MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT FOR MARGINALIZED AND UNDERREPRESENTED GROUPS TOOLKIT

May 2024
This document is made possible by the support of the American People through the United States Agency for International Development (USAID), under the terms of YouthPower2: Learning and Evaluation AID Contract # 47QRAA19D0006K/7200AA19M00018. The contents are the sole responsibility of Making Cents International and do not necessarily reflect the views of USAID or the United States Government.

Mental Health and Psychosocial Support for Marginalized and Underrepresented Groups Toolkit

By:
Jennifer Groves, Team Lead, YouthPower2: Learning and Evaluation
Maggie Zraly, Technical Advisor, Indigenous Peoples, YouthPower2: Learning and Evaluation
Sonali Gupta, Technical Advisor, LGBTQI+ People YouthPower2: Learning and Evaluation
Joanne Lee, Technical Advisor, Persons with Disabilities, YouthPower2: Learning and Evaluation
Alysha Tagert, Technical Advisor, Victims of Torture, YouthPower2: Learning and Evaluation

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

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

Visit YouthPower.org to learn more and follow us on Facebook and Twitter for updates

YouthPower.org **YouthPowerLearning** @YPLearning

For public inquiries and additional information, please email comms@youthpower.org or send mail to Making Cents International, Attn: YouthPower2: Learning and Evaluation, 1050 Connecticut Ave N.W., #65470, Washington, D.C. 20036.

Cover Photo Credits
Top: Silvanus Solomon / Pexels
Left: Prince Hasibul Islam / Pexels
Right: Minneapolis Institute of Art / Flickr

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT FOR MARGINALIZED AND UNDERREPRESENTED GROUPS TOOLKIT

Silvanus Solomon / Pexels

CONTENTS

Acronyms and Abbreviations 1

Key Definitions 3

Ensuring Access to MHPSS for Marginalized and Underrepresented Groups Toolkit 7

- Why is this toolkit needed? 7
- Who is the intended audience? 8
- What is the intended context and populations? 8
- How will this toolkit help me? 8
- How was this toolkit developed? 9
- What are the main takeaways? 9

SECTION 1: Terminology Specific to MHPSS and Marginalized and Underrepresented Groups 10

SECTION 2: A Review of the Literature on MHPSS for Marginalized and Underrepresented Groups 11

SECTION 3: Frameworks that Underpin a Rights-Based Approach to MHPSS for Marginalized and Underrepresented Groups 14

- Inclusive Development and MHPSS 14
- A Rights-Based Approach for MHPSS 15

SECTION 4: Ensuring Inclusion throughout the USAID Program Cycle 17

- Assessment: Identifying and Understanding MHPSS Needs of Marginalized and Underrepresented Populations Designing Program Objectives 17
- Contextualizing and Adapting MHPSS for Marginalized and Underrepresented Groups 18
- Selecting Evidence-Based Interventions 21
  - Budgeting Considerations for Implementing MHPSS Progamming for Marginalized and Underrepresented Populations 22
  - Staffing: Good Practice for Working with Marginalized and Underrepresented Groups 24
- Inclusion of Marginalized and Underrepresented Populations in MEAL Systems for MHPSS Programming 27

MHPSS TOOLS 28

Tool A - Checklist for Inclusive MHPSS Programming 28

Tool B - Contextualization Templates and Tools 34

Tool C - A Rights-based Approach for MHPSS 37

Tool D - Tools for Ensuring Inclusion and Participation in MHPSS Assessments (Section 4 Tools) 39

Tool E - Tools to Support Contextualization and Adaption 41

Tool F - Recommended Tools for LGBTQI+ Population 43

Tool G - Recommended Tools for Persons with Disabilities 45

Tool H - Tools for Strengthening Family Systems and Supporting Caregivers 48

Tool I - Tools for Building Positive Peer Support Interventions 49

Tool J - Tools for Community-based MHPSS and Stigma Reduction 50

Tool K - Tools to Inform the Policy, Legislative and Financing Environment 51

ANNEXES 54

Annex 1: Relevant UN Resolutions Specific to Marginalized and Underrepresented Groups 55

Annex 2: Draft Contextualization Workshop Agenda 56

Annex 3: Global Indicators Adapted for Indigenous Peoples 57

Annex 4: Key Considerations for Securing the Participation of Marginalized and Underrepresented Groups during the Assessment Phase of the Program Cycle 59

Annex 5: List of Key UN Resolutions 61

List of References 60

ACRONYMS AND ABBREVIATIONS

CBT	Cognitive behavioral therapy
C4	Comprehensive, Collaborative, Community-Based Care (Framework)
CBM	Christian Blind Mission
DNH	Do No Harm
GBV	Gender-based violence
IASC	Inter-Agency Standing Committee
LGBTQI+	Lesbian, gay, bisexual, transgender, queer, and intersex people, plus all people of diverse sexual orientations, gender identities, gender expressions, and sex characteristics (SOGIESC)
LMIC	Low- and middle-income country
MEAL	Monitoring, evaluation, adapting, and learning
MHPSS	Mental health and psychosocial support
PYD	Positive Youth Development
SGD	Sustainable Development Goal
SOGIESC	Sexual orientation, gender identity, gender expression and sex
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	Sexual orientation and gender identity and expression
USAID	United States Agency for International Development
VOT	Victims of Torture (program)
WHO	World Health Organization
YP2LE	YouthPower2: Learning and Evaluation

Van Long Bui, Pexels

Key Definitions

Note: Throughout this toolkit, reference boxes, such as the one below, refer the reader to this toolkit's companion document, Integrating Mental Health and Psychosocial Support into Youth Programming. These reference boxes are designed to provide a deeper context and understanding of the material.

USAID's core MHPSS definitions can be found on pages four to six in *Integrating Mental Health and Psychosocial Support into Youth Programming: A Toolkit.*

Marginalized groups: People who are typically denied access to legal protection or social and economic participation and programs, whether in practice or in principle, for historical, cultural, political, and/or other contextual reasons (USAID/DDI 2022). These may include, but are certainly not limited to, women; youth; children in adversity and their families; older persons; persons with disabilities; LGBTQI+ people; displaced persons; migrants; Indigenous Peoples and communities; non-dominant religious, racial, and ethnic groups; people of castes traditionally considered lower; people of lower socioeconomic status; and people with unmet mental health needs (USAID 2023). This toolkit includes discussion of the following marginalized groups:

- **LGBTQI+:** This acronym stands for lesbian, gay, bisexual, transgender, queer, and intersex. The "+" in LGBTQI+ represents additional sexual orientations, gender identities, gender expressions, and sex characteristics (SOGIESC) that do not fit within the "LGBTQI" identity labels. More information on USAID's blueprint for integrating LGBTQI+ individuals in USAID policy and programming can be found in USAID's LGBTQI+ Inclusive Development Policy.
- **Indigenous Peoples:** Globally, there are more than 476 million Indigenous Peoples in 90 countries (Cultural Survival n.d.). Indigenous Peoples live in nearly every country USAID works in and our activities affect many of them. Indigenous Peoples are not a monolithic group, and it is critical to recognize that many distinct voices exist within each community. The USAID Policy on Promoting the Rights of Indigenous Peoples provides the following criteria for identifying Indigenous Peoples (USAID/DDI 2020):
  - Self-identification as a distinct social and cultural group
  - Recognition of this identity by others
  - Historical continuity with pre-colonial and/or pre-settler societies
  - Collective attachment to territories and their natural resources
  - Customary social, economic, or governance institutions that are distinct
  - Distinct language or dialect
  - Resolve to maintain and reproduce their ancestral environments and systems as distinctive peoples and communities

- **Victims of Torture:** The Torture Victims Relief Act of 1998 authorized the United States Agency for International Development (USAID) to work through the Victims of Torture (VOT) program to provide assistance to individuals and families around the world who experienced physical and psychological effects of torture and trauma. Torture is the intentional inflection of physical, emotional, or psychological pain or suffering. The effects of torture are complex, resulting in psychological or physical trauma, and can last a lifetime, affecting survivors' physical and mental health, including one's ability to perform tasks that are important to caring for themselves, their families, and their communities. Recovery from the effects of torture and trauma often requires thoughtful psychological and medical attention (USAID n.d.).
- **Underrepresented groups:** Underrepresented groups are communities or individuals who have limited presence and influence in various sectors of society, such as politics, policymaking, decision-making procedures, employment, economic opportunities, education, and media presence. Underrepresentation is typically rooted in historical discrimination and marginalization based on identity characteristics such as ethnicity, race, sexual orientation and gender identity, disability status, immigration status, and so on. Underrepresentation has harmful consequences for the lives of those affected. When groups continue to be underrepresented, they will continuously be excluded from discussions and decision-making processes that directly affect them, increasing their risk of experiencing oppression and having policies formulated without their input (Emory University n.d.).
- **Persons with disabilities:** Disability is an evolving concept that results from the interaction between persons with impairments (including but not limited to persons who have long-term physical, mental, intellectual, or sensory impairments) and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others. Persons may be born with their disability or acquire it later in life. A person's disability may not always be apparent and, due to stigma, not all may choose to self-identify. Persons with disabilities are part of every group and could experience increased discrimination due to intersections with disability and other facets of their identity. Note that some persons with disabilities prefer "functional conditions," "conditions," or similar terms instead of "impairments (Emory University n.d.)."

Inclusive Development (ID): ID is an equitable development approach built on the understanding that every individual and community, of all diverse identities and experiences, is instrumental in the transformation of their own societies. Their engagement throughout the development process leads to better outcomes. An inclusive development approach ensures that all people can participate fully in and benefit equally from all USAID development efforts (USAID 2023).

Intersectional: The complex, cumulative way in which the effects of multiple forms of discrimination (such as racism, sexism, classism, ableism, ageism, heterosexism, etc.) combine, overlap, or intersect, especially in the experiences of marginalized or underrepresented individuals or groups. An intersectional approach recognizes that many elements of a person's identity can affect how they experience the world. In combination with systems of inequality, these intersecting identities can lead to varying degrees of power and privilege that, in turn, create unique power dynamics, effects, and perspectives affecting individuals' place in society, experience of, and potentially access to development interventions. Further, an intersectional approach advances efforts to address the specific inequalities women and girls face, because they make up approximately half of the population in any given country (USAID 2023).

Stigma: A negative or unfavorable perception, judgment, or stereotype that is attached to a particular individual, group, or characteristic. It is a social phenomenon characterized by the labeling, devaluation, or marginalization of individuals or groups based on attributes such as their race, ethnicity, gender, sexual orientation, disability, mental health condition, or any other characteristic that deviates from societal norms or expectations.

Barriers and Determinants of Mental Health: Barriers to mental health and psychosocial well-being include stigma, structural discrimination, lack of political will, access to healthcare and services, poor quality or limited services, lack of data, human rights violations, violence, abuse, coercion, sustainable resources, and MHPSS financing. Determinants of mental health are relative to each stage of development (the life course). Social determinants include poverty, inequalities, gender-based violence, childhood adversity, lack of coordinated emergency response, poor integration of physical and mental health care, and lack of shared community identity. Mental health and psychosocial well-being are influenced by factors such as lack of secure attachment, violence, exploitation, caregiver mental health, poverty, disease outbreaks, race and gender, exposure to adverse experiences, prolonged conflict, terrorism, mass displacement, family separation, intensifying natural disasters, and climate change.

Katie Yaeger Rotramel / Flickr

Ensuring Access to MHPSS for Marginalized and Underrepresented Groups Toolkit

The COVID-19 pandemic, in 2020 and 2021, brought increased attention to the global mental health and psychosocial support (MHPSS) needs we all have. This has accelerated the demand for MHPSS programming, increased the funds available for program design and development, and highlighted key gaps in programing guidance and resources, particularly for marginalized and underrepresented groups and youth within these groups.

One in four people experience mental health challenges at any given time, with nearly 50 percent of mental health challenges beginning before the age of 14 (WHO 2020). The 2020 Mental Health Atlas reports that suicide is the fourth most common cause of death (WHO 2021a). Suicide is the second leading cause of death for young people aged 15–29 years (Iemmi et al. 2016), and low- and middle-income countries (LMICs) have the highest rates of suicide—approximately 75 percent of all suicides occur in these countries (Breet, Goldstone, and Bantjes 2018), with higher rates among marginalized and underrepresented groups. There is a growing recognition that we have a global mental health crisis that demands a multisectoral and coordinated response to promote mental health and psychosocial well-being, prevent mental health needs from escalating into mental health conditions, and make sure the care and treatment of mental health are accessible and relevant to the stated mental health challenge, while maintaining a high standard of care.

Marginalized and underrepresented communities often experience greater mental health symptoms or need due to political, social, and economic exclusion in host countries and countries of origin. Limited access to care these groups experience in their communities due to the same factors, including the stigma of mental health, further complicate this reality. This toolkit will complement existing materials and resources by focusing on marginalized and underrepresented communities' mental health, exploring specific considerations for assessing their mental health needs, and facilitating access to MHPSS services, including identifying those that are culturally and contextually relevant and responsive to their stated mental health needs.

Why is this toolkit needed?

In 2020–2021, the United States Agency for International Development (USAID) commissioned YouthPower2: Learning and Evaluation (YP2LE) to develop Integrating Mental Health and Psychosocial Support into Youth Programming: A Toolkit (briefly, *Youth MHPSS Toolkit*). This new toolkit is a complement and an accompaniment to that first toolkit, establishing guidance and tools for working with marginalized and underrepresented communities, inclusive of youth in those communities, around the globe. These tools are complementary and should be used in tandem.

The frameworks in this toolkit focus on the process for how to engage marginalized and underrepresented groups in programming, whereas the frameworks in the Youth MHPSS Toolkit are focused on the MHPSS program itself. The Youth MHPSS Toolkit introduced core frameworks that guide and drive USAID-supported MHPSS programming, including USAID's Positive Youth Development (PYD) Framework and IASC's MHPSS Intervention Pyramid. This toolkit will expand on those frameworks by introducing a rights-based approach to mental health, providing guidance on the do-no-harm principle for MHPSS, and using the continuum of care. This secures alignment with broader interagency standards codified in United Nations (UN) resolutions.

This toolkit supports the implementation of USAID's YP2LE toolkit, the *Youth MHPSS Toolkit*, by focusing on what is needed to make sure marginalized and underrepresented youth communities are able to access quality MHPSS programs that are responsive to their stated mental health needs and culturally and contextually relevant. The *Youth MHPSS Toolkit* explores ways USAID programs can support marginalized and underrepresented communities with mental health or psychosocial needs in countries where USAID is present, including conflict-affected areas. USAID can achieve inclusive development by making sure we address mental health needs, especially as we work to advance programming for marginalized and underrepresented communities. The toolkit was developed with the USAID Program Cycle in mind and helps provide recommendations for implementing partners and USAID staff.

Who is the intended audience?

This toolkit, developed under YP2LE, is a reference for USAID Mission and headquarters staff, as well as national and international partners involved in designing, managing, and evaluating MHPSS programming and strategies for marginalized and underrepresented groups, including youth.

What are the intended contexts and populations?

The toolkit is for MHPSS programming for marginalized and underrepresented groups and those in vulnerable situations in both LMIC and humanitarian contexts. It focuses on mental health considerations when working with marginalized and underrepresented groups and highlights do no harm approaches. This toolkit applies USAID's inclusive development approach to MHPSS for marginalized or underrepresented groups to provide helpful guidance, tips, and resources on where to start and how to program effectively. Because many of the tools developed for conflict-affected settings were created for humanitarian action, the toolkit may use the term humanitarian, but the materials are relevant to various contexts.

How will this toolkit help me?

The toolkit provides strategies that take an inclusive development approach in mental health programming, including "do no harm" approaches when working with marginalized or underrepresented communities. It explores ways USAID programs can support marginalized and underrepresented communities with MHPSS programming and youth will be a cross-cutting theme throughout the toolkit. The toolkit was developed with the USAID Program Cycle in mind and translates research into practical recommendations for implementing partners and USAID staff working on MHPSS programming. The toolkit provides **considerations and procedures** for MHPSS programming by:

- Discussing mental health programming, including the most effective, evidence-informed, and evaluated programs specific to circumstances, and considerations for working with marginalized and underrepresented groups as identified through a review of gray and academic literature that "guides" users in development of MHPSS programming for marginalized and underrepresented groups (Section 2).
- Helping the user link their programming to relevant sustainable development goals and a human rights-based approach to mental health for marginalized and underrepresented populations, including relevant United Nations (UN) resolutions and instruments (Section 3).

