FOLLOW THE MONEY

GLOBAL FUNDING OF CHILD AND FAMILY MHPSS ACTIVITIES IN DEVELOPMENT AND HUMANITARIAN ASSISTANCE

THE MHPSS COLLABORATIVE
FOR CHILDREN & FAMILIES IN ADVERSITY

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Cover photo: Angelis*, 13, Kendris*, 14 and Anderson*, 13, live in an informal settlement in Maicao, Venezuela. (Photo: Jenn Gardella/Save the Children)

* Indicates name has been changed

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About the MHPSS Collaborative

The MHPSS Collaborative is a global platform for research, innovation, learning and advocacy in the field of Mental Health and Psychosocial Support (MHPSS). We convene key stakeholders – from children and families with lived experience to service providers, researchers, and policymakers – to work together for children's mental health and wellbeing. We develop and share knowledge on the latest innovations and research in MHPSS in fragile and humanitarian settings. We advocate to ensure donors and decision makers hear the voices of children and families and prioritize policy and funding for MHPSS.

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INTRODUCTION

Conflicts, protracted crises, natural, and man-made disasters, pandemics, and other adversities have significant acute and long-term impacts on the mental health and wellbeing of children, young people, and families. In 2019, 426 million children were living in a conflict zone (Save the Children, 2021), exposing them to violence, atrocities, distressing events, and chronic stress. Without adequate support, these children are at risk of lifelong effects on their physical and mental health and wellbeing (Slone & Mann, 2016) and particularly on their ability to learn, grow, and develop.

The scale of the global mental health crisis among children and young people is alarming. A 2019 study of the global burden of disease (UNICEF, 2021b) showed that an estimated 13% of adolescents aged 10–19 live with a diagnosed mental disorder, representing 80 million adolescents aged 10–14 and 86 million adolescents aged 15–19. The World Health Organization (WHO) also found in 2019 that one in five people (22%) in conflict-affected contexts has a mental health condition – a much higher percentage than the ; global average prevalence rates (1 in 14 people, or 7%) (Charlson, et al., 2019). The social and economic impacts of the global mental health crisis are enormous; a new analysis by the London School of Economics commissioned by UNICEF estimated that the lost contribution to national economies due to mental disorders among young people amounted to nearly US$390 billion a year (UNICEF, 2021b).

Early intervention and ensuring mentally healthy environments are necessary to secure not only children's mental health, but also their physical health, learning, and earning potential (UNICEF, 2021b). Solutions exist for rebuilding lives and societies, that include mental health and psychosocial support (MHPSS) as both life-saving and critical to restoring the functioning of families and societies. The term mental health and psychological support (MHPSS) was coined in 2007 with the publication of the IASC MHPSS Guidelines for MHPSS in Emergency Settings. It is a composite term reflecting a continuum of care interventions, aiming to safeguard or promote psychosocial wellbeing and prevent or treat mental disorders (UNICEF, 2021a). Despite the existence of evidence-based interventions, there is a lack of accessible, high-quality MHPSS services for children, young people and families in adversity – and across the humanitarian, peacebuilding and development nexus – with a myriad of barriers to achieving scale, including stigma, lack of financing in health budgets, siloed care, and lack of skilled workforce capacity, to name a few.

2018 and beyond: a global shift for MHPSS?

The years 2018 and 2019 saw unprecedented interest in MHPSS from key actors within the international community. A sequence of international high-level events took place in 2018, including the Wilton Park Dialogue hosted by DFID and Save the Children; the Rebuilding Lives conference for children impacted by conflict hosted by UNICEF and BMZ; the first ever standalone event on global mental health hosted by Bahrain, Belgium, Canada, Ecuador and the Netherlands at the 73rd session of the UN General Assembly; the first Global Ministerial Mental Health Summit hosted by the UK; and the launch of the Lancet Commission on Global Mental Health and the Sustainable Development Goals.

In 2019, the Netherlands hosted the second Global Ministerial Summit entitled "Mind the Mind Now". The summit focused on MHPSS in crisis situations, and, through a global inter-agency child and adolescent working group, produced a set of recommendations to improve the scale and quality of child and family MHPSS. See Figure 1 below for a timeline of key events in 2018 and 2019 highlighting the importance of MHPSS in global discourse.

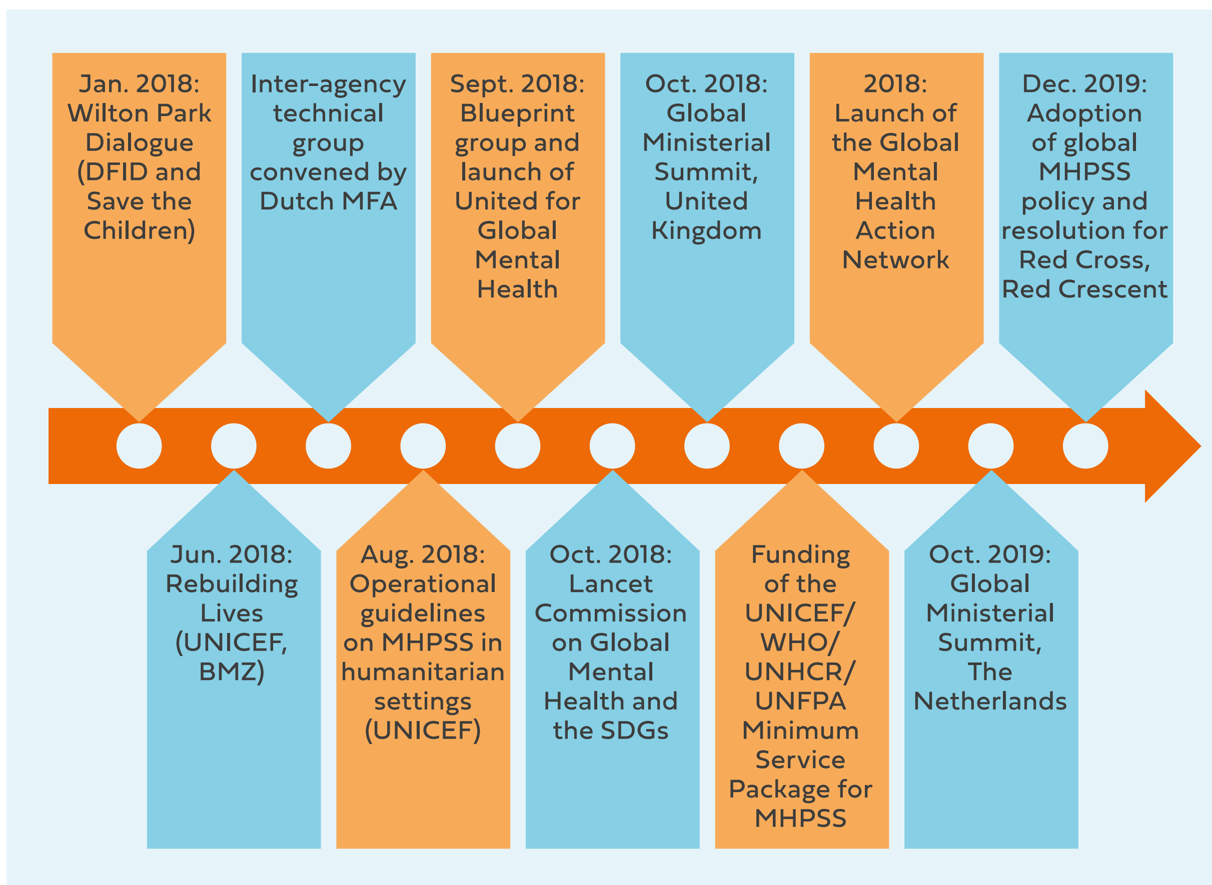

Figure 1 – Timeline of MHPSS advocacy events 2018–2019

The COVID-19 pandemic furthered the momentum and attention to the mental health and wellbeing needs of children, young people, and families, with recognition from UN Secretary-General António Guterres that "vulnerability and mental health problems are part of our collective human experience and should be treated as seriously as physical health issues, including during a global pandemic (United Nations, 2020; UN Secretary-General, 2021).

The question remains whether this increase in focus has been matched by financial commitments and actual spending. There is a lack of clarity regarding humanitarian and development financing for child and family MHPSS as donors do not report how much they allocate to this area of work. MHPSS activities are often integrated within funding allocated for broader education, health or protection activities, with the unique costs of MHPSS programme components remaining unspecified. Without the possibility of tracing MHPSS funding, it is unclear whether the commitments made towards better support for the mental health and wellbeing of children, youth, and families in crises are matched by action. In addition, it is difficult to know what impacts an increase in funding and prioritisation for MHPSS may have on wellbeing outcomes across health, protection, education, and other sectors for children and young people.

PHOTO: CLAIRE THOMAS/SAVE THE CHILDREN

Children taking part in a play and learning programme at a camp for Syrian refugees in northern Iraq.

Rationale and purpose of the study

The MHPSS Collaborative recognises the need to better track the amount of financing for child, youth and family MHPSS. The aim of this study is to get a picture of the international aid provided to activities that support the mental health and wellbeing of children, youth, and families in crisis. This study provides estimates of the grants – ODA and private development finance – allocated in whole or in part to projects providing child and family (CF) MHPSS.

The present study is a follow-up to a previous study we published in 2019 (The MHPSS Collaborative, 2019) examining the proportion of ODA grants – including both development and humanitarian funding – and grants from private development finance invested in child and family MHPSS over the period 2015–2017. This study found that on average, less than 0.5% of international aid was allocated to CF MHPSS, with only US$279 million of funding received in 2017 (The MHPSS Collaborative, 2019).

The present study provides a picture of Official Development Assistance (ODA) grants and private development finance grant investment to child and family MHPSS for the period 2018–2019. It is based on data sourced from the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee's (DAC) Creditor Reporting System (CRS) database and uses and utilizes a more refined methodology for identifying and tracking MHPSS programmes, particularly those integrated within other sectors. It is important to note that data is not yet available for 2020–2021, but an analysis of proportion of funding for these years utilizing the current methodology may provide insight into the impact of attention to MHPSS during COVID-19 and the consequence of a protracted pandemic on proportion of financing for CF MHPSS.

KEY CONCEPTS AND APPROACHES IN MHPSS FOR CHILDREN AND FAMILIES

MHPSS for children and families (CF MHPSS) are interventions and approaches that aim to 1) reduce and prevent harm to mental health and wellbeing, 2) strengthen resilience to recover from adversity, and 3) improve the care conditions that enable children and families to survive, develop and thrive (UNICEF, 2019).

For the purpose of this study, we define "child" as every human being aged 0–18 years, inclusive of children and adolescents. "Family" is a socially constructed concept, it includes children and siblings living with one or both biological parents, or other caregivers such as grandparents, foster parents, and extended family members. The study also considers MHPSS interventions for youth who may include individuals older than 18 years. MHPSS activities focusing on "women and girls" or specific vulnerable groups with a focus on children are also included in the study.

CF MHPSS interventions aim to reduce risks and strengthen protective factors for the child, family/caregiver and community according to the social ecological model (see Figure 2 on page 7). This model incorporates a developmental perspective, strengthens the wellbeing of children and their caregivers, promotes recovery and resilience at individual/family/community levels and provides children and families with safety, stability and nurturance (UNICEF, 2018).

According to UNICEF, "wellbeing describes the positive state of being when a person thrives. It results from the interplay of physical, psychological, cognitive, emotional, social and spiritual aspects that influence a child's and adolescent's ability to grow, learn, socialise, and develop to their full potential. Resilience is understood as 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 the pattern of risk and protective factors in their social and cultural environments" (UNICEF, 2015; UNICEF, 2018).

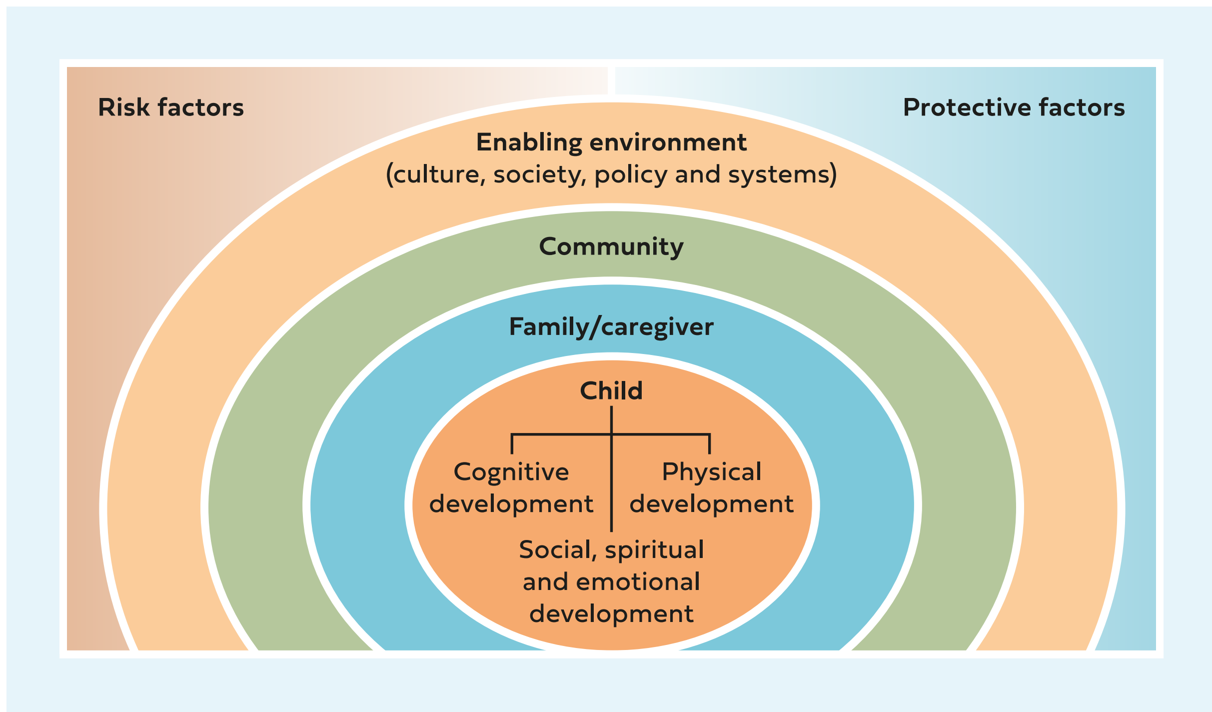

Figure 2 – The social ecological model (UNICEF, 2021a)

MHPSS interventions take many forms to meet all kinds of needs. They encompass therapeutic interventions and care, including by psychiatrists and psychologists, but also activities that contribute to psychosocial wellbeing that are not necessarily led by mental health professionals, such as support and self-help groups, social and emotional learning activities, and positive parenting

PHOTO: EVAN SCHUURMAN/SAVE THE CHILDREN

Majuma and her 18-month-old son fled from Northern Rahine State, Myanmar, and now live at a makeshift settlement in Bangladesh.*

