unicef

for every child

Situational Analysis of School-Based Mental Health and Psychosocial Support Systems in Eastern and Southern Africa

unicef | for every child

This document was prepared by UNICEF's Eastern and Southern Africa Regional Office (ESARO). The lead author of the paper was Patricia Landínez G. under the supervision of Abdihamid Ibrahim Ahmed (UNICEF ESARO Health Specialist), Carolin Wäldchen (UNICEF ESARO Education Specialist), Annika Rigole (UNICEF ESARO Education Specialist) and Joanne Lee (UNICEF ESARO MHPSS Specialist). Sincere appreciation is extended to all UNICEF colleagues who contributed their time, expertise and dedication to shaping the direction and substance of this analysis.

This report would not have been possible without the valuable insights of youth advocates, researchers and policymakers from across the Eastern and Southern Africa region, who generously shared their perspectives through key informant interviews and focus group discussions conducted virtually. Names and other identifying details of participants in key informant interviews and focus group discussions are not included in this report, in accordance with the confidentiality assurances provided at the outset of each consultation.

Cover photo: © UNICEF/UNI769857/Mkhize

Please contact: United Nations Children's Fund Eastern and Southern Africa Regional Office, P.O. Box 44145 Nairobi, Kenya 00100, Telephone: (254) 20-76 22226 | Facsimile: (254) 20-76 22078

Situational Analysis of School-Based Mental Health and Psychosocial Support Systems in Eastern and Southern Africa

Table of Contents

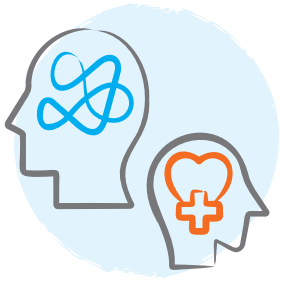
List of Acronyms and Abbreviations

ACDC	African Centre for Disease Control and Prevention
AU	African Union
CAMH	Child and Adolescent Mental Health
CEDAW	Convention of the Elimination of All Forms of Discrimination against Women
CCC	Core Commitments for Children (in Emergencies)
CO	Country Office
CRC	Convention on the Rights of the Child
DRR	Disaster Risk Reduction
ECSA-HC	The East, Central and Southern Africa Health Community
EMIS	Education Management Information System
ESA	Eastern and Southern Africa
ESARO	Eastern and Southern Africa Regional Office (UNICEF)
FGD	Focus Group Discussion
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPS	Health-Promoting Schools
IASC	Inter-Agency Standing Committee
IDP	Internally Displaced Person
INEE	Inter-agency Network for Education in Emergencies
KII	Key Informant Interview
MhGAP	Mental Health Gap Action Programme
MHPSS	Mental Health and Psychosocial Support
MHPSW	Mental Health and Psychosocial Wellbeing
MOE	Ministry of Education
MOH	Ministry of Health
NGO	Non-Governmental Organisation
PHC	Primary Health Care
REPSSI	Regional Psychosocial Support Initiative
SBC	Social and Behaviour Change
SDG	Sustainable Development Goal
SEL	Social and Emotional Learning
UN	United Nations
UNICEF	United Nations Children's Fund
VAC	Violence Against Children
WHO	World Health Organization

© UNICEF/UNI811340/Pouget

Executive Summary

Child and adolescent mental health (CAMH) is an urgent yet persistently overlooked issue in the Eastern and Southern Africa (ESA) region, demanding greater attention from governments and donors. In the ESA region, children and young people grow up amid multiple overlapping crises – extreme poverty, inequality, violence, exclusion, stigma and climate or food insecurity – all of which heighten the risk of mental health challenges. Most mental health conditions begin early in life and, if left unaddressed, can significantly undermine children's development, education, participation and long-term health and wellbeing.



Most mental health conditions begin early in life and, if left unaddressed, can significantly undermine children's development, education, participation and long-term health and wellbeing.

The ESA region is home to approximately 366.5 million children and young people aged 0 to 24, with 45 million more expected in the next decade. This demographic trend highlights the urgent need for timely, sustained investment in systems that can protect, promote and respond to the mental health and psychosocial needs of young people.

Recognizing the strategic role of schools as entry points for mental health and psychosocial support (MHPSS), the UNICEF Eastern and Southern Africa Regional Office (ESARO) commissioned this situational analysis to understand the current landscape of school-based MHPSS. The study reviewed policy frameworks, implementation practices and linkages with primary health care, aiming to identify gaps and inform strategic action to strengthen advocacy, programme design, workforce development and cross-sector coordination.

The analysis applied a mixed-methods approach, combining a regional desk review, an online survey with data from 21 UNICEF Country Offices (COs), 15 key informant interviews (KIIs) and four focus group discussions with stakeholders, including young people.

© UNICEF/UNI734065/Hearfield

Key Findings

The Mental Health Landscape for Children and Adolescents in ESA

- Children and adolescents' mental health and psychosocial wellbeing **receive limited recognition and insufficient prioritization across ESA**, both in policies and service delivery.
- While 67 per cent of countries (14 of 21) have general mental health policies, **only 29 per cent (6 of 21) have specific policies or plans addressing the mental health needs of children and adolescents**.
- A recent review estimates that **27 per cent of adolescents in sub-Saharan Africa experience depression, 30 per cent suffer from anxiety** and **41 per cent face emotional or behavioural challenges**.
- **Multiple, intersecting risk factors undermine children's mental health and psychosocial wellbeing** (e.g., poverty, violence, displacement, HIV, child marriage and early pregnancy, climate and food insecurity, and stigma).
- **Public investment remains critically low**, with most countries spending below the US$2 per capita benchmark for mental health in low-income settings.
- There is a significant shortage of **child and adolescent mental health professionals**, particularly in rural areas, leading to **inequitable access** to services.
- **Services remain fragmented and limited**, constrained by chronic underfunding, insufficient integration into schools and primary health care, and a lack of dedicated child and adolescent mental health workforces.
- Young people consulted called for **greater policy attention, accessible youth-friendly services and opportunities for meaningful engagement in shaping mental health policies and programmes**.

School-based mental health and psychosocial support systems

- **Schools play a pivotal role in shaping the mental health outcomes of children and adolescents**. Schools are uniquely positioned to promote mental health, prevent mental health problems and ensure early intervention when mental health challenges arise.
- While schools can serve as protective environments that promote mental health, they may also expose learners to preventable risks – such as peer-to-peer violence, corporal punishment, social exclusion and academic pressure – that can contribute to or worsen mental health.
- **School-based mental health and psychosocial support interventions contribute to fostering positive mental health** and enhancing socio-emotional skills, while also reducing the prevalence of mental health conditions.
- In ESA, **efforts to integrate MHPSS into education systems are gaining momentum**, particularly following the COVID-19 pandemic. Countries such as Kenya, South Africa, Rwanda, Zimbabwe and Mozambique are embedding social-emotional learning, peer support initiatives and MHPSS training into teacher professional development frameworks.
- **Schools are central to UNICEF's strategy for delivering MHPSS services**. Between 2022 and 2024, 12 UNICEF COs in the region consistently reported school-based MHPSS programming.

School-based MHPSS in Emergencies

- **Children in humanitarian settings face compounded risks, including displacement, family separation, violence and school closures**.
- **School-based MHPSS is crucial during crises yet** is frequently deprioritized in favour of visible needs like shelter and food.
- **Linkages between education, primary health care and child protection systems are often weak** or ad hoc, undermining continuity of care and referral effectiveness.
- **Education in emergencies can serve as a protective factor**, but few systems have embedded MHPSS within disaster risk reduction or recovery strategies.

Barriers to advancing child and adolescent mental health

- Mental health **remains heavily stigmatised in the region** and is often misunderstood or associated with mental illness or spiritual beliefs.
- **Fragmented collaboration between ministries and unclear responsibilities across sectors** lead to disjointed service delivery and ineffective referral mechanisms.
- **In rural and underserved areas, the availability of mental health services and trained professionals is extremely limited**.
- Most **school-based MHPSS interventions rely on short-term, donor-driven funding and lack sustainability**.
- **Teachers face high workloads, large class sizes and inadequate mental health training and support for their own mental health**, hindering their ability to effectively promote learners' learning and mental health.
- **Schools often lack structured and functional referral pathways to health services, while the health sector faces critical shortages of child and adolescent mental health professionals to respond effectively to referrals**.
- **Weak child and adolescent mental health information systems and limited regional research** pose considerable obstacles to the development and implementation of effective policies and programmes.
- **Child and adolescent mental health often lack recognition as a critical development priority**.
- **Caregivers are often left out of the design and implementation of MHPSS programmes**, even though they play a key role in nurturing and protecting children's mental health and wellbeing.
- **Education sector emergency plans often neglect MHPSS programming**, with few frameworks linking it to disaster risk reduction, crisis response, or recovery.

Key Recommendations

The following recommendations are intended to guide governments, development partners, UN agencies and other stakeholders in strengthening school-based MHPSS policies and services across ESA. Grounded in the evidence generated through this situational analysis, they outline priority actions to advance a more coordinated and sustainable approach to promoting and protecting the mental health of children and adolescents in the region.

- Prioritize child and adolescent mental health in national development agendas by **developing and implementing comprehensive, well-funded and evidence-based policies that embed mental health promotion, prevention and access to care within education systems**.
- Strengthen intersectoral coordination by establishing **national frameworks that define clear roles, joint planning and shared accountability for an integrated service delivery model** across education, health and social protection sectors.
- **Design MHPSS interventions that acknowledge and integrate local beliefs**, using social and behaviour change (SBC) strategies to reduce stigma, encourage help-seeking and foster supportive environments for children and adolescents.
- Enhance child and adolescent service delivery through a multi-tiered, integrated approach that bridges education, health and social welfare systems, while also leveraging digital innovations to expand reach and maintain continuity of care.
- Ensuring that the education system is adequately staffed with qualified professionals who can respond to students' mental health needs, and provide continuous training and support to help educators effectively promote wellbeing and offer appropriate support.
- Allocate **dedicated budget lines within national education and health budgets for school-based MHPSS**, and ensure long-term, sustainable financing that extends beyond short-term donor support.
- **Systematically integrate mental health and psychosocial support within school emergency preparedness and response frameworks**.
- Actively **involve youth, caregivers and community leaders in the design, implementation and monitoring of MHPSS interventions**.
- **Incorporate CAMH indicators into national Health Management Information Systems (HMIS) and Education Management Information Systems (EMIS), invest in region-specific research** and establish robust monitoring systems to inform adaptive programming and advocacy.

This situational analysis reaffirms that school-based MHPSS programmes are a critical, yet underutilized, opportunity to promote and protect the mental health of children and adolescents in ESA. **While promising practices exist, progress remains uneven and constrained by systemic barriers. Realising the potential of schools for mental health promotion, early intervention and care requires sustained political will, cross-sector collaboration, increased investment and the meaningful engagement of education stakeholders, including young people**. To be effective, school-based MHPSS must be embedded within broader multisectoral frameworks that advance child and adolescent wellbeing. Moving forward, collective action by governments, development partners and donors will be essential to create equitable, inclusive and responsive systems that meet the mental health needs of all learners.

1. Introduction

> **Every young person shall have the right to enjoy the best attainable state of physical, mental and spiritual health"**
>
> Article 16, African Union Youth Charter

Mental health and psychosocial wellbeing (MHPSW) are fundamental to children and adolescents' overall health, development, educational attainment and life trajectories. However, in the ESA region, mental health issues represent a significant and often overlooked source of concern for young people.

The imperative to prioritize mental health in the ESA region is closely link to the high prevalence of risk factors, including poverty, food insecurity, inadequate access to health services, weak social protection systems, gender inequalities, exposure to violence, unprecedented climate-induced shocks, recurrent disease outbreaks, armed conflict, large scale displacements and the highest prevalence of HIV globally. These often-overlapping challenges exacerbate vulnerabilities and underscore the urgent need to strengthen child and adolescent mental health services across multiple sectors.

In this context, **primary health care is a critical health platform to expand the coverage of child and adolescent mental health services**. The World Health Organisation (WHO) advocates for the integration of mental health into primary health care (PHC), as well as the delivery of services through non-health sectors, highlighting this as a cost-effective and equitable approach to addressing the significant treatment gap. Among these non-health platforms, schools and other learning spaces (hereafter referred to as 'schools') are uniquely positioned to nurture mental health and psychosocial wellbeing. They provide safe and supportive environments that not only promote positive mental health but also help prevent and address mental health challenges in a timely manner.

Within schools, learners have opportunities to strengthen their mental health literacy, cultivate crucial social-emotional skills and access timely

The imperative to prioritize mental health in the ESA region is closely link to the high prevalence of risk factors, including poverty, food insecurity, inadequate access to health services, weak social protection systems, gender inequalities, exposure to violence, unprecedented climate-induced shocks, recurrent disease outbreaks, armed conflict, large scale displacements and the highest prevalence of HIV globally.

support when experiencing emotional distress or other mental health concerns. Moreover, they function as vital bridges that connect learners, their families and critical services (including health, mental health and child protection). In humanitarian contexts, school-based MHPSS[1] interventions become even more critical to safeguard the mental health and wellbeing of learners and educators.

Despite the growing recognition of the importance of integrating MHPSS interventions within primary health care and educational systems, many countries in ESA face persistent challenges in embedding these effectively. Barriers such as resource limitations, policy gaps, weak coordination and stigma persistently restrict access to comprehensive mental health support for children and adolescents. Enhancing MHPSS in schools and reinforcing its linkages with primary health care presents a substantial opportunity to improve early intervention, promote mental wellbeing and cultivate more resilient education and health systems.

Purpose

There is currently no comprehensive resource that maps the landscape of child and adolescent mental health and psychosocial wellbeing in the ESA region, particularly concerning the role of schools within the broader network of mental health services. This situational analysis aims to address this gap by deepening the understanding of the current state of MHPSS within schools and their linkages with primary health care systems across the region. Specifically, the analysis seeks to:

- Assess the current policies, frameworks and state of MHPSS initiatives within schools, including linkages with primary health care.
- Identify gaps and opportunities for strengthening MHPSS in educational contexts.
- Provide actionable recommendations to inform policy advocacy, programme design and effective MHPSS interventions.

The findings are intended to guide policy and strategic action for policymakers and practitioners, supporting efforts to advance advocacy, programme design, workforce capacity-building and cross-sector coordination. The ultimate goal is to contribute to the establishment of stronger and more resilient support systems for children and young people in the region – ensuring that mental health and psychosocial support services for children and adolescents are accessible, sustainable and effectively integrated within educational and health systems.

Structure of the report

This situational analysis is structured as follows. Chapter 3 provides an overview of the MHPSS landscape for children and adolescents in the region, highlighting the prevalence of mental health challenges, key risk factors and existing policy frameworks. Chapter 4 examines the role of schools in promoting and protecting the mental health and wellbeing of learners and educators. Chapters 5 synthesizes the key barriers identified throughout the analysis, while Chapter 6 concludes by presenting strategic recommendations to strengthen the delivery of MHPSS within educational settings.

2. Methodology

This situational analysis employed a mixed-methods approach, integrating quantitative and qualitative data to enhance understanding of the state of school-based MHPSS across the ESA region. The analysis was guided by global and regional frameworks, including UNICEF's Global Multisectoral Operational Framework for MHPSS, the UNICEF Education Strategy 2019–2030, the UNICEF ESAR MHPSS Programme Note and Workplan, the Health Promoting Schools framework, the UNESCO, UNICEF and WHO Policy brief around promoting and protecting mental health in schools along with its compendium of resources, WHO`s Comprehensive mental health action plan 2013–2030, and the Africa CDC Non-communicable diseases and mental health promotion strategy, as well as other relevant child and adolescent mental health resources and evidence.

Data collection

This situational analysis utilized three main methods for data collection:

Desk Review: A review of global and regional policies, academic literature and UNICEF programme documents related to school-based MHPSS and school health services in the ESA region was completed. External sources included international frameworks, global standards and systematic reviews and peer-reviewed papers published between 2015 and 2025. Internal sources comprised the analysis of 2023 and 2024 UNICEF CO annual reports, programme monitoring data and internal evaluations reflecting on MHPSS implementation. This dual approach ensured both global perspectives and local insights were captured to inform the analysis.

