Guidance for MHPSS aspects of child protection in the HNO/HRP 2021

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This note provides operational guidance for CP AoR coordination teams. This guidance will assist you:

1. in defining a feasible and relevant Children in Need (CIN)/ People in Need (PIN) for Mental Health and Psychosocial Support (MHPSS) aspects of child protection;
2. in setting a target for the number of children and caregivers receiving MHPSS services;
3. in defining the activities to meet the needs of children and caregivers.

This guidance builds on lessons learned from the guidance of the previous year and intends that:

- *CIN is defined in a more realistic way;*
- *Targets can be set in function of the situation in the country;*
- *A greater focus is placed on capacity building of the MHPSS Workforce.*

These changes will lead to:

- A more targeted number of beneficiaries for PSS activities. The number of beneficiaries can possibly be lower than in the previous years. At the same time, we will address the more complex problems of smaller groups of children who did not receive services in the past [1].
- A bigger variety of activities for MHPSS aspects of child protection;

[1] Lowering the number of beneficiaries for level 2 might seem contra intuitive. However, it fits in a broader strategy in which (1) recipients of PSS services are primarily reached by other sectors (e.g. education, nutrition) and (2) CP Will gradually start to focus more on level 3 activities, including case management.

- More integrated approaches for MHPSS across sectors.

To understand this guidance, you will need to have a basic understanding of the principles of MHPSS in general, and particularly you will need to know that:

- MHPSS requires an intersectoral approach and coordination;
- MHPSS strategies need to involve the four layers of the MHPSS pyramid.

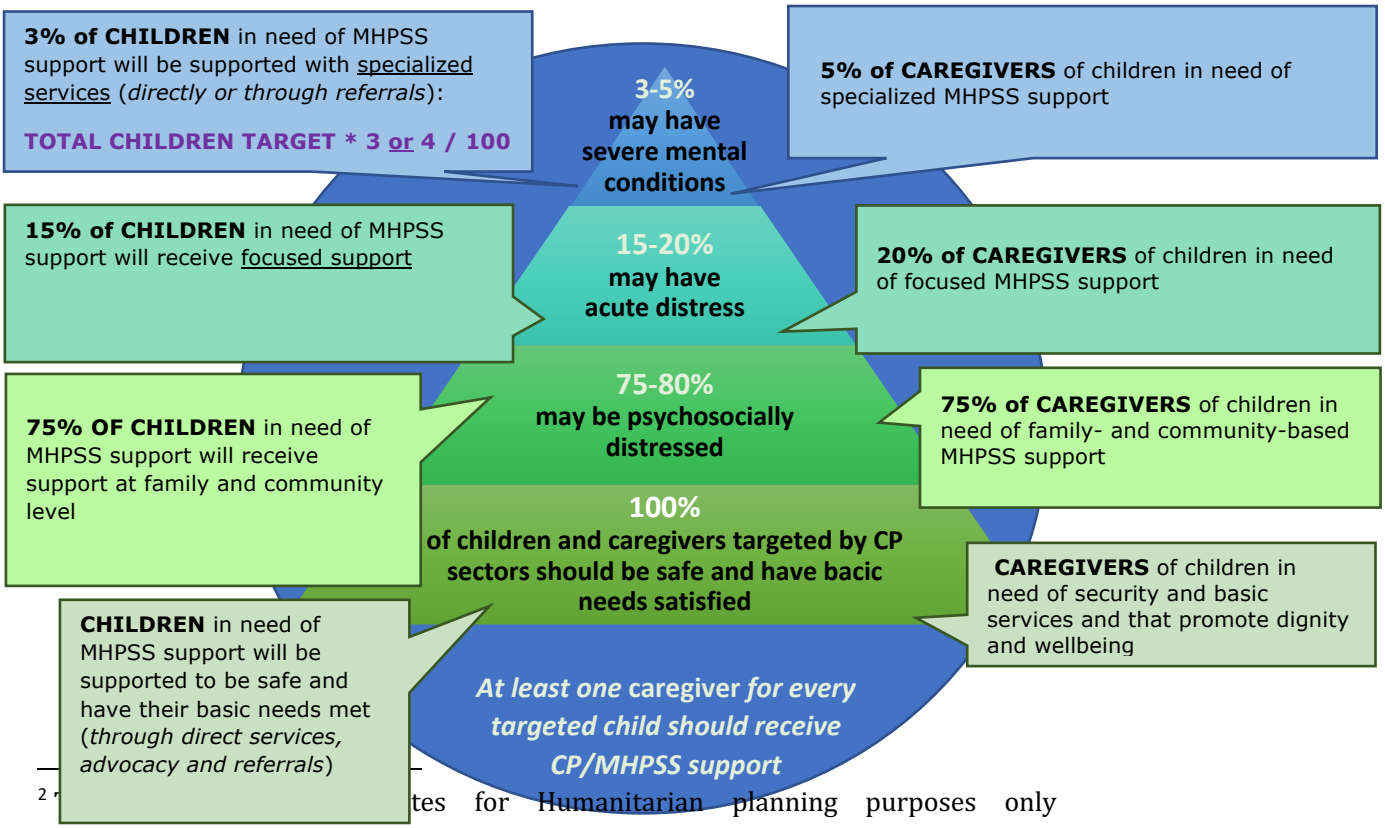
If needed, please consult the IASC Guidelines for mental health and psychosocial support in emergency settings, IASC, 2007. Contact the CP AoR helpdesks if further information is required. For specialized questions, contact the global CP AoR MHPSS Specialist, Koen Sevenants: ksevenants@unicef.org