- The toolkit will focus on four marginalized and underrepresented groups which include Indigenous peoples, LGBTQI+ people, persons with disabilities, and victims of torture. Each group will have a pull out with additional information to consider when developing MHPSS programming.
- Linking back to the *Youth MHPSS Toolkit* YP2LE produced in 2021.

How was this toolkit developed?

A team of consultants with professional background and expertise in MHPSS for each of the marginalized and underrepresented groups highlighted in the toolkit developed this resource. Each consultant conducted a literature review for their population and carried out consultations with implementing agencies, those with lived experiences, and global thought leaders in mental health. The YP2LE team designed this toolkit to complement, not replicate, the Youth MHPSS Toolkit that YP2LE produced in 2021. The team engaged members from marginalized and underrepresented groups through stakeholder consultations and reviews of the draft toolkit. This toolkit also includes population pull-outs that discuss the literature and lessons from the field specific to each population: LGBTQI+ people, persons with disabilities, victims of torture, and Indigenous peoples.

What are the main takeaways?

Main takeaways from this toolkit include:

- *Mental health affects everyone:* Every person has mental health, which can fluctuate from thriving to time-limited distress, chronic conditions, and significantly disabling conditions that affect a person's daily functioning. For those who are members of marginalized and underrepresented populations, it is not their inclusion in a marginalized or underrepresented group that contributes to mental health challenges. Instead, a wide range of factors affect their mental health—distressing events in everyday life, chronic abuse and neglect, a lack of positive coping mechanisms, including systematic and environmental factors such as discrimination and second-order impacts of marginalization.
- *The importance of family and community:* When supporting people from marginalized and underrepresented communities, it is important not only to support the individual but also their family system and community. When involving family of origin, it is important to make sure the youth is not put at increased risk and vulnerability. When the family of origin is not a safe option, family-focused interventions can include the youth's chosen family.
- *Mental health can be integrated across sectors:* Mental health programming is multi-sectoral and can be integrated across sectors. Thus, the principles conveyed in this toolkit can be applied across sectors.
- Common mental health challenges in marginalized and underrepresented groups include depression, suicide, substance use, and anxiety. These common mental health challenges are found within the general population; however, marginalized and underrepresented groups often feel excluded from mainstream mental health services and have a harder time benefiting from MHPSS services and treatments.

SECTION 1:
Terminology Specific to MHPSS and Marginalized and Underrepresented Groups

The following *Key Concepts* outline general contextual elements that can affect all stages—design, implementation, and evaluation—of MHPSS programming with individuals, including youth from marginalized and underrepresented groups. Each should be interpreted with consideration of the local context as part of an ongoing process of addressing culture bias, developing sufficient understanding of local MHPSS needs and resources, and learning from local knowledge on social-structural dimensions of mental health and psychosocial well-being.

Historical discrimination and exclusion based on identity as a barrier: Historical discrimination and exclusion based on identity has resulted in mental health services being inaccessible, unavailable, and at times, unsafe for marginalized and underrepresented groups. When working with a marginalized or underrepresented population, it is important to explore how discrimination has played a role in the population's ability to access MHPSS services and whether they have been excluded from accessing services based on their identity.

Overgeneralization of marginalized communities: Membership in a marginalized or underrepresented community is determined by something that everyone has in common; it should not negate the fact that marginalized and underrepresented groups are also diverse (Baylor University 2021), varying in age, race, sex, gender identity, language, religion, ethnic, Indigenous or social origin, disability, and barriers they face (Baylor University 2021).

Distress expression and mental health literacy: Distress expression of mental health needs often varies depending on language and cultural and gender norms. If MHPSS professionals or those designing programming do not understand these nuances, they may develop care plans that do not address the actual needs of the individual. More importantly, most people do not describe their challenges in clinical terms or the framing of the Diagnostic and Statistical Manual of Mental Disorders or the International Statistical Classification of Diseases and Related Health Problems, especially in LMICs and conflict-affected areas (Baylor University 2021).

Structural vulnerability: Structural vulnerability is the condition of being at high risk for challenges around health, mental health, and well-being outcomes by interfacing with systems that treat people inequitably. Structural vulnerability is mediated by intersectional identities and modified by societal contexts of socioeconomic, political, and cultural gradients of power. Structural vulnerability drives health inequities by reducing the likelihood of opportunities to access or generate health, mental health, and well-being resources and amplifies exposures to violence and risks of harm.

Social suffering: Social suffering refers to the political, economic, and institutional causes of the human experience of suffering and the ways these forms of power influence response to social challenges. Social suffering alludes to the ways suffering takes place collectively or as a social experience.

SECTION 2: A Review of the Literature on MHPSS for Marginalized and Underrepresented Groups

The social, economic, and physical environments we all live in influence MHPSS needs (WHO and Calouste Gulbenkian Foundation 2014). Mental health challenges are directly related to the serious gaps that exist in mental health and psychosocial well-being, which include a historic underinvestment in, and lack of action on, the promotion of states of well-being and the prevention among those living with mental health challenges, determinants of mental health and psychosocial well-being, and barriers to mental health services and care (UNICEF 2022a). This is more pronounced within marginalized and underrepresented communities who face structural and systemic barriers to accessing MHPSS services, making it difficult to receive appropriate care, which results in higher rates of mental health conditions (Baylor University 2021). In addition to the structural and systemic barriers, many marginalized and underrepresented groups face psychosocial challenges and protection risks, which increase the chances of developing mental health and psychosocial symptoms or conditions. Therefore, intentional efforts are required to:

1. Ensure that mental health and psychosocial programming is culturally pertinent and abides by the principle of "do no harm."
2. Support the fulfillment of the right to access to quality MHPSS services that safely and effectively address their mental health and psychosocial needs.

Despite recent successful knowledge-building on effective MHPSS interventions and approaches for quality mental health service delivery in LMICs and humanitarian settings, there has been little progress globally on improved access to safe, appropriate, and culturally relevant care for most people, including marginalized and underrepresented groups. Regarding the services that do exist, many people still face major barriers to access, including youth and families. For example, in many settings, services are located at a central psychiatric care facility, which translates into costs, remote distance, and stigma that make youth from marginalized and underrepresented groups less likely to seek formal MHPSS.

From the literature, we know that:

- Persons with disabilities are more likely to experience several protection risks than to their non-disabled peers, including exposure to sexual violence and violent discipline, neglect, exploitation, exclusion (UNICEF 2021), and bullying (Fang et al. 2022). During emergencies, these risks are intensified (IASC 2019). Children with intellectual, cognitive, and psychosocial conditions are at the greatest risk (IASC 2023). Persons with disabilities often live within institutions that are frequently not well considered in humanitarian responses and where they are likely to be at risk of greater protection violations even beyond violation of their right to live independently and be included in the community (IASC 2023). For a deeper dive, please see the Persons with Disabilities pullout.

Cottonbro / Pexels

- The marginalization, discrimination, and violence LGBTQI+ youth experience on the basis of their sexual orientation, gender identity, gender expression, and sex characteristics; the increased sense of vulnerability; and the pressure to hide their SOGIESC has direct consequences on their mental health and substance misuse, as well as implications for self-harm and suicide. The results of a meta-analysis carried out in high-income countries demonstrate that depression, anxiety, and alcohol and substance use were at least 1.5 times more common among LGBTQI+ individuals (Wainberg et al. 2017). Identity management strategies (i.e., being out in some contexts but not all) have been shown to elevate distress and mental health challenges among LGBTQI+ adults and affect academic achievement for youth (Fish 2020). LGBTQI+ youths are subjected to higher rates of peer victimization, stigmatization, social stress, and family and social rejection than their cisgender and heterosexual peers (Kraus-Perrotta 2022). However, there is a lack of reliable data on the characteristics and experiences of LGBTQI+ youths in LMICs and conflict settings, and research surrounding large-scale prevention, intervention, and health promotion programs that specifically address the mental health of LGBTQI+ youths is scarce (Pike, Kraus-Perrotta, and Ngo 2023; Save the Children 2016; Fish 2020). For a deeper dive, please see the LGBTQI+ pullout.

- Victims of torture and those who experience cumulative trauma (i.e., violence, traumatic loss and witnessing gross human right violations, living in fear or under threat of one's safety [Hoy-Ellis 2023]) have increased risk of mental health and psychosocial challenges, such as somatic complaints, depression, anxiety, social withdrawal, and disrupted attention (Hoy-Ellis 2023). Additionally, there is a struggle in acculturation that adds to loss. Often, they are separated from family and/or homeland, which creates additional grief that is often traumatic (Sangalang et al. 2019). For a deeper dive, please see the Victims of Torture pullout.

- Mental health and psychosocial well-being outcomes among Indigenous Peoples in many countries often appear to reflect similar mental health inequities (e.g., in suicide, psychological distress, depression, anxiety, intergenerational trauma [Hoy-Ellis 2023], and substance misuse) that Indigenous Peoples themselves may understand as connected to the historic injustices of colonization. The World Health Organization (WHO) acknowledges this concern and notes reports of Indigenous Peoples' ongoing disproportionate subjection to violence, including gender-based violence (GBV), racism, poverty, and cultural barriers (WHO 2023). However, there is a lack of research that establishes causal connections between compounded, multiple effects of centuries of colonization experienced over generations and mental health and psychosocial well-being outcomes among Indigenous Peoples (Hoy-Ellis 2023). For a deeper dive, please see the Indigenous Populations pullout.

SECTION 3: Frameworks that Underpin a Rights-Based Approach to MHPSS for Marginalized and Underrepresented Groups

When proposing an MHPSS program, one will need to demonstrate the steps their programming will take to secure the inclusion of marginalized and underrepresented populations. The frameworks presented in this section will guide the approach to program design and planning. The frameworks are more about the process for how to engage marginalized and underrepresented groups in programming, whereas the frameworks in the Youth MHPSS Toolkit are focused on the MHPSS program itself. These tools are complementary and should be used in tandem.

The Youth MHPSS Toolkit introduced core frameworks that guide and drive USAID-supported MHPSS programming, including USAID's Positive Youth Development (PYD) Framework and IASC's MHPSS Intervention Pyramid. This toolkit will expand on those frameworks by introducing a rights-based approach to mental health, providing guidance on the do-no-harm principle for MHPSS, and using the continuum of care. This secures alignment with broader interagency standards codified in United Nations (UN) resolutions.

Inclusive Development and MHPSS

Inclusive development is an equitable development approach built on the understanding that every person, group, and community, of all diverse identities and experiences, is critical in the transformation of their own societies and their engagement throughout the development process will lead to better outcomes. Inclusive development means that all individuals should be able to contribute and benefit from USAID programming. USAID's approach to inclusive development requires the participation and engagement of marginalized and underrepresented populations across the Program Cycle (USAID/DCHA/DRG/HR 2023). Integral to inclusive development are two key principles:

1. **"Do No Harm":** This toolkit complements the Youth MHPSS Toolkit by providing an MHPSS framework for inclusive development that entails a rights-based approach to mental health, guidance on the do-no-harm principle for MHPSS specific to marginalized and underrepresented youth communities, and use of the continuum of care.
2. **"Nothing about Us without Us":** The participation of marginalized and underrepresented groups is central to USAID's inclusive development approach. Marginalized and underrepresented groups should participate in the full Program Cycle, from assessments to design and evaluation. This toolkit increases focus on the integration of human rights, equity, and participation throughout by adapting the IASC "Human Rights and Equity" and "Participation" guidance from the IASC MHPSS Guidelines (IASC 2007). This integration aligns with USAID's Inclusive Development approach to incorporate local knowledge program design by providing tools and resources for maximizing the equitable participation of diverse marginalized and underrepresented groups in MHPSS programming (USAID/DCHA/DRG/HR 2023). This further supports alignment with and operationalizes broader interagency standards codified in the UN resolutions.

To further address equity gaps, the USAID Inclusive Development approach provides guidance and tools to facilitate safe, meaningful opportunities for individuals, including youth, from marginalized and underrepresented groups to participate in the development of mental health programs in an ongoing way—throughout design, implementation, and evaluation—with a focus on improving access to quality MHPSS services that meet the individuals' needs, including youth. Inclusion and Equity programming components include:

- **Utilizing an inclusive development approach in MHPSS program design** to address the needs of, engage with, and support the priorities of marginalized and underrepresented groups in programming by incorporating local knowledge
- **Using an informed apporach when engaging local communities** based on best practices (the most effective evidence-informed and evaluated programs specific to circumstance), USAID's principle of "Nothing about Us without Us," and USAID's Safety/Security-Sensitive and Trauma-Informed Stakeholder Consultations with Members of Marginalized Groups (USAID/DCHA/DRG/HR 2023).

These programming components serve as complementary resources that can be used to streamline a model of community-based mental health services into development program planning and engage with and support the priorities of youth from marginalized and underrepresented groups and other MHPSS stakeholders in contextualization and cultural adaptation.

A Rights-Based Approach for MHPSS

Mental health is a common thread that flows across multiple Sustainable Development Goals (SDGs), including (SDG 3) Good health and well-being; (SDG 4) Quality education; (SDG 8) Decent work and economic growth; (SDG 10) Reduced inequalities; (SDG 11) Sustainable cities and communities; and (SDG 16) Peace, justice, and strong institutions (WHO n.d.). The anchor for these goals is the UN Declaration of Universal Human Rights and the United Nations General Assembly recommends that all programming apply a human rights-based approach. The United Nations Sustainable Development Group provides guidance on how to make sure programming takes a human rights-based approach. A human rights-based approach is also fundamental to upholding the principles of inclusive development and "do no harm" when designing MHPSS programming.

A rights-based approach to inclusion of marginalized and underrepresented groups in MHPSS programming is based on human rights enshrined in and through UN conventions, and addresses inequities, discrimination, and injustices that undermine the realization of marginalized and underrepresented people's right to mental health and well-being. A rights-based approach to MHPSS program development is based on respect for the inherent dignity, autonomy, and independence of everyone. It promotes and protects the right to equity in access to quality MHPSS prevention, promotion, and care/treatment services. It considers the full range of social determinants that affect people's mental health and psychosocial well-being, diverging from the biomedical model's over-focus on diagnosis, medication, and symptom reduction (WHO 2021b). To make sure that MHPSS programs and projects are inclusive of Indigenous Peoples, victims of torture, families who have experienced potentially traumatic events, persons with disabilities, and LGBTQI+ communities, initiatives should focus on developing the capacities of "duty-bearers" to meet their obligations and "rights-holders" to claim their rights in alignment with the standards and principles set forth by core human rights in inclusive development resources (UN Sustainable Development Group n.d.).

Annex 1 of the toolkit includes a one-page summary of the relevant UN Resolutions for working with marginalized and underrepresented groups. This one-pager can be printed out and posted in your office, used in program training, and adapted or expanded based upon your program needs.

Young Southeast Asian Leaders Initiative / Flickr

SECTION 4:
Ensuring Inclusion throughout the USAID Program Cycle

This toolkit was designed to complement, not duplicate, the Youth MHPSS Toolkit. Therefore, the two resources should be used in tandem when designing MHPSS interventions. To support use of these tools together, please see the following that highlights which resource to go to and where.

Multisectoral Integration:
The sector pullout from the Youth MHPSS Toolkit provides illustrative presentations of how MHPSS programming has been integrated into education, gender and GBV, health, violence prevention, peace, and security; and youth employment.

Population Deep Dives:
The Marginalized Groups Toolkit includes population pullouts that discuss the literature and lessons from the field specific to each population: LGBTQI+ people, persons with disabilities, survivors of torture, and Indigenous groups.

Assessment: Identifying and understanding the MHPSS needs of marginalized populations and designing program objectives.

Assessing the MHPSS needs of marginalized populations is essential for designing effective programs that address their unique challenges and promote their well-being. Conducting a comprehensive needs assessment to gather data and insights about the specific MHPSS needs of marginalized groups in the local communities is a prerequisite for robust human-centered and human rights based MHPSS interventions. The assessment should include both quantitative and qualitative methods, such as surveys, interviews, focus groups, and observation. It should explore various dimensions, including cultural, social, economic, and political factors that influence mental health and psychosocial well-being.

It is important to make sure that assessments are conducted in a way that captures the mental health needs of local marginalized populations and can inform mental health programming in the development context. The assessment phase should guide how key mental health concepts are adapted for the local population, what terminology should be used, and how people describe mental health and psychosocial concerns.