Quantitative Data Collection: An online survey was conducted with UNICEF ESA region´s COs in early 2025, targeting key UNICEF sectoral representatives and MHPSS focal points in 21 countries. Responses provided insights into the prevalence, nature and scale of existing MHPSS policies and programming, including in emergency settings, as well as barriers and recommendations for scaling up MHPSS interventions for children, adolescents and their teachers and caregivers.

Qualitative Data Collection: In-depth qualitative data were collected through 15 KIIs[2] and four Focus Group Discussions (FGDs). These consultations engaged a diverse range of stakeholders, including:

- **Young People** – offering insights into their lived experiences and perspectives on mental health and support systems.

- **Multisectoral Teams from UNICEF Country Offices** – sharing expertise on MHPSS programming, policy implementation and cross-sectoral linkages.
- **External Stakeholders** – encompassing representatives from regional NGOs, UN partners, the Africa CDC and researchers contributing to regional and technical insights on mental health policies and interventions.

The qualitative data were systematically analysed through thematic coding, aligned with the core components of the report: policy frameworks, school-based MHPSS interventions and emergency preparedness and response. To ensure the validity and reliability of findings, follow-up consultations were conducted with key stakeholders, enabling the triangulation of data and fostering consensus on key findings and strategic recommendations.

Limitations

While this report elucidates critical insights into the landscape of school-based MHPSS in the region, several limitations must be acknowledged. One of the main challenges is the limited availability of comprehensive, nationally representative data on child and adolescent mental health. Data on the prevalence of mental health among children and adolescents, as well as information on service access and effectiveness, remains scarce or outdated in many countries. Consequently, this analysis relies on fragmented data sources, regional trends and global estimates.

Another limitation arises from the reliance on secondary data and KIIs. While these sources offer valuable insights, they may not fully capture the diversity of experiences and service realities across different countries. Furthermore, comparability across countries poses a challenge, as the context of child and adolescent mental health varies considerably owing to differences in socio-economic conditions, cultural beliefs and governance structures.

Additionally, the effectiveness of MHPSS interventions in schools is often impeded by resource limitations, workforce shortages and inadequate intersectoral coordination. Such factors complicate the ability to draw definitive conclusions regarding the overall impact of policies and programmes at scale. Humanitarian crises, armed conflicts, displacement and climate-related disasters profoundly affect child and adolescent mental health; nevertheless, systematic data collection on MHPSS interventions within these contexts frequently remains insufficient. Despite these challenges, this situational analysis provides a crucial foundation for informing strategic actions and policy advocacy to strengthen school-based MHPSS interventions across the region.

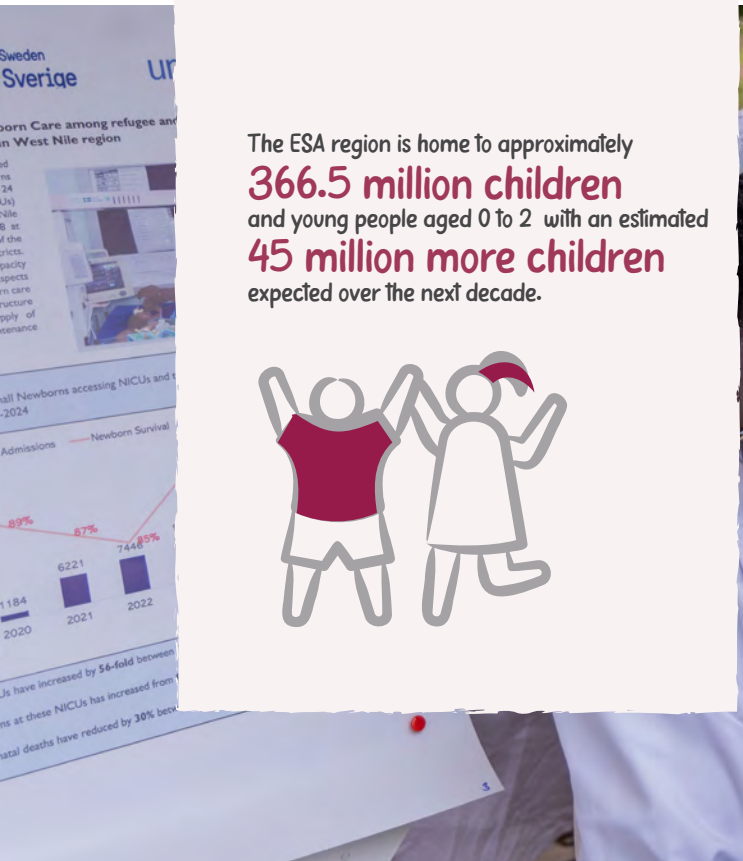
3. Child and Adolescent Mental Health in Eastern and Southern Africa

The ESA region is home to approximately 366.5 million children and young people aged 0 to 23[3] with an estimated 45 million more children expected over the next decade. This rapid population growth underscores the need for strategic investments in social sectors to meet the needs of children and adolescents effectively. UNICEF calls on governments in the region to prioritize long-term planning and resource allocation to ensure that essential services keep pace with demographic changes.[4] Among these priorities, the mental health and psychosocial wellbeing of children and adolescents demand urgent attention from governments, donors and stakeholders across different sectors.[5]

Mental health issues among children and adolescents are an increased regional concern. Poor mental health can severely hinder educational attainment, elevate the risk of school dropout, disrupt social relationships and diminish economic productivity, thereby generating a ripple effect of adverse outcomes that extend into adulthood.[6] Mental illness frequently precipitates poverty for individuals and families.[7]

Youth advocates who participated in FGDs as part of this situational analysis voiced their frustration over the lack of recognition and response to their mental health concerns.

Many feel unheard and dismissed, with decision-makers failing to acknowledge the urgency of their mental health needs. Addressing child and adolescent´s mental health needs is not only critical to overall health, development and holistic wellbeing but also responds to the growing demands of young people themselves.[8] Please see Box 1 for insights shared by youth advocates during the FGD.



The ESA region is home to approximately
366.5 million children
and young people aged 0 to 2 with an estimated
45 million more children
expected over the next decade.

© UNICEF/UNI768834/Watsemba

Box 1. The voices of young people: Urgent call to prioritize their mental health

Young people across ESA stated that mental health remains a low priority for policymakers and service providers. Many describe a pervasive sense of stigma, where mental health is either dismissed as a non-issue or misunderstood as equivalent to severe mental illness. They reported that in several communities, mental health concerns are often trivialized, with young people being told that they are "pretending" or "seeking attention." Others note that discussions around mental health are often met with scepticism, particularly among policymakers. As one youth advocate stated, "even professionals working in government ministries have downplayed the urgency of mental health, seeing it as an exaggerated concern rather than a legitimate crisis".

Access to services remains a critical barrier. Young people highlighted the lack of mental health facilities, particularly in rural and underserved areas. Many of the existing services are concentrated in urban centres, making them inaccessible to most of the population. Even where services exist, young people report negative experiences, describing encounters with professionals who lack adequate training or dismiss their concerns.

The role of schools in supporting mental health is another area of concern. While schools are a central part of young people's daily lives, mental health support within educational institutions is often inadequate. Many youth advocates expressed frustration over the lack of trained professionals in schools, with some institutions only employing a single counsellor for thousands of learners. They called for comprehensive mental health policies that integrate psychosocial support within the school system, ensuring that children and adolescents have access to care in a setting where they spend most of their time.

Young advocates interviewed remain steadfast in their commitment to advocating for change. They are urging stakeholders to prioritize their recommendations, emphasizing the need for comprehensive, inclusive and youth-centred mental health policies and services. Their requests are clear and actionable:

- Accelerate public education campaigns to promote understanding of mental health and reduce stigma.
- Update mental health legislation and policy frameworks to address challenges faced by young people, ensuring their voices are included in policy discussions and decision-making processes.
- Integrate mental health education into school curricula and ensure schools are equipped with trained mental health professionals who can provide age-appropriate support.
- Establish child and adolescent-friendly mental health services that are accessible, inclusive and responsive to the needs of young people in both urban and rural areas.
- Implement inclusive educational programmes to guarantee that children with mental health conditions can continue learning in supportive, non-discriminatory environments.
- Train health care workers on patient-centred care, ethics and confidentiality to create welcoming and youth-friendly environments.

- Emphasize non-medical interventions such as therapy, support groups and community-based programmes to address child and adolescent mental health needs.
- Develop accountability mechanisms for reporting and addressing complaints about poor service quality.
- Promote mentorship and leadership programmes to empower young people in mental health advocacy, equipping them with the skills to lead change in their communities.

Young people in Eastern and Southern Africa are clear: mental health must be taken seriously. They are demanding action from governments, donors and stakeholders to ensure that child and adolescent mental health is no longer an afterthought but a priority. Without urgent investment, stigma will persist, services will remain inadequate, and the cycle of neglect will continue.

3.1 State of Child and Adolescent Mental Health in ESA

Research indicates that approximately one-third of mental health disorders emerge before the age of 14, and nearly half occur before 18.[9] Nearly 37 million adolescents aged 10–19 in Africa are estimated to be living with a mental health disorder, with suicide ranking as the ninth leading cause of death among adolescents aged 15–19. In 2019, suicide mortality rates were highest in Lesotho (72.44 per 100,000) and Eswatini (29.4 per 100,000), and lowest in Tanzania (4.27 per 100,000) and South Sudan (3.85 per 100,000). Anxiety and depression alone account for nearly 50 per cent of mental conditions within this demographic.[10]

Although reliable data on the prevalence of child and adolescent mental health conditions are limited in the region, a recent systematic review estimated that approximately 27 per cent of adolescents in sub-Saharan Africa will be living with depression, 30 per cent with anxiety and 41 per cent with emotional or behavioural problems. According to the WHO, mental, neurological and substance use conditions account for 6 per cent of the total disease burden[11] in the African Region, with depression and anxiety as significant contributors.[12]

While these statistics are concerning, they only represent a portion of the broader mental health landscape. Mental health challenges in children and adolescents are not limited to clinically diagnosed conditions.

37 million adolescents aged 10-19 in Africa are estimated to be living with a mental health disorder, with suicide ranking as the ninth leading cause of death among adolescents aged 15-19.

Mental health challenges in children and adolescents **are not limited to clinically diagnosed conditions.**

Many experience significant psychological suffering and distress, often triggered by extreme poverty, exposure to violence, humanitarian crisis, food insecurity and other socio-environmental stressors. Mental health data often focus mainly on diagnosable conditions, overlooking the large number of children experiencing psychological distress that falls below clinical thresholds. This narrow view risks leaving many vulnerable children without the support they need. A comprehensive approach should combine universal mental health promotion for all children with targeted early intervention and care strategies to identify and support those at greater risk.

3.2. Key Risk Factors and Social Determinants of child and adolescent mental health

Mental health is shaped by a complex interplay of individual attributes – such as the ability to manage one's thoughts, emotions, behaviours and interactions with others – as well as broader social, cultural, economic, political and environmental factors, including national policies, social protection, living standards, educational environments, cultural norms and community social support.[13] These factors can either foster resilience or contribute to mental health challenges. In the ESA region, challenges such as extreme poverty, inequality, violence, exclusion, stigma and climate or food insecurity significantly heighten the risk of mental health problems. These challenges are often intertwined, creating a cycle that jeopardizes mental health and wellbeing. Additionally, the high prevalence of HIV and recurrent emergencies in the region further strains families and communities, compounding the mental health burden of young people. More detail on these key risk factors is provided below:

Socioeconomic Factors

Evidence suggests that **children and adolescents living with low socioeconomic backgrounds are two to three times more likely to experience mental health challenges**.[14] For example, food insecurity is associated with psychological difficulties in children. **Nutritional deficiencies can result in cognitive impairments and behavioural issues, which in turn hinder their ability to learn**.[15] Furthermore, children from low-income families, marginalized communities, or conflict-affected areas are disproportionately exposed to various stressors, including violence, forced displacement, hazardous labour and social exclusion. They also face limited access to essential services such as health care and quality and inclusive education, which exacerbates their vulnerabilities and increases the risk of psychosocial distress and long-term mental health conditions. In addition, restricted access to health care services often results in mental health problems and conditions remaining unaddressed or untreated.

Children and adolescents living with low socioeconomic backgrounds are two to three times more likely to experience mental health challenges.

Nutritional deficiencies can result in cognitive impairments and behavioural issues

Exposure to Violence, Abuse and Discrimination

A considerable number of children and young individuals in ESA are subjected to violence, abuse and discrimination, including gender-based violence (GBV) and social exclusion. Such experiences have profound implications for both physical and mental health. **Children with disabilities and members of marginalized groups frequently encounter heightened risks**. Research confirms that children who endure physical, sexual, or psychological abuse are more prone to depression, anxiety and even PTSD, with severe cases of sexual abuse or neglect linked to an increased risk of suicidal ideation.[16]

Risk Factors and Social Determinants of child and adolescent mental health

Exposure to Violence, Abuse and Discrimination

Socioeconomic Factors

Stigma and cultural perceptions surrounding mental health conditions

Humanitarian Crises and Climate Change

Educational Disruption and Mental Health Risks

Health Burdens and Disease-related Stigma

According to UNICEF,[17] **approximately 120 million children aged 1 to 14 years in the region experience violent discipline at home. Furthermore, around 10 million adolescent learners report experiencing peer-to-peer violence, and approximately 6 per cent of women aged 18 to 29 years report experiences of forced sexual intercourse and other forced sexual acts in childhood**. According to the global school-based student health survey (GSHS), 60 per cent of students in the ESA region have experienced cases of violence and unintentional injury, a statistic that is higher for boys. Incidence ranged from 30 per cent in Malawi and 37 per cent in the United Republic of Tanzania to 71 per cent in Kenya and Zambia.[18] There are 50 million girls and women in ESA today who were married before the age of 18, with the largest share in Ethiopia.[19] Girls most at risk of child marriage often come from the poorest families and live in rural areas. Child marriage is often associated with a lack of education and dropping out of school.

Given that exposure to violence disrupts the body's stress response and brain development, multiple studies have found strong correlations between childhood violence and subsequent mental health challenges. Evidence from the Violence Against Children Survey underscores these associations; for instance, in Namibia, data from the 2019 survey shows that young women aged 18 to 24 who experienced violence during childhood were significantly more likely to report mental distress, engage in self-harm and experience suicidal thoughts. Similarly, young men who endured sexual violence during childhood exhibited a markedly higher probability of encountering mental distress in adulthood.[20]

Approximately 120 million children aged 1 to 14 years in the region experience violent discipline at home; around 10 million adolescent learners report experiencing peer-to-peer violence; approximately 6 per cent of women aged 18 to 29 years report experiences of forced sexual intercourse; other forced sexual acts in childhood.

Educational Disruption and Mental Health Risks

Limited access to education and disruptions in educational continuity are significant risk factors for mental health challenges among children and adolescents. Research conducted in South Africa indicates that school enrolment and a strong sense of belonging within the school environment serve as protective factors for mental health.[21] Nevertheless, in ESA, **an estimated 46 million school-aged children are currently out of school, which includes approximately three in seven children with disabilities**. While being out of school does not directly cause mental health problems, it deprives children of their right to education and essential protective factors such as social support, structured environments and access to critical services.

Additionally, disruptions in education limit opportunities for early identification and intervention, hindering teachers and school staff from recognizing and addressing signs of psychological distress among learners. In 2024, at least 7.8 million children in ESA region experienced climate-related schooling disruptions. Prolonged droughts and floods were the most significant climate hazards that disrupted schools, affecting an estimated 5 million students. In Zimbabwe, 1.8 million children experienced learning disruptions due to droughts, while in South Sudan, almost the entire population of school children, over 2 million, were impacted by a heatwave. Tropical cyclones and floods also played a significant role in large-scale school disruptions, with over 100,000 students being affected by Cyclone Chido in Mozambique (December 2024) and 2 million learners impacted by flooding in Kenya (March 2024). Overall, at least 14 countries in the region experienced climate-related hazards that resulted in school closures.

An estimated 46 million school-aged children are currently out of school, which includes approximately three in seven children with disabilities.