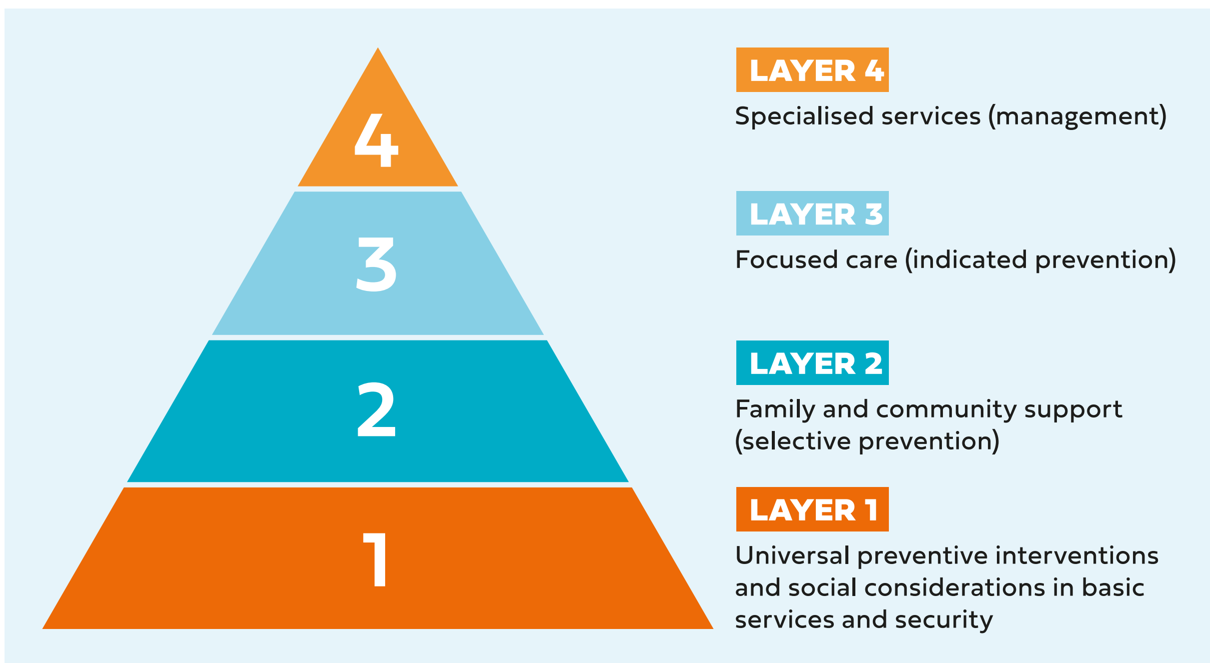

Figure 3 – Intervention pyramid for MHPSS in emergencies (UNICEF, 2021a)

programmes. As described by the Inter-Agency Standing Committee (IASC) in its intervention pyramid for MHPSS in emergencies (Figure 3), MHPSS can be conceptualised in terms of four layers of intervention, from social considerations in basic services and security and family/community supports to more focused or specialised care – all equally important. MHPSS interventions often strive to be multi-layered and inter-sectoral, so although some interventions may focus on activities targeted at one or two specific layers, they interface with other layers for a coordinated system of MHPSS services with referral throughout the various layers of the pyramid.

METHODOLOGY

The present study aims at providing a picture of Official Development Assistance (ODA) grants and private development finance grant investment to CF MHPSS for the period 2018–2019. It is based on data sourced from the Organisation for Economic Cooperation and Development (OECD) Development Assistance Committee's (DAC) Creditor Reporting System (CRS) database (OECD, 2019). ODA is official financial support, concessional in character, that promotes the development and welfare of developing countries in areas such as health, sanitation, education, infrastructure, strengthening tax systems and administrative capacity. ODA can take the form of grants or soft loans, and is provided by official agencies, including state and local governments or by their executive agencies, to countries and territories on the DAC List of ODA Recipients (bilateral ODA to developing countries) and to multilateral development institutions. This study looks at standard grants exclusively. ODA grants are defined as transfers made in cash, goods or services that are provided free of interest and for which no repayment is required. Financial flows mentioned in this study are in US$ constant prices with 2018 as the base year. Please see Box 1 below for further explanation of ODA funding.

BOX 1 Definitions

Commitment: As per the OECD definition "a commitment is a firm obligation, expressed in writing and backed by the necessary funds, undertaken by an official donor to provide specified assistance to a recipient country or a multilateral organisation (OECD, 2022).

Disbursement: "A disbursement is the release of funds to or the purchase of goods or services for a recipient; by extension, the amount thus spent" (OECD, 2022).

Channel of delivery: The channel of delivery is the first implementing partner, the entity that has implementing responsibility over the funds.

This study provides estimates of the grants – ODA and private development finance – allocated in whole or part to projects providing CF MHPSS. As MHPSS activities are integrated across sectors, funding "specifically" or exclusively for CF MHPSS activities cannot be estimated. Therefore, this study examines funding targeted to or allocated partly to CF MHPSS, or funding for projects providing CF MHPSS within different sectors.

The full methodology is provided in Annex A, but the sections below describe how we tracked and analysed MHPSS interventions for inclusion in the study, and the limitations of the study.

How did we track funding for MHPSS interventions?

The tables below clarify which CF MHPSS interventions are tracked and included in the present study. The tables were developed through consensus of the technical advisory group for this study and define how each layer of the pyramid is understood, relevant to specific types of MHPSS approaches and services implemented in emergency settings.

As MHPSS activities are usually integrated into activities in different sectors, it has not been possible to delineate the funding that has been exclusively dedicated to CF MHPSS; we therefore speak of funding targeted or allocated partly to CF MHPSS, or funding for projects providing CF MHPSS in different sectors.

LAYER 1: SOCIAL CONSIDERATIONS IN BASIC SERVICES AND SECURITY
• Advocacy for basic services delivery that fosters inclusive, participatory processes in community engagement, gives attention to special considerations in the sociocultural context (e.g., cultural beliefs, power structures, gender relationships, help-seeking behaviours, the role of traditional healers), and ensures that appropriate services reach the most vulnerable children and families. – This study includes programmes described in the database as involving efforts to ensure that basic services and security are delivered in a way that is sensitive to children's developmental needs, reaches vulnerable children and families and is attentive to participation and safeguarding issues. • Preventative interventions and awareness raising on mental health and psychosocial wellbeing, psychosocial issues, information about availability and access to support and care services through schools and community platforms. – Awareness-raising activities on mental health and psychosocial wellbeing are included in the study only when focusing specifically on children, youth, their caregivers and families.

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LAYER 2: FAMILY AND COMMUNITY SUPPORTS

- Structured psychosocial activities in safe spaces for children, adolescents, youth and women (child friendly spaces, adolescent peer-to-peer groups, youth clubs).
  - The mere establishment of such spaces is not considered as an MHPSS intervention. The study focuses on tracking funding for structured group MHPSS activities within these spaces.
- Supportive, creative, cultural, recreational and sports activities for children that also engage their families and community members.
- Enhancing parental competence, positive parenting training, responsive/nurturing caregiving and information to parents, caregivers and teachers on stress reactions, positive coping strategies and recovery.
- Supporting social and emotional learning and safe and healing learning spaces for children and adolescents.
- Promoting social support networks and support groups for parents (mothers and fathers), other caregivers and teachers and self-help groups for children, youth, and families.
- Safe spaces and counselling for mothers and fathers, adolescent mothers and lactating women. Information and support on nurturing care, attachment, skin-to-skin attachment, mother-child bonds and relationships, mother-baby friendly spaces, baby-friendly spaces, stimulation programmes and early childhood development programmes.
  - Early childhood development programmes that do not make any explicit reference to MHPSS and/or socioemotional skills, responsive care, nurturing care, or early stimulation are not included in this study.
- Family visits carried out with community volunteers or community health/social service workers offering information, supportive listening and referral to needed resources.
- Activation of community support mechanisms: community-based child protection committees, para-health workers and support to traditional structures for healing.
  - These activities are also less visible and difficult to track in the database.
- Communication on positive coping skills and resilience: Life skills for adolescents, for example.

LAYER 3: FOCUSED (NON-SPECIALISED) CARE

- Psychosocial competence training (basic psychosocial skills, psychological first aid, active and empathic listening) for childcare providers (e.g., volunteers, staff, parents/caregivers, teachers), and older children and adolescents, for example WHO's Basic Psychosocial Skills package for COVID-19 responders and psychological first aid for child caregivers, child-to-child psychological first aid.
- Non-specialised mental health care, emotional support and psychosocial support provided by trained and supervised staff. For example, psychoeducation, basic counselling or mentoring, empathic listening and help with problem-solving, conflict resolution.
- Scalable psychological interventions for groups or individuals, such as problem management plus, group interpersonal therapy, thinking healthy (a support intervention for mothers with post-natal and perinatal depression and early adolescent skills for emotions.
- Structured individual and group support and networks facilitated by trained and supervised workers for survivors of particularly distressing events or with particular vulnerabilities (e.g., survivors of gender-based violence or torture, child or youth-headed households and children associated with armed forces and armed groups (CAAFAG)).
- Building capacity in schools to provide MHPSS to children in distress, with mental, neurological, and substance use disorders or disabilities – including identification and referral of at-risk children.

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LAYER 3: FOCUSED (NON-SPECIALISED) CARE *continued*
• Hotlines for responding to mental health concerns. – Only if specific to child, adolescent and caregiver mental health and psychosocial wellbeing. • Referral mechanisms to MHPSS services or services that support mental health care and psychosocial wellbeing at all layers of the pyramid (from social considerations in basic services to specialised services as needed). – These activities are also less visible and difficult to track in the database. • Outreach and case management for complex cases and vulnerable children provided by trained social service providers. – Although a protection activity, MHPSS is woven into all forms of case management for CAAFAG, unaccompanied asylum-seeking children, child protection case management, child survivors of sexual abuse, children with disabilities, etc. • Rehabilitation and reintegration of children in particular circumstances or survivors of distressing events (survivors of sexual violence, CAAFAG, failed asylum seekers). – Many rehabilitation activities are paired with vocational programmes, livelihood support and economic support. Programmes that do not provide any details on the rehabilitation activities implemented and with no explicit reference to MHPSS and socioemotional support are not included in the study.
LAYER 4: SPECIALISED CARE provided by professional mental health workers
• Specialised psychological and mental health interventions for children, youth, and families: clinical mental health services, psychological and/or psychiatric treatment, individual, family and group clinical counselling, interventions for alcohol/substance use problems, psychotherapy, non-pharmacological and pharmacological management of mental disorders • Building capacity and support/supervision (by professional mental health providers) for mental health and social service professionals: schools psychologists/counsellors, clinical social workers. • Promoting quality standards for clinical care of mental, neurologic, and substance use disorders in inpatient and outpatient settings (such as, Mental Health Gap Action Programme training for health and mental health care providers).
OTHER & CROSS-CUTTING
• System and capacity-building activities related to CF MHPSS • Coordination activities related to CF MHPSS • Assessments and research for CF MHPSS

Table 1 – Key CF MHPSS interventions tracked and identified in the study

For each financial flow categorised as CF MHPSS, the research team added a marker or tag: "partial focus on CF MHPSS" or "primary focus on CF MHPSS". Projects tagged "primary focus" are projects that, based on information provided, solely target mental health and psychosocial wellbeing of children, adolescents and their families in activities and/or outcomes and where funding is presumed to be fully dedicated to CF MHPSS activities.

Examples:

Primary focus on CF MHPSS	• "Psychological support for former street children" • "Training of psychotherapists in child psychotherapy, supervision, animal therapy, horticulture therapy" • "Promoting the psychosocial wellbeing of children among the Palestine refugee population in the Gaza Strip"
Partial focus on CF MHPSS	• "Access to quality education and psychosocial support for IDPs and host community children and adolescents in Benghazi" • "Strengthening access to high-quality educational, sport, art, recreational and psychosocial activities for vulnerable children living in the Nablus district and for their families by using an inclusive, cross-cultural approach" • "Grassroot Soccer are looking to use a football curriculum to support adolescents that test positive for HIV with information around treatment, adhering to medication and psychosocial support. The programme aims to deliver messaging through football and then support youth through a year-long support group before empowering them to take care of their status and adhere to treatment moving forward."

Table 2 – Examples of primary or partial focus on CF MHPSS

Limitations of the study

This study provides estimates of ODA and private development finance grants invested in projects primarily or partially providing MHPSS to children and families. It is important to bear in mind the following caveats and limitations:

- The study is limited to the data reported by DAC data submitters for the years 2018 and 2019.
- The study is limited to standard ODA grants and standard grants from private development finance and therefore does not include funding from private individuals and other funding sources unreported to the OECD database.
- The study is limited to the following selection of sectors ("purpose codes"): Education, Health, Population Policies/Programmes & Reproductive Health, Government & Civil Society, Other Social Infrastructure & Services, Other Multisector, Development Food Assistance, Emergency Response, Reconstruction Relief & Rehabilitation, Disaster Prevention & Preparedness, and Refugees in Donor Countries.
- Using keyword searches as a methodology involves a certain level of subjectivity inherent to the choice of keywords and selected criteria for data isolation and selection. Sole keywords in English, French and Spanish were used. A limited number of projects with documentation in Dutch, Polish and Catalan were also detected by the search and included in the analyses (even though the keywords had not been translated into these languages.

- The identification of funding for CF MHPSS is limited to the information provided by the dataset and submitters. In some instances, additional information on projects was collected online. Some projects were not considered due to lack of details and information, in particular projects referring to the rehabilitation or reintegration of children, early childhood development, or child friendly spaces, with no explicit reference to MHPSS activities. Likewise, peace-building activities, camp activities and mine victim assistance activities that did not explicitly refer to MHPSS and to the potential psychological component of their programme were not included.

In addition, improving the methodology with more specific inclusion criteria means that the data from the present study is not directly comparable with the data from the previous study. Changes to the methodology are described in more detail in Box 2 below. Although data aren't directly comparable with respect to sectors, etc., where possible we have made comparisons in the findings on these topics.

BOX 2 What changed in our methodology since our analysis of 2017 funding?

The overall methodology was similar in the two studies, but the approach to what was classified as CF MHPSS was more thoroughly and specifically defined in the present study. As an example, rehabilitation and reintegration programmes, for instance for CAAFAG, were assumed to include an MHPSS component and therefore included as MHPSS activities in the 2017 study, but the present study only classified rehabilitation programmes as CF MHPSS if an MHPSS activity was explicitly mentioned in the project description in the database. Likewise, in the previous study, the mere establishment of child-friendly spaces and safe spaces was considered an MHPSS activity, whereas these were included in the present study only if structured MHPSS activities were provided in these spaces. The present study also increased attention to socio-emotional skills within programmes, especially within projects focusing on life skills or sports, as MHPSS activities often encompass approaches that aim to improve self-esteem and self-confidence. Keywords were also added in this study, such as: emotion, skin-to-skin, breastfeeding, conflict resolution, empathic listening, responsive care, nurturing, self-harm and suicide, as social and emotional learning and early adolescent skills for emotions.

Another important change is the categorisation of funding by sectors. In the previous study funding was categorised as: "CF MHPSS", "CF MHPSS & Training", "CF MHPSS & Education", "CF MHPSS & Protection" "CF MHPSS integrated/component (CF focus)" and "CF MHPSS integrated/component (larger focus group, larger intervention) – a classification that lacked clarity. The present study utilises a more intuitive classification of CF MHPSS projects by sectors; as well as a marker for "primary or partial focus".

OVERVIEW OF CF MHPSS FUNDING

This section provides the study findings for commitments and disbursements from both ODA and private development finance to CF MHPSS from 2018–2019.

ODA and private development finance grants for CF MHPSS (2018–19)

The findings from the current study show a positive trend in financing for CF MHPSS; however, overall funding for CF MHPSS is a very small share of ODA and private development finance grants in both the previous and current study. In total, the present study found that **US$ 392.1 million in grants from ODA and the private sector was disbursed on projects providing CF MHPSS in 2018**. This figure increased by 36% to US$ 533.1 million in 2019. This indicates an overall positive trend for CF MHPSS funding from the previous study which found that US $279 million was disbursed for CF MHPSS in 2017.[1]

	Commitments (US$ million)	Disbursements (US$ million)
2018	**512.82**	**392.13**
ODA Grants	389.15	352.95
Private Development Finance	123.67	39.18
2019	**461.11**	**533.13**
ODA Grants	419.11	468.28
Private Development Finance	42.00	64.84
Total	**973.94**	**925.25**

Table 3 – Grants for CF MHPSS: ODA and private development finance commitments and disbursements (constant 2018 prices) – based on OECD DAC CRS database

1 Data between 2017 (previous study) and 2018–2019 (present study) are not directly comparable due to some differences in methodology (see Box 1). The 2017 study had less strict criteria for inclusion which might have led to an overestimate of spending. The true increase in spending between 2017 and 2019 is therefore likely to be even larger than these estimates suggest.

