trainers to assess competencies.
Theoretical training	MSP 2.4: Support MHPSS competencies of staff and volunteers	For each topic on the curriculum, develop corresponding training materials (e.g., PowerPoint slides, handouts, training guide with learning objective and instructions for exercises) and share with an MHPSS adviser or specialist prior to use. EQUIP platform competency assessments and training evaluation can be carried out at the end of training.	Integrate use of EQUIP competency assessment and training evaluation after each training segment. Collaborate with academic institutions and professional associations to integrate MHPSS into pre-service training and continuing education across the health, education and social service workforce. ⁹⁹
Supervision	For all skills-based training (except psychological first aid) carry out ongoing on-the-job supervision of trained staff.	For all skills-based training (except psychological first aid) carry out ongoing on-the-job supervision of trained staff. Document on-the-job performance based on EQUIP competency-based assessments over specific time periods and an on-the-job supervision checklist.	Establish peer-level or group supervision systems. ¹⁰⁰
Methodology	Carry out theoretical and practical training.	Carry out theoretical and practical training.	Carry out regular refresher training based on post-training competency and knowledge-based assessments; for example, use the EQUIP platform, knowledge-based assessments and supervision to assess gaps in knowledge and skills.
Reporting	Use M&E tools to track knowledge (pre- and post-test), and skills (on-the-job supervision checklist) among trainees.	After each training cycle (as applicable), produce a comprehensive training report that includes the competency and training needs assessment, curriculum, materials, results of pre- and post-test printouts of data visualization from EQUIP platform competency assessments, and supervision checklists of training evaluations, as well as recommendations for future training, and share with the country team and an MHPSS adviser or specialist for sharing and exchange.	Produce a high-quality report that can be shared externally, including with donors, and can be posted on the UNICEF website and the forthcoming UNICEF MHPSS platform.

⁹⁹ The Mental Health Innovation Network, 'Toolkit for the Integration of Mental Health into General Healthcare in Humanitarian Settings, Step 2: Build Capacity of General Healthcare Workers', <www.mhinnovation.net/collaborations/IMC-Mental-Health-Integration-Toolkit/step2-build-capacity-of-general-healthcare-workers>, accessed 27 October 2022.

¹⁰⁰ Ibid.



Putting it into practice for Output 4.3

Supervision in MHPSS programming was the focus of two journal articles published during development of the MHPSS Framework. The articles underscore the importance of MHPSS workforce supervision in ensuring quality of programming, as well as ongoing training and support of the MHPSS workforce. While both journal articles focus on supervision of MHPSS programming in emergencies, the concepts and findings are important for MHPSS programming across all settings.

[Towards an integrated model for supervision for mental health and psychosocial support in humanitarian emergencies: A qualitative study.](#) This study interviewed members of the MHPSS workforce to understand the role that supportive supervision plays in MHPSS service delivery. Research findings will be used to develop a new integrated model for supervision. The research includes discussions on M&E, navigating power imbalances in the supervisory relationships, the need for common terminology and definitions, and different types of supervision (one-to-one, peer-led, group).¹⁰¹

[Examining the evidence for best practice guidelines in supportive supervision of lay health care providers in humanitarian emergencies: A systematic scoping review.](#) This article discusses a systematic review of supervision of health workers in emergency programming. Of the 3,371 articles identified, only 11 met the criteria for inclusion. The studies all reported positive outcomes for clients, service sustainability, and staff wellbeing and performance when supervision was an element of service delivery.¹⁰²



Recommended resources from the [Compendium of MHPSS Resources](#)



The [Ensuring Quality in Psychological Support \(EQUIP\) platform](#) offers assessment tools that support the development of basic helping skills for the MHPSS workforce. The EQUIP platform is helpful when building workforce capacity in basic helping skills, which can increase capacity of all staff. EQUIP competency assessments cover basic helping skills for working with adults (ENACT), children (WEACT) and groups (GROUPECT). MHPSS supervisors and trainers can use EQUIP to assess competency levels and identify any potentially harmful behaviours. Developing competence in basic helping skills can help project staff and other front-line workers build confidence and skills in helping distressed children and families.



Step 2 of IMC's [Toolkit for the Integration of Mental Health into General Healthcare in Humanitarian Settings](#) focuses on building the capacity of general health-care workers. The resource provides guidance on why capacity-building is necessary and the importance of and recommendations for theoretical and practical training, ongoing technical support and supervision. While developed for use among general health workers, such as doctors, nurses and community health workers, it can be used to guide capacity-building efforts across the MHPSS workforce.



UNICEF recommends [WHO's QualityRights e-training on mental health](#) for all members of the MHPSS workforce. The training aims to improve the quality of care in mental health and related services and to promote the rights of people with psychosocial, intellectual and cognitive disabilities.

It covers critical topics in MHPSS service delivery: taking care of one's own mental health; supporting friends, family and colleagues with their mental health; tackling stigma, discrimination, abuse and coercion in mental health services; and taking action in support of transformation of mental health services towards a person-centred, rights-based recovery approach.



The MHPSS MSP provides recommendations on orienting front-line workers and community leaders in basic psychosocial support skills. For more guidance from the MSP on basic helping skills, see [Action 3.2](#) and [Key Consideration 21](#).

¹⁰¹ Perera, Camila, et al., 'Towards an integrated model for supervision for mental health and psychosocial support in humanitarian emergencies: A qualitative study', *PLOS ONE*, vol. 16, no. 10, 6 October 2021.

¹⁰² Abujaber, Nadeen, et al., 'Examining the evidence for best practice guidelines in supportive supervision of lay health care providers in humanitarian emergencies: A systematic scoping review', *Journal of Global Health*, vol. 12, 2022.



Resources for basic helping skills

- [Psychological first aid: Facilitator's manual for orienting field workers](#), WHO, 2013 (also available in [Arabic](#) and [French](#))
- [Training in Psychological First Aid for Red Cross and Red Crescent Societies](#), International Federation of Red Cross and Red Crescent Societies Reference Centre for Psychosocial Support, 2018 (also available in [French](#))
- [How to support survivors of gender-based violence when a GBV actor is not available in your area](#), GBV Guidelines, 2015
- [Preventing suicide: A resource for establishing a crisis line](#), WHO, 2018
- [I Support My Friends: A training for children and adolescents on how to support a friend in distress](#), UNICEF, 2021
- [IASC Guidance on Basic Psychosocial Skills: A Guide for COVID-19 Responders, Inter-Agency Standing Committee](#), 2020 (translated into more than 40 languages)

Output 4.4

Research, evidence and data: An evidence and data ecosystem for MHPSS informs and drives policy changes around MHPSS

To successfully design, implement and evaluate child and adolescent MHPSS services and programmes nationally, regionally and globally, it is essential to have a strong evidence base that sheds light on key determinants and indicators. Further, responsible data-handling practices and systems need to be in place, including processes for children and adolescents to be engaged, included and informed on what works and what does not, based on their opinions and needs. Such a data and evidence base is critical for accountability and provides implementing agencies and relevant stakeholders with guidance on the needs and factors that must be addressed and considered to promote mental health and nurture psychosocial wellbeing. Having well-established research, evidence and data is also critical in the development of evidence-based advocacy and action campaigns and multisectoral programme strategies for MHPSS that are culturally and contextually grounded.

Building the research and evidence base for MHPSS

In 2021, UNICEF published [Mental Health and Psychosocial Support for Children in Humanitarian Settings: An Updated Review of Evidence and Practice](#). The report was first drafted in 2015 and presents practitioners with evidence and practices specific to children in humanitarian settings. The 2021 update included evidence updates (2015–2020) while also

addressing an identified gap in the 2015 review on child and community participation. Key findings from the Evidence and Practice Review were used to inform this MHPSS Framework and are highlighted throughout the document under 'Putting it into practice' sections. While the Evidence and Practice Review was developed in response to identified MHPSS needs during emergencies, it includes examples of evidence and practice across settings.

In 2022, UNICEF's Office of Research – Innocenti published a conceptual framework to inform research on child and adolescent mental health, titled [Child and Adolescent Mental Health and Psychosocial Wellbeing Across the Life Course: Towards an Integrated Conceptual Framework for Research and Evidence Generation](#). The document provides an integrated conceptual framework to inform research efforts, generate evidence, and test and improve measures and methods on child and adolescent mental health. The UNICEF mental health research and evidence generation framework encompasses four core areas of research:

- Epidemiology
- Risk and protective factors
- Interventions research and evidence
- Implementation and scaling science.

In alignment with the MHPSS Framework, the Mental Health Research and Evidence Generation Framework recognizes that children's and adolescents' interactions and environmental influences widen as they grow and develop through the life course. This increases both the potential risks or protective factors for their mental health and psychosocial wellbeing.

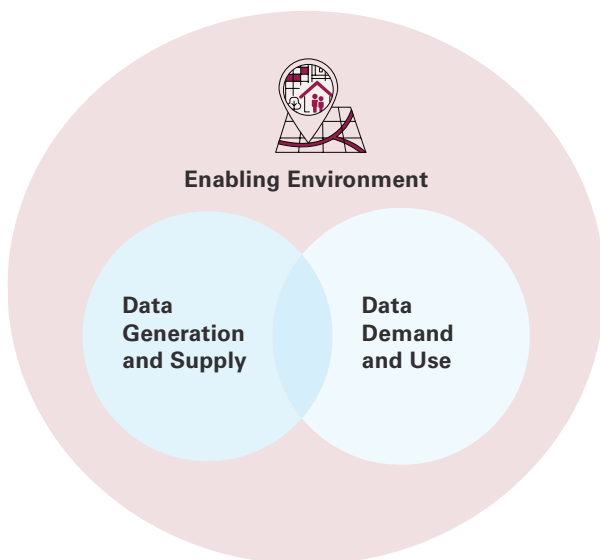
Regional and country research, data and evidence strategies can link localized research and evidence generation with the global evidence base. Regional and country stakeholders can engage in building local and global evidence for MHPSS by participating in and conducting research; designing programmes that have built-in mechanisms for capturing data and learning through programme implementation; and supporting and strengthening monitoring, evaluation, accountability and learning (MEAL) systems (*for more information, see the section on ► [Monitoring, evaluation, accountability and learning for MHPSS](#)*). Implementation science¹⁰³ provides critical information on how to scale and generalize interventions in different settings, how to translate interventions into policy and practice, and how to understand the barriers and facilitators to delivering evidence-based interventions across different contexts.

MEAL is a critical element of this research and evidence generation process. Learning what works and does not work is a crucial part of any programme planning and management process, and MEAL supports that process.

The data ecosystem

When the right data are in the right hands at the right time, decisions can be better informed, more equitable, and more likely to protect child and adolescent rights. This is especially important for child and adolescent mental health in countries where data remain scarce, because good data on the prevalence of mental health conditions and risks and protective factors are essential to inform policy and programmes.

Figure 6 Data ecosystem for child and adolescent mental health



Enabling Environment
Data infrastructure for MHPSS; MHPSS data plans at the national level, feeding into global evidence base; and ethical considerations and safeguarding for minors (including referral pathways and support)

Data Generation and Supply
Reliable data for measuring and monitoring the prevalence of mental health conditions, risks and protective factors; standardized and comparable tools, for example, MMAP; and quality of data

Data Demand and Use
Strengthen data-related capacity of the MHPSS workforce; data use for advocacy and knowledge-sharing about mental health priorities and needs; and evidence-based decision-making

¹⁰³ For more information on implementation science, see <<https://link.springer.com/article/10.1186/s12992-021-00790-5>>.

What do we mean by data? At their core, data are information. Around the world, data can be generated in many ways and can help improve the efficacy of child and adolescent MHPSS programming and practices in humanitarian and development settings. Effective use of disaggregated data not only helps monitor a programme's results but also helps programme managers evaluate trends and patterns to shape results and inform what is working, what is not, which children are thriving, and which are being left behind. Throughout this MHPSS Framework, UNICEF reiterates its [data for children](#) principles and core commitments to equity, supporting government systems and results for children. UNICEF emphasizes the relevance of data demand, supply and use to inform strategic planning, monitor and adjust performance of government systems, and engage communities in dialogue.

The data ecosystem refers to a comprehensive system that requires an environment conducive to data generation (also called data supply), data demand and data use (see *Figure 6*).¹⁰⁴

Since data are core to all MHPSS programming and policy efforts, they cannot be limited to one sector or actor. Effective data systems function both within and across sectors and are generated and leveraged for different uses and contexts. Working with partners and taking a multisectoral approach are therefore essential to create value. It is also important to support strengthening of local and national government systems to generate data, while taking a broader view of demand both across government and the larger data ecosystem. In the context of MHPSS, these principles can provide a common reference point for all investments in data for children, adolescents and caregivers.

Enabling environment

Collecting, storing, preparing, analysing, disseminating and using data for and about child and adolescent mental health and psychosocial conditions and needs can create unique opportunities across the data life cycle. In an age of increasingly ubiquitous technology, social networks and chatbots have been used to provide psychosocial messaging and services in many contexts. In light of how these platforms engage with

individuals and collect their data, it is critical to set up safe and responsible data management practices for and about children. [UNICEF's Responsible Data for Children \(RD4C\)](#) initiative does exactly this. The RD4C principles provide guidance and highlight best practices to enhance responsible handling of data for and about children. The RD4C principles – participatory, professionally accountable, people-centric, prevention of harm across the data life cycle, proportional, protective of children's rights, and purpose-driven approaches to handling data – and tools are intended to support practitioners and decision makers in implementing responsible data systems and actions. The responsible handling of MHPSS data is highly relevant, as sensitive information may be collected from children and adolescents and subsequently processed and shared. For instance, handling disaggregated data for groups such as children exposed to humanitarian crises who experience severe psychological consequences can put these children at risk of being identified, hence re-exposing them to traumas or instigating unwarranted feelings due to stigma.

Data ecosystems and processing (including digital ecosystems) can be complex at times, especially since global data governance frameworks related to children's data are still in formative stages. Recognizing that the data infrastructure for MHPSS is developing in many countries, policymakers and public health and mental health practitioners can seize this window of opportunity to set the data infrastructure for child and adolescent mental health up for success.

There are four central types of infrastructure that can play a role in advancing responsible practices for MHPSS data for children, adolescents and caregivers:

- ❑ Institutional infrastructure (the presence of fully functioning ministries of youth welfare, child and adolescent mental health organizations, etc.)
- ❑ Technical infrastructure (to include MHPSS content in routine or national data collection processes, data governance systems, etc.)
- ❑ Human infrastructure (training the workforce on all aspects of the data cycle, training opportunities for MHPSS data literacy, etc.)

¹⁰⁴ United Nations Children's Fund, 'Ten actions to help your data ecosystem deliver better results for children', lists actionable ideas to strengthen the data ecosystem through an enabling environment, data generation, and data demand and use. See <<https://data.unicef.org/wp-content/uploads/2020/12/Data-for-Children-10-Actions-to-help-data-deliver-better-11-Nov.pdf>>.

- ❑ Legal or policy infrastructure (national policies around child and adolescent mental health and data systems, youth-led and data-driven decision-making spaces within the political system, etc.).

Some of these infrastructures are explored within the MHPSS ► [M&E log frame](#) (Outcome 4).

In general, where government-led plans for collecting, analysing and acting on data exist, programme teams may benefit from leveraging such plans to strengthen the data ecosystem for MHPSS while ensuring progress towards broader goals. Where no national data plan for MHPSS exists, country partners and other stakeholders can work together to decide what sort of data plan would be relevant to understanding and addressing the MHPSS-related priorities of the country's children and adolescents. Many organizations have their own internal reporting standards based on programme and organizational goals, which can be useful to consider. For example, UNICEF uses the strategic plan indicators (see ► [Annex 5](#)) to guide organizational benchmarks for data collection, evaluation, dissemination and tracking.