© UNICEF/UNI840708/Watsemba

Health Burdens and Disease-related Stigma

The region faces a high burden of infectious diseases, including public health emergencies and related stigma, significantly impacting the mental health and wellbeing of children and adolescents and their caregivers. The ESA region carries the largest share of the global burden of HIV in adolescents, and in 2018, about 1.8 million adolescents were living with HIV in the region. According to UNICEF estimates, in 2023 **74,000 new HIV cases among children and adolescents aged 15–19 were recorded in the ESA region**.[22] Adolescents living with HIV often experience stigma and discrimination, which can lead to low self-esteem, anxiety, depression and difficulties in adhering to antiretroviral treatment. Fear of disclosure, social rejection and internalized stigma further exacerbate emotional distress, increasing the risk of social withdrawal and poor health outcomes.

In Kenya, 49 per cent of patients had at least one diagnosis of psychiatric disease or suicidal tendencies; the most common diagnosis was anxiety disorders (32.3 per cent), followed by major depressive disorder (17.8 per cent). Another study from Kampala, Uganda, found that 51.2 per cent of adolescents living with HIV were experiencing significant psychological distress, 19.5 per cent had ever attempted suicide (17.1 per cent during the preceding year), and 30.5 per cent reported having experienced psychotic symptoms in the past.

74,000 new HIV cases
among children and adolescents aged 15-19 were recorded in the ESA region.

Adolescent pregnancy

Adolescent pregnancy remains a significant public health concern in ESA, with rates that are among the highest around the world. Globally, the age-specific adolescent birth rate was estimated at 44 births per 1,000 girls aged 15–19 in 2019. At 92 births per 1,000 girls aged 15–19, the ESA region has the third highest adolescent birth rate in the world. Figures range from 41 in Rwanda to 152 in South Sudan, 163 in Angola and 180 in Mozambique.

Early and unintended pregnancies among adolescents present significant mental health challenges, particularly when compounded by gender discrimination, poverty, school dropout and lack of support systems. Young mothers often face intense social stigma, limiting their access to education and economic opportunities, which in turn heightens the risk of developing mental health problems. The lack of adequate maternal health and psychosocial support services further intensifies these risks, leaving many adolescent mothers without the necessary resources to cope with the pressures of early parenthood and caregiving responsibilities.

Adolescent pregnancy
remains a significant public health concern in ESA.

Humanitarian Crises and Climate Change

Recurrent humanitarian crises, including armed conflicts, forced displacement, public health emergencies and climate change-related disasters such as droughts and floods, have significantly affected millions of children and adolescents in the region. In 2024 alone, 18 out of 21 countries in the region were affected by emergencies, impacting approximately 51 million children. **Over half of the world's crisis-affected children reside in sub-Saharan Africa**.

Over half
of the world's crisis-affected children reside in
sub-Saharan Africa.

Climate change impacts (such as drought-induced famines or cyclones) also threaten mental wellbeing by uprooting families and undermining livelihoods. At the peak of the historic droughts in the Horn of Africa, a total of 2.7 million children in Kenya, Ethiopia and Somalia dropped out of school. In South Sudan, prolonged exposure to war-related traumatic experiences has negatively impacted the psychological wellbeing of those in refugee camps and those remaining in their homeland.[23]

Stigma and cultural perceptions surrounding mental health conditions

In many communities, mental health issues are often misunderstood or attributed to spiritual causes, leading families to seek help first from traditional and religious healers rather than professional mental health providers.[24] Although some traditional healers may collaborate with health professionals for referrals, many families avoid pursuing medical or psychological care due to concerns about stigma, cost, social exclusion, or a lack of awareness regarding the availability of support services. The absence of a structured integration between community-based healing practices and formal mental health services constitutes a significant barrier to care.

3.3. Financing and Access to Child and Adolescent Mental Health Services

The lack of dedicated CAMH policies remains a major barrier to establishing effective mental health care systems in the region. Insufficient government prioritization and underinvestment in mental health significantly hinder efforts in promotion, prevention and care. Public expenditure on mental health is alarmingly low. According to WHO, **government spending on mental health in the African region increased from US$0.10 to just US$0.46 per capita between 2014 and 2020 – still far below the recommended US$2 per capita for low-income countries**.[25] This chronic underinvestment highlights the critical gap in resourcing mental health services, particularly for children and adolescents. Furthermore, it remains difficult to determine how much of the existing budget is specifically allocated to support the mental health of children and young people across sectors and throughout the mental health continuum.

Government spending on mental health in the African region increased from
US$0.10 to just US$0.46 per capita
between 2014 and 2020.

© UNICEF/UNI844150/Pouget

Compounding this challenge is the severe lack of accessible mental health services for children and adolescents across the region. Despite the growing need, access to quality mental health care remains critically limited, marked by an acute shortage of services and trained professionals dedicated to child and adolescent mental health.[26] **Access to MHPSS for children and adolescents and their families in ESA remains alarmingly inadequate across the 21 countries in the region.** According to WHO**, approximately 76 per cent to 85 per cent of individuals with severe mental disorders in low- and middle-income countries do not receive treatment for their conditions. In Africa, the annual rate of mental health outpatient visits is only 14 per 100,000 people, which starkly contrasts with the global average of 1,051 per 100,000**. For example, in South Africa, fewer than one in ten people with mental health conditions receive the necessary care.[27] In some countries, the situation is even more dire.[28]

According to WHO, in countries with specialized child and adolescent mental health professionals, there is only one professional for every 4 million individuals. Furthermore, mental health expertise among health and social care professionals is typically concentrated in urban areas, restricting access for rural populations. This uneven distribution of resources exacerbates inequities, leaving vulnerable children without the critical support they need and widening the gap in mental health care.

76% to 85%
of individuals with severe mental disorders in low- and middle-income countries do not receive treatment for their conditions. In Africa, the annual rate of mental health outpatient visits is only
14 per 100,000 people
which starkly contrasts with the global average of
1,051 per 100,000.

3.4. Policy, Legislative and Governance Frameworks for Child and Adolescent Mental Health

Effective policies and well-structured service delivery models are the foundation for improving child and adolescent mental health. **A robust and multi-sectoral policy framework provides a roadmap for programme development, signals government and stakeholder commitment, establishes mandates for funding mechanisms and clarifies accountability across different sectors for the provision of services**.[29] Effective integration of child and adolescent mental health services into national education and health sector analyses, budgeting and planning is vital for achieving sustainable and inclusive service delivery. This process should also prioritize community-based mental health services and structures, strengthening cross-sectoral linkages to ensure that children and adolescents can access comprehensive support across multiple platforms. By embedding these services within broader policy frameworks, governments can enhance coordination, maximize resource allocation and promote equitable access to mental health care for all young people. This includes establishing clear referral pathways, integrating mental health into primary health care and enhancing cross-sector collaboration.

A policy framework provides a roadmap for programme development, signals government and stakeholder commitment, establishes mandates for funding mechanisms and clarifies accountability across different sectors for the provision of services.

At the global level, key international frameworks shaping mental health policy include the Convention on the Rights of Persons with Disabilities (CRPD), the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

Other global frameworks like the WHO Comprehensive Mental Health Action Plan 2013–2030 and the inclusion of mental health in the Sustainable Development Goals (SDG 3.4) has prompted governments to consider mental health targets. WHO's Comprehensive Mental Health Action Plan 2013–2030 and its child and adolescent mental health guidelines provide blueprints that many ESAR countries are adapting. For instance, the WHO Mental Health Gap Action Programme (mhGAP) has been rolled out in several countries (including Ethiopia, Uganda and Zambia) to train general health workers in managing common mental disorders in all ages.[30]

Recognizing critical gaps in mental health policy and service provision across Africa, various stakeholders have launched a series of strategic continental or regional initiatives aimed at strengthening systems, policies and services for mental health and psychosocial support, including:

- **The UNICEF-WHO 10-year Joint Programme on the Mental Health and Psychosocial Wellbeing of Children and Adolescents (2020–2030)** supports governments in strengthening child and adolescent mental health policies, workforce development, service provision and evidence generation and research. The joint programme signifies a high-level commitment to coordinate efforts and invest in scaling up MHPSS systems across the globe, including in selected countries in the ESAR region.

- **The Framework to Strengthen the Implementation of the Comprehensive Mental Health Action Plan 2013–2030 in the WHO African Region** was endorsed by African countries in 2022. This framework aims to promote mental wellbeing, prevent mental disorders, improve access to care, support recovery, uphold human rights and reduce mortality, morbidity and disability among individuals with mental health conditions. A key target of the framework is for all African nations to develop or update their mental, neurological and substance use policies or strategic plans by 2030. These policies should be evidence-based and aligned with international and regional human rights instruments.

- **The Africa CDC Non-Communicable Diseases, Injuries Prevention and Control, and Mental Health Promotion Strategy (2022–2026)** provides a set of strategic objectives and priority actions to enhance governments' capacity to develop, integrate and implement national and regional mental health frameworks. It emphasizes the promotion of mental health and wellbeing across all policies and supports member states in combating mental health stigma.

- **The Africa CDC Strategic Plan (2023–2027)** reinforces commitments to mental health, with a primary focus on strengthening integrated health systems to prevent and respond to high-burden diseases, including mental health conditions. This plan advocates for innovative health financing, digitalization and strategic partnerships to enhance health security, resilience and self-reliance. To operationalize these strategic objectives, Africa CDC launched the Africa Mental Health Leadership Programme (AMHLP) in March 2024. This initiative aims to train public health professionals and policymakers to develop and implement context-specific, evidence-based mental health strategies within their respective countries.

- **The African Union (AU)** is also developing comprehensive guidelines to address the mental health and psychosocial support needs of populations in conflict, emergency and post-conflict situations. This effort aligns with ongoing regional priorities to enhance mental health services for vulnerable groups.

- **Regional economic communities and health alliances** are also taking action. The East, Central and Southern Africa Health Community (ECSA-HC) – a body of health ministers – passed a resolution to expand

focus on youth mental health, acknowledging the rising rates of mental health conditions among young people in the region. In late 2024, ECSA-HC in partnership with the Commonwealth initiated a Youth Mental Health Project spanning nine countries (Kenya, Lesotho, Malawi, Mauritius, Eswatini, Tanzania, Uganda, Zambia and Zimbabwe). This project adopts a multi-sectoral approach, integrating mental health promotion into sports, arts and youth engagement activities, with the goal of making services more accessible and youth-friendly.

3.5. Child and adolescent mental health policies and services

Significant disparities in mental health policy coverage exist. A review conducted by Regional Psychosocial Support Initiative (REPSSI) of national and regional MHPSS policies in ESA reveals a diverse policy landscape characterized by considerable variations in comprehensiveness and implementation.[31] The absence of specialized child and adolescent mental health policies is particularly concerning. **Only a handful of countries have frameworks that specifically address the mental health needs of children and adolescents**. This lack of targeted policies leaves significant gaps in service provision, early intervention and crisis response for this vulnerable group.

The 2020 WHO Mental Health Atlas identified substantial gaps in mental health policies, legislation, workforce capacity, research and school-based MHPSS interventions across ESA (see table 1). While 67 per cent of countries (14 out of 21) in the region have established general mental health policies, only 29 per cent (6 out of 21) have policies or plans that specifically address the mental health needs of children and adolescents, either as stand-alone or integrated components. In countries where standalone mental health legislation existed, enforcement and regular updates remained significant challenges, with many policies dating back decades, reflecting outdated approaches that do not align with contemporary best practices in child and adolescent mental health care and support.

Furthermore, **the availability of trained child and adolescent mental health professionals is critically low across most countries, with several failing to report relevant data**. Across the 9 countries reporting data, the average was 0.10 per 100,000 children. Research pertaining to mental health is substantially limited, with only a few countries producing annual publications on the topic.

© UNICEF/UNI819788/Pouget

Table 1

Child and adolescent mental health policy landscape. (Data extracted from WHO Mental Health Atlas, 2017 and 2020)

Country	Stand-alone Mental Health Policy or Plan (Year)	Stand-alone Mental Health Legislation (Year)	Stand-alone or Integrated Child Mental Health Policy or Plan (Year)	Mental Health Workers in CAMH Services per 100,000 Population	Annual published articles on Mental health
Angola	●	●	●	●	●
Botswana	● (2003)	● (1971)	●	0.7	3
Burundi	● (2015)	●	●	●	1
Comoros	●	● (2011)	●	●	●
Eritrea	● (2019)	●	● (2019)	0	4
Eswatini	●	● (1978)	●	●	1
Ethiopia	● (2012)	●	●	●	83
Kenya	● (2015)	● (1991)	● (2015)	●	59
Lesotho	●	● (1964)	●	●	●
Madagascar	● (2005)	●	●	0.02	1
Malawi	● (2012)	● (1948)	●	●	●
Mozambique	● (2007)	● (1991)	●	●	●
Namibia	● (2005)	● (1973)	●	●	4
Rwanda	● (2019)	●	● (2012)	0	13
Somalia	●	●	●	0	8
South Africa	● (2013)	● (2002)	● (2003)	0.11	165
South Sudan	●	●	●	●	●
Tanzania	●	● (2008)	●	0.12	28
Uganda	● (2014)	● (2019)	● (2017)	0.03	70
Zambia	● (2005)	● (2019)	●	0	9
Zimbabwe	● (2004)	● (1999)	●	●	9

● No/None ● Yes ● Not Reported

Governments, as the primary custodians of public mental health and child rights, bear the responsibility of establishing institutional, legal, financial and service frameworks to support the mental health and psychosocial wellbeing of children and adolescents, regardless of their circumstances or geographic location. A robust civil society – particularly youth-led organizations and organizations of people with mental disorders and psychosocial disabilities and their families and caregivers – plays a pivotal role in shaping more effective and accountable policies, laws and services. Their engagement is essential to ensure that mental health policies and legislation are tailored to meet contextual needs and align with international and regional human rights instruments. This includes **the Article 16 of the African Youth Charter, which guarantees every young person's right to enjoy the best attainable state of physical, mental and spiritual health. This article mandates that member states implement measures to ensure access to culturally appropriate mental health services, promote the destigmatization of mental illness and foster environments that encourage young people to seek assistance when required.**

In summary, the urgent need for effective policies and robust service delivery models in child and adolescent mental health is underscored by the complex challenges faced in the region. The significant disparities in policy implementation and coverage highlight the necessity for enhanced data collection and research efforts. This will facilitate a deeper understanding of the unique mental health challenges faced by children and adolescents in the region. The critical role of governments, civil society and stakeholders cannot be overstated, as their collaboration is essential for developing and enforcing comprehensive mental health policies that are culturally appropriate, child friendly and effectively address the needs of vulnerable populations. Moving forward, prioritizing the integration of mental health services within existing health care, education and social welfare frameworks; ensuring adequate resource allocation; and promoting community awareness will be vital steps in fostering an environment where children and adolescents' mental health is promoted and protected.

4. School-Based Mental Health and Psychosocial Support Systems

An effective system of care for child and adolescent mental health consists of a coordinated network of services spanning multiple levels and sectors. This includes mental health services embedded within general health care – such as those provided at primary care centres and general hospitals – as well as community-based services. **Beyond the health sector, mental health support can and should also be delivered in everyday settings where children and adolescents live and grow, including schools, youth centres and other social service platforms.**

Within this integrated system, schools and other learning spaces – traditionally viewed solely as educational settings, hold a critical responsibility in safeguarding the physical and mental health of children and young people. Optimal mental health is not only essential for the overall health and wellbeing but is also a critical determinant of educational outcomes and the quality of the learning experience.

Increasingly, digital technologies are being leveraged to expand the reach and continuity of mental health support across this broader service network. Strong linkages between these components are essential to ensure continuity of care, particularly for children and adolescents with complex or ongoing needs.

Mental health support can and should also be delivered in everyday settings where children and adolescents live and grow, including schools, youth centres and other social service platforms.

