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JOFA-ACTE Project Learning Brief on Mental Health and Psychosocial Support (MHPSS)

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Learning Agenda Brief

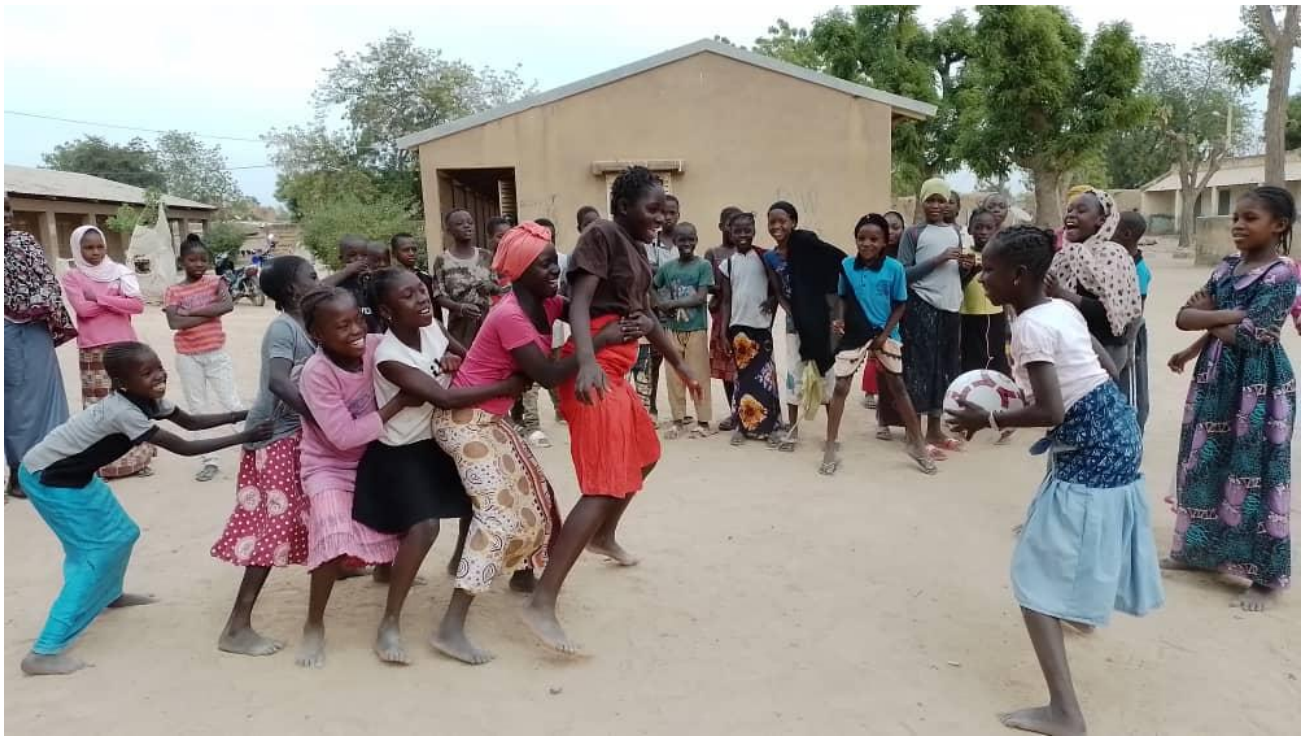
JOFA-ACTE Project Learning Brief on Mental Health and Psychosocial Support (MHPSS) for Children and Families in Burkina Faso and Mali

This learning brief summarizes the main ideas, practices and challenges involved in implementing the JOFA-ACTE project's mental health and psychosocial support (MHPSS) interventions in Mali and Burkina Faso. It builds on the growing recognition of MHPSS as an essential pillar of child protection and well-being in crisis situations. The note focuses on how MHPSS services have been structured, delivered and adapted in these two countries.

The importance of MHPSS

The deteriorating security and humanitarian situation in the Sahel, particularly in Mali and Burkina Faso, has created a critical need for MHPSS interventions, particularly among displaced and conflict-affected children. Exposure to armed violence, forced displacement, loss of parents, violence, poverty, inequality, food insecurity, disease and pandemics, as well as exploitative child labor, has had profound psychosocial consequences for children and adolescents in these contexts.

The main findings of a study conducted in 2023 on the state of MHPSS of adolescents and young people conducted mainly by the Regional Psychosocial Support Initiative (REPSSI) in the Eastern and Southern Africa (ESA) region are as follows: Schooling protects mental health, food insecurity is linked to poorer mental health, access to water and electricity plays a role in well-being, child marriage is a major concern, early and unwanted pregnancies must be avoided, teenage mothers are a risk group, access to health facilities remains low and difficult, access to sexual and reproductive health and rights remains extremely low, loss of parents has a negative impact on well-being, adolescents in Eastern and Southern Africa are exposed to violence and a sense of security is a key factor in well-being (Bandeira et al, 2023).



