INTEGRATING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT INTO YOUTH PROGRAMMING: A TOOLKIT

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INTEGRATING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT INTO YOUTH PROGRAMMING: A TOOLKIT

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USAID's YouthPower2: Learning and Evaluation (YP2LE) generates and disseminates knowledge about the implementation and impact of positive youth development (PYD) and cross-sectoral approaches in international youth development. We are leading research, evaluations, and events designed to build the evidence base and inform the global community about how to transition young people successfully into productive, healthy adults. PYD is defined by USAID as:

> Positive Youth Development (PYD) engages youth along with their families, communities, and/or governments so that youth are empowered to reach their full potential. PYD approaches build skills, assets, and competencies; foster healthy relationships; strengthen the environment; and transform systems.

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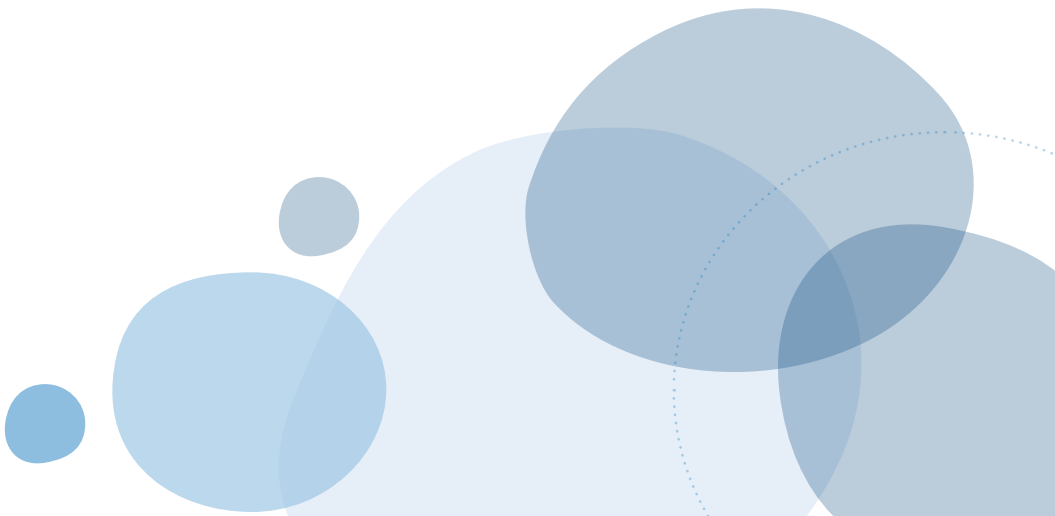
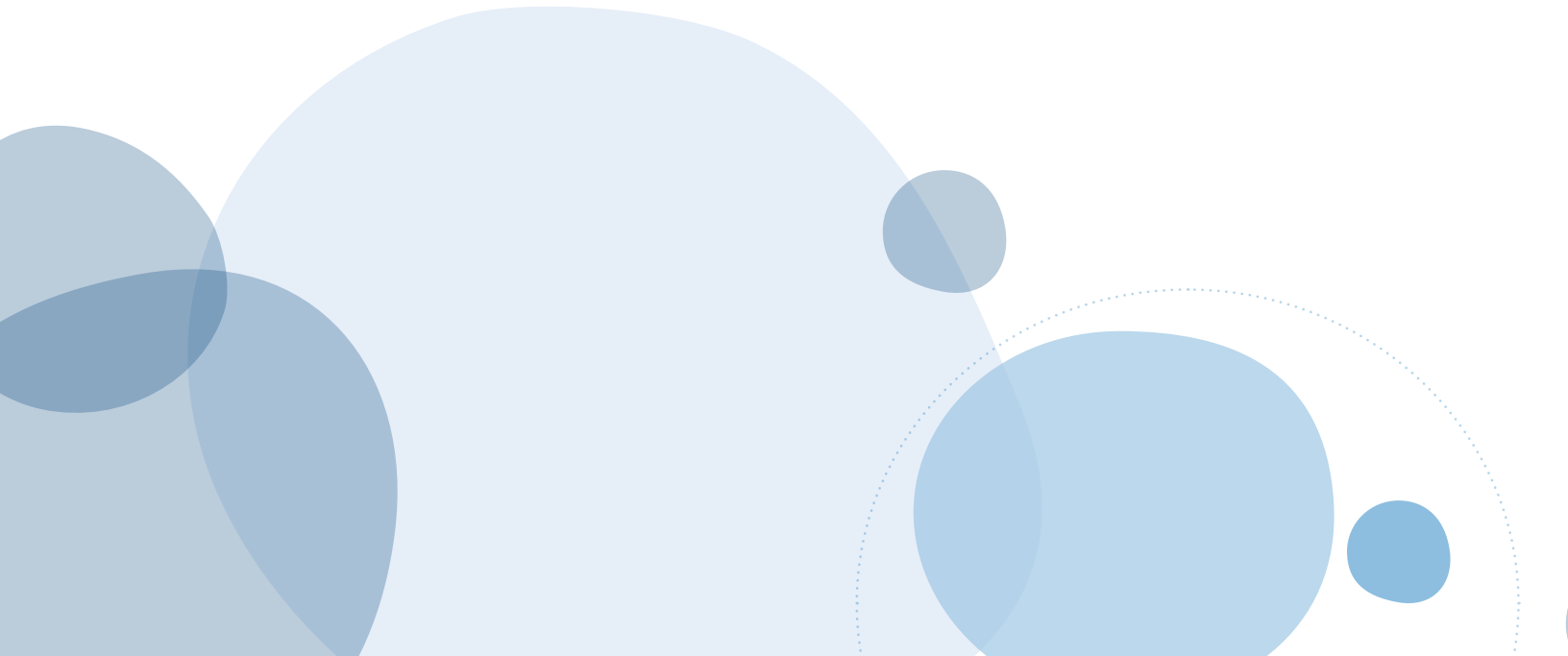


CONTENTS

Integrating Mental Health and Psychosocial Support into Youth Programming: A Toolkit	1
What is the Integrating Mental Health and Psychosocial Support into Youth Programming: A Toolkit?	1
Why is this Toolkit needed?	1
Who is the intended audience?	1
What is the intended context and population?	1
How will this Toolkit help me?	1
Where do I go to…?	2
What are the main takeaways?	3
Section 1: MHPSS Terminology, Definitions, and Contextualization	**4**
USAID's Operational Definitions	4
Contextualizing MHPSS Terminology and Concepts	5
Section 2: The Evidence for Youth MHPSS	**7**
Critical Gaps in Programming and Research	8
Section 3: Frameworks that Support MHPSS Programming	**9**
USAID Positive Youth Development Framework	9
Inter-Agency Standing Committee Intervention Pyramid	10
Section 4: Youth MHPSS and the USAID Program Cycle	**12**
Assessment: Identifying and Understanding Local MHPSS Needs and Selecting Program Objectives	12
Design: Selecting the Interventions	17
Implementation	26
Monitoring, Evaluation, Adapting, and Learning for Youth MHPSS Programming	29
Annex 1: Other Sample Definitions	**35**
Annex 2: MHPSS Illustrative Interventions	**38**
Annex 3: MHPSS Measurement Indicators	**41**
Annex 2/3: End Notes	**53**



Integrating Mental Health and Psychosocial Support into Youth Programming: A Toolkit

What is the Integrating Mental Health and Psychosocial Support into Youth Programming: A Toolkit

This Integrating Mental Health and Psychosocial Support into Youth Programming: A Toolkit provides strategies and tools for designing, implementing, and evaluating mental health and psychosocial support (MHPSS) programs and activities for youth in low- and middle-income countries (LMICs) and conflict-affected contexts. The Toolkit is a resource for standalone youth MHPSS programs and MHPSS activities that are integrated into cross-sectoral youth-focused programs (e.g., health, gender and gender-based violence or GBV, workforce development/youth employment, education, violence prevention, peace, and stability, etc.). The Toolkit includes guidance based on good practice for MHPSS, with recommendations for adapting program designs to community needs and the local context.

Why is this Toolkit needed?

The World Health Organization (WHO) reports that nearly one in five people are impacted by poor mental health in conflict and post-conflict areas and nearly 50 percent of all mental health issues globally start before the age of 14.[1] For youth ages 15 to 29, suicide is the fourth leading cause of death;[2] it is a leading cause of death[3] for those under the age of 15[4]. Despite these high prevalence rates and the negative impacts of poor mental health on education, health, and employment outcomes, youth mental health is grossly under-resourced in international development and neglected in the global public health space and development investments.

Who is the intended audience?

This Toolkit, developed under YouthPower2: Learning and Evaluation, is a reference for USAID field and headquarters staff, as well as national and international partners involved in designing, managing, and evaluating MHPSS programming and strategies for youth.

What is the intended context and population?

The Toolkit includes resources used in both development and humanitarian contexts. It helps you select the right tool(s) given your implementing context and project time frame, as well as the needs of the target population, which should always drive the selection of MHPSS interventions, services, and activities. This Toolkit provides helpful guidance, tips, and resources on where to start and how to program effectively. Since many of the tools developed for conflict-affected settings were created for humanitarian action, the Toolkit may use the term humanitarian, but the materials are relevant to various contexts. The only population that the Toolkit is specifically focused on is youth between the ages of 10 and 29.

How will this Toolkit help me?

This Toolkit will help you:

- Use clear terminology and definitions when working in the areas of youth and MHPSS.
- Be sstrategic and realistic about what to expect of MHPSS programming targeting youth.
- Design etter programs according to the principles of "what works" (what is supported by evidence) and "what might work" (promising activities with less rigorous evidence).
- Understand the recommended qualifications for staff who manage activities that integrate MHPSS.

[1] WHO, Guidelines on mental health promotive and preventative interventions for adolescents: helping adolescents thrive, Geneva: WHO, 2020, https://apps.who.int/iris/bitstream/handle/10665/336864/9789240011854-eng.pdf

[2] WHO, *Suicide worldwide in 2019: global health estimates*, Geneva: WHO, 2021.

[3] "MHPSS Worldwide: facts and figures," Government of the Netherlands, accessed on August 12, 2021 https://www.government.nl/topics/mhpss/funding-and-support-for-mental-health-and-psychosocial-support-in-crisis-situations/mhpss-worldwide-facts-and-figures

[4] Carmen Valle-Trabadelo, "Suicide prevention matters in humanitarian contexts too," Mental Health Innovation, accessed February 2021. https://www.mhinnovation.net/blog/2019/oct/9/suicide-prevention-matters-humanitarian-contexts-too

- Apply examples of illustrative interventions and select appropriate expected outcomes and indicators for youth MHPSS programming
- Prepare an evaluation scope of work to analyze MHPSS activities or needs.

Where do I go to…?

The Toolkit includes four sections that provide a solid foundation for designing MHPSS programs and activities for youth. This Toolkit is not intended to be read from beginning to end, rather it is designed so that you can easily access relevant information. See below for a guide to the Toolkit content.

Conduct a scoping process to identify the mental health and psychosocial needs of youth: Your first step in developing youth MHPSS programming is to identify the target population, understand the population's MHPSS needs, and identify appropriate evidence-based approaches. Guidance on conducting MHPSS assessments can be found in Section 4, "Assessments: Identifying and Understanding Local MHPSS Needs and Selecting Objectives." You may also want to review the section on Contextualizing MHPSS Terminology and Concepts from Section 1. During the scoping phase you will:

- Identify your population and communities of interest
- Ascertain mental health needs, gaps, and opportunities
- Assess how mental health needs vary for different groups of youth based on their identities
- Identify marginalized communities to ensure they can access MHPSS services
- Determine how to provide various levels of care (mental health [MH] services, psychosocial support services [PSS], specialized care, focused care, community, and family supports)
- Identify the ages of the youth you are targeting and where they spend most of their time; assess whether that environment would benefit from a mental health activity
- Determine the length of your program

Effectively design standalone and integrated MHPSS programs: Once you have completed your scoping exercise, decide whether you will address the MHPSS needs through standalone or integrated programming. Examples of integrated MHPSS programming can be found in the sector pull-outs for gender and GBV; violence prevention, peace, and security; education; youth employment; and health. Each pull-out includes detailed examples of program activities and indicators.

Understand foundational concepts for MHPSS: Review Section 1 (USAID MHPSS Terminology and Definitions), which provides a brief overview of key terminology and definitions for MHPSS programming at USAID, and Section 3, which presents frameworks that support MHPSS programming for youth, including a discussion of the strong linkages between USAID's Positive Youth Development (PYD) Framework and the Inter-Agency Standing Committee (IASC) Intervention Pyramid for MHPSS in Emergencies.

Understand evidence-based programming for MHPSS: You will find a brief discussion of the evidence for MHPSS programming, including a summary of the key gaps in programming and research for MHPSS in Section 2, "The Evidence for Youth MHPSS." In addition, you will find linkages to evidence-based programming throughout the Toolkit, including in the sector pull-outs and the key design and implementation recommendations in Section 4.

Effectively staff MHPSS programs: Staffing considerations for MHPSS programming can be found in Section 4, under Implementation, Staffing MHPSS Programs, and Supervision and Coaching.

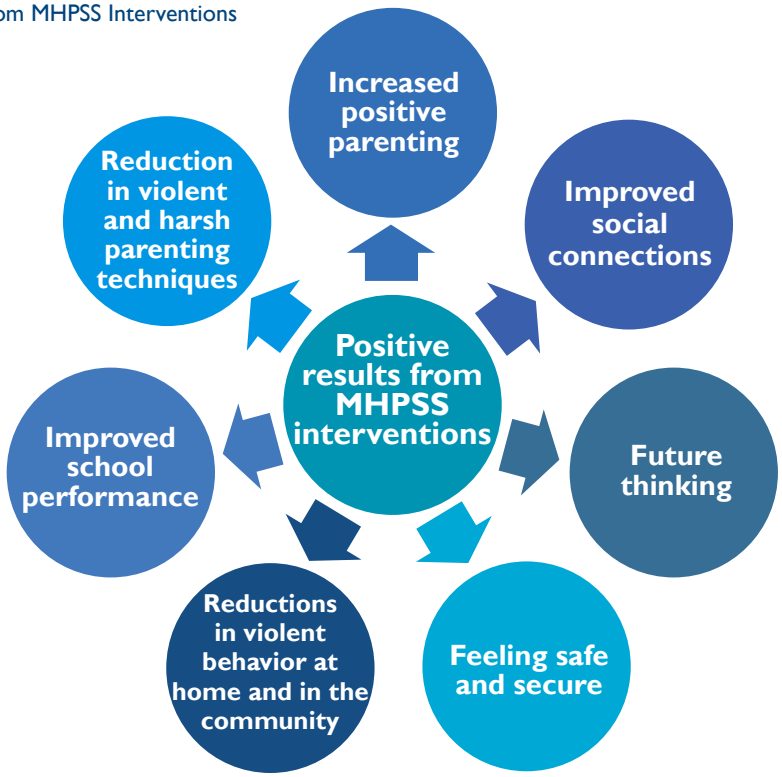
Develop monitoring, evaluation, adapting, and learning systems for MHPSS: If you are looking for guidance on developing a strong monitoring, evaluation, adapting, and learning (MEAL) system for your MHPSS program, review Section 4, Monitoring, Evaluation, Adapting, and Learning for Youth-focused MHPSS Programming. In this section, you will find information on how to effectively create and set up a MEAL system for your program, recommendations on how using your MEAL system will enable you to contribute to the evidence base, and guidance on selecting indicators for youth-focused MHPSS programming.