4.1. The role of schools in advancing child and adolescent mental health and psychosocial wellbeing

Schools play a pivotal role in shaping the mental health outcomes of children and adolescents. These environments can act as both protective spaces that foster positive mental health and, at times, as risk settings that heighten psychological distress. For instance, evidence from Zimbabwe underscores the protective impact of education on mental health outcomes; a policy intervention that removed significant barriers to education for children found that increased access to education had a protective effect on mental health, particularly for women and rural populations.[32] Additionally, research highlights that school engagement and a strong sense of belonging within the learning environment are linked to lower levels of anxiety, depression and suicidal ideation among learners.[33]

However, despite its protective potential, the school environment can also expose students to preventable risks.

Schools can act as both protective spaces that foster positive mental health and, at times, as risk settings that heighten psychological distress.

Peer-to-peer violence, corporal punishment, social exclusion and academic performance-related stress are all factors that can contribute to or exacerbate mental health challenges. Addressing these risks requires a deliberate focus on creating safe, nurturing and inclusive learning environments that are responsive to the mental health and psychosocial needs of both learners and educators.

Schools are uniquely positioned to promote mental health, prevent mental health problems and ensure early intervention when mental health challenges arise. This is particularly crucial in underserved communities, where schools often serve as the main point of access to mental health support.[34] Positioned at the intersection of home and community-based services, schools have the potential to bridge these environments and provide essential services and support.[35]

MHPSS interventions in schools contribute to fostering positive mental health, enhancing empathy, social skills, communication and coping skills, while also reducing the prevalence of mental health conditions such as anxiety and depression. Moreover, schools can help mitigate risk behaviours, including peer-to-peer violence, while improving the social and emotional competencies of learners and educators. When teachers are equipped with strong emotional and social skills, the quality of teacher-student relationships improves, creating a more supportive and nurturing learning environment. Evidence increasingly supports the effectiveness of a whole-school approach to address learners' mental health conditions and mitigate violence among learners.[36] This approach must be comprehensive, addressing multiple dimensions of wellbeing, including physical, social, mental, emotional and environmental factors.[37]

Schools are uniquely positioned to promote mental health, prevent mental health problems and ensure early intervention when mental health challenges arise.

The organization of MHPSS interventions in schools varies between and within countries and is shaped by the structure and governance of health and education systems. The scope of MHPSS interventions ranges from universal programmes aimed at fostering the mental wellbeing of all learners to targeted interventions for those at risk and specialized care for those experiencing significant mental health challenges. Specifically, MHPSS interventions can be grouped into these categories:

- **Universal strategies for mental health promotion** within schools include embedding mental health literacy into school curricula to normalize conversations around mental health, reduce stigma and encourage help-seeking behaviour. Social and emotional learning (SEL) programmes and other resilience-building initiatives are implemented to equip both learners and teachers with coping skills and strategies for emotional regulation. In addition, peer support mechanisms can be reinforced by expanding student-led counselling groups, mentorship initiatives and peer-to-peer support structures that promote a sense of belonging and wellbeing within the school community.

- **Targeted mental health interventions** offer timely support to learners who may be experiencing life challenges or are at risk of developing mental health issues. These interventions facilitate the management of distress and address emerging mental health concerns before they escalate into more severe conditions. Such interventions are particularly beneficial for learners facing significant stressors, such as parental divorce or the loss of a loved one. While these experiences may not necessitate a clinical diagnosis or specialized care, structured support can significantly enhance learners´ capacity to process their emotions and gradually adapt to life changes.

- **Specialized services**, including crisis intervention and formalized referral systems that link schools with primary health care facilities and community-based MHPSS services. Strengthening coordination mechanisms will facilitate timely access to specialized care for children and adolescents experiencing mental health challenges. The use of digital mental health platforms presents further opportunities to improve access, particularly for learners in remote or underserved areas.

For these interventions to be effective, they must be age-appropriate and culturally sensitive, addressing different developmental stages and integrating considerations of gender and socio-cultural factors. Furthermore, effective schools-based MHPSS must also coordinate with broader mental health systems to ensure comprehensive, integrated care. This requires strong partnerships between school staff, caregivers, community members and primary health care providers, who should be trained and supported to integrate basic mental health care with school health services and within primary health care systems.

4.2 School-based Mental Health Policies in Eastern and Southern Africa

Recognizing the crucial role of education in protecting and promoting learners´ mental health, several countries in ESA have integrated mental health into their education policies. However, while school-based mental health initiatives are present in some contexts, their integration remains inconsistent.[38]

© UNICEF/UNI775276/Anthony

Below are some key examples:

South Africa's National Mental Health Policy Framework (2023–2030) emphasizes the **integration of mental health promotion and prevention initiatives within the educational sector**. A key focus of the policy is to strengthen district mental health systems to enhance the early detection and management of child and adolescent mental health disorders in schools, ensuring that effective referral mechanisms are in place. Furthermore, the policy supports the implementation of national strategies, such as the Integrated School Health Policy. It promotes initiatives aimed at enhancing school connectedness during middle childhood, embedding life skills programmes in schools. It also advocates for the embedding of life skills programmes within schools and for measures to prevent suicide and substance abuse in secondary educational institutions. Overall, the framework highlights the **pivotal role of school systems** in facilitating mental health promotion, prevention, early identification and the management of mental health conditions among children and adolescents. It aligns with the School Health Policy and broader national health and education strategies, reinforcing an integrated approach to mental wellbeing within educational environments.

In Kenya, the National Mental Health Policy adopts a 'Mental Health in All Sectors' approach, acknowledging that improving **mental health requires a multi-sectoral effort that extends beyond health care interventions**. Education is identified as a key sector in this framework, with a strong emphasis on integrating mental health promotion within schools. The policy prioritizes life skills education for learners, teacher training in mental health awareness and suicide prevention programmes within schools. Despite the development of this robust policy framework, significant challenges remain in its implementation. Key informants in Kenya have identified issues such as inadequate funding, insufficient workforce capacity, weak coordination between the education and health sectors and the absence of clear referral mechanisms for learners requiring further support. Moreover, there are no clear clinical frameworks for the early identification of mental health problems among children and adolescents, nor established treatment protocols, including inpatient admission procedures. Insufficient data collection within the Kenya Health Management Information System (KHMIS) further limits effective monitoring, due to inadequate tools and indicators. Compounding these challenges, mental health remains heavily stigmatized, resulting in many children with mental health issues being hidden and not receiving timely treatment.

Uganda's Child and Adolescent Mental Health Policy Guidelines (2017) outline a strategy for the establishment of mental, neurological and substance use services within schools. The policy delineates the roles and responsibilities of various sectors, assigning a clear mandate to the Ministry of Education "to **integrate child mental health and MNS disorders into school health programmes and curricula**". Concurrently, the Ministry of Health is tasked with developing a comprehensive monitoring and evaluation system to assess the effectiveness of these services within schools and other institutions. Furthermore, the policy underscores the significance of fostering robust linkages among teachers, peers, parents, health workers and communities to promote mental wellbeing.

Zimbabwe's School Mental Health Policy seeks to establish a comprehensive school health programme that spans from early childhood through secondary education, ensuring that young people develop lifelong positive health behaviours. Aligned with the Curriculum Framework (2015–2022), the policy mainstreams health education across all education levels, incorporating skills-based health education, psychosocial support, a safe learning environment, disaster risk management, school-based health and nutrition services and support for children with special needs. **Schools are expected to strengthen guidance and counselling services to equip learners with essential life skills and provide psychosocial support**. Additionally, referral mechanisms through the school's psychological services will be regularly reviewed to enhance efficiency and service delivery. Nevertheless, stakeholders in Zimbabwe have noted that implementation of the policy is hampered by inadequate training for educators, a shortage of school-based mental health personnel and inconsistent referral pathways for learners in need of specialized care.

The policy examples from South Africa, Kenya, Uganda and Zimbabwe reveal shared recognition of the critical role that schools play in promoting mental health and preventing and responding to students' mental health. All four countries have integrated mental health promotion and life skills education into their school systems and have articulated the importance of intersectoral collaboration. However, differences in implementation capacity and resource allocation remain stark. Across countries, common barriers include limited funding, stigma, weak referral mechanisms and insufficient data systems. These examples underscore the need for continued investment in school-based MHPSS, improved multisectoral governance and contextually tailored implementation strategies that prioritize students' and educators' mental health.

Case example: Mental health policy in South Africa

South Africa stands as one of the few countries in sub-Saharan Africa with a clearly articulated policy on CAMH. The National Mental Health Policy Framework and Strategic Plan (2023–2030), along with a dedicated CAMH policy, marks a significant step forward in embedding mental health within national development priorities.

The country's commitment to CAMH policy dates back to 1977 with the establishment of the Potgieter Commission. This commission recognized the importance of intersectoral collaboration, early identification of CAMH disorders at the PHC level and in schools and recommended strengthening the capacity of health and education personnel to provide appropriate support. These early recommendations laid the foundation for South Africa's approach to mental health policy, which has evolved into a structured, multi-tiered system of governance and service provision.

At the national level, mental health policy and legislation are developed by the Minister of Health in consultation with key stakeholders. Once established, the nine provincial Departments of Health are responsible for developing implementation plans with clear targets, indicators, budgets and timelines. They also oversee the monitoring and evaluation of policy execution, ensuring that interventions align with national priorities. At the district level, Provincial Departments of Health are responsible for implementing interventions at the community level, adapting them to local needs while maintaining alignment with national and provincial strategies.

Within the CAMH, the education sector plays a key role in identifying, supporting, and accommodating children and adolescents with mental health conditions and learning difficulties. The policy highlights the integration of mental health literacy into school curricula, particularly through life skills education, and promotes mental health awareness and promotion programmes within schools. Schools are also expected to provide support services for learners experiencing mental health difficulties, with a specific focus on inclusive education.

To ensure this occurs, the policy emphasizes the importance of training teachers and school-based support teams, equipping them with the skills needed to recognize and respond to learners' mental health needs. In addition, the policy calls for the introduction of suicide prevention and substance abuse prevention programmes within secondary schools.

While significant progress has been made at the national level, challenges at the provincial level have persisted. A 2014 study conducted before the adoption of the new National Mental Health Policy Framework and Strategic Plan (2023–2030) identified several key barriers to policy implementation. These included limited staff capacity, staff shortages, inadequate financial resources and the high burden of mental disorders, particularly among children and adolescents.[39]

UNICEF South Africa has been instrumental in enhancing the mental health and wellbeing of children, adolescents, and their caregivers through comprehensive strategies encompassing policy support, innovative service delivery and community engagement. The organization has advocated for policies that address the unique needs of young populations and supported the development and implementation of national mental health policies, particularly by integrating mental health services within PHC and educational systems.

UNICEF has contributed to the design of innovative service models, such as a peer mentor programme for adolescent girls – including young mothers and those living with HIV – which embeds a mental health component and is under development for national adoption. In addition, UNICEF is also supporting the development of a new tele-support platform to increase access to psychosocial services for learners and teachers, with particular attention to underserved areas and teacher wellbeing. UNICEF also supports behaviour change and community engagement initiatives that challenge harmful norms and promote mental health as a shared responsibility. Through parenting programmes and school-based interventions, UNICEF is fostering environments that are more supportive of children's mental health. Through campaigns like 'On My Mind,' UNICEF works to destigmatize mental health issues and promote open conversations among children, adolescents and caregivers. This initiative focuses on seeking help, shifting narratives, enhancing understanding and encouraging dialogue about mental health.

4.3 The Implementation of school-based MHPSS in ESA

Efforts to integrate MHPSS into schools across ESA are gaining momentum. Countries including Kenya, South Africa, Rwanda, Zimbabwe and Mozambique have made significant advancements by integrating social-emotional learning, peer support initiatives and psychosocial training into their educational frameworks. However, systemic and structural challenges affecting the broader mental health system – such as workforce shortages, fragmented coordination and underfunded services – also constrain the scale and effectiveness of school-based MHPSS. Key challenges identified by stakeholders in relation to the implementation of school-based MHPSS programmes include the presence of systemic barriers – such as high student-to-teacher ratios and ineffective and often informal referral pathways with no accountability. Furthermore, the absence of monitoring and evaluation mechanisms for mental health programmes results in the implementation of interventions devoid of clear indicators of effectiveness.

Promoting schools as strategic entry points for delivering MHPSS is a cornerstone of UNICEF's approach. Schools serve as key platforms for integrated, cross-sectoral MHPSS services reaching children, adolescents and their caregivers. Since 2022, UNICEF has systematically monitored the engagement and comprehensiveness of MHPSS interventions within the education sector, focusing on four key areas: policy development, curriculum integration, teacher training, community engagement and service delivery in emergencies. Regional monitoring data consistently indicate positive progress in the integration of MHPSS into school environments.

Between 2022 and 2024, the implementation of MHPSS programming in the education sector across reporting countries showed steady progress. Twelve countries reported MHPSS programming in schools (see map), with this prevalence remaining relatively stable from 2022 (11 countries reporting) and 2023 (13 countries reporting). Despite this consistency, the scope, scale and target populations of MHPSS programming and advocacy varied significantly across different contexts.

MHPSS in education programming: Mozambique, Burundi, Malawi, Namibia, Zimbabwe, Kenya, Somalia, Swaziland, Uganda, Angola, South Sudan, Madagascar

Notably, the reach of MHPSS interventions at the policy level saw considerable improvement during this period.[40] The proportion of countries achieving this benchmark increased from 36 per cent in 2022 to 42 per cent in 2024 (See table 2 below.)

Table 2: Countries Achieving Benchmark Scores in MHPSS Programming (2022-2024)

2022	2023	2024
Out of 11 countries reporting programming in this area, 36% achieved a score of 2.5 or higher	Out of 13 countries reporting programming in this area, 46% achieved a score of 2.5 or higher	Out of 12 countries reporting programming in this area, 42% achieved a score of 2.5 or higher

This upward trend reflects strengthened capacity and growing commitment to embedding MHPSS within education systems, particularly across three foundational areas: (1) development of strategies, plans and policies that address the mental health and psychosocial needs of children, adolescents and teachers; (2) integration of mental health and wellbeing into national curricula; and (3) community engagement to foster inclusive, supportive learning environments.

© UNICEF/UNI773036/Ngcobo

However, most countries continue to cluster around moderate scores (2.0–3.0), indicating that the integration of MHPSS in education systems remains incomplete and uneven. Significant gaps persist, particularly in ensuring that policies and programmes are comprehensive, adequately resourced and systematically implemented to address the mental health needs of learners and teachers. (See table below)

Table 3: Extent to which education strategies and plans address the mental health and psychosocial needs of children, adolescents and teachers by country (2023-2024)

Country/ reporting year	2023	2024
Mozambique	3,5	3,5
Burundiw	3	3
Malawi	3	2,5
Namibia	3	3,5
Zimbabwe	3	3
Kenya	2,5	2,5
Somalia	2,5	2,5
Swaziland	2,5	2,5
Uganda	2,5	2,5
Angola	2	2
South Sudan	2	2
Ethiopia	1,5	-
Madagascar	1,5	1,5

Extent to which education strategies, policies and plans address the mental health and psychosocial support (MHPSS) needs of children, adolescents and teachers in schools and learning environments [Score 1=Weak; 2= Initiating, 3= Established; 4=Championing]

Table 4: Mainstreaming of child and adolescent health, mental health and wellbeing within national education curricula and training systems, by country (2023-2024)

Country/reporting year	2023	2024
Namibia	3,5	3,5
Zimbabwe	3,5	3,5
Mozambique	3	3,5
Malawi	2,5	2
Swaziland	2,5	2
Burundi	2	2
Ethiopia	2	NR
Kenya	2	2
South Sudan	2	2
Madagascar	1,5	1,5
Somalia	1,5	1,5
Uganda	1,5	1,5
Angola	1	1

Extent to which health, mental health and wellbeing of children and adolescents are mainstreamed in national education curricula and training systems. [Score 1=Weak; 2= Initiating, 3= Established; 4=Championing]

Table 5: Extent to which communities are engaged to improve school/learning environments and promote MHPSS of children and adolescents

Country/reporting year	2023	2024
Malawi	3	3
Namibia	3	3,5
Burundi	2,5	
Mozambique	2,5	2,5
Swaziland	2,5	2
Zimbabwe	2,5	2,5
Ethiopia	2	NR
Kenya	2	2
Somalia	2	2
Angola	1,5	1,5
Madagascar	1,5	1,5
South Sudan	1	1,5
Uganda	1	1

Extent to which communities are engaged to improve school/learning environments and promote MHPSS of children and adolescents. [Score 1=Weak; 2= Initiating, 3= Established; 4=Championing]

Additionally, the integration of MHPSS within teacher development opportunities has progressed more gradually and unevenly compared to other areas of MHPSS programming. Out of the 13 countries reporting in this area, 29 per cent achieved a benchmark score in 2022, increasing modestly to 33 per cent in 2023, followed by a slight decline to 31 per cent in 2024. The number of countries actively reporting in this area fluctuated, with 14 countries participating in 2022 and 13 in 2024. (see table 6)

Table 6: Trends in country performance on integration of MHPSS within teacher training and development opportunities (2022-2024)

Country/reporting year	2023	2024
Burundi	3	3
Namibia	3	3
Uganda	3	2,5
Somalia	2,5	2,5
Malawi	2	2
South Sudan	2	2
Swaziland	2	2
Angola	1,5	1,5
Madagascar	1,5	1,5
Comoros	1	
Eritrea	1	1
Zambia	1	1
Rwanda	NR	2
Mozambique	NR	1
Degree to which MHPSS has been integrated in teacher professional development opportunities. [Score 1=Weak; 2= Initiating, 3= Established; 4=Championing]		

These figures underscore the need for stronger investments and clearer guidance in embedding MHPSS within teacher training systems to ensure educators are adequately supported in their own mental wellbeing and enhance their knowledge and skills in child and adolescent mental health, equipping them with foundational helping skills that enable them to effectively promote and protect learners' mental health in the classroom. Encouragingly, some countries have made notable progress, for instance Burundi and Namibia reported significant advances in teacher professional development opportunities on MHPSS, tailored to their specific contexts. These initiatives reached a sizeable (20–30 per cent) proportion of the teacher population as part of UNICEF's broader efforts to strengthen teacher development systems.

