



GLOBAL MULTISECTORAL OPERATIONAL FRAMEWORK

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

Field demonstration version

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Zheng Rong, a Barefoot Social Worker in North China's Shanxi Province, visits 5-year-old girl Xiaoyu at her home. She helped Xiaoyu's family to raise money for a brain surgery, and apply for government subsidies. Under a programme supported by the Ministry of Civil Affairs and UNICEF, a Barefoot Social Worker is a non-professional social worker selected by a community to provide child protection and welfare services. Each person is trained in essential social work skills, including how to conduct child vulnerability and well-being assessments, monitor family situations. They also spend a great deal of time informing communities on all dimensions of child well-being.

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Field demonstration version

The Global Multisectoral Operational Framework for MHPSS has been developed to operationalize the [UNICEF MHPSS Technical Note \(2019\)](#).

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

This document is for field demonstration only. The final version is expected to be issued in 2022.

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

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LIST OF ACRONYMS

BFS	Baby friendly spaces	LGBTQ+	Lesbian, gay, bisexual, transgender, queer/questioning or other
CB MHPSS	Community-based mental health and psychosocial support	LMICs	Low- and middle-income countries
CCC	Core Commitments for Children in Humanitarian Action	mhGAP	Mental Health Gap Action Plan
CCCM	Camp Coordination and Camp Management	M&E	Monitoring and evaluation
CFC	Caring for the caregiver	MEAL	Monitoring, evaluation, accountability and learning
CFS	Child-friendly spaces	MH	Mental health
CP	Child protection	MHPSS	Mental health and psychosocial support
C4D	Communication for development	MoV	Means of verification
DRR	Disaster Risk Reduction	PFA	Psychological first aid
ECD	Early childhood development	PHC	Primary health care
ECE	Early childhood education	PM+	Problem Management Plus
EQUIP	Ensuring Quality in Psychological Interventions	SDGs	Sustainable Development Goals
FGD	Focus group discussion	SEL	Social and emotional learning
HICs	High income countries	SP	Strategic Plan
HIV	Human immune deficiency virus	SRH	Sexual reproductive health
IASC	Inter-Agency Standing Committee	GBV	Gender-based violence
ILO	International Labour Organization	UNHCR	United Nations High Commissioner for Refugees
IMS	Information management system	UNICEF	United Nations Children's Fund
IOM	International Organization for Migration	WASH	Water, sanitation and hygiene
IPT	Interpersonal therapy	WHO	World Health Organization
KAP	Knowledge, attitudes, and perceptions		
KII	Key informant interview		

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KEY DEFINITIONS

Adolescence

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

Adolescents

Individuals in the 10–18 year age group.²

Caregiver

Caregivers are those responsible for the care of children, and may include mothers and fathers, grandparents, siblings and others within the extended family network, as well as other child caregivers outside of the family network.

Child

Child is defined as all children and adolescents aged 0–18 years of age (according to the Convention on the Rights of the Child). The term is inclusive of boys, girls and LGBTQ+ children; children with protection risks or exposed to serious events; and children with disabilities or with mental health and psychosocial conditions.

Community

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

Community mobilization

“Efforts made from both inside and outside the community to involve its members (groups of people, families, relatives, peers, neighbours or others who have a common interest) in all the discussions, decisions and actions that affect them and their future.” (IASC MHPSS Guidelines, Action Sheet 5.1, p. 61³)

Community participation

The process by which individuals, families or communities assume responsibility for their own welfare and develop the capacity to contribute to their development. Community participation refers to an active process whereby the beneficiaries influence the direction and execution of projects rather than merely receive a share of the benefits.⁴

Culture

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

Family

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

LGBTQ+

Children and young people who are lesbian, gay, transgender, queer/questioning or other.

¹ WHO and UNICEF, *Helping Adolescents Thrive Toolkit: Strategies to promote and protect adolescent mental health and reduce self-harm and other risk behaviours*, Geneva: World Health Organization and UNICEF, 2021. Licence: CC BY-NC-SA 3.0 IGO

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

³ Inter-Agency Standing Committee, *IASC MHPSS Guidelines*, Geneva, 2007.

⁴ Paul, Samuel, 'Community Participation in Development Projects: The World Bank Experience', in 'Readings in Community Participation', Washington, DC: EDI. Chapter 2. (WHO, COMBI), 1987.

Resilience

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.⁵

Wellbeing

Mental health and psychosocial Wellbeing⁶

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

Wellbeing is commonly understood in terms of three domains:

- 1. Personal Wellbeing:** For the individual this includes positive thoughts and emotions such as hopefulness, calm, self-esteem and self-confidence. At the community level, personal wellbeing includes strategic actions to raise awareness and change behaviour about mental health and mental disorders and the importance of seeking help that contribute towards individual wellbeing.
- 2. Interpersonal wellbeing:** This includes nurturing relationships, responsive caregiving, a sense of belonging, the ability to be close to others. At the community level, interpersonal wellbeing is about creating the opportunities and space within the local community to develop these relationships and protective factors.
- 3. Skills and knowledge:** The capacity to learn, make positive decisions, effectively respond to life challenges and express oneself, facilitated also through community services that support wellbeing and the ability to learn how to best address the MHPSS needs in the community, the capacity to

respond to challenges within the community and how to effectively communicate about mental health and psychosocial wellbeing.

Mental health and psychosocial conditions

A wide range of disorders that affect an individual's cognition, emotion and/or behaviour and interfere with the individual's ability to learn and function in the family, at work and in society. In many circumstances, many of these conditions can be successfully prevented and/or treated. They include mental and substance use problems, severe psychological distress, intellectual disabilities, and suicide risk.⁷

Mental health and psychosocial support

A composite term used to describe any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorders.

Persons with disability

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.⁸

MHPSS workforce

MHPSS practitioners who have professional, on-the-job training, and technical competencies in mental health and psychosocial support, including those with the following backgrounds: child and adolescent psychology, counselling psychology, psychotherapist, expressive art therapists, family therapist, educational psychologist, social workers, school counsellors, psychiatric care, psychiatrists, psychiatric nurses, occupational therapists, doctors/primary care physicians and nurses trained in mental health and/or staff who meet the necessary years of on-the-job training and technical competencies for the services that they are delivering.

⁵ Dr Michael Ungar, in Hague Symposium Report, 2015.

⁶ UNICEF, [Mental Health and Psychosocial Technical Note](#), 2019.

⁷ WHO and UNICEF, [Helping Adolescents Thrive Toolkit](#), 2021.

⁸ Convention on the Rights of Persons with Disabilities (CRPD), [Article 1](#).

■ INTRODUCTION



Mental Health and Psychosocial Support (MHPSS) is an institutional priority for the UN, and for UNICEF.



UNICEF supports mental health as a holistic, life course issue relevant to every sector of development and embraces all Sustainable Development Goals (SDGs) as determinants of mental health and psychosocial wellbeing,⁹ underpinning the prevention, promotion and treatment continuum of mental ill health. UNICEF's approach aims to be collaborative and multisectoral – spanning across health, social welfare and child protection, education, gender and other sectors to truly be effective in addressing the global burden of mental health problems.

Accordingly, UNICEF's commitment to achieve the 2030 Agenda requires an increased understanding of the ways in which social conditions determine health and mental health outcomes. Responses to mental health and psychosocial problems in each population need to be multilayered and multisectoral. Health, education, social welfare and child protection, transport, and housing sectors all need to contribute to a 'health in all policies' approach, as reflected in the SDGs.¹⁰ To deliver the SDGs, and for overall promotion of mental health and psychosocial wellbeing, working together with caregivers and adolescents themselves needs to be a cross-cutting strategy. This should take place across all goal areas, including evidence generation, policy dialogue, service delivery design, intervention (where appropriate) and advocacy. Comprehensive monitoring must be done at global, regional, national and local levels using agreed indicators for SDGs and additional indicators as needed.

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

This implies that relevant sectors and areas of work, including health, social welfare and child protection, education, adolescent development and participation, early childhood development, disability, and nutrition, need to be more MHPSS-sensitive, and scale up quality MHPSS interventions for children, adolescents, young people and families in development and humanitarian settings.

As set out in the MHPSS Technical Note,¹¹ good mental health is related to mental and psychosocial wellbeing. UNICEF's work to improve the mental health of children, adolescents, families and communities should include:

- the promotion of mental health and psychosocial wellbeing;
- the prevention of mental health conditions;
- the protection of human rights; and
- the care and treatment of children, adolescents and caregivers affected by mental health conditions.

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

⁹ Breuer, E., M. De Silva, and C. Lund, 'Theory of change for complex mental health interventions: 10 lessons from the programme for improving mental healthcare', *Global Mental Health*, 2018, vol. 16, no. 5. doi:10.1017/gmh.2018.13; 2018

¹⁰ Patel et al. et al., 2018. Patel V, Saxena S, Lund C, Thornicroft G, Baingana F, Bolton P, Chisholm D, Collins PY, Cooper JL, Eaton J, Herrman H, Herzallah MM, Huang Y, Jordans MJD, Kleinman A, Medina-Mora ME, Morgan E, Niaz U, Omigbodun O, Prince M, Rahman A, Saraceno B, Sarkar BK, De Silva M, Singh I, Stein DJ, Sunkel C, Unützer J. The Lancet Commission on global mental health and sustainable development. *Lancet*. 2018 Oct 27;392(10157):1553-1598. doi: 10.1016/S0140-6736(18)31612-X. Epub 2018 Oct 9. Erratum in: *Lancet*. 2018 Oct 27;392(10157):1518. PMID: 30314863.

¹¹ UNICEF, Mental Health and Psychosocial Technical Note, 2019.

AIM OF THE MHPSS FRAMEWORK

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

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

The aim is to more effectively strengthen, promote, protect and mobilize supports and systems within the family and community to support child and family wellbeing and prevent mental health and psychosocial conditions becoming obstacles to meeting key targets in the Sustainable Development Goals. The framework accomplishes this by:

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

The framework will also provide recommendations and tools for developing monitoring and evaluation systems for MHPSS programming.

THE AUDIENCE

The global framework is an operational document for UNICEF staff and partners on MHPSS programming for children, adolescents and families in all contexts, including high income countries (HIC), low- and middle-income countries (LMIC), and humanitarian action. It is intended to be adapted by UNICEF regional and country offices and other agencies working to improve and strengthen the mental health and psychosocial wellbeing of children, adolescents, caregivers/parents and communities. The framework is designed to be particularly useful in LMICs as there is a strong emphasis on the core elements needed to establish and strengthen systems for mental health and psychosocial wellbeing. The framework provides guidance on policy and investment in mental health that is useful across settings, but especially in HICs. MHPSS services are an essential element of response and recovery for humanitarian action across HICs and LMICs.

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

COMPONENTS OF THE GLOBAL FRAMEWORK

UNICEF's Global Multisectoral Operational Framework for Mental Health and Psychosocial Support is designed to support the design and development of MHPSS strategies and action plans at the regional and country levels, as well as field-level MHPSS programming and activities. It is accompanied by a supplementary Implementation Package.

The global MHPSS framework (this document) presents strategies for improving the wellbeing of children and adolescents as well as their caregivers including parents, mothers and teachers; and for

improving the community capacity to deliver MHPSS services and eliminate stigma associated with mental health and psychosocial needs. In this document you can access the following key resources:

- ❑ **Implementation approaches:** Information specific to UNICEF's core approaches for MHPSS programme implementation can be found in this section. This includes: the social ecological model; the life course approach for MHPSS; gender, disability and inclusion; the mental health continuum; layering services across an adapted version of the IASC intervention pyramid; and a discussion on multisectoral supports.
- ❑ **Multisectoral framework:** The framework is structured around the social ecological model with outcomes across the child/adolescent level, the caregiver level, the community level; and society and its systems which create an enabling environment for MHPSS.
- ❑ **Intervention tables:** The framework includes 9 intervention tables that provide programming considerations across the child and adolescent, caregiver, and community levels of the framework. These tables also link to suggested resources that can be found in UNICEF's Compendium of Resources for MHPSS. Detailed guidance on how to use the intervention tables is given in the next subsection.
- ❑ **MEAL for MHPSS:** MEAL (monitoring, evaluation, accountability and learning) for MHPSS includes a theory of change for MHPSS, log frames across the four outcomes of the framework, suggested indicators, and means of verification. The TOC and the log frames are intended to be adapted to reflect your specific programme objectives.

Supplementary Implementation Package:

In addition to the global multisectoral framework for mental health and psychosocial wellbeing, UNICEF has developed an Implementation Package that complements the framework and is to be used alongside it. The Implementation Package includes the following resources:

- ❑ **Assessment and planning:** The planning and analysis component for MHPSS includes brief guidance and tips on how to (1) assess MHPSS needs and gaps in services at the regional and country level and (2) how to use that information to guide and inform strategic planning for MHPSS programming across multiple levels (the project, the district, the national, and the regional levels), and settings (e.g. HRP).
- ❑ **UNICEF's Compendium of Resources:** The compendium of resources is an accompaniment of the framework. The compendium provides valuable information about available resources, including guidelines, training manuals and tools. The description of each resource includes a detailed overview of its features, and information about how to access documentation, training or publications supporting each resource. The compendium is intended to be used as a reference document to identify available resources for implementing MHPSS programming across sectors and settings. The compendium does not describe how to implement particular interventions, but rather provides resources to inspire program development across a broad spectrum of approaches within a multi-layered pyramid of intervention, and a map to point users to additional sources of information. [The Compendium of Resources is a living resource that UNICEF will release updates for periodically.](#) The first version was published in 2018, the second in 2021, and a third update is expected in 2022.
- ❑ **MHPSS research framework:** A comprehensive framework to support research and evidence generation and use efforts for child and adolescent mental health across age groups and at various levels of the child's social ecology.
- ❑ **Key MHPSS documents, resources & briefs:** These short sectoral briefing documents and checklists provide additional field-level guidance on mental health and psychosocial programming and activities, with sector-specific considerations and target audiences.

Navigating the intervention tables

The framework provides a structure and relevant tools for designing and developing MHPSS programming. The intervention tables presented throughout the framework are organized around the child, caregiver, and community levels of support. An intervention table is provided at the end of each intermediary outcome across the child and adolescent, caregiver and family, and community circles of support. The tables link

back to the mental health continuum of care by noting where the intervention falls across the continuum of:

- PROMOTION of mental health and psychosocial wellbeing.
- PREVENTION of mental health conditions and psychosocial problems.
- CARE and treatment of children, adolescents and caregivers with mental health and psychosocial needs and/or conditions.

EXAMPLE OF INTERVENTION TABLE

OUTCOME

Intermediary Outcome

Interventions may include:

Relevant Resources



Considerations for Adaption

□ Sector icons are used to represent which sectors the interventions might be used in – these are suggested designations and may not reflect all the possibilities:



The intervention tables are intended to provide examples of interventions that support the intermediary outcome. There may be some repetition across tables as similar types of interventions may be relevant across levels of the framework.

□ The right-hand side of the tables links to the [Compendium of Community Based MHPSS Resources](#)¹² (MHPSS Compendium of Resources), which can be used to further define and guide your programme design. The resources are divided into four overarching categories: (1) Strategies, Approaches & Framework; (2) Guidelines; (3) Programme Guidance; and (4) Training, with additional resources specific to monitoring & evaluation. The Compendium is a product of an Evidence and Practice Review commissioned by UNICEF in 2015 and again in 2020.

! **Note:** Some resources reflected in the intervention tables are beyond what is included in the current version of the compendium, and will be labeled with x.x. The compendium will be reviewed throughout the demonstration phase, and expected to be finalized in 2022.

¹² Note: A revised version of the compendium, with an updated resource list, will be included in the supplementary Implementation Package to the framework.

MHPSS PRINCIPLES, STANDARDS AND APPROACHES

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

UNDERPINNING PRINCIPLES OF THE GLOBAL MHPSS FRAMEWORK

- ❑ Wellbeing depends upon the interplay of physical, social, cognitive, emotional and spiritual elements.
- ❑ MHPSS has a critical role in creating and supporting conditions for children’s optimal development and wellbeing.
- ❑ Engagement and participation of families, caregivers, educators, communities, and children themselves is central to ensuring enabling environments for children’s development and securing their protection, wellbeing, and future potential.

Global principles & standards underpin the framework

Four core underpinning documents to the global framework are: the guiding principles included in UNICEF’s Strategic Plan (inclusive of the Convention on the Rights of the Child, gender equality and the 2030 agenda), UNICEF’s updated Core Commitments to Children (CCCs), the [Declaration of Astana on Primary Health Care](#), and the *IASC (Inter-Agency Standing Committee) Guidelines on MHPSS in Emergency Settings*.

Fundamental tenets of child wellbeing as enshrined in the Convention on the Rights of the Child¹³ are central to both the guiding principles in UNICEF’s Strategic Plan and in the CCCs. These tenets protect the rights of every child – including rights to basic health and

welfare, family life, education, leisure and cultural activities, and special protection in certain situations such as humanitarian emergencies – and establish common principles and practices across education, health and social welfare.

The Declaration of Astana aims to ensure that people’s physical and mental health problems are addressed through comprehensive promotive, protective, preventive, curative, rehabilitative and palliative care throughout the life course. It strategically prioritizes key system functions aimed at individuals and families and the population as the central elements of integrated service delivery across all levels of care. It also systematically addresses the broader determinants of physical and mental health (including social, economic and environmental, as well as people’s characteristics and behaviours) through evidence-informed public policies and systems across all sectors. It also empowers individuals, families and communities to optimize their physical and mental health, as advocates for policies that promote and protect health and wellbeing, as co-developers of health and social services through their participation, and as self-carers and caregivers to others.

The *IASC Guidelines on MHPSS in Emergency Settings* (2007) and the associated IASC intervention pyramid, while originally developed for humanitarian settings, has become a unifying standard for MHPSS programming across agencies, sectors and contexts (including both development and humanitarian action). The IASC intervention pyramid supports development actors, humanitarian actors, communities and governments to plan, establish and coordinate multisectoral responses to protect and improve people’s mental health and psychosocial wellbeing in a wide range of contexts. The IASC guidelines note that MHPSS refers to “any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorder” and is based on the core principles listed in Table 1, which support a community-based approach.

¹³ UN General Assembly, Convention on the Rights of the Child, United Nations, Treaty Series, vol. 1577, 20 November 1989, p. 3

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

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

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

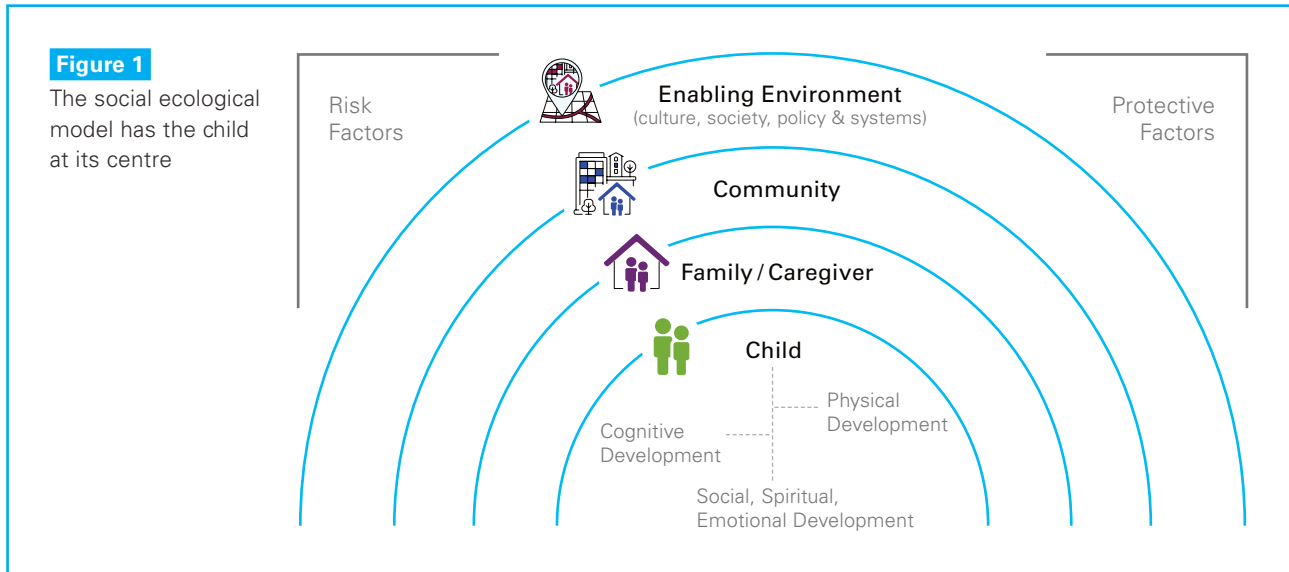
IMPLEMENTATION APPROACHES

The following approaches are fundamental in the approach to mental health and should inform and guide all programming that aims to improve mental health and psychosocial wellbeing for children, families and communities.

Social ecological model

UNICEF's framework is anchored in the social ecological model with the child at the centre surrounded by their family and caregivers, then their communities and finally society with its cultures and norms. MHPSS programmes should apply the social ecological model in the design and implementation of

the programme, including understanding the dynamic relationships between the child/adolescent and each element of their system, and how these dynamics affect their mental health and psychosocial needs. For more information see the brief on the social ecological model in [UNICEF's Mental Health Technical Note](#).



Life course approach

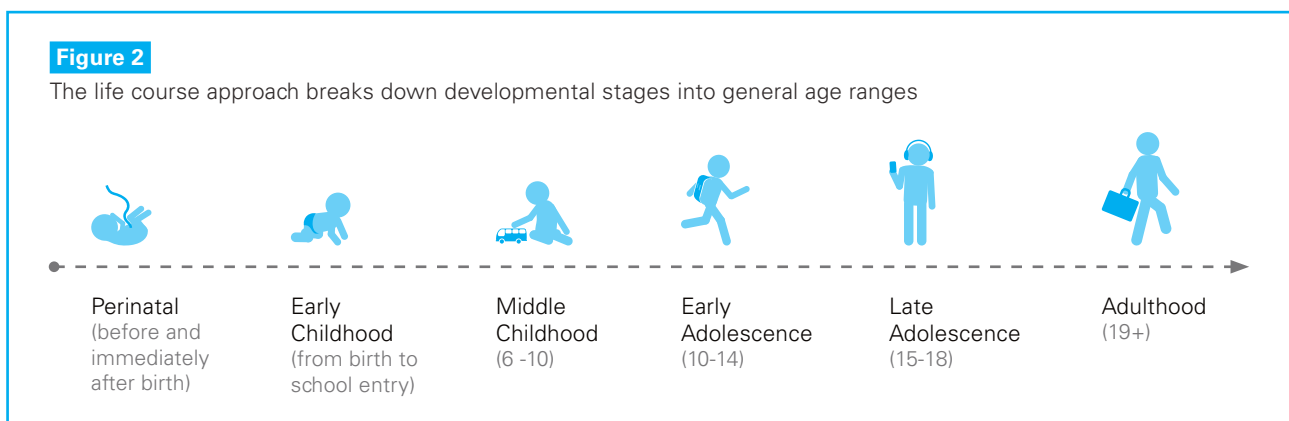
A life course approach to mental health and psychosocial wellbeing acknowledges that child and adolescent wellbeing and resilience are directly linked with the interplay between developmental stage and environmental elements influencing the young person’s risk and protective factors.¹⁴ The framework applies general age ranges for each life course stage from perinatal to adulthood, as reflected in Figure 2.

Taking a life course approach to mental health also requires adapting the developmental stages

based on the needs of the child and/or context.

For example, some children may have mental health and psychosocial needs that place them in a developmental stage that does not align with their biological age. Therefore, a life course approach to MHPSS should be adapted to the needs of the children, their families and the community.

In the framework, we will use ages throughout to provide examples of how to reflect the life course for MHPSS. These age groupings may vary slightly based on the content.



¹⁴ A Life-course approach to programming in UNICEF: What is it, why use it and how does it apply to UNICEF’s programme cycle? For more information or to access the resource please contact your UNICEF contact in your country

Gender, disability & inclusion

All MHPSS programming should consider the specific needs of children and adolescents of all genders to avoid enhancing stigma, discrimination and exclusion of risk groups in communities. Specific measures should be taken to ensure accessibility, inclusion and meaningful participation of children with disabilities, survivors of gender-based and other forms of violence, children formerly associated with armed forces/groups, members of the LGBTQ+ community, adolescent caregivers/parents, and other at-risk groups.¹⁵

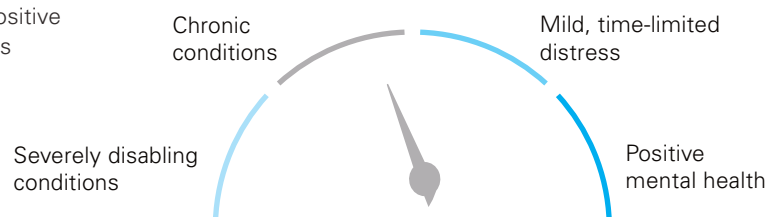
Adolescent engagement and meaningful participation should also be prioritized across sectors, recognizing the pivotal nature of this age group and the priorities set out in UNICEF Second Decade Programme Guidance. As part of the MHPSS Acceleration Initiative UNICEF has developed two key documents that provide a more detailed and focused discussion on gender, disability and inclusion considerations (1) [Gender and Adolescent Mental Health and Psychosocial Support Technical Brief](#) and (2) [Discussion Paper: A Rights-Based Approach to Disability in the Context of Mental Health](#).

The mental health continuum

Everyone sits somewhere on the mental health continuum, and many, if not most, people move along it at some stage – from experiencing good mental health to anything from short-term distress to long-term mental health conditions. Accordingly, UNICEF sees mental health on a continuum of care, addressing the broad spectrum of mental health issues that affect everyone, from specific mental health conditions to the overall mental wellbeing that every child deserves. The continuum of mental health interventions across promotion, prevention and care (early intervention, treatment and continuing care) is integrated throughout the global framework. Programming across the development and humanitarian contexts should all reflect the mental health continuum of care, with a focus on both mental wellbeing and the treatment and care for those with MHPSS needs across the life course. The framework provides programming examples that demonstrate how to think about MHPSS programming across the mental health continuum.

Figure 3

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



¹⁵ The framework will incorporate the gender identity framing that is adopted at the organizational level.

