Photo: Jennifer Flemming

Mental health and psychosocial support in schools: Learning from research in Colombia and Kenya

A synthesis of qualitative research examining the Norwegian Refugee Council's Better Learning Program.

Synthesis Report

THE MHPSS COLLABORATIVE

NRC NORWEGIAN REFUGEE COUNCIL

Supported by PORTICUS

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Acronyms

BLP
Better Learning Program

EIE
Education in emergencies

IDP
Internally displaced Pprsons

I/NGOs
International / Nongovernmental organizations

MHPSS
Mental health and psychosocial support

NRC
Norwegian Refugee Council

PTSD
Post traumatic stress disorder

SEL
Social emotional learning

Introduction: MHPSS and education

This research examines the enabling environments for effective implementation of mental health and psychosocial support (MHPSS) interventions delivered in education settings in humanitarian contexts, with specific focus on the Norwegian Refugee Council's (NRC) Better Learning Programme (BLP) implemented in Kenya and Colombia. This report synthesizes learning from the full research in each of the two countries, emphasizing both the role and value of MHPSS in education programming, as well as the specific perceptions of impact and implementation of the intervention by various education stakeholders.[*] It concludes with a summary of key action points that emphasize enabling factors for intervention efficacy, and that are relevant for stakeholders including schools, communities, implementing organizations, policy and decision-makers, and donors.

[*] For full country research reports, as well as the learning briefs summarizing the research for each country, please visit: mhpsscollaborative.org

Background

At the end of 2022, 40% of the nearly 110 million forcibly displaced people globally were children under the age of 18.[1] Displaced children face acute and chronic adversities that significantly threaten their mental health and psychosocial wellbeing.[2] Research emphasizes that children exposed to war and displacement exhibit a range of distress and stress reactions, including specific fears, dependent behaviors, psychosomatic symptoms, and aggressive behaviors.[3] The urgent needs of children in humanitarian crises underpin various policies and programmatic approaches that include increasing attention to both MHPSS services broadly[4] and in education approaches specifically.[5]

Education is a basic right and access to quality education for refugee children is underlined via strategic priorities and policy by major humanitarian actors and governments hosting significant refugee populations.[6] The provision of quality education has important overlaps with child protection priorities and includes efforts to address children's wellbeing in humanitarian contexts, such as promoting a sense of stability and normalcy, providing important relationships with peers and adults, and opportunities for building life skills.[7] MHPSS in education in emergencies (EiE), including social-emotional learning (SEL), has been identified as an important pathway to address both children's mental health and psychosocial needs and to improve learning outcomes.[8] There is widespread interest from a range of actors in this type of programming, as well as increasing recognition that quality education is reflected not just in academic outcomes (such as literacy and numeracy) but also in those measuring learner psychosocial wellbeing.[9]

This clear interest in MHPSS programming across EiE has, to date, not been reflected in the evidence base. This includes a dearth of evidence to support effectiveness in terms of type of intervention or implementation method; what groups/subgroups of children may most benefit; and how interventions can or should be adapted for specific contexts. Further, although research in high income and stable contexts shows influence of environmental and ecological factors on children's mental health and learning outcomes,[10] there is limited understanding of what aspects of classroom, school, household, and community environments influence children's wellbeing and learning in humanitarian settings.

The specific factors surrounding an MHPSS interventions (in terms of delivery of the interventions, and the socio-ecological factors influencing children beyond the intervention itself) are complex and often poorly understood.[11] Children, caregivers and teachers are more likely to actively participate in and benefit from classroom-based MHPSS interventions if the programs are relevant, acceptable and feasible. This research is based on a social ecological framework that considers the complex interplay between the individual learner; their home and school environments; their community; the relationships built across these levels; the systems and institutions around them; and finally the policy and funding environment of humanitarian and education programming broadly.

