Draft 8

Mental Health and Psychosocial Support Technical Guidance

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Main contributors: Sarah Hildrew, Katharine Williamson, Andrew Clarke, Marie Dahl, Caroline Scheffer, Anne Sophie Dybdal, Nicole Nikolaidis, Nora Charif Chefchaouni, Sameh Hendi, Marta Petagna, Julia Finder, and Anne Filorizzo Pla

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Acronyms

4Ws	Who is where, when, doing what
ANC	Antenatal care
AoR	Area of responsibility
BMS	Breastmilk substitutes
CAAC	Children affected by armed conflict
CAFAAG	Children associated with armed forces and armed groups
CCCM	Camp coordination and camp management
CEFM	Child early and forced marriage
CO	Country office
CP	Child protection
CPiE	Child protection in emergencies
CPMS	Minimum Standards for Child Protection in Humanitarian Action
CRPD	Convention on the Rights of Persons with Disabilities
CSO	Civil society organization
EiE	Education in emergencies
FSL	Food security and livelihoods
GRF	Global results framework
HR	Human resources
IASC	Inter-agency Standing Committee
IDP	Internally displaced person
IYCF	Infant and young child feeding
IYCF-E	Infant and young child feeding in emergencies
LGBTQI +	Lesbian, gay, bisexual, transgender, queer, and intersex
LMIC	Low- and middle-income Country
MAM	Moderate acute malnutrition
MCH	Maternal and child health

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MEAL	Monitoring, evaluation, accountability, and learning
MHM	Menstrual hygiene management
MHPSS	Mental health and psychosocial support
MoV	Means of verification
MS	Minimum standards
MUAC	Mid-upper arm circumference
NFI	Non-food items
OPD	Organization of persons with disabilities
OTF	Outpatient therapeutic feeding
PDQ	Programme development and quality
PFA	Psychological first aid
PHC	Primary healthcare
PNC	Prenatal care
PSEA	Protection from sexual violence and abuse
PSS	Psychosocial support
PTSD	Post-traumatic stress disorder
RG	Reference group
RO	Regional office
SAM	Severe acute malnutrition
SC	Save the Children
SCI	Save the Children International
SDG	Sustainable development goals
SEAH	Sexual exploitation, abuse, and harassment
SEL	Social-emotional learning
SGBV	Sexual and gender-based violence
SMT	Senior management team
SRHR	Sexual and reproductive health and rights

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SRMP	Suicide risk management protocol
SWOT	Strengths, weaknesses, opportunities, and threats
TA	Technical advisor
TE	Technical expert
TFC	Therapeutic feeding centre
TWG	Technical working group
UASC	Unaccompanied and separated children
UN CRC	United Nations Convention on the Rights of the Child
UN CRPD	United Nations Convention on the Rights of Persons with Disabilities
UNICEF	United Nations Children's Fund
VAC	Violence against children
WHO	World Health Organization

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Definition of key terms

Adolescence

Defined generally as a person 9–19 years. In the CPMS, the term refers specifically to persons aged 9– 17 years old, given the focus on children as defined in the Convention on the Rights of the Child. Adolescence can be broken down into the following sub-group: pre-adolescence (9–10), early adolescence (10–14), middle adolescence (15–17) and late adolescence (18–19).

Caregiver

Individual (including parents, siblings and grad parents, close relatives, foster family), community including services providers, or institution (including the State) with clear responsibility (by custom or by law) for the well-being of the child. It most often refers to a person with whom the child lives and who provides daily care to the child

Child

A 'child' is defined as all children and adolescents aged 0-18 years of age (according to the United Nations Convention on the Rights of the Child). The term is inclusive of boys, girls and LGBTIQ children; children with protection risks or exposed to serious events; and children with disabilities or with mental, neurological, and substance use (MNS) disorders.

Child associated with armed forces and armed groups (CAAFAG)

A 'child associated with an armed force or armed group' refers to any person below 18 years of age who is or who has been recruited or used by an armed force or armed group in any capacity, including but not limited to children, boys, and girls used as fighters, cooks, porters, messengers, or spies or for sexual purposes. It does not only refer to a child who is taking or has taken a direct part in hostilities.

Child, Early, Forced M**arriage** and Unions

Child marriage is globally defined as a formal or informal union where one or both parties are under the age of 18. The term early marriage is also used to describe a situation where at least one party is under 18, but the terminology focuses on how being under 18 compromises the ability to consent to marriage. The term forced marriage refers to a situation where at least one party does not provide full and informed consent, irrespective of age. It may also refer to a situation where at least one party is not able to leave or end the marriage. Child marriage is globally defined as a formal or informal union where one or both parties are under the age of 18. The term early marriage is also used to describe a situation where at least one party is under 18, but the terminology focuses on how being under 18 compromises the ability to consent to marriage. The term forced marriage refers to a situation where at least one party does not provide full and informed consent, irrespective of age. It may also refer to a situation where at least one party is not able to leave or end the marriage.[1]

Child safeguarding

[1] SCI.2020.CEFMU technical guidance

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‘Child safeguarding’ refers to a set of policies, procedures, and practices that (1) mitigates and manages risk to ensure no child is harmed while delivering organizational programmes or activities and (2) supports effective reporting and response if harm does occur.

Child sexual abuse

‘Child sexual abuse’ is defined as any form of sexual activity with a child by an adult or by another child who has power over the child. By this definition, it is possible for a child to be sexually abused by another child. Child sexual abuse often involves body contact. This could include sexual kissing; touching; and oral, anal, or vaginal sex. Not all sexual abuse involves body contact. Forcing a child to witness rape and/or other acts of sexual violence, forcing children to watch pornography or show their private parts, showing a child private part (‘flashing’), verbally pressuring a child for sex, and exploiting children as prostitutes or for pornography are also acts of sexual abuse.”[2] It involves either explicit force or coercion or, in cases where consent cannot be given by the child because of his or her young age, implied force.

Children on the move

‘Children on the move’ includes all children moving for a variety of reasons – voluntarily or involuntarily, within or between countries, with or without their parents or other primary caregivers – and whose movement, while it may open up opportunities, might also place them at risk (or increased risk) of economic or sexual exploitation, abuse, neglect, and violence (adapted from Inter-agency Working Group on Children on the Move, cited in IOM, 2011).

Coerced recruitment

‘Coerced recruitment’ includes factors that increase children’s vulnerability to recruitment due to socio-economic conditions, lack of education, neglect, marginalisation, the felt need to protect families and communities, etc.

Community

‘Community’ includes men and women, boys and girls, and other stakeholders in child and family well-being 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 participation

‘Community participation’ is 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.

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[2] IRC, UNICEF. 2012. *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings*. First edition.

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Conflict

'Conflict' is the result of parties disagreeing and acting based on perceived incompatibilities. It is not limited to armed or violent conflict, which implies the use of psychological or physical force to resolve a disagreement.

Conflict sensitivity

'Conflict sensitivity' is an organization's ability to (1) understand the context it operates in, (2) understand the interaction between its intervention and that context, and (3) act upon this understanding to minimize negative impacts and maximize positive impacts on conflict.

Cross-sectoral approach

A 'cross-sectoral approach' is when one core element is incorporated into other sectors like health, education, livelihoods, etc. This toolkit refers to when MHPSS is incorporated as a core element into other sectoral areas. MHPSS programmes are less effective when implemented in isolation or as stand-alone activities, so a cross-sectoral approach to MHPSS is recommended.

Disclosure

'Disclosure' is the process of revealing information. Disclosure in the context of sexual abuse refers specifically to how a non-offending person (e.g., a caregiver, teacher, or helper) learns about a child's experience with sexual abuse. Children disclose sexual abuse differently, and disclosure is often a process rather than a single or specific event. Disclosure about sexual abuse can be communicated directly or indirectly, voluntarily, or involuntarily. Common reasons for non-disclosure of sexual abuse include fear of consequences, fear of dismissal, manipulation, self-blame, partition of the perpetrator and/or family, age, disability, and communication barriers.

Forced recruitment

'Forced recruitment' includes abduction, conscription, quota systems and press-ganging.

Informed assent

The expressed willingness to participate in services. Informed assent is sought from children who are by nature or law too young to give consent, but who are old enough to understand and agree to participate in services. When obtaining informed assent, practitioners must share, in a child-friendly manner, information on services and options available, potential risks and benefits, personal information to be collected and how it will be used, and confidentiality and its limits.

Informed consent

Voluntary agreement of an individual who has the capacity to take a decision, who understands what they are being asked to agree to, and who exercises free choice. When obtaining informed consent, Informed consent practitioners must share, in a child-friendly manner, information on services and options available, potential risks and benefits, personal information to be collected and how it will be

used, and confidentiality and its limits. Informed consent is usually not sought from children under age 15. See also Informed assent.

Integration

'Integrating' MHPSS into other-sector programmes means including elements of MHPSS programming or activities in other-sector responses such as nutrition, camp management, etc. MHPSS integration can strengthen the programme and improve results for children and families.

Intersectionality

Intersectionality is a framework to understand how different forms of oppression, such as ableism, sexism, racism, homophobia, etc. collide to create unique experiences of discrimination and oppression. It is not a theory of social groups or differences, but rather a theory of oppression. In some instances, the concept and practice of intersectionality has been de-politicised, replaced with ideas of 'difference' and omitting the 'oppression' part. Like gender neutrality, this generic focus on difference — and the resulting inclusion of groups who historically and currently enjoy social advantage — masks the purpose of intersectionality and hinders our ability to address multiple oppressions and transform inequalities to achieve gender justice. Intersectionality situates women's and girls' experiences within an understanding of the ways in which multiple forms of power and oppression, such as gender inequality, heterosexism, racism, ableism and class inequalities, influence exposure to GBV and access to services in relation to violence.[3]

Mainstreaming

'Mainstreaming' refers to the inclusion of MHPSS considerations and interventions in other-sector programming. MHPSS mainstreaming requires that the core principles of MHPSS are reflected and embedded in other-sector programmes at all stages of the programme cycle, from planning to implementation.

MHPSS activities

'MHPSS activities' are specific activities designed to support the well-being of children, caregivers, and communities as part of an MHPSS programme, intervention, or response. MHPSS activities are components which can be integrated in other sectors' responses.

MHPSS interventions

'MHPSS interventions' are a set of activities that are selected to improve the mental health and psychosocial well-being of children, caregivers, and communities. An MHPSS intervention can support coping mechanisms and resilience and can be carried out in conjunction with other sectors or as a stand-alone programme.

Multi-layered support

[3] SCI.2021. Gender and power analysis

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‘Multi-layered support’ refers to the different levels of MHPSS support a person may need based on several different factors and relates to the IASC MHPSS Pyramid of Intervention. People need to have access to different layers of support at the same time.

Psychosocial disability

‘Psychosocial disability’ refers to mental health or cognitive conditions or disturbances in behaviour that (1) are perceived as socially unacceptable and (2) result from barriers to social participation and access to rights. The term is usually reserved for persons with more persistent or recurrent functional difficulties related to mental health conditions who are confronted with systematic exclusion and participation barriers. The term is less often used for those with temporary mental health conditions who recover quickly, sometimes in response to MHPSS interventions. During humanitarian emergencies, distress leading to functional difficulties is often transient, and it is important not to label such response as a medical condition or disability.[4]

Resilience

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

Self-harm[5]

‘Self-harm’ is when somebody intentionally damages or injures their body. It’s usually a way of coping with or expressing overwhelming emotional distress and/or persistent feelings of numbness/detachment.

Gender based violence

Gender-based Violence is an umbrella term for any harmful act that is perpetrated against a person's will and is based on socially ascribed (i.e., gender) differences. It includes acts that inflict physical, sexual, or mental harm or suffering, threats of such actions, coercion and other deprivations of liberty.

Sexual Gender-based violence

‘Sexual and gender-based violence’ (SGBV) is an umbrella term for any harmful act that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to a woman, man, girl, or boy based on their gender. SGBV includes, but is not limited to, sexual violence; domestic violence; trafficking; forced or early marriage; forced prostitution; sexual exploitation and abuse; and denial of resources, opportunities, and services.

Sexual violence

‘Sexual violence’ describes acts of a sexual nature a person is caused to engage in by force, threat of force or coercion against that person or another person, or by taking advantage of a coercive

[4] IASC. 2019. Guidelines on inclusion of persons with disabilities.

environment or the person's incapacity to give genuine consent. Coercion can be caused by circumstances such as fear of violence, detention, psychological oppression, or abuse of power. Sexual violence encompasses acts such as rape, sexual slavery, enforced prostitution, forced pregnancy, or enforced sterilization.

Sexual exploitation, Abuse and Harassment

'Sexual exploitation' means any actual or attempted abuse of a position of vulnerability, differential power, or trust for sexual purposes including, but not limited to, profiting monetarily, socially, or politically from the sexual exploitation of another. Some types of forced prostitution can fall under this category.

Suicidal gesture

A 'suicidal gesture' is an attempted suicide or similar self-destructive behaviour, especially when the risk of death is low. Suicidal gestures are different from self-harm as the aim is to kill oneself.

Suicidal ideation

'Suicidal ideation' describes thoughts about or a preoccupation with killing oneself, often as a symptom of major depressive episode. Most instances of suicidal ideation do not progress to attempted suicide. However, all suicidal thoughts should be taken seriously.

Suicide

'Suicide' is the deliberate act of killing oneself. Frequently, suicide occurs in the context of a major depressive episode or continued state of high distress, but it may also occur as a result of substance abuse or another disorder. It sometimes occurs in the absence of any psychiatric disorder, especially in untenable situations, such as extreme or prolonged bereavement or declining health.

Suicide attempt

A 'suicide attempt' is a deliberate, but unsuccessful, attempt to take one's own life.

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1 What should I know about the MHPSS Technical Guidance?

1.1 Aim of the guidance

The Mental Health and Psychosocial Support (MHPSS) Technical Guidance has been developed to support Save the Children and partner staff to mainstream and integrate mental health and psychosocial support into programming across sectors. The Technical Guidance provides information on HOW to concretely implement the actions outlined in the Save the Children MHPSS Cross-sectoral Strategic Framework endorsed in 2020. The Cross-Sectoral Strategic Framework outlines how Save the Children aims to work together with partners to deliver global MHPSS standards and guidance for all children and their caregivers. The Technical Guidance goes beyond the humanitarian focus of the MHPSS Cross-sectoral Strategic Framework to support the implementation of MHPSS interventions in all contexts across the humanitarian-development-peace nexus.

The MHPSS Technical Guidance was developed under the leadership of the MHPSS Technical Guidance Task Team comprised of Save the Children cross-sectoral staff representing the MHPSS Technical Working Group. The process included consultations with country teams from all sectors, regional personnel, and Save the Children International's local and international partners.

The guidelines will be applied both in development and emergency contexts to support the integration of MHPSS in all sectoral programming and the delivery of appropriate and quality MHPSS support. The technical guidance has been developed to lift the worldwide scale and quality of MHPSS programming to best promote and respond to critical gaps in the way Save the Children (SC) and partners respond to the mental health and psychosocial needs of all children, their caregivers, and communities.

1.2 How this guidance will help us

In short, the MHPSS Technical Guidance seeks to:

- Provide technical guidance to Save the Children staff and partners to enable them to operationalize the SC MHPSS strategy and to mainstream and integrate MHPSS in all sectors' programming
- Equip Save the Children and partner staff with safe and effective MHPSS approaches consistent with global standards

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1.2.1Understanding mental health and well-being

Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community.[5]

MHPSS is used to describe *any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental health conditions.*[6]

Well-being describes the positive state of being when a person thrives. In mental health and psychosocial work, well-being is commonly understood in terms of three domains:

1. **Personal well-being:** positive thoughts and emotions such as hopefulness, calm, self-esteem, and self-confidence.
2. **Interpersonal well-being:** nurturing relationships, a sense of belonging, the ability to be close to others.
3. **Skills and knowledge:** capacities to learn, make positive decisions, effectively respond to life challenges and express oneself.[7]

Adolescent well-being is defined as when, "adolescents have the support, confidence, and resources to thrive in contexts of secure and healthy relationships, realizing their full potential and rights."[8] The interrelated domains that underpin adolescent well-being in the UN's framework are:

- Good health and optimum nutrition
- Connectedness
- Positive values and contribution to society
- Safety and a supportive environment
- Learning, competence, education, skills, and employability
- Agency and resilience

The adolescent well-being framework demonstrates the necessary elements to be considered which contribute to mental health and psychosocial well-being.

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[5] WHO. 2001.

[6] IASC. 2007. IACS Guidelines on Mental Health and Psychological Support in Emergency Settings.

[7] Save the Children.2019. MHPSS Cross-Sectoral Strategic Framework in Humanitarian Settings.

[8] Save the Children and UN. Domains of Adolescent well-being.

1.2.2 Identify and recap the main benefits of integrated MHPSS programming

Mainstreaming refers to the inclusion of MHPSS considerations and interventions in other sectors' programming. MHPSS mainstreaming requires that the core principles of MHPSS are reflected and embedded in other-sector programmes at all stages of the programme cycle, from planning to implementation.

Integrating MHPSS into other sector programmes means including elements of MHPSS programming or activities in the responses of other sector, such as nutrition, camp management etc. MHPSS integration can strengthen the programme and improve the results for children and families.

Applying an **MHPSS lens** means looking at interventions' activities and actions to identify ways to support well-being and mental health.

Humanitarian crisis, protracted conflict, and natural disaster can compound risk factors for mental health conditions through exposure to traumatic events, forced displacement, lack of access to regular mental health care and needs, and breakdown and loss of social support systems.

The goal of integrated MHPSS programming is to protect and strengthen the mental health and psychosocial well-being of children, youth, caregivers, and communities through quality, multi-layered and inclusive MHPSS across sectors. Appropriate mental health promotion and prevention interventions can strengthen individuals' capacity to regulate emotions, enhance alternatives to risk-taking behaviours, build resilience for difficult situations and adversities, and promote supportive social environments and social networks.[9]

MHPSS is a cross-cutting issue. Mental health and well-being are foundational to all humanitarian and development goals. Similarly, every aspect of humanitarian and development programming impacts children's well-being. Therefore, every aspect of each intervention should support the mental health and well-being of individuals and communities.

The treatment and support children receive impacts their mental and physical health as well as their brain development. Children cannot survive, thrive, develop, learn, be protected, and grow into healthy, functioning members of society unless they and their caregivers enjoy a reasonable level of personal and interpersonal well-being. Children who live in conflict settings and/or are affected by abuse, violence, or economic hardship are at risk of toxic stress, long term mental health problems, and failure to reach developmental milestones. Integrating MHPSS into all Save the Children programming whenever possible ensures a holistic approach to support the healthy development and well-being of children, families, and communities.

Recent experience with the COVID-19 pandemic, for example, has demonstrated the inequalities and vulnerabilities children may face and how their rights can be violated when they lose access to health, education, and opportunities to play and thrive. Caregivers and families have come under immense pressure and are at heightened risk of anxiety, fear, distress, violence, and abuse. Save the Children

[9] CPAoR and MHPSS collaborative, interagency case management training, *Suicide Prevention and Intervention Protocol for Trained and Supervised Child Protection Case Managers & Paraprofessionals, (to be published)*

advocates for a coordinated response strategy to meet the needs of children and families affected by the COVID-19 pandemic,[10] and MHPSS is an essential element of a holistic response.

Integrating and mainstreaming MHPSS involves using an **MHPSS lens** to look for opportunities (entry points) to enhance and support well-being through collaboration with other sectors' programme activities and processes, in humanitarian and development contexts as well as protracted crises.

To avoid fragmentation and stigmatization, MHPSS activities and services for people at risk should be integrated into wider systems (e.g., existing community support mechanisms, education systems, general health and social services).

Broader, more integrated activities tend to be more acceptable to community members. Cultivating strong relationships and communication between sectors and services helps create a mutually reinforcing network of support across individual, family, community, and societal levels.[11]

Both mainstreaming and integrating MHPSS are critical. In this document, Save the Children focuses primarily on integration while still promoting the application of the MHPSS lens in mainstreaming MHPSS across sectors.[12] Figure 1 provides questions that support an MHPSS lens, the benefits of applying that lens, and the risks of not using it.

Figure 1	Questions that facilitate the application of the MHPSS lens	Relevance to mental health and well-being	The impact of not using an MHPSS lens
1.	Are children's activities appropriate for the participants' age and stage of development?	Children and adolescents thrive when activities align with their age and stage of development and contribute to their emotional, social, and mental well-being.	The goal of the intervention or activity will not be met. Children and adolescents may drop out, or their needs may be overlooked.
2.	Are the activities inclusive and accessible for children with disabilities or at risk of marginalisation?	Children and adolescents with disabilities need access to activities and interventions which support their well-being, mental health, and positive development as any children without disabilities.	Children and adolescents with disabilities and at risk of marginalisation may withdraw facing discrimination, increased isolation, and barriers to their engagement in activities.
3.	Can participants of other sectoral interventions access mental health and	The comprehensive needs of all participants should be addressed when accessing humanitarian support.	Children and adolescents with mental health difficulties or psychosocial disabilities may not receive support or may

[10] Save the Children. 2020. Save the Children's COVID-19 Program Framework and Guidance.

[11] The Mental Health and Psychosocial Support Minimum Services Package: For an effective MHPSS emergency response. www.mhpssmsp.org.

[12] More examples of mainstreaming and integrating MHPSS will be provided in the sections specific to each sector.

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	psychosocial support if necessary?	Participants who require further specialist support should be identified and receive case management/ MHPSS	not attend. This may hinder them from accessing their basic needs.
4.	Are project-related messages and information conflict-sensitive, accessible, disability inclusive, culturally relevant, and appropriate?	All children, adolescents with and without disabilities must be aware of key messages and interventions related to their health, well-being, rights, and entitlements. This will reduce isolation and distress and support well-being and positive development.	People who are not literate may not be aware of their rights and entitlements. People may not be aware of the intervention, or the support offered, thereby denying them the opportunity to engage and exacerbating levels of stress and/or distress. Messages may discourage instead of encouraging participation. Children and adolescents with disabilities may withdraw, facing discrimination, increased isolation, and barriers to their engagement in activities.
5.	Do the intervention activities support coping mechanisms and build on positive coping strategies? Are activities and interventions designed to support (and not undermine) social connectedness and mutual support mechanisms?	The comprehensive needs of all participants should be addressed when accessing humanitarian support. Participants who require further specialist support should be identified and receive case management/ MHPSS. Interventions should identify and build upon existing positive coping mechanisms and support systems.	Interventions may not be sustainable. People will feel powerless or unable to rely on their resilience and strengths in ways they did before. Children and adolescents with mental health difficulties or psychosocial disabilities may not receive support or may not attend. This may hinder them from accessing their basic needs. Existing support systems may be undermined, reducing the circles of support which people have traditionally relied on. People may not be encouraged to focus on existing strengths, which may result in loss of capacity when the project ends.
6.	Are activities and interventions designed and delivered in a way that promotes a sense of physical and emotional safety?	Feeling afraid, at risk, or unsafe undermines and threatens the well-being of individuals, families, and communities.	Children, caregivers, and adolescents will not benefit from other sectoral interventions, including lifesaving services or basic needs. Participants may be exposed to greater risk of harm.

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Integrating MHPSS into other-sector interventions supports comprehensive programming across all levels of an individual's social ecology[13] and can deliver positive outcomes for participants (e.g., increased agency, well-being, and mental health) and the overall intervention. (For sector-specific examples of MHPSS integration, see Section 3.)

1.2.2.1Nutrition

MHPSS in nutrition interventions supports attachment between mother/ caregiver and infant which benefits the infant as it grows and develops. Supporting the mental health and well-being of caregivers enables a more nurturing response to infants and children less than 5 years old, thus improving their nutrition outcomes. The nurturing care framework recommends for infants and children to reach their full potential the five interrelated and indivisible components of nurturing care: good health, adequate nutrition, safety and security, responsive caregiving and opportunities for learning.[14]

MHPSS and nutrition address these core drivers through integrated, holistic support for caregivers and infants: reducing undernutrition, strengthening the caregiver-child relationship, and improving outcomes for families.

Nutrition interventions that incorporate emotional, cognitive, and play stimulation for infants encourage recovery from undernutrition and related health conditions and assist in reaching developmental milestones and healthy development. Nutritional requirements of at-risk groups, including children with disabilities, are more likely to be met where nutrition is integrated with MHPSS. Addressing nutrition, maternal mental health and well-being increases the likelihood that the child will access education, protection, and health services in later life.

Interventions in which caregivers are taught about infant development and shown how to engage and stimulate their infants, be more responsive and affectionate towards them, have demonstrated outcomes:

- Improved maternal mood
- Strengthened mother-infant relationships
- Improved infant health and development outcomes.[15]

[13] Horn, R., et al. "Introduction to *Special section*: mainstreaming psychosocial approaches and principles into 'other' sectors." *Intervention*. 2016. 14(3), 207–210.
[14] WHO, UNICEF, World bank Grou.2018., Nurturing Care for early child development.
[15] Rahman, et al. 2013. Interventions for common perinatal mental disorders in women in low- and middle-income countries: a systematic review and meta-analysis.

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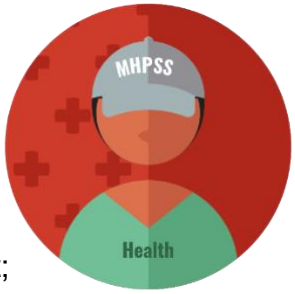
Similarly, interventions expressly designed to improve maternal mental health have had a positive impact on infant health[16] and development.[17]

1.2.2.2Health



Mental and physical health are intimately connected. Mental health problems are a driver of increased morbidity and mortality across the lifespan.[19] Mental health and psychosocial support needs are highly prevalent in most populations (Global Burden of Disease 2019) and are exacerbated in situations of adversity. Living with unaddressed mental health and psychosocial support needs can have a negative effect on a child's growth and development; a parent's caring abilities; family functioning and resilience to health issues or ability to adopt healthy behaviours, and the ability to work and earn. Children and adults with mental health difficulties or physical or intellectual disabilities are sometimes subjected to forced institutionalization where they may be forced to take medication, have unnecessary medical interventions, or experience other rights violations. Most caregivers who are experiencing or affected by mental health problems do not seek support for their mental health difficulties, but they are very likely to present at health services for other reasons.

In contexts affected by communicable diseases – such as cholera, Covid 19 and Ebola – integrating MHPSS in health services has improved treatment and support of both practitioners, survivors and the general population who may be experiencing fear, stigma, isolation, or stress.[18]

Similarly, some of their physical symptoms can be signs or expressions of a mental health problem. Therefore, community-led and public health activities and interventions provide valuable and feasible platforms and entry points for MHPSS integration, particularly for integrating MHPSS knowledge and components into practice and service design, protecting and promoting positive mental health, strengthening positive coping and self-care strategies and reducing social isolation and stigma among others.

1.2.2.3Child Poverty/ FSL

MHPSS programme design should consider child poverty and its associated dimensions (such as poor nutrition, inadequate housing, the increased likelihood of adverse events, and living in poor neighbourhoods) that put

[16] Shukri, N. H. M., Wells, J., Eaton, S., Mukhtar, F., Petelin, A., Jenko-Pražnikar, Z., Fewtrell, M. (2019). Randomized controlled trial investigating the effects of a breastfeeding relaxation intervention on maternal psychological state, breast milk outcomes, and infant behaviour and growth, The American Journal of Clinical Nutrition, Volume 110, Issue 1, July 2019, Pages 121–130, https://doi.org/10.1093/ajcn/nqz033

[17] Refer to Lancet series Maternal Health 2016 , Maternal and child undernutrition

[18] The Alliance for Child Protection in Humanitarian Action. 2018. Guidance Note: Protection of Children During Infectious Disease Outbreaks.

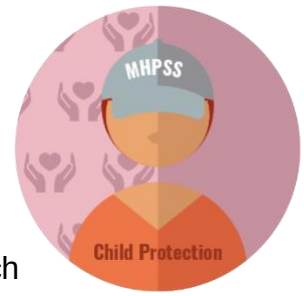
[19] WHO.2018. Mental health primary care: illusion or inclusion?
Walker ER, McGee RE, Druss BG. 2015.Mortality in mental disorders and global disease burden implications: a systematic review and meta-analysis. JAMA Psychiatry.,

children at higher risk of mental health problems.[20] The evidence strongly suggests that the incidence of mental health conditions among children and adolescents can be reduced by addressing severe and persistent poverty, particularly during the early years of a child's life.[21] FSL staff are ideally placed to identify families in need of further support, including individuals who may not be coping or may have mental health difficulties.

MHPSS and FSL interventions can include the household as well as the child. Thus, individual family members can receive support while the family unit receives FSL modalities. Given the causal relationship between disability and poverty, children with disabilities and children from households with people with disabilities are likely to be some of the most impacted by child poverty.

MHPSS and child poverty interventions are particularly beneficial for adolescents and families when they are connected with life skills/ skills development interventions. Such interventions can reduce the risks of violence against women and girls by enabling them to be financially independent and less vulnerable to violence, abuse, exploitation, and neglect. Families who access cash support can be included in social protection and MHPSS programmes in a holistic approach, thus improving child and caregiver well-being.

1.2.2.4Child Protection



Integrating **MHPSS and child protection** benefits a wide range of children with varying vulnerabilities and needs. For example, children formerly associated with armed forces and groups are at less risk of stigmatization when caregivers and foster families are supported with MHPSS approaches. In infectious disease outbreaks, unaccompanied and separated children who received referral support when caregivers where in isolation also received MHPSS which helped them to feel hopeful, discuss their feelings and learn about what was happening in a way which was appropriate to their age and stage of development.[22]

Poor mental health and psychosocial well-being creates vulnerability to violence and exploitation which further undermines well-being and vice versa. Children with disabilities are at even greater risk than those without disabilities.

Including MHPSS in protection interventions, including child protection referral systems, improves programs working to prevent violence, abuse, exploitation and neglect such as play activities with children and parenting programs for caregivers. Interventions with caregivers, community members, teachers and children themselves can improve their protection and well-being outcomes and increase their protection. Incorporating MHPSS into child protection response systems can improve the overall recovery and development of the child. holistic response to the child and has benefits for the child's overall outcome and development.

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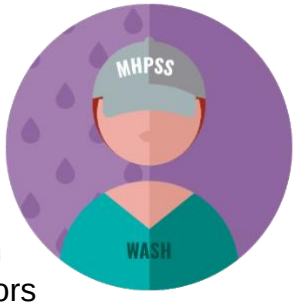
[20] Gibson, K., et al. 2017. Child poverty and mental health: A literature review. CPAG & NZPs.

[21] Ibid.

[22] UNICEF. 2016. Care and Protection of Children in the West African Ebola Virus Disease Epidemic: Lessons learned for future public health emergencies.

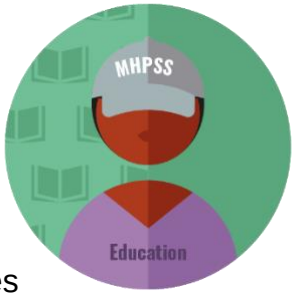
Key Guidance

1.2.2.5WASH



Integrated MHPSS-WASH interventions can improve the safety, security, and dignity of children and families who access hygiene facilities in camps, etc. Inclusive and accessible MHPSS/ WASH infrastructure opens opportunities for the improved hygiene, education, health, and participation of children and young people with disabilities. Programmes and interventions that address menstrual hygiene and harmful traditional practices surrounding menstruation support the dignity of adolescent girls and women. These integration of both sectors aims at improving support for nurturing practices through improved access to water and sanitation, supporting patients with psychosocial support activities in Cholera/Ebola treatment centre, and psychosocial aspects of WASH interventions, including aspects such as culturally sensitive design of interventions, protection and security of care givers, and channels for feedback from affected populations. The integration can also ensure all activities for children and caregivers well-being take place in safe spaces including access to water and sanitation.

1.2.2.6Education[23]



A safe, psychosocially supportive learning environment has benefits for children, teachers, and families. Children experience improved learning and well-being outcomes. School or centre-based interventions involving all children can promote social-emotional development and reduce the likelihood of children being stigmatized because of their participation in MHPSS activities. In educational settings, children who need targeted or specialized MHPSS services can be more easily identified and provided with access to such services (when these focused and specialized services are available). The educational engagement of girls can be improved through MHPSS initiatives that address their gender-based needs. Children with disabilities can better participate through reasonable accommodations that meet their specific requirements.

The well-being of teachers is critical in ensuring students thrive and are safe, protected, and free to learn. Teachers are often the very first responders to children who need focused MHPSS services. Schools should have referral pathways in place, and teachers should know how and when to make referrals. In order to build on the skills, they already have, teachers require training in MHPSS, including psychological first aid for child practitioners (PFA).

When teachers are supported and their well-being is strengthened, the school community is a more supportive environment for children and caregivers. At the same time, engaging parents and caregivers in learning activities increases the support for teachers, improves the participation of children, and improves educational outcomes.

[23] Save the Children. 2017. The Quality Learning Framework.

1.3 Who should use this guidance

This guidance is relevant for Save the Children staff and partners engaged in integrating MHPSS into all sectoral programming. All actors can benefit from the **core guidance**. Staff, volunteers, and partners should particularly reference the sections on psychological first aid and staff well-being.

Sectoral actors and those who are conducting integrated MHPSS programming will find more targeted actions in the **sector-specific guidance**.

The **theme-specific guidance** is particularly appropriate for both Save the Children staff and partners and will prove useful when addressing issues such as child marriage and SGBV.

A short version of the guidelines is available HERE.

1.4 Save the Children's approach to MHPSS

Save the Children's approach to MHPSS is focused on the child, their caregivers, and family and also includes teachers and others responsible for the well-being of children. MHPSS *should not* operate in isolation or as a stand-alone response. It *should* be implemented across sectors to ensure a holistic response that operates over the life course of the child, family, and community. Each sector has a role to play in ensuring the dignity, agency, and well-being of all participants in Save the Children's humanitarian and development programming.

To integrate MHPSS into Save the Children's sectoral programmes and thematic areas of work, the following foundational concepts and frameworks are important for all Save the Children staff:

- Save the Children's Principles and Priorities
- MHPSS Pyramid of Intervention
- Socio-ecological Framework

1.4.1 Save the Children's Principles and Priorities

1.4.1.1 Save the Children's Operating Principles

The following principles underpin Save the Children's approach and are aligned with the IASC's principles and guidelines.

Figure 2	Save the Children Principle	Application of the Principle
1.	Human rights and equity	Promote 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. This means being particularly aware of marginalized groups such as children who are on the move or on the street, living with disabilities, unaccompanied and separated (UASC), and survivors of sexual

		and gender-based violence (SGBV) or association with armed forces and armed groups (CAFAAG).
2.	Participation	Engage children and their caregivers in defining their mental health and psychosocial needs and socio-culturally appropriate support mechanisms and in developing and implementing prevention and response strategies. Include children who are often excluded, including children who live with disabilities; identify as LGBTQI+; or are on the move, in institutions, and living on the street. Ensure participatory approaches are adapted to their age and stage of development.
3.	Do no harm	Reduce the potential for MHPSS and other interventions to cause harm, through activities such as effective coordination, adequate understanding of the local context and power relationships, cultural and gender sensitivity and competence, and awareness of individual capacities and functional limitations. Ensure the appropriate approach is used in each specific context and is implemented by staff who are trained and supported.
4.	Build on local capacities and resources	Support self-help and identify, mobilize, and strengthen existing resources, skills, and capacities of children, families, communities, governments, and civil societies. Community ownership of MHPSS is key to successful interventions and programmes.
5.	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 to reduce stigma of standalone interventions.
6.	Multi-layered supports	Develop a multi-layer system of complementary supports to meet the needs of children, families, and caregivers who are impacted in different ways. Use a twin track approach which provides both mainstreamed and targeted responses.

Save the Children country offices are not expected to facilitate MHPSS on all layers of the pyramid of intervention in a specific context and instead works closely with other partners and national governments to utilize effective referral mechanisms. SC works with partners at the point of programme design to ensure an appropriate, comprehensive MHPSS response that meets the needs of communities.

1.4.1.2Save the Children's MHPSS Priority Areas of Focus

In 2019, Save the Children developed the Mental Health and Psychosocial Support (MHPSS) Cross-Sectoral Strategic Framework in Humanitarian Settings. Within this MHPSS cross sectoral Framework, four areas were identified as critical for the future MHPSS work of Save the Children (which are equally applicable in development contexts):

- Strengthen a cross-sectoral approach to MHPSS in programme design, implementation, and response strategies
- Focus on building basic knowledge of child development and children's well-being for all staff (see the child development and well-being online training,[24] for examples)
- Ensure relevant programmatic staff have necessary knowledge, skills, and capacity to respond to mental health and psychosocial needs (see PFA, child resilience tools, and relevant capacity-building tools)
- Strengthen MHPSS programme cycle management, including MEAL (Indicator guidance)

This resulted in the following priority areas of focus for Save the Children across both humanitarian and development contexts:

1. Build MHPSS technical capacity across the SC movement and with partners
2. Strengthen existing MHPSS services at community and national levels; integrate and mainstream MHPSS across sectors to strengthen care systems from local community to national levels; and engage a range of civil society and governmental actors for sustainability
3. Improve coordination across sectors, civil society organizations (such as youth associations, women's rights organizations, and OPD), national institutions (such as ministries of health, social welfare, and education), and other partners
4. Develop better monitoring, evaluation, accountability, and learning (MEAL) frameworks for MHPSS
5. Contribute to advocacy and policy to improve quality and scale in MHPSS service delivery
6. Strengthen internal staff care and well-being supervision
7. Identify and invest in additional funding for MHPSS

1.4.1.3Save the Children Common Approaches

The Child Protection Pathways to Change[25] highlights the drivers of poor and harmful outcomes for the child, family, community, and society and identifies strategies to address the drivers to achieve short- and long-term results and breakthroughs.

Save the Children has developed a set of common approaches[26] which address the most common problems children face.[27] They include strengthening MHPSS across all Save the Children's work in development and humanitarian contexts. Common approaches which are most relevant to integrating MHPSS are included in the Figure 3 and identify opportunities where MHPSS can be more strongly reflected.

[24] Save the Children. 2018. Children's Development and Wellbeing E-learning.
[25] Save the Children. Child Protection Pathways to Change.
[26] Save the Children. Common Approaches.
[27] Save the Children. 2020. A Catalogue of Common Approaches: Delivering our best work for children (Internal version). common-approaches-catalogue-2020-ch1455299.pdf (savethechildren.org)

Key Guidance

Figure 3	Common Approach	Approach Summary	MHPSS Interventions
1.	Building Brains	The Building Brains[28] package is aligned with the Nurturing Care Framework[29] that promotes holistic early learning and responsive caregiving while leveraging government health, protection, or community-based systems. This common approach empowers mothers, fathers, grandparents, and other caregivers to engage babies and toddlers, including those with disabilities, in the playful and responsive back-and-forth interactions that are essential for healthy brain development.	Building Brains includes sessions to promote inclusion, positive discipline, caregiver well-being, physical and emotional safety, and gender equality. It has also been combined with screening and early intervention programmes to support children with developmental delays and disabilities.
2.	Parenting without Violence (PwV)	PwV[30] is embedded in the socio-ecological framework. It identifies the risk and protective factors and the drivers of violence and physical punishment of children. This common approach also enhances caregivers' and children's capacities, including their ability to provide support to one another, effectively listen and empathize with their children, communicate more effectively, and create positive coping mechanisms to deal with stress and overcome adversity.	Strengthening children and parents' resilience skills is integral to the common approach. Structured group sessions help participants build self-esteem and trust; understand their own feelings; and develop skills in communication, negotiation, and shared problem solving.
3.	Safe Schools	The Safe Schools Common Approach[31] aims to improve children's safety and protection, including their mental health and psychosocial well-being, in and around schools.	MHPSS can be addressed in each of the Safe Schools outcome areas: • **Policy and systems:** Advocate for policies that support child and teacher MHPSS and strengthen referral systems.

[28] Save the Children. Building Brains.
[29] Nurturing Care for Early Childhood Development. https://nurturing-care.org/ [website]
[30] Save the Children. Parenting without Violence.
[31] Save the Children. Safe Schools.

			• **School management:** Identify children's MHPSS needs through participatory risk mapping and include actions to improve MHPSS in risk-informed school improvement plans. • **Facilities:** Construct safe learning facilities to ensure children's access to basic education services. • **Children and Teachers:** Build children's and teachers' MHPSS knowledge and skills through teacher training modules on well-being, SEL, and PFA and children's SEL activities.
4.	Enabling Teachers[32]	This common approach supports teachers to integrate psychosocial support (PSS) and social emotional learning (SEL) into their classroom and to integrate MHPSS into the learning process.	A professional development course and enabling environment to provide concrete ways for teachers to support their own well-being and that of their students.
5.	Steps to Protect	Steps to Protect[33] is a common approach on child protection case management. Embedded in the socio-ecological framework, the approach helps Save the Children and partners to address the needs of the most vulnerable, individual children and their families in an appropriate, systematic, and timely manner.	Case workers will develop, implement, monitor, and review case plans based on the assessment of MHPSS-related child protection issue(s) and risk and protective factors at child, family, and community levels. Plans might include the case worker's direct psychosocial support to a child and/or their family as well as referrals to MHPSS-related services. When assessing and strengthening the existing case management system in a given context, available MHPSS-related services need to be mapped and included in referral pathways, and collaboration/coordination should be sought with MHPSS-related actors.

[32] Save the Children. Enabling Teachers.

[33] Save the Children. Steps to Protect.

1.4.1.4The Save the Children Strategy 2022-2024

The new Save the Children Strategy 2022–2024 outlines the role of MHPSS in transforming the lives of children over the next three years. To respond to the threats to children – including COVID-19, conflict, and climate change – Save the Children is determined to contribute to the well-being and protection of children affected by gender-based violence and conflict as follows:

- **Healthy start in life:** Contribute to over 300 million children using and having equitable access to quality essential health and nutrition services.
- **Safe back to school and learning:** Contribute to over 150 million children achieving well-being and learning outcomes.
- **Live free from violence:** Contribute to over 100 million children affected by conflict and sexual and gender-based violence being protected.
- **Safety nets and resilient families:** Contribute to over 200 million children benefitting from new or strengthened social protection systems and cash and voucher assistance.

The MHPSS technical guidance will contribute to 2022-2024 strategy goals by supporting the integration of MHPSS into other sectors and emphasizing how SC's work will be different. The strategy identifies six enablers, many of which are addressed in this technical guidance:

- Advocate, campaign, and mobilize
- Leverage digital technologies and data
- Enhance strategic partnerships
- Shift power
- Support an agile and inclusive organization
- Grow and optimize resources

1.4.2The MHPSS Pyramid of Intervention[34]

The SC MHPSS cross-sectoral strategic framework is built on the principles and recommendations from the Inter-Agency Standing Committee's Guidelines on Mental Health and Psychosocial Support in Emergency Settings. The guidelines emphasize the importance of strengthening community-based support, using multi-layered interventions, mainstreaming MHPSS approach across different sectors, integrating MHPSS into existing structures and systems, and coordinating services.

A key element of the IASC Guidelines is the MHPSS Pyramid of Intervention (see Figure 4). It demonstrates a layered system of complementary support that can be applied to all contexts to best meet the needs of different people and groups. People cope with emergencies situation differently, and their mental health deals with the experience in different ways and degrees of severity. How people

[34] IASC. 2007. IASC Guidelines on Mental Health and Psychological Support in Emergency Settings.

experience mental health difficulties or how they respond to distressing or difficult events depends upon a myriad of factors, including the support currently available to them, the protective factors which they accessed before the crisis, and the internal factors that they rely upon.

Most people will show typical responses to abnormal events. It is therefore important not to prematurely label people as traumatized. The majority of children and adults will regain normalcy and resilience by accessing existing community supports, basic needs, and security and will require no further support. The pyramid of intervention demonstrates the typical proportion of people who will require different levels of support. For example, Layer 1: "Social Considerations in Basic Services and Security" is essential and fundamental to supporting the mental health and well-being of everyone. Layer 4: "Specialized Services" represents specialized support required by smaller numbers of the population.

The Pyramid represents a "continuum of care" where each layer is essential and complements the others. No form of support is more important than another, and people should be referred to community-led support and other holistic and specialised supports as required and when relevant.

1.4.2.1Social consideration in Basic services and security [35]

Psychosocial interventions at the first layer of the IASC MHPSS pyramid are meant to ensure that conditions are met for the minimum standards of health, safety and dignity of children and families. All people need access to basic services and security as fundamental to recovering and maintaining their (mental) health and well-being. Ensuring these conditions are met in ways that promote human rights, dignity and equality can have a broad impact on mitigating the impacts of emergencies, preventing further harm, and promoting the well-being of children, families, and communities. Community led psychosocial interventions do not typically involve direct provision of basic services or security, but rather advocate for and work together with protection and other sector services to ensure:

- Basic needs (shelter, food, WASH) are provided in ways that respect the culture, dignity and agency of children and families and are sensitive to children's developmental needs.
- Children and families in vulnerable situation, who may be less visible in emergency contexts, are assessed and included in provision of basic needs.
- Overall safety for the community is promoted, and protection risks for children and families are identified and addressed.
- Children and families are safeguarded from abuse, neglect, and exploitation.
- Family unity is promoted through prevention of family separation, identification and care of separated children and family tracing and reunification.
- Children and families have access to critical information about basic services, loved ones, legal rights, and positive coping strategies.

Community-led psychosocial interventions at this layer often work to advocate for service delivery that 1) fosters inclusive, participatory processes in community mobilization, 2) gives attention to special considerations in the socio-cultural context (e.g., cultural beliefs, existing power structures, gender

[35] UNICEF. 2015. Compendium of resources A Supporting Document to UNICEF's Operational Guidance: Community-Based Mental Health and Psychosocial Support. Update 2020

relationships, help seeking behaviours, the role of traditional healers), and 3) ensures appropriate services reach the most vulnerable children and families.

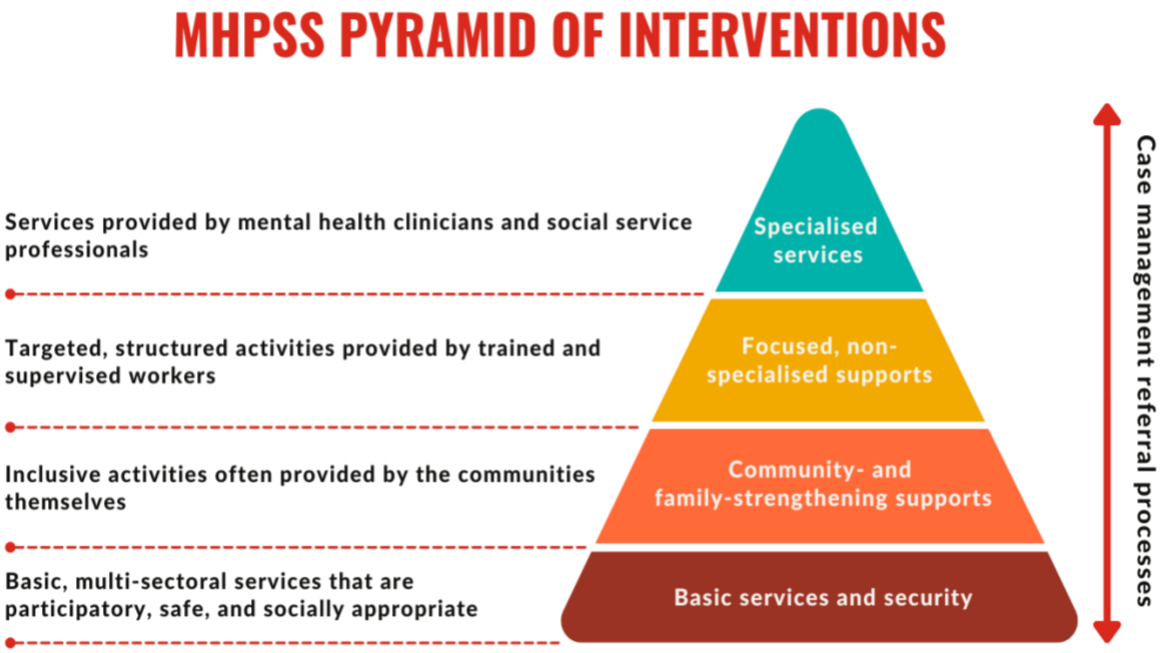


Figure 4: MHPSS Pyramid of Intervention adapted from the Child Protection Minimum Standards[36]

1.4.2.2Focused care: addressing psychosocial distress and protection challenges[37]

Focused care is geared toward strengthening the innate coping of children and families – as well as mobilizing and strengthening existing community social networks and specialized support and referral systems to address particular needs. Whether providers at this layer are mental health or social service professionals or non-specialized staff or lay people who have received training, **it is important that they receive close, regularly available supervision by qualified professionals.** Focused care providers may include community outreach workers, health and social service staff, counsellors, teachers and others. In addition, basic psychosocial competence training can be useful for a range of child caregivers and multi-sector workers who interface routinely with children. Psychosocial competence training topics may include information about child development and children's reactions to stress in the cultural context, PFA and other skills, and knowing when and how to refer for more specialized care.

36 Save the Children. 2018. MHPSS Strategic Framework

37 UNICEF. 2015. Compendium of resources A Supporting Document to UNICEF's Operational Guidance: Community-Based Mental Health and Psychosocial Support. Update 2020

1.4.2.3Save the Children's approach to specialized Layer 4 interventions

Save the Children operationalizes its commitment to strengthening the MHPSS continuum of care by investing in mental health promotion and prevention activities that enhance children's natural strengths and assets and foster individual, family, and community resilience. This is directly aligned to SCI's Global Goal 'Healthy start in life.'

Save the Children also strives to ensure that children and families in need of focused support have access to the level of care they need, whether it is provided by SC or by other organizations or institutional partners. The decision to provide specialized services that respond to more complex mental health and developmental needs should be carefully considered and *would not be appropriate* in contexts where the safety, quality, and continuity of service provision cannot be reasonably ensured. Following are some key considerations that should inform and justify decisions about whether or not it is appropriate to provide more focused or specialized MHPSS support:

- Is the proposed intervention the best use of resources to provide the greatest mental health good for this community or population?
- Can we ensure continuity and sustainability?
- Can it be delivered safely?
- Can supplies of any medicines or other essential aids continue?

1.4.3The Socio-ecological Framework

The Socio-ecological Framework (see Figure 5) places children within the context of their families, communities, and wider society. It demonstrates the role each plays in mitigating risk factors and promoting protective factors to support the healthy development and well-being of children. Placing gender and power dynamics at the centre emphasizes the importance of these dynamics, not only to children, families, and communities, but also to the development, implementation, and support of programmes.

Key Guidance

Each layer of the framework influences how the child is impacted and/or supported in their particular context. Therefore, *all* layers of the framework must be considered when designing and implementing programmes and interventions.

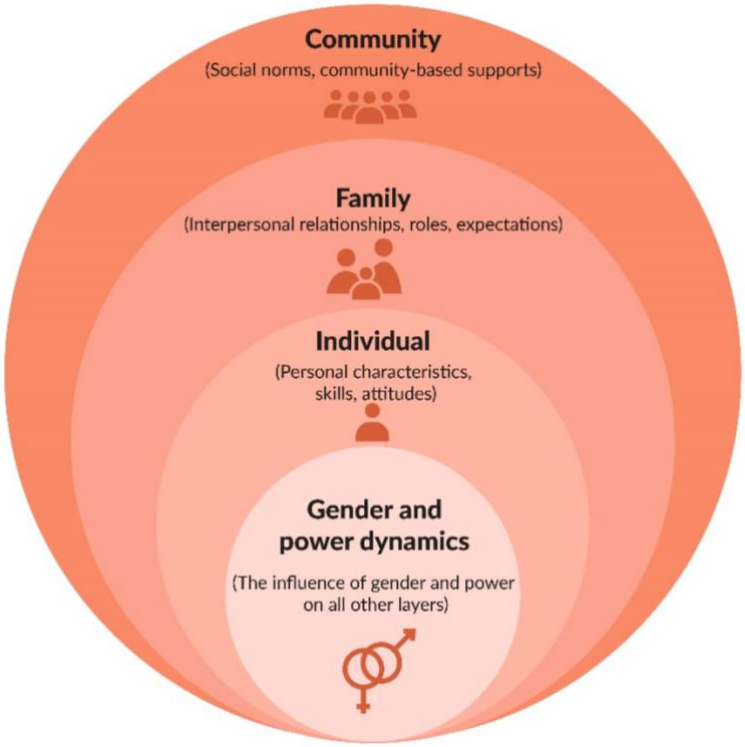


Figure 5[38]: The Socio-ecological Framework

38 Adapted from Save the Children. 2018. Mental Health and Psychosocial Support (MHPSS) Cross-Sectoral Strategic Framework in Humanitarian Settings.