Community mobilization

Mobilizing communities to respond to MHPSS needs will contribute towards improved mental health and wellbeing for children and their families by working with and through a community's natural supports and systems. This contributes to a stronger overall care environment, which promotes inclusion of the most vulnerable children and families in existing supports and reduces the potential for stigma. Mapping and systematically building on local resources such as community networks, practices and processes helps to build scalable and sustainable programmes. This ensures the most vulnerable and hardest-to-reach members of the community know about the available services and how to access them. Taking a community-based approach in both development and humanitarian contexts helps to establish strong continuity of services when communities transition from emergency to recovery to development, or in a development context that is suddenly faced with an emergency. Strengthening natural supports and systems also helps to link MHPSS responses to recovery by linking humanitarian and non-humanitarian response programming. Emergency situations focus attention on the mental health needs of the population and provide an opportunity to transform MHPSS care for children and families for the long term. This may include specialized psychological and social services for those in need – for example children and caregivers with mental disorders, protection risks or serious distress. Emergencies may create a demand for systems strengthening that was not present under development programming. For example, stay-at-home orders, closures of business and international travel restrictions were defining characteristics of the 2020–2021 global pandemic and resulted a surge of demand for MHPSS services that were easily accessible within one's community.

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

Multilayered MHPSS services

The Inter-agency Standing Committee (IASC) intervention pyramid ([see Figure 4](#)) is widely used to describe the multilayered support that makes up a comprehensive, complementary package of MHPSS interventions for people's recovery and wellbeing.¹⁶ Originally developed for use in humanitarian response, the pyramid has since been used in development settings to depict the integrated services that support a given population. The pyramid begins with community foundations and works its way up to specialized care, with fewer people needing the services at each layer. The intervention pyramid is frequently used and adapted to describe MHPSS services across development and humanitarian contexts. The pyramid is helpful in that it provides a way to articulate and understand the layering of services. For example, a programme can have interventions that sit at only one layer of the pyramid or multiple interventions across the pyramid. The pyramid is designed to be used to inform programme planning by multiple sectors. It provides a generalized approach to MHPSS that can be tailored and adapted to a specific programme or sector.

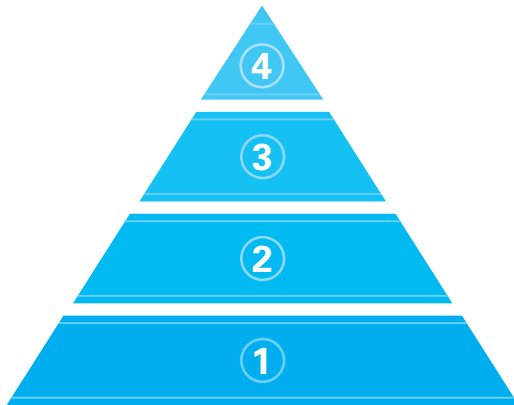
The pyramid also depicts the difference between MHPSS **approaches** and MHPSS **interventions**. MHPSS approaches are about providing services in a way that is beneficial to the mental health and psychosocial wellbeing of the population. This is important to all programmes across humanitarian and development contexts.

Adopting an MHPSS approach means providing activities in ways that are beneficial to the mental health and psychosocial wellbeing of children and families. It is about how the children and community are engaged in the development of programming and the delivery of services. An MHPSS approach can be used by any sector to inform how the beneficiary population is engaged in the process.¹⁷ MHPSS interventions consist of one or several activities with the primary goal of improving the mental health and psychosocial wellbeing of children, adolescents or their caregivers.

¹⁶ This is an adaptation of the IASC MHPSS intervention pyramid that continues to benefit from application in the field and further discussion among experts.

¹⁷ UNHCR, [Operational Guidance Mental Health & Psychosocial Support Programming for Refugee Operations](#), 2013.

Figure 4 The IASC MHPSS intervention pyramid



LAYER 4

Specialized services (management)

LAYER 3

Focused care (indicated prevention)

LAYER 2

Family and community support (selective prevention)

LAYER 1

Universal preventive interventions & social considerations in basic services and security

SERVICES & INTERVENTIONS

Services by mental health clinicians and social service professionals for children and families beyond the scope of general (non-specialized) social and primary health services. Includes interventions for individuals with a diagnosable condition that are intended to cure, reduce the symptoms or effects of the condition.

E.g., individual/family/group psychotherapy for an individual that has been diagnosed with a mental health condition

Interventions for high-risk individuals having detectable symptoms of a mental, emotional, or behavioral disorder, but do not meet the criteria for a diagnosis. Non-Specialized support by trained and supervised workers to children and families, including general (non-specialized social and primary health services).

E.g., program to develop social skills and coping mechanisms for adolescents referred to social services due to behavioral challenges

Interventions for a subgroup who exhibit psychological or social risk factors associated with mental, emotional, or behavioral disorders. Family and community supports for recovery, strengthening resilience and maintenance of mental health and psychosocial wellbeing of children and families.

E.g., support group for children exposed to domestic violence or a group of marginalized adolescents

Interventions for the public that have not been identified to be at risk, including social Considerations in basic services and security in a way that is participatory, safe and socially appropriate to ensure the dignity and wellbeing of all children and community members.

E.g., mental health and substance abuse awareness raising, access to basic survival needs – food, shelter, and disease control.

SUPERVISION & STAFFING

Psychiatrist, psychiatric nurses, psychologist, clinical social workers, occupational therapists, and/or PHC physicians and other professionals who are trained in clinical services including pharmacological treatment and/or management of mental conditions are best suited for delivering focused and clinical services at layer 4. Staff providing services at this layer should be highly skilled in individualized care. Staff equipped to provide services at layer 4 should be able to provide supervision to staff across layers.

Clinical social workers, psychologists, psychosocial workers/ MHPSS providers, nurses, school based MHPSS providers, community health workers who are trained in individualized care, case management and group work are qualified to undertake most interventions at layer 3. Activities can include paraprofessionals and staff who receive on the job training to provide structural MHPSS interventions such as case management, family-based interventions, structured group sessions and school based clinical interventions. Staff providing services at this layer should have a strong understanding of individual care and group interventions. Qualified staff at layer 3 can provide supervision to staff delivering services for the first two layers.

Staff at layer 2 should be highly skilled in leading and facilitating group sessions. Teachers, social workers, and community health workers may all provide services at this layer. Activities at this layer can also include paraprofessionals and staff who receive on-the-job training in community and family supports, including case management

First responders in basic services across sectors & technical staff working on policy and legislation across education, health, and social welfare systems. As interventions at layer one can include a wide range of policy and advocacy level work in a development context to support accessing basic services during a humanitarian response the skill sets for layer 1 activities will vary dramatically. For programs that include a lot of awareness raising, behaviour change, advocacy and policy efforts should include staff skilled in communications, policy and advocacy.

MULTISECTORAL REFERRALS

SUPERVISORY RELATIONSHIPS

Multisectoral supports

Multiple entry points are needed for MHPSS support¹⁸ to adequately meet the needs of all children and caregivers, including those with mental health conditions or those exposed to serious protection risks or traumatic events. Just as community health and social workers do not operate in isolation from formal health and social service systems, nor do MHPSS actors operate in isolation from specialized mental health, protection, social services, and other systems that support child and family wellbeing. Although the percentage of children and adults who require focused or specialized services may be small, they are a neglected and vulnerable group.

It is important for actors across all sectors to be aware of the continuum of MHPSS needs of children and families, and to ensure functional referrals up and down the layers of the pyramid. Interventions can best reach children, caregivers/parents and families when they are integrated within sectors and structures, such as health and social protection structures, rather than as stand-alone programmes (e.g., specialized services without other layers of support).

Other structures also serve as entry points, such as schools, social service systems, community centres and safe spaces, and community organizations such as youth clubs, women's cooperatives and religious organizations. MHPSS programmes should avoid over-targeting sensitive groups (e.g., survivors of gender-based violence or children formerly associated with armed forces/groups) in ways that further their discrimination and exclusion in communities. Instead, it is best to work towards broad support and advocacy to promote the inclusion and wellbeing of all community members, while ensuring that all MHPSS actors are aware of critical referral pathways for sensitive groups.

A multisectoral approach to mental health and psychosocial wellbeing recognizes and builds a continuity of services, coordination, and communication mechanisms across sectors to avoid gaps and to address the continuum of care. More detailed descriptions of these entry points can be found in a range of supporting documents that have been either developed by the respective sectors or form part of a multisector resource that includes sector-specific guidance. A key resource is the Minimum Services Package (MSP),¹⁹ which presents key evidence-based interventions for humanitarian agencies to use in acute emergencies and ongoing humanitarian settings. The MSP (forthcoming 2022) applies a multisector approach to MHPSS service provision but also includes details on key tools and interventions across sectors. The package, while developed for humanitarian contexts, is also an important resource for planning in non-emergency contexts.

¹⁸ This section intentionally does not describe sectors in detail for the following reasons: (1) that would duplicate other resources that provide that level of detail, (2) multisector support needs to be inclusive of all sectors, and focusing in detail on a select few would unintentionally exclude others. Rather, this section focuses on the importance of multisector supports, continuum of supports and needs, and the layering of interventions across sectors.

¹⁹ The MSP is currently being field tested in multiple settings.

OPERATIONALIZING THE MHPSS FRAMEWORK



*Together the social ecological model, the life course approach and the three domains of wellbeing create **UNICEF's framework for mental health and psychosocial Wellbeing.***

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

Together the social ecological model, the life course approach and the three domains of wellbeing create UNICEF's framework for mental health and psychosocial Wellbeing. The support system is built around the concentric circles of the social ecological model with the child/adolescent in the centre, their caregivers in the next circle and the community in the outer circle. The three circles of support are supported and surrounded by the enabling environment, which includes all the systems, policies and structures that are necessary for ensuring mental health and psychosocial wellbeing.

The model engages children as active agents in their ecosystems, in dealing with adversity and, in turn, influencing their families and communities. The layers and networks that exist within and between the circles of support provide for children's social and practical needs²⁰, protection, learning, belonging and identity, and their recovery from critical events. It is a way to visually represent and advocate for inclusive interventions that engage children, adolescents, families, and the community to generate positive change for children and families.

In this section of the framework, UNICEF demonstrates how to operationalize these approaches into a framework that is adaptable and responsive to the programming needs and implementation environment. The section opens with the MHPSS theory of change structured around the social ecological model. The following subsections provide additional discussion around each outcome and subsequent intermediary outcomes, key actions, and potential interventions. Application of the framework in your context may include all or part of the operational framework.

²⁰ Practical needs refer to tangible and immediate needs such as water, food, shelter, clothing, etc.

MHPSS THEORY OF CHANGE

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

UNICEF's MHPSS ultimate **impact** is that the mental health and psychosocial wellbeing of children, adolescents and their caregivers is supported and protected to survive in their communities and societies. This is achieved when MHPSS systems are mobilized, and strengthened to promote child, adolescent, and family wellbeing across **four key outcomes**:

Outcome 1:

Improved child and adolescent mental health and psychosocial wellbeing.

Outcome 2:

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

Outcome 3:

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

Outcome 4:

Improved enabling environment for MHPSS across the policy, legislation and financing systems, the MHPSS workforce, multisectoral supports and referral pathways, and MHPSS research and data.

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

1. addressing the systems and structures that are central to creating societies that value and respect individual and family mental health and psychosocial wellbeing across the social ecological model through strengthening the MHPSS service delivery infrastructure; and
2. addressing the individual's mental health and psychosocial wellbeing by responding to their individual needs (personal wellbeing), their relational needs (interpersonal wellbeing), and the skills and knowledge necessary for mental health and psychosocial wellbeing.

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

UNICEF's MHPSS Theory of Change

IMPACT



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

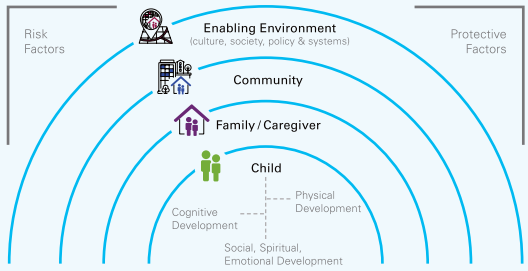
MHPSS LONG-TERM OUTCOMES



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



Outcome 2:
Improved caregiver mental health and psychosocial wellbeing including for parents, caregivers, mothers, family, and teachers



Outcome 3:
Improved community capacity at the district and subdistrict levels for non-stigmatizing, accessible, available, and quality MHPSS service delivery across the primary health care, social welfare and protection, and education systems and structures



Outcome 4:
Improved enabling environment for MHPSS across the policy, legislation and financing systems, the MHPSS workforce, multisectoral supports and referral pathways, and MHPSS research and data

MHPSS INTERMEDIARY OUTCOMES*



Outcome 1.1
Outcome 1.2
Outcome 1.3



Outcome 2.1
Outcome 2.2
Outcome 2.3



Outcome 3.1
Outcome 3.2
Outcome 3.3



Outcome 4.1
Outcome 4.2
Outcome 4.3
Outcome 4.4

* See [Annex 7: UNICEF's comprehensive theory of change](#)



Determinants of Mental Health & Psychosocial Wellbeing:

Lack of secure attachment and/or nurturing care, Violence, exploitation, abuse in the home, Caregiver MH, Poverty, Disease outbreaks, Race and Gender, Exposure to adverse experiences, Prolonged conflict terrorism, mass displacement, family separation, Intensifying natural disasters and climate change.



Barriers:

Stigma and structural discrimination, Lack of political will, Lack of (and access to) health care and services and skilled workforce, Poor quality of limited services; Lack of data, research and analysis; Human rights violations, violence, abuse, coercion in formal and informal institutions, Lack of sustainable resources and political will, lack of MHPSS financing within Universal Health Coverage Benefit packages/schemes with countries, Scale of social determinants: poverty, inequalities, (gender based) violence, childhood adversity, Lack of coordinated emergency response, Poor integration of physical and mental healthcare and comorbidities, lack of shared community identity or dispersion in urban areas.



Problem:

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

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

In children and adolescents, **wellbeing** results from the interplay of physical, psychological, cognitive, emotional, social and spiritual aspects that influence their ability to grow, learn and develop to their full potential.

Resilience is the capacity to overcome adversity and adapt after difficult experiences. The resilience of children results from their innate strengths and capacity for coping, and the risk and protective factors in their social and cultural environments. These may include personal factors (personality, genetic makeup, presence or absence of disabilities); social factors (positive or negative family environments, supportive teachers, positive friendships); and environmental factors (access to essential services and protection, safety of their environment, inclusion and belonging in society). Evidence shows that resilience can be developed in children and adolescents when (1) parents and caregivers are responsive to their social-emotional, early learning and material needs, (2) children have access to learning opportunities, and (3) social cohesion within the community is also strengthened.²¹

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

- ❑ **Safety:** The extent to which a child is secure and free from fear and harm (both physical and psychological) in their relationships and their physical environment.

- ❑ **Stability:** The degree of predictability and consistency in their social, emotional and physical environments.
- ❑ **Nurturance:** The extent to which parents and caregivers are available and able to meet the needs of children and adolescents sensitively and consistently.

In both development and humanitarian contexts, the presence of a stable adult **caregiver**²² aids children and adolescents' overall sense of wellbeing, and re-establishing routines (during times of personal, familial or external crisis) can boost the child and adolescent's coping and recovery. However, caregivers may have their own mental health and psychosocial needs, which may challenge their ability to offer safety, stability and nurturance to the children in their direct care. MHPSS interventions should therefore prioritize the mental health and wellbeing of caregivers, including through preventive and promotive parenting programmes, and responsive care as needed.

The wellbeing of children is thus directly related to their relationships with their caregivers/parents, teachers and the broader community, and is interconnected with their cognitive, physical, social, spiritual and emotional development. It is understood across the three domains of wellbeing:

- ❑ safe & nurturing environments at home, school and in the community.
- ❑ positive relationships that promote inclusion, equality, belonging, and agency.
- ❑ opportunities for stimulation, learning and skills development.

²¹ [SOWC on mental health and wellbeing](#)

²² 'Caregiver' refers to those responsible for the care of children, and may include mothers and fathers, grandparents, siblings and others within the extended family network, as well as other child caregivers, such as teachers, outside of the family network.

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

Safe, nurturing environments at home, school and in the community ensure that children and adolescents are protected from harm, abuse, neglect and violence, and that they receive nurturing care and support in coping with events in their lives, including the ability to respond to violence and abuse when it occurs.²³

There is considerable research proving the significant role that nurturing plays in the earliest stages of child development, which includes how the mother's health during pregnancy affects the child's development over the life course. Children develop rapidly during their first 1,000 days (about two and a half years), laying a foundation for their growth and development over their life course.²⁴ Interventions and services within this outcome are specifically focused on the environmental and individual needs of the child and adolescent.

Safe and nurturing environments at home, at school and in the community are fundamental to the emotional and psychological development of children and adolescents. Support and training for parents and caregivers is important for creating loving, nurturing relationships at home. Children from birth until the age of school entry and beyond depend on nurturing care from their caregivers, learning how to express basic needs and wants, how to recognize emotions in others and express their own emotions. Initially, these relationships are with their primary caregivers, but as they grow and mature social interaction becomes increasingly more important. Young children, from ages five to nine, learn how to play and interact with other children, and then when they enter their early adolescent years (10 to 14 years) their peer relationships become influential on their thoughts and

actions. The young person's interpersonal wellbeing depends on such relationships. They also help to shape their social skills and teach them how to relate with others including across gender, those with disabilities and other minorities. Positive relationships promote young people's inclusion and belonging, and help to build their sense of agency.

Support and training for teachers and others involved in child-focused activities can further help to ensure that adult caregivers have a positive impact on the mental health and psychosocial wellbeing of all children and are equipped to know how to support and, when necessary, refer children who have experienced stressful events for appropriate services. Capacity-building may focus on helping teachers create or adapt learning environments to better meet the learning, mental health and psychosocial wellbeing and safety needs of all in schools and learning environments in development and humanitarian contexts.

Outreach, identification and case management:

Community outreach, education and training of gatekeepers is important for early identification of young people who may need mental health and psychosocial support services. Children and families with specific health or protection needs may require outreach and case management services to assist with identification of and access to services, follow-up, and support. Effective case management requires trained and supervised staff competent in ethical, best practice standards. Referral resources and coordination mechanisms are also needed. Children with protection risks need to be identified quickly, systematically evaluated and referred for appropriate services. Child protection case workers should develop intervention plans that respond to the mental health and psychosocial needs of the child and other members of their family. For example, caregivers with a history of addiction will benefit from case management supports, follow-up and referrals to services across the

²³ WHO, UNICEF, World Bank Group, *Nurturing care for early childhood development: A framework for helping children survive and thrive to transform health and human potential*, Geneva: World Health Organization, 2018. Licence: CC BY-NC-SA 3.0 IGO.

²⁴ WHO and UNICEF, *Nurturing care for early childhood development: A global framework for action and results*, draft, 2018.

health, social welfare and protection systems. Case workers can assist in this process, by working with the families to formulate an action plan with the child and family/caregivers that is responsive to each person's support needs. This will involve ensuring confidential documentation and information management, referrals and monitoring and supporting follow-up appointments.

Case management systems in some settings may not be well developed, but they should not be

ignored, as this workforce will have culturally relevant knowledge and skills. It is important to find out if there is an existing university-trained workforce with the knowledge and skills for strengthening and building the case management infrastructure across health, education, and social welfare and protection systems. Multisectoral system strengthening is essential for establishing strong referral pathways, building capacity, and improving outreach and case management functions for vulnerable children and families.

EXAMPLE FROM THE FIELD

[forthcoming- field examples remain under development throughout the demonstration phase and will be added in the final version of the framework in 2022]























Intervention Table 1.

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

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

Intermediary Outcome 1.1: Children and adolescents have access to safe & nurturing environments, and to quality services that improve their mental health and psychosocial wellbeing: i) at home, ii) at school, and iii) in the community

Interventions may include:	Relevant Resources from The Compendium of Community Based MHPSS Resources
<p>Appropriate MHPSS care and professional social services for children with mental health and psychosocial conditions or children who have been exposed to serious protection violations.</p>	<p>Strategies & Approaches</p> <p>Resource 2.25. Inspire to end violence against children</p>
<p>   Care: Provide group psychological interventions for adolescents facilitated by a provider trained and supervised in an appropriate evidence-based approach.</p>	<p>Resource x.x. HAT (HELPING ADOLESCENTS THRIVE) Toolkit Global Framework on Transferable Skills</p>
<p>  Care: Provide individual psychological interventions facilitated by a trained provider for the treatment of a mental health condition.</p>	<p>Guidelines</p> <p>Resource 2.14. Guidelines for Child Friendly Spaces in Emergencies</p>
<p>  Care: Focused MHPSS for children with mental health and psychosocial conditions.</p>	<p>Resource 2.18 Interim Briefing note addressing mental health and psychosocial aspects of COVID-19 outbreak</p>
<p>  Care: Psychological interventions to support children with gaining autonomy in their daily life through activities that are meaningful, and learning strategies to cope with their mental health conditions.</p>	<p>Resource 2.24. Helping Hands at School and in the Community: Guidance for School-Based Psychosocial Programs for teachers, parents, and children in conflict and post-conflict areas.</p>
<p>   Prevention: Provide children with MHPSS support and psychoeducation to help them manage and cope with distress, mental health conditions or disabilities.</p>	<p>Resource 4.2 Promoting Rights with Psychosocial Disabilities and Community Living for Children</p>
<p>  Care: Case management services for child/adolescent survivors of gender-based violence, including access to counselling services, sexual and reproductive health and protection services.</p>	<p>Resource 6.7. Evaluation of Child Friendly Spaces: Tools and Guidance</p>
<p>   Care: Provide case management services that facilitate the management and support of children with mental health conditions or serious protection risks (e.g., helping them access medications and follow-up appointments).</p>	<p>Resource 6.2 MHPSS Assessments in the Context of Covid-19</p> <p>Programme Guidance</p> <p>Resource 2.5, Move on & Engage</p>
<p>  Promotion: Build MHPSS capacity among community workers and protection case managers in identification and referral, including follow-up support, for children in need of specialized care.</p>	<p>Resource 2.6 Working with Children and their Environment</p>
<p>Promotion: Integrate strategies for the prevention of suicide and self-harm across programmes.</p>	<p>Resource 2.7 Children/Youth Resilience Program</p>
<p> Identifying and referring children who have suffered serious protection risks or traumatic events for specialized care and support (e.g., clinical care by a mental health professional such as a psychologist or psychiatrist)</p>	<p>Resource 2.13. Toolkit for Child Friendly Spaces in Humanitarian Settings</p>
<p>Ensuring children have access to safe and nurturing environments that support their overall mental health and psychosocial development.</p>	<p>Resource 2.15. Safe Healing and Learning Space Toolkit</p>
<p>  Care: Support access to quality structured group activities for children's mental health and psychosocial wellbeing (e.g., creative, and expressive activities) within the community (e.g., in child-friendly spaces and learning spaces).</p>	<p>Resource 2.16. Psychosocial Support for Youth in Post-Conflict Situations: A Trainer's Handbook</p> <p>Resource 2.17 Different Just like you: A Psychosocial Approach Promoting the Inclusion of Persons with Disabilities, Training Guide</p>



Prevention: Build children's transferable skills, including the capacity to think critically, recognize misinformation, and resist peer pressure (including skills in digital literacy and coping with cyberbullying).



Prevention: Children and adolescents have access to quality learning and skills development in formal and non-formal education settings. Support initiatives that build safe, gender-responsive and supportive learning environments for children and adolescents, building positive teacher-student relationships and supportive peer relationships. Encourage school management to promote comprehensive school safety efforts that emphasize both physical and psychological safety.



Promotion: Set up interventions that promote school-age children and adolescents' mental health by enhancing social-emotional learning and skills building as well as substance use prevention (resource WHO-UNICEF HAT toolkit).



Promotion: Identify and address harmful behaviours and social and gender norms to reduce bullying, abuse, neglect, exploitation and violence against children and reduce the stigma with mental health and psychosocial problems.



Promotion: Advocate for the education sector to finance and promote universal access to transferable skill acquisition opportunities for children and adolescents of all ages, genders and abilities in schools and other learning environments, in both development and humanitarian contexts.

Considerations for Adaption

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

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

Resource 3.2 Broken Links: Psychosocial Support for People Separated from Family Members

Resource 4.1 mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings

Training

Resource 3.1 Child Protection Case Management Training Manual for Caseworkers, Supervisors and Managers

Resource 3.3 Non-specialized Counseling Trainer's Manual

Additional Resources:

[UNICEF Gender Responsive Parenting](#)

Early Adolescent Skills for Emotions (EASE): EASE (adolescent version of PM+). WHO (forthcoming). a psychological intervention for young adolescents and their caregivers.

[Align Advancing Learning and Innovation on Gender Norms: Thinkpiece, Social and gender norms and child marriage](#)

[Social Norms, gender norms and adolescent girls: a brief guide](#)

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

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

Relationships at home: Having positive social relationships with parents and caregivers, peers and the larger community is fundamental to children's mental health and psychosocial wellbeing, protection, and optimal development. The primary relationships for children from the prenatal period to birth and early childhood (0–4) are with the parents, primary caregivers, and other family members. Connection with nurturing, stable caregivers is protective for all children and crucial for the development of positive coping and recovery skills during crises. Loving families provide a foundation for children to develop self-esteem, skills for navigating life challenges, gender-equal values and a sense of structure, stability and predictability in their lives. From this starting point, the mental health and wellbeing of parents and caregivers strongly influences the wellbeing of children through responsive caregiving.²⁵ Thus, strengthening the quality of family relationships has protective effects on children's psychosocial wellbeing and development.

Relationships at school, in the community and with their peers:

Positive social relationships in the larger community (with peers, family friends, neighbours, teachers) also give children a sense of inclusion, supporting an enabling environment for their growth and development. As the child enters middle childhood (5–9) their sphere of relationships expands to include their school environment, particularly their relationships with teachers and their peers. In early adolescence (10–14) and late adolescence (15–18) their relationship base expands from home and school to include the community. In many cases, especially during adolescence, in the absence of family support or positive social relations young people are drawn towards a range of community supports, which have both positive and negative impacts. In addition to their protective role, supportive community networks provide opportunities for adolescents to engage with and contribute to their society. They also provide respite for overstressed parents and caregivers and encourage them to use positive parenting practices. Community engagement often happens spontaneously in spaces such as parks, community centres, places of worship, shrines, or water points, or in traditional women's gatherings. These natural connections and forums for connecting may be broken during emergencies and thus programmes may focus on supporting their reactivation.

²⁵ Responsive caregiver refers to the ability of the parent/caregiver to notice, understand and respond to their child's signals in a timely and appropriate manner. For more information see Nurturing Care, '[A closer look at the nurturing care components](#)', 2020.