A two pager that outlines key considerations for securing the participation of marginalized groups during the assessment phase of the program cycle can be found in Annex 4.

Do no harm considerations for adapting programming for marginalized and underrepresented populations	
✓ Do make sure that MHPSS services are accessible to all marginalized and underrepresented groups. This may require supplying staff with additional training to better equip them to provide safe MHPSS services.	✗ Do not assume that marginalized and underrepresented groups want to be identified or have their service locations advertised.
✓ Do engage members of marginalized and underrepresented groups in designing MHPSS assessments and contextualization.	✗ Do not depend on Western frameworks for understanding MHPSS needs.
✓ Do spend time with each community to build an understanding of how they talk about distress and the impact of potentially traumatic events on their mental health.	✗ Do not assume that distress will be expressed the same from one community to the next. Consider that persons with disabilities may have different physical or language needs.
✓ Do spend time learning the background and history of the person you work with. For example, a fear of being followed may appear irrational until you learn more about the individual's history, including where they came from and any past history of persecution.	✗ Do not make assumptions based on western mindset and diagnosis. Do not label someone with a mental health condition without fully understanding their context. For example, an irrational fear of being followed is only irrational if there is no one following them. Victims of torture may have well-founded fears of being followed that appear irrational.

Contextualizing and Adapting MHPSS for Marginalized and Underrepresented Groups

Contextualizing and/or adapting MHPSS programming requires community-informed and intersectional approaches. Individuals, including youth from marginalized and underrepresented groups, and non-youth stakeholders, should be provided with opportunities to engage in iterative program contextualization and cultural adaptation activities as part of supporting local ownership of MHPSS programming. Youth in marginalized and underrepresented populations comprise diverse individuals and groups whose experiences of mental health inequities are shaped by their intersectional identities. This involves aspects of age, race, color, sex, sexual orientation, gender identity, disability, ethnicity, Indigeneity, language, social origin, religion, migration status, survivorship, and other social categories. Individual youth with multiple marginalized and underrepresented identities may face overlapping or compounded social systemic risks for distress, traumatic experiences, and mental health conditions. Different youth have different needs.

Culture bias—interpreting, judging, or acting based on one's own cultural standards—can occur in MHPSS through the unchecked use of presumed universal categories (e.g., youth, community, risk), as well as through the implementation of standardized interventions or tools with little or no consideration for local communities' cultural ways of expressing wellness and distress or engaging in self-help and mutual support. Contextualization helps to mitigate cultural bias and avoid the use of culturally inappropriate interventions that can cause unintended harm.

Context drives adaptation: Adaptation is the process of developing a new version of a program strategy, intervention, or tool to make it more suitable to the context where it will be used.

The toolkit includes the following examples of adapted tools:

- IASC MHPSS Indicators adapted for Indigenous Peoples is included in the monitoring, evaluation, adapting, and learning (MEAL) section.
- A contextualization workshop agenda adapted from UNICEF's Contextualization Guidance for MHPSS in Children Associated with Armed Groups and Armed Forces Programmes can be viewed in Tool E.

In addition, IASC and CBM Global guidelines recognize the requirement to provide tailored programming supports specific to persons with disabilities as part of inclusion. Provision of supports to meet disability-related needs often involves making reasonable accommodations to programming to include persons with disabilities, which may or may not entail more rigorous adaptation.

Kampus Production / Pexels

Do no harm considerations for contextualization and adaptation

	Do		Do not
✓	Do modify vocabulary or wording, replace confusing or irrelevant cultural references or images, add relevant evidence-informed content, and modify the location, timeline, and incentives of activities to contribute to MHPSS effectiveness.	✗	Do not modify key components, theoretical foundations, or implementation parameters (e.g., number of sessions, participant engagement, adequate staff training).
✓	Do translate materials and tools into local languages with careful attention to the translation process. Where no direct translation exists for a word, use what the community uses. More often than not, the community will have words they use to qualify MHPSS-related disorders or challenges we know.	✗	Avoid changing the meaning of words and concepts in translation. Do not try to rush the translation process or expect concepts and words to always translate perfectly from one language to another.
✓	Do follow a recommended protocol for cultural adaptation or translation that is appropriate to the type of intervention or tool.	✗	Do not implement interventions or use tools that were adapted or translated without attention to quality.
✓	Do document and keep a record of adaptations, whether they are adjustments, modifications, translations, or full cultural adaptations of an evidence-based intervention or tool. Include notes on who was involved, the steps followed, and decisions about specific items, words, or concepts to steward supporting evidence of appropriate adaptation.	✗	Avoid spontaneous or undocumented changes to program components that are not informed by the context.
✓	Do make changes to programming to support participants' dignity and avoid causing unintentional harm or exacerbating stigma.	✗	Do not make changes to programming without close coordination with MEAL.
✓	Do protect and support the rights of marginalized and underrepresented groups and provide tailored program supports to promote inclusion.	✗	Do not attempt to adjust or adapt activities to promote inclusion without engagement from marginalized and underrepresented groups.

Selecting Evidence-Based Interventions

Inclusive development's principle of "Nothing about Us without Us" means that marginalized and underrepresented groups are key participants in the design process (selecting interventions, project locations, and key partners), because they can make sure interventions are relevant, acceptable, effective, and responsive to their needs. This section includes criteria for selecting evidence-based interventions, discussions of what works in MHPSS program design, and resources.

Selecting interventions: Use both toolkits when selecting program interventions. The following breakdown describes how these two toolkits approach interventions differently.

- **Youth MHPSS Toolkit:** Suggested interventions are informed by the literature review of what has been found to be effective in LMICs and conflicted-affected contexts across multiple sectors. Interventions are divided into mental health interventions and psychosocial interventions.
- **MHPSS for Marginalized and Underrepresented Groups:** The interventions for marginalized and underrepresented groups are organized by the socio-ecological model. Instead of duplicating the programming strategies and interventions presented in the rest of the toolkit, this toolkit includes a discussion of MHPSS needs for each population at each layer of the socio-ecological model. These illustrative discussions of MHPSS challenges are followed by a list of illustrative interventions across sectors and a collection of suggested tools.

Socio-ecological Model (Youth MHPSS Toolkit)

The YP2LE MHPSS Youth Toolkit introduced USAID's criteria for selecting evidence-based interventions (see Box 1). When working with marginalized and underrepresented groups, there might be very few interventions that meet the first two criteria with clear evidence that the intervention works for the stated challenges with the identified or similar populations. When that is the case, move onto criteria 3 and 4, but make sure to provide a clear justification as to why that intervention was selected, what evidence was found somewhere in the world for similar challenges, or how this intervention indirectly supports the program's theory of change.

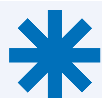
Box 1

Page 17 of the Youth MHPSS Toolkit presents criteria for selecting evidence-based interventions.

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

Once you select the intervention, tailor it for the local population. When necessary, make adaptions or changes to secure equitable inclusion. This requires adapting the interventions to the unique circumstances of the target group. Make sure all interventions are inclusive, respectful, and promote empowerment and resilience within the community.

As discussed in the Youth MHPSS Toolkit, the MHPSS program design may include both clinical and non-clinical components, with mental health care provided alongside psychosocial support activities. More recommendations and programmatic strategies for implementation can be found in the pull-outs.



Budgeting Considerations for Implementing MHPSS Programming for Marginalized and Underrepresented Groups

To effectively implement inclusive MHPSS programming and strategies, make sure that any additional costs are planned and budgeted. Expect that during program implementation, there will be unexpected costs resulting from inclusion strategies. You should always address that immediately with the donor (see equitable budget modification below). The IASC Minimum Services Package for MHPSS includes a costing tool that provides recommended budget categories for MHPSS interventions and activities.

This checklist should be used alongside the YP2LE Youth MHPSS Toolkit's section on budgeting for MHPSS interventions to make sure additional cost related to inclusion of marginalized and underrepresented groups is included during program design and planning.

<table>
<tr><th colspan="2">BUDGETING CONSIDERATIONS FOR SECURING INCLUSION OF MARGINALIZED AND UNDERREPRESENTED GROUPS IN MHPSS PROGRAMMING</th></tr>
<tr><td></td><td>Include consultancy fees for individuals with lived experience to advise on the needs of marginalized and underrepresented groups. For example:
• Consultant with lived experience for victims of torture
• Consultant with lived experience for persons with disabilities
• Consultant with lived experience for LGBTQI+ people
• Consultant with lived experience for Indigenous Peoples</td></tr>
<tr><td></td><td>Adaptation and validation of MHPSS tools includes the cost for ensuring further adaptation and validation for marginalized groups and underrepresented groups.</td></tr>
<tr><td></td><td>Budget for research team or outreach people/assessors (e.g., independent interviewers and blinded assessors) and interviewers includes cost for inclusion of marginalized and underrepresented groups.</td></tr>
<tr><td></td><td>Budget for contextualization workshops (see Annex 2 for a potential workshop agenda) includes cost related to:
• If feasible, ensuring marginalized and underrepresented groups are included and integrated into the workshop
• If necessary, separate workshops for marginalized and underrepresented groups</td></tr>
</table>

BUDGETING CONSIDERATIONS FOR SECURING INCLUSION OF MARGINALIZED AND UNDERREPRESENTED GROUPS IN MHPSS PROGRAMMING	
	Transportation cost includes any additional cost incurred from the participation of marginalized and underrepresented groups. For example: • Additional transportation costs necessary for ensuring marginalized and underrepresented groups can access services in a safe and timely manner • Additional transportation cost related to visiting marginalized and underrepresented groups

Requesting budget for equitable access budget modifications by establishing a procedure for requesting budget modifications when barriers to equitable access are identified. Sometimes, these costs come up during the implementation of the program and there needs to be an established process to make sure that any cost that can help remove barriers to accessing MHPSS services can be requested from the donors. Global guidance from both the Inter-Agency Standing Committee (IASC) and the CBM requires that programs tailor adaptations to the specific needs of the individual. This could include:

- Adaptive services based on individual needs
- Making structural changes to facilities to meet reasonable accommodation standards
- Adding a budget line to partner with a local disability NGO to support your organization, staff, and program in making sure persons with disabilities can access and benefit from the MHPSS services

Mainstreaming disability into MHPSS planning, programming, and budgeting to remove barriers to participation in the MHPSS response and support access for persons with disabilities on an equitable basis with non-disabled persons. Many organizations have already moved to this approach, including UNICEF, CBM, and the International Organization for Migration, who have strongly articulated organizational guidance on including persons with disabilities within their MHPSS programs using a rights-based approach. At a program and intervention level, organizations and programs have provided guidance within their intervention packages on how to make adaptations for children with disabilities (e.g., War Child Holland's Team-Up, Right to Play's Power Games). The use of participatory approaches in assessment and program planning and ownership is a central component of this (useful resources include UNHCR Participatory assessments, PLAN, Light for the World).

Potential topics: Training, Translations, Assessments, Transportation, etc.

The emphasis on inclusion of persons with disabilities has resulted in efforts to include, but not necessarily the adaptation of the tools, resources, and approaches necessary to make sure the interventions are relevant for all participants.

It is important to remember that it is impossible to adapt every activity to meet every impairment. We can only plan for reasonable adjustment, so that the majority still benefits. In some changes, instead of adapting, it is necessary to create new or different initiatives to secure equitable access.

Staffing: Good Practice for Working with Marginalized and Underrepresented Groups

Building an inclusive MHPSS workforce: The national and local workforce described in the Youth MHPSS Toolkit should also include members from local marginalized and underrepresented groups. Global guidance increasingly highlights the reality that the MHPSS workforce can and should include practitioners who provide MHPSS and come from a wide range of backgrounds, including MHPSS practitioners who have completed the "necessary on-the-job training and technical competencies" for the selected interventions (UNICEF 2022). When working with marginalized and underrepresented groups, include opportunities for training in MHPSS interventions to ensure a diverse workforce.

Examples include:

- Racial and ethnic equity and sensitization training
- Respect in the workplace, including tolerance in the workplace
- MHPSS frameworks
- Ostracization and discrimination, shame, identity, and so on
- Socio-political and historical debriefing

Case Example:
While reviewing intake forms, program leadership noticed that the sections on LGBTQI+ people were consistently left blank. While engaging staff to understand why these questions were skipped, they learned that staff felt uncomfortable with the questions. In response, the organization provided awareness-raising sessions around sexual orientation and gender identity and expression (SOGIESC), as well as practical and technical training around SOGIESC (terms and definitions, different gender identities, expressions, and sexual orientation, coming out processes, legal challenges in the host country, biases, discrimination and tropes, mistreatments and psychosocial needs, etc.). During the training, the facilitators encountered two protection monitors who expressed anti-LGBTQI+, discriminatory attitudes. The facilitators then had to do another series of bias checks training, guiding the monitors through their process, while reiterating the "do no harm" and rights-based approach of their work, as well as highlighting the importance of a trauma-informed assessment.

"Do no harm" considerations include:

Do no harm staffing considerations	
Do capacitate primary health care workers, educators, and social workers to effectively work with marginalized and underrepresented groups.	Do not assume that staff will treat everyone equally. We all have unknown biases that affect our attitudes and beliefs and shape how we interact with marginalized and underrepresented groups.

Do no harm staffing considerations

Do	Do not
✓ Do develop guidance and policies to effectively support participants. For example, criminalization of LGBTQI+ people in many countries is a barrier to someone seeking services. Helping staff to understand how to safely provide services for all program participants is essential.	✗ Do not assume that someone requesting MHPSS will feel safe receiving services, particularly if they belong to a marginalized and underrepresented group. They may also choose to not disclose their association or memberships with marginalized and underrepresented groups.
✓ Do train staff in culturally appropriate care, consent and confidentiality. The training should include building an understanding of how marginalized and underrepresented groups may have different cultural norms.	✗ Do not assume that cultural norms are the same across groups. Cultural norms of marginalized and underrepresented groups may differ significantly from the majority population's.
✓ Do make sure that both MHPSS workers and clients have the ability to request a referral to a different MHPSS worker at any point in time. Teams should be diverse in terms of background, skills, and comfort levels when working with diverse populations.	✗ Do not assume that guidance, policies, and training automatically mean people are able to work with someone who is different from them. Making sure that both the client and MHPSS worker feel safe in delivering services includes the freedom to request referrals to an alternate MHPSS worker when either the client or the MHPSS worker feels unsafe at any point in the care relationship.
✓ Do use a trauma-informed and healing-centered approach within the organization and the programming. For more information on what this entails, please review the section "Good Practice for Working with Populations with High Levels of Distress" in the [Youth MHPSS Toolkit (starting on page 27).]	✗ Do not make assumptions about how someone copes with distressing events and situations based on their reactions (or lack thereof) to the stress. Everyone responds to stress differently—some have outward expressive reactions, and others do not. Some may struggle with their stress, while others may have developed strategies and approaches that help their process. Lastly, what triggers a stress reaction in one person may not trigger one in someone else.
✓ Do make sure all MHPSS programming includes strategies at all levels of the IASC intervention pyramid, including strategies to promote considerations in basic safety and security by addressing stigma and discrimination (level 1).	✗ Do not raise awareness of mental health and psychosocial challenges without including access to MHPSS services.

Askar Abayev / Pexels

Inclusion of Marginalized and Underrepresented Populations in MEAL Systems for MHPSS Programming

Use the following key considerations for securing inclusion for marginalized and underrepresented groups within MHPSS MEAL systems alongside the MEAL guidance provided in the Youth MHPSS Toolkit:

- **Adapt indicators:** The IASC Common M&E Framework for MHPSS in Emergency Settings (version 2.0) includes specific guidance on adapting indicators to reflect program participants. The table presented below is an application of the guidance provided in the IASC Common M&E Framework, using standard indicators from the IASC Common M&E Framework and UNICEF's MHPSS Framework.
- **Disaggregate the data:** When appropriate, data should be disaggregated to reflect representation across marginalized and underrepresented groups. However, this may be difficult in contexts where membership in a particular group carries legal consequences. The safety and protection of program participants should always be the priority.
- **Conduct an inclusive development analysis:** Inclusive development analyses should be conducted to identify marginalized groups and their needs, including mental health and psychosocial needs. For more information see USAID's Guide to Inclusive Development Analyses.
- **Secure disability analysis:** MEAL systems should integrate disability analysis in multisectoral and interagency assessment to make sure all members of the community have access to MHPSS programs, including persons with disabilities.
- **Disseminate findings:** Publishing program evaluations, research articles, and implementation science findings is how programs contribute to strengthening the evidence base, which results in improved evidence-based programming for marginalized and underrepresented groups. Findings should also be shared directly with marginalized and underrepresented groups and the organizations that service them in language that is accessible.