2 What is the core MHPSS guidance?

2.1 Keep children safe in MHPSS programming

Children have a right to protection from all forms of abuse and exploitation. Sexual abuse, exploitation, and other forms of harm become possible when there is an imbalance of power, and there are significant imbalances of power between a community in need of aid and the organizations providing aid. This imbalance is even more pronounced in humanitarian contexts. While most humanitarian workers act compassionately and professionally, there are some who will deliberately seek, create, or exploit opportunities to abuse children and adolescents. The control of resources, services, and opportunities is a form of power that is open to abuse by NGO workers, especially those who make decisions about who can access aid or services, when, and how often.

Within Save the Children, Child Safeguarding is making Save the Children safe for children. It is our **individual and collective responsibility** to ensure all children are protected from deliberate or unintentional acts that lead to the *risk of, or actual*, harm caused by Save the Children staff, representatives, partners, volunteers, contractors and visitors to our country programmes. The biggest defining characteristic that distinguishes safeguarding from child protection work is the actor of the alleged harm. Whenever the actor of the harm is a representative of Save the Children or our partners, we treat it like a safeguarding incident. When the actor is not a representative of Save the Children, it is considered a protection issue. When planning MHPSS programming, it is important to set up safeguarding mechanisms as well as work with child protection actors to ensure safe programming for children.

It is critical, therefore, that all workers understand and remain accountable to their responsibility to keep children safe in all aspects of programming. The safeguarding steps that follow will help you keep children safe in integrated MHPSS programmes.

2.1.1Identify safeguarding risks in MHPSS activities

MHPSS activities involve interaction with children and adolescents. Save the Children safeguarding is about protecting children from NGO workers or our own staff and partners. **Conducting a programme safety audit** will help you identify potential safeguarding risks. The main risks include the following:

- **Children in distress can be more easily manipulated**. SC or partners MHPSS workers can take advantage of their position to abuse them psychologically and physically.
- **Because activities for children's well-being are attractive** to children of any age and MHPSS activities target children at risk, such as those who are separated or unaccompanied, on the street, or living with disabilities or mental health conditions, care needs to be taken to ensure that MHPSS activities are not only child-friendly but also safe for children and providing accessible feedback mechanisms.
- **Children at risk may not be aware of their rights** or existing complaint mechanisms and may lack caregiver support. In many communities, members of the LGBTQI+ community may face additional risks.
- **Community-based recreational activities are sometimes run by volunteers.** Country offices do not always have the means to verify their criminal background, for instance in displacement situations.
- **Focused and specialized services can involve one-on-one support.** MHPSS workers can take advantage of this situation to abuse children.
- **Children may share information on sensitive issues**, including protection and gender-based violence (GBV) concerns, during MHPSS activities. MHPSS workers may use this information against the children for sexual exploitation, among other abuse.
- **Children with intellectual, psychosocial disabilities and/or mental health conditions are at greater risk** of being ignored when disclosing abuse from MHPSS workers. They may also need additional support to communicate about and report the abuse.

2.1.2Mitigate safeguarding risks when implementing MHPSS activities[39]

After conducting a safety audit and identifying potential safeguarding risks, it is important to develop strategies to mitigate or prevent those risks. This will ensure that children and caregivers are safe and free to express themselves when participating in activities. Such an atmosphere contributes to the mental health and well-being of both participants and workers.
The following section provides strategies for mitigating risks that are (1) common to all programmes, (2) specific to children with disabilities, and (3) related to sex and gender.

2.1.2.1Common safeguarding risks

It is compulsory that **staff and partners should know how to contact the safeguarding focal point**. To mitigate common safeguarding risks, follow these dos and don'ts.

Do's

- **Train staff running child-friendly activities** on:
  - SC safeguarding

[39] Carter, Cat. 2019. Safeguarding in Emergencies Toolkit. Save the Children.

  - The code of conduct
  - Referral procedures
  - Informed consent principles
  - How to respond to children who are distressed or disclosing sensitive information
- **Ensure that staff obtain informed consent/assent** from caregivers *and* children.
- **Confirm that the location for MHPSS activities is safe** and allows for privacy while being open enough to easily see children and facilitators.
- **Maintain children's dignity and follow ethical guidelines when using images of children** for fundraising purposes.
- **Provide space and opportunities for children and caregivers to share concerns** more privately after programme activities.
- **Provide information to both children and parents about the feedback and reporting channels** available to them.

Don'ts

- **Do not allow children and facilitators to share sensitive stories or information** they may have heard in MHPSS activities unless for referral purposes or to get the child help.
- **Do not encourage children to share sensitive stories publicly.**
- **Do not take any photographs** unless you have received informed consent/assent from the child and caregiver.
- **Do not take photographs or record conversations** on a personal device.

2.1.2.2Risks to children with disabilities

In humanitarian settings, children with disabilities are at increased risk of exploitation and abuse because of stigma, isolation, discrimination, and a lack of support. To better safeguard children with disabilities, follow these do's and don'ts.

Do's

- **Consider what adaptations are needed** to ensure that children with different disabilities can participate in consultations and other programme activities.
- **Share information about activities directly with children** with disabilities.
- **Use discretion when supporting children with disabilities** during activities, breaks, and visits to and from the bathrooms.
- **Arrange transport** for children with disabilities.
- **Schedule programme times** to minimize or avoid child protection or safeguarding issues due to travelling late or in the dark.

- **Be aware** that children with disabilities might not have had the same exposure or capacity-building opportunities as other children and so may not be as quick to provide feedback.
- **Use communication and questioning approaches** that are patient, child-friendly, encouraging, and appropriate to the child's pace and ability.

Don'ts

- **Do not touch children's assistive devices**, wheelchairs, or other aids unless asked to.
- **Do not assist children with intimate and private matters** (e.g., going to the toilet and getting dressed) *unless* they cannot do these things for themselves, and they request your support explicitly.

2.1.2.3Sexual exploitation, abuse, and harassment (SEAH)

Risks associated with gender-based violence (GBV) must be included in safety audits and mitigation strategies. There are some specific challenges to mitigating and responding to sexual exploitation, abuse, and harassment:

- **Lack of understanding.** Some communities may have limited or no understanding of the concept of child sexual abuse, for example in contexts where CEFMU is common or where sexual abuse of younger boys by older men is seen as a 'normal' response to the lack of availability of 'appropriate' female partners. In other communities, the concept of sex may only be divided into 'acceptable' (i.e., within marriage) and 'unacceptable' (i.e. outside of marriage), making discussion of different forms of sexual abuse very difficult.
- **Fear of disclosure.** Survivors may be afraid of the direct and indirect consequences of reporting. Factors that may make them feel threatened or disempowered to disclose include:
  - Living in a camp-based setting and having few opportunities to move or to protect themselves
  - Being violated by perpetrators who are not acting alone, are senior members or decision-makers in an organization, are well-connected in the community, or are members of the survivor's family

To better support children and adults to disclose acts of sexual abuse, particularly those committed by humanitarian workers, follow these do's and don'ts.

Do's

- **Create a safe, supportive environment** to increase the likelihood that survivors will share information with Save the Children that will help us to support them, run a successful investigation, and allow action to be taken against the perpetrator(s).
- **Support programme participants to recognize abusive behaviour.** Without such support, many survivors may not be fully aware that they have experienced

abuse (e.g., a child may believe they are in a loving, consensual relationship with an adult).

- **Have an up-to-date referral list** in place so you know who to contact to provide appropriate support (See section 2.1.3 How to report and refer).

Don'ts

- **Do not judge or express doubt about a disclosure of abuse.** Most disclosures are based in fact.
- **Do not view disclosure of abuse or exploitation as a one-off event.** Disclosure is often a process in which information comes out little by little over a period of time as the survivor develops trust and confidence.

2.1.3Report and refer suspected safeguarding violations

Save the Children is committed to supporting survivors of all forms of violence, abuse, exploitation, and neglect, especially when it is perpetrated by Save the Children staff or partners. SCI is committed to accountability to survivors by addressing perpetrators. The following steps will ensure an appropriate response to disclosed or suspected violations:

- **Assess informal and community systems** that support survivors.
- **Establish functional cross-sectoral referral mechanisms.**
- **Develop and implement a communication plan** on referral pathways.
- **Train and support all staff** on when and how to use available referral pathways including accountability and justice needs towards survivors and perpetrators.

2.1.4Checklist of key considerations to enhance an ethical and do no harm approach

The following checklist can help ensure that integrated MHPSS programming meets ethical standards and supports children's safety.

Checklist of key considerations to enhance an ethical and do no harm approach[40]

☐ Collaborate with local staff and community members to understand and build upon culturally relevant practices and traditions to support the expression and participation of all children and adolescents in MHPSS programmes.

[40] United Nations Children's Fund. 2018. Operational guidelines on community based mental health and psychosocial support in humanitarian settings: Three-tiered support for children and families (field test version).

Key Guidance

☐ Use conflict analysis tools to better understand existing conflicts and power dynamics in project communities to inform conflict-sensitive participation approaches.

☐ Use gender and power analysis and diversity analysis to identify power dynamics associated with gender, age, disability, race, ethnicity, and other factors and use the findings to inform and support inclusive opportunities for participation of children, adolescents, caregivers, and community members from diverse backgrounds, including the most marginalized, in MHPSS programming.

☐ Ensure systematic implementation of child protection policies and procedures.

☐ Provide training and mentoring on psychological first aid and safeguarding for all staff, including community-led staff and volunteers.

☐ Ensure informed consent of parents and caregivers, and informed assent of children and adolescents to participate in MHPSS programmes and services, while taking into consideration their capacity and best interests.

☐ Share information about MHPSS programmes and services in languages and formats that are accessible to all community members.

☐ Clearly define the potential outcomes and limits to participation.

☐ Assess and mitigate risks associated with participation in project activities and make decisions informed by the best interests of the child and the principle of do no harm.

☐ Avoid labelling and stigmatizing children, adolescents or caregivers based on ill-health, disability, care status, or other factors and ensure participation in MHPSS interventions does not lead to stigmatization.

☐ Respect an individual's privacy and confidentiality.

☐ Ensure referral mechanisms are in place to ensure sensitive and timely follow up and to any identified safeguarding concerns and/or other support needs.

☐ Ensure on-going monitoring to identify and sensitively respond to risks, stigma, or other unintended negative outcomes of participatory MHPSS programming.

Key Guidance

☐ Provide feedback to community members (adults, children, and adolescents) about the process and outcomes of their collective participation

☐ Ensure those implementing MHPSS programming with children and families receive on-going support, including appropriate training, mentoring and well-being support

2.1.5Key safeguarding resources

The following guidance can increase your understanding of child safeguarding and its importance to Save the Children.

Able Child Africa and Save the Children. 2021. Disability inclusive safeguarding guidelines.
This guidance has been developed to respond to an existing gap in child safeguarding practices, which often fail to recognize the requirements and adaptations needed to ensure the safety of children with disabilities. Through the guidelines, you will find information about best practices, as well as practical tools and helpful recommendations.

Save the Children. 2019. Save the Children's Child Safeguarding Policy.
Save the Children does not allow any form of child abuse, maltreatment, or poor safeguarding practice. This policy applies to all persons working for us or on our behalf in any capacity and applies during or outside of working hours, every day of the year.

Save the Children. 2019. Safeguarding in emergencies toolkit.

2.2 Include MHPSS in all stages of the programme cycle

When integrating MHPSS considerations into other-sector programmes, it is important to identify 'entry points,' places where it is natural to include MHPSS elements. Helpful considerations when identifying entry points include:

- Are group activities taking place that include parents, caregivers, children, adolescents, etc.?
- Could MHPSS considerations be included in existing group activities?
- Are there elements of other-sector programmes that include messaging or promotion/ mobilisation activities and could incorporate MHPSS messages and considerations?
- How can all sectors' programming support people's mental health and well-being?

Key Guidance

2.2.1Assessments[41]

Priority risks, needs, existing positive coping strategies and preferred solutions should be analysed from an age, gender, and diversity perspective to inform project plans that encompass the needs and strengths of different groups of children. This will also help to ensure that everyone's expectations are realistic, and the process is clear and transparent.

When conducting MHPSS assessments in contexts of crisis, **avoid epidemiological surveys/attempts to quantify mental health conditions in humanitarian contexts**. Refer to available estimates instead (as recommended by WHO). Focus on more qualitative aspects –common manifestations of distress, ways of coping, existing support networks, access to services – and how these differ according to gender, age, displacement, disability status, etc.

Engaging all stakeholders in a context analysis and assessment ensures that all actors (including multi-sectoral, MHPSS, and other-sector staff) will be aware of gaps, existing health-seeking behaviours, and attitudes to mental health and psychosocial distress. When children and families engage in participatory processes such as needs assessments, gaps analysis, or attitudinal surveys, it is important not to overburden people by repeating the same questions at different times. It is essential to collaborate on multi-sectoral processes which offer full, ethical, and meaningful participation opportunities.

The main types of assessment methodologies include analysing existing data which has been collected through desk reviews, collecting new information through MHPSS assessments carried out by MHPSS actors, and collecting new information through integration of MHPSS concerns into assessments by other actors.

It is important for SC COs and partners to have access to, and actively contribute to a joint 4Ws mapping exercises conducted in country by the MHPSS TWG or other coordination platforms. Where MHPSS groups may not exist, it is important to share information on MHPSS interventions collected by education, protection, and/or health clusters or working groups. If capacity exists, SC should lead on or encourage such initiatives to take place if they are not already planned or in place.

Refer to the following recommendations before and during MHPSS assessments:

- **Review existing information** before conducting primary data collection. Include the outcomes of other sectors' assessments, including child protection and health, to identify specific vulnerabilities which may impact MHPSS needs
- **Collect only information that is necessary** and that you have the capacity to analyse.
- **Design the assessment process** in a way that is not solely extractive and that uses existing supports and referral pathways.

41 Save the Children. SC MENA DRAFT MHPSS Assessment Guide. Available on demand. Contact: Marta Petagna at Marta.Petagna@savethechildren.org

Key Guidance

- **Coordinate with other sectors and clusters** to avoid duplication of efforts. Integrate MHPSS-specific elements into multisectoral assessments whenever possible.
- **Ensure interviewers/ facilitators are aware of referral mechanisms** and have worked with child protection and health workers or case managers to (a) identify at-risk or vulnerable children and adolescents and (b) ensure referrals can be made quickly and efficiently.
- **Support girls' participation** by (a) having female interviewers/ facilitators work with female groups or (b) facilitating groups in girls' houses if caregivers are reluctant to allow girls to travel far from home.
- **Ensure children, caregivers, and community leaders understand the intended purpose and use** of the assessment and its results.

2.2.1.1Key assessment resources

IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings. 2012. Who is Where, When, doing What (4Ws) in Mental Health and Psychosocial Support: Manual with Activity Codes (field test-version). *(The IASC Reference group on Mental Health and Psychosocial Support has developed this 4Ws tool to map MHPSS activities in humanitarian settings across sectors. It is envisioned that this tool will be used by groups with MHPSS coordination responsibilities in emergencies with numerous MHPSS actors.)*

Save the Children. 2021. 5 key questions for multi-sectoral need assessments in humanitarian contexts.

MHPSS Minimum Service Package. Gap analysis tool.

2.2.2Planning and design

The MHPSS theory of change explains how people's mental health and psychosocial well-being can be improved.

To maximize the potential of integrated programming, MHPSS should be supported and reflected in country-level strategic planning processes and child rights situational analyses. Relevant programmatic responses can then be planned and designed based on assessment findings and a clear theory of change. Collaboration and coordination with other actors, including an MHPSS focal point, will help ensure that programmes use a multi-layered response to provide complementary MHPSS activities. Most importantly, emotional, and physical safety must be built into the design of integrated MHPSS programmes. (See Figure 6 for a summary of key steps when planning, implementing, and monitoring MHPSS programmes.)

Note: New programming should be developed only when existing ones are not applicable. It is generally preferable to build on existing resources rather than risk duplication.

Key Guidance

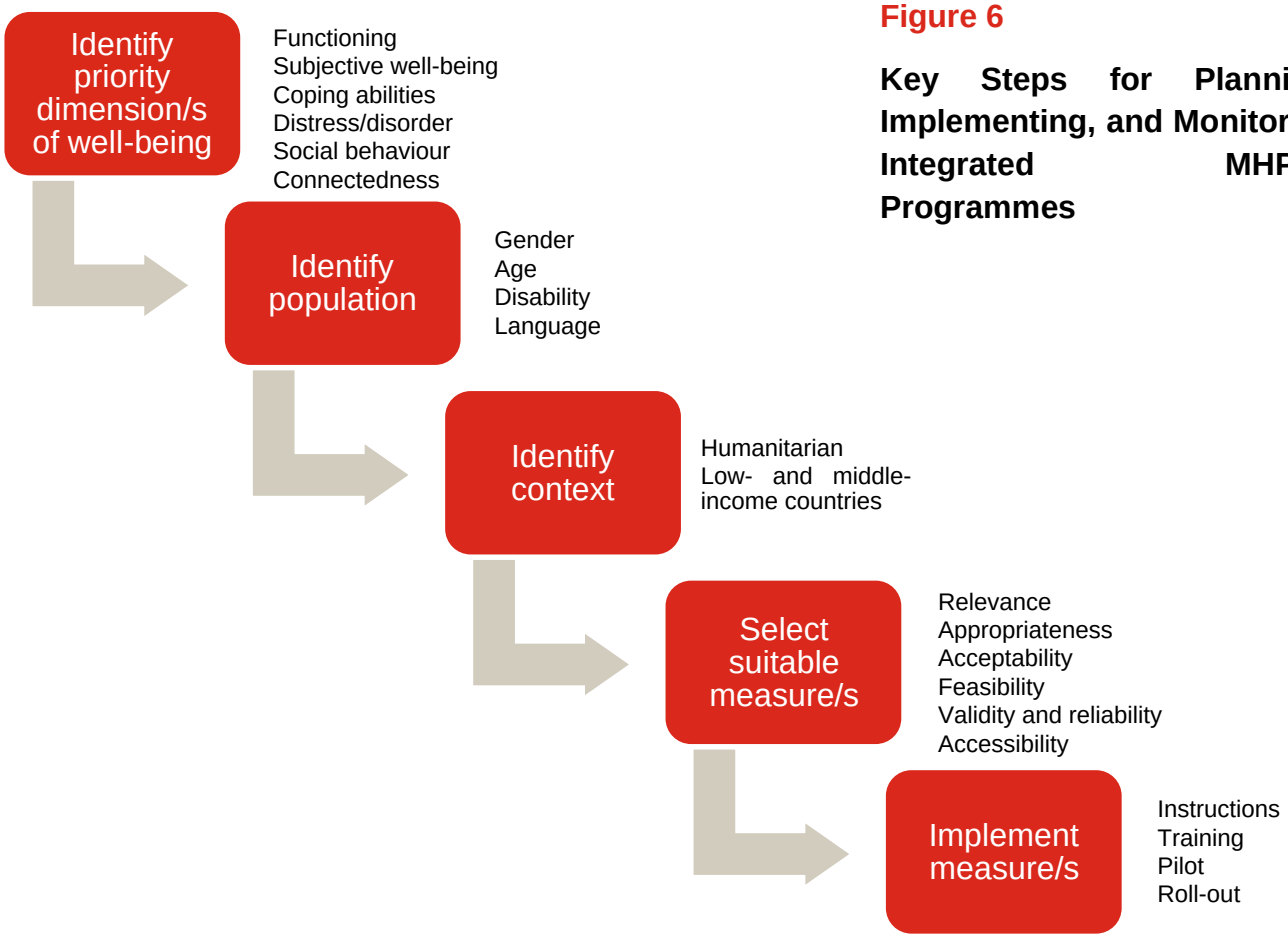


Figure 6

Key Steps for Planning, Implementing, and Monitoring Integrated MHPSS Programmes

The following actions should be taken when planning and designing integrated MHPSS programmes:

1. **Collaborate with other sectors at the beginning.** Immediately after a funding opportunity is identified, convene an inter-sectoral meeting to discuss how to plan the intervention. Allocate and agree on coordination responsibilities. (For more on collaboration, see Section 2.5.)
2. **Budget for participatory multi-sector assessments** that use creative inclusive and child-friendly approaches. (For more on assessments, see Section 2.2.1.)
3. **Map (and establish, when needed) existing, inclusive, formal, and informal MHPSS systems** within the community, including referral pathways and mechanisms. (For more on community-level interventions, see Section 2.5.3.)
4. **Use a disability-friendly approach** to ensure girls and boys with intellectual and psychosocial disabilities have an equal opportunity to participate meaningfully in every stage of the planning process. (For more on disability and inclusion, see Section 4.5.)
5. **Develop an integrated theory of change that reflects the contribution of MHPSS to programme goals.** Ensure the theory of change that underpins the programme includes (a)

MHPSS dimensions that align with the other sectors involved and (b) activities that contribute to well-being.

6. **Formulate integrated programme outcomes and/or include MHPSS outcomes within overall programme design**. Ensure evidence based MHPSS is reflected in the programme at all stages, including MEAL processes.
7. **Select inclusive MHPSS outcome indicators and means of verification (MOVs**) and include them in all project documents. (For more on MEAL, see Section 2.2.4.)
8. **Map required resources and ensured appropriate budget allocations**. (For more on securing resources, see Section 2.6.)
9. **Develop and implement a staff MHPSS capacity-strengthening plan.** (For more on strengthening staff capacity, see Section 2.8.)

2.2.3Implementation

When implementing integrated MHPSS programming, the child and their rights must be at the centre of each intervention and interaction. Throughout the programme cycle, we want to follow best practice and ensure that we 'do no harm.' This is particularly important when specific groups may be at risk of stigmatization for their participation in a programme (e.g., SGBV or CAAFAG).

MHPSS shall be provided responding to all participants requirements, including reasonable accommodations, and adapting methodologies and approaches to include the needs of people with disabilities. Based the twin track approach principles, if children with disabilities face many barriers, they may require provision of tailored MHPSS services.

Another way to 'do no harm' is to consider addressing participants' MHPSS needs under the umbrella of an integrated sectoral intervention. For example:

- WASH programmes that target adolescent girls may include SGBV responses as part of hygiene promotion.
- Child Protection interventions can be carried out in conjunction with cash assistance.
- Children in conflict with the law can be supported through protection and education programming.

When beginning a new MHPSS programme or activity (or an existing programme in a new area), it is recommended to begin with a pilot programme. Cross-sectoral mechanisms should be established to jointly review the programme/ activity according to MHPSS quality standards and reporting guidance. After evaluating the pilot and defining learning points, the programme/ activity can be finalized and scaled up.

The following principles should be followed when implementing integrated MHPSS programming:

Key Guidance

1. **MHPSS considerations should be at the core of all sector programming** – including case management, multi-sectoral, and integrated programming – to enhance well-being and mental health.
2. **Both individuals who receive higher-level support and communities who engage in lower-level support must be able to participate in all aspects of their care and in decisions which affect them.**
3. **Families of children and adolescents who are receiving MHPSS and multi-sectoral support must be engaged** in ways that ensure the child/ adolescent's dignity and capabilities and build upon/ support the family's agency and strengths.
4. **Ensure human resource capacity exists** to implement/ integrate inclusive MHPSS programmes. (For more on the required human resources, see Section 2.7.1.)

Please see the relevant sector guidance in Section 3 for sector-specific guidance on implementing integrated MHPSS programming.

2.2.4Monitoring, evaluation, accountability, and learning (MEAL) and research

To ensure quality MHPSS programming during and after implementation, it is important to develop a MEAL framework that includes appropriate MHPSS goals, outcomes, indicators, means of verification, and accountability activities. This framework will allow programme staff and partners to:

- Calculate targets for MHPSS activities
- Collaborate to ensure coherence across the programme
- Monitor and evaluate the effectiveness of the programme
- Remain accountable to communities and other stakeholders

As with every aspect of integrated MHPSS programming, children and families should be engaged in developing, implementing, and monitoring the MEAL framework. Refer to SCI policy on ethic in research (forthcoming).

2.2.4.1IASC Common Monitoring and Evaluation Framework[42]

Save the Children's MEAL approach builds upon the **IASC MHPSS Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings**, which provides guidance on monitoring and evaluating MHPSS programmes. Primarily developed for emergency settings, it can also be used when transitioning from emergency to development contexts and when conducting disaster risk reduction activities.

[42] Inter-Agency Standing Committee (IASC). 2021. The Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings: with means of verification (Version 2.0).

Key Guidance

The MHPSS framework's overall goal is to 'reduce suffering and improve mental health and psychosocial well-being.' Suggested goal indicators correspond to six key dimensions of mental health and psychosocial well-being:

1. **Functioning:** the ability to carry out essential activities for daily living
2. **Subjective well-being:** feeling calm, happy, capable; not feeling sad, etc.
3. **Ability of people with MHPSS difficulties to cope with problems they may face** skills in stress management, communication, vocation, and conflict management
4. Extent of **prolonged disabling distress and/or presence of MNS disorder** (or symptoms thereof)
5. **Social behaviour:** helping and supporting others
6. **Social connectedness**: the quality and number of connections a person has in their own family, community, and other communities

The framework further articulates 5 outcomes. Three outcomes reflect community-level results around the promotion of mental health and well-being:

1. Emergency responses do not cause harm and are dignified, participatory, community-owned, and socially and culturally acceptable.
2. People are safe and protected, and human rights violations are addressed.
3. Family, community, and social structures promote the well-being and development of all their members

The other two outcomes reflect the results of person-focused interventions around support to, and access to care for, children and adults experiencing psychosocial and/or mental health difficulties.

1. Communities and families support people with mental health and psychosocial problems.
2. People with mental health and psychosocial problems use appropriate focused care.

2.2.4.2 Save the Children's Global Results Framework MHPSS indicator

The IASC encourages humanitarian partners to prioritize commonly agreed-upon indicators to improve coherence of MHPSS MEAL systems across organizations. However, each partner should also select, adapt, or formulate indicators that are relevant to the type of MHPSS work they conduct and the type of result they pursue.

Robust MHPSS indicators are expected to reflect the standard criteria of being *simple*, *measurable*, *achievable*, and *time-bound* (SMART). The IASC guidance document includes a menu of outcome indicators for each of the five outcomes listed above that may be helpful in formulating programme-specific results frameworks.

Key Guidance

In determining what should be measured at the programmatic level, Save the Children uses the levels of the socio-ecological framework to set outcomes and related indicators.

Individual level

Save the Children's individual-level MHPSS outcome is the *improved mental health and psychosocial well-being of individual children, adolescents, family members, and caregivers including teachers, educators, and other adults with care responsibilities towards children whose well-being impacts on the well-being of children.*

Within Save the Children's Global Results Framework (GRF), MHPSS outcomes at this level are measured using the GRF MHPSS Indicator: *the proportion of children, adolescents, family members, or caregivers and services providers who demonstrate improved mental health and/or psychosocial well-being*.

The Global Indicator is intended for cross-cutting use across sectors/themes. This means that results achieved through MHPSS programmes or components across sectors can be measured at the individual level regardless of whether the programme is part of the Child Protection, Health, Nutrition, Education, or any other programmatic portfolio.

Family level

Save the Children's family-level MHPSS outcome is *the family and caregiver's capacities and capabilities to care for and nurture their own and their children's well-being, health, learning, and development*.

The outcome on families can be operationalized and measured through indicators extracted from the menu of global milestone indicators (e.g., the quality of parent-child relationships). Sample indicators include:[43]

- % Of male and female caregivers who report positive caregiver-child relationships
- % Of boys and girls who report they feel their parents/caregivers know a lot about them
- % Of boys and girls who report talking to their family about how they feel
- Quality of caregiver-child interactions

Community level

Save the Children's community-level MHPSS outcome i**s** *the community's willingness and ability to protect and promote the well-being and healthy development of children and families and to support children, adolescents, and caregivers experiencing mental health and/or psychosocial difficulties*.

Sample indicators for measuring the community-level MHPSS outcome include:

[43] Save the Children. PwV Indicator Menu.

- % Of affected people who report receiving accessible information in a timely manner about (a) the emergency, (b) the emergency response, and (c) self-help approaches for positive coping/well-being
- % Of target communities where communal rituals for the dead have been organised
- # of protection mechanisms (such as social services or community protection networks) and/or # of people who receive help from formal or informal protection mechanisms
- Perceptions, knowledge, attitudes (including stigma), and behaviours of community members, families, and/or service providers towards people with mental health and psychosocial problems

Society level

Save the Children's society-level MHPSS outcome is *the social and institutional norms, social and economic policies, and cultural and societal factors that influence children's and caregivers' mental health and psychosocial and developmental well-being, such as funding for MHPSS services*.

Sample indicators for measuring the society-level MHPSS outcome include:

- # Of people who have reported human rights violations and their perceptions about the responses of institutions addressing their case
- % Of medical facilities, social services facilities, and community programmes that have staff trained to identify mental health conditions and to support people with mental health and psychosocial problems
- Increased teacher knowledge of procedures for referral of children with specific protection and mental health needs

Indicators at each level are operationalized and measured through the six dimensions of mental health and well-being identified in the IASC framework (see Section 2.2.4.1.).

2.2.4.3Means of Verification (MoV)

Means of Verifications (MOVs) are quantitative or qualitative tools used to measure results. **Quantitative measures** of MHPSS results include standardised psychometric scales as well as locally developed quantitative surveys. **Qualitative approaches** rely on focus groups discussions, key informant interviews, and other participatory methods of data collection.

Whenever feasible, a mix of quantitative and qualitative measures and the triangulation of results are recommended. This may be more feasible in research and formal evaluation projects and may be less common (but still recommended, whenever possible) in standard monitoring systems.

Choosing the appropriate Means of Verification is a critical step in the formulation of robust MHPSS MEAL frameworks. Some considerations to guide the choice of MOVs include:

- **Relevance:** Is the tool appropriate to the results to be measured? Is it relevant to the dimension of mental health and well-being that the intervention/programme aims to address (subjective well-being, psychosocial functioning, etc.)? This is a critical consideration, as often programmes focusing on specific dimensions of well-being are evaluated through tools that measure different dimensions and lead to inconsistent and unreliable M&E information.
- **Appropriateness:** Is the tool appropriate for the audience (e.g., gender- and age-sensitive)?
- **Acceptability:** Is the tool acceptable to both respondents and people responsible for data collection? Can it be administered safely? (i.e., Can the risk of doing harm be contained?)
- **Feasibility:** Does the tool allow for practical use with respect to ease of administration, length of administration, and analysis and interpretation of the data collected?
- **Validity and reliability:** When measuring abstract constructs of mental health and well-being, does the tool capture what it is meant to be measuring? Does it reflect local understandings of mental health, well-being, distress, etc.? What is the validity and reliability of the tool in the specific context, noting that language adaptations may alter reliability? Will validation work need to be undertaken to establish the effectiveness?
- **Accessibility:** Are there copyright issues or permission requirements related to using the tool?

For more information on selecting MOVs for MHPSS results, see the IASC Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings[44] or the online IASC MHPSS M&E Framework MOV Toolkit.[45] The mhpss.net site includes a search engine and rich database of validated tools and related users' instructions.

Country Offices are also encouraged to refer to SC's guidance for support on humanitarian planning, data collection, measurement, aggregating results, and global- and country-level reporting.[46] **A supplementary guidance document on MOVs for MHPSS will be available in 2023.**

2.2.4.4Evaluation

Well-documented and reliable evaluations are required to develop a better understanding of the approaches and practices that are most effective in specific situations. Evaluations should assess:

- **Whether** a programme has met its objectives
- **What** changes occurred in children's well-being due to programme interventions
- **How** the programme achieved these changes

[44] Inter-Agency Standing Committee (IASC). 2021. The Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings: with means of verification (Version 2.0).

[45] Inter-Agency Standing Committee (IASC). IASC MHPSS M&E Framework MOV Toolkit. mhpss.net

[46] This guidance was still under development at the time of printing.

Evaluations should also account for the needs of the most marginalized and at-risk groups, including children and young people affected by disabilities (either their own or a family member's).

Evaluating MHPSS programmes pose unique challenges. 'Well-being,' a key outcome of MHPSS programming, is subjective and will be defined differently by different people and communities. This difficulty has contributed to the gaps which have formerly existed in MHPSS M&E processes.

To address this challenge, it is important to **identify a common language** when evaluating whether well-being has improved. Properly designed and conducted MHPSS evaluations should provide:

- **Learning** that can be used to improve future programming and to build inter-agency consensus on effective practices
- **Clarity and conclusions** about the programme and/or practice
- **Evidence** that a programme has made a difference to the mental health and coping of children, caregivers, and communities
- **Accountability** to children, families, and other stakeholders
- **Data** on how to sustain positive outcomes and/or the programme itself

2.2.4.5Accountability[47]

Save the Children is committed to being accountable for the promises made to supporters, partners, staff, and most of all, children. Integrated MHPSS programming in humanitarian responses align with the Core Humanitarian Standard on Quality and Accountability (CHS).

To support accountability, Save the Children prioritizes open and transparent reporting. The results of programme evaluations should be made available to stakeholders while ensuring the privacy and protection of programme participants and staff.

Please see SC's resources on **accountability**[48, 49] to children, including **safeguarding**[50] and do no harm.

47 Save the Children. Accountability. Retrieved August 17, 2022.

48 Save the Children. 2021. Strengthening Accountability to Children and Communities in Conflict Areas.

49 Save the Children. 2021. Global Accountability Report 2020: Our journey of accountability.

50 Save the Children. 2020. Feedback and Reporting Mechanism Guidance.

2.2.4.6 Standards to ensure research and MEAL processes are ethical and do no harm

Research and MEAL processes typically involve direct or indirect engagement with individuals and groups, researchers and evaluators must apply ethical principles in order to keep people safe and to ensure their dignity and agency are respected at all stages of the process.

The IASC identifies six key areas that should be prioritized when conducting MHPSS research (see Figure 7):[51]

- Research purpose and benefit
- Analysis of ethical issues
- Participation
- Safety
- Neutrality
- Study design

The following principles should be followed when conducting research or M&E activities on integrated MHPSS programming:

- **All enumerators, researchers and facilitators should be trained** on PFA for child practitioner, Child Safeguarding, and PSEA.
- **All personnel should be trained** on active listening and communicating with children, including children who are marginalized or living with a disability.
- **Questions and discussions about mental health or distressing events should not cause additional distress or anxiety** to participants.
- **Children and communities should understand** why they are participating in activities, should agree to participate, and (parents) should give their informed consent.
- **Child safeguarding mechanisms must be in place**, including up-to-date referral structures and mechanisms, to support children or caregivers who may be identified as requiring support.
- **Ensure consultative process**es are not duplicated and that the same people are not involved repeatedly. Only collect information that is needed and that can be analysed and used.

[51] Inter-Agency Standing Committee (IASC). 2014. IASC Recommendations for Conducting Ethical Mental Health and Psychosocial Research in Emergency Settings.

- **MEAL actors should assist in the design** of child-friendly, accessible, and inclusive feedback mechanisms that support course correction and learning for future programmes.

2.2.4.7Key MEAL resources

IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings. 2012. IASC Reference Group Mental Health and Psychosocial Support Assessment Guide.

Inter-Agency Standing Committee (IASC). 2021. The Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings: with means of verification (Version 2.0).

Inter-Agency Standing Committee (IASC). 2014. IASC Recommendations for Conducting Ethical Mental Health and Psychosocial Research in Emergency Settings.

Save the Children. 'Steps to Protect.' 'Parenting without Violence.' 'Building Brains.' Common Approaches.

Save the Children. Global Indicators.

Save the Children. 2014. Child Protection Outcome Indicators.

The Alliance for Child Protection in Humanitarian Action. 2021. Defining and Measuring Child Well-Being in Humanitarian Action: A Contextualization Guide.

The Alliance for Child Protection in Humanitarian Action. 2021. Defining Evidence-Based Practice for Application in Child Protection in Humanitarian Action: A Position Paper.

2.3 Contextualise MHPSS programming

MHPSS programmes and interventions are most successful when they incorporate and build upon communities' existing local knowledge, experiences, and positive, healthy coping mechanisms. In order to maximize engagement and sustainability, programmes and interventions must use local languages, facilities, and structures and be culturally and contextually appropriate. MHPSS programmes must also take note of marginalized or at-risk groups that are normally excluded from community engagement and the contextual issues that perpetuate discrimination.

Adapting resources and approaches is also necessary in contexts such as infectious diseases, conflict, or insecurity. Strategies or adaptations must be implemented that can enable programming to continue, such as remote support, reduced group activities, staggered activities, etc. The COVID-19 pandemic, the Ebola outbreak, Zika, and cholera have led to the development of significant guidance on the different programming modalities which may be required. Examples of these can be found in the sector-specific sections (see Section 3) and in the key resources at the end of each section of the core and thematic guidance.

The process of adapting and contextualizing integrated programmes should rely on assessment findings and input from communities so that programmes and interventions are

underpinned by local understandings and language used to describing well-being, childhood, and mental health. (For more on assessments, see Section 2.2.1.) National staff and volunteers, community leaders, and community champions (including children) all play critical roles in contextualizing programmes.

For more information on adaptations, see Annex 1. Guidance Note: Contextual and Cultural Adaptation of MHPSS Resources in the UNICEF Compendium of Community Based MHPSS Resources.

2.3.1Incorporate conflict sensitivity into MHPSS programmes

Humanitarian or development programmes can positively and negatively impact the context in which they are implemented, including conflict dynamics. Improving context-specific coordination and coherence among peacebuilding, development, and humanitarian action presents opportunities for reducing the risk of violence in the mid- to long-term and contributes to sustaining peace.[52]

Incorporating conflict sensitivity into all stages of integrated MHPSS programmes and interventions aligns with the 'do no harm' principle and promotes local mechanisms for dispute resolution and social cohesion.

The following actions should be followed to ensure the design and implementation of integrated MHPSS programming is child-centred and conflict-sensitive:

- **Identify underlying tensions between stakeholders or groups** that could prevent children from participating or benefiting from the activities.
- **Assess and respond to the vulnerabilities of children** in situations of real or potential conflict.
- **Acknowledge children's primary interest and role** in building peaceful futures.[53]
- **Include a conflict-sensitive lens in assessments.**
    - **Use a child-centred focus** when gathering information about pre-existing conflicts and tensions in the area.
    - **Assess** how conflict affects children's mental health and well-being.
- **Perform a programme-level conflict sensitivity assessment** (whenever possible) to determine how the specific MHPSS project will prevent children's exposure to harm and contribute to restoring or strengthening cohesive and peaceful environments for children, caregivers, and duty-bearers.

[52] UNICEF. 2016. Conflict Sensitivity and Peacebuilding: Programming Guide.

[53] Save the Children International. 2021. Conflict Sensitivity Guider: A practical roadmap to mainstream conflict sensitivity into programming.

2.3.1.1Key conflict sensitivity resources

IOM. 2019. Section 10: Integration of MHPSS in Conflict Transformation and Mediation. Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement: Second edition.

Save the Children. Context Analysis and Foresight Unit. [CAFU One Net page]

Save the Children International. 2021. A Conflict Sensitive Approach to Partnership.

Save the Children International. 2021. Conflict Sensitivity Guider: A practical roadmap to mainstream conflict sensitivity into programming.

2.3.2Support peace outcomes

The MHPSS approach uses recreational, social, ritualistic, artistic, athletic, and educational activities to bring affected individuals and communities together, restore empathy with one another, promote non-violent behaviour, humanize relationships, stimulate imaginative thinking and creative problem-solving, and foster social cohesion.[54]

Conflict mediation: a process of dialogue in which a mutually acceptable third party with no authority to make binding decisions facilitates communication between conflicted parties, helps them build relationships and mutual understanding, and enables them to generate mutually acceptable solutions.

MHPSS workers can collaborate with community leaders to address conflict through inclusively facilitated community-based activities such as traditional healing and reconciliation rituals, funeral and naming ceremonies, interfaith prayers for a common cause, communal sports activities, community theatre, neighbourhood clean-up, tree plantings, and environmental protection activities.[55]

Counselling, psychoeducation, and conflict mediation (conducted by trained individuals) are also important strategies that MHPSS programmes can use to explore conflict sensitivity and peacebuilding with children and adolescents.

MHPSS workers should be equipped with the following knowledge and skills in conflict transformation and mediation:[56]

- **Background information** on the nature and effects of social conflict
- **Awareness** of the principles and methods of conflict transformation, resolution, and management
- **Ability** to facilitate creative problem-solving activities

[54] IOM. 2019. Section 10: Integration of MHPSS in Conflict Transformation and Mediation. Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement: Second edition.
[55] Ibid.
[56] Ibid.

2.3.3Translate materials

- Funds for translation and/ or accessible formats (braille, easy-to-read) should be considered and allocated at the outset of the programme/ during the planning or costing stage and should be part of the initial budget.
- Engage the key necessary stakeholders (academic institutions, government partners, national actors, and experts) in agreeing on appropriate terms, definitions, and concepts (including those around disability) in the language(s) concerned.
- Collaborate with coordination mechanisms/ working groups to ensure maximum buy-in and, if appropriate, shared processes.

2.3.4Key contextualization resources

UNICEF. 2021. Annex 1. UNICEF Compendium of Community Based MHPSS Resources.

2.4 Advocate for integrated MHPSS programming

Save the Children engages in internal and external advocacy to position MHPSS as a core element of all interventions and to improve the quality and scale of MHPSS service delivery. The Save the Children definition of advocacy is:

> "A set of organised activities to influence government and other institutional policies and practices to achieve lasting changes for children's lives based on the experience and knowledge of working directly with children, their families and their communities."[57]

Any advocacy conducted by Save the Children, but particularly MHPSS advocacy, should meet the following criteria:

- Have child rights at its core
- Draw from programme experience and evidence
- Help achieve impact at scale
- Be well-planned and strategic
- Engage children

At country level, it is important to review the advocacy goals and identify opportunities to include MHPSS in sectoral advocacy strategies. It is also essential to ensure a flow of harmonized messages and actions between internal and external advocacy.

[57] The International Save the Children Alliance. 2007. Advocacy Matters: Helping children change their world. An International Save the Children Alliance guide to advocacy. Participant's Manual.

Key Guidance

2.4.1Steps for building an MHPSS-related advocacy strategy

The sections that follow describe the specific steps that should be taken when designing and implementing an MHPSS-related advocacy strategy.

2.4.1.1Identify constituents and allies who can promote MHPSS change

An advocacy strategy should be holistic and should be developed in collaboration with other sectors to promote the mental health and well-being of children across all developmental stages in humanitarian-development-peace contexts. MHPSS service users, organizations of people with disabilities, and people with lived experience (including children, as appropriate) should be engaged to inform advocacy initiatives and advocate for human rights.

Importantly, SC senior management must continue to support advocacy initiatives related to MHPSS and MHPSS mainstreamed interventions across Save the Children's members and regional and country offices. This can include applying an MHPSS lens and focus to sectoral advocacy strategies.

The following questions can help you identify allies who can support your MHPSS advocacy objective(s):

- **Who is concerned and cares** about the issues enough to join in or help the organization? These allies can be:
    - Individuals
    - National-level actors (e.g., members of Parliament or ministers who are committed to the topic, local NGOs, youth groups)
    - Regional organizations (e.g., MHPSS Working Groups, sub-clusters)
    - International/global groups (e.g. the MHPSS Collaborative, international coalitions, the Global Mental Health Action Network, IASC MHPSS Reference Group)
- **What influence do they have** over perspective targets? (For more on targets, see Section 2.4.1.4.)

The MHPSS Technical Working Group (TWG) develops an annual advocacy plan as part of their advocacy mandate. More information and resources can be found by contacting the MHPSS TWG.

2.4.1.2Identify the MHPSS issues and their root causes

Before developing an advocacy strategy, it is important to identify (a) the issues that children, adolescents, and youth face regarding their mental health and psychosocial well-being and (b) the root causes of those issues. This involves analysing the situation. *The analysis should draw on existing materials such as:*

- Analyses of the child rights, national policy (including those related to social welfare services, education, health, foreign affairs, development cooperation, and finance) and the overall context
- Country-specific needs assessments

- Evidence from research, programmes, other sectors, and field experiences
- Child-participatory data (which adheres to the UNICEF Protocol for Safe and Meaningful Participation of Young People Focusing on Mental Well-being)

Some of this information may be easily obtainable from your constituents and allies (see Section 2.4.1.1.).

2.4.1.3Define an advocacy objective

SC advocates for national budgetary, policy, and legislative change that is reinforced by global-level advocacy in collaboration with SC countries and members. An advocacy strategy begins with identifying an *objective*, the specific change we want to bring about.

MHPSS advocacy activities and objectives should reflect:

- The background, key information, messages, and recommendations in Save the Children's internal and external MHPSS policy statements
- Thematic (see Section 4) and sector-based (see Section 3) messages
- Voices and experiences from the field (including from children)
- Research findings
- Programmatic evidence

Developing an MHPSS advocacy objective involves defining:

- A **long-term goal** (e.g., increased scale for MHPSS)
- The **short-term change** or key step(s) that must happen to achieve the advocacy aim for MHPSS (e.g., policy or practice change)
- The **person or group** who needs to act (e.g., the person with power to make change)
- **An indicator** that will help measure progress towards the goal (e.g., X% of children exhibit Y characteristic by Z year) (For more on measuring progress, see Section 2.2.4.)

Funding for MHPSS integration is a key advocacy topic. The Funding Gap for Child and Family Mental Health and Well-being notes that "whilst donors should continue to expand their integration of MHPSS within education funding, it is important to note that without multi-sectoral coordination and take-up of funding in other sectors, many children and families could miss out on access to adequate MHPSS support."[58]

There is also a need to advocate for research into both traditional and innovative approaches to mainstreaming MHPSS. Results should be accessible for different audiences. This can be

[58] The MHPSS Collaborative. The Funding Gap for Child and Family Mental Health and Well-being.

accomplished by working with MHPSS, MEAL, and other-sector colleagues to capture examples and impacts of innovative approaches.

2.4.1.4Identify the target audience

Advocacy plans may target internal actors as well as range of external audiences at multiple levels, including donor governments, national ministries, bilateral and multilateral agencies, international organizations, and CSOs. The target of advocacy plan will be the people or groups who can *make the desired change*. This includes both proponents who support the change and opponents who could hamper the change.

As part of the planning process, a stakeholder mapping should be conducted to identify the advocacy targets:

- **Primary targets:** those who make the decisions and have the power to make the change. It is important to consider the influence we have with them and/or whether we should identify secondary targets who can influence the primary targets.
- **Secondary targets:** those who have the power over the people with the power to make the change.

2.4.1.5Identify advocacy tactics

Different activities can be used to convey different MHPSS messages to different audiences. It is essential to choose tactics that can best influence your specific target and achieve your advocacy objective. Considering the cross-sectoral nature of MHPSS programming and advocacy, your advocacy plan may include using different tactics and messages for different targets (including different ministries). (For additional guidance, see Urging Ministries to Invest in Mental Health: Guide.[59])

Following are some common advocacy activities and the situations in which they may be used:

- **Reports, briefings, guidance, videos, or other publications.** These may include new or existing SCI reports, updates from programme colleagues, needs assessments, etc.
- **Advocacy meetings.** These can be roundtable discussions, technical briefings, webinars, expert meetings, or informal meeting with key contacts or targets.
- **Letters.** These are most effective if they are linked to an upcoming global event or highlight current MHPSS needs, solutions, and recommendations.
- **Site visits.** These are good tools for showcasing SC's work on MHPSS, presenting issues and solutions, increasing reputation and trust, and highlighting the need for prioritization (e.g. investment, better coordination, etc.).
- **Campaign activities:**

[59] The Global Mental Health Action Network. 2021. Urging Ministries to Invest in Mental Health: Guide.

- **Petitions.** Depending on the number of signatories, these can be offered to parliaments, ministers, and other decision-makers. Child participation is encouraged, if ethical and meaningful.
- **Public events.** These include public relations events that aim to mobilize the wider community. These are often linked to a petition.
- **Marches or protests.** Such activities should always include a focus on participant safety, particularly if children are involved.

2.4.1.6Identify required resources

Implementing an advocacy plan requires resources: people, time, funds, etc. Conducting a strengths, weaknesses, opportunities, and threats (SWOT) analysis through an MHPSS lens will help you determine the resources you have as well as gaps that will need to be filled:

Strengths

List the resources (e.g., money, HR, facilities, reputations, commitments) that your organization/ office can dedicate to the plan. Determine which colleagues, external MHPSS partners, or local partners could participate in or consult about an advocacy strategy (e.g., MHPSS, advocacy, thematic technical advisers, MEAL, PDQ Director, community actors, etc.).

Weaknesses

List the organizational weaknesses that could negatively impact your advocacy plan (e.g. lack of staffing, funding, organizational commitment, expertise, etc.). Remember, these weaknesses do not mean you cannot engage in MHPSS advocacy. It simply means you will need to use internal or external means to fill those gaps.

Opportunities

List the external factors that can support the success of your advocacy plan as well as the specific ways in which this plan can strengthen your CO/RO/Members. This could include increased reputation and funding opportunities.

Threats

List external factors related to the plan that have the potential to harm the organization (e.g., lack of understanding of MHPSS in the specific context). Staff well-being (including safety) should always be considered critical when identifying threats. These threats will need to be addressed when deciding if and how to conduct the advocacy.

Key Guidance

2.4.2Key advocacy guidance and resources

2.4.2.1Key guidance

IASC Reference Group. 2011. Advocacy Package: IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.

International Medical Corps. Cross Cutting Component. Advocate, Coordinate and Network. Toolkit for the Integration of Mental Health into General Healthcare.

2.4.2.2Key resources

Amsterdam Ministry of Foreign Affairs. 2019. Declaration: mind the mind now.

Global Mental Health Action Network. Children and youth. [working group website]

Global Mental Health Action Network. 2022. Financing child and adolescent mental health.

IASC. 2020. Joint Interagency Call for Action on MHPSS 2020.

Save the Children. 2018. Picking Up the Pieces: Rebuilding the lives of Mosul's children after years of conflict and violence.

Save the Children. 2019. A Decade of Distress: The harsh and unchanging reality for children living in the Gaza Strip.

Save the Children. 2019. Blast Injuries: The impact of explosive weapons on children in conflict.

Save the Children. 2019. I Wish Tomorrow Will Not Come: Adolescents and the impact of conflict on their experiences: an exploratory study in Iraq, Egypt, Jordan and Yemen.

Save the Children. 2019. Mental Health and Psychosocial Support (MHPSS) Cross-Sectoral Strategic Framework in Humanitarian Settings.

Save the Children. 2019. Road to Recovery: Responding to children's mental health in conflict.

Save the Children. 2019. Supporting Child-Focused Recovery: Helping children heal from conflict (Discussion Paper).

Save the Children. 2020. Defenceless: The impact of the Israeli military detention system on Palestinian Children.

Save the Children. 2020. Five Years of Fear and Loss: The devastating impact of war on the mental health of Yemen's children.

Save the Children. 2020. Psychosocial Safety: Pathways to psychosocial safety for Syria's displaced children and adolescents: policy brief.

Save the Children. 2021. Anywhere But Syria: How 10 years of conflict left Syria's displaced children without a sense of home.

Key Guidance

Save the Children. 2021. Mental Health and Psychosocial Support (MHPSS) for Children, Adolescents and their Families: Policy Statement, September 2021.

Save the Children. 2021. Weapon of War: Sexual violence against children in conflict.

The MHPSS Collaborative. 2021. Follow the money: Global funding of child and family MHPSS activities in development and humanitarian assistance, Copenhagen.

Save the Children and the MHPSS Collaborative. 2019. Desk Study: Official development assistance to child and family focused Mental Health and Psychosocial Support (MHPSS).

Save the Children and the MHPSS Collaborative. 2020. Copenhagen 2020 Action Plan for Child, Youth and Family MHPSS Outcomes of Save the Children Denmark's 75th Anniversary Conference.

The Alliance for Child Protection in Humanitarian Action. 2022. Advocacy Working Group Strategy: 2021–2025.

The Global Mental Health Action Network. 2021. Urging Ministries to Invest in Mental Health: Guide.

United for Global Mental Health. 2021-2024 Strategy.

WHO. 2021. Comprehensive Mental Health Action Plan 2013–2030.

2.5 Work with others to integrate MHPSS

External partnerships and collaborations help ensure that integrated MHPSS programmes adequately address the identified needs, are culturally and contextually appropriate, and build on community knowledge. The steps below can help you identify the partnerships and collaborations that will best support your programming:

1. **Consider what type of supports** needs to be put in place to increase capacity of the Partner and SC Team.
2. **Assess existing partnerships** to identify those who can provide MHPSS expertise and help fill other capacity gaps.
3. **Clearly define expectations** for each partner, including Save the Children.