Intervention Table 2.

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

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

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

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

Interventions may include:

Supporting all children, including those with mental health conditions or disabilities, to strengthen their interpersonal skills at home and in the community, and ensure that they are able to participate in their communities in meaningful ways.



Care: Adapting services and activities for children based on their specific needs; done by someone who is trained and qualified in adaptive services.



Promotion: Ensure access of children to age- and gender-appropriate individual and group psychosocial support interventions by qualified staff.



Prevention: Creative, cultural and sports activities for children of different ages that also engage their families and community members.



Promotion: Teachers and school administrators are trained and equipped with the necessary skills and knowledge for working with children and adolescents who have mental health and psychosocial conditions or disabilities, including when children need additional care and support beyond their skill set.

Establishing adolescent-specific activities that promote inclusion, belonging and agency.



Care: Support groups for adolescent parents (both mothers and fathers) that are responsive to their social and emotional needs, including the need to be included in activities that are responsive to their needs as an adolescent in addition to their needs as a caregiver.



Promotion: Opportunities for adolescents to contribute to the community, such as by leading activities for younger children, developing or promoting messages about health and coping, and helping in rebuilding efforts.



Preventive: Peer-to-peer groups, youth clubs and group cultural and leisure activities for adolescents, including groups specific to girls' and boys' needs, interests, transferable skills.



Prevention: Collaborate with children and other stakeholders to design, implement and jointly monitor child-friendly, accessible and confidential safeguarding feedback and reporting mechanisms.

Relevant Resources from [The Compendium of Community Based MHPSS Resources](#)

Strategies & Approaches

Resource 2.25. Inspire to end violence against children

Resource x.x. HAT ([HELPING ADOLESCENTS THRIVE](#))

Resource x.x: Global Framework on Transferable Skills

Guidelines

Resource 4.2 Promoting Rights with Psychosocial Disabilities and Community Living for Children

Resource 5.1 MHPSS and Participation Guidance

Resource 5.2 Engaged and Heard! Guidelines for Adolescent Participation and Civic Engagement

Resource 5.4 Mainstreaming psychosocial care and support through child participation

Programme Guidance

Resource 2.2. Adolescent Kit for Expression and Innovation

Resource 2.4. YouCreate Art Kit

Resource 2.5. Move On & Engage

Resource 3.1 Child Protection Case Management Training Manual for Caseworkers, Supervisors and Managers

Resource 2.32. Life Skills Course: The Deals

Resource 3.4 Psychological First Aid Training Manual for Child Practitioners

Resource 3.8 Boxes of Wonder

Resource 4.1 mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings

Resource 5.3 ARC Foundation Module on Children's Participation and Inclusion

Resource x.x: [Care for Child Development Package](#)

Training

Resource 3.3 Non-specialized Counseling Trainer's Manual

Resource 2.36 I Support My Friends

Resource 5.3 ARC Foundation Module on Children's Participation and Inclusion

Considerations for Adaption

Camp vs host community: Is the programme targeting a displaced population? Consider how programmes are bringing together children and adolescents from (1) different cultural groups and (2) similar cultural groups. Cultural activities are important for promoting mental health and psychosocial wellbeing. It's also essential that children and adolescents from different social groups have opportunities to develop positive relationships. Activities that bring together displaced populations with host communities can help promote positive mental health and psychosocial wellbeing.

EXAMPLE FROM THE FIELD

[forthcoming- field examples remain under development throughout the demonstration phase and will be added in the final version of the framework in 2022]

Intermediary Outcome 1.3: Children and adolescents have opportunities for stimulation, learning and skills development that contributes to mental health and wellbeing

As children grow, they gain skills and knowledge. Even in the first months of life, responsive parenting helps children develop the capacity to regulate their emotions and manage adversity. Age-appropriate opportunities for learning and stimulation help children develop problem-solving skills and social-emotional skills (for more information see [A World Ready to Learn](#)). Those opportunities come through supportive social interactions with positive role models; safe and supportive learning environments, both formal and non-formal; and participation in play, sports, creative activities, and the cultural and spiritual life of their communities. Opportunities for stimulation, learning and skills development appropriate to the child's age and developmental stage help children develop cognitive and social and emotional skills for life (for more information see [UNICEF's Global Framework on Transferable Skills](#)). These include problem-solving skills, understanding and expressing emotions, self-regulation, and the capacity to form and maintain relationships – all of which are essential for developing and maintaining resilience.

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

From A World Ready to Learn – advocacy brief.

Schools & safe spaces: Schools and learning environments are at the centre of communities,

serving as valued institutions and community focal points. Schools and learning environments are a crucial part of a wider systems approach to promoting mental health and wellbeing, including gender-equal and inclusive values, preventing mental health problems, and responding to the mental health needs of children and adolescents when required. Schools and learning environments are regarded as the ideal platform for promoting children's mental health and psychosocial wellbeing for several reasons: school provides the opportunity for access to a large population of children; children spend most of their time at school or other learning environments, and teachers and other education personnel play a crucial role in equipping children with the knowledge, attitudes and skills needed to maintain healthy lifestyles and develop critical thinking to address unhealthy behaviours and their physical, psychological and social consequences. Teachers are central to ensure children and adolescents' learning, safety, wellbeing and development. In addition to delivering academic content, teachers must provide a safe learning environment, support children's emotional needs, foster social cohesion, stimulate creativity, and provide the non-specialized foundations for developing transferable skills.

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

**Intervention Table 3.**

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

Outcome 1: Improved child and adolescent mental health and psychosocial wellbeing**Intermediary Outcome 1.3: Children and adolescents have opportunities for stimulation, learning and skills development that contributes to mental health and wellbeing***This approach uses age and developmentally appropriate activities to help children develop cognitive and social and emotional skills.***Interventions may include:**

Supporting access to and engagement in age-appropriate cultural, recreational, and supportive activities (e.g., youth clubs; adolescent peer-to-peer groups; cultural events for healing, normalization, and recovery).

**Care:** Support young children's access to and participation in early childhood development activities and opportunities for early childhood education, and mothers' and babies' access to supportive feeding programmes in baby friendly spaces (BFSs).**Prevention:** Responsive infant caregiving through mother-baby interactions (e.g., in feeding centres, BFSs).**Prevention:** Support identification, family tracing and reunification, and appropriate care for separated children.**Promotive:** Promoting effective collaboration between caregivers, the community, school management and teachers to ensure that schools/learning environments are welcoming, inclusive, safe, and promote all children and adolescents' mental health and psychosocial wellbeing.**Prevention:** Provide children with support and psychoeducation to help them manage and cope with distress, mental health condition or disabilities.**Promotion:** Group recreational and sports activities that promote problem-solving skills, emotional regulation, and the capacity to form and maintain relationships.**Promotion:** Building capacities for teachers in social and emotional learning. Build the capacity of teachers and other education personnel to assist children and adolescents in learning about mental health; develop healthy habits and connect students with additional support when needed.²⁶

Supporting interventions that promote mental health and prevent mental health conditions and substance abuse among school-age children and adolescents.

**Prevention:** Training of caregivers including teachers, counsellors, social workers, and health providers to identify refer children with MHPSS needs to available services as appropriate.**Promotion:** Group activities for child and adolescent wellbeing that build interpersonal, emotional regulation, problem-solving and stress management skills.**Relevant Resources from [The Compendium of Community Based MHPSS Resources](#)****Strategies & Approaches**

Resource 2.25. Inspire to end violence against children

Resource x.x. HAT ([HELPING ADOLESCENTS THRIVE](#))Resource x.x: [Early Childhood Accelerator](#), Analysis & Planning toolkit kit: Social and Emotional Learning resources**Guidelines**

Resource 2.14. Guidelines for Child Friendly Spaces in Emergencies

Resource 2.18 Interim Briefing note addressing mental health and psychosocial aspects of COVID-19 outbreak

Resource 2.24. Helping Hands at School and in the Community: Guidance for School-Based Psychosocial Programs for teachers, parents and children in conflict and post-conflict areas

Resource 2.28 Interagency Guidance Note for integrating early childhood development (ECD) Activities into Nutrition Programs in Emergencies. Why, What and How

Resource 6.7. Evaluation of Child Friendly Spaces: Tools and Guidance

Programme Guidance

Resource 2.5 Move on & Engage

Resource 2.6 Working with Children and Their Environment

Resource 2.7 Children's Resilience Program

Resource 2.8 Youth Resilience Program

Resource 2.13 Toolkit for Child Friendly Spaces in Humanitarian Settings

Resource 2.15 Safe Healing and Learning Spaces

Resource 2.16. Psychosocial Support for Youth in Post-Conflict Situations

²⁶ UNICEF Learning Brief: Integrating MHPSS into Education (forthcoming 2022)



Promotion: Coordinating with the education sector to establish or strengthen school-based mental health and psychosocial promotion and services (i.e., school health programme which includes counselling/psychosocial support and referrals).



Promotion: Awareness raising, and behaviour change about mental health and psychosocial needs within health-care and school settings to address stigma and discrimination.

Improving children's physical and emotional development through health and nutrition, education, and services for caregivers and children:

Prevention: Facilitating basic nutrition and promoting the continuation of exclusive breastfeeding, from immediately after birth to six months of age, together with skin-to-skin body contact and responsive feeding practices.

Promotion: Supporting children's physical and emotional development in all health and nutrition activities by building the capacity of caregivers in nurturing and responsive care.

Resource 2.17 Different. Just like you: A Psychosocial Approach Promoting the Inclusion of Persons with Disabilities, Training Guide

Resource 2.29 Baby Friendly Spaces (BFS): A Holistic Approach for pregnant, Lactating Women and their very young children in emergencies

Resource 2.30. Manual for The Integration of Child Care Practices and Mental Health Within Nutrition Programs

Resource 4.1 mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings

Resource x.x: [Care for Child Development Package](#)

Resource x.x [Caring for the Caregiver](#)

Training

Resource 2.22. Psychosocial Training Manual for Teachers

Resource 3.1 Child Protection Case Management Training Manual for Caseworkers, Supervisors and Managers

Considerations for Adaption

Children with high levels of distress: Education programmes may need to be adapted for children and adolescents living in complex emergencies and/or under high levels of distress (extreme poverty, violence in the home, etc.). These children may need additional support in learning basic concepts and/or catching up to their age to grade levels.



Outcome 2: Improved caregiver mental health and psychosocial wellbeing including for parents, caregivers, mothers, family, and teachers

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

Exposure to traumatic experiences, intimate partner violence, extreme poverty, attacks on schools, and exposure to violence in the home and the community are just some of the risk factors that can affect the mental health and wellbeing of families, caregivers and teachers. Providing support to parents, caregivers and teachers that is focused on their individual needs, coping skills and recovery is necessary for their overall wellbeing and essential to give them the emotional margin necessary to provide children with nurturing care. Achieving this outcome requires strategies that support caregiver wellbeing, coping and recovery, interpersonal wellbeing through family and community support networks, and strengthening and building the necessary skills and knowledge for parenting and supporting children in distress. Interventions for caregivers across these three domains equip them to be responsive to both their needs and the needs of the child in their care.

Intermediary Outcome 2.1: Families/ parents/ caregivers and/or teachers have access to support for developing and maintaining improved mental health and psychosocial wellbeing

Parents and other caregivers (extended family, foster families, teachers, health workers) may require support to cope with distress when it is affecting their own daily lives and wellbeing. Interventions that support caregivers (of all genders) will fall at all layers of the intervention pyramid and will include universal prevention and promotion support²⁷, focused care for distressed caregivers, specialized MHPSS care for caregivers with mental health and psychosocial conditions, and interventions to develop or strengthen positive coping mechanisms. Caregivers may require additional support during emergencies to cope with the impacts of the emergency on their own daily lives and wellbeing. Activities targeting caregivers should be adapted to respond to the unique mental health needs of adolescent parents and caregivers.

Parents, primary caregivers and family wellbeing:

Parents and primary caregivers (of all genders) play a leading role in shaping and directing the experiences and opportunities for children's learning, growth, mental and physical health, psychosocial wellbeing and development.²⁸ While the parent-child relationship will change over the life course it will always be a critical and dynamic relationship. In 2018 WHO launched *Nurturing care for early childhood development: A global framework for action and results*.²⁹ It emphasized the direct linkage between child wellbeing and caregiver mental health, noting that "because

²⁷ Rochat T.J., Redinger S., Rozentals-Thresher R., Yousafzia A., Stein A. (2019). *Caring for the Caregiver*. UNICEF, New York.

²⁸ A UNICEF for Parents Vision – Draft document

²⁹ WHO, UNICEF, World Bank Group, *Nurturing care for early childhood development: A framework for helping children survive and thrive to transform health and human potential*, Geneva: World Health Organization, 2018. Licence: CC BY-NC-SA 3.0 IGO.

responsive care is driven by emotions and motivations – mental health problems can disrupt parenting and caregiving.” When caregivers struggle with their own

mental health and psychosocial wellbeing it is difficult to provide their children with the nurturing care and support that is so essential for their development.

AN IMPORTANT FOCUS ON MATERNAL MENTAL HEALTH AND PSYCHOSOCIAL WELLBEING

The perinatal period, from conception up to one year post-partum, is a time of huge social, physiological and psychological change for women. Childbirth is generally perceived as a positive event in most cultures; however, research suggests that between 20 and 40 per cent of women experience negative psychological symptoms related to the pregnancy and birth.^{30,31,32,33} The prevalence of mental health conditions in the perinatal period is 15–29 per cent,³⁴ with depressive and anxiety disorders being the most common conditions.³⁵ In addition, these disorders are more prevalent in low- and middle-income countries (LMICs) than high income countries (HIC) and they might have a strong effect on the new baby and the wellbeing of the family, especially other children in the family.³⁶ “Screening for psychosocial risk factors during pregnancy is a preventive measure which allows early identification and can enable a network of professional support for the provision of psychological care.”³⁷ “Educating and engaging health professionals providing health care on maternal mental health needs can help to improve mother-child attachment and optimize a healthy start in life.”³⁸

The UNICEF parenting strategy identifies helping parents understand their own mental health and psychosocial needs as essential for enhanced parenting across the life course. From prenatal to early childhood (before birth to age of school entry) it’s essential to focus on maternal mental health and psychosocial wellbeing. Parental stress management skills and coping skills during pregnancy and early childhood have a direct impact on the cognitive and emotional development of the child.³⁹ For parents of children six to ten years of age parents need support in understanding their child’s emotions and social needs

as well as understanding the importance of mental health.⁴⁰ For adolescents (10–18), parents need to continue to nurture their relationships with their child, ensuring an awareness of their child’s emotional and social wellbeing. This includes equipping parents with the necessary skills to identify when their child needs additional support, awareness of emerging mental health issues, and parenting skills for preventing self-harm.⁴¹ Lastly, adolescent parents may need additional supports that are responsive to both their developmental needs, as discussed in the child circles of support, and their needs as parents.

³⁰ Creedy, D. K., I. M. Shochet, and J. Horsfall, ‘Childbirth and the development of acute trauma symptoms: Incidence and contributing factors’, *Birth*, (2000) doi: 10.1046/j.1523-536x.2000.00104.x.

³¹ Soet, J. E., G. A. Brack, and C. Dilorio, ‘Prevalence and predictors of women’s experience of psychological trauma during childbirth’, *Birth*, 2003. doi: 10.1046/j.1523-536x.2003.00215.x

³² Ayers, S., R. Harris, and A. Sawyer, ‘Posttraumatic stress disorder after childbirth: Analysis of symptom presentation and sampling’, *Journal of Affective Disorders*, 2009. doi: 10.1016/j.jad.2009.02.029.

³³ Alcorn, K. L., A. O’Donovan, J. C. Patrick, D. Creedy, and G. J. Devilly, ‘A prospective longitudinal study of the prevalence of post-traumatic stress disorder resulting from childbirth events’, *Psychological medicine*, vol. 40, no. 11, 2010, pp. 1849–1859.

³⁴ Vesga-López, O., C. Blanco, K. Keyes, M. Olfson, B. F. Grant, and D. S. Hasin, ‘Psychiatric disorders in pregnant and postpartum women in the United States’, *Arch Gen Psychiatry*, vol. 65, no. 7, 2008, pp. 805–815. [PMC free article][PubMed] [Google Scholar]

³⁵ National Collaborating Centre for Mental Health (UK), ‘Antenatal and postnatal mental health: clinical management and service guidance: updated edition’.

³⁶ Howard, L. M., P. Piot, and A. Stein, ‘No health without perinatal mental health’, *Lancet*, 2014, 384(9956), pp. 1723–1724. [PubMed] [Google Scholar]

³⁷ Spyridou A., M. Schauer, and M. Ruf-Leuschner, ‘Prenatal screening for psychosocial risks in a high risk-population in Peru using the KINDEX interview’, *BMC Pregnancy Childbirth*, 16:13, Jan 22, 2016. doi: 10.1186/s12884-016-0799-x. PMID: 26801404; PMCID: PMC4722714.

³⁸ Seng, J. S., M. Sperlrich, L. Kane Low, D. Ronis, M. Muzik, and I. Liberzon, ‘Childhood Abuse History, Posttraumatic Stress Disorder, Postpartum Mental Health, and bonding: A Prospective Cohort Study’, *Journal of Midwifery and Women’s Health*, vol. 58, 2013, pp. 57–68.

³⁹ Parenting Strategy – draft document

⁴⁰ Parenting Strategy – draft document

⁴¹ Parenting Strategy – draft document

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

Teacher wellbeing: The individual wellbeing of teachers is essential for ensuring a nurturing and responsive teacher–student relationship. Teacher stress impacts both the quality of teaching and the quality of learning, and it may also have a negative effect on the wellbeing of the child. Their gender, uncertainty about employment status, their level of education, teaching experience, coping mechanisms, and displacement are all factors that will affect the teacher's individual sense of wellbeing.⁴² These factors of wellbeing may be compounded with additional factors that may cause distress – such as teaching in the aftermath of a natural disasters, in a conflict-affected area, in a poorly resourced school, and areas with high rates of community violence. Teacher's may need individual support in coping in difficult circumstances.

Efforts to support teacher wellbeing should consider advocating for the inclusion of teacher wellbeing in national education policies and the availability of resources for teachers to receive psychological and social-emotional support. It is also essential to integrate into pre- and in-service teacher professional development content on gender and culturally sensitive mental health and psychosocial support services in educational institutions. This includes providing practical information on recognizing signs of distress in both staff and learners. Teachers should be given training and tools that enable them to help children reduce stress, foster resilience and coping, and build supportive relationships, preventing short and long-term psychological problems.

Teaching can be an extremely stressful profession, particularly in low resource, crisis, and conflict-affected contexts. **Teachers' stress** not only has negative consequences for teachers themselves, but it also results in lower achievement for students and higher costs for education. **Teachers need support** to continue teaching as they are the backbone of keeping children and adolescents learning and thriving.⁴³ **Teacher wellbeing must be a central consideration** when developing mental health and psychosocial support policies and systems.

⁴² [TWB Landscape Review August 2019_0.pdf \(inee.org\)](#)

⁴³ Falk, Danielle, E. Varni, J.F. Johna, & P. Frisoli, [Landscape Review: Teacher Well-being in Low Resource, Crisis, and Conflict-affected Settings.](#), Education Equity Research Initiative. 2019



Intervention Table 4.

Interventions and activities for developing and maintaining improved wellbeing, coping and recovery in families, parents, caregivers, and/or teachers

Outcome 2: Improved caregiver mental health and psychosocial wellbeing including for parents, caregivers, mothers, family, and teachers

Intermediary Outcome 2.1: Families/parents/caregivers and/or teachers have access to support for developing and maintaining improved mental health and psychosocial wellbeing

Interventions may include:

Specialized social services and/or mental health care for caregivers with mental health conditions, elevated levels of distress, or who have been exposed to serious protection violations.



Care: Individual evidence-based psychological interventions with a trained & supervised mental health provider trained in the treatment of a mental health condition.



Care: Case management for caregivers to support with gaining autonomy in their daily life through activities that are meaningful and learning strategies to cope with their mental health conditions.



Care: Case management services for families and caregivers dealing with mental health and psychosocial conditions in the home, including access to counselling services and protection & welfare services.



Care: Provide focused psychosocial care (for example: scalable psychological interventions, psychological first aid, support groups for parents) for distressed parents/caregivers.



Care: Facilitate the management and support of caregivers with mental health conditions or serious protection risks (e.g., helping them access medications and follow-up appointments).



Care: Implement MHPSS interventions for caregivers in need of additional support within antenatal and postnatal care services, including home visits.



Prevention: Ensure referral and access to clinical MHPSS and professional social services for caregivers/family members with mental health conditions or protection concerns.



Prevention: Assist referral and access of vulnerable families to therapeutic interventions (e.g., evidence-based psychological interventions) and specialized social services.



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

Considerations for Adaption

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

Relevant Resources from [The Compendium of Community Based MHPSS Resources](#)

Strategies & Approaches

Resource 2.25. Inspire to end violence against children: Parent & Caregiver Support; Education and Life Skills

Programme Guidance

Resource 3.2 Broken Links: Psychosocial Support for People Separated from Family Members

Resource 6.6 Assessing mental health and psychosocial needs and resources: Toolkit for humanitarian settings

Resource x.x [Caring for the Caregiver](#): CFC aims to build front-line workers' skills in strengths-based counselling to increase caregivers' confidence and help them develop stress management, self-care and conflict resolution skills to support their emotional wellbeing

Training

Resource 2.17 Different. Just like you: A Psychosocial Approach Promoting the Inclusion of Persons with Disabilities, Training Guide

Resource 2.22. Psychosocial Training Manual for Teachers

Resource 3.1 Child Protection Case Management Training Manual for Caseworkers, Supervisors and Managers

Resource 3.3 Non-specialized Counseling Trainer's Manual

Intermediary Outcome 2.2: Parents/caregivers have access to family and community support networks that improve their mental health and psychosocial wellbeing

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

Family and community support networks:

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

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

The interpersonal dynamics in the school context should also be considered as these relationships will impact the overall wellbeing of teachers and students. Positive peer relationships between teachers contributes to improved overall wellbeing, as do the relationships between teachers and school leadership, teachers and parents, and the resources available at the school. Schools should foster supportive teaching environments that are collaborative as opposed to competitive and pressure driven.

MHPSS activities that engage caregivers at this layer can include parent-teacher committees, involving parents and caregivers in coaching or mentoring children, and engaging families and caregivers in school events such as sporting or cultural activities. The community may participate in ensuring that safe structures are developed and maintained for formal and non-formal education, and in identifying and embracing vulnerable children (e.g., children with disabilities).











Intervention Table 5.

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

Outcome 2: Improved caregiver mental health and psychosocial wellbeing including for parents, caregivers, mothers, family, and teachers

Intermediary Outcome 2.2: Parents/caregivers have access to family and community support networks that improve their mental health and psychosocial wellbeing

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

Interventions may include:	Relevant Resources from The Compendium of Community Based MHPSS Resources
<p>Providing access to support (community support, focused or specialized care) for caregivers.</p>	<p>Strategies & Approaches</p> <p>Resource 2.25. Inspire to end violence against children: Parent & Caregiver Support</p>
<p> Care: Group evidence-based psychological interventions for caregivers facilitated by a trained and supervised MHPSS provider.</p>	<p>Programme Guidance</p> <p>Resource 3.2 Broken Links: Psychosocial Support for People Separated from Family Members</p>
<p> Prevention: Strengthen networks of support for parents, teachers, and other caregivers in the community through, for example, peer support groups (for parents, mothers/women, father/men) and/or safe spaces (for mothers and lactating women, Baby Friendly Spaces).</p>	<p>Resource x.x, Caring for the Caregiver: CFC aims to build frontline workers' skills in strengths-based counselling to increase caregivers' confidence and help them develop stress management, self-care and conflict-resolution skills to support their emotional wellbeing.</p>
<p> Promotion: Promote effective collaboration between caregivers, the community, school management and teachers to ensure that schools/learning environments are welcoming, inclusive, safe, and promote all children and adolescents' mental health and psychosocial wellbeing.</p>	<p>Resource x.x: REAL Fathers Initiative</p>
<p> Prevention: Mother-infant groups that support responsive caregiving (e.g., providing MHPSS in breastfeeding spaces).</p>	<p>Training</p> <p>Resource 2.17 Different. Just like you: A Psychosocial Approach Promoting the Inclusion of Persons with Disabilities, Training Guide</p>
<p>Prevention: Provide routine forums for psychosocial support of teachers and educators.</p>	<p>Resource 3.1 Child Protection Case Management Training Manual for Caseworkers, Supervisors and Managers</p>
<p> Promotion: Facilitating inclusion and participation of families of people with mental health conditions, disabilities and/or protection risks in communal activities that is responsive to their needs.</p>	<p>Resource 3.3 Non-specialized Counseling Trainer's Manual</p>
<p>Strengthening services and systems for nurturing and responsive caregiving.</p>	
<p> Prevention: Provide social support to parents and primary caregivers, including through parents' associations and support groups, school and community-based activities.</p>	
<p> Prevention: Promote bonding and responsive parenting between infants/young children and parents/primary caregivers through guided early childhood development sessions.</p>	
<p> Promotion: Support governments and partners to strengthen cross-sectoral coordination and collaboration to design, implement and evaluate context, gender and age-specific and evidence-based strategies, plans, and policies to address the mental health and psychosocial support needs of children, adolescents, parents/ caregivers and teachers in schools and learning environments.</p>	

Promotion: Promote learning as something that can happen in everyday moments and through responsive and affectionate interactions between children and their caregivers and teachers.



Promotion: Raise awareness of and promote responsive caregiving through national and community-based communication for development campaigns. Highlight the benefits of responsive caregiving: protecting children against injury and the negative effects of adversity, supporting the recognition of and appropriate response to illness, promoting healthy brain, emotional and physical development, and building trust and social relationships.

Promotion: Raise awareness of early childhood development as a 'pathway to peace'.⁴⁴

Considerations
for Adaption

Age responsive: Some interventions may need to be adapted for the age of the caregivers. For example, some children may live with elderly caregivers and/or in child-headed households. Responding to the mental health and psychosocial needs of the primary caregiver should also take into consideration any additional needs based on the age of the caregiver.

EXAMPLE FROM THE FIELD

[forthcoming- field examples remain under development throughout the demonstration phase and will be added in the final version of the framework in 2022]

⁴⁴ Leckman, J., C. Panter-Brick, and R. Salah, Pathways to Peace: The transformative power of children & families, MIT Press, 2014.