Additionally, when working with data – and specifically data collection methods – ethical considerations and safeguarding measures for working with children and adolescents must be met. When conducting research or collecting data with those under the age of 18, it is of utmost priority to ensure the human dignity of all who participate is honoured and that all participants' rights and wellbeing are fully respected and protected from the onset to completion of data collection and programme intervention or research.

Key ethical considerations when collecting data with minors include the following:

- ❑ Comply with key ethical research principles:
 - Doing good (i.e., find new knowledge that could be useful for society)
 - Avoiding harm (physically, mentally or financially, when collecting data or by reporting results in potentially harmful ways)

- Respecting autonomy (obtaining informed consent from parents and minors, and ensuring that participants are made aware of their rights and protection)
- Prioritizing justice (abstaining from doing research on a vulnerable group in order to help other groups).

- ❑ Establish referral pathways to protect minors and support their mental health needs by providing psychosocial support.
- ❑ Ensure data confidentiality and data safety conform with best practices.

Data generation or supply

Reliable data on MHPSS are critical to address child and adolescent mental health needs effectively and to establish a sound body of evidence around mental health conditions and risk and protective factors. Good data can inform and support quality design, implementation and evaluation of evidence-based policies and programmes for child and adolescent mental health. Therefore, it is important to implement data collection tools, such as the measurement for mental health among adolescents at the population level (see the ► [MMAP case example in putting it into practice for Output 4.4](#)).

Data demand and use

Understanding, analysing, using and disseminating data are essential as we work towards delivering the best results for child and adolescent MHPSS needs (see UNICEF's [Data Quality Framework](#)). Given the rising burden of mental health conditions and several interconnected health crises that threaten the health and wellbeing of children and adolescents, data-driven decision-making can be powerful in uniting various actors towards shared goals and maximizing the impact of investments and efforts by following reliable evidence.

Data-driven advocacy can be a powerful tool for amplifying mental health-related needs, priorities and solutions for and by children and adolescents locally and globally. Data play an important role in supporting youth voices and helping them spread messages about the issues that are most important to them.



Putting it into practice for Output 4.4

Measurement of mental health among adolescents at the population level (MMAP)

Data on adolescent mental health are largely lacking across countries. These data are essential, however, for global monitoring, prioritization of policies and programmes, and allocation of resources for adolescent mental health.

To address the global lack of data on adolescent mental health, UNICEF, with the support of experts, is leading efforts to develop a suite of data collection tools to measure key aspects of mental health among adolescents at the population level (MMAP) across countries through a rigorous approach. This effort involves cultural adaptation of tools to capture local expressions of mental health and is intended to strengthen key aspects of the data cycle: data generation, availability, accessibility, analysis, and use of key mental health indicators across countries in a standardized and comparable manner.

The MMAP module is designed to be included in nationally representative surveys or school surveys or as a tool for programme monitoring.

Data collection using MMAP tools will allow for:

- Comparable data on key aspects of adolescent mental health (prevalence of symptoms of depression and anxiety, functional limitations, care-seeking, connectedness, suicidal thoughts and behaviours)
- Collection of equity-sensitive data that can be stratified to ensure measurement of the most vulnerable populations
- Monitoring and evaluation of adolescent mental health programmes implemented at local and national levels and among special population groups, including adolescents on the move or pregnant or parenting adolescents
- Assessment of risk and protective factors for adolescents' mental health.

The MMAP protocol is now publicly available and can be implemented in different settings.

Using research and data to develop Brazil's Pode Falar platform

In Brazil, the [CoVid Adolescents survey](#) revealed a worsening perception of subjective wellbeing and an increase in symptoms of depression and anxiety in adolescents, especially girls. Considering this and related research, UNICEF and partners launched Pode Falar ('Speak Up'), a free online platform that provides a safe and anonymous space for adolescents and young people (ages 13–24) to learn and talk about mental health.

As of January 2022, the website had reached more than 35,000 adolescents and young people (78 per cent female, 18 per cent male, and 2 per cent non-binary). Most users were between the ages of 14 and 17, and about 2 per cent reported having a disability. The platform has been accessed across Brazil, with the highest number of users based in São Paulo, followed by Ceará, Rio de Janeiro and Minas Gerais.

For more information on the Pode Falar platform and on using chatbot technology for MHPSS service delivery for adolescents, explore the following articles, publications and media resources:

- The project site: The [Pode Falar platform](#)
- Pode Falar's research findings were published in '[Ajuda virtual em saúde mental para adolescentes e jovens na pandemia de COVID-19: considerações práticas a partir de relato de experiência](#)', Revista Publicação CEAPIA, starting on page 24.



Recommended resources from the [Compendium of MHPSS Resources](#)

- [Mental Health and Psychosocial Support for Children in Humanitarian Settings: An Update of Evidence and Practice](#), November 2020: This review provides practitioners with a review and update on effective practices and evidence in the field of MHPSS. It was first drafted in 2015, presenting evidence and practice specific to children in order to support the implementation of MHPSS activities in humanitarian settings. This updated 2020 review includes recent evidence updates (2015–2020), addresses an identified gap in the 2015 review, and includes additional evidence on child and community participation. It serves as a compilation of evidence and best practices around MHPSS for children across settings.
- [Child and Adolescent Mental Health and Psychosocial Wellbeing Across the Life Course: Towards an Integrated Conceptual Framework for Research and Evidence Generation, UNICEF Office of Research](#): This document incorporates children's developmental stages and the dynamic environment in which they live and grow. The framework is informed by a review of existing theoretical frameworks on mental health and child development, and adapts and integrates elements of other key models in child development and mental health.

- [Data for Children Strategic Framework](#): The strategic framework begins with UNICEF’s approach to data work: laying out the necessity of a demand-driven model that maintains an appropriate balance between demand for, supply and use of data. Based on that approach, it also provides an outline of the changes that UNICEF needs to make in the coming years – shifting the emphasis of some data work, improving capacity to carry it out and deepening the partnerships that will be needed to undertake it successfully. The document concludes with key issues that UNICEF country offices should consider in plotting their own data investments in the coming years.
 - [Results-Based Management Handbook](#): Results-based management (RBM) is a management approach that seeks to ensure that all actors contribute directly or indirectly to a defined set of results. In UNICEF’s case, these results aim to promote positive change for children. RBM has been a feature of UNICEF programming for several decades and relies on evidence-based decision-making.
 - [Indicators for routine monitoring of effective mental healthcare coverage in low- and middle-income settings: a Delphi study](#): The aim of this study was to identify indicators for the measurement of effective coverage of mental health treatment. This study provides data on how mental health services and financial coverage can be assessed in LMICs. Fifty-two unique indicators were generated (based on a total of 876 responses from participants), and the selected indicators were scored for significance, relevance and feasibility. The 15 highest-ranked indicators cover the different domains of measuring effective mental health treatment coverage. This set of indicators is highly stable between the different groups of experts, as well as between the different participating countries.
 - [Ethical standards for mental health and psychosocial support research in emergencies: review of literature and current debates](#): This article presents a review of multidisciplinary literature to identify specific ethical principles applicable to MHPSS research in emergencies. The article identifies and discusses unresolved issues exemplified through six different debates relating to the application of ethics in emergency settings:
 - » What constitutes fair benefits?
 - » How should informed consent be operationalized?
 - » Is there a role for decision-making capacity assessments?
 - » How do risk management approaches affect the construction of ethical research?
 - » How can ethical reflection best be achieved?
 - » Are ethical review boards sufficiently representative and equipped to judge the ethical and scientific merit of emergency MHPSS research?
 - [Recommendations for Conducting Ethical Mental Health and Psychosocial Research in Emergency Settings](#): Recognizing the complexities of emergencies and the need for ethical recommendations to support MHPSS research in emergency settings, the IASC Reference Group on MHPSS established specific guidance to:
 - » Ensure MHPSS research in emergencies benefits affected people
 - » Design research to fill knowledge gaps in MHPSS theory and practice in emergencies
 - » Avoid bad practice, such as research without satisfactory consent of participants
 - » Better understand how to manage ethical challenges in MHPSS research during emergencies
 - » MEAL for MHPSS.
-

■ **Monitoring, evaluation, accountability and learning (MEAL) for MHPSS**



*The M&E log frame for the MHPSS Framework supports the assessment, design, implementation and M&E of **MHPSS strategies implemented by UNICEF and its partners around the world.***

UNICEF is working to reaffirm and better operationalize MHPSS commitments as an area of increasing importance across sectors in development and humanitarian contexts.

Monitoring, evaluation, accountability and learning (MEAL) can contribute to this organizational priority by focusing on intended results and their pathways, generating quality and timely data and evidence, and understanding findings and recommendations. The MEAL process involves collecting and analysing data over the course of an MHPSS programme. It provides opportunities for learning and accountability towards stakeholders while building the evidence base to

improve MHPSS programming and support advocacy and policy work. In this manner, MEAL enables policymakers, programme officers and other key stakeholders to effectively address the MHPSS needs in a country and region.

Every programme developed under the MHPSS Framework should include an individual MEAL plan to monitor, evaluate, learn and provide opportunities for accountability on the effectiveness or impact of the MHPSS intervention or programme. Individual programmes' MEAL plans should detail whether the intervention or programme achieved its intended objectives; whether it did so effectively and efficiently; and whether it was affordable, scalable and sustainable. In this way, the MEAL plan also supports MHPSS programme teams towards ensuring accountability from all stakeholders included in a programme's design, implementation and evaluation.

Box 6 The four components of a MEAL strategy

The four components included in a MEAL strategy are monitoring, evaluation, accountability and learning.

Monitoring: Providing ongoing and rigorous monitoring by collecting data on a regular basis to determine progress and identify if activities need to be modified. Monitoring can help identify intended and unintended positive and negative consequences of an MHPSS programme or policy early in its life cycle, thus providing space to learn and adapt to ensure that communities receive the best results.

Evaluation: Examining how successful programming has been in achieving what it set out to do and what the results are in the context of MHPSS, for children's, adolescents' and families' mental health and psychosocial wellbeing (see ► [Evaluation section](#)).

Accountability: Ongoing engagement and participation, information-sharing and establishment of feedback mechanisms to guide design and implementation of the programme. Engaging various stakeholders, such as young people, community leaders, mental health professionals, parents or caregivers, and other mental health advocates, can be a helpful strategy to hold programmes accountable.

Learning: Embedding processes for learning, reflection and building an evidence base for future programming. The right learning strategy can facilitate documenting, absorbing and disseminating knowledge around what works and does not work in terms of different MHPSS programmes.

The MEAL components of the MHPSS Framework

In the MHPSS Framework, the MEAL strategy is composed of two elements:

- ❑ The M&E log frame, which is a tool that builds on the ► [TOC](#) and presents relevant indicators and means of verification for the outputs and outcomes for monitoring and evaluating MHPSS programming (see ► [Annex 4](#))
- ❑ The accountability and learning mechanisms included in the programme strategy.

Each MHPSS programme is unique to its context. Programme leaders should use the global TOC, the M&E log frame and the accountability and learning principles as a template and adapt them to create more specific and contextualized versions that fit their M&E needs.

Furthermore:

- ❑ The M&E log frame presented in this document is offered as a reference for choosing or adapting relevant indicators for programme monitoring. It does not constitute a reporting requirement.
- ❑ The MEAL strategy of the MHPSS Framework may be useful to:
 - Inspire or guide the process of defining or strengthening pre-existing or new programme-specific M&E log frames
 - Have a common reference of various potential outcomes, outputs, indicators and means of verification, and various terminologies for MEAL relevant to MHPSS programming.

The following list of example questions may be helpful to consider while adapting the MEAL components to country programmes and context-specific needs:

- ❑ What are the goals of the programme, and which target groups does it engage within the community?
- ❑ How will the community be engaged with the programme?
- ❑ What means of verification can be used to measure relevant outcomes, outputs and inputs?
- ❑ How will adolescents and youth be engaged in collecting, interpreting and using the data?

The log frame presented in this document draws on the [Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings](#), originally developed in 2016 and updated in 2020 by the IASC MHPSS Reference Group. The log frame is also aligned with shared language about MHPSS approaches and quality practices.

► [Annex 4](#) provides the full version of the global MHPSS log frame, expanding on the summary log frame presented in Table 5, and outlining suggested indicators and means of verification (MoV) for each key outcome and output. Several of these suggested indicators feed directly into UNICEF's Strategic Plan and Core Standard Indicators and are identified and adapted for a general audience within the global MHPSS log frame (see ► [Annex 5](#)).






Box 7 Key components of the M&E log frame

The M&E log frame for the MHPSS Framework supports the assessment, design, implementation and M&E of MHPSS strategies implemented by UNICEF and its partners around the world.

The M&E log frame (also known as a logic/impact model or logical framework) refers to a tool that illustrates the linear interpretation of outcomes and outputs needed to achieve the ultimate expected impact of a specific programme implementation.

Log frames are useful for illustrating how different activities and outputs influence the outcomes of an MHPSS intervention and show the causal linkages between these components.

Definitions and examples of the four components of the M&E log frame¹⁰⁵

	Definition	Examples
 <p>Impact</p>	<p>The impact is the highest level of long-term effects or changes produced by an intervention. The impact may indicate changes in inner, social, economic, environmental, civil, political or other dimensions affecting an individual and community’s health status.</p>	<p>The mental health and psychosocial wellbeing of children, adolescents and their caregivers is supported and protected to survive and thrive in their communities and societies.</p>
 <p>Outcome</p>	<p>Outcomes are the medium-term changes that are logically expected to occur if an intervention or programme is achieving one or more of its outputs. These can be community- or population-level changes in individual or institutional performance.</p>	<p>Improved child and adolescent mental health and psychosocial wellbeing (Outcome 1)</p>
 <p>Output</p>	<p>Outputs are shorter-term changes in skills or abilities and capacities that are directly achieved through the activities of a programme, policy or intervention. These could include changes in access to and quality of services for children and adolescents, behaviour and practices, decision-making, policymaking, and increased efficiency or effectiveness.</p>	<p>Children and adolescents have access to support systems that facilitate positive relationships that promote inclusion, belonging and agency (Output 1.2).</p>
 <p>Activity</p>	<p>Activities are actions, processes or work performed or implemented through which inputs or resources are mobilized to achieve a programme’s outputs and goals.</p>	<p>Children and adolescents attend friendly peer and group support spaces that provide MHPSS free of charge or at very affordable rates.</p>
 <p>Input</p>	<p>Inputs are the financial, human, material, technological and informational resources needed to conduct and implement a programme.</p>	<p>Trained community personnel are available to run friendly peer and group support spaces. Locations are safe and well maintained. Funds are available to run a programme.</p>

Additionally, indicators are units of measurement, both quantitative and qualitative, that specify what will be measured. Indicators enable programme evaluators to answer whether the desired changes have been achieved. Quantitative indicators include the number, percentage or share, or rate or ratio of children, adolescents or caregivers involved in an MHPSS programme. Qualitative indicators measure quality or other aspects of a programme that cannot be easily quantified. These may include perceptions, qualities, knowledge, capacity, opinions, levels of satisfaction and other such experiences. Indicators are described further under the section on monitoring.

Finally, the means of verification (MoV) are tools or methods used to measure suggested indicators. MoV may result in qualitative or quantitative data – both approaches are important and can be valuable for learning, monitoring and evaluation. In fact, using a combination of quantitative and qualitative MoV can be a strength, as this enables triangulation of data using different types of information. The M&E log frame does not provide an MoV for each indicator because of the variation in preferences, relevance and availability among different settings in terms of measuring MHPSS-related change. Instead, a non-exhaustive set of example MoV is provided for each indicator (see ► [Annex 6](#)). It is recommended that programme teams choose MoV that best fit programme needs.

