FORUM REPORT
5th Regional Psychosocial Support Forum
Date: 27-29 August 2019
Venue: Safari Hotel, Windhoek, Namibia

REPSSI leads in mainstreaming psychosocial support into programmes and services for girls, boys and youth in East and Southern Africa

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Psychosocial Wellbeing For All Children
Acronyms

ART  Antiretroviral Therapy
CATS  Community Adolescent Treatment Supporters
CBO  Community Based Organisation
CBWCY  Community Based Work with Children and Youth
CDSS  Community Day Secondary Schools
CPT  Child Protection Team
CRC  United Nations Convention on the Rights of the Child
CSE  Comprehensive Sexuality Education
CSO  Civil Society Organisation
EAC  East African Community
ECD  Early Childhood Development
ECCD  Early Childhood Care and Development
EMIS  Education Management Information System
FDCY  Forcibly Displaced Children
GBV  Gender Based Violence
HEART  Healing and Education through Arts
PSS  Psychosocial Support
MHPSS  Mental Health and Psychosocial Support
SADC  Southern African Development Community
SRH  Sexual and Reproductive Health
SRHR  Sexual and Reproductive Health Rights
1. Forum Resolutions

WE, THE DELEGATES at the 2019 Psychosocial Support (PSS) Forum comprising of experts from Government Ministries and Departments responsible for Children and Youth, Health, Education and Skills Development from East Africa Community (EAC) Partner States and Southern African Development Community (SADC) Member States, International cooperating partners, civil society, academic partners, children and youth from 25 countries around the world, including journalists, who met to deliberate on ethical reporting about children and reported about the Forum to the region, funding partners, representatives of UN agencies, practitioners and the world at large, gathered in Windhoek, Namibia from the 27-29th August 2019 under the theme “Breaking Barriers...Creating Connections”.

ACKNOWLEDGING guidance on PSS as articulated in instruments such as The United Nations Convention on the Rights of the Child; The African Charter on the Rights and Welfare of the Child; The Maputo Plan of Action on the Continental Policy Framework on Sexual and Reproductive Health and Rights (SRHR); The SADC Minimum Package of Services for Orphans and Vulnerable Children and Youth; The SADC Psychosocial Support Conceptual Framework; The EAC Children’s Policy; The EAC Regional Minimum Standards for Comprehensive Services; The Sustainable Development Goals; The Africa We Want 2063 Agenda and country specific National Plans of Action;

RECOGNISING that African girls, boys and youth’s psychosocial and mental wellbeing are affected by factors such as HIV, neglect, poverty, conflict, disability, stigma and discrimination of minorities populations; limited access to health and social services; child marriages; teen parenting; child abuse; cyber bullying; and broader child protection issues; and that parents and caregivers of children and youth are affected by similar factors;

UNDERSTANDING the benefit of PSS interventions for girls, boys and youth, where PSS is a continuum of love, care and protection that enhances the holistic development (cognitive, social, emotional, spiritual and motor skills) of a person and strengthens their social and cultural connectedness and resilience. Therefore, emphasise strongly that the meaningful engagement of girls, boys and youth is critical for their empowerment and overall wellbeing. Noting that the holistic nature of psychosocial and mental wellbeing requires that PSS is appropriately, adequately and consistently provided through home, family, school, friends, community, local and national services;

ACKNOWLEDGING on-going efforts by Governments, Regional Economic Communities, Development Partners and Civil Society Organisations (CSOs) to provide PSS and mental health and improve the wellbeing of girls, boys, youth, their families, caregivers and communities;

CONVINCED that collective efforts by Governments, Regional Economic Communities, Development Partners, Civil Society, Religious Organisations, the Private Sector and communities can bring about comprehensive psychosocial and mental wellbeing of girls, boys, youth, their families, caregivers and communities by addressing risks and strengthening protective factors for thriving and health functioning;

Given the 2019 Forum theme, IDENTIFIED that a major barrier in effectively and efficiently addressing issues affecting children and youth is poor coordination at all levels between different sectors (and within sectors) that focus on children and youth.

The Forum therefore issues the following resolutions and recommendations based on the objectives to break barriers and create sustainable connections in mental health and psychosocial support (MHPSS):

We call upon decision and policy makers;

i. To align national laws and policies with international, continental and regional frameworks and best practices to protect the psychosocial and mental wellbeing of children and youth;
ii. To show leadership to promote coordination of efforts and develop a SADC protocol on rights and wellbeing of children and young people;
iii. To recognise the linkages between PSS and mental health in interventions targeting children, youth and caregivers to build their resilience;
iv. To allocate resources for MHPSS and increase transparency on MHPSS spending;
v. To create conducive legal and policy environments to harness the potential of technology to strengthen MHPSS innovations and interventions;
vi. To create legal and policy environments that protect children and youth when using different technologies;

We call upon implementers (programmatic);

i. To provide PSS to build the mental health, psychosocial wellbeing and resilience of pregnant adolescent girls, young mothers and fathers and their children;
ii. To proactively promote psychosocial and mental wellbeing of young girls and boys in order for them to effectively apply knowledge on SRHR;
iii. To collaborate, network and encourage research and documentation on MHPSS in the region;
iv. To promote the transfer of MHPSS best practices between national governments, agencies, regional bodies and global institutions;

We call upon young people;

i. To use research-based evidence in MHPSS policy development.

xi. To improve MHPSS preparedness and response taking into account stressors and shocks such as climate change and others;

x. To strengthen MHPSS capacity of local frontline responders including local law enforcement, health care providers, humanitarian and emergency responders;

xi. To improve MHPSS preparedness and response taking into account stressors and shocks such as climate change and others;

x. To create comprehensive safeguards policies to protect children and youth;

We call upon research bodies and institutions;

i. To show leadership to promote coordination of efforts and develop a SADC protocol on rights and wellbeing of children and young people;
ii. To allocate resources for MHPSS and increase transparency on MHPSS spending;

We call upon researchers and institutions;

i. To promote the transfer of MHPSS best practices between national governments, agencies, regional bodies and global institutions;

We call upon NGOs and CSOs;

i. To promote the transfer of MHPSS best practices between national governments, agencies, regional bodies and global institutions;

We will work towards realisation of these resolutions in the next two years and report on progress at the next Regional PSS Forum in 2021.
2. Opening remarks

The 5th Psychosocial Support Forum was hosted in Windhoek, Namibia from the 27th-29th August 2019, with 362 registered participants from 24 countries around the world.

The Forum was themed “Breaking Barriers...Creating Connections” and was officially opened by the Namibian Deputy Minister of Gender Equality and Child Welfare, Lucia Witbooi. The Minister shared that the Namibian Government has adopted a firm stance on the issue of child marriage by enacting the Child Care and Protection Act, setting the legal age for marriage as 21 years of age. “Although the Act is setting the age of majority at 18 years, the Child Care and Protection Act still prescribes that a person can only enter into marriage at the age of 21 and if younger than 21, the parental consent should be obtained”, she stated. According to the Minister, legal frameworks have limitations too, and while great strides have been made, a recent study has revealed that child marriages are more difficult to detect in traditional settings where they still happen.

Also sharing welcoming remarks was the UNICEF Country Representative to Namibia, Rachel Odeke, who stressed that hosting the Forum in Namibia is timely as it coincides with the 30th anniversary celebration of the United Nations Convention on the Rights of the Child (CRC). Namibia was one of the first countries to sign and ratify the CRC, six months after gaining independence in 1990. “Its guiding principles are: non-discrimination, devotion to the best interests of the child [as paramount], respect for the view of the child, and the inherent right to life, survival and development. Therefore, this conference will investigate some of the outstanding issues,” stressed Odeke.

The Acting Chief Executive Officer of the Regional Psychosocial Support Initiative (REPSSI), Lynette Mudekunye, shared that the Forum presentations over the three days speak to the theme as they were carefully crafted to share experiences on various issues. These include the link between psychosocial and mental wellbeing, sexual and reproductive health and rights; investing in the social services workforce; using technology as a catalyst to break barriers; breaking barriers and creating connections through national and regional coordination as well addressing the psychosocial needs of children and youth in humanitarian and emergency settings, to name but a few. She also encouraged participants to remain resilient, even as REPSSI as an organisation was in mourning over the loss of Chief Executive Officer Noreen Masiiwa Huni, and a moment of silence was observed in her memory.

In her opening remarks, Mudekunye said: “Resilience is the strength to stand up when life has knocked you down, the ability to even look up and hope, to see new possibilities and opportunities. REPSSI today is boosted by so many friends, colleagues and partners who have gathered here from all over the world, by the incredible hospitality of the Namibian government and our CSO partners who have gone way beyond just supporting the preparations for this forum, to genuinely co-owning the forum with us.”

“Challenge: Make new connections”

“Nothing for us without us”
Amir Fouad, Assistant Regional Director SDC, emphasised that the fight against HIV and AIDS is far from over. HIV infections among adolescents are on the rise and more adolescents die every year from AIDS-related illnesses than from any other cause. Of the 1.7 million adolescents living with HIV globally in 2017, 65% resided in Eastern and Southern Africa. There are also growing and alarming disparities in HIV mortality between adolescent boys and girls. He further highlighted the value which SDC places on psychosocial support, “at SDC, we see psychosocial support as a critical enabler of building resilient communities and an indispensable component of any strategy to holistically respond to so many of today’s challenges all along the humanitarian-development spectrum.”

