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REGIONAL BRIEF: AFRICA

THE STATE OF THE WORLD'S CHILDREN 2021

ON MY MIND

Promoting, protecting and caring for children's mental health

A TIME FOR LEADERSHIP ON MENTAL HEALTH

Fear. Loneliness. Grief.

As the coronavirus pandemic descended on the world in 2019, these powerful emotions enveloped the lives of many millions of children, young people and families. In the early days especially, many experts feared they would persist, damaging the mental health of a generation.

In truth, it will be years before we can really assess the impact of COVID-19 on our mental health.

For even if the potency of the virus fades, the pandemic's economic and social impact will linger: over the fathers and mothers who thought they had left the worst of times behind them, but are once again struggling to put food in a baby's bowl; over the boy falling behind in school after months of disrupted learning; and the girl dropping out to work on a farm or in a factory. It will hang over the aspirations and lifetime earnings of a generation whose education has been disrupted.

Indeed, the risk is that the aftershocks of this pandemic will chip away at the happiness and well-being of children, adolescents and caregivers for years to come – that they will pose a risk to the foundations of mental health.

For if the pandemic has taught us anything, it is that our mental health is profoundly affected by the world around us.

Far from being simply a question of what is going on in a person's mind, the state of each child's or adolescent's mental health is profoundly affected by the circumstances of their lives – their experiences with parents and caregivers, the connections they form with friends and their chances to play, learn and grow. Mental health is also a reflection of the ways their lives are influenced by the poverty, conflict, disease and access to opportunities that exist in their worlds.

If these connections were not clear before the pandemic, they certainly are now.

This is the reality that is at the heart of *The State of the World's Children 2021*.

A challenge ignored

Indeed, what we have learned is that mental health is positive – an asset: It is about a little girl being able to thrive with the love and support of her family, sharing the ups and downs of daily life. It is about a teenage boy being able to talk and laugh with his friends, supporting them when they are down and being able to turn to them when he is down. It is about a young woman having a sense of purpose in her life and the self-confidence to take on and meet challenges. It is about a mother or father being able to support their child's emotional health and well-being, bonding and attaching.

The links between mental and physical health and well-being, and the importance of mental health in shaping life outcomes, are increasingly being recognized. They are reflected in the connection between mental health and the foundations of a healthy and prosperous world acknowledged in the Sustainable Development Goals. Indeed, that agreement among the nations of the world positioned the promotion and protection of mental health and well-being as key to the global development agenda.

Despite all this, governments and societies are investing far, far too little in **promoting**, **protecting** and **caring** for the mental health of children, young people and their caregivers.

A time for leadership

At the heart of our societies' failure to respond to the mental health needs of children, adolescents and caregivers is an absence of **leadership** and **commitment**. We need commitment, especially financial commitment, from global and national leaders and from a broad range of stakeholders that reflects the important role of social and other determinants in helping to shape mental health outcomes. The implications of such an approach are profound. They demand that we set our sights on a clear shared goal of supporting children and adolescents at crucial moments in their development to minimize risk – and maximize protective – factors.

Besides commitment, we also need **communication**: We need to end stigmas, to break the silence on mental health, and to ensure that young people are heard, especially those with lived experience of mental health conditions. Without their voices being heard and their active participation and engagement, the challenge of developing relevant mental health programmes and initiatives will not be met.

And we need **action**: We need to better support parents so that they can better support their children; we need schools that meet children's social and emotional needs; we need to lift mental health out of its 'silo' in the health system and address the needs of children, adolescents and caregivers across a range of systems, including parenting, education, primary health care, social protection and humanitarian response; and we need to improve data, research and evidence to better understand the prevalence of mental health conditions and to improve responses.

A time for action

The COVID-19 pandemic has upended our world, creating a global crisis unprecedented in our lifetime. It has created serious concerns about the mental health of children and their families during lockdowns, and it has illustrated in the starkest light how events in the wider world can affect the world inside our heads. It has also highlighted the fragility of support systems for mental health in many countries, and it has – once again – underlined how these hardships fall disproportionately on the most disadvantaged communities.

But the pandemic also offers an opportunity to build back better. As *The State of the World's Children's 2021* sets out, we know about the key role of parents and caregivers in shaping mental health in early childhood; we know too about children's and adolescents' need for connection; and we know about the dire impact that poverty, discrimination and marginalization can have on mental health. And while there is still much work to be done in developing responses, we already know the importance of key interventions, such as challenging stigmas, supporting parents, creating caring schools, working across sectors, building robust mental health workforces, and establishing policies that encourage investment and lay a solid foundation for mental health and well-being.

The African Union can scale up efforts and mobilize Member States to make mental health a priority across sectors, enhancing mental health-care services for children and young people. We have a historic chance to commit, communicate and take action to promote, protect and care for the mental health of a generation. We can provide support for the foundation of a generation equipped to pursue their dreams, reach their potential and contribute to the world.