The study found that important commitments to CF MHPSS were made in 2018, with a total of US$ 512.8 million of grants from ODA and the private sector combined. In 2019 commitments to projects providing CF MHPSS amounted to US$ 461.1 million. The high-profile events that occurred in 2018 (see Introduction) brought unique attention to MHPSS and may have favourably influenced this increase in commitments.

Donors, however, did not increase their commitments in 2019 (US$ 461.1 million), although that year saw an increase in disbursement, possibly reflecting multi-year commitments made in 2018 that were spent over the two years.

Grants with a primary focus on CF MHPSS

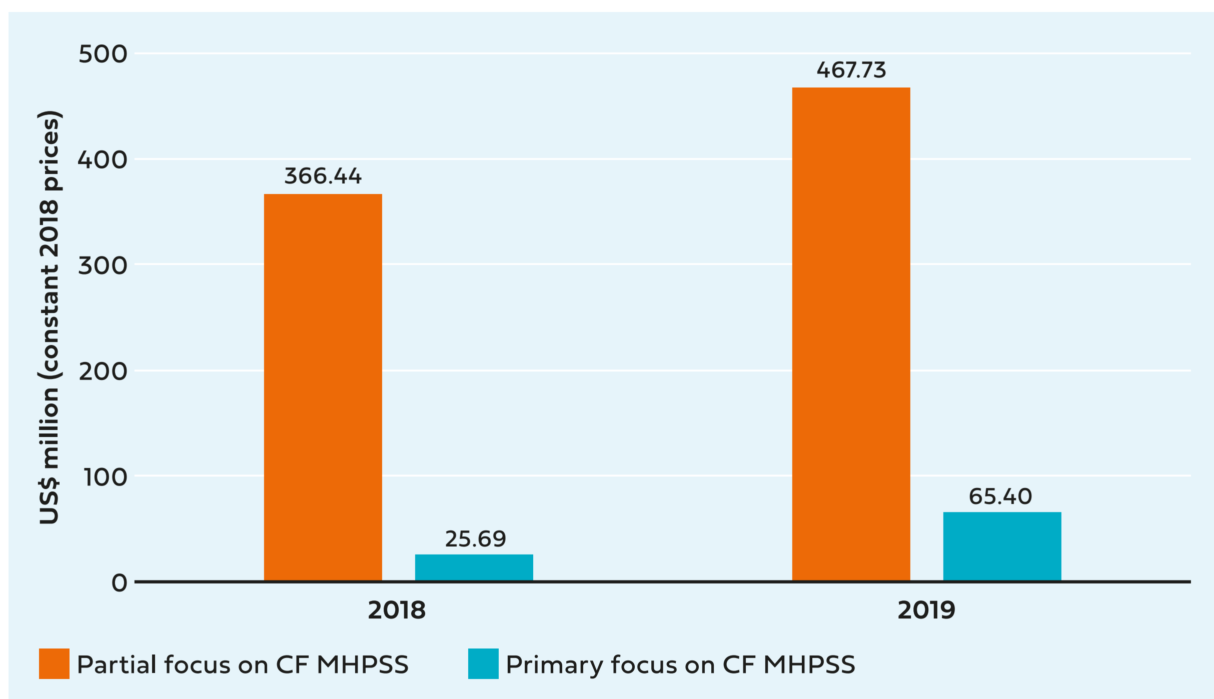

Figure 4 – Partial and primary focus on CF MHPSS/ ODA and private development finance disbursements for CF MHPSS, total over 2018–2019 – based on OECD DAC CRS database

Funding within most grants tracked in this study represents CF MHPSS programming integrated within larger multisectoral or sector-specific projects, rather than funding solely for CF MHPSS programming. It is estimated that the total private and ODA funding dedicated specifically to projects with a primary focus on CF MHPSS **amounted to US$ 25.7 million in 2018, or 7% of the total CF MHPSS funding. In 2019, this share increased to almost US$ 65.4 million (12%)**, showing an increase in donors' interest in addressing the MHPSS needs of children and families. Most of the projects with a primary focus on CF MHPSS were found in the education and health sectors.

ODA GRANT SPENDING ON CF MHPSS

ODA grants commitments and disbursements

The amount of ODA funding spent on CF MHPSS has increased year-by-year, with US$ 267 million spent in 2017, US$ 352.9 million spent in 2018, and US$ 468.3 million in 2019 (including both projects with a primary and partial focus on CF MHPSS).

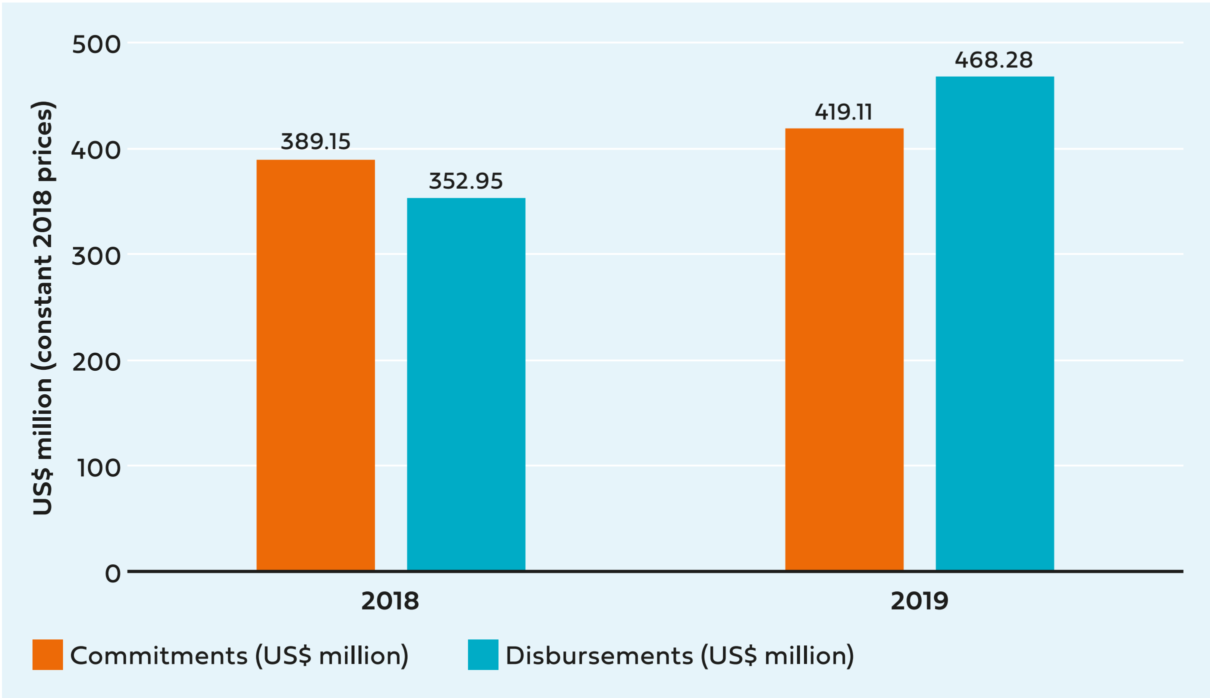

Figure 5 – ODA for CF MHPSS: disbursements – based on OECD DAC CRS database

While the absolute amount of funding increased, **the proportion of overall ODA funding for CF MHPSS remained low, representing only 0.24% of ODA standard grants in 2018 and 0.1% in 2019**. The increase in ODA funding to CF MHPSS could therefore be explained by an increase in total net ODA disbursed by donors in 2018 and 2019.

This shows a positive trend as compared with the share of CF MHPSS as part of overall ODA grants in 2015 (0.14%), 2016 (0.15%) and 2017 (0.18%), but the

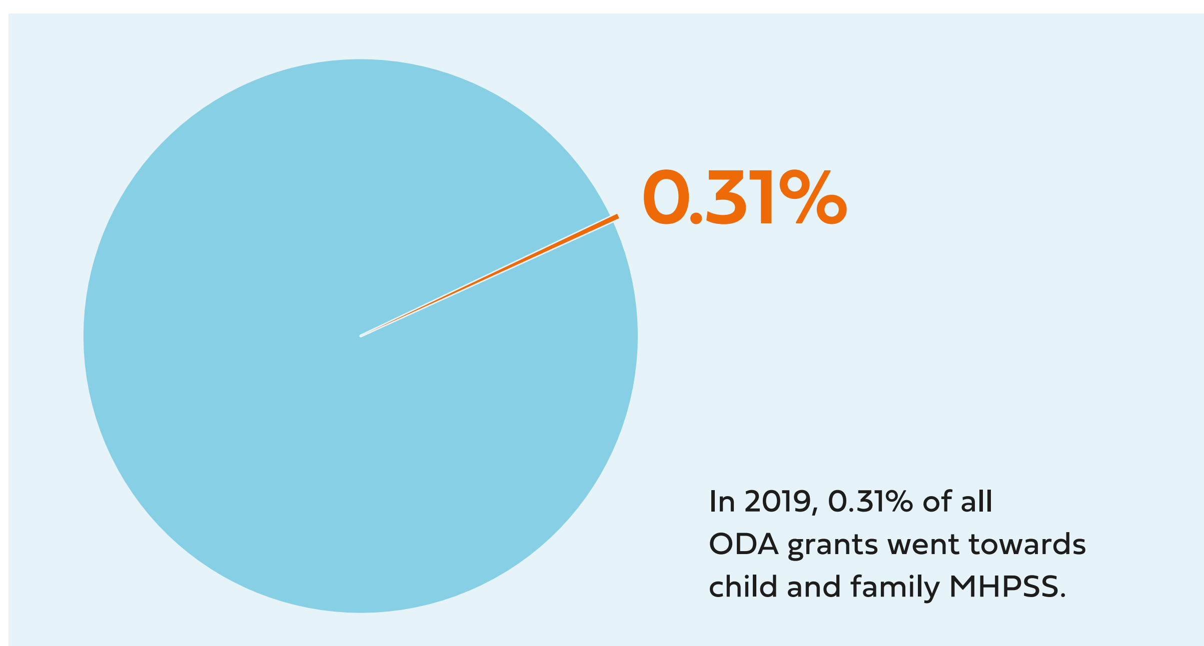

Figure 6 – Percentage of ODA grants for CF MHPSS

increase is only marginal as compared with the prioritisation of MHPSS that donors were promising in high-level events such as the two inter-ministerial summits on mental health hosted by the UK in 2018 and the Netherlands in 2019 (Government of the Netherlands, 2019).

Recipients

Over 2018–19, ODA grant spending on CF MHPSS was primarily concentrated in two geographical areas in countries defined as low-to-middle income countries (LMICs):

- South of Sahara with 42% of total spending according to the database, but more particularly countries in middle and eastern Africa: Tanzania, the Democratic Republic of Congo (DRC), and Ethiopia.
- Middle East with 30% of total spending identified, and mainly in Jordan, Syria, and Iraq.

This indicates a shift in regional focus compared with data from the previous study, in which the Middle East represented 52% of the share of CF MHPSS funding in 2017. This may be explained by the protracted nature of the Syria regional crisis, which topped the spending in 2017 but may have suffered from donor fatigue as the conflict approached its 10-year mark (CARE, et al. 2018). The worsening of crises in the Central Sahel and Great Lakes regions over 2018–2019 may further explain an increase in donor attention to the South of Sahara region.

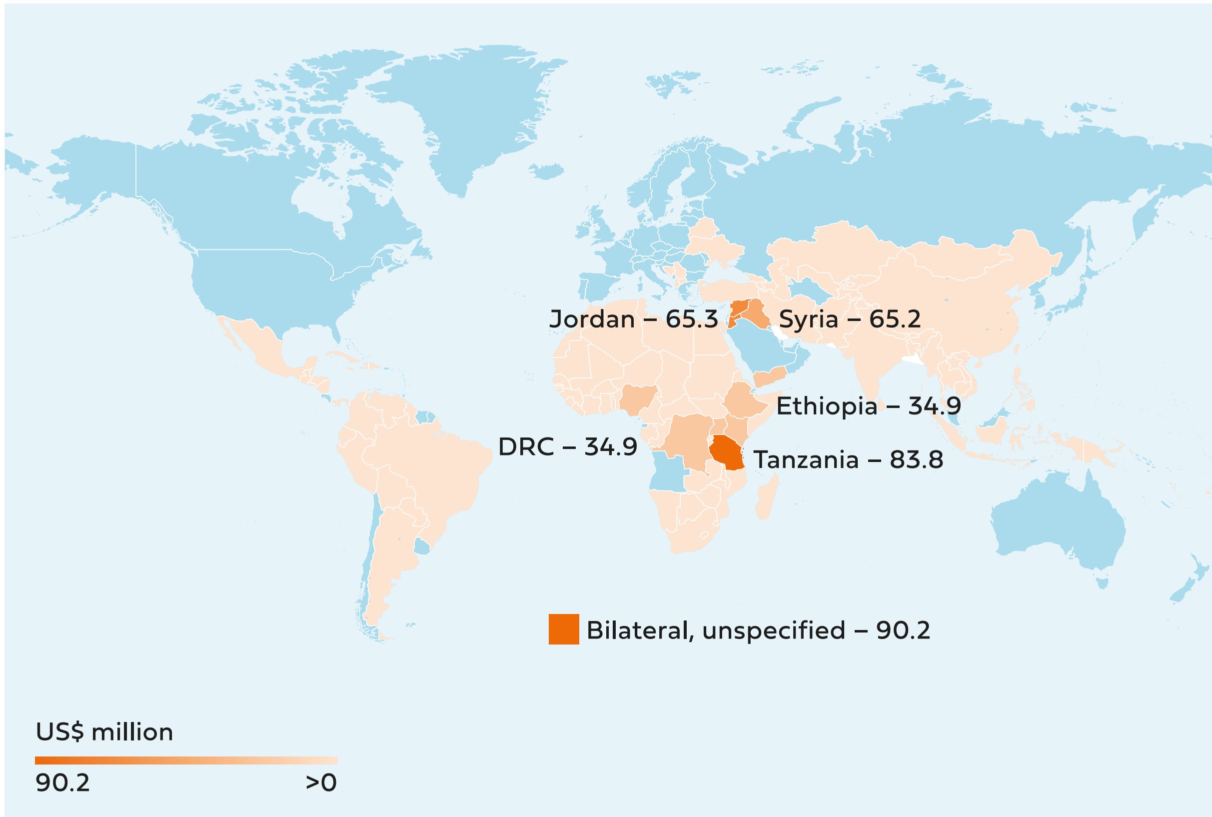

Figure 7 – Map of recipients of ODA standard grants to CF MHPSS (2018–19) – based on OECD DAC CRS database