The East Africa Community representative, Morris Tayebwa narrated the relationship between REPSSI/RIATT ESA and the EAC, how this has led to a strong conviction that PSS is important for every child and young person in the region. The EAC Minimum Standards for Comprehensive Services for Children and Young People raise awareness and understanding of psychosocial wellbeing.

Children’s presentation to the main PSS Forum

We are African youth members who attended the PSS Pre-Forum, which was hosted by the Government of Namibia, Children’s Radio Foundation (CRF), EGPAF, RIATT ESA, REPSSI and South Africa AIDS Foundation. We are here today to raise points on the issues we face as youth in all countries. This is what we have to say:

1. Educate parents on sexual health to change their views as it is no longer a taboo:
   - Provide professional social workers to counsel our youth and avoid discrimination and stigma
   - Create awareness programmes
   - More sexual education to better the lives of girls and boys.

2. We as African children feel that we are not represented by people in authority and so do not want them to have influence over us. We want our influences to be among us, people that know our experience and feel what we do.

3. We adolescents have been struggling to understand HIV and other diseases. Make PSS a priority.

4. We as children and young people want to share our views in a comfortable space and be able to influence other youth without having authority and dominance over us.

5. As young people we have a lot of skills to show but we can have good education resources to grow or develop them. We need internet connection to make our learning easier. We need good teachers to ensure proper education.

6. Let us be provided with quality education and have fresher minds dominate the companies and offices of our societies.

7. We have a lot of discussions around us but we never find solutions, and where we find solutions they are not implemented.

8. No one has a right to rob a child their childhood. Let a child be a child. There is always time for childhood.

9. Last but not least, let us have meaningful innovation concerning our health issues.

"Nothing for us without us; the youth is for the youth"
3. Thematic discussions

3.1 Psychosocial needs of children and youth in humanitarian and emergency settings

Exposure to humanitarian and emergency situations poses significant risks to the mental health and psychosocial wellbeing of affected populations. Children and adolescents are particularly vulnerable given that conflict and other humanitarian emergencies often disrupt the very social institutions, community resources, economic livelihoods, and infrastructural supports that children depend on for normal growth and development. The IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007), recognise the pervasive and destructive nature of un-addressed, or under-addressed, mental health and psychosocial needs due to conflict and other humanitarian crises and advice collaboration across sectors and agencies in coordinating MHPSS support endeavours.

The MHPSS Collaborative highlighted that in these circumstances, there is a pressing need to focus on scaling up, diffusion and scaling deep of MHPSS provisions for children, youth and families. The advancement done in adult MHPSS in terms of evidence-based interventions, policy making, and advocacy must be expanded to reach this very vulnerable sector of the population (children).

The Forum established that in-emergency settings often physical needs get attended to quicker and little is done for psychosocial response. In addition, some people post-emergency or humanitarian crises still prefer to stay at home and not at the camps, leading to them being excluded from the support offered at the camps. Furthermore, sexual and reproductive needs were not taken into consideration as partners were separated. Special needs of people living with HIV were neglected as it was difficult for people to continue treatment without adequate food and access to medicine. Hence REPSSI sought to fill this gap. The region should invest in capacity building in MHPSS for emergencies and humanitarian crisis situations. It was also emphasised that there is a need to improve preparedness and response, and to strengthen the capacity of local actors as frontline responders and invest in the coordination mechanism to avoid fighting for space and recognition. Technology can be used to facilitate collaboration and integration.

Efforts to address the psychosocial needs of children and youth in humanitarian and emergency settings require that resilience be a key component. Lessons were shared from Zimbabwe on how resilience was built in children affected by Cyclone Idai. It was also established that resilience in children can be nurtured as children by nature carry an innate capacity for happiness, joy and, while they grieve, they can bounce back from grief quickly. Therefore, the child and by extension the family needs to be the centre of any interventions to build resilience. It is equally important that any such efforts should allow children to verbalise their feelings and normalise these feelings through child friendly spaces. It was noted that to build resilience takes time and is equally a multi-sectoral effort.

The impact of armed conflict and forced displacement on the mental health and psychosocial wellbeing of boys and girls was discussed. Lessons were shared from the Horn of Africa and a case was made for the drafting of an advocacy strategy on MHPSS in emergencies and conflict situations, with a specific focus on children since they are a particularly vulnerable group. The (terre des hommes) is focusing on the addressing the wellbeing of forcibly displaced children and youth through an initiative that i) improves access to livelihoods options; ii) addresses limitations in policy implementation; iii) facilitates psychosocial support; iv) provides access to education and v) reduces discrimination in accessing services.

The ‘Graduating to Resilience’ Project accentuated the importance of mapping service providers in order to facilitate linkages in humanitarian and emergency settings. Lessons were drawn from a Rwandan refugee settlement where digital tools were used to conduct mapping of service providers such as health centres, schools, government institutions, gender based violence service providers, and community based organisations (CBOs) and non governmental organisations. The results of this mapping was that the majority of the enrolled households felt supported and satisfied with the support from the coaches who offered the possibility for referrals and actual weekly coaching on various topics. Furthermore, self-efficacy or the ability to accomplish goals (a large component of wellbeing) was recorded to have increased within the first six months of implementation.

Systematic approaches to recruiting, capacity development and deploying coaches to improve MHPSS outcomes for women, children and youth in refugee setting is essential. Lessons were shared from Uganda where interventions that to effect reached 6,629 households with weekly services. This intervention also recorded that 99% of participant households were satisfied with the support offered by coaches. Hence the use of a systematic approach to recruitment, capacity development and deployment of social service workforce ensures high quality psychosocial and mental wellbeing service delivery by skilled frontline workforce, and facilitates timely programme learning and adaptation. It further builds a sustainable community-based social service system for efficient referrals and linkages.

Language constraints can be overcome with bridging courses and hiring of multilingual coaches. Technology and its role in service delivery was also discussed as it is in real time, allowing one to assess who is in need and who can meet their needs. The preparedness of aid workers and their ability to respond to all issues affecting children and youth as a result of displacement was highlighted as needing to be included as part of the Forum resolution.

Engaging the youth in PSS programs within refugee settings is critical. Lessons were drawn from Uganda where a needs assessment established that only 38.7% of adolescents (18-24 years) reported to have participated in psychosocial programmes. Therefore, establishing that poor psychosocial functioning among children manifested in behavioural and conduct disorders in later years led to the establishment of Youth Centres as safe environments for the delivery of PSS programmes. The intervention saw 70% of the youth participating in sports and recreational activities organised in a way to support the psychosocial needs of young people. Furthermore, the identification of traumatised children and youth was better facilitated. This enabled referral to the nearest identified facilities that handled mental/psychological health using the established case management referral system. The intervention further promoted unity among community members, refreshed their minds, increased their morale in participating in community activities, healed their trauma, and helped to reduce chances of developing diseases.

The Forum also discussed creating safe spaces for children and youth during emergency situations in order to meet their psychosocial needs. Lessons were shared from Malawi on how Children’s Corner services were used. The Children’s Corner is a community space for both in- and out-of-school children aged 6 to 18 years aiming at providing PSS and protection. The intervention saw 70% of the youth participating in sports and recreational activities organised in a way to support the psychosocial needs of young people. Furthermore, the identification of traumatised children and youth was better facilitated. This enabled referral to the nearest identified facilities that handled mental/psychological health using the established case management referral system. The intervention further promoted unity among community members, refreshed their minds, increased their morale in participating in community activities, healed their trauma, and helped to reduce chances of developing diseases.

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3.2 Dealing with early and unintended pregnancies

One of the Eastern and Southern Africa (ESA) commitment targets is to reduce early and unintended pregnancy by 75% by 2020. A study conducted by UNESCO shows that the levels of early and unintended pregnancy in the region is very high, with at least 15% of 15-19 year-olds having already been pregnant at some stage in their lives. This prompted different players including UNESCO, SAAIDS and Save the Children to carry out a regional campaign to address the issue in the region. The regional campaign focuses on upholding the right to education for pregnant girls and young mothers through implementation of re-entry and continuation policies. The campaign also looks at how to strengthen the implementation of the CSE programme in schools through sharing of information on how to prevent pregnancy. Other factors also need to be considered including improving access to sexual and reproductive health (SRH) services and addressing gender based violence (GBV) in and out of school.

The ‘Let’s Talk’ campaign running in 21 countries helps to promote social and behaviour change through engaging stakeholders to address barriers to effective implementation of interventions that will help to reduce early and unintended pregnancies. Stakeholders are required to address cultural and religious norms which hinder dialogue on sexual health at family or community level between the young people and adults/caregivers. Schools should be centres for care and support for pregnant girls and young mothers. Issues of stigma and discrimination in schools (perpetrated by teachers, other learners or parents of learners) should be addressed through provision of PSS to all learners, not just those who are pregnant or mothers. Adequate PSS should also be provided by family members. Research shows that retaining girls in school has the effect of reducing HIV infection rates. Life skills education for girls and boys either in schools or out of school is a key ingredient of CSE and can improve the ability of young people to seek SRH services and information.