Intermediary Outcome 2.3: Caregivers/family develop skills for parenting and supporting children and adolescents in distress (MHPSS needs)

Knowledge, skills and behaviour for supporting children in distress can help improve the quality of caregiver–child practice and interactions at home and school and in the community. Caregivers may benefit from information and initiatives that build their skills in responsive caregiving. This also helps caregivers to know when a child may need referral for more specialized support. Information about stress reactions of children at different ages and developmental stages – and strategies to support them – can help parents re-establish a sense of their own effectiveness as parents in challenging situations. Support groups for parents/caregivers of children with mental health conditions, developmental disabilities or serious distress can provide forums for sharing resources, information and strategies. This can be particularly beneficial for parents of children with disabilities who may deal with both stigma and being isolated at home with poor support systems, limited access to school, ECE (early childhood education) or specialized services.

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









Teachers would benefit from a wide range of skills and knowledge that includes both techniques for supporting distressed children and the necessary skills and knowledge for teaching at the right level. Level of education, teaching experience, content knowledge and cultural competence were all identified as factors impacting a teacher’s wellbeing. Relevant topics for MHPSS capacity-building among caregivers include:

- ❑ being aware of your own mental health and psychosocial wellbeing needs,
- ❑ understanding and practising self-care for caregivers,
- ❑ the conditions for optimal child development,
- ❑ how children of different ages respond to and understand stressful and traumatic events,
- ❑ skills training in active and empathic listening (i.e., psychological first aid),
- ❑ knowing one’s limits and how and when to refer,
- ❑ supporting parents and caregivers,
- ❑ how to foster a positive classroom and school environment instead of a competitive and pressure-inducing one.



Intervention Table 6.

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

Outcome 2: Improved caregiver mental health and psychosocial wellbeing including for parents, caregivers, mothers, family, and teachers	
<p>Intermediary Outcome 2.3: Caregivers/family develop skills for parenting and supporting children and adolescents in distress (MHPSS needs) <i>This approach improves the quality of caregiver–child interactions at home, school and in the community, and helps caregivers to know when a child may need referral for more specialized support.</i></p>	
Interventions may include:	Relevant Resources from The Compendium of Community Based MHPSS Resources
<p>Caregivers are equipped with the necessary skills and knowledge to be responsive to their own wellbeing and that of the children under their care.</p>	
 <p>Prevention: Caregivers receive psychoeducation on stress reactions, coping and recovery.</p>	<p>Strategies & Approaches</p> <p>Resource 2.25. Inspire to end violence against children: Parent & Caregiver Support.</p> <p>Resource x.x. HAT (HELPING ADOLESCENTS THRIVE) Toolkit: Strategy 3: Caregiver Supports</p> <p>Resource x.x: Global Framework on Transferable Skills⁴⁵</p> <p>Guidelines</p> <p>Resource 2.18 Interim Briefing note addressing mental health and psychosocial aspects of COVID-19 outbreak</p> <p>Resource 2.24. Helping Hands at School and in the Community: Guidance for School-Based Psychosocial Programs for teachers, parents, and children in conflict and post-conflict areas.</p> <p>Resource 2.28 Inter-agency Guidance Note for integrating early childhood development (ECD) Activities into Nutrition Programs in Emergencies. Why, What, and How</p> <p>Resource 4.2 Promoting Rights with Psychosocial Disabilities and Community Living for Children</p> <p>Programme Guidance</p> <p>Resource x.x Caring for the Caregiver</p> <p>Resource 2.6 Working with Children and Their Environment</p> <p>Resource 2.7 Children's Resilience Program, Parenting support</p> <p>Resource 2.8 Youth Resilience Program, Parenting support</p> <p>Resource 2.15. Safe Healing and Learning Spaces, Parenting modules</p> <p>Resource 2.17 Different. Just like you: A Psychosocial Approach Promoting the Inclusion of Persons with Disabilities, Training Guide</p>
 <p>Prevention: Strengthen family care and nurturing family environments through positive parenting training (e.g., how to help children of different ages and developmental stages cope with emergency).</p>	
 <p>Prevention: Strengthening capacity of caregivers to provide nurturing, responsive care to meet children’s daily needs.</p>	
 <p>Prevention: Build capacity of families/caregivers in self-help and mutual support for specific psychosocial problems (e.g., scalable problem management self-help interventions).</p>	
 <p>Prevention: Support teachers by equipping them with the necessary skills for ensuring their own wellbeing, establishing positive coping skills and the necessary knowledge and skills for each age group and subject that they teach.</p>	
 <p>Promotion: Provide training and information on positive parenting knowledge, skills, and behaviour among caregivers.</p>	
 <p>Promotion: Building teacher and other educators’ capacity to support children with mental health and psychosocial needs and facilitate their meaningful participation</p>	
 <p>Promotion: Build the capacity of parents and other caregivers (teachers) to support distressed children (e.g., PFA, parenting skills training to support children with disabilities) and in self-care.</p>	
<p>Caregivers are equipped with the necessary skills and knowledge to be responsive to their own wellbeing and that of the children under their care.</p>	
 <p>Care: Support to distressed caregivers through culturally appropriate models of engagement (e.g., gender-specific support groups; focused support or treatment for caregivers).</p>	

⁴⁵ UNICEF, Global Framework on Transferable Skills, 2019.



Prevention: Build the capacity of education staff through pre-service teacher training to promote safety, respect, and non-discrimination in learning environments, including through programmes that promote gender equality and meaningful participation of all children.



Prevention: Build capacity for caregivers to navigate the MHPSS care systems (e.g., to ensure adherence to treatment protocols; to advocate for adequate care for their children).

Providers who work with caregivers are equipped with the necessary skills and knowledge to deliver effective and quality MHPSS services across the MH continuum of care, prevention and promotion.



Prevention: Train and supervise non-specialized staff to provide individual and group psychosocial interventions for vulnerable caregivers/families (e.g., support to mothers with post-partum depression, interpersonal group therapy).



Prevention: Training parents, health workers and other caregivers in supporting children with mental health conditions.



Prevention: Build capacity among community MHPSS workers in identification, referral and case management for parents/caregivers in need of specialized care.



Prevention: Build capacity and self-care of teachers to create positive, safe classroom environments.

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



Prevention: Support parents'/caregivers' ability to provide for the family's basic needs (e.g., facilitate access to livelihood strategies).

Building capacity of teachers and other educators in the knowledge and provision of MHPSS.



Prevention: Training teachers to (a) observe children and adolescents' behaviour and identify mental health and psychosocial concerns, (b) provide basic psychosocial support, and (c) refer children and adolescents in need of specialized MHPSS services.



Promotion: Work with governments and partners to promote the integration of MHPSS literacy and transferable skills grade-level curriculum in national education curricula (aiming for universal access to transferable skills in pre-schools, primary and secondary school, and other learning settings). When possible, advocate for the inclusion of MHPSS staff and resources in the national/subnational school system, including a specialized team to intervene in crisis (school attacks, natural disasters, and other emergencies, etc.)



Promotion: Ensure managers of schools and learning centres understand and prioritize an inclusive, child-friendly, supportive and gender-equal educational environment where teachers regularly interact with children on an individual level and without discrimination.

Resource 2.29 Baby Friendly Spaces (BFS): A Holistic Approach for pregnant, Lactating Women and their very young children in emergencies

Resource 3.2 Broken Links: Psychosocial Support for People Separated from Family Members

Resource 4.1 mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings

Resource 6.6 Assessing mental health and psychosocial needs and resources: Toolkit for humanitarian settings

Resource x.x: Care for [Child Development Package](#)

Training

Resource 2.22. Psychosocial Training Manual for Teachers

Resource 3.1 Child Protection Case Management Training Manual for Caseworkers, Supervisors and Managers

Resource 3.3 Non-specialized Counseling Trainer's Manual



Promotion: Advocate and provide technical support to design, implement and evaluate pre-service and in-service professional development programmes to develop teachers' MHPSS capacity. Supporting programmes that give teachers MHPSS literacy training, subject matter knowledge and appropriate skills to support transferable skills development. These skills include psychological first aid as well as the use of non-judgemental, child friendly, and normalizing language with children and caregivers exhibiting any sign of distress or mental health issues.

Considerations for Adaption

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

EXAMPLE FROM THE FIELD

[forthcoming- field examples remain under development throughout the demonstration phase and will be added in the final version of the framework in 2022]



Outcome 3: Improved community capacity at the district and subdistrict levels for non-stigmatizing, accessible, available, and quality MHPSS service delivery across the primary health care, social welfare and protection, and education systems and structures

The community level of support describes an overarching approach to the delivery of mental health and psychosocial support that is (1) accessible within the community, (2) free or affordable, and (3) rooted in community-led action and response at the district and subdistrict levels. This includes both community-based approaches to MHPSS and community-led interventions and services for MHPSS. Community-based interventions provide more strategic psychosocial and mental health approaches with the aim of building on existing individual and community resources, capacities and resilience. A community-based approach for MHPSS is challenging. It requires time and commitment, and a willingness to listen and be open to new ideas and ways of approaching problems. It also requires the ability to address harmful practices or historical patterns of exclusion and marginalization of some groups effectively and respectfully. Because some local practices can cause harm, MHPSS workers must examine and support local practices and resources only if they fit with international standards of human rights. The community level of support includes service providers and structures that surround the child and family including political, economic and social service structures (e.g., health and education), as well as institutions and structures for culture and leisure and spiritual/religious life. UNICEF's community-based approach to MHPSS is the core of interventions across outcome 3.

A community-based approach:

- ❑ strengthens natural supports and systems.
- ❑ makes use of community knowledge and capacities.
- ❑ requires skills and a thorough analysis of local practices and resources to carry out MHPSS programmes in line with the principle of 'do no harm'.
- ❑ ensures community engagement in all phases of programming.
- ❑ addresses interventions at all layers of the IASC MHPSS pyramid.

At the heart of a community-based approach to MHPSS is participation. Participation recognizes the important role that children, adolescents, their families and caregivers and broader community play as drivers of their own mental health and psychosocial wellbeing.⁴⁶ Active engagement of communities across the MHPSS programme life cycle can contribute towards improved wellbeing by providing a greater sense of control, so that people exercise their sense of agency, and ensure that the needs specific to their lives and communities are driving the MHPSS programme response and delivery.

⁴⁶ UNICEF, MHPSS & Participation: Guidance document to accompany the MHPSS Compendium of Resources, October 2020.

UNICEF's Guidance document on MHPSS and Participation outlines six key reasons why participation is essential for MHPSS:

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

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

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

Intermediary Outcome 3.1: Strengthened community awareness and positive behaviour change for child, adolescent and family/caregiver mental health, psychosocial wellbeing and protection, rooted in a stigma- and judgement-free environment

Mental health is a global issue that affects every community and is consistently underfunded regardless of national income levels.⁴⁷ National perceptions of mental health and psychosocial wellbeing can and do impact how individuals at the community level respond to and cope with mental health conditions. Stigma is often a barrier to seeking treatment and services but there are strategic actions that can be taken at the community level to raise awareness of mental health conditions and the importance of seeking help.

Awareness of child and family wellbeing and protection needs helps to mobilize communities to take positive action by providing clear information about MHPS risk factors, protective factors, and the needs of children and families. For example, stigma reduction campaigns for people with mental health conditions are essential in changing negative community perceptions about mental health conditions.

Children and adolescents have a right to participate in stigma reduction campaigns, particularly when the issues directly concern or interest them. Participation-driven community-based MHPSS enhances self-confidence and personal development, particularly when engaged on issues relevant for their daily lives. Their active participation helps to build communication skills – particularly in relation to mental health and psychosocial wellbeing – as well as problem-solving and negotiation skills.⁴⁸ Lastly, as communities discover how to support and care for one another the emphasis shifts from treatment to promotion and prevention, resulting in more children, adolescents and families being reached with critical mental health and psychosocial wellbeing messaging. Participation in awareness raising of mental health and psychosocial wellbeing can result in more meaningful relationships; it also increases self-esteem and provides a sense of mastery and control.⁴⁹

⁴⁷ UNICEF, Mental health for all children and youth people, strategic advocacy framework and global advocacy plan (draft – March 2021).

⁴⁸ UNICEF, MHPSS & Participation: Guidance document to accompany the MHPSS Compendium of Resources, October 2020

⁴⁹ Ibid.














Intervention Table 7.

Interventions and activities for strengthened community awareness and positive behaviour change

Outcome 3: Improved community capacity at the district and subdistrict levels for non-stigmatizing, accessible, available, and quality MHPSS service delivery across the primary health care, social welfare and protection, and education systems and structures

Intermediary Outcome 3.1: Strengthened community awareness and positive behaviour change for child, adolescent, and family/caregiver mental health, psychosocial wellbeing and protection, rooted in a stigma- and-judgement free environment
This approach aims to mobilize communities to take positive action by providing clear information about the needs of children and how to fulfil them.

Interventions may include:	Relevant Resources from The Compendium of Community Based MHPSS Resources
<p>Stigma reduction campaigns for people with mental health conditions, CP messaging, including on unequal gender norms influencing gendered differences in child and adolescent mental health</p>	<p>Strategies & Approaches</p> <p>Resource 2.25. Inspire to end violence against children</p>
<p> Promotion: Raising awareness of distress reactions of children in emergencies, according to age and developmental stage.</p>	<p>Resource x.x. HAT (HELPING ADOLESCENTS THRIVE) Toolkit</p>
<p> Promotion: Work with community leaders and resource people to promote stigma reduction and inclusion/ participation of children and families with disabilities or MHPSS problems.</p>	<p>Resource x.x: Early Childhood Accelerator, Analysis & Planning toolkit kit: Social and Emotional Learning resources are included throughout the toolkit.</p>
<p> Promotion: Promote mental health, behaviour change and community awareness campaigns about available focused care and supports for children, caregivers, and families in need.</p>	<p>Guidelines</p> <p>Resource 1.x. Global Alliance for Disaster Risk Reduction & Resilience in the Education Sector</p>
<p>Develop a communication for development (C4D) strategy to address stigma and discrimination, undo prevailing myths regarding mental health problems and promote a support seeking behaviour among children, adolescents, and teachers and other education personnel in schools and learning environments.</p>	<p>Resource 2.14 Guidelines for Child Friendly Spaces in Emergencies</p> <p>Resource 2.18 Interim Briefing note addressing mental health and psychosocial aspects of COVID-19 outbreak</p>
<p> Promotion: Raise awareness and build capacity in school systems to support children with distress, mental health conditions or disabilities, including identification and referral of at-risk children, caregivers, and families in need.</p>	<p>Resource 2.24. Helping Hands at School and in the Community: Guidance for School-Based Psychosocial Programs for teachers, parents and children in conflict and post-conflict areas.</p>
<p> Promotion: Implementing community-wide, targeted awareness-raising activities that combat stigma, discrimination, and abuse linked to mental health issues, and promote help-seeking behaviour.</p>	<p>Resource 4.2 Promoting Rights with Psychosocial Disabilities and Community Living for Children</p> <p>Resource 5.1 MHPSS and Participation Guidance</p>
<p> Promotion: Community messaging on children's stress reactions and coping strategies.</p>	<p>Resource 5.2 Engaged and Heard! Guidelines for Adolescent Participation and Civic Engagement</p>
<p> Promotion: Strengthen social service systems for coordinated care, case management, and referral for children and families with MHPSS and protection needs.</p>	<p>Resource 5.4 Mainstreaming psychosocial care and support through child participation</p>
<p> Promotion: Help to identify and develop functional referral resources and procedures for clinical mental health care and professional social services for children and families in need.</p>	

<p>Supporting an enabling legal and policy environment for provision and access to mental health care, treatment and support.</p>	<p>Programme Guidance</p>
<p>Establishing or strengthening laws, policies, and procedures that ensure a safe, supportive learning environment at all levels.</p>	<p>Resource 2.5 Move on & Engage</p>
<p>   Promotion: Advocacy to ensure an enabling legislative environment (e.g., decriminalizing suicide).</p>	<p>Resource 2.6 Working with Children and Their Environment</p>
<p> Promotion: Supporting development and implementation of national mental health policies, strategies and plans that include children and adolescents.</p>	<p>Resource 2.13 Toolkit for Child Friendly Spaces in Humanitarian Settings</p>
<p> Promotion: Support governments to develop policies and plans that prioritize not only access and learning, but also mental health and psychosocial wellbeing of children, adolescents, parents/caregivers and educators.</p>	<p>Resource 2.15 Safe Healing and Learning Spaces</p>
<p>Promotion: Integrate mental health and psychosocial support needs of children and teachers in education sector analysis, planning, and monitoring.</p>	<p>Resource 2.17 Different. Just like you: A Psychosocial Approach Promoting the Inclusion of Persons with Disabilities, Training Guide</p>
<p> Promotion: Strengthening information systems, evidence, and research on MHPSS.</p>	<p>Resource 3.4 Psychological First Aid Training Manual for Child Practitioners</p>
<p> Promotion: Establish national crisis helplines, that ensure confidential and 24-hour support, through trained hotline employees and volunteers who provide information and critical resources.</p>	<p>Resource 4.1 mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings</p>
<p> Promotion: Creating national strategies, policies and procedures to prevent and address discrimination and bullying in learning environments.</p>	<p>Resource 5.3 ARC Foundation Module on Children’s Participation and Inclusion</p>
<p> Promotion: Supporting laws and policies that ban all corporal punishment and capacity-building programmes for educators in the constructive handling of challenging behaviour.</p>	<p>Training</p>
<p> Promotion: Develop or strengthen teacher training curricula that support safe, supportive learning environments, including through training on gender and disability-sensitive approaches, participatory methods, social and emotional learning, and child protection principles and concerns.</p>	<p>Resource 5.3 ARC Foundation Module on Children’s Participation and Inclusion</p>
<p> Promotion: Strengthening policies to ensure the design of educational facilities in line with universal design standards that ensure facilities are disaster resilient, safe, dignified and accessible to all children.⁵⁰</p>	<p>Resource 2.36 I Support My Friends</p>
<p>Considerations for Adaption</p>	<p>Referrals pathways between development and humanitarian systems: In some instances, countries may have two systems: one for development services and another for humanitarian services. MHPSS systems building should always focus on building and strengthening referrals across systems, which may include understanding and adapting programming to complement both development and humanitarian contexts. Strategies may need to be adapted to allow for this.</p>

⁵⁰ See Global Alliance for Disaster Risk Reduction & Resilience in the Education Sector, ‘[Guidance, Tools, Research & Evidence](#)’, 2021.

EXAMPLE FROM THE FIELD

[forthcoming- field examples remain under development throughout the demonstration phase and will be added in the final version of the framework in 2022]

Intermediary Outcome 3.2: Strengthened community mental health and psychosocial wellbeing support systems across sectors, including innate community capacities to support children, adolescents, parents/ caregivers and families

MHPSS interventions help to activate and restore natural supports within community and family care systems when they have been weakened by external factors and/or mental health issues within the family. High levels of distress occur in all contexts and can be caused by a wide range of factors such as extreme poverty, violence in the home, conflict and/or natural disasters, and even global pandemics; all of which can sometimes make it hard for children and families to access support systems or utilize positive coping mechanisms. Interventions and services at the community level can help to strengthen a person's interpersonal wellbeing by creating the opportunities within their local community to develop supportive nurturing relationships and responsive caregiving, creating a sense of belonging, and creating the opportunity and space for community members to develop close relationships with others that they have commonalities with but may not have otherwise known.

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

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

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

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

In some contexts, such as during emergencies where there are significant displacements, humanitarian actors may provide support in mobilizing communities in identifying activities and interventions that can activate local supports. Examples include group-based activities like cooking clubs, parenting support groups,

cultural dance clubs, and other club-based activities that bring members of the community together around a shared interest. Community mobilization, and support to community organizations, may also include support to community leaders in promoting positive gender and social norms on child and family wellbeing, including reducing stigma and discrimination against children with disabilities.

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



How to navigate the intervention tables

Intervention Table 8.

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

Outcome 3: Improved community capacity at the district and subdistrict levels for non-stigmatizing, accessible, available, and quality MHPSS service delivery across the primary health care, social welfare and protection, and education systems and structures

Intermediary Outcome 3.2: Strengthened community mental health and psychosocial wellbeing support systems across sectors, including innate community capacities to support children, adolescents, parents/caregivers and families
This approach acknowledges and strengthens community resources to support children and families.

Interventions may include:

Strengthening community led action and advocacy for the promotion of mental health and psychosocial wellbeing, reduce stigma and increase access to community-based and led MHPSS services.



Prevention: Communication for development activities and capacity-building of community organizations, including women's groups, to strengthen outreach to vulnerable families.



Promotion: Support to community leaders (e.g., faith leaders) in promoting child protection and mental health and psychosocial wellbeing.



Prevention: Vulnerable children and families, who may be less visible in emergency contexts, are assessed and included in services to meet basic needs.



Prevention: Building capacity and supervising MHPSS workers in scalable evidence-based individual or group psychological interventions ([see Annex 6 Scalable interventions](#)).



Prevention: Family unity is promoted through prevention of family separation, identification and care of separated children, and family tracing and reunification.



Promotion: Children and families have access to important information about basic services, loved ones, legal rights and positive coping strategies.

Relevant Resources from [The Compendium of Community Based MHPSS Resources](#)

Strategies & Approaches

Resource x.x Early Childhood Accelerator, Analysis & Planning toolkit kit: Social and Emotional Learning resources are included throughout the toolkit.

Guidelines

Resource 2.14 Guidelines for Child Friendly Spaces in Emergencies

Resource 2.24 Helping Hands at School and in the Community: Guidance for School-Based Psychosocial Programs for teachers, parents, and children in conflict and post-conflict areas

Resource 4.2 Promoting Rights with Psychosocial Disabilities and Community Living for Children

Resource 5.1 MHPSS and Participation Guidance

Resource 5.2 Engaged and Heard! Guidelines for Adolescent Participation and Civic Engagement



Prevention: Facilitate opportunities for children and adolescents to contribute to community improvement and service activities.⁵¹



Promotion: Facilitate community meeting, psychoeducation, parent/ caregiver/ teacher support and training to provide infant and young child learning, skills development and stimulation and facilitate active play.

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



Promotion: Building the capacity of health-care workers in child-friendly communication and supporting children's and adolescent's participation in health-care decisions.



Promotion: Ensure collaboration between health and child protection sectors to ensure health-care services are child- and family-friendly, including in the times, spaces and methods used in service delivery.



Promotion: Ensuring strong referral networks and promoting collaborative working with social services, education and child protection to address health and mental health and psychosocial wellbeing cross-sectorally.



Prevention: Promote existing national crisis helplines that ensure confidential and 24-hour support, through trained hotline employees and volunteers. Volunteers can provide information and critical resources to persons in distress or their loved ones, and are able to make referrals to specialized services, support groups, and legal support, if needed.



Promotion: Developing participatory approaches and community-based mechanisms that support the participation of children, families and community members in school management.



Promotion: Conduct national and community-based awareness-raising campaigns that promote learning that starts at birth and takes place within and outside formal educational settings.



Prevention: Peer-led support groups and education programmes that encourage respectful communication and connection between primary caregivers and adolescents and understanding of adolescents' mental health and psychosocial needs and how to support them.

Considerations for Adaption

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

Resource 5.4 Mainstreaming psychosocial care and support through child participation

Programme Guidance

Resource 2.7 Working with Children and Their Environment

Resource 2.17 Different. Just like you: A Psychosocial Approach Promoting the Inclusion of Persons with Disabilities, Training Guide

Resource 3.4 Psychological First Aid Training Manual for Child Practitioners

Resource 4.1 mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings

Training

Resource 5.3 ARC Foundation Module on Children's Participation and Inclusion

⁵¹ This allows children to feel effective, positive belonging, positive identity, transcendence. Serving others can be a positive coping mechanism for children with MH and PS needs.

Intermediary Outcome 3.3: Strengthened multisectoral care systems (PHC, social welfare & protection, education) for children, adolescents and families, including use/leveraging of family-friendly policies

MHPSS programming needs to support and strengthen care systems at local, regional and national levels.

Interventions that engage participation by the community are more likely to be meaningful and sustainable – and to help restore people’s sense of competence and self-agency to meet new challenges and be hopeful about the future. Strengthening resources and capacities for self-help makes best use of people’s knowledge and capacities to recover, and to help their children do the same.

Strengthening formal care systems includes stronger promotive, preventive and responsive MHPSS services within health, education and social welfare and protection systems for coordinated care, case

management, and referrals for children and families with MHPSS and protection needs. Social workers, health-care workers and teachers are all part of the care system that delivers MHPSS services at the community level. A strengthened care system is one that links these services together and makes them accessible within the community. For example, psychosocial services could be provided in the community by MHPSS practitioners and/or members of the community who have been trained in specific approaches and receive supervision from the local health system or social welfare and education system. Ensuring that these services are provided in the community, while also linked to the formal system, increases accessibility of services and ensures ongoing quality oversight of service delivery. It is important that interventions work to mobilize existing community supports (parents, teachers, health and social service workers, religious leaders) or re-establish community structures, while ensuring that they are inclusive and work towards the best interests of all children.

EXAMPLE FROM THE FIELD

[forthcoming- field examples remain under development throughout the demonstration phase and will be added in the final version of the framework in 2022]









Intervention Table 9.

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

Outcome 3: Improved community capacity at the district and subdistrict levels for non-stigmatizing, accessible, available, and quality MHPSS service delivery across the primary health care, social welfare and protection, and education systems and structures

Intermediary Outcome 3.3: Strengthened multisectoral care systems (PHC, social welfare & protection, education) for children, adolescents, and families, including utilization/leveraging of family-friendly policies
This approach includes capacity-building in the social services, education, protection and health systems, which protect children and families and promote their mental health and psychosocial wellbeing.