Definition of MHPSS in child protection

UNICEF defines MHPSS as a broad continuum of mental health and psychosocial services, including promotive, preventive and specialized care, within child protection and education systems, with an emphasis on community, family and peer support as fundamental to well-being (UNICEF, 2021a). A rights-based approach is also essential: according to the USAID toolkit (2023/24), child-centered MHPSS programmes must respect every child's

right to dignity, participation and protection, particularly of marginalized groups, and must be adapted to local contexts, as highlighted in key sections dealing with cultural adaptation, inclusion and responsive design (USAID, 2023/24, pp.14-18).

Health, both psychological and physical, is at the heart of the definition of child labor in international law. Article 32 of the United Nations Convention on the Rights of the Child (UNCRC) calls on States Parties to take legislative, administrative, social and educational measures to ensure the realization of "the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development" (UNCRC, 1989: Article 32, ILO, 2011, pp. 9-10).

Structural obstacles to access to MHPSS on the ground

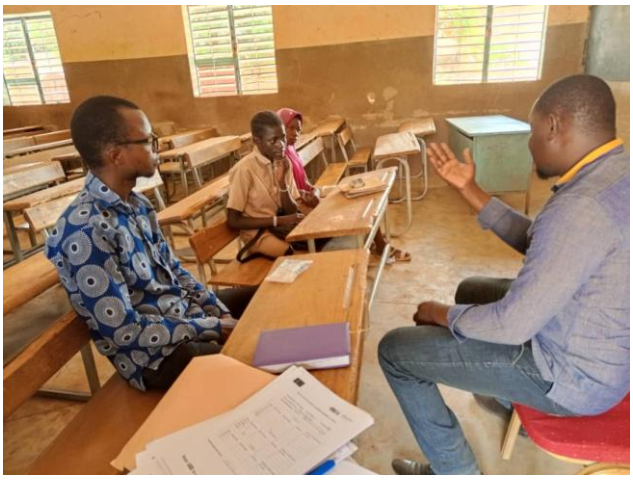
As in most Sahelian countries, formal mental health services in Mali and Burkina Faso remain underdeveloped and centralized. The WHO (2022) reports that mental health infrastructures are mainly confined to urban areas, with little integration into primary care or community health systems. Rural and conflict-affected populations often turn to traditional healers or religious leaders to manage psychosocial distress - an approach that may reflect local beliefs, but often fails to address underlying trauma.

The UNICEF/WHO Regional Study on Children's Mental Health (2022) found that services for young people were either ad hoc or integrated into broader emergency responses, with limited system-wide planning. In addition, the stigma associated with mental health problems - often seen in spiritual or moral terms - remains a significant barrier to accessing these services (Betancourt et al., 2013).

Community and sectoral approaches

In response to these limitations, MHPSS is often provided through community initiatives. Child-friendly spaces, peer groups and mobile health clinics offer accessible and culturally appropriate support to children in need (UNICEF and WHO, 2022). An example is an EU-funded education and protection programme launched in 2020 that has reached over 130,000 displaced children in Mali, Burkina Faso and Niger through school-based psychological first aid, peer support and accelerated learning, all aimed at psychosocial recovery and educational reintegration (DG ECHO, 2022).

More generally, MHPSS can and should be mainstreamed across all sectors, including education, health, protection and livelihoods. The MHPSS Minimum Package of Services, developed collaboratively by WHO, UNICEF, UNHCR and UNFPA, describes how cross-sectoral programmes - involving teachers, social workers, health staff and community volunteers - can expand access and promote holistic care (MHPSS MSP, 2022). Parenting programmes, youth clubs, school-based social-emotional learning and safeguarding case management are all cited as effective multi-level interventions.



Digital tools also support service delivery. In Burkina Faso, Terre des Hommes (2023) reports the use of the Child Protection Information Management System Plus (CPIMS+), a secure digital case

management system developed by Primero and supported by UNICED and IRC, to identify, monitor and refer children at risk, including survivors of violence and exploitation. CPIMS+ helps frontline workers, such as social workers and community case managers, to securely record, track and manage information about vulnerable children, including those who have been abused, neglected or exploited. It ensures that children receive timely support by enabling different agencies to coordinate and monitor each case effectively, while protecting children's privacy through robust data protection measures.

Child labor, displacement and mental health: Summary of empirical findings

Empirical evidence confirms the importance of an integrated MHPSS. Andersen et al (2022) found in a multi-country cohort study including Mali that 96% of community MHPSS beneficiaries reported reduced distress and 82% improved their daily functioning. Similarly, Save the Children's EU-funded programme has achieved good results in supporting the return of children to safe and supportive learning environments (EU Humanitarian Aid, 2022).

Burkina Faso-specific data from Ismayilova et al (2016) found high rates of depression (15%) and post-traumatic stress disorder (PTSD) (18%) among ultra-poor children, with emotional consequences most severe among those facing abuse or exploitation. These findings are in line with global research linking child labor with harmful psychological consequences. In addition, Sturrock and Hodes (2016) conducted a systematic literature review of epidemiological studies on child labor in low- and middle-income countries and its mental health consequences. Their conclusion highlights that the burden of mental ill health due to child labor is significant given the known number of children working. Risk factors for poor mental health include involvement in domestic work (e.g. domestic workers living with their employers may experience abuse and isolation), young age (older children may be more resilient and cope better) and higher work intensity (due to an indirect effect, e.g. loss of schooling, or a direct effect, e.g. exhaustion). This could lead to isolation, low self-esteem and the perception of an external locus of control (Sturrock & Hodes, 2016). As early as 2011, the International Labour Organisation highlighted the psychosocial consequences of hazardous work, including long-term effects on development and social withdrawal (ILO, 2011, pp. 29-34). It introduces a "model of the causes and consequences of psychosocial risks and the impact of child labor" including psychosocial risks, stress response, individual characteristics and long-term consequences on the working child (ILO, 2011, p. 36).