Other relevant leaders, men and boys should also be part of the solution. Strong leadership is required from Ministries of Health and Education if the campaign is to be successful. Leaders need to realise that in order to harness the demographic dividend, addressing early and unintended pregnancy and promoting CSE is fundamental.

The Government of the Republic of Namibia is committed to ensuring that adolescents and young people are free from HIV and unplanned pregnancies, as well as GBV. The collaboration between and within line ministries is essential for the success of CSE. This collaboration between line ministries is evidenced by the memorandum of understanding between the Ministries of Health and Education on School Health in Namibia. This strengthened the implementation of the CSE programme in schools. Development partners have also come on board to support the CSE programme. CSE is also supported by strong policy frameworks and related instruments:

- The Constitution of the Republic of Namibia (Article 20)
- National Strategic Framework on HIV 2017/18 – 2021/22
- Child Care and Protection Act
- Inclusive Education Policy
- School Health Policy
- Prevention and Management of Learner Pregnancy Policy
- Adolescence Friendly Health guidelines
- Sexual and Reproductive Health Policy
- Namibia School Health Initiative

The Ministry of Education selected 2,077 Life Skills teachers (which translates to at least one Life Skills teacher per school in the country) and at least 700,000 learners were reached. Another 800 Life Skills teachers were trained on the CSE Online module. It is estimated that they have reached 36,448 young people in schools. Considering the importance of CSE, the Government resolved to revise the Life skills curriculum to include and mainstream CSE. The inclusion of CSE in the curriculum has been factored beyond the Life Skills subject to include other subjects as well. CSE material was developed to aid teachers in implementing the CSE programme. To adhere to the value of inclusive education, CSE material has been produced in braille. It should be noted that there are a number of young people who are out of school who also require information on CSE. Thus, CSOs were engaged to support the implementation of CSE in schools.

Through the Parliamentarian Committee on SRHR and HIV Governance, political leaders at national and sub-national levels have been sensitised on CSE and SRH information. A total of 150 leaders were reached, including parliamentarians (national), regional councillors and traditional leaders, and as a result two motions were introduced in Parliament (Teenage Pregnancy and Child Marriage).

In Malawi, the Young Women’s Christian Association (YWCA) in partnership with REPSSI looked at the need to promote psychosocial and mental wellbeing of young mothers by sharing lessons from a project site. The project has a wide reach due to its strategic partnerships with various stakeholders including local communities and government. Overall the intervention highlighted that improving the PSS of adolescent mothers can have a significant impact in improving the parenting of children, which in turn can enhance the development and wellbeing of these children. The Forum also discussed PSS for pregnant adolescents and young mothers to empower them to make right decisions regarding SRH among other key issues. It is acknowledged that adolescent mothers receive very limited PSS from family members, community and friends. Lessons were shared from South Africa on how adolescent girls are supported, not just before the pregnancy but after as well.

The psychosocial and mental wellbeing of adolescent mothers and young women improves as a consequence of gender sensitive communities. Adolescent girls’ SRH and psychosocial wellbeing can be improved using a group-based methodology where community mentors and health professionals shared SRH lessons in a participatory format – giving girls peer-based PSS to discuss sensitive issues together and then to engage the wider community (other girls, parents, and community members) in what they had learned.

In Rwanda, CBOs supported by Firelight Foundation actively connected adolescent girls and young women to nearby health centres that provided voluntary counselling and testing and family planning services. This kind of intervention helps to prevent HIV, sexually transmitted infections (STIs), and unplanned pregnancies amongst the girls who participate in the programme. Furthermore, as measured by a baseline and endline survey, girls’ self-confidence, ability to care for their health, and recognition of their value increased. Peer support contributed to a reduction in girls’ feelings of isolation through understanding that there are many others who experience the same challenges. Community mind-sets have also become more supportive – with parents increasingly valuing their girls and a “ripple effect” of girls empowered to share their knowledge with other girls and members of the community. A key lesson highlighted is that CBOs are powerful instigators of improved psychosocial wellbeing amongst vulnerable adolescent girls, with group-based education in SRH being a low-cost method of improving their wellbeing. However, it is essential for CBOs to be supported with the right skills, resources, and methodologies to ensure their programming is truly girl-centered and has the intended benefits.

The Forum further shared lessons from Uganda on how to build resilience by engaging adolescent and young mothers in a refugee context. The INSPIRE strategy and the Vijana Life Skills Model were discussed respectively to that effect. The Vijana Life Skills Model especially, empowers adolescents to understand who they are, appreciate where they are going, better manage their challenges and consequently adopt positive behaviours. Parents were also trained to achieve that as they are, appreciate their parenting responsibility, adopt positive (authoritative) parenting behaviour, values, skills and attitudes, towards enabling parents to accompany their children to maturity. The results observed were that there was an improvement in the girls’ characters, communication skills, relationships between youth and their parents/caregivers and other family members, and an increase among youth re-joining school in addition to better self-care. Adolescent girls and young women re-enrolled in school gained confidence to express their ideas for improving child care practices while lessons were evidenced during the training and home visits; and improved relationships between the adolescent girls and young mothers and their parents/caregivers. It was concluded that life skills training impacts reasoning and decision making of adolescents; beneficency/engagement/decision making in planning and implementing activities is critical; that the parenting training was a necessity as expressed by the girls.

Lessons were also shared from the Resilient Adolescent Mothers for Healthy Children (RAM4CH) project in Zimbabwe. It was established that working with adolescent mothers should be part of mainstream child protection, and not just as an emergency response. Young fathers should also be included in support efforts for young mothers. The economic dependency of young girls on men (both young and old) should be mitigated as part of supporting young mothers. Interventions should have a prevention focus to properly address the issue. Tradition and culture were identified as a contributing factor for child marriage or sexual relations with young girls. Educators often complain that they are not trained to handle pregnant/young mothers in school, therefore highlighting the need for capacity building in this regard.

The Save the Children Sweden SRHR project focuses on improving SRHR outcomes for children and adolescents and young people aged 5–24 years in eight ESA countries. The interventions at country level include integration of SRH information with psychosocial and mental wellbeing using the life coach approaches. The project also uses the Process Oriented Approach to
reach parents, teachers, community health providers, and community leadership (including traditional and religious leaders) in order to change their mindsets on SRHR and enable them to support children, adolescents and young people to achieve balanced mental wellbeing.

Through the Adolescent SRHR project (2018), 239,591 children, adolescents and young people were reached with age-appropriate information on SRHR and HIV prevention information. In Zambia, 10 schools reported reduced incidences of unintended pregnancies from an average number of 145 incidences per year out of 3,500 girls targeted in the age-bearing age to 24 cases in 2018. This showed that the pregnancy rate dropped from 4% incidence to 0.7% in 2018, far below the national annual pregnancy rate of 4.2%. In Zanzibar, Tanzania, 16 clubs were established for adolescents living with HIV, in collaboration with community and health care facilities, to provide PSS related to self-stigma, promote treatment adherence and to provide SRHR and HIV integrated services among adolescents living with HIV. The project also worked with trained religious leaders in Kenya, Malawi, Swaziland, South Africa and Tanzania, who mainstreamed SRH and mental wellness into their teachings and used scriptures and theological principles to deliver the messaging.

3.3 Transfer of knowledge and skills

Taking into consideration the increasing number of complex problems faced by children, youth and caregivers themselves, knowledge and skills transfer for community/care workers is more necessary now than ever. Lessons were shared from Botswana on how children, youth and caregivers of today are undergoing multiple psychosocial and economic challenges caused by modernisation. To that effect, in 2004 REPSSI and UNICEF initiated a Community Based Work with Children and Youth (CBWCY) certificate to ensure that vulnerable populations such as caregivers and volunteers working with children and in difficult situations receive the professional care and support they are entitled to. A key recommendation made was for the University of Botswana to fully adopt the programme from REPSSI and administer it according to the country’s clientele needs. The Forum motivated that the social service Workforce is an inclusive concept referring to a broad range of governmental and non-governmental professionals and paraprofessionals who work with children, youth, adults, older persons, families and communities to ensure healthy development and wellbeing. The social service workforce focuses on preventative, responsive and promotive services that are informed by the humanities and social sciences, Indigenous knowledge, discipline-specific and interdisciplinary knowledge and skills, and ethical principles. Social service workers engage people, structures and organisations to facilitate access to needed services, alleviate poverty, challenge and reduce discrimination, promote social justice and human rights, and prevent and respond to violence, abuse, exploitation, neglect and family separation. Therefore, UNICEF in consultation with the Global Social Services Workforce Alliance crafted new guidelines to provide cohesion, and these guidelines are informed by evidence of what works and lessons learned from the field. They are further designed to accelerate UNICEF regional and country programming to better plan, develop and support the social services workforce with national and regional partners. The Global Advocacy Toolkit was also discussed as an initiative that provides advocates with a common set of tools to bring about greater political and programmatic priority for strengthening the social service workforce. A call to action was made to prioritise strengthening of the social service workforce to better protect children and achieve the Sustainable Development Goals.

