

Child Protection Learning Brief #2

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RESPONDING TO THE MENTAL HEALTH AND PSYCHOSOCIAL IMPACT OF COVID-19 ON CHILDREN AND FAMILIES

I. Introduction

Children thrive when they feel safe and protected, when family and community connections are stable, and when their basic needs are met.¹ Unfortunately, the COVID-19 pandemic has disrupted many of the foundations that assure children's mental health and wellbeing. This child protection learning brief examines different strategies to deliver mental health and psychosocial support within different sectors and across different contexts. It is intended to assist UNICEF country offices and practitioners as they respond to the impact of COVID-19 on children and families.



“The effects of COVID-19 have highlighted how **mental health problems can impact anyone and everyone.**”

The Child Protection Learning Briefs aim to extract, synthesise and analyse learning on child protection risks and programme adaptation in the COVID-19 pandemic, contributing to improving policy, advocacy and programme results during infectious disease outbreaks.



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UNICEF's approach to mental health and psychosocial support (MHPSS) builds on the strengths of children, caregivers, and communities.² Its work is informed by the social ecological framework, which posits that child development and wellbeing are embedded in the context around them.³ This includes friends and families, schools and communities, sociocultural influences, as well as broader political and economic factors. Each of these components is critical to safeguarding children's wellbeing and supporting their development.

Recognizing that children's wellbeing is linked to their environment impacts the delivery of MHPSS services. UNICEF considers mental health as

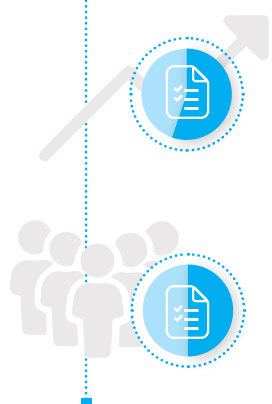
a crosscutting issue that requires collaboration across sectors such as child protection, education, social protection and gender, as well as health.⁴

Since the onset of the pandemic, UNICEF has been working across these sectors to respond to emergent MHPSS needs.⁵ UNICEF's efforts have focused on continuing to provide essential services; responding to new needs; adapting services to reach vulnerable groups amidst restrictions; protecting service providers and recipients of care; and offering technical support across sectors, particularly as more countries are responding to the urgency of the situation.

UNICEF and its partners have been at the forefront of developing strategies and guidelines to ensure that MHPSS activities continue during the pandemic, including the 'COVID-19 Operational Guidance for Implementation and Adaptation of MHPSS Activities for Children, Adolescents, and Families' and the Inter-Agency Standing Committee's (IASC) 'Basic Psychosocial Skills: A Guide for COVID-19 Responders.' As of mid-September, they have provided more than 70 million children and caregivers with community-based mental health and psychosocial support and messaging across 118 countries (see Figures 1 to 3).⁶