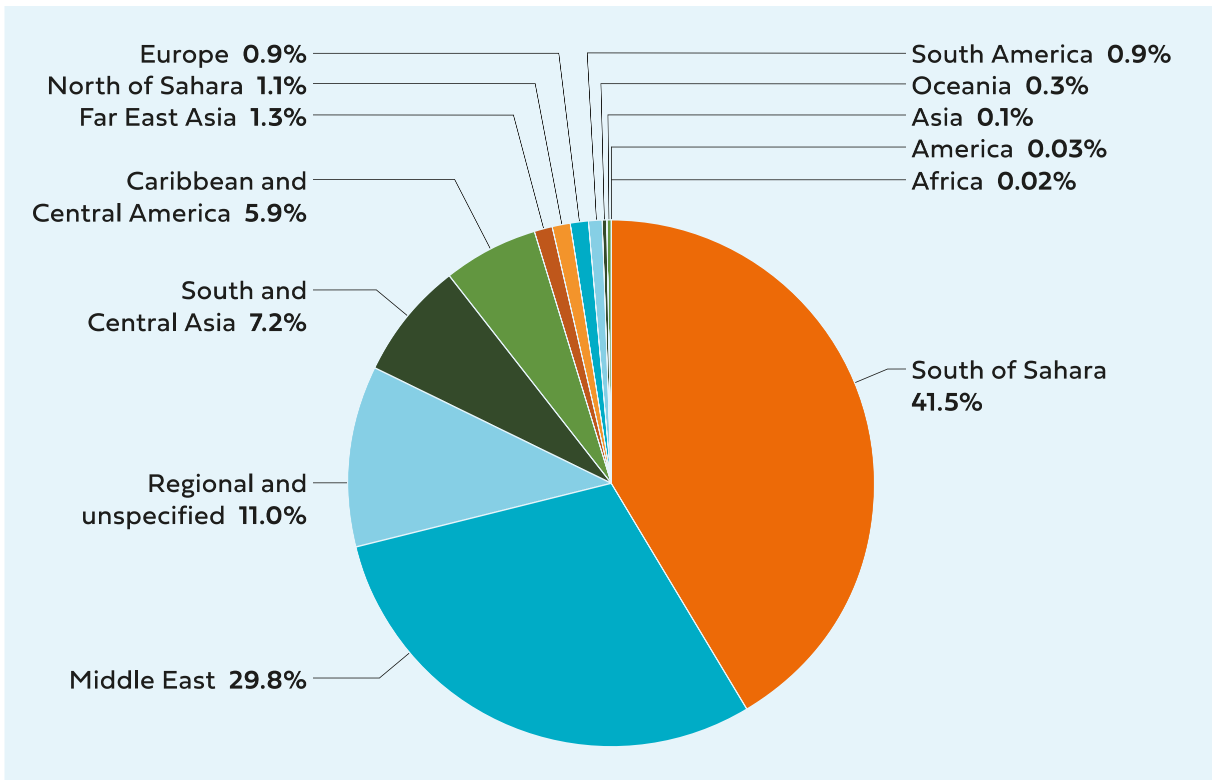

Figure 8 – ODA grants for CF MHPSS by region (disbursements 2018–2019)

PHOTO: SAM TARLING/SAVE THE CHILDREN

Khalida, 42, sits with her sons Hassouni*, 9, and Sameer*, 7, in their home in Mosul.*

An analysis (Save the Children, 2020c) of grave violations against children living in conflict zones found that the worst conflict-affected countries in which to be a child in 2018 were: Afghanistan, Central African Republic , DRC, Iraq, Mali, Nigeria, Somalia, South Sudan, Syria and Yemen. **Despite children's high exposure to violence and distressing experiences in these countries, Central African Republic, Mali, Somalia and South Sudan are absent from the top 20 recipients for ODA funding for CF MHPSS, even when countries hosting refugees fleeing these conflicts are included.** In 2018, Afghanistan was the country with the highest number of children killed and maimed in conflict and it was the deadliest and most violent year of the Yemen conflict on record.[2] Yet, neither country ranked among the top 10 recipients of CF MHPSS ODA funding. Additionally, Lebanon, South Sudan and the occupied Palestinian territory[3] were among the top 10 recipients of CF MHPSS in 2015–2017 but they subsequently dropped off the list. This is despite the protracted Syrian refugee crisis in Lebanon, ongoing violence in South Sudan, and the "Great March of Return" demonstrations in Gaza leading to a health and protection crisis during 2018–2019. **This may indicate a disconnect between levels of funding and MHPSS needs for children and families in crisis situations, as well as unpredictability of this funding for humanitarian and fragile situations.**

2 Yemen data gathered by the Armed Conflict Location & Event Data Project (ACLED)

3 Referred as West Bank and Gaza Strip by the OECD

Tanzania tops the list of recipients of ODA grants for CF MHPSS, but this is mostly due to one major USAID-funded multisectoral project targeting vulnerable Tanzanian children and young people with only a partial focus on MHPSS. This example exposes the limits of our ability to track CF MHPSS funding without clearer data on exactly how much is allocated to MHPSS activities embedded in larger multisectoral projects.

ODA grants for CF MHPSS recipients	2018	2019	Total 2018–19
Bilateral, unspecified	23.82	66.42	90.24
Tanzania	45.16	38.60	83.76
Jordan	52.03	13.32	65.34
Syrian Arab Republic	24.77	40.46	65.24
Iraq	28.83	24.86	53.68
DRC	11.12	23.82	34.94
Ethiopia	21.26	13.68	34.94
South of Sahara, regional[4]	1.86	28.95	30.81
Kenya	11.08	12.99	24.07
Nigeria	8.18	15.57	23.75
Uganda	13.49	10.01	23.50
Yemen	3.68	17.36	21.04
Namibia	13.07	5.67	18.74
Honduras	9.04	8.67	17.71
West Bank and Gaza Strip	6.26	8.86	15.13
Afghanistan	7.70	7.33	15.03
Bangladesh	4.64	9.78	14.42
Lebanon	6.82	7.31	14.14
Nepal	0.66	9.35	10.01
Middle East, regional	0.21	9.60	9.81

Table 4: Top 20 recipients of ODA standard grants for CF MHPSS – based on OECD DAC CRS database. The three highest values in each column are highlighted in light blue.

4 In the OECD DAC CRS database, each financial flow has only one recipient country to avoid double-counting when summing up activities. An activity benefiting several recipients is therefore classified by region or sub-region.

Donors

The largest donors of ODA standard grants for CF MHPSS during 2018 and 2019 were the US, the UK and Sweden. These were followed by Germany and Canada. Over 75% of ODA funding for CF MHPSS in 2018–2019 was from these top five donors. The UK, Canada, the EU, Spain and Switzerland significantly increased their investments from 2018 to 2019.

Looking at the share of ODA that these donors provided to CF MHPSS over 2018-2019, Canada (0.9%), Sweden (0.8%) and the UK (0.4%) tend to spend a higher proportion than the average share of ODA funding for CF MHPSS (0.28) across donors during that period.

The increase in ODA spending on CF MHPSS from the UK can be explained by their global leadership in this sector during 2018–2019, hosting high-level events such as the Wilton Park dialogue on the mental health needs of children and adolescents affected by conflict and the first inter-ministerial global Mental Health Summit. They co-chair the MHPSS donors group together with the Netherlands and have developed an approach and theory of change on MHPSS that they launched in August 2020 (DFID, 2020). Canada saw an important increase in their investment to CF MHPSS with the inclusion of psychosocial

Disbursements (US$ million – constant 2018 prices)

ODA grants for CF MHPSS – Donors	2018	2019	Total 2018–19	Share of CF MHPSS funding as part of overall ODA contribution over 2018–2019
United States	113.46	113.99	227.45	0.3%
United Kingdom	59.44	76.65	136.08	0.4%
Sweden	41.32	47.28	88.59	0.8%
Germany	43.16	41.32	84.48	0.3%
Canada	0.14	83.93	84.07	0.9%
EU Institutions	26.70	31.46	58.15	0.2%
Italy	6.83	8.81	15.64	0.2%
Switzerland	4.95	9.88	14.83	0.2%
Spain	3.41	10.91	14.32	0.2%
Netherlands	9.92	2.68	12.60	0.1%

Table 5– ODA for CF MHPSS: top 10 donors – based on the OECD DAC CRS database. The three highest values in each column are shaded in light blue.

support in humanitarian crisis as part of their Feminist International Policy (Government of Canada, 2021). With funding and support from Global Affairs Canada, Global Challenges Canada's Mental Health Program was also relaunched in 2019, with the aim of funding innovations to help young people's mental health in LMICs.

Sweden is a top donor to CF MHPSS both in terms of amount of funding and also relative to their ODA overall spending. This can be explained by their prioritisation of a child rights perspective as part of their development cooperation policy (Government of Sweden, 2016), and 2019 saw the creation of the Global MHPSS Network, bringing together Swedish actors in the sector. Their MHPSS report, which provides an overview of the priorities of the Swedish International Development Cooperation Agency on MHPSS, highlights that "children and adolescents are an important group that is highly affected by mental health", showing their focus on this age-group in their MHPSS work (KIT Royal Tropical Institute, 2020).

Who delivers the ODA funding for MHPSS to children and families?

Over the period 2018–19, **the main channels of delivery of ODA grants for CF MHPSS are NGOs and civil society (47.62%) and multilateral organisations (39.52%). The first largest delivery channel is International NGOs (44.68%)** – in particular, Pact World (8%), Save the Children (3%), Family Health International 360 (3%), World Education Inc. (2%), Christian Aid (2%), Mercy Corps (1%), Plan International (1%) and Catholic Relief Services (1%). The second largest delivery channel is UN agencies (35.49%), with **UNICEF ranking first, channelling around 29% of all identified ODA grants for CF MHPSS**. While UNICEF channels almost a third of CF MHPSS funding, it is worth noting that the agency works with international and national civil society partners for implementation.

As compared with the analysis made for 2015–2017, **the role of NGOs and civil society as a delivery channel has increased**, taking a larger proportion in 2018-2019 than on average during the previous period (41%). However, **less than 3% of funding is channelled directly through local and national civil society actors**. Although international NGOs and UN agencies channel some of their funding for CF MHPSS to local partners, this suggests that CF MHPSS ODA funding is far from meeting the Grand Bargain target of at least 25% of humanitarian funding to local and national responders.

Channels of delivery	Disbursements (US$ million) 2018–2019	Share of total (%)
NGOs and civil society	391.07	47.62%
International NGO	366.91	44.68%
National NGO	21.50	2.62%
NGO and civil society (no details)	2.66	0.32%
Multilateral organisations	316.30	39.52%
United Nations Children's Fund	237.51	28.92%
United Nations Population Fund	22.02	2.68%
United Nations Development Programme	19.78	2.41%
World Bank Group	16.00	1.95%
International Organisation for Migration	6.97	0.85%
United Nations Educational, Scientific and Cultural Organisation	4.93	0.60%
United Nations Relief and Works Agency for Palestine Refugees in the Near East	3.71	0.45%
Organization of American States	1.89	0.23%
United Nations Entity for Gender Equality and the Empowerment of Women	1.22	0.15%
United Nations Office on Drugs and Crime	1.15	0.14%
United Nations Office of the United Nations High Commissioner for Refugees	0.48	0.06%
World Health Organization	0.46	0.06%
International Labour Organisation	0.19	0.02%
Public sector institutions	52.36	6.37%
Donor Government	25.49	3.10%
Recipient Government	20.31	2.47%
Third Country Government (Delegated co-operation)	6.56	0.80%
Private sector institutions	25.78	3.14%
Private sector in provider country	23.31	2.84%
Private sector in recipient country	2.41	0.29%
Private sector in third county	0.06	0.01%
University, college or other teaching institution, research institute or think-tank	17.71	2.16%
Other and not specified	16.52	2.01%
Network	1.49	0.18%
Grand Total	**821.23**	**100.00%**

Table 6 – Channels of delivery

PRIVATE DEVELOPMENT FINANCE GRANT SPENDING ON CF MHPSS

Private development finance for CF MHPSS

The DAC CRS database includes project-level information from 39 private donors and philanthropic foundations.[5]

The year 2018 saw an important amount of funding from the private sector to CF MHPSS, with US$ 123.67 million committed, of which US$ 39.18 million was disbursed. This is a huge increase compared with 2017 when the private sector provided US$13.25 million of funding to CF MHPSS. In 2019, commitments were lower (US$ 42 million) than in 2018, but private sector disbursements to CF MHPSS increased to almost US$ 65 million in 2019: a 65% increase from 2018.

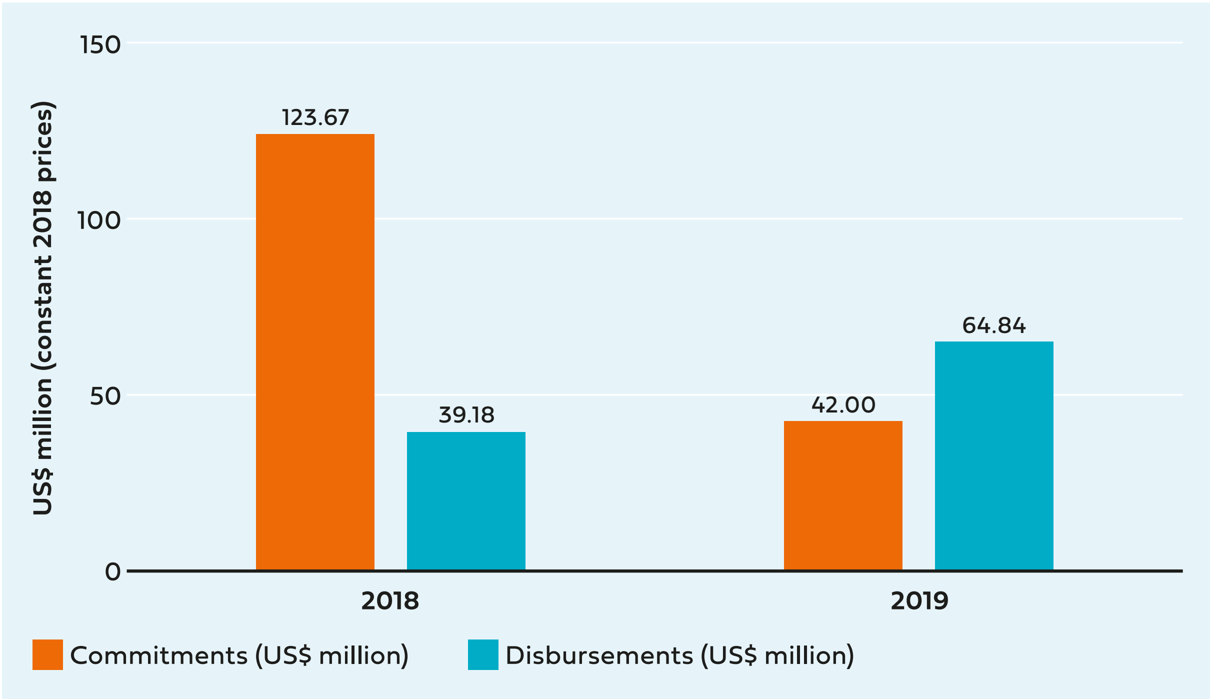

Figure 9 – Private development finance for CF MHPSS: commitments and disbursements – based on OECD DAC CRS database

5 See DAC and CRS code lists for the complete list of private donors: https://www.oecd.org/dac/financing-sustainable-development/development-finance-standards/dacandcrscodelists.htm

The high level of commitment in 2018 is explained by the LEGO Foundation and MacArthur Foundation awards of US$ 100 million each to Sesame Workshop to bring a programme of learning through play to children affected by the Rohingya and Syrian refugee crises (see Box 3 on page 29). This funding is multi-year, explaining the higher level of disbursements in 2019.

The share of private sector funding as part of total aid to CF MHPSS is important as it represents 12% of the funding tracked in this study. While it remains a modest contribution as compared to ODA, the increase in funding from private donors and philanthropic foundations is a much welcome development as they can play a key role in filling the gap to address the global child mental health crisis. Private development finance tends to be more flexible and quicker, and can fund pilot approaches that can be brought to scale and then accelerate the case for government and donor investment.

