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Integrating youth mental health into cash transfer programmes in response to the COVID-19 crisis in low-income and middle-income countries

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Lancet Psychiatry 2021; 8: 340–46

Published Online February 4, 2021 https://doi.org/10.1016/S2215-0366(20)30382-5

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Social protection measures can play an important part in securing livelihoods and in mitigating short-term and long-term economic, social, and mental health impacts of the COVID-19 pandemic. In particular, cash transfer programmes are currently being adapted or expanded in various low-income and middle-income countries to support individuals and families during the pandemic. We argue that the current crisis offers an opportunity for these programmes to focus on susceptible young people (aged 15–24 years), including those with mental health conditions. Young people living in poverty and with mental health problems are at particular risk of experiencing adverse health, wellbeing, and employment outcomes with long-term consequences. They are also at risk of developing mental health conditions during this pandemic. To support this population, cash transfer programmes should not only address urgent needs around food security and survival but expand their focus to address longer-term mental health impacts of pandemics and economic crises. Such an approach could help support young people's future life chances and break the vicious cycle between mental illness and poverty that spirals many young people into both socioeconomic and mental health disadvantage.

Young people's mental health during crises

Many young people (aged 15–24 years) who live in low-income and middle-income countries (LMICs) are experiencing the effects of COVID-19 and the consequences of associated restrictions and lockdown measures, often with limited support from social or other government programmes. With less access to social welfare safety nets, COVID-19 lockdowns, physical distancing, and other measures pose much greater threats to livelihoods and survival in LMICs than in high-income countries.[1] Evidence from past crises and economic shocks suggests that mental health and economic impacts endure well beyond the crisis period.[2–6] For example, suicide rates can remain high for years after the crisis ends,[4] a trend that has been linked to persistent unemployment rates.[7] Young people, including those with pre-existing mental health conditions, might be especially vulnerable to the effects of crises, such as COVID-19. Evidence from economic crises shows that young people are more likely to take high-risk jobs, in which they might experience violence and exploitation,[6] and to experience long-term unemployment after an economic crisis.[6] They are much less likely to have financial savings or other assets that help them mitigate the effects of the crises. Evidence shows that being confined to a small space and not being able to maintain school and regular social connections can lead to various negative mental health effects for young people,[8] exacerbated for those with existing mental health conditions[8] and those living in poverty.[9,10] In LMICs, where young people represent a fifth of the total population,[11] the effects of COVID-19 could strongly influence countries' future economic growth.[12] Thus, there are strong economic arguments for governments to support young people's economic circumstances and also their mental health.[13]

The role of cash transfer programmes (CTPs) in supporting youth mental health

Evidence suggests that CTPs and other social protection measures (such as social benefits, access-to-fair-credit schemes, and active labour market programmes) can improve mental health[14–18] and reduce suicide rates.[19–22] Among young people, evidence suggests that CTPs in east Africa reduced symptoms of depression by as much as 38%.[23–25] Mechanisms by which CTPs might affect youth mental health involve multiple pathways. For example, by providing material support to attend school or participate in social or leisure activities, CTPs can help young people to be more confident or assertive, and feel positive about their future.[18,26–28] Programmes can also have wider spill-over effects on communities' social capital, thus contributing to mental wellbeing beyond the level of the individual young person.[18,29,30] In response to COVID-19, some LMICs expanded their social protection measures including CTPs. In addition to providing emergency aid, many countries have made modifications to existing CTPs, allowing them to build on their infrastructure and administrative resources. Preliminary evidence suggests that from a total of 559 social assistance measures taken in response to COVID-19 in 168 countries worldwide, half of these measures relate to expansions of CTPs.[31]

The table presents four examples of how large programmes have adapted to COVID-19. The example CTPs are from three upper middle-income countries (Brazil, Colombia, and South Africa), all of which are marked by high levels of inequality. The example CTPs were chosen as the research team is currently doing a large multi-site study in those countries, which investigates the impact of CTPs on youth mental health and life chances.[32] The information was provided by research partners based in