However, at the service delivery level, progress in integrating MHPSS within school settings remains limited. Most countries report that mental health services in schools are either lacking or insufficiently developed. Despite these challenges, UNICEF's support for MHPSS service delivery programmes across child protection and education sectors in the ESA region reached 3,106,313 children and adolescents in 2024, with a gender distribution of 53 per cent female and 47 per cent male.

© UNICEF/UNI769722/Mkhize

Five essential pillars for promoting and protecting mental health and psychosocial well-being in schools and learning environments

A BRIEFING NOTE FOR NATIONAL GOVERNMENTS

UNITED NATIONS TRANSFORMING EDUCATION SUMMIT 2022

This briefing is intended for policymakers, national governments, mental health and education coalitions and advocates. It outlines key policy recommendations to strengthen education systems to protect and promote the mental health and psychosocial well-being of children and adolescents, including support for their teachers and caregivers

Mental health is an integral component of health and well-being and influences academic, social and economic outcomes across the lifespan. Having good mental health means being better able to interact with others, function, cope and thrive. It is a basic human right.[1] Mental health exists on a complex continuum, with experiences ranging from an optimal state of well-being to experiencing severe mental health conditions with related suffering and often an important impact on the capacity to carry out daily activities.

The first two decades of life is a critical period for the development of foundational competencies that can shape a learner's mental health trajectories. At this particular stage of rapid development and learning, children and adolescents are highly susceptible to environmental influences. Experiences and environments can harm mental health. Or they can be shaped to promote and protect it.[1]

A global call to invest and act to promote and protect the mental health of children and adolescents in schools and other learning environments.

At the Transforming Education Summit (TES) 2022, UNICEF, the United Nations Educational, Scientific and Cultural Organization (UNESCO) and WHO collaboratively issued a policy brief urging governments globally to take urgent action to strengthen education systems to protect and promote the mental health and psychosocial wellbeing of children and adolescents. The policy brief emphasized the vital role of education in nurturing mental health, resilience and overall wellbeing. It advocated for increased investment and requisite policy reforms to ensure that every child learns in an environment that prioritizes wellbeing and mental health, applicable in both humanitarian and development contexts. The policy brief delineated five essential pillars that all governments are encouraged to implement to provide comprehensive MHPSS for learners, educators and caregivers. These priority actions encompass the following:

- **Establishing an enabling learning environment that fosters positive mental health and wellbeing** by incorporating mental health literacy and social-emotional learning within curricula, as well as designing and implementing school-based mental health policies that are responsive to student needs.
- **Ensuring children and adolescents have access to early intervention and mental health services** by equipping schools with trained personnel, such as school counsellors, social workers and supervised teachers, who can be tasked with delivering psychosocial support and creating clear referral pathways that connect schools to health and social welfare services.
- **Promoting teachers' wellbeing** by providing educators with access to mental health and psychosocial support.

- **Enhancing the knowledge and skills pertaining to mental health and psychosocial support within the education workforce** and reinforcing collaboration among educators, school psychologists, social workers and community health providers.
- **Fostering meaningful collaboration between schools, families and communities** to create a safe and nurturing learning environment that promotes mental health awareness, reduces stigma and fosters strong support systems.

This is a call to action for urgent global action and investment to ensure that every child enjoys their right to education in a learning environment that promotes their wellbeing and good mental health.

4.4. Integrating MHPSS within Education in Emergencies

The Impact of Emergencies on Children's Mental Health and Education

Unprecedented climate-induced shocks, recurrent public health emergencies, armed conflict and large-scale displacements compounded by significant macroeconomic challenges threaten the lives of 51 million children in ESA. Many of these children are confronted with multiple crises simultaneously, resulting in repeated and prolonged displacement.

Currently, nearly 12 million people are internally displaced within the region, **while 4.6 million people have sought refuge, reflecting a 14 per cent increase since 2023**, largely due to escalating conflicts in neighbouring Sudan and the Democratic Republic of the Congo. In crisis-affected areas, schools, often serving as protective spaces, are destroyed or rendered non-functional, leaving children without access to education, stability and psychosocial support. Between 2015 and 2024, over 2,500 attacks on schools were verified across Africa, accounting for 38 per cent of such incidents globally. Within ESA, Somalia was among the countries most affected by these incidents. Furthermore, public health emergencies have disproportionately affected women and children, with numerous countries experiencing outbreaks of cholera, measles, mpox and Marburg virus disease.41 Educational outcomes are similarly dire, **with nearly 47 million children in the region out of school**.

In stable environments, family, school and community networks play a vital role in supporting children's mental health and emotional resilience. However, emergencies often erode these protective supports. Family separations due to displacement, loss of caregivers and loved ones, and economic hardship reduce children's access to emotional support. Additionally, disruptions in social structures also lead to changes in traditional caregiving roles, with children frequently assuming responsibilities beyond their capacity, including caring for younger siblings, contributing to household income, or engaging in harmful survival strategies such as child labour.

Climate-induced shocks, recurrent public health emergencies, armed conflict and large-scale displacement challenges threaten the lives of

51 million children

in ESA.

© UNICEF/UNI640023/Pouget

Heightened Risks to Mental Health and Wellbeing

Children and adolescents living through crises face heightened risks to their mental health and psychosocial wellbeing. The intersection of violence, displacement, family separation, food insecurity and loss of livelihoods creates a profoundly stressful environment for children and their caregivers. The sudden, cumulative and often prolonged nature of such stressors creates a destabilizing context, increasing children´s vulnerability to psychosocial distress and the development of mental health problems. Global estimates suggest that approximately 22 per cent of children and adolescents affected by emergencies are likely to develop mental health conditions such as adjustment disorders, depression and anxiety. For forcibly displaced adolescents, the risk of depression increases with the duration of displacement, especially when protective structures are weak or absent.[42]

One of the consequences of emergencies is the disruption of education. The closures of schools, attacks on schools and breakdown of support systems disrupt learning, peer connection, access to safe learning environments and essential services provided in schools. The connection between mental health and educational attainment is bidirectional and mutually reinforcing. Poor mental health can reduce a child's ability to focus, engage and retain information in school – while lack of access to education can worsen mental health outcomes, reinforcing cycles of distress and disempowerment. It´s important to stress that the effects of adverse life experiences can be exacerbated if interactions with peers and adults in the schools are perceived as negative.

Global estimates suggest that approximately 22% of children and adolescents affected by emergencies are likely to develop mental health conditions such as adjustment disorders, depression and anxiety.

Adolescents who feel disconnected from their peers, such as being a victim of peer-to-peer violence in schools, are more likely to experience depression and anxiety.[43]

While many children experience psychological distress following crises, a significant proportion can recover over time, particularly when they have access to essential services, stability is restored and they are supported by nurturing environments both at home and in school. However, for others, the impact is more enduring.

Despite the many challenges, children and adolescents affected by crises demonstrate remarkable resilience when provided with appropriate support. Caregiver support, access to mental health and psychosocial support, and strong community engagement play a critical role in their recovery. In emergency contexts, mental health and psychosocial support serves not only to fulfil the right to learning but is also a vital pathway to recovery, helping to restore a sense of structure, belonging and hope for the future for affected children.[44]

Mental Health and Psychosocial Support programmes, aiming to protect, promote, prevent and/or treat mental health conditions are considered a key priority by international actors in humanitarian emergencies. The Interagency Standing Committee Reference (IASC) Group on Mental Health and Psychosocial Support in Emergency Settings provides comprehensive guidance on integrating MHPSS interventions. These range from incorporating social and psychological considerations in the delivery of basic services, to mental health promotion and prevention and clinical treatment for those affected by mental disorders.[45] More recently, the IASC has introduced the Mental Health and Psychosocial Support Minimum Service Package (MHPSS-MSP) to improve coordination and prioritize essential MHPSS interventions in emergency settings. This package outlines high-priority MHPSS activities to be implemented across various sectors, including education.

It serves as a framework to guide stakeholders in addressing existing gaps and advancing MHPSS efforts in these challenging contexts.

Every school system contains children and adolescents affected by adversity, including neglect, abuse, abandonment, the death of caregivers, exposure to violence, peer-to-peer violence and discrimination; and the impacts of conflict, displacement and natural disasters. Without timely support, these experiences of adversity can have a cumulative and lasting effect on their physical and mental health, as well as on their learning and development.[46]

The Role of Education in children and adolescent's recovery

Evidence consistently underscores the protective role of safe and inclusive education systems in humanitarian contexts. Schools provide routine, structure and predictability – critical stabilizing factors for children coping with distress. Systematic reviews highlight that education in emergencies contributes positively to children's psychosocial wellbeing and recovery, functioning as a protective environment that mitigates stress, fosters resilience and restores a sense of normalcy.[47]

Social and emotional learning has emerged as a critical component of education mental health support in crisis-affected settings. These programmes support children in developing a set of skills such as self-awareness, stress management, emotional regulation, empathy and conflict resolution. Studies have demonstrated that these programmes not only strengthen children's mental wellbeing but also contribute to peacebuilding and social cohesion in post-conflict societies.[48]

Integrating MHPSS into programmes that aim to strength the resilience of education systems has the potential to improve learning outcomes, reduce the risk of mental health disorders, and strengthen broader community resilience.[49] The integration of MHPSS into regular education programmes can enhance the capacity of the education system. Given the many barriers that can impact the mental health of children, adolescents, teachers and parents/caregivers in humanitarian settings, schools must be supported to address both the short-term mental health challenges that arise immediately following a crisis, as well as the long-term mental health conditions that may develop over time. However, there remains a need for further research and evidence to inform how best to operationalize MHPSS within education in emergencies programming.[50]

Preparing education systems and settings to respond to crises relies heavily on building the capacity of the school community to integrate MHPSS as a core element of school-based risk reduction, resilience education and emergency preparedness. The Comprehensive School Safety Framework (CSSF) 2022-2030 highlights the importance of integrating MHPSS into education systems as a means of strengthening resilience, ensuring school safety and supporting children's mental health and wellbeing. The framework calls for strengthening capacities of teachers and other education personnel to deliver risk reduction and resilience education content and respond to the mental health and psychosocial needs of children through pre-service and in-service training and strengthen support services and identification and referral mechanisms for teachers and children experiencing mental health problems.

Social and emotional learning has emerged as a critical component of education mental health support in crisis-affected settings supporting children in developing a set of skills such as self-awareness, stress management, emotional regulation, empathy and conflict resolution.

The RAPID Approach: Bridging Recovery and Long-Term System Strengthening

In response to the education crisis caused by COVID-19 school closures, UNICEF and its partners developed the RAPID framework – an evidence-based, five-pillar approach to accelerate learning recovery while laying the foundation for long-term education system resilience. A key element of the framework is the intentional integration of mental health and psychosocial support, ensuring that learners' emotional wellbeing is prioritized alongside academic catch-up as children returned to school.

The RAPID framework consists of five actions: (1) Reach every child and keep them in school; (2) Assess learning levels regularly; (3) Prioritize teaching the fundamentals; (4) Increase the efficiency of instruction; and (5) Develop psychosocial health and wellbeing. The fifth pillar has played a critical role in embedding MHPSS as a core, cross-cutting priority within education systems – informing policy, planning and teacher professional development. Initially conceived as an emergency response tool, RAPID has since evolved into a strategic mechanism for Ministries of Education to integrate MHPSS within broader sector reforms.

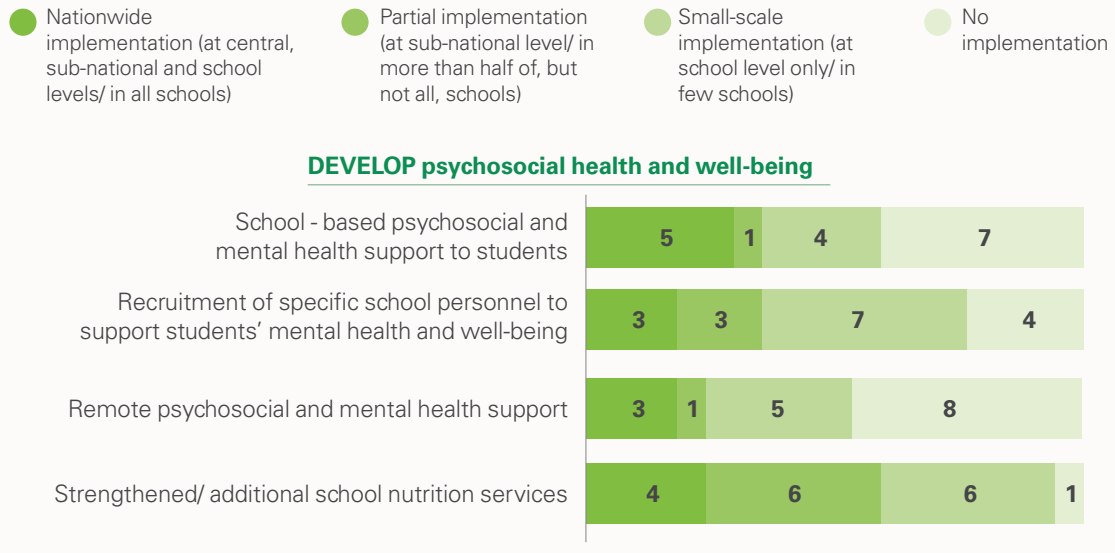
Data from the 2024 Foundational Learning Action Tracker, UNICEF's monitoring system for RAPID, highlights uneven progress across countries in ESA in implementing the fifth pillar: "Develop psychosocial health and wellbeing". While many countries have made strides in strengthening school nutrition services, the scale up of school-based mental health support remains limited. Nearly half of the countries reporting have yet to initiate such services.

The recruitment of dedicated school personnel for MHPSS, such as counsellors and social workers, is ongoing in some countries but remains insufficient. Remote psychosocial support is the least developed area.

These data trends indicate that while awareness of MHPSS has grown, institutionalization within national education systems is still in early stages. Progress is often fragmented and dependent on external funding or pilot initiatives, rather than being embedded in long-term sector plans or budget frameworks.

RAPID Survey (June-August 2024) regional results

Note: A total of 17 countires in the region responded to the survey in 2024: Angola, Burundi, Comoros, Eritra, Ethiopia, Kenya, Madagascar, Malawi, Mozambique, Namibia, Rwanda, Somalia, South Africa, South Sudan, Uganda, Zambia and Zimbabwe.