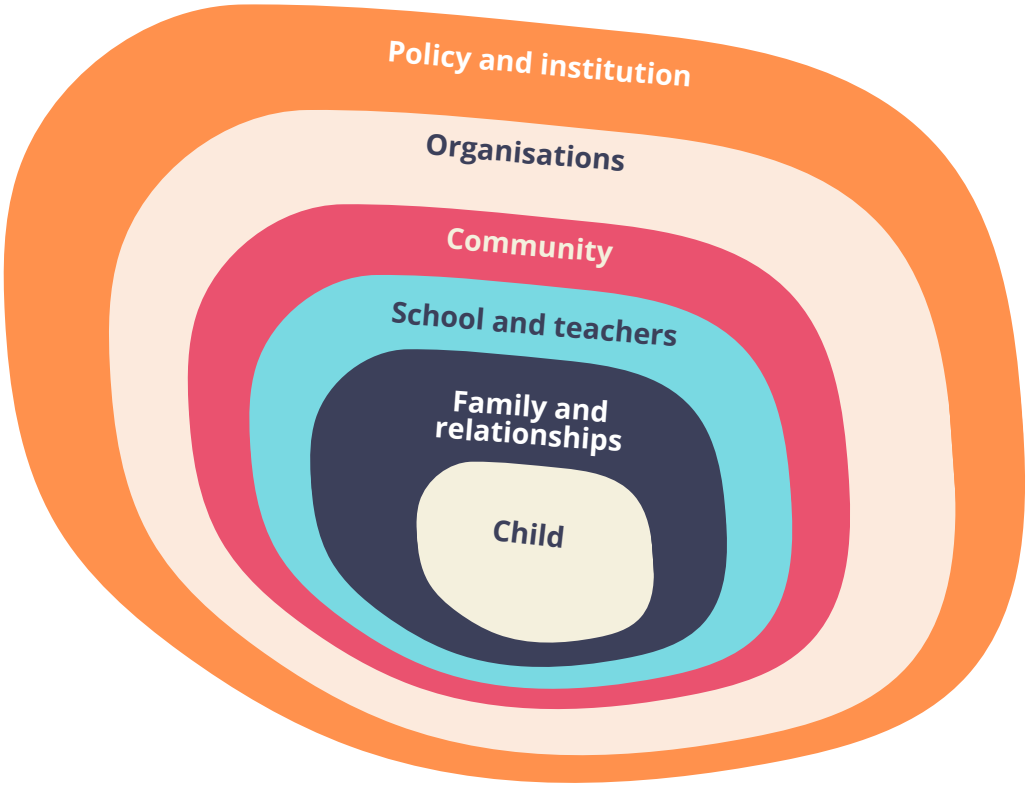


Figure 1: The social ecological framework for understanding children's psychosocial wellbeing in education contexts

Children learn in an environment that is situated within a larger "ecosystem." Their lives and wellbeing are notably influenced by their relationship with families or caregivers; with friends and peers; with teachers and school administrators; and with other community members such as religious leaders. Schools are a critical site of influence, and learners, teachers, and families see the role of education as contributing to holistic wellbeing, human development, and learning that includes both academic and life skills. Such education relies on actors and action in the education system largely, including education and health policies that reflect mental health and wellbeing of children as clearly articulated priorities.

Improving understanding of this social ecology around learners can lead to more relevant and impactful program design and implementation, and provide the building blocks for future study of impact.

The research

This research set out to examine the enabling environments for MHPSS interventions delivered in education settings in humanitarian contexts, with specific focus on NRC's BLP implemented in Kenya and Colombia. The research was underpinned by the following five research objectives, included in Table 1.

Table 1: Research objectives

To understand what contributes to an enabling environment for MHPSS interventions and approaches to improve holistic wellbeing, from the perspective of children, teachers, caregivers, and other education actors.
To understand the role of education systems, including schools (and formal and nonformal programmes), and educators in contributing to children's holistic wellbeing from the perspective of children, teachers, caregivers, and other education actors.
To describe similarities and differences of enabling environments for MHPSS interventions across diverse contexts, including both geographic location and type of emergency or adversity.
To understand how an MHPSS intervention may be useful and relevant in dynamic contexts, such as in the case of education interruptions, and what the role of schools is in supporting children's holistic wellbeing.
To understand the perceived impact of NRC's Better Learning Programme in Kenya and Colombia, in order to contribute to organizational and programmatic learning and implementation.

NRC's BLP is a PSS/SEL programme which can be integrated within education programming. It is NRC's flagship classroom-based PSS intervention for children in crisis affected communities. The BLP is a holistic approach to supporting children's recovery from traumatic events experienced during conflict and from the impacts of displacement on both displaced and host communities, by improving conditions for learning. The programme mobilizes a child's support network of caregivers, teachers, and counsellors, encompassing a multi-layered approach to restore a sense of normality and hope.

The BLP consists of three components of programme intervention. The first, BLP-1, is a general, classroom-based PSS approach targeting all children and young people. The BLP-2 is a small group intervention to support resilience amongst a more specific target group of academic underachievers. The BLP-3 is a specialized PSS approach to address nightmares, which many children experience as a chronic symptom of traumatic stress. Finally, BLP for Youth is a combined intervention integrating both BLP1 and BLP2 implemented through participatory approaches and targets learners 17-24 years old. The implementation of BLP-1 in schools in Kenya (Kakuma Refugee Camp, Kalobeyei Settlement, and Kakuma host community schools) and in five departments of Colombia (Nariño, Magdalena, Arauca, Caquetá and Guaviare), was the focus of study for this research.

BLP was first implemented in 2012 in Palestine and has since grown current implementation to 33 countries worldwide. This implementation is supported by various programmes in each country, as well as by a regional and global level BLP unit. Resources to support country offices in implementing BLP 1 include: Guidance and Tools to Implement BLP 1; a Monitoring and Evaluation/Research Toolkit; and a Classroom Sessions supporting document.

Methods

To achieve the research objectives, the target population for participation in the research included children, teachers, caregivers, implementing organization staff, school administration and boards, community-based education actors, and education officials (at local, regional, sub-national, and national level). The research team collected data at 10 schools across 5 locations in Colombia, and 9 schools in 3 locations in Kakuma, Kenya. The participating learners were aged 5-20 and included internally displaced persons (IDPs), migrants, indigenous, and armed conflict victims in Colombia, and refugees and host community children in Kenya. An overview of research participants is presented in Table 2, below.

Table 2. Research participants overview

Participant Type	Kenya	Colombia	Total
Learner	114	87	201
Teacher	67	68	135
School administration	9	4	13
School Board of Management or Parent Teacher Association	9	--	9
Caregiver	24	35	59
Education stakeholder	3	5	8
Partner Organizations	3	--	3
NRC staff	3	15	18
Totals:	232	214	446

Primary data collection was conducted by a Research Coordinator in each country, supported by Research Assistants or enumerators, and supervised by the Lead Researcher. The methods of data collection included (a) targeted document review; (b) qualitative data collection via key informant interviews and focus group discussions; and (c) introductory and validation workshops with implementers and key stakeholders. Data was analyzed using thematic analysis, completed collaboratively amongst the lead research and all country research coordinators. Data was analyzed to first address all research objectives and country-specific research questions, and then deductively to include additional themes as relevant.