MEASUREMENT AREA	SECTOR	INDICATORS
Care	Cross-Sectoral Indicator	Number of young Indigenous women, young Indigenous men, and nonbinary Indigenous youth receiving focused care (e.g., psychological first aid, linking people with psychosocial challenges to resources and services, case management, psychological counselling, psychotherapy or clinical management of mental health conditions) [O4.4, IASC]
Uptake and compliance	Cross-Sectoral Indicator	Percentage of available focused MHPSS programs that offer evidence-based care relevant to the culture, context, and age of Indigenous youth [O5.7, IASC]
Care	Cross-Sectoral Indicator	Level of satisfaction among young Indigenous women, young Indigenous men, and nonbinary Indigenous youth with mental health and psychosocial conditions regarding the care they received [O5.8, IASC]

Tool A - Checklist for Inclusive MHPSS Programming

CHECKLIST FOR INCLUSIVE MHPSS PROGRAMMING			
Instructions: This checklist provides a list of questions to help a project team systematically consider the inclusion of marginalized and underrepresented groups in each stage of the project cycle. Teams should review the checklist both at the start of a project and routinely throughout implementation. The checklist is not exhaustive but meant to spark discussion around key human rights principles and support teams and their local partners to develop more inclusive MHPSS programming.			
QUESTIONS FOR CONSIDERATION		**YES**	**NO**
Questions related to a rights-based approach for MHPSS			
	Have you identified key right-holders [insert relevant marginalized and underrepresented groups] and duty-bearers (those who govern – policymakers, health officials, health providers, etc.) that have a stake in your activity?		
	Have you identified power relationships, discriminatory practices, stigma, inequities faced by [insert relevant marginalized and underrepresented groups] in the project's context?		
	Have you reviewed the relevant human rights conventions and instruments for [insert relevant marginalized and underrepresented groups] in your program to make sure they are protected and promoted in [insert country name]'s constitution, domestic laws/ policies? Have these rights been ratified? Have you explored the extent to which any applicable laws are implemented and enforced in practice? (Marginalized Toolkit page 37 for a selection of relevant rights-based documents/resources)		
	Have you identified the empowerment capacity gaps of [insert relevant marginalized and underrepresented groups] that constrain them from claiming their right to MHPSS? And the accountability capacity gaps of duty-bearers to meet their obligations?		

[1] Check out: UN Women: Lessons Learned from Evaluations: Capacity Development in Women's Economic Empowerment Programmes.
[2] UNESCO defines duty-bearers as: Duty-bearers are entities or individuals having a particular obligation or responsibility to respect, promote and realize human rights and to abstain from human rights violations. It is commonly used to refer to State actors, but non-State actors can also be considered duty-bearers.

	Do health policies integrate mental health considerations for specific populations at higher risk of mental health challenges, such as people with HIV, pregnant adolescents, migrant populations, or [insert relevant marginalized and underrepresented groups]?		
	Does a human right–based approach to [insert relevant marginalized and underrepresented groups] exist in the country's process of policy formulation, implementation, and evaluation of mental health programs and services?		
	Have you identified the relevant Sustainable Development Goals for your program?		
Needs Assessment and Situation Analysis			
	What opportunities do you see for further integration of MHPSS for [insert relevant marginalized and underrepresented groups] into existing or ongoing programs? How about across sectors?		
	Are you aware of programming implemented in your country that has a component related to MHPSS? Is it considered a humanitarian or development program? Gather program documents and any relevant measurement and evaluation tools used, such as completed evaluations. Did these programs mention strategies for ensuring inclusion of [insert relevant marginalized and underrepresented groups]?		
	Have you identified the specific challenges that different [insert relevant marginalized and underrepresented groups] face?		
	Have you developed a strategy to ensure proper and meaningful community engagement of [insert relevant marginalized and underrepresented groups] in the project design?		
	Have you identified the psychosocial factors that [insert relevant marginalized and underrepresented groups] face?		
	Have you identified the available programmatic interventions and services for [insert relevant marginalized and underrepresented groups]? What is missing?		
	Have you identified the laws and policies governing the lives of [insert relevant marginalized and underrepresented groups]?		
	Have you analyzed how the socio-cultural context affects these marginalized communities? Are there any stigmas to be aware of?		
	Have you identified what the types of psychosocial needs and MHPSS challenges that [insert relevant marginalized and underrepresented groups] face and why (systems approach)? For example, does this population have intergenerational trauma, experienced government oppression and criminalization due to their membership and association with a group, or face social stigma?		

	What are the common social attitudes or popular cultural beliefs about mental health for [insert relevant marginalized and underrepresented groups] and about accessing services?		
	Are there attitudinal differences between rural and urban regions or any differences among groups, such as generations, social or economic classes, ethnicities, or different genders?		
	Is there a national or regional strategy or plan to address stigma related to mental health across sectors?		
	Is attempting suicide considered a crime? What steps have been taken to remove barriers to seeking help for suicidal ideation or after a suicide attempt?		
	Is substance use criminalized and are hospitals legally obligated to report patients who come in with substance in their system?		
	Have you reviewed the legal frameworks that affect [insert relevant marginalized and underrepresented groups] and identified those laws that establish criminalization by association?		
	Are service provides bound by law to report [insert relevant marginalized and underrepresented groups]?		
	Have you developed any key messages or advocacy for government or donors on MHPSS? Do you have an opinion regarding the capacity of your country office or any partners in the design and implementation of these?		
Stakeholder Engagement and Coordination			
	Have you identified the relevant stakeholders? Who are the relevant stakeholders?		
	Are there any MHPSS and protection working groups or clusters that we can be part of?		
	Is there any discrimination in the service provision based on identity, socio-political or socioeconomic backgrounds?		
	Who among the local partners, stakeholders, and community members can we engage in a meaningful way for co-creation and co-design of the project?		
	Are there any protection against sexual exploitation and abuse (PSEA) and child safeguarding clusters we can be part of?		
Design and Planning			
	Have you defined the project, its objectives, and its partners?		
	Have you involved [insert relevant marginalized and underrepresented groups] in the planning of project activities?		
	Have you established partnerships with [insert relevant marginalized and underrepresented groups] organizations that can assist in supporting members from relevant groups in designing activities in a relevant way?		

	Have you considered the benefits and risks from potential project policies and activities for [insert relevant marginalized and underrepresented groups] selecting implementation strategies?		
	Have you aligned the implementation strategy to ensure services/ programs will be available, accessible, acceptable, and of high quality for ? And reviewed standards and policies to ensure participation, non-discrimination, and accountability?		
	Have you identified what interventions are required to close the most important gaps in empowerment capacities of?		
	Have you identified what interventions are required to close the most important gaps in accountability capacities of the key duty-bearers?		
	Have you ensured that project information, materials, and curricula will be available in accessible formats?		
	Have you designed an orientation process for project staff and partners on disability inclusion?		
Implementation			
	Have you established routine ways for [insert relevant marginalized and underrepresented groups] to continue to be engaged in activity implementation and in the review of progress/results?		
	Have you established mechanisms and review procedures to ensure that [insert relevant marginalized and underrepresented groups] are in fact benefiting from project implementation?		
	Is project implementation contributing as intended to the empowerment capacities of [insert relevant marginalized and underrepresented groups]? And to the accountability capacities of duty-bearers?		
	Are persons with disabilities not using the project's services? Have measures been taken to investigate these situations and target potentially excluded groups?		
	Have unintentional discriminatory practices been identified during implementation? And if so, have they been rectified?		
Budget and Staffing			
	Does your budget include costs related to equity, diversity, and inclusion?		
	Do you have budget cost necessary to train all staff in trauma-informed approaches? (see MHPSS Youth Toolkit, page 27 and USAID Guidance on Safety/Security-sensitive and trauma-informed stakeholder consultations with members of marginalized and underrepresented groups)		

	Does the program budget include clinical supervision? (see MHPSS Youth Toolkit)		
	Does the budget include cost for capacity-strengthening needs, accessibility needs, and other specific considerations for equipping marginalized and underrepresented groups to participate in the program?		
	Have you established clear eligibility criteria for staff recruitment and plans for helping staff develop the skills needed for working with all program participants?		
	Did you establish a process to ensure budget and design for independent accountability mechanisms?		
	Do your recruitment strategies included outreach to marginalized communities?		
	Do you have plans to foster equity, inclusion, and staff well-being in place?		
	Does the project capacitate primary health care workers, educators, and social workers to effectively work with marginalized populations?		
	Have you developed guidance and policies to effectively support participants? For example, criminalization of LGBTQI+ in many countries is a barrier to someone seeking services. Helping staff to understand how to safely provide services for all program participants is essential.		
	Are you using a trauma-informed and healing-centered approach within the organization and the programming? For more information on what this entails, please review the section "Good Practice for Working with Populations with High Levels of Distress" in the Youth MHPSS Toolkit (starting on page 27).		
	Did you ensure all MHPSS programming includes strategies at all levels of the IASC intervention pyramid, including strategies to promote considerations in basic safety and security by addressing stigma and discrimination (level 1)?		
Monitoring and Evaluation (M&E)			
	Have persons [insert relevant marginalized and underrepresented groups] been involved in defining success for the project and establishing the M&E plan?		
	Are data routinely disaggregated by [insert relevant marginalized and underrepresented groups]?		
	Does the M&E plan include targets to measure progress in relation to availability, accessibility, acceptability, and quality of services?		

	Does the M&E plan measure the ways in which the project ensures human rights principles, including participation, inclusion, and transparency related to [insert relevant marginalized and underrepresented groups]? (Process Indicator)		
	Does the M&E plan measure goods, services, and deliverables produced to strengthen the capacity of [insert relevant marginalized and underrepresented groups] and duty-bearers? (Output Indicator)		
	Does the M&E plan measure the legal, policy, institutional, and behavioral changes leading to better performance of [insert relevant marginalized and underrepresented groups] in realizing their right to mental health and psychosocial support and duty-bearers to meet their obligations? (Outcome Indicator)		
	Does the M&E plan measure sustained, positive changes in the life, dignity, and well-being of [insert relevant marginalized and underrepresented groups]? (Impact Indicator)		
	Did [insert relevant marginalized and underrepresented groups] and duty-bearers participate in deciding how the results will be disseminated?		
	Are M&E staff trained on trauma-informed evaluation and assessment?		
	Are M&E staff trained on safeguarding?		
	Is the M&E approach co-designed or reviewed by members of the community?		
	Are the tools culturally relevant and adapted?		
	Are the tools translated and administered in the local community's language / native tongue / spoken dialect?		
	Is there a qualitative component to M&E? (storytelling is truly important in helping to make the invisible visible especially for marginalized communities)		

Adapted from the following resources:

- UNFPA. 2006. "HRBA Checklist of Questions, from A Human Rights-Based Approach to Programming: Practical Implementation Manual and Training Materials."
- Management Sciences for Health. n.d. "Inclusive Health Checklist."
- UNICEF. 2023. "Conducting a Multisectoral Situational Analysis for MHPSS: A Practical Guide for Country-Level Assessments."

Tool B - Contextualization Templates and Tools

IASC Contextualization Guidance

The lists below, excerpted from IASC/WHO/UNHCR guidance on assessing mental health and psychosocial needs and resources, can be used as a reference to support a desk review, a contextual analysis, and/or a consultative contextualization workshop with stakeholders.

2. General Context

- 2.1 Geographical aspects (e.g., climate, neighboring countries)
- 2.2 Demographic aspects (e.g., population size, age distribution, languages, education/literacy, religious groups, ethnic groups, migration patterns, groups especially at risk to suffer in humanitarian crises)
- 2.3 Historical aspects (e.g., early history, colonization, recent political history)
- 2.4 Political aspects (e.g., organization of state/government, distribution of power, contesting sub-groups or parties)
- 2.5 Religious aspects (e.g., religious groups, important religious beliefs and practices, relationships between different groups)
- 2.6 Economic aspects (e.g., Human Development Index, main livelihoods and sources of income, unemployment rate, poverty, resources)
- 2.7 Gender and family aspects (e.g., organization of family life, traditional gender roles)
- 2.8 Cultural aspects (traditions, taboo, rituals and practices related to health and well-being)
- 2.9 General health aspects
  - 2.9.1 Mortality, threats to mortality, and common diseases
  - 2.9.2 Overview of structure of formal, general health system

3. Mental health and psychosocial context

- 3.1 Mental health and psychosocial problems and resources
  - 3.1.1 Epidemiological studies of mental disorders and risk/protective factors conducted in the country, suicide rates
  - 3.1.2 Local expressions (idioms) for distress and folk diagnoses, local concepts of trauma and loss
  - 3.1.3 Explanatory models for mental and psychosocial problems
  - 3.1.4 Concepts of the self/person (e.g., relations between body, soul, spirit)
  - 3.1.5 Major sources of distress (e.g., poverty, child abuse, infertility)
  - 3.1.6 Role of the formal and informal educational sector in psychosocial support
  - 3.1.7 Role of the formal social sector (e.g., social services) in psychosocial support
  - 3.1.8 Role of the informal social sector (e.g., community protection systems, neighborhood systems, other community resources) in psychosocial support
  - 3.1.9 Role of the non-allopathic health system (including traditional or indigenous health system) in mental health and psychosocial support
  - 3.1.10 Help-seeking patterns (where people go for help and for what problems; who accompanies them; potential barriers to access)

- 3.2 The mental health system
  - 3.2.1 Mental health policy and legislative framework and leadership
  - 3.2.2 Description of the formal mental health services (primary, secondary and tertiary care). Consider the relevant Mental Health Atlas and WHO-AIMS reports among other sources to find out availability of mental health services, mental health human resources, how mental health services are used, how accessible mental health services are (for example distance, fee for service), and the quality of mental health services
  - 3.2.3 Relative roles of government, private sector, NGOs, and traditional healers providing mental health care

Initial stakeholder consultation matrix

Introduction to the tool

Conducting an initial stakeholder consultation matrix will help to facilitate rapid initial learning about the social-structural inequities affecting the mental health and psychosocial well-being among youth from marginalized and underrepresented groups in the context of engagement in mental health program development and access to MHPSS service delivery. This inquiry was synthesized with the following frameworks and tools in this toolkit to develop the matrix:

- Three core levels of the C4 Framework
- Continuum of care
- Program strategies for MHPSS with youth in marginalized and underrepresented groups, organized by the socio-ecological model
- Designing for inclusive development programming approaches

Tool: MHPSS Inequities and Youth in marginalized and underrepresented groups

Initial stakeholder consultation matrix

Instructions:

- For the questions below, replace "youth from marginalized and underrepresented groups" with: Indigenous youth, LGBTQI+ youth, or youth with disabilities as applicable
- Conduct informal consultations with at least one representative for each of the 30 boxes in the table below—this will help to ensure hearing a variation of perspectives on MHPSS inequities affecting youth in marginalized and underrepresented groups during the initial stages of program development
- Adhere to professional or local community ethical standards for community consultation

QUESTION KEY

S&H: What are the structural and historical factors of the mental health inequities disproportionately affecting youth from marginalized and underrepresented groups?

B: What are the barriers to accessing quality MHPSS care for youth from marginalized and underrepresented groups?

B: What are the barriers to engaging in mental health program development among youth from marginalized and underrepresented groups?

N: What are the MHPSS needs of youth from marginalized and underrepresented groups?

P: What are the MHPSS priorities among youth from marginalized and underrepresented groups?