Defining children and caregivers in need of mental health and psychosocial support services

When an emergency strikes, the mental health and psychosocial wellbeing of children and caregivers can be affected in diverse ways and to varying extents. It is important for CP actors to identify and quantify the different levels of mental health and psychosocial needs of the target groups in order to plan adequately.

Through the Humanitarian Needs Overview, all humanitarian sectors - including child protection as one of the Areas of Responsability of the protection cluster - carry out a comprehensive analysis to ultimately estimate the number children and caregivers in need of protection services. Below you will find a step-by-step guide on how to make calculations and reach a conclusion for the HNO/HRP exercise 2021.

We use the following standards to decide on the number of children and caregivers in need of MHPSS services within child protection work[2]:



2 [illegible] tes for Humanitarian planning purposes only

Steps to determine the children in need of MHPSS services in the HNO 2021

The logic of the sequence of steps below is the following: In step 1, you gather essential information to estimate how many children are in need of MHPSS services and have access to services in the affected context. In step 2, you adjust these numbers in line with the global estimates of needs outlined above. In step 3, you summarize your conclusions.

Step 1: Gathering essential context-specific information

1. Search for the overarching CIN in the geographical area that was prioritized by CP AoR.

2. You estimate how many children in 2021 can be assisted on MHPSS level 2 (PSS, CFS, recreational activities, etc.). To make this estimate, you can look at 5Ws, the previous HRP, service providers available in the region or reports.

3. You estimate how many children in 2021 can be assisted on level 3 (case management and focused non-specialized support. See). We do NOT include Psychological First Aid (PFA) as a service on level 3 here[3]. Many countries have few or no level 3 service providers. However, level 3 support is necessary. In case there are no level 3 service providers, you will have to build the workforce. The CP AoR will provide assistance if you make the request. If you do not have service providers on level 3 yet or you cannot reach a realistic estimate, you can calculate 20% of the number children who can be assisted on level 2 and take this figure as the number of children who can be assisted on level 3.

4. You estimate how many children in 2021 can be assisted on level 4 (specialized services). You can ask the health cluster for this information. Alternatively, you can ask service providers active in the prioritized geographical area: psychologists, psychiatrists and primary health care providers who received mhGAP training. We expect the number of providers and the number of children who can receive assistance on level 4 to be low.

5. You search for the average number of children per household in the prioritized geographical area. You can find this information probably at IOM, UNHCR, WFP, etc. In most cases, the government and/or OCHA should have one figure that everybody agreed upon

[3] PFA is in principle a level 3 activity. However, PFA cannot replace the more complex care that we aim for in this guidance note. You can include – for the sake of the HNO/HRP planning – include the numbers of children reached with PFA in level 2.

