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Sustaining Investment in MHPSS Localisation and Integration:

Case studies

THE MHPSS COLLABORATIVE

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Sustaining Investment in MHPSS Localisation and Integration: Case studies

Introduction

This document contains six selected case studies that were collected for the paper *"Sustaining Investment in MHPSS Localisation and Integration: Recommendations for donors"*.

The paper is the product of a project led by the MHPSS Collaborative, in partnership with Peace of Mind Foundation, Save the Children, MHPSS.net, Terres des hommes, Mental Health Innovation Network (MHIN), the Global Mental Health Action Network (GMHAN), George Washington University Center for Global Mental Health Equity, and UNICEF with funding from Peace of Mind Foundation, Save the Children Netherlands and DANIDA.

It draws on a review of published and grey literature on humanitarian financing, localisation, and integration; key informant interviews with funders, practitioners, and researchers on what good funding looks like from both sides of the funding relationship; case studies on localisation and integration in practice across different contexts; and featured approaches showing how particular funders and implementing organisations have built these principles into the way they work.

We would like to express our gratitude to everyone who contributed to this piece by providing case studies and participating in interviews and workshops.

You have generously shared your time, expertise, perspectives and knowledge with us to provide a solid foundations for these recommendations.

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CASE

01

RESILAC 2

Case 01: RESILAC 2

Action Against Hunger, consortium lead | Lake Chad Basin: Chad, Cameroon, and Nigeria | 2024 to 2028, ongoing | Funded through the French Development Agency and the European Union | Delivered through a consortium of INGOs and 17 national and local organisations | Government partners: Ministries of Health across the three countries

In the Lake Chad Basin, RESILAC 2 is working to make psychosocial support available through services people already use. A person arriving at a cash distribution point, health post, protection activity, sexual and reproductive health service, or community dialogue space can be identified for support without having to ask for a mental health service by name. Across Chad, Cameroon, and Nigeria, the programme embeds MHPSS within health, protection, food security and livelihoods, sexual and reproductive health, and social cohesion work, with referral pathways linking the different entry points. Those pathways became harder to maintain when external humanitarian funding to the region was cut in 2025. Several partner organisations that helped sustain the wider service network lost funding and scaled back, putting pressure on coordination and referrals even though RESILAC 2's own grant remained in place.

Context

RESILAC 2 operates in parts of Chad, Cameroon, and Nigeria affected by protracted insecurity, displacement, climate-related shocks, and gaps in basic services. An estimated 82 percent of the population shows signs of psychological distress, often linked with poverty, displacement, gender-based violence, food insecurity, and weakened social ties. Insecurity and administrative barriers also restrict staff movement in some areas, making services harder to deliver and monitor.

The service base across the region is limited, and stigma can make it difficult for people to seek mental health support directly. In this setting, a response organised mainly around separate mental health services would have reached fewer people, especially in areas where communities were already accessing other forms of humanitarian, public, and community-based support.

Approach

RESILAC 2 integrates MHPSS across five sectors: health, protection, food security and livelihoods, sexual and reproductive health, and social cohesion. The programme places psychoeducation, structured psychosocial support, and early case identification within services that communities already use, so that support is encountered through familiar platforms rather than through a separate mental health entry point.

Referral pathways connect these entry points, allowing someone identified through a food distribution point, health post, protection activity, sexual and reproductive health service, or community dialogue space to be linked to additional support where needed. The programme also works with public systems, including through joint supervision with Ministries of Health, so that MHPSS practice is connected to existing structures and standards. To build toward longer-term sustainability, RESILAC 2 conducts advocacy at local, national, and regional levels to integrate MHPSS into the primary health care package and strengthens the capacity of the local actors through whom that integration runs, including medical teams, religious leaders, and traditional

leaders trained in the programme's approaches.

Seventeen national and local organisations help deliver the model across the three countries. Their presence is particularly important in areas where access restrictions limit the movement of international staff, and where continuity depends on organisations already working close to communities.

CASE

01

RESILAC 2

What it looked like on the ground

RESILAC 2 trained local facilitators, community leaders, community health workers, and psychosocial support workers to deliver psychoeducation and identify cases early using tools adapted to local contexts. At this stage of implementation, 327 local actors have been trained.

Joint supervision with Ministries of Health supports quality and helps embed MHPSS within public structures. More than 400 local governance bodies have also been engaged to bring psychosocial wellbeing into community planning.

Structured psychosocial support, including Problem Management Plus and trauma-focused interventions, is delivered alongside psychoeducation. People who progress in recovery can then be supported into income-generating activities, linking psychosocial support with livelihoods and reducing the risk that distress continues or returns under economic pressure.

RESILAC 2 also contributes to MHPSS technical working groups across the three countries. As funding pressures intensified in the region, this coordination role became more important for keeping referral pathways open and encouraging resource-sharing among partners. The programme runs from 2024 to 2028, so the figures reported here reflect implementation progress rather than final outcomes.