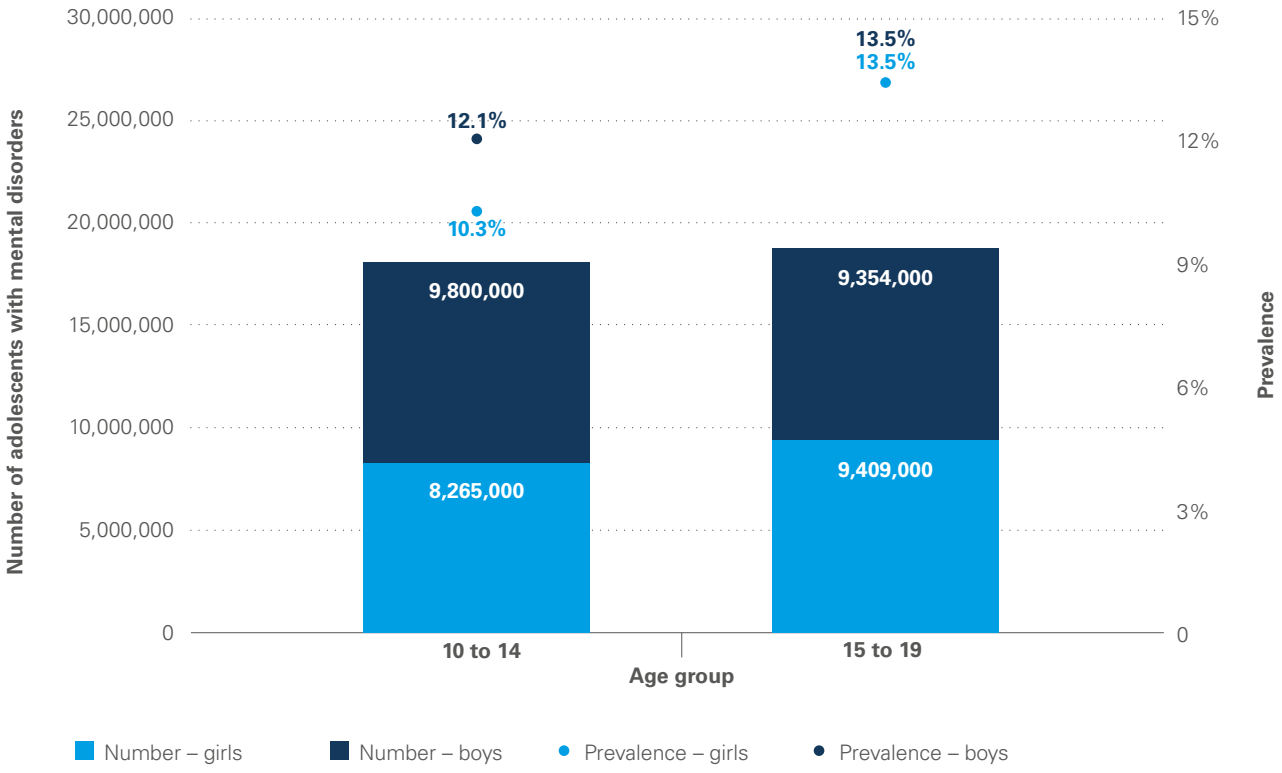
BY THE NUMBERS

Prevalence of mental disorders

Nearly **37 million** adolescents (aged 10–19) live with a mental disorder in Africa.

Nearly 37 million adolescents (aged 10–19) live with a mental disorder in Africa.

Estimated prevalence and number of adolescents aged 10–19 with mental disorders in Africa, 2019



Note: The number of adolescents with mental disorders is rounded to the nearest 1,000; calculations are based on multiple disorders, including: depression, anxiety, bipolar, eating, autism spectrum, conduct, schizophrenia, idiopathic intellectual disability, attention deficit/hyperactivity and a group of personality disorders.

Source: UNICEF analysis based on estimates from the Institute for Health Metrics and Evaluation (IHME), Global Burden of Disease Study, 2019.

Estimated prevalence of mental disorders among adolescents aged 10–19 in Africa, 2019