The University of Eswatini is delivering a two-year PSS certificate programme targeting students who work in CBOs that deliver protection and wellbeing services to children and youth. It was concluded that while service learning projects related and focused on specific problems identified and the justifications thereof were good, they were not properly structured and supporting information was disconnected and randomly chosen. A key recommendation for this intervention was that Mentors should provide advice and guidance to the students when they choose, justify and implement their service learning projects. Also that service learning projects should be subject to the university’s appraisal and approval processes before implementation to ensure linkages between the content chosen, students’ practical experience and theories in the modules. Mentors should emphasise the role of experiential learning from the service learning projects as part of the students’ capacity development process.

The Forum also engaged on how building PSS capacity of the social services workforce can contribute to the wellbeing of adolescents living with HIV. Lessons were shared from the Democratic Republic of Congo, Eswatini, Kenya, Malawi and Tanzania respectively. It was emphasised that, besides building capacity in PSS, communities and professionals alike need to be re-equipped.

In South Africa, the Department of Social Development developed the Psychosocial Conceptual Framework which proposes key strategies to implement at different levels to strengthen PSS; advocate, mainstream and provide a reference guide for PSS in the development of policies, strategies, programme design and implementation; monitoring and evaluation. This further developed the PSS guidelines to harmonise practices and offer practical guidance to those who deliver PSS services to ensure the psychosocial wellbeing of beneficiaries.

The Department of Social Development developed a Community Care Centre Model to address the diverse needs of individuals, families and communities, informed by the situational analysis of child-headed households in South Africa. This model of care brings a variety of services closer to the people (in rural areas and hard to reach areas) and provides quality comprehensive services to beneficiaries in the context of HIV and AIDS in order to address the diverse needs of individuals, families and communities. Seventeen Community Care Centres are being implemented, with the aim to expand the programme to reach more communities.

The Capacity Building programmes for the Community Care Centres aimed to improve understanding of services by social service practitioners (including PSS services) and how to implement them innovatively. The Life skills programme has contributed to building the resilience and improving the psychosocial wellbeing of beneficiaries (orphans, vulnerable children and youth). Managers were empowered to manage the centres better; communities had improved access to a wide range of quality, comprehensive services; allowed for the combination of two or more models (i.e. Home and Community Based care. ISIBINDI model, Drop in Centres) as informed by the community needs and service demands to address the diverse needs of communities.

The Firelight Foundation study on the critical role played by CBOs shows that CBOs work to create change, engaging with and influencing government, mobilising community demand for services, innovating solutions and creating knowledge, and participating in networks and discourse. These components of their work – including the shifting of systems and discourses – are crucial to both the impact and sustainability of CBOs.
3.4 Schools as centres of care and support
The Forum discussed the power of community engagement in promoting sustainable education. Lessons were shared from Malawi on how child marriages and poor educational outcomes amongst adolescent girls in community based secondary schools were problematic due to cultural practices and widespread poverty in the southern parts of the country. Sanitation was also highlighted as a big concern as some girls would miss classes due to their menstrual cycle, often averaging six to seven days a month, which translates to 15 days of classes missed in a term, making it very difficult to recover this lost school time.

The interventions carried out included social and political mobilisation and awareness, which aimed to change mindsets on the importance of girls’ education; the negative consequences of teenage pregnancies and child marriages; laws and policies that support girls’ education; and the role and responsibilities of the community. Capacity building for schools and community-based structures was also prioritised with focus on resource mobilisation, governance, leadership and record keeping. The uniqueness of this approach is that it directly empowered the community to identify and address barriers to girls’ education, and it is cost effective, sustainable and scalable.

The session further reflected on the extent to which patterns and demographics correlate to physical fighting among school-attending adolescents in Namibia. Emphasis was therefore placed on how interpersonal violence was a problem and needed to be examined in order to present a framework; e.g. the Haddon Matrix which might be useful for practitioners in preventing and mitigating physical violence in school settings as it can be applied to nearly any health and social issue. Furthermore, the matrix has been useful in the development of policies, interventions and frameworks at various levels.

Lessons from South Africa showed that the definition of family was evolving as it expanded to teachers as well as the school is now playing the role of family. The Forum discussed how GBV in schools can be prevented. It was established that empowering girls should take centre stage, and thereafter boys should be engaged to ensure that they have the right mindset when it comes to the opposite sex through a REPSSI activity called “Peace is a decision”. Findings show that male learners were the greatest victims as well as perpetrators of violence. Further priority should always be placed on how to make communities safer.

Participants revealed that communities have the potential to identify and address education challenges if they are well equipped and kept in the loop on the progress of interventions. Furthermore, physical violence in schools was discussed as a global phenomenon that affects learners in most schools. While the definition of family has expanded to include communities, emphasis was then placed on men to become more active in parenting and community programs. The session also highlighted the need to support boys in interventions aimed at preventing GBV.

The Injury Epidemiology and Prevention Research Group study identified problematic physical fighting among adolescents in Namibia and recommends public health and school-based programming that simultaneously targets risk behaviours and conflict resolution to reduce rates of physical fighting.

3.5 Technology as a catalyst to breaking barriers
Technology is rapidly evolving and changing the way we live. With an estimated 3 out of 5 children in Africa having access to technology, technology, we need to start looking at how we can leverage technology to improve the wellbeing of children. One of these technologies is Artificial Intelligence, which is the theory and development of computer systems using modelling data to perform tasks normally requiring human intelligence, such as visual perception, speech recognition, decision-making, and translation between languages.

‘Ariel Club Superstars’ is a WhatsApp group platform which is used to provide PSS for young people living with HIV. The group members include trained professionals who ensure that the correct information is disseminated. There are no privacy concerns as everyone on the group is a person living with HIV, making the interactions transparent and reliable to all the members. This experience placed emphasis on the need for PSS to evolve with trends, especially with what appeals to young people such as social media platforms. The forum also explored common themes and emerging trends for eMental Health and ePsychosocial Support. The key objective was to become familiar with evidence-based eMental Health and ePSS in order to understand different ways that digital technology is being applied within limited resource settings and to identify future opportunities. Findings to that effect reflect that emerging trends such as machine learning, predictive analytics, games, wearables, robotics and virtual reality present opportunities worth exploring to facilitate mental health, first aid, ecological
momentary assessments, hotlines, peer networks and mass advocacy. There is need for mental health and PSS advocates and programmers alike to familiarise themselves with the ‘Principles for Digital Development’ as they answer questions on whether the use of technology is appropriate in this regard. It was established that technology is a strength as it presents diverse modes and applications that can be context specific. However, a limitation to technology exists on potential positive publication bias in existing research as most studies were pilots and long-term outcomes have not been assessed. A key take away is that low-tech and existing digital technology can be used to support mental health and PSS service delivery and promote healthy behaviours.

AVSI also shared how toll-free lines and databases can be used for effective handling of beneficiary complaints and feedback related to protection and psychosocial wellbeing of women, children and youth. Lessons were shared from Rwamagana refugee settlement as part of the ‘Graduating to Resilience’ project. The project provided users with information on how to use the toll-free line and toll-free line personnel were recruited and trained on the management of the line and database. The project further designed data entry forms/automated databases to register in real-time all complaints/feedback received. How it works is that, following data entry, an automated table of results and visual dashboard is produced showing: the type of complaints/feedback recorded, mechanism used for receiving them, action taken, and case status. The results of this intervention enable the project team to plan better, make decisions and follow-up or allocate cases to relevant authorities. It was noted that while the toll-free line served its purpose as a service to handle complaints and feedback, there is a need for PSS to be offered in real time beyond logging a complaint and this is one of the limitations experienced with technology.

The Forum also considered how to harness artificial intelligence to improve child wellbeing. Examples were given from projects in Uganda on how smart phones enable coaches to efficiently and effectively deliver MH/SS services for youth and children in refugee contexts. It was also stressed that technology provides easy detection of PSS needs of households as these can be tracked in real time, and it has widened the capacity of social workers to respond to varying psychosocial needs of households including referrals.

It is important for programmers or interventions to be good stewards of technology especially regarding child online protection. Challenges identified include data sharing, multiple actors, systems and vast fragmentation. It is not that technology might fail, but rather concerns around what is behind the technology. Principles for Digital Development must be taken into consideration as technology needs to be child friendly in all contexts. However, not everything is bad when it comes to technology as the benefits are numerous when used appropriately and safely.

In Mozambique and Eswatini, a formative research study including interviews with implementing partners, informed five exploratory workshops with 40 young people living with HIV and 8-10 Community Adolescent Treatment Supporters (CATS). These workshops established the best role for an intervention to empower CATS with a tool to aid better conversations with beneficiaries.

A digital app offered a creative and interactive way to engage our audience, with the benefits of recording and standardising data collected over time. This prototype allowed CATS to structure conversations and gather key data about beneficiary adherence on a regular basis, whilst motivating beneficiaries by making their adherence journey tangible, via the customisation of a personalised avatar. After conducting regular focus groups with participating CATS in both countries:

- Implementing partners had seen improvements in CATS app usage
- Beneficiaries found the app engaging and fun
- The app had provided a platform for beneficiaries to ask questions that were previously thought of as uncomfortable.

Food for thought:

- How does technology address the influence of culture and tradition on the world views of MH/SS recipients?
- How adaptable and sustainable is the use of technology in MH/SS?
- How much is the client satisfied with online service and which tracking mechanisms should be used?
- Do we have adequate child safeguarding policy on internet use(s) especially social platforms.