Although regional data remain limited, information from Eastern and Southern Africa reveals similar concerns. According to UNICEF (2023), young people in crisis contexts face structural exclusions, low trust in health systems and few safe spaces for emotional expression, highlighting the need for age-appropriate and adolescent-led responses.

Filling the gaps: Community responses to children's mental health in Burkina Faso

In a context of prolonged crisis and internal displacement, Burkina Faso is facing growing challenges in terms of mental and psychosocial health, particularly for children. In addition, a number of significant gaps in the accessibility of MHPSS services have been identified. These include a weak institutional framework, with no specific legal basis or sustainable national funding for mental health; the high cost of care, which makes specialized services inaccessible to vulnerable families, particularly outside major cities; and persistent social stigma, which discourages the use of formal services. There are also significant geographical inequalities, with most specialist services concentrated in urban centers, while rural areas remain largely underserved.

Community services lack sustainability, as many depend entirely on temporary humanitarian funding. In addition, identification mechanisms are weak due to limited resources, poor coordination and inadequate training of community and professional actors. Support for parents, vital for children's well-being, is sporadic and unstructured. Finally, the lack of a reliable and up-to-date national database hinders effective planning and targeted MHPSS interventions.

In response, the EU-funded JOFA-ACTE project has implemented community-based MHPSS interventions to support the emotional well-being, protection and resilience of vulnerable children. This report summarizes the lessons learned from the implementation of the project, highlighting the types of services provided, identification mechanisms, engagement with families and good practice.

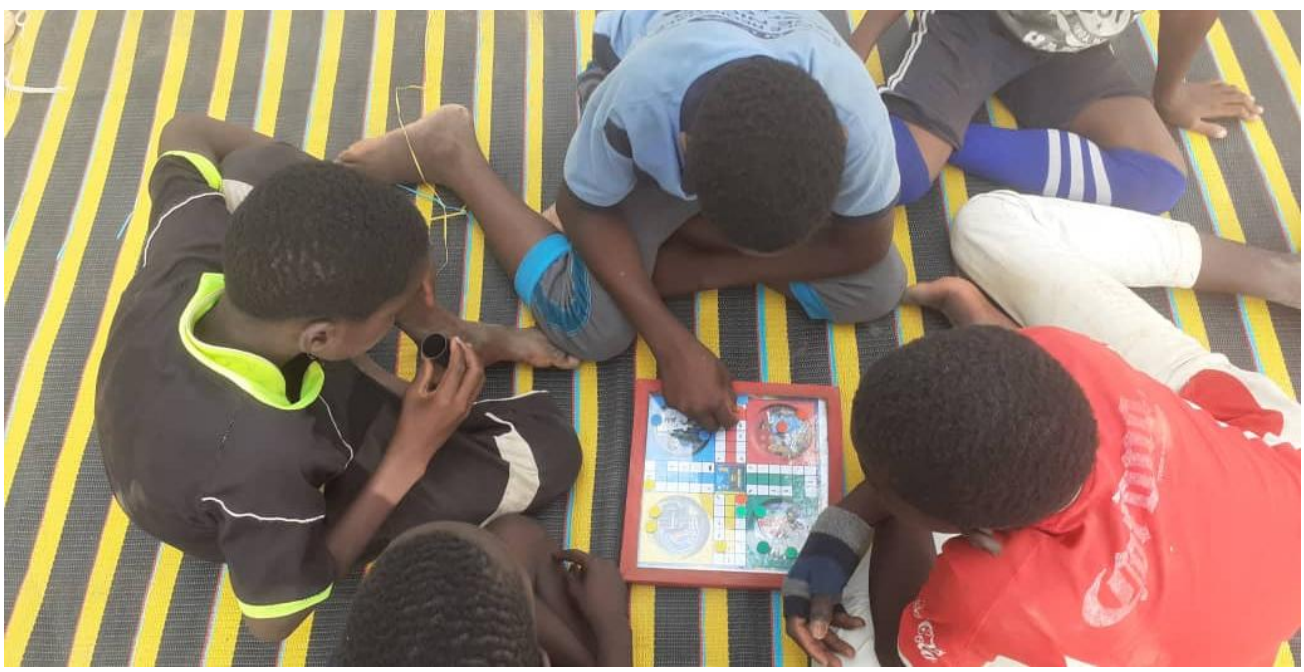
The availability and distribution of MHPSS services in Burkina Faso is marked by a strong divide between urban and rural areas and a reliance on community initiatives. Formal services include:

- **Psychiatric hospitals** in Ouagadougou and Bobo-Dioulasso offer specialized services (consultations, hospitalization), but are inaccessible to most rural populations.
- **Private psychotherapy centers** exist in the towns, offering support for children, adolescents and adults, but remain unaffordable for most.
- **Traditional therapeutic consultations**, more accessible in rural areas, are the most common recourse for mental health care due to financial constraints and cultural beliefs.