¹⁰⁵ Based on information from UNICEF’s [Results-Based Management Handbook](#) and the [IASC Common Monitoring and Evaluation Framework](#).

Table 5 M&E log frame (summary version)

Outcome/ Output	Description
 Outcome 1	Child and adolescent: Improved child and adolescent mental health and psychosocial wellbeing
Output 1.1	Children and adolescents have access to safe and nurturing environments and quality services that improve their mental health and psychosocial wellbeing at home, at school and in the community
Output 1.2	Children and adolescents have access to support systems that facilitate positive relationships that promote inclusion, belonging and agency
Output 1.3	Children and adolescents have opportunities for stimulation, learning and skills development that contribute to mental health and wellbeing
 Outcome 2	Caregivers: Improved caregiver mental health and psychosocial wellbeing, including for parents, caregivers, mothers, family and teachers
Output 2.1	Parents, caregivers, mothers, families and teachers have access to support for developing and maintaining improved mental health and psychosocial wellbeing
Output 2.2	Parents, caregivers, mothers, families and teachers have access to family and community support networks that improve their mental health and psychosocial wellbeing
Output 2.3	Parents, caregivers, mothers, families and teachers develop skills for parenting, teaching, and supporting children and adolescents in distress (MHPSS needs)
 Outcome 3	Community: Improved community capacity at the district and subdistrict levels for non-stigmatizing, accessible, available and quality MHPSS service delivery across the primary health care, social welfare and protection, and education systems and structures
Output 3.1	Stigma- and judgement-free environments for mental health and psychosocial wellbeing are established through social and community awareness, acceptance and positive behaviour change for children, adolescents and their parents, caregivers, families and teachers
Output 3.2	Community mental health and psychosocial wellbeing support systems are strengthened across sectors, including community capacities to support children, adolescents, parents, caregivers, families and teachers
Output 3.3	Multisectoral care systems (PHC, social welfare and protection, education) for children, adolescents, parents, caregivers, families and teachers, including family-friendly policies, are developed and strengthened
 Outcome 4	Systems: An improved enabling environment for MHPSS is created across policy, legislation and financing systems, the MHPSS workforce, multisectoral supports and referral pathways, and MHPSS research and data
Output 4.1	Policy, legislation and financing: An effective policy, legislative and financing environment is available and accessible by putting supportive mechanisms in place for quality MHPSS delivery
Output 4.2	Strengthened multisectoral systems and referral pathways: Multilayered support systems and processes within existing structures include functional referral systems across PHC, social welfare and protection, and education
Output 4.3	Workforce development and capacity: Strengthened capacity among the MHPSS workforce supports the provision of quality age- and gender-responsive MHPSS care across all sectors
Output 4.4	Research, evidence and data: An evidence and data ecosystem for MHPSS informs and drives policy changes around MHPSS

Monitoring

Establishing a plan to track the achievement of the short-term, intermediate and long-term results and goals of all MHPSS programmes is a critical part of effective programming. Monitoring is an ongoing process that uses data collection at different points throughout a programme and can help staff determine if activities need to be adapted, improved or adjusted as the programme progresses. By developing an effective monitoring system for MHPSS activities, programme teams can lay the foundation to conduct effective evaluations and to hold teams, governments and other actors accountable to meeting the various MHPSS needs of children and adolescents. Some key questions to consider when developing a monitoring plan include:

Is the programme reaching its target audiences?

- Is implementation proceeding as planned?
- Are expected results being achieved?
- What is the quality of the intervention or programme results?
- Are additional resources required to achieve results?
- Are programme amendments or adjustments needed?

Types of monitoring

[UNICEF's Results-Based Management Handbook](#) lists three types of monitoring, which are described below. Depending on the needs and goals of an MHPSS programme, staff may select one monitoring strategy over another or use different types at various points in the programme's life cycle.

Figure 7 Three types of monitoring for MHPSS programmes



Implementation monitoring: Are we implementing as planned?

Routine oversight of the implementation of different activities to establish the extent to which the inputs and activities are proceeding according to the plan. For example, if a mental health awareness campaign is being planned, implementation monitoring would include tracking the various activities needed to implement that campaign.



Results monitoring: Are we achieving the expected results?

Periodic measurement of the outputs and outcomes of a programme. Results monitoring supports the assessment of potential bottlenecks and enablers, and/or changes in the capacities (outputs) or performance (outcomes) of the actors, systems or structures involved in the MHPSS programme. For example, results monitoring could explore whether the mental health awareness campaign led to a decrease in mental health stigma in that community.



Situation monitoring: Is a particular situation changing or not?

In impact or situation monitoring, a condition or set of conditions is monitored. For example, monitoring the situation of a population of children experiencing a particular situation can help in drawing conclusions about the impact of a programme on their mental health and psychosocial well-being.

Indicators for monitoring

Indicators are signals of achievement or change related to the expected results of a programme. They provide a simple and reliable means to measure changes in MHPSS-related outputs and outcomes and the performance and overall impact of an MHPSS programme. Indicators may further be disaggregated by various dimensions, including but not limited to age, sex, ethnicity and diversity (such as children with disabilities, including intellectual disabilities), to support and promote equity across efforts.

Common indicators for MHPSS are still nascent, and there are various efforts from UNICEF and its partners to create shared tools and platforms to measure MHPSS outcomes.

The presented log frame included in this document provides suggested indicators that can be adapted to a specific programme design. Additional guidance on crafting and developing indicators can be found in the [recommended resources](#) listed at the end of the MEAL section.

Identifying or developing indicators for each level of the programme-specific MHPSS log frame and planning how to measure them is an iterative process which may involve multiple rounds of revising and adapting, and helps test if a programme's goals are actually measurable.

An indicator helps answer the question, 'have we accomplished our objective?' When identifying indicators for the M&E log frame, select one or a limited number of key indicators that can best demonstrate progress of the outputs, outcomes and impact. Generally, a combination of quantitative and qualitative indicators allows for cross-checking and triangulation of findings, which can promote a richer understanding of what has been achieved.

Finally, as mentioned under ► [Output 4.4](#), data on indicators need to be collected to determine progress towards mental health outcomes and goals, and regular data collection is a key element of an effective monitoring strategy. Choosing a data collection method depends on the type of indicator, the purpose of the information being gathered, and how often it will be gathered. The MoV can play an integral role here and help identify how to obtain data (such as through survey reports, information systems, publications or interviews). Data may be collected at the beginning (baseline), during implementation (midline) and towards the end (endline) of a programme through predetermined metrics. However, while monitoring requires data collection, data collection is not synonymous with monitoring. In other words, monitoring goes beyond simply collecting data. The data must then be used to analyse and compare actual results to expected results at different points to measure an MHPSS programme's performance and make needed changes and amendments that improve child and adolescent mental health.

Evaluation

In the context of MHPSS, evaluations examine how successful programming has been in achieving what it set out to do and what the results are for children's, adolescents' and families' mental health and psychosocial wellbeing.

This section briefly describes how evaluation of MHPSS programmes may be integrated into programme cycles and used to inform decision-making. The section draws from multiple sources, including the [Revised Evaluation Policy of UNICEF](#) and the [Inter-Agency Guide to Evaluation of Psychosocial Programming in Humanitarian Crises](#), which remains a relevant and applicable guide on evaluation planning, design and conduct in both humanitarian and development settings.

Evaluation planning and conduct

Evaluations should be planned and scheduled in accordance with programming cycles and when results can best contribute to key decision-making moments.

To help determine whether an evaluation is relevant, feasible, and likely to provide useful information, programme teams can conduct an evaluability assessment. Specifically, an evaluability assessment will help clarify programme logic and coherence; assess the adequacy and validity of indicators, tools and systems for monitoring, measuring and verifying results; assess the availability of human and financial resources to monitor and evaluate the expected results; and guide approaches to the evaluation of the programme. To help guide these exercises, UNICEF issued a [Guidance Note for Conducting Evaluability Assessments in UNICEF](#).

Depending on the nature of questions to be addressed, evaluations can take different forms. For example, evaluations examine processes, performance, outcomes or impact with designs and methods suited to that purpose.

The subject matter of an evaluation also varies and might include, for example, a donor-funded project, a country programme or a national strategy. For example, within UNICEF, evaluation of MHPSS programming

at the country level is often conducted as a stand-alone programme or theme, though it may also be incorporated into a country programme evaluation or as part of a regional initiative.

Box 8 Rights-holders' participation in evaluations

Needs and interests of rights-holders should be put at the centre of evaluation design and implementation. Rights-holders are usually the best judges of the effectiveness of humanitarian or development work. [UNICEF Guidance Note: Adolescent participation in UNICEF monitoring and evaluation](#) provides ideas for adolescent involvement in evaluation processes.



Putting it into practice for MHPSS evaluations

Evaluation example:

[Evaluation and Costing of the Pilot Programme on the Promotion of Adolescent Mental Health and Prevention of Suicide in Kyzylorda Oblast, Kazakhstan](#)

As Kazakhstan had one of the highest adolescent suicide rates in the world, the government introduced a number of reforms and policy drivers aimed at improving life and wellbeing, including a 'Plan of actions for the implementation of development of health care – Densaulyk – for 2016–2019'. That plan identifies key health systems' weaknesses and includes among its targets a reduction in suicide rates among those aged 15–17. UNICEF's country programme has been predominantly supporting the government to implement its reform agenda. This includes support to the Adolescent Suicide Prevention Project, a pilot project to promote mental health and prevent adolescent suicide that was implemented in one region from 2015 to 2017.

UNICEF Kazakhstan commissioned an independent evaluation of the Adolescent Suicide Prevention Project to reflect on the programme's contribution over the pilot period. The evaluation used a reconstructed TOC as a mechanism to map the programme's components and describe how the pilot was set up and how it was meant to operate. The evaluation team found the model was viable and improved timely identification and referral of adolescents at risk of self-directed violence. Using mixed-methods approaches, the evaluation team identified positive and measurable improvements in mental health and wellbeing of adolescents, especially those at risk. Outcome data showed that suicidal ideation, depression, stress and anxiety were significantly reduced among targeted at-risk adolescents. Official statistics from local authorities confirmed that the pilot programmes resulted in a sharp decrease in the number of suicides among adolescents aged 15–17.

Using the findings and recommendations of the evaluation among others, UNICEF secured commitment from other regions of Kazakhstan to scale up the programme, and 16 of the country's 17 regions allocated budget and launched the programme in 2018. The government's prioritization of the programme resulted in a decrease in the number of adolescent deaths due to self-harm. In the age group 15–17 years old, the number of suicide cases decreased by 51 per cent between 2013 and 2018. In addition to providing necessary evidence to support scaling up the national MHPSS programme, the evaluation contributed to the knowledge on mental health strategies and approaches that government and public health organizations used in reforming adolescent mental health and suicide prevention programmes, protocols and policies nationwide.

Evaluation example:

[Evaluation of Eswatini Country Programme 2016–2020](#)

Established in 2006 with support from UNICEF Eswatini, support groups known as teen clubs aimed to help adolescents living with HIV build positive relationships, improve their self-esteem and acquire life skills through peer mentorship, ultimately leading to improved clinical and mental health outcomes and a healthy transition into adulthood.

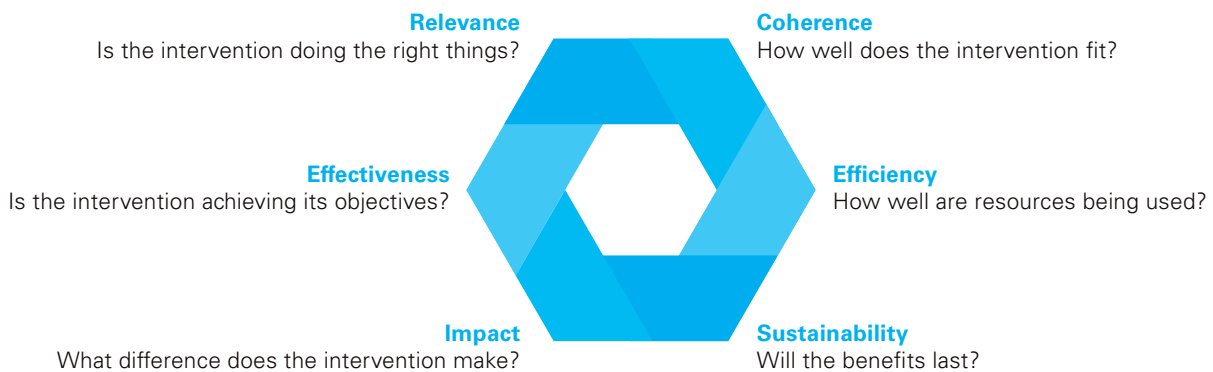
The country programme evaluation found unexpected results in regard to the teen clubs. Run by the Baylor College of Medicine, the clubs produced results beyond the primary objective of providing psychosocial support to adolescents and improving antiretroviral therapy adherence. As expected, improved treatment adherence enabled better health outcomes and increased the confidence of teen club members. In turn, according to parents, this contributed to children's improved performance at school.

Evaluation criteria and questions

UNICEF follows the [OECD-DAC Network on Development Evaluation defined evaluation criteria](#). Evaluation criteria are standards or principles used as the basis for making evaluative judgements. The selection of criteria and evaluation questions depends

on the purpose of the evaluation and the needs of the evaluation's primary intended users. Criteria should be applied thoughtfully and adapted to the context of each intervention and evaluation. Evaluation questions will then determine the evaluation design, sampling approaches, data collection and analysis methods.

Figure 8 Examples of evaluation questions in the context of MHPSS¹⁰⁶



Dissemination and use of evaluation results

All evaluations should have a dissemination plan at the outset, and evaluation reports together with [management responses](#) should be made publicly available (unless otherwise informed by the provisions set out in the [United Nations Executive Board decision 2012/13, 'Office of Internal Audit 2011 annual report to the Executive Board'](#), guiding dissemination of internal audit reports that might endanger an individual's security). The use of evaluation findings and recommendations can be enhanced by the provision of evaluation results in forms that are usable by decision makers, including communication and advocacy materials and tools tailored to users' specific needs.

Finally, stakeholders are more likely to use an evaluation if they understand and feel ownership of the process and findings, which is in turn more likely if they have been actively involved throughout.¹⁰⁷ This means there should be repeated interactions between the intended users and key stakeholders.

This could be done by setting up reference groups, whose members can provide advice at different times of the evaluation and help frame actionable recommendations.

Challenges to MHPSS evaluation and potential solutions

The following subsection identifies key challenges that MHPSS evaluation teams may encounter, and provides suggestions on how they can be addressed.

There is limited evidence to proceed with the evaluation

The availability and quality of existing data are essential to conducting evaluations. Evaluability assessments can be useful tools to help determine the adequacy and validity of indicators, tools and systems for monitoring, measuring and verifying results, and bringing adjustments and corrections to programme design and implementation.

¹⁰⁶ Some questions are taken from the [Inter-Agency Guide to the Evaluation of Psychosocial Programming in Emergencies](#). Please refer to the guide for additional evaluation questions related to psychosocial programming.

¹⁰⁷ Patton, Michael Quinn, *Utilization-Focused Evaluation: The New Century Text*, 3rd ed., SAGE Publications, Thousand Oaks, Calif., 1996.

Stigma and discrimination affect participation of partners and rights-holders in evaluation

Observance of ethical standards and cultural sensitivities is critical for MHPSS-focused evaluations to protect vulnerable groups of children and adolescents. The tools used should reflect these sensitivities and can be developed with local stakeholders and MHPSS experts to make the evaluation culturally relevant and acceptable. It is advisable to test tools with a small group of partners and rights-holders and adjust them if needed. A number of ethical considerations are covered in the [UNEG Ethical Guidelines for Evaluation](#), and these should be followed when evaluating MHPSS programmes.