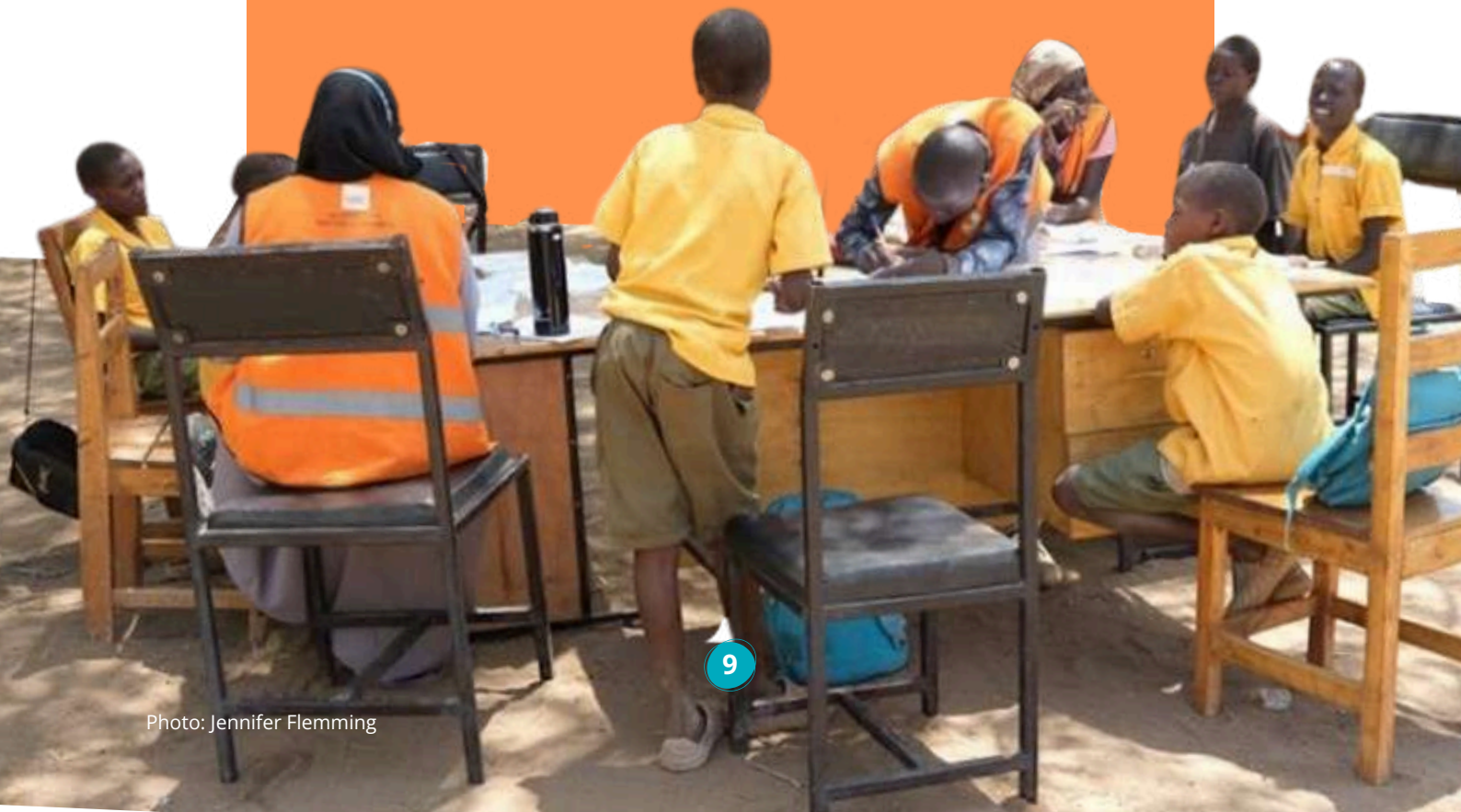


Photo: Jennifer Flemming

Photo: Alejandro Henao Guáqueta

The foundations of an MHPSS intervention: Understanding context

Kenya context: Refugees and MHPSS

Kenya has long been a host to refugees from neighbouring countries; in 2023 the number of registered refugees and asylum seekers within its borders was approximately 655,000.[12] Refugees are spread across three primary camps (Dadaab, Kakuma, and Kalobeyei integrated settlement), and are also integrated into host communities in both urban and rural settings. As of September 2023, Kakuma and Kalobeyei (the sites of this research) hosted approximately 276,000 individuals.[13] Kakuma hosts refugees from South Sudan, Somalia, the Democratic Republic of Congo, Ethiopia, Burundi, Sudan, Uganda, Eritrea, and others. Children make up approximately 55 percent of refugees in Kakuma.[14]

Currently, all camps face challenges related to overcrowding, limited access to basic services (such as healthcare, adequate food, education, and clean water), and poor economic opportunities. Refugees often face significant mental health challenges due to the traumas they have experienced prior to arrival in Kenya, including exposure to violent conflict, displacement, and extreme loss.[15] Many refugees suffer from conditions such as post-traumatic stress disorder (PTSD), depression, and anxiety. These challenges are exacerbated by the uncertainty of their situations, lack of resources, and limited access to healthcare, often leaving affected populations underserved.[16]

The need for MHPSS services for refugees in Kenya is notable, and information related to prevalence of mental health and behavioural problems is lacking. While Kenyan law extends certain rights and protections—including the right to access health services and education—to its refugee residents, there are few official policies that explicitly speak to MHPSS concerns of the refugee population at large.