Private development finance actors spent 0.6% of their total funding on projects providing MHPSS to children and families. This proportion increased to 1% in 2019, showing the growing interest of private sector actors in MHPSS, especially as DAC donors only spent 0.31% of their total ODA funding on CF MHPSS.

Top private sector donors

The three largest private donors of CF MHPSS funding (2018–19) are the MacArthur Foundation, the LEGO Foundation and the Wellcome Trust. They are followed by the Bernard van Leer Foundation and the Bill & Melinda Gates Foundation. These top five donors represent 85% of the private sector funding for CF MHPSS

Disbursements (US$ million – constant 2018 prices)

ODA grants for CF MHPSS – Donors	2018	2019	Total 2018–19
John D. & Catherine T. MacArthur Foundation	9.00	24.67	33.67
LEGO Foundation	9.06	15.46	24.51
Wellcome Trust	3.49	10.65	14.15
Bernard van Leer Foundation	4.67	4.29	8.96
Bill & Melinda Gates Foundation	5.22	1.99	7.21
Charity Projects Ltd (Comic Relief)	1.57	2.78	4.34
Oak Foundation	1.66	2.21	3.87
Conrad N. Hilton Foundation	1.70	1.97	3.66
Children's Investment Fund Foundation	0.88	0.53	1.42
David & Lucile Packard Foundation	1.20		1.20

Table 7 – Private Development Finance grants for CF MHPSS: top 10 donors – based on the OECD DAC CRS database. The three highest values in each column are shaded in light blue.

in 2018–2019, showing the small number of private donors and philanthropic foundations involved in CF MHPSS financing. The top three donors are also responsible for the increase in disbursement in 2019, as the MacArthur Foundation, the LEGO Foundation and the Wellcome Trust all significantly increased multi-year funding commitments in 2018.

The small number of private actors involved in CF MHPSS funding highlights a need for more private philanthropists to fund MHPSS for children and families. A study (United for Global Mental Health, 2020) looking at the potential of next generation philanthropists to catalyse action for global mental health showed that funding barriers included a lack of understanding of mental health, stigma around the issue, a perception that it is hard to measure progress, lack of trust and transparency, an unwillingness to fund mental health services in LMICs, and fragmented investment. A collective approach led by leading private foundations funding CF MHPSS could help galvanise funding and more participation from private donors and philanthropic foundations.

Recipients of private development finance

Identified private funding for **CF MHPSS was mostly allocated to countries in crisis such as Syria, Iraq and Bangladesh** – essentially through Sesame Workshop activities financed by the MacArthur Foundation and the LEGO Foundation. The fourth largest recipient is Brazil, with substantial funding invested in early

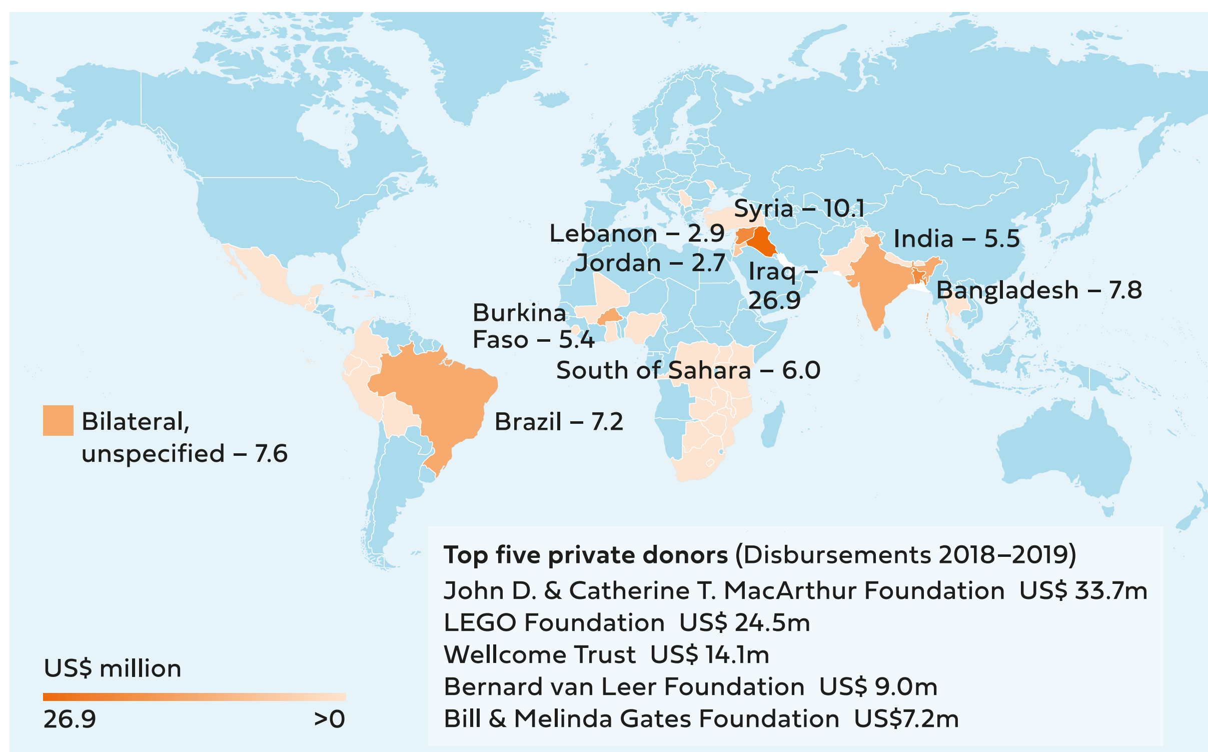

Figure 10 – Map of recipients and donors of private development finance to CF MHPSS (2018–19) – based on OECD DAC CRS database

childhood development and parenting programmes from the Bernard van Leer Foundation. For example, The Parents+ Programme combines coaching activities for parents and other caregivers about early child development with at least one service designed to meet a child and/or her parents' basic needs, including their mental health.[6] It focuses on parents' and caregivers' wellbeing, as well as responsive caregiving behaviours.

Channels of delivery of private development finance

The study found that private development finance to CF MHPSS is largely channelled through international NGOs (66%). **In particular, Sesame Workshop channelled 42% of the private sector funding to CF MHPSS** (see Box 3 on page 29). Private development finance is also much more likely to fund national NGOs (14%) than ODA funding (only 3% allocated). Similarly, private donors and

Channels of delivery	Disbursements (US$ million) 2018–2019	Share of total (%)
NGOs and Civil Society	82.92	79.71%
International NGO	68.28	65.64%
National NGO	14.64	14.07%
University, college or other teaching institution, research institute or think-tank	15.75	15.14%
Multilateral Organisations	2.18	2.10%
UNICEF	2.02	1.94%
Pan-American Health Organisation	0.73	0.70%
WHO	0.17	0.16%
OECD Development Centre	0.12	0.11%
Public sector institutions	1.27	1.22%
Recipient Government	1.27	1.22%
Network	0.61	0.58%
Private institutions	0.38	0.43%
Private sector in recipient country	0.26	0.25%
Private sector institution (no details)	0.12	0.12%
Private sector in third country	0.07	0.06%
Grand Total	**104.03**	**100.00%**

Table 8: Channels of delivery of private development finance

6 https://issuu.com/bernardvanleerfoundation/docs/bvlf-annualreport18-digital-pages

philanthropic foundations provide a significant amount of funding to CF MHPSS research, dedicating 15% of their funding to universities, research institutes and think tanks, a much higher percentage than research funding from ODA grants (2.16%). Universities receiving the most funding for CF MHPSS from private financing include King's College London (5%), London School of Hygiene & Tropical Medicine (3%), Boston College (2%), and Emory College (2%).

BOX 3 Sesame Workshop – "Play to Learn" and "Ahlan Simsim"

Funded by the MacArthur Foundation and the LEGO Foundation, Sesame Workshop partnered with IRC and BRAC to reach refugee children with high-quality early learning. This resulted in the Play to Learn programme in Cox's Bazar, Bangladesh, and Ahlan Simsim in countries affected by the Syria crisis (Iraq, Jordan, Lebanon and Syria). The programmes support playful interactions between children and their caregivers to foster children's social-emotional growth. Working with New York University (NYU) Global TIES Center, the outcomes of the programmes will be measured through a multi-year, evidence-based research and evaluation programme. This will generate knowledge on what early learning interventions are most effective for children in crisis – including in addressing issues related to stress and adversity and the impact of child and caregiver-focused programmes on parenting, caregivers' wellbeing and children's development. It will also enable adaptation and scaling up of the programmes.

PHOTO: KRISTIANA MARTON/SAVE THE CHILDREN

Children at a child-friendly space in Southern Tigray

SECTORAL ANALYSIS

Guidelines recommend that MHPSS interventions are multi-layered and integrated within existing sectors, services and support structures. For example, the Copenhagen 2020 Action Plan for Child, Youth and Family MHPSS advises to firmly root MHPSS within the ecology of the child and implement 'whole family' approaches to child and family mental health and psychosocial wellbeing, mainstreamed and integrated across sectors, and in particular within health, protection and educational systems (The MHPSS Collaborative, 2021).

To investigate in which sectors CF MHPSS is most integrated, the research team categorised each financial flow confirmed as providing CF MHPSS under categories representing the common sectors for integrated service delivery: education, protection, health, livelihood, nutrition, and culture, art and sport – as well as a category for multi-sector integration. "CF MHPSS multisector" includes projects integrated through multiple sectors with no main sector identifiable, for instance "education, protection and WASH", or "health, food security and education". Table 9 and Figure 11 on page 31 examine the total spending for CF MHPSS, both private grant funding and ODA standard grants, across these sectors for the period 2018–2019.

Based on available data, the study found that **most of the CF MHPSS spending was integrated within the education sector – with 36% of total CF MHPSS funding identified during 2018 and 2019**. An analysis of CF MHPSS & Education funding also showed that 38% of the funds were channelled through UNICEF, and that 29% of the grants (US$ 96.3 million) are investments for the global fund "Education Cannot Wait" (ECW) (see Box 4 on page 33).

The second largest category in terms of spending is **"CF MHPSS & Multisector" (29% of spending identified)**. Multisector grants tend to be quite large; therefore, despite fewer projects for this category in the database, it represented a substantial share of CF MHPSS funding.

The third largest sector was **the protection sector, which includes 17% of total CF MHPSS spending identified** and 26% of funding flows or projects. **The health sector is ranked fourth (10%) in amount spent**, but third in number of projects.

Smaller amounts of spending are seen for CF MHPSS integrated within Livelihood (6%), Nutrition (0.8%), and Culture, Art and Sport (0.2%) categories.

Sectors of integration	Number of financial flows identified (2018–19)	Number of financial flows identified (%) (2018–19)	Disbursements 2018–19		Disbursements			
					(US$ million)		(%)	
			(US$ million)	(%)	2018	2019	2018	2019
CF MHPSS & Education	723	32%	333.17	36.0%	128.00	205.18	32.6%	38.5%
CF MHPSS Multisector	355	15%	266.30	28.8%	124.54	141.75	31.8%	26.6%
CF MHPSS & Protection	596	26%	161.70	17.5%	77.49	84.22	19.8%	15.8%
CF MHPSS & Health	393	17%	96.99	10.5%	35.02	61.97	8.9%	11.6%
CF MHPSS & Livelihood	151	7%	58.29	6.3%	23.75	34.54	6.1%	6.5%
CF MHPSS & Nutrition	34	1%	7.03	0.8%	2.49	4.54	0.6%	0.9%
CF MHPSS Culture, Art, Sport	42	2%	1.77	0.2%	0.84	0.93	0.1%	0.2%
Total	**2.294**	**100%**	**925.25**	**100%**	**392.13**	**533.13**	**100%**	**100%**

Table 9 – Grants for CF MHPSS: ODA and private development finance disbursements – 2018 and 2019, by sector of integration (constant 2018 prices) – based on OECD DAC CRS database. The three highest values in each column are shaded in light blue.

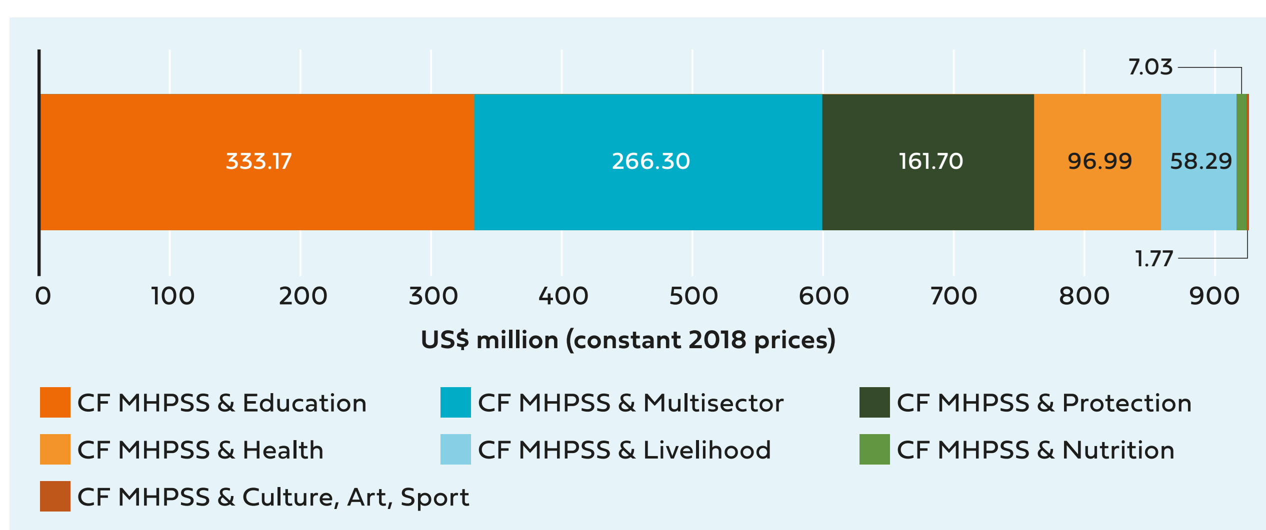

Figure 11 – Total 2018–19 CF MHPSS ODA and private development finance by sectors – based on OECD DAC CRS database

Education – the main entry point for CF MHPSS funding

This study therefore shows that the traditional association of CF MHPSS interventions with the sectors of health and protection is no longer the case. Education is now used as a main entry point, with CF MHPSS & Education funding even exceeding the amount going to large multisectoral grants.

ODA funding for education in general reached its highest amount ever recorded in 2018 with US$15.6 billion of funding disbursed (UNESCO, 2020), and has catalysed the increase in CF MHPSS funding within education programming. MHPSS is also integrated in major donors' education in emergencies (EiE) policies, such as Directorate-General for European Civil Protection and Humanitarian Aid Operations, which refers to it most frequently in its EiE policy guidelines versus those of other sectors.[7] This greater funding investment was also accompanied by greater focus on MHPSS by the EiE community as the Inter-agency Network for Education in Emergencies (INEE) published its guidance note on psychosocial support in 2018 (INEE, 2018). The present costing study found that 29% of the grants identified as "CF MHPSS & Education" – US$ 96,3 million – are investments channelled through the global fund "Education Cannot Wait". In 2019, Education Cannot Wait focused its policy improvement efforts on MHPSS and called for the integration of MHPSS in humanitarian response as part of quality education investments (Education Cannot Wait, 2020).