	Familias en Acción (Colombia)	Jóvenes en Acción (Colombia)	Bolsa Familia Program (Brazil)	Child Support Grant (South Africa)
Programme characteristics before COVID-19				
Population coverage	2·7 million families (17·5% of total population)	208 430 people aged 16–24 years (2·4% of the total population in this age range)	14·3 million households (20–25% of the total population)	12 million children aged 0–17 years (61% of the total population in this age range)
Ways of identifying households or individuals	Geographical; various administration identification systems, including SISBÉN, census lists of indigenous people, registry of conflict victims, and networks for overcoming extreme poverty (eg, UNIDOS)	By age; various administration identification systems, including SISBÉN and Instituto Colombiano de Bienestar Familia for youths in protective measures, census lists of indigenous people, registry of conflict victims, networks for overcoming extreme poverty (eg, UNIDOS), and registers for Familias en Acción	Geographical; income threshold (monthly per capita <$33); household characteristics (pregnant mothers; children aged 0–17 years)	Income threshold (US$3275 per year for a single person or $6555 for a couple)
Amount of cash per household or individual	$17–33 per month	$18–54 monthly for tuition fee and $160 twice a year for staying successfully in an education programme and for performing well	$35 per month (average)	$28 per month
Conditional or unconditional*	Conditional	Conditional	Both	Unconditional
Conditionalities	Child health checks; regular school attendance	Registration in educational programme; no disciplinary or academic penalties; completion of academic period; achievement of passing mark	Medical consultations; vaccinations; school attendance	Not applicable
Government investment into programme	0·2% of GDP	0·004% of GDP	0·4% of GDP	7·5% of GDP
Method of money administration	Bank account transfer (option of money transfer for collection if beneficiary does not have bank account)	Bank account transfer (option of money transfer for collection when beneficiaries cannot access financial products)	Electronic card or bank account transfer	Collection at bank, pay points, or retailers
Changes in response to COVID-19				
Threshold for inclusion (extended population coverage)	Payments to households that were in the administration register but previously excluded because of non-compliance with conditionalities	Expanded coverage to 296 222 people (some of this coverage was due to an expansion of the age range to 16–28 years, which was planned before COVID-19)	Inclusion of 1·2 million families that were on waiting list	Unchanged
Payment amount or provision	Three additional payments of $39 per household	Two additional payments of $95 per beneficiary	Three additional payments of $115–230 per month for 3 months; depending on local authority resources and distribution options: food basket, voucher, or card for families of children who receive free school meals	Each caregiver received an additional $16·5 in May, 2020, and an additional $26 from June-October, 2020, regardless of number of children; all other grantees received an additional $13 for 6 months (May-October, 2020)
Conditionalities	Waived	Waived	Waived for 120 days (from March 20, 2020)	Not applicable

SISBÉN=Sistema de Identificación de Potenciales Beneficiarios de Programas Sociales. *Programmes that set out conditions that need to be met by the beneficiary household in order to receive the payment are called conditional; programmes that provide the payment without conditions are called unconditional.

Table: **Response of cash transfer programmes to COVID-19 crisis in Colombia, Brazil, and South Africa**

those countries and includes data from information sources available to partners, complemented by publicly available data from websites of international organisations, such as the World Bank and published literature. All four programmes have expanded vertically (ie, increasing payments to existing programme beneficiaries) and three programmes (in Brazil and Colombia) have also expanded horizontally (ie, increasing population coverage) in response to COVID-19. In addition to modifications made to existing CTPs, emergency aid programmes have been introduced in all three countries, which cover populations who are not programme beneficiaries of CTPs. In some instances, these emergency programmes (eg, Ingreso solidario in Colombia, Auxílio emergencial in Brazil, and Special COVID-19 Social Relief of Distress Grant in South Africa) have built on the existing infrastructure and processes of CTPs. For example, the emergency programmes use their infrastructure for targeting and delivering programmes by taking data from available registries to define their new target populations and by using existing (digital) payment systems for processing and delivery of payments. At the same time, some of these emergency aid programmes (eg, Auxílio emergencial) also developed new technologies (mobile applications) to reach out to populations that were not previously registered.