3.6 Improving HIV outcomes

Stigma, non-disclosure or denial of one’s HIV status, as well as the phenomenon of pill burden, present a challenge for ART adherence in adolescents and young people living with HIV. Common factors affecting ART adherence were identified as lack of knowledge, stigma, non-disclosure, denial of status, lack of support, peer pressure, pill burden and poor nutrition. Lack of responsive health services for adolescents living with HIV remain a barrier to SRH. Disclosure of HIV status to a child and adolescent, coupled with PSS, are critical components of comprehensive HIV care. However, the rates of status disclosure in sub-Saharan Africa remains low. The Elizabeth Glaser Pediatric AIDS Foundation (EGPAAF), as a member of the New Ventures Advancing Pediatric HIV Care Collaborative, addressed this by developing a tool to support adolescent HIV disclosure within schools. It was the strongest that adherence is sustainable and amongst preteens and teens that adhering to ART adherence barriers can improve treatment programmes for those living with HIV. This is even more important when considering adolescents and young people living with HIV, which is the only age group experiencing increased HIV-related mortality and morbidity. It was also established that treatment adherence is not just about taking a tablet and that the different factors influencing adherence to ART are complex and dynamic. Therefore, multiple holistic interventions are needed at a social, systems and individual level. Importantly, interventions at a health facility or community level need to take into account the psychosocial and mental wellbeing of adolescents and young people.

The Forum shared experiences from Namibia where it was established that the Namibian Government is committed to ensuring that adolescents and young people are free from HIV and unplanned pregnancies as well as GBV. Therefore, there is inter-ministerial collaboration between specific line ministries, for example, where a memorandum of understanding was signed between the Ministries of Health and Education respectively on school health.

Some countries are trying out differentiated service delivery as an answer to improving health among the youth. Differentiated ART service delivery is a client centred approach that considers the preferences and expectations of young people living with HIV (an example given was that of the Mapale Health Centre). The role of peer supporters becomes very important as they support the health care workers during the delivery of ART during teen clubs, especially conducting adherence counselling, partial disclosures and full disclosures. They also play a role in being the voice in the teen club review meeting which happens after teen clubs in order for the health care workers to get feedback services provided. They also support with tracking of defaults and are supposed to check if their assigned clients attend their appointments on time, and if they are due for a check on their viral load. Key issues highlighted show that there is scaling up of differentiated ART delivery model to additional clinics in the city. Data has shown that males had lower retention and adherence rates, which points to the need to review the concept and make it accessible to males. Engagement of the community was key in successful running of the model as was seen in the results from the second phase of the model.

Across REACH and READY+ countries, Paediatric-Adolescent Treatment Africa (PATA) conducted a cross-sectional semi-structured survey with 33 health providers from health facilities across 10 sub-Saharan African countries. The survey aimed to better understand health providers’ perspectives and experience of power to influence adolescent HIVSRHR programmes and services. Univariate statistics and thematic coding were used to analyse quantitative and qualitative data. Respondents were 85% female, with a mean age of 40 years. All health providers considered themselves advocates for adolescents and young people living with HIV. Most felt that they had a major (75%) or fair amount (22%) of influence on improving services. Advocacy activities included representing adolescents and young people living with HIV and/or their voices on different facility platforms, reinforcing the provision of differentiated services to these clients, and supporting empowerment and growth of adolescents and young people living with HIV. Reported changes resulting from their advocacy included introduction of new or improved services and operational changes; for example, the introduction of differentiated service delivery models such as weekend adolescent clinics for ART referrals and support groups.

An ABCD tool was developed to support young mothers dealing with stressful situations. It encompasses four domains: ASK (assessing psychosocial needs of young mothers), BOOST (Cognitive Behaviour Therapy (CBT)-based group sessions based on Thinking Healthy modules), CONNECT (linking young mothers to professional care), and DISCUSS (interactive chat forums between peer supporters and professional advisors). The tool was developed through a staged participatory process including structured input from peer supporters (n=20), technical advisors (n=4), and health providers (n=30) in four countries (Malawi, Zambia, Uganda, Tanzania). The tool can be integrated into facility care, contributing to a comprehensive package of psychosocial care for this population, and identifying vulnerable mothers who may be overlooked. It allows for real-time content adaptations and up-to-date resources according to context-specific differences and peer supporter needs.
REPSSI leads in mainstreaming psychosocial support into programmes and services for girls, boys and youth in East and Southern Africa

3.7 Linking child protection and psychosocial support

The Forum discussed the issue of strengthening child protection teams to meet the PSS needs of children, with lessons from Shinyanga, Tanzania. OPE, which is supported by Firelight Foundation, facilitated the establishment and orientation of Child Protection Teams (CPTs) at village and ward levels. Collaborating with the Social Welfare Officer from the District Community Development Department, CPTs were trained using the National Plan of Action guidelines on ending violence against women and children. This approach was unique since other organisations concentrate on strengthening CPTs at higher levels (regional and district). OPE works to strengthen the CPTs at the grassroots level where child abuse cases occur. A challenge was highlighted whereby there is tendency to threaten people who have reported child marriages and early pregnancies. This behaviour limits access of information on child marriages/early pregnancies among the CPTs at village level. CPTs, however, have identified informants from the community who report child abuse cases directly to the Ward Social Welfare Officer/Community Development Officer through a special mobile number. The Social Welfare Officer then informs the CPTs to enable them to prevent an incident from happening or to follow-up on the case if the incident has already happened. Observed changes were that community members are now more aware of issues that affect children in their communities and they could take action by reporting cases to CPT members who would refer them to the Police and Social Welfare Desk. A key success of this intervention was that communities were informed and empowered. There should be an establishment of local synergies in protecting children and identifying GBV, sexual harassment, early marriage and early/unintended pregnancy. Organisations should look into building life skills and promoting the financial education of girls, boys and young mothers.

Further, the Forum considered having community mentors as a way to ensure strong interactive social work case management practices to effectively engage and work with children on the streets. Lessons from Namibia showed that there is a need to address enabling factors such as adults who lure children into begging on the street and as a form of business. The Government of Namibia is working on a strategy to mitigate this situation, premised on five pillars: prevention, working with families, communities, the role of stakeholders and health. This strategy is currently being implemented in Gobabis in a pilot phase, before eventually being rolled out nationwide.

The Forum further looked at enhancement of psychological wellbeing of children in alternative care within the East African region. A rapid assessment of the legal and care practices in the region revealed challenges such as lack of information on the impact of care arrangements on children’s psychological development. Lessons were shared from Malawi where it was established that CBOs are one of the greatest unrealised assets in the goal of achieving lasting outcomes for children. This is because they exist at the intersection of the child and the community, can operate in remote environments, understand and can respond to local contexts; have the reputation, connections and gravitas to shift norms; and are a critical part of the workforce necessary to support the psychosocial wellbeing of children and youth. Research by Sherr et al. (2016) found that HIV-affected youth in South Africa receiving support from CBOs were less likely to experience domestic conflict and abuse, had fewer depressive symptoms and social problems, and demonstrated more prosocial behaviour at follow-up compared to participants without CBO contact. It was noted that legislation and national HIV policies have an impact on adherence to HIV treatment by adolescents and young people. A situational analysis of legislation and national HIV policies impacting adolescents and young people living in ESA was presented. The analysis acknowledged adolescents as a unique group requiring targeted services. It called for decriminalisation of HIV exposure or transmission and advised that countries should review and align their laws and policies with international best practices.

There is need to engage para-social workers to follow up adolescents living with HIV and improve their health outcomes. Para-social workers are an important community structure that can significantly improve the delivery of high quality HIV services and psychosocial and health outcomes. Para-social workers can strengthen linkages to additional services like counselling, psychosocial and legal support, and ensure that clients are supported along the continuum of testing, treatment and care.

The forum emphasised the importance of CBOs and their ability to facilitate real-time interventions such as positive caregiver to child and child-to-child interactions. Lessons were shared from Malawi where it was established that CBOs are one of the greatest unrealised assets in the goal of achieving lasting outcomes for children. This is because they exist at the intersection of the child and the community, can operate in remote environments, understand and can respond to local contexts; have the reputation, connections and gravitas to shift norms; and are a critical part of the workforce necessary to support the psychosocial wellbeing of children and youth. Research by Sherr et al. (2016) found that HIV-affected youth in South Africa receiving support from CBOs were less likely to experience domestic conflict and abuse, had fewer depressive symptoms and social problems, and demonstrated more prosocial behaviour at follow-up compared to participants without CBO contact.

One girl who was tested positive for HIV through the programme said the following: “I’m HIV positive, and before joining this programme I was hopeless. I felt like I would die any time as a result of stigma. Every person ignored me and I hated living with people who were HIV negative. It’s only after I joined this programme that I regained my hope once again and I started living again. I have hope for the future. I live peacefully with my neighbours and I’m no longer a burden on anyone”.

VSO works through training and deployment of STEPS (Support for Treatment Empowerment Pillar Soldiers) who are facility (clinic) based peer supporters. The emphasis is on creating a conducive environment for adolescents and guardians as well as service providers to understand the dynamics of these adolescents and their situation and work together in the health service provision chain (home, institutions) to ensure quality service provision. When the steps of the ladder are achieved, the adolescents and youths will adhere to treatment and have access to SRH services which are key for survival and improved quality of life.