	Girls and boys aged 10–19		Girls aged 10–19		Boys aged 10–19	
Country	Prevalence %	Number	Prevalence %	Number	Prevalence %	Number
Algeria	15.9%	1,037,795	15.7%	499,902	16.1%	537,892
Angola	11.8%	836,483	11.6%	415,557	12.1%	420,926
Benin	11.7%	343,473	11.4%	168,652	12.0%	174,820
Botswana	11.0%	48,530	10.6%	23,266	11.3%	25,264
Burkina Faso	11.6%	614,978	11.2%	295,433	12.1%	319,546
Burundi	12.2%	340,165	11.6%	166,692	12.8%	173,473
Cabo Verde	11.2%	11,522	10.9%	5,524	11.6%	5,998
Cameroon	11.5%	802,489	11.3%	390,751	11.7%	411,739
Central African Republic	13.6%	169,960	13.3%	83,639	14.0%	86,322
Chad	12.2%	488,546	12.0%	243,009	12.4%	245,537
Comoros	11.2%	16,611	10.6%	7,776	11.8%	8,834
Congo	11.8%	132,327	11.5%	65,222	12.0%	67,105
Côte d'Ivoire	11.3%	646,171	11.0%	302,096	11.6%	344,075
DRC*	12.8%	2,673,914	12.4%	1,283,548	13.2%	1,390,366
Djibouti	10.8%	24,547	10.2%	10,161	11.4%	14,386
Egypt	16.0%	3,142,769	15.6%	1,465,943	16.4%	1,676,827
Equatorial Guinea	11.8%	44,175	11.6%	18,053	12.0%	26,122
Eritrea	11.7%	185,184	11.1%	86,344	12.2%	98,840
Eswatini	11.1%	28,001	10.6%	13,085	11.5%	14,916
Ethiopia	11.4%	3,030,964	10.8%	1,404,527	11.9%	1,626,437
Gabon	11.9%	43,252	11.6%	21,897	12.2%	21,355
Gambia	12.3%	67,141	12.5%	34,836	12.0%	32,306
Ghana	11.2%	768,949	10.9%	370,013	11.5%	398,936
Guinea	11.8%	349,989	11.6%	174,027	12.0%	175,962
Guinea-Bissau	11.6%	51,702	11.3%	25,268	11.9%	26,434
Kenya	11.0%	1,337,466	10.4%	622,287	11.6%	715,180
Lesotho	12.0%	53,145	11.8%	26,119	12.1%	27,026
Liberia	12.6%	143,050	12.7%	71,637	12.5%	71,413
Libya	16.8%	192,711	16.8%	93,459	16.9%	99,252
Madagascar	11.8%	740,358	11.3%	350,021	12.4%	390,337
Malawi	11.7%	575,915	11.2%	277,878	12.3%	298,037
Mali	10.9%	582,553	10.5%	277,962	11.4%	304,591
Mauritania	10.6%	103,747	10.1%	49,936	11.2%	53,811
Mauritius	11.9%	20,737	12.0%	10,363	11.8%	10,373
Morocco	16.5%	1,045,265	16.4%	507,067	16.7%	538,198
Mozambique	12.1%	868,509	11.5%	425,872	12.7%	442,637
Namibia	10.7%	53,528	10.2%	25,709	11.2%	27,819
Niger	11.7%	668,582	11.3%	327,633	12.0%	340,950
Nigeria	10.8%	5,702,873	10.3%	2,837,487	11.2%	2,865,386
Rwanda	11.7%	347,748	11.2%	168,475	12.1%	179,272
Sao Tome and Principe	11.1%	5,419	10.9%	2,650	11.4%	2,770
Senegal	11.0%	393,752	10.5%	180,801	11.4%	212,952
Seychelles	10.9%	1,524	10.4%	716	11.3%	808
Sierra Leone	12.5%	240,915	12.3%	120,765	12.6%	120,150
Somalia	13.7%	680,304	12.9%	307,403	14.5%	372,901
South Africa	11.1%	1,042,299	10.9%	505,413	11.3%	536,887
South Sudan	11.8%	288,149	11.5%	133,646	12.1%	154,503
Sudan	17.4%	1,650,078	16.9%	773,424	17.9%	876,654
Togo	12.2%	215,687	12.0%	102,287	12.4%	113,400
Tunisia	17.0%	284,474	16.9%	136,249	17.1%	148,225
Uganda	12.5%	1,314,482	11.9%	618,277	13.1%	696,205
United Republic of Tanzania	11.4%	1,508,376	10.9%	731,753	11.9%	776,623
Zambia	11.2%	488,885	10.7%	236,972	11.7%	251,914
Zimbabwe	10.8%	377,749	10.0%	176,817	11.6%	200,932

*The Democratic Republic of the Congo

Note: Figures are based on these disorders: depression, anxiety, bipolar, eating, autism spectrum, conduct, schizophrenia, idiopathic intellectual disability, attention deficit/hyperactivity (ADHD) and a group of personality disorders.

Source: UNICEF analysis based on data from the IHME, Global Burden of Disease Study, 2019.

Suicide estimates

Suicide is the ninth most common cause of death among adolescents aged 15–19 in Africa.