Understand Safe Programming, Do No Harm for MHPSS, and other considerations when working with distressed populations: The Toolkit elaborates on strategies to ensure the development of programming that does not inadvertently result in harm to beneficiaries and provides considerations for working with populations with high levels of distress. Throughout the document, Do No Harm (DNH) considerations—an important part of MHPSS programming—are tagged with this icon. Throughout the Toolkit, you will find summary tables that provide an overview of DNH considerations for MHPSS programming. The tables have been adapted from the IASC Guidelines for Mental Health and Psychosocial Support in Emergencies. These are intended to reinforce key considerations for best practice.

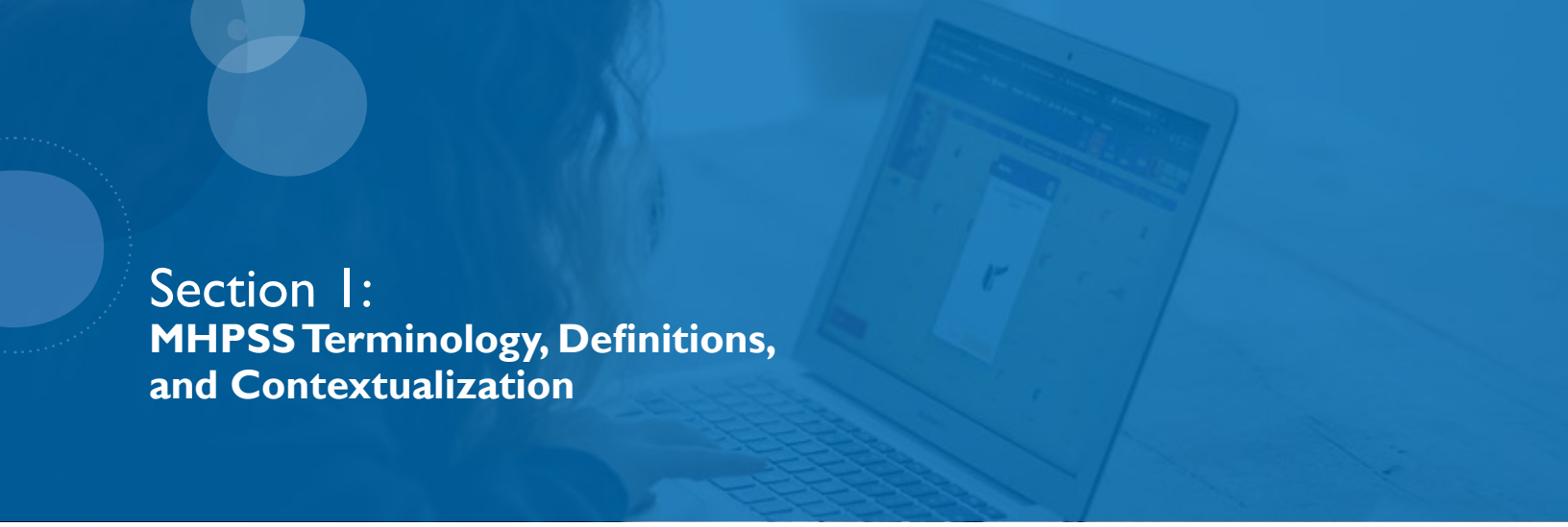
What are the main takeaways?

- **There is a strong and growing evidence base** for the utility of MHPSS programming across LMICs and conflict-affected areas that demonstrates positive results for youth, their families, and their communities. Figure 1-1 shows several examples of positive results from MHPSS interventions.

Figure 1-1: Positive Results from MHPSS Interventions



- **Ongoing technical (including clinical) supervision and in-service training for MHPSS staff are essential.**
- **MHPSS programming should layer services** that respond to different levels of need. For example, a program may simultaneously offer preventative activities that address mental health stigma, psychosocial support services that support the family unit, and services that respond to the individual's MHPSS needs. Both MH Care and PSS are critical elements of any MHPSS program.
- There are numerous points to consider throughout the **program cycle of a youth-focused MHPSS program**, including but not limited to: the special needs of the target population, the special needs of caretakers and care providers, cultural context, perception of mental health and associated stigma, local staff capacity, availability of MHPSS-related referral resources, and service delivery modes.



Section 1:
MHPSS Terminology, Definitions, and Contextualization

This section of the Toolkit introduces MHPSS terminology, including USAID's operational definitions of MHPSS terms and the definitions of other agencies. It also provides examples of how terms are translated across cultures and communities.

USAID's Operational Definitions

USAID's operational definitions for MHPSS terms seek to explain the difference between MH care and PSS and make clear the need for both in MHPSS programming. These definitions should guide the design, implementation, monitoring, and evaluation of USAID-funded programs. For reference, Annex 1 includes terms and definitions you may encounter when working with other donors and implementing partners in MHPSS.

Caregiver: A caregiver is someone who provides daily care, protection, and supervision of a child. This does not necessarily imply legal responsibility and/or age. Where possible, the child should have continuity in who provides their day-to-day care (e.g., a person who is most closely attached to the child and responsible for the daily care and support of young children). Primary caregivers include parents, other persons who are directly responsible for the child at home, and caregivers outside the home, such as in organized daycare.[6]

Mental Health Interventions: Interventions that address mental conditions through personalized care delivered to individuals or small groups with similar conditions. These include psychotherapy, psychoeducation to clients and their families, and pharmacology.

Psychosocial Interventions: Interventions that focus on addressing stress through changes in the environment to make it less stressful (inclusive of the individual's physical environment and social environment), or by broadly applicable information and skills that can be easily disseminated to large groups or by media and are generally relevant to populations under duress.

Positive Youth Development: An approach that engages youth along with their families, communities, and/or governments so that youth are empowered to reach their full potential. PYD approaches build skills, assets, and competencies; foster healthy relationships; strengthen the environment; and transform systems.[7]

Positive Youth Development Dimensions of Well-being: Well-being describes the state where youth thrive. It relates to the PYD domains by looking at individual well-being, interpersonal well-being, and skills and knowledge:

[6] MCI – ECD toolkit – Renee Perez, Email message to author, April 21, 2021

[7] "YouthPower: Promoting Positive Youth Development," YouthPower2: Learning and Evaluation, accessed March 31, 2021, https://www.youthpower.org/positive-youth-development

- Individual well-being includes positive thoughts and emotions such as hopefulness, self-esteem, and self-confidence and relates to youth agency in the PYD framework. Agency includes positive identity, beliefs and values that one holds about him/herself and his/her future, and self-efficacy, belief in one's ability to do things well.
- Interpersonal well-being speaks to nurturing relationships, a sense of belonging, self-esteem, and self-confidence. It is a combination of assets and contributions in the PYD framework. Assets include having interpersonal skills (i.e., communication and social skills), recognizing emotions (i.e., ability to identify feelings and emotional reactions), and having self-control (i.e., manage emotions and regulate one's behavior). Contribution includes engagement in activities that have a sense of meaning.
- Skills and knowledge are needed to make positive decisions, effectively respond to life changes, and express oneself. Skills and knowledge relate most directly to the enabling environment in the PYD framework. *Enabling environment* includes bonding (positive emotional attachment), belonging and membership (sense of being cared for and supported), and a sense of safety, (both physical and psychological).

Trauma: A deeply distressing or disturbing experience and/or physical injury. The term trauma is often used clinically when discussing determinants of a mental health condition. Distress can often be used as an alternative term to trauma.

Traumatic Event: Deeply distressing or disturbing event, the results of which can intrude on daily life and increase the likelihood of developing mental health conditions.

Youth: Individuals between the ages of 10 and 29 years old.[8]

Contextualizing MHPSS Terminology and Concepts

Contextualization is the process of adapting programmatic approaches, concepts, and terminology to the local customs, values, and beliefs while maintaining fidelity to the core concepts and approaches.[9] This process is essential when designing and implementing MHPSS programming. Contextualizing MHPSS terminology, approaches, and concepts reduces the risk of causing unintended harm and helps to prevent harmful practices.[10] This process requires engaging local stakeholders to translate MHPSS concepts correctly—both linguistically and culturally. Strategies for contextualization include:

- Conduct foundational qualitative work (e.g., open-ended interviews with individuals and groups) as part of situational analyses/needs assessments with the local population to understand their concepts and views on mental health, including their core MHPSS terminology.
- Where possible, hire MHPSS professionals and translators from the local population. Local MHPSS professionals will have a deeper understanding of the cultural nuances surrounding mental health and psychosocial well-being. In addition, procure translation services from the area where the program will be implemented, as the understanding of key concepts related to mental health and psychosocial well-being can vary between communities, even within the same state.
- Use clinical terminology only when describing clinical interventions or services to be delivered by trained clinicians. When talking with beneficiaries, use descriptive language (in the local language) that helps to build an understanding of the MHPSS concepts and core issues. The use of the local lexicon to help communicate mental health concepts is recommended.

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[8] USAID, USAID Youth in Development Policy: Realizing the Demographic Opportunity, October 2012, https://www.usaid.gov/policy/youth

[9] Sarah F. Coleman, Hildegarde Mukasakindi, Alexandra L. Rose, Jerome T. Galea, Beatha Nyirandagijimana, Janvier Hakizimana, Robert Bienvenue, et al., "Adapting Problem Management Plus for Implementation: Lessons Learned from Public Sector Settings Across Rwanda, Peru, Mexico and Malawi," Intervention 19, no. 1 (January 1, 2021): 58, https://doi.org/10.4103/INTV.INTV_41_20.

[10] Michael G. Wessells, "Do No Harm: Toward Contextually Appropriate Psychosocial Support in International Emergencies," American Psychologist 64, no. 8 (2009): 842–54, https://doi.org/10.1037/0003-066X.64.8.842.

This Toolkit points to resources on contextualizing MHPSS programming, including aligning with local terminology used to describe mental health concerns and local approaches to developing positive coping techniques. The following resources include sections that relate directly to contextualization and are included in the Toolkit:

- "Design, Implementation, Monitoring, and Evaluation of Mental Health and Psychosocial Assistance Programs for Trauma Survivors in Low Resource Countries: A User's Manual for Researchers and Program Implementers (Adult Version), Module 1" (Johns Hopkins University): includes six modules that walk the user through how to design, implement, monitor, and evaluate MHPSS programming for trauma survivors. Module 1 is useful during the assessment phase and for understanding local perceptions of MHPSS concepts related to torture and other traumatic experiences.
- "Adapting Problem Management Plus for Implementation: Lessons Learned from Public Sector Settings Across Rwanda, Peru, Mexico, and Malawi": describes the contextualization process used by Partners in Health (PIH) to adapt Problem Management Plus across multiple settings. This article may be used to help identify the necessary steps to contextualize your MHPSS interventions and approaches.
- "Defining and Measuring Child Well-Being in Humanitarian Action: A Contextualizing Guide" (The Alliance for Children Protection in Humanitarian Action): focuses on how to develop contextually appropriate measures for well-being and helps understand how to build a localized understanding of core concepts related to MHPSS.

Photo Credit: Pexels - Matheus Bertelli

Section 2:
The Evidence for Youth MHPSS

Research shows that MHPSS interventions targeting youth ages 10 to 29 can result in positive changes in mental health and psychosocial well-being. There is a small but growing evidence base for youth-focused MHPSS programming in LMICs and conflict-affected countries that speaks to a range of interventions, such as approaches based on cognitive behavioral therapy (CBT),[11] parenting interventions,[12, 13] structured group activities, case management,[14] and community-focused interventions,[15] including individual interventions using paraprofessionals and/or lay counselors.[16] Limitations in the evidence are due to a lack of rigorous evaluations of community-based MHPSS interventions, the challenges of conducting research in complex emergencies with migratory populations, the difficulty of conducting evaluations that target different populations across multiple contexts, and the cost of large multi-context, multi-population MHPSS research initiatives.[17]

USAID has created a MHPSS database[18] and Summary to house research on MHPSS interventions across contexts, types of interventions, and outcomes. This database is available to anyone interested in designing and implementing evidence-based MHPSS programming and can help organizations develop effective programs by providing access to curated collections of MHPSS research.

Having clear, evidence-based MHPSS outcomes that drive quality program design and implementation has been shown to improve the results of the interventions. A multi-country, multi-partner study of Child Friendly Spaces found that the impacts on child and adolescent well-being varied widely depending on the quality of the MHPSS program design and delivery.[19] One example of the importance of evidence-based MHPSS outcomes is Youth Save Ghana, a program that focused on supporting youth set up savings accounts. While the program design did not include any targeted psychosocial interventions, it attempted to show changes in well-being as an indirect outcome in a randomized control trial (RCT). They found little to no impact on the psychosocial well-being of youth who participated in the program.[20] If a program wants to see improvements in mental health and psychosocial well-being, it should be designed with interventions and strategies shown to be effective in achieving those MHPSS outcomes.

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[11] Catholic Relief Services, "Cognitive Behavioral Therapy Informed Curriculum," https://www.crs.org/our-work-overseas/research-publications/cognitive-behavioral-therapy-informed-curriculum

[12] Lindsay Stark, et al., "Preventing violence against refugee adolescent girls: findings from a cluster randomized controlled trial in Ethiopia," BMJ Global Health, vol. 3, no. 5 (2018).

[13] Kim Ashburn, et al., "Evaluation of the Responsible, Engaged, and Loving (REAL) Fathers Initiative on Physical Child Punishment and Intimate Partner Violence in Northern Uganda," Prev Sci., vol. 18, no. 7 (October 2018): 854-864.

[14] Waves for Change, Waves for Change Learning Brief, https://www.waves-for-change.org/w4c-impact/

[15] Creative Associates, Community, Family and Youth Resilience (CFYR) Program – Final Program Report, July 2016 – November 2020," November 2020, http://pdf.usaid.gov/pdf_docs/PA00X45Z.pdf

[16] Dixon Chibanda, "The Friendship Bench programme: a cluster randomised controlled trial of a brief psychological intervention for common mental disorders delivered by lay health workers in Zimbabwe," International Journal of Mental Health Systems, no. 9 (2015).

[17] Emily E. Haroz, et al., "What works in psychosocial programming in humanitarian contexts in low- and middle-income countries: a systematic review of the evidence," Intervention: Journal of Mental Health and Psychosocial Support in Conflict-Affected Areas, vol. 18, no. 18 (2020): 3-17.

[18] Columbia University Mailman School of Public Health and World Vision International, "Evaluation of Child Friendly Spaces: Findings from an Inter-Agency Series of Impact Evaluations in Humanitarian Settings." https://www.wvi.org/sites/default/files/Evaluation%20of%20CFS_Final%20Research%20Report.pdf

[19] Giana Chowa, et al., "Impacts of Financial Inclusion on Youth Development: Findings from the Ghana YouthSave Experiment," CSD Research Report (2015)

[20] The USAID MHPSS Database can be accessed at the following website: https://docs.google.com/spreadsheets/d/1P4IXCjF50b9N3F3WSRZeQIFpZvGMHuRiV_9RHWKTn_Q/edit?usp=sharing

Critical Gaps in Programming and Research

The following are gaps in the current evidence base:

- **Suicide prevention and response:** Interventions that address suicide in LMICs and conflict-affected areas are scarce, despite suicide ranking as a leading cause of death among youth globally[21] The issue is rarely mentioned in evaluations of MHPSS interventions.
- **Replication:** Few MHPSS interventions have been evaluated more than once. Replication of research for interventions across multiple contexts is essential in strengthening the global evidence base for MHPSS. The USAID MHPSS Database and Summary is an important tool for identifying interventions that have been replicated and/or approaches that have been implemented in more than one context.
- **Impact of MHPSS on physical health and other outcomes:** Very few MHPSS programs have looked at the linkage between mental health and psychosocial well-being and physical health or other outcomes. Yet there is a lot of evidence linking the presence of mental health conditions with poorer physical health, poor education, low income and unemployment.
- **Systems strengthening:** While institutions, societal laws, and structures are essential aspects of a holistic MHPSS response, few programs focus on strengthening the capacity of the national health or social welfare systems to provide mental health and/or psychosocial support.
- **Workforce capacity:** Workforce capacity is a key challenge for agencies implementing MHPSS interventions, with many noting a lack of available professionals with the skills to deliver the interventions as designed. In many cases, no professionals with the necessary qualifications are available. To address this gap, there is a growing trend to have more highly trained providers "task shift" or "task share" with individuals who have less training using a collaborative care model strategy.[22] A key recommendation from the 2018 Berlin Expert Meeting, which included experts in MHPSS from United Nations (UN) agencies, donor governments, and international non-governmental organizations, was that programs should include coaching and supervision for non-specialist MHPSS staff at all levels.[23]
- **Disability and inclusion:** Very few researched programs examine how interventions should be adapted to meet the needs of youth with disabilities. Waves for Change is one of the few examples of a program that has adapted and evaluated its intervention for youth with disabilities. [24]

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[21] WHO, Suicide worldwide in 2019: *global health estimates*, Geneva: WHO, 2021.