3.8 Investing in early childhood development

There is abundant evidence about the importance of early experiences in influencing lifelong development and extensive research that shows the impact of both risk and protective factors in early childhood in low- and middle-income countries. Hence, quality early childhood development (ECD) programmes offer great opportunity in sub-Saharan Africa where large numbers of children face substantial barriers in achieving their developmental potential (McCoy et al., 2016). It was also noted that ECD remains the least prioritised and resourced component of the education sector in sub-Saharan Africa, with less than 12% of children accessing quality ECD services. Furthermore, the quality of teaching and learning practices remained weak,
with many ECD caregivers struggling to facilitate and support child-directed play and to effectively foster and teach early literacy, early numeracy, and early knowledge about the natural world. Due to shortage of trained ECD teachers, a key barrier is dependency on low skilled volunteers as caregivers. The lessons learned therefore are that CBOs hold tremendous potential and network ability to provide ECD services to marginalised children, but need support in terms of capacity, knowledge and skills. Workshops are therefore being conducted to achieve good results. Task sharing and training by ECD teachers with supervision. Recognising the role of communities in facilitating this development, Firelight has been supporting CBOs in southern Malawi to build the capacity of caregivers at ECD centres to implement positive ECD practices.

The Forum further looked at how arts can be used to heal and educate vulnerable children and provide safe spaces for children. In Malawi, Save the Children integrated Healing and Education through the Arts (HEART) in ECD and Children’s Centres. HEART Adults should be trained on a regular basis to integrate arts-based PSS into their classrooms and centres. The expected results are that classrooms and centres transform into emotionally supportive environments in which children are able to process, express, share, understand, and support themselves and their peers. Another component of art in MH-PSS is the use of storytelling and movement. Story telling is a universally successful vehicle to engage children and youth, but even more so in Africa, due to its strong oral culture and history of stories told by elderly women. Movement also has a universal appeal. Eswatini, for example, is known for its Umiso, Sibaca and many more cultural forms of creative expression through movement. Movement is scientifically proven to improve learning and memory due to the positive emotions it evokes. The outcomes were that children could recognise, name and show their emotions better. They were more aware of their feelings. They could think about their feelings and thoughts. The children could also easily relate to each other. For the teachers, there was increased awareness and understanding of children’s emotional needs. Teachers and children were able to share more personal space and the teachers become more skilled in identifying children’s problems. This also allowed the teachers to become more aware of their own strengths and sensitivities. Teachers become more versatile in using interactive teaching strategies.

The RISE tool was developed to measure how caregivers support aspects of children’s Relationships, Illness/Health, Safety, and Early Learning in communities in Eastern and Southern Africa. Each letter in the acronym corresponds to a domain in the global Nurturing Care Framework. The focus of the tool is on the caregiver-child relationship and the role of the caregiver in providing responsive care, safety and security, opportunities for early learning, as well as support for good health and adequate nutrition.

RISE is a measurement tool designed to provide a brief, systematic measurement of the caregiving relationship. RISE is a caregiver-focused measurement system, and can be used to capture care experiences of children under the age of 5. The RISE caregiving tools presented here were developed following a thorough review of existing tools. We examined a large number of tools employed in caregiving research, before selecting the most suitable tools for use in the present settings. Items from existing measures of caregiving were then selected and categorised on the basis of their relevance to the caregiving domains outlined in the Nurturing Care Framework. The most suitable items for each Nurturing Care Domain were then selected, adapted during site visits to four East and Southern African countries, and compiled into the two versions (one for caregivers, one for ECD centres) of the new caregiving measure.

The Children in Motion – Children Emotion programme, a storytelling programme with movement and creative exploration at its core, helps to bring feelings and self-awareness into the classroom. As children are invited and enticed to discover their own colours, spirit, strength and beauty, emotional literacy is enhanced, and pro-social skills and problem solving are improved.

3.9 Preventing gender based violence

Lessons were shared from Zimbabwe on an intervention called ‘Pachoto’, which means by the fire side. Pachoto facilitates a safe space for girls and young women to mobilise, organise and articulate their needs and aspirations in respect of SRH education, services, and legal protection. Women gather at ‘Pachoto’ to perform their traditional gender role of cooking, and it is a place of warmth, as women chat away, laugh, and share secrets and recipes. Pachoto therefore creates a platform for young women to share, exchange, offload, learn and unwind. The Pachoto model has strengthened the PSS systems of young women and girls resulting in improved health outcomes, challenging harmful practices, enhancing their knowledge systems and participation. Rural women share common challenges such as physical violence and patriarchal social hierarchies. Key lessons from this model is that the engagement of young women in the programme yielded sustainable outcomes since they have the skills to shape and influence communities’ attitudes, perceptions, beliefs and practices, through dialogues. The Pachoto members are now change agents in their own right.

Furthermore, cohesion with traditional leaders was also highlighted. Traditional leaders matter as they are custodians of culture. Their authority and influence go beyond their chiefdom’s physical boundaries. Their words and decrees carry more weight to influence such things as school attendance, review of negative cultural practices, fostering protection of children, and preventing child marriage. They are strategic agents of change and there is a need to form partnerships and develop action plans. The expected results of such cohesion is that involvement of key stakeholders is critical in combating child marriage and related vices. Hence traditional leaders should be supported to develop structured responses guided by chiefdom development plans; interventions aimed at working with traditional leaders should be sustained over time; adequate resources need to be allocated to projects aimed at working with traditional leaders; interventions on ending child marriage need to involve everyone, including children and youth. Work on ending child marriage should be anchored on existing structures, practices and approaches.

Participants were challenged to consider how to create an enabling environment for improved the SRH and mental wellbeing of girls and women through male engagement. VSO works through the training and deployment of male advocates and peer educators and the implementation of local community-based ‘husband schools’ and ‘boys clubs’ to engage men and boys on a range of issues, all of which impact detrimentally on the mental and physical health of women and girls. Best practices were shared from Kenema District, Sierra Leone. It identified that men need to be engaged in a constructive discussion around issues and help identify their own solutions in this regard. The intervention focused on men as the perpetrators but at the same time getting them to rationalise the benefits of behaviour change. The intervention captures community interest and builds momentum within the community at a number of levels. It encourages men to think at an individual level about their behaviours and to explore the advantages to them of changing these behaviours. At the community level it supports a role for men to work with other men to raise awareness, challenge behaviours and mediate domestic disputes. Gaining the support of chiefs and traditional leaders at an early stage is a key component to the work of laying strong foundations upon which to build the project. This work is significantly strengthened by the by-law harmonisation work at district level, which has had strong buy-in from traditional leaders and the authorities. The work done in schools with boys’ clubs is fostering positive behaviour change in young men who are also are playing a watchdog role in schools.

Below are the impacts of the intervention as experienced by the following people:

- **Court and police perspectives:** Traditional leaders have changed their attitudes somewhat and many are now advocating against violence on women and girls in their own communities. The continuous education provided to men at community level has led to improved outcomes at court level in terms of successful prosecution. Police Family Support Unit now deals with approximately 50% fewer cases of domestic and sexual violence per month since the intervention began.

- **Wives’ perspectives:** “Previously I became old, now I’m beautiful again and I feel like a young woman again”. “Before my husband said that when our first daughter reached age 12 she should undertake the initiation but the training he received made him change his mind because he realises about the health risks of female genital mutilation”
During the forum, the African Union Goodwill Ambassador, Nyaradzayi Gumbonzvanda, challenged participants to reflect and provide recommendations to strengthen the regional work on ending child marriage, especially targeting the SADC institutions and the African Union. The discussion was preceded by a briefing on SADC Model law and the establishment of the Model Law for the Eradication of Child Marriage and Protection of Children who experience marriage, as well as the status of the African Union Campaign on Ending Child Marriage, which has been extended to 2023, and for which there are ongoing consultations on its strategic plan.

Some of the ideas shared include:

i. Find a new word for child marriage in order to reveal the multiple layers of child abuse, exploitation and rights violations.

ii. Resource, recognise and scale up community level interventions, innovations and learning.

iii. Re-invest in community values towards children, parenting skills and socialisation that reclaims the African identity and values that each child is everyone's child.

iv. Resource and strengthen counselling and guidance in school, and provision of PSS services in communities and other centres.

v. Strengthen the policy framework to go beyond the marriage laws and prioritise other sectoral laws relevant to ending child marriage i.e. education, health, social services.

vi. Integrated quality, accessible and cost-effective services, i.e. child friendly police and courts, availability of trained, motivated and resourceful guidance and counselling teachers; professionals to deal with PSS and mental wellbeing of children including case management.

vii. Increase knowledge management and accountability, which demands close collaboration of diverse service providers.

viii. Establish accountability, enforcement mechanisms that compels countries to comply with regional and continental commitments.

3.10 Improving the quality of life of adolescents living with HIV/AIDS

The Forum engaged in a discussion on comprehensive HIV, SRHR and PSS service integration in the form of an interactive and facilitated talk show. The panelists included a young person living with HIV, who shared her story with participants. Another panelist was Ready+ coordinator, who shared about the CATS model, which aims to make adolescents living with HIV more resilient. The third panelist was a midwife and nurse from Eswatini, who gave an implementer's perspective. The fourth was a REPSSI representative from Eswatini, who emphasised the importance of involving communities in MHPSS efforts.