The following sections describe the different individuals and groups that may be able to collaborate on integrated MHPSS programming.

2.5.1Partners

There are different ways to work with partner organizations. Partners can be (a) direct implementers or (b) part of a mixed approach where Save the Children staff work directly with communities alongside partner organizations, government entities, and other structures. Regardless of the approach, partners must be actively and equitably engaged in programming. Principles of equality and transparency must always be at the core of partner relations.

Key Guidance

Save the Children must have the capacity and competencies to support partner organizations to carry out project activities in a way that maximises their expertise, supports new directions and responses in project activities, and enables trust between both organizations.

Regional and country offices can take the following actions to facilitate and support partners in strengthening their focus on MHPSS:

- **Use mapping activities and coordination structures** to identify organizations with MHPSS capacity and interest. On-going 4Ws and initial scoping and mapping exercises can identify potential partners, including organizations of persons with disabilities.
- **Work with partners to:**
    - **Jointly assess** their strengths, areas that need support, and types of capacity building that are helpful.
    - **Develop tailored action plans** for capacity building.
    - **Develop proposals** that reflect significant input from partners, including the cost of human resources.
- **Ensure partners have an allocated budget line** to train SC staff on their area of expertise.
- **Establish how capacity will be supported.** To avoid duplication, make use of multi-organization capacity needs assessments and training that arise from interagency initiatives, coordination platforms, and cluster or working groups.
- **Ensure referral pathways are in place**, including inter-agency case management between partners and Save the Children.

2.5.1.1Key partnership resources

Save the Children. Competency Framework.

Save the Children. Individual capacity assessment tool.

Save the Children. Organizational capacity assessment tool.

Save the Children. 2013. Save the Children Partnership Engagement Guide.

2.5.2Other sectors

One of the main goals of integrated programming is to establish or strengthen a collaboration framework on MHPSS with other sectors. The following actions can support unified, multi-sectoral MHPSS collaboration:

- **Identify entry points** for integrated MHPSS programming based on the centrality of the child and the social ecological framework.

Key Guidance

- **Develop a common coordination framework and approach** to MHPSS (including language and definitions) that will be used across sectors.
- **Identify the benefits** to sectors and other stakeholders of working together on MHPSS programming.

2.5.3Community actors and community-level interventions

The 'localization' model is supported by international standards and guidance.

Core Humanitarian Standard[60]

- Commitment #4: "Communities and people affected by crisis know their rights and entitlements, have access to information and participate in decisions that affect them."
- Quality Criterion: "Humanitarian response is based on communication, participation, and feedback."

Minimum Standards for Child Protection in Humanitarian Action[61]

- Principle 3: Children's participation
- Principle 4: The best interests of the child
- Principle 5: Enhance people's safety, dignity and rights and avoid exposing them to further harm

Community mobilization and ownership are critical for successful MHPSS integration. As shown in the Socio-ecological Framework (see Section 1.4.3.), children do not function in isolation but need to be understood within their context. Children, caregivers, and community members must be included in all stages of the
programme cycle to ensure delivery of contextually and culturally appropriate support.

Before implementing any MHPSS intervention, it is essential to map (a) existing community-led approaches, capacities, skills, knowledge, resources, and structures and (b) barriers to mobilization of all children.

Figure 8
The Community Participatory Evaluation Tool (CPET)[62] is a rapid participatory tool that can be used to

[60] CHS Alliance, Group URD, and the Sphere Project. 2014. Core Humanitarian Standard on Quality and Accountability.

[61] The Alliance for Child Protection in Humanitarian Action. 2020. Minimum Standards for Child Protection in Humanitarian Action: 2019 Edition.

[62] Bragin, Martha. 2005. The Community Participatory Evaluation Tool for psychosocial programs: a guide to implementation. Intervention, 3(1), 3–24.

Key Guidance

Communities and families have existing formal and informal child protection systems in place that support children and caregivers. There is a risk of undermining local ways of coping if MHPSS interventions do not take them into account, build on them, and incorporate them into programming. (Figure 8 describes the CPET, a tool that can be used to support community members' engagement in programme design, implementation, and evaluation.)

It is also important to take note of and include persons with disabilities and other vulnerabilities who are often excluded when communities engage with external actors. If children, adolescents, and adults that are most impacted by discrimination and inequality are included in all steps of the programme cycle, there is less risk of participants being stigmatized for their participation and a greater likelihood of long-term sustainability. (For more on disability and inclusion, see Section 4.5.) Figure 9 provides a list of resources on community-led interventions that specifically address discrimination, stigma, and human rights abuses.

develop indicators of children's psychosocial well-being as part of a plan to support community-level MHPSS activities in accordance with local beliefs and practices.

The CPET provides guiding questions for gender-separate interviews and focus group discussions with traditional and religious elders; teachers; birth attendants; mothers, fathers, and other caregivers; and children and adolescents to elicit community concepts on optimal child development and the coping mechanisms that families use to enable children and adolescents to grow up well in 'normal' times.

The tool can then be used to measure progress toward:

- The restoration of positive coping mechanisms
- The identification and elimination of negative ones
- The degree to which children and adolescents are able to meet developmental milestones over time

A users guide is also available on MHPSS.net.

Figure 9	Community-led Initiative	Purpose	Resource
	Conduct awareness sessions	Highlights opportunities that exist within communities to promote mental health, prevent mental health conditions, and expand access to mental health services	mhGAP Community Toolkit: field test version; Part 2, Module 1.1: How to talk about mental health in your community[63]
	Provide appropriate services	Provides guidance for CSOs and NGOs on engaging the local community to identify local mental health needs and match them with	mhGAP Community Toolkit: field test version; Part 1, Planning mental health services in your community[64]

[63] WHO. 2019. mhGAP Community Toolkit: Field test version.

[64] Ibid.

	activities that build on available resources and opportunities	
Deliver non-discriminative, human rights-based interventions	Provides practical tips on delivering non-discriminative and human rights-based mental health activities, programmes, and interventions in the community	Mental health, disability, and human rights. WHO Quality Rights core training – for all services and all people; Topic 1: Understanding discrimination and denial of rights[65]
Address the stigma of mental health conditions	Provides guidance for combatting stigma, discrimination, social exclusion, and human rights abuses that affect people with mental health conditions	mhGAP Community Toolkit: field test version; Part 2, Module 1: How to talk about mental health[66]

2.5.3.1Existing community structures

Existing community platforms and structures provide important opportunities for MHPSS promotion, prevention, interventions, and activities. Health settings; schools; and neighbourhood, community, social, and work groups can all be used to mobilise communities around MHPSS and to deliver MHPSS services. The benefits of using community structures to provide mental health services include:

- **Reducing the stigma, discrimination, and social exclusion** faced by people with mental health conditions and psychosocial disabilities
- **Providing the full spectrum of accessible and convenient MHPSS services** (awareness, promotion, prevention, and service provision)
- **Providing accessible entry points and referral pathways** (where available) to primary care and other health-care services

2.5.3.2Involving men and boys

It is very important to include men (including young adolescent males and boys, young fathers, and older men) in MHPSS programming. Some men struggle to access mental health support or express the need for support because of cultural expectations or a lack of suitable services. Working with men requires an understanding of and engagement with gender roles, cultural norms, and gender programming for men and women.

MHPSS programming can support discussions of sex and gender roles, emotional regulation, violence and domestic violence, and healthy role models. Further guidance can be found in the Bel Salameh

[65] WHO. 2019. Mental health, disability, and human rights. WHO Quality Rights core training – for all services and all people. Course guide.

[66] WHO. 2019. mhGAP Community Toolkit: Field test version.

Psychosocial Support Manual,[67] which suggests topics to explore with men and the capacities needed to facilitate MHPSS programmes with men and young men.

2.5.3.3Involving children

Children know what they need to feel well and how to identify the barriers they face. They can participate in MHPSS programming in many ways, and strategies should be employed that meet their age, stage of development, disability, and risks. The process of participation fosters a sense of agency and contributes to children's well-being and feelings of control. It is important to encourage ethical participation that does not contribute to or reinforce existing challenges faced by children in vulnerable situations, marginalized populations, and/ or children with disabilities.

Lack of opportunities to participate in issues that affect them constitutes a denial of children's rights and is a risk factor in terms of protection, well-being, and healthy development.

Children must be able to participate at all levels of the MHPSS pyramid (see Figure 10) and in all stages of the programme cycle (see 'Community engagement and participation' in Community-Based Mental Health and Psychosocial Support in Humanitarian Settings.[68])

Some exercises to support children's engagement in **assessments** and situational analyses include:

- **Risk and body mapping:** Children identify what it means to feel safe, how their environment contributes to their health and safety, and what can be changed or improved. (For guidance on conducting the mappings, see the Child and Youth Resilience Measure.)[69]
- **Problem tree:** Children identify problems and the impacts they have on their lives. (For guidance on creating problem trees, see The ARC resource pack[70] or A Kit of Tools.[71]

As part of the **planning** process, children, adolescents, caregivers, and community members should be encouraged to identify and elaborate on plans to enhance their on-going participation, agency, and self-help capacity.

Children are both stakeholders and 'experts' in how the project worked, how it could be improved, and any challenges which need to be addressed. Tools that can support children's engagement in

[67] ABAAD, European Union. 2017. The Psychosocial Support Manual. The MHPSS Training Pack.

[68] United Nations Children's Fund. 2018. Operational guidelines on community based mental health and psychosocial support in humanitarian settings: Three-tiered support for children and families (field test version).

[69] Refer to: Resilience Research Centre. 2018. CYRM and ARM user manual.

[70] Action for the Rights of the Child. 2009. Section 5, Exercise 5. Foundation module 4: Participation and inclusion. ARC resource pack: Study Material.

[71] Save the Children Norway. 2008. A Kit of Tools for Participatory Research and Evaluation with Children, Young People and Adults: A compilation of tools used during a Thematic Evaluation and Documentation on Children's Participation in Armed Conflict, Post Conflict and Peace Building, 2006–2008.

evaluating the strengths and weaknesses of an intervention include 'H Assessment' and 'Stories of Most Significant Change.'[72]

Figure 10 MHPSS Layers	Examples of children's participation
Layer 1 **Layer 2** **Layer 3**	• **Child/ youth groups** with formal links for participation and representation in community-based protection or community development mechanisms to improve health/ other outcomes • **School councils** with opportunities to influence school governance and more psychosocially supportive school environments • **Accessible and safe online and offline platforms** for children and adolescents to influence national, regional, or global policies and practices which affect them.
Layer 4 (Can be facilitated by mental health specialists with individual children)	• **Goal setting activities** to plan engagement and identify steps to achieve • **Individual support** to explore healthy relationships and supports children can draw on as they receive specialist support

2.5.3.4Key community engagement resources

Save the Children. Accountability to Children and Communities Toolkit.

Save the Children. Localisation Collection. https://resourcecentre.savethechildren.net/collection/localisation/

Save the Children. 2020. Feedback and Reporting Mechanism Guidance.

Save the Children. 2020. Information Sharing and Communication with Children and Communities.

Save the Children and War Child. Community Level Child Protection: Participatory facilitation using creative methods to strengthen community engagement and ownership – Resource Pack. Literature review.

Save the Children Norway. 2008. A Kit of Tools for Participatory Research and Evaluation with Children, Young People and Adults: A compilation of tools used during a Thematic Evaluation and Documentation on Children's Participation in Armed Conflict, Post Conflict and Peace Building, 2006–2008.

UNICEF. 2020. Engaged and Heard! Guidelines on Adolescent Participation and Civic Engagement.

UNICEF. 2020. Minimum quality standards and indicators in community engagement.

UNICEF. 2021. UNICEF Compendium of Community Based MHPSS Resources.

[72] Save the Children Norway. 2008. A Kit of Tools for Participatory Research and Evaluation with Children, Young People and Adults: A compilation of tools used during a Thematic Evaluation and Documentation on Children's Participation in Armed Conflict, Post Conflict and Peace Building, 2006–2008.

2.5.4Coordination mechanisms

2.5.4.1The role of coordination in MHPSS

MHPSS coordination is essential to providing high-quality support to affected populations. Creating and maintaining links between different sectors is an essential role of the MHPSS coordination mechanism. The principal platform for MHPSS coordination at country level are the Technical Working Groups (see Figure 10). Ideally, the various platforms should merge into a common, intersectoral platform that focuses on analysis, capacity building, mainstreaming, and integration. Effective MHPSS coordination ensures that:

- All MHPSS actors can collaborate and come together
- Gaps are covered in an MHPSS response
- There is accountability for affected populations
- Best practice is followed in MHPSS programming
- The response is more sustainable
- Non-MHPSS actors are sensitized to MHPSS

Intersectoral coordination can also help avoid the division that sometimes occurs between ‘mental health’ and ‘psychosocial support’ and can support agreement on shared and coordinated activities.

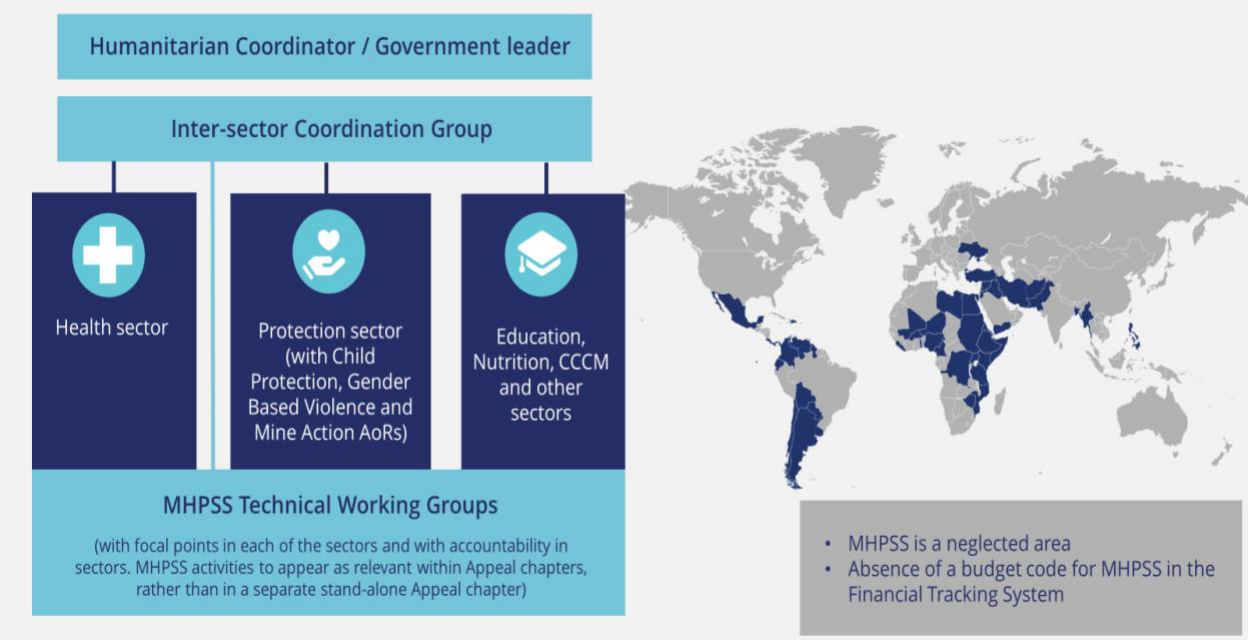


Figure 10. MHPSS coordination at country level in the humanitarian cluster system[73]

2.5.4.2Global commitments to MHPSS coordination

Recent years have shown increased global commitments to MHPSS coordination. For example, a 2019 UN General Assembly report[74] asked for continued emphasis on coordination and dialogue at global and field levels to respond to the increasing needs experienced by communities in humanitarian crises. The report particularly highlighted the importance of:

- Supporting initiatives that address the mental health and psychosocial needs of communities
- Identifying and integrating innovative approaches
- Sharing best practice to promote effective cooperation

In 2020, a Joint Interagency Call for Action on MHPSS[75] (a) designated MHPSS as a cross-cutting issue that has relevance for health, protection, education, nutrition, and all clusters in emergency contexts and (b) supported the creation and work of country-level MHPSS Working Groups in all migration, refugee, and humanitarian contexts. The following mechanisms seek to meet the call for enhanced global MHPSS coordination:

- Dutch Surge Support (DSS) MHPSS 2021
- MHPSS.net
- IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings

2.5.4.3Save the Children's role in MHPSS coordination

Save the Children's MHPSS and Localization Strategies affirm the organization's commitment to engaging in coordination mechanisms at local, country, and global levels. By actively participating in coordination mechanisms, SC helps ensure that:

- Children's voices are heard and elevated
- Children are actively considered in efforts to communicate with families and communities
- Coordination platforms share findings specifically relating to children and caregivers
- Local stakeholders lead, participate in, and engage with coordination platforms and mechanisms
- Tools and policies are developed to support local stakeholders' participation in coordination

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[73] Reproduced from Harrison, S., et al. 2020. MHPSS and protection outcomes: Why joint action to improve mental health and psychosocial wellbeing of people affected by conflict, violence and disasters should be a priority for all protection actors. Policy Discussion Paper – September 2020. Global Protection Cluster and IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings.

[74] UN Secretary-General. 2019. Strengthening of the coordination of emergency humanitarian assistance of the United Nations: report of the Secretary-General.

[75] IASC. 2020. Joint Interagency Call for Action on MHPSS 2020.

Save the Children further engages in coordination in the following ways:

- Co-chairing and actively participating in the IASC MHPSS Reference Group[76] and its working groups
- Leading the Education Cluster together with UNICEF, which can help strengthen the MHPSS agenda at country and structural level
- Seconding an MHPSS coordination specialist to the global Child Protection Area of Responsibility
- Holding a leadership position for the Inter-agency Network for Education in Emergencies (INEE) as co-lead of the PSS-SEL working group, which influences priorities for integrating MHPSS into EiE
- Co-leading or engaging in country-level Education, Child Protection, Nutrition, and/or Health clusters, working groups, or other coordination groups

2.5.4.4Actions to strengthen MHPSS coordination

Despite the importance of MHPSS coordination, there may be challenges that limit individuals' or organizations' participation in such mechanisms. Challenges to participating in MHPSS coordination can include:

- Lack of established MHPSS coordination mechanisms and for a in non-humanitarian contexts
- Lack of funding to contribute to shared initiatives
- Lack of time to participate in coordination mechanisms
- Lack of attendance by decision-makers
- Perceived lack of relevance of the coordination structure
- Ownership of MHPSS by other sectors (e.g., health or child protection), leaving no place for MHPSS-specific coordination
- Specific barriers to local actors' participation, such as language issues, mandate incompatibility, or 'over shadowing' by international organizations
- Lack of funding for the co-chair position

Save the Children partners and staff can take the following actions to overcome these challenges and participate in and strengthen MHPSS coordination:

[76] IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings. interagencystandingcommittee.org

Key Guidance

- Establish connections and relationships with other sectors, including attending other cluster meetings to share information on MHPSS.
- Establish an MHPSS coordination mechanism (where one does not already exist) with other interested organizations, such as a community of practice or a sub-group of an existing relevant mechanism (government structure, academic forum, etc.).
- Invite other cluster leads to MHPSS coordination meetings on a regular basis to explore opportunities for collaboration and to encourage the implementation of focal points.
- Ensure assessments are multi-sectoral and include MHPSS issues.
- Establish multi-sectoral trainings.
- Encourage COs with capacity to take lead or co-lead roles in inter-agency MHPSS platforms.
- Encourage COs to strengthen participation and representation in such platforms.
- Create opportunities for joint activities, including advocacy and messaging.
- Ensure other sectors and clusters are aware of the existence of the MHPSS coordination group and be prepared to support and provide guidance on MHPSS programming and best practice.
- Inform donors of the benefits of mainstreaming MHPSS programming and coordination.
- Ensure national actors are engaged and aware.
- Ensure all decisions align with national polices.

In SC programmes where there is no MHPSS TA or MHPSS-specific staff member, the following actions can be taken:

- Ensure a representative from child protection, education, or another sector participates in MHPSS coordination structures whenever possible and attend inter-sectoral cluster meetings so that:
    - MHPSS messages can be disseminated
    - SC personnel can learn about and contribute to discussions, policy decisions, and inter-agency initiatives
- Consider creating an MHPSS subgroup under another working group structure.
- Engage in global or regional initiatives (see Section 2.5.4.2.) and SC MHPSS coordination structures.

Where capacity exists, SC should strongly consider taking on a leadership/ co-lead role in MHPSS coordination and programming.

Key Guidance

2.5.4.5Key coordination resources

Harrison, Sarah, et al. 2020. MHPSS and protection outcomes: Why joint action to improve mental health and psychosocial wellbeing of people affected by conflict, violence and disasters should be a priority for all protection actors. Policy Discussion Paper – September 2020. Global Protection Cluster.

Harrison, Sarah, et al. 2021. Engagement of protection actors in MHPSS: the need for cross-sectoral cooperation. Forced Migration Review.

IASC. 2010. Mental Health and Psychosocial Support in Emergency Settings: What should Protection Programme Managers Know?

IASC. 2011. Mental Health and Psychosocial Support in Emergency Settings: What should Humanitarian Health Actors know?

IASC. 2020. Joint Interagency Call for Action on MHPSS 2020.

IASC Reference Group. MHPSS Coordination Handbook. [under development at time of printing]

2.5.5Referral pathways

Functional, cross-sectoral referral pathways and mechanisms ensure that children and caregivers have access to a continuum of care up and down the MHPSS pyramid. The following steps will help ensure that children can receive the support they need when they need it:

- **Assess informal and community systems** that provide different levels of support across different sectors and at all levels of the MHPSS pyramid and socio-ecological framework.
- **Develop service maps** for MHPSS to support referral system.
- **Ensure functional cross-sector referral mechanisms and case management** are in place to provide support at all levels of the MHPSS pyramid and socio-ecological framework, including specialist support where available.
- **Ensure all programme staff have access to the referral pathways** and are aware of when and how to refer.
- **Develop and implement** an accessible, child-friendly communication plan on referral pathways.

2.5.5.1Key referral resources

Inter-agency Training on Safe Identification and Referral. (Under development at time of printing)

The Alliance for Child Protection in Humanitarian Action. 2019. Inter-agency Child Protection Case Management Standard Operating Procedures.

Save the Children. 'Section 4.8: SOPs.' 'Section 4.9: Service Mapping and Referral Pathways.' Steps to Protect Common Approach.

See section on SRMP.

2.5.6Key collaboration resources

Capacity assessment of individuals and groups (SC MENA)

2.6 Secure resources for integrated MHPSS programming

Maximizing the reach, implementation, and sustainability of quality MHPSS programming requires funding, funding that is assured for the timescale of the programme and that enables assessments and on-going MEAL initiatives to take place.

Resource mobilization and advocacy responsibilities must be defined and agreed upon by all programme partners. This includes identifying joint and sector-specific resource sources and advocating for and securing funding for integrated and MHPSS-specific programmes.

The following line items should be included in MHPSS budgets:

- **MHPSS expertise,** ideally a country MHPSS advisor or MHPSS specialist function. This should be funded from budgets across various sectors.
- **Technical supervision** of MHPSS staff. It is important to consider who and how technical supervision can be provided and budget this into programming.
- **On-going capacity building** for staff and partners, including inter-agency initiatives.
- **Staff well-being and support,** including specialist support if necessary.
- **All aspects of programme development/ adaptation, implementation and evaluation** (see Section 2.7.1. and the MHPSS Minimum Services Package.[77]
- **Advocacy,** including development and implementation of advocacy messages (e.g., educating funders on the importance of MHPSS) and contextual analyses (as needed).

2.7 Develop a team that can integrate MHPSS

Each SC programme will be governed by the allocated funds, the available MHPSS capacity, and other constraints. Where resources are limited, the human resource emphasis should be on community led MHPSS rather than the top layers of the

[77] The Mental Health and Psychosocial Support Minimum Services Package: For an effective MHPSS emergency response. DRAFT. www.mhpssmsp.org

Key Guidance

intervention pyramid in accordance with SC's institutional MHPSS approach.

The success of integrating inclusive MHPSS across all sector programmes and services is dependent on the Save the Children leadership, staff, and partners. Integration requires a team approach with diverse skills, including sector-specific technical knowledge, awareness of MHPSS approaches, and support from programme quality directors and other senior management team members. Each team member must be aware of their role and responsibilities. How the team plans the intervention and collaborates is critical to developing, implementing, and evaluating, not only the programme outcomes, but also how they worked as a team and which processes contributed to successful MHPSS mainstreaming.

2.7.1Identify key roles and responsibilities

Save the Children's MHPSS Strategic Framework identifies the roles and responsibilities needed to deliver quality, multi-layered, cross-sectoral MHPSS programming. Clearly defined roles and responsibilities support the identification of capacity-building needs and strategies and helps ensure all those involved are supported (see Section 2.8.).

Figure 12 presents sample roles and responsibilities that should be considered when staffing integrated MHPSS programmes. This exact structure may not be appropriate for all Country or Regional Offices. For example, some contexts may not have a dedicated, cross-sectorial MHPSS TA. However, MHPSS roles and responsibilities can be allocated to other technical experts (TEs) in line with agreed-upon integrated MHPSS plans. (More detailed job descriptions for the sample roles and responsibilities related to MHPSS can be accessed HERE.)

The following actions will help ensure that integrated MHPSS programme is properly staffed and coordinated:

- **Coordinate across sectors to define roles and responsibilities for MHPSS components/ programmes** in all aspects of the programme cycle (including implementation, resource mobilization, and MEAL) with reference to SC job descriptions and competencies.
- **Agree on the way sectoral actors will implement** defined components of MHPSS activities.
- **Document roles and responsibilities** and share with partners in all relevant sectors.
- **Establish information-sharing agreements** for data that is useful to sectors and partners.
- **Ensure that all SC MHPSS staff and all sector staff engaged in MHPSS programming** liaise with the global-level MHPSS TA.

Key Guidance

Figure 12 Sample MHPSS Roles	Sample MHPSS Responsibilities[78]
RO MHPSS TA	Links global and regional levels. Responsible for technical support, resource development/ contextualization. Role supports regional advocacy and influencing, facilitates cross-country learning and capacity building.
CO MHPSS TA	Responsible for technical support, resource development/ contextualization in country. Strong delivery of MHPSS across sectors and themes, supports national advocacy and influencing. External representation on priority MHPSS issues.
CO MHPSS Specialist	Receives technical support from MHPSS TA. Responsible for training and technical support to child protection, health, nutrition, etc. and collaborates with them to provide evidence-based content for integrated MHPSS programming. Supports the delivery of community led MHPSS promotion and prevention activities. Responsible for structured training activities, including groups and person focused. May operate as TA, depending on context.
MHPSS Officer/ MHPSS practitioner	Supports the mainstreaming of MHPSS in line with regional and global standards. The role encompasses direct implementation alongside capacity building and coaching and supervision of staff, including multi-sectoral staff. Under the supervision of the MHPSS TA.
Psychologist*	Provides evidenced-based, person-centred MHPSS support. Support provided to young people and caregivers identified through project activities and cross-sectoral referrals. Responsible for referral to specialist support and follow up.
MHPSS supervisor	Relevant in contexts where there are large person-focused portfolios, such as case work.
MHPSS volunteer	Volunteers may play a pivotal role in MHPSS implementation under the supervision of MHPSS officers/ practitioners. May facilitate activities in child- or women-friendly spaces, community-based child protection committees, and community outreach. Volunteers should receive on-going training and mentoring, a stipend for their time, and in-kind support, depending on the context.

**SC does not advocate for prioritising the recruitment of psychologists. In some contexts, the recruitment of psychologists could undermine national MHPSS initiatives and have a negative impact on the capacity and sustainability of national MHPSS programmes. SC contexts where this is the case should focus on strengthening the capacity of staff and partners, investing in comprehensive supervision and mentoring, and referral.*

[78] Save the Children. 2019. MHPSS cross sectorial Strategic Framework.

Key Guidance

2.7.1.1Key staffing resources

Save the Children. Generic Competency Framework.

disasterready.org. Promoting Children's Development and Wellbeing. https://get.disasterready.org/promoting-childrens-development-wellbeing/%20 [online open-source training]

2.7.2Support staff well-being

Save the Children believes support staff well-being should come within internal structure and considered for all staff. To that end, **all Save the Children staff and volunteers**, especially those engaged in MHPSS, must be able to access staff well-being initiatives that support self-care strategies. Supporting staff well-being helps ensure staff:

- Recognize and respect their personal limits and needs
- Have strategies for self-care in place
- Can identify and seek specialized and non-specialized personal support when needed
- Are working according to their capacities and strengths
- Respond compassionately to children and families who are struggling
- Do not burn out!

If possible, it is preferable to provide external support for self-care and staff support. This can be in the form of individual support. All staff should be able to access this support without having to request it from their line manager. This encourages staff members to communicate freely and be able to benefit from impartial, neutral support.

To help operationalize staff support in CO and programme operational practices, Save the Children created the Global Accountability Report 2019: Delivering more for children by supporting staff health and wellbeing. Human resources, managers, and staff are supported to implement workplace well-being practices, manage individual and team stress, create opportunities for staff to relax, and care for themselves and their peers.

2.7.2.1Key staff care resources

Save the Children. Mental Health Champions Resource Hub.

Save the Children. 'Staff care.' Steps to Protect Training.

Save the Children. 2015. Stress Management for Staff: One-day training programme.

The Alliance for Child Protection in Humanitarian Action. 2018. Case Management Supervision and Coaching Package. Chapter 4: Staff Care and Wellbeing.

2.8 Strengthen staff's essential skills for integrated MHPSS

2.8.1Competencies and capacity strengthening

The Save the Children Competency Framework outlines the *core competencies* needed for all sector staff, including MHPSS. The *sector-specific competencies* necessary for integrating MHPSS can be found in Section 3 of this document. Other Save the Children frameworks, such as the Disability Technical Competency Framework, outline *additional competencies* that MHPSS staff should have.

All staff in all sectors need support to 'grow' into the required competencies. On-going capacity strengthening and supervision will enable staff to effectively work in MHPSS. As more MHPSS interventions are informed by evidence and research and more attention is paid to MHPSS, staff and partners must have opportunities to:

- Learn
- Adapt
- Consolidate experiences
- Reflect on best practice and what is working well

The changing context of the programme and the roles of the specific staff members or community volunteers will dictate what training and capacity-strengthening activities are required to ensure staff can appropriately respond to the needs of the community and do no harm.

A capacity-strengthening plan should be developed and implemented that responds to the capacity needs identified in the assessment (see Section 2.2.1.) and planning (see Section 2.2.2.) stages. See Figure 13 for a list of key competencies required by specific actors and activities/ resources that can be used to develop and enhance staff knowledge and skills in those areas.

Figure 13	Menu of Competency-strengthening Activities
1.	**Recognize and respond appropriately to signs of distress in oneself and others** *(MHPSS staff, other relevant sectoral staff, partners)*
	• Train all personnel in MHPSS competencies (e.g., safeguarding, PFA for Child Practitioners, Basic Helping Skills, referral pathways, active listening, communicating with children): ▪ Online and in-person workshops ▪ Promoting Children's Development and Wellbeing[79] ▪ Save the Children Psychological First Aid Training Manual for Child Practitioners[80]
2.	**Practice self-care to ensure staff work compassionately and according to their capacities and strengths**

[79] disasterready.org. Promoting Children's Development and Wellbeing. https://get.disasterready.org/promoting-childrens-development-wellbeing/%20 [online open-source training]

[80] Save the Children Denmark. 2013. Save the Children Psychological First Aid Training Manual for Child Practitioners.

(All)

Build staff well-being into CO and programme operational practices:

- Familiarize staff with Save the Children's commitment to staff well-being
- Ensure staff have self-care strategies in place
- Ensure staff can access personal specialized and unspecialized support when needed

3. **Maximize the potential of MHPSS integration**
(MHPSS staff)

Train staff to:

- Reflect MHPSS in country strategic planning processes:
  - Child Rights Situational Analysis
  - Country strategic planning processes
- Plan and design an inclusive, contextualized programmatic response that is based on assessment findings and features a clear theory of change, measurable goals and indicators, and participatory evaluation processes

4. **Reflect MHPSS in multi-sectoral assessments**
(MHPSS staff)

Train staff to:

- Coordinate common MHPSS assessment questions and terminology across sectors and actors:
  - SCI 5 MHPSS assessment questions for multi-sector humanitarian assessments
- Utilize global standardized assessment tools:
  - IASC MHPSS Assessment Guide[81]
  - WHO/ UNHCR MHPSS assessment toolkit[82]
- Follow child/ community participation guidelines.
- Liaise with others (including coordination groups) to know what is implemented by other sectors and what MHPSS entry points and/or programming gaps exist:
  - IASC 4Ws in MHPSS[83]

5. **Establish or strengthen a collaboration framework on MHPSS with other sectors**
(MHPSS staff, other relevant sectoral staff)

Train staff to:

- Identify and communicate the benefits of working together on MHPSS programming to diverse stakeholders, including children
- Facilitate agreement on common language, definitions, and approaches to be used by all sectors
- Select entry points with respect to the centrality of the child and the social ecological framework

6. **Determine external partnerships and collaborations**
(PDQ, MHPSS TA, other relevant sectoral staff)

[81] IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings. 2012. IASC Reference Group Mental Health and Psychosocial Support Assessment Guide.

[82] WHO and UNHCR. 2012. Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for humanitarian settings.

[83] IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings. 2012. Who is Where, When, doing What (4Ws) in Mental Health and Psychosocial Support: Manual with Activity Codes (field test-version).

Train staff to:

- Assess existing and potential partnerships to identify MHPSS expertise and collaboration potential:
  - Capacity assessment of individuals and groups
  - Supports that are needed to increase capacity
- Clearly define roles and responsibilities for all actors across sectors and in all aspects of implementation, resource mobilization, and MEAL
  - Align with SC job descriptions and competencies
  - Agree how sectors will implement defined components of MHPSS activities
  - Document roles and responsibilities and share with partners in all relevant sectors
  - Establish information-sharing agreements for data that is useful to sectors and partners
  - Develop a capacity-strengthening plan that addresses the needs of all actors
- Collaborate with community partners

2.8.1.1Key MHPSS competency resources

Save the Children.disasterready.org. Promoting Children's Development and Wellbeing.

IASC. 2007. IASC Guidelines on Mental Health and Psychological Support in Emergency Settings.

MHPSS.net

Save the Children. 2021. A catalogue of key resources. Adolescent Wellbeing Framework – A critical opportunity to fulfil human rights and drive change.

Save the Children Denmark. 2013. Save the Children Psychological First Aid Training Manual for Child Practitioners.

UNICEF. 2021. UNICEF Compendium of Community Based MHPSS Resources.

Save the Children. MHPSS Adolescent Programming in the Middle East and North Africa Region, Desk Review. Available on demand. (Contact MHPSS TWG)

2.8.2Psychological First Aid (PFA)

The principles of Psychological First Aid (PFA) are foundational to all integrated, cross-sectoral MHPSS support for communities. PFA is based on a *Look, Listen, Link* model. Through clear, supportive responses, it supports psychosocial well-being and immediate support of adults and children in crisis by helping them to:

- Feel safe, connected, calm, and hopeful
- Understand stress, distress, loss, and grief
- Access social, practical, physical, and emotional support
- Safely help themselves and their communities

All Save the Children staff and partners should be trained in PFA for child practitioners.

PFA can be provided by anyone and is a psychosocial approach that is flexible to the needs of the person being helped. This flexibility means that an individual may only require a brief, supportive interaction to help them feel calm and to provide information on specific services, while another person may need further support and links to more extensive, focused support.[84] PFA has been designed to be provided at each layer of the pyramid of intervention. Although considered part of focused interventions, **PFA is not a therapeutic tool** and is not considered a Level 3 intervention. There are different PFA packages, including PFA for child practitioners,[85] peer-to-peer PFA I support my friend,[86] PFA in infectious disease contexts,[87] and PFA II Dealing with traumatic Response.

2.8.3Suicide risk management and self-harm

Suicidal ideation, behaviour, attempts do not occur in isolation. They are often, but not always, associated with a mental health condition, such as depression, psychosis, or substance abuse. In adolescents, suicidal behaviour can often be associated with drug use and impulsivity.

SC staff can be among the first to identify the warning signs and reduce the risk of suicide by intervening when a child is in a state of crisis.

SC has developed suicide risk management protocols that align with the SC MHPSS Cross-sectoral Strategic Framework and the Steps to Protect Common Approach and are inspired by Caring for Child Survivors of Sexual Abuse[88] and the WHO Mental Health Gap Action Programme.[89]

2.8.3.1The SC Suicide Risk Management Protocols (SRMP) package[90]

The SRMP package is designed to develop a suicide-safe approach. **It is not a guide to implement therapy or therapeutic support to a suicidal patient.** The SRMP consists of three sections:

1. **Country Office Internal Implementation Checklist** supports country offices in assessing internal systems and readiness for package implementation. The implementation checklist is designed to check the SRMP against country-level strategic priorities and capacity. Steps must be validated by the senior management team (SMT) to ensure their involvement and

84 Snider, L. 2017. Psychological First Aid: Five Year Retrospective (2011-2016). Church of Sweden.

85 Save the Children Denmark. 2013. Save the Children Psychological First Aid Training Manual for Child Practitioners.

86 Save the Children, The MHPSS Collaborative, UNICEF, WHO. 2021. I Support My Friends: A training for children and adolescents on how to support a friend in distress.

87 IASC. IASC Guidance on Basic Psychosocial Skills – A Guide for COVID-19 Responders.

88 The IRC, UNICEF. 2012. Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings. First edition.

89 WHO. Mental Health and Substance Use. Mental Health Gap Action Programme (mhGAP).

90 The tools are currently being piloted. To access the checklist, contact the MHPSS TWG chair.

endorsement of the decision-making process and outcome. The SRMP can only be implemented once every step of the checklist has been signed off and endorsed by country-level programme development and quality (PDQ) and SMT to ensure quality suicide prevention programming.

2. **The SRMP general protocol** mobilises staff on suicide risk management, provides basic skills to identify and respond to disclosures of suicidal ideation, and provides guidance on referral and level of urgency needed when responding. It also provides guidance on how to support a child in urgent crisis until the child can be supported by a specialist (e.g., SRMP Focal Point or mental health specialist). The general protocol also provides guidance on conducting critical suicide prevention work in the community.

3. **The SRMP detailed protocol** is built on a suicide-safe care model and outlines steps for identification and referral. **These basic skills do not equip staff with skills and processes to assess and treat patients with suicidal ideation** but aims to assess level of risk and ensure appropriate, specialist follow-up.

3 How do we integrate MHPSS into our sectoral work?

3.1 Nutrition

To achieve their full potential, children need:

- Nurturing care: good health, nutrition, security, and safety
- Opportunities for early learning for the young child
- Responsive caregiving across all domains.

The home environment is an important place for the provision of nurturing care for infants and young children, given first and foremost by their primary caregivers.[91]

3.1.1Key messages on integrating MHPSS and nutrition

The following messages summarize the importance of integrating MHPSS and nutrition. These messages can be used to build awareness among stakeholders at all levels of the socio-ecological model.

- Exposure of pregnant girls and women, mothers, and all ages to prolonged psychosocial distress, such as separation due to pandemic and/or forced migration, without adequate MHPSS support impairs healthy development and has long-term implications for mental health and well-being for their child(ren).
- Caregivers' capacity to provide adequate care to the child is enhanced by helping them gain fuller knowledge and understanding of nurturing care, strengthening their confidence, and reducing isolation.[92]

[91] WHO, UNICEF, the World Bank Group, the ECD Action Network and the Partnership for Maternal, New-born and Child Health. 2019. Operationalizing Nurturing Care for Early Childhood Development The role of the health sector alongside other sectors and actors.

[92] Corna, F., Tofail, F., Chowdhury, M. R. Roy, and Bizouerne, C. 2019. Supporting maternal mental health of Rohingya refugee women during the perinatal period to promote child health and well-being: a field study in Cox's Bazar. Intervention, 17(2), 160–168.

Key Guidance

- Integrating MHPSS into prevention programmes – such as home-visiting programmes that follow up on nurturing care practices and developmental milestones – ensures an optimal positive impact on the child's first 1,000 days.
- Growing up with caregivers who are affected by severe distress or mental health conditions may increase babies' vulnerability to undernutrition, related disability, and disrupted development.
- Adolescent mothers are at higher risks of postpartum depression, which can negatively affect their caregiving abilities.
- All nutrition staff should have basic knowledge on child development milestones, maternal mental health, and malnutrition's impact on child behaviour.
- Protecting the physical safety and emotional development of infants and young children should include protecting, promoting, and supporting breastfeeding and complementary feeding.
- Almost all women, including stressed mothers, can physiologically breastfeed.
- Promoting breastfeeding while failing to adequately enable and support women to do so is damaging to maternal mental health.[93]
- Mothers urgently need reassurance, realistic information, compassionate and skilled support, and an enabling environment to nurture, nourish, and protect their infants.

3.1.2Rationale for Integrating MHPSS and nutrition

3.1.2.1Caregiver well-being

The **perinatal period** is a period of heightened vulnerability to mental health challenges (for mothers and children) that may negatively affect caregiving, child-caregiver relationships, infant feeding, care practices, and healthy child development. In LMICS, about 15.6% of pregnant women and 19.6% of women[94] who have just given birth experience a mental health condition, primarily depression. Women who have experienced pregnancy loss may have difficulties providing nurturing care, as being pregnant again can bring back painful memories and emotions.[95] The stigma attached to perinatal mental health conditions can make it difficult to seek help. It is now estimated that 20% of postpartum parental deaths result from suicide.[96]

Evidence from LMICs suggests that maternal mental health interventions delivered by non-specialised service providers can contribute to positive outcomes for mothers (reduced prevalence of common

[93] Brown, A. 2019. *Why Breastfeeding Grief and Trauma Matter*. Pinter & Martin Ltd.

[94] Fisher, J., Cabral de Mello, M., Patel, V., Rahman, A., Tran, T., Holton, S., and Holmes, W. 2012. Prevalence and determinants of common perinatal mental disorders in women in low- and lower-middle-income countries: a systematic review. *Bulletin of the World Health Organization*, 90(2), 139–149G. https://doi.org/10.2471/BLT.11.091850

[95] Moro, Neuman, and Réal. 2008. Maternités en exil : mettre des bébés au monde et les faire grandir en situation transculturelle.

[96] Kendig, et al. 2017.

perinatal mental health conditions)[97] and infants (improved breastfeeding practices and infant growth).[98] Interventions that teach mothers about infant development, provide strategies for engaging and stimulating their infants, and encourage maternal responsiveness and affection have been shown to:

- Improve maternal mood
- Strengthen the mother-infant relationship
- Improve infant health and development outcomes[99]

Similarly, interventions expressly designed to improve maternal mental health have a positive impact on infant health and development.[100]

3.1.2.2Malnutrition in infancy and early childhood

During emergencies, as well as in many development settings, infants and young children are exposed to a higher risk of malnutrition, morbidity, delayed development, and mortality.[101] Comprehensive postnatal support, including breastfeeding support, is critically important to address increased rates of distressing birth experiences, adverse birth outcomes, and/or postnatal separation that may negatively impact caregiver well-being and increase difficulties with breastfeeding. Neuroscience shows that breastfeeding (and the associated eye synchronicity) can begin to rewire trauma connections in the brain.[102]

Breastfeeding support also helps ensure proper nutrition for children. Undernourished children may engage less with their surroundings and caregivers and may cease to cry or seek attention. As a result, they may not receive the care, nutrition, stimulation, or support required to reach developmental milestones.[103]

Malnutrition can cause structural damage to the brain and affect motor and exploratory skills, future cognitive development, and schooling outcomes.[104] A growing body of evidence links nutritional deficiencies in infancy and early childhood to longer-term temperamental difficulties, including increased irritability, more frequent/intense negative emotions, and lower levels of self-regulation (ability

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97 Clarke, K., King, M., and Prost, A. 2013. Psychosocial Interventions for Perinatal Common Mental Disorders Delivered by Providers Who Are Not Mental Health Specialists in Low- and Middle-Income Countries: A Systematic Review and Meta-analysis. *PLoS medicine*, 10(10), e1001541. https://doi.org/10.1371/journal.pmed.1001541

98 Tol, W. A., Greene, M. C., Lasater, M. E., Le Roch, K., Bizouerne, C., Purgato, M., Tomlinson, M., and Barbui, C. 2020. Impact of maternal mental health interventions on child-related outcomes in low- and middle-income countries: a systematic review and meta-analysis. *Epidemiology and psychiatric sciences*, 29, e174. https://doi.org/10.1017/S2045796020000864

99 Rahman, et al. 2013. Interventions for common perinatal mental disorders in women in low- and middle-income countries: a systematic review and meta-analysis.

100 Rahman, et al. 2013.

101 Dozio, E., Le Roch, K., and Bizouerne, C. 2020. Baby friendly spaces: an intervention for pregnant and lactating women and their infants in Cameroon. *Intervention*, 18(1), 78–84.

102 Arfuso, Chimine. Quoted in: Brown, A. 2019. *Why Breastfeeding Grief and Trauma Matter*. Pinter & Martin Ltd.

103 Dozio, E., Le Roch, K., & Bizouerne, C. 2020. Baby friendly spaces: an intervention for pregnant and lactating women and their infants in Cameroon. *Intervention*, 18(1), 78–84.

104 Victora, C.G. et al. (2008) Maternal and child undernutrition: consequences for adult health and human capital. *Lancet*, 371(9609), 340–57.

of the child to soothe themselves). These temperamental characteristics are associated with an increased risk of internalizing problems (such as anxiety) or externalizing problems (such as aggression) during pre-school and middle childhood.[105]

The first thousand days including the postpartum are the ideal entry point to deliver sensitive and holistic responses that can support all mothers, including the youngest mothers, by:

- Reducing anxiety
- Increasing confidence
- Strengthening their ability to provide responsive care
- Fostering secure attachment

3.1.2.3High-risk groups to prioritise for integrated services

- **Survivors of gender-based violence** may experience heightened difficulties feeding and caring for children and negative breastfeeding outcomes, which increases the risk of malnutrition. While breastfeeding offers a means of healing for some survivors of sexual abuse, others will find breastfeeding too distressing and will require skilled support with feeding their infant a different way.
- **Caregivers on the move.** Refugees and internally displaced persons (IDPs) often experience isolation, disrupted social support (such as inter-generational transmission of nurturing care practices), and limited access to external resources. Once settled in camps or host communities, MHPSS support groups, for example, can effectively support mental health and responsive caregiving.
- **Mothers with disabilities** face multiple stigmas. From pregnancy onwards they may face barriers to accessing support and services that can increase their risks of additional psychosocial disabilities.
- **Parents of children with disabilities** must deal with their own feelings towards their child as well as potential stigmatization from the community. These situations can negatively influence help-seeking practices and can deprive children of responsive caregiving, breastfeeding, or timely diagnosis of malnutrition. Infants and children with disabilities may lose/ become separated from supportive caregivers and be placed in residential care where food programmes and early stimulation are overlooked.

[105] Wachs, Theodore D. 2009. Models linking nutritional deficiencies to maternal and child mental health. *The American Journal of Clinical Nutrition*, 89(3), 935S–939S. https://doi.org/10.3945/ajcn.2008.26692B

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- **Child early and forced marriage and unions** (CEFMU) (see Section 4.2.) and **adolescent pregnancy** (AP) are associated with problems in parenting,[106] education,[107] and breastfeeding. Growing evidence shows that AP increases perinatal risks such as low birthweight or prematurity.[108] Low birthweight and poor health increase the risk of undernutrition, a risk factor for mild intellectual disability.[109] Girls who marry early usually face a lack of autonomy and a subordinate household position, which can lead to poor (mental) health outcomes for the mother and her child.[110]
- **Women experiencing breastfeeding difficulties** (e.g., sore or cracked nipples, pain, concerns about low milk supply) should be prioritized for skilled breastfeeding support and MHPSS. While a good breastfeeding experience can be supportive of maternal well-being, breastfeeding difficulties can negatively impact maternal mental health. Research suggests that mothers who experience breastfeeding difficulties are also at risk for reduced bonding with their infants.[111]
- **Infants who are dependent on breastmilk substitutes** (BMS) for their nutrition (and their caregivers) require prioritisation within integrated MHPSS and infant and young child feeding in emergencies (IYCF-E) services to mitigate the risks of not breastfeeding on caregiving practices, maternal mental health, and overall child well-being and survival.

3.1.3Integrated MHPSS-Nutrition interventions

3.1.3.1Programmatic considerations

The following programmatic considerations should be prioritized when integrating nutrition and MHPSS programming:

- **Raise the awareness of all nutrition personnel** on MHPSS issues, including those that affect health-seeking behaviour for marginalized groups (e.g., stigmatization, access, discrimination, etc.)
- **Ensure that MHPSS is reflected in nutrition assessments** and nutrition is reflected in MHPSS-focussed assessment to avoid duplication
    - SCI 5 MHPSS assessment questions for multi-sector humanitarian assessments
- Utilize global standardized assessment tools:

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106 Secco, M. L. and Moffatt, M. E. K. 2003. Situational, maternal, and infant influences on parenting stress among adolescent mothers. *Issues in Comprehensive Pediatric Nursing*, 26(2), 103–122.

107 Erulkar 2013

108 Bilano, et al. 2014; Ganchimeg, et al. 2013,2014; Malabarey, et al. 2012

109 Groce, N., et al. 2013. Stronger Together: Nutrition-Disability Links and Synergies – Briefing Note.

110 Marphatia, A.A., Ambale, G.S., and Reid, A.M. 2017. Women's Marriage Age Matters for Public Health: A Review of the Broader Health and Social Implications in South Asia. *Front Public Health*, 5(269). doi: 10.3389/fpubh.2017.00269

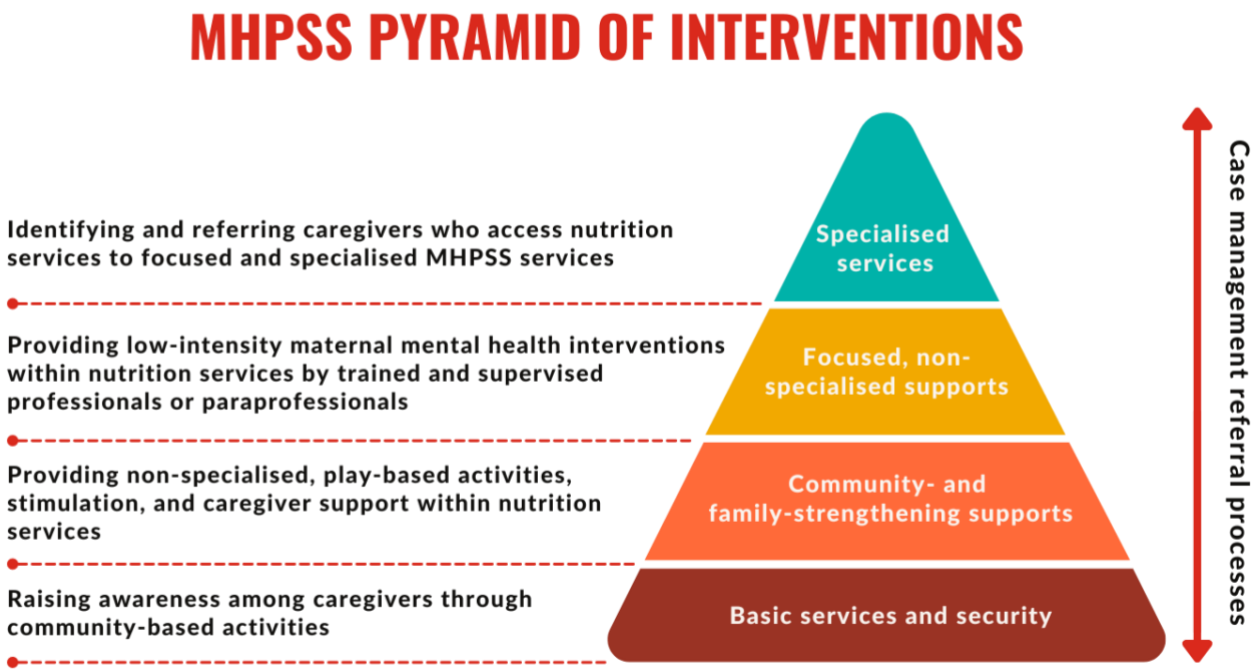
111 Roth, M.C., Humphreys, K.L., King, L.S., et al. 2021. Breastfeeding Difficulties Predict Mothers' Bonding with Their Infants from Birth to Age Six Months. *Maternal and Child Health Journal*. **(5),** 777–785.