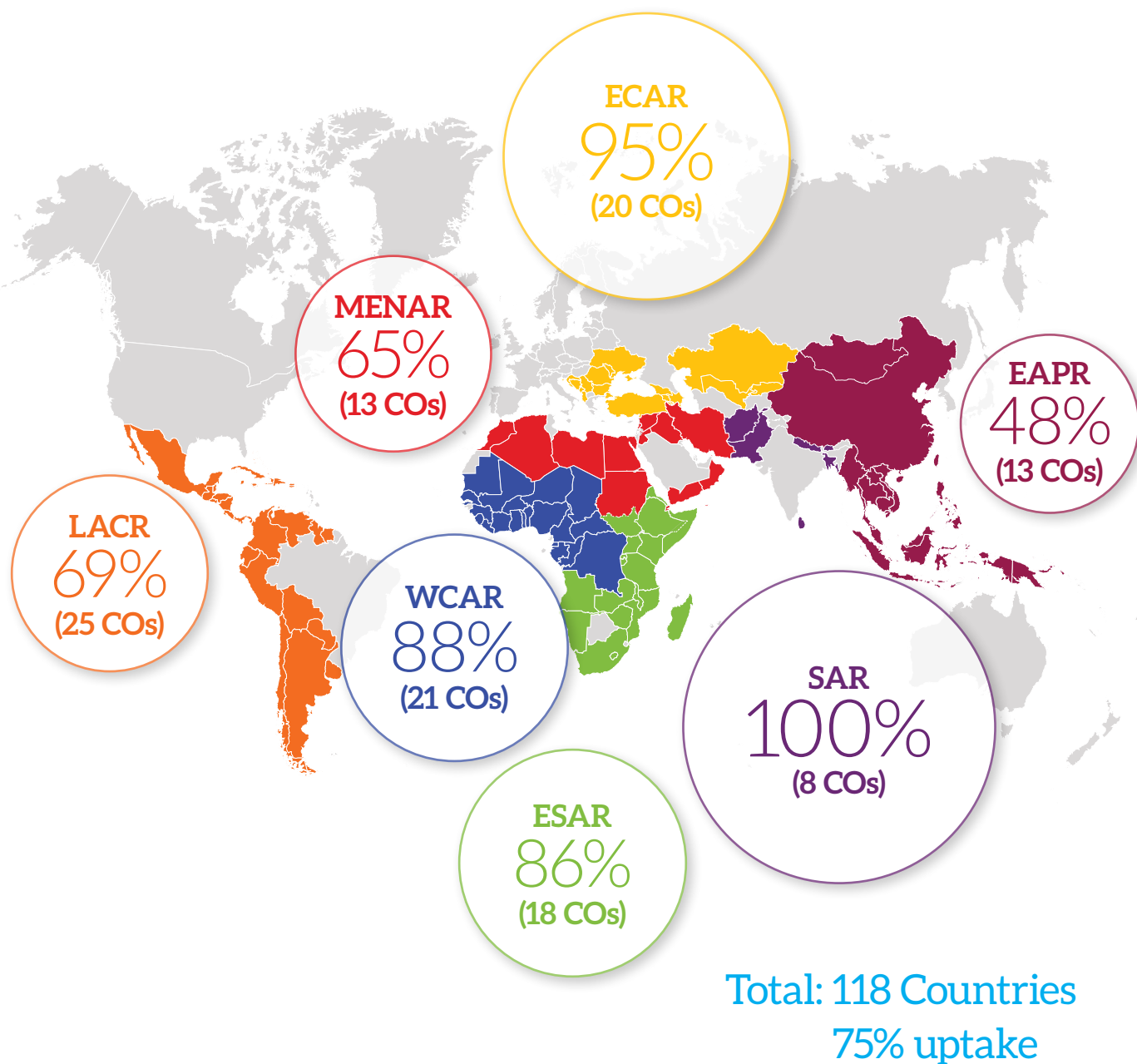
This learning brief outlines the emerging mental health risks and programme responses during COVID-19. It concludes by offering some key lessons learned and making the case for a sustained multi-sectoral response.

A recent survey⁷ of government responses to COVID-19 found:



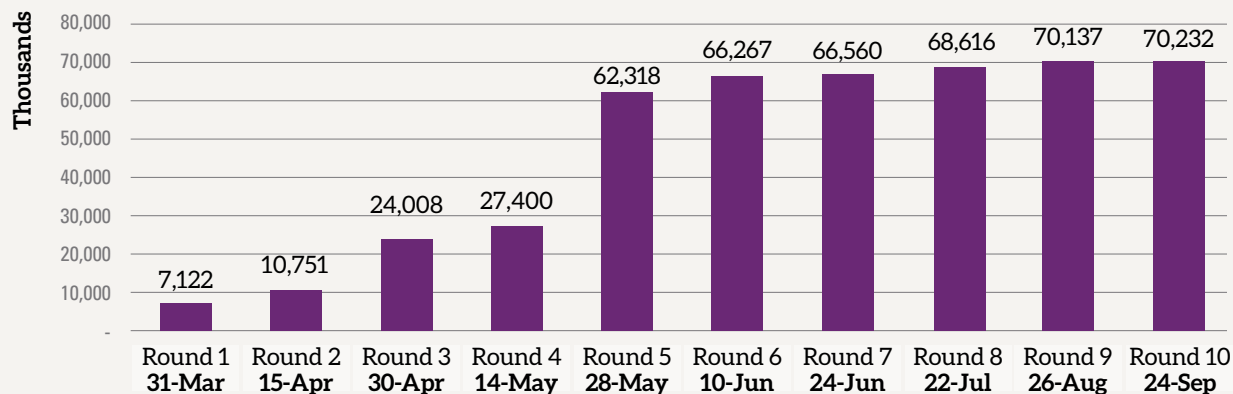
- 82 of the 148 programme countries surveyed perceived MHPSS services nationally to have increased as compared to the same time last year
- 74 of 148 programme countries surveyed believed the government has introduced measures for the safety and mental health and psychosocial needs of the social service workforce since the pandemic began

Figure 1: Percentage of countries per region working on MHPSS in response to COVID-19