[22] Kiran L. Grant, Magenta Bender Simmons, and Christopher G. Davey, "Three Nontraditional Approaches to Improving the Capacity, Accessibility, and Quality of Mental Health Services: An Overview," *Psychiatric Services 69*, no. 5 (May 2018): 508–16. https://doi.org/10.1176/appi.ps.201700292.

[23] Federal Ministry for Economic Cooperation and Development, UNICEF, *Rebuilding Lives: Addressing Needs, Scaling Up and Increasing Long-term Structural MHPSS Interventions in Protracted and Post-Con lict Settings,* Expert Meeting, Berlin, Germany, July 4-5, 2018, https://www.mhinnovation.net/sites/default/files/downloads/resource/Report_Rebuilding%20Lives_Expert%20Meeting%20Berlin_4-5%20July%202018%5B2%5D.pdf

[24] Waves for Change, *Noluthando Surf Therapy Pilot – An Internal Study*, 2018, https://www.waves-for-change.org/wp-content/uploads/2018/02/Noluthando-surf-therapy-pilot_An-internal-study.pdf

Photo Credit: Pixabay - Syauqi Fillah

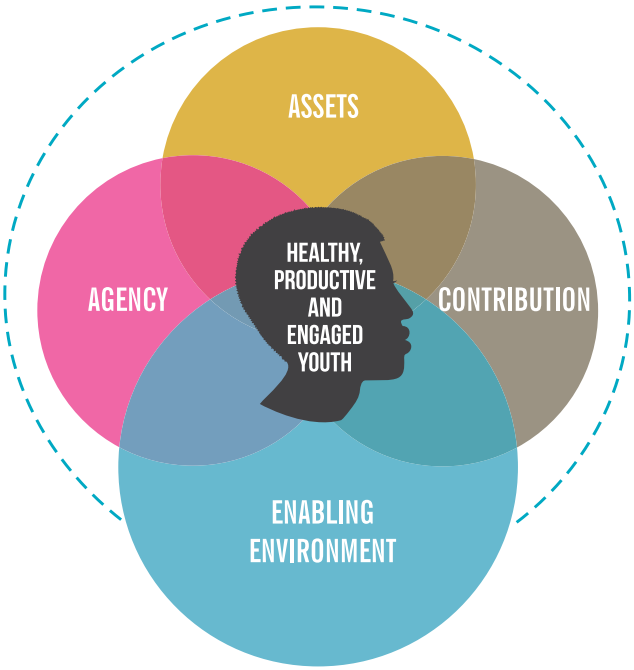
Section 3:
Frameworks that Support MHPSS Programming

This section discusses key frameworks that support MHPSS programming at USAID: (1) USAID's PYD framework and (2) the IASC Intervention Pyramid.

USAID Positive Youth Development Framework

USAID's PYD approach helps youth become healthy, productive, and engaged in their futures, families, and communities by supporting their development across four domains: (1) assets, (2) agency, (3) contribution, and their (4) enabling environment.

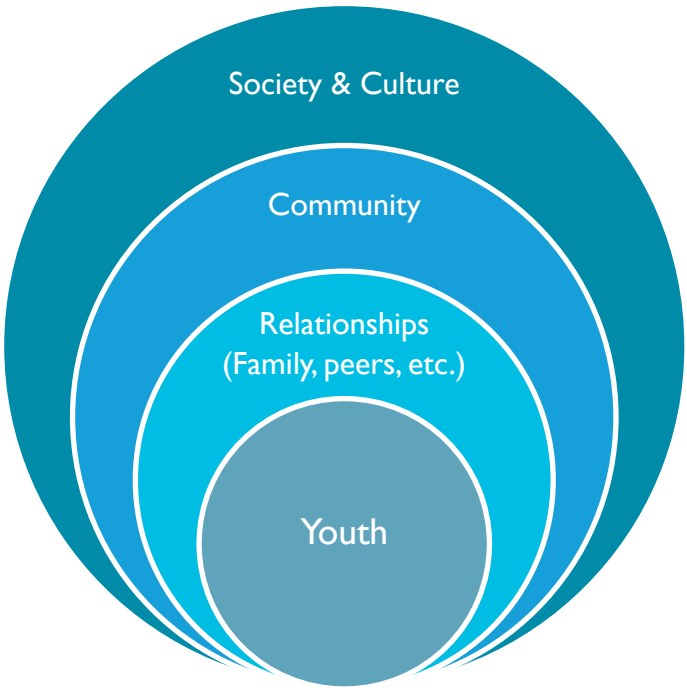
Figure 3-1: PYD Framework



Applying the PYD lens to mental and psychosocial support involves looking at the four PYD domains to identify the core elements that contribute to positive well-being. While investments across the PYD domains will contribute to an improved sense of well-being, some youth will need additional support. MHPSS interventions complement and build on programming that applies a PYD framework by (1) strengthening elements that build positive well-being, (2) making sure programs can refer youth for additional services, when necessary, and (3) ensuring access to mental health services for youth who need more focused support that extends beyond PSS.

The PYD approach emphasizes engaging youth in their social-ecological systems (the social-ecological model is commonly used to understand the key systems that impact an individual's mental and psychosocial well-being). Within this model, youth are the center of their ecosystems, surrounded by their families, communities, peers, and society and culture.

Figure 3-2: Socio-ecological Model



The youth layer looks at the individual needs for cognitive, physical, and emotional development. The next circle is the family and concerns the family's relationship with the youth. This circle can include relationship dynamics within the family unit as well as the psychosocial needs and struggles of others in the family unit that directly impact the youth. The community and peers layer looks at the relationships between the youth and peers and community, including schools, clubs, and churches. Lastly, the model looks at the impact of society and culture on the youth and the way they engage society and culture. This model includes a broad set of structural, cultural, and functional features that impact the youth directly, including laws, policies, the economy, the environment, social norms, and values and beliefs. Youth engage with their ecosystems using the skills developed across four domains of PYD. Emotional and psychological well-being is directly related to the interplay between the individual and his or her social environment.

Inter-Agency Standing Committee Intervention (IASC) Pyramid

The IASC Intervention Pyramid (Figure 3-3) is widely used to describe the multi-layered support that makes up a comprehensive, complementary package of MHPSS interventions for different groups.[25] Originally developed for use in humanitarian response, the pyramid has since been used in development settings to describe the integrated services that support a given population. According to the pyramid, responding to needs related to basic services and security will contribute to improved well-being for the largest number of individuals. As you move up the pyramid, the services become more specialized in terms of who receives support service(s). Programs should layer services across the pyramid. Note that it is essential that all MHPSS programs map out referral pathways for services between layers of the pyramid..

[25] IASC, IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, Geneva: IASC, 2007, https://interagencystandingcommittee.org/iasc-task-force-mental-health-and-psychosocial-support-emergency-settings/iasc-guidelines-mental

The IASC Intervention Pyramid is a commonly used framework for MHPSS programming, and many of the tools and resources included in this Toolkit will either mention the intervention pyramid or frame content around it.

Figure 3-3: Inter-Agency Standing Committee Intervention (IASC) Pyramid

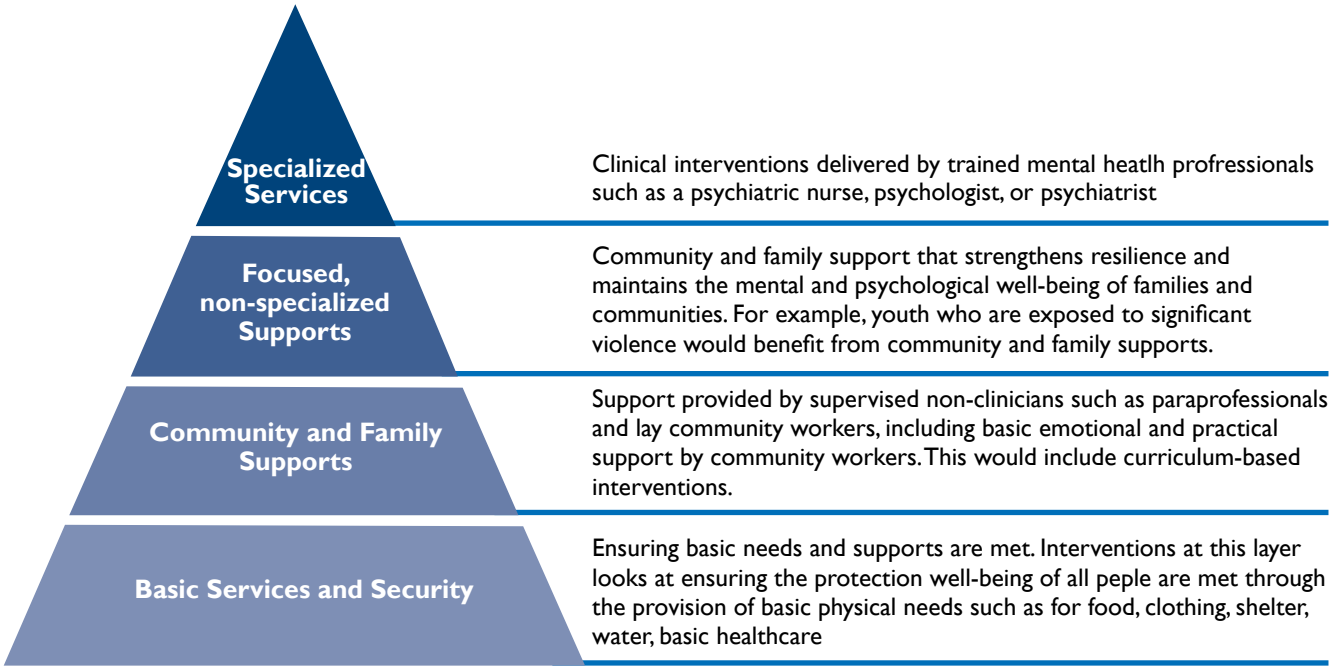


Photo Credit: Pixabay

Section 4:
Youth MHPSS and the USAID Program Cycle

This section of the Toolkit discusses how MHPSS programming can be viewed within the USAID Program Cycle (i.e., assessment, design, implementation, and monitoring, evaluation, and learning). The Toolkit presents relevant considerations and useful resources and tools for each phase of the cycle.

Assessment: Identifying and Understanding Local MHPSS Needs and Selecting Program Objectives

Programs addressing the social, emotional, and psychological well-being of youth must be rooted in a deep understanding of the local context and concepts. As such, the first step in designing a program is assessing the mental health and psychosocial needs of youth. Any such assessment must include local viewpoints. When designing the assessment, keep in mind the following:

Programs addressing the social, emotional, and psychological well-being of youth must be rooted in a deep understanding of the local context and concepts. As such, the first step in designing a program is assessing the mental health and psychosocial needs of youth. Any such assessment must include local viewpoints. When designing the assessment, keep in mind the following:

- **Mapping of services, service providers, and coordination systems:** As part of any assessment, make sure to map the local and national mental health and social services systems and referral pathways for critical services. Also, map the existing coordination systems. It is critical that all actors—humanitarian and development—actively engage in national and local coordination systems managing the MHPSS response. Separate coordination systems increase confusion and can result in questionable MHPSS interventions (see Box 4-1).
- **Qualitative and quantitative assessment tools:** Quantitative instruments, which consist mostly of closed questions and are usually developed by external groups, alone cannot shed light on the local context. Use both quantitative and qualitative assessment tools. Qualitative approaches, in particular, can help you explore the following:
  - *How the community perceives mental health:* This includes priorities, terminology, causes, manifestations, and effects. These insights are critical to selecting and adapting instruments and program activities.
  - *Gender considerations:* Young men, women, boys, and girls may experience and communicate about distressing events differently. They may also express and cope with their distress differently. Assessments should find ways to surface and understand these differences.
  - *Disability inclusion:* Any MHPSS assessment and goal-setting process should consider how people with disabilities perceive mental health, as well as how they benefit (or not) from supportive interventions.
- **Conflict-sensitivity:** How social groups experience distressing events can vary. As such, avoid generalizing the population's perceptions and experiences of events, as well as its coping mechanisms. To understand potential sensitives related to MHPSS programming and topics, seek out any available recent conflict analyses that may be available.
- **Cultural adaptation:** Consider how assessments and programming tools translate to the local context and culture. Because MHPSS concepts can vary substantially from one community

to the next, it is good practice to adapt materials in partnership with local youth and other stakeholders.

  - *Use validated instruments:* Variation between cultures requires adapting measurement instruments to the local context. This includes testing MHPSS tools for local validity before using them, unless a locally validated instrument exists.

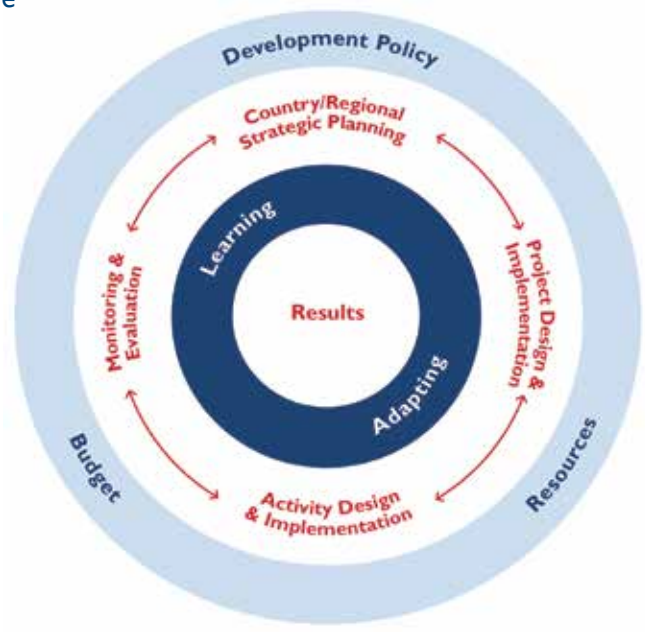
- **Workforce assessment:** Consider whether the national and/or local psychological or social services workforce has the necessary training to implement the selected interventions, and what training and education will be necessary for establishing a trained cadre of psychosocial workers from the local population. Professional training and certifications will vary between countries so the assessment should determine what additional training would equip staff with the necessary qualifications to implement the proposed interventions.
- **Youth engagement:** Engage youth as active participants in any assessment process. They can provide important insights into mental health and psychosocial problems, needs, and priorities that will help you develop relevant, effective, and sustainable MHPSS programs.
- **Ethical considerations:** The IASC Action Sheet 4.2 Enforce Staff Codes of Conduct and Ethical Guidelines should serve as a reference for codes of conduct and ethical considerations when designing youth-focused MHPSS programs.

Box 4-1: Learning from Fragmented Coordination on MHPSS in South Sudan

In 2015, coordination for MHPSS programming in South Sudan was very fragmented. The country had three separate mental health working groups: one for development actors, one in the health cluster as part of the humanitarian response, and one in the protection cluster as part of the humanitarian response.