Interventions may include:	Relevant Resources from The Compendium of Community Based MHPSS Resources
<p>Equipping community leaders and local services providers with the necessary skills and knowledge to be responsive to the mental health and psychosocial support needs in their community.</p>	<p>Strategies & Approaches</p> <p>Resource x.x HAT (HELPING ADOLESCENTS THRIVE) Toolkit</p> <p>Resource x.x Early Childhood Accelerator, Analysis & Planning toolkit kit</p>
<p>  Prevention: Work with community and intersectoral actors to appropriately identify and reach out to vulnerable parents/caregivers (with mental health conditions, disability or serious distress) for care and referral to relevant supports/services.</p>	<p>Guidelines</p> <p>Resource 2.18 Interim Briefing note addressing mental health and psychosocial aspects of COVID-19 outbreak</p> <p>Resource 2.24. Helping Hands at School and in the Community: Guidance for School-Based Psychosocial Programs for teachers, parents and children in conflict and post-conflict areas</p>
<p>   Prevention: Targeted MHPSS capacity-building initiatives for parents and other caregivers (e.g., teachers), family members, and children and adolescents themselves, including volunteers and youth leaders.</p>	<p>Resource 4.2 Promoting Rights with Psychosocial Disabilities and Community Living for Children</p>
<p>  Prevention: Provide outreach services to vulnerable families for psychosocial support, protection services and referral to specialized care and other sector services as needed.</p>	<p>Resource 5.1 MHPSS and Participation Guidance</p>
<p>  Prevention: Ensure access of families/caregivers (especially those who are vulnerable) to information about supports, services, loved ones and rights.</p>	<p>Resource 5.2 Engaged and Heard! Guidelines for Adolescent Participation and Civic Engagement</p>
<p>   Promotion: Build capacity and support the work of mental health and social service professionals, (e.g., school psychologists, clinical social workers) with at-risk children and families.</p>	<p>Resource 5.4 Mainstreaming psychosocial care and support through child participation</p>
<p>Coordinating MHPSS services and referral systems across education, child protection, social welfare and health systems.</p>	<p>Programme Guidance</p> <p>Resource 2.7 Working with Children and Their Environment</p>
<p>   Promotion: Children and families have access to essential information about basic services, loved ones, legal rights and positive coping strategies.</p>	<p>Resource 2.17 Different. Just like you: A Psychosocial Approach Promoting the Inclusion of Persons with Disabilities, Training Guide</p>
<p>   Prevention: Basic needs (shelter, food, WASH) are provided in ways that respect the culture, dignity and agency of children and families and are sensitive to children’s developmental needs.</p>	<p>Resource 3.4 Psychological First Aid Training Manual for Child Practitioners</p>
<p>   Promotion: Access to health care, livelihood and educational opportunities.</p>	<p>Resource x.x Guidance and technical packages on community mental health services</p>
<p>   Promotion: Overall safety for the community is promoted, and protection risks for children and families are identified and addressed.</p>	
<p>   Promotion: Work with shelter and camp management to ensure appropriate shelter accommodation for the privacy and comfort of families.</p>	

<p>Improving capacity of primary health care staff to provide quality mental health services.</p>	<p>Training</p>
<p> Prevention: Supporting health-care providers and nutrition actors to identify and refer parents with mental health concerns, including new mothers, and infants and young children at risk due to protection concerns, poor growth, or developmental disabilities.</p>	<p>Resource 5.3 ARC Foundation Module on Children's Participation and Inclusion</p>
<p>Promotion: Build the capacity of health service staff to be age- and gender-sensitive while delivering care and to challenge stigma and discrimination.</p>	
<p>Promotion: Strengthening the capacity of health-care professionals and paraprofessionals in providing child-friendly services, including through age-appropriate child-friendly communication techniques and supporting children's and adolescent's meaningful participation in health-care decisions.</p>	
<p>  Promotion: Building the capacity of health-care providers and nutrition actors to provide basic psychosocial and positive parenting support to parents and caregivers.</p>	
<p>   Promotion: Building the capacity of community health workers, educators and community volunteers to appropriately identify, support and refer vulnerable children, adolescents and families to child protection and/or MHPSS services.</p>	
<p>Considerations for Adaption</p>	<p>Emergencies can provide strategic opportunities to strengthen and/or establish critical MHPSS systems. Development and humanitarian actors need to ensure that there is strong communication and collaboration across and within national health, education, social welfare and child protection service structures to reduce duplication and/or the establishment of parallel systems.</p>



Outcome 4: Improved enabling environment for MHPSS across the policy, legislation and financing systems, the MHPSS workforce, multisectoral supports and referral pathways, and MHPSS research and data

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

Intermediary Outcome 4.1: Policy, legislation & financing: The policy, legislative, and financing environment is developed and strengthened to ensure that supportive mechanisms are in place for quality mental health and psychosocial service delivery

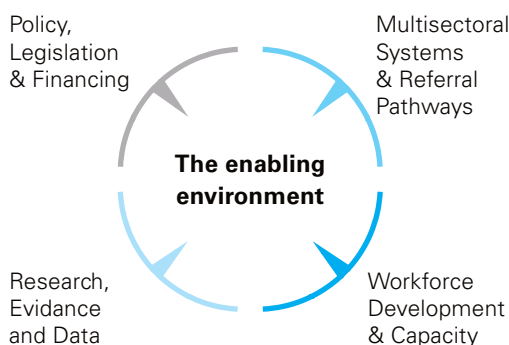
The policy, legislative and financing environment necessary for efficient MHPSS service delivery includes policies, laws, institutions, culture and social and gender norms that create (1) a system that facilitates access to affordable and non-stigmatizing MHPSS for all children, adolescents, their families and communities; and (2) a supportive environment for voice, agency and action of advocates and users of MHPSS, including youth and caregivers.

The first step in developing a multisectoral strategy for MHPSS is to conduct a comprehensive analysis of the enabling environment that engages children and adolescents throughout the process to capture their perceptions of their mental health and psychosocial needs and the necessary services. The national **legislation, policies and financing** across health, social welfare and education systems determines what kinds of MHPSS services are available and accessible across the child/adolescent, caregiver, and community outcomes. These systems are essential for creating an environment that is responsive to the MHPSS needs of the population. An examination of the enabling environment for each context will determine what services are needed, who the primary service providers are, and where the biggest gaps are in service provision.

The analysis should include the MHPSS needs, the available services and the critical gaps across the promotion, prevention, and the care and treatment continuum.

Figure 5

The enabling environment for MHPSS has four main components that underpin and reinforce the circles of support



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

Table 2 depicts strategic actions across policy, legislation, financing, and advocacy for MHPSS. The recommended key actions are reinforced by UNICEF's global advocacy strategy four accelerators for MHPSS.⁵²

- 1. Investment for all:** secure greater and better investment in inclusive and gender-responsive mental health and psychosocial support services across all sectors and community services and structures for all children, adolescents, caregivers/parents and families, from high income countries, low- & middle-income countries, and humanitarian settings. Services must be appropriate for and adapted to specific cultural contexts.
- 2. Promotion and prevention in the family:** support caregivers/parents and families, through rolling out parenting programmes⁵³ to promote positive parenting and nurturing caregiving, and support caregiver wellbeing and mental health.
- 3. Response in the school and community:** ensure that all children and adolescents learn and interact in safe, supportive and secure environments, both online and offline, with supportive relationships with teachers and peers and access to mental health services for all who need them.
- 4. Changing the public conversation on mental health:** key actions around legislation, policy, services

and investment are directly related to changing the global conversation and public perception on mental health & mental ill health, and related issues of abuse and neglect. It will include tackling stigma and discrimination, promoting positive parenting practices, and equipping mental health-informed and resilient communities and societies.

Table 2 Key actions within the enabling environment

KEY ACTIONS WITHIN THE ENABLING ENVIRONMENT

LEGISLATION

- ❑ Legislation secures the rights of people with mental health conditions.⁵⁴ This may include supporting law reform processes to abolish laws and regulations that permit coercion and discriminate against service users and persons with disabilities receiving mental health care. Legislation ensures children are protected and have access to quality MHPSS services.
- ❑ Legislation ensures access to mental health care for all, including establishing policies and financing for the delivery of MHPSS services within the community.
- ❑ Legislation establishes guidelines and standards for promotive, preventive and responsive mental health and wellbeing policies in schools.⁵⁵
- ❑ The legislative and policy environment secures public financing for parenting support programmes that promote positive parenting and nurturing caregiving and support caregiver wellbeing.⁵⁶
- ❑ Legislation supports the development of community-based and community-led MHPSS services.
- ❑ National, regional and local legislation supports access to mental health and psychosocial support services across PHC, education and social welfare and protection services.
- ❑ Development and implementation of mental health-related laws and policies ensure active consultation and involvement of target groups of direct or indirect impact, including children and adolescents with disabilities.

⁵² UNICEF's Mental Health and Global Advocacy Strategy April 2021

⁵³ A technical note on the minimum package required for quality parenting programmes is under development, to be launched later in 2021.

⁵⁴ EAPRO Draft MHPSS Framework

⁵⁵ Mental Health and Global Advocacy Strategy April 2021

⁵⁶ Mental Health and Global Advocacy Strategy April 2021

POLICIES

- ❑ Ministries/departments develop policies that promote mental health and psychosocial wellbeing for all, including gender-responsive and inclusive family-friendly policies (such as paid parental leave, breastfeeding support, access to affordable quality childcare and child benefits) and access to care and treatment that provide parents and caregivers with time, resources and services.
- ❑ Integration of mental considerations in health policies that focus on specific populations at higher risk of mental health challenges – i.e., HIV, pregnant adolescents, humanitarian and migrant populations.
- ❑ Ministries/departments of education include policies and financing supporting the integration of school-based MHPSS services for children, adolescents and teachers.
- ❑ Integrate the mental health and psychosocial support needs of children and teachers in education sector analysis, planning, budgeting and monitoring.
- ❑ Institutional care for individuals with more serious mental health conditions.
- ❑ Ministries/departments of social welfare include policies that facilitate access to MHPSS services when necessary.
- ❑ The legislative and policy environment secures public financing for parenting support programmes that promote positive parenting and nurturing caregiving and support caregiver wellbeing.⁵⁷
- ❑ Promote a human rights-based approach to disability in the process of policy formulation, implementation and evaluation of mental health programmes and services.

FINANCING

- ❑ Prioritize financing of MHPSS services across government ministries.
- ❑ Financing supports community participation in MHPSS needs assessment and analysis.
- ❑ How is financing distributed for MHPSS services? Are these services funded across sectors? What actions are needed to increase funding for core services?
- ❑ Identify the local evidence base and critical gaps for mental health and psychosocial wellbeing.

FINANCING (cont.)

- ❑ Legislation ensures funding for MHPSS data and evidence.
- ❑ The legislative and policy environment secures public financing for parenting support programmes that promote positive parenting and nurturing caregiving and support caregiver wellbeing.⁵⁸
- ❑ Mobilize resources for community-based, peer-led and human rights-based responses and services that are inclusive of persons with disabilities.
- ❑ Mobilize resources for outreach activities for individuals who are institutionalized, live in confinement or are restricted or deprived of liberty at home or within their community.

ADVOCACY

- ❑ Global advocacy and communications to build awareness and understanding among decision makers, parents and caregivers of positive parenting practices and the importance of caregiver mental health and wellbeing.⁵⁹
- ❑ Global communications to build awareness and understanding among decision makers, schools and other stakeholders on the importance of school-based mental health policies.⁶⁰
- ❑ National advocacy and targeted advocacy for populations at increased risk for mental health and psychosocial needs to share policy guidelines on standards for promotive, preventive and responsive mental health and wellbeing policies in schools.⁶¹
- ❑ National advocacy to share policy guidelines on standards for promotive, preventive and responsive mental health and wellbeing policies in schools.⁶²
- ❑ Advocate and provide technical support to key ministries for the inclusion of teacher wellbeing in national education policies.
- ❑ Raise awareness of the risks of overdiagnosis, overtreatment and overmedicalization of children and adolescents and of the right to informed consent of children and adolescents, with or without disabilities, in the context of mental health.

⁵⁷ UNCIEF's Mental Health and Global Advocacy Strategy April 2021⁵⁸ Ibid.⁵⁹ Ibid.⁶⁰ Ibid.⁶¹ Ibid.⁶² Ibid.

Intermediary Outcome 4.2: Strengthened multisectoral systems & referral pathways: Strengthened multilayered support systems and processes within existing structures, including functional referral systems across PHC, Social Welfare & Protection, and Education

A mental health and psychosocial system of support comprises the government ministries, institutions and implementing agencies that are legally responsible for the delivery of services for MHPSS, including both community-based MHPSS services and facility-based mental health services. This requires identifying which government ministries have mandates and budgets for the delivery of mental health and psychosocial services and how accessible these services are to the local population. In most contexts this will include health, education, and social welfare but depending on the location, laws and policies there may be other government ministries.

The ability of cross-sectoral mental health budgets through health, education, and social welfare service providers to support individuals, families- and communities is directly linked to the laws, legislation- and available financing for MHPSS across these systems. Multisectoral supports are essential in providing comprehensive MHPSS for children, adolescents, their families and communities. These supports may be provided through stand-alone sector-specific interventions, part of a larger multisector programme, or belong to a system of wrap-around services (see textboxes on the right). Regardless of the format, it is essential for agencies to recognize that they are one part of the child/adolescent's ecosystem that includes supports from multiple sectors and systems, and that each of these systems is dependent upon the laws, legislation and available financing.

SECTOR-SPECIFIC INTERVENTIONS:

A specific intervention intended to respond to a specific MHPSS need, for example:

- Mental health treatment by a primary health care provider under a health programme.
- SEL activities provided in an education programme.

MULTI-SECTORAL PROGRAMME:

A MHPSS programme implemented across more than one sector to respond to MHPSS needs, for example:

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

SYSTEM OF WRAP-AROUND SERVICES:

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

- Social workers and/or trained case workers from the social welfare & protection sectors who have been trained in case management and referral services.

Additionally, and equally essential, are the organizations and key partners actively providing services at the local, national, regional and international levels. Support the involvement of individuals, families, communities and civil society through their participation in the development and implementation of policies and plans that have an impact on health. Increase community ownership and contribute to the accountability of the public and private sectors for more people to live healthier lives in enabling and health-conducive environments. This includes key local non-governmental agencies and key international non-governmental agencies.

Universal **health care** reaffirms the right of every human being, without distinction of any kind, to the highest attainable standard of physical and mental

health. It implies that all people have access, without discrimination to a nationally determined set of the necessary promotive, preventive, curative, rehabilitative and palliative essential health services, with special emphasis on the poor, vulnerable and marginalized segments of the population. Strengthening MHPSS services delivery within **primary health care (PHC)** is an inclusive, effective and efficient approach to enhance people's physical and mental health. MHPSS service delivery through PHC includes ensuring that those with mental health conditions receive appropriate screening, diagnoses, treatment, and medication when necessary.

Strengthening the ability of the **education sector** to deliver quality MHPSS services ensures that all children and teachers benefit from the integration of mental health and psychosocial services in the school systems. This may include the delivery of social-emotional learning curricula, access to school-based counselling services, and the delivery of peer-to-peer support networks. The education system is an ideal platform for supporting and promoting the development of mental health and psychosocial wellbeing ([See Annex 7 Brief on integration of education and MHPSS](#)). In emergency contexts, education gives students a sense of normalcy and stability which can help to improve their mental health and psychosocial wellbeing. The education system is also integral in shaping and defining social norms and can play a vital role in addressing stigma and attitudes towards mental health and psychosocial wellbeing.

Social welfare systems, including child protection services, provides children and their families with the supportive interventions needed to adapt and cope with mental health and psychosocial needs in the home and the community. Those working on the front-line of social welfare are often supporting children and families during very distressing circumstances. The social welfare service providers need to be equipped

to counsel families and children in distress, which may include referrals to additional services.

Referral pathways are a core aspect of MHPSS service delivery and should be established across service providers. Referrals between health services, social welfare, and education systems should be clearly documented, agreed upon between government authorities and agencies, and regularly updated/validated.⁶³ Strengthening the referral pathways between providers is central to strengthening the MHPSS system.

From building blocks to a multisectoral framework: how we work together

UNICEF's global MHPSS framework promotes a multisectoral integration of the social ecological model, UNICEF's life course approach to programming, and the IASC intervention pyramid for MHPSS. These frameworks come together to create a system that responds to the MHPSS needs of children and their families across UNICEF's three domains of wellbeing.⁶⁴ The response system depends on a multisectoral support system that delivers services across all layers of the intervention pyramid across the life course.

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

MHPSS services are most effective when they are designed to work together with other sectors rather than being separate pillars of interventions.

⁶³ The contact details should be regularly updated and validated due to potentially high turnover rates across the MHPSS workforce.

⁶⁴ Information on the Domains of Well-being can be found in [UNICEF's Mental Health Technical Note](#)

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

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

Intermediary Outcome 4.3: Workforce development and capacity: Capacity strengthened among professional and non-specialist MHPSS providers in quality age- and gender-responsive MHPSS care across all sectors

As the term 'mental health and psychosocial support' implies, there is a close relationship between the psychological and social aspects of a child's development and wellbeing. Various personal, social and environmental factors influence the wellbeing of children and families and their ability to recover from adversity. A strong MHPSS workforce spans across the health, education, social welfare and child protection sectors and is essential for providing the services that are responsive to the psychological and social aspects of the child's development and wellbeing. The MHPSS workforce should be equipped to provide social and psychological interventions at all layers of the pyramid as well as supports delivered by both professional and trained MHPSS staff.

The MHPSS workforce includes staff who have professional and/or on-the-job training in mental health and psychosocial support, including those with the following backgrounds: child and adolescent psychology, psychiatric care, counselling psychology, social work, educational psychology, occupational therapist, doctors/primary care physicians and nurses trained in mental health and/or staff who meet necessary ongoing on-the-job training and technical competencies for the services that they are delivering. The technical competencies for project staff should be directly relevant to the professional competencies needed for the selected interventions. During the multisectoral assessment of the enabling environment it should be clear what the national and local capacity is for delivering MHPSS services across sectors. In some countries, there might only be one psychiatrist in the country, or a psychologist trained in counselling may not have developed the competencies needed for a particular intervention.

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

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

- Clinical services provided by mental health professionals (e.g., psychological, or psychiatric services including pharmacological treatment of mental conditions).
- Management of mental conditions by nurses, clinical officers and physicians.
- Specialized protection and social services (e.g., case management, outreach to vulnerable families) provided by social service professionals.⁶⁵

- Trained workers who demonstrate the appropriate competencies, and receive proper training and regular supervision by mental health clinicians, can provide scalable interventions to support adults and children experiencing common mental health disorders. (*See Annex 6 Scalable Interventions* for more information) With training and supervision, trained workers can provide non-clinical psychosocial support to children and families, such as:
 - Peer support.
 - Cultural and recreational activities for children.
 - Identification of vulnerable families for referral to specialized supports.
 - Basic helping skills such as psychological first aid (PFA), which includes assessing needs and concerns; helping people address basic needs; listening to and comforting people and helping them feel calm; helping connect to information, services and social support; and protecting people from further harm.⁶⁶

⁶⁵ UNICEF may work through credible partners in the field in providing specialized services such as clinical mental health care. Partners should be familiar with and comply with international quality standards for specialized services, such as the IASC MHPSS Guidelines and mhGAP in Humanitarian Settings Guidelines.

⁶⁶ WHO, War Trauma Foundation and World Vision International, 'Psychological First Aid: Guide for Field Workers', 2011.

Staffing and Supervision Across the Intervention Pyramid

In a comprehensive MHPSS approach, **apprentice and professional actors work together across the intervention pyramid to meet the community's needs** (see Figure 4's "Supervision & staffing").

Establishing minimum competencies, qualifications and standards for MHPSS workers is an important aspect of a community-based approach. Ideally, programmes would include staff across all layers of the intervention pyramid, even if they are not implementing at layer 4. At a minimum the programme should be able to provide referrals to services at all levels of the pyramid. All MHPSS programming should have systems for supervision, coaching, assessing competencies and in-service training included in the design of the programme. **MHPSS Supervision** is a relationship that supports the psychosocial workers' technical competence and practice, promotes wellbeing and enables effective and supportive monitoring of case work.⁶⁷

Maintaining quality standards in MHPSS capacity-building

UNICEF covers both immediate and long-term MHPSS needs, with the goal of sustainability. The global lack of child and adolescent mental health practitioners and services and human resources means UNICEF invariably begins work in an environment with little – if any – existing capacity. Accordingly, UNICEF works to strengthen local capacity through training and mentoring MHPSS workforce covering the entire spectrum of mental health and psychosocial support, ranging from psychological first aid and community services designed to meet basic needs of an entire population, to mental health services for individuals needing more specialized care.

The Ensuring Quality in Psychological Interventions (EQUIP) platform offers assessment tools to ensure that

staff and front-line workers have adequate competencies in the foundational helping skills. EQUIP competency assessments cover foundational helping skills working with adults (ENACT), children (WEACT) and working with groups (GROUPACT). MHPSS supervisors and trainers can use EQUIP to assess competency level and any potentially harmful behaviour.

The EQUIP platform is helpful in building the workforce capacity in foundational helping skills, which can help to increase capacity of all staff to deliver PFA. PFA is a basic helping skill that all staff in MHPSS programming should be trained in. It can help project staff and other front-line workers build confidence, skills and competencies in helping distressed children and families. This promotes high quality standards in the implementation of PFA as well as helping supervisors and trainers to identify specific areas or topics for training to improve the capacity of workers to implement PFA interventions effectively. Older children and adolescents can learn child-to-child PFA skills to be applied under the guidance of trusted adults. The 'I Support My Friends' resource kit provides an implementation guide and training curriculum to implement PFA peer support among older children and adolescents. During humanitarian response programming PFA is particularly important for all staff who are working with the affected population. PFA skills supported by EQUIP competency assessments can be used by project staff working in all sectors to help project staff take an MHPSS approach to their programming.

MHPSS planning should always include a workforce development and capacity-building strategy. The following table can be used to provide guidance on core considerations as to what should be considered and included in workforce development and capacity-building programme strategies. Table 3⁶⁸ provides core areas for workforce development and capacity-building guidance.

⁶⁷ Alliance for Child Protection in Humanitarian action, USAID, 'Child Protection Case Management Supervision and Coaching Training Package', fact sheet.

⁶⁸ Adapted from Murray et al., 'Building capacity in mental health interventions in low resource countries: an apprenticeship model for training local providers', International Journal of Mental Health Systems, 5:30 2011. <http://www.ijmhs.com/content/5/1/30>

Table 3 Core areas for workforce development and capacity-building guidance

Domain	Minimum	Comprehensive
Competency and Needs Assessment	Conduct training needs pre-assessment through multiple methods including questionnaires on knowledge and perceived competencies, pre-training competency assessments using role play / the EQUIP platform, FGD with trainees and (where possible) on-the-job observations and site visits.	Carry out quarterly capacity and training needs assessments and formative evaluations through interviews, EQUIP platform competency assessment role plays, surveys and/or FGD to inform ongoing refresher trainings and/or on-the-job training & supervision. Assess for ToT potential among trainees and /or local MH staff and/or professionals.
Curriculum	Develop a curriculum training document which is clearly based on competencies and training needs assessment. The EQUIP platform can be used to establish a baseline competency assessment and repeated over time intervals to measure improvement or current training needs. This can be used to develop bespoke training curricula which include learning objectives, topics to be covered, time needed for each topic and trainee requirements to pass. EQUIP can be used alongside knowledge assessments such as pre/post-test that are developed / adapted to correspond to the bespoke training curriculum.	Develop UNICEF training material in compliance with global guidelines and best practices. Develop and implement ToT training through training candidates, co-training with candidates and observing candidates while training. EQUIP competency-based assessment role plays can be integrated into ToT to ensure ToT trainer competency as well as building the capacity of ToT trainers to assess competencies.
Theoretical Training	For each topic on the curriculum, develop corresponding training materials (e.g., PowerPoint slides, handouts, training guide with learning objective and instructions for exercises) and share with MHPSS advisor or specialist prior to use. EQUIP platform competency assessments and training evaluation can be carried out at the end of training.	Integrate use of EQUIP competencies assessment and training evaluation after each training segment.
Supervision	For all skills-based training (except PFA) carry out ongoing on-the-job supervision of trained staff. Document on-the-job performance based on EQUIP competency-based assessments over specific time periods and on-the-job supervision checklist.	
Methodology	Carry out theoretical and practical training.	Carry out regular refresher training based on post training competency and knowledge-based assessments, using EQUIP platform, knowledge-based assessment and supervision to assess gaps in knowledge and skills.
Reporting	After each training cycle (as applicable) produce a comprehensive training report which includes the competency and training needs assessment, curriculum, materials (as annexes), results of pre-post-tests printout of data visualization from EQUIP platform competency assessments, and supervision checklists and of training evaluations as well as recommendations for future training and share with country team and MHPSS advisor or specialist for sharing and exchange.	

Intermediary Outcome 4.4 Research, evidence & data: Improved evidence and data ecosystem for MHPSS that informs and drives policy changes around mental health and psychosocial support

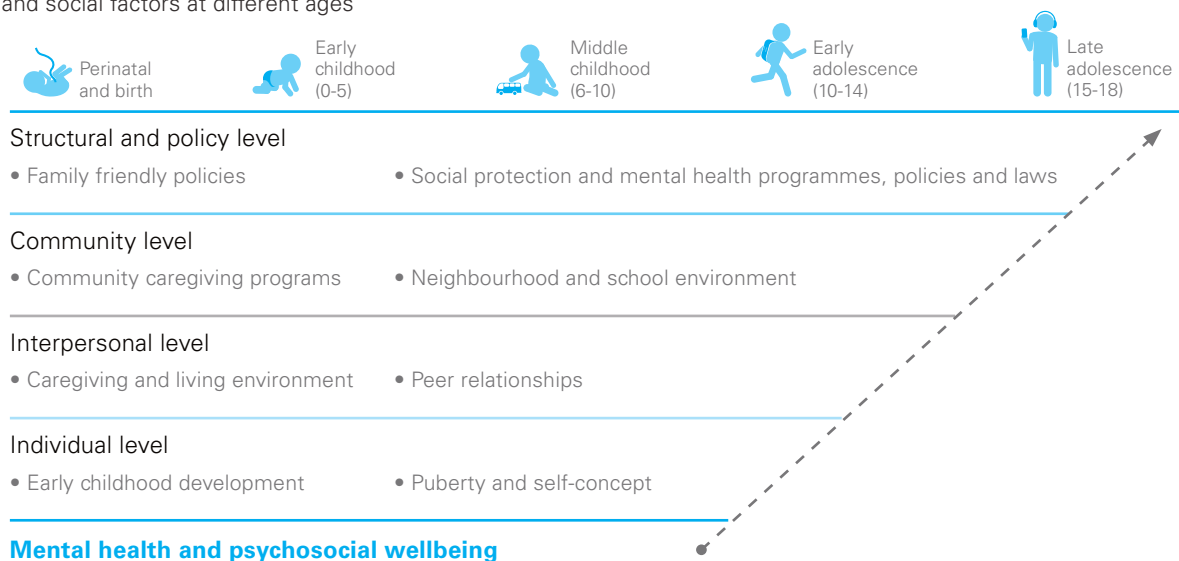
To successfully design, implement and evaluate MHPSS services nationally, regionally and globally, it is essential to have a strong evidence base that sheds light on key determinants and indicators for child and adolescent mental health. This evidence base provides implementing agencies with guidance on what works, why, and which factors can be adapted to prevent mental health conditions and promote psychosocial wellbeing. It is also critical in the development of evidence-based advocacy campaigns as well as a multisector programme strategy for MHPSS that is culturally grounded. Therefore, it is important to consider [UNICEF's Mental Health Research and Evidence Generation Framework](#), which can guide the collection, analysis and dissemination of data on the prevalence of mental health conditions; explain the determinants and drivers of mental health and psychosocial wellbeing; and aid the development and prioritization of psychosocial interventions and services for targeted population subgroups.