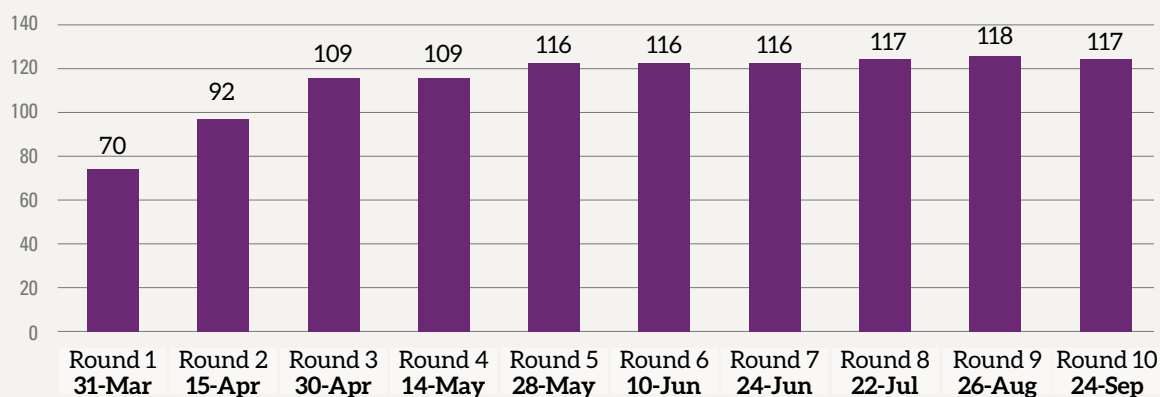
Source: Data downloaded from the UNICEF inSight Global SitRep indicators dashboard on 25 September 2020.

Figure 2: Number of children and caregivers provided with community-based mental health and psychosocial support and messaging in response to COVID-19, from 31 March to 24 September 2020



Source: Data downloaded from the UNICEF inSight Global SitRep indicators dashboard on 24 September 2020.

Figure 3: Number of countries providing mental health and psychosocial support and messaging to children and caregivers in response to COVID-19, from 31 March to 24 September 2020



Source: Data downloaded from the UNICEF inSight Global SitRep indicators dashboard on 24 September 2020.

II. Emerging risks to mental health and psychosocial wellbeing in the context of COVID-19

While the full impact and long-term fallout of COVID-19 remain to be seen, it is clear that restricted movement, closed schools, physical distancing,⁸ and fear of the disease are impacting the mental health and wellbeing of children, adolescents and caregivers.⁹

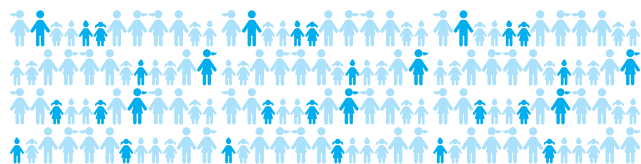
Emergencies like COVID-19 exacerbate mental health problems across entire populations.

The pandemic has meant that most children continue to live under some form of a physical distancing mandate such as lockdowns and school closures,¹² which may have adverse effects on their mental health and wellbeing. In a recent survey involving more than 17,000 parents and 8,000 children across 46 countries, 83 per cent of children and 89 per cent of parents reported an increase in negative feelings, while 46 per cent of caregivers said that they observed signs of psychological distress in their children.¹³ Children may worry about their caregivers or older family members contracting or dying of the disease. Some are stressed about the economic wellbeing of their families.¹⁴ They may also feel anxious about when and if a return to a sense of normalcy will happen.

As of August 2020, 143 countries have enacted country-wide school closures impacting 1.2 billion children.¹⁵ UNESCO estimates that the economic fallout of the pandemic could mean that upwards of 24 million children and young people across 180 countries are at risk of dropping out.¹⁶ These school closures disproportionately impact the poorest children. For example, school feeding programmes are often the main meal for children and they rely on them for proper nourishment. Hence, school closures not only hinder children's academic progression; particularly for the youngest, the lack of nutrition may have irreversible effects on their brain development.¹⁷

Caregivers are under increased levels of stress, too.¹⁸ Many demonstrate hypervigilance over the need to protect their children and themselves from infection. Added pressures may include caring for sick or older family members, balancing work and home-schooling, and confronting new financial difficulties due to economic downturns. Physical distancing can limit their access to the social support that they need. These compounding stressors may lead to tension within families and between parents and children. Indeed, some experts worry that these stressors will lead to a rise in suicide rates.¹⁹

Even before the pandemic, the global mental health burden of disease was high. Research shows that globally:



- 10 to 20 per cent of children and adolescents experience mental disorders
- half of all mental disorders start before the age of 14¹⁰
- one in four children have a caregiver with a mental disorder¹¹



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The effects of COVID-19 intensify the stress and uncertainty of the situation of marginalized individuals or groups. Those exposed to poverty or violence, who have pre-existing physical or mental health conditions, and/or are already living in a humanitarian emergency are likely at higher risk, particularly if access to other essential services is also constrained.²⁰ Those living in protracted settings of conflict or displacement may not have the resources to cope with compounded adversities.