The increasing focus on MHPSS integration within EiE is welcome progress, as EiE programmes are a critical and relevant channel for children and young people to access needed mental health and socio-emotional supports, as well as to support their learning. As mentioned in the INEE Guidance Note on Psychosocial Support (INEE, 2018), education can offer a stable routine and structure providing a sense of normalcy for children whose lives have been disrupted by emergencies, as well as opportunities for friendship, play, relational skills and social supports – all of which are crucial to children's wellbeing and learning. Integrating MHPSS programming in education systems helps children affected by conflict to access opportunities for healing, recovery, growth, and increasing resilience. Safe schools and non-formal learning spaces are ideal environments for providing psychosocial support and structured play activities, and for encouraging the development of interpersonal and socio-emotional skills. School-based interventions that address anxiety, depression and suicide are also proven to be cost-effective. A new study from 2021 showed a return on investment of US$ 88.7 on every dollar invested in these interventions in LMICs (RTI International, 2021).

7 Unpublished policy analysis carried out by Save the Children and the MHPSS Collaborative

BOX 4 Education Cannot Wait

Education Cannot Wait (ECW) is the first global fund dedicated to education in emergencies (EiE) and protracted crises and was established in 2016 at the World Humanitarian Summit.

In 2019, ECW started to increasingly integrate MHPSS in its policy and signed a Memorandum of Understanding with the MHPSS Collaborative. (Education Cannot Wait, 2019). As part of its replenishment during the 2019 UN General Assembly, ECW called jointly with Save the Children and the MHPSS Collaborative for sustainable child and family MHPSS funding as part of ECW-supported programming (Save the Children, 2019).

Education Cannot Wait advocates for humanitarian responses to routinely integrate MHPSS as part of good-quality education programming and has made it a required component in all Education Cannot Wait country investments. Education Cannot Wait pushes for all Education in Emergencies and Protracted Crises programming to teach children and adolescents social emotional learning and/or life skills building competencies in self-awareness, interpersonal skills and thinking skills – either by integrating them into existing academic curricula or as additional subjects. Education Cannot Wait also funds teacher wellbeing programs and teacher training on MHPSS.

It is important to note that to effectively secure the wellbeing and rights of children, young people, and families – especially those most vulnerable – integration of MHPSS within education funding must be coordinated with matching investments for MHPSS integration in other sectors (such as health and protection) and multisectoral coordination. Children in conflict-affected countries are more than twice as likely – and adolescents more than two-thirds more likely – to be out of school compared with those in countries not affected by conflict (UNESCO, 2015), leaving over 100 million children out of school in emergency-affected countries in 2018 (UNICEF, 2018a). These children are often the most vulnerable – in particular girls and poorer children – and are more likely to be exposed to protection risks, and yet cannot be reached by school-based MHPSS interventions.

A "whole school" approach addresses the mental health and psychosocial needs of all members of a school system, from students to staff to caregivers and the broader community. It is recommended to achieve sustainability and impact by strengthening the care and support systems within all layers of the socio-ecological environment of children and families. A review of evidence (The

MHPSS Collaborative, 2021a) of school-based MHPSS interventions implemented in humanitarian contexts in LMICs showed that most programmes included in the review had single levels of intervention – for example, the child level only or teacher level only. A whole school approach requires MHPSS integration not only through education channels, but also through other sectors and existing supports to ensure a safe, nurturing environment for all children and families.

As CF MHPSS and education projects expand, it is also key for researchers and practitioners in the global MHPSS and EiE communities to come together to evaluate the effectiveness of various interventions on children's wellbeing and learning outcomes, including multi-layered, integrated approaches. A recent realist review conducted by the MHPSS Collaborative and funded by Porticus has found that there is currently a limited evidence base on the mechanisms of action and impacts of CF MHPSS interventions integrated within EiE in humanitarian settings (The MHPSS Collaborative, 2021a).

Protection – still "counting pennies"

To track funding for "CF MHPSS & Protection", we looked at MHPSS interventions integrated with and provided through the protection and child protection sectors but also interventions reported in the OECD classification as "human rights", "ending violence against women and girls" and "aid with justice and legal support".

There is no analysis of the amount of ODA that is allocated to the protection sector (Norwegian Refugee Council, 2020) – potentially explaining its lower representation within CF MHPSS funding and making it difficult to track funding trends within this sector over time. However, studies looking at development funding for the protection sector showed that protection sub-sectors that systematically incorporate MHPSS receive low levels of ODA funding. For example, less than US$ 1.1 billion (0.6%) of global ODA funding went to projects addressing violence against children in 2015 (ChildFund Alliance, et.al, 2017), only US$ 1.3 billion (less than 1%) of ODA-funded activities targeted gender-based violence (GBV) in 2018, and the level of international support for mine action stood at only US$ 642.6 million in 2018 and US$ 561.3 million in 2019 (Development Initiatives, 2021).

In addition, a study of protection financing trends within humanitarian funding between 2013–2019 found that this sector is chronically underfunded, both in relation to the amount requested as part of humanitarian appeals and as compared with other sectors (Norwegian Refugee Council, 2020). Child protection in particular received on average 47% of the amount required for this sub-sector in humanitarian plans and represented only 1.4% of the humanitarian funding tracked in the OCHA Financial Tracking System (FTS) in 2019 (Child Protection Area of

Responsibility & Save the Children, 2020). Adequate funding for the child protection sub-sector is critical for the health, mental health and wellbeing of children and families in emergencies. Increasing child protection funding is likely to result in higher levels of funding for CF MHPSS. An analysis shows that, as of 2021, nearly US$ 7 out of every US$ 10 requested for child protection is for projects integrating MHPSS (Child Protection Area of Responsibility & Save the Children, 2020).

It should be noted that while funding levels for the protection sector need to increase to meet demand, closer engagement of all protection actors on MHPSS is needed to ensure better MHPSS integration and sustainable and effective protection outcomes (Protection Cluster, 2020).

Health – CF MHPSS neglected in funding for a sector that is key for its implementation

The "CF MHPSS & Health" category includes MHPSS interventions implemented by or directed to the health sector. It generally includes interventions of the third and fourth layer of the IASC pyramid: focused care and specialised services by primary health actors and mental health clinicians.

In 2018, health ODA stood at US$ 22.2 billion (Development Initiative, 2020a), but only a very small amount (US$ 35.02 million, or 0.16%) of international aid to health was spent on CF MHPSS that year. A calculation by United for Global Mental Health also found that mental health represents only 1% of development funding to health (United for Global Mental Health, 2022), and therefore mental health services targeting children, youth and caregivers are likely to represent an even lower proportion of health funding. Fewer individuals are expected to need specialised MHPSS interventions, as compared with child protection and education activities targeting the general population (e.g., school-based and community-based activities for all children). This is a potential explanation for the lower spending for specialised services; but does not account for the fact that the unit cost of focused care and specialised services is also higher, and demand is high, particularly in emergency settings. Estimates show that 166 million adolescents aged 10–19 live with a diagnosed mental disorder as defined by WHO and one in five people (22%) in conflict-affected contexts are living with a mental health condition (UNICEF, 2021b). Furthermore, MHPSS interventions have a high return on investment for public health and more widely for the economy – every dollar invested in treating mental disorders saves up to $5.70 in economic cost and health returns (Chisholm, et al., 2016).

Lack of integration of MHPSS within antenatal and maternal health care can also have a negative impact on children at the critical stage of development very early in life. Around one in five mothers in LMICs are estimated to experience mental

health problems during pregnancy and/or during the first year after childbirth. Perinatal depression has been shown to have negative physical and mental health outcomes for both mother and infant, including reduced utilisation of services, poor mother-infant developmental nurturing, poor feeding and malnutrition, increased substance use, inadequate prenatal care, low birth weight, preterm delivery, postpartum depression and suicide (Gelaye, et al., 2016).

MHPSS actors note that very few specialised services for children and young people exist in emergency settings and LMICs. A 2013 study by Médecins Sans Frontières on children's access to their mental health services in the DRC, Iraq, and the occupied Palestinian territory showed that children – including adolescents – accounted for a small proportion of those presenting to programmes not specifically targeting these age groups. The authors conclude that there is a need for child-specific mental health service information, community-based outreach activities, and linkages to other sectors to adequately meet the demand for MHPSS services for children and adolescents (Lokuge, 2013). The number of psychiatrists who specialise in treating children and adolescents is also extremely low: fewer than 0.1 per 100,000 people in LMICs (UNICEF, 2021b). It is therefore urgent for health actors to better integrate MHPSS within health programming, prioritise multi-layered interventions and support national health authorities to implement nationally and locally owned mental health services that cater to children and families' needs.

The Red Cross Red Crescent Movement (RCRC Movement) has also strengthened its strategic commitment to include MHPSS across sectors. Most notably, a resolution and global policy advocating for States and the RCRC Movement to increase efforts to ensure early and sustained access to good-quality MHPSS services for people affected by armed conflicts, natural disasters and other emergencies were adopted in December 2019 (International Red Cross and Red Crescent Movement, 2019). Comprehensive surveys of almost all actors in the RCRC Movement in 2019 and 2021 show that the primary challenges faced in implementing MHPSS were due to lack of sufficient funding (International Red Cross and Red Crescent Movement, 2021) .

Beyond integration, the main donors to international aid in the health sector have a critical role to play in ensuring increased funding for MHPSS to meet demands and ensure the mental health and optimal development of children and young people. This includes the Global Fund to end HIV and TB, which funds services that provide an important entry point to resources and capacity for the delivery of MHPSS for children, youth and their families at every stage of the care continuum (United for Global Mental Health, 2021).

Other sectors – more opportunities to meet child, youth and family MHPSS needs

While education, health, and protection are prioritised in funding for cross-sectoral integration of MHPSS, other sectors provide further opportunities for funding CF MHPSS and ensuring that children and families are reached with the support they need.

Livelihood represents only 6% of the ODA and private finance funding for CF MHPSS but growing evidence shows that integrating MHPSS into livelihood support for caregivers or youth in humanitarian and fragile settings can mutually increase outcomes in both sectors (Schininá, et al., 2016). Interventions that provide vocational and professional training for caregivers or youth, cash and economic support such as microcredits and support for livelihood opportunities can address the stress that financial struggles bring to caregivers and young people. In turn, support to their mental health and wellbeing can facilitate their access to livelihood opportunities and skills and capacity to sustain livelihoods.

There is only a small proportion (0.8%) of CF MHPSS funding within nutrition programmes despite clear evidence of the need for and benefits of early intervention in this sector. Acting early in the life course – from pregnancy through early childhood – is key to preventing mental health problems in the future. An analysis of the funding to early childhood development in emergencies (Moving Minds Alliance, 2020) found that health and nutrition interventions represented more than 90% of development aid to early childhood development in emergencies. This would suggest that the vast majority of programmes reaching young children and their caregivers do not integrate MHPSS, therefore missing an opportunity for mutually beneficial outcomes in maternal mental health, feeding, and early socio-emotional and cognitive stimulation, all essential for children's survival, growth and development. One way to promote MHPSS integration would be to develop indicators that are sensitive to children's social emotional development in nutrition programmes (The MHPSS Collaborative, 2021). The Moving Minds Alliance – a multi-stakeholder partnership combining programmatic, funding and research expertise to support prioritisation of the youngest refugees and their caregivers – has taken the lead in integrating MHPSS into nutrition and feeding programmes in crisis settings, setting an example for other donors.

Lastly, a new category was included in this study pertaining to culture, art and sport. This category includes activities focusing on art-based activities such as art or music therapy and MHPSS through sport and culture but implemented outside of formal education and protection systems. So far, this category represents small amounts (0.2% of CF MHPSS funding identified) but is a growing field with interesting potential for integrating MHPSS through socially

and culturally acceptable entry points. A few examples of projects under this category are: 1) Coaching for Life (The Arsenal Foundation with Save the Children), a unique coaching programme focusing on physical, mental and emotional wellbeing to build children's courage and inner strength through football;[8] 2) "Waves for change" or surf therapy, an MHPSS and sport programming providing child-friendly mental health services and mentoring by coaches and mental-health professionals;[9] and 3) TeamUp (War Child with Save the Children and UNICEF), which provides children with a suite of structured sports, play and movement activities and emotional support.[10] This recognition of sport-related MHPSS interventions is positive as there is growing evidence that it is an effective and acceptable strategy for protecting and promoting MHPSS among crisis-affected people such as displaced populations (Rosenbaum, et al., 2021).

PHOTO: MUSTAFA SAEED/SAVE THE CHILDREN

Mohammed, 13, lives in an IDP camp in Somalia after fleeing conflict in his community. He lost his right leg in a bomb blast.*

8 Read about the partnership here: https://www.savethechildren.org.uk/about-us/who-we-work-with/corporate-partners/arsenal

9 Read more here: https://waves-for-change.org/what-we-do/surf-therapy/

10 Read more here: https://www.warchildholland.org/projects/teamup/

FUNDING FOR MHPSS TO CHILDREN AND FAMILIES IN VIEW OF ACTUAL NEEDS

One key challenge in highlighting the funding gap for CF MHPSS is that it is difficult to measure the MHPSS needs of children and families in humanitarian and fragile contexts. While the Global Humanitarian Needs Overview increasingly mentions MHPSS needs – in particular, for children – data on MHPSS is mostly monitored by health and protection sectors and joint assessments tend to overlook it. This lack of data then prevents greater integration across sectors and donors are not incentivised to increase or sustain their funding to CF MHPSS based on needs.

Despite the lack of a comprehensive overview of CF MHPSS needs there is overwhelming evidence that they have been increasing in the past few years. The number of children living in conflict zones has increased from 415 million in 2018 to 426 million in 2019 (Save the Children, 2020c), putting more children at risk of experiencing serious distress and adversity.

In 2018, research from Save the Children looking at the impact of conflict and violence on children and their families showed that 95% of children in Gaza reported feelings of depression, hyperactivity, a preference for being alone, and aggression (Save the Children, 2019), and that almost half of children surveyed in Mosul felt grief all or a lot of the time (Save the Children, 2018). Just before the start of the COVID-19 pandemic, UNICEF warned that the number of children displaying symptoms of psychosocial distress in Syria doubled in 2020 (UNICEF, 2021c), and a survey carried out by Save the Children found that more than half of children in Yemen said they felt sad and depressed (Save the Children, 2020a). Levels of funding and the low proportion of aid going to CF MHPSS in 2018–2019 was therefore far from sufficient to address the staggering impact that crises have on children's mental health, as well as all of the mid-to-longer-term effects this can have on their societies.

While it will take years to fully capture the impact of COVID-19 on children's mental health and wellbeing, a number of assessments indicate that the pandemic has had a devastating toll. A global survey carried out in 37 countries

in 2020 showed that more than 8 in 10 children (83%) reported an increase in negative feelings after the start of the pandemic and that the disruption to their education was one of the most significant stressors (Save the Children, 2020b). Looking specifically at the impact of COVID-19 in conflict-affected countries, War Child and World Vision surveyed children in Colombia, the DRC, Jordan, Lebanon and the occupied Palestinian territory and found that more than half (57%) of children had MHPSS needs as a direct result of COVID-19 and lockdowns, with 40% of children and 48% of parents identifying COVID-19 as the main risk to their emotional wellbeing (World Vision and War Child, 2021). According to an international survey of children and caregivers in 21 countries conducted by UNICEF and Gallup in the first half of 2021, one in five young people aged 15–24 reported feeling depressed or having little interest in doing things (UNICEF, 2021b). A WHO survey conducted during the pandemic in 2020 revealed that preventive and promotive services and programmes were the most severely affected mental health programmes. Around three-quarters of school mental health programmes were wholly or partially disrupted by the pandemic, and only about 30% of mental health services for children, adolescents and older adults remained functioning without disruption (WHO, 2020).