Community and project-supported services include:

- **Child-Friendly Spaces**: Supported by NGOs and the Ministry of Humanitarian Action, these spaces are safe places where children can play, learn and receive emotional support. Mobile Child-Friendly Spaces are deployed in hard-to-reach areas or in emergency situations.
- **Safe spaces and discussion groups**: Present in displaced persons' camps and vulnerable communities, they offer peer support, stress reduction and social bonding, with the help of qualified social or community workers.
- **Listening centers:** Often integrated into schools or community centers, they provide early detection and confidential psychosocial support.
- **Children's and young people's clubs**: As part of JOFA-ACTE, 14 clubs have been reactivated, reaching 594 children with psychosocial education, discussions, games and awareness-raising on child protection and well-being. These clubs enable children to express themselves, play and form bonds with their peers, and are effective because they help to strengthen the resilience and emotional balance of children under stress.

Early identification of children suffering from psychological distress or psychosocial vulnerability is the cornerstone of effective MHPSS provision in Burkina Faso. As part of the JOFA-ACTE project, a multi-actor approach has been used to strengthen detection and response capacity at several levels of the child protection ecosystem.



Social workers and child protection agents have been at the forefront of this effort. In 2024 alone, 26 social workers were trained in psychological first aid (PFA). This training has significantly improved their ability to identify signs of emotional and psychological distress in children, conduct initial assessments and refer or manage cases according to their severity. As a result of this enhanced capacity and the use of a structured case management approach, 820 children have been individually supported by the end of 2024. This approach provides individualized care for vulnerable children through coordinated assessment, referral and monitoring of cases. It is reinforced by the CPIMS+ digital tool (as presented in the introduction to this brief), which facilitates the registration and secure management of cases. This approach is effective because it ensures structured and sustainable support, focused on the specific needs of each child.

Community child protection committees have also played a vital role, particularly in rural and peri-urban areas where professional services are scarce. These committees, rooted in local communities, take advantage of their proximity and relationships of trust with families to identify vulnerable children. In two years, 329 children have been identified by these structures and referred for appropriate support under the JOFA-ACTE project.

In addition, health workers, whether general practitioners or those with basic mental health training, helped to identify children during routine medical consultations. They were able to detect potential symptoms of mental distress - such as anxiety, sleep disorders or behavioral changes - and refer children to psychosocial services if necessary. Some NGOs (e.g. Alliance for International Medical Action (ALIMA), Médecins Sans Frontières (MSF) use mobile clinics that integrate mental health into their services (health, nutrition, protection). They operate in areas where security is a major challenge.

Teachers and educators were often the first line of observation, particularly in formal or non-formal educational settings. The educators trained as part of the project were better equipped to recognize behavioral warning signs, such as aggression, withdrawal or difficulty concentrating. Their integration into the guidance system bridged the gap between schools and MHPSS services, ensuring earlier support for the children concerned.

There are also a number of services for parents. Awareness-raising sessions help parents to better understand their children's emotional needs. Similarly, discussion groups are organized, providing a space for sharing experiences, freely expressing difficulties, challenges and emotions, and strengthening solidarity between parents. These groups also help to ease psychological stress and create links with other families in similar situations. Professionals also work with families to improve communication, stress management and educational practices. The aim is to support the family and positive parenting, strengthen parenting skills and promote caring and protective parenting.

Free psychological helplines have been set up to enable children and families to benefit from remote and anonymous psychological support that includes aspects of mental health, used for protection, gender-based violence and health. They are run by trained professionals.

The main success factors in Burkina Faso are community awareness, which enables them to better understand mental health problems, reduce stigma and encourage the use of available services; strong community involvement, including local leaders, volunteers and associations; alignment with national policies and the participation of government actors, including ministers, in conferences on mental health, demonstrating growing political support; the mobilization of sufficient resources; and the existence of MHPSS technical working groups, which facilitate coordination between NGOs, public institutions and technical partners. These groups reinforce the coherence of actions and encourage the sharing of experience and good practice. Nevertheless, holistic approaches face certain obstacles: limited coverage of the CPIMS+ tool and lack of familiarity with CPIMS+ among stakeholders, lack of resources (in particular funding and qualified human resources) for implementation, unfavorable cultural norms, poor integration with education and family systems and lack of knowledge of identification and referral tools.