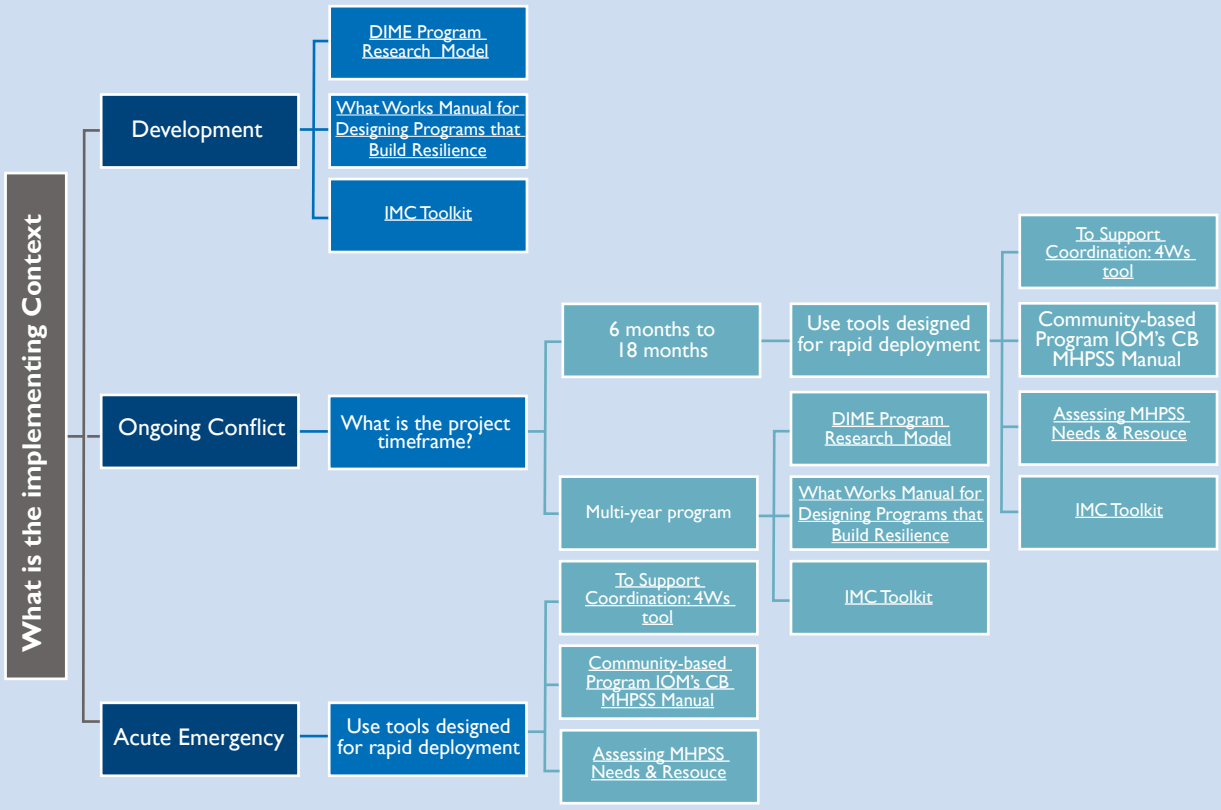
The siloed and fragmented approach to MHPSS coordination excluded key sectors that were actively promoting psychosocial support interventions, led to conflicting guidance on best practice for MHPSS, and contributed to the spreading of programming approaches that were potentially harmful. Addressing the fragmented systems involved engaging all working groups to streamline coordination into one system. To avoid this problem in the future, it is critical that development and humanitarian actors participate in the same coordination mechanisms for MHPSS programming.

Figure 4-1: USAID Program Cycle



MHPSS Assessment Tools

The following tools can be helpful during the assessment phase of the program cycle. When choosing a tool, consider the type of program and the time available for the assessment. Programs that require rapid planning, target conflict-affected and displaced populations, and/or are short, for example, should use tools specifically developed for rapid deployment. The decision tree provided below can aid you in identifying which type of tool to select (e.g., timeframe, staffing available, context).



mhGAP – Operational Manual: If you are building a MHPSS program that has a strong systems- strengthening and/or capacity building component then the mhGAP Operational Manual will be a key resource. In Section 2: Prepare, you will find guidance on conducting a situational assessment during the program planning phase.

The DIME Program Model: If you are planning a multi-year project and conducting a baseline study, then the DIME tool from Johns Hopkins University may be a good fit. The model guides you through the assessment phase, from the initial steps to the baseline study, with guidance on conducting a qualitative study; discerning the nature of priority problems; drafting, translating, and validating assessment instruments; and undertaking a MHPSS baseline study (Modules 1-3). The model also discusses the importance of developing a localized understanding of mental health and psychosocial concepts, including how people talk about their mental health and/or well-being, natural coping mechanisms during adversity, and how people communicate about their problems.

What Works—A Manual for Designing Programs that Build Resilience: If you are developing a program that has a strong social-ecological approach and an emphasis on strengthening and/or building resilience then this free manual from the Resilience Research Center may be a good starting point.

IMC Toolkit for the Integration of Mental Health into General Healthcare in Humanitarian Settings: Step 1 of the IMC toolkit provides guidance on how to assess and plan for integrating mental health into the local health system. If you are looking for guidance on how to carry out a situational analysis for MHPSS, then this toolkit would provide a good step-by-step approach.

IASC Who is Where, When, Doing What in Mental Health and Psychosocial Support (4 Ws Tool): The IASC 4Ws tool supports the MHPSS coordination processes in emergency settings. During the assessment phase, this tool will support the mapping of services and referral pathways. It can also be used when designing programming where there is an active humanitarian program, even if funded with multi-year development funds. This resource is useful when assessing MHPSS referral needs during the acute phase of an emergency, as well

IOM's Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement Manual: Chapter 3 of this IOM manual covers assessing and mapping displaced populations, including refugee and internally displaced populations living in camps and/or with host communities. This manual is particularly helpful when applying a community-based MHPSS approach. This resource is useful when assessing MHPSS needs in the acute phase of an emergency and in established camps.

Assessing Mental Health and Psychosocial Needs and Resources: This tool from WHO and UNHCR provides guidance on assessing MHPSS needs and resources for populations affected by conflict and other emergencies. The toolkit will help you select assessment topics related to MHPSS, estimate the prevalence of mental health problems, and collect qualitative and quantitative data. It includes 12 recommended tools for assessing the mental health and psychosocial needs of affected populations. This resource is useful when assessing MHPSS needs in the acute phase of an emergency.

Youth Programming Assessment Tool: The Youth Programming Assessment Tool (YPAT) helps youth-serving civil society organizations (YSOs) reflect upon their own internal programming and institutional practices and identify areas for improvement. The tool sets standards of best practice and provides concrete steps and examples for how a YSO can operationalize Positive Youth Development (PYD) with the ultimate goal of improving programming to enhance developmental outcomes for youth.

Photo Credit: Pixabay - Abhishek Kandel

Figure 4-1: Do No Harm and Assessment and Coordination Considerations

LOCAL SUPPORTS AND STRENGTHENING CARE SYSTEMS	DNH CONSIDERATIONS (IASC)	
	✓ Tailor assessment tools to the local context.	✗ Do not use assessment tools not validated in the local, emergency-affected context.
	✓ Identify and reach marginalized groups	✗ Do not assume what works for one group will work for all groups.
	✓ Recognize that everyone manages and responds to distress differently. Some people may function well, whereas others may be severely affected and may need specialized supports. It is not possible to confidently predict how people will respond to adverse events.	✗ Do not assume that everyone who experiences an adverse event is traumatized, or that people who appear resilient need no support
	✓ Ask questions in the local language(s) and in a safe, supportive manner that respects confidentiality.	✗ Do not duplicate assessments or ask very distressing questions without providing follow-up support.
	✓ Use psychological first aid and trauma-informed approaches with key informants during assessments.	✗ Do not ask people to recount events or assume that having experienced an adverse event automatically results in a mental health issue..
	✓ Pay attention to gender differences.	✗ Do not assume that emergencies affect men, women, boys, or girls in the same way, or that community programs will be of equal help or accessibility for women.
	✓ Establish one overall coordination group on mental health and psychosocial support.	✗ Do not create separate groups on mental health or on psychosocial support that do not talk or coordinate with one another.
	✓ Support a coordinated response, participating in coordination meetings and adding value complementing the work of others	✗ Do not work in isolation or without thinking of how one's own work fits with that of others.
	✓ Organize access to a range of supports, including psychological first aid, for people in acute distress after exposure to an extreme stressor.	✗ Do not provide one-off, single-session psychological debriefing for people in the general populations as an early intervention after exposure to conflict or natural disaster.

Design: Selecting the Interventions

Once you have identified MHPSS needs and defined the program theory of change and objectives, you are ready to select interventions. It is important to engage youth in the design process (selecting interventions, project locations, and key partners), as they can ensure interventions are relevant, acceptable, effective, and responsive to their needs. This section includes criteria for selecting evidence-based interventions, discussions of what works in MHPSS program design, and resources.

Selecting Evidence-based Interventions

When designing your program, you can select interventions from among those discussed in the sector pull-outs or resources linked in the Toolkit. Regardless of how you select the intervention(s), be prepared to justify the selected intervention using the following criteria, which appear in descending order of importance:

1. There is evidence this intervention works for the stated problems with the identified population.
2. There is evidence this intervention works for the same or similar problems with similar populations.
3. There is evidence somewhere in the world that this intervention works for these or similar problems.
4. There is no direct evidence, but existing evidence indirectly supports the intervention's theory of change (promising).

See the 'What Works in MHPSS Programming' and 'Promising Approaches in MHPSS' sections below for more evidence that will help you assess interventions against these criteria.

MHPSS program designs should include both clinical and non-clinical components. Mental health care should be made available alongside psychosocial support activities. This combination ensures that youth participants with varying needs can access the necessary levels of care. Information gathered in the assessment phase, such as local capacity or existing MHPSS services, can determine which interventions should be included in the program vs. which levels of intervention can be referred out to existing local or international actors. For example, if access to local mental health professionals is limited, consider incorporating a capacity-building component for paraprofessionals and lay counselors into your program to improve local mental health services.

Age-related developmental considerations should inform the selection and design of MHPSS interventions, with activities tailored to the ages of beneficiaries with adaptations for early adolescents (10-14), older adolescents (15-19), and young adults (20-29). Many of the recommended interventions and resources included in this Toolkit provide guidance on how to best adapt the program depending on the ages of the beneficiaries. For example:

- Some adolescents may play an active caregiver role for younger siblings or be parents themselves. Interventions that target caregivers may need to be adapted based on age and developmental considerations.
- Many young adults are already parents and would benefit from interventions that support the development of positive parenting skills.[26]

Evidence-based Recommendations for MHPSS Programming

The following are recommendations for MHPSS programming grounded in the evidence base. These common components of MHPSS interventions are included in the desk review and/or highlighted in the sector pull-outs.

- **Integrate MHPSS interventions into school systems:** School-based interventions targeting youth ages 11-19 can include a range of approaches, including brief lay counselor-

[26] Kim Ashburn, et al., "Evaluation of the Responsible, Engaged, and Loving (REAL) Fathers Initiative on Physical Child Punishment and Intimate Partner Violence in Northern Uganda," Prev Sci., vol. 18, no. 7 (October 2018): 854-864.

- delivered problem solving,[27] case management linked to schools,[28] community-based school makeovers combined with after-school clubs,[29] and sports-based interventions.[30] School-based interventions can also be adapted to the needs of out-of-school youth, for example by reaching youth at other locations besides schools where they might access services, such as youth or community centers.
- **Apply a social-ecology approach:** There is a growing body of evidence that supports integrative MHPSS approaches that address negative exposures across social ecological levels.[31] Multi-level interventions have been shown to be successful as they recognize youth as active members of their environments and, as such, target interventions to include key actors in an individual's social ecology: family, peers, schools, and community levels. One example of this is Waves for Change in South Africa that links interventions at multiple levels (e.g., family, school, and community).
- **Focus on group-based and/or community-based interventions:** Programs that see positive outcomes include group interventions. The peer-based activities include but are not limited to a CBT-based curriculum with classwork and application labs,[32] sports therapy,[33] and leadership training. Most community-based approaches for PSS use group-based activities.
- **Integrate two or more dimensions of well-being:** Programs that engage youth on multiple dimensions of well-being such as Glasswing International's Sanando Heridas project in El Salvador and Save the Children's Responsible, Engaged, and Loving (REAL) Fathers initiative in Uganda have been shown to increase opportunities for engagement based on individual interests and impact more than one dimension of well-being.
- **Include mentoring and coaching with integrated case management:** Programs that use a case management approach with mentoring and coaching at both the individual and family levels provide youth with stability and support. This approach strengthens coping mechanisms and/or helps prevent maladaptive thinking and behavior patterns.[34]
- **Provide clinical supervision for staff:** To increase the quality of programming, staff who deliver MHPSS services in either a group or individual setting need access to supervision. This supervision ensures staff receive ongoing support and training throughout the life of the program.
- **Hire local staff to design and deliver MHPSS services:** Program design and delivery should be socially and culturally meaningful to local populations. This is important to ensure they are are relevant and achieve their intended aims. Hiring local staff attends to the cultural and ethical aspects of supporting the mental health and psychosocial wellbeing of different groups.[35]

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[27] Daniel Michelson, "Effectiveness of a brief lay counsellor-delivered, problem-solving intervention for adolescent mental health problems in urban, low-income schools in India: a randomised controlled trial," Lancet Child Adolesc Health, vol. 4, no. 8 (2020): 571-582.

[28] Waves for Change, Waves for Change Learning Brief, 2020, https://www.waves-for-change.org/w4c-impact/

[29] "Community Schools," Glasswing International, https://glasswing.org/community-schools/

[30] Judith McFarlane, "Preventing Peer Violence Against Children: Methods and Baseline Data of a Cluster Randomized Controlled Trial in Pakistan," Global Health: Science and Practice, vol. 5, no.1, (March 2017):115-137.

[31] Bennouna C, Fischer HT, Wessells M, Boothby N. Rethinking child protection in emergencies. Int J Child Health Nutr. 2018;7(2):39–46.

[32] Waves for Change, Waves for Change Learning Brief, 2020, https://www.waves-for-change.org/w4c-impact/

[33] "Research Trial: Creating a Safe Space to Connect, Find Empathy and Heal," Friendship Bench Zimbabwe, https://www.friendshipbenchzimbabwe.org/digital-trial

[34] Waves for Change, Waves for Change Learning Brief, 2020, https://www.waves-for-change.org/w4c-

[35] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6036649/

Examples of Promising MHPSS Approaches and Programs

The following MHPSS approaches and/or programs are considered "promising" but are not yet fully recommended because they lack strong supportive evidence of impact, either because they use tools that have not yet been validated and tested with youth or because research on their effectiveness is ongoing. They are appropriate where programs or approaches that do have evidence either do not exist or are not available. When using promising approaches, programs should (1) adapt the approach to the local context, (2) document the adaptations, and (3) include a strong MEAL component to determine which components are effective. Programs that use promising approaches with strong MEAL components can help to build and inform the evidence base, particularly if data collection is done as research.