The programme does not have a TOC

Sometimes a programme may not have a TOC that shows the anticipated UNICEF contribution to high-level results, as well as assumptions that can be tested or validated through an evaluation.

It is advisable to have a TOC or other description of MHPSS programme logic in place. A TOC acts as a tool to generate and depict a common understanding of how and why a desired change is expected in a particular context, and should be elaborated with stakeholder engagement. If a programme does not have a TOC, one can be created at the beginning of an evaluation. UNICEF's [Global MHPSS TOC](#) should be used as a reference to develop or adapt a TOC specific to a country's context and needs. The Information Brief & Checklist - Adapting the MHPSS TOC provides guidance to country offices on adapting the MHPSS Framework's TOC.

Accountability

Accountability is a critical part of all MHPSS programming and environments that support evaluations. Delivery of results should be clear and shared among programme staff and other stakeholders. This requires an identification of roles, responsibilities and processes for mechanisms of review, knowledge-sharing and decision-making.

Accountability ensures that power is shared between community members, donors, researchers and other relevant stakeholders to hold programme staff and organizations accountable for the work they are doing and the outcomes and goals of the interventions, programmes, policies and priorities. Accountability is especially important when working with vulnerable or marginalized communities.

Global efforts towards accountability for MHPSS include [Countdown Global Mental Health 2030](#), which is an independent monitoring platform that draws upon a range of indicators to measure the current state of global mental health.

Key considerations for accountability within MHPSS programming

As the [2022 UNICEF Youth Advocacy Guide](#) notes, bringing about collective change is the spirit of advocacy. Collective change requires collective action, and this can be enhanced by setting up accountability mechanisms from the outset. Accountability plays an essential role in ensuring effective and responsible child and adolescent MHPSS programming and policy processes, just as it does across all other sectors. Especially when engaging with young people, accountability ensures that all relevant stakeholders – including programme teams, political leaders, community leaders and young people themselves – are part of a shared social contract that says everyone will remain cognizant of existing layers of power dynamics, ensure and honour follow-through on commitments made, demonstrate impact, and share knowledge about what works and what needs to be improved when it comes to MHPSS and related outcomes.

Data and monitoring tools are key elements of accountability. Having access to data on the situation of children and adolescents, availability and use of services, and other important aspects of mental health is critical for accountability and powerful for youth to understand the situation and advocate when change is needed. For example, as the Youth Advocacy Guide highlights, the language used in commitments can be an important way to hold leaders and other system actors accountable for what they have committed to do.¹⁰⁸ Having reliable data and monitoring tools can help a team monitor and evaluate whether commitments are being followed through appropriately, and can inspire advocacy for assessment and change when they are not. In this regard, the MEAL process can be recognized as a team sport, conducted in partnership with all stakeholders involved and with various ways to ensure accountability from each actor. Thus, accountability may also be strengthened by co-designing and collaborating with young people for transforming youth mental health in their communities and globally. Intergenerational leadership can be particularly effective in this process, recognizing the unique skill sets and experiences that young people and technical experts can bring to create shared accountability mechanisms for action.

Programme teams or organizations working directly with young people, or with youth participation as part of their mental health and wellbeing mandates, may benefit from critically assessing the presence and quality of accountability mechanisms in place to develop and maintain reliable feedback loops, to ensure transparency of processes and results, and to protect the physical and psychological safety of young people. Furthermore, when engaging with young people directly, special care must be taken to communicate and set clear expectations throughout a programme's life cycle, so as to actively steer away from disempowering them, for example, through lack of follow-up, token representation or other harmful means. Ongoing monitoring and evaluation of results, as well as the intentional incorporation of learning and feedback mechanisms throughout a programme, can support this.

Learning

Learning is an integral part of a MEAL plan, as it ensures that programme planning, implementation and evaluation can achieve the best results for children and adolescents. It also lets programme leaders use that learning to continually adjust, improve and strengthen programmes and the evidence base for MHPSS. According to the [International Medical Corps Toolkit for the Integration of Mental Health into General Healthcare in Humanitarian Settings](#), learning includes the systematic documentation and use of lessons learned, recommendations and observations that emerge from the monitoring, evaluation and accountability processes. These learnings can be used to improve programming and to build the evidence and knowledge base for MHPSS internally and externally. Learning from programming will bring the greatest success when grounded in transparent approaches.

Learning can happen throughout a programme's life cycle when:

- ❑ Programming has ongoing M&E mechanisms and accountability tools
- ❑ Programme teams or organizations develop collaborative partnerships with other agencies, communities and governments working on MHPSS programming to facilitate cross-organizational knowledge- and resource-sharing
- ❑ Programme teams or organizations share what does and does not work and ensure key resources are open source and easily accessible
- ❑ Community-led and -facilitated learning processes are established at all stages of a programme to provide the community with opportunities to directly engage and influence the learning process.

¹⁰⁸ United National Children's Fund, '2022 UNICEF Youth Advocacy Guide', UNICEF, New York, 2022, p. 23.



Recommended resources from the [Compendium of MHPSS Resources](#) for MEAL

- [IASC Common Monitoring and Evaluation Framework for MHPSS in Emergency Settings: With means of verification \(Version 2.0\)](#): The IASC Common Monitoring and Evaluation Framework provides guidance in the assessment, design, implementation and M&E of MHPSS programmes in humanitarian settings. It includes an overall goal, associated outcomes and impact-level and outcome-level indicators, as well as information on specific data collection tools to measure MHPSS indicators (i.e., the MoV). This resource can help teams identify and leverage existing MHPSS indicators.
- [Measuring mental health among adolescents at the population level \(MMAPI\)](#): The MMAPI suite of tools and standard procedures will guide adaptation and use of suitable tools and measures to enable collection of robust, standardized data at the population level for symptoms of anxiety and depression, functional limitations due to mental health-related conditions, suicide ideation and attempt, and care-seeking and connectedness. This resource can help teams identify and leverage existing MHPSS indicators.
- [Countdown Global Mental Health 2030](#): Countdown Global Mental Health 2030 is an independent monitoring platform that draws upon a range of factors and indicators, from economic performance to attitudes towards mental health care, to measure the current state of global mental health. This resource can help teams identify and leverage existing MHPSS indicators and is particularly important when thinking about accountability.
- IMC's [Toolkit for the Integration of Mental Health into General Healthcare](#) includes a section specific to MEAL. The resource provides guidance on why capacity-building is necessary, the importance of and recommendation for both theoretical and practical training, ongoing technical support and supervision. While developed for use among general health workers, such as doctors, nurses and community health workers, it can be used to guide capacity-building efforts across the MHPSS workforce.
- [2022 UNICEF Youth Advocacy Guide](#): This guide was developed by adolescents based upon their experiences of what meaningful youth engagement looks like around the globe. It includes sections focused on adolescent engagement and accountability in the data collection and analysis process. This is a key resource for ensuring meaningful engagement of adolescents in the MEAL aspects of MHPSS programming.

■ Annexes

Annex 1: Strategies for community engagement and participation

Communities and cultures are dynamic. They provide the structures and systems for safety in people's lives, work and education, as well as the social and psychological foundations of wellbeing for children and families. They change constantly as people adapt to new realities, environments, resources and challenges, particularly with the upheaval of familiar ways of life caused by emergencies.

Communities are also diverse, with subgroups and power dynamics that determine who participates in decision-making and to what extent. For example, community power relationships may exclude some vulnerable groups (e.g., based on their ethnicity, religion or disability).

When the structures and fabric of community life are damaged by emergencies, MHPSS interventions use the process of community engagement and participation to help maintain, activate or restore community and family capacity to support children's wellbeing. What existed previously may need to be restored, abandoned or altered in the new context for the wellbeing of all community members following an emergency. People affected by an emergency, particularly one involving massive displacement, may or may not identify as part of the same community, and subgroups within communities may or may not feel included, safe or respected.

Inclusion and participation of all community members are at the core of MHPSS work and require great efforts of engagement. As such, engagement is not something 'done' to a community; rather, it is a process undertaken in partnership with community members as they assess their situation, consider priorities to help children and families, and develop solutions based on their needs and resources. Inclusion and participation ensure programmes:

- ❑ Are relevant to local realities, cultural values and understandings
- ❑ Make the best use of local resources

- ❑ Effectively identify children and families who are vulnerable or have special needs, and actively promote their inclusion in interventions and relief efforts
- ❑ Strengthen the natural supports in families and communities to care for children
- ❑ Strengthen capacities of childcare systems for broad impact
- ❑ Promote local ownership of programmes for long-term sustainability.

Community engagement is based on certain principles, including a rights-based approach that incorporates an age, gender and diversity analysis to ensure broad, meaningful participation of community members, including those who traditionally may be marginalized. It is also based on the principle of empowering individuals to understand their situation, make informed decisions and assume ownership of solutions for sustained impacts. It incorporates transparency and accountability of all stakeholders.

Engaging communities

In complex situations, careful attention must be paid to the process of approaching communities and ensuring inclusion and participation throughout the programme cycle. Engaging communities begins with recognizing and acknowledging people's resilience, capacities, skills and resources for self-care and self-protection. Engagement involves:

- ❑ Working with a community and its leaders
- ❑ Understanding a community's dynamics and structures
- ❑ Building on community capacities and strengths to find solutions to identified concerns
- ❑ Working in partnership to plan, implement and monitor interventions at all phases of the programme management cycle.

The process of community engagement raises awareness of the needs of vulnerable or marginalized groups. It can play a powerful role in reducing stigma and discrimination affecting vulnerable children and families.

Communities displaced by an emergency also interact with host communities in a variety of ways – sometimes being absorbed by or integrating with them, sometimes living separately. Tensions may arise over resources or sociocultural differences. The relationship between affected people and host communities needs to be examined, with host communities involved in the process.

Environment also influences community engagement processes. For example, when refugees or displaced families are scattered in an urban environment, identifying and engaging with them requires different strategies than if they are located together in a refugee camp.

Six steps of engagement and participation

1. Learn about the context.
2. Identify and meet community stakeholders.
3. Conduct an inclusive, participatory assessment of needs and resources.
4. Facilitate inclusive, participatory planning of solutions and interventions.
5. Support programme implementation by community actors.
6. Monitor and evaluate interventions together.

Learn about the context

Before entering a community, learn about the emergency and the sociocultural context for children and families. A situation analysis provides an overview of the emergency context, including a mapping of risks, resources and priority areas for intervention. Analysis begins with a desk review of existing information about:

- The emergency and environments where affected children and families are living (including host communities)
- How many people are affected and who are the most vulnerable (e.g., unaccompanied children)
- The history of the emergency and what the communities have experienced
- Risks for children and families, as well as existing resources (e.g., services, facilities)

- Sociocultural customs and ways of caring for and protecting children and families
- How children and caregivers with psychosocial distress or mental health conditions are included in (or excluded from) support structures.

Identify and meet community stakeholders

Stakeholders, including individuals and groups who may be affected by MHPSS interventions, can influence programmes and have an interest in or be a resource for interventions. Stakeholders are a diverse group and include governmental, NGO and civil society personnel; organizations for children's care, such as school boards; religious organizations; youth and women's groups; formal and informal leaders, including women leaders such as female elders and midwives; people with disabilities; women and men (including LGBTQ+ people); child caregivers; and children themselves. Vulnerable children and families may be hidden, so it is important to inquire sensitively about who and where they are and appropriate ways to reach them.

A stakeholder analysis is the first step undertaken in partnership with the community and ensures inclusive representation in community engagement activities. It is important to make a good first impression. See the tips below for some ideas in meeting and engaging stakeholders.

Box 9 Tips for meeting and engaging community stakeholders¹⁰⁹

- Understand community practices and traditions prior to entering communities in order to appropriately engage different groups and members.
- Work with and through community leaders (formal and informal). Inform them of plans for assessment and programme planning and seek their counsel. Community leaders can be instrumental in guiding and supporting entry into communities and promoting inclusion and participation of various stakeholders, including women and children.
- Identify an existing committee or community group or organization through which to access the community and share information.
- Explain who you are, why you are there, and what you can and cannot do (i.e., manage expectations).
- Focus on listening. Use opportunities for informal meetings in various locations.
- Arrange meetings for mutually convenient times and check to be sure meetings accommodate the schedules of children and parents or caregivers.
- Work with leaders on outreach strategies to ensure messages reach everyone, not just a select few.
- Deliver messages in simple, culturally sensitive language that everyone can understand.
- Identify and engage diverse stakeholders, including children of all ages, and children and caregivers with mental health conditions, distress or disabilities.
- Be consistent, respectful and transparent in all dealings. Follow up on any actions in a timely way.

Conduct an inclusive, participatory assessment of needs and resources

Involving the community in the assessment not only provides valuable information for MHPSS interventions, it also acknowledges and helps engage individual and community agency for recovery and restoring hope. It brings diverse voices to an understanding of the community, how the emergency has affected community coping capacities, and how different community members see their own risks and resources.

Talk with all those who influence the structures and systems of support for child wellbeing: mothers, fathers and other primary caregivers; teachers and other childcare providers; and various community stakeholders. Find ways to appropriately engage children of different ages and those who may be marginalized, such as children or caregivers with disabilities.

Engaging diverse voices means ensuring that age, disability and gendered perspectives are reflected. This supports meaningful participation and helps include boys and girls, women and men, and vulnerable or marginalized children and families. Consider talking with boys and girls separately to obtain a gendered perspective on children's needs. Accessing various groups appropriately and safely requires careful consideration of the sociocultural context. For example, men may need permission to speak privately with women, and caregivers should be consulted to approve children's participation in assessment activities.

Below are some general tips for engaging children in participatory assessment.

¹⁰⁹ United Nations High Commissioner for Refugees, 'A Community-Based Approach in UNHCR Operations', UNHCR, Geneva, 2008, p. 44.

Box 10 Tips for engaging children in participatory assessments

- Meet parents or caregivers to explain the assessment and ask permission for children to participate.
- Put children at ease according to their age or developmental stage and culture, such as by sitting with them on the ground, singing, playing or drawing.
- Use simple language and concepts.
- Be patient and take time to build trust, especially with children who have had distressing experiences.
- Accept and support children's emotions – do not judge them for how they feel.
- Help children reduce any stress and tension.
- Validate what children say – do not challenge, shame or undermine them.
- Do not probe about upsetting details or emotions.
- Convey a sense of hope and safety.
- Understand that children may view and explain their situation through fantasy, inventing explanations, using symbolism or emphasizing seemingly unimportant details. Listen respectfully.
- Be sensitive to gender, culture, ethics and power relationships between adults and children.

Participatory assessments include focus group discussions, community mapping, key informant interviews and surveys. Key questions to consider in inclusive, participatory assessments include:

- How has the community coped with distress and challenges in the past?
- How has the emergency affected those coping mechanisms?
- How are vulnerable children and families identified, helped and supported?
- How are children or caregivers who have psychological distress or mental health problems viewed and supported (or overlooked)?
- What are the key mental health, psychosocial and protection concerns for children and families?
- What do boys and girls of different ages say are their particular concerns and priorities?
- What do caregivers identify as their concerns and priorities?
- Who is most at risk, and how can they best be reached and assisted?
- What is the perspective of children and families experiencing psychological distress or mental health problems, including developmental disabilities?
 - » What are their concerns and priorities?
 - » What coping strategies do they use, and how do they seek help?
 - » What barriers do they encounter in receiving services and support?
- What resources and structures exist?
- Who are key resource people for children and families (e.g., teachers, social workers, women leaders)?
- What childcare structures and natural supports are currently functioning (e.g., formal and informal education, social service systems), and what are the gaps?
- What is helpful, and what is harmful? What support mechanisms can be activated or restored, and what needs to be adapted to respect the rights of children and families?