Evolution of care systems: Strengthening support for child and family mental health in Mali

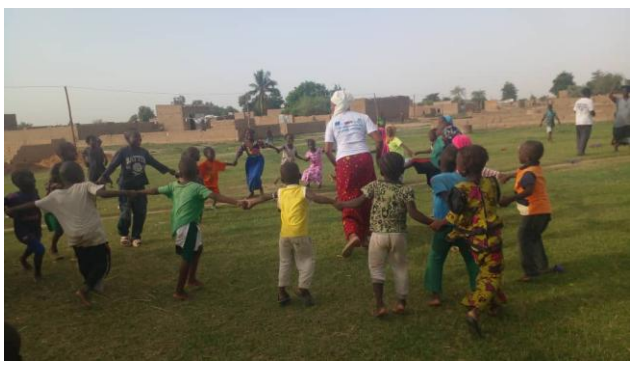
In recent years, MHPSS services in Mali have become more professional, structured and organized. Previously, they were social and community-based and provided on a voluntary and spontaneous basis. Nowadays, they are provided immediately to people with specific needs, difficulties, victims of accidents and disasters (natural or man-made). Local departments of the Ministry of Health and Social Development (MSDS), local departments of the Ministry for the Promotion of Women, Children and the Family, NGOs (international, national and local) and civil society organizations provide these services.

In Mali, the JOFA-ACTE project provides MHPSS services. In Mali, the identification of children in need of maternal and child health services relies on both community and institutional mechanisms. A variety of actors are involved in detection, often working in coordination at community, education and health levels.
Community leaders, teachers, health workers and child protection committees play an essential role in identifying children showing signs of distress. Identification often takes place during home visits, outreach activities or routine classroom observations. Signs such as withdrawal, aggression or sudden changes in behavior often trigger a referral to psychosocial services. Children are also identified during medical consultations or visits to social centers, where trained staff (particularly in child and adolescent health) can detect emotional and behavioral symptoms. In addition, listening centers, child-friendly spaces and protection centers offer opportunities for early identification during recreational or psycho-educational activities. It is important to note that some cases of psychological distress are reported by the children themselves or by their family members, which reflects a growing awareness within communities. Humanitarian emergencies, including displacement and conflict, also constitute a context in which children at risk are systematically screened by intervention teams.

Recognizing the critical role of carers in children's mental health, JOFA-ACTE and its partners have implemented several family-focused interventions in Mali and Burkina Faso (see above). Parents benefited from psychological and psychosocial support, including group counselling sessions, emotional support groups and parental guidance groups. These platforms provided parents with tools to better understand and respond to their children's psychological needs while dealing with their own stressors. In addition, the programme offered economic and material assistance to vulnerable families, including food and non-food items during holidays or crises, such as the start of the school year or post-disaster periods. These measures aim to reduce the economic burden that often exacerbates family stress and is detrimental to children's well-being.

Despite certain limitations, several promising practices have emerged from the JOFA-ACTE programme in Mali and offer valuable lessons for future scaling-up. In particular, vulnerability assessments and family mapping have been effectively implemented at community level, often facilitated by trained local structures. These tools made it possible to systematically identify children at risk and prioritize services according to need. Several factors have contributed to the successful implementation of MHPSS in Mali:

- The **strong involvement of the community**, particularly in mapping and monitoring families, has made it possible to provide appropriate support at local level. The active involvement of local leaders, youth groups and protection committees, both in identifying needs and delivering aid, has been a key factor. This community-based approach not only fosters trust and cultural relevance, but also sustainability through local ownership.



- **Referral systems** were supported by both humanitarian actors and community mechanisms, which improved coverage. Referral mechanisms between schools, health centers and child protection actors were functional and often strengthened by a common understanding and tools. These links ensured that children identified in one sector could be followed up in another, thereby promoting continuity of care.
- **Community psycho-education** has helped to reduce stigma and promote open-mindedness about mental health issues, encouraging more open discussion and better use of services.
- **Political commitment** has been demonstrated by the participation of ministers and government representatives in national mental health events, a sign of growing legitimacy.
- **Frameworks for technical collaboration**, such as regional coordination platforms, promote integration and learning.
- **Adequate funding and technical resources** have ensured quality training and equipped centers to deliver MHPSS.

The creation of peer support groups and psycho-educational activities in displacement sites and child-friendly spaces have proved particularly valuable. These safe and structured environments have enabled children to express their emotions, learn coping mechanisms and engage with trusted adults and peers.

In addition, Mali's regional coordination frameworks have played an essential role in harmonizing interventions and facilitating collaboration between the various stakeholders. These platforms have improved case monitoring, cross-referencing and standardized training efforts. In addition, the strategic storage of psychosocial material by civil servants and protection focal point persons has enabled rapid deployment in the event of an emergency. Collectively, these models show that, when well-coordinated and community-led, MHPSS interventions can be both effective and scalable.

Despite considerable efforts to expand MHPSS in Mali, implementation remains hampered by structural and operational limitations that affect both reach and quality. Administrative delays and complex bureaucracy have emerged as a major obstacle to a rapid response, particularly in areas where children face acute distress related to conflict, displacement or gender-based violence.

The lack of human and financial resources is glaring. There are too few trained psychosocial workers and psychologists, and existing services are stretched to the limit. This gap is even more pronounced in rural and insecure areas. As the consortium's project leader points out, "human and financial resources are limited", and where they do exist, they are concentrated in urban centers. Psychosocial services for disabled children, for example, are virtually non-existent, and the education system is often unable to meet their specific emotional and cognitive needs.