  - IASC MHPSS Assessment Guide[112]
  - WHO/ UNHCR MHPSS assessment toolkit[113]

- **DO NOT** use MHPSS assessments to screen for mental disorders
- **Coordinate common terminology** across sectors and actors
- **Use a participatory approach** that follows child/ community participation guidelines.
- **Liaise with others** (e.g. coordination groups, MHPSS TWGs, health cluster, INEE, MHPSS.net, MHPSS Collaborative) to know what is implemented by other sectors and what MHPSS entry points and/or programming gaps exist:
  - IASC 4Ws in MHPSS[114]

3.1.3.2Aligning MHPSS-nutrition interventions to the MHPSS pyramid

The following sections show key entry points/ approaches at each level of the MHPSS pyramid that can be used in integrated MHPSS-nutrition programming.



112 IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings. 2012. IASC Reference Group Mental Health and Psychosocial Support Assessment Guide.

113 WHO and UNHCR. 2012. Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for humanitarian settings.

114 IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings. 2012. Who is Where, When, doing What (4Ws) in Mental Health and Psychosocial Support: Manual with Activity Codes (field test-version).

3.1.3.2.1 Level 1: Basic services and security

Integrated interventions at the first level of the MHPSS pyramid seek to meet the following goals:

- Children and infants benefit from holistic MHPSS and nutrition support which is appropriate to their age and stage of development.
- Mothers and other caregivers benefit from support which helps them to meet their child(ren)'s needs and encourages healthy development.

Actions that can support those goals include:

- **Raising (mental) health awareness** through integrated community-based activities (e.g., leaflets and interactive health messaging)
- **Ensuring all community members can access** nutritional services with dignity and agency
- **Equipping volunteers** to use mid-upper arm circumference (MUAC) with community members

Key considerations when implementing these actions include:

- **Nutrition staff should be trained** in MHPSS approaches, active listening, and PFA (see Section 2.8.2.).
- **Information should be delivered** via multiple communication modes (e.g., poster, audio/loudspeaker) to improve access to all, including those with disabilities

3.1.3.2.2 Level 2: Community- and family-strengthening supports

Integrated interventions at the second level of the MHPSS pyramid seek to meet the following goals:

- Mothers and other caregivers have access to psychosocial support interventions, peer support, and guidance from other volunteers within the community.
- Infants receive holistic support designed to improve both nutritional and developmental outcomes.

Actions that can support those goals include:

- **Providing psychosocial and recreational activities** for non-specialized support within nutrition services. Refer to:
    - Action Contre la Faim. 2006. Revised 2013. Manual for the Integration of Child Care Practices and Mental Health into Nutrition Programs.
    - Action contre la Faim. 2014. Baby Friendly Spaces: Holistic Approach for Pregnant, Lactating Women and their very young children in Emergency.
- **Providing early childhood development activities** within nutrition services. Refer to:

Key Guidance

  - Action contre la Faim. 2014. Baby Friendly Spaces: Holistic Approach for Pregnant, Lactating Women and their very young children in Emergency.
  - Global Technical Assistance Mechanism for Nutrition. 2020. Supportive Spaces for Infant and Young Child Feeding in Emergencies: Technical Brief.
  - Save the Children. Building Brains Common Approach.

- **Providing interventions fostering well-being** of caregivers and pregnant girls and women. Refer to:

  - Action contre la Faim. 2014. Baby Friendly Spaces: Holistic Approach for Pregnant, Lactating Women and their very young children in Emergency.
  - Mental Health Innovation Network. The Friendship Bench.
  - Save the Children. 'Caregivers' wellbeing.' Building Brains Common Approach.
  - Save the Children. 2014. My First Baby: Guide for Adolescent Girls.
  - Save the Children. 2019. Our First Baby: Health education for adolescents who are pregnant or first-time parents.

- **Provide inclusive activities and ensure access to children and mother with disabilities.**

  - UNICEF. Nutrition. Including children with disabilities in humanitarian action, https://sites.unicef.org/disability/emergencies/index.html [website]

Key considerations when implementing these actions include:

- MHPSS activities should initially involve all mothers and infants.
- Build on – and avoid undermining – existing community support structures (e.g., women's groups)
- Encourage timely, scheduled activities (e.g., group education or play sessions).
- Ensure IYCF/IYCF-E activities cover topics such as responsive feeding and caregiving, normal new-born behaviours, maternal mental health, child stimulation, baby massage, and attachment.
- Ensure breastfeeding sessions are adapted for mothers with disabilities to support bonding, provide adequate nutrition for children, and avoid stigmatization from community, stepfamily, and others.
- Work with caregivers on learning and responsive caregiving (see Building Brains Common Approach).
- Strengthen emotional and cognitive stimulation for children with severe or moderate acute nutrition (SAM and MAM). (Refer to early childhood development activities in the Building Brains Common Approach.)

3.1.3.2.3 Level 3: Focused, non-specialized supports

Integrated interventions at the third level of the MHPSS pyramid seek to meet the following goals:

- Child well-being improves through increased nutritional support alongside improved caregiver attachment, maternal mental health, and strengthened coping skills.
- Caregivers experiencing mild-moderate mental health difficulties (e.g., depression, anxiety) or who require more focused, tailored support (e.g., during a difficult pregnancy) receive appropriate support.

Actions that can support those goals include:

- Providing focused, non-specialized support/ low-intensity psychological interventions within nutrition services by trained and supervised professional or paraprofessional workers who may be:
    - MHPSS workers placed within nutrition services
    - Nutrition workers trained on MHPSS interventions

Key considerations when implementing these actions include:

- Encourage broader family engagement, including fathers and grandparents, where possible.
- Use Supportive Spaces for IYCF-E (e.g., Mother-Baby Areas, Baby-friendly Spaces) to reach pregnant women and caregivers of children under two with these interventions.
- Use dedicated hours (e.g., adolescent-only hours) to provide more focused support where appropriate.

Resources that can support implementation of these actions include:

Save the Children. 2022. MHPSS & IYCF-E counselling package- Training of Trainers for Frontline Workers. Available on demand from the Mental Health and Psychosocial Support TWG (MHPSSTWG@savethechildren.org).

Save the Children. 'Caregivers' wellbeing.' Building Brains Common Approach.

WHO. 2015. Thinking Healthy: A manual for psychological management of perinatal depression.

3.1.3.2.4 Level 4: Specialized services

Integrated interventions at the fourth level of the MHPSS pyramid seek to meet the following goals:

- Maternal mental health conditions are identified and found relevant support.
- Infants and children with symptoms of depression are Identified and treated.
- The impact of malnutrition on child mental health and development is mitigated.

Actions that can support those goals include:

- Identifying and referring caregivers who access nutrition services to focused and specialized MHPSS services by:
    - Integration of pro-active screening into the intake process for nutrition services
    - Continuous monitoring by trained/sensitized nutrition staff during nutrition service provision
    - Self-presentation by caregivers

Key considerations when implementing these actions include:

- To ensure effective referrals, nutrition staff should have up-to-date information (e.g., admission criteria, location, opening hours, days for new admissions, cost).
- Consider using technology to improve access to specialized services where these are not available in person (e.g., remote counselling), taking into consideration the need for cultural competency.
- Ensure data protection when providing referrals to avoid stigmatization or discrimination leading to potential separation from the infant.

Resources that can support implementation of these actions include:

ENN, LSHTM, and collaborators. 2021. MAMI Care Pathway Package, Version 3.
Save the Children. COMPASS for Health, Nutrition & WASH.

3.1.4Potential challenges and solutions

Figure 14 shows common challenges to implementing integrated MHPSS-nutrition programmes as well as key considerations and potential solutions that can help overcome those challenges.

Figure 14	Challenges	Considerations and Recommendations
1.	Limited capacity to identify and reach higher-risk pregnant girls and young mothers such as: • Those experiencing child, early, or pregnancy-related forced marriage • Those who are pregnant or young mothers out of wedlock • Women and girls exposed to/survivors of SGBV, including those who are pregnant due to sexual violence	**Considerations** • Increase communication and awareness of maternal and infant mental health and well-being in nutrition services. • Ensure communication is accessible to all, including caregivers with disabilities or who do not speak the local languages. • Ensure interventions include exploration of staff attitudes, reflective practices, and ways to address attitudinal barriers. **Recommendations** • Liaise closely with FSL sector to identify families in need of nutritional and other support.

	• Pregnant girls, women, and young mothers on the move	• Liaise closely with the (child) protection sector to provide relevant interventions/case management as required.
2.	Limited capacity to provide MHPSS: • Lack of capacity • Nutrition team overwhelmed by cases • Lack of understanding of link between malnutrition and child well-being	**Considerations** • Nutrition workers must be trained to identify issues which may indirectly impact a caregiver's ability to responsively care for and feed their child (e.g., missing family members, food insecurity, violence in the home) and to provide practical assistance with accessing relevant services. **Recommendations** • Build regular capacity-strengthening opportunities into on-going staff training and support, including development of user-friendly and locally meaningful vocabulary that can be used to discuss MHPSS-related issues. • Ensure manageable caseloads and appropriate client-provider ratios. • Make nutrition staff aware of specialist referral systems in case there is no local capacity. • Train staff on nurturing care practices. • Link with ECD[115] programmes and initiatives where possible.
3.	Stigmatization of mothers/ caregivers who receive specialized support	**Considerations** • Communities may perceive help-seeking behaviour as a demonstration of 'not being a good mother.' **Recommendations** • Implement awareness-raising campaigns that: ▪ Normalize mental health and basic strategies for supporting well-being and self-care. ▪ Identify and demystify perinatal mental health conditions ▪ Explaining how to support the mental health of mothers • Collaborate with MHPSS and health service providers to provide confidential structures that enable individuals to receive initial support (e.g., help lines, CMAM,[116] OTP,[117] stabilization centres).

[115] Early childhood development

[116] Community-based management of acute malnutrition

[117] Outpatient therapeutic feeding programme

		• Implement nurturing care for all PLW[118] and infants accessing nutritional support.
4.	Lack of staff capacity to accommodate early stimulation activities for children or caregivers with disabilities	**Recommendations** • If integrating inclusive activities into feeding programmes presents challenges, design simple messages about ECD, feeding children with difficulties, etc. • Conduct sensitization sessions to raise awareness of children with disabilities' nutrition, relevant international and national actors (e.g., OPDs[119]), barriers to accessing services, and existing approaches to address those barriers. • Provide theoretical and practical training in: ▪ Disability-inclusive integrated nutrition interventions ▪ ECD facilitation ▪ Early stimulation and responsive caregiving for infants and young children with disabilities ▪ Approaches for making traditional feeding practices and breastfeeding patterns inclusive • Include modules on the following in nutrition team curriculum: ▪ Mental health ▪ Milestones ▪ The impact of undernutrition on emotional and cognitive development ▪ The needs of children with disabilities • Provide practical training to parents with disabilities on how to stimulate their children emotionally and cognitively. • Use Steps to Protect Common Approach modules on communication with children with disabilities to enhance IYCF training.
5.	Lack of supportive government/ authorities' systems in place for the integration of MHPSS in nutrition from Governments and authorities	**Recommendations** • Advocate with ministries of education and universities to include MHPSS in occupational standards, competency frameworks, and training curricula for professional profiles such as nurse and nutritionist. • Advocate to include knowledge on the consequences of malnutrition on child mental health and well-being in social workers' curricula.

[118] Pregnant and lactating women

[119] Organizations of persons with disabilities

6.	Lack of focused specialised and non-specialised MHPSS supports to refer mothers and children	**Considerations** • Ensuring caregivers see the same nutrition worker at each visit (continuity of care model) can support improved detection of MHPSS needs. • There is a risk that providers may step outside their scope of practice, particularly where services are overloaded and specialist capacity is unavailable. Ensure that nutrition and MHPSS workers understand their roles, responsibilities, limitations, and when to refer. **Recommendations** • Liaise and engage with national, regional, and local coordination mechanisms in MHPSS, health, child protection and education to identify support and referral systems. • Work with child protection, health, and other actors (if possible) to enable referral to case management services. • Collaborate and engage with community members to identify safe, informal community level interventions • Train nutrition team on ECD in running home visits. • Provide MHPSS modules on IYCF and IYCF-E. • Train and supervise nutrition frontliners with adequate experience and skill-sets to deliver low-intensity psychological interventions (ex. Thinking Healthy,[120] PM+).
7.	Limited capacity to set up and maintain supportive supervision systems on MHPSS in integrated MHPSS/nutrition programmes	**Considerations** • Consider establishing: ▪ inter-agency collaborations to strengthen supervision systems across organizations ▪ Peer supervision systems ▪ Facilitated communities of practice/ platforms to share good practices and lessons learned • Ensure staff have strategies in place to address their own stress and well-being (e.g., peer support networks, coaching, mentoring, fair and supportive HR policies). **Recommendations** • Encourage peer support and monthly technical supervision.

[120] WHO. 2015. Thinking Healthy: A manual for psychological management of perinatal depression.

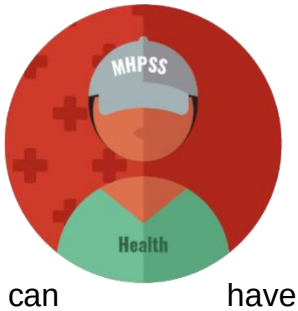
		• Ensure teams have access to national support hotlines. • Ensure managers organise informal field visits and team discussions to assess challenges and supervision needs. • Devote 10 mins. at the beginning of team meetings to sharing MHPSS good practices and challenges of the week. • Have team members prepare case studies around MHPSS activities or consequences of maternal mental health on child development to exchange good practice and knowledge.
8.	Lack of consideration of MHPSS at project planning stage	**Considerations** • Consider ways to integrate MHPSS and nutrition at the earliest point possible, providing evidence-based advice on: ▪ The MHPSS approach's impact on child development in malnutrition contexts ▪ Nurturing care's impact on mother-child relationships and attachment quality **Recommendations** • Build programmes with stepped capacity building. Bridge with good practices so nutrition staff can observe the impact of MHPSS activities and own their changes. • Ensure MHPSS is reflected in nutrition assessments. • Have MHPSS workers join the nutrition team when relevant.

3.1.5Key nutrition resources

ENN, LSHTM, and collaborators. 2021. MAMI Care Pathway Package, Version 3.

Technical Rapid Response Team, Save the Children, Irish Aid. Infant & Young Child Feeding in Emergencies (IYCF-E) Individual Capacity Assessment Tool for Health and Nutrition Service Providers.

3.2 Health



3.2.1Key messages on integrating MHPSS and health

The following messages summarize the importance of integrating MHPSS and health. These messages can be used to build awareness among stakeholders at all levels of the socio-ecological model.

- Living with unaddressed mental health and psychosocial support needs can have a negative effect on a child's growth and development; a parent's ability to give appropriate care, work, and earn; and a family's functioning, resilience, and ability to adopt healthy behaviours.
- Most children, mothers, and/or caregivers who are experiencing or affected by mental health problems do not seek support for their mental health difficulties, but they are very likely to present at health services for other reasons.
- Although referral options may be limited in many settings, it is important to identify and use referral opportunities that include clinical or service-based routes and community-based structures that can provide local peer support.
- Integrating MHPSS into healthcare practice can help avoid distress and increase compliance for children and caregivers who access health services.
- When planning to integrate MHPSS into health services and programmes, it is important to consider the level and type of intervention that is appropriate or safe to develop ('do no harm').

3.2.2Rationale for integrating MHPSS and health

Mental health and psychosocial support needs are highly prevalent in most populations (Global Burden of Disease, 2019) and are exacerbated in situations of adversity. Living with unaddressed mental health and psychosocial support needs can have a negative effect on a child's growth and development; a parent's caring abilities; family functioning and resilience to health issues or ability to adopt healthy behaviours, and the ability to work and earn. Children and adults with mental health difficulties or physical or intellectual disabilities are sometimes subjected to forced institutionalization where they may be forced to take medication, have unnecessary medical interventions, or experience other rights violations.

Most children, mothers, and/or caregivers who are experiencing or affected by mental health problems do not seek support for their mental health difficulties, but they are very likely to present at health services for other reasons. Similarly, some of their physical symptoms can be signs or expressions of a mental health problem. Therefore, community-led and public health activities and interventions provide valuable and feasible platforms and entry points for MHPSS integration, particularly for:

- Integrating MHPSS knowledge and components into practice and service design
- Identifying and supporting affected children and caregivers

- Enabling access to other help where available
- Protecting and promoting positive mental health
- Strengthening positive coping and self-care strategies
- Enhancing peer supports
- Reducing social isolation and stigma

A limitation to effective integrated MHPSS-health services is the lack of referral options in many settings. In all settings, it is important to identify and use referral opportunities that include clinical or service-based routes and community-based structures that can provide local peer support. Community-based health interventions and primary healthcare providers can be ideal settings for providing focused, non-specialized support to children and caregivers who are experiencing more pronounced or more enduring forms of distress. Such supports must implement evidence-based approaches and be delivered by trained staff under the guidance and supervision of specialized mental health professionals.

As with all health care, it is important to maintain and be mindful of a 'do no harm' approach when integrating MHPSS. Unfortunately, children and their caregivers – particularly children with disabilities or from marginalized groups – sometimes experience avoidable distress and anxiety accessing health services. Children and families can experience fear, anxiety, and distress due to:

- Unequal access to healthcare and discrimination in their experiences with health services
- Separation from parents when receiving healthcare
- Unfriendly provider attitudes
- Health providers who do not listen to children and caregivers
- Lack of appropriate and accessible information about what is happening
- Unnecessary or painful investigations
- Poorly integrated and uncoordinated systems of care
- Witnessing severe injury, illness, and/or death while attending a health facility
- Sexual exploitation in exchange for receiving healthcare services

These causes of distress generally result from (a) a lack of awareness among health workers about the effect of their practices and (b) systems that do not consider their effect on children and families. These issues (and ways to improve them) are often not directly related to resources. They arise in high-income as well as low-income countries and humanitarian settings.

Strengthening the MHPSS skills of staff and integrating components that identify and support MHPSS needs into commonly used care and services can enhance the effectiveness and utilization of primary

healthcare, maternal and new-born support, nutrition, and reproductive health services. Recognizing and supporting the MHPSS needs of children and/or caregivers can also improve compliance with other treatments or health advice and improve outcomes for children and families.

3.2.3Integrated MHPSS-health interventions

3.2.3.1Programmatic considerations

MHPSS interventions or services in health programmes should generally focus on:

- Community- and health service-based activities that promote positive mental health, provide peer support, and address stigma
- Health service interventions that are focused and therapeutic but can be delivered by trained non-mental health specialists with the support and supervision of an appropriately qualified mental health professional

Examples of these interventions include:

- Basic counselling
- Mental health enquiry during antenatal care
- Facilitated groups
- Psycho-education activities
- Low-intensity psychological interventions (e.g. Problem Management Plus,[121] Thinking Healthy[122])
- Systematic integration of mental health in primary health care through the mhGAP[123] programme

3.2.3.2Aligning MHPSS-Health interventions to the MHPSS pyramid

The following sections show key entry points/ approaches at each level of the MHPSS pyramid that can be used in integrated MHPSS-health programming.

3.2.3.2.1 Level 1: Basic services and security

Integrated interventions at the first level of the MHPSS pyramid seek to meet the following goals:

- Health workers recognize value of psychological factors in providing care.
- Available support options are known and utilized.

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121 WHO. 2018. Problem Management Plus (PM+): Individual psychological help for adults impaired by distress in communities exposed to adversity. (Generic field-trial version 1.1)

122 WHO. 2015. Thinking Healthy: A manual for psychological management of perinatal depression.

123 WHO. Mental Health Gap Action Programme (mhGAP). https://www.who.int/teams/mental-health-and-substance-use/treatment-care/mental-health-gap-action-programme [website]

Key Guidance

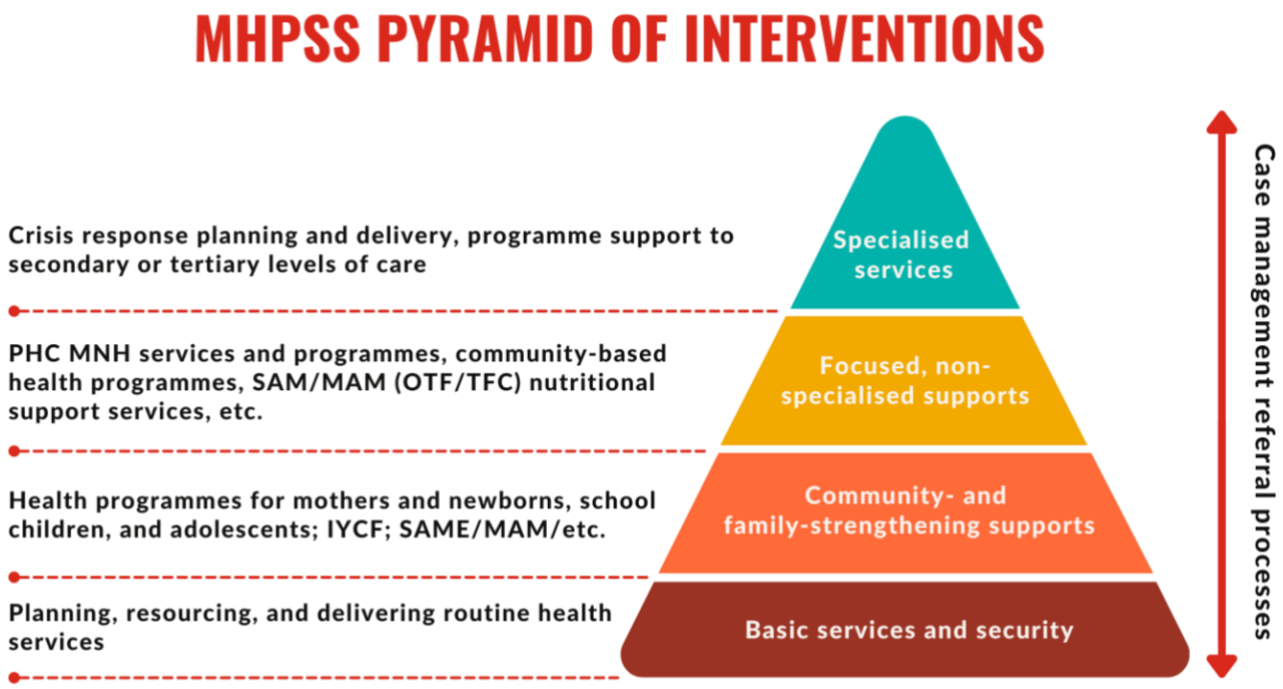
- Health services present less risks to the psychological well-being of children and families.
- Communities show increased acceptability of MHPSS interventions.

Actions that can support those goals include:

- **Planning and resourcing health care services.** Refer to IASC MHPSS in Emergency Settings Series of Booklets. 2011. What Should Humanitarian Health Actors Know?
- **Delivering routine health services** with basic communication skills. Refer to Save the Children Denmark. 2013. Save the Children Psychological First Aid Training Manual for Child Practitioners.
- **Planning** a cross-sectoral humanitarian response. Refer to IASC MHPSS in Emergency Settings Series of Booklets. 2011. What Should Humanitarian Health Actors Know?
- Training all health staff on:
    - PFA for child practitioners (see Section 2.8.2.)
    - Basic helping skills such as BHS Package from MENAEE RO (available on demand)
    - Referral pathways for health services and psychosocial support programmes
    - Establishing 'child-friendly'/ 'safe spaces' in health facilities (see 3.1.3 Integrated nutrition)

Key considerations when implementing these actions include:

- Barriers to prioritization may arise due to low health worker awareness of the benefits of integration.



3.2.3.2.2 Level 2: Community- and family-strengthening supports

Integrated interventions at the second level of the MHPSS pyramid seek to meet the following goals:

- Existing supportive community assets are strengthened.
- Community members can access needed services within their local community.

Actions that can support those goals include:

- **Implementing:**
    - Maternal and new-born health programmes (see 3.1 Nutrition)
    - Community-led health programmes
    - School-based health programmes
    - Infant feeding activities (IYCF)
    - Adolescent health programmes
    - SAM[124]/ MAM[125]/ nutritional support services

Refer to:

[124] Severe acute malnutrition
[125] Moderate acute malnutrition

Key Guidance

Save the Children. 2022. MHPSS & IYCF-E counselling package- Training of Trainers for Frontline Workers. Available on demand from the Mental Health and Psychosocial Support TWG (MHPSSTWG@savethechildren.org).

World Health Organization, United Nations Children's Fund, World Bank Group. 2018. Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential. Licence: CC BY-NC-SA 3.0 IGO.

- **Building upon** existing programmes, community groups, and structures:
  - Women's groups
  - Pregnant women's groups
  - Child, adolescent, and school clubs

  Refer to WHO. 2019. mhGAP Community Toolkit: Field test version.

- **Engaging men and boys** in workplaces, barazas, and community committees. (See Section 2.5. Involving Men and boys.)
- **Conducting** community-led, participatory MHPSS resource mappings and care planning. (See Section 2.5.3 Community-led and Section 2.2.1 Assessment.) Refer to WHO. 2018. Preventing suicide: a community engagement toolkit. Licence: CC BY-NC-SA 3.0 IGO.
- **Delivering messaging** on IYCF-E[126] and attachment. Refer to Save the Children. 2022. MHPSS & IYCF-E counselling package – Training of Trainers for Frontline Workers. Available on demand from the Mental Health and Psychosocial Support TWG (MHPSSTWG@savethechildren.org).
- **Using disability-positive approaches** that encourage positive community attitudes towards parents with disabilities and parents of infants/children with disabilities. (See Section 4.5 Integrated MHPSS and disability inclusion interventions.)

Key considerations when implementing these actions include:

- Focus on the promotion and protection of positive mental health.
- Prioritize interventions that reduce isolation and build networks of social connectedness and support.
- Ensure inclusion and equity for the groups at risks and marginalised
- Develop interventions with respect for social norms and beliefs.

[126] Infant and young child feeding in emergencies

- Understand and address community perceptions of the causes and presentations of poor mental health.
- Work to normalize and de-stigmatize mental health.
- Ensure messaging is accessible and appropriate for all (including children and those with disabilities).

Resources that can support implementation of these actions include:

Save the Children.2017 .Psychological First Aid for Children II - Dealing with traumatic responses in children.

Save the Children. 2022. MHPSS & IYCF-E counselling package- Training of Trainers for Frontline Workers. Available on demand from the Mental Health and Psychosocial Support TWG (MHPSSTWG@savethechildren.org).

3.2.3.2.3 Level 3: Focused, non-specialized supports

Integrated interventions at the third level of the MHPSS pyramid seek to meet the following goals:

- Children and caregivers access support in conjunction with other supports, including health.

Actions that can support those goals include:

- **Implementing and participating with**:
  - Primary healthcare maternal and newborn health services and programmes. Refer to WHO. 2015. Thinking Healthy: A manual for psychological management of perinatal depression.
  - Community-led health programmes. Refer to:
    IFRC MHPSS in primary health care settings training package.
    WHO. 2019. mhGAP Community Toolkit: Field test version.
    WHO. 2018. Problem Management Plus (PM+): Individual psychological help for adults impaired by distress in communities exposed to adversity. (Generic field-trial version 1.1).
  - SAM[127]/ MAM[128] (OTF[129]/TFC[130]) nutritional support services. Refer to:
    ENN, LSHTM, and collaborators. 2021. MAMI Care Pathway Package, Version 3.
    SCI IYCF MHPSS counselling package.
    WHO. 2015. Thinking Healthy: A manual for psychological management of perinatal depression.

[127] Severe acute malnutrition
[128] Moderate acute malnutrition
[129] Outpatient therapeutic feeding
[130] Therapeutic feeding centres

  - Adolescent health programmes. Refer to WHO. Helping adolescents thriving tool kit.
- **Including routine enquiries** about maternal well-being at ANC[131] and PNC[132] (+ / - screening)
- **Providing basic counselling and emotional support** from non-specialist health workers. Refer to IFRC MHPSS in primary health care settings training package.
- **Integrating psychoeducation activities** into PHC,[133] MCH,[134] SRHR,[135] and nutrition service provision. Refer to IFRC MHPSS in primary health care settings training package.

Key considerations when implementing these actions include:

- Carefully contextualize intervention approaches or packages.
- Avoid actions that increase social stigma.
- Provide regular, supportive supervision for providers.
- Develop and implement practice guidelines and/or standard operating procedures that cover:
  - Eligibility
  - Entry routes into support
  - Coordinated care
  - Confidentiality
  - Record-keeping
  - Emergency procedures
- Develop and implement effective referral pathways.
- Connect interventions with schools, learning environments, peer-support groups, and self-help groups.

Other resources that can support implementation of these actions include:

Johns Hopkins Bloomberg School of Public Health. 'Common Elements Treatment Approach (CETA). Global Mental Health. https://www.jhsph.edu/research/centers-and-institutes/global-mental-health/talk-therapies/common-elements-treatment-approach/ [website]

3.2.3.2.4 Level 4: Specialized services

Integrated interventions at the fourth level of the MHPSS pyramid seek to meet the following goals:

131 Antenatal care
132 Prenatal care
133 Primary healthcare
134 Maternal and child health
135 Sexual and reproductive health and rights

- Children in need of specialized support have access to referral structures and a continuum of care (i.e., can be referred up and down the pyramid).

Actions that can support those goals include:

- **Planning and delivering** an appropriate crisis response.
- **Providing programme support** to secondary or tertiary level care.

Key considerations when implementing these actions include:

- Consider whether or not the intervention meets SC organizational mandates and is sustainable:
    - Can you ensure continuity?
    - Can it be delivered safely?
    - Can the supply of required medications continue?
- Evidence of need is not sufficient to justify intervention at this level if safety, quality, continuity, or service provision cannot be reasonably ensured.
- Parents and caregivers must be safely involved in approaches and interventions (see Section 2.1. on safeguarding).
- Parents and caregivers may also benefit from receiving support.
- Complex and/or enduring mental health conditions should receive specialist psychiatric support from clinicians, including specialized psychotherapy.

Approaches that can support implementation of these actions include Cognitive Behavioural Therapy (CBT), Systemic therapy, or Psycho-dynamic therapy.

3.2.4Potential challenges and solutions

Figure 15 shows common challenges to implementing integrated MHPSS-health programmes as well as potential solutions that can help overcome those challenges.

Figure 15	Challenges	Recommendations
1.	Lack of staff capacity or knowledge of mental health that leads to problems identifying children and caregivers in need of support	• Train health staff on local signs of well-being and 'doing well;' clinical signs and common presentations of mental health problems; and links between mental health, physical health, and disability. • Ensure regular capacity-strengthening opportunities are built into on-going staff training and support, including development of user-friendly and locally meaningful vocabulary that can be used for discussing MHPSS-related issues.

Key Guidance

		• Ensure doctors and health professionals are trained on trauma-informed support. • Develop job supervision to support staff's knowledge and implementation.
2.	Poor understanding of child development leads to misclassification of behaviours/responses, including over-diagnosis of normal response to abnormal situations.	• Consider integrating with education/ early child development/ child protection, and Parenting without Violence Common Approach. • Ensure that capacity-building approaches and materials for health staff reflect a biopsychosocial and developmental approach to mental health and well-being. • Use psychoeducation to support understanding and awareness of normal reactions to crisis, including among people with medical conditions and disabilities. • Use the SCI Building Brain Common Approach to build capacity on child development. • Develop job supervision to support staff's knowledge and implementation.
3.	Lack of consideration of MHPSS at project planning stage	• Adopt MHPSS considerations as mandatory items for all projects in initial rapid needs assessments and in project response/ planning tools. • Recognize the relationship of core principles to MHPSS (e.g., 'do no harm', participation, etc.).
4.	Inclusion of unsustainable specialized interventions in short-term humanitarian programmes	• Do not start specialised interventions in short-term humanitarian programmes that have no possibility of continuation. • Use peer-to-peer support to strengthen Level 3 interventions. • Use MHPSS helplines and remote systems to provide emotional support in case of crisis.
5.	Lack of contextually relevant tools – misappropriation of tools and misinterpretation of results	• Select screening/assessment tools that have been validated for context/language/age/gender. • In emergency contexts, avoid conducting epidemiological surveys to determine prevalence of mental health conditions – refer to global estimates instead. • Ensure staff are well trained on how to administer tools and analyse and interpret results. • Do not use tools of mental health diagnosis to identify people in distress.
6.	Healthcare environments that: • Do not recognize or value the importance of	• Implement programmes that support active listening and responsiveness to patients. • Base assessment and quality of care improvement cycles on child rights-based standards and criteria.

	psychological factors in providing care • Present identifiable risks to the psychological well-being of children and families • Result in significant psychological harm	• Implement capacity-building and pathways to enable and obligate health workers to proactively respond to psychological distress and mental health concerns. • Mainstream principles of trauma-informed care into health programming/services delivery. • Train all health staff to communicate with children, including those with disabilities, about medical procedures or treatments in language that is understandable to them. • Ensure meaningful and accessible feedback mechanisms are in place which allow for anonymous complaints and suggestions. • Ensure mechanisms are in place to address staff stress and well-being, including peer support networks, coaching, mentoring, fair and supportive HR policies, etc.
7.	Lack of, or lack of awareness of: • Existing clinical and non-clinical specialist support • Referral pathways • Providers' responsibility to refer	• Engage in '4Ws'[136] mapping and use findings to inform design of referral and support pathways. • Invest in capacity-building non-specialist support options and cadres (task-shifting). • Collaborate with and engage community members to identify community support mechanisms. • Liaise and engage with national, regional, and local coordination mechanisms in MHPSS, child protection, and education to identify support and referral systems. • Work with child protection (and others) to enable referral to case management services.
8.	Potential screening for mental health conditions and needs that cannot be addressed	• Ensure organizational access to ethical advice when deciding and planning: ▪ What to screen for and when ▪ Treatment options ▪ Referral and resource options ▪ Use the IASC recommendation for conducting ethical MHPSS • Align referral pathways for additional support to the layers/ services of the MHPSS pyramid.
9.	Stigmatization of people who receive specialist MHPSS support in health care	• Train health professionals and community health workers on MHPSS approaches. • Ensure training curricula explore staff attitudes and explain models of mental health and MH conditions.

[136] Who is where, when, doing what

		• Implement promotion activities that normalize mental health and basic strategies for supporting well-being and self-care. • Work with schools/ community groups to de-mystify mental health. • Engage with service-users associations or groups and facilitate their participation in inter-agency coordination platforms/ mechanisms. • Engage with community and religious leaders to discuss traditional explanatory models of mental health conditions and their potential impact in terms of stigmatization. • Encourage confidentiality or structures that enable individuals to receive initial support (e.g., help lines, drop-in centres, etc.).
10.	Lack of supportive systems from governments and authorities in place for the integration of MHPSS in health	• Develop investment cases to support sensitization and discussions with government actors and to show how improved MHPSS impacts and supports the achievement of their priorities and targets. • Advocate with governments and relevant actors to strengthen systems that support the integration of MHPSS and health.
11.	Low acceptability of some services	• Involve clients/ communities in intervention planning, service model design, and monitoring. • Contextualise intervention models and packages. • Consider providing services in multi-purpose community facilities.
12.	Lack of access to children, adolescents, and families most impacted by inequality and discrimination	• Ensure children with disabilities, LGBTQI+, marginalized children, and families who are traditionally excluded can access health services that respect their rights to equity, kindness, information, and dignity. • Carry out awareness raising and attitudinal change about issues which may affect children's access/ acceptance, including girls, young mothers, former CAAFAG, LGBTQI+ children, or children who have been excluded or are at risk of exclusion from health services.
13.	Gaps in available evidence on the impact of integrating MHPSS in health	• As much as possible, ensure MHPSS related interventions are measurable and evidence-based and use rigorous monitoring and evaluation.
14.	Poor utilization of existing evidence base	• Register for free access to research/ publications at Hinari.[137]

[137] WHO. Hinari. https://partnership.who.int/hinari [website]

	• Subscribe to local monthly journal clubs or research summaries of MHPSS-related research. • Develop organizational relationships with partners who are concerned with translating research into policy and practice. • Raise awareness of and routinely connect with key knowledge management and research partners (e.g., MHPSS Collaborative,[138])

3.2.5Key health resources

Children and War Foundation. 2019. Training in the Manual "Teaching Recovery Techniques (TRT)" London, October 31 and November 1, 2019. https://www.childrenandwar.org/training-in-the-manual-teaching-recovery-techniques-trt-london-february-18-19-2019/ [website with contact information for upcoming trainings]

Nurturing Care for Early Childhood Development. Nurturing Care Handbook. https://nurturing-care.org/handbook/ [website]

Save the Children. 2022. MHPSS & IYCF-E Training for Frontline Workers. Available on demand from the MHPSS TWG.

Technical Rapid Response Team, Save the Children, Irish Aid. Infant & Young Child Feeding in Emergencies (IYCF-E) Individual Capacity Assessment Tool for Health and Nutrition Service Providers.

WHO. 2015. Thinking Healthy: A manual for psychological management of perinatal depression.

WHO. 2016. Standards for improving quality of maternal and new-born care in health facilities.

WHO. 2018. Preventing suicide: a community engagement toolkit. Licence: CC BY-NC-SA 3.0 IGO.

WHO. 2018. Problem Management Plus (PM+): Individual psychological help for adults impaired by distress in communities exposed to adversity. (Generic field-trial version 1.1).

WHO. 2018. Standards for improving the quality of care for children and young adolescents in health facilities.

WHO. 2019. mhGAP Community Toolkit: Field test version.

WHO. 2019. The WHO special initiative for mental health (2019-2023): universal health coverage for mental health. World Health Organization. https://apps.who.int/iris/handle/10665/310981 License: CC BY-NC-SA 3.0 IGO

[138] The MHPSS Collaborative. https://mhpsscollaborative.org/ [website]

3.3 Child poverty/Food security and livelihoods (FSL)

3.3.1 Key messages on integrating MHPSS and child poverty/FSL

The following messages summarize the importance of integrating MHPSS and child poverty/FSL. These messages can be used to build awareness among stakeholders at all levels of the socio-ecological model.

- MHPSS and child poverty interventions are beneficial for adolescents and families when linked with life skills/ skills development interventions.
- The evidence strongly suggests that the incidence of mental health problems among children and adolescents can be reduced by addressing severe and persistent poverty, particularly during the early years of a child's life.139
- FSL staff are ideally placed to identify families in need of further support, including individuals who may not be coping or who may have mental health difficulties.
- Families engaged in child poverty or FSL programmes can be included in integrated MHPSS programming using a holistic approach, with the aim of improving child and caregiver well-being, development, and functioning.

3.3.2 Rationale for integrating MHPSS and child poverty/FSL

Although poverty is often interpreted as lack of income, consumption, or assets, it is being increasingly understood and defined in terms of the multiple deprivations people face in their daily lives, or *multidimensional poverty.*[140] Children who lack access to education and health services, for example, are deprived of their rights and face multidimensional poverty factors which negatively influence their mental health and well-being. Nearly 58 per cent of children who live in countries affected by protracted conflict and fragility live in extremely poor households.[141] Studies show that poverty in the earliest years of childhood may be more harmful than poverty later in childhood.

Poverty exacerbates the risks for mental health and psychosocial problems among communities and families. Research indicates that poverty profoundly impacts cognitive development and coping mechanisms with regard to social trust and long-term planning.[142] The circle of poverty, including for persons with a disability, can result in psychosocial disabilities associated with restricted access to services, social support, and other resources.

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139 Gibson, K., et al. 2017. Child poverty and mental health: A literature review. Commissioned for New Zealand Psychological Society and Child Poverty Action Group.

140 UNICEF. 2021. A review of the use of multidimensional poverty measures: Informing advocacy, policy and accountability to address child poverty.

141 UNICEF and the World Bank Group. 2016. Ending Extreme Poverty: A Focus on Children.

142 Sleek, S. 2015. How Poverty Affects the Brain and Behaviour.

Research shows that low-income parents are more likely than others to use an authoritarian and punitive parenting style and less able to provide stimulating learning experiences in the home.[143] A possible cause of this may be that poverty and income insecurity increase psychological distress, compromise parents' mental health, and negatively affect parents' interactions with their children.

For children, poverty is a deeply physical, emotional, and social experience. Many children prioritize the psychological and social experience of poverty (e.g., humiliation, shame, and stigma) over any material deprivation.[144] Children interpret a part of their own well-being (and indeed that of others) through their social relationships. This means that interventions that address the purely physical characteristics of impoverishment may not necessarily improve a child's well-being or quality of life nor resonate with what children are seeing or feeling.[145]

3.3.3Integrated MHPSS-child poverty/FSL interventions

3.3.3.1Programmatic considerations

Integrated MHPSS-child poverty/FSL interventions should seek to:

- Ensure that MHPSS programme design considers child poverty and its associated dimensions (e.g., poor nutrition, inadequate housing, increased likelihood of adverse events, and living in poor neighbourhoods) that put children at higher risk of having mental health problems[146]
- Ensure systematized measurement of well-being outcomes for FSL staff and use the evidence to advocate for increased investment in MHPSS and programmes that address child poverty

3.3.3.2Aligning MHPSS-child poverty/FSL interventions to the MHPSS pyramid

The following sections show key entry points/ approaches at each level of the MHPSS pyramid that can be used in integrated MHPSS-child poverty/FSL programming.

3.3.3.2.1 Level 1: Basic services and security

Integrated interventions at the first level of the MHPSS pyramid seek to meet the following goal:

- Children and caregivers are aware of their rights and entitlements, which decreases distress.

Actions that can support those goals include:

- **Conducting awareness/messaging campaigns** to cash assistance and access to basic needs

143 Gibson, K., et al. 2017. Child poverty and mental health: A literature review. New Zealand Psychological Society and Child Poverty Action Group.

144 Wordsworth, D., et al. 2005. Working Paper 1. Understanding Children's Experience of Poverty: An Introduction to the DEV Framework. Christian Children's Fund.

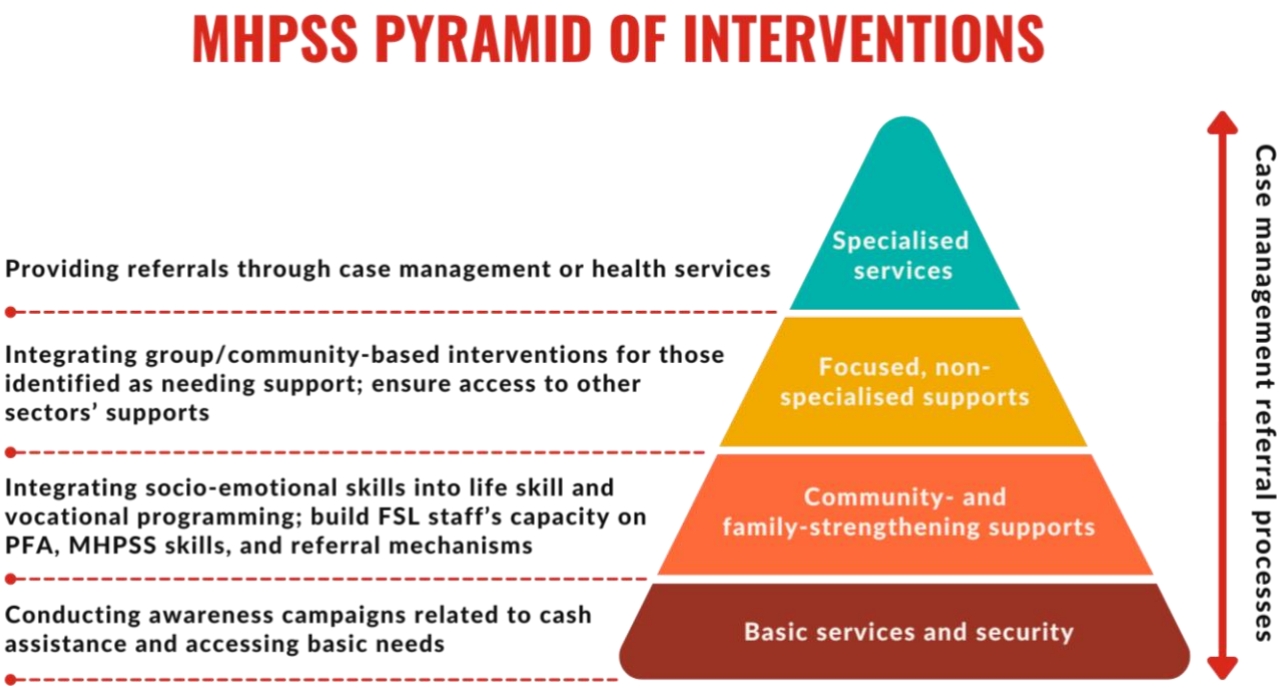
145 Wordsworth, D., et al. 2005. Working Paper 1. Understanding Children's Experience of Poverty: An Introduction to the DEV Framework. Christian Children's Fund.

146 Gibson, K., et al. 2017. Child poverty and mental health: A literature review. Commissioned for New Zealand Psychological Society and Child Poverty Action Group.

- **Mobilizing communities** to support children and their caregivers in resource-poor settings

Resources that can support implementation of these actions include:

REPSSI. 2011. The Journey of Life: Community Workshops to Support Children- REPSSI.



3.3.3.2.2 Level 2: Community- and family-strengthening supports

Integrated interventions at the second level of the MHPSS pyramid seek to meet the following goal:

- Family and caregiving environments are strengthened to promote children's healthy development and to protect them from inequality.

Actions that can support those goals include:

- **Integrating socio-emotional skills** into life skills and vocational skills
- **Integrating MHPSS** strongly within capacity-building curriculum for FSL staff (e.g., psychological first aid, referral mechanisms)

Key considerations when implementing these actions include:

- Save the Children's 'Choices, Voices, Promises'[147] can help challenge gender norms and increase life skills.

Resources that can support implementation of these actions include:

IFRC Reference Centre for Psychosocial Support and Save the Children. The Children's Resilience Programme: Psychosocial support in and out of schools.

Save the Children. HEART: healing and education through the arts.

Save the Children. Life Skills for Success: Supporting young people to succeed in work and life.

Save the Children. 2015. Save the Children's Child Resilience Programme.

Save the Children, UNICEF, and War Child. Team Up and the Team Up at Home handbook

The Alliance for Child Protection in Humanitarian Action. 2021. Toolkit for Monitoring and Evaluating Child Protection when using Cash and Voucher Assistance.

3.3.3.2.3 Level 3: Focused, non-specialized supports

Integrated interventions at the third level of the MHPSS pyramid seek to meet the following goal:

- Young men demonstrate increased self-esteem, self-confidence, and self-perception.
- Caregivers have strengthened MHPSS and social networks.

Actions that can support those goals include:

- **Integrating group-/community-based interventions** for caregivers and children identified as needing support
- **Ensuring access to other-sector supports**, including child-friendly spaces, mother's groups, etc.

Resources that can support implementation of these actions include:

Danish Red Cross and International Federation of Red Cross and Red Crescent Societies Reference Centre for Psychosocial Support. 2015. The Resilience Programme for Young Men: A psychosocial handbook.

International Rescue Committee. 2018. Girl Shine.

Save the Children. 2015. Save the Children's Child Resilience Programme.

[147] Save the Children. 2015. Choices, Voices, Promises: Empowering Very Young Adolescents to form Pro-Social Gender Norms as a Route to Decrease Gender Based Violence and Increased Girls' Empowerment.

The Alliance for Child Protection in Humanitarian Action. 2017. Field Handbook on Unaccompanied and Separated Children: Inter-agency Working Group on Unaccompanied and Separated Children.

3.3.3.2.4 Level 4: Specialized services

Integrated interventions at the fourth level of the MHPSS pyramid seek to meet the following goal:

- Children and caregivers in need of specialized support have access to referral structures and a continuum of care (can be referred up and down the MHPSS pyramid).

Actions that can support those goals include:

- **Using referral mechanisms** to provide appropriate case management and health services

Key considerations when implementing these actions include:

- If capacity exists, provide referrals for specialist support colleagues in other sectors, such as health or child protection.

Resources that can support implementation of these actions include:

Integrated MHPSS-child protection guidance.

Save the Children. Steps to Protect Common Approach.

Save the Children. Suicide Risk Management Protocols (SRMP).

3.3.4Potential challenges and solutions

Figure 16 shows common challenges to implementing integrated MHPSS-child poverty/FSL programmes as well as potential solutions that can help overcome those challenges.

Figure 16	Challenges	Recommendations
1.	Stigmatisation	• Train child poverty/ FSL personnel (including community health workers) on MHPSS approaches. • Ensure referral pathways for additional support link to all layers and services of the MHPSS pyramid. • Implement awareness-raising campaigns to: ▪ Normalize mental health and basic strategies for supporting well-being and self-care. ▪ De-mystify post-natal depression and support maternal mental health. • Collaborate with MHPSS and health service providers to implement confidential structures that enable individuals to receive initial support (e.g., help lines, drop-in centres, etc.).

		• Implement well-being and psychosocial support services for all mothers and infants who access child poverty support.
2.	Lack of staff capacity or knowledge on: • Mental health • Identification of children and caregivers who need support	• Provide PFA training to child poverty staff. • Build regular capacity-building opportunities into on-going staff training and support. • Develop user-friendly and locally meaningful vocabulary that can be used for discussing MHPSS-related issues. • Ensure staff are aware of specialist referral systems in case there is no capacity available locally. • Train staff on attachment and play-based approaches. • Link with ECD[148] programmes and initiatives where possible.
3.	Lack of accountability to affected populations	• Implement programmes designed to support listening to caregivers, mothers, and their families. • Ensure all staff have received capacity building on communicating with children, open questions, using language which does not alienate or limit understanding (e.g., descriptions of treatments should be easy to understand). • Ensure anonymous feedback structures are in place. • Support staff to address their own stress and well-being, including through peer support networks, coaching and mentoring schemes, fair and supportive HR policies, etc.
4.	Lack of access to the most vulnerable populations	• Provide access to young mothers, children who have married early, children and adolescents who have been affected by physical or sexual violence, mothers and children with disabilities, marginalized mothers, and children, and those who are traditionally excluded. • Strengthen coordination mechanisms in humanitarian contexts (e.g. education, protection, and MHPSS clusters/working groups) to support referrals and follow-up. • Liaise closely with FSL sector to identify families in need of child poverty and other support.
5.	Lack of consideration of MHPSS at project planning stage	• Consider ways to integrate MHPSS and child poverty at the earliest point possible. • Do not try and do 'everything at once.' Consider capacity, resources, and simple initiatives that can be included and built upon as time progresses.

[148] Early childhood development

6.	Lack of specialist support/ referral avenues	• Liaise and engage with national, regional, and local coordination mechanisms in MHPSS, health, child protection, and education to identify support and referral systems. • Work with child protection and health actors (and others if possible) to enable referrals to case management services. • Collaborate and engage with community members to identify safe, informal community supports.
7.	Lack of supportive systems on the part of governments and authorities for the integration of MHPSS, FSL, or cash assistance	• Advocate with governments and relevant actors to strengthen systems that support the integration of MHPSS and child poverty into all health and child poverty spaces.
8.	Lack of evidence available to show the impact of integrating MHPSS into FSL programming	• Ensure interventions are measurable and evidence based as much as possible, with rigorous monitoring and evaluation processes in place.

3.3.5Key child poverty/FSL resources

Global Protection Cluster. Cash and Voucher Assistance and Protection. [website] https://www.globalprotectioncluster.org/old/cash-and-voucher-assistance-and-protection/

Save the Children. 2021. Money Matters: A toolkit for caseworkers to support adult and adolescent clients with basic money management. Field testing version April 2021.

The Alliance for Child Protection in Humanitarian Action. 2020. 'Standard 16: Strengthening family and caregiving environments.' Minimum Standards for Child Protection in Humanitarian Action. 2019 Edition.

The Alliance for Child Protection in Humanitarian Action. 2021. Toolkit for Monitoring and Evaluating Child Protection when using Cash and Voucher Assistance.

3.4 Child protection

3.4.1Key messages on integrating MHPSS and child protection

The following messages summarize the importance of integrating MHPSS and child protection. These messages can be used to build awareness among stakeholders at all levels of the socio-ecological model.