What supported the work

Embedding MHPSS within several sectors helped people access support through services they already trusted. A person could encounter psychosocial support through a health post, food security activity, protection service, or social cohesion platform, reducing reliance on separate mental health entry points.

Joint supervision with Ministries of Health helped align the work with national systems and created relationships needed for integration into public structures. Contextual adaptation of tools and manuals also improved acceptance, especially where standard assessment tools required translation or adjustment to fit local language and practice.

Community governance structures provided existing platforms for discussing psychosocial wellbeing in local planning. Partnerships with national and local organisations extended the programme into areas affected by access restrictions, where local actors were better placed to maintain contact with communities.

What made it difficult

Insecurity, access restrictions, and administrative delays made field monitoring difficult, especially in areas where direct verification was already hard. Inflation and fuel shortages added further pressure by reducing mobility and increasing operating costs.

CASE

01

RESILAC 2

Men and persons with disabilities remained underrepresented, partly because the group-based and standardised delivery methods that allowed the programme to reach more people did not always work for those less likely to enter community activities or standard service points.

Working across three countries placed pressure on supervision and quality. Wider coverage increased reach, while also making consistency harder to maintain across teams, tools, and settings.

Assessment tools, including WHO-5, WHODAS, and HADS, required continuous translation and cultural adaptation. The programme had to balance comparability across countries with the need for tools that local teams and communities could use meaningfully.

Funding

RESILAC 2 is financed through a multi-year development consortium grant running from 2024 to 2028, supported primarily by the French Development Agency and the European Union. The development orientation of the grant provides a longer timeframe and broader mandate than short-term humanitarian funding, which is important for integration into public systems.

The multi-country, multi-sector design also allows MHPSS to be embedded across health, protection, food security and livelihoods, sexual and reproductive health, and social cohesion. This gives the programme more room to work across the realities people face, rather than organising support around one sector at a time.

The wider funding environment still affected the model. Several consortium partners depended on U.S. humanitarian funding, and when that funding was cut, some partners downsized or suspended services. This weakened referral pathways, slowed coordination mechanisms that relied on partner participation, and placed pressure on the wider MHPSS ecosystem around the programme.

RESILAC 2's own financing remained stable, and its development-oriented structure helped maintain continuity. The experience still shows that integrated programming depends on more than the stability of one grant. Referral pathways, coordination groups, and complementary services rely on a network of actors that can weaken when other funding streams collapse.

What this suggests for funders

First, funders should support multi-sector and cross-cluster programming directly, since MHPSS can only be integrated across health, protection, livelihoods, sexual and reproductive health, and social cohesion when grants are designed to pay for work across those boundaries. Single-sector financing can make integrated work harder to design, deliver, and report.

Second, funders need to protect referral and coordination systems across the wider ecosystem, because integration depends on the partners holding those systems together. RESILAC 2's experience shows that a cut to one funding stream can weaken the whole referral network, even when individual programmes remain funded.

Third, institutional partnerships should be treated as part of delivery, rather than as background coordination. Joint supervision with Ministries of Health, participation in technical working groups, and links to public systems are

central to whether MHPSS can remain in place beyond a project cycle.

Fourth, the practical conditions needed for integration should be funded as work in their own right. Contextual adaptation of tools, supervision, monitoring in hard-to-reach areas, and outreach to men and persons with disabilities all require time and budget, and should not be expected to emerge through service delivery alone.

CASE

01

RESILAC 2

CASE

02

REPSSI

Case 02: REPSSI

REPSSI (Regional Psychosocial Support Initiative) | Kiryandongo settlement and Kampala, Uganda | 2019 to 2025 | Funded through Sida and bilateral development partners | Government partners: Office of the Prime Minister, Kiryandongo District Local Government, Kampala Capital City Authority

At Panyadoli Health Centre IV, a government facility serving part of Kiryandongo settlement's population of more than 75,000 displaced people from nine countries, a counsellor reflected on what six years of REPSSI's work had changed in her practice and at home: "*I received knowledge on offering psychosocial support which is everyone's need. I am effectively using the skills I acquired to support the clients at the facility as well as my fellow staff. My family relationships have improved. We love, care and share with each other.*"

Context

A recent assessment in Kiryandongo found that 85 percent of adults had experienced conflict-related trauma, women headed 65 percent of households, and adolescents faced disrupted education, early pregnancy, and limited access to sexual and reproductive health services. Across the settlement, three health centres, eleven schools, and a small number of protection services were expected to respond to needs that rarely appeared in isolation.

A woman experiencing domestic violence, depression, and food insecurity could move between several organisations, repeat her story through separate intake processes, and still receive support that treated each issue apart from the others. REPSSI's work responded to this fragmentation by placing psychosocial support within the services and community structures people already used.

Approach

REPSSI integrated psychosocial support into government health facilities, teacher development programmes, school activities, Village Savings and Loan groups, and Kampala Capital City Authority's social welfare services. Health workers, teachers, savings group facilitators, and social welfare staff were trained and supported to include psychosocial support within their existing responsibilities, while government ownership was built through district structures, service agreements, and links to existing programmes.