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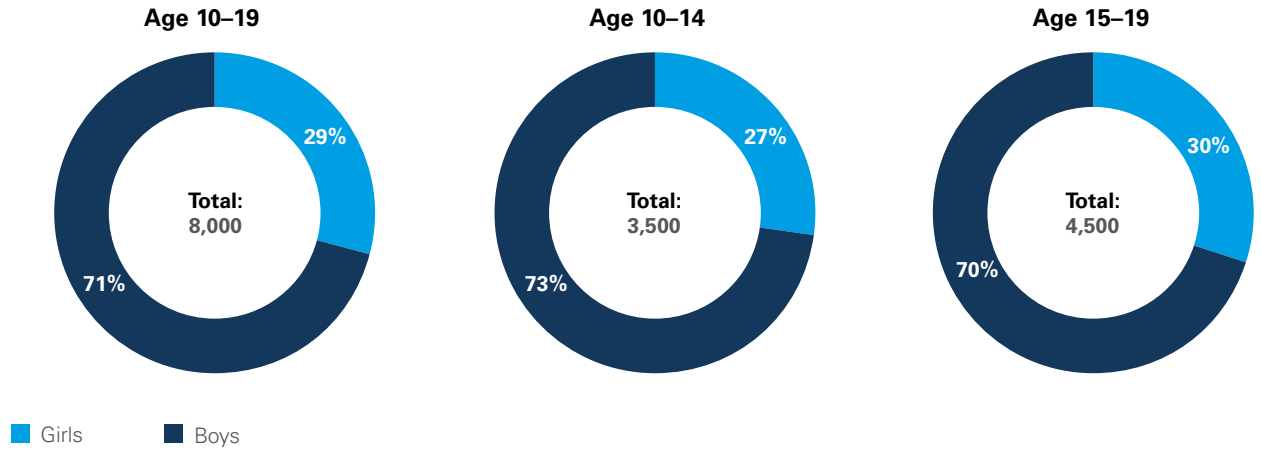
Top 10 causes of death among adolescents aged 15–19 in Africa, 2019

Cause	Ranking	Deaths (per 100,000)
Road injury	1	17
Tuberculosis	2	13
HIV/AIDS	3	11
Interpersonal violence	4	10
Maternal conditions	5	9
Diarrhoeal diseases	6	7
Malaria	7	5
Lower respiratory infections	8	4
Suicide	**9**	**3**
Meningitis	10	3

Source: UNICEF analysis based on WHO Global Health Estimates 2019; estimates were calculated using population data from the United Nations Population Division World Population Prospects, 2019.

More than 20 adolescents lose their lives every day due to suicide in Africa.

Estimates of suicide as a cause of death in Africa, 2019.



Note: Results are rounded to the nearest 100; confidence intervals for estimated number of deaths for adolescents at different ages groups are: 10–19, 4,230–13,770; 10–14, 1,770–6,270; 15–19, 2,460–7,499.

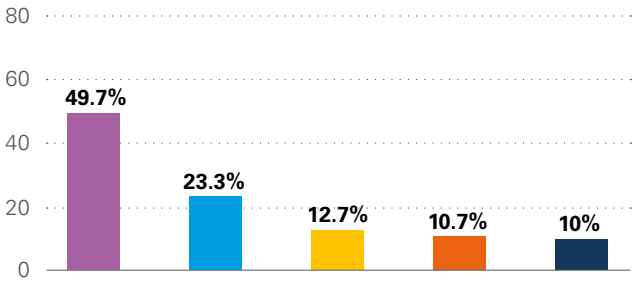
Source: UNICEF analysis based on WHO Global Health Estimates 2019; estimates were calculated using population data from the United Nations Population Division World Population Prospects, 2019.

Anxiety and depression

Anxiety and depression account for **almost 50 per cent of mental disorders** among adolescents aged 10–19 in Africa.

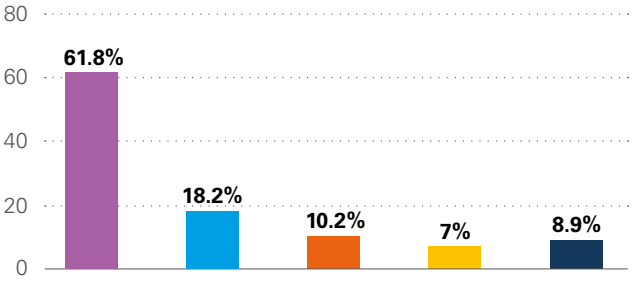
Estimates of key mental disorders among adolescents in Africa, 2019

Boys and girls aged 10–19

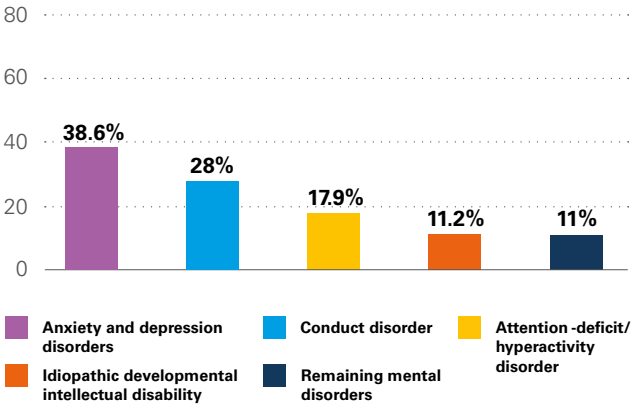


Among adolescent girls, anxiety and depression accounts for more than **60 per cent** of mental disorders.