- The experience of violence, abuse, exploitation, and neglect causes psychosocial distress and can lead to longer-term mental health problems for children, particularly when experienced during early childhood.
- Exposure to prolonged psychosocial distress (toxic stress) without adequate caregiver support, such as for children living in protracted humanitarian crises, can impair healthy development and have negative long-term implications for mental health.
- Psychosocial distress and mental health problems in children or caregivers increase children's vulnerability to violence, abuse, exploitation, and neglect and can potentially drive cycles of abuse.
- An integrated focus on mental health/ psychosocial support and child development across socio-ecological levels can:
    - Reduce vulnerability to child protection risks
    - Build children's resilience
    - Ensure an effective MHPSS response to those children who experience violence, abuse, exploitation, and neglect.
- Integrated MHPSS-child protection programming requires the coordination of a continuum of support that involves caregivers, school staff, community focal points, and formal services as appropriate.
- All child protection staff should have a basic knowledge of child development, including:
    - The different stages and domains
    - Attachment and communication with children
    - The impact of toxic stress on a child's development
    - Risk and resilience
    - How to recognize and respond to the specific forms of emotional distress in children

3.4.2Rationale for integrating MHPSS and child protection

Child protection and MHPSS are closely interlinked. Children who have experienced violence, abuse, exploitation, or neglect are most likely to experience psychosocial distress and mental health problems.

Conversely, psychosocial distress and mental health problems increase children's vulnerability to violence, abuse, exploitation, and neglect. The risks of stigma, discrimination, abuse, and associated mental health problems are even greater for children with disabilities.

Caregivers who experience psychosocial distress and mental health problems can have difficulty providing nurturing care, including nutrition, security, and safety. This lack of nurturing care can have lasting impacts on children's development and well-being, particularly in the crucial early years.

These dynamics are heightened for children living through humanitarian crises such as conflict, disaster, epidemics, and food insecurity. The loss of, or separation from, a parent or caregiver may lead to grief and anxiety. Lack of access to basic services, particularly school and learning, can negatively impact the well-being and mental health of children and adolescents. All of these can result in high levels of distress and can negatively impact their emotional, physical, social, and cognitive development.

Parents, caregivers, and teachers must be supported to understand and respond appropriately to children's emotional and behavioural reactions to difficult events. At the community level, MHPSS approaches can challenge stigma and address harmful traditional practices associated with mental health problems. Providing social and recreational opportunities for children of all ages, genders, and abilities supports their well-being. Child protection systems, including community and school systems, should be linked to MHPSS services and supports at all levels of the MHPSS pyramid. Child protection social workers, para-social workers, and community volunteers must be able to identify mental health and psychosocial support needs and refer children and caregivers for focused MHPSS support. MHPSS staff must be able to refer children for child protection services where needed.

In humanitarian crises, child protection work is guided by the Minimum Standards for Child Protection in Humanitarian Action,[149] which provide guidance on integrating MHPSS and child protection.

3.4.3Integrated MHPSS-child protection interventions

3.4.3.1Programmatic considerations

Effective, multi-sectoral referral pathways must be in place between child protection, MHPSS, and other services at all levels of the MHPSS pyramid and the Socio-ecological Framework.

3.4.3.2Aligning MHPSS-child protection interventions to the MHPSS pyramid

The following sections show key entry points/ approaches at each level of the MHPSS pyramid that can be used in integrated MHPSS-child protection programming.

3.4.3.2.1 Level 1: Basic services and security

Integrated interventions at the first level of the MHPSS pyramid seek to meet the following goals:

[149] The Alliance for Child Protection in Humanitarian Action. 2020. Minimum Standards for Child Protection in Humanitarian Action. 2019 Edition

Key Guidance

- Children affected by humanitarian crises receive coordinated MHPSS services and support across child protection, education, and health.
- Children affected by humanitarian crises receive consistent care, predictable routines, and access to social activities.
- All children and families know what services are available and can access them.

Actions that can support those goals include:

- **Promoting MHPSS** in humanitarian coordination. Refer to IASC MHPSS in Emergency Settings Series of Booklets. 2011. What should protection programme manager know?
- **Restoring** a sense of safety. Refer to The Alliance for Child Protection in Humanitarian Action. 2017. Toolkit on Unaccompanied and Separated Children: Inter-agency Working Group on Unaccompanied and Separated Children.
- **Promoting access** to basic services for all children. Refer to IASC Task Team on Inclusion of Persons with Disabilities in Humanitarian Action. 2019. 'Chapter 16: Protection.' Guidelines: Inclusion of Persons with Disabilities in Humanitarian Action. Inter-Agency Standing Committee.
- **For general information**, refer to The Alliance for Child Protection in Humanitarian Action. 2020. 'Standard 18: Case management.' Minimum Standards for Child Protection in Humanitarian Action. 2019 Edition.

Key considerations when implementing these actions include:

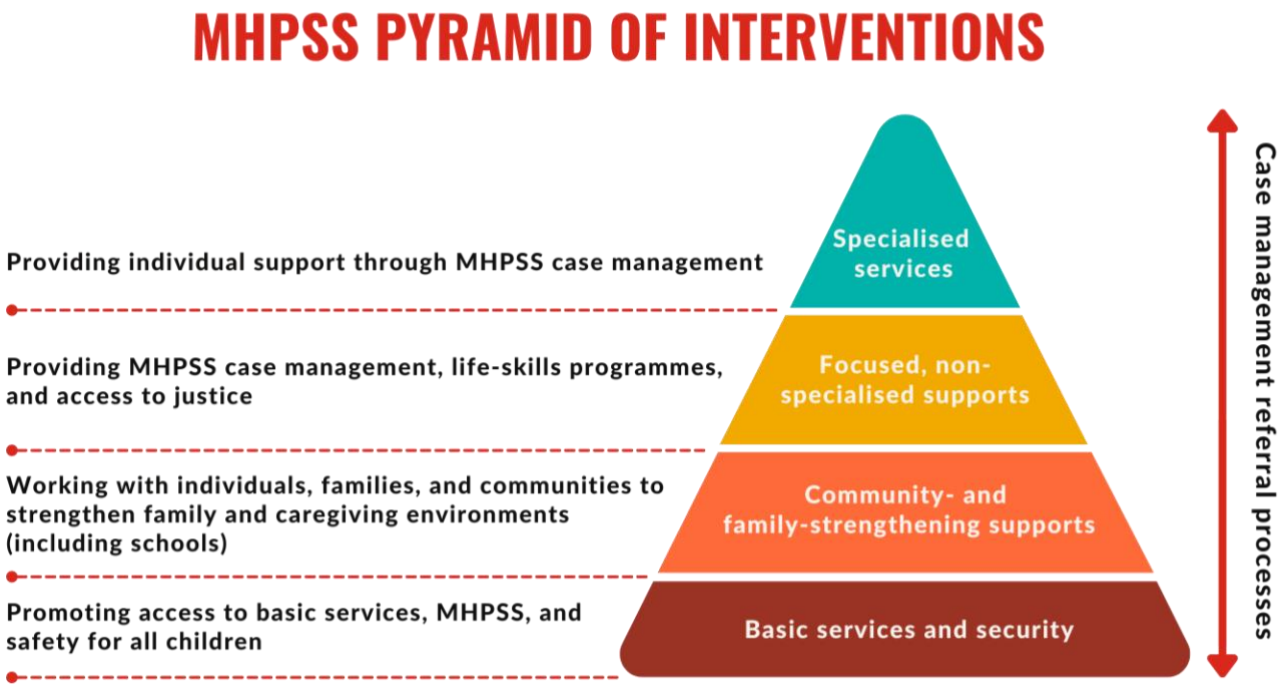
- Actors should understand how MHPSS coordination works in national systems or humanitarian coordination and how child protection can support.
- Localization should be encouraged by supporting co-leadership of humanitarian coordination by national authorities and NGOs.
- Messaging should explain how to promote children's psychosocial well-being within the home and community.
- Information on available services and humanitarian assistance should be presented in child-friendly formats.

Resources that can support implementation of these actions include:

IASC MHPSS in Emergency Settings Series of Booklets .2011.What should protection programme manager know ?

IASC Task Team on inclusion of Persons with Disabilities in Humanitarian Action. 2019. 'Chapter 16: Protection.' Guidelines: Inclusion of Persons with Disabilities in Humanitarian Action. Inter-Agency Standing Committee

The Alliance for Child Protection in Humanitarian Action. 2017. Toolkit on Unaccompanied and Separated Children: Inter-agency Working Group on Unaccompanied and Separated Children.



3.4.3.2.2 Level 2: Community- and family-strengthening supports

Integrated interventions at the second level of the MHPSS pyramid seek to meet the following goals:

- Parent-child relationships and interactions are positive, non-discriminatory, and violence-free.
- The well-being of pregnant women, infants, young children, and their mothers/ caregivers is improved by supporting caregiving practices.
- Family and caregiving environments are strengthened to promote children's healthy development and to protect them from maltreatment and other negative effects of adversity.
- Children live in communities that promote their well-being and prevent abuse, neglect, exploitation, and violence against children.
- Children leaving armed forces and armed groups have their mental health and psychosocial support needs met throughout the release and reintegration process.
- Girls and boys who have experienced or are at risk of SGBV are safe and have their mental health and psychosocial support needs met within their communities.
- Girls and boys who have been injured by landmines or other explosive remnants of war are included and supported within their communities.

Key Guidance

- Teachers and children have the knowledge and skills to keep children safe and promote their well-being in and around schools.

Actions that can support those goals include:

- Support and provide guidance to parents/ caregivers to help them care for their children. Refer to:
    - Save the Children. Parenting without Violence Common Approach.
    - International Rescue Committee and The Alliance for Child Protection in Humanitarian Action. 2021. Growing Stronger Together: A Parenting Program to Support the Reintegration of Children and Prevent their Recruitment.
- Support mother/child groups (see Nutrition). Refer to Action contre la Faim. 2014. Baby Friendly Spaces: Holistic Approach for Pregnant, Lactating Women and their very young children in Emergency.
- Strengthen family and caregiving environments (see Child poverty/ FSL). Refer to:
    - Save the Children. HEART at Home: Guidance for parents/caregivers to support children with expressive arts at home.
    - Save the Children. 'Component 1: Positive parenting group sessions, adult-child interactions, home visits.' Parenting without Violence MEAL Toolkit.
- Work with communities to protect children. Refer to IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings. Community-based Approaches to MHPSS Programmes: A Guidance Note.
- Support the reintegration of children associated with armed forces and armed groups (see CAAFAG). Refer to:
    - The Alliance for Child Protection in Humanitarian Action. 2022. CAAFAG Programme Development Toolkit: Guidelines.
    - The Alliance for Child Protection in Humanitarian Action. 2020. 'Life in the armed group or armed force: Mental health and psychosocial wellbeing' and 'Lessons learnt on key outcomes expected from the reintegration process: Mental health and psychosocial wellbeing.' Girls Associated with Armed Forces and Armed Groups: Lessons learnt and good practices on prevention of recruitment and use, release and reintegration.
- Strengthen social support for children who have experienced sexual and gender-based violence (see SGBV and CEFMU).
- Strengthen social support for child victims of landmines and explosive remnants of war. Refer to:

Key Guidance

  - International Federation of Red Cross and Red Crescent Societies Reference Centre for Psychosocial Support (PS Centre). 2015. Different. Just like you: A psychosocial approach promoting the inclusion of persons with disabilities.
  - UNICEF. 2014. 'Chapter 5: Child-focused Victim Assistance.' Assistance to Victims of Landmines and Explosive Remnants of War: Guidance on Child-focused Victim Assistance.

- Promote well-being in and around schools by responding to child protection and MHPSS concerns (see Education). Refer to:

  - Save the Children. HEART: Healing and education through the arts.
  - Save the Children. 'Action Pack 2: Safe Schools Management; Activity 9: Strengthen Reporting and Referral Procedures.' Safe Schools Common Approach.

- Promote peer to peer support. Refer to United Nations Children's Fund, Save the Children/MHPSS Collaborative and World Health Organization. 2021. I Support My Friends.

- Strengthen caregivers' mental health and social networks by using safety net programming to alleviate stress and mitigate negative coping mechanisms. Refer to:

  - Save the Children. 'Part 1: Basic Psychosocial Skills Refresher' and 'Part 2: Basic Psychosocial Skills.' Basic Helping Skills for Home-based MHPSS.
  - Save the Children, UNICEF, and War Child. Team Up and the Team Up at Home handbook.

- Provide group support for pregnant and lactating mothers, with a focus on SGBV. Refer to Save the Children. 'Mobilize Families and Communities.' Preventing and Responding to Child, Early, and Forced Marriage and Unions.

- Provide support to foster families and children unaccompanied or separated. Refer to:

  - Save the Children. 2013. 'Chapter 4.7: Caregiver and staff roles in supporting children's psychosocial wellbeing' and 'Tool 11: Example Emergency Response Interagency Statement Regarding Coping in the Aftermath of an Emergency (Haiti, 2010).' Alternative Care in Emergencies Toolkit.
  - The Alliance for Child Protection in Humanitarian Action. 2017. 'Chapter 3.1: Preventing and preparing for separation.' Field Handbook on Unaccompanied and Separated Children: Inter-agency Working Group on Unaccompanied and Separated Children.

- Provide support to UASC. Refer to:

  - The Alliance for Child Protection in Humanitarian Action. 2017. 'Tool 04: UASC prevention and preparedness measures.' Toolkit on Unaccompanied and Separated Children: Inter-agency Working Group on Unaccompanied and Separated Children.

  - The Alliance for Child Protection in Humanitarian Action. 2017. 'Chapter 8.3: Actions to take when UASC are identified.' Field Handbook on Unaccompanied and Separated Children: Inter-agency Working Group on Unaccompanied and Separated Children.

- Support sexual and reproductive health (see Health). Refer to Save the Children. 'Comprehensive Sexuality Education.' My Sexual Health and Rights Common Approach.

Key considerations when implementing these actions include:

- Assessment and planning phases should define linkages between child protection risks and mental health and psychosocial distress.
- Provide support to families and communities into which children return or integrate.
- Support children to find a role within their community.
- Work with communities to promote acceptance and community cohesion while ensuring the safety of children, families, communities, and service providers.
- Emphasize resilience building, life skills, peer-to-peer support, support from community and religious leaders, and referrals to individualized specialist support where necessary.

Other resources that can support implementation of these actions include:

Save the Children. Child-friendly Spaces Toolbox and Case Studies.

'Chapter 7: Release and Reintegration.' The Paris Principles: The Principles and Guidelines on Children Associated with Armed Forces or Armed Groups. 2007.

Global Education Cluster and Child Protection Area of Responsibility. 2020. 'South Sudan example of collaboration on delivering school-based MHPSS.' CP-EiE Collaboration in Coordination Framework. p. 19.

Save the Children. 'Action Pack 4: Teachers and Children; Module 8: Acting against SGBV and Module 9: Social and Emotional Learning.' Safe Schools Common Approach.

Save the Children. 'Component 1: Positive parenting group sessions, adult-child interactions, home visits.' Parenting without Violence MEAL Toolkit.

The Alliance for Child Protection in Humanitarian Action. 2020. 'Standard 7: Dangers and injuries,' 'Standard 11: Children associated with armed forces or armed groups,' 'Standard 16: Strengthening family and caregiving environments,' and 'Standard 17: Community-level approaches.' Minimum Standards for Child Protection in Humanitarian Action. 2019 Edition.

3.4.3.2.3 Level 3: Focused, non-specialized supports

Integrated interventions at the third level of the MHPSS pyramid seek to meet the following goals:

- Child protection case workers can understand and respond to the MHPS needs of children, provide basic counselling, supportive listening and advice and information to children and caregivers, and make appropriate referrals.

Key Guidance

- Life-skills programmes support adolescents to develop social skills, higher-order thinking, self-control, positive self-concept, and communication skills.
- Sexual and reproductive health programmes empower adolescents to mitigate the risk and manage the impact of SGBV (see SGBV and CEFMU).
- Boys and girls are empowered and feel valued, respected, and safe within their families and communities.
- Children who have experienced violence, abuse, exploitation, and neglect are supported to access justice in as safe, effective, and meaningful ways as possible.

Actions that can support those goals include:

- Provide individual support through low-intensity psychological intervention. Refer to WHO. 2016. Problem Management +.
- Provide group support through low-intensity psychological intervention. Refer to WHO. Problem Management + in group.
- Implement life-skills programmes (see Child poverty/ FSL). Refer to Save the Children. Life Skills for Success Common Approach.
- Build resilience of children and youth through narrative therapies. Refer to:
    - REPSSI. 2016. Tree of life.
    - REPSSI. 2009. Making a hero book.
    - Save the Children. 'Component 2: Structured group sessions for children and young people (6–9, 10–13, 14–17).' Parenting without Violence Common Approach.
- Support survivors of SBGV. Refer to:
    - International Rescue Committee. 2012. 'Chapter 6: Psychosocial Interventions for Child Survivors,' 'Training Module 17: Psychosocial Interventions,' and 'Child and Family Psychosocial Needs Assessment Tool.' Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings [First Edition].
    - Save the Children. 'Section 6: Special Circumstances (SGBV, UASC, CoM, CAAFAG).' Steps to Protect Common Approach.
- Increase and ensure quality in psychological support of staff and partners. Refer to EQUIP for enhancing MHPSS services and its supervision.

Key considerations when implementing these actions include:

- Small group-based methodologies can be used to build protective assets and foster more equitable gender attitudes, behaviours, and norms.

Key Guidance

Other resources that can support implementation of these actions include:

‘Chapter 8: Justice.’ The Paris Principles: The Principles and Guidelines on Children Associated with Armed Forces or Armed Groups. 2007.

Save the Children. Steps to Protect Common Approach.

The Child Protection Working Group. 2014. Inter -Agency Guidelines for Case Management and Child Protection—The Role of Case Management in the Protection of Children: A guide for policy and programme managers and caseworkers.

3.4.3.2.4 Level 4: Specialized services

Integrated interventions at the fourth level of the MHPSS pyramid seek to meet the following goals:

- Child protection case workers can understand and respond to the MHPS needs of children with specific and complex issues.

Actions that can support those goals include:

- Provide individualized support through child protection case management (see CAAFAG, SGBV, CEFMU, and Children facing loss and grief).

Key considerations when implementing these actions include:

- Link interventions with Suicide Risk Management Protocols and the Suicide Intervention Protocols.

Resources that can support implementation of these actions include:

UNICEF. 2014. ‘Chapter 5.4: Psychological and psychosocial support.’ Assistance to Victims of Landmines and Explosive Remnants of War: Guidance on Child-focused Victim Assistance.

3.4.3.3 Aligning MHPSS-child protection interventions to the Socio-ecological Framework

The Socio-ecological Framework presented in the beginning of this document shows three levels – individual, family, and community – being influenced by gender and power dynamics. Figure 18 illustrates how Save the Children's goals for integrated MHPSS-child protection interventions fit into this model. Specific interventions can address specific socio-ecological levels.

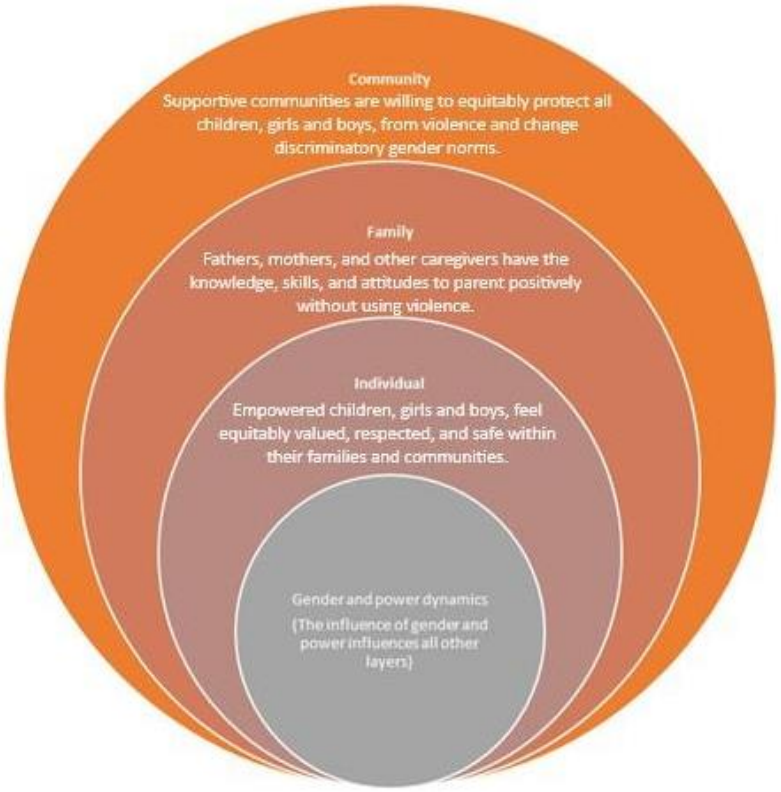


Figure 18: Integrated MHPSS-child protection according to the Socio-ecological Framework

3.4.3.3.1 Individual

Individual-level interventions supported by Save the Children include:

- Individualized child protection case management (e.g. Steps to Protect, Caring for Child Survivors)
- Life-skills programmes (Life Skills for Success)
- Sexual and reproductive health

3.4.3.3.2 Family

Family-level interventions supported by Save the Children include:

- Parenting programmes (Parenting without Violence Common Approach)
- Mother/child support groups (e.g. IYCF/MHPSS Training Package see Nutrition)
- Strengthening family and caregiving environments (e.g. social safety nets)
- Family tracing and reunification

3.4.3.3.3 Community

Community-level interventions supported by Save the Children include:

- Community-level child protection (e.g. Community-led Child Protection Common Approach)
- Group activities for child well-being (e.g. Child Resilience within Parenting without Violence Common Approach, child-friendly spaces, HEART, Team Up)

- Prevention of separation
- Reintegration of CAAFAG
- Social supports for SGBV survivors (e.g. Preventing and Responding to Child, Early, and Forced Marriage and Unions)
- Addressing barriers to education
- Promoting well-being in and around schools (e.g. Safe Schools Common Approach)

3.4.3.3.4 Society

Many versions of the Socio-ecological Framework include another layer: society. Save the Children's societal goal is: 'Institutional systems and legal frameworks are gender-sensitive, support families, and ban violence against women and children.'

Society-level interventions supported by Save the Children include:

- **Integrated systems-building and social service workforce strengthening** (with health and education)

  In an integrated national MHPSS framework, government departments with a focus on health, education, and child protection also support children's MHPSS (e.g. Iraq child-focused recovery approach to Nexus Programming).

- **Data collection and child rights reporting**

  Data is systematically collected to monitor states' efforts to promote psychological recovery and social reintegration of children who experience violence, abuse, exploitation, or neglect; torture or cruel, inhuman, or degrading treatment or punishment; or armed conflicts (e.g. Child Rights Reporting Common Approach, especially article 39).

- **Integrated MHPSS in humanitarian coordination**
- **Access to justice**

3.4.4Potential challenges and solutions

Figure 18 shows common challenges to implementing integrated MHPSS-child protection programmes as well as potential solutions that can help overcome those challenges.

Figure 18	Challenges	Recommendations
1.	Limited knowledge and capacity to address the MHPSS needs of children who have experienced specific	• Train all child protection staff on how to support the mental health and psychosocial well-being of children who have experienced specific child protection issues through direct

	forms of violence, abuse, exploitation, and neglect	support and referral for specialised services (see SGBV, CAFAAG, Children on the move, and Loss and grief). • Train and raise awareness of child protection staff on the linkages between mental health and disability and promote their meaningful participation in MHPSS/CP activities.
2.	Limited access of child protection staff to children most at risk of violence, abuse, exploitation, and neglect and/or with highest MHPSS needs because of movement restrictions or remoteness	• Use adaptations of all common approaches for the COVID-19 context support remote working. • Refer to best practice in the provision of remote, person-focused MHPSS.
3.	Limited access of child protection staff to children most at risk of violence, abuse, exploitation, and neglect and/or with highest MHPSS needs because of security or non-acceptance	• Identify entry points with access to affected communities and 'at risk' children and caregivers (e.g. health and nutrition services) and integrate key messages about child protection and MHPSS. • Use population or household registration exercises to identify children at particular risk (e.g. separated children, married girls, and children with disabilities) and to reach them with key messages. • Use radio and other remote communication means to provide information to caregivers on how to understand and support their children.
4.	Lack of focused specialised and non-specialised MHPSS supports to refer children to	• Work at the community level to identify and strengthen safe, child-friendly, and gender-sensitive community-level MHPSS (e.g. child/ adolescent peer-to-peer support, para-social worker training on providing individual and group psychosocial activities) to address child protection and MHPSS needs. • Work across sectors (e.g., health, education, child protection) at the national and sub-national levels and through humanitarian coordination mechanisms to identify focused, specialised and non-specialised MHPSS services and to strengthen referral mechanisms. • Identify critical key gaps in service provision and collectively advocate for national/ donor funding to address these gaps.
5.	Short funding cycles and weak pipelines that prevent needed, sustained child protection-MHPSS interventions	• Consider planned longevity in the design of child protection and MHPSS interventions (particularly in humanitarian contexts). (e.g., If presence may be short-term, only address what can be achieved through short-term interventions and focus on capacity-building for key stakeholders.)

		• Where medium- to long-term presence is planned, develop MHPSS-child protection programme strategies, objectives, and steps that address specified needs and cross funding cycles. • Seek medium-term or renewable funding sources and engage donors in dialogue to explain the need for sustained interventions. • Ensure SMT oversight and decision-making on the initiation, quality, and sustainability of interventions that support work with individual children on sensitive issues.
6.	Weak or non-existent coordination mechanisms for MHPSS in humanitarian crises	• Take actions to develop and strengthen cross-sectoral coordination MHPSS mechanisms (see Section 2.5.4.). • Focus on strengthening localization and the inclusion of people with disabilities within coordination activities and mechanisms.
7.	Lack of framework to support the integration of child protection and MHPSS across government departments	• Work with national-level advocacy and child rights governance colleagues to develop a cross-sectoral approach to MHPSS, including a framework with objectives, actions, and accountabilities across relevant ministries and departments.
8.	Lack of child focus within accountability mechanisms	• Promote a child-centred approach to justice for children by always considering the best interest of each child involved and obtaining the child and caregivers' informed consent/assent. • Promote adherence to international legal principles related to children in contact with the law (e.g. The Riyadh Guidelines,[150] Rules for the Protection of Juveniles Deprived of their Liberty,[151] and The Beijing Rules[152]). • Work with global and national advocates to support justice for international crimes against children, including ensuring better and more sustained outreach, witness protection, and psychosocial support.
9.	Lack of evidence demonstrating the impact of integrating MHPSS and child protection	• Consider using the global definition of child well-being[153] as an objective for child protection programming and develop a contextualised framework for measuring it.

[150] United Nations General Assembly. 1990. United Nations Guidelines for the Prevention of Juvenile Delinquency (The Riyadh Guidelines). General Assembly resolution 45/112. Adopted 14 December 1990.

[151] United Nations General Assembly. 1990. United Nations Rules for the Protection of Juveniles Deprived of their Liberty. General Assembly resolution 45/113. Adopted 14 December 1990.

[152] United Nations General Assembly. 1985. United Nations Standard Minimum Rules for the Administration of Juvenile Justice ("The Beijing Rules"). General Assembly resolution 40/33. Adopted 29 November 1985.

[153] The Alliance for Child Protection in Humanitarian Action. 2021. Defining and Measuring Child Well-Being in Humanitarian Action: A Contextualization Guide. p.7.

Key Guidance

3.4.5Key child protection resources

Save the Children. 'Section 4.8: SOPs' and 'Section 4.9: Service Mapping and Referral Pathways.' Steps to Protect Common Approach.

The Alliance for Child Protection in Humanitarian Action. 2020. 'Standard 10: Mental health and psychosocial distress;' 'Standard 15: Group activities for child well-being;' 'Standard 16: Strengthening family and caregiving environments;' 'Standard 17: Community-level approaches;' 'Standard 18: Case Management;' and 'Standard 24: Health and child protection.' Minimum Standards for Child Protection in Humanitarian Action. 2019 Edition.

The Alliance for Child Protection in Humanitarian Action. 2022. Standard Operating Procedures (SOPs) Template.

IA Training on Safe Identification and Referral *(forthcoming)*

3.5 WASH

3.5.1Key messages on integrating MHPSS and WASH

The following messages summarize the importance of integrating MHPSS and WASH. These messages can be used to build awareness among stakeholders at all levels of the socio-ecological model.

- Access to safe, culturally appropriate WASH facilities and interventions is a primary need for all.
- Lack of access to clean, safe, and appropriate hygiene and sanitation facilities can be a significant source of stress for children, caregivers, and communities.
- Integrating MHPSS into WASH programmes can support the development and implementation of safe, secure facilities which meet the diverse and critical needs of all community members.
- Specific groups (e.g., menstruating girls and women, mothers and children, persons with disabilities, etc.) must be consulted in the design and implementation of WASH facilities and interventions.
- Vulnerable groups can be reached more easily when MHPSS and community-based approaches are integrated into WASH programming.
- MHPSS interventions can help address harmful traditional practices that may surround menstruation.

3.5.2Rationale for integrating MHPSS and WASH

Lack of access to clean, safe, and appropriate hygiene and sanitation facilities can be a significant source of stress for children, caregivers, and communities. In order to ensure the well-being of communities, WASH facilities must be developed in collaboration with the people who need them. By more explicitly integrating MHPSS into WASH programmes, we can support the development and implementation of safe, secure facilities which meet the diverse and critical needs of all members of the community.

Access to safe WASH facilities is a primary need for all and is particularly important for specific groups of people, including:

- People experiencing mental health difficulties that impact their ability to manage their hygiene needs and those of their children
- Adolescent girls and women
- Infants and young children
- Persons with disabilities

Key Guidance

- Unaccompanied and separated boys aged 10–13

Similarly, vulnerable groups can be reached more easily when MHPSS and community level interventions approaches are integrated into WASH programming. MHPSS-WASH messaging needs to be accessible and adapted for children, people with disabilities, and other vulnerable groups so that hygiene messages (including on infectious disease outbreaks) and hygiene promotion activities are clear, comprehensive, and culturally appropriate.

Adolescent girls and women should never be excluded from accessing WASH facilities due to safety concerns, lack of privacy, or facilities which do not support their dignity. Participatory MHPSS approaches and messaging can support women and girls to engage in decision-making on facility design, participate in menstrual hygiene programmes, and develop solutions that are culturally appropriate and ensure their health, human rights, and dignity.

Menstrual issues (e.g., disposal of waste, management and cleaning of menstrual products, etc.) can be extremely difficult for women and girls. Girls and adolescents who are not supported in the management of menstruation face the risk of school drop-out, as they may face stigma, shame, and challenges to their mental well-being. MHPSS interventions can help address harmful traditional practices that may surround menstruation. Strategies such as group discussions and consultations and engagement with women's groups, community leaders, teachers, the school community, and sexual and reproductive health programmes can support WASH programmes to improve the lives of adolescent girls and women who menstruate.

Infants and young children are particularly susceptible to WASH-borne diseases and diseases caused by unsafe water and poor sanitation". This can be a source of emotional stress to mothers and caregivers as well as a significant cause of health problems and disease in communities and vulnerable populations.

Mothers, caregivers, and children need to be consulted on ways to facilitate access to water points that are easily accessible, safe, and numerous enough that children do not miss school or spend long hours waiting at water and washing points. Integrated MHPSS-WASH approaches can maximize opportunities for mothers and children to engage in the design and management of facilities to keep them safe, protect their health, and support their well-being and daily functioning.

Unaccompanied and separated boys aged 10–13 is a vulnerable group that lacks parental care and faces huge risks of sexual and other forms of violence. In planning WASH facilities, it is crucial to provide separate showers and toilettes for this particular group of children and to provide regular monitoring and feedback/complaint mechanisms for them.

People with disabilities need access to appropriate hygiene and sanitation facilities which support their dignity and human rights. Children with disabilities often find it difficult to use hygiene and sanitation facilities that do not use universal design standards. This can potentially cause emotional and/or physical distress.

Cultural relevance should be considered to ensure all aspects of WASH programming are sensitive and appropriate, particularly the development and distribution of hygiene and dignity kits (including for SGBV response and prevention) for the people who need them. Key MHPSS messages about stress and coping, self-care, and seeking help can be integrated in these activities.

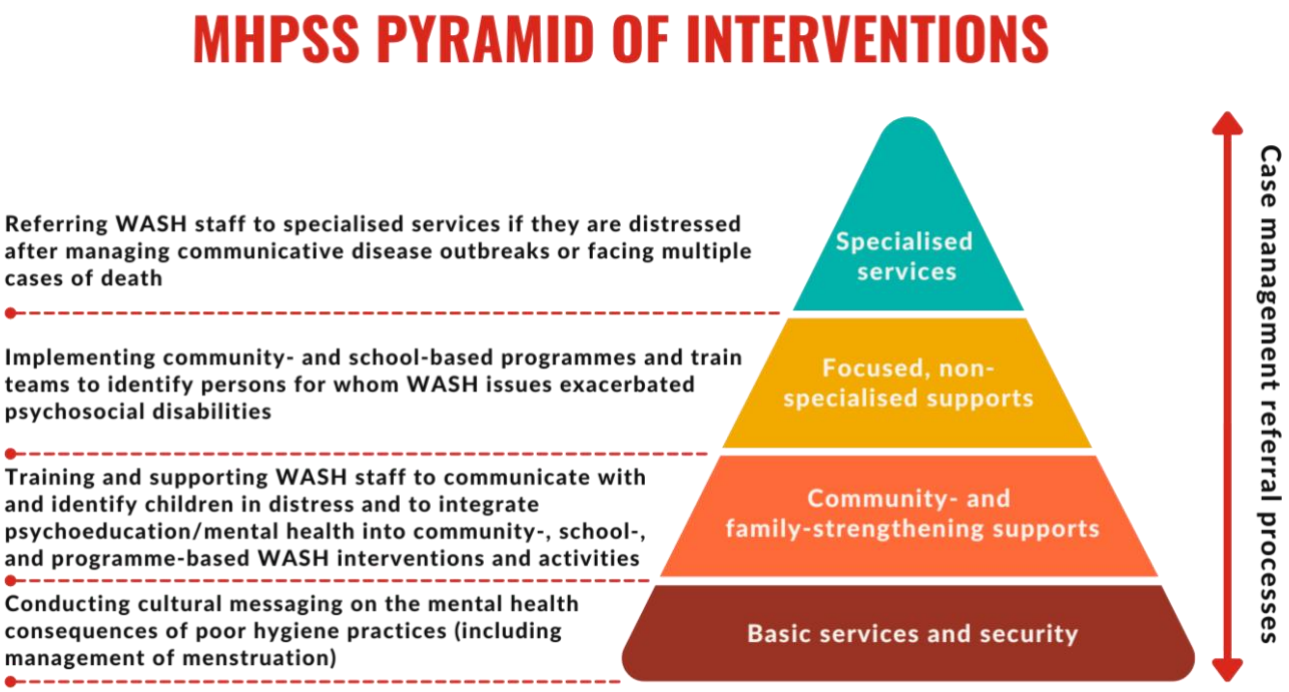
3.5.3Integrated MHPSS-WASH interventions

3.5.3.1Programmatic considerations

- Refer to the IASC MHPSS guidelines in emergency settings. Action sheet 11.1 Include specific social considerations (safe and culturally appropriate access for all in dignity) in the provision of water and sanitation.
- All WASH staff should receive an orientation on:
  - Training on Psychological First Aid
  - Promoting safety and protection in all water sanitation activities
  - Referral pathways to health services and psychosocial support providers[154]

3.5.3.2Aligning MHPSS-WASH interventions to the MHPSS pyramid

The following sections show key entry points/ approaches at each level of the MHPSS pyramid that can be used in integrated MHPSS-WASH programming.



[154] Child fund. 2015.Strengthening community-based child protection referral pathways-a resource manual. Module 6 Community engagement

Key Guidance

3.5.3.2.1 Level 1: Basic services and security

Integrated interventions at the first level of the MHPSS pyramid seek to meet the following goals:

- WASH planners and staff recognize the psychological factors (cause and effect) relating to WASH.
- WASH services present less risks to psychological well-being of children and families.
- Increased opportunities for and acceptability of equitable access to WASH exist for all.

Actions that can support those goals include:

- **Planning and resourci**ng WASH services and interventions
- **Conducting messaging** about basic services available to people affected by humanitarian crisis or emergency
- **Engaging in community-based hygiene** promotion activities
- **Integrating MHPSS messages** into the distribution of hygiene and dignity kits
- **Raising awareness** of integrated MHPSS dimensions (e.g., stress, coping and self-care strategies, etc.)

Key considerations when implementing these actions include:

- Barriers to prioritisation due to low WASH staff awareness of benefits on MHPSS integration

Resources that can support implementation of these actions include:

The Alliance for Child Protection in Humanitarian Action. 2020. 'Standard 26: Water, sanitation and hygiene (WASH) and child protection.' Minimum Standards for Child Protection in Humanitarian Action. 2019 Edition.

3.5.3.2.2 Level 2: Community- and family-strengthening supports

Integrated interventions at the second level of the MHPSS pyramid seek to meet the following goals:

- Interventions reduce isolation and build networks of social connectedness and support.
- Mental health is normalized and de-stigmatized.

Actions that can support those goals include:

- **Implementing** integrated community- and school-based WASH programmes. Refer to Oxfam. Working with children in Hunatraian WASH programmes.

- **Supporting and building upon** existing programmes, community groups (e.g. women's groups, child, and school clubs), and structures. Refer to Manual for a Community-Led Urban Safety Audit (pages 43-71).
- **Engaging with men and boys** in workplaces/ community spaces
- **Installing well-being stations** at water collection points
- **Using disability-positive approaches**. Refer to IASC guidelines on inclusion of persons with disabilities in humanitarian action – section on mental health.
- **Integrating psychoeducation activities** into WASH service provision in case of epidemy. Refer to:
    - Country-based example of Haitian Psychosocial Support programme Cholera outbreak: note on community beliefs, feelings and perceptions
    - ACF. 2013. Luttons contre le choléra !le rôle des EAH et SMPS dans le lutte contre le choléra -in French.

Key considerations when implementing these actions include:

- Low WASH staff awareness of the benefits of integration could be a barrier to prioritizing integration.
- Programming should include a focus on promoting/ protecting positive mental health.
- The inclusion and equity of the most vulnerable groups should be a primary emphasis.

Resources that can support implementation of these actions include:

Child Protection Area of Responsibilities. 2021. Working with other sectors to enhance outcomes of MHPSS elements of child protection. An introductory guide for child protection practitioners. Section on WaSH.

3.5.3.2.3 Level 3: Focused, non-specialized supports

Integrated interventions at the third level of the MHPSS pyramid seek to meet the following goals:

- Communities support all members' mental health and equal access to appropriate WASH facilities
- Communities prevent and manage conflict in a constructive manner when facing migration and displacement.

Actions that can support those goals include:

- **Supporting and implementing** integrated community- and school-based WASH programmes
- **Providing access** to basic counselling and emotional support from non-specialist workers

- **Supporting or developing** facilitated peer support/ self-help groups. Refer to WHO. 2020. Doing what matters in time of stress.

Key considerations when implementing these actions include:

- WASH plays a key role in ensuring the well-being of people, including persons with disabilities and their families, who may need to access extra quantities of water as well as extra or specific hygiene-related items, and have reliable access to water and sanitation infrastructures.[155]
- Persons with disabilities who live in isolation or in institutions, or who are not included in mainstream services, such as education, may be excluded from WASH-related information and therefore be at higher health and water-related risks, which can be life-threatening for them and their families.[156]
- Providers must receive regular, supportive supervision.
- Practice guidelines and/or standard operating procedures must cover eligibility, entry routes into support, coordinated care, confidentiality, record-keeping, and emergency procedures.

Resources that can support implementation of these actions include:

PFA II dealing with traumatic response in children[157]

IASC. 2019. Guidelines on inclusion of persons with disabilities in Humanitarian Action. Section 18 Water, Sanitation and Hygiene.

3.5.3.2.4 Level 4: Specialized services

Integrated interventions at the fourth level of the MHPSS pyramid seek to meet the following goals:

- WASH staff make appropriate referrals to specialized services as needed and available.

Actions that can support those goals include:

- **Referring** those in need to specialized services during crisis response WASH delivery wherever possible
- **Establishing referral pathways** to adjunct specialist support for people with complex or long-term mental health needs

Key considerations when implementing these actions include:

- WASH staff will not always be able to provide this level of support (see Section 1.4.2.1.).

[155] IASC.2019. Guidelines on inclusion of persons with disabilities in Humanitarian Action. Section 18 Water, Sanitation and Hygiene
[156] IASC.2019. Guidelines on inclusion of persons with disabilities in Humanitarian Action. Section 18 Water, Sanitation and Hygiene
[157] Save the Children.2017.PFA II Dealing with traumatic response in Children

3.5.4Potential challenges and solutions

Figure 19 shows common challenges to implementing integrated MHPSS-WASH programmes as well as potential solutions that can help overcome those challenges.

Figure 19	Challenges	Recommendations
1.	Stigmatization of women and people with disabilities	• Train WASH personnel, including community health workers, on MHPSS approaches. • Ensure referral pathways for additional support link to all layers and services of the MHPSS pyramid. • Implement awareness-raising campaigns on normalizing mental health and basic strategies for supporting well-being and self-care. • Implement integrated awareness-raising campaigns that de-mystify mental health and deliver health and hygiene messages. • Implement awareness-raising to deconstruct harmful practices and attitudes which perpetuate stigmatization of people with disabilities.
2.	Lack of access to WASH for people with disabilities	• Collaborate with other organizations to conduct needs assessments and mappings to appropriately adapt WASH facilities for persons with disabilities. • Organise meetings with community representatives and collaborate with them in providing additional support for persons with disabilities. • Work with MHPSS teams at national, regional, and global levels to strengthen collaboration between MHPSS and WASH for persons with disabilities.
3.	Lack of staff capacity for integrating MHPSS and WASH (including lack of capacity or knowledge that leads to low identification of children and caregivers in need of support)	• Train all WASH staff on PFA. • Build regular capacity-building opportunities into on-going staff training and support, including development of user-friendly and locally meaningful vocabulary that can be used for discussing MHPSS-related issues. • Ensure collaboration at field level (i.e., co-deploy MHPSS expertise with WASH). • Train staff on how poor mental health influences people's access to sanitation and use of good hygiene practices. • Train and support staff to prioritize the psychosocial needs of children with disabilities. • Ensure staff receive supervision and mentoring.
4.	Lack of capacity in active listening and interpersonal skills	• Implement programmes to support listening to caregivers and children.

Key Guidance

		• Train all staff on communicating with children, open questions, and using language which does not alienate or limit understanding. • Train and support staff to communicate with children with disabilities, including those with communication challenges.
5.	Lack of feedback mechanisms for children and families	• Ensure anonymous feedback structures are in place (not only suggestion boxes).
6.	Lack of supervision support for field-level staff	• Ensure staff have strategies in place to address their own stress and well-being (e.g., peer support networks, coaching and mentoring schemes, fair and supportive HR policies).
7.	Inequitable access to WASH for the most vulnerable groups	• Ensure access to young mothers, children who have married early, children and adolescents who have been affected by physical or sexual violence, mothers and children with disabilities, marginalized mothers and children, and those who are traditionally excluded. • Strengthen coordination mechanisms in humanitarian contexts (e.g. education, protection and MHPSS clusters/working groups) to support referrals and follow-up. • Liaise closely with other sectors (FSL, protection, health) to identify families in need of WASH and other support. • Train WASH staff to facilitate inclusion in interventions.
8.	Lack of consideration of MHPSS at project planning stage	• Consider ways to integrate MHPSS and WASH at the earliest point possible. • Do not try and do ‘everything at once:’ consider capacity, resources, and how to include simple initiatives that can be built upon as time progresses. • Include the needs of children with disabilities during the project design and planning phases.
9.	Lack of knowledge of/ access to clinical and non-clinical specialist support	• Liaise and engage with national, regional, and local coordination mechanisms in MHPSS, health, child protection, and education to identify support and referral systems. • Work with child protection and health actors (and others if possible) to enable referral to case management services. • Collaborate and engage with community members to identify safe, informal community supports.
10.	Lack of MHPSS staff at the field level	• Ensure that MHPSS staff will be part of field teams. • Provide MHPSS TA from different sources.
11.	Lack of awareness of sexual harassment and GBV risks at WASH locations	• Inform staff about risks and previous examples of good practices in establishing latrines and showers. • Work with key WASH staff to install adequate lighting in and around the latrines and showers to avoid potential sexual harassment and/or GBV.

12.	Lack of supportive systems by governments and authorities for integrating MHPSS into WASH	• Advocate with governments and relevant actors to strengthen systems which support the integration of MHPSS and WASH.
13.	Lack of evidence that shows the impact of integrating MHPSS into WASH	• Ensure interventions are as measurable and evidence based as possible, with rigorous monitoring and evaluation processes.
14.	Low utilization of the existing evidence base	• Register for free access to research/ publications (e.g., WHO-Hinari Programme: https://partnership.who.int/hinari) • Join local monthly journal clubs or access links to monthly research summaries of MHPSS-related research.
15.	Lack of privacy and appropriate gender-sensitive facilities for appropriate menstrual hygiene	• Work with technical and operational WASH staff at the field level to ensure facilities are both gender- and MHM- appropriate. • Have MHPSS staff provide WASH staff with short trainings on the important links between MHPSS, WASH, and MHM. • Organize discussions with community representatives and women to explore contextual MHM issues and collectively find acceptable solutions.

3.5.5Key WASH resources

Ghassemi, Emily. 2021. 'What do we actually know about mental health and handwashing? Findings from a scoping literature review on handwashing and mental health in humanitarian crises.' IRC.

GWC Helpdesk. 'Global WASH Cluster.' [website] https://www.washcluster.net/

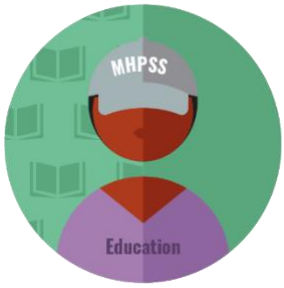
MHCP and WASH sectors. 2013. 1+1=3: How to integrate WASH and MHCP activities for better humanitarian projects. ACF International.

The Alliance for Child Protection in Humanitarian Action. 2020. 'Standard 26: Water, sanitation and hygiene (WASH) and child protection.' Minimum Standards for Child Protection in Humanitarian Action. 2019 Edition.

WHO and Hinari. 'Hinari Access to Research for Health programme.' [website] https://partnership.who.int/hinari

Key Guidance

3.6 Education



This document focuses on the integration of MHPSS within all formal and non-formal learning spaces, including schools, temporary learning spaces, and home-based learning. For the purposes of the document, the term 'learning spaces will include **all safe settings where learning takes place**.

3.6.1Key messages on integrating MHPSS and Education

The following messages summarize the importance of integrating MHPSS and education. These messages can be used to build awareness among stakeholders at all levels of the socio-ecological model.

- All children have the right to a quality education that supports their learning and well-being. Integrating MHPSS into quality, psychosocially supportive and protective education leads to improvements in children's well-being as well as their overall learning and academic outcomes.[158]
- Save the Children promotes the integration of MHPSS within all schools and learning spaces, including early childhood care and development (ECCD) centres, primary and secondary schools, temporary learning spaces, and child-friendly spaces.
- MHPSS integration into Education programmes should extend into the home and engage learners' families in understanding, experiencing, and supporting their children's (and their own) social and emotional development and well-being. This includes also to involve caregivers and communities in learning activities
- Teachers/facilitators who are stressed, struggling to manage their own emotions, overworked, or dealing with large groups of children may find it more difficult to teach and model/provide emotional stability to children who are struggling academically and/or emotionally. Teachers/facilitators must be supported to develop and foster strategies that support their own mental health and well-being.
- The educational engagement and outcomes of girls and boys can be improved by implementing MHPSS approaches and initiatives that address their needs. Girls who access quality education benefit from academic achievement, peer support, and reduction in isolation and are more likely to send their own children to school.
- Many children with disabilities do not have access to quality instruction and support because of a lack of tailored, responsive strategies, and/or because they face discrimination, stigmatization, and bullying.
- Qualitative MHPSS interventions within schools should include actions that:

[158] INEE. 2018. Guidance Note. Psychosocial Support: facilitating psychosocial wellbeing and social and emotional learning.

- Support teachers' well-being and strengthen teachers' capacity to identify, respond to, and refer children in need of higher-level services
- Psychological first aid (PFA) training for child practitioner's version for teachers ensure that teachers learn the child development and tools to be able to combine knowledge and understanding around children in distress.
- Incorporate social-emotional learning (SEL) as a key component in the formal curriculum, teacher/facilitator practice, extracurricular activities and learning at home promote children's development and well-being
- Ensure inclusion and support for all children in learning environments, including those with pre-existing mental health conditions, physical and/or psychosocial disabilities, or other MHPSS needs.
- Inter-sector and inter-agency coordination is critical. Encourage and support the education coordination groups (Cluster, EiE Working Group, Local Education Group etc.) to engage with CP, GBV, and health coordination groups to **define role and responsibilities for each sector in responding to the needs of the children, caregivers and teachers to avoid duplication, maximize the coverage and improve the quality of care** (see guidance on inter-cluster collaboration for MHPSS).

3.6.2Rationale for integrating MHPSS and Education

All children have the right to a quality education[159] that supports learning and well-being. A quality education is critical to supporting children's well-being, and well-being is critical to overall learning and academic success. Child well-being is informed by how children interact with their peers, family, community, and society around them, at different points in their lives. Well-being is enhanced when children can fulfil their personal and social goals, and hindered when exposed to harm, like violence or toxic stress. Prolonged exposure to toxic stress can have long-term negative impacts on executive functioning and emotional regulation – potentially impacting cognitive development and the ability to learn.

Both Education and MHPSS approach support children's well-being and holistic child development.[160] By promoting holistic development (i.e., cognitive, emotional, spiritual, social, and physical), education helps children (from birth to the start of adulthood) to fulfil their goals and reach their greatest potential. By protecting and promoting psychosocial well-being, and preventing/treating mental distress and problems, MHPSS increases children's potential to learn, thrive, and respond to life's challenges.

[159] **Basic Education:** Covers the education stages as defined by the education laws in the country. Save the Children follows UNESCO's definition of Basic Education[1] which includes a whole range of educational activities, taking place in various settings, that aim to meet basic learning needs as defined in the World Declaration on Education for All (Jomtien, Thailand, 1990). It also covers a wide variety of non-formal and informal public and private activities intended to meet the basic learning needs of people of all ages.

[160] Holistic child development is the ongoing process of growth that starts from the moment children are conceived and continues until they reach adulthood. It includes the cognitive, emotional, spiritual, social, and physical development of children and is concerned with helping them reach their greatest potential. REPSS (August 2009)

Key Guidance

The integration of MHPSS into quality, psychosocially supportive and protective education not only leads to improvements in children's well-being but also to their overall learning and academic outcomes.[161] For example, an evaluation of a programme in Afghanistan and Palestine, which integrated psychosocial support with classroom instruction, found a reduction in nightmares, distressing emotions and physical illness, an increase in interest in attending school and completing homework, and an increased sense of safety.[162] Children's well-being and learning can be supported by integrating MHPSS into the following aspects of quality education (see Save the Children's Quality Learning Framework).

3.6.2.1Safe and protective Learning environments

Save the Children promotes the integration of MHPSS within all schools and learning spaces; this includes ECCD centres, schools, temporary learning spaces/child-friendly spaces. Regular attendance at safe schools and learning spaces provides structure and routine, gives children opportunities to learn, play and socialize in healthy and green spaces, and access to peers and supportive adult role models. All of this is particularly important for mental health and psychosocial well-being, especially in periods of instability or in contexts of crisis. When children are exposed to violence in schools and learning spaces, bullying, stigmatisation or exclusion, their healthy development into adulthood may be curtailed, and their learning outcomes are negatively affected. MHPSS approach is fundamental to addressing violence and supporting safe and protective learning environments in which all children can learn and thrive. The integration of MHPSS in schools and learning spaces includes the establishment of referral mechanisms and the strengthening of the capacities of school leaders and teachers to identify, respond to and refer children to MHPSS appropriate services.

3.6.2.2Engaging caregivers and the school community

Parents, caregivers, and families are children's first teachers and play a critical role in supporting holistic child development from birth through to adulthood. During the early years of life and often in crisis, like the Covid-19 school closures, parents/caregivers support home-based learning and children's education continuity. As a result, MHPSS integration into education programmes should also extend into the home and engage learners' families in understanding, experiencing, and supporting their children's social and emotional development and well-being. This must also include MHPSS for parents/caregivers who may also be experiencing distress or traumatic situation.