However, several promising developments across the region illustrate how countries are beginning to transition from short-term emergency responses to institutionalized approaches. For example, Ethiopia has incorporated MHPSS into its Teacher Education Curriculum Framework, building long-term professional capacity. In Burundi, schools have introduced designated "school aunts or fathers": trusted adults available to listen to learners' concerns. Uganda is advancing national guidance and counselling guidelines through its school family initiative, aiming to embed psychosocial support within its education system.

UNICEF is supporting these shifts by working closely with Ministries of Education to embed MHPSS into sector planning, teacher wellbeing strategies and cross-sector coordination mechanisms. The RAPID framework, though originally designed for COVID-19 recovery, is increasingly being used as a strategic tool for institutional reform, positioning MHPSS as a core enabler of inclusive, equitable and resilient education systems.

Case example: Advancing MHPSS in Fragile Contexts – Lessons from South Sudan

South Sudan continues to face a deeply complex mental health landscape, shaped by decades of political instability, armed conflict, economic hardship and recurring environmental crises. Prolonged displacement due to conflict, coupled with ongoing insecurity and widespread flooding, has severely affected the wellbeing of children, adolescents and their caregivers. Today, nearly 9 million people – over two-thirds of the population – are estimated to be in need of humanitarian assistance.

Mental health challenges among children and adolescents are prevalent. Yet, the national capacity to assess and respond to these needs remains extremely limited. Reliable and comprehensive data is scarce; the most recent household survey dates back to 2010, and current information is largely drawn from small-scale assessments conducted by humanitarian actors. This absence of national-level data continues to impede evidence-based planning and policy development.

Despite ongoing challenges, South Sudan is making meaningful progress in integrating MHPSS within the education sector. Notably, the Ministry of General Education and Instruction has incorporated MHPSS into the General Education Sector Plan (2023–2027), signalling a growing commitment to addressing the mental health and psychosocial wellbeing of both learners and teachers. This marks a significant shift from short-term, reactive interventions to a more structured and sustainable approach embedded within national education systems.

UNICEF has played a catalytic role in advocating for the integration of MHPSS in education and continues to support a range of initiatives aimed at strengthening this agenda. These include working with the Ministry of Education to expand MHPSS training for teachers, supporting the inclusion of social and emotional learning (SEL) programmes in schools, and promoting peer-to-peer support initiatives. UNICEF is also engaged in efforts to improve referral mechanisms, ensuring that schools are better equipped to respond to the diverse mental health needs of children and adolescents, both within the school environment and through connections to external services.

4.5 Linkages between schools and primary health care and other sectors for MHPSS

Strengthening the linkages between schools and PHC systems is essential to ensuring comprehensive and continuous mental health and psychosocial support for children and adolescents. Schools are often the first point of contact for young people experiencing distress, making them critical platforms for early identification and initial support. However, in the absence of robust referral pathways and intersectoral collaboration, the continuum of care is fragmented, limiting the reach and effectiveness of mental health responses.

An integrated, multisectoral service delivery model – anchored in collaboration between education, health and social protection systems – is essential to bridging these gaps. **Across the ESA region, efforts to strengthen such linkages have been uneven**. Some countries, such as South Africa, Uganda and Kenya, have articulated clear roles for both sectors within national mental health policies, yet implementation challenges persist due to limited workforce capacity, undefined referral protocols and lack of intersectoral coordination. For instance, in several countries, teachers are expected to identify and support students with mental health needs but are not provided with clear mechanisms to refer them to professional services within the health system, or the health system itself cannot respond due to the scarcity of child and adolescent mental health specialists.

UNICEF's programming on MHPSS in the ESA region is guided by a comprehensive, multisectoral and rights-based approach aimed at promoting the mental health and psychosocial wellbeing of children, adolescents, caregivers and frontline service providers.[51] This programming addresses a complex landscape of challenges across the region, including poverty, conflict, displacement, food insecurity, gender inequalities, high HIV prevalence and recurrent natural disasters. These vulnerabilities, compounded by systemic gaps in mental health services and persistent stigma, underscore the urgency of investing in this area of work.

© UNICEF/UNI354457/Kanobana

At the regional level, UNICEF has elevated MHPSS as a strategic priority across both humanitarian and development contexts. The 2023–2025 Regional MHPSS Programme Note and Workplan outlined six priority areas that support COs and partners in scaling up quality, integrated and cross-sectoral MHPSS programming. These priorities include: (1) data and evidence generation; (2) advocacy and strategic partnerships; (3) addressing social determinants of mental health; (4) adolescent engagement; (5) promoting schools as integrated platforms for MHPSS; and (6) workforce capacity development. Each of these areas is designed to bolster policy implementation, enhance service delivery and strengthen community resilience. Underpinning these priorities are key principles of community-based approaches, gender and disability mainstreaming, innovation and meaningful engagement of young people and caregivers.

Currently, UNICEF´s MHPSS programming is operational in 20 of the 21 countries in the region. Thirteen countries have established school health programmes targeting learners aged 6–19 years, offering an integrated package of interventions aimed at promoting the wellbeing and healthy development of learners. These school health programmes include interventions that address multiple health and wellbeing needs, such as the prevention of substance use, mental health promotion and care, nutrition through school meals, sexual and reproductive health and rights (SRHR), physical activity, hygiene and sanitation, immunisation, and vision, hearing and oral health screening. These services are strategically embedded within the school environment to ensure accessibility and continuity of care for students. Mental health promotion and care are included as part of school health programmes in Angola, Botswana, Ethiopia, Kenya, Lesotho, Mozambique, Namibia and Rwanda.

While schools offer a highly effective platform for health and nutrition service delivery, many of the most vulnerable children and adolescents remain out of school. It is therefore imperative to explore other complementary platforms – including community centres, mobile clinics and community-based services to ensure that essential MHPSS interventions reach all children, particularly those who are out of school.

The Bete approach, meaning "My Home" in Amharic, exemplifies effective cross-sectoral collaboration between education and child protection to support children in humanitarian settings in Ethiopia. This integrated initiative provides a safe and inclusive space for out-of-school children – particularly if they are internally displaced persons (IDPs), refugees, or in host communities – aged 6 to 18 years. By combining accelerated learning, foundational literacy and numeracy, and skills development with child protection services, Bete addresses both learning, MHPSS and protection needs. Children at risk of or experiencing violence, exploitation, neglect and harmful practices are supported through access to social welfare services, case management, referrals and mental health and psychosocial support. Bete demonstrates how leveraging resources and aligning objectives across sectors can deliver holistic, child-centred responses that strengthen both learning and mental health outcomes.

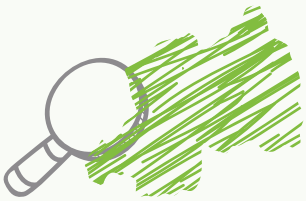
UNICEF has supported multisectoral approaches to address child and adolescent mental health. For instance, in the health sector, **11 countries report collaboration with governments to integrate mental health services within PHC**. Eight of these countries are delivering child and adolescent mental health services with UNICEF support, while in three countries, such services are planned and budgeted without direct UNICEF involvement.

11 countries report collaboration with governments to integrate mental health services within PHC.

Additional efforts include community and digital platforms to expand access, with nine countries delivering MHPSS interventions through digital platforms and eight implementing community-based initiatives via youth platforms, sports, music and cultural activities.

Furthermore, UNICEF has supported multisectoral initiatives addressing caregiver mental health, recognizing the interdependence between the wellbeing of children and that of their caregivers. Ten countries reported implementation of multisectoral approaches in this area through health platforms. UNICEF's support has included advocacy to integrate caregiver mental health in sectoral policies and strategies, capacity development of frontline workers delivering the Caring for Caregivers package or similar interventions in eight countries, expansion of access to services, awareness-raising initiatives at the community and national levels, and investments in data monitoring and research.

Case example: UNICEF Rwanda: Strengthening the Integration of MHPSS Across Sectors and Standalone Initiatives



Rwanda has made significant strides in strengthening its mental health and psychosocial support systems with a solid policy framework and a government commitment to improving child and adolescent mental health services. UNICEF has played a key role in supporting the government in scaling up interventions across sectors, beginning with a landscape analysis that led to the integration of mental health services within primary health care and schools. Furthermore, coordination mechanisms such as the Technical Working Group (TWG), where the Rwanda Biomedical Centre (RBC) plays a central role with UNICEF as a co-chair, have strengthened national efforts in the sector.

A key lesson learned in Rwanda's approach to MHPSS has been the importance of deliberate and systematic integration of mental health and psychosocial support into both sectoral and standalone initiatives. Recognizing that mental health is a cross-cutting issue, the Rwanda Country Office has worked to map existing MHPSS efforts across sectors, ensuring that interventions in education, health, child protection and social policy are aligned and complementary rather than fragmented.

To operationalize this, an internal mapping exercise was initiated to identify MHPSS-related activities across different programme areas, allowing teams to pinpoint gaps, overlaps and opportunities for synergy. This process facilitated the development of shared priorities and action points, ensuring that mental health is not treated as an isolated issue but rather embedded within schools, health care facilities, communities and digital platforms.

In addition to sectoral integration, efforts have been made to ensure MHPSS is embedded in standalone initiatives, such as parenting and sports for development programmes. For example, MHPSS has been integrated into life skills programmes in schools, ensuring that students receive psychoeducation as part of their broader education experience.

Similarly, digital platforms and tools are being leveraged to expand access to mental health resources, particularly for adolescents and young people.

This integrated approach has strengthened Rwanda's ability to deliver MHPSS in a holistic and sustainable manner, making mental health a core component of both multi-sectoral strategies and targeted interventions. Moving forward, the office will continue to enhance coordination efforts, ensuring that mental health remains a priority across different sectors and platforms while also strengthening monitoring systems and resource mobilization to support long-term sustainability.

5. Barriers to Advancing School-Based and Overall Child and Adolescent Mental Health Policies and Services

The advancement of child and adolescent mental health policies and services in ESA faces numerous barriers that impede the development of coherent and comprehensive systems. Stakeholder consultations have highlighted critical challenges that significantly affect the design, implementation and sustainability of MHPSS initiatives across the region. Key barriers identified include:

The burden of stigma on child and adolescent mental health policy and service development

> **Mental health is heavily stigmatized, often associated with poverty or spiritual beliefs. This stigma discourages families from seeking help. In rural areas, children with conditions like autism are often neglected or hidden"**
>
> - UNICEF Staff

Stigma remains a pervasive barrier to prioritizing and addressing child and adolescent mental health across the region. Deeply rooted in cultural beliefs and misconceptions, mental health issues are often associated with poverty or spiritual interpretations, discouraging families from seeking help and hindering open discussions within communities.

In Zimbabwe, stakeholders noted that numerous parents and educators perceive mental health conditions through a spiritual framework, which results in hesitance to seek professional support for children in distress. In Mozambique, mental health conditions – particularly severe ones – are often perceived as manifestations of witchcraft and are commonly treated by traditional healers. In South Sudan, cultural stigma discourages families from acknowledging mental health challenges, thereby limiting the demand for services. Similarly, in Kenya, stigma and social exclusion deter learners from accessing available psychosocial support, particularly in rural areas. Furthermore, the stigma associated with mental health conditions extends to educators. Teachers who experience stress, burnout, or trauma may hesitate to seek assistance due to concerns regarding perceptions of weakness or incompetence.

The stigma surrounding mental health not only affects individuals but also hinders policy development and effective intervention. Key informants across several countries

have identified persistent stigma and widespread misconceptions as considerable barriers to the advancement of policies and the execution of effective interventions. Misinformation, misunderstanding and a lack of awareness among decision-makers regarding effective policy alternatives further complicate progress.[52] Unfortunately, compared to adult mental health, the understanding of child and adolescent mental health is even less prevalent among the public and policymakers in low- and middle-income countries.[53] This limited awareness contributes to inadequate policy responses and insufficient investment, leaving children and young people without access to critical mental health services.

Weak multi-sectoral coordination and Undefined Roles

> **"UNICEF could play a key role in strengthening coordination across ministries, leveraging technology for awareness and training, and developing monitoring tools to evaluate MHPSS programmes effectively".**
>
> – Researcher working in the ESA region

Designing and implementing effective child and adolescent mental health policies and services necessitates a collaborative approach that unites services and stakeholders across various sectors. However, many countries face challenges stemming from weak coordination among these sectors and vague definitions regarding roles and budget allocations. This has led to fragmented and inadequate service delivery within schools and PHC centres. Such disjointedness often delays early intervention, complicates referral pathways to PHC and obstructs the development of a cohesive system of mental health support system.

Without well-defined roles and responsibilities, interventions often end up being fragmented, causing children who need mental health support to slip through the cracks. Key informants reported that education and health professionals often work in isolation, with nominal communication and joint planning. This makes it especially challenging to develop a coordinated response to the mental health needs of children in schools and through referrals to other sectors. Additionally, inter-ministerial coordination is often fragmented and characterized by a reactive rather than proactive approach.

For instance, despite mental health being embedded in multiple national policies in Mozambique, the absence of a formal coordination mechanism between the education and health ministries has led to inefficient service delivery and unclear referral processes for learners in distress. Likewise, while mental health has been included in the education sector plan in South Sudan, poor collaboration between sectors and the absence of dedicated school-based mental health professionals continue to be significant barriers to effective implementation. In Kenya, informants pointed out that schools and PHC centres operate much too independently. In Zimbabwe, coordination among ministries and service providers was described as reactive and ad hoc, leading to delays in identifying and supporting children and adolescents with acute needs.

Limited availability of child and adolescent mental health services in rural or underserved regions

Access to child and adolescent mental health services remains highly unequal, with urban areas typically having more resources compared to rural and underserved communities. A severe shortage of mental health specialists further limits the reach of school-based MHPSS programmes. A critical shortage of trained professionals – such as school counsellors, social workers and psychologists – exists within educational systems across the region. Many educators receive minimal training in mental health support, and those who do often lack access to ongoing professional development opportunities. Furthermore, existing school counselling departments are frequently underfunded, compelling teachers to assume additional duties without appropriate training.

Child and adolescent mental health is underfunded

Public expenditure on mental health continues to be disproportionately low. Globally, investment in mental health remains markedly lower than in other health priorities, leading to chronically underfunded services. **In 2020, the median expenditure on mental health in low-income countries was merely US$0.02 per person per year, while in lower-middle-income countries, it was US$0.34.**[54] In the absence of dedicated budgets for child and adolescent mental health, families in many countries in the region are compelled to rely on out-of-pocket payments for essential services that ideally should be financed publicly. Even when funding is allocated, it often suffers from inconsistencies and is vulnerable to fluctuations arising from political cycles and donor priorities, hindering the sustainability of long-term programmes.

School-based MHPSS programmes experience chronic underfunding, compounded by financial and human resource constraints that inhibit the expansion of effective initiatives. In emergencies, underinvestment in MHPSS in education in emergencies remains a recurrent challenge. Although there is increasing awareness of the importance of mental health in education, funding allocations remain insufficient. In Mozambique, mental health programming is often deprioritized in favour of more visible humanitarian needs such as food assistance, shelter and infrastructure. Stakeholders reported that MHPSS initiatives are commonly viewed as non-essential, resulting in limited financial support. In South Sudan, the provision of mental health services in schools is heavily reliant on short-term donor funding. This dependence undermines programme sustainability and limits the potential for long-term integration into national education strategies. Many initiatives cease once external funding cycles conclude, with little institutional support for continuation. The lack of funding also undermines PHC centres, which should serve as referral points, rendering them ill-equipped.

In 2020, the median expenditure on mental health in low-income countries was merely US$0.02 per person per year.

Overburdened School Systems

In many educational institutions, large class sizes (often exceeding 1:60) and limited instructional time hinder teachers from integrating MHPSS components into their daily classroom practices. These challenges are further compounded by educators' elevated levels of stress and burnout, diminishing their capacity to address learners' mental health needs effectively. An International Institute for Capacity Building in Africa (IICBA) study conducted in 14 African countries reveals that a third of teachers and teacher educators were depressed, and one-fifth to one-fourth were affected by stress during COVID.