This UNICEF mental health research and evidence generation framework aligns with this global framework, and recognizes that as children and adolescents grow through the life course, their interactions and influences in the environment also widen, hence increased risk and/or protective factors for their mental health and psychosocial wellbeing. Their mental health is, influenced by myriad dynamic factors at different layers of the social environment across their developmental stages – individual, interpersonal, community and structural and policy levels. Different factors have greater impact at different ages and across these levels.

The UNICEF mental health research and evidence generation framework encompasses five core areas of research (1) epidemiology, (2) researching risk and protective factors, (3) researching evidence and practice, (4) implementation science, and (5) monitoring, evaluation, accountability and learning. Regional and country research, data and evidence strategies should link localized research and evidence generation with the global evidence base.

Figure 6

The mental health and psychosocial wellbeing of children and adolescents are influenced by different environmental and social factors at different ages



Source: Priscilla Idele, Manasi Sharma, Purna Banati and David Anthony, *Child and Adolescent Mental Health and Psychosocial Wellbeing: A conceptual Framework for Research and Evidence Generation and Use*. UNICEF Innocenti – Office of Research, Florence, 2021.

EPIDEMIOLOGY: Research should help to answer key questions about mental health by providing projections of how many people are affected, who is affected (e.g., across gender and other sociodemographic groups), where they are most affected (geographic differences), and what is the economic and social impact of mental health conditions. Answers to these questions will help understand the magnitude of the problem and shape key legislative, policy and financing efforts. Epidemiology focused on MHPSS should have the following considerations:

- ❑ Research to measure the magnitude of mental health outcomes e.g., anxiety, depression, suicide, substance abuse, conduct disorder.
- ❑ Estimating the burden of mental health through other forms of data collection, including modelling scenarios of investment and the cost of inaction.

RISK AND PROTECTIVE FACTORS: Identifying the risk and protective factors for mental health outcomes is important for developing effective interventions and programmes, and for providing an enabling environment for children and adolescents to thrive. These factors will vary from one context to the next. Each community, school and family unit will have its own set of interacting factors, and MHPSS programmes will need to take a nuanced approach to identifying these factors as what is protective in one context can be a risk factor in another. A comprehensive delineation of key mental health determinants will answer questions of what the causes of risk or protection are and how they impact mental health and wellbeing. It is important to note that:

- ❑ Research should link the child's stage of development to the risk and protective factors.
- ❑ Research and evidence generation should be designed so that it is age- and context-appropriate.

EVIDENCE AND PRACTICE FOR INTERVENTIONS:

Research must be carried out to test existing interventions, adapt programmes to different contexts and develop new solutions for mental health across the prevention, promotion, treatment and continuing care continuum. This includes research on interventions across multiple platforms and contexts that:

- ❑ provide both clinical and non-clinical services.
- ❑ provide online and offline approaches to service delivery.
- ❑ focus on the prevention and promotion of wellbeing procedures, public health campaigns, policy and advocacy interventions.
- ❑ include interventions across domains of wellbeing and the circles of care.

Evidence and practice research helps to answer the questions of **what works, how, for who, where, why?**

IMPLEMENTATION SCIENCE: Implementation science provides critical information on the **scalability and generalizability of interventions**, how to translate interventions into policy and practice, and how to understand the barriers and facilitators to delivering evidence-based interventions across different contexts. Research should look at the facilitators or barriers to delivering interventions across:

- ❑ the components of the MHPSS framework;
- ❑ multiple levels of service delivery (individual, household, community/societal, national, global); and
- ❑ across contexts (high- or low-income countries; development vs humanitarian; for various gender groups, vulnerable groups such as children with disabilities, LGBTQ+ etc., by age group, in rural vs urban, using online vs offline, etc.).

MONITORING, EVALUATION, ACCOUNTABILITY, AND LEARNING FOR MHPSS



*The log frame for the global MHPSS Framework supports the assessment, design, implementation and M&E of **MHPSS strategies implemented by UNICEF and its partners around the world.***

MONITORING, EVALUATION, ACCOUNTABILITY

& LEARNING (MEAL): Every programme developed under the global framework should include a MEAL strategy to monitor and **evaluate the effectiveness** or health impact of intervention and/or programme. The MEAL strategy should answer the question of whether the intervention or programme **achieved its intended objectives; effectively and efficiently**; and whether it is **affordable, scalable and sustainable**.

The monitoring and evaluation (M&E) process helps make sense of the data collected through the course of an MHPSS programme so that it can be analysed and used to provide information to policymakers, programme officers, and other key stakeholders to address the MH needs in a country and region.

Monitoring is the process by which routine data is collected to track the changes of a programme over time, whereas **evaluation** measures how successful the programme's activities have been in meeting the expected outcomes and goals set by the programme or intervention. Monitoring is an ongoing process that uses data collection at different points throughout the programme and can determine if activities need to be adapted, improved or adjusted as the programme progresses. Evaluation requires data collection at the beginning (baseline) and at the end of the programme (end line) and helps compare how the programme or intervention affected a certain health outcome in the community.

An **M&E plan or log frame** details a programme's objectives, interventions and means of verifying progress. It sets out how expected results relate to key goals and objectives, how the data will be collected, key changes expected at the programme and population level, and the resources needed to implement the programme.

M&E 101: KEY COMPONENTS OF AN M&E LOG FRAME

They key components of a log frame are:

The **impact** is the big picture goals that the programme or intervention aims to achieve.

The **outcomes** are the short- or intermediate-term results that can be seen at the community level as a result of the programme. These include changes in attitudes, skills, knowledge, and/or behaviour as a result of the programme.

Outputs are the direct results achieved through the activities, such as the number of people that attended a workshop or engaged with an intervention.

The **activities** are the actions or processes carried out in order to achieve the programme's goals, such as a training event, a workshop or an awareness campaign.

Finally, the **inputs** are the resources needed to conduct and implement the programme itself. This includes technical assistance, funding, human resources, training, supplies, and more.

Additionally, **indicators** are units of measurement that specify what is to be measured. Indicators are intended to answer whether the desired impact, outcomes or outputs have been achieved. These can be quantitative (e.g., percentages or numbers of people), or qualitative (e.g., perceptions, quality, type, knowledge and capacity).

Finally, the **means of verification (MoV)** are the tools used to measure the suggested indicators. The proposed framework does not provide a MoV for each indicator because of the variation in preferences among different settings in terms of measuring change. Sometimes, a combination of MoVs may be most helpful: for example, a programme team may choose to use a combination of a survey and focus group discussions to investigate progress along a specific outcome.

MONITORING & EVALUATION OF MHPSS PROGRAMMING

The log frame for the global MHPSS framework supports the assessment, design, implementation and M&E of MHPSS strategies implemented by UNICEF and its partners around the world. The framework and log frame help programme staff to learn from and improve MHPSS approaches to support children and families in various crisis contexts.

The log frame draws on the '[Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings](#)' originally developed in 2016 and updated in 2020 by the IASC MHPSS Reference Group. It contributes to a shared language about MHPSS approaches and to quality practices in implementation. The log frame also links to and references UNICEF's 2022-2025 Strategic Plan using the codes provided in [Annex 5 UNICEF's Strategic Plan MHPSS related Outputs, Outcomes, and Indicators](#).

However, each MHPSS programme is unique to its context. Each programme requires its own M&E framework depending on the specific activities and envisioned outcomes and goals. The M&E log frame is closely aligned with the Theory of Change model used by the programme and can be adapted to in-country needs and priorities. As such, this log frame can be used as inspiration for designing an M&E framework relevant to specific programme approaches. It is not expected that programme staff will report against every impact, outcome and output indicator contained in the framework, but rather will choose relevant indicators, adapt them or add their own accordingly. However, the strategic planning indicators described above may serve as a core set of indicators that all countries can align and report towards.

Based on the MHPSS Theory of Change model, the mental health and psychosocial wellbeing of children, adolescents and their caregivers are supported and protected when MHPSS systems are mobilized and strengthened across four key outcomes:

1. Improved child and adolescent mental health and psychosocial wellbeing.
2. Improved caregiver mental health and psychosocial wellbeing (parents/ caregivers/mothers/teachers).
3. Improved capacity at the district and subdistrict levels for non-stigmatizing, accessible, available, and quality MHSS service delivery (PHC, social welfare & protection, education).
4. Improved enabling environment for MHPSS.

The MHPSS log frame enables programme staff to develop a clear understanding of the goals of the project, and define the logical connections between the impact, outcomes and intermediary outcomes. It also provides information about means of verifying progress, and key indicators that can be used to measure progress in key goal areas.

Indicators should be disaggregated by age and sex, as well as for diversity (including children with disabilities, including intellectual disabilities, ethnicity, etc). Means of verification (MoV) are suggested for measuring outcome and output indicators.

- [Annex 4](#) elaborates specific indicators for each key outcome and their corresponding outputs, also suggesting means of verification (MoVs) and best practices for data collection and reporting,
- Indicators that feed directly into UNICEF's Strategic Plan (SP), are identified throughout the tables via the coding system presented in [Annex 5](#).

Vulnerable children and adolescents are defined as at-risk children and adolescents or with identified protection risks if they fall in any of the following categories: unaccompanied or separated children; children associated with armed groups; survivors of gender-based violence (GBV).

The MHPSS log frame presented below includes the four main outcomes of the monitoring and evaluation framework, and the intermediary outcomes associated with each primary outcome. As described above, the detailed log frame is available under [Annex 4](#).

MHPSS Log Frame

OUTCOME / INTERMEDIARY OUTCOME

DESCRIPTION



OUTCOME 1

Improved child and adolescent mental health and psychosocial wellbeing

Intermediary Outcome 1.1

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

- i. at home
- ii. at school
- iii. in the community

Intermediary Outcome 1.2

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

Intermediary Outcome 1.3

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



OUTCOME 2

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

Intermediary Outcome 2.1

Families/parents/caregivers and/or teachers have access to support for developing and maintaining improved mental health and psychosocial wellbeing.

Intermediary Outcome 2.2

Parents/caregivers have access to family and community support networks that improve their mental health and psychosocial wellbeing.

Intermediary Outcome 2.3

Caregivers/family develop skills for parenting, teaching, and supporting children and adolescents in distress (MHPSS needs).



OUTCOME 3

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

Intermediary Outcome 3.1

Strengthened community awareness and positive behaviour change for child, adolescent, and family/caregiver mental health, psychosocial wellbeing, and protection, rooted in a stigma- and judgement-free environment.

Intermediary Outcome 3.2

Strengthened community mental health and psychosocial wellbeing support systems across sectors, including innate community capacities to support children/adolescents, parents/caregivers and families.

Intermediary Outcome 3.3

Strengthened multisectoral care systems (PHC, social welfare and protection, education) for children, adolescents and families, including utilization/leveraging of family-friendly policies.



OUTCOME 4

Improved enabling environment for MHPSS across the policy, legislation and financing systems, the MHPSS workforce, multisectoral supports and referral pathways, and MHPSS research and data

Intermediary Outcome 4.1

Policy, Legislation and Financing: The policy, legislative and financing environment is developed and strengthened to ensure that supportive mechanisms are in place for quality mental health and psychosocial service delivery.*

Intermediary Outcome 4.2

Strengthened multisectoral systems & referral pathways: Strengthened multilayered support systems and processes within existing structures, including functional referral systems across PHC, social welfare & protection and education.

Intermediary Outcome 4.3

Workforce development & capacity: Capacity strengthened among professional and non-specialist MHPSS providers in quality age- and gender-responsive MHPSS care across all sectors.

Intermediary Outcome 4.4

Research, evidence, & data: Improved evidence and data ecosystem for MHPSS that informs and drives policy changes relating to mental health and psychosocial support.

* Note to readers: This includes policies, laws, institutions, culture, and social and gender norms that create (1) a system that facilitates access to affordable and non-stigmatizing MHPSS for all children, adolescents, their families, and communities; and (2) a supportive environment for voice, agency and action of advocates and users of MHPSS, including youth and caregivers.

■ ANNEXES

ANNEX 1: STRATEGIES FOR COMMUNITY ENGAGEMENT AND PARTICIPATION

Communities and cultures are dynamic. They provide the structures and systems for safety in people's lives, work and education, and the social and psychological foundations of wellbeing for children and families. They change constantly as people adapt to new realities, environments, resources and challenges, particularly with the upheaval of familiar ways of life caused by emergencies.

Communities are also diverse, with subgroups and power dynamics that determine who participates in decision-making and to what extent. For example, community power relationships may exclude some vulnerable groups (e.g., based on ethnicity, religion, disability).

When the structures and fabric of community life are damaged by emergencies, MHPSS interventions use the process of community engagement and participation to help maintain, activate or restore community and family capacity to support children's wellbeing. What existed previously may need to be restored, abandoned or altered in the new context for the wellbeing of all community members following an emergency. People affected by an emergency, particularly one involving massive displacement, may or may not identify as part of the same community and subgroups within communities may or may not feel included, safe or respected.

Inclusion and participation of all community members is at the core of MHPSS work and requires great efforts of engagement. As such, engagement is not something 'done' to a community; rather, it is a process in partnership with community members as they assess their situation, consider priorities to help children and families and develop solutions based on their needs and resources. It ensures programmes:

See compendium

Resource in Layer 1.

The REPSSI Journey of Life: Community Workshops to Support Children: Workshop series for community mobilization to support children and caregivers in resource-poor settings.

- ❑ are relevant to local realities, cultural values and understandings
- ❑ make the best use of local resources
- ❑ effectively identify children and families who are vulnerable or have special needs, and actively promote their inclusion in interventions and relief efforts
- ❑ strengthen the natural supports in families and communities to care for children
- ❑ strengthen capacities of childcare systems for broad impact
- ❑ promote local ownership of programmes for long-term sustainability.

Community engagement is based on certain principles, including a rights-based approach that incorporates an age, gender and diversity analysis to ensure broad, meaningful participation of community members, including those who may traditionally be marginalized. It is also based on the principle of empowering individuals to understand their situation, make informed decisions and assume ownership of solutions for sustained impacts. It incorporates transparency and accountability of all stakeholders.

Engaging communities

In complex situations, careful attention must be paid to the process of approaching communities and ensuring inclusion and participation throughout the programme cycle. Engaging communities begins with recognizing and acknowledging their resilience, capacities, skills and resources for self-care and self-protection. It involves:

- ❑ working with the community and its leaders
- ❑ understanding the community's dynamics and structures
- ❑ building on community capacities and strengths to find solutions to identified concerns
- ❑ working in partnership to plan, implement and monitor interventions at all phases of the programme management cycle.

The process of community engagement raises awareness of the needs of vulnerable or marginalized groups. It can play a powerful role in reducing stigma and discrimination affecting vulnerable children and families.

Communities displaced by an emergency also interact with host communities in a variety of ways – sometimes being absorbed and integrating with them, sometimes living separately. Tensions may arise over resources or sociocultural differences. The relationship between affected people and host communities needs to be examined, with host communities involved in the process.

Environment also influences community engagement processes. For example, when refugees or displaced families are scattered in an urban environment, identifying and engaging with them requires different strategies than if they are located together in a refugee camp.

Six steps of engagement and participation

1. Learn about the context.
2. Identify and meet community stakeholders.
3. Conduct an inclusive, participatory assessment of needs and resources.
4. Facilitate inclusive, participatory planning of solutions and interventions.
5. Support programme implementation by community actors.
6. Monitor and evaluate interventions together.

Learn about the context

See compendium

Resource in Section 5.

Assessing mental health and psychosocial needs and resources: Toolkit for humanitarian settings (WHO, UNHCR)

Before entering a community, learn about the emergency and the sociocultural context for children and families. A situation analysis provides an overview of the emergency context, including a mapping of risks, resources and priority areas for intervention. It begins with a desk review of existing information about:

- ❑ The emergency and environments where affected children and families are living (including host communities).
- ❑ How many and who are the most vulnerable (e.g., unaccompanied children).
- ❑ The history of the emergency and what the communities have experienced.
- ❑ Risks for children and families as well as existing resources (e.g., services, facilities).
- ❑ Sociocultural customs; ways of caring for and protecting children and families.
- ❑ How children and caregivers with psychosocial distress or mental health condition are included (or excluded) in support structures.

Identify and meet community stakeholders

Stakeholders, include individuals and groups who may be affected by MHPSS interventions, can influence programmes, and have an interest in or can be a resource for interventions. Stakeholders are a diverse group including governmental, NGO and civil society personnel; organizations for children's care, such as school boards; religious organizations; youth and women's groups; formal and informal leaders, including women leaders such as female elders and midwives; people with disabilities; women and men (including

LGBTQ+ people); child caregivers; and children themselves. Vulnerable children and families may be hidden, so it is important to inquire sensitively about who and where they are, and the appropriate ways to reach them.

A stakeholder analysis is the first step undertaken in partnership with the community and in ensuring inclusive representation in community engagement activities. It is important to make a good first impression. See the tips below for some ideas in meeting and engaging stakeholders:

TIPS FOR MEETING AND ENGAGING COMMUNITY STAKEHOLDERS

- ❑ Understand community practices and traditions prior to entering communities in order to appropriately engage different groups and members.
- ❑ Work with and through community leaders (formal and informal). Inform them of plans for assessment and programme planning and seek their counsel. Community leaders can be instrumental in guiding and supporting entry into communities, and in promoting inclusion and participation of various stakeholders, including women and children.
- ❑ Identify an existing committee or community group/organization through which to access the community and share information.
- ❑ Explain who you are, why you are there, and what you can and cannot do (manage expectations).
- ❑ Focus on listening and use opportunities for informal meetings in various locations.
- ❑ Arrange meetings for mutually convenient times and check to be sure meetings accommodate the schedules of children and parents/caregivers.
- ❑ Work with leaders on outreach strategies to ensure messages reach everyone, not just a select few.
- ❑ Deliver messages in simple, culturally sensitive language that everyone can understand.
- ❑ Identify and engage diverse stakeholders, including children of all ages, and children and caregivers with mental health conditions, distress or disabilities.
- ❑ Be consistent, respectful and transparent in all dealings. Follow up on any actions in a timely way.

Source: Adapted from 'A community based approach in UNHCR operations', UNHCR, 2008, p. 44.

Conduct an inclusive, participatory assessment of needs and resources

Involving the community in the assessment not only provides valuable information for MHPSS interventions, it also acknowledges and helps engage individual and community agency for recovery and restoring hope. It brings diverse voices to an understanding of the community, how the emergency has affected community coping capacities and how different community members see their own risks and resources.

Talk with all those who influence the structures and systems of support for child wellbeing: mothers, fathers and other primary caregivers; teachers and other childcare providers; and various community stakeholders. Find ways to appropriately engage children of different ages, and those who may be marginalized such as children or caregivers with disabilities.

Engaging diverse voices means ensuring that age, disability and gendered perspectives are reflected. This helps include boys and girls, women and men, and vulnerable or marginalized children and families, and it supports meaningful participation. Consider talking with boys and girls separately to get a gendered perspective on children's needs. Accessing various groups appropriately and safely requires careful consideration of the sociocultural context. For example, men may have to get permission to speak privately with women, and caregivers should be consulted to approve children's participation in assessment activities.

Below are some general tips for engaging children in participatory assessment.

TIPS FOR ENGAGING CHILDREN IN PARTICIPATORY ASSESSMENTS

- ❑ Meet parents/caregivers to explain the assessment and ask permission for children to participate in it.
- ❑ Put children at ease, such as by sitting with them on the ground, singing, playing or drawing, according to their age and developmental stage and culture.
- ❑ Use simple language and concepts.
- ❑ Be patient and take time to build trust, especially with children who have had distressing experiences.
- ❑ Accept and support their emotions – do not judge them for how they feel.
- ❑ Help them to reduce any stress and tension.
- ❑ Validate what children say – do not challenge, shame or undermine them.
- ❑ Do not probe about upsetting details or emotions.
- ❑ Convey a sense of hope and safety.
- ❑ Understand that they may view and explain their situation through fantasy, inventing explanations, using symbolism or emphasizing seemingly unimportant details – listen respectfully.
- ❑ Be sensitive to gender, culture, ethics and power relationships between adults and children.

Source: 'Participatory assessment in operations' (UNHCR, 2006); 'Psychological First Aid: Guide for Field Workers' (WHO, 2011); 'Monitoring and Evaluation Framework for Psychosocial Support Interventions' (International Federation of Red Cross and Red Crescent Societies, Psychosocial Reference Centre, 2015)

Participatory assessments include FGDs, community mapping, key informant interviews and surveys.

Key questions to consider in inclusive, participatory assessments include:

- How has the community coped with distress and challenges in the past?
 - How has the emergency affected those coping mechanisms?
 - How are vulnerable children and families identified, helped and supported?
 - How are children or caregivers who have psychological distress or mental health problems viewed and supported (or overlooked)?
 - What are the key mental health, psychosocial and protection concerns for children and families?
 - What do boys and girls of different ages say are their particular concerns and priorities?
 - What do caregivers identify as their concerns and priorities?
 - Who is most at risk, and how can they best be reached and assisted?
- What is the perspective of children and families experiencing psychological distress or mental health problems, including developmental disabilities?
 - What are their concerns and priorities?
 - What coping strategies do they use and how do they seek help?
 - What barriers do they encounter in receiving services and support?
 - What resources and structures exist?
 - Who are key resource persons for children and families (e.g., teachers, social workers, women leaders)?
 - What childcare structures and natural supports are currently functioning (e.g., formal and informal education, social service systems) and what are the gaps?
 - What is helpful and what is harmful? What support mechanisms can be activated or restored, and what needs to be adapted to respect the rights of children and families?

See compendium

The Compendium contains resources and toolkits useful for the design of participatory assessment questions and other M&E tools.

Resource in Section 5.



Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings (WHO, UNHCR, 2012) contains practical tools for designing and conducting an assessment of mental health and psychosocial needs and resources in major humanitarian crises. See Tool 10 'Participatory Assessment: Perceptions by General Community Members' for guidance on interviews with general community members, including free listing and further questions.

Facilitate inclusive, participatory planning of solutions and interventions

The information gathered (situational and stakeholder analyses and the participatory assessment) are then shared and analysed together with stakeholders to plan the way forward. Work with the community to identify women and men, boys and girls – of all ages, as well as from vulnerable or marginalized groups – as representatives in the planning process. Engage children and family and community caregivers in designing programmes they feel are relevant to their needs and suitable to the culture and context. For example, in designing programmes for youth, bring adolescents together to brainstorm approaches and activities they would find interesting and relevant to their lives.

UNICEF and partners may work with a community committee in planning solutions and interventions. The committee's membership should be diverse. The group works together to examine risks and resources for children and families, identify priorities for action, and develop feasible solutions. Ensuring diverse and meaningful participation may require planning. For example, in some cultures women and children, or people with disabilities, may not have participated previously in such discussions. They may be unaccustomed to speaking up and having their opinions regarded seriously. Sensitize and orient the group on the value of inclusive, participatory processes and together determine what are acceptable ways to achieve this in the culture.

TIPS FOR INCLUSIVE, PARTICIPATORY PLANNING

- ❑ When holding a planning meeting, clearly state its goals and objectives and the agenda.
- ❑ Respect everyone, being sensitive to culture and giving people ample time to speak.
- ❑ Share the results of situation and stakeholder analyses and participatory assessments in ways everyone can understand.
- ❑ Do not immediately propose solutions; rather, facilitate a discussion on how best to respond, what resources can be mobilized and how, and what support they can expect from you.
- ❑ Facilitate a process to agree on a strategy (objectives, activities, roles and responsibilities), ensuring the strategy is inclusive and rights-based and addresses the needs of vulnerable children and families.
- ❑ Clarify links between the planning and budgeting process for implementing programmes.
- ❑ Help establish joint problem-solving mechanisms and regular feedback mechanisms.
- ❑ Provide a summary of the planning outcomes and ensure community representatives have mechanisms to disseminate the information to community members.

In planning solutions and MHPSS interventions, help communities identify sociocultural practices for the care and protection of children and families that uphold human rights and do not discriminate or stigmatize certain groups. Work with them on how to sensitively identify vulnerable children and families in ways that do

not expose them to further harm. Also help to identify local organizations (community or governmental) and/or people from affected communities to implement interventions for child and family wellbeing and protection.

Support programme implementation by community actors

The role of UNICEF and partners is to support programme implementation with technical and financial assistance to community actors. MHPSS interventions seek to maximize community and governmental resources that can continue after emergency funding ends. Whenever possible, support existing community initiatives and structures and build the capacity of the community to sustain their own solutions. For example, identify local organizations (community or governmental) and/or people from among affected communities to implement interventions for children and families.

- **Financial assistance:** Community engagement and participation processes raise awareness of issues and solutions that community members will often begin to address themselves. The level of financial assistance communities receive depends on the emergency situation and phase, the urgency of the needs and the capacity of the community to activate their own resources. It is important to manage the use of financial and material incentives carefully. Be careful not to erode natural volunteering and local ownership of the programme by reliance on incentives that may end with changes in funding streams. UNICEF and partners can support natural helping activities not only through financial assistance but also by providing meeting spaces, facilitating sharing, and providing information and training.
- **Technical assistance:** For plans to be successful, programme implementers need to have the skills, knowledge and systems to implement them, ensure their quality and track their progress over time. Activities in this step of community engagement include:
 - **Recruit:** Programme staff or volunteers can be recruited locally. Recruitment strategies should avoid weakening existing structures by pulling away skilled staff members. Help programme implementers develop recruitment procedures that ensure fair and equitable opportunities,

are appropriate to the culture and gender of children and families they will be helping, and appropriately screen for child protection concerns (e.g., check references).