PROGRAM DEVELOPMENT AND SERVICE DELIVERY	Consult with Youth	Consult with Family	Consult with School	Consult with Community	Consult with Societies/ Systems
Topic: USAID Mental health program development	S&H, B, N, P	S&H, B, N, P	S&H, B, N, P	S &H, B, N, P	S&H, B, N, P
Topic: Promotion interventions	S&H, B, N, P	S&H, B, N, P	S&H, B, N, P	S&H, B, N, P	S&H, B, N, P
Topic: Prevention interventions	S&H, B, N, P	S&H, B, N, P	S&H, B, N, P	S&H, B, N, P	S&H, B, N, P
Topic: Care – Psychological interventions	S&H, B, N, P	S&H, B, N, P	S&H, B, N, P	S&H, B, N, P	S&H, B, N, P
Topic: Care – Mental health in primary care (pharmacological prescribers)	S&H, B, N, P	S&H, B, N, P	S&H, B, N, P	S&H, B, N, P	S&H, B, N, P
Topic: Care – Specialized mental health care and urgent or hospital-based care	S&H, B, N, P	S&H, B, N, P	S&H, B, N, P	S&H, B, N, P	S&H, B, N, P

Tool C - A Rights-Based Approach for MHPSS

Key Resources and Tools

https://www.voicesofyouth.org/act/how-write-about-disability-rights how to write about disability rights.

Human Rights-Based Approach. This website provides guidance on how to take a human rights approach in development assistance. It includes links to recommended tools and resources key to securing a human rights-based approach. This website and the tools it links to are essential in making sure programming is anchored in human rights. https://unsdg.un.org/2030-agenda/universal-values/human-*rights-based-approach.*

Light for the World Resource Book on Disability Inclusion. The resource book on disability provides guidance on how to ensure disability inclusion in development programs and anchors this guidance in the CRPD. resource_book_disability_inclusion.pdf (licht-fuer-die-welt.at).

USAID's Disability Communication Tips outlines five core tips for communicating with and about persons with disabilities. It also includes an "Easy Reference Guide" with a list of suggested phrases and phrases to avoid. https://www.usaid.gov/sites/default/files/2023-01/USAIDDisabilityCommunicationsTips2021_508_1.pdf

WHO's Guidance on Community Mental Health Services: Promoting Person-Centered and Rights-Based Approaches, dated June 9, 2021. This guidance document provides person-centered and human rights-based approaches in mental health, along with recommendations and action steps for developing community mental health services that respect human rights and focus on recovery. https://www.who.int/publications-detail-redirect/9789240025707.

QualityRights. WHO's QualityRights Initiative aims to change mindsets and practices to promote the rights and recovery to improve the lives of people with psychosocial, intellectual, or cognitive disabilities everywhere. WHO's QualityRight's webpage includes a comprehensive collection of training and guidance documents, all of which have been translated into multiple languages. Including the following training sessions: Human rights; Mental health, disability, and human rights; Legal capacity and the right to decide. https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools.

Disability-Inclusive Development 101 E-Learning Course is an introductory course for USAID Staff and partners which provides a general overview of disability concepts, disability inclusive development and USAID policies. The course ensures a common understanding of trends and USAID requirements related to persons with disabilities in development.[6] https://www.usaid.gov/inclusivedevelopment/disability-inclusive-development-101-course.

Selected Literature

UNICEF's Discussion Paper titled A Rights-Based Approach to Disability in the Context of Mental Health, published in New York in 2021. This discussion paper introduces a rights-based approach to mental health the YP2LE team will use to inform this toolkit's approaches to MHPSS service delivery. https://www.unicef.org/media/95836/file/A%20Rights-Based%20Approach%20to%20Disability%20in%20the%20Context%20of%20Mental%20Health.pdf.

The mental health continuum literature: Patel, V., S. Saxena, C. Lund, G. Thornicroft, F. Baingana, P. Bolton, J. UnÜtzer, et al. 2018. "The Lancet Commission on Global Mental Health and Sustainable Development." *The Lancet*, 392(10157), 1553-1598.

[6] USAID. Disability-Inclusive Development 101 E-Learning Course. Accessed at https://www.usaid.gov/inclusivedevelopment/disability-inclusive-development-101-course on 14 August 2023.

The First Nations Mental Health Wellness Framework: Kyoon-Achan, Grace, Naser Ibrahim, Rachel Eni, Wanda Phillips-Beck, Josée Lavoie, Kathi Avery Kinew, and Alan Katz. 2021. Beyond Care: *Validating a First Nations Mental Wellness Framework. Canadian Journal of Community Mental Health*. 40(1): 67-80. https://doi.org/10.7870/cjcmh-2021-005.

Key Resource: *Expanding Mental Health Services in Low-and Middle- Income Countries: A Task-Shifting Framework for Delivery of Comprehensive, Collaborative Community-Based Care:* http://dx.doi.org/10.1017/gmh.2023.5.

UNICEF's *Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings*, which complements the C4 framework by also recommending a community-based approach that anchors service delivery through community-based institutions—primary health care, education, and social welfare. For more information, see Outcomes 3 and 4 in the theory of change: Global Multisectoral Operational Framework | UNICEF.

Tool D - Tools for Ensuring Inclusion and Participation in MHPSS Assessments (Section 4 tools)

Key Resources and Tools

Young People's Participation and Mental Health | UNICEF. This resource was developed by UNICEF's Adolescent Development and Participation team for use by all, including young people who want to ensure a participatory process at all stages of program design and development. https://www.unicef.org/reports/young-peoples-participation-and-mental-health.

USAID's *Safety/Security-Sensitive and Trauma-Informed Stakeholder Consultations with Members of Marginalized Groups*. This resource outlines practices that assist in conducting consultations with individuals and organizations of marginalized and underrepresented groups in a way that is sensitive to their safety/security concerns and prior experiences of trauma. https://www.usaid.gov/sites/default/files/2022-12/Marginalized_Groups_PDF.pdf.

The World Vision's Gender Equality and Social Inclusion (GESI) – The World Vision's Approach and Theory of Change. This resource provides guidance on how to more effectively contribute to the well-being of the most vulnerable children, their families, and communities through evidence-based GESI transformative change. The resource provides guidance on how to conduct a GESI analysis and assessment (also referred to as a Gender and Inclusive Development Analysis at USAID). Gender_Equality_and_Social_Inclusion_Approach_2021.pdf (wvi.org).

Guidelines for Consulting with Children and Young People with Disabilities (2016). The guidelines provide practical considerations and tips for consulting with children and young persons with disabilities in a variety of situations. Consulting and ensuring the meaningful participation of persons with disabilities is a "must do," as outlined in IASC guidelines for both humanitarian responses and MHPSS response in humanitarian context. The resource aims to equip individuals with the knowledge and skills necessary to communicate with children with a variety of disabilities to make sure they are consulted with and can meaningfully contribute to activity. These guidelines set out tips and suggestions for the entire consultation process, including planning for the consultation, general considerations for consulting with children with disabilities, and specific tips for communicating with children with different types of impairments. The guide provides some case study examples from the field. https://plan-international.org/publications/guidelines-children-and-young-people-with-disabilities/.

Washington Group of Questionnaires – The Washington Group on Disability Statistics. This resource provides seven different question sets related to disability. Information on each of the different question sets can be found on the pages related to each question set. https://www.washingtongroup-disability.com/question-sets/.

Resource Book on Disability Inclusion (2017). The book provides guidance and tools for disability inclusion to support programmatic development and implementation. It supplies core concepts, theoretical knowledge, and basic information about disability inclusion and the process of mainstreaming disability at organization and program levels. This is supported by "how-to" pages, which give practical tips and tools on how to apply inclusion with a range of populations and with different impairments. Checklists are available as a supporting tool and further resources are listed. The final section contains a *Trainer-facilitator's Guide*, which provides guidance for trainers on how to use the materials for workshop and training events. The guide is not a training manual, but suggestions and examples on how to use the materials. https://www.light-for-the-world.org/publications/resource-book-on-disability-inclusion/

Selected Literature

Cultural bias and MHPSS, Force Migration Review. This journal article from the Force Migration Review provides a discussion on cultural bias and MHPSS. The article highlights that cultural bias, when left unchecked, may result in missed opportunities and harmful effects often resulting in overlooking and missing the mental health needs of the local populations.[7]

Promoting Mental Health in Indigenous Populations. Experiences from Countries. This report provides a discussion on mental health in Indigenous populations in Argentina, Brazil, Canada, and Chile. The report provides examples of meetings that were held in each of the countries with Indigenous populations, including meeting agendas and a write-up of the outcomes. This resource is useful for those who want to plan similar workshops to explore mental health in marginalized groups. [8]

[7] Ocampo, J., M. Audi, and M. Wessells. 2021. "Culture Bias and MHPSS." Forced Migration Review, (66).
[8] Pan American Health Organization (PAHO)/WHO. 2016. Promoting Mental Health in Indigenous Populations. Experiences from Countries. A collaboration between PAHO/WHO, Canada, Chile, and Partners from the Region of the Americas 2014–2015. Project report. Washington, D.C.: PAHO/WHO. Accessed July 13, 2023. https://iris.paho.org/bitstream/handle/10665.2/28415/9789275118979_eng.pdf?sequence=1&isAllowed=

Tool E - Tools to Support Contextualization and Adaptation

Key Resources and Tools

USAID Suggested Approaches for Integrating Inclusive Development Across the Program Cycle in Mission Operations: Additional help for ADS 201. https://usaidlearninglab.org/sites/default/files/resource/files/additional_help_for_ads_201_inclusive_development_180726_final_r.pdf.

DD/Inclusive Development Hub/USAID Policy on Promoting the Rights of Indigenous Peoples. March 2020. https://www.usaid.gov/sites/default/files/2022-05/USAID-IndigenousPeoples-Policy-mar-2020.pdf.

UN Permanent Forum on Indigenous Issues note on Indigenous Determinants of Health in the 2030 Agenda for Sustainable Development. April 2023. Indigenous determinants of health in the 2030 Agenda for Sustainable Development: (un.org).

UNICEF Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers across Settings. https://www.unicef.org/reports/global-multisectoral-operational-framework.

UNICEF Mental Health and Psychosocial Support in Children Associated with Armed Groups and Armed Forces Programmes: Contextualization Guidance. https://mhpsscollaborative.org/wp-content/uploads/2022/02/FINAL-MHPSS-in-CAAFAG-Programs-Contextualization-Guidance.pdf.

Alliance for Child Protection in Humanitarian Action, Contextualization How-to Guide, Child Protection Minimum Standards. https://alliancecpha.org/sites/default/files/technical/attachments/4._contextualising_the_cpms.docx.pdf.

IASC, The Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings: With Means of Verification. (Version 2.0). https://interagencystandingcommittee.org/system/files/2021-09/%20IASC%20Common%20Monitoring%20and%20Evaluation%20Framework%20for%20Mental%20Health%20and%20Psychosocial%20Support%20in%20Emergency%20Settings-%20With%20means%20of%20verification%20%28Version%202.0%29.pdf.

USAID Learning Lab. *Adapting in Practice Accessed*. https://usaidlearninglab.org/resources/adapting-practice.

USAID'S Collective Action to Reduce Gender-based Violence (CARE-GBV). *How to Integrate Mental Health and Psychosocial Interventions in Gender-Based Violence Programs in Low-Resource Settings*. https://makingcents.com/wp-content/uploads/2021/01/CARE-GBV_04_MHPSS_v6-508.pdf.

UN Partnership on the Rights of Persons with Disabilities (UNPRPD) and UNWOMEN. *Intersectionality Resource Guide and Toolkit.* https://www.unwomen.org/en/digital-library/publications/2022/01/intersectionality-resource-guide-and-toolkit.

Peace in Practice and World Health Organization, Brief on Translating and Adapting the Psychological First Aid: Guide for Field Workers. https://pscentre.org/wp-content/uploads/2018/12/2018-PFA-Translation-and-Adaptation-Guidance.pdf.

UNICEF. 2020. COVID-19 *Operational Guidance for Implementations and Adaptation of MHPSS Activities of Children, Adolescents and Families*. https://drive.google.com/file/d/1A6hDzW-Per-meCr1jluEv2-hmOLhipbW/view.

Selected Literature

Perera, C., A. Salamanca-Sanabria, J. Caballero-Bernal, et al. 2020. "No Implementation without Cultural Adaptation: A Process for Culturally Adapting Low-Intensity Psychological Interventions in Humanitarian Settings." *Confl Health* 14, 46. https://link.springer.com/article/10.1186/s13031-020-00290-0.

Nemiro A., E.V. Hof, and S. Constant. 2021. "After the Randomised Controlled Trial: Implementing Problem Management Plus Through Humanitarian Agencies: Three Case Studies from Ethiopia, Syria and Honduras." *Intervention* 19:84-90. https://www.interventionjournal.org/article.asp?issn=1571-8883;year=2021;volume=19;issue=1;spage=84;epage=90;aulast=Nemiro;type=0>.

Ocampo, J., M. Audi, and M. Wessells. 2021. "Culture Bias and MHPSS." *Forced Migration Review*, (66). https://ora.ox.ac.uk/objects/uuid:cd9a5855-63c2-4185-a80c-55dae110153a/download_file?file_format=application%2Fpdf&safe_filename=ocampo-audi-wessells.pdf&type_of_work=Journal+article.

Ubels, T., S. Kinsbergen, J. Tolsma, and D.J. Koch. 2022. "The Social Outcomes of Psychosocial Support: A Grey Literature Scoping Review." *SSM-mental health*, 100074. https://www.sciencedirect.com/science/article/pii/S2666560322000147.

Bourgois, P., S.M. Holmes, K. Sue, and J. Quesada. 2017. "Structural Vulnerability: Operationalizing the Concept to Address Health Disparities in Clinical Care". *Acad Med*. Mar;92(3):299-307. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5233668/.

Tool F - Recommended Tools for LGBTQI+ Population

The following tools were identified during the review of the literature and stakeholder consultations. Some of the tools were developed specifically for the LGBTQI+ community and others, while not designed for this population, provide relevant program activities that can help support the development of positive relationships and coping mechanisms.

Addressing sexual violence against men, boys, and LGBTIQ+ persons in humanitarian settings. A field-friendly guidance note by sector. A growing body of evidence demonstrates that LGBTIQ+ individuals with diverse SOGIESC are targets of sexual violence in conflict, flight, and displacement. The aim of this guidance note is to outline key actions and considerations for service provision per sector to support frontline workers to better address sexual violence against men, boys, and LGBTQI+ persons. The guidance note draws upon and consolidates existing humanitarian guidance, including guidance related to health, MHPSS, child protection, and GBV, and contextualizes the existing guidance with learning from research to provide additional insights and context for service providers. The guidance note is a starting point to complement existing guidance and is based on current knowledge of these challenges. https://reliefweb.int/report/world/addressing-sexual-violence-against-men-boys-and-lgbtiq-persons-humanitarian-settings.

UNICEF's Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children and Families across Settings (MHPSS Framework). The framework is an operational document on MHPSS programming for children, adolescents, and families in all contexts, including high income countries, LMICs, and humanitarian action. The framework applies a socio-ecological approach that integrates development/lifespan approach. https://www.unicef.org/reports/global-multisectoral-operational-framework.

Additional tools from UNICEF include:

- *Gender in Adolescent Mental Health, A Technical Note.* A core resource in the implementation packages for the MHPSS Framework, this technical note provides a gendered discussion on adolescent mental health.
- *Gender-Responsive Parenting.* A technical note and tips on gender-responsive parenting provide a review of key concepts related to gender-responsive parenting and brief guidance on gender-responsive parenting. The tips on gender-responsive parenting provides guidance to caregivers. https://www.unicef.org/eca/media/16436/file/Gender_Responsive_Parenting.pdf and https://www.unicef.org/eca/media/16446/file/Tips_on_Gender_Responsive_Parenting.pdf.

Talking Parents, Healthy Teens.[11] This is a program to help parents learn parenting and communication skills that would facilitate communication with their adolescent children, promote healthy adolescent sexual behaviors, and reduce sexual risk behaviors. The program is provided at worksites as a means of easily reaching a large number of parents. It is an eight-week, one hour per week program. **[Promising intervention]** http://www.cdc.gov/pcd/issues/2006/oct/06_0012.htm.

CDC/PEPFAR Families Matter! Program (FMP). FMP is an evidence-based, parent-focused intervention designed to promote positive parenting and effective parent–child communication about sexuality and sexual risk reduction, including risk for child sexual abuse and GBV, for parents or caregivers of 9- to 12-year olds in Africa. https://stacks.cdc.gov/view/cdc/26190.

Parenting of Adolescents: Programming guidance. This guidance document provides an overview of healthy child/adolescent development and guidance to providers and stakeholders on developing evidence-based programs to support parenting and caregiving of adolescents. https://www.unicef.org/reports/parenting-adolescents.