Parents/caregivers and children's families are all part of the school/learning space community (including teachers/facilitators, school leadership and personnel, and all those with a vested interest in children's education). School communities need to be strengthened to provide a safe, protective, and inclusive learning environment. When the school community fully comprehends the significance and value of MHPSS, mainstreaming MHPSS into the school becomes a priority, and the school can then be a center of care and support for learners' holistic development.

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161 Education cannot wait. 2019. Healing and Recovery Through Education in Emergencies.

162 World Bank. 2021. The Global Cost of Inclusive Refugee Education. pg. 20

3.6.2.3Teachers' well-being and role

Educators have a crucial role to play in supporting the mental health and psychosocial well-being of learners. However, when teachers/facilitators are stressed, struggling to manage their own emotions, are overworked or dealing with large groups of children, their ability to teach, and model/provide emotional stability to children who may be struggling academically and/or emotionally, becomes more difficult. Under such circumstances, teachers/facilitators may resort to using physical and humiliating punishment. Teachers/facilitators themselves must develop and foster strategies to support their mental health and well-being so that they can respond to the educational and emotional needs of their students.

Integrating MHPSS into teacher/facilitator professional development programs provides educators with the assistance, knowledge, and skills to foster the development of all children, including those exposed to adversity. Training, coaching, and support for teachers/facilitators can improve their well-being and provide them with a clear understanding of their role in promoting the well-being of their students and creating a safe and protective environment

3.6.2.4Socio and Emotional Learning

Social and Emotional Learning (SEL) is a form of Mental Health and Psychosocial Support (MHPSS) that is specific to education. SEL is the process through which children acquire and effectively apply the knowledge, attitudes, and skills necessary for their holistic development. These skills are generally organized into cognitive, social, and emotional domains and interact with individual attitudes, beliefs, mindsets, and values (EASEL Lab, 2022). Integrating SEL into learning at home with parents/caregivers, as well as in curricula, teacher/facilitator practice, and school-wide activities, fosters children's development of social and emotional skills, which are critical to children's well-being and development. For more information and practical guidance on SEL, refer to Save the Children's SEL in Education Program guidance

3.6.2.5Gender transformative Education

In many countries girls are denied their right to education, putting them at risk for early forced marriage, child labor, sex trafficking, and other forms of harm. Of those girls who manage to attend school/learning spaces, many face violence, abuse, and harassment at the hands of teachers/facilitators and fellow students in school or by men and militants on the way to school. Harmful gender norms and practices also affect what and how girls learn and are taught. Lower literacy outcomes put girls behind their male peers and affect future participation in society and employment opportunities. Both not accessing education, and attending unsafe schools and learning spaces, jeopardize girls' well-being.

Quality education will provide gender-transformative teaching and learning processes in a safe, inclusive, and empowering environment, supported by parents, community, peers and a gender-transformative policy environment. Girls who access education benefit from academic achievement, peer support, and reduction in isolation and are more likely to send their own children to school. When MHPSS is integrated into education, girls in particular benefit. For example, for adolescent girls, including young mothers, who face obstacles in completing school, MHPSS with parents/caregivers

and girls themselves, can foster supportive and empowering home environments that are supportive of education. MHPSS integration into learning at home and in schools/learning spaces helps to create safe and protective environments, and increases in girls' participation, empowerment learning, and ultimately, well-being.

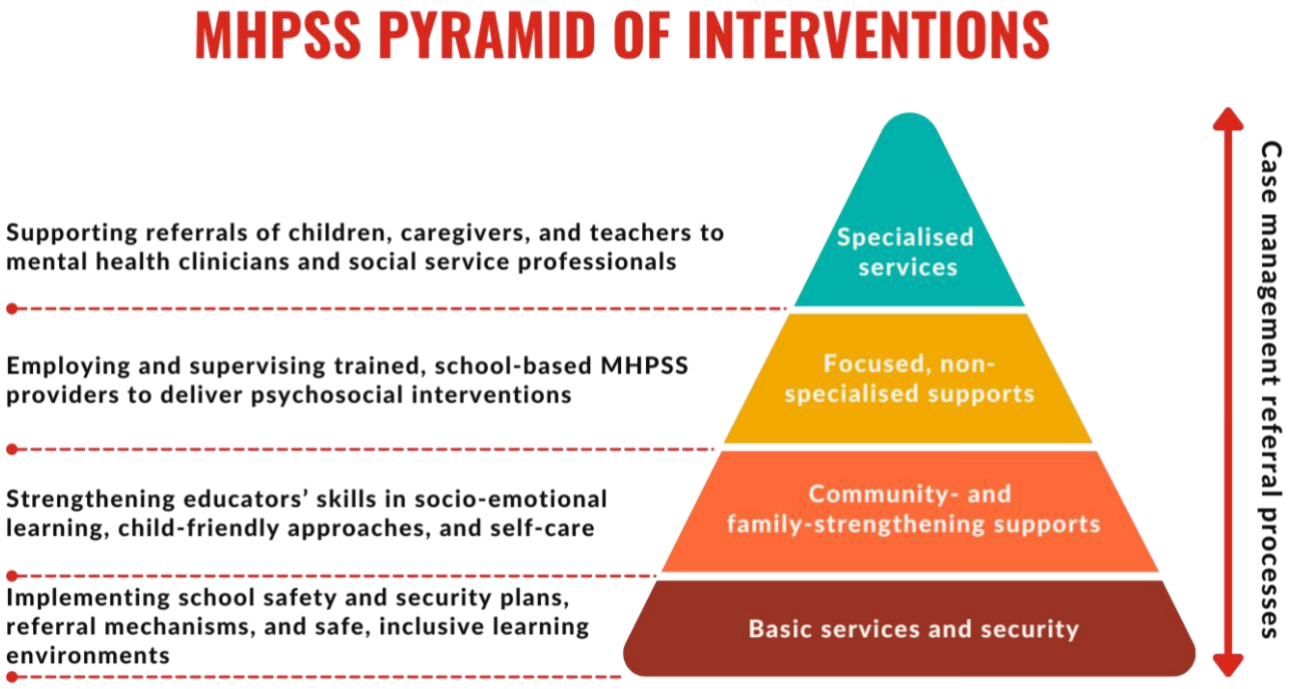
3.6.2.6Inclusive and accessible education for children with disabilities

A quality education is inclusive and accessible to all children, including children with disabilities. Many children with disabilities do not have access to quality instruction and support because of a lack of tailored, responsive strategies, and/or because they face discrimination, stigmatization, and bullying. Girls with disabilities are highly likely to be hidden from sight, and experience violence, negligence, sexual abuse, exploitation, and humiliation.

Children with disabilities' access to education, learning and well-being outcomes can be improved when different sectors, including education, health and MHPSS come together to support meaningful participation and learning alongside their peers. For example, SEL activities can support children with disabilities to acquire and effectively apply the knowledge, attitudes, and skills necessary to understand and manage emotions, set, and achieve positive goals, feel and show empathy for others, establish maintain positive relationships and make responsible decisions, and process and retain information. See Section 4.5. for more guidance on inclusion.

3.6.3Integrated MHPSS-education interventions

The following sections provide key entry points/ approaches at each level of the MHPSS pyramid that can be used in integrated MHPSS-education programming.



Key Guidance

3.6.3.1.1 Level 1: Basic services and security

Integrated interventions at the first level of the MHPSS pyramid seek to meet the following goal:

- Boys and girls with and without disabilities benefit from child-friendly messaging and a healthy, quality learning environment that prevents violence, bullying, or isolation and supports children's development and well-being.

Actions that can support those goals include:

- **Developing and implementing** school safety and security plans as part of MHPSS DRR.
- **Developing and implementing** school policies that support teachers to identify, report, and refer children in need of MHPSS targeted or specialized services
- **Promoting** safe and inclusive learning environments
- **Advocating for** upgraded national curriculum tackling stigma and discrimination for all children

Key considerations when implementing these actions include:

- If MHPSS activities are not taking place in schools, consider how to create links with formal education settings to encourage school attendance and decrease risks of mental health issues due to isolation and lack of social skills and cognitive stimulation.
- Referral mechanisms should provide access to comprehensive, cross-sectoral services across the MHPSS pyramid and socio-ecological framework.

Resources that can support implementation of these actions include:

GFDRR, Save the Children, and UNESCO. 2015. Towards Safer School Construction: A community-based approach.

Enabling teachers CA. Module 19 on PSS-SEL.

3.6.3.1.2 Level 2: Community- and family-strengthening supports

Integrated interventions at the second level of the MHPSS pyramid seek to meet the following goals:

- Children experience improvements in their well-being and overall learning and academic outcomes.
- Teachers are equipped to promote all children's healthy expression in learning environments.
- Young children benefit from healthier social and emotional development and responsive caregiving activities.
- Teachers and educators increase their ability to positively children, including young children, who are in distress or facing difficulties.

Key Guidance

Actions that can support those goals include:

- **Implementing** interventions that support social and emotional learning, such as:
    - Art- and play- based interventions. Refer to HEART programs.
    - Positive parenting programmes. Refer to Save the Children, HEART at home for parents caregivers to support children expressive arts at home).
    - Life skills classes. refer to Save the Children. 2015. The Child and Youth Resilience Measure (CYRM).
    - Peace curricula: Safe Schools Common Approach, SEL toolkit.
- **Supporting** teachers through well-being initiatives, training, and on-going supervision. Refer to:
    - SEL toolkit
    - Save the Children. 'Action Pack 4; Module 3: Building Positive Teacher-student Relationships.' Safe Schools Common Approach.
- **Strengthening** teachers' and other educators' knowledge/ skills in active listening, child-friendly communication, and children's social and emotional development. Refer to INEE. 2018. Guidance Note. Psychosocial Support: facilitating psychosocial wellbeing and social and emotional learning.)
- **Strengthening** caregivers 'skills and knowledge to stimulate infant and young children. Refer to Save the Children. Building Brains Common Approach.
- **Educating** the school community on strategies to address stigma and discrimination. Refer to:
    - REPSSI, APSSI, and the IFRC Reference Centre for Psychosocial Support. 2021. A Hopeful, Healthy, and Happy Living and Learning Toolkit: Activity Guide.
    - Save the Children. 'Action Pack 4: Children's Activities – Living Well Together.' Safe Schools Common Approach.
    - Save the Children. 'Action Pack 4: Teachers and Children; Module 8: Acting against SGBV and Module 9: Social and Emotional Learning.' Safe Schools Common Approach.
    - International Rescue Committee. 2016. My Safety, My Wellbeing: Equipping Adolescent Girls with key knowledge and skills to help them to mitigate, prevent and respond to Gender Based Violence.
- **Including** fathers/ male caregivers in school-home activities to support MHPSS. Refer to:
    - Save the Children. HEART at home for parents caregivers to support children expressive arts at home.
    - Save the Children. 2015. The Child and Youth Resilience Measure (CYRM) module for parents.
- **Implementing** activities for children:

- Who have dropped out of school or are unable to return. Refer to:
  - Save the Children. 2015. The Child and Youth Resilience Measure (CYRM).
  - Save the Children. 2020. Social Emotional Learning Distance Activity Pack.
  - The MHPSS Collaborative for Children and Families in Adversities and Save the Children. 2020. Tips for parents and caregivers during COVID-19 School Closures: Supporting children's wellbeing and learning.
- Who have been out of school. Refer to:
  - Save the Children and The MHPSS Collaborative. 2020. Let's Talk About It: Welcome back check-in guidance
  - Save the Children. 2015. The Child and Youth Resilience Measure (CYRM).

Key considerations when implementing these actions include:

- School should be an inclusive space for all children to learn and be supported, including migrants, LGBTQ+ children, and children with disabilities. Refer to Save the Children, UNICEF, and War Child. Team Up and the Team Up at Home handbook.
- Educate the school on Specific strategies to address stigma and discrimination (see Sections 3.4. Child protection, 4.5. Disability and inclusion, and 4.6. Children on the move).

Other resources that can support implementation of these actions include:

Save the Children. 'Action Pack 4: Teachers and Children; Module 9: Social and Emotional Learning.' Safe Schools Common Approach.

SC Colombia, Socio Emotional Learning tool kit (in Spanish)

World Bank.2018. Step by step curriculum Toolkit Promoting Social and Emotional Learning (SEL) in Children and Teens.

3.6.3.1.3 Level 3: Focused, non-specialized supports

Integrated interventions at the third level of the MHPSS pyramid seek to meet the following goal:

- Children have strengthened coping skills, including emotional regulation, increased resilience, more hope for the future, and more satisfaction with daily life.

Actions that can support those goals include:

- Ensuring psychosocial and psychological interventions for children, caregivers, and teachers (including social and primary health services) are delivered by trained and supervised workers. Refer to War Child Holland and WHO. 2019. Early adolescents' skills for Adolescents psychological interventions.

Key Guidance

- Engaging school based MHPSS providers (such as counsellors/ psychologists) in both direct support and referral. Refer to IRC. 2022. Learning in healing classroom: trauma informed approach.[163]
- Implementing programmes for adolescent mothers (see Sections 4.2. CEFMU, 3.1. Nutrition, and 3.4. Child protection.)
- Raising awareness of teachers and educators around suicide ideation, warnings, risks, and protective factors (see Section 2.8.3.)
- Collaborating with child/ youth clubs to raise teenagers' awareness of suicide ideation and self-harm (see Section 2.8.3.)

Key considerations when implementing these actions include:

- Where mental health professionals are not available, work with MHPSS implementing partners to integrate Layer 3 services into the education sector.
- Staff should be able to appropriately use referral mechanisms and support case management.

Resources that can support implementation of these actions include:

Narrative therapies such as:

REPSSI. 2016. Tree of life

REPSSI. 2009. Making a hero book.

3.6.3.1.4 Level 4: Specialized services

Integrated interventions at the fourth level of the MHPSS pyramid seek to meet the following goals:

- Children in need of specialized support have access to referral structures and appropriate care with consent.
- With the support of specialist MHPSS professionals, teachers strengthen their capacity to support students in need of specialist support in education and include children with mental health conditions into the classroom.

Actions that can support those goals include:

- **Facilitating** children's, caregivers', and teachers' access to mental health clinicians and social service professionals (e.g., psychiatrists, psychiatric nurses, psychologists, clinical social workers, occupational therapists, PHC physicians, and other professionals who are trained in clinical services).

[163] International Rescue Committee. Healing Classrooms: Helping children thrive in times of crisis. https://www.rescue.org/uk/irc-uks-healing-classrooms

- **Supporting** children with mental health conditions, psychosocial disabilities, and severe distress due to SGBV or conflicts affected among over sources of stress to attend a school with accommodation of the curriculum and reduction of risks of stigmatisation through increase capacities of teachers to create safe school.

Key considerations when implementing these actions include:

- MHPSS specialist interventions should be implemented after situations such as suicide and self-harm, SGBV against students, harassment of teachers against students or students against students, bullying and escalation in conflicts, or sudden-onset emergencies/ crises.
- Schools and teachers may need additional support when reintegrating children into school after crises.

Resources that can support implementation of these actions include:

PFA II dealing with traumatic response in children[164]

3.6.3.1.5 Cross-cutting: Services that apply to all levels of the MHPSS pyramid

Cross-cutting interventions seek to meet the following goals:

- The evidence base is used to improve the quality of integrated MHPSS-education programmes for children and teachers.
- Global-level leadership ensures that all education clusters are effectively implementing MHPSS for children and caregivers.
- Teachers and educators feel more equipped and better able to respond to children in distress.

Actions that can support those goals include:

- **Engaging** in the systematized collection, measurement, and documentation of data and evidence on learning and well-being outcomes for teachers, caregivers, and children (including the impact of teacher and learner well-being support [including SEL] on academic learning outcomes)
- **Advocating for** increased investment in psychosocially safe education
- **Strengthening and participating in** coordination across sectors and agencies
- **Implementing** well-being initiatives, training, and on-going supervision for teachers and educators

[164] Save the Children.2017.PFA II Dealing with traumatic response in Children

- **Supporting** teachers' and educators' ability to identify their personal capacities and limitations and seek support when they need it

Key considerations when implementing these actions include:

- Teachers may also be exposed to high risks and may not be available to engage with students.
- Teacher well-being opportunities may include the establishment of peer support networks, teacher learning circles, coaching, and mentoring.

Resources that can support implementation of these actions include:

Save the Children. *Social-Emotional Learning Foundations (SELF)*.

Save the Children. 'Action Pack 4; Teacher Module 2: Teacher Well-being.' Safe Schools Common Approach.

Save the Children. 'Module 19: PSS-SEL' and 'Module 20: Teacher Well-being.' Enabling Teachers Common Approach.

3.6.4 Potential challenges and solutions

Figure 20 shows common challenges to implementing integrated MHPSS-education programmes as well as potential solutions that can help overcome those challenges.

Figure 20	Challenges	Recommendations
1.	Stigmatization of pupils, educators, and caregivers, who receive MHPSS in learning spaces	• Build capacity of teachers/educators on MHPSS and SEL on awareness around discrimination, stigma, consequences of exclusion/ discrimination on well-being • Initiate child friendly and inclusive MHPSS awareness programming. • Ensure means of communication are accessible to all (language, format). • Develop and roll out anti-bullying and harassment programmes in learning spaces and communities • Ensure parents of children receiving specialized support are supported and collaborate with the services providing support in learning spaces
2.	Lack of parental support for the mainstreaming of MHPSS within learning spaces	• 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 negative effects of adversity, supporting the recognition of and appropriate response to illness and disability, promoting healthy brains, emotional and physical development, and building trust and social relationships . • Engage parents through Parent Teachers Associations (PTAs) or similar initiatives to support parenting, parents' well-being and the well-being of their children and their ability to learn (refer to CA PWV) • Engage in community mobilization initiatives and create opportunities for dialogue and build knowledge and understanding of MHPSS amongst caregivers - including through parenting sessions and associated activities
3.	Lack of MHPSS understanding and capacities within the teaching force and school leadership	• Provide training and supervision in MHPSS and SEL for school leaders, teachers and school personnel • Support school leaders' and teachers' well-being • Support teachers in developing SEL competencies and integrating SEL into their teaching practice to support their student's well-being and learning
4.	Learning environments and education system are not inclusive (not accessible to children with disabilities, CAFAAG, children on the move or adolescent parents, and members of the LGBTQ community)	• Conduct awareness raising on issues that may affect children's access/ acceptance including girls, young mothers, former CAFAAG, LGBTQI+, excluded or at risk of exclusion, etc.) • Conduct national and community-based awareness-raising campaigns that promote learning that starts at birth and takes place within and outside formal educational settings to identify early as possible children with disability. • Support the development of national strategies, policies and procedures to prevent and address discrimination and bullying in learning environments. • Develop or strengthen teacher training curricula that support safe, supportive learning environments, including through training on gender and disability-sensitive approaches, participatory methods, and child protection principles and concerns • Strengthening policies to ensure the design of educational facilities is in line with universal design standards that ensure facilities are disaster resilient, safe, dignified, and accessible to all children.

5.	Lack of effective referral mechanisms to specialist support system (where they do exist)	• Map out and liaise with, and engage with national, regional, and local coordination mechanisms in MHPSS (e.g., the MHPSS Working Group), health, child protection and education to identify support and referral systems • Work with child protection and health actors (and others if possible) to establish and enable referral to case management services. Seek guidance from the education cluster, CP AoR, and health cluster. • Collaborate with and engage with community members to identify safe informal community supports • In coordination with schools and out-of-school programmes, promote existing national crisis help-lines where they exist
6.	Lack of supportive systems in place for the integration of MHPSS in Education from Governments and authorities	• Advocate and build capacity with governments especially Ministry of Education and relevant actors to strengthen systems that support the integration of MHPSS and education in all learning spaces • If resources exist, embed MHPSS providers in the learning spaces to provide focused care and serve as a link to more specialized care when relevant. • Ensure staff have capacity and supervision, and dedicated time during the school day or lesson to focus on developing SEL skills and practising activities that support student well-being • Advocate for and build the capacity of governments and relevant actors to strengthen systems that support integrated MHPSS-education in all learning spaces.
7.	Lack of evidence showing the impact of integrating MHPSS into education	• From the design stage, develop and adapt qualitative tools to monitor and evaluate MHPSS in education • Ensure structured PSS and SEL interventions in learning spaces are measurable, with participatory monitoring and evaluation processes in place. • Assess caregivers, teachers, and students' SEL competencies and skills at baseline and end line. • Refer to section on MEAL and MOV (see Section 2.2.4.).
	Duplication of MHPSS services delivered through education and other sectors (e.g. Child Friendly Spaces)	• Internally, at planning stage ensure that MHPSS services implemented in schools to not duplicate services from other sectors, or targeting the same children. Adjust ensure complementarity rather than duplication. For example, delivering SEL services in schools could free up resources to deliver higher level MHPSS services through CP programmes, rather than

	targeting the same children with recreational activities in CFS. • Encourage and support the education coordination groups (cluster, EiE Working Group, Local Education Group etc.) to adopt roles and responsibilities for the sectors and strengthen service mapping and referral pathways so that children's access to the whole spectrum of MHPSS services is improved. (Example of Niger's inter-cluster collaboration on MHPSS here[165], and Global Education Cluster guidance here[166].)

3.6.5Key education resources

Save the Children. HEART programs

Save the Children.2022. Social emotional learning in education programming

Save the Children. Safe Schools Common Approach.

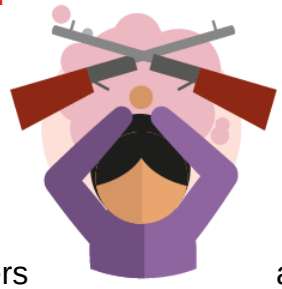
Save the Children. Enabling Teachers Common Approach.

[165] https://educationcluster.app.box.com/s/2pfa9wxzz3ekfh5r5g6j4jqg2clwo2ul
[166] https://educationcluster.app.box.com/s/nghv78xczlcfgs8xi3rv3rgktdakjpz7

4 How do we integrate MHPSS into our thematic work?

Different life experiences and situations (presented here as 'themes') expose children and families to different risks. The sections that follow present some of the interventions that can be used to support the mental health and psychosocial needs of people facing these specific situations.

4.1 Children associated with armed forces and armed groups (CAAFAG)



4.1.1Key messages on integrating MHPSS and CAAFAG

The following messages summarize the importance of integrating MHPSS and CAAFAG. These messages can be used to build awareness among stakeholders at all levels of the socio-ecological model.

- CAAFAG's profiles are diverse, and many factors influence how each child reacts to diverse experiences of structural violence, conflict, and loss. This diversity is also reflected in the different sets of skills, assets and resources for their resilience and well-being that are linked to their age and developmental stage.
- 'Recruitment' may be forced (e.g., child abduction, conscription, quote systems or press-ganging) or coerced (e.g., occurring due to a lack of education or livelihoods opportunities, social marginalisation, peer or social pressure, need for protection or a sense of needing to protect families and communities). Risk factors for coercion are often seen as drivers of poor mental health, which may also contribute to deciding to engage or return with armed forces and groups (such as addiction, gender issues).
- Association with armed forces or groups puts children at great risk of being a direct target, perpetrator, and/or witness of potentially traumatic events such as physical, psychological, and

sexual violence and atrocities.167 A key issue of recruitment and use is that children growing up in protracted conflict areas are in an environment that normalises violence and hatred towards others. The normalisation of violence and hatred is towards others and those who are different from the group or force they are associated with, not just other armed actors.

- Upon leaving armed groups and forces, and reconnecting with communities, children and their families face a disproportionately high level of daily stressors, including stigma, discrimination, and socio-economic adversity.[168]
- Actual or perceived association with armed groups exposes many children to detention by governments (especially boys), rejection from families and communities, and additional protection threats. Girls who return with children are at particular risk of stigmatization and exclusion.
- During reintegration, children may experience challenges to defining their new identity as civilians, including:
    - Recognizing that his/her previous role and 'identity' may have to change[169]
    - Struggling to use the confidence and skills they developed during their association in civilian life
    - Re-learning his or her culture, dialect, and religion[170]
- Children should not be expected to return to being exactly as they were prior to recruitment. Reintegration support is important to support children (and others) find and establish a productive role and identity within communities. In some cases, a child's name and religion may have been deliberately changed in an effort to make them forget the culture or religion from which they came. Helping a child re-learn his or her culture, dialect and religion is important, though this may well take longer than just the preparatory stage.[171]

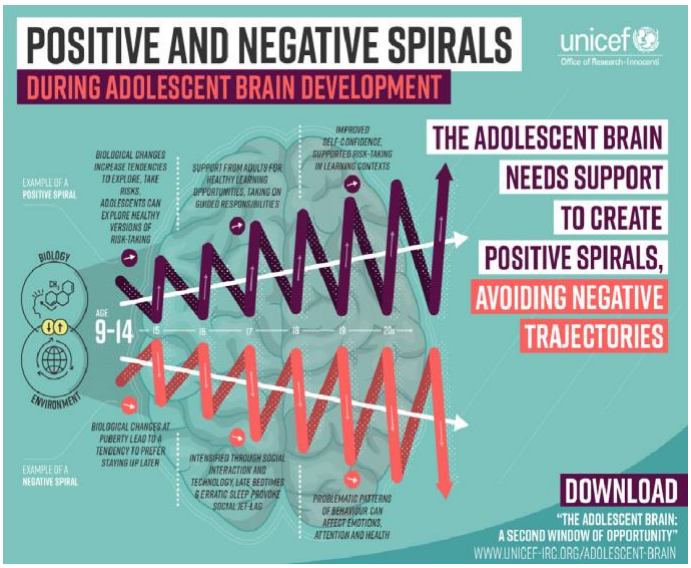
4.1.2Rationale for integrating MHPSS and CAAFAG

Children associated with armed forces and armed groups (CAAFAG) is the recommended term for children who are recruited and used by armed forces or armed groups for a wide range of purposes and roles, including non-combat roles. The combination of conflict, recruitment, and use impacts many aspects of life for CAAFAG and other conflict-affected children.[172] Often they experience loss of home

[167] UNICEF and The Alliance for Child Protection in Humanitarian Action. 2020. Guidance on CAAFAG in COVID-19: Key Messages and Considerations for Programming for Children Associated with Armed Forces or Armed Groups During the COVID-19 Pandemic, v.1.
[168] Tonheim, 2017.
[169] Inter-agency group on children's reintegration. 2016. Guidelines on Children's Reintegration.
[170] Inter-agency group on children's reintegration. 2016. Guidelines on Children's Reintegration.
[171] Save the Children. 2016. Guidelines on children reintegration.
[172] Medeiros, et al. 2019. 'Life after armed group involvement in Nepal: A clinical ethnography of psychological well-being of former "child soldiers" over time.' Transcultural Psychology, 57(1), 183–196. doi: 10.1177/1363461519850338; Wessells, M. G. 2016. 'Children and armed conflict: Introduction and overview.' Peace and Conflict: Journal of Peace Psychology, 22(3), 198–207. https://doi.org/10.1037/pac0000176

and caregivers, insecurity, displacement, community breakdown, cultural alienation, and collapse of social and care systems.[173]

Armed conflict threatens children's mental health and psychosocial well-being through repeated, daily exposure to stressors in structurally violent environments.[174] Factors related to association that can negatively impact children's cognitive development may include limited access to nutritious food and safe shelter, living in harsh conditions, a lack of secular education, exposure to an unruly or overly disciplined environment, experiencing prolonged and extreme violence, and modelled hatred/discrimination of others (a distorted sense of right and wrong) (see Figure 24).



Association with armed groups puts children at heightened risk of anxiety, depression, notable increases in aggression and hostility, and severe stress disorders, such as toxic stress. Toxic stress is a prolonged activation of stress response systems in the absence of adequate protective relationships.[175] Studies show that toxic stress can:

- Alter the architecture of a developing child's brain
- Jeopardize optimal child development
- Have serious, long-term impacts on children's learning and earning potential, physical and mental health, substance use, and relationships, including violence

CAAFAG's profiles are diverse, and many factors influence how each child reacts to diverse experiences of structural violence, conflict, and loss. This diversity is reflected in the different sets of skills, assets, and resources that are linked to their age and developmental stage and influence their resilience and well-being.

Children's individual and collective agency in shaping their own well-being, coping, and resilience is critically important for preventing their recruitment, supporting their disengagement from armed forces and armed groups, and successfully reintegrating them into civil society.[176] Parents' and caregivers' mental health and well-being are also key protective factors that reduce vulnerability to recruitment.

[173] United Nations University. 2018. Cradled by Conflict: Child Involvement with Armed Groups in Contemporary Conflict.

[174] Miller, K. E., & Rasmussen, A. (2010). 'War exposure, daily stressors, and mental health in conflict and post-conflict settings: bridging the divide between trauma-focused and psychosocial frameworks.' Social Science & Medicine, 70(1), 7–16. DOI: 10.1016/j.socscimed.2009.09.029

[175] Centre on the Developing Child. 'Toxic Stress.' Harvard University. [website] https://developingchild.harvard.edu/science/key-concepts/toxic-stress/

[176] Hart, 2006; Medeiros, 2012; Shepler, 2014

Key Guidance

How is a child's cognitive development impacted by association with armed actors and living in conflict?

Armed conflict threatens children's mental health and psychosocial well-being and can result in toxic stress, a prolonged activation of stress response systems in the absence of protective relationships. This jeopardizes optimal child development. Toxic stress can alter the architecture of a developing child's brain, and studies have shown it can have long-term, serious impacts on children's learning and earning potential, health risks, risks for mental health conditions and substance use disorders, and relational problems, including violence. Armed conflict also threatens children's mental health and well-being through the repeated exposure to daily stressors of structurally violent environments. Children are at heightened risk for anxiety, depression, and severe stress disorders following their association, with notable increases in aggression and hostility.

Influencing factors can include limited access to nutritious food, safe shelter and living in harsh conditions, a lack of secular education, being exposed to an unruly or overly disciplined environment, experience of violence, experience of prolonged and extreme violence and encouraged hatred/discrimination of others (a distorted sense of right and wrong)

How good mental health and well-being can contribute to decreased vulnerability to recruitment?

Acknowledging children's individual and collective agency in shaping their own well-being, coping and resilience is critically important for supporting the prevention of their recruitment as well as their disengagement from armed forces and armed groups and successful reintegration into civil society. Acknowledging and supporting parents and caregivers' mental health and well-being are keys protective factors reducing vulnerability to recruitment. Before implementing preventative MHPSS activities, it is advised to work with children in the community to use a social ecological approach to identify the main risks and protective factors. please refer to the CP AoR Alliance prevention Framework[177] for practical guidance on identification of risks and preventive factors.

Based on these factors, interventions should be built to address themes dealing with emotions, relationships with peers and adults, conflict, and peace, and strengthening identity, and a sense of belonging to their community. The provision of opportunities and economic stability are an added component to holistically strengthen positive mental health and well-being, interventions should be established in collaboration with faith-based leaders and schools to identify children at risk and work on resilience and positive coping mechanisms. Involving of traditional and religious leaders facilitate conditions for community mobilisation and ownership, community self-help and social support and conditions for appropriate communal, cultural, spiritual, and religious healing practices (refer to IASC MHPSS RG, on working with faith based actors in MHPSS,[178] Community mobilization and support, from p 42).

[177] CP AoR.202. Primary prevention framework for child protection in humanitarian action - summary

[178] IASC MHPSS RG.2018. Faith sensitive approach in humanitarian response.

Key Guidance

4.1.2.1Key considerations when working with CAFAAG

4.1.2.1.1 Children in justice

Male CAAFAG may experience unique gender-based risks to their safety, physical and mental health, psychosocial well-being, and development. Male CAAFAG, particularly those who have crossed the threshold to adolescence, are more likely to be presumed to be violent extremists or terrorists, separated from mothers and families. They are placed in detention with adult combatants and may criminalized for their association rather than seen as victims of recruitment and use by armed forces and armed groups (even boys as young as 10 years old). It is important to liaise with authorities, governments, and policy makers to enable children in detention to be supported in keeping with strategies used to support former CAAFAG.

4.1.2.1.2 Impact of SGBV on mental health of CAFAAG

Key gender and SGBV considerations when implementing these actions include:

- Sexual violence can have a significant long-term psychosocial impact and frequently causes severe stigmatisation which impacts survivors' experience of reintegration (see Section 4.3.).
- Boys may be more likely to be directly engaged in hostilities (i.e., witnessing, experiencing, and perpetrating violence, sometimes under force or threat) than been physically injured during combat. Girls can also be combatants and willingly join armed forced /groups. the assumptions that they do not hold the process of acknowledgment and reintegration process.
- Male CAAFAG may experience unique gender-based risks to their safety, physical and mental health, psychosocial well-being, and development. Boys may also be silent survivors of sexual violence during their association with armed forces and armed groups, and struggle with shame for both what they have experienced as well as acts committed during their association.
- Boys associated with armed groups may spend all or part of their formative developmental years within a culture that Promotes masculine expectations of violence, power, and competitiveness, rejects weakness or expression of emotion and deprives them of protection and nurture from caregivers. Addressing masculine gender stereotypes and the specific experiences and expectations among returned boy CAAFAG provides a pathway for positive engagement and identity within their families and communities.

Resources that can support implementation of these actions include:

The Alliance for Child Protection in Humanitarian Action. 2020. Girls Associated with Armed Forces and Armed Groups: Lessons learnt and good practices on prevention of recruitment and use, release, and reintegration.

4.1.3Integrated MHPSS-CAAFAG interventions

The following sections present key entry points/ approaches at each level of the MHPSS pyramid that can be used in integrated MHPSS programming for children associated with armed forces and armed groups.

4.1.3.1.1 Level 1: Basic services and security

Integrated interventions at the first level of the MHPSS pyramid seek to meet the following goals:

- CAAFAG experience a supportive social environment that addresses their basic needs, preserves their dignity, honours their agency, and upholds their rights.

Actions that can support those goals include:

- **Using child-first language** (e.g., 'children' instead of 'soldiers') when identifying and addressing the MHPSS needs of CAAFAG to practice the core principles of human rights and equity and to reduce discrimination and stigma[179]
- **Ensuring** that MHPSS programmes identify and integrate cultural and social determinants of adolescent girls' and boys' psychosocial well-being to achieve positive outcomes
- **Conducting** a conflict sensitivity analysis to inform the use of MHPSS activities (see Section 2.3.1.) and use the Save the Children Programme Guidelines on Addressing Recruitment & Use of Children by Armed Forces[180]
- **Introducing** conflict mediation (as needed) into MHPSS components of CAAFAG programmes to monitor conflict dynamics and ensure conflict sensitivity (see Section 2.3.1.)[181]
- **Expanding** the concept of caregiver to include others beyond parents (e.g., other members from the community, mentor figures, etc.)
- **Disseminating key messages** (e.g., via mass media, FM radios, social media campaigns) to encourage the return of children associated with armed groups and armed forces only after a context sensitive analysis. Public messaging could put children and communities at further risk of harm (and children at risk of re-recruitment, abduction, being killed or attacked).
- **Conducting community awareness campaigns** on the benefits of reintegration to the community

[179] MHPSS Collaborative, UNICEF. 2022.Mental Health and Psychosocial Support in Children Associated with Armed Groups and Armed Forces Programmes: Operational Guidance, UNICEF, New York
[180] Save the Children Programme Guidelines on Addressing Recruitment & Use of Children by Armed Forces
[181] IOM. 2021. Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement [Second edition].

Key Guidance

- **Strengthening** general, community-level structures that support the mental health/well-being of all conflict-affected children

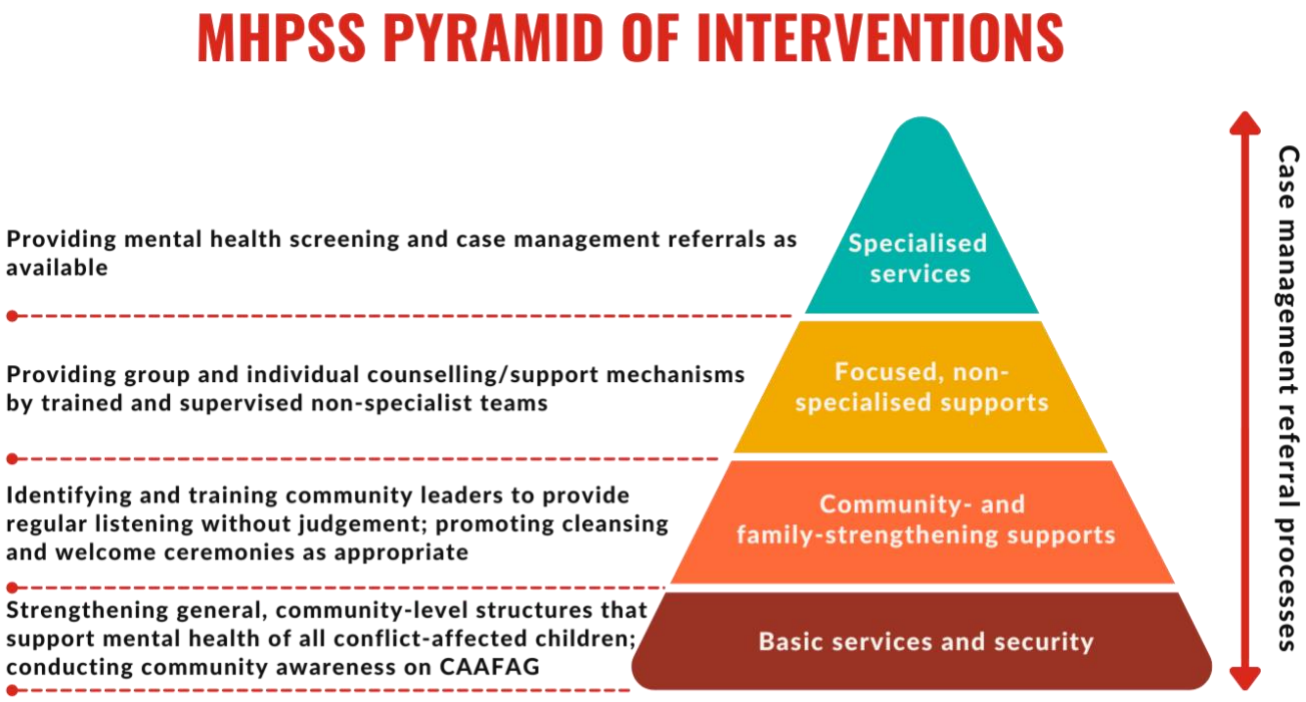
Key considerations when implementing these actions include:

- Most children who leave armed forces or armed groups do not go through formal release processes but return to communities (not necessarily their communities of origin) themselves.
- All support that aids reintegration, including MHPSS interventions, should be accessible within communities in a manner that does not require a former CAAFAG to disclose their background.
- Mental health and psychosocial efforts that only target CAAFAG as a category when providing basic services may intensify stigma and resentment within the community and undermine efforts to strengthen mental health systems.
- In some cases, children may not want to return to their family of origin, so alternative care arrangements should be considered and supported. awareness sessions shall tackle issues for girls who return with children who are at particular risk of stigmatization and exclusion.

Resources that can support implementation of these actions include:

IOM. 2021. Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement [Second edition].

MHPSS Collaborative, UNICEF. 2022.Mental Health and Psychosocial Support in Children Associated with Armed Groups and Armed Forces Programmes: Operational Guidance, UNICEF, New York



4.1.3.1.2 Level 2: Community- and family-strengthening supports

Integrated interventions at the second level of the MHPSS pyramid seek to meet the following goals:

- Families and communities support the mental health, reintegration, and well-being of CAAFAG.

Actions that can support those goals include:

- **Identifying and training** community members who are willing and able to provide regular listening without judgement (e.g., teachers or religious leaders)
- In certain context, and after thoughtful consideration of risk, a cleansing ritual can be considered as supporting the psychosocial well-being of boys and girls and contributing to community acceptance. However, care should be taken to avoid reinforcing perceptions of girls AFAG as "sinful". The ceremonies are more effective with children who believe in it as well as when communities believe in spiritual purification.[182]
- In places where cleansing rituals are not used, encouraging welcome ceremonies where a traditional or religious leader welcomes the girls' and boys' home, forgives them for the past and forgives the family and the community for not being able to protect them. Girls and boys should

[182] The Alliance for Child Protection in Humanitarian Action. 2020. Girls Associated with Armed Forces and Armed Groups: Lessons learnt and good practices on prevention of recruitment and use, release, and reintegration.

not be forced to perform rituals against their will and an assessment of potential harm should be conducted and confidentiality should be ensured.[183]

- **Establishing** mother- and baby-friendly spaces for adolescent mothers associated with armed forces and armed groups that focus on strengthening attachment and bonding between babies and caregivers. Tailoring interventions with children born in armed groups, children can be more psychologically impacted by the release process rather than exposure to the violence they grew up in since birth. Ensuring a continuum of care for all CAAFAG, including those who were born in armed groups.
- **Implementing** interventions with infant and caregivers that:
    - Target the development of identity
    - Prioritize the deconstruction of violence as a mean of communication or survival
    - Supporting emotional regulation, peer-to-peer support, and interactions with host communities that can reduce stigma, harassment, and bullying
- **Engaging** with formal and informal education settings to mitigate the effects of war on children affected by armed conflict and support resilience, build their self-esteem through the acquisition of knowledge while offering opportunities for socialising with their peers.
- **Ensuring access** to approaches that strengthen inclusion to the community such as activities supporting resilience and coping mechanisms.
- **Facilitating access** to livelihood activities, in priority for adolescents who do not want to return to their family / community or are orphans.

Key considerations when implementing these actions include:

- Communities are often unaware that reintegration benefits communities, not just the children being reintegrated.
- Non-focused activities should rely on community representatives, such as community and religious leaders but also women and youth organization.
- Girls and boys **should not be forced to perform rituals against their will**. An assessment of potential harm should be conducted, and confidentiality should be ensured.[184]
- Children born and raised within context of armed forces or groups can be more psychologically impacted by the release process or the return to the community by their caregivers than the exposure to the violence they grew up with because this can profoundly challenge their understanding of the world and their place within it.

183 UNICEF (2021) Technical Note on Girls Associated with Armed Forces and Armed Groups.

184 The Alliance for Child Protection in Humanitarian Action. 2020. Girls Associated with Armed Forces and Armed Groups: Lessons learnt and good practices on prevention of recruitment and use, release, and reintegration.

- Formal and informal education settings can mitigate the effects of war on children affected by armed conflict by supporting the acquisition of knowledge, offering opportunities for peer interactions, supporting resilience, and building children's self-esteem.[185]

Resources that can support implementation of these actions include:

MHPSS Collaborative, UNICEF. 2022. Mental Health and Psychosocial Support in Children Associated with Armed Groups and Armed Forces Programmes: Operational Guidance, UNICEF, New York

Child Soldiers International. 2017. Practical Guide To foster community acceptance of girls associated with armed groups in DR Congo.

The Alliance for Child Protection in Humanitarian Action. 2020. Girls Associated with Armed Forces and Armed Groups: Lessons learnt and good practices on prevention of recruitment and use, release, and reintegration.

4.1.3.1.3 Level 3: Focused, non-specialized supports

Integrated interventions at the third level of the MHPSS pyramid seek to meet the following goals:

- Community-based and non-specialised actors support the mental health and well-being of CAAFAG, their families, and their communities.

Actions that can support those goals include:

- **Adopting a gender-sensitive approach** to release *in conflict-affected communities involved in release or return to community* by:
    - Ensuring that female personnel are trained on how to deliver MHPSS services safely and sensitively to girls and dealing with disclosures of sexual abuse
    - Ensuring facilitators understand the MHPSS needs of survivors of SGBV and use strategies to help them build on any psychosocial skills they learned during the period of association and support them with necessary services (including reproductive health services), while ensuring confidentiality
    - Remembering that boys may also be survivors of sexual violence, and consideration must also be taken for safe and culturally appropriate care and support for boys.[186]
    - Developing collective support mechanisms where girls and boys can bond with each other and enhance their sense of belonging and collective identity.
- **Implementing group and individual counselling** sessions to help children to express their feelings and emotions

185 Child Soldiers International. 2017. Practical Guide To foster community acceptance of girls associated with armed groups in DR Congo.

186 MHPSS Collaborative, UNICEF. 2022.Mental Health and Psychosocial Support in Children Associated with Armed Groups and Armed Forces Programmes: Operational Guidance, UNICEF, New York

Key Guidance

- **Providing focused support** through case management services, community-based psychosocial approaches (e.g., community ceremonies of acceptance), and peer-to-peer interventions.
- **Creating support groups** on disenfranchised grief and allowing rituals and healthy grieving processes (see Section 4.4.).

Key considerations when implementing these actions include:

- Facilitators must understand MHPSS needs of girls and boys ' survivors of SGBV (see Section 4.3.) and use strategies to help them build on any psychosocial skills they learned during the period of association, support them with necessary services (including reproductive health services), and ensure confidentiality. Refer to Caring for child survivor's module on psychosocial support.
- Boys may also be survivors of sexual violence, and they must also receive safe and culturally appropriate care and support.[187]
- Art-based approaches (e.g., photography, video, theatre, music, and visual art) can provide participants with a means to safely communicate about difficult experiences with each other and with the community.
- To ensure quality and safe interventions, non-specialist teams should be trained and supervised in providing psychosocial support through psychoeducation, scalable psychological interventions (PM+[188]), and narrative therapies (Tree of Life[189]).
- Death is part of the daily lives of children associated with armed conflicts. Loss of close relatives can be a driver to join armed forces, seeking for revenge or protection.[190] Children may have lost peers, friends, and family members in armed groups. On return to their communities, it may not be accepted for them to mourn perceived 'perpetrators.' Practitioners should work on creation of support groups on disenfranchised grief, allowing rituals and healthy grieving processes. (See Section 4.4 Children facing loss and grief.)

Resources that can support implementation of these actions include:

The Alliance for Child Protection in Humanitarian Action. 2020. Girls Associated with Armed Forces and Armed Groups: Lessons learnt and good practices on prevention of recruitment and use, release, and reintegration.

[187] MHPSS Collaborative, UNICEF. 2022.Mental Health and Psychosocial Support in Children Associated with Armed Groups and Armed Forces Programmes: Operational Guidance, UNICEF, New York

[188] WHO. 2016. Problem management plus (PM+): individual psychological help for adults impaired by distress in communities exposed to adversity. [WHO generic field-trial version 1.0]

[189] REPSSI. 2016. Tree of Life: A workshop methodology for children, young people and adults.

[190] UNPD. 2017.

Save the Children, The MHPSS Collaborative, UNICEF, WHO. 2021. I Support My Friends: A training for children and adolescents on how to support a friend in distress.

4.1.3.1.4 Level 4: Specialized services

Integrated interventions at the fourth level of the MHPSS pyramid seek to meet the following goals:

- Boys and girls are individually and appropriately supported throughout release from armed forces and groups and reintegration into host communities.

Actions that can support those goals include:

- **Implementing the following** in contexts where specialist mental health support services are available:
    - Running mental health screenings upon release and 3 months after release
    - Ensuring case workers are trained to identify and refer children who are in severe distress and did not go through formal release structures
    - Providing clinical follow-up that focuses on the totality of the child's experience (without an over-focus on ideology) and aims to protect and restore children's well-being and minimize stigma and isolation

Key considerations when implementing these actions include:

- Addiction and the process of rehabilitation can be a vector to re-enrolment, and children engaged in rehabilitation need support:
    - In context where there are no specialised services, find local organisations or peer support to accompany the process and identify a close contact to call in case of crisis and potential relapse (in contexts where specialist mental health support services are not available).
    - Drugs consumption can make children feel powerful. When children stop taking drugs or alcohol they can develop symptoms of depression and anxiety, low self-esteem and may demonstrate suicide ideation can appear (refer Section 2.8.3 Suicide risks management and self-harm)
- Following reintegration, children with psychosocial disabilities and mental health conditions may struggle to receive support and may have felt more secure and safe in the armed group than in the community where they may face stigma and discrimination.
- Drug consumption can make children feel powerful. When children stop taking drugs or alcohol, they can develop symptoms of depression, anxiety, low self-esteem, and suicidal ideation (see Section 2.8.3.).

4.1.4Key and complementary CAAFAG resources

The Alliance for Child Protection in Humanitarian Action. 2022. CAAFAG Programme Development Toolkit: Guidelines

Key Guidance

The Alliance for Child Protection in Humanitarian Action. 2020. Girls Associated with Armed Forces and Armed Groups: Lessons learnt and good practices on prevention of recruitment and use, release, and reintegration.

The Alliance for Child Protection in Humanitarian Action. 2020. 'Standard 10: Mental health and psychosocial distress' and 'Standard 11: Children associated with armed forces or armed groups.' Minimum Standards for Child Protection in Humanitarian Action. 2019 Edition.

The Mental Health and Psychosocial Support Minimum Services Package.2021. Resource in the MHPSS for At-Risk Groups annex of the MHPSS MSP. www.mhpssmsp.org

Complementary:

WHO and UNICEF. 2021. Helping Adolescents Thrive Toolkit: Strategies to promote and protect adolescent mental health and reduce self-harm and other risk behaviours.

Save the Children Programme.2020. Guidelines on prevention and response to Recruitment and Use of Children. SC Middle East.

Paris Principles Handbook (upcoming in 2022)

4.2 Child, early, and forced marriage and unions (CEFMU)

4.2.1Key messages on integrating MHPSS and CEFMU

The following messages summarize the importance of integrating MHPSS and CEFMU. These messages can be used to build awareness among stakeholders at all levels of the socio-ecological model.

- Girls are more likely to experience child, early, and forced marriages and unions (CEFMU), though boys can also experience CEFMU. Children with and without disabilities can experience CEFMU.
- Girls married as children are at increased risk of emotional distress, depression, and suicidality induced by their exposure to SGBV and the burden of handling marital responsibilities at an early age.[191] Girls are more likely to have early pregnancies and experience dangerous complications in pregnancy and childbirth and are at more risk of acquiring HIV.
- Girls who are exposed to sexual violence may be forced to marry the perpetrator and blamed/shamed for sexual violence, entrenching the cyclical nature of the violence.
- Many girls who marry young are often denied access to the right to education or prospects for future education and in addition it is often more difficult for married, pregnant or young mothers to return to school, further limiting their future opportunities to livelihoods and paid employment'.
- Young, married men/fathers do not always face the same barriers to education as young, married girls/mothers, though they often leave school to seek work to support their new families. Patriarchal norms around masculinities impact self-help seeking and stigmatise access to MHPSS services.
- Children with disabilities may be married even earlier than their peers. From an intersectionality lens, girls living with disabilities who are at risk of/ or who experience CEFMU face unique and additional barriers to service provision, additional levels of community level stigma and isolation and risk to further forms of violence with implications for MHPSS.
- Adolescents' girls and boys living with intellectual and psychosocial disabilities are often wrongly considered asexual and deprived access to SRHR education.
- Adolescent girls who are married, divorced, or widowed are often left out of programmes that target adolescents and youth. They do not fit neatly into groups of unmarried children in their same age group, nor groups of married women who are often older, leaving a gap of needed services for this group at higher risks of distress.

[191] Save the Children. 2021. *Preventing and Responding to Child, Early, Forced Marriage and Unions: Technical Guidance 2021*.

- Adolescents' girls may self-initiate their marriage to escape abusive households, reduce social isolation, or gain more freedom/ independence. This does not however imply choice, but rather an environment that denies other opportunities for girls to be able to have options on ways to meet their basic needs, for families to survive and thrive, and for future opportunities and safety.
- Key drivers of CEFMU include:
    - Gender inequality
    - Poverty
    - Protracted conflicts and displacement
    - Social norms (including parental desire to 'protect' girls from other forms of violence or perceived risks to their "purity" via consensual encounters with male peers)
- MHPSS interventions should tackle the 4 main drivers of emotional distress for girls facing early, forced, marriage and union:
    - SGBV
    - Poverty
    - Negative impacts of the practices on sexual and reproductive health,
    - Isolation

4.2.2Rationale for integrating MHPSS and CEFMU

4.2.2.1Impacts of CEFMU on adolescents' mental health

Adolescence is a critical window of opportunity to improve the well-being, future life chances, and outcomes for young people. CEFMU is a violation of human rights that disproportionately affects adolescent girls and is a form and cause of SGBV. CEFMU exposes adolescent girls to significant pressures – running a household, marital responsibilities (most notably their partner's sexual demands), and child-bearing and -rearing – that can have serious consequences for the mental health and well-being of girls, both in the short and long terms.[192] Girls married as children are at increased risk of emotional distress, depression, and suicidality induced by their exposure to SGBV and the burden of handling marital responsibilities at an early age.[193]

Depending on the culture, once married, girls are often taken to their husband's household. Some girls who marry young and live with their husband's family describe the emotional pain of separating from their own families and being subjected to various forms of abuse from their in-laws without recourse to the protection of their families (Howe et al, forthcoming).