There are early indications that the international community did not adequately respond to this huge increase in MHPSS needs and delivery challenges. An analysis of COVID-19 financing for mental health found that funding for interventions that included MHPSS received a mere US$ 16.1 million (0.54%) of the US$ 2.98 billion allocated to the Global Humanitarian Response Plan as of October 2020 (United for Global Mental Health, 2020b).

PHOTO: SACHA MYERS/SAVE THE CHILDREN

Mariana, 25, displaced by conflict in Cabo Delgado, Mozambique.*

Building back better after COVID-19: the time to act for child and family MHPSS is now

2020 posed many challenges, with major disruptions to MHPSS services due to COVID-19, but it also brought more opportunities to the child and family MHPSS agenda. From the very start of the pandemic, UN Secretary-General António Guterres called for mental health to be "front and centre of every country's response to and recovery from the COVID-19 pandemic" (United Nations, 2020). A review of the 2020 Humanitarian Response Plans (HRPs) and Regional Response Plans (RRPs), including the Rohingya Joint Response Plan and Venezuela Refugee and Migrant Response Plan (RMRP), indicates that all response plans included MHPSS activities, even if not all plans used the abbreviation. Some donors included MHPSS as part of their funding to COVID-19 response and recovery. The US included psychosocial support in humanitarian and fragile settings as part of their "Strategy for Supplemental Funding to Prevent, Prepare for, and Respond to Coronavirus Abroad", and the EU, Germany, the Netherlands and Sweden funded MHPSS projects. From the private sector side, a few actors also announced their prioritisation of child and family MHPSS in their funding to the COVID-19 response. The Lego Foundation announced a partnership with FutureLearn to deliver Social Emotional Learning Through Play to children aged 0–16 affected by COVID-19 disruption (Lego Foundation, 2022). The Wellcome Trust has made mental health a priority, and in January 2020 committed £200 million to a five-year mental health programme (Wellcome Trust, 2022). In 2020, the Moving Minds Alliance also called for prioritising the mental health and wellbeing of parents and caregivers, and support for their ability to promote their children's learning and development in their report *COVID-19 in Pre-Existing Humanitarian Crises: Youngest children and caregivers face a double emergency*.

Building on efforts started in 2018, the MHPSS community came together in September 2020 at Save the Children Denmark's 75th Anniversary Conference to further highlight the need for investing in MHPSS for children and families in adversity. As a result, the Copenhagen 2020 Action Plan for Child, Youth and Family MHPSS was launched by Denmark, the Netherlands, Save the Children and the MHPSS Collaborative, which was endorsed by 30 agencies, including youth organisations, from across the globe. The international community met again in 2021 at the "Mind Our Rights, Now!" global mental health summit in Paris, sustaining the momentum from the two previous mental health inter-ministerial conferences.

In order to improve MHPSS capacity in humanitarian response in 2020, the Netherlands also launched the Dutch Surge Support mechanism building and bringing MHPSS capacity to humanitarian emergencies, together with the IASC Reference Group for Mental Health and Psychosocial Support in Emergencies. In 2021, the Directorate-General for European Civil Protection and Humanitarian Aid Operations included MHPSS as part of its Humanitarian Implementation

BOX 5 Mental Health in International Development and Humanitarian Settings (MINDS) Act

The first ever US legislation to address MHPSS in US-funded foreign assistance, the MINDS ACT, was introduced in June 2021 following lobbying by international aid organisations working in MHPSS. If passed, it would establish an MHPSS Coordinator and Working Group within USAID, the main governmental donor, to promote cooperation across sectors and agencies, and therefore better integrating MHPSS in US-funded programmes. Accountability is built into the MINDS Act, as it requires annual briefing to Congress on the amount of US foreign assistance spent on child and family MHPSS programming. The funding data would include a list of MHPSS programmes with committed funds from the State Department and USAID to improve access to and quality of MHPSS programming in development and humanitarian contexts.

Plan Enhanced Response Capacity. It encourages partners to integrate MHPSS across sectors, invests in building an evidence base to inform policy and practice, and promotes better information sharing. To integrate child and family MHPSS permanently into US-funded programming, legislation – the MINDS Act – was introduced in the US Congress and, if passed, would be ground-breaking for the area as it would both increase funding and improve coordination (see Box 5).

The progress in child and family MHPSS policy discourse are positive signs but the insufficient funding received in 2018–2019 shows that concrete commitments are needed to transform words into action. It is particularly worrying that funding trends for 2020 showed a substantial cut to ODA overall (Development Initiatives, 2021b), with a particular risk for aid to education (UNESCO, 2020), that in turn can affect funding for child and family MHPSS. The UK – the second biggest donor to child and family MHPSS – announced in 2020 that it would cut its international aid budget from 0.7 to 0.5% of gross national income and an analysis of the Foreign, Commonwealth and Development Office's spending shows that this cut disproportionately affected funding for programmes targeting children and youth (Save the Children UK, 2021).

Policies and funding to scale up MHPSS services are urgently needed to help children and families in crises to cope with adversity and to ensure sustainable and high-quality systemic change. Beyond promises, it is therefore urgent for the international community to collectively work towards greater investment in child and family MHPSS, but also to hold key stakeholders to account by better tracking funding that goes to this area.

CONCLUSIONS AND RECOMMENDATIONS

This research study examined ODA and private development finance grants for Child & Family MHPSS reported through the OECD DAC CRS database for the years 2018 and 2019, including funding for primary CF MHPSS projects and those that include CF MHPSS activities as a component integrated within other sectors. The findings show that unique international attention to CF MHPSS in 2018–2019 led to a relative increase in ODA and private sector funding in these years. In terms of spending or disbursements, both ODA grants and private development finance for CF MHPSS increased over the period with a 35% increase for ODA grants and a 65% increase for private funding. While this suggests a positive trend in donor policy, a different picture emerges when looking at the proportion of CF MHPSS funding as part of wider ODA and private sector funding. The share of spending allocated to CF MHPSS over total ODA grants is estimated at only 0.24% in 2018 and 0.31% in 2019 – a drop in the ocean compared to the staggering needs. In particular, the COVID-19 pandemic revealed an important underinvestment in mental health that needs to be redressed urgently and the trend of increase in 2018–2019 remains insufficient.

In practice, only a few donors contributed to the increase, with five donor countries providing 75% of the total ODA funding to child and family MHPSS. More efforts are needed to ensure that funding is long term and predictable, and for levels of funding to match the needs of the most affected children, youth and families, as this study has shown that key contexts of violence and conflict were absent from the top 20 recipients of ODA funding. Local civil society actors can play a key role in ensuring that the most vulnerable are reached, yet received only 3% of the ODA funding to CF MHPSS, with INGOs and UN agencies representing the main delivery channels. Although UN agencies and INGOs work with local civil society actors to deliver their programmes, localisation of CF MHPSS with meaningful participation and representation of people with lived experience can only happen if more funds are channelled directly to local civil society.

One key trend of the past few years that this study highlights is the increasing role of the private sector, with private sector funding now representing 12% of the funding tracked in this study. Yet, the paucity of private sector actors involved in CF MHPSS financing means that very few projects get funded through this channel, and that CF MHPSS is missing out on funding that could more appropriately lead to innovation and evidence.

This study is also the first attempt at identifying in which sectors CF MHPSS is most integrated. This brought to light the key role played by education as a main entry point for CF MHPSS funding, with 36% of total CF MHPSS funding during 2018 and 2019. This is welcome and the result of a recognition of the link between learning and children's wellbeing and a coordinated and deliberate effort from key education sectors to integrate MHPSS in policies and practice. As a follow-up to this priorisation, more research is needed to understand the effectiveness of education in emergency MHPSS interventions. The rest of the sectoral distribution however shows that some sectors need to be better prioritised by donors – such as protection, and in particular child protection – but that others – such as health, nutrition and early childhood development – need greater efforts to integrate CF MHPSS.

Finally, the limitations of this study mean that we can only report on key trends as part of CF MHPSS financing. For greater visibility and accountability for CF MHPSS, better reporting, tracking and coordination for the funding of this area is needed. This would allow all actors to recognise where policy commitments are not met and also where sectors and contexts may be underserved when considering the needs of children, youth and families in adversity. The MHPSS community coming together to build a tracking system and work towards a minimum funding target would be a key stepping stone in ensuring that adequate and sufficient resources are being invested in improving the mental health and psychosocial wellbeing of millions of children, young people and families in crises across the world.

Recommendations

Findings from this study demonstrate the urgency for the international community to collectively work towards greater investment for Child & Family MHPSS, but also to hold key stakeholders to account by better tracking funding that goes to this area.

Donors, including donor governments, multilateral donors and private sector actors should:

- Systematically **track funding to child and family MHPSS** as a separate category, using the definitions outlined in this study and the composite term "MHPSS" to allow for more universal and structural monitoring of the annual contribution of international aid to CF MHPSS.
- Provide **more long-term and flexible funding for CF MHPSS in line with the needs on the ground**. As conflicts become increasingly protracted, consistent, sustainable and multi-year funding for CF MHPSS is more important than ever to support children across the life cycle.
- **Coordinate better among donors** and encourage more donor governments and private sector actors to invest in CF MHPSS. This should include the good

practice of continuing the MHPSS donors' group, with governments taking responsibility in co-leading.

- **Maintain robust funding to education and increase funding to protection** – in particular, child protection – as part of ODA, since both sectors already integrate CF MHPSS.
- **Increase funding to integrated programming for CF MHPSS, in particular for health, nutrition and early childhood development** to reach children early in their life cycle.
- **Provide funding and create financing mechanisms for local CF MHPSS actors**, in line with the Grand Bargain commitments (at least 25% of humanitarian funding to local and national responders as directly as possible).
- **Invest in research and evidence-generation, including practice-based research**, on how best to optimise the development of children and young people in adverse circumstances.

UN agencies, humanitarian coordination mechanisms, NGOs and civil society actors should:

- Jointly **develop a minimum funding target to address CF MHPSS needs globally and across sectors**. This could be based on a costing of the MHPSS Minimum Service Package.[11]
- Include **a sub-section on MHPSS in country and regional humanitarian response plans** through coordination with MHPSS technical working groups in humanitarian crises.
- **Integrate MHPSS in Interagency Rapid Needs Assessments, earmarking funding to MHPSS and tracking MHPSS funding** through OCHA's Financial Tracking Service.
- **Develop feasible and relevant social and emotional development indicators** within nutrition programmes and health outreach to support the integration of CF MHPSS within health and nutrition.
- **Adopt a common language and monitoring and evaluation approach for MHPSS across sectors** using global tools such as the MHPSS Minimum Service Package and the IASC Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support Programmes in Emergency Settings".[12]. This could include developing a theory of change with associated actions across and within sectors to better understand the impact of programming to achieve positive outcomes.
- **Facilitate the inclusion and participation of local MHPSS actors** in coordination and planning mechanisms.

11 See more information at: https://mhpssmsp.org/en

12 For more information, see https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/iasc-common-monitoring-and-evaluation-framework-mental-health-and-psychosocial-support-emergency

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ANNEXES

Annex A – Methodology

Building on the research methodologies of Save the Children's Unprotected report and the report Counting Pennies (I and II), this study looks at humanitarian and development investment – ODA eligible – to mental health and psychosocial support for children and families (CF MHPSS) (Child Protection Area of Responsibility & Save the Children, 2019; ChildFund Alliance, et.al, 2017; World Vision International, 2021). The study is based on data reported to the OECD DAC CRS database for the period 2018–2019[13] and focuses on grants,[14] and more specifically on standard grants[15] from ODA and private development finance.[16]

MHPSS is traditionally associated with the sectors of health and protection, but MHPSS is intersectoral and is increasingly integrated in other sectors of humanitarian and development assistance, such as education and nutrition. The DAC CRS database has one purpose code linked to MHPSS entitled "Promotion of mental health and well-being" under the Health sector, but many projects providing MHPSS interventions are reported under different purpose codes and sectors. The study therefore considers a number of sectors within the CRS database to search for CF MHPSS funding.[17]

CF MHPSS funding is identified in the database using a keyword search methodology. Two sets of keywords relating to 1) MHPSS (see Annex B) and 2) to children and families (see Annex C) are searched in the database for each activity flow's title, short and long descriptions under the sectors selected. The keywords selection is based on Table 1 which lists MHPSS interventions the study aims to identify. Based on the OECD guidelines, the title and short

13 Data for 2018 and 2019 was downloaded from the OECD DAC CRS website on 22/03/2021.

14 Thereby excluding debt instruments, mezzanine finance instruments, equity and shares in collective investment vehicles, debt reliefs, guarantees and insurances.

15 Thereby excluding interest subsidy, and capital subscription on deposit and encashment basis.

16 Other flows recorded into the CRS database, such as Non-export credit other official flows (OOF), Officially supported export credits, Private Foreign Direct Investment, Other Private flows at market terms, Non flow, Other flows (e.g. non-ODA component of peacebuilding operations) are not included in the study.

17 Financial flows with purpose codes beginning with: 11 Education; 12 Health; 13 Populations Policies/Programmes & Reproductive Health; 15 Government & Civil Society; 16 Other Social Infrastructure & Services; 43 Other Multisector; 52 Development Food Assistance; 72 Emergency Response; 73 Reconstruction Relief & Rehabilitation; 74 Disaster Prevention & Preparedness; and 93 Refugees in Donor Countries.

descriptions are reported in English or French and are limited to 150 characters. The long description is the project summary and has no length limitation; it is mostly reported in English or French but on occasions in other languages such as Spanish, German, Dutch or Czech. In this study, the list of keywords was established in English and then translated into French and Spanish to consider activity flows reported in these languages. It is worth noting that by inserting a keyword in its singular form, the plural of the same word or derived word with the same root will be included; for instance, the keyword 'child' will flag titles or descriptions containing words like 'children' and 'childhood'.

The double keyword search resulted in 18,730 flows to be controlled for the years 2018 and 2019 (i.e., flows including at least one keyword of each set). The research team then proceeded to individually control each flow based on the information provided in the database to check if the activity includes a CF MHPSS intervention.