Colombia context: Ongoing conflict and adversity & MHPSS

Colombia is facing a deep-rooted humanitarian crisis, fueled by internal conflicts since 1958 and resulting in over 2.17 million IDPs by 2022.[17] This crisis has been compounded by the arrival of more than 2.47 million Venezuelan migrants by May 2023.[18] These factors have led to widespread community displacement, poverty, and disruption to daily life. The nation is recognized as the third most neglected in terms of displacement crises globally, as reported by NRC in 2022, with a mere 38% of its funding needs met and dwindling media attention to the conflict.[19] Education has been particularly impacted, with displaced children facing numerous educational barriers and schools in IDP-dense areas struggling with overcrowding and limited resources.

A notable aspect of this crisis is the urgent need for MHPSS programming, particularly for impacted children, adolescents, and the larger educational communities. Prolonged exposure to violence and instability has led to heightened levels of anxiety and depression among children and youth. While Colombian laws mandate mental health care and early detection in schools, there is a significant gap between policy and implementation of such programs, especially in rural and conflict-affected areas. The lack of mental health programming in schools, coupled with the limited reach of state mental health services in many regions, underscores the urgent need for enhanced MHPSS initiatives to address the growing mental health crisis among Colombia's children and youth.

Challenges and risks in context

In humanitarian contexts, there are specific MHPSS risks for children and families. Simultaneously, the dynamic and often fragile nature of the context itself poses challenges for the implementation of both education and MHPSS interventions. While global education actors such as I/NGOs seek to respond to the needs of learners, families, and communities in crisis, contextual differences require adaptable, flexible approaches to assure such needs are met. MHPSS programs in fragile locations must be both context- and conflict-sensitive, underlining the importance of local partnership and leadership within the education system and communities.

In both Kenya and Colombia, this research emphasized that **MHPSS programs need to be accompanied by interventions that help meet the basic needs of the population in order to truly improve mental health and wellbeing.** Schools, and the relationships with trusted adults that are cultivated there, must offer both physical and emotional safety to learners. This includes transportation between home and school.

In addition, there are significant current challenges within the education systems themselves that will persist as obstacles to the success of a school-based MHPSS intervention. **It is critical to consider how an intervention implemented in schools may itself be impeded by those same challenges, such as overcrowded classrooms or barriers to reaching learners with disabilities.** Ultimately, the goal is to effectively and inclusively reach children in the context of these challenges, acknowledging that a specific MHPSS intervention will likely be unable to offer broader, systemic "fixes."

Table 3, below, offers summary of key context-related challenges that were described by research participants in Kenya and Colombia. These include those relevant to the daily lives of residents in each location; the specific challenges that schools and education systems face; the subsequent education risks for learners; the MHPSS risks for those learners; and the challenges to adequate implementation of MHPSS-related services.

Table 3. Specific context-related considerations

	KENYA	COLOMBIA
Context-related challenges	Basic needs often unmet; few livelihood opportunities;	Ongoing conflict and violence; ongoing displacement/ migration; poverty and unmet basic needs; lack of services
School-related challenges	Severely overcrowded classrooms; multiple languages in classrooms; overage learners and multi-age classrooms; lack of adequate learning materials; lack of inclusive access	Danger in travel to/from school; Armed actors around the school; Schools not prepared to receive migrant or refugee students
Education risks for learners	Drop out and nonattendance, especially for youth; early marriage and early pregnancy; child labor	Drop out and nonattendance; Forced recruitment; early marriage and early pregnancy; child labor
MHPSS /Education-system and policy challenges	Policies not implemented or in an insufficient way;	Policies not implemented or in an insufficient way; MHPSS government duties delegated to I/NGOs
MHPSS-related risks for learners	Ongoing stress; past exposure to severe trauma; post-traumatic stress disorder (PTSD), depression, and anxiety	Constant exposure to violence and severe trauma; basic needs unmet; dysregulated adult figures; disruption of social and community networks; modification of family roles; cultural detachment
Challenges for MHPSS-related services	Limited formal services available; most often provided by I/NGOs	Limited or non-existent formal services available; difficult access; most often provided by I/NGOs

Key supporters of learner and community mental health & wellbeing

Significant mental health and psychosocial related risks persist for learners (as well as broader education community members) due to the notable challenges of context. In both Kenya and Colombia, there are national policies and programs related to wellbeing and MHPSS services for learners. The responsibilities of schools to provide such services to learners are established in both education and health policy. In both countries, schools should (by state law) have an available counselor to serve children and their families, as well as detection and referral systems for mental health issues in children. However, in both countries there is a significant gap between what is stated in legislation and what is implemented and accessible in schools.

In Kenya, the research found that the presence of counselors in schools is inconsistent and there is a lot of staff turnover, and in Colombia many of the interviewed schools do not have counselors or have one counselor for hundreds or even thousands of students, and that is the only school related MHPSS service given.