Furthermore, disenfranchised social groups may face additional forms of discrimination, including blame for the disease.²¹ Recent migrant families may struggle to find information about how to protect themselves if they do not know the language of their new environment.

Stay-at-home mandates have contributed to a 'shadow pandemic' of gender-based violence.²² In many settings, the marginalized status of women and girls means they are often uniquely affected by the pandemic in other ways, too. Experts warn that the fallout from COVID-19 has placed girls at

higher risk of child marriage, unwanted pregnancy, and female genital mutilation.²³ School closures have obliged women and girls to take on more childcare responsibilities or forego paid work. These factors will have knock-on effects for their mental health and psychosocial wellbeing.

The Executive Director of UNICEF recently cautioned that if children's wellbeing is not adequately addressed, "The mental health consequences for a generation of children and young people could far surpass the immediate health and economic impact of the COVID-19 pandemic, leaving long-term social and economic consequences in its wake."²⁴

In short, when it comes to psychosocial wellbeing and mental health, emergencies such as COVID-19 exacerbate existing problems and create new ones. Since the start of the pandemic UNICEF has committed to reducing the suffering of affected populations and enhance their ability to regain a sense of normalcy. The next section turns to examine these efforts.

III. Adaptation and innovation: Five strategies for delivering MHPSS programming during COVID-19

UNICEF has been at the forefront of ensuring the continuity of MHPSS services during COVID-19. For example, the document, 'COVID-19 Operational Guidance for Implementation and Adaptation of MHPSS Activities for Children, Adolescents, and Families,' offers practitioners specific ways to deliver and adapt MHPSS activities during the evolving pandemic.²⁵ Informed by this guidance, UNICEF and its partners are adapting and responding to MHPSS during COVID-19 in different ways, depending on whether a country is under lockdown, the intensity of the lockdown, access to internet-enabled mobile technology, government support for MHPSS services, the capacity of systems and staff members, etc. Drawing on UNICEF's operational guidance, this section looks at five strategies for implementing and adapting MHPSS in the context of COVID-19. The brief then highlights each strategy by drawing on evidence-informed practices from the field.

1. Taking stock of MHPSS needs and available resources

Delivering MHPSS during COVID-19 requires taking stock of the context. That is, UNICEF and its partners need to understand the situation facing the populations they are working with and the available resources and capacities to respond to their needs. A needs assessment is an integral part of this process and can be realized through rapid surveys and consultations with children, adolescents and adults in the community. Taking stock of available resources includes mapping existing MHPSS services implemented through child protection, health, education, and other services and systems, drawing upon existing information and mappings, and identifying standardized tools and guidelines that can be adapted for the local context and needs.

Carrying out rapid assessments to learn about mental health concerns facing adolescents. In April, the Thailand Country Office used Facebook Live to conduct an online survey with 6,700 adolescents across the country. The survey

found that 7 in 10 adolescents felt the pandemic is negatively affecting their mental health and psychosocial wellbeing, while 8 in 10 reported feeling worried about the financial status of their family. UNICEF used this information to organize follow-up information sessions on Facebook Live that focused on mental health and wellbeing. Children and youth submitted questions to a panel of mental health specialists who offered tips for how to deal with stress, living in physical isolation, and anxiety around misinformation.²⁶ These sessions reached more than 380,000 young people.

Drawing on and adapting UNICEF operational guidelines to train staff and develop programming. Working alongside the government, the Pakistan Country Office compiled a training package for social workers. It translated and adapted the UNICEF MHPSS operational guidance and PowerPoint slides to reflect emerging needs and to consider which material would be most relevant to social workers. In Pakistan, this proved to be an overview of MHPSS, the role of communities, the importance of tackling stigma, prevention of mental disorders, and promoting participation and inclusion. Training sessions focused on how to deliver MHPSS both virtually and in person. By the end of June, more than 1,800 social workers had been trained on MHPSS, and 33,000 people received psychological first aid and counselling services across three provinces.

In Viet Nam, UNICEF has been supporting the development of a training package on MHPSS for child protection staff, social workers and helpline staff. The training is based on relevant guidelines from UNICEF, the World Health Organization (WHO) and the Asian Disaster Preparedness Center. It focuses on systematic understanding of disasters, including COVID-19, and psychosocial impacts on children, guidelines and principles on MHPSS from the IASC, psychological first aid, and basic trauma-focused psychological interventions for children in the aftermath of disasters.

Adapting and distributing global resources and tools to meet local needs.

The book *My Hero is You*²⁷ is the result of a project developed by the IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings. It is designed to help children cope with COVID-19 and was developed through consultations with 1,700 children, parents, caregivers and teachers across 104 countries. Since its release, *My Hero is You* has been translated into over 60 languages.²⁸ In Viet Nam alone, with UNICEF support, the book exists in nine different dialects. The story has taken many forms around the world. It has been delivered through storytelling initiatives, virtual storytelling sessions,²⁹ audiobooks, videos, radios, and on television. The story is currently being further adapted to reach more young people and their caregivers (see Box 1).