Table 1: Your findings	Numbers
Overarching CIN in the prioritized geographical area	
How many children can be assisted on level 2 in 2021	
How many children can be assisted on level 3 in 2021	
How many children can be assisted on level 4 in 2021	
Average number of children per household	

Step 2: Calculations and comparisons with global estimates

You can use https://percentagecalculator.net/ for the calculations below:

1. What percentage of children can be assisted on level 2 in relation to the CIN in prioritized areas? %
   If the percentage in question 1 exceeds 75%, you have to calculate 75% of the CIN in prioritized areas to obtain an adjusted number of children who can be assisted on level 2. If the percentage is 75% or less, the adjusted number of children who can be assisted on level 2 remains the same[4].
   Note: *consult the annex included in this guidance on Inter-sector Coordination*

2. What percentage of children can be assisted on level 3 in relation to the CIN in prioritized areas? %
   If the percentage in question 3 is less than 15%, you have to calculate 15% of the CIN in prioritized areas to obtain an adjusted number of children who can be assisted on level 2. If the percentage is 15% or more, the adjusted number of children who can be assisted on level 3 remains the same

3. What percentage of children can be assisted on level 4 in relation to the CIN in prioritized areas? %
   If the percentage on question 4 is less than 3%, you have to calculate 3% of the CIN in prioritized areas to obtain an adjusted number of children who can be assisted on level 4. If the percentage is 3% or more, the adjusted number of children who can be assisted on level 4 remains the same

Table 2: Your findings	Numbers

[4] In many countries this implies that we will reduce the number of beneficiaries for CP and the investment on level 2 in favor of beneficiaries and budget allocations on level 3.

Adjusted no. of children who can be assisted on level 2	
Adjusted no. of children who can be assisted on level 3	
Adjusted no. of children who can be assisted on level 4	
Total number of children who can be assisted (total of the 3 lines above)	

Note: If you had to make adjustments in in one of the numbers above , you will have to make investments and/or build capacity in the corresponding MHPSS layer. This needs to be mentioned in the HNO.

4. Calculate the 'CP MHPSS coverage', which is the percentage of children who are most in need and should be assisted through available MHPSS services. In other words, you will calculate the coverage. To get the CP MHPSS coverage you to calculate the percentage of the total number of children who require MHPSS assistance (table 2) in relation to the CIN in the prioritized geographical area (table 1). You can use https://percentagecalculator.net/T

Table 3: Your findings	Percentage
CP MHPSS coverage	

Note that the CP MHPSS coverage is not part of the HNO, but it will be part of the HRP. It will also be important data for other documents (GHRP, MHPSS RG, global CP AoR, etc.).

5. You calculate the number of primary caregivers in need of MHPSS support for the HNO 2021 by dividing the total number of children in need of MHPSS support (table 2) by the average number of children per household (table 1).

6. Next, you calculate which services are needed by which group of primary caregivers.

Table 4: Your findings	Number
Total number of primary caregivers in need of MHPSS support	
primary caregivers who require assistance on level 2 (75% of the total number of primary caregivers)	
Primary caregivers who require assistance on level 3 (20 % of the total number of primary caregivers)	
Primary caregivers who require assistance on level 4 (5% of the total number of primary caregivers)	

Step 3: What to write in the HNO

Insert the following or similar wording in the HNO. What is in *italics* is essential. The rest is optional. The information in brackets indicates where you can find the information.

Children in the [country] face significant problems that need to be addressed with MHPSS services. These problems include:

The total number of children in need of MHPSS services is XX (table 2). YY Children will need community/family based MHPSS services (table 2), YY children will need focused non-specialized support and YY children will need specialized services (table 2). To achieve the desired results of the support provided to children, we also need to provide support to their primary caregiver. The total number of caregivers who need MHPSS support is XX (table 4). XX caregivers (table 4) need to be assisted with PSS activities, YY caregivers (table 4) with focussed non-specialized care and YY caregivers (table 4) with specialized services.