Table 4: MHPSS School Services

	Kenya	Colombia
Availability of counselors in schools	Inconsistent, caused by shortage of qualified staff and significant staff turnover	Many schools do not have one; some schools have one for many students (e.g. one counselor serving 1200-1400 students)
School detection and referral systems	Inconsistently accessed; inconsistently described or understood by school staff and parents/communities	Non-functional

Teachers

I think something important [...] is the trust that we give to the students. Because through trust, they approach us and tell us about the problems they have, the needs they have. what they face daily. what they experience in their homes. So. I think that is the most important thing we can offer them, and based on that, we can give them advice and guide them for their future life. ***Teacher from Nariño, Colombia***

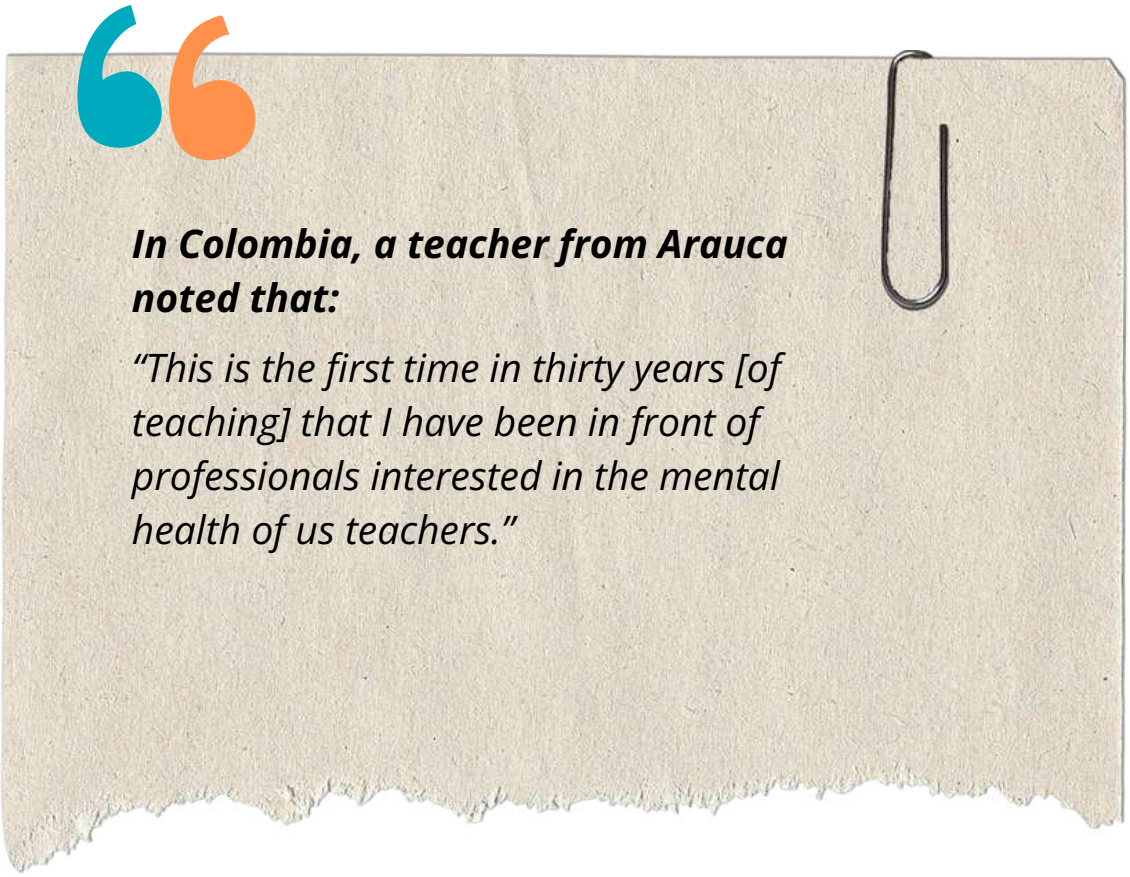
In the absence of sufficient provision of MHPSS services by the state, education actors—often operating at the school or community level—fill this gap. Based on data from both Kenya and Colombia, two key actors are consistently responsible for assuring the holistic wellbeing of learners in their contexts: **teachers and I/NGOs.**

In both Kenya and Colombia teachers are often the frontline of mental health support for learners in their contexts. In both countries, teachers emphasize that an essential component of their job is to support the psychological and emotional wellbeing of their students, in addition to facilitating learning. Caregivers describe believing that their children are safe in school in part due to the trusting, close relationships children have with their teachers. Principals and school administrators note that teachers are relied upon to recognize students with greater mental health needs in order to assure they get the necessary support.

This value of teachers and their critical role in student wellbeing was common in all locations of research. And while teachers describe this role as an essential part of their job, they also note that their own mental health and wellbeing are often impacted by the many demands of their jobs. Teachers commonly described their psychosocial support responsibilities, piled onto their teaching responsibilities, as **extremely overwhelming.** In addition, teachers in both countries are exposed to the same contextual risks as their students, and thus often struggle with similar challenges such as the effects of displacement. Many teachers in Kenya, for example, are refugees themselves; in Colombia, many are victims of (or have been frequently exposed to) armed conflict.

Teachers contend with many school-related challenges while attending to their students' needs such as overcrowded classrooms; lack of sufficient materials and resources; students from different backgrounds or who speak different languages in one classroom; and regular work overload. In one Kakuma refugee camp school, a teacher noted having 189 students in a single classroom.

Despite these risks and challenges, **neither country has formal mechanisms for supporting teacher wellbeing.** Additionally, teachers are not formally trained to provide psychosocial support, despite being the adults most likely to administer to the daily mental health needs of students.



In Colombia, a teacher from Arauca noted that:

"This is the first time in thirty years [of teaching] that I have been in front of professionals interested in the mental health of us teachers."

The realities of context—including adversity faced by teachers and lack of support—diminish both teachers' own wellbeing and the quality of their performance as professionals. NRC seeks to address the role of teachers and caregivers in the wellbeing of learners via its "supporting the supporters" approach. Notably, in Kenya where BLP has been more fully implemented over a longer time period, NRC teachers trained in BLP described the continued professional development and support provided to them. Simultaneously, a notable challenge of implementation in the Kakuma context is high rates of teacher turnover, meaning that such investment in teachers is an ongoing challenge. Still, the positive impacts of investment in teacher capacity and support should be emphasized, a point that is made clear in the positive descriptions of BLP via these teachers. Such description of positive investment in teacher wellbeing was nonexistent in the Colombia research sites.