2. Raising awareness and sharing information about mental health

Raising awareness and sharing information is another critical component to the MHPSS response. Information should be factually accurate, accessible, and contextualized to reflect the local situation and counter stigma and misinformation.³¹ During COVID-19, UNICEF has been working across sectors to share information through in-person and remote methods.

Community messaging to reach children and caregivers, especially when digital or phone options are not possible.

In Cox's Bazar, Bangladesh, the MHPSS working group developed audio-recorded awareness-raising material for children during COVID-19.



BOX 1. Adapting *My Hero is You* to reach different populations

- UNICEF and its partners collaborated with Stanford University to transform the book into a video to improve accessibility in nonliterate communities.
- UNICEF is supporting the IASC in the development of a supplemental guide for parents and caregivers entitled *Action for Heroes* which includes recommendations linked to eight icons featured in *My Hero is You*. The guide offers support to parents and caregivers to address topics related to COVID-19 and help children manage their feelings and emotions. It also offers activities for children based on the book.
- As a supplement to the story-book, UNICEF supported the IASC by co-leading process to develop and launch the IASC MHPSS materials on youth mental health, in partnership with *Voices of Youth*. The key messages were developed by mental health professionals with inputs from young people. The launch included a call for youth to come up with creative ways to share how youth can better take care of their mental health.
- In the United States, an inter-tribal workgroup convened to re-write the story and illustrations entirely. Their adaptation, titled *Our Smallest Warriors, Our Strongest Medicine*,³⁰ conveys a similar point as *My Hero is You* but offers a story and illustrations that reflect indigenous peoples, values, and communities.

The International Organization for Migration's (IOM) MHPSS unit complements this work by delivering information about COVID-19 and MHPSS by bicycle. For this programme, the IOM hired Rohingya refugees to ride through the camp with megaphones to deliver pre-recorded messaging in three languages.³² By mid-June, the initiative had reached approximately 67,000 people across the camp.

UNICEF country offices have implemented community messaging through similar means. The Uganda Country Office is supporting para-social workers with bicycles to reach community members and facilitate the provision of basic psychosocial support. In Cambodia, the country office and its partners have been using loudspeakers to reach communities without regular access to technology. Since the programme began in early April, nearly 500,000 children and caregivers in Cambodia have received information around MHPSS, parenting, and COVID-19 prevention through a combination of social media platforms and these community awareness-raising campaigns. In the Lao People's Democratic Republic, UNICEF developed television and radio advertisements with messages supporting child protection. To reach those without access to television or radio, UNICEF helped procure 4,800 USB flash drives to disseminate messages to villages through community loudspeakers.³³

Employing digital strategies to share information. In China, the UNICEF Country Office partnered with the China Youth League (CYL) to develop podcasts raising awareness about mental health for adolescents. Episodes cover themes such as anti-bullying, anti-stigma, anxiety and themes related to mental health in the COVID-19 context. Within a few hours of its launch on CYL's national social media platform in mid-May, more than 100,000 adolescents had tuned into the podcast. Similarly, the Indonesia Country Office used TikTok to reach over 500,000 people, including over 290,000 children with messaging around child protection.

In Ethiopia, the UNICEF country office worked with Save the Children to produce eight television spots on positive parenting and mental health concerns. These spots have aired nationally through

television programmes designed specifically for children and have reached more than 9.2 million children and parents. In Eswatini the country office supported UNESCO and the Ministry of Education and Training to develop television and radio spots on how to cope with stress and anxiety. The television spots have been broadcast in breaks during televised remote schooling lessons.

The Malawi Country Office has translated parenting tips to the local language, Chichewa, and uploaded it to a website called the Internet of Good Things.³⁴ In Viet Nam, UNICEF has focused on developing materials for the local context. Specifically, it has supported the development of communication on MHPSS for children and adolescents in quarantine centres, for children in social protection centres, at home and for parents to take care of their children.³⁵

Using helplines to support adolescents and caregivers and provide messaging. In the Dominican Republic, UNICEF and its partners developed a family helpline to provide remote mental health services for children, adolescents and caregivers. In addition to providing MHPSS, the helpline offers referrals to specialized public services, such as those addressing suicide risk, psychiatric crisis and violent situations. The services are available 24 hours a day and in multiple languages, including Dominican Sign Language. People can access the hotline via phone, WhatsApp or by chatting directly on the helpline's webpage. Since it began in June, the helpline has assisted more than 870 children, adolescents and adults.