These new homes can be in a different village or town. Preliminary research in South Sudan and Northern Iraq indicates that displaced girls who marry as children and later are divorced or widowed

[192] Husain, M.I., Waheed, W., and Husain, N. 2006. Self-harm in British South Asian women: psychosocial correlates and strategies for prevention. Annals of General Psychiatry 5(7). DOI: 10.1186/1744-859x-5-7.
[193] Save the Children. 2021. *Preventing and Responding to Child, Early, Forced Marriage and Unions: Technical Guidance 2021*.

face particular vulnerabilities including social stigmatization and psychological distress (Howe et al., forthcoming).

In many contexts, because of the high bride dowry paid, husbands may be older than the girls, the girls may not be the first wife, and their primary expected role may be to reproduce.[194] Adolescent pregnancy increases risk of complications for both mothers and babies; mothers face increased risk of obstructed labour and postpartum haemorrhage, and babies are more likely to be born premature or with low birth weight, increasing the risks of intellectual disabilities.[195]

The lack of information and ability to make choices around SHRH also influences their mental health. Adolescent girls who struggle to conceive, experience miscarriage or still birth, or do not give birth to boys are at significant risk of stigmatization, rejection, and threats of replacement by new wives. In some cases, parents cannot reimburse their daughter's dowry, so their daughter cannot return home after rejection. Another reason for preventing girls to come back to her parents are shame upon family would prevent siblings from marrying and causes stigma and shame. These situations can lead to suicidal ideation.

Adolescent girls who are married, divorced, or widowed are often left out of programmes that target adolescents and youth. few reasons are underlying such as denial of access from husband and family to programming. Mixed programming can exclude girls as it is then available more to adolescent boys and seen as culturally inappropriate for girls to attend. Adolescents' girls divorced and widowed may face stigma from their families and communities, and as a result, may experience significant mental health difficulties. (Howe et al. Forthcoming)

Many girls who marry young must also give up their education or prospects for future education (Efevbera et al. 2019; Howe et al, forthcoming; UNICEF 2014). Both informal and formal restrictions on married, pregnant, or post-partum girls' school attendance (e.g., *no access to school to married girls allowed*) make it difficult for young, married women and/or mothers to continue their education, even if they and their families wish it. The same restrictions do not apply to young, married men and/or fathers. The loss of educational opportunity and benefits can have serious and long-lasting effects on the mental health and well-being of both girls and their children. (Howe et al. Forthcoming)

Children with disabilities may be married even earlier than their peers.[196] Parents may be afraid of dying and leaving their child with disabilities without proper care, so they seek a husband/ wife to ensure these tasks.[197,198] Cognitive and communication difficulties, sensory impairment, mental health conditions, and other psychosocial disabilities may reduce the likelihood that young girls disclose the fear or existence of a forced marriage. [199,200]

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[194] International Centre for Research on Women. 2017. *A Life not Chosen: Early Marriage and Mental Health*.
[195] Groce, N., et al. 2013. Stronger Together: Nutrition-Disability Links and Synergies – Briefing Note.
[196] Rauf, B., Saleem, N., Clawson, R., Sanghera, M., and Marston, G. 2013. Forced marriage: Implications for mental health and intellectual disability services. *Advances in Psychiatric Treatment,* 19(2), 135–143. DOI: 10.1192/apt.bp.111.009316.
[197] Samuel, M. 2008. Parents use forced marriage as care option for learning disabled. *Community Care*.
[198] Clawson, R., Vallance, P. 2010. *Forced Marriage and Learning Disabilities: Multi-Agency Practice Guidelines*. HM Government.
[199] Samuel, M. 2008. Parents use forced marriage as care option for learning disabled. *Community Care*.
[200] Clawson, R., Vallance, P. 2010. *Forced Marriage and Learning Disabilities: Multi-Agency Practice Guidelines*. HM Government.

Adolescents with intellectual and psychosocial disabilities are often wrongly considered asexual and deprived access to SRHR education, which can lead to unwanted and/or unexpected pregnancy. An arranged marriage may then be used to avoid stigma or shame for the family.[201] Adolescent girls who become pregnant and deliver a baby with a disability may experience additional stigma and mental health issues.[202]

4.2.2.2Drivers of CEFMU

There are a variety of factors that drive CEFMU. In protracted conflicts and areas controlled by armed groups and armed forces, growing evidence suggests that girls face higher risks of CEFMU via abduction, sexual violence, and forced marriage and union by armed groups (Burgess, 2020[203]).

There is also a strong connection between CEFMU and deeply held beliefs and social norms regarding girls' sexuality. Key considerations in the practice of CEFMU often include preventing girls' premarital sexual activity; protecting their chastity, reputation, honour, and virginity; and preserving family honour.[204] In India, CEFMU provides financial security for girls with limited employment opportunities (Roest, 2016)

It is important to mention that not all early marriages are forced. Recent research on self-initiated marriage (SC Nepal, 2019) forthcoming) shows that female youth self-initiate their marriage to escape abusive households, reduce social isolation, or gain more freedom/ independence (Howe et al. Forthcoming).

4.2.3Integrated MHPSS-CEFMU interventions

The following sections present key entry points/ approaches at each level of the MHPSS pyramid that can be used in integrated MHPSS programming for children affected by child, early, and forced marriage and unions.

The implementation of MHPSS activities in CEFMU programmes should be based on an analysis of CEFMU to understand the societal, cultural, and religious drivers and to build contextualized MHPSS programmes. Contextualisation should include analysis of cultural idioms around mental health and well-being and link with drivers of CEFMU.

4.2.3.1.1 Level 1: Basic services and security

Integrated interventions at the first level of the MHPSS pyramid seek to meet the following goals:

- Adolescent girls and boys are supported to prevent CEFMU.

[201] Rauf, B., Saleem, N., Clawson, R., Sanghera, M., and Marston, G. 2013. Forced marriage: Implications for mental health and intellectual disability services. *Advances in Psychiatric Treatment,* 19(2), 135–143. DOI: 10.1192/apt.bp.111.009316.
[202] Marvin-Dowle, K., Kilner, K., Burley, V. J., & Soltani, H. (2018). Impact of adolescent age on maternal and neonatal outcomes in the Born in Bradford cohort. *BMJ Open*, 8(3), e016258.
[203] Burgess, R.A., et al. 2022. Overlooked and Unaddressed: A narrative review of mental health consequences of child marriages. *PLOS Global Public Health*. 2(1) DOI: 10.1371/journal.pgph.0000131.
[204] Save the Children. 2021. *Preventing and Responding to Child, Early, Forced Marriage and Unions: Technical Guidance 2021*.

Key Guidance

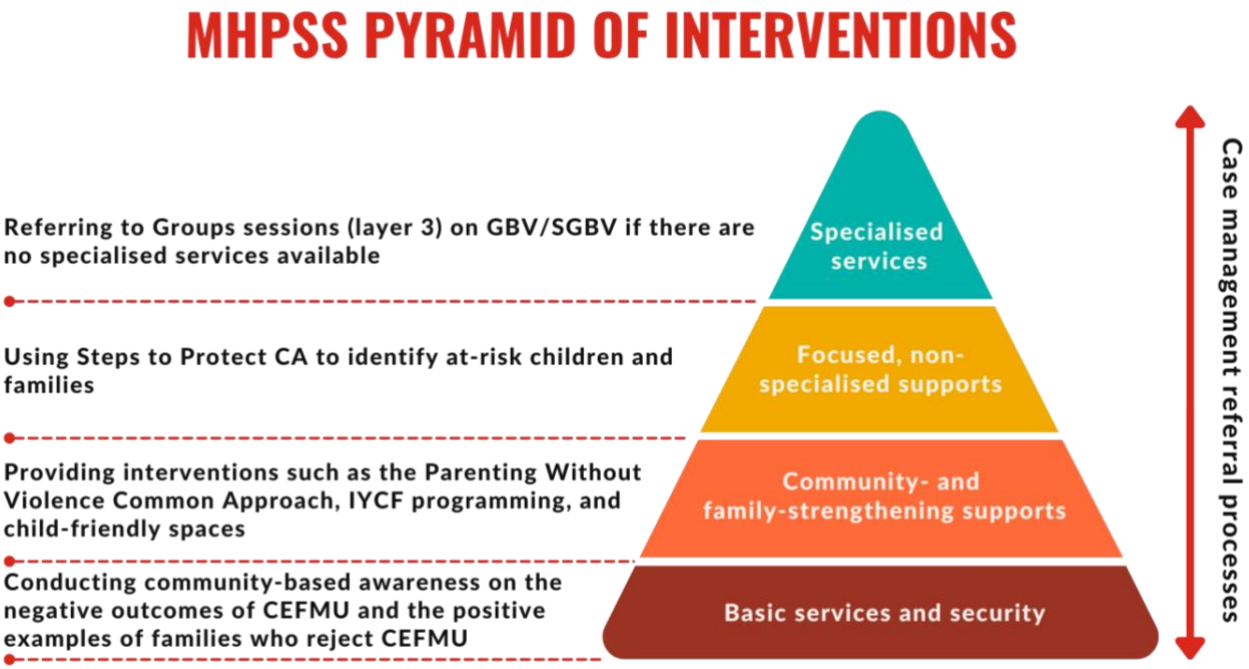
- Boys and men should prevent CEFMU and not accept to marry girls – the tasks should NOT only be put on girls when this is a strong community social norm, and they cannot prevent CEFM on their own.
- Young, married girls can access their full and equal rights.

Actions that can support those goals include:

- **Ensuring** that MHPSS interventions design focuses on both preventing CEFMU and ensuring married girls can access their full and equal rights. This includes facilitating access to vital SRH services and family planning when available.
- **Supporting access** to educational opportunities that are adapted to out-of-school adolescent mothers (including activities that are outside of formal school settings and accelerated learning programmes for girls whose education has been disrupted due to early marriage or pregnancy). Creating awareness among community on consequences of isolation and stigmatisation around girl's mental health and their potential babies when excluded from school due to their marital status.
- **Implementing awareness-raising campaigns** that cover the mental health outcomes of CEFMU, and the physical and emotional consequences (including risk of disabilities) of early pregnancy on mothers and babies.

Resources that can support implementation of these actions include:

Save the Children. 2021. *Preventing and Responding to Child, Early, Forced Marriage and Unions: Technical Guidance 2021*.



4.2.3.1.2 Level 2: Community- and family-strengthening supports

Integrated interventions at the second level of the MHPSS pyramid seek to meet the following goals:

- Families and community-based actors take steps to reduce the incidence and impact of CEFMU on adolescent girls and boys, but also mothers' and babies' physical and mental health.
- Through activities for child well-being in safe spaces, PSS activities will raise awareness on difference between friendship and loving relationships. Depending on the context and using gender sensitive approach, activities should address questions around different stage of loving relationship, addressing emergent sexuality. Refer to SCI. 2021. Engaging men in the elimination of Child marriage, guide for facilitator.

Actions that can support those goals include:

- **Using case management tools** to identify children at risk of CEFMU and girls who are married and may be experiencing difficulties and MHPSS within the case management process.
- **Implementing MHPSS interventions** that tackle the 4 main drivers of emotional distress for girls facing early, forced, marriage and union: SGBV, poverty, Negative impacts of the practice on reproductive health and isolation.[205]

[205] Burgess, R.A., et al. 2022. Overlooked and Unaddressed : A narrative review of mental health consequences of child marriages. *PLOS Global Public Health*. 2(1) DOI: 10.1371/journal.pgph.0000131.

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  - MHPSS interventions integrated into SGBV should be mindful of the types of union, girls and boys married as adolescents, adolescent girls married with their perpetrator and or girls and boys formerly married CAFAAG.
  - MHPSS interventions integrated into SRHR should consider risks of early pregnancy, lack of access to family or miscarriage as potential risks of related mental health conditions. See Sections 3.1 Nutrition, 3.2 Health, and 4.4 Loss and grief.

- **Engaging faith leaders** in preventing CEFMU and emphasizing the consequences of CEFMU on the mental health and well-being of girls and boys. Refer to Save the Children. 2020. Guidance for Engaging Traditional Leaders: Child marriage.

- **Using IYCF MHPSS programming and spaces** for pregnant women and lactating mothers to support learning around challenges with childbirth, provide access to peer support, and support appropriate parenting and attachment (see Sections 3.1.Nutrition and 3.2 Health).

- **Ensuring activities for child well-being** in child-friendly spaces raise awareness of the difference between friendship and loving relationships. Using the Parenting without Violence Common Approach and Building Brains Common Approach to support the well-being of children.

- **Working with country office-level digital teams**, as in some contexts, many self-initiated marriages start through mobile applications.

- **Supporting girls who have refused marriage** or have been married by supporting peer-to-peer support groups that can:

  - mentor and provide emotional support for girls facing similar situations (i.e., the 'With girls, for girls' principle)
  - Help face stigma and potential exclusion with referral to level 3 services when relevant

- **Using a community-owned approach** that promotes families who reject CEFMU, voices key messages on CEFMU, and highlights existing alternatives. Refer to SCI. Voices, Choices, Promises.

Key considerations when implementing these actions include:

- Interventions at this level should ensure strong linkages between advocacy, child rights, and community mobilization actors.

- Unmarried and married adolescents' girls and boys could benefit from building skills related to communication, conflict mitigation, stress management, emotional awareness, and self-esteem. This may help improve relationships with their own parents and may influence decisions related to marriage.

- Activities on relationships should be tailored to the context; use a gender-sensitive approach and transformative whenever possible and safe to do so; and address questions around the different stages of loving relationships and emergent sexuality.

- Facilitators need to know how to identify children in distress, as individual follow-up might be needed (see Section 3.4 Child protection).

Resources that can support implementation of these actions include:

Men Care, Save the Children, Sonke Gender Justice. 2021. Engaging Men in the Elimination of Child Marriage: Facilitation Manual. Sonke Gender Justice.

Save the Children. Choices, Voices, Promises Program

Save the Children. Steps to Protect Common Approach.

Save the Children. 2020. Guidance for Engaging Traditional Leaders: Child marriage.

4.2.3.1.3 Level 3: Focused, non-specialized supports

Integrated interventions at the third level of the MHPSS pyramid seek to meet the following goals:

- Girls and boys married or at risk of marriage receive appropriate MHPSS through coordinated case management
- Girls aged out of child protection case management are referred to appropriate SGBV CM agencies for women survivors.

Actions that can support those goals include:

- **Use IYCF programming** and consider linking with spaces for pregnant women and lactating mothers to meet where they can engage in relevant learning opportunities around challenges with childbirth, access peer support and support in parenting and attachment (refer to Sections 3.1 Nutrition and 3.2 Health.)
- In addition with case management and potential SGBV management, use Parenting without violence common approach to support the well-being of girls and boys married. They could benefit from building skills related to communication, conflict mitigation, stress management, emotional awareness, and self-esteem. This may help improve relationships with their own parents and may influence decisions related to marriage.

Key considerations when implementing these actions include:

- If SGBV is suspected, staff should refer to CP case management staff for support. Cases must be managed through the case management system with the support of MHPSS staff.
- Girls' and boys' adolescents may self-initiate their marriage to escape abusive households, reduce social isolation, or gain more freedom/ independence. MHPSS focused services such as

WHO Problem Management +[206] could support the adolescent to decrease risks situation and develop positive coping mechanisms.

Resources that can support implementation of these actions include:

Save the Children. Steps to Protect Common Approach.

4.2.3.1.4 Level 4: Specialized services

Integrated interventions at the fourth level of the MHPSS pyramid seek to meet the following goals:

- Girls and boys at risk or in severe distress related to CEFMU have access to specialised services when relevant (meaning the support of a clinical assessment).
- Girls and boys facing exacerbation of their mental health and psychosocial disabilities related to forced marriage and union access specialised services when accessible and relevant.

Actions that can support those goals include:

- Referring boys and girls to specialised services, where relevant, accessible, and available.
- MH specialized Staff are supervised closely and work in collaboration with other to promote holistic support and ensure community acceptation

Key considerations when implementing these actions include:

- CEFMU leads to SGBV, lack of SRHR, and maternal mental health-related conditions. These violations or rights and psychological violence could lead to related mental health conditions. it is important to assess the needs and refer to adequate specialised services only when symptoms are increased with the months, with suspicion of risks of self-harm, suicide ideation or high risks for the child. Drivers of MHPSS challenges such as SBGV poverty, isolation and challenges linked with SHRH should be addressed through the different layers of interventions and community led.
- If no specialised services are available, follow recommendations in Section 4.3.3. to support girls who are at risk of sexual violence or abuse.
- Consider identification of remote specialised services in case of not accessible in the community or epidemic context.
- Mental health-related data (diagnostic, minutes of sessions, etc.) should be protected and not accessible to the family-in-law without the boys' and the girls' consent.

[206] WHO. 2016. Problem management plus (PM+): individual psychological help for adults impaired by distress in communities exposed to adversity. [WHO generic field-trial version 1.0]

Key Guidance

4.2.4Key CEFMU resources

Save the Children. 2020. Preventing Child Marriage in Somaliland.

Save the Children. 2021. *Preventing and Responding to Child, Early, Forced Marriage and Unions: Technical Guidance 2021*.

UNFPA and UNICEF. Technical Note on Partnering with Men and Boys to End Child Marriage in the Global Programme to End Child Marriage.

UNFPA-UNICEF Global Programme to End Child Marriage. [website] https://www.unicef.org/protection/unfpa-unicef-global-programme-end-child-marriage

4.3 Sexual and gender-based violence (SGBV)

Gender-based violence is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e., gender) differences between males and females. It includes acts that inflict physical, sexual, or mental harm or suffering, threats of such acts, coercion and other deprivations of liberty. These acts can occur in public or in private.[207] The term "GBV" is most commonly used to underscore how systemic inequality between males and females, which exists in every society in the world, acts as a unifying and foundational characteristic of most forms of violence perpetrated against women and girls. The term "gender-based violence" also includes sexual violence committed with the explicit purpose of reinforcing gender inequitable norms of masculinity and femininity.

According to the Child Protection Minimum Standards, SGBV is any act that is perpetrated against a person's will that is based on gender norms and unequal power relationships. It encompasses threats of violence and coercion. It can be physical, emotional, psychological, or sexual in nature, and can take the form of a denial of resources or access to services. It inflicts harm on women, girls, men, and boys. The GBV Interagency Minimum Standards refers to six core forms of violence directed at someone based on their gender, gender expression or perceived gender. This includes rape, sexual assault, forced marriage, denial of resources, opportunities or services and psychological/emotional abuse.

4.3.1Key messages on integrating MHPSS and SGBV

The following messages summarize the importance of integrating MHPSS and SGBV. These messages can be used to build awareness among stakeholders at all levels of the socio-ecological model.

- MHPSS is an essential component of a multisectoral response to SGBV against children of all gender identities, and MHPSS outcomes should be integrated into all programming that address SGBV against children and GBV more broadly against adults of all gender identities.
- While survivors' experiences vary, the impacts of SGBV on mental health and psychosocial well-being can have far-reaching consequences for individuals, families, and communities. Psychological effects of SGBV can include feelings of fear, sadness, guilt, and anger, as well as anxiety, depression, self-harm, suicidal ideation, and addiction. Alongside social consequences, such as stigma, isolation, and discrimination, these effects can contribute to difficulties in maintaining or establishing relationships, child development and disruptions to education.
- Addressing the mental health and psychosocial needs of survivors and those disproportionately at risk of SGBV is critical to promoting healing, empowerment, and meaningful participation in education and recreational activities and long-term economic and livelihoods opportunities.

[207] GBV AoR, 2019. Minimum standard on Gender Based Violence.

Key Guidance

- We must always assume that GBV is happening in a community and SGBV can be happening to any child, even if they do not disclose. Sexual abuse occurs throughout childhood and across contexts, cultures, and classes. This risk is then exacerbated by other risk factors such as those living with disabilities, unaccompanied and separated children (UASC).
- Community and CSO must be encouraged to embrace a culture that respects children's rights and supports children who have experienced SGBV and to move away from shaming or stigmatizing survivors, which can be a driver of CEFMU. An integrated approach to child sexual abuse and exploitation that addresses mental health and psychosocial distress, poverty, gender inequality, reproductive health and rights, parenting skills, and conflict resolution is required.[208]
- Responses SGBV against children and adolescents of all gender identities must be survivor and child centred, be strengths based, abide by do no harm principles, ensure an intersectional approach (including their SOGIESC), and meet the age and development needs of the child. Responses should not cause stigma and activities should not target them in isolation: programmes on Levels 2-3 of the MHPSS pyramid should be open to all children.
- Focused and Specialized group or individual support can take place only if confidentiality is ensured and the support is provided by a MHPSS specialist (see Section 3.4.).

4.3.2Rationale for integrating MHPSS and SGBV

Sexual and gender-based violence (SGBV) is rooted in unequal power relations. Child sexual abuse is inherently tied to power imbalances associated with being a child. Discriminatory socio-cultural beliefs and norms, a lack of legal protection, and socio-economic discrimination drive and worsen the effects of SGBV. There are many gendered internal and external barriers to receiving care. Many cases of SGBV are not reported because children are fearful of the negative consequences of disclosure. In some contexts, being identified as a survivor of sexual violence can lead to social exclusion, isolation, discrimination, loss of dignity, further violence, or even threats to life. These risks may also extend to the survivor's family and immediate community.[209] Also, while poor mental health and psychosocial well-being are not causes of GBV, promoting protective factors at the individual, relationship, and community levels—such as empathy, communication skills, coping, emotional regulation, and nurturing family environments—has been shown to have positive impacts on the well-being of survivors of SGBV. When driven by the needs and priorities of survivors and children at risk of SGBV, MHPSS can complement and bolster gender-transformative prevention approaches that address root causes of violence such as gender inequality and power imbalances.

All children can be at risk of SGBV, but the risks are statistically higher for children with disabilities, children who live away from parents and caregivers or in abusive households, and children in institutions. Child sexual abuse often involves body contact. However, not all sexual abuse involves

[208] Save the Children. 2005. *10 Essential Learning Points: Listen and Speak out against Sexual Abuse of Girls and Boys*.

[209] International Federation of Red Cross and Red Crescent Societies Reference Centre for Psychosocial Support. 2015. *Sexual and gender-based violence – A two-day psychosocial training. Training guide*.

body contact. Abuse can also happen online. Forcing a child to witness a sexual act, force children to watch or exploit children for pornography, show private parts or verbally pressure a child for sex is also sexual abuse.

4.3.2.1Impacts on children

The MHPSS impacts of SGBV against children begin with children and extend into their families. Child survivors of SGBV can face a range of psychological and psychosocial consequences. Psychological consequences can include: [210]

- **Emotional consequences:** anxiety, fear, insecurity, anger, shame, self-hate, self-blame, withdrawal, and hopelessness
- **Cognitive consequences:** concentration difficulties; hyper-vigilance; and repeated experience of the abuse/ event through flashbacks, nightmares, negative thinking and coping mechanisms or/and intrusive memories
- **Behavioural consequences:** inability to sleep, avoidance (e.g. some survivors tend to avoid certain situations that remind them of the traumatic event), social isolation, withdrawal, changes in eating behaviour; delinquent and/or self-destructive behaviour (e.g. changes in school performance, changes in or abandonment of friendships, and/or acts of self-harm), and substance abuse
- **Mental health consequences:** depression, post-traumatic stress disorder, anxiety disorder, eating disorders; and substance abuse but also related psychosomatic symptoms

Psychosocial consequences can include:

- **'Victim-blaming':** In some contexts, survivors may be stigmatised and isolated. They, rather than the perpetrator, are often blamed for the incident (e.g. because of the way the victim dresses). The stigma may also affect the survivor's family. This may lead to rejection by partners/families/communities, separation from children, loss of function in society, or loss of job and source of income.
- **Unplanned pregnancies:** Girls often have to carry the child of a perpetrator to term and face the added risks inherent in early pregnancy. Note that in many areas of interventions. adolescents' girls may not have the choice but to carry the child to term.
- **Child Early and Forced marriage and Union:** Girl survivors can be forced to marry the perpetrator to maintain the family honour (see Section 4.2.2.2.).

[210] International Federation of Red Cross and Red Crescent Societies Reference Centre for Psychosocial Support. 2015. *Sexual and gender-based violence – A two-day psychosocial training. Training guide.*

4.3.2.2Impacts on male survivors

Boys face unique barriers to disclosure of their experiences of abuse, and may be exposed to physical violence, shame and exclusion as a result of challenging societally enforced patriarchal norms and a lack of awareness on appropriate response services that meet the unique needs of boy-survivors of SGBV. Adolescent boys may consider being a survivor can be seen as a counter-cultural experience for males and anticipate stigmatisation, including consequences for their family. SGBV challenges the common view of masculinity (i.e., men and boys should be strong, in control, and dominant). Depending on the cultural context, men may be extremely reluctant to talk as they feel ashamed, weak, and guilty.

Perpetrators often use male-directed sexual violence to turn the person into a vulnerable, helpless 'victim,' so men and boys affected by SGBV may struggle with their self-image and social identity. Being forced into sexual acts with another man directly challenges the sexual status of a man and may make survivors question their sexual orientation. This is especially difficult in cultures where homosexuality is taboo or prohibited by law. Boys might put themselves at high risk of additional violence against them by reporting SGBV due to these laws, policies and believes.

Male survivors may also face internal (individual) and external (social) barriers to accessing care. Social stigma and issues related to victimization and masculinity may make it difficult for boys to seek help. Moreover, in many settings, services for sexual violence are geared toward women and girls; boys may not be aware of similar opportunities for them to seek help.[211] In addition, all services are underfunded and often with very few trained staff. This is even less for children pat of the LGBTQI + community.

4.3.2.3Impact on caregivers [212]

Non-offending caregivers can experience a range of normal emotional reactions when a child discloses sexual abuse: anger, disbelief, shock, worry, deep sadness, and fear. Caregivers may not know what to do or where to seek help. They may want the problem to 'go away' or not even realize that sexual abuse can cause harm and that their child needs care. They may blame themselves for not paying attention to their child's behaviours or may feel they have failed as parents and have not protected their child. Some parents may wonder why their child chose to disclose to others and not to them directly. Caregivers may experience feelings of betrayal, confusion, and disbelief.

When the offender is a close family member, partner of the caregiver, or breadwinner for the family, the non-offending caregiver may face difficult choices in order to protect the child. Some may not be in a position to do so due to unequal power relations. Even in the most constrained circumstances, the caregiver should be supported to acknowledge the abuse and validate the survivor's experience, even if they cannot protect them. Caregivers need to be aware that believing their child and standing by him or her is crucial for their child's recovery.

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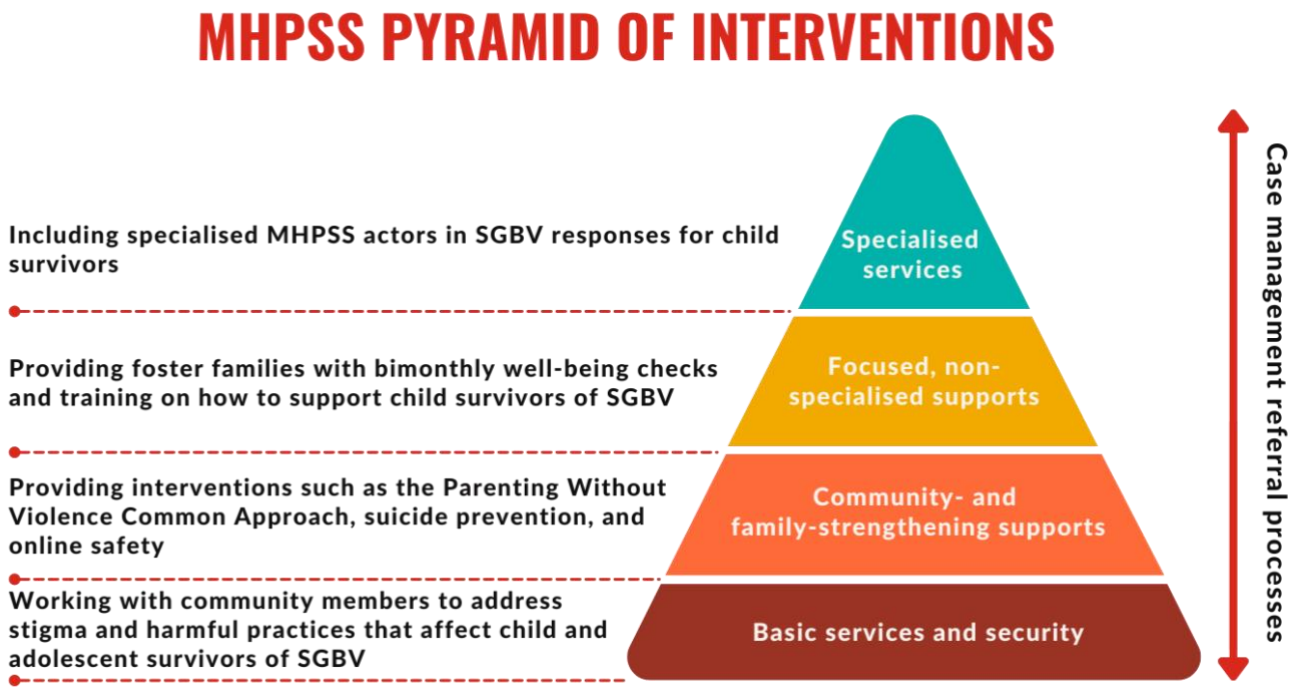
211 International Federation of Red Cross and Red Crescent Societies Reference Centre for Psychosocial Support. 2015. *Sexual and gender-based violence – A two-day psychosocial training. Training guide*.

212the IRC, UNICEF. 2012. *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings*. First edition.

Caregivers need support to recognize and manage their own distress and to support the child. Responding to cases of child sexual abuse requires service providers to have strategies and skills for positively involving non-offending caregivers in the child's healing and recovery.

4.3.3Integrated MHPSS-SGBV interventions

The following sections provide key entry points/ approaches at each level of the MHPSS pyramid that can be used in integrated MHPSS programming for children affected by sexual and gender-based violence.



4.3.3.1.1 Level 1: Basic services and security

Integrated interventions at the first level of the MHPSS pyramid seek to meet the following goals:

- Child survivors of SGBV, their family and close relatives are safe and can access basic services that are age, gender appropriate and accessible to all.
- Greater awareness among community and national institution on the rights protecting all children with and without disabilities against any forms of sexual abuse.

Actions that can support those goals include:

- **Equipping** service providers, parents, caregivers, and others community actors to recognize (and refer) the common signs and symptoms of sexual abuse at different ages because most boys and girls will remain silent.
- **Educating children** on the dangers of grooming and online safety.

- **Building** children's online and off-line MHPSS skills in communication, setting boundaries, healthy relationships, emotional awareness, and self-esteem.

Key considerations when implementing these actions include:

- Signs of sexual abuse differs by stage of development and age (see 'Knowledge Area 6: Sexual Abuse Impacts Across Age and Developmental Stages' in Caring for Child Survivors of Sexual Abuse[213] and Section 3.4. Child protection).

Resources that can support implementation of these actions include:

IASC. 2020. Basic Psychosocial Skills.

IRC, UNICEF. 2012. *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings*. First edition.

4.3.3.1.2 Level 2: Community- and family-strengthening supports

Integrated interventions at the second level of the MHPSS pyramid seek to meet the following goals:

- Families, community members and services providers work to appropriately prevent, mitigate, and respond to SGBV against children.

Actions that can support those goals include:

- **Capacity strengthening** of education personnel and other stakeholders directly engaging with children on gender equality, SGBV core concepts, identification and referral and PFA for child practitioners.in addition training on mental health, and well-being consequences of breaching professional obligations related to violence against children.[214]
- **Teaching children** to understand the risks of exposure to sexual abuse and knowing where and how to report incidences. Strengthening avenues for safe disclosure of abuse and community support mechanisms around SGBV (where safe and non-identifying).
- **Working with community members** to address issues that stigmatize or harm child and adolescent survivors of rape (e.g., forcing a girl to marry her perpetrator, isolation, and exclusion) through:
    - Value clarification and attitude transformation (VCAT)[215]
    - Community mobilisation
    - Engagement approaches that involve caregivers, community and religious leaders, and children and adolescents

[213] the IRC, UNICEF. 2012. 'Knowledge Area 6: Sexual Abuse Impacts Across Age and Developmental Stages.' 'Chapter 1: Core Child Sexual Abuse Knowledge Competencies.' *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings*. First edition. pp. 31.
[214] WHO. 2016. *INSPIRE: Seven Strategies for Ending Violence Against Children*.
[215] SC Norway is currently working with IPAS and Norwegian Church Aid (NCA) developing the VCAT around FGM and CEFMU.

- Work with women leaders and community elders as 'gender champions' to emphasize the rights of girls, without activities that risk the safety, confidentiality and dignity of the survivor or child at risk of SGBV.

- Designing programmes that help children understand and manage the impacts of abuse through child-friendly education and information sharing. Refer to ABAAD. 2017. Psychosocial manual chapter 9 supporting Children survivors of sexual abuse.[216]
- Supporting families' healing through education on child sexual abuse and strategies for supporting the affected child (see Parenting without Violence and UNICEF, the IRC. Caring for Child Survivors of Sexual Abuse.

Key considerations when implementing these actions include:

- When children are sexually harassed in school, it can undermine their sense of personal dignity and safety, disrupt their education, cause them to skip or drop out of school, and interfere with their ability to reach their full potential in life.[217]
- Programmes that focus on improving children's knowledge about how to increase their safety and reduce their risk to sexual abuse' may include the following topics: body ownership, good touch vs. bad touch, recognizing abusive situations, saying 'no,' and disclosing to a trusted adult.
- Caregivers should be engaged in prevention as part of parenting programmes or caregiver MHPSS interventions.

Resources that can support implementation of these actions include:

Save the Children. Parenting without Violence Common Approach.

WHO. 2020. mhGAP Intervention guide : do what matters in times of stress: an illustrated guide.

4.3.3.1.3 Level 3: Focused, non-specialized supports

Integrated interventions at the third level of the MHPSS pyramid seek to meet the following goals:

- Non-specialist actors and caregivers prevent and respond to SGBV against children.

Actions that can support those goals include:

- **Training** all frontline staff who work in MHPSS on the capacities needed to support child survivors of SBGV and their families (see Basic Psychosocial Skills[218]) and the need to coordinate directly with CP CM staff or refer cases to service providers who work directly with survivors.

[216] Abaad MENA. 2017. The MHPSS training package. PSS manual.
[217] Ontario Human Rights Commission. 2011. *Sexual harassment in education*.
[218] IASC. 2020. 'Module 2: Supportive communication in everyday interactions.' *Basic Psychosocial Skills*.

- **Training** service providers on suicide risk management protocols and self-harm practices (see Section 2.8.3.).
- **Training** foster families in child safeguarding and child protection, basic communication skills with children survivors on sexual violence (refer to UNICEF, module on basic communication skills) and dealing with children in distress (refer to PFA II dealing with traumatic response in children[219]).
- **Ensuring** caregiver and foster families receive bimonthly (minimum) well-being checks/ supervision, with strategies for children to safely disclose or report concerns.

Key considerations when implementing these actions include:

- Foster families as well as biological families need to be aware of how to support a child survivor of SGBV (refer to PFA II dealing with traumatic response in children[220]).

Resources that can support implementation of these actions include:

Save The Children.2017. PFA II dealing with traumatic response in children.[221]

The Internal Rescue Committee. Caring for Child Survivors of Sexual Abuse - UNICEF.

WHO.2022. MH gap: Doing what matters in times of stress.

4.3.3.1.4 Level 4: Specialized services

Integrated interventions at the fourth level of the MHPSS pyramid seek to meet the following goals:

- Girls and boys at risk of or affected by SGBV have meaningful, equitable access to specialized services when relevant, appropriate and with their informed consent.

Actions that can support those goals include:

- **Referring** child survivors of SGBV to appropriate specialized services if they exist.
- **Mapping** services that exist to support child survivors of SGBV
- MHPSS service providers and interagency MHPSS working groups train SGBV service providers on key principles within MHPSS to support child survivors of SGBV. Similarly, SGBV service providers train MHPSS staff on SGBV core concepts to support holistic and child-/survivor-centred approaches to MHPSS and SGBV service provision.

Key considerations when implementing these actions include:

- The WHO Mental Health Gap Action Programme (mhGAP) defines advanced psychosocial intervention as ‘an intervention that takes more than a few hours of a health-care provider’s time

[219] Save the Children.2017.PFA II Dealing with traumatic response in Children
[220] Save the Children.2017.PFA II Dealing with traumatic response in Children
[221] Save the Children.2017.PFA II Dealing with traumatic response in Children

to learn and typically more than a few hours to implement.' This includes several types of advanced MHPSS interventions, such as cognitive behavioural therapy (CBT), family counselling and therapy, and parent skills training.[222] These interventions should be managed by trained and supervised professionals.

- Supervision – remote or face-to-face – should be ensured before the specialist has been added on referral pathways.
- Data protection on specialised services related to SGBV and MHPSS should be protected to avoid causing harm.
- Human resources that can support implementation of these actions include:
    - Local, specialised service providers link with the MhGAP HIG initiative.
    - Youth and women local organisation linking with community, preventing stigmatisation of girls and boys benefiting from specialised services due to related consequences of SGBV.

4.3.4Key SGBV resources

Save the Children. Steps to Protect Common Approach.

IRC, UNICEF. 2012. Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings. First edition.

The IRC, Women's Refugee Commission. 2015. Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings: A Toolkit for GBV Practitioners.

UNHCR. 2012. Working with Men and Boy Survivors of Sexual and Gender-based Violence in Forced Displacement.

WHO. 2019. Caring for women subjected to violence: A WHO curriculum for training health-care providers.

Gender based Violence Area of Responsability. 2021. Addressing Sexual Violence against Men, Boys, and LGBTIQ+ Persons in Humanitarian Settings: A Field-Friendly Guidance Note by Sector.

[222] WHO. 2010. mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings. [Note: A newer version of this guide is available: WHO. 2016. mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings. Version 2.0.]

4.4 Children facing loss and grief

4.4.1Key messages on integrating MHPSS for children facing loss and grief

The following messages summarize the importance of integrating MHPSS for children facing loss and grief. These messages can be used to build awareness among stakeholders at all levels of the socio-ecological model.

- 'Grief' is the name given to the painful emotions, as well as thoughts and behaviours, that people feel in response to the loss of loved ones, persons, or places with which they feel a connection.
- Children who have been secure in their attachment in their two first years are more likely to deal with death in a healthier way, with a better sense of belonging, autonomy, and resilience skills.
- Psychosocial support is only one way of helping people who are separated from their loved ones, and it can be provided in many different ways.
- In order to appropriately respond to and refer children experiencing loss – and recognize whether their reaction may be the result of something other than grief – it is critical to understand:
    - The beliefs and practices of the child and family's culture and religion
    - The child's situation (i.e., developmental stage, type of loss, who has died or is 'lost,' risk and protective factors, etc.)

4.4.2Rationale for integrating MHPSS for children facing loss and grief

'Grief' is the name given to the painful emotions, as well as thoughts and behaviours, that people feel in response to the loss of loved ones, persons, or places with which they feel a connection. Though grief is often associated with death, the same painful emotions accompany being separated from family, friends, as well as familiar places such as home, school, or a place of worship. Grief also accompanies the loss of a sense of security or hope for and confidence in the future. A child may experience loss or grief from both external and internal losses, and their effects can be overwhelming (Jones, 2014).

Grief can continue for a long time when life circumstances are challenging. It can also return unannounced months after a child has appeared to forget or recover. It may be triggered by a reminder, such as an anniversary, a favourite activity that the child did with the lost person, or a particular song on the radio that they both enjoyed.

Dealing with Separation. Forced displacement is a significant source of loss and grief. One of the main consequences of forced displacement is leaving behind family and friends, belongings, places, routines, and other sources of identity, security, belonging, and meaning. Detachment from home and culture can cause conflict within children who feel 'split-in-two,' especially when those who support them cannot relate. This may lead to a further loss of their sense of trust, control, autonomy, dignity, and

belief in the future as they navigate numerous stressors during and after their flight[223] (see Section 4.6.). Such extensive loss exacerbates pre-existing mental health conditions and increases the risk of prolonged psychological stress and emotional and physical pain.

The feeling of being abandoned by their caregivers will affect children's feelings of attachment to their parents or caregivers and bring a sense of loss and grief. Loss of attachment can happen during a separation due to infectious disease (e.g., Ebola, COVID-19, cholera). Babies and children can be placed in alternative care with no proper explanation for the separation (see Sections 3.1.Nutrition and 3.2.Health).

Dealing with Death. Death is often another source of abandonment and loss. Suicide is the fourth leading cause of death for adolescents (WHO). School mates and friends can be deeply affected by a peer's suicide. School staff should be attentive to changes of behaviour, eating disorders, difficulty concentrating, and withdrawal from friends (see *Helping Adolescents Thrive Toolkit*).[224] Following the death of a loved one, the child needs closure. Funerals and the associated rites are important to begin the healing process. When situations of displacement, protracted conflict, and lockdown prevent this mourning process, children may remain confused and grieving.

Dealing with loss of limbs or body part. Children may be amputated following a mine, explosive devices, non-communicable disease such as diabetes or a road accident among other sources of amputations. Children and adolescents can be in denial, refusing prosthesis and orthosis and developing related mental health conditions. Children may feel phantoms pain.

Reactions to loss and grief, and associated appropriate responses, may differ according to the specific culture. Different coping strategies exist such as:

- Perceiving death as a transition rather than the end of life
- Maintaining bonds or even contact with the deceased
- Experiencing death as a community event
- Using death as a celebration of life.[225]

These coping mechanisms draw upon religious, spiritual, and cultural beliefs and practices and may be very important for children (particularly those who are displaced and far from home) to feel a sense of belonging to their and their loved one's culture and community.

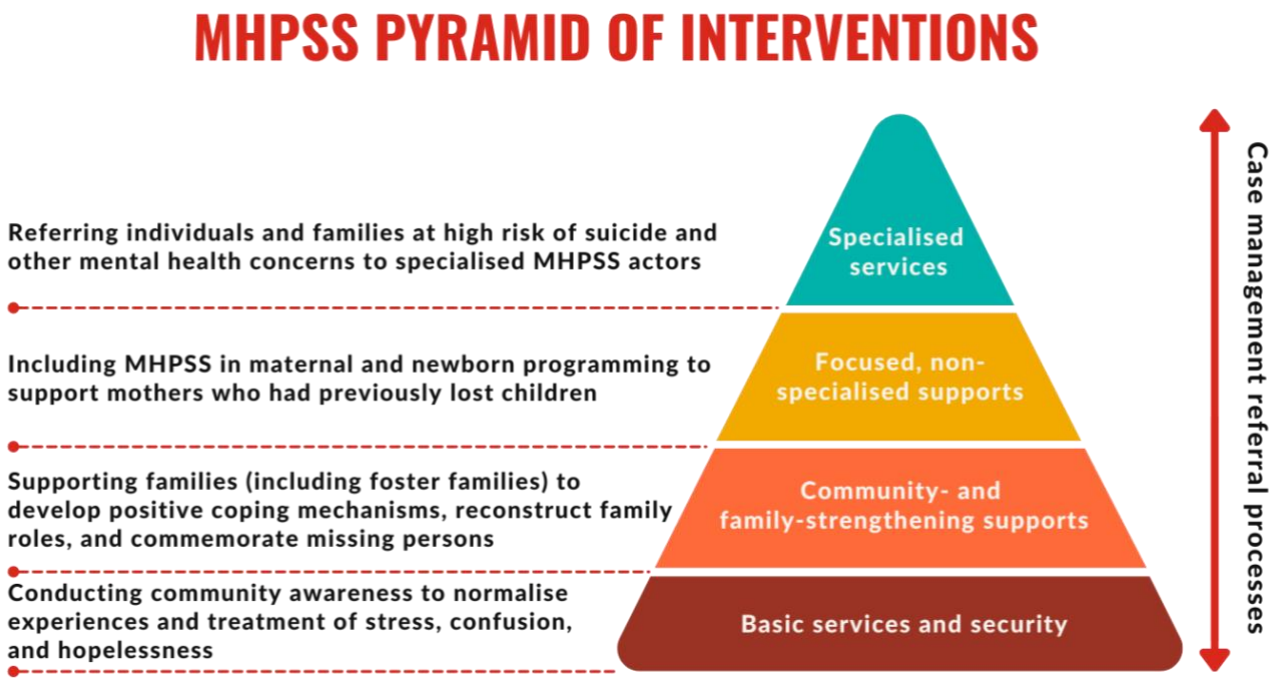
[223] Jones, Lynne.

[224] WHO and UNICEF. 2021. Helping Adolescents Thrive Toolkit: Strategies to promote and protect adolescent mental health and reduce self-harm and other risk behaviours.

[225] Kuehn, Philip D. 2013. Cultural Coping Strategies and their Connection to Grief Therapy Modalities for Children: An Investigation into Current Knowledge and Practice.

4.4.3Integrated MHPSS interventions for children facing loss and grief

The sections below provide key entry points/ approaches at each level of the MHPSS pyramid that can be used in integrated MHPSS programming for children facing loss and grief.



4.4.3.1.1 Level 1: Basic services and security

Integrated interventions at the first level of the MHPSS pyramid seek to meet the following goals:

- Children facing loss and grief regain a sense of security and comfort through increased understanding of normal response to abnormal situations by the community and service providers.

Actions that can support those goals include:

- **Conducting psychoeducation** to normalize and understand the experience of loss and grief, including the accompanying feelings of stress, confusion, and hopelessness. (Refer to PFA for child practitioners. Section on Psychoeducation.[226])

Key considerations when implementing these actions include:

- Social media can be used to share psychoeducational messages by youth advocates for mental health and survivors.

226 Save the Children. 2013. PFA for child practitioners.

- Psychoeducation can be an entry point to implement MHPSS to address loss and grief.

4.4.3.1.2 Level 2: Community- and family-strengthening supports

Integrated interventions at the second level of the MHPSS pyramid seek to meet the following goals:

- Families including foster families, services providers including teachers and community members provide appropriate support to children facing loss and grief.

Actions that can support those goals include:

- Using a MHPSS need assessment to frame the intervention and should include ways to assess if the loss is due to separation or/and death and evaluate the risks and protective factors of the individual or family affected. MHPSS support in loss and grief can include:
    - Groups sessions on 1/ Psychoeducation normalising levels of stress, confusion, and feelings of hopelessness. 2/ Opportunities for children to talk about the missing person, learn to recognise and name the feelings associated with loss and grief in order to know what the feelings
    - Group activities centred on developing strategies to deal with grief: identification of triggers and learning to manage emotions associated through breathing exercises, singing songs, drawing and other activities.
    - Group activities focusing on developing positive coping mechanisms: find ways to reconstruct roles in the family and create rituals to commemorate the missing person
- **Facilitating peer and group support** to help adolescents work through the grieving process and address feelings of guilt and distress after a peer's suicide. Refer to WHO and UNICEF. 2021. Helping Adolescents Thrive Toolkit: Strategies to promote and protect adolescent mental health and reduce self-harm and other risk behaviours.
- **Supporting families**, including foster families, to reconstruct roles in the family and create rituals to commemorate the missing person. Refer to The Child Protection Area of Responsibility and The MHPSS Collaborative. 2020. Communicating with Children about Death, and Helping Children Cope with Grief.
- **Supporting foster families** to deal with children experiencing loss and grief. Refer to PFA II dealing with traumatic response in children.[227]
- **Creating opportunities** for children to talk about the missing person and to recognise and name the feelings associated with loss and grief.

Key considerations when implementing these actions include:

[227] Save the Children.2014. PFA II dealing with traumatic response in children.

- Complication in the interaction with the developmental task of the adolescent: in early adolescence, the young person engages in a mental review of his/her life, often resulting in a disappointment in parents. This disappointment is one of the reasons for the anger of adolescents towards parents. However, if at this moment a parent dies then one may face two contradictory feelings surfacing in the young person: the parents become a hero because of the death, and there is anger towards the parent as part of his/her development process. Early adolescence is there for the most difficult age to lose a parent. Helping the child is not very complicated: articulating feelings, both negative and positive. A support group will help.

Resources that can support implementation of these actions include:

The Child Protection Area of Responsibility and The MHPSS Collaborative. 2020. Communicating with Children about Death, and Helping Children Cope with Grief.

Mhpss.net. 2020. Toolkit on COVID19, section loss and grief.

WHO and UNICEF. 2021. Helping Adolescents Thrive Toolkit: Strategies to promote and protect adolescent mental health and reduce self-harm and other risk behaviours.

The Child Protection Area of Responsibility. 2022. podcast: Helping children cope with grief at war.

The Child Protection Area of Responsibility. 2020. Mourning a loved one when you can attend a funeral.

4.4.3.1.3 Level 3: Focused, non-specialized supports

Integrated interventions at the third level of the MHPSS pyramid seek to meet the following goals:

- Non-specialist actors can appropriately support children experiencing loss and grief through group support activities.

Actions that can support those goals include:

- **Implementing MHPSS interventions** (including counselling and peer support) that support mothers who have lost babies and children, faced miscarriage or still birthed to bond and engage with their new-born.
- **Training service providers** to support children's use of positive coping mechanisms using the IA CM case management training module on loss and grief (forthcoming). Main activities recommend group activities rather than individual to strengthen peer to peer support.
- When relevant and appropriate, conducting a **suicide risk assessment** and developing a safety plan with a child experiencing loss and grief. Only trained staff and partners are in charge of this assessment. (See Section 2.8.3.).

Key considerations when implementing these actions include:

- **Disenfranchised grief:** children may not be allowed to grief, e.g. if the father is part of the national army or armed group and armed forces that is considered as an enemy, if the father is incarcerated, etc. The right to grief has been taken away. The solution is to create a confidential relation between (MH) PSS worker and child, and work through the mourning process in a secure setting.
- Healthy strategies to deal with grief include identifying triggers and managing emotions through breathing exercises, singing songs, drawing, and other activities.
- Children who have been secure in their attachment in the 1,000 first days are more likely to deal with death in a healthier way, with a better sense of belonging, autonomy, and increased resilience skills.
- A mother who has lost a child(ren) might find it difficult to provide nurturing care to her new-born, which increases the risk of poor attachment skills and undernutrition (see Sections 3.1. and 3.2.).

Resources that can support implementation of these actions include:

Save the Children. Steps to Protect Common Approach.

IASC MHPSS RG.2022. Addressing Suicide and self-harm in humanitarian settings. forthcoming.

Only when previous access to training and with supervision in place. Do not apply for children!

WHO. mhpGAP interventions package. Group Problem Management Plus (Group PM+): group psychological help for adults impaired by distress in communities exposed to adversity.

WHO. mhGAP intervention package. Problem management plus (PM+): individual psychological help for adults impaired by distress in communities exposed to adversity.

4.4.3.1.4 Level 4: Specialized services

Integrated interventions at the fourth level of the MHPSS pyramid seek to meet the following goals:

- Children and related mental health conditions, psychosocial disabilities or severe distress experiencing triggering loss and grief have access to appropriate specialised support.

Actions that can support those goals include:

- **Managing phantom limbs:** the explanation relies on time for the brain to adapt. The specialised service provider shall use mirror therapies to accompany the brain area to accommodate. This therapy can be home based and managed by close family on a daily basis.
- **Group sessions** are recommended for children who faced amputation, focusing on body image and dealing with new identity. As many children might be triggered easily and have developed related mental health issues, it is recommended that these sessions be facilitated by psychologists.

Key considerations when implementing these actions include:

- In the absence of trained specialists, only use interventions at the first three levels of the MHPSS pyramid.

4.4.4Key loss and grief resources

Child Protection Area of Responsibility and The MHPSS Collaborative. 2020. Communicating with Children about Death, and Helping Children Cope with Grief.

Save the Children. Steps to Protect Common Approach.

Save the Children and Child Protection Area of Responsibility. 2020. Mourning for a loved one when you cannot attend funeral services.

WHO and UNICEF. 2021. Helping Adolescents Thrive Toolkit: Strategies to promote and protect adolescent mental health and reduce self-harm and other risk behaviours.

Inter agencies case management package. Module on loss and grief. forthcoming

4.5 MHPSS and disability inclusion

4.5.1Key messages on integrating MHPSS and disability inclusion

The following messages summarize the importance of integrating MHPSS, disability inclusion. These messages can be used to build awareness among stakeholders at all levels of the socio-ecological model.