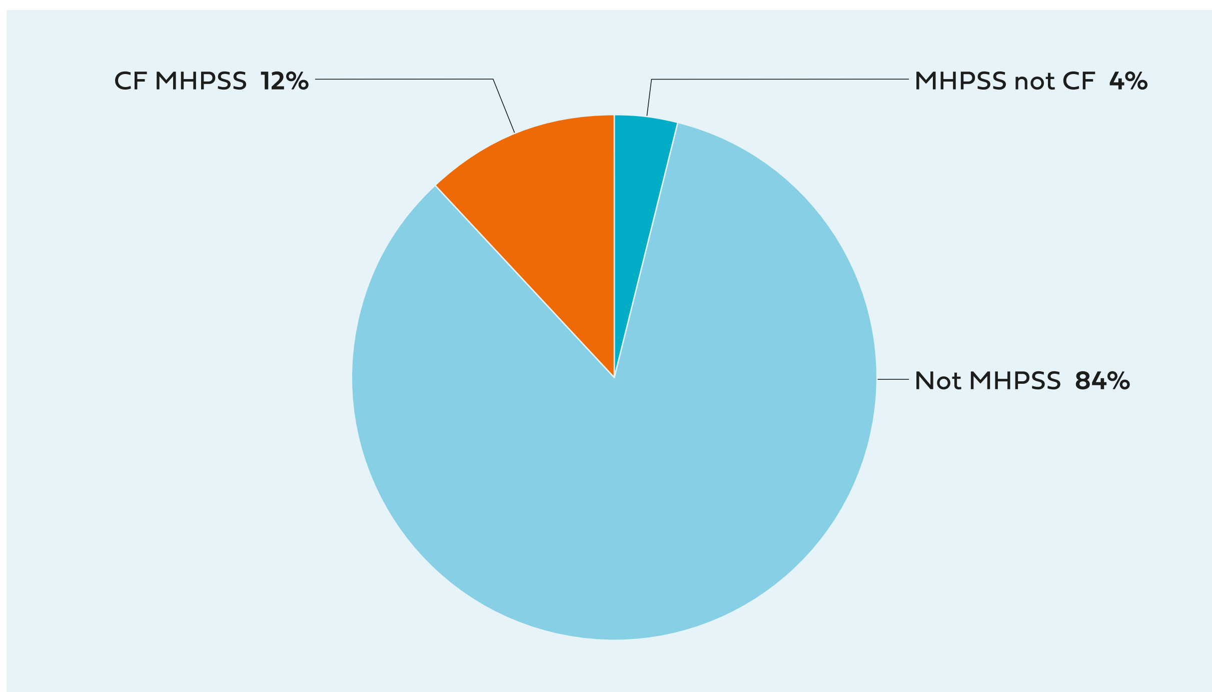

Figure 12 – Overview of study's database and results of the control phase

As a result of the control phase, 12% of financial flows of the study's database were confirmed to provide MHPSS to children and families (a total of 2,294 flows). Another 690 flows (almost 4%) were found to include MHPSS activities but did not present a focus on children and families. Finally, 84% of the flows from the original study's database (15,746 flows) were excluded on the basis that they do not include MHPSS activities (titled "not MHPSS" in the above chart) or did not provide enough information to conclude that they do. The vast majority of these flows included a more "generic keyword" such as resilience or rehabilitation and

the control phase confirmed that these flows did not refer to MHPSS activities and can be considered "false positive". Other flows and projects have been removed as they lack details and information to confirm the presence of MHPSS activities. Among those are:

- 279 flows referring to the rehabilitation or reintegration of youth or children with disabilities, street children, CAAFAG and children/youth in conflict with the law, as well as child detainees with no additional details or explicit reference to MHPSS
- 725 flows referring to early childhood development with no further details
- 52 flows referring to the establishment of child-friendly spaces and safe spaces with no information on the type of activities provided in these spaces – often in reference to gender-based violence or sexual and reproductive health and rights.

Annex B – MHPSS Keywords

Keywords (English)	Includes (English)	French	Includes (French)	Spanish	Includes (Spanish)
MHPSS	(mental health and psychosocial support)	SMSPS	(sante mentale et soutien psychosocial)	SMAP	(salud mental y apoyo psicosocial)
PSS	(psychosocial support)	SPS		–	
psycho	psychological, psycho-social, psychosocial support/ interventions, psychoeducation psychotropic medications, psychological clinical support, psychosis/ses, basic psychosocial support skills, psychosocial disability, psychologists, psychosocial counsellors	–	soutien psychosocial, psychologues, psychologique, psychosocial, psycho-social	psico	psicosocial, psicológico, ...
psychia	psychiatry/ist, psychiatric drugs and institutions, neuropsychiatric disorders...	–	psychiatrique, psychiatre,	psiquia	psiquiátrica, neuropsiquiátricos...
–		–		psí	
mental health	mental health care, support, interventions...	santé mentale		salud mental	
mental		mentaux		–	
wellbeing		bien ?tre	bien etre, bien être	bienestar	
Well being	Well-being, well being	bien-?tre	bien-etre, bien-être	bien estar	
emotional support		soutien émotionnel		apoyo emocional	
counsel	counsellor, counselling; counselling activities	consulta	consultation(s)	–	consultar, consulta
–		consulter		consultore	consultores
treatment		traitement		tratamiento	
therap	therapy(ies), therapeutic, psychotherapy,	thérap	therapie, thérapeutique, psychothérapie,	terap	terapéuticos, psicoterapia, terapia
PFA	(Psychological first aid)	PSP	(Premiers secours psychologiques)	PAS	(primeros auxilios psicológicos)
stress	distress, toxic stress, acute stress, chronic stress, traumatic stress	–	stress, stress toxis, stress chronique	estrés	estrés tóxico, estrés cronico, estrés postraumático

Keywords (English)	Includes (English)	French	Includes (French)	Spanish	Includes (Spanish)
–		d?tresse		–	
–		angoisse		angustia	
anxiety	anxiety, anxiety disorders	anxi?t?	anxiété, anxiete	ansiedad	
trauma	trauma(s), traumatic experiences...	–	traumatisme	–	traumatizados, estrés postraumático, traumáticos
PTSD	(post-traumatic stress disorder)	SSPT	syndrome de stress post-traumatique	TEPT	(trastorno de estrés postraumático)
depress	post-natal/ perinatal/maternal depression, depression, depressed, anti-depressant	dépress	dépression, antidépresseur	depresi	depresión, antidepresivo, depresiones
–		déprim	déprimé.e.s	deprim	deprimidos
disorders	psychotic disorders, post-traumatic stressdisorder, oppositional defiant disorder, mental disorders, severe mental disorders, anxiety disorders, mood disorders, neuropsychiatric	trouble	(s)	trastorno	(s)
safe?space	(s)	espaces sûrs		espacios seguros	
–		–		espacios protegidos	
Friendly space	child friendly spaces, mother-baby friendly spaces, adolescent/youth friendly spaces.	espaces amis		espacios acogedores	Espacios Acogedores para los Niños y jovenes
–		–		espacios de acogida	
–		espaces adaptés		espaces adaptados	los espacios adaptados a los niños
–		espaces pour enfants		–	
CFS	(child friendly spaces)	EAE	(espaces adaptes aux enfants/ espaces amis des enfants)	–	
BFS	baby friendly spaces	–		–	
–		centre d'animation		centros de animación	

Keywords (English)	Includes (English)	French	Includes (French)	Spanish	Includes (Spanish)
–		centres d'animation		–	
social support	social support network	soutien social		apoyo social	
support group	structured support group, support group for mothers, caregivers, children, adolescents, victims of...	groupes de soutien		grupos de apoyo	
–		groupes de discussion		–	
club	youth clubs, mothers clubs, kids clubs	–	clubs de jeunes,	–	clubes de juventud, clubes de jovenes...
Self help	self-help groups	entraide	groupe d'entraide	autoayuda	
–		développement personnel		–	
mothers group	adolescent mothers groups	groupe de mère		grupos de madres	
women's groups		groupes de femmes		grupos de mujeres	
youth groups		groupes de jeunes		grupos de jóvenes	
mother-child	mother-child groups, mother-child bond,	mères et enfants		madres e hijos	grupos de madres e hijos
children-mothers	children-mothers relationship	mères-enfants		madres-hijos	
–		mère-enfant		madre-hijo	
–		mère et l'enfant		madre y el niño	
–		mere-enfant		madre y el hijo	
parent	parental competences/ parental skills/ parenting education/ parent support groups/parenting/ positive parenting/ parent coaching/ parenting without violence	–	programmes consacrés au rôle des parents, formation des parents/ parentalité/ compétences parentales	padres	+ parentalidad
family responsibility		–		–	
visit	family visits	–	visites a domicile	–	Visitas domiciliarias
recreational activities		activités récréatives		actividades recreativas	
after-school	After-school activities	p?ri-scolaires	activites péri-scolaires	extraescolares	
–		para-scolaires		–	

Keywords (English)	Includes (English)	French	Includes (French)	Spanish	Includes (Spanish)
group activities	structured group activities	activités de groupe	activités de groupe(s) structurées	actividades en grupos	
supportive activities		activités de soutien		actividades de ayuda	
	coaching for lige, sport for protection	–	sport, sportif/ sportive(s)	deporte	
play		jeu		jugar	
–		jeux		–	
to cope		mécanismes de survie		hacer frente	
coping	positive/ constructive coping methods or mechanisms, coping skills/ strategies	capacités d'adaptation		–	
Life?skills	Life-skills, life skills	compétences de la vie		aptitudes para la vida	
–		apprentissage de la vie		competencias para la vida	
recover	recover, recovery, emotional/ psychological recovery	r?tabli	rétablissement	recuper	recuperacion, recuperar, recuperando, capacidad de recuperación
habilita	(re)habilitate, (re) habilitation, (re) habilitating	relèvement	+ réhabilitation	–	rehabilitación
reintegr	reintegrate, reintegration	réintégr	réintégration	–	reintegración
re-integr	re-integrate, re-integration	réinser		–	
r?adapt	readapt, readaptation	–	réadaptation	adaptación	adaptación
re-adapt	re-adapt, re-adaptation	méthodes positives d'adaptation		–	
resilien	resilient, resilience	résilien	résilience, mécanismes de résilience	–	resiliencia
case management		gestion de cas		manejo de casos	
referral	referral mechanisms and systems	référencement		referencia	
referring		référer		–	
autism		–	autisme	–	autismo
epileps	epilepsy	–	epilepsie	–	epilepsia
schizophreni	schizophrenia	–	schizophrenie	esquizofrenia	

Keywords (English)	Includes (English)	French	Includes (French)	Spanish	Includes (Spanish)
ADHD		TDA	ou TDAH	–	TDAH
insomni	insomnia	–	insomnie	–	insomnio
developmental delay		retard de d?veloppement		retraso del desarrollo	
–		–		retraso en el desarrollo	
developmental milestones		?tapes de d?veloppement		–	
developmental disabilit	developmental disability/ies	–		–	
intellectual disabilit	intellectual disability/ies	déficience intellectuelle		deficiencia intelectual	deficiencia intelectua
intellectual impairment		handicap intellectuel		discapacidad intelectual	
intellectual handicap		incapacité intellectuelle		incapacidad intelectual	
neurolo	neurologic	–	neurologique	neuroló	neurológico
substance abuse		abus de	Abus de drogues	abuso de sustancias	
–		toxico	toxicomanie	–	
adversity		adversité		adversidad	
child development		développement de l'enfant		desarrollo del niño	
–		–		desarrollo infantil	
early childhood development		développement de la petite enfance		desarrollo de la primera infancia	
ECD	(early childhood development)	DPE	(développement de la petite enfance)	DPI	(desarrollo de la primera infancia)
stimulation	stimulation programs	–		estímulo	
mhGAP		–		–	
problem management plus		–		–	
PM+	(problem management plus)	–		–	
CAAFAG	(children associated with armed forces and armed groups)	EAFGA	(enfants associés aux forces armées ou à des groupes armés)	NAFAGA	Los Niños y Niñas Asociados con Fuerzas Armadas y Grupos Armado
child soldier		enfants soldat		niño soldado	
anxiolytic		anxiolytique		ansiolítico	
SEL	social and emotional learning	ASE	Apprentissage social et émotionnel	–	

Keywords (English)	Includes (English)	French	Includes (French)	Spanish	Includes (Spanish)
emotional	social and emotional learning, emotional development, emotion awareness, emotional regulation	?motion	émotion, apprentissage émotionel,	–	
–		affectif		–	
helping skills		–		–	
EASE	emotion awareness and skills enhancement program	–		–	
IYCF	infant and young child feeding	–		–	
Breastfeeding		–		–	
Skin to skin	skin-to-skin	peau à peau		–	
problem?solving		résolution de problèmes		–	
conflict resolution		résolution des conflits		–	
empathic listening		écoute empathique		–	
suicid	suicide, suicidal ideation	–	suicide, pensées suicidaire	–	
nurturing		–		–	
responsive care		–		–	
responsive feeding		–		–	
thinking healthy		–		–	
self?harm		–		–	
selfharm		–		–	
MNS	Mental, neurologic and substance use	–		–	
IPT	interpersonal therapy	–		–	
neurolog	neurologic , neurology,	–	neurologique	–	
behavioural	behavioural disorders	comporte mentaux		–	
MtMSG	mother-to-mother support groups	–		–	
PwMD	Persons with Mental Disability				

The root "psy" was also searched in the database, and proved useful in identifying activities where typos were made: for instance 'psyco-social'.

Annex C – Child and Families Keywords

Keywords (English)	Includes (English)	French	Includes (French)	Spanish	Includes (Spanish)
child	Childhood, children, separated children, unaccompanied children, street children, refugee and migrant children, child soldiers, child caregivers, child-headed households	enfan	Enfants, enfance, petite enfance, enfants non-accompagnes ou separés, enfants des rues, enfants refugies ou migrants, enfants soldats...	niño	niños no acompañados,
–		–		niña	
youth		jeune	(s), jeunesse	jóvenes	
–		–		juventud	
young	young people	–		joven	
infant	(s)	–	infantile	–	infantil, infante
–		–		infancia	
adolescen	adolescent(s), adolescence	–	adolescent (e) (s), adolescence	–	adolescente (s), adolescencia
girl	(s)	fille	(s)	–	
boy	(s)	garcon	(s)	–	
–		garçon	(s)	–	
minor	(s), unaccompanied minors...	Mineur	(s)	menor	menores, menor de edad
newborn	(s)	nouveau?n?	nouveau-né	recién nacid	recién nacido(a)
new-born	(s)	nouveaux?n?	nouveaux-nés	–	
–		nourisson	(s)	–	
–		neonat	neonatal	–	neonato/a
baby		Bébé		bebé	bebés
babies		bebe		–	
orphan	(s), orphanage(s)	orphelin		huérfan	huérfano(s), huérfana(s)
family		famille	(s), famille d'accueil	–	familia(s)
families		familia	familial	–	
parent	(s), parenting, parental	–	parent(s), parentalité	paternidad	+ padres + parentalidad
caregiver		tuteur	(s)	cuidador	cuidadores
caregiver	care-giver	gardien	(s)	guardián	guardianes
kid	(s)	–		–	
mother	(s)	mere	(s)	madre	(s)
–		mère	(s)	–	
father	(s)	pere	(s)	padre	(s)
–		père	(s)	–	
pregnant	(s)	enceinte	(s)	embarazada	(s)

Keywords (English)	Includes (English)	French	Includes (French)	Spanish	Includes (Spanish)
UASC	(unaccompanied and separated children, unaccompanied asylum seeking children)	ENAS	(enfants non accompagnes et separes)	–	
CWD	(children with disabilities)	ESH	(enfants souffrant de handicaps)	–	
–		–		NNA	Niños, niñas, y adolescentes; NNA no acompañados/as
CAAFAG	(children associated with armed forces and armed groups)	EAFGA	(enfants associés aux forces armées ou à des groupes armés)	NAFAGA	Los Niños y Niñas Asociados con Fuerzas Armadas y Grupos Armado
–		EAFAGA	(enfants associés aux forces armées ou aux groupes armés)	–	
CLWS	(children living and working on the streets)	–		–	
OVC	(orphans and vulnerable children)	OEV	(Orphelins et Enfants Vulnérables)	NHV	niños huérfanos y vulnerables
teacher		enseignant		maestro	
–		–		maestra	
CFS	Child-friendly spaces + CFS facilitators	EAE		–	
BFS	Baby-friendly spaces and facilitators	–		–	
pupils		eleves		alumnos	
–		élèves		–	
lactating	lactating women/ mothers	allaitant	mère et femmes allaitantes	lactante	mujeres/madre lactantes
sibling	(s)	fr?re	frère(s)	hermano	
–		sœur	sœur(s)	hermana	
student		?tudiant	étudiant	estudiante	
–		–		–	
years old		âgés de		–	
year old		ages de		–	
learning through play		apprendre en jouant		–	
education		–		Educacion	
ECD		DPE		DPI	
juvenil	juvenile	–		–	
school		ecole		escuela	
–		école		–	
natal		–		–	
toddler		–		–	
Maternal		–		–	

THE MHPSS
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FOR CHILDREN & FAMILIES IN ADVERSITY