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In Jamaica, the country office helped establish a national parenting hotline using a public-private partnership. The goal of the helpline is to provide parenting advice and mental health and psychosocial support to caregivers and to make referrals to other relevant services. The focus of the hotline is to support the wellbeing of parents to create safe and positive living and learning environments for children at home. The programme gives special consideration to the situation of children with disabilities.

The Malaysia Country Office partnered with the National Early Childhood Intervention Council (NECIC) to provide remote and online MHPSS for children and adolescents with disabilities. The partnership allowed UNICEF and NECIC to reach over 800 people with community-based psychosocial support.

3. Delivering MHPSS across sectors

Promoting good mental health is essential to the wellbeing and fulfilment of rights of all children. In line with the UNICEF 'Technical Note on Mental Health and Psychosocial Support',³⁶ all sectors should incorporate MHPSS in their work, and strengthening multi-sectoral coordination MHPSS mechanisms should be evident in programme design, implementation, and monitoring. The nature of COVID-19 requires that multi-sectoral approaches be flexible enough to respond to changing conditions. This can include, for example, adapting MHPSS programming to account for school closures and reopenings, developing emergency referrals to tertiary care, or harmonizing MHPSS services across health programmes and remote education channels.

Preparing teachers and schools to respond to MHPSS needs when schools reopen. The East Asia and the Pacific Regional Office (EAPRO), in collaboration with the Global Education Cluster and the Child Protection Area of Responsibility, has developed a package to support country offices to integrate child protection and MHPSS into the back-to-school agenda.³⁷ This package includes tips for school management and teachers to respond to mental health concerns as children return to school.³⁸ It describes the types of mental health concerns that children will likely face, what signs of distress may look like, and how to intervene

with appropriate action and referral. The tips also highlight the importance of schools supporting teachers to manage their own stress and meet their own MHPSS needs. The regional office has encouraged its country offices to adapt these tips to their own contexts and to pair them with adequate training and supervision of teachers.

Similar preparations are happening in other regions. Across the Eastern and Southern Africa (ESA) region, UNICEF has been working with education ministries to ensure that teachers are trained to offer basic MHPSS services to support children once schools are reopened. For example, in Eswatini, UNICEF is supporting the Ministry of Education to provide MHPSS services. Mental health guidance is now part of a package of trainings that teachers receive. They are learning how to engage with children on issues such as school reopening and COVID-19. At each school, trained focal points are available to provide basic psychosocial support and counselling to children. In EAP, the Myanmar Country Office has received funding from the Global Partnership for Education to support the training of 75,000 teachers on MHPSS by November.

The Middle East and North Africa Regional Office (MENARO) has developed a preparedness package for teachers as schools look to reopen. The three-module workbook includes a focus on the relationship between wellbeing, teaching, and learning. It helps teachers learn how to identify a child in distress and to intervene appropriately and provide a referral. The training package is available in several languages. As of September 2020, the Ministry of Education in the United Arab Emirates has already started contextualizing the information for its public schools, while the Sharjah Emirate is introducing this packet into its private schools.

Adjusting the curriculum to respond to MHPSS needs in schools. In Viet Nam, UNICEF supported the Ministry of Education and Training to share operational guidelines and assist with the roll-out of a 'back-to-school' campaign. Prioritizing children's psychosocial wellbeing is among the core features of the campaign which entailed making adjustments to the curriculum. For example, some stressful examination requirements have

been temporarily dropped so children can focus on being comfortable at school and not feel pressure on academic performance. Similarly, the Latin America and Caribbean Regional Office (LACRO) has developed a series of guidance notes for education systems around the reopening of schools in the region. Among the recommendations is a focus on integrating MHPSS actions across different areas of the educational environment.³⁹

Integrating MHPSS programmes across sectors to overcome logistical challenges and resource constraints. Apart from developing a radio play based on the *My Hero is You* book, the Papua New Guinea Country Office has introduced another innovative response to deliver MHPSS messaging to children and families by partnering with a water, sanitation and hygiene (WASH) programme. UNICEF tapped into the in-person service-delivery component of the

WASH programme to distribute MHPSS materials to families as a part of 6,000 hygiene kits. These materials included information for hotlines for survivors of violence, leaflets for caregivers on self-care and parental support and a copy of *My Hero is You* translated into Tok Pisin. UNICEF estimates that they will be able to reach 18,000 children and 12,000 caregivers using this approach.

Coordinating MHPSS with the health sector to deliver MHPSS. In Guinea Bissau, UNICEF worked with the Ministry of Health to provide remote psychosocial support to the children of 44 caregivers infected with COVID-19. They supplemented this with in-person home visits for critical cases. The Social Service Unit from the Ministry of Health, including social workers and psychologists, partnered with the social welfare ministry to provide the support.