Another challenge cited during the session was the lack of appropriate materials and equipment to support children through play, art therapy or trauma-informed learning. As was said during the webinar, “There is a lack of appropriate equipment and materials”, which has an impact on the ability to offer quality, age-appropriate interventions.

Community interventions are often project-based, and many services risk disappearing once funding ends. This undermines trust, particularly when carers come to rely on structures that cannot be maintained. In addition, there is a gap between psychosocial support and wider social protection services, where "The link between psychosocial support activities and social protection interventions is not always clear" [Le lien entre les activités de soutien psychosocial et les interventions de protection sociale n'est pas toujours clair].

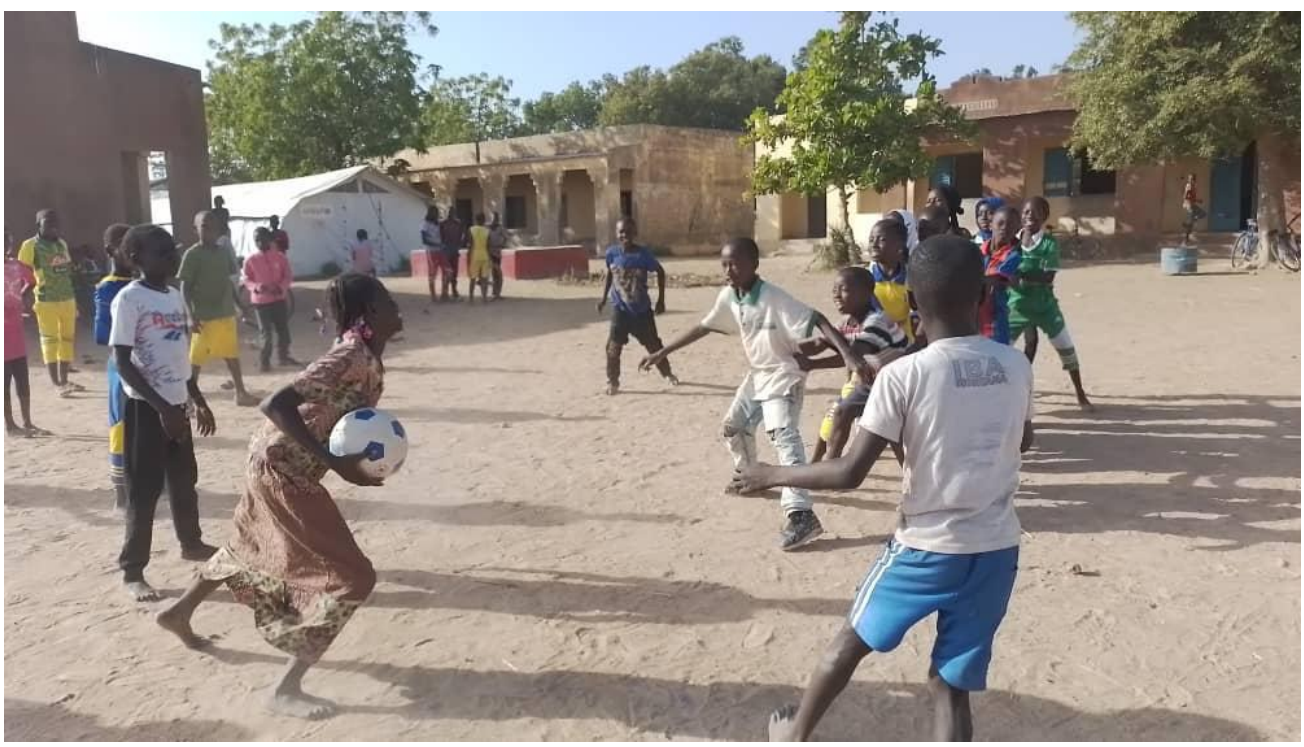
Finally, regional stakeholders highlighted the problems of accessibility for children with disabilities, particularly in formal education. They pointed out that the system lacks specialized staff, transport and adapted learning tools, which puts this group at even greater psychosocial risk.

Despite the progress made, the path towards a fully integrated and holistic MHPSS system in Mali remains hampered by multiple systemic issues. One of the biggest obstacles is poor coordination between NGOs and government institutions, leading to fragmented service delivery, duplication of effort and missed

opportunities for synergy. In the absence of stronger national frameworks, project-based interventions risk remaining compartmentalized and incoherent.

The availability of specialist services is also limited, particularly those at the top of the IASC MHPSS intervention pyramid, such as psychiatric care for children with severe needs. Even where basic services are available, referral pathways are incomplete or poorly implemented, preventing children from benefiting from a full continuum of care.

Another gap is the lack of harmonized screening tools and structured protocols. Different players use different approaches to identification, referral and follow-up, which complicates case management and data consolidation. This situation is exacerbated by the poor integration of MHPSS into the primary healthcare system, which prevents children, particularly in rural or marginalized communities, from receiving timely care.
In many regions, the use of digital tools or standardized case management systems remains weak, hampering real-time monitoring and inter-agency collaboration. In addition, deep-rooted stigma, particularly in rural areas where mental illness is seen as a spiritual condition, continues to discourage families from seeking formal support. Finally, the lack of integration between education and public health systems results in fragmented care, with school-age children not always receiving adequate or ongoing psychosocial support in their learning environment.