The Forum discussed how to build and strengthen resilience among adolescents living with HIV in rural communities towards the realisation of full SRHR. Lessons were shared from Zimbabwe using an approach which focuses on the home, school, hospital and community at the centre. The model has four steps to help the adolescent accept their HIV status. The adolescent is made aware that they can choose to disclose their status and the adolescent is further equipped with information on adherence to treatment. Lessons learnt show that there is a need to expand CSE and SRH services for young people living with HIV. It was also noted that peer supporters in rural areas have specific challenges such as transport and monitoring, evaluation and data reporting on young people living with HIV. There is need to strengthen adolescent protection and social protection measures. Key recommendations include: promoting youth leadership – young people living with HIV need to see more local peer “heroes” who are also living with HIV, exchange learning with similar programmes. The model also needs to be further documented and adopted as a best practice in peer-to-peer management of HIV and AIDS in rural areas in Zimbabwe.

The Forum further discussed lessons from Cameroon on how to provide PSS to HIV-positive adolescents in crisis. The areas of intervention in this regard were treatment and retention. In less than one year, all the adolescents in the programme had received at least a one-to-one PSS service. There was a perceived rise in the self-esteem of the adolescents, they had developed stronger coping mechanisms and felt adequately equipped in the fight against HIV. Caregivers felt supported by the interventions provided to them and their adolescent children. There was also increased consciousness of the needs of adolescents among service providers. Services were also now more adolescent friendly than ever before. Challenges experienced included inadequate capacity and weak systems in providing PSS to adolescents living with HIV in a polarised environment. Displacement of families away from the programme area due to insecurity made follow-up of the adolescents extremely difficult. Lessons learned include that PSS is key to improving the emotional wellbeing of adolescents living with HIV. A peer approach to providing PSS to adolescents and young people is key in meeting the needs of this age group. When
adolescents and young people are empowered to lead actions they can easily channel their energy into very productive activities. In recruiting young people to support the facility staff, there is need for comprehensive training on what it means to work and how to behave at the workplace. Peer supporters, just like their peers, need continuous PSS. Overall, a combination of inadequate capacity and weak systems in providing PSS to adolescents living with HIV in a polarised environment have significant implications for access, retention in, and adherence to ART, and can be reflected in viral loads. This calls for a conflict sensitive approach to providing PSS with a view to match the increased psychosocial needs imposed on clients by the dynamics of conflict.

3.11 Policy formulation and implementation

The Forum also discussed domestication of the SADC Minimum Package of Services and the SADC PSS Conceptual Framework, drawing lessons from South Africa. The PSS Conceptual Framework at SADC level was developed due to the fact that PSS was less understood and was the missing link in the Minimum Package of Services for orphans and other vulnerable children and youth. Challenges experienced include a lack of vital documents, weak referrals, lack of confidentiality, some families not being receptive and expensive costs attached to specialised psychological services.

Key recommendations included the need to strengthen ongoing capacity building for implementers, coordinating structures and linkages, regular evaluations of PSS, effective monitoring system, creating platforms for support and debriefing, and resource mobilisation.

The Forum also noted that the progress made by most SADC countries in developing policies focusing on the positive development of children and youth in general, and PSS in particular, still requires greater commitment through resource allocation at national level. As a consequence of resources challenge, children and youth in the region have limited ability to cope with their social, emotional, psychological and spiritual needs. Understanding the mindset of the government towards the social services sector is a starting point for the deepening of analysis on specific interventions such as PSS. The social service workforce plays a crucial role in protecting girls and boys and promoting their wellbeing. Government’s responsibility to provide social services to children as a specific group requires a response through national budget allocations. One of the key indicators of the level of commitment to provide PSS to children is the allocations made towards the human resources for the delivery of this service. These allocations may be in the form of remuneration and, more importantly, training, of personnel for the provision of quality PSS services to children in different circumstances across the provinces/regions that make up a nation. In most SADC countries, however, the numbers of personnel (for example, social workers) present at various levels and right up to grassroots level, are inadequate compared to the demand for psychosocial services by children and youth in difficult circumstances. The Forum noted inadequate national budget allocations to PSS programmes as a challenge in most SADC countries, and recommends prioritisation of PSS as an essential service for child and youth development, as well as efficient and effective use of national resources in order to enable spending for PSS services.

The Child Rights Network for Southern Africa (CRNSA), emphasised the need for a SADC Protocol for Children. This will build on the momentum created by the SADC Minimum Package of Services. Since a protocol will be more binding, it will create opportunity for greater commitment by the member states to children’s rights.

The Protocol, therefore, will:

- Provide a functional, regional, legislative and institutional framework to facilitate the development, co-ordination, harmonisation and strengthening of national efforts geared towards the promotion of children’s rights and child wellbeing.
- Guide SADC member states parties in prioritisation and integration of children and young people’s rights in their planning, budgeting and resource mobilisation processes.
- Establish and strengthen existing inter-country partnerships on the promotion of the rights, protection and wellbeing of children and young people.
- Guide SADC member states in the monitoring and evaluation of the implementation of the UNCRC, ACRWC and national commitments to children and young people’s rights.
- Strengthen capacity in research, advocacy, knowledge management and innovation on rights and wellbeing of children and young people.

The Forum also discussed the state of funding for children in the SADC report. The report was premised on the understanding that beyond the ratifications of international and regional children’s rights instruments, as well as promulgation of impeccable laws, realisation of children’s rights will not be actualised until adequate resources are availed. Funding trajectories in the SADC show that of 16 SADC member states, nine of them have been ranked by the World Bank as middle-income countries. Most countries in southern Africa do not feature prominently on the list of countries that receive official development assistance (ODA).

The amount of funding that has been coming to Africa has reduced significantly since countries under far-right leadership would want to focus internally. The migration crisis also led to European governments being overwhelmed by the number of people seeking asylum in their countries. To avert the situation, money that has been meant for international aid is being directed to dealing with the influx of immigrants on the door step of Europe. Furthermore, the Mexico City Policy is a U.S. Government policy that requires foreign NGOs to certify that they will not “perform or actively promote abortion as a method of family planning” with non-U.S. funds as a condition for receiving U.S. global family planning assistance, as of January 23, 2017.

Therefore, the prospects and opportunities for financing child rights in SADC should factor in the idea of strengthening national governments’ capacity to mobilise resources domestically, an idea which is gaining currency. This comes in the wake of the same governments having leakages within their systems resulting in them not benefitting as much in increasing their fiscal spaces. The major aspect on DRM is strengthening of the countries’ tax systems so that the citizenry and corporates may contribute to the development of their countries. In addition, the rise of African philanthropy as a financing mechanism is a much needed conversation as Africa has the fastest growing market of High Net Worth Individuals in the world.

Meanwhile, SADC is in the process of developing a framework for the inclusion of philanthropic activities in supporting its regional integration agenda. Remittance in Southern Africa is also important factor as migrant remittances have become a major source of financing for developing countries and are particularly important in Sub-Saharan Africa.

SADC Member States should improve collection, disaggregation and dissemination of budget data through observation of the dictates of UNCRC General Comment No. 5 (2003) on General Measures of Implementation by collecting in real time and sharing budget allocation and utilisation data amongst all relevant stakeholders encapsulating all areas of child protection, health and education.

In light of general comment No. 19 (2016) on public budgeting for the realisation of children’s rights, SADC member states are recommended to ensure that public spending on child focused sectors and programmes are adequate, equitable, efficient and effective, and are undertaken within transparent and inclusive public finance management processes. It is only through increased and improved quality of public spending that SADC member states can sustainably deliver essential services such as health, child protection, education, nutrition and social assistance to all children. Public-Private Partnerships should be explored as a strategy to finance child focused sectors in SADC countries.

There is need for the governments to build sustainability for its programmes, especially the free primary education programmes that are being implemented in some SADC countries. Domestic resource mobilisation is critical as a sustainable way of ensuring sustainability in provision of resources for this sector. To promote domestic resource mobilisation member states will need to review their revenue collection mechanism as well adopt strategies that can enable revenue authorities to efficiently and effectively collect taxes from the huge informal sector in the region.

Citizen engagement in budgeting processes: The budget formulation stage is key in the determination of priorities and allocation in a national budget. The budget process can be strengthened by incorporating child and youth sensitive budgeting and promoting their participation in the budget process. It is important to make sure that children and youth are involved in the strategic planning and identification of needs stage of the budget process.

Reduced allocations to child focused programmes (either due to dwindling donor funds or low revenues) will limit the services provided to children. Vulnerable families will be mostly affected due to poverty. Available resources should also be directed towards creating opportunities for community-based responses that promote income generation for vulnerable households, in order to give children in the region a better chance of enjoying basic rights and by doing so ease the burden of poverty.

An efficient system of resource use which looks at the specific needs of specific children, and by doing so informs the provision of the appropriate basket of goods, is necessary in SADC countries. This approach will free resources towards critical needs for children in different circumstances and by doing so promote equitable distribution of resources.

Overall the call of this report is that having good laws and policies is not good enough. There should be a lucid and deliberate public investment in the implementation of those policies so that every child, regardless of context, can access quality services.