[11] Eastman K.L., R. Corona, and M.A. Schuster. 2006. "Talking Parents, Healthy Teens: A Worksite-Based Program for Parents to Promote Adolescent Sexual Health." Prev Chronic Dis [serial online] 2006 Oct [date cited]. http://www.cdc.gov/pcd/issues/2006/oct/06_0012.htm.

Helping Adolescents Thrive (HAT) Guidelines on mental health promotive and preventive interventions for adolescents (2020) and the HAT toolkit (2021). The guidelines provide evidence-informed recommendations on psychosocial interventions to promote states of well-being and prevent mental disorders among adolescents. The guidelines are based on evidence from studies of interventions delivered to 10- to19-year-olds. The HAT toolkit, has been developed to improve programming for adolescent mental health promotion and prevention and support the implementation of the WHO HAT guidelines on mental health promotive and preventive interventions for adolescents. The toolkit describes evidence-informed approaches for promoting states of well-being, preventing mental health conditions, and reducing engagement in self-harm and risk behaviors.

- HAT Guidelines https://www.who.int/publications/i/item/9789240011854
- HAT Toolkit https://www.who.int/publications/i/item/9789240025554

Connect with Respect: Preventing GBV in Schools.[12] This resource is designed to assist teachers to deliver education programs in early secondary school. It has been designed for students between 11 and 14 years of age but can be adapted for use with older students. It provides age-appropriate learning activities on important themes and concepts relating to the prevention of GBV and promotion of respectful relationships. Tool also assists school leaders to better understand how to take a whole-school approach to the prevention of school-related gender-based violence. https://www.mhpss.net/toolkit/children-and-families-mhpss-resource-collection/resource/connect-with-respect-preventing-gender-based-violence-in-schools.

Child Protection Sessions for Parents and Caregivers. Research indicates that LGBTQI+ youth's experiences can include violence and discrimination by peers, teachers, and family. Given these experiences, this workshop, developed by Save the Children, may be relevant in capacitating caregivers/parents of LGBTQI+ youth to effectively protect their child/children and to establish a positive relationship with them. https://resourcecentre.savethechildren.net/document/child-protection-sessions-caregivers-and-parents-training-toolkit/.

Additional resources

- Program H M D: A toolkit Kit for Action: Engaging Youth to Achieve Gender Equity: https://www.equimundo.org/wp-content/uploads/2015/01/Program-HMD-Toolkit-for-Action.pdf
- IRC's Women's Protection and Empowerment: https://www.rescue.org/outcome/empowerment
- UNCIEF's Gender Toolkit: https://www.unicef.org/rosa/sites/unicef.org.rosa/files/2018-12/Gender%20Toolkit%20Integrating%20Gender%20in%20Programming%20for%20Every%20Child%20UNICEF%20South%20Asia%202018.pdf

[12] UNESCO. 2016. "Connect with Respect: Preventing Gender-Based Violence in Schools".

Tool G - Recommended Tools for Persons with Disabilities

The following tools were identified during the review of the literature and stakeholder consultations.

Humanitarian inclusion standards for older people and people with disabilities help humanitarian organizations ensure nobody is marginalized or left behind during emergency responses. This handbook is available in Arabic, English, French, Indonesian (Bahasa), Korean, Nepali, Spanish, Tetum, and Ukrainian.

Inter-Agency Standing Committee (IASC) *Guidelines for Inclusion of Persons with Disabilities in Humanitarian Action* set out essential actions that humanitarian actors must take to effectively identify and respond to the needs and rights of persons with disabilities who are the most at risk of being left behind in humanitarian settings. The recommended actions in each chapter place persons with disabilities at the center of humanitarian action, both as actors and as members of affected populations. They are specific to persons with disabilities and the context of humanitarian action, and build on existing and more general standards and guidelines.

ADWG's **Disability Inclusion Tip Sheet** is three-page tip sheet that provides at-a-glance guidance on what disability inclusion is.

ADWG's **Tip Sheet for Assistive Device Provision** guidance note provides a set of standards on prescription, measurement, and use making sure that assistive devices humanitarian actors provide reach the most vulnerable, are safer, and benefit those the most in need.

ADWG's ***Accessibility*:** Technical Guidance Notes and Good Practices on Accessibility should be a go-to reference and resource on all accessibility-related things within international assistance. It includes an overview of core definitions, standards, and design specifications to ensure buildings and basic services meet accessibility standards.

The Washington Group on Disability Statistics' Questionnaires provide seven different question sets related to disability. Information on each of the different question sets can be found on the pages related to each question set.

Resource Book on Disability Inclusion (2017) provides guidance and tools for disability inclusion to support programmatic development and implementation. It supplies core concepts, theoretical knowledge, and basic information about disability inclusion and the process of mainstreaming disability at organization and program levels. This is supported by how-to pages, which give practical tips and tools on how apply inclusion with a range of populations and with different impairment. Checklists are available as a supporting tool and further resources are listed. The final section contains a Trainer-facilitator's Guide, which provides guidance for trainers on how to use the materials for workshop and training events. The guide is not a training manual, but a set of suggestions and examples on how to use the materials.

Disability Inclusion in Child Protection And Gender-Based Violence Programs: Guidance for Psychosocial Support Facilitators by Women's Refugee Committee includes guidance, key actions, and tools to improve outreach and identification of children with disabilities for psychosocial support activities; to adapt existing psychosocial support activities; and to support children and adolescents with disabilities who are at medium to high risk of child protection concerns and targets different local facilitators. The guide includes detailed information on the types of barriers children with disabilities interact with and identifies children who may be at a particularly high risk to protection and rights violations.

A Toolkit for Integrating Gender Equality and Social Inclusion in Design, Monitoring and Evaluation (2020) provides checklists for organizations to assess how well they are addressing GESI challenges within their programming and their organization as a whole, and supports overall program development. MEAL social inclusion refers to all members of the community, but specifically targets

marginalized groups and persons with disability. The GESI lens has a strong theory of change that while relating to World Vision International-specific vision and mission, can also be applied in other organizations.

Guidelines for Consulting with Children and Young People with Disabilities **(2016)** provide practical considerations and tips for consulting with children and young persons with disabilities in a variety of situations. Consulting and ensuring the meaningful participation of persons with disabilities is a "must do," as outlined in IASC guidelines for both humanitarian responses and MHPSS response in humanitarian context. The resource aims to equip individuals with the knowledge and skills necessary to communicate with children with a variety of disabilities to make sure they are consulted with and can meaningfully contribute to the activity.

These guidelines set out tips and suggestions for the entire consultation process, including planning for the consultation, general considerations for consulting with children with disabilities, and specific tips for communicating with children with different types of impairments. The guide provides some case study examples from the field.

IASC Information Note on Disability and Inclusion in MHPSS **(2023)** provides guidance for strengthening the disability inclusiveness of MHPSS responses and programs in emergency settings. It is intended to supplement the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (2007) and translates this guideline and the *IASC Guidelines on Inclusion of Persons with Disabilities in Humanitarian Action* to the planning, implementation, and evaluation of MHPSS for persons with disabilities. Consistent with these two foundational documents, it is rooted in a rights-based approach, is cross sectoral, and is for application across the lifespan, also recognizing the needs of individuals both in communities and in institutional care.

Different Just Like You and accompanying 1-day training guide provide practical guidance in planning and implementing psychosocial activities for a range of populations with disabilities. The handbook describes best practice in psychosocial support and inclusion, with many (if not most) of the adapted activities described being movement-based (sports and other physical activities). Activities to support relaxation are also described. The handbook is aimed at professionals and volunteers working with persons with disabilities or those who want to make sure that persons with disabilities are able to be integrated into MHPSS-based programs This includes schoolteachers, social workers, pedagogues, sheltered workshop instructors, health workers, and coaches and/or volunteers in organizations, sports clubs and recreational facilities.

Community Mental Health Good Practice Guide: Inclusive Mental Health and Psychosocial Support (MHPSS) in Humanitarian Emergencies **(2023)** considers inclusion across the whole MHPSS program lifecycle; highlights a number of standalone MHPSS interventions; explores how these can be facilitated in a way that supports persons with disabilities, including persons with psychosocial disabilities; and outlines the approach needed to do no harm and maintain best practice in supportive inclusive MHPSS.

International Organization for Migration's Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement Manual integrates disability inclusion throughout the document. Specific examples include:

- Definitions of community assessment, engagement/participation, and partnerships (pp. 33–35)
- Sector-specific activities (e.g., protection, livelihood, sports and play) and specific MHPSS interventions provided by psychosocial mobile teams; the potential need for additional and /or tailored and targeted supports for persons with disabilities is also acknowledged
- Acknowledgement of the risk of exclusion, barriers, and or potential inadvertent harm from "inexperienced programming" or programming that does not have an inclusivity lens
- Recommendation for training on disability inclusion and recognition of disability as a topic that should be considered as part of the monthly training sessions for the psychosocial mobile teams,

which forms part of the supervision and quality assurance approach; the manual links to various other resources to support inclusion, including for adapting sports and games, international guidelines, and tools to support programming (e.g., Washington Group questions)

- Chapter 14 (community-based support for people with severe mental disorders), which adopts a human rights-based approach to supporting people with severe mental health conditions and links to mhGAP, and a commits to providing full spectrum of services/IASC Pyramid; however, reference to CAMHs is limited

A case example of disability-inclusive MHPSS from Iraq (pp. 35–38) Annex 1.

Tools for Delivering Individualized Services

The following tools and/or approaches should be contextualized for the population that will receive the services. For some marginalized and underrepresented groups, these tools would be considered "promising" in that there will be no direct evidence that these tools work for x population in x context, but there is indication that they would.

MHPSS YOUTH TOOLKIT
Page 20 for a comprehensive list of MHPSS Design Tools

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

ACCESS Open Minds (ACCESS OM):[13] ACCESS OM is a pan-Canadian project that worked to improve youth mental healthcare in the First Nation community of Eskasoni, a rural Mi'kmaq community, by blending Indigenous and Western methodologies. A preexisting "Fish Net Model" of youth mental health center transformed. Appropriate care in the new model consists of youth being given the choice, in consultation with a clinician, to have a standard Western mental health service or an Indigenous method of improving well-being, or any combination of the two they prefer. The Indigenous methods offered include working with Elders in a traditional medicine garden, participating in land-based nature programs and summer culture camps, taking part in traditional ceremonies, and practicing traditional crafts. (Promising Intervention)

Disability Inclusion in Child Protection and Gender-Based Violence Programs: Guidance for Psychosocial Support Facilitators. This resource by Women's Refugee Committee includes guidance, key actions, and tools to improve outreach and identification of children with disabilities for psychosocial support activities, adapt existing psychosocial support activities, and support children and adolescents with disabilities who are at medium to high risk of child protection concerns; the resource targets different local facilitators. The guide includes detailed information on the types of barriers children with disabilities interact with and identifies children who may be at a particularly high risk for protection and rights.

[13] Hutt-MacLeod, D., H. Rudderham, A. Sylliboy, M. Sylliboy-Denny, L. Liebenberg, J.F. Denny, P. Boksa, et al. 2019. Eskasoni First Nation's transformation of youth mental healthcare: Partnership between a Mi'kmaq community and the ACCESS Open Minds research project in implementing innovative practice and service evaluation. Early Intervention in Psychiatry, pp. 13, 42–47.

Tool H - Tools for Strengthening Family Systems and Supporting Caregivers

Talking Parents, Healthy Teens. Talking Parents, Healthy Teens is a program to help parents learn parenting and communication skills that would facilitate communication with their adolescent children, promote healthy adolescent sexual behaviors, and reduce sexual risk behaviors. The program is provided at worksites as a means of easily reaching a large number of parents. It is an 8-week, 1 hour per week program. (Promising Intervention) http://www.cdc.gov/pcd/issues/2006/oct/06_0012.htm. [14]

The U.S. Centers for Disease Control and Prevention (CDC)/President's Emergency for Fund for AIDS Relief (PEPFAR) The Families Matter! Program (FMP). The FMP is an evidence-based, parent-focused intervention designed to promote positive parenting and effective parent–child communication about sexuality and sexual risk reduction, including risk for child sexual abuse and GBV, for parents or caregivers of 9- to 12-year olds in Africa. For more information, please see the two pager https://stacks.cdc.gov/view/cdc/26190.

Parenting of Adolescents: Programming guidance. This guidance document provides an overview of healthy child/adolescent development and guidance to providers and stakeholders on developing evidence-based programs to support parenting and caregiving of adolescents. https://www.unicef.org/reports/parenting-adolescents.

Child protection sessions for parents and caregivers. Research indicates that LGBTQI+ youth experiences can include violence and discrimination by peers, teachers, and family. Given these experiences, this workshop, developed by Save the Children, may be relevant in capacitating caregivers/parents of LGBTQI+ youth to effectively protect their child/children and establish a positive relationship with them. https://resourcecentre.savethechildren.net/document/child-protection-sessions-caregivers-and-parents-training-toolkit/.

Caring for the Caregivers. This module aims to build front-line workers' skills in strengths-based counselling to increase caregivers' confidence and help them develop stress management, self-care, and conflict-resolution skills to support their emotional well-being. The prototype version of the module consists of three core manuals to guide the training and implementation process. This prototype is currently being validated in eight countries through implementation research. https://www.unicef.org/documents/caring-caregiver.

Sibling Support for Adolescent Girls. This is a family-based program that aims to address the protection risk for adolescent girls. The program strengthened the quality of relationships between family members and resulted in overall improved mental health and psychosocial well-being. This approach could be adapted for marginalized and underrepresented groups to strengthen family relationships. https://www.mercycorps.org/research-resources/sibling-support-adolescent-girls-emergencies

[14] Eastman, K.L., R. Corona, and M.A. Schuster. 2006. "Talking Parents, Healthy Teens: A Worksite-Based Program for Parents to Promote Adolescent Sexual Health." Prev Chronic Dis [serial online] Oct [date cited]. http://www.cdc.gov/pcd/issues/2006/oct/06_0012.htm.

Tool I - Tools for Building Positive Peer Support Interventions

One–to–one peer support by and for people with lived experience (QualityRights, WHO). A training module for one–to–one support provided by a peer who has personal experiences similar to that of another person. It has been translated into Catalan, Czech, and Korean. https://apps.who.int/iris/bitstream/handle/10665/329591/9789241516785-eng.pdf?sequence=1&isAllowed=y.

Peer Support groups by and for people with lived experience (WHO QualityRights Guidance Module). Guidance on how to create and strengthen peer-support groups for people with psychosocial, intellectual, or cognitive disabilities and their families and care partners. It has been translated into Catalan, Czech, and Korean. https://apps.who.int/iris/handle/10665/329594.

I Support My Friends. This resource builds on the principles of psychological first aid to equip adolescents and youth with the skills and knowledge to support their friends in distress, under the mentorship and guidance of trusted adults. The four-part resource kit has been jointly developed by UNICEF, Save the Children, the MHPSS Collaborative, and WHO. *I Support My Friends* recognizes the agency and capacity of the individual to develop the skills to support their friends and ensures that they can do so safely with close adult supervision and attention to child safeguarding. The training builds on existing evidence-informed materials and global experience in working with children and adolescents. At its heart are the globally endorsed principles of LOOK, LISTEN, LINK to guide a humane, practical response to people in distress, as described in Psychological First Aid: Guide for Field Workers and the Psychological First Aid Training Manual for Child Practitioners. I Support My Friends empowers children and adolescents to identify and support their peers in distress while recognizing the role they naturally play in the protective networks of their peers. https://www.unicef.org/documents/i-support-my-friends.

Tool J - Tools for Community-based MHPSS and Stigma Reduction

Stigma Reduction to Trigger Change for Children (STRECH), War Child Holland. STRETCH is a research-based, multi-component intervention applicable across stigmas and contexts. This tool was developed to address any/all stigmas. The STRECH approach, while well-developed, will undergo further feasibility testing in 2024, followed by effectiveness studies. While the tools for the STRECH intervention will not be readily available for a couple of years, the research articles may still be of interest to those looking to address stigma.

- Stigma reduction interventions for children and adolescents in low- and middle-income countries: Systematic review of intervention strategies - ScienceDirect
- Assessing stigma in low- and middle-income countries: A systematic review of scales used with children and adolescents - ScienceDirect
- Understanding Stigmatisation: Results of a Qualitative Formative Study with Adolescents and Adults in DR Congo | SpringerLink

Global multisectoral operational framework | UNICEF. This resource includes a section that discusses stigma inclusive of recommended interventions that could be adapted for programming needs. Stigma is discussed in Outcome 3, specifically output 3.1 "Stigma- and judgment-free environments for mental health and psychosocial wellbeing are established through social and community awareness, acceptance, and positive behavior change for children, adolescents, and their parents, caregivers, families and teachers." https://www.unicef.org/reports/global-multisectoral-operational-framework.