Additionally, teachers, who are frequently the first point of contact for learners experiencing distress, often lack formal training in identifying mental health concerns and facilitating referrals. The delegation of guidance and counselling responsibilities to untrained teachers not only places an unsustainable burden on educators but also reduces the likelihood that learners will receive timely and appropriate support. This gap in capacity underscores the need for targeted investments in teacher training, as well as the recruitment and retention of specialized mental health professionals within the education sector.

Despite growing recognition of the importance of MHPSS in learning environments, key informants from various countries observed that financial limitations severely impede implementation efforts within the education sector. In South Sudan, for example, mental health has been incorporated into the General Education Sector Plan (2023–2027), yet a clear budget allocation to support school-based MHPSS initiatives is non-existent. In Kenya, guidance and counselling responsibilities in schools are frequently assigned to teachers who lack formal mental health training, primarily due to financial constraints preventing the hiring of dedicated professionals. This gap in trained personnel places an additional burden on educators who are already stretched thin by overcrowded classrooms and competing priorities.

© UNICEF/UNI416998/Translieu/Nyaberi

Referral mechanisms for mental health services through schools are significantly hampered by the chronic shortage of trained mental health professionals. On the African continent, there exist only 1.4 mental health workers per 100,000 individuals, in stark contrast to the global average of 9 per 100,000. This disparity constrains the capacity of schools to effectively link learners experiencing mental health challenges to appropriate care and support services in the health system. The scarcity of mental health professionals is further exacerbated by weak referral systems that are often under-resourced and lack clear protocols for coordination between schools and health services.

In contexts such as South Sudan and Mozambique, referrals from schools to community-based mental health services are limited, largely due to infrastructural gaps and the absence of established pathways for follow-up and support. In Kenya, while the Ministry of Education has made strides towards integrating mental health awareness in schools, the lack of specialized personnel to handle referrals significantly limits the effectiveness of these efforts.

In South Sudan, key informants reported that although teachers are often expected to serve as frontline providers of psychosocial support, many are themselves affected by the cumulative impact of conflict-related stress, displacement and precarious working conditions. These factors significantly undermine their capacity to offer consistent emotional support to learners, particularly when their own mental health and wellbeing are compromised.

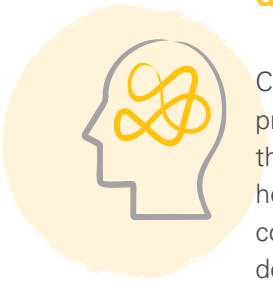
Weak mental health information systems and limited research

> **Research should focus on understanding the magnitude of mental health issues among children and adolescents, both in schools and communities. This data would help shape targeted interventions and gain political traction".**
>
> - UNICEF Specialist

A significant gap in accurate and disaggregated data on child and adolescent mental health persists across the ESA region. Weak mental health information systems and the scarcity of research concerning mental health among children and adolescents pose considerable obstacles to the development and implementation of effective policies and programmes. According to WHO, mental health indicators are not systematically incorporated into health management information systems in many countries, which results in a lack of reliable data to inform decision-making processes. Similarly, mental health and well-being indicators are not yet systematically integrated into EMIS across most countries in the region. Recent initiatives have begun to address this gap, particularly in West and Central Africa, where 11 countries have incorporated core health and wellbeing indicators into their EMIS frameworks. These indicators primarily focus on areas such as HIV education, gender-based violence and life skills, with mental health often included under broader well-being categories. The absence of comprehensive mental health indicators within education data systems undermines efforts to design and implement evidence-based policies and limits the visibility of mental health within broader education sector planning.

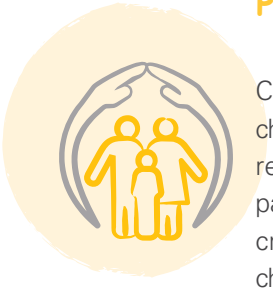
In Kenya, the Kenya Health Information System (KHIS) does not include disaggregated data by age, limiting visibility of the mental health needs of children and adolescents. In Mozambique, data collection efforts remain fragmented, with existing studies focusing primarily on specific issues such as HIV and violence against children rather than providing a comprehensive understanding of national mental health needs. School-based mental health interventions lack rigorous monitoring and evaluation mechanisms. The absence of comprehensive national data on the prevalence of mental health conditions and the efficacy of school-based interventions significantly restricts policymakers' ability to craft targeted strategies.

Child and adolescent mental health is often not seen as a development priority



Child and adolescent mental health often lack recognition as a critical development priority. Key informants engaged during the data collection process emphasized that regional policymakers do not sufficiently prioritize child and adolescent mental health. Research indicates that poor public awareness and low political willingness constitute significant barriers to advancing child and adolescent mental health policy development.[55] In the context of sub-Saharan Africa, child and adolescent mental health policies have garnered relatively little attention from policymakers, a situation attributed to stigma and a lack of comprehensive understanding of the relationship between mental health and social determinants, such as poverty.[56] The ACDC echoes this concern, highlighting that numerous mental health challenges in the African continent have not received adequate attention from public policymakers, resulting in insufficient prioritization. This lack of political commitment has impeded progress in formulating and executing robust policies and programmes.

Limited inclusion of caregivers and families in MHPSS Programmes



Caregiver engagement remains inconsistent, despite its critical role in supporting children's mental health. Involving caregivers and families in MHPSS programmes represents a valuable opportunity to reinforce children's mental health. By providing parents and caregivers with the necessary knowledge and skills, it´s possible to create a supportive environment that extends beyond the school setting and enhances children's wellbeing at home.

Gaps in Embedding MHPSS in Emergency Preparedness and Response

Another significant challenge is the lack of comprehensive emergency preparedness plans that integrate mental health and psychosocial considerations within the education sector. While some schools have received training on disaster risk reduction, these efforts are often disconnected from mental health preparedness strategies. In Kenya and Mozambique, stakeholders noted the absence of standardized frameworks to embed MHPSS into emergency planning at school level.

6. Recommendations

The following recommendations have been developed to guide governments, development partners, UN agencies and other stakeholders in strengthening school-based mental health and psychosocial support systems across Eastern and Southern Africa. Rooted in the evidence gathered through this situational analysis, these recommendations highlight priority actions needed to address the mental health and psychosocial needs of children and adolescents. They reflect both the urgent demand for systemic reform and the promising opportunities to scale up contextually appropriate, multisectoral interventions that improve mental health outcomes and resilience among children, adolescents and those who care for them.

1. Elevating Child and Adolescent Mental Health in National Agendas:

Public awareness and political commitment are critical to ensuring that child and adolescent mental health attains the attention and prioritization it rightly deserves. In numerous countries, the lack of specific policies addressing child and adolescent mental health issues undermines the establishment of structured support systems. Policymakers must take deliberate and strategic actions to formulate comprehensive policies that lay a solid foundation for mental health and psychosocial support services targeting children and adolescents. Stakeholders have underscored the necessity for policies that are practical, sufficiently funded and grounded in empirical evidence, while also aligning with international human rights standards – particularly the Convention on the Rights of the Child.

Effective policies should clearly define objectives, strategic approaches, and evaluation frameworks to assess impact and effectiveness. They must also specify the roles of various stakeholders to enable coordinated efforts across educational institutions, primary health care centres and community programmes. Moreover, policies should ensure the appropriate allocation of resources to address mental health needs in diverse contexts. It is crucial for policies to include strategies for mental health promotion and prevention in schools and educational settings, focusing on culturally sensitive approaches that resonate with local communities.

Embedding mental health and psychosocial support programmes and interventions within national education systems offers a transformative opportunity to combat stigma and significantly improve access to essential services. Regional and national policies must explicitly recognize educational institutions as vital contributors to the promotion and prevention of mental health among children and adolescents.

In this context, educational settings must be adequately equipped with the resources and capacities necessary to achieve the following strategic objectives:

- **First**, integrating culturally sensitive mental health literacy into school curricula and teacher training programmes is crucial. This approach not only raises awareness among learners,

caregivers and educators but also helps to normalize conversations around mental health, reducing stigma and encouraging help-seeking behaviours.

- **Second**, mental health support must be embedded within school health policies to ensure that learners receive the care and assistance they need. Establishing national guidelines to standardize mental health services across all schools is essential. This framework should also prioritize workforce capacity building, systematic monitoring and sustainable funding allocation. It´s paramount that suicide prevention programmes are embedded in school health services and programmes.

- **Third**, it is critical to develop clear and efficient referral pathways that link schools with health and social services. These mechanisms enable swift and effective support for learners experiencing mental health challenges, ensuring that no child is left without the assistance they need.

- **Additionally**, strengthening workforce capacity is fundamental to effective MHPSS integration. Prioritizing the training of teachers and school counsellors equips them with the skills to identify, support and refer learners experiencing mental health issues, building a frontline of support within educational environments.

- **Finally,** creating safe and inclusive learning environments is necessary to protect learners' mental health. Implementing protective policies against violence, discrimination and social exclusion within schools fosters a supportive atmosphere where learners feel safe and valued.

By integrating MHPSS into educational policies and workforce development, schools can serve as foundational hubs for mental health promotion and early intervention, strengthening the overall mental health system.

2. Whole Systems Approach: Strengthening Intersectoral Coordination for child and adolescent mental health:

Achieving lasting improvements in child and adolescent mental health requires more than political commitment and financial investment – it demands robust intersectoral coordination among governments, civil society and development partners. Clear delineation of roles and collaborative efforts among key stakeholders are essential for the effective design and implementation of mental health policies and services. Successful coordination relies on well-defined responsibilities, joint training programmes and integrated service delivery models that enhance efficiency and accountability. Establishing national frameworks for intersectoral collaboration can significantly streamline service delivery and improve accountability across ministries. Such frameworks encourage synchronized planning and foster cooperation between the education, health and social welfare sectors, ensuring that mental health and psychosocial support services are effectively delivered in both routine and emergency contexts.

In emergency settings, the Minimum Service Package for Mental Health and Psychosocial Support (MHPSS-MSP) provides a practical framework that can be adopted by all sectors to guide joint planning, harmonize interventions and ensure that affected populations – particularly children and adolescents – have access to timely and appropriate mental health support through multiple platforms and service delivery entry points.

3. Embracing Cultural Perspectives in Mental Health Programming:

To enhance the effectiveness of mental health interventions in the ESA region, it is essential to move beyond purely biomedical perspectives and incorporate local cultural understandings of mental health. Acknowledging indigenous perspectives can facilitate more culturally sensitive approaches to mental health support, which involves acknowledging the influence of religious and cultural beliefs on individuals' experiences, perceptions and responses to mental health treatment.[57] Targeted community engagement and awareness campaigns should be designed to normalize discussions around mental health, reduce stigma and encourage help-seeking behaviours. Furthermore, leveraging existing community support structures can enhance the effectiveness of mental health and psychosocial support interventions. To maximize reach and effectiveness, the use of SBC mechanisms and strategies is crucial, as they can drive positive shifts in attitudes, behaviours and community norms around mental health.

4. Strengthening Service Delivery for Child and Adolescent Mental Health and Psychosocial Support:

To improve access to quality mental health and psychosocial support services for children and adolescents in ESA, it is recommended to enhance service delivery through a multi-tiered, integrated approach that bridges education, health and social welfare systems. This includes the integration of MHPSS within PHC to ensure early intervention and support for children and adolescents experiencing mental health challenges. Embedding mental health services into PHC facilities requires training community health workers, nurses and primary care providers on basic child and adolescent mental health targeted interventions. Furthermore, given their proximity to children and adolescents, schools should be positioned as pivotal in mental health promotion and prevention and the establishment of effective referral pathways. Lastly, community-based mental health networks should also be expanded to leverage existing structures to provide culturally sensitive psychosocial support, reduce stigma and facilitate community-driven approaches to mental health awareness and care.

Moreover, in certain contexts, digital innovation presents a significant opportunity to expand the reach and accessibility of MHPSS, particularly settings where in-person services are often limited. To maximize this potential, it is recommended to invest strategically in the development and scaling of digital platforms that disseminate mental health information and connect children and adolescents with trained mental health professionals and support services through mobile and online technologies.

5. Capacity building: Strengthening the School Workforce for Mental Health Support:

Ensuring that the education system is adequately staffed with qualified professionals is essential to prevent children from receiving insufficient support and teachers from being overburdened with mental health responsibilities that extend beyond their professional capacity. Integrating mental health knowledge into both pre-service and in-service teacher training curricula will furnish educators with the knowledge and skills necessary to recognize signs of psychological distress, provide fundamental psychosocial support and facilitate timely referrals when necessary. While teachers should not be expected to function as mental health professionals, appropriate training will enable them to play a crucial role in fostering supportive learning environments and promoting learners' socio-emotional wellbeing.

A comprehensive strategy to respond to the diverse learners' mental health needs requires the deployment of trained mental health professionals in educational settings – including school psychologists, social workers, school counsellors

and nurses – to offer direct mental health support to learners. For example, expanding training opportunities for social workers and community health promoters to provide services within schools will further enhance the capacity of educational institutions, ensuring that learners receive timely and appropriate care.

Furthermore, integrating digital tools into teacher professional development can enhance educators' ability to recognize and respond to learners' MHPSS needs effectively. Online training modules, mobile learning applications, and virtual peer-support networks for teachers represent flexible and cost-effective pathways for continuous learning in MHPSS best practices. These technologies can strengthen the capacity of school staff to support student wellbeing, even in remote or underserved areas.

6. Financing and sustainability: Securing Sustainable Financing for School-Based Mental Health Services:

To effectively address the mental health needs of children and adolescents, governments must allocate dedicated funding to strengthen mental health services within schools. Chronic funding shortages have been consistently identified as a significant barrier to expanding school-based mental health interventions. Addressing this gap requires a strategic commitment to allocate at least 5 per cent of national health budgets specifically to mental health initiatives,[58] while ensuring that these services are integrated into the budgets of relevant ministries, including Education, Health and Social Services. This integrated funding approach promotes better coordination and maximizes impact. However, increasing budget allocations alone is not sufficient. It is equally important to optimize the use of existing resources through transparent expenditure tracking, improved accountability mechanisms and targeted workforce development.

Findings from UNICEF and RTI underscore the substantial economic implications of mental health challenges among children and adolescents in Sub-Saharan Africa. The cost of inaction on school-based MHPSS is estimated to be US$112 billion (in 2022 US$) in economic losses over the lifetime of the affected children and adolescents. These losses are primarily attributed to reduced educational attainment, lower productivity and heightened vulnerability to social and economic disadvantage. Conversely, the economic benefits of investing in MHPSS programmes across the mental health continuum far outweigh the costs of implementation.

7. Integrating MHPSS into Comprehensive School Emergency Preparedness and education response plans:

To enhance the resilience of education systems and ensure the continuity of both learning and mental health support interventions during crises, it is essential to systematically integrate mental health and psychosocial support within school emergency preparedness and response frameworks. This includes incorporating child and adolescent mental health considerations into all phases of disaster planning – preparedness, response and recovery – through structured, all-hazards risk assessments, prevention strategies, crisis response protocols and recovery mechanisms. Clear roles and responsibilities for MHPSS provision must be defined across all levels of the education system.

8. Community and Family Engagement: Mobilizing Families, Youth and Communities for Mental Wellbeing:

Actively engaging young people and caregivers in policy design and implementation through consultative platforms is essential to ensure their voices are reflected in decision-making processes. This participatory approach not only strengthens ownership but also drives community-level change. To be effective, these efforts should be complemented by community-based awareness campaigns that challenge stigma and promote a broader understanding of mental health as an

integral part of overall wellbeing. Leveraging local leaders and community networks can amplify these messages, making them more culturally resonant and impactful.

Strengthening collaboration among schools, families and communities is vital for promoting the mental wellbeing of children and adolescents. Engaging parents, youth and community leaders in school-based mental health initiatives helps to create supportive environments, reduce stigma and encourage help-seeking behaviours.

The following are some key strategies recommended by interviewed stakeholders:

- Design community-driven awareness programmes to increase mental health literacy and reduce stigma, actively involving families and local leaders in dialogue and advocacy.
- Empower traditional and faith-based leaders to champion mental health, normalizing help-seeking behaviours and strengthening local support systems.
- Integrate mental health into Parenting Programmes, equipping families with skills in positive parenting, stress management and effective communication to create nurturing home environments.
- Promote Youth-Led Mental Health Initiatives, encouraging adolescents to co-design mental health solutions that reflect their needs and realities, fostering ownership and peer support.
- Strengthen school-family communication, enhancing collaboration through regular meetings, home visits and digital platforms to extend mental health support beyond the classroom, creating a cohesive support network for learners.