Horizontal and vertical expansions of CTPs support the more general trend for these programmes to become a

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key social protection measure for many LMICs.[33] Yet, many of these programmes do not specifically address the mental health-related needs or vulnerabilities of young people and their long-term mental health. Although conditional CTPs seek to incentivise human capital investments in early life and adolescence, CTPs often do not target young people directly and cash is usually given to the primary caregiver.[34,35] An example of a CTP that specifically addresses the mental health-related needs of young people is the Colombian Jóvenes en Acción (Youth in Action), which offers direct monthly payments to young people for attending and completing education programmes (table). Programme components include those of mental health promotion, which offer learning modules that teach self-regulation and other socio-emotional skills. Although the effects of Jóvenes en Acción on mental health have not yet been assessed, findings from an evaluation done before the COVID-19 pandemic suggest that this programme can effectively improve the chances of young people entering formal employment,[36] which is a probable contributor to improved long-term mental health.

Challenges and opportunities for integrating mental health into CTPs

Inevitably during crises, policymakers prioritise the most immediate concerns, such as providing food and medical care to those at risk of malnutrition and physical illness. Mental health is typically given lower priority, in part because it is perceived to have a less immediate effect on mortality (other than suicide).[37] Even when policymakers are aware that poor mental health is more costly than most other major non-communicable diseases,[38] they might not invest in mental health. Often influenced by misconceptions about mental health, historical underfunding, and bureaucracy, policymakers might not wish to divert limited health system resources away from existing priorities. Similarly, health policymakers might not be aware of the effects that CTPs can have on mental health, and that programmes—although not always intentionally—might address many social determinants of mental health.[39]

However, crises also present opportunities to change systems and priorities. Experiences from past emergencies show that mental health can become a priority of system reform.[40] International organisations have called for more attention and system wide responses to youth mental health during the COVID-19 crisis globally.[41,42] To be effective, responses will require different sectors to come together, potentially sharing resources and agreeing common objectives, for instance working across social welfare or protection, employment, and health spheres. This call for policy change offers opportunities to look beyond the immediate crisis and promotes long-term economic and mental health resilience in line with the Sustainable Development Goals.[43,44]

Recommendations for integrating mental health into CTPs

Based on evidence from evaluations of CTPs and of mental health responses to pandemics, we outline several principles and opportunities for integrating mental health into CTPs. Underlying these recommendations is a definition of mental health that follows *The Lancet's* Commission on global mental health, which considers problems on "a continuum from mild, time-limited distress to chronic, progressive, and severely disabling conditions",[45] and which emphasises the need for interventions that range from promoting mental health and wellbeing and preventing mental health problems to treatment and rehabilitation.[45]

Recommendation 1

CTPs should target susceptible young people at risk of or living with mental health conditions. Established welfare and social protection structures could be used to identify young people at risk of developing mental health conditions during or after the pandemic without a need to invest in formal mental health assessment procedures. Lessons from CTPs that have targeted susceptible young people, including those with a disability or who are orphans, highlight the viability of doing so, for example by using existing community routes such as local child protection committees.[23,35] Recent innovations have been developed to identify clusters of population risk factors, for example through the Identifying Depression Early in Adolescence tool in Brazil and Nepal,[46] which confer greater vulnerability than any one risk factor. However, to specifically target young people with pre-existing mental health conditions, mental health care or welfare systems need to be strengthened in line with international law and WHO best practice recommendations.[47] Advocacy is needed to include mental health conditions as conferring eligibility for CTPs, under the umbrella of broader definitions of vulnerability or disability-related criteria.

Digital technologies might also offer opportunities to reach young people who might otherwise not access programmes for which they are eligible (for example, because their mental health condition makes access difficult for them or because of limited access to transport). Surveys conducted of those aged 18 years or older in 11 LMICs across four global regions show that the vast majority (about 90%) have their own mobile phone or access to one; and about half of these mobile phones are smartphones.[48] Another study[49] by the same research institution found that globally—including in LMICs—young people are more much more likely to have smartphones, access to internet, and access to social media compared with adults. Various tools exist, from low cost ones that largely build on existing technologies (eg, SMS) to comprehensive products that have been specifically designed for CTPs and that include various functions (eg, electronic payments, managing conditionalities, and providing updates). However, these

efforts need to complement other mechanisms and build on existing welfare system structures as not all susceptible individuals are able to access or use such technologies,[50] and they can be costly and difficult to implement.[31,51]