Girls aged 10–19



Boys aged 10–19



Note: The sum of the prevalence of individual disorders exceeds 100 per cent due to the co-morbidity between the disorders; calculations are based on these disorders: depression, anxiety, bipolar, eating, autism spectrum, conduct, schizophrenia, idiopathic intellectual disability, attention deficit/hyperactivity and a group of personality disorders.

Source: UNICEF analysis based on IHME Global Burden of Disease Study, *2019*.

The cost of mental disorders in Africa

US$30.3 billion

This figure is the annual loss of human capital from mental disorders based on country-specific values for disability-adjusted life years (DALYs). The estimate is based on the value of lost mental capital – or cognitive and emotional resources – that children and young people would contribute to economies if they were not thwarted by mental health conditions. David McDaid and Sara Evans-Lack of the Department of Health Policy of the London School of Economics and Political Science started with estimates of the burden of disease attributable to mental health expressed in DALYs. One DALY represents the loss of a year of healthy living caused by disability or premature death. The researchers then assigned a monetary value to each disability-free year based on the average output each person contributes in an economy. One DALY is therefore equivalent to a country's gross domestic product (GDP) per capita, expressed in purchasing power parity (PPP) terms. This formulation allows comparisons to be made globally. (See *The State of the World's Children 2021* for a full account of the costs of mental disorders.)

The analysis in these pages includes data from the Institute for Health Metrics and Evaluation (IHME), World Health Organization (WHO) and World Population Prospects (WPP). Data were available for 54 Member States of the African Union. Data were not available for the Sahrawi Arab Democratic Republic.

CASE STUDY

Kenya

Call for Help: An open line for protecting children

In a protected booth, carefully separated from her co-workers, Barbra Sillingi listens intently before speaking calmly into her telephone headset.

As a counsellor in the Nairobi offices of Childline Kenya, a national helpline for children that addresses mental health and violence against children, 'listen to them' is her mission and her passion.

"When a child comes to you and tells you something, we should not ignore them," Sillingi said. "We should listen to their voice, listen to what they are saying because they also have feelings. They also need to be loved."

The number of calls to the helpline more than doubled during the pandemic. Many children struggled to cope with the restrictions on movement, and some faced increased dangers, especially during school closures. That left them in need of someone who could really listen. Throughout, Barbra Sillingi has offered counselling to every one of her callers and has referred some cases to local authorities for intervention.

"Children go through a lot of stresses and mostly parents do not understand," she said.

Childline Kenya was set up in 2004 with support from the Government of Kenya, UNICEF and other partners. The free 24-hour emergency service allows callers to anonymously

An open line: Counsellor Barbra Sillingi takes helpline calls from children in Kenya.
© UNICEF/UN0489179/Orina

report child abuse and other child protection concerns by calling the free helpline number, 116, or visiting Childlinekenya.co.ke. It offers one-on-one counselling and connects children with support services in their communities.

Childline Kenya also works with the Department of Children's Services to intervene when children are in danger and, when possible, place them with other family members.

UNICEF provides funding for counsellors and equipment and training for staff members. It is also working with the Department of Children's Services to ensure a gradual increase in public financing for operation.

"While there were restrictions on movement and children were out of school, this was one of the few channels for children and adults to report incidents of abuse, but also for children to express themselves," said Bernard Njue Kiura, UNICEF Kenya Child Protection Specialist. UNICEF also got the word out through a nationwide public awareness campaign, 'Spot it, Stop it', that encouraged children in need to call the free 116 helpline.

"Since COVID-19, people here in Kenya are more open about discussing mental health issues: from Government, to service providers, to communities, to children," Kiura said. "The capacity to speak about it has increased."

CASE STUDY

Sierra Leone

Caring for the Caregiver

Mbalu Turay knew immediately that Kankay Suma was experiencing significant stress.

As a trained counsellor, community health worker and facilitator of the local Mother's Support Group (MSG), Mbalu saw the signs as soon as she first met the pregnant mother of three.

"I can look at the mothers in the MSG meetings and immediately recognize someone going through a hard time," Mbalu said.

Kankay was, indeed, "going through a hard time." She lives outside town in a rural part of Kambia district in Sierra Leone, where she was struggling with the 30-minute walk to collect water and the task of gathering firewood. She was isolated from neighbours. And she was experiencing complications with her pregnancy.

Using the skills she learned from Caring for the Caregiver (CFC) training, Mbalu gained Kankay's trust and was able to provide emotional support. She also linked Kankay to a community health supervisor.

In the weeks after they met, Mbalu visited Kankay daily to counsel her, listen to her concerns and provide practical tips on managing stress.

"In our community, when someone is exhibiting signs of sadness, others may chastise them for it," Mbalu said.

Support for mother: A community health worker in Sierra Leone "wraps her arms around" a mother and newborn.
© UNICEF/UN0475700/Duff/VII Photo

"However, thanks to the CFC programme, [many of us] are now aware that it's better to be kind and sympathetic to those who are feeling down."