- **Remote delivery:** Some MHPSS programs have adapted their service delivery mechanisms due to COVID-19, for example, using technology platforms to offer remote support. Friendship Bench is currently researching the effectiveness of its COVID-19 adaptation, which entails using digital platforms in the treatment of anxiety and depression.[33] Waves for Change has also incorporated remote delivery of services. The Common Elements Treatment Approach (CETA) Program, with USAID/Victims of Torture Fund support, has developed methods for remote delivery of CETA and remote method of supervision and training. While several organizations have moved toward using technology platforms to deliver services, the evidence base for these interventions in LMICs and conflicted-affected areas is limited. Remote delivery is a promising approach for MHPSS programming and due to COVID-19, it is likely to continue and expand (ideally linked to existing health and education service systems). Agencies looking to include remote delivery should check the most recent literature to capture any new developments and learnings.
- **Early Adolescents Skills for Emotions (EASE):** EASE is a WHO-led, multi-partner, and multi-country research initiative that is undergoing RCTs in Jordan, Lebanon, Pakistan, and Tanzania.[36] The RCTs are looking at whether the delivery of promising psychological interventions by a non-specialist can reduce symptoms of depression, anxiety, and distress in adolescents between the ages of 10 and 14. Once WHO has completed the planned RCTs, the trial results will be made available on their website. If the RCTs show these interventions to be effective, WHO will publish the EASE methodology on its website for use by any partner.
- **Singing to the Lions:** Singing to the Lions is a promising program that targets youth ages 10-18 who have experienced multiple adverse events. The program teaches youth new skills to respond to adversity, abuse, and violence, as well as how to create protective layers in their lives. It covers six themes during a workshop (which can run three full days or six half days). Youth are organized by age and gender in groups of 20 to 30. The Singing to the Lions tool was developed following an assessment of how violence affected children in Zimbabwe. While it has not been evaluated yet, it is available to all on the website of Catholic Relief Services: https://www.crs.org/our-work-overseas/research-publications/singing-lions.

[36] Aribel Impact Lab (Research & Innovation at the IRC), Early Adolescent Skills for Emotions, https://www.svri.org/forums/forum2019/Presentations/Early%20Adolescent%20Skills%20for%20Emotions%20Annan.pdf

The following resources can help as you design programs and select interventions:

MHPSS Design Tools

WHO Mental Health Gap Action Program (mhGAP): In use since 2008, the WHO mhGAP includes several resources focused on mental health that can inform program design and implementation. The program has an evidence resource center on the following topics: depression; epilepsy and seizures; dementia; conditions related to stress; psychosis and bipolar disorders; child and adolescent mental disorders; alcohol use disorders; self-harm and suicide; drug use disorders; and other significant emotional and medically unexplained somatic complaints. mhGAP has developed several key publications that are useful for program developers including:

mhGAP Intervention Guide: Provides practical guidance for mental, neurological, and substance use disorders in non-specialist health settings—making it an important programming resource for programs in LMICs. It includes guidance on essential care and practice and thematic-specific modules. The intervention guide was updated in 2016 to reflect learning gathered during use in the field and emerging research on key topics. It includes a section on child and adolescent mental and behavioral disorders, substance use, and suicide. This resource is available in multiple languages.

mhGAP Humanitarian Intervention Guide: Provides guidance for first responders dealing with mental neurological and substance use conditions during emergencies and where access to specialists and treatments is limited. The guidance supports staff in health facilities and programs with the necessary skills to assess and manage acute stress, grief, depression, post-traumatic stress disorder, psychosis, epilepsy, intellectual disability, harmful substance use, and risk of suicide. This resource has been translated into multiple languages.

mhGAP Community Toolkit: Serves as a useful guide for programs that want to increase access to community-based mental health services in the primary health care system. It provides tools for community providers on mental health promotion and prevention, and how to increase access to mental health services. This resource has been translated into multiple languages.

WHO-UNICEF Helping Adolescents Thrive (HAT) Toolkit: HAT Accompanies the "Guidelines on Promotive and Preventive Mental Health Interventions for Adolescents." The toolkit is centered around four core strategies: (1) implementation and enforcement of policies and laws, (2) environments to promote and protect adolescent mental health, (3) caregiver support, and (4) adolescent psychosocial interventions. Each strategy provides practical guidance on approaches, examples, focus exercises, implementation considerations, and key resources.

Restoring Hope and Dignity: Manual for Group Counseling, Center for Victims of Torture: The Center for Victims of Torture (CVT) has published a manual for group counseling that can be freely downloaded from their website. The manual was developed for use in LMICs and humanitarian/conflict-affected contexts. CVT developed the resource based on over 20 years of practice in group counseling with individuals who experience distress and reduced daily functioning from extreme stress related to war, torture, or human rights violations. The 10-session group counseling model is designed to be delivered by trained local counselors, who receive ongoing training and supervision.

BelSalameh: The MHPSS Training Pack/The Mental Health Manual: Developed by ABAAD in Syria, the MHPSS Training Pack covers the full range of MHPSS services: (1) mental health, general concepts, and mental disorders; (2) primary counseling, (3) Narrative Exposure Therapy (NET); (4) family systemic counseling and; (5) self-care. This resource may be of particular interest and use for agencies implementing MHPSS programming in the Middle East and North Africa (MENA) region.

International Medical Corps Toolkit for the Integration of Mental Health into General Health Care in Humanitarian Settings: The toolkit focuses on integrating mental health into primary health care settings, primarily in humanitarian settings, though the emphasis

on primary health care systems, the strengthening of health care systems to provide mental health services, and overall sustainability makes the toolkit relevant for LMICs and conflict-affected areas. Programs looking to strengthen the capacity of local health care providers to deliver mental health systems would find this toolkit to be extremely useful during program design and implementation.

Caring for the Caregivers: This resource provides guidance on MHPSS support for parents and caregivers. It can be useful when designing interventions that support youth who are parents. Interventions should consider the needs of adolescent parents vs. those in their 20s. The resource includes an entire section on the mental health and well-being of the caregiver.

A Hopeful, Healthy and Happy Living Toolkit: Developed and published in 2021 by REPSSI, APSSI, and the IFRC's Psychosocial Resource Center, this toolkit is a resource pack for children, parents/caregivers, and teachers impacted by the global pandemic of 2020-2021. The toolkit is a helpful resource for a program seeking to meet the psychosocial needs of adolescents, parents, caregivers, and teachers. It can be helpful when designing programming to respond to the psychosocial needs resulting from school closure, remote learning, and stay-at-home orders.

IOM Community Based MHPSS Manual: This resource provides extensive guidance on interventions that target the community as a whole and includes specific guidance for both mental health and psychosocial support interventions. The IOM manual provides information and guidance on a wide range of PSS interventions, including psychosocial mobile teams for conflict-affected communities outside of camp settings; socio-relational and cultural activities, rituals and celebrations, sports and play, non-formal education and informal learning, livelihood programming, and peacebuilding,

The manual also provides guidance on mental interventions such as counseling, as well as community-based responses for those with severe mental disorders. It includes information on individual services and the delivery of CBT and interpersonal psychotherapy (IPT). It discusses approaches that use psychosocial workers trained in a specific model of service delivery such as the "Friendship Bench" and "Being Buddies" models. Finally, the guidance addresses a community-based response to more severe mental disorders and the need to link with health systems for the delivery of services and medicines.

USAID's YouthPower Action Youth Engagement Training: The training aims to prepare USAID staff, other donor organizations, and implementing partners to meaningfully include youth in development initiatives.

Global Framework on Transferable Skills: Published by UNICEF in 2019, the Global Framework is an essential resource for education, youth employment, and violence prevention programs that want to integrate MHPSS. Transferable skills include cognitive, social, and emotional skills that can be used for academic and non-academic outcomes, in formal and informal academic settings, the social engagement sectors, child protection, violence prevention, and girls' empowerment, among others. This resource is intended to be a living document that will be updated periodically.

Social-Emotional Learning in USAID Basic Education Programs: How-to Note: This How-To-Note provides guidance on how to include and integrate skills-based social and emotional learning across the USAID program cycle into basic education programs, which serve children and youth (including adolescents) with a variety of formal and informal education programs, including youth workforce programs.

Evidence Based interventions for LMICs

USAID MHPSS Database and Database Summary: The USAID MHPSS database is a collection of interventions that have been scientifically evaluated in low- and middle-income countries. You can use this database to find interventions that have an evidence base. The

database summary document "USAID Mental Health and Psychosocial Support Database (MHPSSD) Describing Scientific Evidence for Non-Drug MHPSS Programs in Low- and- Middle-Income Countries" provides an overview of the database, an overview of the literature, a typology of interventions, a table with outcomes supported by two or more studies, key findings, information on how to use the database, and a description of its limitations. The database and summary are regularly updated to provide the latest evidence.

Common Elements Treatment Approach (CETA): CETA is an evidence-based psychological intervention developed for and tested in LMICs that depends on trained and supervised community-based workers for service delivery. It was largely developed and researched with support from USAID Victims of Torture Fund. The approach helps treat depression, anxiety, substance use, interpersonal violence, and trauma. Johns Hopkins University (JHU) has completed studies on this treatment approach in Ethiopia, Iraq, Myanmar, Thailand, Ukraine, and Zambia (other studies are ongoing). The approach can be used for children five years and older. JHU has also recently adapted the approach for remote delivery of short and long versions of CETA, supervision, and training. More information can be found on the CETA website.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): TF-CBT is an evidence-based psychological intervention for children, adolescents, and their caregivers that need additional support following traumatic experiences. It is a structured short-term treatment that follows a set structure/number of sessions. TF-CBT has been adapted for use with individuals and groups and across multiple settings, including in development, conflict-affected, and humanitarian contexts. It is a recommended intervention for supporting the mental health needs of children and adolescents in both INSPIRE and the HAT Toolkits. The toolkit directs you to the research page at Johns Hopkins University which provides more information on the evidence for TF-CBT, including specific research projects and partners in LMICs.

Compendium of Resources: This resource is a supporting document to UNICEF's Operational Guidance for Community Based Mental Health and Psychosocial Support. It was developed following a review of evidence and practice for MHPSS in emergencies within child protection, education, and health programming. The compendium includes a collection of interventions that have been evaluated for individual services, parents/caregivers, education, community, multi-layered approaches, and cross-cutting issues. It also breaks programs down by age and level on the intervention pyramid.

Problem Management Plus (PM+) and Group Problem Management Plus (PM+): PM+ and Group PM+ is an intervention published by the WHO that provides brief psychological interventions to reduce the symptoms of depression, anxiety, and distress in adults. Tested in Kenya, Nepal, Pakistan, and Uganda, the approach was found to be effective in reducing feelings of distress, depression, and anxiety. The tools were developed specifically for adults, making them appropriate for youth ages 18-29.

Social and Emotional Learning and Soft Skills Online Learning Module: This learning module covers how social and emotional learning (SEL) and soft skills support literacy and numeracy, key milestones in SEL, program examples from Honduras and Nigeria, key research and evidence documents, and the dos and don'ts of implementing SEL interventions.

Best Practices on Effective SEL/Soft Skills Interventions in Distance Learning: The purpose of this review is to provide evidence on effective, equitable, and inclusive SEL practices that can be delivered via distance learning modalities in USAID-recipient countries. USAID has also recently published, as a companion to this work, a SEL during COVID Annotated Bibliography.

Interpersonal Psychotherapy for Youth/Adolescents (IPT-A): IPT-A is an evidence-based, time-limited mental health intervention for adolescents with mild/moderate/major depression;

for pre-adolescents with depression (family-based IPT-A); and as a crisis intervention for youth with suicidal ideation. IPT-A aims to decrease depressive symptoms and increase interpersonal functioning by helping the adolescent to build skills for more effective management of interpersonal difficulties and crises (such as grief, conflicts, life changes, and loneliness). Individual and group IPT-A have shown effectiveness in a number of settings including school-based clinics, outpatient mental health settings, primary care, and in humanitarian contexts such as in camps for persons experiencing displacement and other post-disaster conditions in high and low-resource regions. It is a recommended intervention for adolescents with depression by a number of national and international best practice guidelines including in the UK NHS Children and Young People's Training Programmes (CYP IAPT), NICE Guidelines, and is part of the INSPIRE project in Kenya. To explore IPT-A manuals and resources, visit the following link (https://div12.org/treatment/interpersonal-psychotherapy-for-depression/#treatment-manuals). For access to the toolkit, please contact the Global Mental Health Lab at Teachers College, Columbia University (gmh.lab@tc.columbia.edu).

Future Resources

The following resources are slated to be released in late 2021 and 2022.

UNICEF's Global MHPSS Framework (anticipated late 2021): UNICEF's Global Multi-sectoral Operational Framework for Mental Health and Psychosocial Support is designed to support the design and development of MHPSS strategies and action plans at the regional and country levels, as well as field-level MHPSS programming and activities. The Global MHPSS Framework presents strategies for improving the wellbeing of children and adolescents as well as their caregivers including teachers; and for improving the community capacity to deliver MHPSS services and eliminate stigma associated with mental health and psychosocial needs. As an operational document the MHPSS Global Framework has the following key resources:

- A discussion of **key implementation approaches**, including, the social ecological model, the life course approach for MHPSS, gender, disability, and inclusion considerations; the mental health continuum; the layers of services across an updated version of the IASC intervention pyramid and a discussion of multi-sectoral supports.
- A **MHPSS Theory of Change** that can be applied across settings. The TOC is an application of the social ecological model with outcomes at the individual, family, community, and systems/policies levels. It also recognizes that an individual's wellbeing is directly linked to the interactions between the different levels of the social ecological model.
- A collection of 9 **intervention tables** across for the first three outcomes of the TOC and recommend actions/strategies at the systems, institutions, and policy level.
- **MEAL for MHPSS** that includes quick guidance on MEAL 101 for MHPSS and a detailed log frame that aligns with the TOC.

MHPSS Minimum Service Package (MSP) (anticipated in 2022): A joint project led by UNICEF and WHO in collaboration with UNHCR and UNFPA, the MSP is a set of priority MHPSS activities to be implemented across sectors in all humanitarian contexts.

Protocol to Increase Safe and Meaningful Participation of Young People Focusing on Mental Health and Psychosocial Well-being (UNICEF, anticipated in 2022): The protocol will be useful for agencies that want to engage youth in the MHPSS assessment, design, and implementation of MHPSS programs. The protocol provides practical guidance and resources to safeguard the well-being of youth who are participating and engaged in programs that address sensitive topics. The protocol also discusses the MHPSS benefits for youth who have meaningful engagement across programming, research, advocacy, and communication efforts.

Figure 4-3: Do No Harm Considerations for Local Supports and Strengthening Care Systems

LOCAL SUPPORTS AND STRENGTHENING CARE SYSTEMS	DNH CONSIDERATIONS (IASC)	
	✓ Facilitate the development of community-owned, managed, and run programs that can be collaborative with government models and systems.	✗ Do not use a charity model that treats people in the community mainly as beneficiaries of services.
	✓ Build local capacities, supporting self-help and strengthening the resources already presented in affected groups.	✗ Do not organize supports that undermine or ignore local responsibilities and capacities.
	✓ Learn about and, where appropriate, use local cultural practices to support local people.	✗ Do not assume that all local cultural practices are helpful or that all local people are supportive of particular practices.
	✓ Uses methods from outside the culture where it is appropriate to do so.	✗ Do not assume that methods from abroad are necessarily better or impose them on local people in ways that marginalized local supportive practices and beliefs.
	✓ Build government capacities and integrate mental health care for emergency survivors in general health services and, if available, in community mental health services.	✗ Do not create parallel mental health services for specific sub-populations.
	✓ Train and supervise primary/general care workers in good prescription practices and basic psychological support.	✗ Do not provide psychotropic medication or psychological support without training and supervision.
	✓ Use generic medications that are on the essential drug list of the country.	✗ Do not introduce new, branded medications in contexts where such medications are not widely used.
	✓ Establish effective systems for supporting, and, if possible, referring severely affected people.	✗ Do not establish screening for people with mental disorders until you have in place appropriate and accessible services to care for identified persons.
	✓ Organize access to a range of supports, including psychological first aid, for people in acute distress after exposure to an extreme stressor.	✗ Do not provide one-off, single-session psychological debriefing for people in the general populations as an early intervention after exposure to conflict or natural disaster.