Recommendation 2

CTPs should explore the provision of resources to support mental health and non-stigmatising information about COVID-19. Evidence from previous and current pandemics suggests that misinformation and stigma about pandemics present great threats to mental wellbeing, and can lead to social exclusion of the bereaved or those believed to have been in close contact with those infected.[52] Although these threats relate to all populations, in some countries or settings young people might be particularly vulnerable to misinformation and stigma as they might not have the capacity to handle the frequency or to analyse the accuracy of information shared via social media.[53,54] Providing accurate, up-to-date, and non-stigmatising information about COVID-19, as well as increasing mental health literacy and signposting to locally relevant community support and resources, is an important part of an effective mental health response.[55,56] As staff employed by CTPs or other welfare programmes are in contact with recipients (either personally or via digital technologies), they are well-placed to share relevant information and resources. Mobile phone texting is commonly used by CTPs to disseminate information. In addition, some large CTPs have well established and active social media platforms. For example, the Colombian Jóvenes en Acción has 50 000 followers on Twitter. Both mobile phone texting and social media can be used to provide up-to-date and accurate messages about COVID-19 and about mental health promotion. These channels might include signposting to national mental health self-help lines, websites with mental health resources, or local community groups (as and when those are reopening). Donors also have an important role in facilitating the provision of resources to support mental health and non-stigmatising messages about COVID-19. For example, UNICEF has provided US$13 million to fund programmes that facilitate access to learning for children and young people and specifically requests that programmes should incorporate anti-stigma (related to COVID-19) and mental health promotion messages.[57]

Recommendation 3

CTPs should consider opportunities for increasing access to mental health support for young people. This means strengthening access to mental health interventions, as well as potentially, where resources and infrastructure permit, offering mental health interventions or components as part of CTPs. Programmes can be designed to facilitate access to support concerned with promotion, prevention, and treatment. As part of preventative efforts, universal programmes that incorporate interpersonal skills and emotion regulation elements have been shown to improve young peoples' mental health.[58] Experiences from CTPs highlight the importance of teaching young people coping skills that help them to pursue educational or employment goals despite their challenging circumstances.[35] As previously mentioned, the Colombian Jóvenes en Acción' is an example of a CTP that incorporates such mental health components. In addition, as countries come out of lockdown due to COVID-19, there are opportunities for CTPs to include social integration programmes for youth. Although evidence on cross-sector responses to pandemics is scarce, some promising effects on youth mental health have been associated with community programmes focused on arts, playing games, and sports.[52] Those were implemented after the acute phase of the Ebola crisis to facilitate the social (re)inclusion of young people, who had become orphaned or for other reasons socially excluded during this pandemic. The potential benefits of combining financial support with treatment have been suggested by a trial in Liberia,[59] which found that an integrated cash transfer and cognitive-behaviour-therapy intervention led to reductions in criminal behaviour and improved self-control among young, unemployed men. Although such intervention requires additional investment of human and financial resources, they might be provided by trained community or lay health workers to increase feasibility.[60]

Recommendation 4

Evaluations of CTPs should include an assessment of their mental health impact. Previous evaluations of CTPs have focused on capturing internalising problems through measures of depression or anxiety (such as the Centre for Epidemiological Studies and Depression Scale), as well on capturing suicide rates.[20] Measures of general psychological distress, such as the Self-Reporting Questionnaire or General Health Questionnaire, have been widely used with young populations and can allow comparisons across different settings.[61,62] However, there is also evidence that programmes might have an impact on externalising problems and anti-social behaviours such as crime or violence,[59] which have substantial long-term social and economic impacts for individuals and society.[63] More general indicators of mental wellbeing, such as the Warwick-Edinburgh Mental Wellbeing Scale, or quality of life, such as the Child Health Utility 9D Index, might be useful for assessing mental health promotion components of CTPs. These dimensions are important to capture as they improve coping with stress and are linked with future economic outcomes.[64] Most of these measures can be used as self-report questionnaires and completed using digital technologies and might therefore be feasible to assess during lockdown. In countries where lockdown measures are changing frequently or vary geographically, questions on the current lockdown situation could be included in the

questionnaires, to help understand the influence on mental health. Although remote assessments are the only option available during lockdown, there are limitations of this method, in particular due to unequal access among those with low educational and socioeconomic status.[49] Changes to methods might need be adapted to include face-to-face assessments after the acute phase of the pandemic, and comparisons will need to include different methods of assessments.