To provide these services, we need to invest and build capacity for service delivery for PSS services/focussed non-specialized support/specialized services (see note under table 2)

Service delivery of MHPSS in different layers should also be reflected in the HRP, as well as the need for capacity building.

What counts as MHPSS level 1, 2, 3 and 4 activities?

Mental Health and Psychosocial support: Mental Health and Psychosocial support refers to services/programmes that aim to reconnect children with family members, friends and neighbors; foster social connections; networks and interactions; strengthen family and community supports to re-establish routines and normalcy, supportive social connections, and opportunities for learning, growth and coping with new challenges; facilitate positive relationships with caregivers, friends, teachers and others in the community essential to children's self-esteem and sense of inclusion, supporting their optimal development, and giving children opportunities for self-expression and a sense of agency in their lives; build on and support children's and the communities' innate resilience to crisis; and strengthen capacity in identifying children and caregivers with mental health problems or severe distress that interferes with their daily functioning, providing them with general support and focused care activities, and referring to specialized services as needed.

According to the IASC Guidelines for Mental Health and Psychosocial Support in Emergency Settings which guides UNICEF programmes, **"the composite term mental health and psychosocial support is used to describe any type of local or outside support that aims to protect or promote psychosocial well-being (PSS) and/or prevent or treat mental conditions (MH)".**

With increasing numbers of children displaced and affected by protracted emergencies, UNICEF and the CP AoR is shifting away from working primarily through child-friendly spaces to more holistic, community-led services, focusing on strengthening family and social supports and mental health and psychosocial support systems (MHPSS).

PRIORITY FOR EACH LAYER *Our goal*	WHAT CAN CHILD PROTECTION ACTORS DO? *Examples of actions*	GOOD PRACTICE	KEY SYNERGIES *Together is better*
Level 1: Safety and basic needs are met	• Advocate with concerned actors on behalf of affected children and caregivers when safety concerns arise and basic services aren't available • Develop 2-way cross-sectoral referral pathways across layers of intervention and train other sectors on how to identify and refer cases of concerns • Ensure early identification of children in need of protection and other humanitarian assistance, through regular presence at arrival points, camp gates, outreach activities, etc.	• Appoint one partner and one alternate partner to represent CP in discussions in relevant clusters and working groups, including the MHPSS working group. • Ensure CP has a voice at the inter-sectoral forums and camp coordination meetings. • Consider joining other sector's awareness activities and integrate child protection messages. • Develop multi-sectoral programmes with relevant sectors, such as Livelihood, for economic strengthening and reintegration of particularly vulnerable groups. • Ensure all CP actors have a child safeguarding policy in place. • Develop context-specific awareness activities and life-saving messages and make them available in the local language/s.	Government counterpart Camp Coordination and Camp Management Protection Cluster WASH Education Health Nutrition Education Shelter Food Security/ Livelihood Providers of security services
Level 2: Social connections are re-established,	• Deliver structured age and sex-appropriate psychosocial activities in	• Support community-led interventions and identify, engage and work within existing	Education Livelihood CCCM