- **Train and supervise:** Build the capacity of local volunteers and staff (within community groups and care structures) through participatory, skills-based training and ongoing supervision. Set minimum qualifications for the various roles and tasks of the job. Train and supervise volunteers and staff to ensure they meet those qualifications and feel equipped for their tasks. Ongoing supervision is essential in MHPSS programmes to build skills and knowledge to respond to emerging challenges and to support staff and volunteers in their work. 'Care for the caregivers' is not a luxury in MHPSS programmes – it is fundamental to quality programming and preventing burnout.
- **Establish information management and standard operating procedures (SOPs):** Systems and procedures are essential to the success of any programme. Help to develop and train programme implementers in useful systems of documentation and information management that meet ethical requirements (e.g., confidentiality). Documentation and information management systems should be feasible and user-friendly to ensure they are implemented and give an accurate picture of needs and progress. SOPs should include systems for assessing and responding to specific problems with guided protocols (e.g., coordination and referrals). SOPs help volunteers and staff do their work effectively and efficiently and make sure that children and families get the care they need.

Monitor and evaluate interventions together

Programme M&E is critical, and for transparency and accountability it should involve diverse members of the community. Include a wide range of voices in the feedback about programme outcomes and effectiveness in M&E strategies to get a clear and comprehensive view of the impact of interventions (including any

shortcomings) from different perspectives. Regular feedback mechanisms allow for timely feedback so programmes can be adjusted to ensure their safety and effectiveness. This also provides assurance that vulnerable children and families are included in participation mechanisms and service provision.

TIPS FOR MONITORING AND EVALUATING INTERVENTIONS WITH THE COMMUNITY

- ❑ Engage children, their caregivers and other community stakeholders in visualizing programme success in order to design useful indicators.
- ❑ Find out what elements of the programme are or are not working well for boys and girls of different ages by triangulating information from parents/caregivers (e.g., teachers) and children.
- ❑ Have an established plan to address any risky situations revealed by M&E processes.
- ❑ Design monitoring methods that are feasible for staff and community members to implement, and use simple tools for programme evaluation that allow for participation of different community groups.
- ❑ Do not be defensive about findings; rather, listen and learn, and agree together on improvements.
- ❑ Be sure to provide M&E data to children, caregivers and community stakeholders in forums that help them to improve strategies for longer-term care of children and for advocacy purposes.

ANNEX 2: ACTION SHEETS FROM IASC GUIDELINES FOR MHPSS IN EMERGENCY SETTINGS

The IASC MHPSS Guidelines contain relevant action sheets for various sectors – these are indicated below for each sector.

What Protection Actors Can Do (Action Sheets 3.1, 3.2, 3.3)

Protection actors in UNICEF and its partner organizations are often the primary implementers of MHPSS programmes. There is a natural link between children's protection and wellbeing, and interventions for each are closely related. For example, MHPSS approaches may focus on:

- ❑ building the capacity of caregivers of children (including teachers) to better recognize and respond to protection needs.
- ❑ developing functional referral networks between schools and social services.
- ❑ identifying and referring children who have suffered serious protection risks or traumatic events for specialized care and support, as necessary, to help them recover.
- ❑ identifying and addressing harmful behaviours.
- ❑ preventing separation and prioritizing reunification with caregivers.
- ❑ facilitating alternative care arrangements when necessary.

What Health and Nutrition Actors Can Do (Action Sheets 6.1 to 6.5, and 9.1)

Mental health is an integral part of general health as enshrined in the slogan 'no health without mental health!' However, many emergencies occur in areas of the world that lack adequate clinical mental health services, and existing services are often damaged or weakened by the emergency. Thus, strengthening the capacity of health and nutrition actors in communities is an important aspect of MHPSS intervention strategies. Health and nutrition actors can play an important role in recognizing and providing appropriate treatment and support to children and caregivers with mental health conditions or other specialized MHPSS needs. For example,

- ❑ Primary care staff can provide care and treatment based upon the *Mental Health GAP (mhGAP)* in Humanitarian Settings standards.
- ❑ Community health workers can receive training and supervision to appropriately identify, support and refer vulnerable children and families to clinical mental health care or social services.
- ❑ Nutrition actors can help to identify, support and refer mothers with post-partum depression or infants and young children at risk due to protection concerns, poor growth or developmental disabilities.

See compendium

Resource in Layer 2.

- ❑ Baby Friendly Space: Holistic approach for pregnant, lactating women and their very young children in emergency (ACF)
- ❑ Manual for the Integration of Child Care Practices and Mental Health within Nutrition Programs (ACF)

Care practices of child caregivers (mothers, fathers, other caregivers, siblings) include providing food, health care, stimulation and emotional support necessary for children to survive and thrive. The ways in which those practices are performed – such as the affection and responsiveness to the child – are critical to positive

outcomes for children's growth and development. Nutrition actors therefore pay particular attention to the mental wellbeing of caregivers themselves, and their capacity to stimulate social, emotional and cognitive development of their children. One model of intervention is baby friendly spaces, which provide a safe space for feeding and attending to the experiences and wellbeing of mothers, babies and children. Nutrition actors can also support cultural care practices that support mothers and babies, such as infant massage in India or post-partum rest for mothers in many Muslim countries.⁶⁹

What Education/ECD Actors Can Do (Action Sheet 7.1)

Education (both formal and non-formal) and ECD activities are essential to children's safety, wellbeing and development. ECD activities promote positive care practices during the critical early years of children's development. Examples of ECD activities include:

- Community dialogue and psychoeducation, parent support and training to:
 - provide infant and young child stimulation and facilitate active play
 - facilitate basic nutrition and promote the continuation of breastfeeding
 - promote bonding between infants and caregivers.
- Programmes to support the care of young children by their families and provide social support to caregivers.

Education is generally highly valued by families and communities and restarting learning activities for children following emergencies helps to restore routine and normalcy to daily life. Social and emotional learning through formal and informal learning spaces is an important aspect of children's development. It refers to "a process of acquiring social and emotional values, attitudes, competencies, knowledge and skills that are essential for learning, effectiveness, wellbeing

and success in life." These are closely aligned with the qualities of psychosocial wellbeing and resilience that children acquire through their optimal development: self-awareness, emotional literacy, persistence, motivation, empathy, relational skills, effective communication, self-esteem, self-confidence, respect and self-regulation.⁷⁰

Sometimes, children and teachers find learning difficult when they are faced with conflict or disaster. Schools can be given supports to provide developmental learning methods, based on reinforcing systems for the entire school community that can promote growth and learning. Schools and other safe spaces can also serve as important access points for children and families to receive other services, such as nutrition through school feeding programmes. Sports, cultural and other activities can engage children, their families and the larger community, restoring a sense of belonging and promoting healing and recovery.

⁶⁹ Engle, P., 'The role of caring practices and resources for care in child survival, growth and development: South and Southeast Asia', *Asian Development Review*, vol. 17, no. 1,2, 1999, pp. 132–167.

⁷⁰ International Network for Education in Emergencies (INEE), 'INEE Background Paper on Psychosocial Support and Social Emotional Learning for Children and Youth in Emergency Settings', 2016.

What Camp Coordination and Camp Management (CCCM) Actors Can Do (Action Sheet 10.1)

CCCM lead agencies coordinate the operations of various actors that provide essential services in camps for refugees and internally displaced people. They are essential in ensuring human rights standards are upheld, protection and assistance programmes are coordinated in a holistic way, and psychosocial wellbeing considerations are included to protect the dignity of survivors and enhance the overall humanitarian response.

- ❑ The role of CCCM actors begins with assessment, ensuring MHPSS needs and the resources of children and families are adequately and appropriately assessed.
- ❑ They also ensure all humanitarian staff working in the camps are briefed in basic MHPSS knowledge and skills to support distressed children and families and provide necessary referrals.
- ❑ CCCM actors may co-chair an MHPSS coordination group in the camp to help mainstream MHPSS activities across sectors and engage the affected community in service planning and delivery.
- ❑ CCCM actors can also help to assess and address MHPSS needs and resources in host communities, and liaise with civil society and government representatives to complement the temporary services provided in the camp setting and strengthen the MHPSS care structures in the area.

What WASH Actors Can Do (Action Sheet 11.1)

WASH actors play an important role in ensuring boys and girls, men and women have safe and appropriate access to WASH facilities in ways that contribute to their protection and wellbeing. A gendered perspective in the design and implementation of WASH facilities in campsites, schools and other locations is essential because of the unique risks faced by girls and women around these areas. Engaging girls and women (in addition to boys and men) in assessing needs and priorities around WASH facilities is the first step to ensure safe, appropriate facilities. This includes, for example:

- ❑ Separate and private bathing and latrine facilities for men and women, locks on latrine doors and well-lit latrine areas help to minimize protection risks.
- ❑ Water access points should be nearby and easily accessible to women and families who use them frequently for activities of daily living.
- ❑ Deciding together with women and child caregivers the best placement and design of water access points can help to promote areas where women can meet each other, have dialogue and form connections.

Keeping a developmental perspective also in mind, WASH actors can help to meet the particular hygiene needs of adolescent girls who are menstruating. They require access to clean water and safe, private facilities for washing in schools and other learning spaces. Being sensitive to these needs and ensuring their access to adequate hygiene in learning environments reduces their risk of dropping out.

ANNEX 3: UNICEF KEY COMMITMENTS, FRAMEWORKS AND MINIMUM STANDARDS

UNICEF minimum standards and guidelines for humanitarian action	
Overall policy	
<p><i>Core Commitments for Children in Humanitarian Action</i></p> <p>UNICEF, 2020</p>	<p>UNICEF's central policy for upholding the rights of children affected by humanitarian crisis. The CCCs promote predictable, effective and timely humanitarian action through partnership between governments, humanitarian organizations and others.</p> <p>https://www.unicef.org/emergencies/ore-commitments-children</p>
Child protection	
<p><i>Minimum Standards for Child Protection in Humanitarian Action</i></p> <p>The Alliance for Child Protection in Humanitarian Action</p>	<p>Provides minimum standards for child protection work in humanitarian settings.</p> <p>https://alliancecpha.org/en/CPMS_home</p>
Mental health and psychosocial support	
<p><i>Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings</i></p> <p>Inter-Agency Standing Committee, 2007</p>	<p>Guidelines to enable humanitarian actors to plan, establish and coordinate a set of minimum multisectoral responses to protect and improve people's mental health and psychosocial wellbeing in emergencies.</p> <p>http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf</p>
Education	
<p><i>INEE Minimum Standards for Education: Preparedness, Response, Recovery Handbook</i></p> <p>Inter-Agency Network for Education in Emergencies, 2010</p>	<p>19 standards that aim to enhance the quality of educational preparedness, response and recovery in humanitarian settings, and to meet the educational rights and needs of people affected by disaster.</p> <p>http://www.ineesite.org/en/minimum-standards</p>
HIV/AIDS	
<p><i>Guidelines for Addressing HIV in Humanitarian Settings</i></p> <p>Inter-Agency Standing Committee, 2010</p>	<p>Guidelines for providing a minimum set of HIV prevention, treatment, care and support services to people affected by humanitarian crises.</p> <p>file:///Users/useruser/Downloads/IASC_HIV_Guidelines_2010_En%20(1).pdf</p>
Children with disabilities	
<p><i>Children with Disabilities: Ending discrimination and promoting participation, development and inclusion</i></p> <p>UNICEF, 2007</p>	<p>Provides recommendations for upholding the rights of children with disabilities in programmes in humanitarian settings.</p>
Gender-based violence	
<p><i>Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on prevention of and response to sexual violence</i></p> <p>IASC Taskforce on Gender in Humanitarian Assistance, 2005</p>	<p>Guidelines for establishing and coordinating a set of minimum multisectoral interventions to prevent and respond to sexual violence in emergencies.</p> <p>https://www.un.org/ruleoflaw/files/tfgender_GBVGuidelines2005[1].pdf</p>
<p><i>Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service</i></p> <p>International Rescue Committee, 2012</p>	<p>Guidance for health and psychosocial staff in providing care and treatment to child survivors of sexual abuse in humanitarian settings.</p> <p>Caring for Child Survivors - Child Protection at the IRC (childprotectionpractitioners.org)</p>
<p><i>Conflict Sensitive Education Pack</i></p> <p>Inter-Agency Network on Education in Emergencies, 2013</p>	<p>Guidance and tools for integrating conflict sensitivity into education programmes in fragile and conflict-affected settings.</p> <p>http://toolkit.ineesite.org/toolkit/Toolkit.php?PostID=1148</p>

ANNEX 4: UNICEF'S MULTISECTORAL MHPSS LOG FRAME

UNICEF'S multi-sectoral MHPSS log frame includes the four outcomes of the MHPSS Framework, along with their intermediary outcomes and outputs. MHPSS outcomes, intermediary outcomes, and outputs are supported with corresponding descriptions, indicators, and suggested means of verification (MoV) providing

clarity and organisation about each outcome or output area. Notably, relevant Strategic Planning (SP) indicators from UNICEF's 2022-2025 Strategic Plan that correspond to MHPSS are also listed, along with the corresponding Goal Areas (GAs). More information about the SP indicators are presented in Annex 5.

Outcome 1: Improved Child and Adolescent Mental Health and Psychosocial Wellbeing		
Description	Indicators	Means of Verification (MoV)
Intermediary Outcome 1.1		
1.1 Children and adolescents have access to safe and nurturing environments, and to quality services that improve their mental health and psychosocial wellbeing: i. at home ii. at school iii. in the community Strategic Plan GA1 1.14	<ul style="list-style-type: none"> Percentage of target group members (such as at-risk children, adolescents, and parents/families/caregivers) who feel safe i) at home, ii) school, and iii) in the community Percentage of children, adolescents, caregivers/teachers receiving MHPSS services, demonstrate improvement in relevant domains of mental health and psychosocial wellbeing SP Indicator GA1 1.14: Percentage of children and adolescents who report symptoms of depression and/or anxiety reporting contact with health professional or counsellor for mental health care (MMAP) 	<ul style="list-style-type: none"> Focus group discussions (FGDs) and Key Informant Interview (KII) reports with: i) children, ii) family/caregivers Child, adolescent, parents, caregiver, and community KAP/other surveys disaggregated for age, gender, diversity Programme activity records See IASC M&E Framework for additional MoV & guidance specific to measuring changes in mental health and psychosocial wellbeing
Output 1.1		
1.1.a The service delivery of basic needs for vulnerable children and adolescents ensures equitable access	<ul style="list-style-type: none"> Number of vulnerable children and adolescents identified and referred for basic services (report by various domains of sociodemographic characteristics, e.g., age, sex, residence, SES, displacement status, etc) Number of standard operating procedures (SOPs), referral pathways and service directories developed (report by various domains of sociodemographic characteristics, e.g., age, sex, residence, SES, displacement status, etc) 	<ul style="list-style-type: none"> Referral resource lists, forms and procedures, and referral information management system (IMS) (follow-up report) Service and agency mapping reports

<p>1.1.b. Safe spaces (including learning spaces) are:</p> <p>i. utilized by,</p> <p>ii. meet the MHPSS needs of children and adolescents</p>	<ul style="list-style-type: none"> • Number of vulnerable children and adolescents who use safe spaces (report by age, sex, residence, SES, displacement status, etc). • Number of schools with a safety policy. • Number of vulnerable children and adolescents reporting satisfaction with MHPSS services provided by safe spaces 	<ul style="list-style-type: none"> • Activity reports and registration logs • School safety policies developed • Child, adolescent, parents, family and caregiver satisfaction surveys
<p>Intermediary Outcome 1.2</p>		
<p>1.2. Children and adolescents have access to support systems that facilitate positive relationships that promote inclusion, belonging, and agency.</p>	<ul style="list-style-type: none"> • Percentage of children and adolescents with mental health and psychosocial conditions who report receiving adequate support from parents/ caregivers and family members • Percentage of children and adolescents with mental health and psychosocial problems that have access to supportive social networks i) at home, ii) in schools, and iii) in the community • Percentage of vulnerable children and adolescents who received focused care, including i) PFA, ii) psychotherapy or clinical management of mental health disorders, and/or iii) psychological counselling • Percentage of vulnerable children and adolescents with access to i) referral systems to link people with psychological problems to resources and services, ii) case management services • Percentage of children and adolescents reporting awareness of appropriate, effective peer and group support activities and how to access them. 	<ul style="list-style-type: none"> • Focus group discussions (FGDs) and Key Informant Interview (KII) reports with: i) children and adolescents, ii) parents/family/caregivers • Child, adolescent, family, caregiver, and community KAP/other surveys disaggregated for age, gender, diversity • Programme activity records
<p>Output 1.2</p>		
<p>1.2.a. Outreach services are provided to vulnerable children and adolescents</p>	<ul style="list-style-type: none"> • Percentage of vulnerable children and adolescents requiring outreach services who are referred for appropriate protection and MHPSS services. • Percentage of vulnerable children and adolescents receiving community outreach case management services. 	<ul style="list-style-type: none"> • Referral forms, referral IMS data (follow-up report) • Service and agency mapping reports
<p>1.2.b. Child and adolescent peer and group support is available and accessible</p>	<ul style="list-style-type: none"> • Number of children and adolescents engaged in design of youth clubs, peer-to-peer support strategies, etc. 	<ul style="list-style-type: none"> • Child and adolescent surveys, disaggregated for age, gender and diversity • Activity reports

<p>1.2.c. Family care and nurturing family environments are strengthened</p>	<ul style="list-style-type: none"> • Number of children and adolescents reunified with family members or in other permanent care arrangements. 	<ul style="list-style-type: none"> • IMS data from family tracing and reunification activities • Parent/caregiver surveys • Programme cycle monitoring reports • Activity records from feeding centres, etc.
<p>Intermediary Outcome 1.3</p>		
<p>1.3 Children and adolescents have opportunities for stimulation, learning and skills development that contributes to mental health and wellbeing</p>	<ul style="list-style-type: none"> • Percentage of children and adolescents with access to defined opportunities to develop their socioemotional skills at i) home, ii) in schools, and iii) in the community • Percentage of children and adolescents with mental health and psychosocial problems who participate in livelihood activities in the community 	<ul style="list-style-type: none"> • Focus group discussions (FGDs) and Key Informant Interview (KII) reports with: i) children and adolescents, ii) parents/family/caregivers • Child or adolescent, caregiver/ family/parent, and community KAP/ other surveys disaggregated for age, gender, diversity • Program activity records
<p>Output 1.3</p>		
<p>1.3.a. School environments that are supportive of children and adolescent’s mental health and wellbeing, development, and learning</p> <p>Strategic Plan GA 2 2.2.6, GA 2 2.2.3</p>	<ul style="list-style-type: none"> • Number of schools implementing strategies to strengthen supportive environments (e.g., teacher training in basic psychosocial concepts, anti-bullying campaigns) • SP Indicator GA 2. 2.2.6: Percentage of countries institutionalizing holistic skills development to support learning, personal empowerment, environmental sustainability, active citizenship and/or employability and entrepreneurship (UNEP, UNESCO) • SP Indicator GA 2 2.2.3: Percentage of countries with effective student and community participation within the education system (GPE, UNESCO, World Bank) 	<ul style="list-style-type: none"> • School activity reports and materials developed (e.g., anti-bullying)

Outcome 2: Improved caregiver mental health and psychosocial wellbeing including for parents, caregivers, mothers, family, and teachers

Description	Indicators	Means of Verification (MoV)
Intermediary Outcome 2.1		
2.1. Families/Parents/caregivers and/or teachers have access to support for developing and maintaining improved mental health and psychosocial wellbeing	<ul style="list-style-type: none"> Percentage of parents/caregivers reporting ability to cope with common problems of children and adolescents (e.g., through skills related to stress management, conflict resolution, problem-solving or positive parenting; or knowledge of where to seek help or information) Percentage of parents/caregivers that have access to supportive social networks at i) home, ii) in schools, and iii) in the community 	<ul style="list-style-type: none"> Child, adolescent, parent/family/caregiver and community KAP Surveys Child, adolescent, parent/family/caregiver FGD, KII and informal interview reports Programme staff conversations of child/adolescents and family/parent/caregiver interactions Programme monitoring reports (activity reports) IMS data on CP/MHPSS structures developed and used Child/adolescent, parent/family, caregiver surveys disaggregated for age, gender and diversity Community social network mapping Programme activity records
Output 2.1		
2.1.a. Mental health and psychosocial well-being and development of family/caregivers/teachers are supported	<ul style="list-style-type: none"> Number of vulnerable family/parents/caregivers accessing livelihood opportunities 	<ul style="list-style-type: none"> Child/adolescent/youth, parent/caregiver and family surveys Activity reports, attendance sheets
2.1.b. School staff and systems are supported to recognize and respond to focused psychosocial support and protection needs of children and adolescents Strategic Plan GA 2 2.2.1	<ul style="list-style-type: none"> Percentage of schools with increased links to mental health and social service referrals. SP Indicator GA2. 2.2.1: Percentage of countries with effective teacher development system (GPE, UNESCO, World Bank). 	<ul style="list-style-type: none"> Training reports Referral resource lists, forms and procedures (SOPs), and referral IMS
Intermediary Outcome 2.2		
2.2 Parents/Caregivers have access to family and community support networks that improve their mental health and psychosocial wellbeing	<ul style="list-style-type: none"> Percentage of family/parents/caregivers reporting on positive social cohesion within families and communities 	<ul style="list-style-type: none"> Child/adolescent, parent/caregiver and community KAP Surveys Child/adolescent, parent/family, caregiver FGD, KII and informal interview reports Programme staff observations of child/adolescent, parent/caregiver interactions Programme monitoring reports (activity reports) IMS data on CP/MHPSS structures developed and used Child/adolescent, parent/family, caregiver surveys disaggregated for age, gender and diversity Community social network mapping Programme activity records

Output 2.2.		
<p>2.2a. Family/caregiver care and nurturing family/caregiver environments are strengthened.</p>	<ul style="list-style-type: none"> • Number of parents/caregivers provided with support in positive and responsive caregiving. 	<ul style="list-style-type: none"> • IMS data from family tracing and reunification activities • Parent/caregiver surveys • Programme cycle monitoring reports • Activity records from feeding centres, etc.
<p>2.1.b. Children, adolescents, and parents/families/caregivers with psychosocial support and protection needs are supported by family and community networks and services</p> <p>Strategic Plan GA 3 3.1.2</p>	<ul style="list-style-type: none"> • Number of children, adolescents, and parents/caregivers reporting access to community support groups and family network activities for distress and mental health and psychosocial wellbeing concerns. • Number of family and community psychosocial support networks and services identified and activated for the support of children, adolescents and parents/caregivers in need. • SP Indicator GA 3 3.1.2: Number of mothers, fathers and caregivers reached through parenting programmes through UNICEF-supported programmes (WHO). 	<ul style="list-style-type: none"> • Child and caregiver surveys • Project reports of documented, active community groups
Intermediary Outcome 2.3		
<p>2.3 Caregivers/family develop skills for parenting, teaching, and supporting children and adolescents in distress (MHPSS needs)</p> <p>Strategic Plan H2 2.9</p>	<ul style="list-style-type: none"> • Percentage of parents/caregivers reporting supportive parenting skills and knowledge of child/adolescent MHPSS needs • Percentage of parents/caregivers reporting quality of caregiver–child interactions (e.g., nurturing and stimulating interactions supporting children’s optimal development). (quality interactions to be defined) • SP Indicator H2.9: Number of country offices that meet organizational benchmarks for integrated parenting support programmes that promote children’s and adolescents’ optimal development 	<ul style="list-style-type: none"> • Child/adolescent, family/parent/caregiver and community KAP Surveys • Child/adolescent, family/parent/caregiver FGD, KII and informal interview reports • Programme staff observations of child/adolescent, parent/caregiver interactions • Programme monitoring reports (activity reports) • IMS data on CP/MHPSS structures developed and used • Child/adolescent, family/caregiver surveys disaggregated for age, gender, and diversity • Community social network mapping • Programme activity records
Output 2.3		
<p>2.3.a. Family/parents/caregivers are supported to recognize and respond to their own MHPSS needs and that of their children and adolescents</p>	<ul style="list-style-type: none"> • Number of trainings, psychosocial education and supportive group sessions conducted for family/parents and caregivers in self-care and care for children and adolescents in need of support. • Number of parent/caregiver and baby responsive caregiving and stimulation sessions provided (e.g., in feeding centres). 	<ul style="list-style-type: none"> • Training and supervision reports • KII and FGD reports

Outcome 3: Improved community capacity at the district and subdistrict levels for non-stigmatizing, accessible, available, and quality MHPSS service delivery across the primary health care, social welfare and protection, and education systems and structures)		
Description	Indicators	Means of Verification (MoV)
Intermediary Outcome 3.1		
<p>3.1. Strengthened community awareness and positive behaviour change for child, adolescent, and family/ caregiver mental health, psychosocial wellbeing, and protection, rooted in a stigma- and judgement-free environment.</p> <p>Strategic Plan H2 2.5</p>	<ul style="list-style-type: none"> • Number of target communities where representatives of children/ adolescent and caregiver/families are included in decision-making processes on their safety. • Number of target communities where children and adolescents participate in communal rituals, cultural activities and celebrations. • Percentage of community members with improved perceptions, knowledge, attitudes and behaviours towards children/adolescents and families/caregivers with mental health and psychosocial problems. • SP Indicator H2.5: Percentage of country offices that meet organizational benchmarks for reducing stigmatization and discrimination towards children and families marginalized due to disabilities, sociocultural background or migration status. 	<ul style="list-style-type: none"> • Child/adolescents, family/parents, caregiver surveys disaggregated for age, gender and diversity • Community social network mapping • Programme activity records • KAP survey conducted pre-post programme implementation
Output 3.1		
3.1.a. Community members are engaged in assessment, design and planning of child and family MHPSS programmes.	<ul style="list-style-type: none"> • Percentage of families/caregivers who report being actively involved in different phases MHPSS programme development (e.g., in needs assessment, programme design, implementation and M&E). 	<ul style="list-style-type: none"> • Programme cycle monitoring tools (attendance sheets, meeting reports) • Child and family/caregiver questionnaires (disaggregated for age, gender and diversity)
3.1.b Target communities are engaged in monitoring and reporting MHPSS needs through formal or informal mechanisms.	<ul style="list-style-type: none"> • Percentage of target communities trained on formal and informal mechanisms of MHPSS, monitoring and reporting of at-risk groups. • Number of community members who report enhanced capacities in recognizing and responding to at-risk children/adolescent and families/caregivers. 	<ul style="list-style-type: none"> • Programme cycle monitoring forms (activity and meeting reports) • Training reports • Pre/post KAP measures • On-the-job competence measures