I/NGO'S

In both Kenya and Colombia, education stakeholders (including principles, school boards, local education officials, Ministry officials) note that **I/NGOs are often the main provider or implementer of MHPSS-specific interventions.**

In Colombia, there was emphasis on the lack of options for MHPSS support broadly. In all schools visited for data collection, BLP was the only MHPSS-related program recognized. NRC staff noted that I/NGO programming is almost always met with approval and support by the Secretaries of Education, but that such support does not extend beyond allowing implementation. This has implications for the sustainability of such programming beyond the presence of I/NGO actors, as well as continuity when such actors encounter funding gaps.

In Kenya, there was slightly greater availability of MHPSS services, and awareness of the general population of how to access support if needed. BLP is administered through both NRC directly in schools, as well as by partner organizations who have been trained to use BLP. At the time of data collection, significant progress had been made across Kakuma to assure BLP is sustainable and effectively implemented by local partners and formal schools. NRC has further worked towards institutionalization of BLP at the national level via training of Ministry of Education staff. Ultimately, the goal is for BLP to be utilized as the overarching SEL approach for Kenya formal schools.

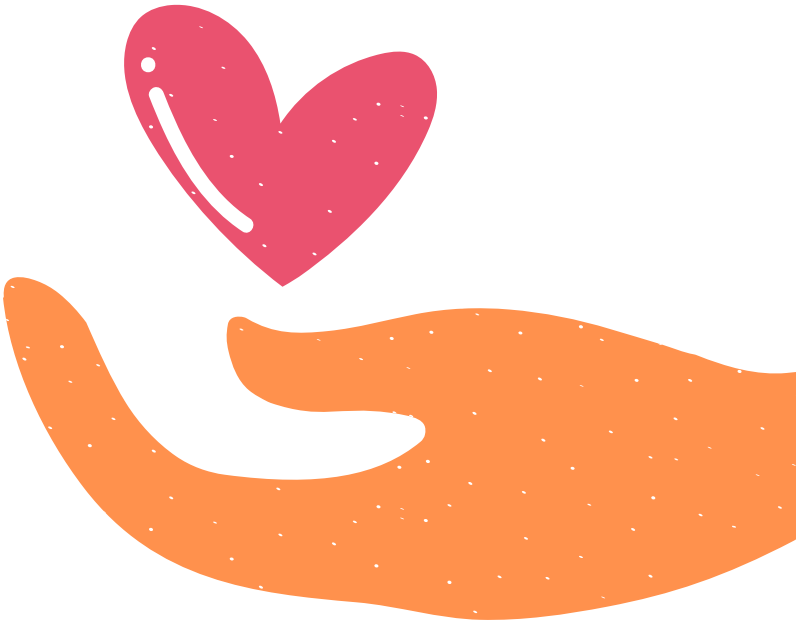


Photo: Jennifer Flemming

MHPSS implementation: Learning from BLP in the field

Perceptions of the impact of BLP

BLP is viewed by all education stakeholders—across both countries and each of the locations within each country—as an important contribution to education programming in that context. Research participants note that its holistic approach, which prioritizes learner wellbeing within schools, is highly relevant and appropriate for learners across the Colombia and Kakuma schools.

Since BLP is implemented in classrooms by teachers, it happens more consistently and reliably than other psychosocial support. This is a key advantage of BLP, according to the research, and underscores the value of prioritizing such programming in education spaces. Teachers and school staff emphasize the usefulness of BLP activities, as well, in providing playful and child-centered activities that differ from the traditional classroom activities. BLP is thus useful **for learning and the establishment of enabling environments for learning.**

In both countries, there was notable description of the ways in which BLP has impacted learners. Perceived outcomes include enhanced emotional awareness and management, with better social emotional skills to cope with stress and calm themselves; and improvements to the overall learning environment, with less conflicts in the classroom and more concentration on learning tasks. Importantly, learning and learning readiness are not a directly targeted outcome for NRC, but were readily described by teachers in both countries as a notable area of impact.

After doing the BLP exercises, my thoughts don't wander. I put bad thoughts aside and am thinking about the exercise. After doing those exercises, the body relaxes and even if I had pain somewhere, I become okay. My brain is operating very well! ***Learner from Kakuma***

The perceived impacts of BLP were described in greater detail and specificity in Kenya, where BLP has been implemented for longer. Still, all types of actors in Colombia—including learners, caregivers, teachers, and other education stakeholders—noted the impact of BLP specifically but also MHPSS programming more broadly for learners. Summary of key perceived outcomes by country are noted in Table 5, below.