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3.12 Correctional services restoring dignity

The workshop looked at VSO’s key PSS approaches towards the prison population, namely: social accountability, social inclusion in gender and resilience. Prison inmates form part of a marginalised population and require certain support systems. The support required could be in the form of counselling during rehabilitation, counselling after release, education, therapy, as well as family time. A case study was presented from Zimbabwe, where VSO engaged inmates to rate the food, health and education services in prison. The discussion in this workshop was on how linkages were formed with referral services, e.g. legal, and how VSO handled pushback and challenges they might have encountered from correctional officers and government officials. The case of prisoners with mental health issues and social inclusion were also brought forward. While it was emphasised that the prison population should not only mean the prisoner but the correctional officers and other duty bearers, it is also important to address traditional beliefs on how a prisoner should be treated.

Experience from Zambia was shared on how a ‘Soccer Model’ was used to enhance SRH as well as rights to psychosocial wellbeing in three correctional services. Below is a testimony about the model:

Adoption of this model is said to have resulted in improved service delivery as inmates are now able to test for HIV on site during tournaments, which has increased the number of inmates on treatment. Other improvements included increased knowledge in sexual reproductive rights, and it was shared that officers and inmates can now discuss HIV information openly, which was not the case before. The Forum also discussed the need to reintegrate inmates into communities and how this needs to be complemented by psychological preparation for both family members and inmates themselves to address stigma and discrimination. Lessons were shared from Tanzania emphasising that reintegration is difficult for many offenders because they face a variety of challenges simultaneously, including difficulty in finding jobs as they tend to be uneducated and unskilled. Furthermore, employers generally hesitate to employ someone with a criminal record. It was recommended that resilience building for inmates and PSS should be prioritised in the reintegration process for all parties involved, starting with inmates, their relatives, the relevant authorities and then the community at large.

While on the issue of building resilience among juvenile population through psychosocial counselling, challenges were identified as inadequate number of psychosocial counsellors, inmates originating from hard to reach groups in society (mostly marginalised and with limited access to sexual and reproductive health), while demand for sexual and reproductive health services remained low due to a lack of knowledge. There are also few skilled social workers with expertise in MHPSS for the prison population. Lessons were further shared on how to form and strengthen national and regional ex-prisoners’ associations from Eswatini, Malawi, Zambia and Zimbabwe. The aim was to demonstrate a mechanism for improved coordination for ex-inmates nationally and regionally. The challenges shared highlighted that upon release, ex-prisoners have very little support in terms of income, family relations and limited skills to aid their re-entry and successful reintegration into the community. They also struggle to integrate due to inadequate life skills and entrepreneurial skills, diseases, disability and mental ill health. Stigma, discrimination and rejection are also of grave concern among this population.

“This programme has given me a sense of purpose. It allows me to pass on HIV and sexual health information to my players and explain how important it is to be tested for HIV and screened for STIs. This keeps my days busy and allows me to concentrate on something meaningful.

I may be transferred, and if I do, I will sit with officer in charge to try and continue with the programme even though I’ll be at a different facility.”

- Webby Jones, TackleAfrica Coach and inmate at Mwembeshi Maximum prison.
Moderator: Janet Bauer

Vulnerable children who lack self-esteem and confidence face life’s challenges with great difficulty. They can do poorly in school, take unhealthy risks, lack connections, and have emotional problems.

Tens of thousands of children have participated in the simple, yet transformative, Great Child Class. Children expressed themselves freely, were heard, became aware of natural strengths, and received peer affirmations. They built confidence, connections and resilience; then identified challenges and changed their lives, despite tremendous social and economic hardships.

This class for all children has been used in 150 organisations, in a variety of settings by teachers and others, in eight countries in eight languages. Classes included orphans, children with disabilities, vulnerable teen girls, and children affected by HIV/AIDS.

Reports state that after classes, children participate more, raise grades, help others, and become leaders. A teacher said that children always feared speaking, but in this class it was like 'bushfire' with high spirits and all hands up to talk. Another said it was a paradigm shift, a new culture of unconditional love and caring.

Data from several Kenyan schools that implemented this class:
- statistically significant improvement in end-of-year examination scores
- average retention rates increased by 57%
- average graduation rates increased by 60%

Teachers attributed these changes directly to Great Child.
4. Closing remarks

In her closing remarks, the Namibian Deputy Minister of Gender Equality and Child Welfare, Lucia Witbooi endorsed the call for a SADC child rights protocol, “Some of the Sector Protocols make partial mention of children in narrow specific contexts. The global conventions such as the African Charter on the Rights and Welfare of the Child and the United Nation Convention on the Rights of the Child have gaps that make it rather difficult for Member States to effectively implement, monitor and report on it. It is therefore necessary that we have a protocol focusing on children’s needs specifically.”

Connie Kganakga, Regional Chairperson for REPSSI Board of Directors and Kadai Mansaray Sibanda Regional Operations Director, VSO highlighted the importance of networking and partnerships if we are to realise psychosocial and mental wellbeing for all children and young people. Participants were encouraged to engage children and young people throughout the programme life cycle for sustainable impact.

5. The children and youth
Psychosocial Support Forum

The Children and Youth Forum preceded the 5th PSS Forum which was organized under the banner Breaking Barriers, Creating Connections as REPSSI continued to deliver on its long-standing commitment to involving children and young people recognizing that children and youth are key in responding to the issues concerning mental health and psychosocial care and support.

The Children and Youth Forum was hosted by The Government of Namibia and REPSSI in partnership with RIATT-ESA, EGPAF, Children’s Radio Foundation (CRF) and South Africa AIDS Foundation. It brought together 61 children and youth from 13 countries in Eastern and Southern Africa region to discuss key issues that affect them, their families and communities. The issues addressed included; Gender Based Violence, Child marriage, Early and Unintended pregnancies, climate change and social connectedness. Overall, the conference aimed at equipping the young delegates with advocacy and communication skills and provided a platform and a safe space for children and youth to engage and share their personal and lived experiences.
The First Lady of Namibia’s Interaction with the Children and Young People

Discussion with the First Lady of the Republic of Namibia, Her Excellency, Madame Monica Geingos during a session chaired by the EGPAF ambassador, Brian Ahimbisibwe, on issues affecting children and young people, gave participants the confidence and exposure of having their issues heard at a very high level of authority. The Child President of the Republic of South Africa, Theo van der Westhuizen also had an opportunity to interview the First Lady on radio.

Message from the First Lady

- The best laws are irrelevant if they are not adequately enforced and practiced. We have to ensure there is enforcement of law at all levels.
- A lot still needs to be done in changing our mindsets in terms of what we find acceptable as definitions of what is harmful for children.
- Each and every one of us has the responsibility to condemn behaviour that facilitates harm to children, reporting incidents to authorities and once reported the authorities must do everything in their power to make sure the perpetrators are put to book.
- The social norms that bring harm to children are often linked to tradition but not necessarily the leaders themselves. Traditional, religious and community leaders need to ensure they make child violations unacceptable and we need to ensure these leaders are included in these conversations.
- Traditions are not static, they evolve with time and society has a big role to play within that revolution. Nothing in our traditions and society cannot evolve, particularly if it is harmful to children, women or anyone else.

Key messages from the pre-forum

- SRH programmes and services should address the differing needs of young people in early, middle and late adolescence as well as those that take account of the challenges faced by adolescents living with HIV especially girls.
- Invest and ensure that girls are kept in school especially as education is a protective factor against child marriage and HIV infection. Also develop comprehensive package that enables teen mothers to be re-integrated into schools and society at large without discrimination.
- Policies and programmes that promote social connectedness must be prioritized when developing interventions aimed at improving psychosocial and mental wellbeing.
- Engaging men and boys in ending GBV through Government-supported programmes which examine and challenge attitudes in order to end discrimination against girls and women.

Policy makers should enact and enforce laws that address environmentally unfriendly acts which lead to climate change.

You must be proud of your Africanness. The problem is every time we hear about Africa, it is on a negative term and there is no way that does not affect young people’s self-belief of who they are. Who they are is associated with their nativity. There is so much pride that comes with being an African, there is so much history and culture that children and young people need to know and be proud of.
6. Conclusion

Overall, the Forum had the following three main objectives that informed the parallel break away sessions, workshops, plenaries and panel discussions:

i. Objective 1: To share experiences of and identify strategies for PSS as an enabler of the Sustainable Development Goals
ii. Objective 2: To facilitate research collaboration, learning communities and communities of practice across disciplines, sectors, and initiatives to promote resilience in girls, boys, youth, families and communities
iii. Objective 3: To influence policy formulation and implementation to promote psychosocial and mental wellbeing of all children and families.

The breakaway sessions highlighted many issues and offered recommendations on how to improve various interventions. Nonetheless, across most of the sessions the following issues kept arising, namely:

- The need for a comprehensive regional PSS database
- The need for cross-country collaborations and exchanges in PSS
- The need for regional guidelines on technology and PSS
- The importance of empowered communities in PSS interventions
- The importance of supporting the African boy child/man in PSS
- The importance of resilience in PSS
- The importance of demystifying mental health in PSS.

The Forum resolved to work towards the realisation of its resolutions in the next two years and report on progress at the next PSS Forum in 2021.
REPSSI leads in mainstreaming psychosocial support into programmes and services for girls, boys and youth in East and Southern Africa.