- Children with disabilities frequently experience discrimination, exclusion, and other rights violations.
- Children with disabilities are 17 times more likely to be institutionalized than other children.
- Children with cognitive and intellectual disabilities do not always present with mental health conditions or psychosocial disabilities. However, due to violence, abuse, neglect, and/ or lack of stimulation they are as likely as other children to struggle with high level of distress
- The inclusion and participation of children with disabilities on an equal basis with others is supported by the **twin-track approach** which includes mainstreaming disability inclusion and designing and implementing tailored and focused actions as part of the MHPSS response.

4.5.2Rationale for integrating MHPSS and disability inclusion

Children with disabilities are not a homogenous group however they all frequently experience discrimination and exclusion. Often, their human rights are violated as a result of the barriers they face to inclusion, participation and realising their rights. Physical inaccessibility, negative attitudes, lack of access to information, and discriminatory laws and practices can expose children with disabilities to segregation, confinement, restraints on their autonomy, or threats to their physical and mental integrity.[228] Furthermore, community led organizations, health care workers, and case workers may not listen to girls and boys with disabilities or believe them when they disclose violence, especially if the survivor has intellectual or psychosocial disabilities. Children with cognitive and intellectual disabilities do not always present with mental health conditions or psychosocial disabilities. However, due to violence, abuse, neglect, and/ or lack of stimulation they are as likely as other children to struggle with high level of distress.

Intersectionality between gender, disability, and mental health. Girls with disabilities often face increased discrimination based on gender and disability. This is due to deeply rooted gender norms as well as cultural beliefs around disability (i.e., the cause of disability, expectations of what children with disabilities can or cannot do, etc.). Girls with disabilities may be excluded from opportunities to learn about sexual violence and healthy relationships, to develop new skills, and to strengthen peer networks. Girls with disabilities are also exposed to higher risks of SGBV compared to girls without disabilities,

[228] IASC. 2019. Guidelines: Inclusion of Persons with Disabilities in Humanitarian Action.

mainly because perpetrators perceive them as unable to physically defend themselves or effectively report incidents of violence.[229] They may be targeted for rape, abuse, and exploitation and may have less capacity to negotiate power in intimate relationships.[230] Boys with disabilities are at even higher risks of SGBV than girls with disabilities. The associated shame and guilt and the lack of access to legal services and awareness about their rights increase challenges to disclosure and reporting.

Institutionalisation and mental health. Children with disabilities are 17 times more likely to be institutionalized, and the rate may be higher for children with mental health conditions.[231] Children with disabilities are often placed in institutions because their parents don't have access to or cannot afford the necessary treatment, rehabilitation, or access to inclusive education. An institution is understood to be any residential setting where an 'institutional culture' prevails. An institutional culture for children can be defined as follows:

> *Children are isolated from the broader community and obligated to live together; children and their families do not have sufficient control over their lives and decisions which affect them; and/ or the requirements of the organization take precedence over children's individual needs.*

This definition usually includes large residential homes or 'orphanages' (including compound/cluster facilities and congregate care) as well as smaller facilities with strict regimes, facilities for children who have committed minor offences, residential healthcare facilities, and residential special schools.[232]

Children in institutions are most likely to be deprived of loving family care and face life-long physical and psychological harm as a consequence.[233] These impacts include attachment disorders, cognitive and developmental delays, and a lack of social and life skills that lead to multiple disadvantages during adulthood.[234] Babies, in particular, fail to develop as they should without one-to-one interaction, and research demonstrates the severe impact of institutionalisation on early brain development.[235] Children who are removed from institutions after the age of six months often face severe developmental impairment, including mental and physical developmental delays. Long-term effects of living in institutions can include severe developmental delays, related disability, and increased rates of mental health difficulties and suicide risks.[236] Children living in residential institutions are also more likely to go missing than children in families.[237]

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229 Women's Refugee Committee and Child Fund International. 2016. *Gender-based Violence against Children and Youth with Disabilities: A Toolkit for Child Protection Actors*.

230 Ortovella, S. and Lewis, H. 2012. Forgotten Sisters – A Report on Violence against Women with Disabilities: An Overview of Its Nature, Scope, Causes and Consequences. Violence Against Women with Disabilities Working Group.

231 LUMOS, Hope and Homes for Children. 2017. *Putting Child Protection and Family Care at the Heart of EU External Action*.

232 LUMOS, Hope and Homes for Children. 2017. *Putting Child Protection and Family Care at the Heart of EU External Action*.

233 Berens, A.E. and Nelson, C.A. 2017. 'The science of early adversity: is there a role for large institutions in the care of vulnerable children?' *The Lancet*. *386*(9991) 388–398. DOI : https://doi.org/10.1016/S0140-6736(14)61131-4

234 Nelson, C., Zeanah, C., et al. 2007. 'Cognitive Recovery in Socially Deprived Young Children : The Bucharest Early Intervention Project.' *Science*. *318*(5858) 1937–1940. DOI: 10.1126/science.1143921

235 Judge, S. 2003. 'Developmental recovery and deficit in children adopted from Eastern European orphanages.' *Child Psychiatry Hum Dev*. *34*(1) 49–62. DOI: 10.1023/a:1025302025694

236 Mulheir, G. et al. 2012. Deinstitutionalisation—A Human Rights Priority for Children with Disabilities. *The Equal Rights Review*. Vol. 9. 117–137.

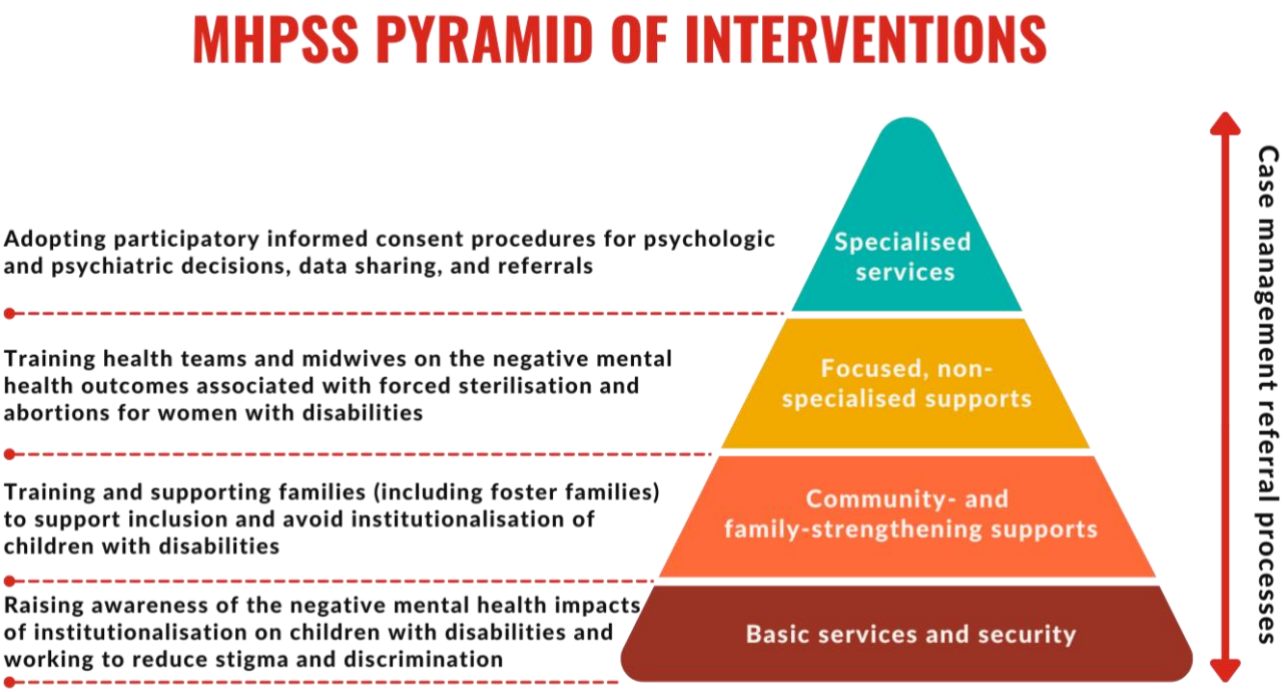
237 European Commission. 2013. Missing Children in the European Union: Mapping, data collection and statistics.

Intersectionality with children living on the street, disability, and mental health. Children living in the street are more likely to be more at risk of psychosocial disabilities because of mental health issues or abandonment due to other disabilities. Children on the street may be connected with Madrassa. It is important to work with religious leaders of madrassa to identify children in severe distress related to their disability. In addition, Children living in the street and with newly acquired disabilities may have adopted negative coping mechanisms including addiction to drugs and alcohol. The addiction might increase mental health symptoms and put them in constant danger.

Children and parents with disabilities like other children benefit psychologically and socially from MHPSS activities that provide opportunities to make friends, participate in the community, experience personal achievement, fun, and enjoyment and build networks of support. Engagement in MHPSS interventions can also contribute to an acceptance of disability and a more independent approach to life.

4.5.3Integrated MHPSS and disability inclusion interventions

The following sections provide key entry points/ approaches at each level of the MHPSS pyramid that can be used in integrated MHPSS, disability, and inclusion programming.



4.5.3.1.1 Level 1: Basic services and security

Integrated interventions at the first level of the MHPSS pyramid seek to meet the following goals:

- All children receive safe and secure support (including preventative efforts) for their mental health and well-being and can participate free from exclusion, isolation, and discrimination based on disability, gender, ethnic status, etc.

Key Guidance

Actions that can support those goals include:

- **Identifying** the attitudinal, environmental, institutional, financial, and communication barriers that prevent children and parents /caregivers with disabilities from joining a programme and working on solutions to promote their participation and remove barriers
- **Mainstreaming disability inclusion** within MHPSS planning, programming, and budgeting to remove barriers and support accessibility to participation in MHPSS programmes
- **Building and reviewing programmes** through a diversity lens to ensure:
    - Programme design supports the engagement of participants from diverse genders, marginalized groups, disabilities, and ages in all stages of the programme cycle
    - Modalities support children's healthy development according to their age and stage of development
    - Language and communication style is accessible for children/ caregivers of different ages and physical, mental, or psychosocial disabilities
    - include indicators reflect the diversity of participation
- **Advocating for laws and policies** that ensure informed consent for people with disabilities.
- **Advocating for adolescents** with mental health conditions, intellectual and psychosocial disabilities to have access to their medical files and other available supports
- **Ensuring** that children with disabilities who are unaccompanied or separated are not placed in institutions and have access to appropriate alternative care, including foster families.

Key considerations when implementing these actions include:

- When supporting accessibility, always address the barriers not the impairment!
- Social media can be used to share psychoeducational messages by youth advocates for mental health and survivors.
- Laws in many countries allow people with psychosocial, intellectual, or cognitive disabilities to be detained on the basis of their diagnosis.
- Often, children with psychosocial, intellectual, or cognitive disabilities are not given full information about their health or mental health care, access to other opinions and views, or information about other important supports and services in the community (e.g., peer support groups). MHPSS actors and CSOs should lead strong advocacy to support girls with psychosocial, intellectual, and cognitive disabilities to access their right to informed consent regarding any procedures related to their body.
- There are often limited opportunities for children with disabilities – particularly those with psychosocial, cognitive, and intellectual disabilities – to meaningfully participate in and influence

MHPSS responses; decision-making; planning/ programming; and monitoring, evaluation, and research.[238]

Resources that can support implementation of these actions include:

IASC guidelines on inclusion of persons with disabilities in humanitarian action.

WHO. 2012. *WHO Quality Rights Tool Kit*.

4.5.3.1.2 Level 2: Community- and family-strengthening supports

Integrated interventions at the second level of the MHPSS pyramid seek to meet the following goals:

- All parents/ caregivers with disabilities can access and effectively use inclusive, safe, and secure MHPSS services, including preventative efforts.
- All children with disabilities can participate meaningfully at safe and accessible MHPSS intervention
- Community-based actors identify and support the mental health and well-being of all children, parents, and caregivers with disabilities.

Actions that can support those goals include:

- **Building the capacities** of child protection, education, and health team members to interact with children who have psychosocial disabilities and mental health conditions. refer to Inclusive education tool kit, section on SEL
- **Mobilizing and equipping** influential community members (e.g., religious leaders of madrassas) to:
    - Identify children, parents, and caregivers who are in severe distress related to their disability
    - Challenge norms and attitudes that perpetuate or legitimize violations of the rights of children with disabilities
- **Allocating dedicated budgets and resources** for community led and human rights oriented MHPSS responses and services that are inclusive of persons with disabilities (e.g., deploying peer support to assist children with cognitive, intellectual and psychosocial disabilities and mental health conditions in affected areas)
- **Including community members** (e.g. organizations of people with disability (OPD) staff, self-advocates with intellectual and psychosocial disabilities, mental health service users, family

[238] IASC MHPSS RG. 2021. Action sheet on MHPSS and disability inclusion, draft.

members, and caregivers) in trainings on disability inclusion for health, education, and child protection service providers

- Implementing the WHO Quality Rights Tool Kit to protect the lives and dignity of persons who are institutionalized, strengthen human rights surveillance, and safeguard family and community links during crisis
- Supporting the development of protocols that prevent coercive treatment, including forced institutionalisation, forced medication, forced electroconvulsive treatment, and physical and chemical restraints. Refer to WHO. 2012. WHO Quality Rights Tool Kit.
- Supporting parents to use positive parenting skills when caring for their children with disabilities. Refer to Abilis and SCI. 2010. Parenting without violence adaptation: inclusion of parents and children with disabilities in PwV.
- Training, supervising, and supporting alternative care providers, including foster families, in disability inclusion (including inclusive communication, managing violent behaviour, and identifying and managing potential signs and symptoms of distress). Refer to country-based example: SC Rwanda. 2020. Guide for volunteers Children with disabilities. Parents workshop.
- Informing parents of children with disabilities about the importance of their children's SRHR to help protect them from unwanted pregnancy and encourage healthy sexual behaviour. Refer for country-based examples: SC. 2019. Sexuality and adolescents with disabilities.

Key considerations when implementing these actions include:

- Positive parenting support may include:
    - Providing parents of children with disabilities with MHPSS via focus groups or peer support where they can discuss the challenges (economic, behavioural, social) that they face
    - Validating existing positive practices
    - Adapting Save the Children's resources (e.g. Parenting without Violence) for use with children and parents/ caregivers with disabilities
- There is often an assumption that girls with disabilities are asexual, which allows caregivers to dismiss their sexual and productive health rights.

Resources that can support implementation of these actions include:

Save the Children. Parenting without Violence Common Approach.

Save the Children. 2022. Disability & inclusion toolkit for rural communities.

UNICEF. 2017. Guidance: Including Children with Disabilities in Humanitarian Action. General.

Women's Refugee Committee and Child Fund International. 2016. *Gender-based Violence against Children and Youth with Disabilities: A Toolkit for Child Protection Actors*.

4.5.3.1.3 Level 3: Focused, non-specialized supports

Integrated interventions at the third level of the MHPSS pyramid seek to meet the following goals:

- Service providers are equipped to identify, refer, and deliver services (including case management) to children with intellectual and psychosocial disabilities and mental health conditions safely and securely.

Actions that can support those goals include:

- **Designing and implementing** tailored and focused actions as part of the MHPSS response to ensure that child disability-related requirements are met and that caregivers and children with disabilities are supported to fulfil their potential. When dealing with early childhood with disabilities, refer to Therapeutic early stimulation tool kit: training guide.
- **Supporting** the child protection and health sectors to promote independent and effective monitoring of all alternative care placements and outpatient facilities when providing community care, support, and alternative care options
- **Placing children** with disabilities in appropriate, family-based alternative care where necessary.
- **Training health teams** (including midwives) on the mental health consequences of forced sterilization, inability to access family planning, and forced abortion on girls and women with disabilities. Refer to WHO. 2012. WHO Quality Rights Tool Kit.
- **Identifying and addressing** misconceptions, stereotypes, and stigmatising beliefs among MHPSS workers; policy makers; and child protection, education, and health service providers about disability, including the misconception that children with disabilities always need specialized services. Refer to WHO. 2012. WHO Quality Rights Tool Kit.

Key considerations when implementing these actions include:

- All tailored and focused actions should collaborate with MHPSS experts and providers in MHPSS/ disability inclusion technical working groups (when relevant) and consider the voices of children with disabilities (including those with psychosocial and intellectual disabilities), their families, and OPDs.
- MHPSS, health, and related messaging that targets individuals with disabilities should be easy-to-read, translated into sign language and/ or Braille, and otherwise adapted to meet specific communication needs.
- Avoid using the 'medical model of disability.' Rather, encourage the social and rights-based models that focus on removing barriers and accepting diversity in functioning as a part of the human experience.

4.5.3.1.4 Level 4: Specialized services

Integrated interventions at the fourth level of the MHPSS pyramid seek to meet the following goals:

- Children and parents/ caregivers with disabilities can access specialised services as needed and available when the child has related mental health symptoms and conditions.
- Moving children from institutions to community-led accommodations (including foster families) that provide appropriate MHPSS and ensure their continued care and protection.

Actions that can support those goals include:

- Ensuring that service providers who refer to specialized services adopt informed consent procedures for psychological and psychiatric decisions and data sharing that enable children with disabilities and their caregivers to make informed decisions for themselves.[239]

Key considerations when implementing these actions include:

- Psychotherapeutic treatments that need follow-up should only be initiated when follow-up is likely to occur.
- In the absence of trained specialists, only use interventions at the first three levels of the MHPSS pyramid.

4.5.4Key disability and inclusion resources

IASC Task Team on inclusion of Persons with Disabilities in Humanitarian Action. 2019. *Guidelines: Inclusion of Persons with Disabilities in Humanitarian Action*. Inter-Agency Standing Committee.

Save the Children. 2021. *Save the Children's Disability Inclusion Policy: Lifting barriers, realising equality*.

CBM. 2021. Community Mental Health Good Practice Guides.

Watters, L and Orsander, M. 2021. *Disability-inclusive child safeguarding guidelines*. Able Child Africa.

WHO. 2012. *WHO Quality Rights Tool Kit*.

The Washington Group on Disability Statistics and UNICEF. 2016. The Washington Group/UNICEF Module on Child Functioning.

[239] IASC Task Team on inclusion of Persons with Disabilities in Humanitarian Action. 2019. Guidelines: Inclusion of Persons with Disabilities in Humanitarian Action. Inter-Agency Standing Committee.

4.6 Children on the move[240]

4.6.1 Key messages on integrating MHPSS for children on the move[241]

The following messages summarize the importance of integrating MHPSS for children on the move. These messages can be used to build awareness among stakeholders at all levels of the socio-ecological model.

- When providing MHPSS to children and families on the move, it is important to recognize the stress, fear, frustrations, and hardships associated with migration and displacement while also acknowledging children and families' aspirations to reach their destination.
- For adults and children on the move, most emotional distress and conditions are directly related to current stresses, worries, and uncertainty about the future rather than past traumatic experiences.
- Separation from family members during displacement is a highly distressing event that can have a negative impact on child development.
- MHPSS interventions should:
    - Be culturally relevant
    - Treat all people with dignity and respect
    - Support self-reliance
    - Strengthen children's, families', and caregivers' psychosocial well-being
- MHPSS should be prioritized for children, particularly children who are separated, unaccompanied, and live with disabilities.
- Psychotherapeutic treatments that need follow-up should only be initiated when follow-up is likely to occur.
- MHPSS interventions for children on the move should include actions that support sustainable integration into host communities.

4.6.2 Rationale for integrating MHPSS for children on the move

The term 'children on the move' encompasses a wide group of children, including children who are migrants, refugees, asylum-seekers, unaccompanied and separated, internally displaced, trafficked, Roma children, or members of other nomadic groups. Children may migrate or be displaced with parents, caregivers, other people who are known to them, or on their own. Some children

240 Save the Children. 2018. Protecting Children on the Move: A guide to programming for children affected by migration and displacement.

241 Recommendations mostly adapted from Save the Children, HIAS, IFRC, TdH, IASSW, and the MHPSS Collaborative. 2021. Mental Health and Psychosocial Support for People on the Move during COVID-19: A Revised Multi-agency Guidance Note.

may move in and out of different categories within the same journey or over time, affecting their sense of belonging and identity.[12]

The reasons, patterns, and consequences of children's movement are diverse and complex.[242] Through the socio-ecological lens, an understanding of the drivers for girls and boys to move is crucial to inform relevant and effective MHPSS programming that helps prevent toxic stress, distress, and mental health conditions and also supports well-being. It is also important to recognise and understand children's own roles in decision-making, both as a trigger for movement and as a force for their own self-protection.[243]

Well-being and good mental health can be challenged by migration and displacement.[244] The context and nature of their movement affect the likelihood of risks children face. For example:

- Children and adolescents **in transit** are often exposed to sexual and gender-based violence (see Section 4.3.), forced labour, extortion, exploitation, and other abuses.[245]
- Economic deprivation among **refugees and internally displaced people** increases the likelihood of engagement in hazardous or exploitative child labour and, in some contexts, forced and early child marriage (see Section 4.2.)(United Nations, 2019).
- Rates of conditions related to extreme stress, such as post-traumatic stress disorder (PTSD), are higher in **refugees** than in people who are not forcibly displaced.[246]
- Children affected by **armed conflict** and other situations of violence may have been survivors of witnesses to, and/ or perpetrators of acts of violence.

For most refugees and migrants, however, potentially traumatic events from the past are not the only, or even the most important, sources of psychological distress. Stresses and worries related to their current condition and uncertainty about the future can be very powerful causes of emotional distress. Forced migration requires multiple adaptations in short periods of time. An acute sense of urgency among children and caregivers on the move may prompt them to take extreme medical and psychosocial risks, and their fast-paced mobility through several countries typically leaves very little time for MHPSS service provision.

The loss of family income and access to services may reduce adults' capacity to care for young children, increase the burden of care on older siblings, and/ or pressure children into child labour or human trafficking.[247] In new surroundings, where they have no job, often no right to work, and they lose their normal role as providers in the family, parents can experience a significant loss of control, agency, and

242 Save the Children. 2018. *Protecting Children on the Move: A guide to programming for children affected by migration and displacement*.

243 International Organization for Migration. 2013. *Children on the Move*.

244 Schininà, G. (2019) *Mental Health and Migration: Definitions and Complexities, Manual on Community-Based MHPSS in Emergencies and Displacement*. A newer version of this publication is now available: IOM. 2021. *Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement. Second Edition.*

245 UNICEF. 2020. What Works to Protect Children on the Move: Rapid Evidence Assessment.

246 Save the Children, HIAS, IFRC, TdH, IASSW, and the MHPSS Collaborative. 2021. *Mental Health and Psychosocial Support for People on the Move during COVID-19: A Revised Multi-agency Guidance Note*.

247 UNICEF. 2020. *What Works to Protect Children on the Move: Rapid Evidence Assessment*.

self-esteem. This in turn can negatively impact their caregiving capacity. Both adults and children become more at risk of abuse and neglect. Additionally, the way that care, protection, and assistance are provided may induce or aggravate problems (e.g., undermining human dignity, discouraging mutual support, or creating dependency).

Separation from family members during displacement is a potential and highly distressing event that can have a negative impact on child development. Many separated children struggle from multiple losses and grieve for parents, siblings, places, and the life they left behind (see Section 4.4. loss and grief).[248] For young children, an attachment figure is essential for their sense of agency, safety, and well-being and gives a sense of security in the midst of chaos.

The emotional impact of separation and its effect on their development will depend on a child's age, developmental stage, resilience, circumstances, and length of separation. Children who are separated may:

- Feel overwhelmed, confused, and distressed
- Experience extreme fear and worries, sleep problems and nightmares, and outbursts of strong emotions such as anger and sadness
- Regress to an earlier stage of development

Research shows that loneliness, depression, and isolation can affect unaccompanied asylum-seeking children for many years.[249] racism, discrimination, xenophobia faced on daily basis, by host community and sometimes peers have a profound impact on the feeling of loneliness and leading to potential depression symptoms. Particular efforts should be made to support unaccompanied and separated children with no little chance to be reunited with families and relatives.

When providing MHPSS to children and families on the move, it is important to recognize the stress, fear, frustrations, and hardships associated with migration while also acknowledging children and families' aspirations to reach their destination.

4.6.3Integrated MHPSS interventions for children on the move

The following sections provide key entry points and or approaches at each level of the MHPSS pyramid that can be used in integrated MHPSS programming for children on the move.

4.6.3.1.1 Level 1: Basic services and security

Integrated interventions at the first level of the MHPSS pyramid seek to meet the following goals:

- All children on the move (and their families) can access and effectively use inclusive, safe, and secure MHPSS services, including preventative efforts.

248 *Joint Statement on Women and Girls towards the Global Refugee and Migrant Summits, September 2016*.

249 *Joint Statement on Women and Girls towards the Global Refugee and Migrant Summits, September 2016*.

Key Guidance

Actions that can support those goals include:

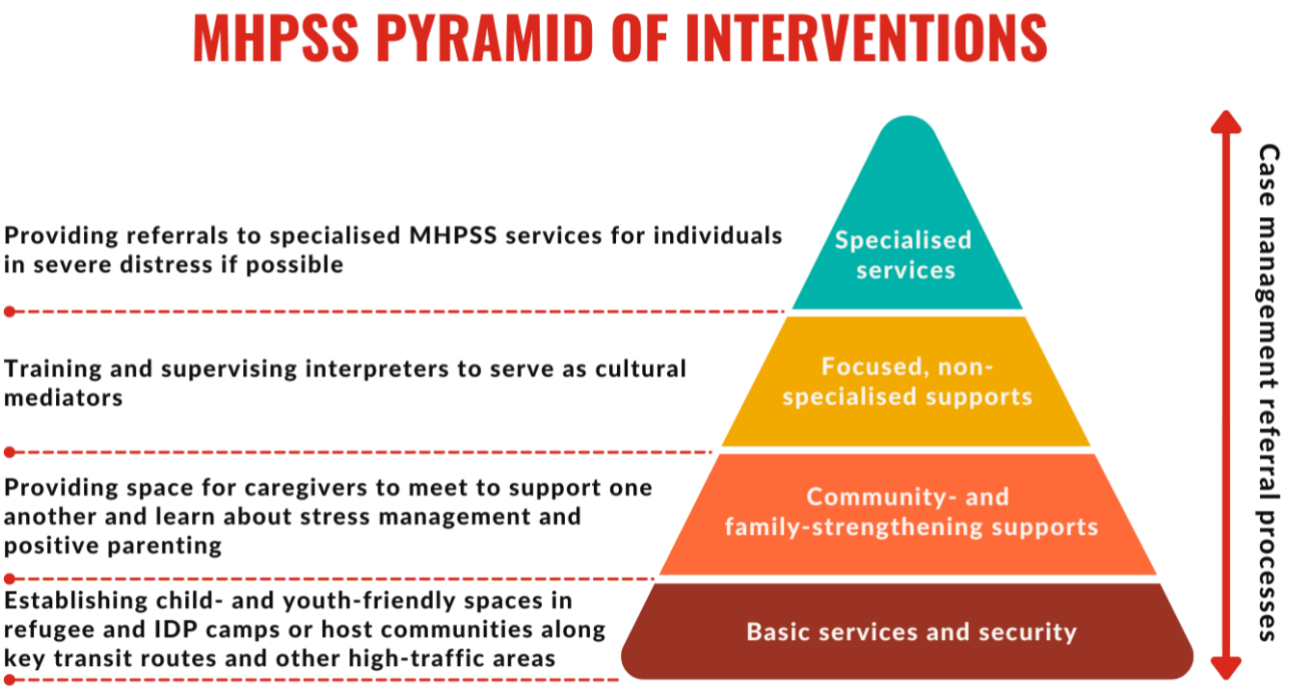
- **Ensuring MHPSS services** for children on the move are provided in dignified ways that respect the individuals' autonomy and privacy
- **Consulting with children on the move** to identify their needs and capacities and to build child-friendly assistance around their suggestions
- **Ensuring children and young people can access information** about their asylum claims, their right to access services, and the availability of support
- **Ensuring any interventions are culturally relevant**, including using trained interpreters and/or cultural mediators from migrants' countries of origin where possible and appropriate

Key considerations when implementing these actions include:

- Everyone, including children with and without disabilities and from minority groups, have the right to be treated with equity and without discrimination (see Section 4.5.).
- Wherever possible, support should enable children to maintain a sense of personal control. This is a prerequisite for appropriate MHPSS but can be difficult to accomplish for children who do not stay long in one place.
- It is best to avoid using community or family members as interpreters. Children should not be used as translators for their parents. With training and supervision, some interpreters can have a more comprehensive role as cultural mediators. A cultural mediator uses their knowledge of the values, beliefs, and practices within their own cultural group along with knowledge of the different care systems in the host context to serve as an intermediary between a person and a service provider.
- Children on the move are likely to feel disempowered and experience negative mental health consequences when they lack information on their rights, awareness of how to get help, access to education, etc.

Resources that can support implementation of these actions include:

Save the Children, HIAS, IFRC, TdH, IASSW, and the MHPSS Collaborative. 2021. Mental Health and Psychosocial Support for People on the Move during COVID-19: A Revised Multi-agency Guidance Note.



4.6.3.1.2 Level 2: Community- and family-strengthening supports

Integrated interventions at the second level of the MHPSS pyramid seek to meet the following goals:

- All parents/ caregivers with disabilities can access and effectively use inclusive, safe, and secure MHPSS services, including case management and family reunification support, as needed.
- Host communities support the mental, physical, and psychosocial well-being of children and families on the move, especially children who are unaccompanied or separated.

Actions that can support those goals include:

- **Ensuring interventions** in formal and non-formal education settings are safe and effective and employ teachers from the same population who have been trained on establishing trust with displaced children (see Section 3.6.). Refer to Save the Children, UNICEF, and War Child. Team Up and the Team Up at Home handbook.
- **Establishing child- and youth-friendly spaces** in refugee and IDP camps or host communities along key transit routes, border areas, reception centres, destination locations, and 'listening points' along transit routes.
- **Prioritizing MHPSS for children**, particularly those who are separated, unaccompanied, and living with disabilities. Refer to SC Girls on the Move curriculum - forthcoming.

Key Guidance

- **Engaging family members** in MHPSS interventions. Refer to parenting on the move training package and Tips for Combating stress for parents and children on the move.[250]
- **Providing space for caregivers** to support one another and learn about stress management and positive parenting. Refer to Parenting on the move training package.[251]
- **Running drop-in centres** for unaccompanied, separated, and street-connected children. Refer to Boxes of Wonder.[252])
- **Implementing interventions** to support caregivers, including pregnant teenagers, with advice on how to care for babies and infants (see Section 3.1.).
- **Establishing opportunities** for life skills workshops and peer education with and by children and young people in communities and schools (refer to Children's Resilience Programme[253] or HEART[254])
- **Establishing peer-to-peer support** for children on the move (refer to I Support My Friends[255] and Girls on the move curriculum)
- **Training foster parents** of unaccompanied, asylum-seeking and refugee children to provide culturally aware and appropriate support to the child such as:
    - Nurturing care practices
    - Positive parenting
    - Managing loss and grief
    - Managing children's emotions
    - Positive discipline
    - Supporting children in distress
- **Facilitating family reunification ser**vices for families have become separated
- **Providing alternative care arrangements**, when family reunion is not possible, that:
    - Are in the best interest of the child
    - Prioritize the option of returning to their immediate or extended family
- **Facilitating dignified burials** and mobilizing people from the same religious background to attend burials in support of families that experience the death of a loved one during their journey

[250] Save the children. 2022. Tips for Combatting stress for parents and children on the move
[251] Save the children. 2021. Parenting on the Move: Program for empowerment and promoting the development of competencies of parents of children up to 12 years of age, in situations of migrations and refugeehood
[252] Save the Children. 2018. *Boxes of Wonder: Creation on the Program with Children on the Move*.
[253] Save the Children. 2012. *The Children's Resilience Programme: Psychosocial support in and out of schools*.
[254] Save the Children. *HEART: Healing and education through the arts*
[255] Save the Children, The MHPSS Collaborative, UNICEF, WHO. 2021. *I Support My Friends: A training for children and adolescents on how to support a friend in distress*.

Key Guidance

- **Supporting** the sustainable integration of children on the move into host communities
- **Ensuring** that integrated, child-led community projects with new and host children include a community mapping of barriers to participation, including cultural beliefs and stigma
- **Supporting all sectors** to integrate interventions that support children and caregivers' mental health and psychosocial well-being

Key considerations when implementing these actions include:

- Family and social supports are the best protection in response to distress, and attachment to a caring adult is a key protective factor for children. It is therefore important to keep parents and children together.
- Migration can lead to positive outcomes for girls, boys, and families. Children and families migrate to fulfil their aspirations for a better life and/or to escape violence, conflict, or insecurity.[256] However, migrant, refugee or asylum-seeking children and families can also be at risk of abuse, exploitation, and discrimination in their host communities.
- Mental health and well-being programmes should be held in safe and secure spaces and should involve both displaced children and children from host communities.
- Programme selection should consider the emotional and physical stability of children and caregivers. In-depth interventions should not be started as children may move from place to place.
- Safe, child-friendly spaces in refugee or IDP camps, and/or host communities may successfully be used to deliver a range of psychosocial interventions to enhance the psychosocial well-being of children on the move, including:
    - Creative arts
    - Play
    - Group therapy
    - Counselling
    - Psychoeducation
    - Cognitive behavioural therapy
    - Joint sessions for youth from refugee, migrant, and host communities (including community planning)[257]
- Consider that in many settings there may be different from several backgrounds and languages. Important to consider interventions that are non-verbal, of which Team Up is an example: Save the Children, UNICEF, and War Child. Team Up and the Team Up at Home handbook.

[256] UNICEF. 2020. *What Works to Protect Children on the Move: Rapid Evidence Assessment*.
[257] UNICEF. 2020. *What Works to Protect Children on the Move: Rapid Evidence Assessment*.

Key Guidance

Resources that can support implementation of these actions include:

Save the Children. *HEART: Healing and education through the arts*

Save the Children. 2018. *Boxes of Wonder: Creation on the Program with Children on the Move*.

Save the Children, The MHPSS Collaborative, UNICEF, WHO. 2021. *I Support My Friends: A training for children and adolescents on how to support a friend in distress*.

Save the Children, UNICEF, and War Child. Team Up and the Team Up at Home handbook (in particular the non-verbal component of Team Up for children on the move)

Save the Children. 2022 Girls on the Move: A curriculum for girls affected by migration & displacement (forthcoming)

Save the Children. 2012. *The Children's Resilience Programme: Psychosocial support in and out of schools*.

4.6.3.1.3 Level 3: Focused, non-specialized supports

Integrated interventions at the third level of the MHPSS pyramid seek to meet the following goals:

- Service providers are equipped to safely and securely identify, refer, and deliver services (including case management and family reunification support) to children on the move.

Actions that can support those goals include:

- **Training MHPSS staff and sector focal points** on suicide risk management for children/ adolescents who disclose self-harm or suicidal ideation (see Section 2.8.3.)
- **Identifying (and providing services/referrals to) children** in need of immediate focused and specialised services (including case management and family reunification services), if available
- **Providing an interpreter** or, ideally, an MHPSS support worker from the same cultural background and appropriate gender so that the child can express themselves and their needs freely
- **Implementing group-based MHPSS interventions** with unaccompanied and separated children
- **Restoring communication and links** between children on the move and their parents, caregivers, or family members via e-mail, phone, etc. if physical reunification is not currently possible.

Key considerations when implementing these actions include:

- Children, adolescents, and caregivers on the move may develop a mental health condition, while those with pre-existing, chronic, or severe conditions may become particularly vulnerable.

- For children who display acute signs of distress, the priority should be on stabilization by providing psychoeducation, information, and physical safety.
- It is very important to pay attention to the cultural and language needs of children and adolescents in severe distress. Some children will prefer to speak to someone of a specific gender, so the gender of the interpreter and the MHPSS support worker should also be carefully considered to ensure an appropriate person.
- Evidence-based research on group-based MHPSS interventions shows that both participating staff members and unaccompanied minors reported increased trust and communication and participating staff members felt empowered to facilitate groups independently using group-based MHPSS interventions for unaccompanied and separated refugee children.[258]

Resources that can support implementation of these actions include:

Save the Children, HIAS, IFRC, TdH, IASSW, and the MHPSS Collaborative. 2021. *Mental Health and Psychosocial Support for People on the Move during COVID-19: A Revised Multi-agency Guidance Note*.

MHPSS Collaborative. "Seamless" MHPSS Cross-Border Care for Children, Youth and Families.

4.6.3.1.4 Level 4: Specialized services

Integrated interventions at the fourth level of the MHPSS pyramid seek to meet the following goals:

- All children, parents/ caregivers, and families on the move can access specialized services, if available, as needed.

Actions that can support those goals include:

- **Referring** migrant, refugee, and asylum-seeking children and caregivers to counsellors, psychologists, and other specialised services as required (e.g., survivors of sexual violence, those with pre-existing mental health conditions)

Key considerations when implementing these actions include:

- In the absence of trained specialists, only use interventions at the first three levels of the MHPSS pyramid.
- An impediment to most conventional psychotherapeutic interventions for children and adolescents on the move is that they often require multiple sessions. Therapeutic techniques need to be adapted to the fact that the first time you see a person may be the last. Therefore:
    - **Do not** start psychotherapeutic treatments that need follow-up when follow-up is unlikely

[258] Garoff, F. et al. 2018. 'Development and implementation of a group based mental health intervention for unaccompanied minors.' *Scan J Psychol*. 2019 Feb;*60*(1):7–15. doi: 10.1111/sjop.12497. Epub 2018 Nov 19. PMID: 30452082.

- **Do not** inadvertently harm the person by encouraging them to talk about difficult experiences outside a stable and clinical context
- **Do not** use trauma-focused, single-session interventions including, but not limited to, critical incident stress debriefing.

Resources that can support implementation of these actions include:

- Local specialist providers, if available.

4.6.4Key children on the move resources

Save the Children. 2018. Protecting Children on the Move: A guide to programming for children affected by migration & displacement.

Save the Children. 2018. Boxes of Wonder: Creation of the program with children on the move.

Save the Children and CIP. 2021. Parenting on the Move.

Save the Children. (2022 - forthcoming) Girls on the Move: A curriculum for girls affected by migration & displacement.

Save the Children, HIAS, IFRC, TdH, IASSW, and the MHPSS Collaborative. 2021. *Mental Health and Psychosocial Support for People on the Move during COVID-19: A Revised Multi-agency Guidance Note*.

Save the Children, The MHPSS Collaborative, UNICEF, WHO. 2021. *I Support My Friends: A training for children and adolescents on how to support a friend in distress*.

For further knowledge: Lynne Jones, giving the Voices of children refugees

4.7 Shelter and settlements

4.7.1Key messages on integrating MHPSS into shelter and settlements

The following messages summarize the importance of integrating MHPSS, shelter, and settlements. These messages can be used to build awareness among stakeholders at all levels of the socio-ecological model.

- Participatory approaches to improving settlement and shelter conditions that utilize the skills and capacity within the community contribute to greater community cohesion, social well-being, and resilience to future shocks.
- People with mental health conditions and psychosocial disabilities need shelter and support from trained professionals.
- Overcrowded camps and settlements with limited or no services increase stress levels, exacerbate mental health problems, and negatively impact children and family members.
- Elements of living environments that are not 'lifesaving' are still essential for well-being (e.g. natural lighting; plants and green spaces; space around the house for growing crops and other livelihood activities; recreational, sport, and play areas; and tools to decorate and personalize homes).
- Country based MHPSS specialists should participate in camp coordination and camp management (CCCM) clusters and Shelter and NFI (Non-food Items) Working Group meetings to voice and advocate for appropriate shelters and the integration of cultural and family needs into camp design.
- Adolescents have particular shelter needs: lack of personal space increases their risks of violence and insecurity and hinders healthy adolescent development.

4.7.2Rationale for integrating MHPSS into shelter and settlements

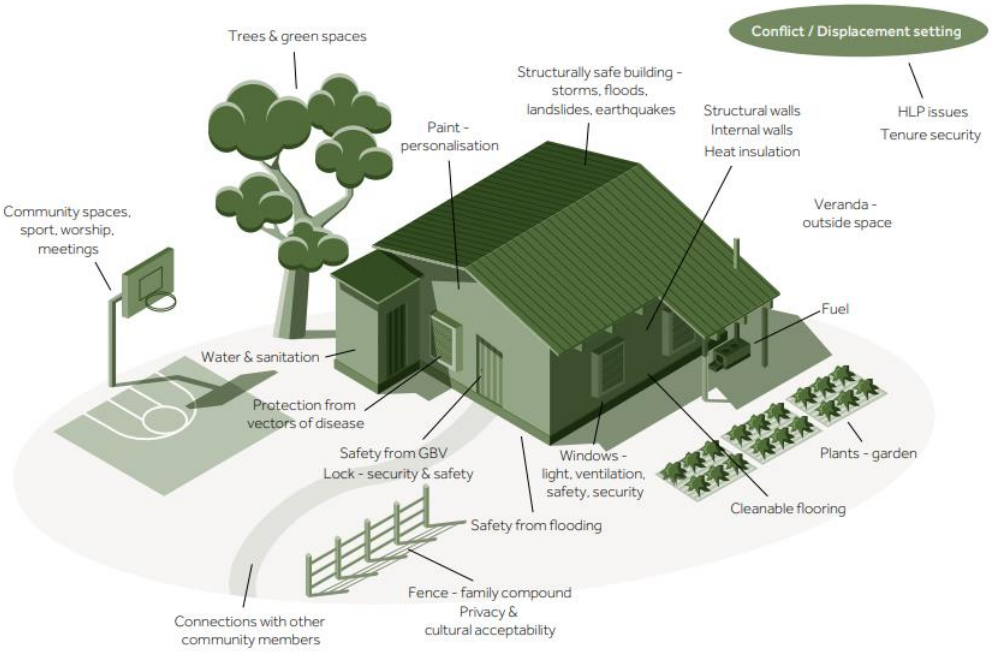
Shelter is central to family life, particularly for women and children who spend more time in the home and are more likely to live in poor conditions.[259] Housing is so important that it is included in the UNICEF child well-being index. Substandard housing contributes to children's poor health and developmental delay. In fact, the type of housing is more important than socio-economic status in determining growth.[260]

Unhealthy and inadequate living environments may cause children, families, and communities to experience increased insecurity, fear, anxiety, and interpersonal tensions. This is further exacerbated

[259] Thomson, H., et al. 2001. 'Health effects of housing improvement: systematic review of intervention studies.' *BMJ*. *323*(7306):187–90. DOI: 10.1136/bmj.323.7306.187. PMID: 11473906; PMCID: PMC35268.

[260] USAID. 2020. *The Wider Impacts of Humanitarian Shelter and Settlements Assistance: Key findings report*.

in areas of high density with competing needs for space, amenities, resources, and services. Living in crowded conditions limits privacy and risks weakening family relationships. Studies of overcrowded housing reveal an increase in conflicts between couples and siblings (Barnes et al., 2013). Poor quality housing can cause mental distress for parents, especially mothers, and increase the risks of child maltreatment. Evidence shows that children living in crowded and cramped conditions are significantly more likely to develop poor mental health conditions;[261] may have poorer cognitive and psychomotor development; or may be more anxious, socially withdrawn, stressed, or aggressive.



Housing instability also has negative impacts on child mental health. Children who are homeless or living on the street are three to four times more likely to have mental health problems and staying in overcrowded shelters increases the likelihood of mental health conditions among children.[262]

People's living conditions significantly impact their ability to cope with and recover from crisis, including people with pre-existing mental health issues.[263] For example, nearly one quarter of earthquake survivors develop forms of PTSD. The mental and emotional impact of earthquakes has been called 'the other invisible disaster' (Bennett, 2015; Dai et al., 2016).[264] The home-based lockdown in many countries in response to the COVID-19 pandemic has further highlighted the need for improved planning and consideration in the design of neighbourhoods and homes in order to support mental health and well-being.

It is clear that shelter and settlement factors impact child development, mental health, and well-being, but reconstruction alone cannot build back what was lost. Integrated MHPSS, shelter, and settlement

261 WHO. 2010. *International workshop on housing, health, and climate change*.

262 USAID. 2020. *The Wider Impacts of Humanitarian Shelter and Settlements Assistance: Key findings report*.

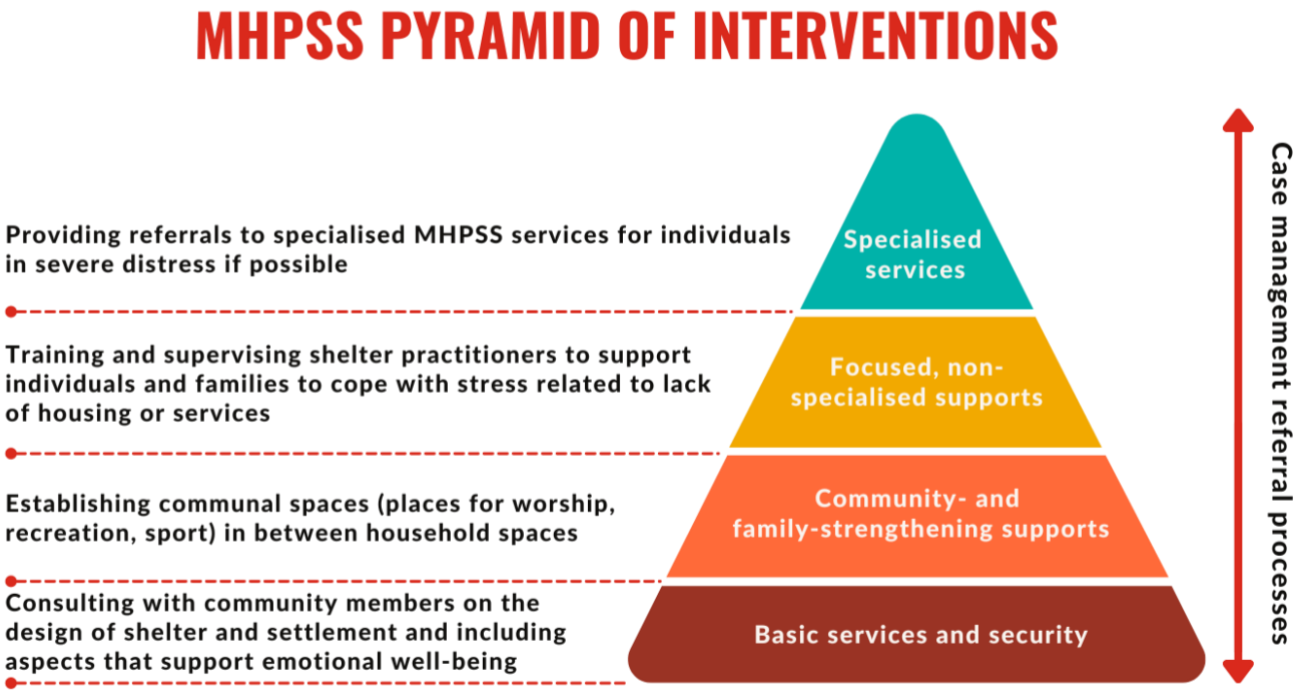
263 Tucker, M. 2020. 'Mental Health and Psychosocial Support and Shelter.' In Webb, S., Weinstein Sheffield, E. and Flinn, B. (Eds.) *Towards Healthier Homes in Humanitarian Settings: Proceedings of the Multi-sectoral Shelter & Health Learning Day 14th May 2020*. Oxford Brookes University and CARE International UK.

264 Based on research by Olivia Nielsen and Luis Triveno (World Bank) originally published on the World Bank website (Triveno and Nielsen, 2020).

programming can contribute to the psychological well-being of families and communities (see Figure 25[265]).

4.7.3Integrated MHPSS, shelter, and settlements interventions

The following sections provide key entry points/ approaches at each level of the MHPSS pyramid that can be used in integrated MHPSS programming for children in need of shelter.



4.7.3.1.1 Level 1: Basic services and security

Integrated interventions at the first level of the MHPSS pyramid seek to meet the following goals:

- All children and their families are able to access safe, secure shelter that supports their mental health and well-being with no discrimination on legal status, disability, and gender.

Actions that can support those goals include:

- **Including shelter** elements in MHPSS assessments
- **Including MHPSS** elements in shelter and settlement assessments
- **Consulting** with children, parents, and caregivers to incorporate elements into their shelter that will support their mental health and well-being

Key considerations when implementing these actions include:

[265] Webb. S. and Weinstein Sheffield, E. 2021. *Mindful Sheltering: Recognising and Enhancing the Impact of Humanitarian Shelter and Settlements on Mental Health and Psychosocial Well-Being.* Oxford Brookes University and CARE International UK.

- People who were part of a shelter intervention that helped improve their living conditions reported gaining moral support and hope for the future and were motivated to undertake further works by themselves.[266]
- MHPSS assessments should address the following shelter questions:
    - Does the design of the shelter include adequate space and/ or amenities for children and families?
    - Is there adequate light, ventilation, etc.? (i.e., Is there mould, a mud floor, etc. that could increase the risks of poor physical health, including diarrhoea and respiratory problems?)
    - Are the structures and living conditions safe and secure?
    - How do the layout and (urban) planning of the neighbourhood impact the mental health of children, families, and communities?
    - Is there overcrowding that can create or increase social tensions?
    - Are there adequate services (i.e., power, electricity, water, and drainage)?
    - Are their physical or attitudinal barriers that restrict universal access, dignity, etc., particularly for persons with disabilities and vulnerable groups?
- Shelter assessments should be consultative and participatory and include the needs of all boys and girls, parents, and caregivers.

Resources that can support implementation of these actions include:

International Federation of Red Cross and Red Crescent Societies. 2011. PASSA: Participatory Approach for Safe Shelter Awareness.

IASC MHPSS. 2012. MHPSS in emergencies setting: What should camp coordination and camp manager know?

4.7.3.1.2 Level 2: Community- and family-strengthening supports

Integrated interventions at the second level of the MHPSS pyramid seek to meet the following goals:

- Families and communities promote all children's access to safe, supportive shelter.

Actions that can support those goals include:

- **Implementing community-based interventions** that address attitudinal barriers to children's access to safe shelter, especially for children who have disabilities or are from marginalized groups
- **Supporting communities** to include MHPSS considerations when planning new and redesigning existing structures and neighbourhoods

[266] Webb. S. and Weinstein Sheffield, E. 2021. *Mindful Sheltering: Recognising and Enhancing the Impact of Humanitarian Shelter and Settlements on Mental Health and Psychosocial Well-Being.* Oxford Brookes University and CARE International UK.

Key Guidance

Key considerations when implementing these actions include:

- When shelter practitioners engage with a community, they should explore the deeper cultural and practical understandings to determine what the actual needs are related to the context and culture (e.g., establish an understanding of the meaning of 'home,' 'well-being,' etc.).[267]

Resources that can support implementation of these actions include:

Webb. S. and Weinstein Sheffield, E. 2021. *Mindful Sheltering: Recognising and Enhancing the Impact of Humanitarian Shelter and Settlements on Mental Health and Psychosocial Well-Being.* Oxford Brookes University and CARE International UK.

4.7.3.1.3 Level 3: Focused, non-specialized supports

Integrated interventions at the third level of the MHPSS pyramid seek to meet the following goals:

- Shelter practitioners are equipped to identify and refer children in need of shelter related MHPSS.

Actions that can support those goals include:

- **Training** shelter practitioners and other service providers to identify and appropriately refer children who need MHPSS due to their lack of adequate shelter

Key considerations when implementing these actions include:

- Actors in education, health, and MHPSS may often be positioned to first identify children who are in distress and should be prepared to determine whether inadequate shelter is a contributing factor.

4.7.4Key shelter and settlements resources

Global Alliance for Disaster Risk Reduction & Resilience in the Education Sector. 2015. *Towards Safer School Construction: A community-based approach.*

International Federation of Red Cross and Red Crescent Societies. 2011. *PASSA: Participatory Approach for Safe Shelter Awareness*.

Global Shelter Cluster. 'Shelter and Health.' ShelterCluster.org. https://sheltercluster.org/resources/shelter-and-health [website]

Webb, S., Weinstein Sheffield, E. and Flinn, B. (Eds.) 2020. *Towards Healthier Homes in Humanitarian Settings: Proceedings of the Multi-sectoral Shelter & Health Learning Day 14th May 2020*. Oxford Brookes University and CARE International UK.

[267] Webb. S. and Weinstein Sheffield, E. 2021. *Mindful Sheltering: Recognising and Enhancing the Impact of Humanitarian Shelter and Settlements on Mental Health and Psychosocial Well-Being.* Oxford Brookes University and CARE International UK.

Key Guidance

Webb. S. and Weinstein Sheffield, E. 2021. *Mindful Sheltering: Recognizing and Enhancing the Impact of Humanitarian Shelter and Settlements on Mental Health and Psychosocial Well-Being.* Oxford Brookes University and CARE International UK.