As caregivers, we often focus solely on the physical needs of our children. This program has opened our eyes to the importance of their emotional and psychological wellbeing as well. We are now better equipped to support them in all aspects of their lives. ***Caregiver from Nariño, Colombia***

Table 5: Perceived Outcomes of BLP in each country

Perceived outcomes of BLP	
Colombia	Kenya
• Enhanced emotional intelligence and awareness in children • Improved classroom management due to less disruptive behavior and conflict • Positive impact on student wellbeing • Conducive learning environment, including increased engagement and concentration of learners • Holistic development of learners with emphasis on social emotional skills	• Improved strategies for coping with stress and difficult situations • Improved strategies for calming and clearing the mind, which helps focus on the present • Greater satisfaction and happiness while at school • Less conflict with those around them • Better concentration and increased engagement with learning activities in class • Conducive learning environment • Overall improved readiness to learn • Lower school dropout and nonattendance rates

I feel like I can say that BLP was meant for all. It's not just learners. As a teacher when I come to school in the morning and enter the classroom, [sometimes] you find that you are stressed out already… But when you use the BLP techniques for yourself, the stress lessens and you feel much better. I believe that I have to be in a well state of mind before I can deliver anything to my students. ***Teacher FGD in Kenya***

In addition to descriptions of impact, **a notable finding of the research in both countries is that adults that have experienced the value of BLP in their own life are then committed to teaching and transmitting it to learners.** As is noted above, BLP is delivered in school classrooms, and thus its delivery is dependent on the teachers and school administrators. The majority of adult research participants who had been exposed to and understood BLP were enthusiastic about its relevance and potential impact. Often, this was because they had used activities or concepts themselves in order to reduce stress or cope with overwhelming aspects of daily life. Adults—be it teachers, caregivers, or school administrators—thus become a critical enabling factor for implementation of programming.

Contextualization of BLP

Many globally-designed MHPSS programs, like BLP, are designed to provide support, guidance, and tools, with the intention of the programming to be contextualized to be locally relevant and appropriate. **Notably, there is tension between this provision of resources and guidance developed at the global level, and the need for locally-led and contextually relevant programming.** This is especially true with programming such as MHPSS, which is characterized by subjective concepts such as wellbeing and impacted by local norms and perceptions around mental health.

Education actors in both Kenya and Colombia emphasized the value of MHPSS programming broadly, and BLP specifically. **This research emphasizes that there is significant desire for global technical support, especially when it is carried out in collaboration with locally-led action that prioritizes relevance and flexibility.** A key request noted in both countries was continued support and development of guidance on how to contextualize such resources while maintaining their purpose and efficacy.

Importantly, contextualization often happens at multiple phases. First, a broad contextualization helps define and translate terms and concepts in context, as well as to integrate the activities within other programs (noting that BLP is not a standalone program but is instead integrated into other NRC programs, typically education). Secondly —and critical to emphasize—is that contextualization then also happens at the classroom level, by teachers as needed.

In Kakuma, for example, the camp is inhabited by refugees from Sudan, South Sudan, Ethiopia, Somalia, the Democratic Republic of Congo, and others, with an estimated 13-15 different languages spoken across its camps. There are different norms and social customs (and, for example, different gender norms), as well as different perceptions and understandings of mental health. In the Kakuma schools, it is not uncommon for a teacher to have over 100 students in a classroom, with many languages and ages alongside each other. Thus, while there is broad contextualization of BLP to the realities of daily life in Kakuma, there will be additional changes made by teachers based on the specific learners in their classroom each day. Teachers in Kenya noted, for example, the need to select specific BLP activities that were possible to do with limited mobility for when their classrooms bulged to 150 or more students with limited space to move.

In Colombia, each of the research locations included learners of notably different backgrounds, including indigenous communities, migrants and displaced people, and those not displaced but impacted by ongoing conflict and poverty. In Arauca, teachers described the adaptation of BLP activities to reflect indigenous customs and norms. Such adaptation—which was considered to move beyond a more standard contextualization activity—reflected the need to connect with learners around their emotions and psyche in a way that they fundamentally understood.

Photo: Jennifer Flemming

In both Kenya and Colombia, it was observed that the recognition of BLP (whether by name or by the specific activities it includes) impacted how it was perceived. In other words, when learners, teachers, caregivers, and other actors could specifically recognize and describe the program they were more likely to emphasize its value and impact. In Kenya—where BLP is more established—BLP is well recognized by name and its positive impact on learner wellbeing was commonly and easily noted. In Colombia, there were locations where establishing the exact activities of BLP was necessary in order for research participants to comment on their experiences. In these contexts, participants often had a more challenging time describing the exact nature of the impact of these activities. **A potential takeaway from this finding is that an overarching approach is valued and easier to understand, whereas a selection of activities aimed at improved wellbeing may be easy to use, but less readily understood as a cohesive approach.**

Also importantly, there are many context-specific challenges that are critical for MHPSS programs such as BLP aimed at inclusivity. In Kenya, it is absolutely essential to assure BLP activities can be effectively used in overcrowded classrooms; with learners with disabilities; with girls in the context of diverse gender norms; and with overage learners who may perceive activities with young children as less relevant to them. Such challenges for inclusion will become increasingly relevant as BLP is delivered over longer periods of time in increasingly diverse contexts globally.

Photo: Alejandro Henao Guáqueta

Photo: Jennifer Flemming

Key action points

This research is based on a social ecological framework which situates the learner within a broader ecosystem of actors, relationships, and contextual details. In the locations of this research, children's lives and wellbeing are notably influenced by their relationship with families or caregivers; with friends and peers; with teachers and school administrators; and with other community members such as religious leaders. Schools are a critical site of influence, and learners, teachers, and families see the role of education as contributing to holistic wellbeing, human development, and learning that includes both academic and life skills.

Such education relies on actors and action in the education system largely, including education and health policies that reflect mental health and wellbeing of children as clearly articulated priorities. Increased understanding of these priorities—and actionable commitment to them—is required across all levels of actors described above. This importantly includes Secretaries of Education, Ministry of Education, and other policy and decision-makers that influence such policy. It also includes external humanitarian actors, such as implementers from NGOs (both at national and global level) and donors.