Recommended resource from the [Compendium of MHPSS Resources](#)

The compendium contains resources and toolkits useful for the design of participatory assessment questions and other M&E tools.

[Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings](#) (WHO, UNHCR, 2012) contains practical tools for designing and conducting an assessment of mental health and psychosocial needs and resources in major humanitarian crises. See Tool 10 'Participatory Assessment: Perceptions by General Community Members' for guidance on interviews with general community members, including free listing and further questions.

Facilitate inclusive, participatory planning of solutions and interventions

The information gathered (situational and stakeholder analyses and the participatory assessment) is then shared and analysed together with stakeholders to plan the way forward. Work with the community to identify women and men, boys and girls of all ages, and people from vulnerable or marginalized groups as representatives in the planning process. Engage children and family and community caregivers in designing programmes they feel are relevant to their needs and suitable to the culture and context. For example, in designing programmes for youth, bring adolescents together to brainstorm approaches and activities they would find interesting and relevant to their lives.

UNICEF and partners may work with a community committee in planning solutions and interventions. The committee's membership should be diverse. The group works together to examine risks and resources for children and families, identify priorities for action, and develop feasible solutions. Ensuring diverse and meaningful participation may require planning. In some cultures, for example, women and children or people with disabilities may not have participated previously in such discussions. They may be unaccustomed to speaking up and having their opinions regarded seriously. Sensitize and orient the group on the value of inclusive, participatory processes and together determine what are acceptable ways to achieve this in the culture.

Box 11 Tips for inclusive, participatory planning

- When holding a planning meeting, clearly state its goals, objectives and agenda.
- Respect everyone, being sensitive to culture and giving people ample time to speak.
- Share the results of situation and stakeholder analyses and participatory assessments in ways everyone can understand.
- Do not immediately propose solutions; rather, facilitate a discussion on how best to respond, what resources can be mobilized and how, and what support participants can expect from you.
- Facilitate a process to agree on a strategy (objectives, activities, roles and responsibilities), ensuring the strategy is inclusive and rights-based and addresses the needs of vulnerable children and families.
- Clarify links between the planning and budgeting processes for implementing programmes.
- Help establish joint problem-solving mechanisms and regular feedback mechanisms.
- Provide a summary of the planning outcomes and ensure community representatives have mechanisms to disseminate the information to community members.

In planning solutions and MHPSS interventions, help communities identify sociocultural practices for the care and protection of children and families that uphold human rights and do not discriminate or stigmatize certain groups. Work with them on how to sensitively identify vulnerable children and families in ways that do not expose them to further harm. Also help identify local organizations (community or governmental) or people from affected communities to implement interventions for child and family wellbeing and protection.

Support programme implementation by community actors

The role of UNICEF and its partners is to support programme implementation with technical and financial assistance to community actors. MHPSS interventions seek to maximize community and governmental

resources that can continue after emergency funding ends. Whenever possible, support existing community initiatives and structures and build the capacity of the community to sustain their own solutions. For example, identify local organizations (community or governmental) or people from among affected communities to implement interventions for children and families.

Financial assistance: Community engagement and participation processes raise awareness of issues and solutions that community members will often begin to address themselves. The level of financial assistance communities receive depends on the emergency situation and phase, the urgency of the needs, and the capacity of the community to activate its own resources. It is important to manage the use of financial and material incentives carefully. Be careful not to erode natural volunteering and

local ownership of the programme by reliance on incentives that may end with changes in funding streams. UNICEF and partners can support natural helping activities not only through financial assistance but also by providing meeting spaces, facilitating sharing, and providing information and training.

- **Technical assistance:** For plans to be successful, programme implementers need to have the skills, knowledge and systems to implement them, ensure their quality, and track their progress over time. Activities in this step of community engagement include:
- **Recruiting:** Programme staff or volunteers can be recruited locally. Recruitment strategies should avoid weakening existing structures by pulling away skilled staff members. Help programme implementers develop recruitment procedures that ensure fair and equitable opportunities, are appropriate to the culture and gender of children and families they will be helping, and appropriately screen for child protection concerns (e.g., check references).
 - **Training and supervising:** Build the capacity of local volunteers and staff (within community groups and care structures) through participatory, skills-based training and ongoing supervision. Set minimum qualifications for the various roles and tasks of the job. Train and supervise volunteers and staff to ensure they meet those qualifications and feel equipped for their tasks. Ongoing supervision is essential in MHPSS programmes to build skills and knowledge to respond to emerging challenges and support staff and volunteers in their work. ‘Care for the caregivers’ is not a luxury in MHPSS programmes – it is

fundamental to producing quality programming and preventing burn-out.

- **Establishing information management and standard operating procedures (SOPs):** Systems and procedures are essential to the success of any programme. Help to develop and train programme implementers in useful systems of documentation and information management that meet ethical requirements (e.g., confidentiality). Documentation and information management systems should be feasible and user-friendly to ensure they are implemented and give an accurate picture of needs and progress. SOPs should include systems for assessing and responding to specific problems with guided protocols (e.g., coordination and referrals). SOPs help volunteers and staff do their work effectively and efficiently and make sure that children and families get the care they need.

Monitor and evaluate interventions together

Programme M&E is critical, and for transparency and accountability it should involve diverse members of the community. Include a wide range of voices in the feedback about programme outcomes and effectiveness in M&E strategies to get a clear and comprehensive view of the impact of interventions (including any shortcomings) from different perspectives. Regular feedback mechanisms allow for timely feedback so programmes can be adjusted to ensure their safety and effectiveness. This also provides assurance that vulnerable children and families are included in participation mechanisms and service provision.

Box 12 Tips for monitoring and evaluating interventions with the community

- Engage children, their caregivers and other community stakeholders in visualizing programme success in order to design useful indicators.
- Find out which elements of the programme are working well and which are not for boys and girls of different ages by triangulating information from parents or caregivers (e.g., teachers) and children.
- Have an established plan to address any risky situations revealed by M&E processes.
- Design monitoring methods that are feasible for staff and community members to implement, and use simple tools for programme evaluation that allow participation of different community groups.
- Do not be defensive about findings; rather, listen and learn, and agree together on improvements.
- Be sure to provide M&E data to children, caregivers and community stakeholders in forums that help them improve strategies for longer-term care of children and for advocacy purposes.

Annex 2: Action sheets from IASC guidelines for MHPSS in emergency settings

The IASC MHPSS Guidelines contain relevant action sheets for various sectors. These are indicated below for each sector.

What protection actors can do (Action Sheets 3.1, 3.2, 3.3)

Protection actors from UNICEF and its partner organizations are often the primary implementers of MHPSS programmes. There is a natural link between children's protection and wellbeing, and interventions for each are closely related. For example, MHPSS approaches may focus on:

- ❑ Building the capacity of caregivers (including teachers) to better recognize and respond to protection needs
- ❑ Developing functional referral networks between schools and social services
- ❑ Identifying and referring children who have suffered serious protection risks or traumatic events for specialized care and support, as necessary, to help them recover
- ❑ Identifying and addressing harmful behaviours
- ❑ Preventing separation and prioritizing reunification with caregivers
- ❑ Facilitating alternative care arrangements when necessary.

What health and nutrition actors can do (Action Sheets 6.1 to 6.5, and 9.1)

Mental health is an integral part of general health, as enshrined in the slogan 'No health without mental health!'¹¹⁰ However, many emergencies occur in areas of the world that lack adequate clinical mental health services, and existing services are often damaged or weakened by the emergency. Thus, strengthening the capacity of health and nutrition actors in communities is an important aspect of MHPSS intervention strategies. Health and nutrition actors can play an important role in recognizing and providing appropriate treatment and support to children and caregivers with mental health conditions or other specialized MHPSS needs. For example:

- ❑ Primary care staff can provide care and treatment based upon the Mental Health GAP Humanitarian Intervention Guide ([mhGAP-HIG](#)).
- ❑ Community health workers can receive training and supervision to appropriately identify, support and refer vulnerable children and families to clinical mental health care or social services.
- ❑ Nutrition actors can help identify, support and refer mothers with post-partum depression or infants and young children at risk due to protection concerns, poor growth or developmental disabilities.



Recommended resources from the [Compendium of MHPSS Resources](#)

The compendium contains resources and toolkits useful for MHPSS in nutrition programming during humanitarian response:

- [Baby Friendly Spaces: Holistic approach for pregnant, lactating women and their very young children in emergency](#), Action Contre la Faim, 2014
- [Manual for the Integration of Child Care Practices and Mental Health into Nutrition Programmes](#), Action Contre la Faim, 2013
- [The Mental Health and Psychosocial Support Minimum Service Package](#)

¹¹⁰ Prince, Martin., et al., 'No health without mental health', *The Lancet* 2007, vol. 307, 8 September 2007, p.859-877.

Care practices of child caregivers (mothers, fathers, other caregivers or siblings) include providing food, health care, stimulation and emotional support necessary for children to survive and thrive. The ways in which those practices are performed – such as affection and responsiveness to the child – are critical to positive outcomes for children’s growth and development. Nutrition actors therefore pay particular attention to the mental wellbeing of caregivers and their capacity to stimulate social, emotional and cognitive development of their children. One model of intervention is baby-friendly spaces, which provide a safe space for feeding babies and attending to the experiences and wellbeing of mothers, babies and children. Nutrition actors can also support cultural care practices that support mothers and babies, such as infant massage in India or post-partum rest for mothers in many Muslim countries.¹¹¹

What education and early childhood development (ECD) actors can do (Action Sheet 7.1)

Education (both formal and informal) and ECD activities are essential to children’s safety, wellbeing and development. ECD activities promote positive care practices during the critical early years of children’s development. Examples of ECD activities include:

- Community dialogue and psychoeducation and parent support and training to:
 - Provide infant and young child stimulation and facilitate active play
 - Facilitate basic nutrition and promote the continuation of breastfeeding
 - Promote bonding between infants and caregivers.
- Programmes to support the care of young children by their families and provide social support to caregivers.

Education is generally highly valued by families and communities, and restarting learning activities for children following emergencies helps restore routine and normalcy to daily life. Social and emotional learning through formal and informal learning spaces

are important aspects of children’s development. It is a process of acquiring social and emotional values, attitudes, competencies, knowledge and skills that are essential for learning, effectiveness, wellbeing and success in life. These competencies are closely aligned with the qualities of psychosocial wellbeing and resilience that children acquire through their optimal development: self-awareness, emotional literacy, persistence, motivation, empathy, relational skills, effective communication, self-esteem, self-confidence, respect and self-regulation.¹¹²

Sometimes, children and teachers find learning difficult when they are faced with conflict or disaster. Schools can be given supports to provide developmental learning methods, based on reinforcing systems for the entire school community that can promote growth and learning. Schools and other safe spaces can also serve as important access points for children and families to receive other services, such as nutrition through school feeding programmes. Sports, cultural and other activities can engage children, their families and the larger community, restoring a sense of belonging and promoting healing and recovery.

What camp coordination and camp management (CCCM) actors can do (Action Sheet 10.1)

CCCM lead agencies coordinate the operations of various actors that provide essential services in camps for refugees and internally displaced people. They are essential in ensuring human rights standards are upheld, protection and assistance programmes are coordinated in a holistic way, and psychosocial wellbeing considerations are included to protect the dignity of survivors and enhance the overall humanitarian response. The role of CCCM actors begins with assessment, ensuring MHPSS needs and the resources of children and families are adequately and appropriately assessed. CCCM actors also:

- Ensure all humanitarian staff working in the camps are briefed in basic MHPSS knowledge and skills to support distressed children and families and provide necessary referrals

¹¹¹ Engle, Patrice, ‘The Role of Caring Practices and Resources for Care in Child Survival, Growth and Development: South and Southeast Asia’, Asian Development Bank, vol. 17, nos. 1 and 2, 30 June 1999, pp. 132–167.

¹¹² International Network for Education in Emergencies, ‘INEE Background Paper on Psychosocial Support and Social and Emotional Learning for Children and Youth in Emergency Settings’, INEE, New York, 2016.

- ❑ May co-chair an MHPSS coordination group in the camp to help mainstream MHPSS activities across sectors and engage the affected community in service planning and delivery
- ❑ Help assess and address MHPSS needs and resources in host communities, and liaise with civil society and government representatives to complement the temporary services provided in the camp setting and strengthen the MHPSS care structures in the area.

What WASH actors can do (Action Sheet 11.1)

WASH actors play an important role in ensuring boys and girls, men and women have safe and appropriate access to WASH facilities in ways that contribute to their protection and wellbeing. A gendered perspective in the design and implementation of WASH facilities in campsites, schools and other locations is essential because of the unique risks faced by girls and women around these areas. Engaging girls and women (in addition to boys and men) in assessing needs and priorities around WASH facilities is the first step to ensure safe, appropriate facilities. This includes, for example:

- ❑ Separate and private bathing and latrine facilities for men and women, locks on latrine doors and well-lit latrine areas, which help to minimize protection risks
- ❑ Water access points that are nearby and easily accessible to women and families who use them frequently for activities of daily living
- ❑ The best placement and design of water access points, decided together with women and child caregivers, to promote areas where women can meet, talk, and form connections.

Keeping a developmental perspective in mind, WASH actors can help meet the particular hygiene needs of adolescent girls who are menstruating. These girls require access to clean water and safe, private facilities for washing in schools and other learning spaces. Being sensitive to these needs and ensuring girls' access to adequate hygiene in learning environments reduces their risk of dropping out.

Annex 3: UNICEF key commitments, frameworks and minimum standards

Table 6 UNICEF minimum standards and guidelines for humanitarian action

Overall policy	
Core Commitments for Children (CCCs) in Humanitarian Action , UNICEF, 2020	UNICEF's central policy for upholding the rights of children affected by humanitarian crises, the CCCs promote predictable, effective and timely humanitarian action through partnership between governments, humanitarian organizations and others.
Child protection	
2019 Edition of the Minimum Standards for Child Protection in Humanitarian Action (CPMS) , The Alliance for Child Protection in Humanitarian Action	Provides minimum standards for child protection work in humanitarian settings
MHPSS	
IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings , 2007	Guidelines to enable humanitarian actors to plan, establish and coordinate a set of minimum multisectoral responses to protect and improve people's mental health and psychosocial wellbeing in emergencies
IASC Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support Programmes in Emergency Settings , 2017	IASC's MHPSS Reference Group guidance in the assessment, research, design, implementation and M&E of MHPSS programmes in emergency settings
Education	
INEE Minimum Standards for Education: Preparedness, Response, Recovery , Inter-Agency Network for Education in Emergencies, 2010	Nineteen standards that aim to enhance the quality of educational preparedness, response and recovery in humanitarian settings and to meet the educational rights and needs of people affected by disaster
INEE Conflict Sensitive Education Pack , Inter-Agency Network on Education in Emergencies, 2013	Guidance and tools for integrating conflict sensitivity into education programmes in fragile and conflict-affected settings
HIV/AIDS	
IASC Guidelines for Addressing HIV in Humanitarian Settings, 2010 , Inter-Agency Standing Committee, 2010	Guidelines for providing a minimum set of HIV prevention, treatment, care and support services to people affected by humanitarian crises
Children with disabilities	
A Rights-Based Approach to Disability in the Context of Mental Health , UNICEF, 2007	This discussion paper proposes a framework to ensure a rights-based approach to programming related to disability in MHPSS at UNICEF.
Gender-based violence	
Guidelines on Gender-Based Violence Interventions in Humanitarian Settings , IASC Taskforce on Gender in Humanitarian Assistance, 2005	Guidelines for establishing and coordinating a set of minimum multisectoral interventions to prevent and respond to sexual violence in emergencies
Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies , UNFPA, 2015	These standards promote the safety and wellbeing of women and girls in emergencies and provide practical guidance on how to mitigate and prevent gender-based violence in emergencies and facilitate access to multisectoral services for survivors.
Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service , International Rescue Committee and UNICEF, 2012	Guidance for health and psychosocial staff in providing care and treatment to child survivors of sexual abuse in humanitarian settings


Annex 4: UNICEF’S multisectoral MHPSS M&E log frame (detailed version)

UNICEF’S multisectoral MHPSS log frame includes the four outcomes of the MHPSS Framework along with their outputs, suggested indicators and MoV, providing guidance on how to report on individual programmes. Notably, relevant core standard indicators (CSIs) from

the UNICEF Strategic Plan, 2022–2025 that are relevant for MHPSS programming are also listed.