In addition to the framework, UNICEF also has a global stigma reduction campaign #OnMyMind: Better mental health for every child | UNICEF.

Community Mental Health Good Practice Guide: Anti-Stigma and Awareness-Raising Resource. In this resource, CBM shares key learnings and insights from their and partner programming on anti-stigma, anti-discrimination, and awareness raising work. The resource also includes the perspectives of people with mental health conditions and/or psychosocial disabilities. https://www.cbmuk.org.uk/resource/community-mental-health-good-practice-guide-anti-stigma-and-awareness-raising/.

Tool K - Tools to Inform the Policy, Legislative and Financing Environment

Global multisectoral operational framework | UNICEF. UNICEF's MHPSS Framework includes a section specifically focused on policy, legislation and financing. It can be found under Output 4.1 and includes guidance on advocacy and MHPSS, as well as recommended key actions across policy, legislative, and mental health financing. https://www.unicef.org/reports/global-multisectoral-operational-framework.

IASC Advocacy Package: IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. This is the go-to resource for anyone who works on mental health advocacy and/or messaging. https://interagencystandingcommittee.org/system/files/1304936629-UNICEF-Advocacy-april29-Enghlish.pdf.

Source. Source is an international online resource center managed by Humanity and Inclusion, which includes a repository of advocacy tools.

Promoting rights-based policy and law for mental health by WHO. This resource discusses WHO's work with countries to develop and implement progressive mental health and related policies and laws in line with international best practice and human rights standards, including the CPRD. Policies and laws are the cornerstones for a coordinated government effort to promote the rights of persons with disabilties, including psychosocial, intellectual, and cognitive disabilities, and put in place services and supports to meet their needs and promote their recovery. Examples of key resources on this page include:

- Guidance and technical package on community mental health services
- The WHO mental health policy and service guidance package
- Comprehensive Mental Health Action Plan 2013–2030

Mental Health Atlas. The atlas is released every three years and is a compilation of data provided by countries around the world on mental health policies, legislation, financing, human resources, availability and use of services, and data collection systems. It serves as a guide for countries for the development and planning of mental health services. The *Mental Health Atlas 2020* includes information and data on the progress made toward achieving mental health targets for 2020 set by the global health community and included in *WHO's Comprehensive Mental Health Action Plan*. The atlas includes data on newly added indicators on service coverage, mental health integration into primary health care, preparedness for the provision of MHPSS in emergencies and research on mental health. It also includes new targets for 2030.

Tools for Budgeting MHPSS Programs

The Mental Health and Psychosocial Support Minimum Service Package's MHPSS MSP Costing Tool. This tool is in development and will help in creating program budgets for some of the most common budget items. It includes budgeting for MHPSS related workshops and similar. The tool is currently being validated and tested, and will be launched in late 2023 or in 2024. https://mhpssmsp.org/en.

Age and Disability Working Group's (ADWG's) Disability Inclusion Tip Sheet. This three-page tip sheet provides at-a-glance guidance on what disability inclusion is.

ADWG's Tip Sheet for Assistive Device Provision. The purpose of this guidance note is to provide a set of standards on prescription, measurement, and use ensuring that assistive devices humanitarian actors provide reach the most vulnerable, are safer, and benefit those the most in need.

ADWG's Accessibility: "Technical Guidance notes and good practices." The technical guidance notes and good practices on accessibility should be a go-to reference and resource on all accessibility-related things within international assistance. It includes an overview of core definitions, standards, and design specifications to make sure buildings and basic services meet accessibility standards.

Recommended Tools

Different Just Like You. The resource and accompanying one-day training guide provide practical guidance in planning and implementing psychosocial activities for a range of populations with disabilities. The handbook describes recommended practices in psychosocial support and inclusion, with many (if not most) of the adapted activities described being movement-based (sports and other physical activities). Activities to support relaxation are also described. The handbook is aimed at professionals and volunteers working with people with disabilities or those who want to make sure persons with disabilities are able to be integrated into MHPSS-based programs This includes schoolteachers, social workers, pedagogues, sheltered workshop instructors, health workers, and coaches and/or volunteers in organizations, sports clubs, and recreational facilities. The resource package includes the handbook https://pscentre.org/?resource=different-just-like-you-english&selected=single-resource, a one-day training guide https://pscentre.org/?resource=different-just-like-you-training-manual-english&wpv_search=true&selected=single-resource, and a training slide deck https://pscentre.org/?resource=different-just-like-you-ppt-english&wpv_search=true&selected=single-resource.

A Toolkit for Integrating Gender Equality and Social Inclusion in Design, Monitoring and Evaluation (2020). This tool provides checklists for organizations to assess how well they are doing in addressing GESI challenges within their programming and their organization as a whole and supports overall program development. MEAL social inclusion refers to all members of the community, but specifically targets marginalized groups and persons with disability. The GESI lens has a strong theory of change that while relating to World Vision International-specific vision and mission, can also be applied in other organizations. https://wvusstatic.com/2020/landing-pages/gender-equality/Gender_Equality_and_Social_Inclusion_DME_Toolkit_2021.pdf.

Global multisectoral operational framework | UNICEF includes a section specifically focused on workforce development. It can be found under Output 4.3 and includes guidance specific to staffing for MHPSS programming, including a table focused on core competencies. https://www.unicef.org/reports/global-multisectoral-operational-framework.

WHO EQUIP is a platform of materials, such as a digital assessment tool and e-learning courses, for enhancing training and supervision for improved MHPSS services. It provides guidance and tools to assess and monitor competencies in helpers to build safe, effective, and high-quality MHPSS services.

Tools for MEAL

YP2LE MHPSS Toolkit. The toolkit includes illustrative indicators for MHPSS programming that span across USAID sectors. The indicators were created by reviewing USAID's existing indicators for MHPSS from across sectors, the IASC M&E Framework, and UNICEF's indicators from the MHPSS Framework (demonstration version). https://www.youthpower.org/toolkit-youth-mental-health-and-psychosocial-support-toolkit.

IASC Information Note on Disability and Inclusion in MHPSS (2023). Provides guidance for strengthening the disability inclusiveness of MHPSS responses and programs in emergency settings. It is intended to supplement the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (2007) and translates this guideline and the *IASC Guidelines on Inclusion of Persons with Disabilities in Humanitarian Action* to the planning, implementation, and evaluation of MHPSS for persons with disabilities. Consistent with these two foundational documents, it is rooted in a rights-based approach, is cross sectoral, and is for application across the lifespan, also recognizing the needs of individuals both in communities and in institutional care.

Global multisectoral operational framework | UNICEF includes a section on MEAL that discusses theories of change, outcomes, outputs, and indicators for MHPSS. It is further supported by a MHPSS log frame in annex 4 with recommended indicators. https://www.unicef.org/reports/global-multisectoral-operational-framework.

"An introduction to participatory monitoring and evaluation: the missing link between inquiry and impact - ActivityInfo" https://www.activityinfo.org/blog/posts/2021-03-15-an-introduction-to-participatory-monitoring-and-evaluation-the-missing-link-between-inquiry-and-impact.html.

"A beginner's guide to inclusive monitoring and evaluation: from talking to doing" ActivityInfo https://www.activityinfo.org/blog/posts/2021-01-19-a-beginners-guide-to-inclusive-monitoring-and-evaluation.html.

Annexes

Annex 1: Relevant UN Resolutions Specific to Marginalized and Underrepresented Groups

United Nations Convention on the Rights of Persons with Disabilities (CRPD). Adopted in 2006, the CRPD situates disability within a social and rights-based framing, and reaffirms that all persons with all types of disabilities must enjoy all human rights and fundamental freedoms on an equal basis with others. Convention on the Rights of Persons with Disabilities | OHCHR.

Resolution adopted by the United Nations General Assembly, Human Rights Council, "Mental Health and Human Rights," A/HRC/RES/36/13, 28 September 2017. This resolution includes direct linkages to the Sustainable Development Goals related to MHPSS and links to the marginalized groups this toolkit prioritizes. A/HRC/RES/36/13 (undocs.org).

The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). UNDRIP protects the right for indigenous people to enjoy the highest possible level of physical and mental health, to have access to their traditional medicines, and to maintain their health practices (Article 24). UNDRIP_E_web.pdf and UN Declaration on the Rights of Indigenous Peoples | OHCHR.

The International Labour Organization's Convention on the Rights of Indigenous and Tribal Peoples in Independent Countries, No. 169. This convention has a section on "Part V. Social security and health," stating that governments shall ensure that adequate health services are made available to the peoples concerned, or shall provide them with resources to allow them to design and deliver such services under their own responsibility and control, so that they may enjoy the highest attainable standard of physical and mental health.

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). CEDAW was adopted in 1979, and ratified by 189 states. Commonly known as an international bill of rights for women, it requires countries to eliminate discrimination against women and girls and to promote their equal rights in all spheres of society. [15]

The International Convention on the Elimination of All Forms of Racial Discrimination (1965). This convention calls on governments to uphold universal human rights by condemning "all manifestations and practices of racial, religious, and national hatred." Article 1 of the convention describes racial discrimination as being "any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life."[16]

Mandate of Independent Expert on Protection Against Violence and Discrimination Based on Sexual Orientation and Gender Identity. Renews the mandate of the UN Independent Expert on Sexual Orientation and Gender Identity (IESOGI). The IESOGI's thematic reports include, "Report on the right to the enjoyment of the highest attainable standard of physical and mental health of persons, communities and populations affected by discrimination and violence based on sexual orientation and gender identity in relation to the Sustainable Development Goals". https://daccess-ods.un.org/access.nsf/Get?OpenAgent&DS=A/hrc/res/50/10&Lang=E

---

[15] *UN Women. 2016. Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)* for Youth. Accessed June 28, 2023. https://www.unwomen.org/en/digital-library/publications/2016/12/cedaw-for-youth#:~:text=The%20Convention%20on%20the%20Elimination,women's%20and%20girls'%20equal%20rights.

[16] OHCHR. 2016. *International Convention on the Elimination of All Forms of Racial Discrimination*. UN General Assembly resolution 2106 (XX). Accessed June 28, 2023. https://www.ohchr.org/en/instruments-mechanisms/instruments/international-convention-elimination-all-forms-racial.

Annex 2: Draft Contextualization Workshop Agenda

Develop the contextualization workshop agenda and consider engaging an external consultant

The following agenda is intended to inform your collaborative approach to planning for a contextualization workshop. The planning should include representative from the marginalized community.

SAMPLE AGENDA ITEMS

- Results of the MHPSS service mapping
- Findings from the MHPSS and marginalized and underrepresented groups context analysis
- Reflection on key concepts for consideration in the contextualization of MHPSS programming with youth from marginalized and underrepresented groups (see Key Contexts below)
- Familiarization with the *MHPSS for Marginalized Communities Toolkit*
    - Facilitation of small group exercises to review and contextualize the toolkit components:
        - Definition of terms specific to MHPSS and marginalized and underrepresented groups
        - Frameworks that underpin a rights-based approach to MHPSS for marginalized populations
    - Inclusive development and MHPSS
        - Principles of "Do No Harm", "Nothing about Us without Us"
        - A rights-based approach for MHPSS
        - A continuum of care approach and the mental health continuum
        - *USAID Framework for Comprehensive, Collaborative Community-based Mental Health and Psychosocial Care in LMICs and Conflict Affected Countries*
    - Ensuring inclusion throughout the USAID Program Cycle
        - Assessment: Identifying and understanding the MHPSS needs of marginalized populations and designing program objectives
        - Designing MHPSS programs to ensure inclusion of marginalized and underrepresented groups
        - Ensuring marginalized populations can access MHPSS services during program implementation
        - MEAL for MHPSS
    - Population Pull-Outs: Indigenous peoples, Families that have experienced traumatic events, Persons with disabilities, LGBTQI+

The lead agency might consider engaging an external consultant to facilitate the workshop if:

- Significant pre-workshop MHPSS capacity strengthening is needed
- It can boost government interest and support
- Support is needed to carry out the contextualization process and complete the outputs

Annex 3: Global Indicators Adapted for Indigenous Peoples

Each of the indicators was drawn from the sets of MHPSS indicators in either the IASC Common M&E Framework for MHPSS in Emergency Settings: with means of verification (version 2.0) or the UNICEF Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings, then adapted for the Indigenous populations programming context. (Navigate to the exact original indicators easily by using the code letter/ numbers at the end of each indicator). For each original indicator, any mention of a person, target group, or social role was changed to various iterations on Indigenous peoples.

INDICATORS FOR MEASURING IMPACTS AND OUTCOMES IN MHPSS PROGRAMMING WITH INDIGENOUS PEOPLES	
Key	• The indicators labeled with a G or an O along with a number are adapted from the IASC Common M&E Framework for MHPSS in Emergency Settings: with means of verification (version 2.0) framework, pp. 20–22. • The indicators labeled with a U along with a number are adapted from the UNICEF Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings framework, pp. 105–114.

Strategies	Indicators
1. Explore ways to integrate, as appropriate, safe and evidence-based traditional and complementary MHPSS services.	• Number of young Indigenous women, young Indigenous men, and nonbinary Indigenous youth receiving focused care (such as psychological first aid, linking people with psychosocial challenges to resources and services, case management, psychological counseling, psychotherapy or clinical management of mental health conditions) [O4.4] • Percentage of available focused MHPSS programs that offer evidence-based care relevant to the culture, context and age of Indigenous youth [O5.7] • Level of satisfaction among young Indigenous women, young Indigenous men, and nonbinary Indigenous youth with mental health and psychosocial conditions regarding the care they received [O5.8]
2. Adopt an inclusive and participatory approach. Take into account Indigenous traditional knowledge and practices in research and programming.	• Percentage of communities where Indigenous youth representatives are included in decision-making processes on their safety [O2.3] • Perceptions, knowledge, attitudes (including stigma) and behaviors of community members, families and/or service providers towards Indigenous youth with mental health conditions and psychosocial distress [O4.4]
3. Encourage the attraction, training, recruitment and retention of Indigenous peoples as MHPSS staff and volunteers.	• Percentage of Indigenous staff and volunteers who receive supportive supervision [U4.3] • Percentage of Indigenous staff and volunteers who receive supportive continuing education opportunities [U4.3]

Strategies	Indicators
4. Contribute to MHPSS capacity strengthening with and for Indigenous peoples.	• Percentage of young Indigenous women, young Indigenous men, and nonbinary Indigenous youth who report being actively involved in different phases of MHPSS programming (e.g., participation in needs assessment, program design, implementation and M&E activities) [O1.2] • Percentage of communities where local Indigenous people have been enabled to design, organize, and implement MHPSS programming themselves [O1.3] • Percentage of intersectoral staff and volunteers who have the capacity to provide culturally appropriate, respectful services that minimize harm to to children, adolescents, and their families [U4.3]
5. Address the MHPSS needs of Indigenous peoples.	• Number of barriers to accessing care among young Indigenous women, young Indigenous men, and nonbinary Indigenous youth [GI.3] • Percentage of young Indigenous women, young Indigenous men, and nonbinary Indigenous youth who report being treated unfairly because of mental health conditions [GI.6] • Percentage of young Indigenous women, young Indigenous men, and nonbinary Indigenous youth of who feel connected to others in their surrounding social area [GI.6] • Level of social capital, both cognitive (level of trust and reciprocity within communities) and structural (membership and participation in social networks, civil or community groups) among young Indigenous women, young Indigenous men, and nonbinary Indigenous youth, with and without mental health conditions or psychosocial distress [O4.3], [O3.5] • Traditional community structures and stakeholders for Indigenous youth's well-being are activated [U3.2]
6. Promote the dissemination of basic, accessible, and intercultural information on MHPSS.	• Percentage of young Indigenous women, young Indigenous men, and nonbinary Indigenous youth who report receiving accessible MHPSS information in their local Indigenous language in a timely manner [O1.9] • Percentage of young Indigenous women, young Indigenous men, and nonbinary Indigenous youth who report receiving accessible information in their local Indigenous language about their equal right to mental health [O1.3]