This final section offers five key actions aimed at stakeholders closest to schools and implementation, that emphasize the most important learning from the two research contexts. The report concludes with a presentation of enabling factors and recommendations for actors of different levels of the social ecological framework, as Table 6. **Importantly, in order to assure impact of an intervention on the mental health and wellbeing of communities in a given context, a comprehensive approach that involves all actors of the system is required.** For a full explanation of action points and recommendations, see the individual Kenya and Colombia reports.

Action 1

Understand the context you are working in.

Before and during implementation, it is critical to include the perspective and collaboration of local actors. This includes community-led assessment and design. What specific stressors do the community face? How do these stressors impact and interact with the delivery of education? What are the relationships like amongst schools, communities, and other stakeholders? How can a program contribute to ongoing efforts to enhance local capacity?

Action 2

Contextualize.

As is done with BLP, programs need to attend to the specific needs of the communities they are working with, as well as the children in the classroom. This includes contextualization of materials and resources for relevant content and terms; language; cultural norms and beliefs; resources and capacity of the schools and the classrooms; transportation and security; etc. The goal is to find effective balance between standardization of and fidelity to the original program design, and adapting to the assets and needs of local learners and communities.

Action 3

Advocate for fulfillment of MHPSS policy at the systems level.

In humanitarian contexts there may be gaps in provision of services at the national or local level. While there are national level policies relating to MHPSS in both Kenya and Colombia, these policies are not implemented at the school level. It is essential that MHPSS programming includes advocacy with systems-level actors to push for the fulfillment of these policies, and to work together with I/NGO actors in the meantime to ensure full coverage of services.

Action 4

Prioritize professional development and continued support for teachers.

Education actors acknowledge the essential value of ongoing training and professional development of teachers, and connect the provision of such training with teacher wellbeing. Teacher wellbeing is an important outcome to support in and of itself, in addition to how it impacts learner wellbeing.

Action 5

Make trainings experiential and emphasize the value of MHPSS for all.

When adults experience the value of MHPSS in their own lives, they are more effective at delivering MHPSS programs in their classrooms, schools, or homes. Trainings for field staff and teachers —as well as outreach to caregivers and community members— should include experiential activities for adults to practice their own social emotional skills.

Table 6: Enabling factors and suggested actions across the social ecological framework

Enabling factors and key suggested actions

Learner level enabling factors and suggested actions:	• Ensure basic needs are met. • Develop supporting, trusting relationships with learners, teachers, and their caregivers. • Support learners to develop positive relationships with peers. • Support learners to recognize and talk about different emotions. • Engage caregivers in supporting their children at home and in school. • Facilitate active and engaging activities that align with learners' interests. • Ensure that spaces are safe and accessible for all learners. • Provide adequate learning materials for all learners. • Provide opportunities for play and recreational activities (e.g. being in nature, caring for living beings, collaborative play)

Caregiver level enabling factors and suggested action:

- Provide MHPSS for caregivers.
- Ensure active and transparent participation of caregivers in school life.
- Strengthen relationships between caregivers and the wider community.
- Ensure that programs are sustainable and continuous.
- Strengthen relationship between the school and home.
- Promote positive reinforcement and parenting practices.

Teacher and school level enabling factors and suggested action:

- Ensure that schools are physically safe and secure, and that they provide relief from external challenges
- Create environments that are engaging and conducive to learning.
- Provide continuous training and professional development for teachers.
- Prioritize teacher wellbeing.
- Integrate MHPSS and SEL activities into the curriculum.
- Integrate local cultures into programming when relevant.
- Center inclusion and ensure MHPSS activities are relevant for all learners.
- Support adaptation of programmes and materials to meet the assets and needs of learners.

Community level enabling factors and suggested actions:

- Strengthen relationships between schools and wider community.
- Support non-school-aged community members to access MHPSS services.
- Strengthen relationships between the school and other community-based institutions and spaces.
- Provide access to MHPSS for older adolescents and youth.
- Provide access to MHPSS for adolescent girls including young mothers.

Suggested actions for national level implementers:

- Align MHPSS outcomes with the national curriculum.
- Recognize and address the foundational need for basic services and security.
- Contextualize and adapt programs to meet the needs of your setting.
- Center inclusion in MHPSS programs.
- Strengthen coordination between schools and MHPSS services.
- Facilitate dialogue around a shared vision of how schools support wellbeing.
- Include children's own healthy coping strategies in MHPSS programs.
- Develop transparent recruitment processes and provide continued support and professional development for teachers.
- Provide support for teacher wellbeing.
- Actively engage caregivers and the community in MHPSS programming.
- Explore opportunities for resource mobilization and partnerships.
- Collaborate and share resources, learnings, and expertise on MHPSS implementation.
- Develop or support national level guidelines for implementation and contextualization.

Suggested actions for global level implementers:

- Provide sufficient time, support, resource, and guidance for contextualization of MHPSS programs.
- Advocate for integration of MHPSS into policy and curriculum at a national level.
- Center localization in MHPSS programming.
- Ensure sustainability of programming.
- Engage in cross-sectoral collaboration.
- Develop and maintain an effective monitoring and evaluation framework.

Suggested actions for donors:

- Provide more, multi-year and flexible funding for MHPSS programs.
- Fund institutional capacity strengthening.
- Fund multi-sectoral programs.
- Support advocacy efforts for integrating MHPSS into national level policy and strategies.
- Fund continued research on MHPSS programming, with particular emphasis on child-centered and community-led approaches.

Photo: Alejandro Henao Guaqueta

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