Recommendations

A. Recommendations for governments and national authorities

1. **Develop national MHPSS policies and strategies:** The governments of Mali and Burkina Faso should co-create inclusive national strategies for mental health and psychosocial support (MHPSS) that prioritize children and adolescents. These strategies should clearly define institutional roles, funding mechanisms and minimum service standards to ensure consistency and accountability. By embedding MHPSS in broader national frameworks, such as education, health and child protection, governments can ensure sustainability beyond humanitarian cycles. This approach is in line with Africa CDC's Mental Health Leadership Initiative and the AU Guidelines on MHPSS in emergencies, both of which emphasize governance, policy clarity and planning.

2. **Institutionalize MHPSS across all sectors:** There is an urgent need to integrate MHPSS into existing public systems, particularly education, healthcare and social protection. Ministries need to integrate MHPSS into teacher training programmes, school health policies, primary care protocols and social work programmes. Standard operating procedures (SOPs) should guide implementation and ensure that children can be supported at all points of contact - from schools and clinics to community centres. This recommendation reflects the priorities of the AU MHPSS strategy for teachers and the AU Education Strategy (CESA 16-25).

3. **Invest in workforce development and retention**: To ensure the availability of quality MHPSS services, governments need to invest in staff capacity. This includes integrating psychosocial training into the initial and continuing education of teachers, social workers and health professionals. Structured mentoring and certification programmes can enhance skills, while long-term employment plans and incentives will help retain staff, particularly in remote and crisis-affected areas. This priority is supported by the Africa CDC Mental Health Leadership Initiative, which sees human resources as an essential pillar of national preparedness.

4. **Improve national data and monitoring systems:** Reliable and disaggregated data is essential to understand the mental health needs of children and to monitor the reach and effectiveness of services. Governments should invest in national data systems capable of capturing children's mental health indicators and case management progress. Digital platforms such as CPIMS+ should be developed and institutionalized to enable real-time tracking, referral and follow-up of patients. Monitoring and evaluation tools need to be standardized in line with global and continental best practice, as recommended by the AU MHPSS guidelines and Africa CDC.

5. **Tackling stigma and promoting mental health literacy:** Reducing stigma remains one of the biggest barriers to MHPSS adoption. Governments should launch culturally-based awareness campaigns, using radio, schools, community theatre and religious leaders, to increase mental health literacy and normalise help-seeking behavior. It will be essential to involve traditional and religious leaders as champions of change. These efforts echo the first pillar of the AU toolkit on youth mental health, which emphasizes the importance of raising public awareness and transforming social norms.

B. Recommendations for INGOs, NGOs and civil society

6. **Expand access to community-based and inclusive MHPSS services**: Non-governmental actors should expand access to community-based services, particularly in rural areas and areas affected by displacement. This includes developing child-friendly spaces, youth clubs and mobile outreach units that offer structured psychosocial support. Programmes must be included to adapt tools and environments to the needs of children with disabilities, survivors of violence and those who are not in school. Interventions should incorporate play, peer support and psycho-education as essential components, echoing AU calls for community and youth-centerd care.

7. **Supporting families and carers:** The well-being of the family is essential to the child's mental health. INGOs and NGOs should develop parenting education programmes that help carers manage stress, develop emotional skills and adopt positive discipline methods. Group counselling and discussion forums can foster solidarity, reduce isolation and provide psycho-education. These approaches are in line with pillar 4 of the AU Youth Toolkit, which prioritizes the role of the family and social environment in young people's mental health.

8. **Strengthening case identification and management:** Frontline workers need practical training and tools to quickly identify psychosocial distress and respond effectively. INGOs should invest in building the capacity of teachers, social workers, health professionals and community leaders to detect early signs of mental health problems, provide psychological first aid and use structured case management systems such as CPIMS+. These actions support AU guidance on integrated referral systems and trauma-informed responses, particularly in emergency situations.

9. **Promoting community engagement and local leadership**: The successful implementation of MHPSS depends on the engagement of trusted community structures. Civil society actors should mobilize child protection committees, youth clubs and local leaders to facilitate dialogue, reduce stigma and support early identification. These groups can also serve as platforms for peer support, resilience-building and awareness-raising activities, ensuring local ownership and sustainability. This recommendation reflects the AU's emphasis on local leadership and context-specific programming.

C. Recommendations for donors and international partners

10. **Provide flexible and long-term funding for MHPSS:** Donors should prioritize flexible and long-term funding streams that go beyond immediate humanitarian assistance. Investments should support systems strengthening, workforce development and the integration of MHPSS into national service delivery. Funding should also be inclusive of under-represented groups and responsive to regional disparities. Such flexible funding essential to achieve the sustainable, rights-based impact envisaged by frameworks such as the AU Charter on the Rights and Welfare of the Child and Agenda 2063.

11. **Support coordination and regional learning**: To avoid duplication and promote innovation, donors should invest in coordination platforms and knowledge exchange initiatives. Technical working groups at national and regional levels should be supported to harmonise tools, training and guidance mechanisms. Transnational learning, particularly between Sahelian countries, can help replicate good practice and inform regional policy-making, in line with AU commitments to continental collaboration and solidarity.