CFC trains front-line workers to support the emotional well-being of caregivers – the mothers, fathers and others who provide primary care for newborns and young children. It recognizes that caregivers' mental health and emotional well-being is the foundation that allows them to nurture and care for their children. This nurturing care, in turn, builds a child's lifelong mental health.

The programme builds the interpersonal and counselling skills of front-line workers and provides them with a package of materials and activities that can be used to strengthen caregivers' confidence, emotional well-being and ability to connect and support their young children.

Mbalu put these skills to use when she first met Kankay. And even after Kankay gave birth to her son Mark, Mbalu continued to visit the family.

"Mbalu wrapped her arms around me and took me to a hospital for the first time in my life," Kankay said. "She showed me what it means to take care of myself and my family."

WHAT YOUNG PEOPLE SAY

Background: For this edition of *The State of the World's Children* report, UNICEF teamed up with researchers from the Global Early Adolescent Study at Johns Hopkins Bloomberg School of Public Health (JHU) to host focus group discussions on mental health and well-being. From February to June 2021, local partners facilitated focus group discussions for adolescents aged 10–14 and 15–19 in 13 countries worldwide. In Africa, the focus groups were implemented in the **Democratic Republic of the Congo (DRC)**, **Kenya** and **Malawi**. This brief includes quotes from some of the adolescents who participated in the focus groups. A fuller companion report on the discussions will be released in 2022.

The COVID-19 pandemic has dramatically shifted the lives of young people all over the world. When schools closed, adolescents – who increasingly rely on connections with peers as they mature – were cut off from those social networks. During the focus group discussions, adolescents described significant impacts on mental health.

> *"When I think about everyone that has died because of the disease, it makes me sad and when I learn the number of cases is increasing, it makes me stressed." (Younger boy, DRC)*

> *"I was worried because we are used to being with friends at school from the morning to the evening... During confinement we didn't do anything to avoid worrying we just stayed at home." (Younger girl, DRC)*

Some adolescents suggested that when **schools were closed**, many adolescents spent unsupervised time engaging in **drug and alcohol use and risky sexual behaviours:**

> *"During this period of COVID-19... young people have gone wild drinking beer because of frequent changes in opening dates for schools. (Older boy, Malawi)*

> *"COVID really disturbed [adolescents]. A lot of people got pregnant and... a lot of people have dropped out of school. (Younger girl, Malawi)*

> *"When COVID-19 began schools were closed... that is the time young people... boys and girls started joining bad groups. You find that young people take bhang [marijuana] and chew miraa [khat]... And if you are a girl you leave in the morning... without even telling your mother where you are going, you can link up to the other girls and walk around aimlessly come back home late at night." (Younger girl, Kenya)*

Peer relationships were an important topic of discussion in several countries. Adolescents identified social support and close friends as being strongly protective of their mental health; however, they also emphasized the negative impact of 'bad' friends and peer pressure:

> *"[Think about] the problem of depression and lack of confidence. [Maybe] you know... the talents of your friends [very well], like singing and playing football. [So], you give them courage and also encourage them... that they are able to do that which their heart desires.... By doing that you will be building his self-esteem." (Older boy, Kenya)*

> *"One of the problems we are facing in this area is peer pressure. You will find that most young people are copying their peers' behaviour. For instance, maybe the group you are chatting with smokes marijuana and you don't smoke, eventually you are going to start smoking so that you could conform to the group's way of living..." (Older boy, Malawi)*

Adolescents also discussed the ways in which mental health conditions can increase vulnerabilities and lead to **self-harm**:

"There are some girls when they get impregnated, they kill themselves. Some take drugs to terminate the pregnancy and others hang themselves because they do not want the pregnancy." (Younger girl, Malawi)

"Some of the problems young people face include that when their relationship has ended you would find boys committing suicide, and also being depressed. Also if there is a misunderstanding with parents at home and they have yelled at him, the boy becomes depressed and thinks of committing suicide just to vanish out of the world." (Younger boy, Malawi)

Adolescents also emphasized the impact of violence on mental health, including **gender-based violence:**

"Abuses are mostly faced by girls... [such as] forcing the child to do household chores beyond her age. The child is young but she is doing everything, even [with her parents] telling her to leave school because she is a girl. They say there is a boy so a girl will not have any benefit in [the] future, so they make the girl do all the household chores at home and the boys do nothing." (Older girl, Malawi)

"[Young people] don't walk freely because they are always afraid of being attacked by other people in the streets." (Younger boy, Malawi)

"Rape changes the psychological behaviour of a person. A girl who has been raped will always be afraid that boys will approach her." (Older girl, DRC)

Adolescents mentioned the **rippling impacts of poverty** on their lives, illustrating the many different pathways between financial instability and mental health:

"At school, there are rules that everyone should dress up completely... you need a good shoe. You find that at your home they cannot provide that for you and you are putting on 'crocs'. Others... they get that 'croc' and start throwing it at each other. "Look at this!" And the whole class starts laughing at you. It is so painful for us young people... it is so terrible... So without any emotional or psychological support, that is when you hear that a student has committed suicide." (Older boy, Malawi)

"When their parents lack money, they may even drop out of school because they can't raise their school fees to educate them.... After dropping out of school he will get involved in theft and if she is a girl, she will get involved in prostitution." (Older boy, Kenya)

"There are also parents who push their child to become kuluna [criminals]. When you ask for money at home your father tells you "you are already a grown boy, your friends went to earn money and you stay here asking for some, you have to go find some too". (Older boy, DRC)

"There are others who are eager to finish school but you would find that in their homes there is financial inadequate support. You would find that they go to school intermittently which makes children to lose hope and give up on their future." (Younger boy, Malawi)

Issues regarding **mental health stigma** were echoed during the focus group discussions, in which adolescents discussed the ways in which such stigma can impede help-seeking behaviours:

"When he knows that he has a problem, but he is not willing to share with anyone... That thing will eat him up." (Older boy, Kenya)

"If you... have ever had a bad name, one day you did something bad... and you never... bothered to apologize, whenever any person sees you, they just remember the bad things that you did.... So, when you seek help or assistance people will discourage others from helping you." (Older boy, Kenya)

A FRAMEWORK FOR ACTION

The State of the World's Children 2021 has set out the mental health challenges facing children and adolescents and their families. It has shown that these challenges are global – from the poorest village to the wealthiest city, children and their families are suffering pain and distress. At an age and stage of life when children and young people should be laying strong foundations for lifelong mental health, they are instead facing challenges and experiences that can only undermine those foundations.

The cost for us all is incalculable.

It does not have to be this way. And it should not be this way.

Our priorities are – or should be – clear. We may not have all the answers, but we know enough to be able to act now to **promote** good mental health for every child, **protect** vulnerable children and **care** for children facing the greatest challenges.

This report sets out a framework to help the community, governments, schools and other stakeholders in Africa do just that, grounded in three core principles, for every child, everywhere: **Commitment** from leaders, backed by investment; **Communication** to break down stigmas and open conversations on mental health; and **Action** to strengthen the capacity of health, education, social protection and other workforces; better support families, schools, and communities; and greatly improve data and research.

Commitment, Communication, and Action for Mental Health

TO COMMIT means strengthening leadership to set the sights of a diverse range of partners and stakeholders on clear goals and ensuring investment in solutions and people across a range of sectors.

Provide regional leadership. Building on existing efforts, stronger regional and national leadership is needed to align stakeholders around clear goals and set priorities; to develop financing models that can help bridge the investment gap; to develop partnerships to share knowledge and experience – globally, regionally and nationally – on delivering services, building capacity, gathering data and evidence, and providing mental health and psychosocial support (MHPSS) in crisis and emergency settings; and crucially, to monitor and evaluate progress. The African Union institutions should support this process, ensuring that mental health is a priority across sectors and facilitating stakeholder engagement and technical support around mental health issues.

Invest in supporting mental health. Mental health is woefully underfunded. Many governments spend only a few cents per capita directly on mental health, and allocations from international development assistance are meagre. Most spending goes into psychiatric services, meaning that almost nothing is spent on mental health prevention or promotion. In recent years, there has been considerable focus on, as well as support for, setting specific targets for mental health in health budgets – typically at least 5 per cent in low- and middle-income countries (LMICs) and at least 10 per cent in high-income countries.

Following recommendations of the Social Agenda 2063 and the Africa Health Strategy 2016–2030, the African Union Member States can scale up investments in mental health, creating the necessary conditions for all children and

young people to access mental health services. Investment is needed across sectors, not just in health, to support a strong focus on workforce development in health, education and social protection systems. Clear targets need to be set, and new and innovative sources of funding and investment need to be identified to meet those targets. And a guiding principle for all investment – regional and national – is that it must be in line with rights-based approaches that take account of the needs of people with lived experiences and comply with international human rights instruments.

TO COMMUNICATE means tackling stigmas around mental health, opening conversations and improving mental health literacy. It means amplifying the global conversation on mental health to raise awareness and mobilize all stakeholders to take action and facilitate learning. It also means ensuring children, young people and people with lived experience are part of the conversation, that they have a voice and can meaningfully engage in the development of mental health responses.

Break the silence, end stigma. Governments and other stakeholders, including the media, should work to break down stigmas around mental health and promote a message of inclusiveness. When adequate support and opportunities are available, living with a mental health condition or psychosocial disability need not be an obstacle to living a happy and healthy life. Tackling stigma also means promoting mental health literacy – supporting children, adolescents and caregivers to better understand how to promote positive mental health, how to recognize signs of distress in themselves and in others, and how to seek help when they most need it.