Annex 4: Key Considerations for Securing the Participation of Marginalized and Underrepresented Groups during the Assessment Phase of the Program Cycle

<table>
<tr><td>Securing participation is both safe and meaningful:</td><td>Participation has the greatest value and impact when participants feel comfortable enough to share their voices. This is particularly true for marginalized and underrepresented groups who often feel invisible. UNICEF's Protocol for Practitioners on Young Peoples Participation and Mental Health outlines five stepping stones[17] for securing safe and meaningful participation of young people:
1. Self-reflect to become more aware of power relations, assumptions, and biases concerning young people and their mental health and psychosocial well-being needs.
2. Assess resources and capacities to determine whether there are sufficient time and resources for safe and meaningful participation.
3. Identify risks, harms and benefits of participation.
4. Mitigate risks and harms and strengthen support systems, enhancing safe participation.
5. Follow up and monitor, use monitoring and evaluation learning to enhance and improve future processes.</td></tr>
<tr><td>Considering the date, time, and location of meetings</td><td>Including members from marginalized and underrepresented groups in the program planning and implementation team will help in planning inclusive meetings with program participants that happen at locations members from these groups naturally go to, at times that work well for marginalized and underrepresented groups within the community, and on a date that does not conflict with any special days for that community. Following are examples of unintended barriers created when the date, time, and location of meetings are not considered.
▪ Cultural barrier: marginalized and underrepresented groups may have a holiday that is not part of mainstream culture.
▪ Physical barrier: Some locations may be difficult for persons with disabilities to enter if they are physically inaccessible, e.g. to wheelchair riders and/or persons using mobility devices.
▪ Protection barrier: Members of one group may not feel safe going to certain areas and will never attend a meeting hosted in areas where they do not feel safe.</td></tr>
<tr><td>Making sure that "inclusion and mainstreamed" is not at the expense of tailored data collection.</td><td>When working with marginalized and underrepresented groups, sometimes the very questions that need to be asked will be different or additional to those for the wider population (for more information, review: https://www.washingtongroup-disability.com/). Participatory data collection will help reduce the risk of unintentional bias during data collection. One effective strategy is to balance quantitative indicators with qualitative indicators, because numbers do not tell the whole story about equitable engagement.[18]</td></tr>
</table>

[17] UNICEF. 2022. *Young People's Participation and Mental Health: A Protocol for Practitioners*. p. 11. New York: UNICEF. Young People's Participation and Mental Health | UNICEF.
[18] A beginner's guide to inclusive monitoring and evaluation: from talking to doing - ActivityInfo: information management software for M&E, reporting and case management. January 19, 2021. Accessed on 28 June 2023 at https://www.activityinfo.org/blog/posts/2021-01-19-a-beginners-guide-to-inclusive-monitoring-and-evaluation.html

Including/having people with lived experience participate in assessment and analysis	Including people with lived experience helps to make sure their voices, perspectives, and experiences influence and inform the understanding of their MHPSS needs. Engage community leaders, organizations, and individuals who are representative of the population to ensure inclusivity and cultural sensitivity, and consider links to historical discrimination and exclusion based on identity and distress experience and mental health literacy. Engaging those with lived experiences is essential in making sure the assessment process captures the range of MHPSS needs, terminology, and barriers.
Including considerations for mapping services.	Service providers and coordination systems may unintentionally exclude marginalized and underrepresented groups—inclusive program assessment and design may mitigate that by engaging marginalized and underrepresented groups in the assessment process. Engaging representatives from marginalized and underrepresented groups during the mapping of services can help identify non-traditional services available in the community and establish where different groups feel comfortable seeking services and what accessibility challenges may exist for these groups. Additionally, their inclusion in qualitative and quantitative assessment as well as in multi-sectoral needs assessments will result in data that are more reflective of the full range of MHPSS needs in the community.
Distress experience and mental health literacy	The terminology and/or physical expression used to discuss or describe mental health may be specific from one community to the next. Contextualization of MHPSS for the local communities should include understanding how different communities discuss distress, including localized mental health literacy. Distress experience and mental health literacy can vary from one township to the next and from one sub-population to the next.
Consider inter-sectionality	Recognize that individuals within marginalized populations may have intersecting identities and face multiple forms of marginalization. Factors such as gender, age, disability, ethnicity, and sexual orientation can significantly influence mental health and psychosocial well-being. Analyze the intersectional dynamics and identify the specific needs and challenges that arise from these intersections.
Contextualize the findings	Analyze the data collected during the needs assessment and identify common themes, patterns, and challenges. Consider the socio-cultural, political, and economic contexts and any other obstacles the marginalized population lives faces. This analysis will help in understanding the root causes of mental health challenges and barriers to accessing appropriate support.

Annex 5: List of Key UN Resolutions

United Nations Convention on the Rights of Persons with Disabilities (CRPD). Adopted in 2006, the CRPD situates disability within a social and rights-based framing, and reaffirms that all persons with all types of disabilities must enjoy all human rights and fundamental freedoms on an equal basis with others. Convention on the Rights of Persons with Disabilities | OHCHR.

Resolution adopted by the United Nations General Assembly, Human Rights Council, "Mental Health and Human Rights," A/HRC/RES/36/13, 28 September 2017. This resolution includes direct linkages to the Sustainable Development Goals related to MHPSS and links to the marginalized groups this toolkit prioritizes. A/HRC/RES/36/13 (undocs.org).

The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). UNDRIP protects the right for indigenous people to enjoy the highest possible level of physical and mental health, to have access to their traditional medicines, and to maintain their health practices (Article 24). ***UNDRIP_E_web.pdf and UN Declaration on the Rights of Indigenous Peoples | OHCHR.***

The International Labour Organization's Convention on the Rights of Indigenous and Tribal Peoples in Independent Countries, No. 169. This convention has a section on "Part V. Social security and health," stating that governments shall ensure that adequate health services are made available to the peoples concerned, or shall provide them with resources to allow them to design and deliver such services under their own responsibility and control, so that they may enjoy the highest attainable standard of physical and mental health.

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). CEDAW was adopted in 1979, and ratified by 189 states. Commonly known as an international bill of rights for women, it requires countries to eliminate discrimination against women and girls and to promote their equal rights in all spheres of society.[19]

The International Convention on the Elimination of All Forms of Racial Discrimination (1965). This convention calls on governments to uphold universal human rights by condemning "all manifestations and practices of racial, religious, and national hatred." Article 1 of the convention describes racial discrimination as being "any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life."[20]

[19] UN Women. 2016. Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) for Youth. Accessed June 28, 2023. https://www.unwomen.org/en/digital-library/publications/2016/12/cedaw-for-youth#:~:text=The%20Convention%20on%20the%20Elimination,women's%20and%20girls'%20equal%20rights.
[20] OHCHR. 2016. International Convention on the Elimination of All Forms of Racial Discrimination. UN General Assembly resolution 2106 (XX). Accessed June 28, 2023. https://www.ohchr.org/en/instruments-mechanisms/instruments/international-convention-elimination-all-forms-racial

SF Nigeria / Flickr

List of References

Ashburn, et al. n.d. "Evaluation of the Responsible, Engaged, and Loving (REAL) Fathers Initiative on Physical Child Punishment and Intimate Partner Violence in Northern Uganda."

Baylor University. 2021. Gil Taylor Behavioral Health Symposium. Accessed January 10, 2023. https://socialwork.web.baylor.edu/research-impact/gil-taylor-behavioral-health-symposium/2021-gil-taylor-behavioral-health-symposium.

Breet, E., D. Goldstone, and J. Bantjes. 2018. "Substance Use and Suicidal Ideation and Behaviour in Low- and Middle-Income Countries: A Systematic Review." BMC Public Health, 18:549. Retrieved from: https://doi.org/10.1186/s12889-018-5425-6.

Cultural Survival. n.d. The Issues. Accessed June 8, 2023. https://www.culturalsurvival.org/issues.

Emory University. n.d. Common Terms. Emory University: Atlanta, GA. Accessible at: https://equityandcompliance.emory.edu/resources/self-guided-learning/common-terms.html#:~:text=Historically%20Underrepresented,%2FLatinos%2C%20and%20Native%20Americans.

Fang, Zuyi, et al. 2022. "Global Estimates of Violence against Children with Disabilities: An Updated Systematic Review and Meta-Analysis. The Lancet Child and Adolescent Health, vol. 6, no. 5, 17 March 2022, pp. 313–323.

Fish, J.N. 2020. "Future Directions in Understanding and Addressing Mental Health among LGBTQ Youth." Journal of Clinical Child and Adolescent Psychology, 49(6), 943–956. ISSN: 1537-4416 print/1537-4424. DOI: 10.1080/15374416.2020.1815207.

Gender-Based Violence Information Management System (GBVIMS). 2017. Interagency Gender-Based Violence Case Management Guidelines. Accessible at: http://www.gbvims.com/wp/wp-content/uploads/Interagency-GBV-Case-Management-Guidelines_Final_2017.pdf.

Hoy-Ellis, Charles P. 2023. "Minority Stress and Mental Health: A Review of the Literature." Journal of Homosexuality, 70:5, 806-830, DOI: 10.1080/00918369.2021.2004794.

Inter-Agency Standing Committee (IASC). 2023. "Information Note on Disability and Inclusion in MHPSS."

IASC. 2019. "Guidelines, Inclusion of Persons with Disabilities in Humanitarian Action." IASC Task Team on inclusion of persons with disabilities in humanitarian action.

IASC. 2007. "IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings." Geneva, Switzerland: IASC.

Iemmi, V., J. Bantjes, E. Coast, K. Channer, T. Leone, D. McDaid, A. Palfreyman, B. Stephens, and C. Lund. 2016. "Suicide and Poverty in Low-Income and Middle-Income Countries: A Systematic Review." The Lancet Psychiatry, 3(8),774-783.

Kraus-Perrotta, C., C. Gamsey, and J. DeMulder. 2022. Neglected Gaps in Improving the Health, Wellbeing, and Care for Sexual and Gender Minority Young People Living in Low- and Middle-Income Countries: A Scoping Review. DOI: https://doi.org/10.21203/rs.3.rs-1923127/v1.

Mcjnewsblog. 2016. Applying a Profound Stress and Attunement Approach. [blog post] March 14. Accessed July 13, 2023. https://mcjnewsblog.wordpress.com/2016/03/14/applying-a-profound-stress-and-attunement-approach/#:~:text=Attunement%3A%20Attunement%20is%20the%20process,profound%20stress%20indicators%20through%20empathy.&text=Through%20this%20framework%20they%20develop,adaptive%20responses%20to%20adolescents'%20stressors.

Newman, P.A., Shirley, M., Prabhuc, P.A. & Tepjanb, S. (2022). HIV and mental health among young people in low-resource contexts in Southeast Asia: A qualitative investigation. Global Public Health, 17 (7), 1200–1214. https://doi.org/10.1080/17441692.2021.1924822.

Pike I., C. Kraus-Perrotta, and T.D. Ngo. 2023. A Scoping Review of Survey Research with Gender Minority Adolescents and Youth in Low- and Middle-Income Countries. PLoS ONE 18(1): e0279359. Accessible at: https://doi.org/10.1371/journal.pone.0279359.

Sangalang, C.C., D. Becerra, F.M. Mitchell, S. Lechuga-Peña, K. Lopez, and I. Kim. 2019. "Trauma, Post-Migration Stress, and Mental Health: A Comparative Analysis of Refugees and Immigrants in the United States." J Immigr Minor Health. 2019 Oct;21(5):909-919. DOI: 10.1007/s10903-018-0826-2. PMID: 30244330.

Save the Children. 2016. Every Last Child: The Children the World Chooses to Forget. Accessible at: https://resourcecentre.savethechildren.net/document/every-last-child-children-world-chooses-forget/.

Stark et al. n.d. "Preventing Violence against Refugee Adolescent Girls."

UNICEF. 2022a. "Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers across Settings." New York: UNICEF.

UNICEF. 2022b. "Learning Brief on Mental Health and Psychosocial Support (MHPSS) in Education." New York: UNICEF.

UNICEF. 2021. "Seen, Counted, Included: Using Data to Shed Light on the Well-Being of Children with Disabilities." New York: UNICEF.

United Nations Population Fund (UNFPA). n.d. Healing When Crisis Strikes. Accessible at: https://www.unfpa.org/sites/default/files/pub-pdf/MHPSS-CountryCasesAndOverview.pdf.

United Nations Sustainable Development Group. n.d. Human Rights-Based Approach. Accessible at: https://unsdg.un.org/2030-agenda/universal-values/human-rights-based-approach.

University of Waterloo. n.d. Defining the Mental Health Continuum. Accessed September 26, 2023. https://uwaterloo.ca/thrive/resources/thrive-toolkit/defining-mental-health-continuum.

USAID Bureau for Development, Democracy, and Innovation (DDI)/Inclusive Development Hub. 2022. Safety/Security-Sensitive and Trauma-Informed Stakeholder Consultations with Members of Marginalized Groups. Washington, D.C.: USAID. Accessed June 3, 2023. https://www.usaid.gov/sites/default/files/2022-12/Marginalized_Groups_PDF.pdf.

USAID. 2023 (forthcoming). "Inclusive Development Policy, Additional Help for ADS 201."

USAID. 2023. Integrating LGBTQI+ Considerations into Education Programming. Accessible at: https:// https://www.usaid.gov/document/integrating-lgbtqi-considerations-education-programming-0.

USAID. n.d. MHPSS Program Highlights. Accessible at: https://www.usaid.gov/inclusivedevelopment/mental-health/programs.

USAID/DCHA/DRG/HR. 2023. Suggested Approaches for Integrating Inclusive Development Across the Program Cycle in Mission Operations: Additional help for ADS 201. Accessed June 1, 2023. https://www.usaid.gov/sites/default/files/2023-10/USAID-ID-Hub_ADS-201-AH-Document_Oct-2023_1.pdf.

Wainberg, M.L., P. Scorza, J.M. Shultz, L. Helpman, J.J. Mootz, K.A. Johnson, Y. Neria, J.M. Bradford, M.A. Oquendo, and M.R. Arbuckle. 2017. "Challenges and Opportunities in Global Mental Health: A Research-to-Practice Perspective." Curr Psychiatry Rep., 19(5): 28. doi:10.1007/s11920-017-0780-z.

Waves for Change. 2019/20. Reflections. Accessible at: https://waves-for-change.org/latest-annual-report-w4c/.

World Health Organization (WHO). 2023. The Health of Indigenous Peoples: Draft Resolution Proposed by Australia, Bolivia (Plurinational State of), Brazil, Canada, Colombia, Cuba, Ecuador, European Union and its Member States, Guatemala, Mexico, New Zealand, Panama, Paraguay, Peru, United States of America and Vanuatu. Seventy-sixth World Health Assembly. Accessible at: https://apps.who.int/gb/ebwha/pdf_files/WHA76/A76_ACONF1-en.pdf.

WHO. 2021a. Mental Health ATLAS 2020. Geneva, Switzerland: WHO. Accessible at: https://www.who.int/publications/i/item/9789240036703.

WHO. 2021b. Guidance on Community Mental Health Services: Promoting Person-Centered and Rights-Based Approaches." Geneva, Switzerland: World Health Organization. (Guidance and technical packages on community mental health services: promoting person-centered and rights-based approaches). Licence: CC BY-NC-SA 3.0 IGO. https://apps.who.int/iris/bitstream/handle/10665/341648/9789240025707-eng.pdf.

WHO. 2020. Guidelines on Mental Health Promotive and Preventive Interventions for Adolescents: Helping Adolescents Thrive. Geneva, Switzerland: WHO. Accessible at: https://apps.who.int/iris/bitstream/handle/10665/336864/9789240011854-eng.pdf.

WHO. 2019. The mhGAP Community Toolkit: Field Test Version. Accessible at: https://www.who.int/publications/i/item/the-mhgap-community-toolkit-field-test-version.

WHO. n.d. Fact Sheet on Sustainable Development Goals (SDGs): Health Targets. Accessed June 28, 2023. https://apps.who.int/iris/bitstream/handle/10665/340847/WHO-EURO-2018-2364-42119-58012-eng.pdf?sequence=1&isAllowed=y.

WHO and Calouste Gulbenkian Foundation. 2014. Social Determinants of Mental Health. Geneva, Switzerland: World Health Organization. Accessible at: https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf.

UNHCR / Flickr