(See ► [Annex 5](#) for more information on the UNICEF Strategic Plan, 2022–2025 indicators.)

Table 7 Detailed multisectoral log frame


Description	Indicators*	Means of verification (MoV)**
Outcome 1: Child and adolescent		
 <p>Improved child and adolescent mental health and psychosocial wellbeing</p>	<ul style="list-style-type: none"> • Percentage of children and adolescents who feel safe and supported: <ul style="list-style-type: none"> » At home » At school » In the community. • Percentage of children and adolescents who benefit from access to nurturing environments (e.g., supportive schools, safe and hygienic housing conditions) that offer programmes to improve their mental health and psychosocial wellbeing • Percentage of children and adolescents with mental health and psychosocial needs who report satisfaction with supportive social networks: <ul style="list-style-type: none"> » At home » At school » In the community. • Percentage of children and adolescents with access to opportunities that improve their mental health and wellbeing through stimulation, learning and skills development: <ul style="list-style-type: none"> » At home » At school » In the community. • Percentage of children and adolescents receiving MHPSS clinical or non-clinical services who demonstrate improvement in relevant domains of mental health and psychosocial wellbeing 	<ul style="list-style-type: none"> • Child, adolescent, parent, caregiver and community surveys designed to assess relevant domains of MHPSS • Programme activity records

* Where relevant, disaggregate and report indicators by various domains of sociodemographic characteristics (e.g., age, sex, residence, socioeconomic status, displacement status).

** See the [IASC M&E Framework](#) for additional MoV and guidance specific to measuring changes in mental health and psychosocial wellbeing.


Description	Indicators	Means of verification (MoV)
Output 1.1		
<p>Children and adolescents have access to safe and nurturing environments and quality services that improve their mental health and psychosocial wellbeing:</p> <ul style="list-style-type: none"> • At home • At school • In the community. 	<ul style="list-style-type: none"> • Equitable access to service delivery of MHPSS basic needs for children and adolescents: <ul style="list-style-type: none"> » Number of children and adolescents identified and referred to MHPSS services, as well as the number who accessed services » Number of children and adolescents who receive appropriate interventions and resources after expressing mental health and psychosocial wellbeing needs » Number of children and adolescents receiving community outreach and case management services » Number of children and adolescents in need receiving focused clinical and non-clinical care, including: <ul style="list-style-type: none"> - Psychotherapy or clinical management of mental health conditions - Non-clinical, community-based mental health interventions, etc. » Number of children and adolescents who report symptoms of depression or anxiety who were in touch with a health professional or counsellor for mental health care (MMAP).¹¹³ • Safe and nurturing spaces (including housing and learning spaces) are utilized by and meet the MHPSS needs of children and adolescents: <ul style="list-style-type: none"> » Number of children and adolescents who: <ul style="list-style-type: none"> - Access safe spaces that meet their MHPSS needs - Report satisfaction with the MHPSS services provided by the safe spaces. » Number of schools: <ul style="list-style-type: none"> - With a safety policy developed or implemented that support child and adolescent mental health and psychosocial wellbeing and protection - Where children and adolescents (or their parents, family and caregivers) report satisfaction with the comprehensiveness and quality of implementation of safety and safeguarding policies that protect and promote their MHPSS needs. 	<ul style="list-style-type: none"> • Referral resource lists, forms and procedures, and referral information management system (follow-up report) • Service and agency mapping reports • Child, adolescent, parent, caregiver and community surveys designed to assess relevant domains of MHPSS • Activity reports and registration logs • Policy mapping and analysis
Output 1.2		
<p>Children and adolescents have access to support systems that facilitate positive relationships that promote inclusion, belonging and agency</p>	<ul style="list-style-type: none"> • Quality and appropriate peer-to-peer and other social support systems that promote inclusion, belonging and agency are available and accessible: <ul style="list-style-type: none"> » Number of children and adolescents with access to nurturing and caring support systems and actors » Number of child- and adolescent-friendly peer and group support spaces that are free of charge or very affordable » Number of children and adolescents engaged in co-designing and participating in or accessing youth clubs, peer-to-peer support strategies, etc. » Number of children and adolescents who report feeling a sense of inclusion, belonging and agency due to opportunities, services or positive environments provided: <ul style="list-style-type: none"> - At home - At school or other educational settings - In the community. 	<ul style="list-style-type: none"> • Child, adolescent, family, caregiver and community surveys • Programme activity records • Referral forms, referral information management system data (follow-up report)

¹¹³ Indicator from the UNICEF Strategic Plan, 2022–2025 (see [Annex 5](#)).

Description	Indicators	Means of verification (MoV)
Output 1.3		
<p>Children and adolescents have opportunities for stimulation, learning and skills development that contribute to mental health and wellbeing</p>	<ul style="list-style-type: none"> • Children and adolescents are exposed to school or other educational environments that are supportive of mental health and wellbeing through opportunities for stimulation, skills development and learning: <ul style="list-style-type: none"> » Number of children and adolescents in schools or other educational settings where mental health awareness, emotional regulation and skills development opportunities are integrated into school curricula or extracurricular activities. • Children and adolescents benefit from community environments and services that are supportive of mental health and wellbeing, development and learning: <ul style="list-style-type: none"> » Number of adolescents with mental health and psychosocial problems who: <ul style="list-style-type: none"> - Receive training on skills to contribute to livelihood activities in the community - Participate in livelihood activities in the community. » Number of children and adolescents who reported having strengthened their skills in specific domains related to mental health and psychosocial wellbeing (e.g., emotional regulation, stress management, problem-solving, interpersonal skills, assertiveness, self-esteem). 	<ul style="list-style-type: none"> • Child, adolescent, caregiver, family, parent or teacher surveys • School activity reports and materials developed (e.g., anti-violence) • Programme or policy documents
Outcome 2: Caregivers		
 <p>Improved caregiver mental health and psychosocial wellbeing, including for parents, caregivers, mothers, family and teachers</p>	<ul style="list-style-type: none"> • Percentage of parents, caregivers, families and teachers reporting the ability to cope or thrive with their own mental health and psychosocial wellbeing • Percentage of parents, caregivers, families and teachers who report an improved sense of subjective wellbeing (e.g., feeling strong, hopeful, capable, rested, interested and happy; not feeling helpless, depressed, anxious or angry) • Percentage of parents, caregivers, families and teachers who feel supported by their community and family networks to improve their mental health and psychosocial wellbeing • Percentage of parents, caregivers, families and teachers reporting supportive parenting and teaching skills and knowledge of child or adolescent MHPSS needs 	<ul style="list-style-type: none"> • Programme monitoring reports (activity reports) • Child, adolescent, caregiver, family, parent or teacher surveys • Community social network mapping
Output 2.1		
<p>Parents, caregivers, mothers, families and teachers have access to support for developing and maintaining improved mental health and psychosocial wellbeing</p>	<ul style="list-style-type: none"> • Mental health and psychosocial wellbeing and development of parents, caregivers, families and teachers are supported: <ul style="list-style-type: none"> » Number of parents, caregivers, families and teachers participating in or accessing mental health and psychosocial: <ul style="list-style-type: none"> - Support services - Capacity-building activities - Resources or programmes. » Number of parents, caregivers, families and teachers reporting satisfaction with resources available for supporting or developing their MHPSS knowledge and coping skills » Number of parents, caregivers, families and teachers who have access to support and opportunities to nurture and improve their mental health and psychosocial wellbeing <ul style="list-style-type: none"> - At home - At school - In the community. 	<ul style="list-style-type: none"> • Programme monitoring reports (activity reports) • Referral resource lists, forms and procedures, and referral information management system (follow-up report) • Parent, caregiver, family and teacher surveys • Community social network mapping


Description	Indicators	Means of verification (MoV)
Output 2.2		
<p>Parents, caregivers, mothers, families and teachers have access to family and community support networks that improve their mental health and psychosocial wellbeing</p>	<ul style="list-style-type: none"> • Parents', caregivers', families' and teachers' care and nurturing environments are strengthened: <ul style="list-style-type: none"> » Number of parents, caregivers and families reporting positive social cohesion within families and communities » Number of family and community psychosocial support networks and services identified, activated and providing quality support for parents, caregivers, families and teachers in need. • Parents, caregivers, families and teachers with psychosocial support and protection needs are supported by family and community networks and services: <ul style="list-style-type: none"> » Number of parents, caregivers, families and teachers engaging with community support groups and family network activities and reporting access to quality support for their mental health and psychosocial wellbeing needs » Number of parents, caregivers, families or teachers with mental health and psychosocial needs who report receiving adequate support from:¹¹⁴ <ul style="list-style-type: none"> - Family members - Community networks. 	<ul style="list-style-type: none"> • Parent, caregiver, family and teacher surveys • Community social network mapping • Programme monitoring reports (activity reports) • Project reports of documented, active community groups • Referral resource lists, forms and procedures, and referral information management system (follow-up report)
Output 2.3		
<p>Parents, caregivers, mothers, families and teachers develop skills for parenting, teaching, and supporting children and adolescents in distress (MHPSS needs)</p>	<ul style="list-style-type: none"> • Parents, caregivers, families and teachers are supported to recognize and respond to their own MHPSS needs and those of their children and adolescents: <ul style="list-style-type: none"> » Number of parents, caregivers, families and teachers with access to skills development and strengthening programmes to cope with common problems of children and adolescents (e.g., through skills related to stress management, conflict resolution, problem-solving or positive parenting, or knowledge of where to seek help or information) » Number of parents, caregivers, families and teachers provided with support in positive and responsive caregiving » Number of parents, caregivers, families and teachers who report having benefited from training, psychosocial education and supportive group sessions in self-care and care for children and adolescents in need of support » Number of mothers, fathers and caregivers reached through parenting programmes (see ► Annex 5) » Number of parents, caregivers and families reporting quality caregiver-child interactions (e.g., nurturing and stimulating interactions supporting children's optimal development). • School staff and systems are supported to recognize and respond to focused psychosocial support and protection needs of children and adolescents: <ul style="list-style-type: none"> » Number of schools with increased links to mental health and social service referrals » Level of effectiveness of teacher development system (see ► Annex 5) » Number of schools or other educational settings implementing strategies to strengthen supportive environments (e.g., teacher training in basic psychosocial concepts, anti-violence campaigns) » Number of teachers and school administrators (including staff in child-friendly spaces and ECD centres) trained in identifying and responding to focused MHPSS needs of children and adolescents » Extent to which the education system is resilient and can respond to humanitarian crises (see ► Annex 5). 	<ul style="list-style-type: none"> • Parent, caregiver, family and teacher surveys • Community social network mapping • Programme monitoring reports (activity reports) • Project reports of documented, active community groups • Referral resource lists, forms and procedures, and referral information management system (follow-up report)

¹¹⁴ Making Cents International, 'Integrating Mental Health and Psychosocial Support into Youth Programming: A Toolkit', Making Cents International, Washington, D.C., September 2021.

Description	Indicators	Means of verification (MoV)
Outcome 3: Community		
 <p>Improved community capacity at the district and subdistrict levels for non-stigmatizing, accessible, available and quality MHPSS service delivery across the primary health care, social welfare and education systems and structures</p>	<ul style="list-style-type: none"> • Percentage of community members with improved perceptions, knowledge, attitudes and behaviours towards the MHPSS needs of children, adolescents and their parents, caregivers, families and teachers • Percentage of community organizations across different sectors (e.g., health, education) that meet organizational benchmarks for reducing mental health stigma and discrimination towards children, adolescents and families marginalized due to disabilities, sociocultural background or migration status • Percentage of children, adolescents and their caregivers, parents and families who report satisfaction with the capacity of various formal and informal social structures and care systems (such as schools or informal education for children and adolescents of all ages, health care, social services, ECD programmes, women’s groups and youth clubs) to promote and support their mental health and wellbeing • Percentage of health facilities that provide mental health services at the primary, secondary and tertiary levels for children, adolescents and their caregivers, parents and families in need of MHPSS • Percentage of available programmes at the community level focusing on prevention of mental illness and promotion of mental health and psychosocial wellbeing for children, adolescents and their caregivers, parents and families that offer evidence-based care • Percentage of children, adolescents and their parents, caregivers, families and teachers reporting a decreased sense of social stigma around mental health after community interventions and programmes 	<ul style="list-style-type: none"> • Child, adolescent, parent, caregiver, teacher and community surveys designed to assess relevant domains of MHPSS • Programme cycle monitoring forms (activity and meeting reports) • Community social network mapping • Referral resource lists, forms and procedures, and referral information management system (follow-up report)
Output 3.1		
<p>Stigma- and judgement-free environments for mental health and psychosocial wellbeing are established through social and community awareness, acceptance and positive behaviour change for children, adolescents and their parents, caregivers, families and teachers</p>	<ul style="list-style-type: none"> • Community awareness and behaviour change interventions for MHPSS stigma-reduction issues are implemented: <ul style="list-style-type: none"> » Number of children, adolescents and their parents, caregivers, families and teachers engaged in programmes that promote and support MHPSS and stigma- and judgement-free environments » Number of children, adolescents, parents, caregivers, families and teachers reporting satisfaction with MHPSS knowledge-sharing initiatives developed and implemented by and through existing community supports and structures. • MHPSS messages are developed, disseminated and reach community stakeholders, including children, adolescents, caregivers, parents, families and teachers: <ul style="list-style-type: none"> » Number of community members, caregivers, parents, families and teachers who received messaging about MHPSS programmes and support for children, adolescents and their parents, families and caregivers » Number of communities and parents, families and caregivers reached through various information campaigns and initiatives to promote a stigma- and judgement-free view of mental health needs, challenges and approaches. 	<ul style="list-style-type: none"> • Child, adolescent, parent, caregiver, teacher and community surveys designed to assess relevant domains of MHPSS • Programme cycle monitoring forms (activity and meeting reports) • Community social network mapping

Description	Indicators	Means of verification (MoV)
Output 3.2		
<p>Community mental health and psychosocial wellbeing support systems are strengthened across sectors, including community capacities to support children, adolescents, parents, caregivers, families and teachers</p>	<ul style="list-style-type: none"> • Community members are engaged in assessment, design and planning of MHPSS programmes focused on children, adolescents, parents, caregivers, families or teachers: <ul style="list-style-type: none"> » Number of communities where representatives of children, adolescents and their parents, caregivers, families or teachers are included in decision-making processes on their safety and wellbeing » Number of communities trained on formal and informal mechanisms of MHPSS monitoring and reporting of at-risk groups » Number of community members who report enhanced capacities in recognizing and responding to at-risk children, adolescents and their parents, caregivers, families or teachers. • Traditional community structures and stakeholders for children's, adolescents', parents', caregivers', families' and teachers' mental health and wellbeing are activated: <ul style="list-style-type: none"> » Number of communities (such as villages or neighbourhoods) where steps have been taken to identify, activate or strengthen local resources that support psychosocial wellbeing and development of children and adolescents » Number of family and community psychosocial support networks and services identified and activated for the support of children, adolescents, parents, caregivers, families and teachers in need » Number of children, adolescents, parents and caregivers provided with community-based MHPSS services (UNESCO, WHO, World Bank)¹¹⁵ » Number of children, adolescents, parents, caregivers, families and teachers with access to or who report satisfaction with mental health programmes embedded within community-based platforms (e.g., youth platforms, sports, music, culture) » Numbers of parents, caregivers, families, teachers, community members or health-care workers with access to the following services or community support mechanisms to promote their own mental health: <ul style="list-style-type: none"> - Advocacy to integrate mental health services for caregivers in sectoral policies and strategies - Capacity development of front-line workers through training modules or packages around caring for caregivers - Coverage of and access to mental health clinical and non-clinical community-based MHPSS services for caregivers - Awareness-raising activities on caregiver mental health through community- or national-level mental health campaigns and awareness-raising activities. 	<ul style="list-style-type: none"> • Child, adolescent, parent, caregiver, teacher and community surveys designed to assess relevant domains of MHPSS • Programme cycle monitoring forms (activity and meeting reports) • Community social network mapping • Training reports and on-the-job competence

¹¹⁵ Indicator from the UNICEF Strategic Plan, 2022–2025 (see [Annex 5](#)).