Recommendation 5

Mental health impacts should be considered when making decisions about the amount, duration, and administration of CTPs. For example, irregular payments can lead to increased stress among youth,[65] and longer duration of payments could reduce depression among young people.[33] As payments are currently being changed (ie, the amounts and method of access are modified; table), clear communication about the nature of such changes might avoid increased stress. Although conditionalities incentivise behaviour (eg, school attendance when lockdown restrictions are not in place) that might lead to improved mental health, they can also increase psychological distress if they are difficult to achieve for the young person, and if the amount at risk presents an important proportion of the family's income.[24] Since most programmes have removed their conditionalities during lockdown (table), there are opportunities to consider alterations to conditionalities, or the way they are administered in the future, which could promote better mental health.

The extent to which recommendations are applicable and can be implemented will depend on contextual factors in countries, such as the existing infrastructure for mental health care, welfare systems, and other sectors such as education, as well as the characteristics and nature of CTPs. The availability of digital infrastructure is another factor. In countries in which CTPs are the main or only social protection measure, some of which will be run with very limited infrastructure, it might still be feasible to implement some light touch changes such as revising eligibility thresholds (recommendation 1) or providing accurate and up-to-date messages about COVID-19 and about mental health promotion and prevention (recommendation 2). In countries that have some resources for providing mental health interventions, recommendation 3 can be considered. Such provision does not necessarily require specialist mental health professionals but can be provided by trained community workers or volunteers.

Similarly, recommendations apply differently for countries or regions depending on the state of the pandemic they are in. For example, recommendation 4 is likely to play a more important part during the acute phase of the pandemic, whereas recommendations 3 and 5 might become more relevant as countries ease restrictive measures. However, as lockdown might be a long-term or repeating reality for some regions or countries, alternative methods for providing mental health components (eg, via phone or online) might need to be explored. Decision makers need to reflect carefully about their current situation and possible future scenarios with regards to the pandemic to decide how they can operationalise those recommendations in their specific context.

Conclusion

There are compelling reasons to integrate mental health into social protection programmes, particularly for young people. Mental health is unlikely to be a priority when designing social protection policies. However, there is an opportunity now to highlight just how important mental health is to the current and future economic wealth of countries, and to highlight the benefits of addressing mental health and poverty simultaneously.[66–68] Health policymakers might make a more convincing case for action using language which also resonates with finance ministries and international donors: protecting the mental health of youth is vital for future economic growth. Fundamentally, there is also an opportunity to think about the role of social protection schemes beyond the immediate crisis.

Although politicians need to make immediate decisions, collecting evidence during crises and drawing from existing evidence and ongoing research are equally important. The CHANCES-6 project[32] is a prime example that seeks to unpack some of the mechanisms by which CTPs influence the mental health and life chances of young people in six countries in Latin America and sub-Saharan Africa. This knowledge could inform responses to the COVID-19 pandemic that can mitigate the long-term economic and mental health consequences that will follow.

Contributors

AB and SE-L conceptualised the manuscript. AM, AP, AZ, CSP, CL, CZ, DM, EG, PH, PM, RA, and YD contributed with information relevant to a specific country or topic, and provided general feedback. DM, EG, MA, PH, and YD contributed to the editing of the manuscript.

Declaration of interests

AB, SE-L, EG, YD, PH, CL, AP, CSP, DM, PM, RA, AZ, CZ, and MA report a grant from the Economic and Social Research Council (ESRC, ES/S001050/1) for the project: "Poverty reduction, mental health and the chances of young people: understanding mechanisms through analyses from 6 low- and middle-income countries" (UK Research and Innovation Global Challenges Research Fund). CL reports personal fees from Prudential Africa, outside the submitted work. YD, PH, and RA report grants from ESRC (number 730181) for the project: "Improving mental health and human capital: developing a mental health intervention for 'Youth in Action' programme in post-conflict areas in Colombia". MA reports grants from the European Commission Horizon 2020 and the National Institute for Health Research; and personal fees from WHO, outside the submitted work. YD reports consultancy fees from the World Bank and the Food and Agricultural Organization for the design of the targeting instrument for social programmes in Saint Lucia and Zambia; and the United Nations Development Programme for the analysis of the potential impact of COVID19 on poverty in Colombia. As of Jan 7, 2021, YD reports to the undersecretary of Socioeconomic Planning of the Bogota Planning Secretariat. AM declares no competing interests.

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