<p>3.1.c. Community awareness and behaviour change interventions for MHPSS, stigma reduction issues are implemented.</p>	<ul style="list-style-type: none"> • Priority areas for community awareness and behaviour change interventions are identified to support child/adolescent wellbeing and safety. • Number of community actions for stigma reduction implemented (media dissemination, community meetings, community drama, etc.). • Number of child and adolescents and family/parent wellbeing and protection initiatives developed and implemented by and through existing community supports and structures. 	<ul style="list-style-type: none"> • Reports of FGDs, informal and formal KIIs • Project cycle monitoring reports
<p>3.1.d. MHPSS messages are developed, disseminated and reach community stakeholders, vulnerable children, adolescents and their families.</p>	<ul style="list-style-type: none"> • Number of i) community members, ii) families, iii) teachers who received MHPSS messaging about the needs of at-risk children, adolescents and families • Number of sessions held to offer psychosocial education (e.g., on child and adolescent development and wellbeing, stress responses and coping for children, adolescent, and caregivers) to family/parent/caregivers and community stakeholders 	<ul style="list-style-type: none"> • Activity records • Attendance sheets • Programme cycle monitoring reports • Pre-post knowledge check assessments for sessions
<p>Intermediary Outcome 3.2</p>		
<p>3.2 Strengthened community mental health and psychosocial wellbeing support systems across sectors, including innate community capacities to support children/adolescents, parents/caregivers, and families</p>	<ul style="list-style-type: none"> • Percentage of target communities (i.e., villages, neighbourhoods or institutions such as mental hospitals and orphanages) with formal or informal mechanisms that engage in protection, monitoring and reporting of safety risks or at-risk groups (e.g., children/adolescents, women, people with severe mental health conditions). 	<ul style="list-style-type: none"> • Child/adolescents, family/parents, caregiver surveys disaggregated for age, gender and diversity • Community social network mapping • Programme activity records
<p>Output 3.2</p>		
<p>3.2.a. Traditional community structures and stakeholders for child/adolescents and parents/family wellbeing are activated.</p> <p>Strategic Plan GA 3 3.2.7</p>	<ul style="list-style-type: none"> • Number of sessions held with community leaders and representative stakeholders to identify and assess community needs and resources for child and adolescent wellbeing. • Number of family and community psychosocial support networks and services identified and activated for the support of children, adolescents and parents/caregivers in need. • SP Indicator GA 3 3.2.7: Number of UNICEF-targeted children, adolescents, parents and caregivers provided with community-based mental health and psychosocial support services (UNESCO, WHO, World Bank). 	<ul style="list-style-type: none"> • Community mapping of needs and resources • Activity records • Attendance sheets • Programme cycle monitoring reports

Intermediary Outcome 3.3		
<p>3.3 Strengthened multi-sectoral care systems (PHC, Social Welfare and Protection, Education) for children, adolescents, and families, including utilization/leveraging of family-friendly policies</p>	<ul style="list-style-type: none"> • Number of target communities (such as villages or neighbourhoods) where steps have been taken to identify, activate or strengthen local resources that support psychosocial wellbeing and development of children. • Number of formal and informal social structures that include specific mental health and psychosocial provisions or supports for children/adolescents and families. • Percentage of affected children/adolescents and parents/family members who use different formal and informal social structures (such as schools or informal education for children/adolescents of all ages, health care, social services, ECD programmes, women's groups and youth clubs). • Percentage of people diagnosed with MH conditions who receive clinical management from medical services (primary, secondary or tertiary health care). • Percentage of available programmes focusing on prevention and promotion of MHPSS for children, adolescents and parent/caregivers that offer evidence-based care. 	<ul style="list-style-type: none"> • Focus group discussion (FGD) reports • Training and supervision reports • Quality standards checklist • Key informant interviews (KIIs) and informal interview reports • KAP surveys • Programme staff observations of child/adolescent/caregiver interactions • Programme monitoring reports (activity reports) • IMS data on CP/MHPSS structures developed and used • Child and adolescent surveys, disaggregated for age, gender and diversity
Output 3.3.		
<p>3.3.a. School staff and systems are supported to recognize and respond to focused psychosocial support and protection needs of children and adolescents.</p> <p>Strategic Plan GA 2 2.1.2</p>	<ul style="list-style-type: none"> • Number of teachers and school administrators (including CFS animators and staff of ECD centres) trained in identifying and responding to focused psychosocial support and protection needs of children/adolescents • Number of schools with increased links to mental health and social service referrals • SP Indicator GA2 2.1.2: Percentage of countries with a resilient education system that can respond to humanitarian crises (ECW, GPE, UNESCO, World Bank) 	<ul style="list-style-type: none"> • Training reports • Referral resource lists, forms and procedures (SOPs), and referral IMS • Knowledge indicators or surveys

Outcome 4: Improved enabling environment for MHPSS across the policy, legislation and financing systems, the MHPSS workforce, multisectoral supports and referral pathways, and MHPSS research and data		
Description	Indicators	Means of Verification (MoV)
Intermediary Outcome 4.1		
<p>4.1. Policy, Legislation and Financing: The policy, legislative, and financing environment is developed and strengthened to ensure that supportive mechanisms are in place for quality mental health and psychosocial service delivery.</p> <p>Note to readers: This includes policies, laws, institutions, culture, and social and gender norms that create (1) a system that facilitates access to affordable and non-stigmatizing MHPSS for all children, adolescents, their families, and communities; and (2) supportive environment for voice, agency and action of advocates and users of MHPSS, including youth and caregivers.</p>	<ul style="list-style-type: none"> • Number of new policies, legislations and costed plans with MHPSS components for children, adolescents and parents/caregivers • Percentage of countries that demonstrate increased mental health spending for children, adolescents, and their parents/caregivers across at least three sectors (GAP 3 Framework) • Percentage of countries that have mechanisms to support child and adolescent participation and engagement in decision-making processes 	<ul style="list-style-type: none"> • Quality standards checklists for CP/MHPSS interventions • Programme cycle monitoring tools • CP/MHPSS IMS • Child, adolescent, and family satisfaction surveys, FGDs and KII reports • IMS medical services data • Programme cycle monitoring reports • Referral reports • MHPSS quality standard checklists • MHPSS quality standards checklists • Child, adolescent, and family satisfaction surveys disaggregated for age, gender, and diversity
Output 4.1		
<p>4.1.a. National, subnational, and local leadership and governance structures for MHPSS exist and trigger policy change related to mental health for children, adolescents, family/caregivers, and teachers</p> <p>Strategic Plan H1.1.c, H3.7</p>	<ul style="list-style-type: none"> • Number of countries with a dedicated government body overseeing mental health policy and programming at the national, subnational and local levels (adapted for MHPSS from WHO-AHA Framework) • Number of countries with dedicated structures and processes for child and adolescent' participation in decision-making for mental health programming at the national, subnational, and local levels (adapted for MHPSS from WHO-AHA Framework) • Number of countries where i) child, ii) adolescent, iii) caregiver, and iv) teacher's MHPSS needs are addressed within the national legal and policy framework (adapted for MHPSS from WHO-AHA Framework) • Number of countries where training on MHPSS concepts is incorporated into national curricula for teachers and DRR plans 	<ul style="list-style-type: none"> • Programme cycle monitoring tools • Policy analyses • Key informant interview reports or Focus Group Discussions • National curricula incorporating MHPSS/CP quality training

	<ul style="list-style-type: none"> • Number of countries where governments use administrative data on child, adolescent, caregiver/teacher mental health and psychosocial wellbeing to i) evaluate department performance, ii) plan and allocate resources, iii) respond to periodic monitoring requests from international and regional intergovernmental organizations, and iv) to set policies to protect mental health outcomes (adapted to MHPSS from UNICEF Administrative Data System on Justice for Children framework.) • SP Indicator H1.1.c: Number of countries that took advocacy action that triggered policy change related to mental health of children and young people, and to bring an end to neglect, abuse and childhood traumas. • SP Indicator H3.7: Number of countries in which UNICEF-supported policymaking or budgeting is informed by data, research, and evaluation. 	
<p>4.1.b National policies and strategies that address child, adolescent, and caregiver/teacher mental health are fully costed, and budgets for implementation are secured.</p> <p>Strategic Plan 1.5.3</p>	<ul style="list-style-type: none"> • Number of countries with costed plan/strategy for child and/or parent/caregiver MHPSS (GAP 3 framework). • Number of countries implementing costing and investment monitoring tools for MHPSS (GAP 3 framework). • Number of countries that have financial risk protection mechanisms in place for MHPSS (adapted to MHPSS from WHO AA-HA Framework). • SP Indicator 1.5.3: Number of countries with a plan or strategy for child and/or adolescent mental health (WHO). 	<ul style="list-style-type: none"> • Programme cycle monitoring tools • Policy analyses • Key informant interview reports or Focus Group Discussions
Intermediary Outcome 4.2		
<p>4.2. Strengthened Multi-Sectoral Systems & Referral Pathways: Strengthened multilayered support systems and processes within existing structures, including functional referral systems across PHC, Social Welfare & Protection, and Education</p>	<ul style="list-style-type: none"> • Number of countries that have established referral pathways between health, education, social welfare, and protection systems. • Number of countries that have a strategy for ensuring free and accessible access to MHPSS services across health, education, social welfare, and protection sectors. 	<ul style="list-style-type: none"> • Quality standards checklists for CP/MHPSS interventions • Programme cycle monitoring tools • CP/MHPSS IMS • Child, adolescent, and family satisfaction surveys, FGDs and KII reports • IMS medical services data • Programme cycle monitoring reports • Referral reports • MHPSS quality standards checklists • Child, adolescent, and family satisfaction surveys disaggregated for age, gender, and diversity

Output 4.2.		
4.2.a. Functioning referral systems are established	<ul style="list-style-type: none"> • Number of countries with functioning referral systems (IFRC Psychosocial M&E framework). • Number of countries tracking delivery and referral information related to mental health and psychosocial support services for children and adolescents. 	<ul style="list-style-type: none"> • Programme reports
4.2.b. MHPSS is integrated within existing structures for primary health Strategic Plan GA1 1.5.1, GA1. 1.5.2	<ul style="list-style-type: none"> • SP Indicator GA1. 1.5.1: Number of countries integrating mental health services in primary health care, including through school and digital platforms. • SP Indicator GA1. 1.5.2: Number of countries implementing multisectoral approaches to caregiver mental health. 	<ul style="list-style-type: none"> • Programme reports • Facility surveys
Intermediary Outcome 4.3		
Workforce Development & Capacity: Capacity strengthened among professional and non-specialist MHPSS providers in quality age- and gender-responsive MHPSS care across all sectors.	<ul style="list-style-type: none"> • Percentage of staff trained on and following guidance (e.g., IASC MHPSS Guidelines, CP frameworks) on mental health and psychosocial support approaches. 	<ul style="list-style-type: none"> • Quality standards checklists for CP/ MHPSS interventions • Programme cycle monitoring tools • CP/MHPSS IMS • Child, adolescent, and family satisfaction surveys, FGDs and KII reports • IMS medical services data • Programme cycle monitoring reports • Referral reports • MHPSS quality standard checklists • MHPSS quality standards checklists • Child, adolescent, and family satisfaction surveys disaggregated for age, gender, and diversity
Output 4.3		
4.3.a. Intersectoral staff and volunteers have the capacity to provide culturally appropriate, respectful services that minimize harm to children and families.	<ul style="list-style-type: none"> • Number of staff working across sectors trained in basic psychosocial support principles (e.g., PFA and 'do no harm' strategies such as IASC MHPSS Guidelines). • Number of staff working across sectors trained in basic psychosocial support principles who demonstrated improved knowledge. • Number of teachers and school administrators (including CFS animators and staff of ECD centres) trained in assessing and responding to children and adolescent's needs for psychosocial support, development and social-emotional learning. 	<ul style="list-style-type: none"> • Pre-post assessments • On-the-job checklists

	<ul style="list-style-type: none"> • Number of community care providers trained and supervised in appropriate, focused psychosocial support to parents/caregivers with mental health and psychosocial problems. 	
4.3.b. Accessible, coordinated and inclusive focused and specialized MHPSS care are promoted within health, mental health and social service systems and other community systems for children/adolescents and families/caregivers	<ul style="list-style-type: none"> • Number of medical facilities, social services facilities and community programmes that have at least one staff member who is trained to help children/adolescents and families/caregivers with mental health and psychosocial problems. • Number of medical facilities, social services facilities and community programmes that have and apply procedures for referral of children/adolescents with mental health and psychosocial problems. 	<ul style="list-style-type: none"> • Programme cycle monitoring tools • Key informant interview reports or Focus Group Discussions
4.3.c. Supportive supervision and continuing education opportunities are available for professional and non-specialist MHPSS providers.	<ul style="list-style-type: none"> • Number of countries that have supervisory systems for professional and non-specialist MHPSS providers to support their roles. • Number of countries that provide refresher training and continuing education opportunities for MHPSS service providers. • Number of health staff trained in basic psychosocial support (including PFA) and referral procedures. • Number of medical, social service and community programme staff trained in the identification, management and referral of children/adolescents and families with mental health problems. 	<ul style="list-style-type: none"> • Programme cycle monitoring tools • Key informant interview reports or Focus Group Discussions • Training and supervision reports
Intermediary Outcome 4.4		
4.4. Research, Evidence, & Data: Improved evidence and data ecosystem for MHPSS that informs and drives policy changes around mental health and psychosocial support Strategic Plan GA 3. 3.8	<ul style="list-style-type: none"> • Number of countries implementing data collection efforts to report on key indicators related to MHPSS at national and subnational level. • SP Indicator GA 3 3.8: Number of countries tracking delivery and referral information related to mental health and psychosocial support services for children and adolescents (UNESCO, WHO, World Bank). 	<ul style="list-style-type: none"> • Quality standards checklists for CP/MHPSS interventions • Programme cycle monitoring tools • CP/MHPSS IMS • Child, adolescent, and family satisfaction surveys, FGDs and KII reports • IMS medical services data • Programme cycle monitoring reports
		<ul style="list-style-type: none"> • Referral reports • MHPSS quality standard checklists • MHPSS quality standards checklists • Child, adolescent, and family satisfaction surveys disaggregated for age, gender, and diversity

Output 4.4		
<p>4.4.a MHPSS interventions utilize evidence-based strategies aligned with international quality standards.</p>	<ul style="list-style-type: none"> • Number of SOPs, service directories and referral pathways developed within mental health, CP, social service and other community support systems. • Number of MHPSS programmes demonstrating minimum quality standards per international guidelines. • Number of countries that have developed and demonstrate minimum quality standards per international guidelines for promotive, preventive, and responsive mental health and wellbeing in schools (adapted from GAP 3 framework). • Number of countries measuring change along relevant domains of mental health and psychosocial wellbeing for children, adolescents, parents, caregivers, and teachers. 	<ul style="list-style-type: none"> • Quality standards checklists for CP/ MHPSS interventions • CP/MHPSS IMS • Programme cycle monitoring reports • Referral reports • MHPSS quality standard checklist • MHPSS quality standards checklists • IMS medical services data
<p>4.4b. Data infrastructure and resources are mature and enable completeness of data on child, adolescent, caregiver/teacher mental health and psychosocial wellbeing</p> <p>Strategic Plan GA1 1.4.5</p>	<ul style="list-style-type: none"> • Number of countries with management and information systems for MHPSS that collect age and gender and at-risk disaggregated data (adapted for MHPSS from WHO-AHA Framework). • Number of countries that collect standardized and reliable data on mental health and psychosocial wellbeing for children, adolescents, and parents/caregivers/teachers at the national and subnational levels • Number of countries with quality control or systems measures that support administrative data quality assurance for mental health and psychosocial wellbeing. • Number of countries with a national statistics office or central reporting facility, with a clear mandate and role, is responsible for collating, reviewing and publishing data on the achievement of justice for children. • Number of countries where key indicators on mental health and psychosocial wellbeing are well known among policymakers, leaders, researchers/academics, media, and other relevant stakeholders. • SP Indicator GA1. 1.4.5: Availability of comparable data on non-communicable diseases, disability, injuries, mental health and children's environmental health (WHO). 	<ul style="list-style-type: none"> • Program evaluation reports • Pre and post program evaluation measures, • KII/FGD Reports • Quality standards checklist

ANNEX 5: UNICEF'S STRATEGIC PLAN MHPSS RELATED OUTPUTS, OUTCOMES, AND INDICATORS

This annex presents a summary of indicators from UNICEF's 2022-2025 Strategic Plan (SP) relevant to MHPSS. This annex is the key for the SP coding used in the log frames for Annex 4, and may be used as guidance for making the necessary linkages between the SP indicators and the MHPSS log frame. The indicators are specific to mental health and can

be found across Goal Areas 1 (Survive and Thrive), 2 (Learns and acquires skills for the future), and 3 (Protected from violence, exploitation, abuse, neglect, and harmful practices). UNICEF partners and others may choose to use this resource as an example of one way to approach institutional and strategic level indicators for MHPSS.

MENTAL HEALTH SPECIFIC INDICATORS FROM THE UNICEF STRATEGIC PLAN (SP) 2022-25	
	<i>Indicator description</i>
Goal Area 1. Every child, including adolescents, survives and thrives, with access to nutritious diets, quality primary health care, nurturing practices and essential supplies.	
Outcome Indicator 1.14: Percentage of adolescents who report symptoms of depression and/or anxiety reporting contact with health professional or counsellor for mental health care (MMAP)	
Result area 4: Children, including adolescents, benefit from programmes that improve their health and development, in development and humanitarian contexts.	Output Indicator 1.4.5. Availability of comparable data on non-communicable diseases, disability, injuries, mental health and children's environmental health (WHO)
Result area 5: Children, including adolescents, and caregivers have access to quality programmes that improve their mental health and psychosocial wellbeing, in development and humanitarian contexts.	Output Indicator 1.5.1. Number of countries integrating mental health services in primary health care, including through school and digital platforms
	Output Indicator 1.5.2. Number of countries implementing multisectoral approaches to caregiver mental health
	Output Indicator 1.5.3. Number of countries with a plan or strategy for child and/or adolescent mental health (WHO)
Goal Area 2. Every child, including adolescents, learns and acquires skills for the future	
Result area 1: Equitable and inclusive access to learning opportunities, including in humanitarian and fragile contexts	Output Indicator 2.1.2. Percentage of countries with a resilient education system that can respond to humanitarian crises (ECW, GPE, UNESCO, World Bank) <u>Dimension on MHPSS:</u> Mental health and psychosocial support for children, adolescents and teachers <u>Sub Dimension:</u> Policies and plans, Curricula, Community engagement
Result area 2: Improved learning, skills, participation, and engagement for all children and adolescents, in development and humanitarian contexts	Output Indicator 2.2.1. Percentage of countries with effective teacher development system (GPE, UNESCO, World Bank) <u>Dimension:</u> Teachers development <u>Sub Dimension on MHPSS:</u> Teacher MHPSS
	Output Indicator 2.2.6. Percentage of countries institutionalizing holistic skills development to support learning, personal empowerment, environmental sustainability, active citizenship and/or employability and entrepreneurship (UNEP, UNESCO) <u>Dimension:</u> Mainstreaming skills development within the national education/training <u>Sub Dimension on MHPSS:</u> Transferable skills development

Goal Area 3: Every child, including adolescents, is protected from violence, exploitation, abuse, neglect and harmful practices.	
Outcome Indicator 3.8. Number of countries tracking delivery and referral information related to mental health and psychosocial support services for children and adolescents (UNESCO, WHO, World Bank)	
Result area 1: Children, including those affected by humanitarian crises, are protected from violence, exploitation, abuse and neglect	Output Indicator 3.1.2. Number of mothers, fathers and caregivers reached through parenting programmes through UNICEF-supported programmes (WHO)
Result area 2: Children, including those affected by humanitarian crises, benefit from the promotion of care, mental health and psychosocial wellbeing and justice.	Output Indicator 3.2.7. Number of UNICEF-targeted children, adolescents, parents and caregivers provided with community-based mental health and psychosocial support services (UNESCO, WHO, World Bank)
Change strategies (HOW)	
H1. Advocacy and communications	Indicator H1.1.c. Number of countries that took advocacy action that triggered policy change related to the UNICEF Global Advocacy Priorities: Mental health of children and young people, and to bring an end to neglect, abuse and childhood traumas

ANNEX 6: SCALABLE INTERVENTIONS

Scalable interventions are described at layer 3 of the IASC MHPSS intervention pyramid. They are evidence-based individual and group interventions developed by a range of agencies (including WHO) that show promising results in helping parents and caregivers in emergencies. Scalable interventions can be delivered by non-specialized providers with proper training and regular supervision by mental health clinicians; helpful given the lack of trained mental health providers in many contexts. Scalable interventions include:

□ **PM+**, a brief, individual intervention (also available in group format) that can help adults, including parents/caregivers in emergencies, suffering from prolonged, disabling distress involving depression, anxiety and stress. The term problem management (PM) refers to a type of counselling that helps people address and manage problems and recognizes that many of people's problems cannot be 'solved'.

The plus (+) in PM+ refers to behavioural strategies that are added to problem management, such as behavioural activation ('Getting going, keep doing'), managing stress and strengthening social support. Parents and caregivers in emergencies face many problems, like poverty and ongoing violence, that are out of their control. PM+ can help with a range of disabling mood and anxiety problems; it does not attempt to solve all of people's problems or provide a diagnosis of mental disorder.

□ **Group IPT**, group interpersonal therapy, is an adaptation of well-documented, evidence-based treatment that has been used for depression and other mental health problems in different age groups and diverse community and health services settings. The WHO model of group IPT is a simplified format of eight-session groups for people with depression to help them understand interpersonal problems (e.g., conflict, changing roles, and bereavement) that contribute to their depression and ways to manage them effectively.

Both PM+ and Group IPT can be implemented in health and social services structures by dedicated staff (lay psychosocial workers, professional social workers and psychologists) in community centres run by NGOs or government, or by supervised general staff (e.g., nurses, community workers) in non-specialized and specialized service capacities and settings.

□ **Thinking Healthy** is an approach developed by WHO and partners for the psychosocial management of perinatal depression. This is a priority condition, as around 15 per cent of mothers in low- and middle-income countries suffer from a mental disorder after childbirth. The model involves training community health workers in how to support mothers with perinatal depression through evidence-based cognitive behavioural therapy techniques. Key aspects of the model include:

- Integration into routine home visits by trusted community health workers and complementing key maternal and child health messages
- Focusing on mother–infant wellbeing rather than maternal depression in order to reduce the risk of stigmatizing the mother
- Creating a common agenda of infant optimal development to encourage family participation in infant wellbeing
- Empowering and activating mothers to seek and practice practise health-promoting activities through structured, pictorial guidance, which is also accessible to non-literate mothers.




ANNEX 7: UNICEF'S COMPREHENSIVE THEORY OF CHANGE




IMPACT:

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

MHPSS systems are mobilized, strengthened, and restored to promote child and family wellbeing by:

OUTCOME	Outcome 1:  Improved child and adolescent mental health and psychosocial wellbeing	Outcome 2:  Improved caregiver mental health and psychosocial wellbeing including for parents, caregivers, mothers, family, and teachers	Outcome 3:  Improved community capacity at the district and subdistrict levels for non-stigmatizing, accessible, available, and quality MHPSS service delivery across the primary health care, social welfare and protection, and education systems and structures
MHPSS INTERMEDIARY OUTCOMES	Children and adolescents have access to safe & nurturing environments, and to quality services that improve their mental health and psychosocial wellbeing: <ol style="list-style-type: none"> I. At home, II. At school, III. In the community 	Families/parents/caregivers and/or teachers have access to support for developing and maintaining improved mental health and psychosocial wellbeing	Strengthened community awareness and positive behaviour change to promote child, adolescent, and family/caregiver mental health, psychosocial wellbeing and protection, rooted in a stigma- and judgement-free environment
Children and adolescents have access to support systems that facilitate positive relationships that promote inclusion, belonging, and agency	Parents/caregivers have access to family and community support networks that improve their mental health and psychosocial wellbeing	Strengthened community mental health and psychosocial wellbeing support systems across sectors, including innate community capacities to support children, adolescents, parents/caregivers, and families	
Children and adolescents have opportunities for stimulation, learning and skills development that contributes to mental health and wellbeing	Parents/caregivers develop skills for parenting, teaching, and supporting children in distress (MHPSS needs)	Strengthened care systems (PHC, social welfare & protection, education) for children, adolescents and families, including utilization/leveraging of family-friendly policies	

Outcome 4: Improved enabling environment for MHPSS across the policy, legislation and financing systems, the MHPSS workforce, multisectoral supports and referral pathways, and MHPSS research and data 

4.1 Policy, legislation & financing: The policy, legislative and financing environment is developed and strengthened to ensure that supportive mechanisms are in place for quality mental health and psychosocial service delivery. This includes policies, laws, institutions, culture, and social and gender norms that create (1) a system that facilitates access to affordable and non-stigmatizing MHPSS for all children, adolescents, their families, and communities; and (2) a supportive environment for voice, agency and action of advocates and users of MHPSS, including youth and caregivers.

4.2 Strengthened multisectoral systems & referral pathways: Strengthened multilayered support systems and processes [\(see Figure 4\)](#) within existing structures, including functional referral systems across PHC, social welfare & protection, and Education.

4.3 Workforce development & capacity: Capacity strengthened among professional and non-specialist MHPSS providers in quality age and gender-responsive MHPSS care across all sectors.


4.4 Research, evidence & data: Improved evidence and data ecosystem for MHPSS that informs and drive policy changes around mental health and psychosocial support.

Determinants of Mental Health & Psychosocial Wellbeing:

Lack of secure attachment and/or nurturing care, Violence, exploitation, abuse in the home, Caregiver MH, Poverty, Disease outbreaks, Race and Gender, Exposure to adverse experiences, Prolonged conflict terrorism, mass displacement, family separation, Intensifying natural disasters and climate change.

Barriers:

Stigma and structural discrimination, Lack of political will, Lack of (and access to) health care and services and skilled workforce, Poor quality of limited services; Lack of data, research and analysis; Human rights violations, violence, abuse, coercion in formal and informal institutions, Lack of sustainable resources and political will, lack of MHPSS financing within Universal Health Coverage Benefit packages/schemes with countries, Scale of social determinants: poverty, inequalities, (gender based) violence, childhood adversity, Lack of coordinated emergency response, Poor integration of physical and mental healthcare and comorbidities, lack of shared community identity or dispersion in urban areas.

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



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