Description	Indicators	Means of verification (MoV)
Output 3.3		
<p>Multisectoral care systems (primary health care, social welfare and protection, education) for children, adolescents, parents, caregivers, families and teachers, including family-friendly policies, are developed and strengthened</p>	<ul style="list-style-type: none"> • Parents, caregivers, families and teachers have access to multisectoral care (e.g., health, education, child protection, social services) to support their own mental health and that of children and adolescents under their care: <ul style="list-style-type: none"> » Number of available programmes in the community, school, etc. offering multisectoral care that addresses MHPSS for children, adolescents and their caregivers, parents and families » Cross-sectoral referral systems are available and accessible to promote and protect mental health and psychosocial needs of children, adolescents, parents, caregivers, families or teachers » Level of institutionalization of holistic skills development to support learning, personal empowerment, environmental sustainability, active citizenship, social cohesion or employability and entrepreneurship.¹¹⁶ 	<ul style="list-style-type: none"> • Child, adolescent, parent, caregiver, teacher and community surveys designed to assess relevant domains of MHPSS • Programme cycle monitoring forms (activity and meeting reports) • Community social network mapping
Outcome 4: Systems		
 <p>An improved enabling environment for MHPSS is created across policy, legislation and financing systems, the MHPSS workforce, multisectoral supports and referral pathways, and MHPSS research and data</p>	<ul style="list-style-type: none"> • Increase in national-level mental health spending and appropriate mental health costing and expenditure for children, adolescents and their parents, families, caregivers and teachers across at least three sectors • Availability of mechanisms to strengthen leadership, governance and legislation for child and adolescent mental health • Extent to which youth-engaged and youth-led decision-making processes at the local, subnational and national levels for mental health and psychosocial wellbeing exist within a country • Extent to which a country has integrated effective policies to support child, adolescent and parent, family, caregiver and teacher mental health into the overall policy infrastructure • Availability of country-level strategies for ensuring free and accessible access to MHPSS services across health, education, social welfare and protection sectors • Implementation of country-level multisectoral approaches to child, adolescent, parent, family, caregiver and teacher mental health • Percentage of clinical and non-clinical staff trained on and following guidance (e.g., IASC MHPSS Guidelines, child protection frameworks) on MHPSS approaches to provide age- and gender-responsive MHPSS care across sectors • Implementation of data collection efforts to report on key indicators related to MHPSS at national and subnational level • Extent to which country-level processes for using data on MHPSS-related indicators to inform policymaking or budgeting are developed and utilized 	<ul style="list-style-type: none"> • Programme cycle monitoring reports • Child, adolescent, parent, caregiver, teacher and community surveys designed to assess relevant domains of MHPSS • Policy analyses and mapping • Referral reports

¹¹⁶ Indicator from the UNICEF Strategic Plan, 2022–2025 (see [Annex 5](#)).

Description	Indicators	Means of verification (MoV)
Output 4.1		
<p>Policy, legislation and financing: An effective policy, legislative and financing environment is available and accessible by putting supportive mechanisms in place for quality MHPSS service delivery</p> <p>Note to readers: This includes policies, laws, institutions, culture, and social and gender norms that create a system that facilitates access to affordable and non-stigmatizing MHPSS for all children, adolescents, their families and communities and a supportive environment for the voice, agency and action of advocates and users of MHPSS, including youth and parents, families and caregivers.</p>	<ul style="list-style-type: none"> • National, subnational and local leadership and governance structures for MHPSS exist and trigger policy change related to mental health for children, adolescents, parents, caregivers, families and teachers: <ul style="list-style-type: none"> » Number of countries with a plan or strategy for child and adolescent mental health (WHO)¹¹⁷ » Extent to which the country's mental health advocacy action triggered or supported mental health policy change related to the advocacy priorities (see ► Annex 5) » Existence of an in-country dedicated government body overseeing mental health policy and programming for children, adolescents, parents, caregivers, families and teachers at the national, subnational and local levels¹¹⁸ » Existence of dedicated structures and processes for child and adolescent participation in decision-making for mental health programming at the national, subnational and local levels (see ► Annex 5) » Existence of a national legal and policy framework that addresses the MHPSS needs of children, adolescents and their parents, caregivers, families and teachers (see ► Annex 5). • National policies and strategies that address children's, adolescents', parents', caregivers', families' and teachers' mental health are fully estimated, and budgets for implementation are secured: <ul style="list-style-type: none"> » Existence of national policies, legislation, estimated plans and strategies for children's, adolescents', parents', caregivers', families' and teachers' MHPSS » Existence of national-level financial risk protection mechanisms in place for MHPSS¹¹⁹ » Extent to which a country demonstrates increased mental health spending for children, adolescents and their parents, families and caregivers across at least three sectors.¹²⁰ 	<ul style="list-style-type: none"> • Programme cycle monitoring reports • Child, adolescent, parent, caregiver, teacher and community surveys designed to assess relevant domains of MHPSS • Policy analyses and mapping • Referral reports
Output 4.2		
<p>Strengthened multisectoral systems and referral pathways: Multilayered support systems and processes within existing structures include functional referral systems across primary health care, social welfare and protection, and education</p>	<ul style="list-style-type: none"> • Functioning referral systems are established: <ul style="list-style-type: none"> » Existence of a national-level strategy for ensuring free and accessible access to MHPSS services across health, education, social welfare and protection sectors » Existence of national- or subnational-level tracking of delivery and referral information related to MHPSS services for children and adolescents (UNESCO, WHO, World Bank) (see ► Annex 5). • MHPSS is integrated within existing structures for PHC, social welfare and protection, and education systems: <ul style="list-style-type: none"> » Scale of integration of mental health services into PHC, including through school and digital platforms (see ► Annex 5) » Extent of integration of caregiver mental health services across sectors (see ► Annex 5) » Existence of a mental health sector policy or plan (or equivalent guidance document) across sectors which includes the provision of mental health services for children, adolescents and their caregivers in PHC that are planned, budgeted and implemented. 	<ul style="list-style-type: none"> • Programme cycle monitoring reports • Child, adolescent, parent, caregiver, teacher and community surveys designed to assess relevant domains of MHPSS • Policy analyses and mapping • Referral reports

¹¹⁷ Indicator from the UNICEF Strategic Plan, 2022–2025 (see [Annex 5](#)).

¹¹⁸ Indicator adapted for MHPSS from the [WHO Mental Health Atlas](#). For a brief description of the Mental Health Atlas, see the [Compendium of MHPSS Resources under 'Output 4.1'](#).

¹¹⁹ Indicator adapted for MHPSS from the WHO-AHA Framework.

¹²⁰ Indicator adapted from UNICEF's 'Global Advocacy Priority 3 – Mental health framework' (internal document).

Description	Indicators	Means of verification (MoV)
Output 4.3		
<p>Workforce development and capacity: Strengthened capacity among the MHPSS workforce supports the provision of quality age- and gender-responsive MHPSS care across all sectors</p>	<ul style="list-style-type: none"> • Intersectoral staff and volunteers have the capacity to provide culturally appropriate, respectful services that minimize harm to children, adolescents and their families: <ul style="list-style-type: none"> » Training on MHPSS concepts is incorporated into national curricula for teachers and disaster risk reduction plans » Number of staff working across sectors trained in basic psychosocial support principles (e.g., psychological first aid and 'do no harm' strategies, such as IASC MHPSS Guidelines, mhGAP interventions) and demonstrating improved knowledge » Number of community care providers trained and supervised in appropriate, focused psychosocial support to parents and caregivers with mental health and psychosocial problems. • Accessible, coordinated and inclusive focused and specialized MHPSS care is promoted within health, mental health and social service systems and other community systems for children, adolescents, parents, caregivers, families and teachers: <ul style="list-style-type: none"> » Number of health facilities, social services facilities and community programmes that have at least one staff member who is trained to help children, adolescents, parents, caregivers, families and teachers with mental health and psychosocial needs » Number of health facilities, social services facilities and community programmes that have and apply procedures for referral of children and adolescents with mental health and psychosocial needs. • Supportive supervision and continuing education opportunities are available for professional and non-specialist MHPSS providers: <ul style="list-style-type: none"> » Existence of supervisory systems for professional and non-specialist MHPSS providers to support their roles » Existence of refresher training and continuing education opportunities for MHPSS service providers » Number of health, social services and community programme staff trained in the identification, management and referral of children, adolescents, parents, caregivers and families with mental health needs. 	<ul style="list-style-type: none"> • Training and supervision reports • Quality standards checklist • Programme cycle monitoring reports • Child, adolescent, parent, caregiver, teacher and community surveys designed to assess relevant domains of MHPSS • Policy analyses and mapping • Referral reports

Description	Indicators	Means of verification (MoV)
Output 4.4		
<p>Research, evidence and data: An evidence and data ecosystem for MHPSS informs and drives policy changes around MHPSS</p>	<ul style="list-style-type: none"> • MHPSS interventions utilize evidence-based strategies aligned with international quality standards: <ul style="list-style-type: none"> » Extent to which in-county national, subnational and local governments use data on child, adolescent, caregiver and teacher mental health and psychosocial wellbeing to: <ul style="list-style-type: none"> - Evaluate performance of programmes - Plan and allocate resources - Respond to periodic monitoring requests from international and regional intergovernmental organizations and set policies to protect mental health outcomes.¹²¹ » Implementation of costing and investment monitoring tools for MHPSS¹²² » National plans for measuring change and using data along relevant domains of mental health and psychosocial wellbeing for children, adolescents, parents, caregivers and teachers » MHPSS-related policymaking or budgeting are informed by data, research and evaluation » Development and demonstration of minimum quality standards per international guidelines for promotive, preventive and responsive mental health and wellbeing in schools and other settings.¹²³ • Data infrastructure and resources are available, mature and enable collection and monitoring of data on child, adolescent, caregiver and teacher mental health and psychosocial wellbeing: <ul style="list-style-type: none"> » Availability of comparable data on non-communicable diseases, disability, injuries, mental health and children's environmental health (see ► Annex 5) » Inclusion of MHPSS indicators in available management and information systems across sectors that collect data disaggregated by age, gender and at risk¹²⁴ » Routine collection of standardized and reliable data on key standardized indicators on mental health and psychosocial wellbeing for children, adolescents, parents, caregivers, families and teachers at the national and subnational levels » Existence of quality control or systems measures that support administrative data quality assurance for mental health and psychosocial wellbeing » Existence of mechanisms to promote data use from key indicators on mental health and psychosocial wellbeing is well known to inform policymakers, leaders, researchers, academics, media and other relevant stakeholders. 	<ul style="list-style-type: none"> • Programme cycle monitoring reports • Child, adolescent, parent, caregiver, teacher and community surveys designed to assess relevant domains of MHPSS • Policy analyses and mapping • Referral reports

¹²¹ Indicator adapted for MHPSS from 'Administrative Data System on Justice for Children', UNICEF, 2021.

¹²² Indicator from UNICEF's 'Global Advocacy Priority 3 – Mental health framework' (internal document).

¹²³ Ibid.

¹²⁴ Indicator adapted for MHPSS from the WHO-AHA Framework.

Annex 5: UNICEF Strategic Plan MHPSS-related outputs, outcomes and indicators

Note: Intended for use by UNICEF offices to support UNICEF’s internal institutional (Strategic Plan) reporting on MHPSS.

This annex presents a list of indicators from the [UNICEF Strategic Plan 2022–2025 Integrated Results and Resources Framework](#)¹²⁵ that are relevant to MHPSS. This annex may be used as guidance as country offices review and adopt the MHPSS log frame according to local contexts and make the necessary linkages with the Strategic Plan (SP). The indicators in this annex are specific to mental health and can be found across the SP Goal Areas 1 (Survive and thrive), 2 (Learn and acquire skills for the future) and 3 (Protected from violence, exploitation, abuse, neglect and harmful practices). UNICEF partners and others may choose to use this resource as an example of one way to approach institutional and strategic-level indicators for MHPSS.

Note that no stand-alone or parallel reporting is expected for these SP indicators related to MHPSS. Most data for SP reporting are already collected as part of the country office end-of-year reporting process. At the global level, UNICEF aggregates and analyses the data reported by country offices to report on the results of the SP through the Annual Report of the Executive Director. Progress on the SP results pertaining to MHPSS will be monitored through above-mentioned existing processes.

Core standard indicators (CSIs)¹²⁶ are country-relevant versions of the SP indicators. They replace the strategic monitoring questions that were previously used to report on the SP. CSIs can be embedded in the country programme results framework and in the results assessment module.

Table 8 UNICEF’s mental health-specific SP indicators and CSIs

	UNICEF’s SP indicators 2022–2025	UNICEF’s CSIs 2022–2025	Corresponding sections in UNICEF’s global MHPSS log frame
Goal Area 1: Every child and adolescent survives and thrives, with access to nutritious diets, quality primary health care, nurturing practices and essential supplies			
Goal area-level (outcome) indicator	SP outcome indicator 1.14: Percentage of adolescents who report symptoms of depression or anxiety reporting contact with health professional or counsellor for mental health care (MMAP)	This indicator is not collected through UNICEF’s CSI mechanisms	Output 1.1: Children and adolescents have access to safe and nurturing environments and quality services that improve their mental health and psychosocial wellbeing: <ul style="list-style-type: none"> • At home • At school • In the community.
Result area 4: Children, including adolescents, benefit from programmes that improve their health and development in development and humanitarian contexts	SP output indicator 1.4.5: Availability of comparable data on non-communicable diseases, disability, injuries, mental health and children’s environmental health	This indicator is not collected through UNICEF’s CSI mechanisms	Output 4.4: Research, evidence and data: An evidence and data ecosystem for MHPSS informs and drives policy changes around MHPSS

¹²⁵ UNICEF staff can view the methodological notes for each indicator on [SharePoint](#) (internal UNICEF link).

¹²⁶ UNICEF staff can view the CSIs on [SharePoint](#) (internal UNICEF link).