Budgeting for MHPSS Interventions

While there is significant interest in costing MHPSS programming, not much has been published on the topic to date. Several agencies, however, are undertaking costing exercises to better understand the cost-benefit analysis of MHPSS interventions. In addition, UNHCR, UNICEF, and WHO are developing a Minimum Services Package for Emergencies, as noted above, which is expected to include the cost of recommended minimum services.

At a minimum, programs should ensure that the following elements are reflected in program budgets:

Staff costs: Staff costs include supervision, in-service training, and training activities. Also keep in mind the staff-to-beneficiary ratios, which will depend on the intervention. Generally, you will have higher cost-per-beneficiary for individual psychological interventions than group-based interventions. You will also have higher per-beneficiary costs during the staff training period.

- Case management services should be kept to a level that realistically enables a caseworker to provide the necessary follow-up with each client, maintain detailed case files/records, communicate with his or her supervisors, and follow up on referrals in a timely manner. Standard 18: Case Management from the 2019 edition of the Child Protection Minimum Standards, recommends: (a) one caseworker for every 25 children and (b) one supervisor for every five to six caseworkers.
- Individual and group psychological interventions: The counselor to client ratio will be determined by the requirements of the selected interventions. Keep in mind the following considerations to ensure a healthy MHPSS worker-to-client ratio:
    - Training requirement: Some approaches may limit the number of clients immediately following the training. For example, PM+ recommends starting newly trained "helpers" off with a maximum load of two clients for five sessions (10 hours).
    - Supervision: Supervision can be done individually or in groups of no more than six MHPSS workers. MHPSS workers should receive between one and three hours of supervision a week. The number of supervision hours will vary depending on the needs for the selected intervention and the experience and expertise of the MHPSS worker.
    - Planning time: MHPSS workers should be given sufficient time to plan for each session and post-session, as well as time to update and maintain client records. Newly trained MHPSS workers may need more time for planning and record-keeping than more experienced MHPSS workers. Selected interventions should provide guidance on the time needed for planning/prep between sessions.
    - Time in session: This is the time allocated for the MHPSS worker to facilitate sessions directly with their clients, whether individual or group sessions. For budget planning, time in session will specify the number of individuals who participate in therapy sessions after the planning and supervision time (mentioned above) is considered. Group sessions should be limited to six to eight participants. Program design should specify the number of sessions each client will be offered and whether they are individual and/or groups sessions. It should also recommend how many sessions a trained MHPSS worker can facilitate on a daily and/or weekly basis.

Assessments: Additional cost considerations related to assessments include the development and local testing of instruments or tools and training materials for assessment team members.

Transportation costs: This can include the cost of staff travel to beneficiary homes or project sites, as well as the cost of transporting beneficiaries to and from project sites.

Translation services: High-quality translation is essential when contextualizing interventions and associated tools for the program. Consider these costs when budgeting for the program, especially in areas where interventions need to be refined and adapted for each community.

Intervention adaptation: Interventions will need to be adapted to the local context (as informed by the assessment), so resources should be budgeted for this. This includes any revisions to program materials, translation, and the hiring of MHPSS experts in the intervention, who usually will be the trainers.

Implementation

Sound staffing structures are key for effective, impactful programming. At the start of implementation, program teams should develop a staffing plan that establishes supervision that includes continuing coaching.[37] When implementing MHPSS programs, keep in mind the following:

- Map and establish referral pathways before starting program activities.
- Make sure all staff understand how to use referral pathways.
- Equip staff with the necessary training, resources, and supervision to implement the selected interventions.
- Put in place standard operating procedures (SOPs) for dealing with suicidality, which is more common in youth compared to other age groups. The SOPs must include safety procedures for all staff on how to identify and deal with suicidality. Ensure all staff know what to do if a beneficiary exhibits suicidal ideation. For more guidance, CETA Global have developed helpful materials."
- Put in place safeguarding policies and procedures that adhere to the Prevention of Sexual Exploitation and Abuse requirements, USAID's child safeguarding guidance, and local safeguarding laws and guidelines.

Staffing MHPSS Programs for Impact and Success

Program staff should have technical training, resources, and supervision appropriate to the selected interventions. The assessment phase should have determined the national and local capacity for delivering psychological and social services. Some LMICs, for example, might have only one psychiatrist in the whole country; or maybe psychologists trained in counseling are not skilled in the approaches used by the proposed intervention. The following considerations are useful to keep in mind when developing the program's staffing plan:

- **MHPSS technical advisors:** A MHPSS technical advisor should provide guidance and technical oversight to any program implementing MHPSS activities. This position should be filled by someone trained in clinical social work or counseling psychology. In some programs, this individual will provide direct clinical supervision to field-based staff or supervise the supervisors. Implementing organizations should also have a technical position at their headquarters to ensure MHPSS programming meets quality and technical standards.
- **National and local workforce capacity:** It is important to develop a workforce development and capacity-building plan based on the workforce assessment findings. In most contexts, programs will depend on a local MHPSS workforce that will need to be well trained in the selected MHPSS interventions. You will need to create a workforce development plan using an apprenticeship approach that guides staff through the necessary on-the-job skill development for their roles as they work. Lastly, the stigma around mental health is common in many countries. This stigma will impact how MHPSS professionals are perceived, valued, and compensated. Providing compensation commensurate with job responsibilities will ensure staff feel valued and respected.
- **Staff qualifications:** Staff qualifications for MHPSS programming will vary dramatically depending on the program design. Figure 4-1 maps the layers of the IASC Intervention Pyramid to staff qualifications, with considerations for clinical supervision across the layers.

[37] For a definition of coaching and its relationship to supervision, please reference: Chapter 1: Defining Supervision and Coaching of the Alliance for Child Protection in Humanitarian Action's Child Protection Case Management Supervision and Coaching Training Package, 2018, available at https://resourcecentre.savethechildren.net/library/case-management-supervision-and-coaching-package-chapter-1-defining-supervision-and-coaching

Programs need to include, or link to, external services that provide staff across all layers of the pyramid if existing providers are not available. The exception is the fourth layer: training new specialized professional mental health workers is beyond the current recommended scope of USAID MHPSS programming. Programs should be equipped to refer to services at all levels of the pyramid.

Supervision and/or Coaching

All MHPSS programs should include systems for supervision, coaching, and in-service training. Keep in mind the following considerations:

- **MHPSS supervision** "is a relationship that supports the MHPSS worker's technical competence and practice, promotes well-being and enables effective and supportive monitoring of case work."[38] The following resources provide guidance on what supervision is, and is not, in a social service workforce, sample job descriptions, training resources, guidance on **staff care and well-being**, and templated resources:
  - Case Management Supervision and Coaching Training Package
  - Guidance Manual on Strengthening Supervision for the Social Service Workforce

Figure 4-4: Do No Harm and Staffing Considerations

STAFFING CONSIDERATIONS	DNH CONSIDERATIONS (IASC)	
	✓ Check references when recruiting staff and volunteers. Build the capacity of new personnel from the local and/or affected community.	✗ Do not use recruiting practices that severely weaken existing local structures.
	✓ After training on mental health and psychosocial support, provide follow-up supervision, coaching, and monitoring to ensure that interventions are implemented correctly.	✗ Do not use one-time, stand-alone, or very short training without follow-up if preparing people to undertake complex psychological interventions.

Good Practice for Working with Populations with High Levels of Distress

The following recommendations and resources will help equip staff with the skills to do no harm as they implement youth-focused MHPSS programming.

Youth engagement: UNICEF's "MHPSS and Participation" document includes a section focused on DNH considerations when working with youth and discusses a range of critical topics, including informed consent and confidentiality, unrealistic expectations, stigma and other risks, culturally relevant and adolescent-friendly tools, and feedback and accountability.

Trauma-informed and healing-centered approach to MHPSS programming: Adopting a trauma-informed approach means understanding the bio-psychosocial impact of trauma and using that knowledge to guide the programs. Agencies that wish to adopt a trauma informed approach may find these tools helpful:

[38] For a definition of coaching and its relationship to supervision, please reference: Chapter 1: Defining Supervision and Coaching of the AlliancThe Alliance for Child Protection in Humanitarian Action, USAID, Child Protection Case Management Supervision and Coaching Training Package, https://resourcecentre.savethechildren.net/node/13636/pdf/cm_supervision_and_coaching_fact_sheet.pdf

Tools for adopting a trauma-informed approach

SAMHSA Technical Note on Trauma-Informed Approach: While developed for the U.S. context, this resource provides a useful overview of what a trauma-informed approach looks like at the organizational level and within clinical services. Agencies may want to use this resource as a guide in developing their own organizational approach to trauma-informed programming.

Chemonics Trauma-Informed Approaches to Development Checklist: Chemonics' trauma-informed checklist is a useful example for those looking at organizational-level approaches. The checklist can be used across the organization to guide program design, thereby reducing the risk of unintended harm or traumatization for populations under high levels of distress.

Protection mainstreaming and accountability to affected populations: Programs in emergency contexts should refer to the USAID/Bureau for Humanitarian Assistance's Emergency Application Guidelines (Section 10.6 Accountability to Affected Populations, protection mainstreaming). Additional information on accountability to affected populations can be found in the IASC Revised Commitments on Accountability to Affected Populations Guidance Note.

Psychological First Aid (PFA): PFA is a basic skill set for first responders that includes knowing how to talk with someone who is distressed, often due to a recent critical event. PFA training focuses on developing active listening skills, including to look (i.e., pay attention to a situation), listen (i.e., pay attention to the person), and link (i.e., connect the person to the necessary supports). PFA is something anyone can be trained in—it is NOT counseling, therapy, or a clinical intervention. Furthermore, it is NOT a detailed discussion of what happened or a means of pressing the person to share what happened. Several PFA tools are available and two are listed in the 'MHPSS Implementation Tools' table below.

Suicide Prevention and Response: While there is an urgent need to increase access to mental health and psychosocial services for youth with suicidal ideation, providing these services is difficult in countries where mental health capacity is low and stigma around suicide is high. We recommend the following when implementing MHPSS programming:

- Develop SOPs for suicide prevention and response and mandate that all staff are trained in the SOPs.
- Ensure that referral pathways are clear on where and how to refer anyone with suicidal ideation.
- Suicide prevention is a priority, however, do not attempt to raise awareness or engage in suicide prevention activities until you have in place prevention or treatment options and referral pathways for anyone who needs help.
- Consider available national resources (e.g., a national suicide hotline) and how to connect program staff and beneficiaries with those resources. The following resources can help as you develop agency strategies and approaches:

MHPSS Implementation Tools

I Support My Friends: Published by Save the Children, UNICEF, and WHO, this PFA toolkit is designed for use with adolescents ages nine or older. It includes a theory and implementation guide, a training manual, training of facilitators package, and a participant workbook.

International Federation of Red Cross and Red Crescent Societies (IFRC) PFA Tools: IFRC has several PFA tools on its website, most of which are available in several languages. It also has new resources developed in response to COVID-19, including Action Tool 19 in IFRC's COVID-19 Toolkit, as well as a tool for remote PFA.

WHO Mental Health Gap Action Program (mhGAP): In use since 2008, WHO mhGAP includes several mental health resources that can inform program design and implementation. Resources relevant to developing SOPs and interventions for suicide prevention and response include the following:

- mhGAP resource page focused on self-harm and suicide. Provides resources that include assessments for self-harm/suicide in persons with priority mental, neurological, and substance use disorders; recommendations for removing means of self-harm; and information on the usefulness of regular contact, the use of the problem-solving approach, hospitalization for persons with self-harm, how to reduce access to means of suicide, and school-based interventions for reducing deaths from suicide and suicide attempts among young people.
- mhGAP Intervention Guide Version 2.0: Includes a chapter on self-harm and suicide. The guidance is useful for understanding how to assess someone with suicide ideation. It includes a decision tree that can guide users through the assessment process and guidance on managing self-harm/suicide through responses to three levels: (1) medically serious acts of self-harm, (2) imminent risk of self-harm/suicide, and (3) risk of self-harm/suicide and best practice for follow-up. Also included are recommended PSS approaches for self-harm/suicide.
- mhGAP Humanitarian Intervention Guide: Includes a chapter on self-harm/suicide that covers assessment, management, and follow-up.

HAT: Helping Adolescents Thrive: The HAT guidelines and toolkit promote mental health and the prevention of mental disorders, self-harm, and other risk behaviors in adolescents. The guidelines look at self-harm and suicide through a research lens; the toolkit, meanwhile, looks at these issues in terms of national legislation and policy work.

Monitoring, Evaluation, Adapting, and Learning for Youth MHPSS Programming

A well-defined monitoring, evaluation, adapting, and learning (MEAL) plan is essential for demonstrating that MHPSS interventions have contributed to improved individual and/or group well-being. It is important to have a clear set of indicators linked to the desired program outcomes, as well as a system for tracking indicators. Ask yourself the following questions as you develop your program's MEAL plan:

- What instruments will we use to measure mental health conditions and psychosocial needs? The final determination of instrument selection should be based on assessment findings and stakeholder consultations.
- What strategies will we use to contextualize the measurement instruments? For more information on contextualization, please see Section 1.
- How will we engage youth in collecting and interpreting the data? You will want to reference USAID's guidance in integrating youth in monitoring and evaluation.

Contributing to the Evidence Base through Monitoring, Evaluation, and Learning Initiatives

Learning from evaluations and other research initiatives should be made widely available and shared with the broader community of practice. Learning what does and does not work is instrumental in changing how donors and implementing agencies approach and plan for MHPSS programming. Keep in mind the following considerations:

- **Provide ongoing monitoring:** Rigorous ongoing monitoring will help you determine what is and is not working and modify activities accordingly. Ongoing monitoring also helps program staff identify and address unintentional negative consequences.
- **Partner with other agencies:** To expand learning on specific MHPSS approaches, agencies should work together to implement the same intervention across contexts and document learning on that intervention from one location to the next. This kind of collaboration will help us determine whether an intervention is effective across locations and populations (versus just in a targeted population).
- **Share what does not work:** Determining and documenting what does and does not work is critical to building the knowledge base for MHPSS. Don't be afraid to admit when something is not working or worry that sharing disappointing findings will lead to a decrease in funding. Not everything will work, and when it doesn't, we need to learn and adapt to move the field of MHPSS forward.
- **Contribute towards evidence building:** MEAL for MHPSS should contribute towards the building of the evidence base. Promising interventions that lack a solid evidence base should include MEAL as research.

MHPSS Monitoring, Evaluation, Adapting, and Learning Resources

IASC Common Monitoring & Evaluation Framework for Mental Health and Psychosocial Support Programming in Emergency setting: 2017: The M&E Framework—the first common framework for MHPSS to be developed by the IASC—has served as the basis for MHPSS indicators and objectives for development and humanitarian programming. The framework is currently being updated, and the new version will include a section on means of verification.

A Compendium of Tools for the Assessment of the Mental Health and Psychosocial Wellbeing of Children in the Context of Humanitarian Emergencies: This resource provides a collection of assessment tools and includes a discussion on cultural validity, reliability, and feasibility.

The DIME Program Research Model: This resource includes guidance on monitoring and learning for MHPSS, as well as contextualizing and validating tools.

USAID's **PYD Measurement Toolkit** provides detailed guidance on developing goals, objectives, theories of change, frameworks, and logical frameworks for youth programming. The **PYD Youth Center Toolkit** also provides useful guidance on articulating objectives for your programs.

USAID's **Youth Engagement Community of Practice (YE CoP) technical brief** offers measurement statements and guidance for monitoring and evaluating youth programs. In addition, it provides an online tool with illustrative indicators that may be useful for monitoring and evaluation purposes. Both measurement statements and indicators are classified at three levels: (1) youth, (2) program or organization, and (3) enabling environment.