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In Tanzania, UNICEF supported the training of PSS teams in two regions. They were assigned to accompany groups of contact tracers to provide basic MHPSS services to confirmed or suspected cases of COVID-19, their contacts and the wider community. The country office in Uganda has partnered with Butabika Hospital to train MHPSS teams on child protection risks in the context of COVID-19. Team members include psychologists, psychiatrists, psychiatric clinical officers, and mental health nurses. These teams have been deployed across the country to help provide MHPSS services in quarantine and treatment centres.

4. Adapting MHPSS programmes to deliver services

Physical distancing mandates have presented challenges for MHPSS programming. UNICEF country offices are working to adapt programmes to reach children and their families. How they do so partially depends on national disease mitigation strategies. Sometimes programmes have been able to shift to digital communication platforms to reach people safely. In many other instances, remote service provision is not possible and programmes have focused on providing services through physical distancing.

Delivering MHPSS services to children on the move. With large numbers of children on the move throughout the ESA region, UNICEF country offices have been supporting governments and partners to provide MHPSS services to migrants, including returnees and unaccompanied and separated children. For example, in Ethiopia, UNICEF has been supporting the government to recruit more social workers to work in quarantine facilities set up for migrants and returnees, many of whom have been forcibly returned from neighbouring countries. Social workers are providing children and caregivers with MHPSS services as well as case management services. Across Latin America, support spaces have been set up to serve Venezuelan migrants and refugees. This includes MHPSS services that have been adapted through virtual helplines, WhatsApp groups, and Facebook chats.⁴⁰

Adapting to emerging mental health needs through digital solutions.

In Malaysia, UNICEF created a dedicated online social space on Telegram where young users get regular updates on MHPSS, feedback to their questions in real-time, and receive referrals. The programme, called @KitaConnect,⁴¹ is a result of findings from a U-Report survey on the types of mental health and psychosocial problems facing adolescents. The information is delivered in an adolescent-friendly way and offers interactive activities. Through the platform, UNICEF is also able to link users to relevant service providers and make referrals to hotlines for gender-based violence and MHPSS. By May, @KitaConnect had more than 2,000 subscribers.



Developing capacity and strengthening evidence of child helplines during pandemics. The global Child Protection Area of Responsibility and EAPRO are collaborating to help streamline the use of data from helplines to improve service provision across the region. This will be aligned to Child Helpline International's efforts to strengthen data collection systems. While this initiative is just beginning, the hope is to better utilize data from child helplines to improve child protection responses and prevention of violence against children and gender-based violence.

5. Building capacity of the workforce across sectors in MHPSS

MHPSS has assumed greater importance and visibility in the light of the COVID-19 pandemic. Mental health services are increasingly considered by governments to be an essential part of the

response to the pandemic.⁴² As such, more investment is needed in capacity-building for MHPSS resources. This means more development in the training of people who provide these services across sectors, including specialists and non-specialists, those who run helplines, social workers, health workers and mental health providers.⁴³ A key component of this is investing in self-care and institutional care programmes to promote the mental health and wellbeing of staff members.

Some country and regional offices are using COVID-19 as an opportunity to highlight the importance of MHPSS for government-led initiatives. By early July, 18 out of 21 country offices across ESA were contributing to MHPSS activities. The East and Southern Africa Regional Office (ESARO) has worked toward strengthening the inclusion of MHPSS in government and preparedness and response strategies with a focus on health. ESARO collaborated with the WHO Regional Office for Africa by providing a checklist of readiness actions on MHPSS. WHO then distributed the list to member states in the region. ESARO has also been leading a regional MHPSS group established to facilitate the coordination of capacity-strengthening activities, to avoid duplication of work and to share best practices and guidance. The regional MHPSS group is working with the WHO-led technical working groups to strengthen the integration of MHPSS considerations in all sectors of the COVID-19 response.

Responding to the mental health needs of frontline workers has been formally adopted into MHPSS programming. In India, UNICEF is working with the government to respond to the MHPSS

needs of frontline workers using a smartphone app. This work is being carried out in partnership with a range of different government-run institutes for mental health and social work. Over 600 mental health professionals have signed up to provide their services on the app. They have each volunteered to provide online psychosocial support to frontline workers across the country. The app is able to connect users to a mental health professional based on their choice of language and geography. It also has tips for self-care and tools for self-assessment.

Building capacity of the child protection workforce in MHPSS to better support children and caregivers. New approaches are being developed to train professionals at a distance so that existing institutional training is not halted due to COVID-19. In Mexico, UNICEF developed self-care promotion and capacity-building for professionals who are working with children on the move. Within the COVID-19 context, a series of weekly webinars on positive parenting and mental health and psychosocial support targets professionals working with children on the move (from shelters, institutions, NGOs, etc.) and has established a recognized space for capacity-building within Mexico and beyond. More than 13,000 people have tuned into these webinars. In some states, individual and group counselling sessions are being offered to the same target group.