	UNICEF's SP indicators 2022–2025	UNICEF's CSIs 2022–2025	Corresponding sections in UNICEF's global MHPSS log frame
Result area 5: Children, adolescents and caregivers have access to quality programmes that improve their mental health and psychosocial wellbeing in development and humanitarian contexts	SP output indicator 1.5.1: Number of countries integrating mental health services in primary health care, including through school and digital platforms	CSI 1.5.1: Scale of integration of mental health services into primary health care, including through school and digital platforms	Output 4.2: Strengthened multisectoral systems and referral pathways: Multilayered support systems and processes within existing structures include functional referral systems across primary health care, social welfare and protection, and education
	SP output indicator 1.5.2: Number of countries implementing multisectoral approaches to caregiver mental health	CSI 1.5.2: Extent of integration of caregiver mental health services across sectors	
	SP output indicator 1.5.3: Number of countries with a plan or strategy for child and adolescent mental health (WHO)	This indicator is not collected through UNICEF's CSI mechanisms	Output 4.1: Policy, legislation and financing: An effective policy, legislative and financing environment is available and accessible through supportive mechanisms in place for quality MHPSS service delivery
Goal Area 2: Every child and adolescent learns and acquires skills for the future			
Result area 1: Equitable and inclusive access to learning opportunities, including in humanitarian and fragile contexts	SP output indicator 2.1.2: Percentage of countries with a resilient education system that can respond to humanitarian crises (ECW, GPE, UNESCO, World Bank) Dimension on MHPSS: MHPSS for children, adolescents and teachers Sub-dimension: Policies and plans, curricula, community engagement	CSI 2.1.2: Extent to which the education system is resilient and can respond to humanitarian crises	Output 2.3: Parents, caregivers, mothers, families and teachers develop skills for parenting, teaching, and supporting children and adolescents in distress (MHPSS needs)
	Result area 2: Improved learning, skills, participation and engagement for all children and adolescents, in development and humanitarian contexts	SP output indicator 2.2.1: Percentage of countries with an effective teacher development system (GPE, UNESCO, World Bank) Dimension: Teachers' development Sub-dimension on MHPSS: Teachers' MHPSS	
	SP output indicator 2.2.6: Percentage of countries institutionalizing holistic skills development to support learning, personal empowerment, environmental sustainability, active citizenship, social cohesion and/or employability and entrepreneurship (UNDP, UNEP, UNESCO)	CSI 2.2.6: Level of institutionalization of holistic skills development to support learning, personal empowerment, environmental sustainability, active citizenship, social cohesion and/or employability and entrepreneurship	Output 3.3: Multisectoral care systems (primary health care, social welfare and protection, education) for children, adolescents, parents, caregivers, families and teachers, including family-friendly policies, are developed and strengthened

	UNICEF's SP indicators 2022–2025	UNICEF's CSIs 2022–2025	Corresponding sections in UNICEF's global MHPSS log frame
Goal Area 3: Every child and adolescent is protected from violence, exploitation, abuse, neglect and harmful practices			
Goal area-level (outcome) indicator	SP outcome indicator 3.8: Number of countries tracking delivery and referral information related to MHPSS services for children and adolescents (UNESCO, WHO)	This indicator is not collected through UNICEF's CSI mechanisms	Output 4.2: Strengthened multisectoral systems and referral pathways: Multilayered support systems and processes within existing structures include functional referral systems across primary health care, social welfare and protection, and education
Result area 1: Children, including those affected by humanitarian crises, are protected from violence, exploitation, abuse and neglect	SP output indicator 3.1.2: Number of mothers, fathers and caregivers reached through parenting programmes through UNICEF-supported programmes (WHO)	CSI 3.1.2: Number of mothers, fathers and caregivers reached through parenting programmes through UNICEF-supported programmes	Output 2.3: Parents, caregivers, mothers, families and teachers develop skills for parenting, teaching, and supporting children and adolescents in distress (MHPSS needs)
Result area 2: Children, including those affected by humanitarian crises, benefit from the promotion of care, mental health and psychosocial wellbeing and justice	SP output indicator 3.2.7: Number of UNICEF-targeted children, adolescents, parents and caregivers provided with community-based MHPSS services (UNESCO, WHO)	CSI 3.2.7: Number of UNICEF-targeted children, adolescents, parents and caregivers provided with community-based MHPSS services	Output 3.2: Community mental health and psychosocial wellbeing support systems are strengthened across sectors, including community capacities to support children, adolescents, parents, caregivers, families and teachers
Change strategies (HOW)			
H1: Advocacy and communications	SP H1.1 (c): Number of countries that took advocacy action that triggered policy change related to the mental health of children and young people and to bringing an end to neglect, abuse and childhood traumas	CSI H1.1 (c): Extent to which UNICEF advocacy action triggered or supported policy change related to the UNICEF global advocacy priorities	Output 4.1: Policy, legislation and financing: An effective policy, legislative and financing environment is available and accessible by putting supportive mechanisms in place for quality MHPSS service delivery

Annex 6: Means of verification (MoV) for MHPSS

As described in ► [Box 4](#): 'Key components of a log frame', means of verification (MoV) are tools or methods used to measure suggested indicators. Selected monitoring tools and approaches that may be used by programme staff are provided below. Examples included in this table come from Table 4.2 in UNICEF's [Results-Based Management Handbook](#) and Table 2 in the [IASC Common Monitoring and Evaluation Framework](#).

For using and adapting MHPSS scales and tools, see the [IASC MHPSS M&E Framework MOV Toolkit](#), which provides further information, including guidance on responsible use of the scales and tools.

Note: The detailed global MHPSS log frame (see ► [Annex 4](#)) includes some examples of quantitative MoV. Further examples, including from qualitative MoV, can be found in this section.

Type of data system	Means of verification
Routine data systems collect information across time periods and different levels, i.e., individual, administrative units and administrative levels.	<ul style="list-style-type: none"> • National record systems: For example, health management information system • Sentinel surveillance: For example, antenatal care clinics as sentinel sites for HIV surveillance • Field monitoring systems: For example, community-level field monitoring
Surveys are widely used in monitoring and assessing access, demand, availability and quality of services and programmes.	<ul style="list-style-type: none"> • Population-based surveys: For example, nationally representative surveys such as the UNICEF-supported Multiple Indicator Cluster Survey (MICS) and USAID-supported Demographic Health Survey, which are publicly available. • Purposive sample surveys: In this survey, the sample group is targeted to have specific attributes and can be logically assumed to be representative of the population of interest. • SMS-based surveys: Samples can only include mobile phone users or use mobile phone users as intermediaries to reach other people. Samples may be biased, but technology allows for a high volume of data to be collected quickly.
<p>Qualitative methods are more open-ended and are often conducted through interviews, focus groups and other qualitative data collection methods.</p> <p>For information on quantitative methods, refer to the IASC Common Monitoring and Evaluation Framework (see Table 1 in the IASC Framework).</p>	<ul style="list-style-type: none"> • Observation and documentation: For example, observation can happen during sessions of an activity or in the community to evaluate relevant outcomes. • Interviews: May include brief ethnographic interviews to collect and assess indicators of wellbeing or key informant interviews. • Most significant change: This is a systematic method of collecting stories about outcomes. • Free listing: This method asks participants to identify and rank issues or problems by priorities. • Cards or visual prompting: These can usually prompt discussions around outcomes and indicators. • Focus group discussions: These usually involve open-ended or semi-structured small interactive discussions with four to eight people who share certain characteristics and may have common experiences. Focus groups can be useful for analysing specific complex problems and identifying attitudes and priorities in smaller groups. • Mapping: Mapping involves drawing some aspect of an individual, their community or their social connections to identify risks and resources, social relationships, locations or areas of importance, and others. For example, body mapping is a method that includes outlining the body and identifying important areas of pain or distress. Lifeline is another method where participants are asked to draw a lifeline of important events and discuss the impact of MHPSS actions. • Creative data-generating methods: These methods are unique and innovative ways to engage participants. For example, diary entries, storytelling, crafting and photovoice are examples of creative data-generating methods where participants either document, tell their stories or document their lives through pictures, respectively.

Type of data system	Means of verification
<p>Feedback and complaint mechanisms offer options for people to provide their thoughts.</p>	<ul style="list-style-type: none"> • Feedback and complaint mechanisms: These include a wide range of processes through which different stakeholders are directly engaged and their voices amplified to improve policy and programming. They often require specific channels and standard operating procedures to ensure that sensitive issues are handled with necessary attention to safety and confidentiality.
<p>Participatory methods are well suited for higher-frequency data collection on changes in vulnerabilities and understanding of various variables of interest at the local level. They are also an effective tool to strengthen accountability by engaging directly with the community.</p>	<ul style="list-style-type: none"> • Community score cards: These are usually participatory, citizen-driven accountability methods that enable and empower citizens and community members to analyse programmes and interventions directly and ensure collaborative actions to overcome gaps. In these approaches, community members often define what is being measured in relation to specific concerns and engage directly with the data collection and meaning-making process. • Participatory rural appraisal (PRA), visualization in participatory planning (VIPP) and other variations: These combine a variety of processes and techniques to collect, analyse and disseminate data that are accessible to communities themselves, as well as other critical stakeholders. PRA, for example, draws from qualitative data collection methods, including surveys, and adds techniques to help visualize collective analysis. VIPP, on the other hand, tends to focus more on group analysis for planning, with a range of participatory workshop techniques.
<p>Real-time monitoring is a technology-based innovation that accelerates the pace of data collection and analysis.</p>	<ul style="list-style-type: none"> • Real-time monitoring is frequent data collection and reporting that uses different methodological approaches (such as routine data systems, community-based monitoring and rapid surveys) to increase the pace of results.

Annex 7: Advocacy blueprint

UNICEF mental health advocacy blueprint

The overarching aim of UNICEF's mental health advocacy strategy is to secure quality investment and action to support and protect the mental health of all children and young people. Our advocacy approach focuses on ensuring that every child benefits from loving, nurturing, safe and supportive relationships in

the home, at school and in the community, as well as access to quality mental health and psychosocial support services. We encourage colleagues to amend and adapt the following advocacy blueprint, including outcomes, indicators and activities, to their regional or national contexts as required.

We will

Understand, map and fill data and evidence gaps, making strategic use of existing and upcoming data, and provide evidence-based promising solutions, to support country-level advocacy efforts and alignment with global outcomes.

Form and strengthen global, regional and national partnerships and coalitions with influential partners and leverage high-level forums and moments, including by developing and aligning targeted key messages and advocacy narratives.

Collate and release new policy and technical guidance on evidence-based interventions to aid global, regional or national advocacy and development of national policies and mental health action plans. This includes a specific focus on parenting programmes, school policies and overall community mental health services, with a renewed focus on prevention, especially in a child's early years.

Build advocacy capacity in UNICEF offices and with key strategic partners and establish MEAL mechanisms to assess the impact of our advocacy in shifting the public narrative, enabling policy change and investment towards effective service delivery.

Develop global strategic communications strategy, including promoting the #OnMyMind campaign. Work with user groups and communities, including caregivers and young people, through global, regional and national networks to build an understanding of mental health and support their power and agency with skills and resources to advocate for change.



Because

Lack of awareness on mental health, especially prevention, family and community support (versus treatment), persists among policymakers and the public. This is linked to evidence gaps and limited availability of data on mental health problems, interventions and services, especially related to children and families.

The narrative on mental health, abuse and neglect is fragmented and inconsistent. There is a pressing need to build a shared understanding of the importance of and need for MHPSS.

There is limited government capacity (technical, human and financial resources) and understanding of what works. MHPSS is an underfunded area in all countries, rich and poor, due to relatively low political will or commitment and public demand for these services. This is compounded by limited government capacity (technical, human and financial resources) and understanding of what works, as well as competing demands on public finances.

Advocacy success at the national level is integral to achieving global mental health goals and the SDGs, while growing capacity and skills related to advocacy across UNICEF remain limited and advocacy is not often measured robustly. Competing agendas and difficulty in quantifying progress related to MHPSS have caused a lack of mental health prioritization.

Stigma and discrimination still exist in nearly every country. The lack of understanding of mental health and limited recognition of the importance of mental health care in different cultural contexts results in reduced demand for services.



This will

Enable a strategic, evidence-informed approach to secure greater and better investment in MHPSS across all sectors and community services and structures.

Enhance UNICEF's thought leadership and credibility in this area; create broad consensus around our key asks; and build momentum for ensuring children, adolescents and caregivers are at the heart of the global mental health agenda.

Build the evidence base and case for investment in multigenerational approaches to child, adolescent and caregiver mental health and wellbeing. Influence national policymakers to commit to quality and sustainable action and investment on mental health.

Result in strong multisectoral national or regional advocacy in line with global approaches, by ensuring all relevant teams across UNICEF and its partners have the confidence and advocacy skills to pursue national-level opportunities to influence policymakers and other advocacy targets towards our desired result, with clear roles, responsibilities and accountability.

Enable us to influence the public discussion on mental health and aid in reducing associated stigma and discrimination as the conversation continues to grow both online and offline. Promote increased awareness and behaviour change and rally demand from key audiences to encourage action from decision makers.



So that

We can change knowledge, attitudes and perceptions, tackle taboos and secure the necessary action and investment required to support and protect the mental health and wellbeing of all children, young people and their caregivers.

Potential advocacy activities and tactics (indicative list)

- ❑ Support the roll-out of new [MICS](#) adolescent mental health and caregiver modules, especially among advocacy champion and Joint Program countries.
- ❑ Develop a global advocacy toolkit and resources, including guidance on how offices can support development and implementation of quality national action plans on mental health.
- ❑ Promote engagement at strategic events, conferences and summits to convene key stakeholders, demonstrate evidence and highlight children's, adolescents' and caregivers' lived experiences and needs.
- ❑ Develop integrated communications and media strategies to build national awareness of key issues and asks.
- ❑ Establish partnerships for mental health research and advocacy to generate policy guidelines.
- ❑ Create targeted advocacy and communications across sectors (health, education, child protection, etc.) to build consensus and awareness among key decision makers and secure public statements and government commitments.
- ❑ Co-create platforms with and for young people to discuss advocacy actions that promote mental health.
- ❑ Conduct mental health awareness campaigns and surveys to measure increase in knowledge, attitudes, perceptions and behaviours.

We recommend ensuring you have clear SMART (Specific, Measurable, Achievable, Realistic and Time-phased) advocacy goals and have completed comprehensive stakeholder mapping before defining tactics. More details on the advocacy strategy process, including a full list of possible advocacy tactics, can be found on the UNICEF Advocacy Portal.¹²⁷

¹²⁷ Consult your local UNICEF office to gain access to the UNICEF Advocacy Portal.

Annex 8: MHPSS in Education Learning Brief

UNICEF's [Learning Brief on Mental Health and Psychosocial Support \(MHPSS\) in Education](#) provides guidance to UNICEF Education staff and implementing partners on MHPSS programming in education. It aims to create a shared understanding among education colleagues about MHPSS across all settings where UNICEF works – from humanitarian to development contexts.



Learning Brief on Mental Health and
Psychosocial Support (MHPSS) in Education

Annex 9: Myanmar's Multisectoral MHPSS Strategy

Myanmar country example: [UNICEF Myanmar's Multisectoral MHPSS Strategy](#) was developed in 2021 as part of the Country Office's response to the country's complex emergency. This strategy outlines the UNICEF principles, standards and approaches of multisectoral MHPSS as outlined in the MHPSS Framework, the [Mental health Technical Note](#) and the [MHPSS Minimum Services Package](#). It also outlines specific actions recommended for a multisectoral approach, as identified by the national MHPSS team, to be taken in Myanmar to achieve minimum MHPSS services and activities over the duration of the strategy, 2022–2025.



UNICEF Myanmar

**Mental Health and Psychosocial Support
Multi-Sectoral Strategy 2022-2025**

December 2021

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¹²⁸ Adapted from Murray, Laura K., et al., ‘Building capacity in mental health interventions in low resource countries: An apprenticeship model for training local providers’, *International Journal of Mental Health Systems*, vol. 5, no. 1, December 2011.

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