Selecting Indicators for MHPSS Programming

Measurement Areas and Definitions

USAID MHPSS programming has six core measurement areas: (1) safety, (2) program implementation and access, (3) uptake and compliance, (4) function, (5) mental health and well-being, and (6) care, as defined in the table below. MHPSS program indicators should be classified by the measurement areas.

1. **Safety:** Mental health and psychosocial well-being are highly dependent on ensuring both physical and psychological safety. Feeling safe both reduces and prevents mental health and psychosocial problems. This measurement area considers two components of safety: internal and external (see Annex 2). [39]
2. **Program Implementation and Access:** Program implementation and access indicators measure factors directly related to implementing the program as designed and may include indicators focused on the number of people trained or the delivery of services as intended.
3. **Uptake and Compliance:** Uptake and compliance indicators measures focus whether program participants complete the program as intended.
4. **Function:** Function refers to the ability to carry out expected and regular activities for daily living, which will differ according to factors such as culture, age, and gender.[40] This includes play and other enjoyable activities. Indicators can refer to ability or difficulty in performing these activities.
5. **Mental Health and Well-being:** Measures changes in mental health and psychosocial wellbeing as a result of the program activities
6. **Care:** Care indicators measure how people with mental health and psychosocial problems use appropriate care (Appropriate care refers to (1) mental health (MH) care, which is care designed or tailored to specific mental conditions and (2) nonspecific care or psychosocial support (PSS) that addresses stress and improves mental well-being without regard to specific conditions. Problems addressed by MH and PSS may include social problems (e.g., sexual violence or discrimination); psychological distress; mental, neurological, and substance use disorders; intellectual disability; or any combination of these.

Illustrative Indicators

The following list of indicators, organized by measurement area and sector, draws on MHPSS indicators collected from various USAID sector-focused programs, the IASC M&E Framework for MHPSS, and UNICEF's Operational Guidelines for Community Based MHPSS. The reference key identifies the source for each indicator. Indicators without a source were developed specifically for this toolkit. Annex 2 defines each measurement area and provides required and supplemental indicators.

Reference Key

* USAID
** UNICEF – Operational Guidelines[41]
*** Inter-Agency Standing Committee[42]

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[39] Inter-Agency Standing Committee (IASC) Reference Group for Mental Health and Psychosocial Support in Emergency Settings, A Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings, Geneva: IASC, 2017. https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/iasc-common-monitoring-and-evaluation-framework-mental-health-and-psychosocial-support-programmes

[40] Ibid

[41] United Nations Children's Fund, Operational guidelines on community based mental health and psychosocial support in humanitarian settings: Three-tiered support for children and families (field test version), New York: UNICEF, 2018, https://www.unicef.org/media/52171/file

[42] Inter-Agency Standing Committee (IASC) Reference Group for Mental Health and Psychosocial Support in Emergency Settings, A Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings, Geneva: IASC, 2017. https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/iasc-common-monitoring-and-evaluation-framework-mental-health-and-psychosocial-support-programmes

Measurement Area	Sector	Indicators
Safety	MHPSS	Percentage of youth screened for suicide ideation.
	MHPSS	Perceptions of safety from outside threats. These could be perceived danger from family, community, and (maybe) outside community.
	MHPSS	Percentage of youth who receive care after expressing suicidal ideation.
	MHPSS	Proportion of youth expressing suicidal ideation who receive a suicide prevention protocol.
Program Implementation and Access	MHPSS*	Number of people trained in MHPSS-related topics.
	MHPSS*	Number of MHPSS supervision sessions facilitated.
	MHPSS	Level of fidelity to the MHPSS model of service or delivery of services as designed.
	Gender and GBV*	Number of people reached by a USG-funded intervention providing GBV services (e.g., health, legal, psycho-social counseling, shelters, hotlines, etc.). (USAID F-indicator GNDR-6) Sector Pull-out: Gender and GBV
	Gender and GBV*	Percentage of trained teachers and administrators who are aware of how to prevent, report, and respond to sexual and gender-based violence. Sector Pull-out: Gender and GBV
	Education*	Proportion of schools/learning spaces with referral systems to mental health, psychosocial, and social services. Sector Pull-out: Education
	Education*	Number of teachers in USG-supported programs trained on how to support learners' psychosocial well-being. (USAID F-indicator 3.2.1-44) Sector Pull-out: Education
	MHPSS**	Number of MHPSS standard operating procedures (SOPs), referral pathways, and service directories developed. Sector Pull-outs: Education; Youth Employment; Violence Prevention, Peace, and Security; and Health
Uptake and Compliance	MHPSS	Number of people who start/complete the MHPSS program or Number of individuals who accessed MHPSS services.
	Humanitarian Assistance*	Number of consultations for any mental health condition. Sector Pull-out: Health
	Gender and GBV*	Percentage of target population that views GBV as less acceptable after participating in or being exposed to USG programming. (Adapted USAID F-indicator GNDR-7) (The adaptation is the use of "target population" instead of "participants.") Sector Pull-out: Gender and GBV
	MHPSS*	Number of program participants who adhere to MHPSS treatment regime. Sector Pull-out: Health

Measurement Area	Sector	Indicators
Function	MHPSS**	The ability to carry out essential activities for daily living, which will differ according to factors such as culture, age, and gender. Sector Pull-outs: Youth Employment; Violence Prevention, Peace, and Security; and Health
	MHPSS	Ability of caregivers to cope with problems (through, for example, stress management skills, conflict management skills, problem-solving skills, parenting skills, knowledge of where to seek help or information and resources needed to access care). Sector Pull-outs: Gender and GBV; Education; Violence Prevention, Peace, and Security
Mental Health and Well-being	MHPSS	Decrease in symptoms (e.g., depression, anxiety, posttraumatic stress, substance abuse) pre/post appropriate care.
	MHPSS	Increase in positive thoughts, feelings, and behaviors.
	MHPSS	Changes in the environment that contribute to improved psychosocial wellbeing. This would be a program level indicator. Should reflect changes that are important to the community and are feasible.
	Education*	Percentage of learners showing increased psychosocial well-being using context-specific index/measures of well-being. Sector Pull-out: Education
	MHPSS**	Subjective well-being improved including feeling calm, safe, strong, hopeful, capable, rested, interested and happy; not feeling helpless, depressed, anxious, or angry. Sector Pull-outs: Education; Youth Employment; Violence Prevention, Peace, and Security; and Health
	MHPSS***	Social connectedness referring to the quality and number of connections an individual has (or perceives to have) with other people in their social circles of family, friends, and acquaintances (social connections may also go beyond one's immediate social circle and extend, for example, to other communities). Sector Pull-outs: Education; Youth Employment; Violence Prevention, Peace, and Security; and Health
	MHPSS***	Number of people with mental health and psychosocial problems who report receiving adequate support from family members. Sector Pull-outs: Gender and GBV; Youth Employment; Violence Prevention, Peace, and Security; and Health
	Youth*	Increased ability to recognize and respond positively to emotions at the conclusion of training/programming. Sector Pull-out: Youth Employment
	Youth*	Increased ability to plan and set goals at the conclusion of training/programming. Sector Pull-out: Youth Employment

Measurement Area	Sector	Indicators
Care	Youth Violence Prevention*	Increased knowledge, often tied to building empathy for others. Sector Pull-out: Violence Prevention, Peace, and Security
	Youth Violence Prevention*	Increased awareness, often tied to one's behavior impacting others. Sector Pull-out: Violence Prevention, Peace, and Security
	MHPSS**	Percentage of formal and informal social structures that include specific mental health and psychosocial services or supports for youth. Sector Pull-out: Health
	MHPSS***	People with mental health and psychosocial problems use appropriate care

Photo Credit: Pexels - Baganiah Lawrence

ANNEX 1: Other Sample Definitions

The following table shows commonly used terms, as defined by organizations that work in MHPSS. We have included this table to give you a sense of the range of definitions you may encounter when working with other donors and implementing partners.

Key Term	Definition	Source
Child Well-being	A dynamic, subjective, and objective state of physical, cognitive, emotional, spiritual, and social health in which children's optimal development is achieved through: ▪ Safety from abuse, neglect, exploitation, and violence. ▪ Basic needs met, including those promoting survival and development. ▪ Connection to and care provided by consistent, responsive caregivers. ▪ Supportive relationships with relatives, peers, teachers, community members, and society at large. ▪ Opportunity for children to exercise agency based on their evolving capacities.	"Defining and Measuring Child Well-Being in Humanitarian Action," The Alliance for Child Protection in Humanitarian Action
Mental Health	A state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community.	"Mental Health: Strengthening Our Response," the World Health Organization (WHO)
Mental Health	A state of well-being in which an individual realizes their abilities, can cope with the normal stresses of life, can work productively, and is able to contribute to their community.	"Mental Health at the International Rescue Committee (IRC)," IRC
Mental Health	A state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.	"International Red Cross and Red Crescent Movement policy on addressing mental health and psychosocial needs," International Red Cross and Red Crescent Movement

Key Term	Definition	Source
Mental Health and Psychosocial Well-being	Well-being describes the positive state of being when a person thrives. In adolescents, it results from the interplay of physical, psychological, cognitive, emotional, social, and spiritual aspects that influence one's ability to grow, learn, socialize, and develop to their full potential. Well-being is commonly understood in terms of three domains: ▪ Personal Well-being: Positive thoughts and emotions such as hopefulness, self-esteem, and self-confidence. ▪ Interpersonal Well-being: Nurturing relationships, responsive caregiving, a sense of belonging, and the ability to be close to others. ▪ Skills and Knowledge: The capacity to learn, make positive decisions, effectively respond to life changes, and express oneself.	"Mental Health and Psychosocial Technical Note," UNICEF, Save the Children
Mental Health and Psychosocial Support	Any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or treat mental health conditions.	"International Red Cross and Red Crescent Movement policy on addressing mental health and psychosocial needs," International Red Cross and Red Crescent Movement
Psychosocial	The interconnection between the individual (i.e., a person's internal, emotional, and thought processes, feelings, and reactions) and her or his environment, interpersonal relationships, community, and/or culture (i.e., her or his social context).	"International Red Cross and Red Crescent Movement policy on addressing mental health and psychosocial needs," International Red Cross and Red Crescent Movement
Psychosocial	The dynamic relationship between the psychological and social dimensions of a person's life. The two dimensions influence one another and are very closely linked. They can be described as follows: Psychological Dimension: Internal, emotional, and thought processes, feelings, and reactions. Social Dimension: Relationships, family and community networks, social values, and cultural practices.	"Strengthening Resilience: A global selection of psychosocial interventions," IFRC Reference Centre for Psychosocial Support
Psychosocial Intervention	Interventions that aim to address the psychological effect of conflicts, including the effects on behavior, emotions, thoughts, memory, and functioning and social effects such as changes in relationships, social support, and economic status.	"Mental Health at the International Rescue Committee (IRC)," IRC

Key Term	Definition	Source
Psychosocial Support	A process of facilitating resilience within individuals, families, and communities; enabling families to bounce back from the impact of crises and helping them to deal with such events in the future. By respecting the independence, dignity, and coping mechanisms of individuals and communities, psychosocial support promotes the restoration of social cohesion and infrastructure.	"Child Protection at the IRC," IRC
Psychosocial Support	Actions relating to the social and psychological needs of individuals, families, and communities.	"International Red Cross and Red Crescent Movement policy on addressing mental health and psychosocial needs," International Red Cross and Red Crescent Movement
Psychosocial Support	The processes and actions that promote the holistic wellbeing of people in their social world. It includes support provided by family and friends.	"INEE Minimum Standards for Education: Preparedness, Response, Recovery," Inter-agency Network for Education in Emergencies

ANNEX 2: MHPSS Illustrative Interventions

The Toolkit includes sector pull-outs to give more in-depth information about possible interventions in education; gender and GBV; health; violence prevention, peace, and security; and youth employment. The following table is a quick reference summary of the illustrative activities presented in the sector pull-outs.

Sector	Dimensions of Well-being	PYD Domain	Illustrative Activities
Education	Individual and Interpersonal Well-being	Enabling Environment	Establishing referral systems within the school system that include internal referrals to school counseling services and external referrals to other services including but not limited to child protection caseworkers, counseling services, and social welfare.
	Skills and Knowledge	Assets, Agency	Implementing social and emotional learning curriculum in classrooms.
	Individual and Interpersonal Well-being	Enabling Environment	Providing teachers and educators with psychosocial support.
	Individual Well-being	Assets, Agency, Enabling Environment	Providing access to self-help curricula that are age-appropriate and developed for use in schools.
	Skills and Knowledge	Assets, Agency, Enabling Environment	Implementing after-school programs with structured psychosocial activities.
	Interpersonal Well-being	Contribution, Enabling Environment	Engaging the community in maintaining the school facilities and developing strategies for increasing school safety.
Gender & GBV	Skills and Knowledge	Assets	Organizing life-skills sessions for adolescent girls ages 10-19 to increase their assets, social networks, and safety.[1]
	Interpersonal Well-being	Assets, Enabling Environment	Providing access to safe spaces where girls can increase their protective factors and build positive peer relationships.[2]

Sector	Dimensions of Well-being	PYD Domain	Illustrative Activities
Health	Interpersonal Well-being	Enabling Environment	Supporting parent and caregiver group discussions that provide parents/caregivers with the space to talk about the experiences of caring for girls with a focus on fostering supportive attitudes towards adolescent girls.[3]
	Individual and Interpersonal Well-being	Agency, Assets, Enabling Environment	Providing access to GBV services, including GBV case management that are responsive to the needs of adolescent girls.[4]
	Interpersonal Well-being	Assets, Agency, Enabling Environment	Offering individual and group-mentoring sessions for fathers to build parenting and interpersonal-relationship skills, thereby contributing towards a reduction in harsh parenting and a reduction in intimate-partner violence.[5]
	Individual Well-being	Enabling Environment	Providing case-management services for survivors of gender-based and sexual violence that respond to their psychosocial needs.[6]
	Individual Well-Being	Assets, Agency	Offering one-on-one counseling with a lay counselor trained in basic cognitive behavioral therapy.
	Skills and Knowledge	Assets, Enabling Environment	Providing focused psychosocial support for adolescents using a curriculum.
	Skills and Knowledge	Enabling Environment	Training frontline medical staff in trauma-informed approaches.
	Individual Well-being, Skills and Knowledge	Assets, Agency, Enabling Environment	Providing clinical mental health services by a trained clinician.
	Skills and Knowledge	Enabling Environment	Strengthening community mental health infrastructure and services.[7]
Violence Prevention, Peace, and Security	Skills and Knowledge	Assets	Offering structured activities for youth that target physical activity, interpersonal skills, and curriculum focused on developing coping skills.[8, 9]
	Individual Well-being, Interpersonal Well-being	Enabling Environment	Mentoring youth with weekly group and one-on-one sessions with the mentor, home visits with the mentor and parents.[10]
	Skills and Knowledge	Enabling Environment	Training teachers and school administrators on how to work with youth and how to recognize youth who need additional services and referral pathways.[11]

Sector	Dimensions of Well-being	PYD Domain	Illustrative Activities
	Individual Well-being	Assets, Agency	Supporting mentor-led structured group activities to help youth be more aware of their emotions. Structured groups included physical fitness, arts and crafts, vocational skills, leadership, academic clubs, and technical skills.[12, 13]
Youth Employment	Skills and Knowledge	Assets	Delivering a weekly group-based cognitive behavioral therapy curriculum to adolescents.[14]
	Skills and Knowledge	Contribution	Offering structured multinational group activities (e.g., fitness, arts and crafts, vocational skills, and technical skills) that help adolescents become more engaged with their emotions and develop empathy.[15]
	Skills and Knowledge	Assets (peer coaches) Enabling Environment (mentors)	Training youth peer coaches and mentors in job-readiness skills.