© UNICEF/UNI832821/Andrianantenaina

9. Monitoring, evaluation, data and learning: Driving Change Through Data and Research:

Strengthening region-specific data collection is essential to bridge this gap. This includes generating cross-national and nationally representative data on mental health prevalence and integrating child and adolescent mental health indicators into national health and education information systems. Such integration enables the tracking of service availability, intervention outcomes and programme impact, ensuring policies are responsive to the unique mental health needs of children and adolescents in schools.

Investing in regionally driven research is equally critical to understand how, why, for whom and under what conditions MHPSS interventions in educational settings improve wellbeing, resilience and learning outcomes. Locally generated evidence supports the design of tailored, school-based mental health programmes that reflect the realities of children and communities. Strong monitoring frameworks are also necessary to ensure accountability, assess service quality and enable adaptive programming based on real-time data.

Key stakeholders advocate for increased investment in CAMH data and research.

Strengthening data systems will not only reveal the magnitude of mental health challenges faced by children and adolescents but also enhance political commitment, enable targeted interventions and optimize resource allocation. In the absence of robust data, it is challenging to evaluate the effectiveness of existing programmes or adapt strategies to emerging needs.

Together, these recommendations offer a coherent and actionable framework for advancing child and adolescent mental health in the region. Their implementation requires political will, sustained financing and public-private partnerships that centre the voices of young people and communities.

By investing in school-based MHPSS and its integration with broader systems of care, governments and stakeholders can contribute to building more resilient education systems and ensuring that every child and adolescent has the opportunity to thrive and fulfil their potential.

7. Conclusion

This situational analysis highlights the urgent and growing need to strengthen mental health and psychosocial support policies and services for children and adolescents across Eastern and Southern Africa. **The findings underscore that while there is increasing recognition of the role of schools in promoting mental wellbeing and preventing mental health conditions, progress across the region remains uneven and hindered by systemic challenges, including chronic underinvestment, limited workforce capacity, fragmented intersectoral coordination and persistent stigma**. Although promising practices are emerging – such as the integration of mental health literacy and socio-emotional skills into curricula, teacher training and integration of MHPSS within school health programmes – these efforts are often pilot-based, donor-driven and insufficiently embedded within national education and health systems.

Schools represent a powerful, yet underutilized, platform for advancing child and adolescent mental health. They offer daily, structured and nurturing environments where early identification, prevention and support can be scaled up. However, achieving impact requires coordinated, multisectoral strategies that link education with primary health care, child protection and social services. The analysis affirms the importance of embedding MHPSS within broader education sector reforms and emergency preparedness plans, while promoting youth and caregiver engagement, contextually tailored programming and robust data systems. Moving forward, collective action and sustained investment are imperative to ensure that school-based MHPSS becomes a cornerstone of inclusive, safe and supportive learning environments across the region. Only then can the right to mental health for every child and adolescent be fully realized.

8. References

1 Mental health and psychosocial support is a composite term used to describe any type of local or outside support that aims to protect or promote psychosocial well-being or prevent or treat mental disorders. Originally coined for use in emergency settings, this term is now widely accepted and used by UNICEF and partners across settings to safeguard the dynamic relationship between psychological aspects of experience (a person's thoughts, emotions, feelings and behaviour), the wider social experience (relationships, traditions) and values and culture.

2 KIIs and FGD were conducted with a diverse group of stakeholders, including representatives from regional bodies such as the Regional Psychosocial Support Initiative (REPSSI) and the African Centre for Disease Control and Prevention (ACDC); academic experts from the Universities of Cape Town and Nairobi; youth advocates, officials from Ministries of Health; representatives of the Inter-agency Network for Education in Emergencies (INEE); and technical specialists from UNICEF working across education, health and child protection sectors. Country-level perspectives were gathered from UNICEF offices in Rwanda, Mozambique, South Africa, Kenya, Zimbabwe and South Sudan.

3 Retrieved from: https://www.unicef.org/esa/education

4 Retrieved from: https://www.unicef.org/esa/stories/child-population-demographics-shifts-and-trends-eastern-and-southern-africa

5 United Nations Children's Fund, *The State of the World's Children 2021: On My Mind – Promoting, protecting and caring for children's mental health*, UNICEF, New York, October 2021, <https://www.unicef.org/media/114636/file/SOWC-2021-full-report-English.pdf>.

6 Kieling, C., Buchweitz, C., Caye, A. et al., 'Worldwide Prevalence and Disability From Mental Disorders Across Childhood and Adolescence: Evidence From the Global Burden of Disease Study', JAMA Psychiatry, vol. 81, no. 4, pp. 347–356, 2024, <doi:10.1001/jamapsychiatry.2023.5051>.

7 World Health Organization, *Mental health and development: targeting people with mental health conditions as a vulnerable group*, WHO, Geneva, 2010.

8 Johns Hopkins Bloomberg School of Public Health and United Nations Children's Fund, *On My Mind: How adolescents experience and perceive mental health around the world*, JHU and UNICEF, Baltimore and New York, May 2022.

10 World Health Organization and the United Nations Children's Fund, Mental health of children and young people: service guidance, WHO and UNICEF, Geneva, 2024.

10 United Nations Children's Fund, The State of the World Children 2021, Regional Brief, UNICEF, 2021, <https://www.unicef.org/media/109886/file/SOWC%202021%20Africa%20regional%20brief.pdf>.

11 Defined by WHO, the burden of disease refers to the impact of a health problem on a population, measured by the loss of healthy life years due to premature death and disability. A Disability-Adjusted Life Year is the metric used to measure disease burden.

12 African Centre for Disease Control and Prevention, African CDC Strategic Plan 2023–2027, ACDC, 2 September 2023, <https://africacdc.org/download/africa-cdc-strategic-plan-2023-2027/>.

13 World Health Organization and Calouste Gulbenkian Foundation, Social determinants of mental health, WHO and Calouste Gulbenkian Foundation, Geneva, 2014.

14 Maurer, J., Meyrose, AK., Kaman, A. et al., 'Socioeconomic Status, Protective Factors, and Mental Health Problems in Transition from Adolescence to Emerging Adulthood: Results of the Longitudinal BELLA Study', Child Psychiatry Hum Dev, 2023, <https://doi.org/10.1007/s10578-023-01582-1>.

15 Melchior, M., Chastang, J.F., Falissard, B. et al., 'Food insecurity and children's mental health: a prospective birth cohort study', PLoS One, vol. 7, no. 12, 2012, <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0052615>.

16 United Nations Children's Fund, Violence against Girls, Boys and Women in Southern Africa: A statistical profile, UNICEF, New York, 2023.

17 Ibid.

18 United Nations Children's Fund, 'A Synthesis of Noncommunicable Disease Risk Factors and Landscape Analysis of Adolescent Health Policies in Eastern and Southern Africa: with deep dive on mental health, obesity/overweight', UNICEF, 2021.

19 Retrieved from: https://data.unicef.org/resources/child-marriage-in-eastern-and-southern-africa-a-statistical-overview-and-reflections-on-ending-the-practice/.

20 Retrieved from: https://cdn.togetherforgirls.org/assets/files/Namibia-VACS-brief_mental-wellness.pdf.

21 Rossouw, L., Watt, K., Davidson, L.L., Desmond, C., 'The social determinants of adolescent anxiety and depression in peri-urban South Africa', PLOS Ment Health, vol. 1, no. 6, 2024, <https://doi.org/10.1371/journal.pmen.0000173>.

22 Retrieved from: https://www.unicef.org/press-releases/fast-facts-critical-gains-hiv-response-adolescents-especially-girls-remain.

23 Tutlam, N.T., Chang, J.J., Byansi, W. et al., 'War-Affected South Sudanese in Settings of Preflight, Flight, and Resettlement: A Systematic Review and Meta-analysis of Trauma-Associated Mental Disorders', Glob Soc Welf, vol. 11, pp. 193–210, 2024, <https://pmc.ncbi.nlm.nih.gov/articles/PMC11588307/>.

24 Saade, S., Parent-Lamarche, A., Khalaf, T. et al., 'What barriers could impede access to mental health services for children and adolescents in Africa? A scoping review', BMC Health Serv Res, vol. 23, 2023, <https://doi.org/10.1186/s12913-023-09294-x>.

25 Retrieved from: https://www.afro.who.int/news/urgent-action-needed-accelerate-mental-health-progress-african-region.

26 Jörns-Presentati, A., Napp, A-K., Dessauvagie, A.S., Stein, D.J., Jonker, D., Breet, E. et al., 'The prevalence of mental health problems in sub-Saharan adolescents: A systematic review', PLoS ONE, vol. 16, no. 5, 2021, <https://doi.org/10.1371/journal.pone.0251689>.

27 Sorsdahl, K., Petersen, I., et al. 'A reflection of the current status of the mental health care system in South Africa', SSM - Mental Health, vol. 4, 2023, <https://doi.org/10.1016/j.ssmmh.2023.100247>.

28 Sankoh, O., Sevalie, S., Westone, M., 'Mental health in Africa', The Lancet, vol. 6, iss. 9, September 2018, <https://www.thelancet.com/action/showPdf?pii=S2214-109X%2818%2930303-6>.

29 Shatkin, J.P., Belfer L.M., 'The global absence of child and adolescent mental health policy', Child Adolescent Ment Health, vol. 9, no. 3, 2004, pp. 104–108.

30 Owen, J.P., Baig, B., Abbo, C., Baheretibeb, Y., 'Child and adolescent mental health in sub-Saharan Africa: a perspective from clinicians and researchers', BJPsych Int., vol. 13, no. 2, 2016, pp. 45-47, <https://pubmed.ncbi.nlm.nih.gov/29093899/>.

31 REPSSI, 'Review and analysis of existing national and regional MHPSS policies in Eastern and Southern Africa', REPSSI, 2023.

32 Kondirolli, F., Sunder, N., 'Mental health effects of education', Health Economics, vol. 31, iss. S2, 2022, pp. 22-39, <https://doi.org/10.1002/hec.4565>.

33 Orygen, 'A review of secondary school-based mental health prevention programs', <https://www.orygen.org.au/Training/Resources/General-resources/Toolkits/Implementing-school-based-mental-health-prevention>.

34 Cappella, E., Frazier, S.L., Atkins, M.S., Schoenwald, S.K., Glisson, C., 'Enhancing schools' capacity to support children in poverty: an ecological model of school-basedmental health services', Adm Policy Ment Health, vol. 35, no. 5, 2008, pp. 395-409, <https://link.springer.com/article/10.1007/s10488-008-0182-y>.

35 Dray, J. et al., 'Systematic Review of Universal Resilience-Focused Interventions Targeting Child and Adolescent Mental Health in the School Setting', Journal of the American Academy of Child and Adolescent Psychiatry, vol. 56, no. 10, 2017, pp. 813-824.

36 Wells, J., 'A systemic review of universal approaches to mental health promotion in schools', Health Education, vol. 103, 2003, pp. 197-220, <https://doi.org/10.1108/09654280310485546>.

37 Weare, K., Markham, W., 'What do we know about promoting mental health through schools?', Promotion & Education, vol. 12, nos. 3-4, 2005, pp. 118-122, <https://doi.org/10.1177/10253823050120030104>.

38 World Health Organization, Mental Health Atlas 2020, WHO, Geneva, 2021.

39 Mokitimi, S., Schneider, M., de Vries, P.J., 'Child and adolescent mental health policy in South Africa: History, current policy development and implementation, and policy analysis', International Journal of Mental Health Systems, vol. 12, 2018, <https://ijmhs.biomedcentral.com/articles/10.1186/s13033-018-0213-3>.

40 As recorded by UNICEF´s systems strengthening indicator framework, which uses a four-point scale to assess progress across key building blocks on system integration, wherein a score of 2.5 or higher out of 4 signals that foundational structures are in place and beginning to function effectively.

41 United Nations Children's Fund, Humanitarian Action for Children Appeal. Eastern and Southern Africa, UNICEF, 2014, <https://www.unicef.org/esa/media/14996/file/2025-HAC-ESA(2).pdf>.

42 Disaster Preparedness Advisory Council, Committee On Pediatric Emergency Medicine, 'Ensuring the Health of Children in Disasters', Pediatrics, vol. 136, no. 5, 2015; Reed, R.V. et al., 'Mental health of displaced and refugee children resettled in low-income and middle-income countries: risk and protective factors', The Lancet, vol. 379, no. 9812, 2012, pp. 250-265.

43 Choi, A., 'Emotional wellbeing of children and adolescents: Recent trends and relevant factors', OECD Education Working Papers, no. 169, OECD Publishing, Paris, 2018, <https://www.oecd.org/en/publications/emotional-well-being-of-children-and-adolescents_41576fb2-en.html>.

44 Bosqui, T. J., Marshoud, B., 'Mechanisms of change for interventions aimed at improving the wellbeing, mental health and resilience of children and adolescents affected by war and armed conflict: a systematic review of reviews', Conflict and Health, vol. 12, no. 1, 2018, <https://doi.org/10.1186/s13031-018-0153-1>.

45 Inter-Agency Standing Committee, IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, IASC, Geneva, 2007.

46 Choi, 'Emotional wellbeing of children and adolescents'.

47 Nemiro, A., Hijazi, Z. O'Connell, R., Coetzee, A., Snider, L., 'Mental health and psychosocial wellbeing in education: The case to integrate core actions and interventions into learning environments', Intervention, vol. 20, no. 1, pp. 36-45, January–June 2022, <https://journals.lww.com/invn/fulltext/2022/20010/mental_health_and_psychosocial_wellbeing_in.5.aspx>.

48 Bosqui, T.J., Marshoud, B., 'Mechanisms of change for interventions aimed at improving the wellbeing, systematic review of reviews', Confl Health, vol. 12, no. 15, May 2018, <https://pubmed.ncbi.nlm.nih.gov/29760768/>.

49 Dybdahl, R., Williams, J., 'Special Issue on Psychosocial Support and Social and Emotional Learning in Emergencies', Journal on education in emergencies, vol. 7, December 2021.

50 United Nations Children's Fund, 'Mental health and psychosocial support for children in humanitarian settings: an updated review of evidence and practice', UNICEF, 2020.

51 UNICEF's programming on Mental Health and Psychosocial Support (MHPSS) is grounded in the UNICEF Strategic Plan (2022–2025) and the Global Multisectoral Operational Framework for MHPSS.

52 Thornicroft, G., Sunkel, C., Milenova, M., 'How to stop stigma: implementing the Lancet Commission on ending stigma and discrimination in mental health', The Lancet Psychiatry, vol. 11, iss. 2, 2024.

53 Zhou, W. et al. 'Child and Adolescent Mental Health Policy in Low- and Middle-Income Countries: Challenges and Lessons for Policy Development and Implementation', Frontiers in psychiatry, vol. 11, March 2020, <https://pubmed.ncbi.nlm.nih.gov/32256399/>.

54 United for Global Mental Health, 'Financing of mental health: the current situation and ways forward', United for Global Mental Health, <https://unitedgmh.org/app/uploads/2023/10/Financing-of-mental-health-V2.pdf>.

55 Zhou et al. 'Child and Adolescent Mental Health Policy in Low- and Middle-Income Countries'.

56 Sequeira, M., Singh, S., Fernandes, L., Gaikwad, L., Gupta, D., Chibanda, D., Nadkarni, A., 'Adolescent Health Series: The status of adolescent mental health research, practice and policy in sub-Saharan Africa: A narrative review', Trop Med Int Health, vol. 27, no. 9, 2022, pp. 758-766, <https://pubmed.ncbi.nlm.nih.gov/35906997/>.

57 Matsoele, N.F.C., Tadi, N.F., 'Mental health literacy in black South African communities', Journal of Psychology in Africa, vol. 34, no. 3, pp. 260–268, 2024, <https://doi.org/10.1080/14330237.2024.2363690>.

58 United for Global Mental Health, 'Financing of mental health'.


unicef
for every child