12. **Ensure alignment with AU commitments:** Finally, international partners should work closely with governments and NGOs to implement MHPSS programmes in line with AU frameworks. These include the AU Youth Mental Health Toolkit, the Teacher MHPSS Strategy, the Africa CDC Mental Health Leadership Pillars and the Charter on the Rights and Welfare of the Child. This alignment ensures legitimacy, policy coherence and shared responsibility between national and regional systems.

Together, these recommendations represent a unified and achievable roadmap for building inclusive, resilient and locally-led MHPSS systems in Mali and Burkina Faso. They call for an integrated approach - linking families, communities, schools, health services and protection systems - to address the complex mental health needs of children in fragile contexts. By aligning operational priorities with African Union frameworks, such as the AU Toolkit on Young People's Mental Health, the MHPSS Continental Strategy for Teachers and the African Charter on the Rights and Welfare of the Child, stakeholders are not only reinforcing best practice, but realizing a continental vision based on equity, dignity and psychosocial well-being. Achieving this vision will require coordinated leadership, sustained investment and a commitment to amplify the voices of children and their caregivers at all levels of intervention.

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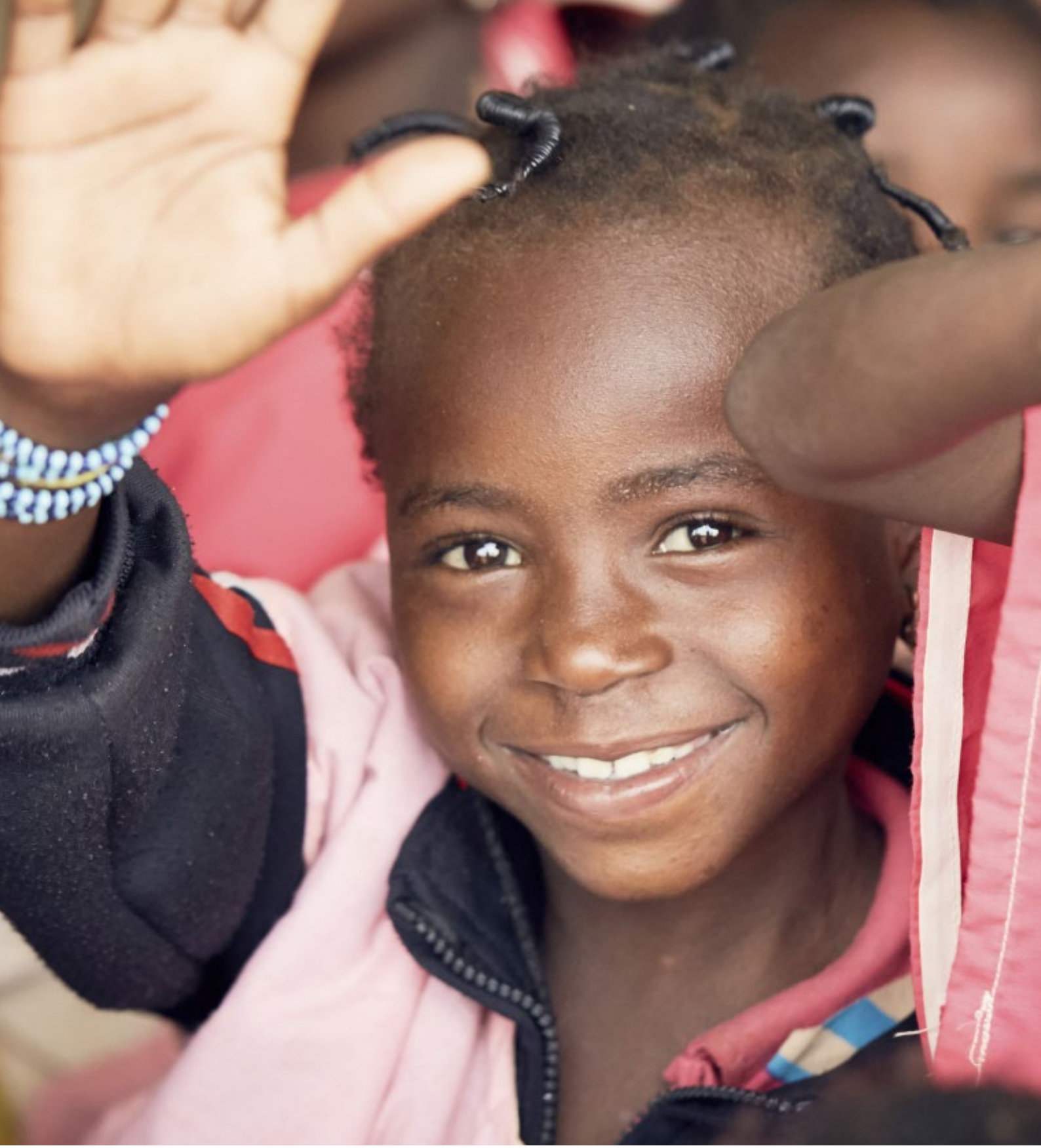

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