Ensure young people have a say. Continued support is needed to provide all young people, especially those with lived experience of mental health conditions, with the means for active and meaningful engagement. This can be done through, for example, investment in community youth groups, co-creation of peer-to-peer initiatives and training programmes.

TO ACT means working to minimize the risk factors and maximize the protective factors for mental health in key areas of children's and adolescents' lives, especially the family and school. More broadly, it also means investment and workforce development across some key sectors and systems, including mental health services and social protection, and the development of strong data collection and research.

Support families, parents and caregivers. Supporting parents and caregivers is essential to building child and adolescent well-being and to reducing and preventing violence against children. Stable relations at home can help protect children against toxic stress and promote resilience and overall well-being.

- **Promote responsive caregiving and nurturing connections**. Parenting programmes need to be scaled up, with a focus on social and emotional learning to support families and children to develop positive attachments and to create a positive home environment.
- **Help parents support their children's health and well-being.** Parents and caregivers need support to engage with their children throughout the child's and adolescent's life to foster their social, emotional, physical and cognitive development. Training programmes and counselling should share knowledge on health, nutrition and child development, and stimulate learning within the home.
- **Care for caregivers' mental health.** Mental health programmes must prioritize caregivers, providing support to manage chronic stress and conflict, and to enhance coping strategies.
- **Give parents training to respond to children's mental health challenges.** Skills training for parents can improve the developmental, behavioural and familial outcomes for children and adolescents facing mental health challenges. Investments must be made to scale up family-centred approaches, including those designed to be delivered by non-specialists.

Ensure schools support mental health. Schools play a unique and vital role in the lives of children and adolescents. Violence and bullying – both by teachers and other students – as well as excessive pressure to succeed can undermine children's mental health; on the other hand, a warm school environment and positive relationships between students and between students and teachers can bolster it.

- **Invest in a whole-of-school approach to mental health.** A holistic approach means considering all the ways in which schools affect children's development and well-being. It should seek to encourage a positive and warm school climate that makes children feel safe and connected. It should

provide regular mental health and psychosocial well-being training for teachers and other personnel and for children, adolescents and families.
- **Strengthen teachers' knowledge and socioemotional competencies.** Teachers and other school personnel need support to build their capacity so that they, in turn, can help children and adolescents learn about mental health and develop healthy habits, and so that they can recognize students in need of additional support.
- **Prevent suicide.** Specialized training for teachers and peers (as well as parents, school counsellors, social and health workers) can help ensure that at-risk children are identified and provided with support. National suicide prevention programmes can play an important role in restricting access to the means of suicide, encouraging responsible media reporting, and identifying and removing harmful content on social media.

Strengthen and equip multiple systems and workforces to meet complex challenges. The focus for mental health programming and services needs to broaden to take advantage of opportunities to promote, protect and care for mental health not just in health services, but in areas like social protection and community care. But, for this to happen effectively and sustainably, child- and family-focused workforces and relevant systems need to be strengthened both to deliver services across systems and settings, and to ensure that the needs and human rights of every child are upheld.

- **Integrate mental health services into social protection and community care systems.** Services need to be provided across sectors and delivery platforms, including health, education, social protection and community care. Community-based interventions are particularly positioned to identify and support at-risk children who require specialized care. Invest in training for community workers and ongoing support and supervision to build their knowledge and skills.
- **Provide MHPSS interventions in humanitarian and fragile settings.** Responses in those settings must be context specific and multi-layered, providing children the necessary means and resources to cope with anxiety and severe forms of distress. Specialized care for the most vulnerable populations should be offered.
- **Respect child rights in mental health services.** Child rights must be respected in the design and provision of mental health services, with service users treated not as patients but as individuals with rights. Care should be person-centred, free of coercion, recovery-oriented and supportive of decision-making.
- **Address gender inequalities in mental health programming.** Mental health programmes must actively seek to redress gender inequalities by assessing and addressing the needs of women, girls, boys, men and non-binary individuals through data collection, wide consultation and participation, and monitoring.

Improve data, research and evidence. Data on the mental health of children, adolescents and caregivers are sadly lacking, especially in LMICs, where most of the world's adolescents live. Lack of data and evidence renders children with mental health conditions invisible and is a major obstacle to policy development and planning. Progress on mental health is also hampered by lack of research and inadequate investment in implementation research.

- **Strengthen research.** Greater investment is needed in research on children and adolescents, which should be cross-culturally applicable, adaptable to local realities and capable of capturing diverse experiences and realities.
- **Routinely monitor mental health.** A determined effort is needed to develop a consensus-based set of core indicators covering the prevalence of mental health conditions, the provision of mental health care, and the extent of efforts to promote mental health.
- **Support implementation research and science.** Increase investment in implementation science, which investigates how a range of factors can impede or accelerate the implementation of policies and interventions.

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Cover photo: Play and early learning are critical foundations of lifelong mental health. Here a boy plays at an early learning centre in Rwanda.