mild psychosocial distress is addressed	safe spaces and/or through mobile models • Collaborate with schools: train and support teachers to identify and refer cases of concern and provide PSS • Support caregivers' wellbeing and parenting skills through direct psychosocial support and trainings • Engage adolescents to lead psychosocial activities, community projects and peer-to-peer supportive networks • Develop functional referral networks between schools and social services	supports when adapting evidence-based interventions. • Work together with education to search how education can take over the delivery of PSS activities, so that child protection practitioners can focus more on working on level 3 of the MHPSS pyramid. **There is advanced support available at the global CP AoR**. • Ensure there are MHPSS services available for the age group 0-3 and their caregivers. • Encourage child and community participation. • Ensure that your strategy is not largely built on recreational activities. Structured PSS activities and level 3 actions are very much needed. • Identify and build on existing supportive community practices.	Protection Cluster
Level 3 **Acute psychosocial distress is taken care of**	Psychological interventions by non-specialists (e.g. problem management +) • Lay counselling • Support groups with specific focus • Case management • Recruit MHPSS advisors/specialists in the CP team and link these also with Case Management (consider inter-agency resource sharing)	**We are aware that in most countries, level 3 activities are not yet or hardly existing. We strongly encourage you to request support from the global CP AoR which can provide you with guidance materials and help you to create a work force for delivering services.** • Define how the methodology, required skills and objectives differ from non-focused interventions. • Plan a tailored response for the specific needs of particularly vulnerable groups. • Consider building synergies with actors specialized in MH and other actors (the academia, governmental MH department, etc.) to enhance CP's MHPSS capacity.	Nutrition Education GBV Sub Cluster Health Livelihood
Level 4 **Mental health disorders and other mental conditions are taken care of**	• Psychosocial and pharmacological support for children with severe MH conditions • Develop functional referral networks between schools and social services (e.g. PHC centres with PHC providers trained in identification and management of priority MH conditions) • Identify and refer children and caregivers who have suffered serious protection risks or traumatic events for specialized care and support, as necessary	• Ensure that all children and caregivers who access this level of intervention benefit also from the previous layers (*avoid providing this service as stand-alone support*). • Ensure that partners have the necessary skills to deliver this type of intervention. • Promote inter-agency technical resource sharing.	Health

For more ideas on activities for each layer look at the UNICEF Community Based MHPSS operational Guidelines.

If you have questions, suggestions or if you require support, please contact the MHPSS Specialist at the global CP AoR: ksevenants@unicef.org

Annex on Inter-sector Coordination

Step 2.1a: Calculating number of children who can be assisted on level 2

The responsibility to deliver MHPSS services for children should not fall only to Child Protection. Through coordination with other sectors, the responsibility to deliver MHPSS services across different levels of the MHPSS pyramid can be shared and duplication of services avoided.

In coordination with other sectors, agree who can most effectively and efficiently deliver different services for children. E.g. Education is a universal service, which almost all children should be accessing. Collaborating with Education to deliver level 2 services (e.g. semi-structured PSS sessions) through schools could reach more children and free up critical CP resources and time for level 3 activities and referrals at different layers.

Considerations for calculating adjusted number of children who can be assisted at level 2 *(Step 2.4)*:

- Consult with other sectors on their level 2 targets for children (and caregivers)
- Compare these figures (and with CP's) to the children in need of MHPSS services (table 1)
    - The total should not exceed 100% of children – this means there is double targeting, and children may receive duplicate services from two (or more) sectors
- Considering the level 2 coverage from other sectors, calculate the gap in coverage that Child Protection could contribute to (**up to a maximum of 75%** as per this CP AoR guidance note)
    - If other sectors (e.g. education) are covering 50% of children in need with Level 2 activities, CP can consider covering only the other 50% who are not targeted
    - Even if other sectors' coverage is less than 25%, CP should still only target a maximum of 75% of children in need of MHPSS services
        - In this case, consider how to collaborate to support the other sectors to increase their level 2 coverage (e.g. can CP provide the technical support – developing MHPSS content and training) to roll out through other sectors?

Step 3: Conclusions for the HRP

MHPSS service delivery requires inter-sector collaboration to provide coherent support at, and referrals between, multiple levels. HRP chapters should briefly explain how CP is working with other sectors, and clearly delineate the roles and responsibilities of each sector in delivering and monitoring (through 4Ws) MHPSS services.

e.g. 1: *Child Protection sector will work with Education to establish referral mechanisms in schools to facilitate referrals of children requiring MHPSS services at levels 3 and 4. Child Protection actors will conduct service mapping and train education personnel on safe identification and referral of children requiring specialised services. Education actors will monitor the number of education personnel trained and number of children referred through school-based referral mechanisms.*

e.g. 2: *Child Protection sector will work with Education to enhance provision of level 2 MHPSS services through school-based delivery. Child Protection will provide technical support to develop the content and training package and CP actors will provide ToTs and school-based trainings for Education. Education actors will monitor the number of education personnel trained and children benefitting from school-based MHPSS services.*