In Tanzania, UNICEF has partnered with Pact and John Snow International to develop a MHPSS remote learning programme for 356 social welfare officers across 78 districts strengthening their support skills for children and families affected by COVID-19.



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IV. Key lessons learned

The effects of COVID-19 have raised the visibility and importance of mental health in new and important ways, highlighting how mental health problems can impact anyone and everyone. This has created a window for dialogue, action and investment. Many governments now view MHPSS as a critical and life-saving component to their COVID-19 response. UNICEF has maintained its focus on implementing and adapting MHPSS services so that children, adolescents, and caregivers get the care and support they need.

The mental health and psychosocial problems that were brought on or exacerbated by COVID-19 are unlikely to dissipate anytime soon, even if the situation improves. The gradual lifting of restrictions may allow schools to reopen, for example, but this will introduce a new set of stressors and anxieties. Households will continue to deal with stressful situations, economic shocks and uncertainty.⁴⁴ Below are some lessons learned for how the MHPSS response can be sustained, both in the immediacy of the crisis and in the longer term.

- **Strengthen the ability of systems to deliver MHPSS services during the pandemic and over the longer term.** Systems strengthening requires the forging of strong collaboration with governments and a cross-sectoral approach, as well as providing services across multiple tiers of MHPSS. MHPSS resources across health, social welfare and education need to be boosted. Providing MHPSS services must be considered an essential component of the response to any crisis, including the current pandemic. Rendering the support essential will contribute to improving the services offered as well as enhancing the profession more broadly.

- **Improve opportunities for participation in all phases of MHPSS programming.** Several examples in this brief highlighted how children's voices helped inform MHPSS interventions. This was achieved mostly through self-reports using social media. However, more can be done to strengthen feedback loops to ensure children's participation at all phases of programme planning.⁴⁵ More innovative methods are also needed to ensure the voices of the most vulnerable and marginalized groups are heard, such as those with disabilities, children on the move, street children, indigenous children, those deprived of their liberty and children in low-resource and/or humanitarian settings who do not have access to internet-enabled technology.
- **Community messaging about MHPSS must continue to be an important aspect of outreach.** Communities often value population-based messaging as a means to deliver information. Several examples in the brief illustrated how community messaging has the potential to reach a large number of people. It offers a non-stigmatizing way to provide accurate information on mental health and psychosocial wellbeing, where to receive services, and how to improve help-seeking behaviour.
- **Innovations and adaptations⁴⁶ have been vital to deliver information and services to people – and they can potentially do more.** Online platforms and helplines can play an important role in reaching children, adolescents and caregivers with MHPSS support as part of wider efforts. In many countries, these innovations are still a new service. More can be done to improve and enhance the services these

helplines offer such as offering phone-based counselling services as well as improving screening and referral systems. At the same time, technology will not solve everything. More attention must be given to children on the margins who are unable to access helplines due to disability, poverty, gender discrimination or other factors.

- **Staff-care and self-care are crucial components of MHPSS service provision that must be taken as the new normal for MHPSS programming.** COVID-19 has impacted frontline workers in real ways. Organizations have a duty of care to ensure that their staff members are cared for and safe.⁴⁷ Interventions must support staff as individuals through personal self-care responses as well as through institutional responses, including individual support, group support, organizational support, and social support. Institutionalizing staff-care and self-care must be taken as a real component of doing MHPSS programming, one which must be taken (and budgeted for) as a programme cost.
- **As the pandemic evolves, more operational guidance on MHPSS is needed.** When the pandemic began, many countries sought guidance and technical support to adapt MHPSS programming to the realities of COVID-19. UNICEF responded by offering different resources that country offices could use in their context. As the pandemic evolves, countries will need additional technical guidance to respond to new phases of the pandemic, e.g., schools reopening (or closing again), responding to new outbreaks, or improving monitoring and evaluation activities.

V. Conclusion

The COVID-19 pandemic has placed the wellbeing and protection of a generation of children, adolescents and caregivers at risk. Despite facing many challenges, UNICEF country offices and partners are delivering MHPSS services through innovative strategies and by adapting programmes. For these efforts to remain successful, UNICEF must continue to keep children, families and communities at the heart of its MHPSS programme response and advocacy strategy. UNICEF must also continue to forge strong collaborations across sectors and with governments. Through these efforts, UNICEF has a unique opportunity to improve its programming while strengthening the capacity of systems to deliver MHPSS services both during the pandemic and in the longer term.



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Endnotes

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