ANNEX 3: MHPSS Indicators for Youth-focused Programming

Measurement Area and Definitions

USAID MHPSS programming has six core measurement areas: (1) safety; (2) program implementation and access; (3) uptake and compliance; (4) function; (5) mental health and well-being; and (6) care, as defined below. Indicators for MHPSS programming should be classified by these areas.

Illustrative Indicators

The following list of indicators, grouped by measurement area and sector, was developed by reviewing MHPSS indicators from various USAID sector-focused programs, the Inter-Agency Standing Committee's M&E Framework for MHPSS, and UNICEF's Operational Guidelines for Community Based MHPSS. The reference key below identifies the source for each indicator. Indicators without sources were developed specifically for this toolkit.

Reference Key

* USAID

** UNICEF – Operational Guidelines

*** Inter-Agency Standing Committee

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Measurement Area	Description	Sector	Indicators
Safety	Mental health and psychosocial well-being are highly dependent on ensuring both physical and psychological safety. Feeling safe and being protected can both reduce and prevent mental health and psychosocial problems. This measurement area considers two components of safety: (1) external and (2) internal. **External Safety:** refers to the subjective impression of freedom from threat or likelihood of violence or loss as well as objectively being free from threat.[16] **Internal Safety:** refers to the person's sense of emotional safety and whether there may be a threat of harm to self or others.[17]	MHPSS	Percentage of youth screened for suicide ideation
		MHPSS	Perceptions of safety from outside threats. These could be perceived danger from family, community, and (maybe) outside community.
		MHPSS	Percentage of youth who receive care after expressing suicidal ideation
		MHPSS	Proportion of youth expressing suicidal ideation who receive a suicide prevention protocol
		MHPSS	Perceptions, knowledge, attitudes (including stigma), and behaviors of community members, families, and/or service providers toward people with mental health and psychosocial problems
		MHPSS	Percentage of target communities with formal or informal mechanisms that engage in protection, monitoring, and reporting of safety risks or at-risk groups (for example, children, women, people with severe mental disorders)
		MHPSS	Percentage of target communities where representatives of target groups are included in decision-making processes on their safety
		Youth Violence Prevention*	Number of participants obtaining and/or maintaining employment, obtaining educational and career credentials, and experiencing improved mental and/or behavioral health (e.g., cessation of alcohol or drug use, decreased stress, increased association with prosocial peers) Sector Pull-out: Violence Prevention, Peace, and Security
		Youth Violence Prevention*	Percent change in arrests or convictions of young people enrolled in the program vs. those eligible for the program but not enrolled Sector Pull-out: Violence Prevention, Peace, and Security

Measurement Area	Description	Sector	Indicators
		Youth Violence Prevention*	Percent change in violent criminal offenses and victimizations, including homicide, aggravated assault, rape, and robbery, in intervention areas vs. areas without the intervention Sector Pull-out: Violence Prevention, Peace, and Security
		Youth Violence Prevention*	Reduced rates of _____ (e.g., bullying, psychological distress, interpersonal violence, gender-based violence, abuse) More specific examples include: Percent change in student self-reported frequency of (1) bullying behavior and (2) victimization before and after program implementation, disaggregated by gender Percent change in peer-reported frequency of (1) bullying behavior and (2) victimization before and after the program, disaggregated by gender Sector Pull-out: Violence Prevention, Peace and Security
		Education*	At least one indicator that addresses external safety such as: Percentage of students saying that they have missed one or more days of class this school year because (insert safety issue affecting attendance) Survey data on student and teacher perceptions of school safety Sector Pull-out: Education
		Youth*	Increased feeling of safety in their physical environment (specify what the environment is i.e., home, school, outside of the home, etc.)
		Youth*	Increased feeling of psychological safety in their environment
		Gender and Gender-based Violence (GBV)*	Learners' and teachers' perceptions of gender safety while at learning space/school Sector Pull-out: Gender and GBV

Measurement Area	Description	Sector	Indicators
Program Implementation and Access	Program implementation and access indicators measure factors directly related to implementing the program as designed and may include indicators focused on the number of people trained or the delivery of services as intended.	MHPSS*	Number of people trained in MHPSS-related topics
		MHPSS*	Number of MHPSS supervision sessions facilitated
		MHPSS	Level of fidelity to the MHPSS model of service or delivery of services as designed
		MHPSS**	Number of MHPSS standard operating procedures, referral pathways, and service directories developed[18] Sector Pull-outs: Education; Youth Employment; Violence Prevention, Peace, and Security; and Health
		MHPSS**	Percentage of formal and informal social structures that include specific mental health and psychosocial provisions or supports for children and families[19]
		Counter Trafficking in Persons*	Number of service providers that receive training, technical assistance, or capacity building in victim-centered and trauma-informed services
		Gender and GBV*	Number of people reached by a U.S. Government (USG)-funded intervention providing GBV services (e.g., health, legal, psycho-social counseling, shelters, hotlines, etc.) (USAID F-indicator GNDR-6) Sector Pull-out: Gender and GBV
		Gender and GBV*	Percentage of trained teachers and administrators who are aware of how to prevent, report, and respond to sexual and gender-based violence Sector Pull-out: Gender and GBV
		Gender and GBV*	Number of schools with gender-sensitive referral pathways established as per referral pathway guidelines -

Measurement Area	Description	Sector	Indicators
		Education*	Percentage of teachers/facilitators who receive at least one support visit per month Sector Pull-out: Education
		Education*	Percentage of teachers/facilitators who follow scripted lesson plans in social and emotional learning (SEL) during observation Sector Pull-out: Education
		Education*	Proportion of schools/learning spaces with referral systems to mental health, psychosocial, and social services Sector Pull-out: Education
		Education*	Proportion of schools/learning spaces offering mental health/psychosocial support for children and youth Sector Pull-out: Education
		Education*	Number of teachers in USG-supported programs trained on how to support learners' psychosocial well-being (USAID F-indicator 3.2.1-44) Sector Pull-out: Education
		Education*	Proportion of schools/learning spaces with psychosocial support or counseling available for teachers Sector Pull-out: Education
		Social Services*	Number of organizations delivering quality social services according to national and international standards
		Social Services*	Number of girls and boys who have experienced violence reached by health, social work, or justice/law enforcement services
		Social Services*	Number of caregivers reached with supportive family preservation services
Uptake and Compliance	Uptake and compliance indicators measure whether program participants complete the program as intended	MHPSS	Number of people who start/complete the MHPSS program or Number of individuals who accessed MHPSS services

Measurement Area	Description	Sector	Indicators
		MHPSS*	Number of MHPSS sessions facilitated
		MHPSS*	Number of group and individual therapy sessions attended by participants
		MHPSS*	Number of home visits by program facilitators
		MHPSS*	Number of dropouts from MHPSS program
		MHPSS*	Number of program participants who adhere to MHPSS treatment regime Sector Pull-out: Health
		Humanitarian Assistance*	Number of individuals participating in psychosocial support services
		Humanitarian Assistance*	Number of consultations for any mental health condition Sector Pull-out: Health
		Humanitarian Assistance*	Number and percent of community members who can recall target health education messages
		Humanitarian Assistance*	Number of individuals participating in child protection services
		Gender and GBV*	Percentage of target population that views GBV as less acceptable after participating in or being exposed to USG programming (Adapted[20] USAID F-indicator GNDR-7) Sector Pull-out: Gender and GBV
		Social Services*	Number of USG-assisted organizations and/or social service delivery systems that serve vulnerable persons strengthened (Adapted[21] USAID F-Indicator ES.4.3)
Function	Function refers to the ability to carry out expected and regular activities for daily living, which will differ according to factors such as culture, age, and gender.[22] This includes play and other enjoyable activities. Indicators can refer to ability or difficulty in performing regularly necessary activities.	MHPSS**	The ability to carry out essential activities for daily living, which will differ according to factors such as culture, age, and gender Sector Pull-outs: Youth Employment; Violence Prevention, Peace and Security; and Health

Measurement Area	Description	Sector	Indicators
		MHPSS	Ability of caregivers to cope with problems (through, for example, stress management, conflict management, problem-solving, and parenting skills, and knowledge of where to seek help or information and resources needed to access care) Sector Pull-outs: Gender and GBV; Education; and Violence Prevention, Peace, and Security
Mental Health and Well-being	Measures changes in mental health and psychosocial wellbeing as a result of the program activities **Mental health:** A state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community.[23] **Wellbeing:** describes the state where youth thrive. It relates to the Positive Youth Development (PYD) domains by looking at individual well-being, interpersonal well-being, and skills and knowledge: ▪ Individual well-being includes positive thoughts and emotions such as hopefulness, self-esteem, and self-confidence and relates to youth agency in the PYD framework. Agency includes positive identity (beliefs and values that one holds about him/herself and his/her future) and self-efficacy (belief in one's ability to do things well).	MHPSS	Decrease in symptoms (e.g., depression, anxiety, post-traumatic stress, substance abuse) pre/post appropriate care.
		MHPSS	Increase in positive thoughts, feelings, and behaviors
		MHPSS	Changes in the environment that contribute to improved psychosocial wellbeing ▪ This would be a program level indicator ▪ It should reflect changes are important to the community and are feasible
		MHPSS**	Subjective well-being improved, including feeling calm, safe, strong, hopeful, capable, rested, interested, and happy; not feeling helpless, depressed, anxious, or angry[24] Sector Pull-outs: Education; Youth Employment; Violence Prevention, Peace and Security; and Health
		MHPSS***	Social connectedness referring to the quality and number of connections an individual has (or perceives to have) with other people in their social circles of family, friends, and acquaintances (social connections may also go beyond one's immediate social circle and extend, for example, to other communities)[25] Sector Pull-outs: Education; Youth Employment; Violence Prevention, Peace, and Security; and Health

Measurement Area	Description	Sector	Indicators
	▪ Interpersonal well-being speaks to nurturing relationships, a sense of belonging, self-esteem, and self-confidence. It is a combination of youth assets and contribution in the PYD framework. Assets include having interpersonal skills (communication and social skills), recognizing emotions (ability to identify feelings and emotional reactions), and having self-control (manage emotions and regulate one's behavior). Contribution includes engagement in activities that have a sense of meaning. ▪ Skills and knowledge are needed to make positive decisions, effectively respond to life changes, and express oneself. Skills and knowledge relate most directly to the enabling environment in the PYD framework. Enabling environment includes bonding (positive emotional attachment), belonging and membership (sense of being cared for and supported), and a sense of safety (physically and psychologically).	MHPSS***	Number of people with mental health and psychosocial problems who report receiving adequate support from family members Sector Pull-outs: Gender and GBV; Youth Employment; Violence Prevention, Peace, and Security; and Health
		Gender and GBV*	Percentage of females who report increased self-efficacy at the conclusion of USG-supported training/programming (USAID F-indicator GNDR-3) Sector Pull-out: Gender and GBV
		Education*	Percentage of learners showing increased psychosocial well-being using context-specific and validated index/measure of well-being Sector Pull-out: Education
		Education*	Friendships and peer connections increased among learners compared to before the crisis Sector Pull-out: Education
		Education*	Percentage improvement of student well-being using context-specific and validated index/measure of well-being Sector Pull-out: Education
		Education*	Percentage of learners showing increased psychosocial well-being (using context-specific index/measures of well-being)* Sector Pull-out: Education
		Youth*	Increased interpersonal skills at the conclusion of training/programming
		Youth*	Increased self-control skills at the conclusion of training/programming
		Youth*	Increased ability to recognize and respond positively to emotions at the conclusion of training/programming Sector Pull-out: Youth Employment

Measurement Area	Description	Sector	Indicators
		Youth*	Increased positive identity at the conclusion of training/ programming
		Youth*	Increased ability to plan and set goals at the conclusion of training/programming Sector Pull-out: Youth Employment
		Youth*	Increased positive beliefs about own future at the conclusion of training/ programming
		Youth*	Improved bonding with members of family/community/ peers/school group at the conclusion of training/ programming
		Youth*	Increased opportunities for prosocial involvement in family/community/peers/school group at the conclusion of training/programming
		Youth*	Increased family support at the conclusion of training/ programming
		Youth*	Number/proportion (%) of youth with mentors at the conclusion of training/ programming
		Social Services*	Number of children who report an improved sense of well-being after a social services intervention (e.g., positive adaptive capacity, feeling safe and nurtured in environment, social and emotional capabilities, etc.)
		Social Services*	Percentage of students that display reduced risk factors following the completion of a social service secondary prevention service
Care	Care indicators measure how people with mental health and psychosocial problems use appropriate care.[26] Mental health and psychosocial problems may include social problems (such as sexual violence or discrimination), psychological distress;	MHPSS**	Percentage of formal and informal health-related social structures that include specific mental health and psychosocial services or supports for youth[27] Sector Pull-out: Health

Measurement Area	Description	Sector	Indicators
	mental, neurological, and substance use disorders; intellectual disability; or any combination thereof. Use of appropriate care indicates that care provided to the individual is accessed, used, and helpful in one or more ways (for example, by improving functionality, coping, reducing symptoms of mental illness, increasing social supports, reducing social problems, and so forth, without severe adverse effects). To enable the most potential benefits from care, feasible evidence-based approaches and interventions should be provided to address specific needs. This might also require focused care that is adapted and relevant to meet other special needs, such as children, individuals with developmental problems, gender, or people living with other disabilities Appropriate care means that people need assistance appropriate to their needs, which may include individual assistance and treatment but not necessarily. Treatment would likely be used in clinical mental health programs. It underscores that "access to appropriate care" is inclusive, available, accessible, acceptable, effective, and of good quality. Appropriate access ought to be provided by duty bearers (such as nation-states) but may need to be temporarily provided by non-state actors (such as non-governmental organizations) in emergency, recovery, and developing contexts.	MHPSS***	People with mental health and psychosocial problems use appropriate care
		MHPSS***	Percentage of medical facilities, social services facilities, and community programs that have staff trained to identify mental disorders and to support people with mental health and psychosocial problems
		MHPSS***	Number of women, men, girls, and boys who receive psychosocial and psychological care (such as psychological first aid, linking people with psychosocial problems to resources and services, case management, psychological counseling, psychotherapy, or other psychological interventions)
		MHPSS*	Increase in relevant skills, often tied to improved decision-making regarding care Sector Pull-out: Violence Prevention, Peace, and Security
		Youth Violence	Percent change in youth attitudes towards violence and propensity/willingness to use violence to solve conflicts before and during implementation of the program
		Prevention*	Sector Pull-out: Violence Prevention, Peace, and Security
		Youth Violence Prevention*	Protective factors for youth, which improve their ability to avoid involvement in criminal activities Sector Pull-out: Violence Prevention, Peace, and Security
		Youth Violence Prevention	Improved behaviors, often tied to impulse control Sector Pull-out: Violence Prevention, Peace, and Security
		Youth Violence Prevention*	Increased knowledge, often tied to building empathy for others Sector Pull-out: Violence Prevention, Peace, and Security

Measurement Area	Description	Sector	Indicators
	Care may be delivered by specialized professionals (such as qualified psychiatrists, social workers, psychologists, etc.), trained lay counselors/helpers, or trained service providers who are not necessarily specialized in MHPSS care (such as general nurses, physicians, community health workers, and classroom teachers). Focused care could range from community-based to inpatient services and from informal to formal supports.[28]	Youth Violence Prevention*	Increased awareness, often tied to one's behavior impacting others Sector Pull-out: Violence Prevention, Peace, and Security

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ANNEX 2/3: End Notes

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[20] Adaptation is use of "target population" instead of "participants."

[21] Adaptation is addition of "social" before "service delivery."

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