At Panyadoli Health Centre IV, staff in the adolescent clinic were trained in trauma-informed care, and MHPSS screening was added to adolescent consultations. Community outreach extended support to families who had difficulty reaching the facility, and the district has since taken ownership of the model and replicated it in two additional facilities.

In schools, teachers were trained in psychosocial support, and peer champion clubs were added to the timetable. Sports tournaments and debate competitions created further spaces for participation and support, reaching 1,162 participants in 2023. By 2025, psychosocial support had been added to district-level in-service teacher development, reaching 47 new teachers without REPSSI's direct presence.

In livelihoods and protection, 25 Village Savings and Loan groups engaged 650 participants, 85 percent of them women, and accumulated more than 456 million Ugandan shillings in collective savings. Weekly meetings included HIV prevention, GBV awareness, child protection content, and peer psychosocial

support. Domestic violence cases among participants fell by 95 percent, while a related violence prevention programme involving 1,605 boys documented 27 cases where participants intervened to stop violence.

CASE

02

REPSSI

In Kampala, REPSSI integrated MHPSS into KCCA's GBV and child protection services. Cognitive behavioural therapy groups reached 53 women from nine nationalities and recorded a 70 percent reduction in depression symptoms. The work has since been formalised through a service agreement with KCCA.

What supported the work

Working through government and community systems gave the programme a stronger chance of continuing beyond REPSSI's direct implementation. Existing services provided the entry points, while REPSSI added training, tools, referral links, and coordination support.

The programme also translated results into terms each sector could recognise. A reduction in domestic violence among savings group members could be discussed with protection actors, livelihoods donors, and local government, each of whom could see how the work related to their mandate.

Regular coordination with UNHCR, the Office of the Prime Minister, Kiryandongo District Local Government, KCCA, and sector partners allowed partners to agree roles, address practical issues, and reduce duplication. The process took time, but it was part of the work rather than an administrative add-on.

What made it difficult

Early budgets did not fully cover the time required for coordination, which left some links between sectors weaker than intended where joint planning and follow-up were underfunded.

Health workers and teachers also needed more follow-up than the original training model allowed. When caseloads, patient numbers, or school targets increased, some staff returned to previous routines, making coaching and refresher training necessary.

Some parts of the work relied heavily on relationships between REPSSI staff and government counterparts. Implementation moved more easily where those relationships had been built over several years, while staff changes sometimes weakened the links. The activities that lasted through turnover were those written into protocols, job descriptions, service agreements, and monitoring systems.

Funding

REPSSI's work was financed through a portfolio of grants from Sida and bilateral development partners over six years, with individual grants lasting between one and three years.

Grants built around broader outcomes, such as adolescent health or community resilience, gave REPSSI more room to respond to connected needs. Grants tied to narrow MHPSS activities made integration harder because psychosocial results achieved through savings groups, protection work, or education activities were often reported under those sectors rather than as MHPSS results.

CASE

02

REPSSI

Government capacity-building was also difficult to fund. Training public workers, developing joint protocols, supporting coordination, and adding MHPSS to monitoring systems were essential to the model, yet often treated as secondary to service delivery.

What this suggests for funders

First, integrated grants need reporting systems that can recognise multi-sector outcomes. When psychosocial results are achieved through clinics, schools, savings groups, or protection services, reporting should allow those results to sit where they occur instead of forcing them into a narrow MHPSS attribution frame.

Second, coordination needs its own budget because joint planning, government engagement, referral links, and inter-agency meetings are part of delivery in an integrated programme, rather than administrative extras.

Third, training needs follow-up and institutional backing through coaching, refresher sessions, supervision, protocols, job descriptions, and monitoring tools, which help practice survive workload pressure and staff turnover.

Fourth, integration needs time. One-to-two-year grants can start the work, while longer cycles are needed for government and community systems to absorb the changes.

CASE

03

REPSSI Peer Champions

Case 03: REPSSI Peer Champions

REPSSI (Regional Psychosocial Support Initiative) | Kiryandongo settlement, northern Uganda | 2019 to 2025 | Funded through Sida and bilateral development partners

One of the refugee peer champions trained by REPSSI in Kiryandongo settlement describes the role as something that supports both the young people she works with and her own transition into adulthood: “Being a peer champion is supporting me through my transition from childhood to adulthood. Whatever I share with my peers communicates back to me. I consider my life as an example to my fellows at school and community.” Her experience reflects the premise behind the model REPSSI began building in 2019: in a settlement where professional support could never meet the scale of need on its own, refugees already living in the community had to become part of the settlement’s MHPSS infrastructure.

Context

Kiryandongo settlement is home to more than 75,000 people who have fled conflict across East and Central Africa. Around 60 percent are under eighteen, with South Sudanese refugees making up 45 percent of the population, Congolese refugees 25 percent, and Rwandese, Sudanese, and Eritrean communities making up most of the rest.

The needs facing young people were material, social, and psychological at the same time. A baseline study of 201 adolescents aged 12 to 19 found that only 11 percent had electricity at home, only 8 percent had running water, and half had gone to sleep hungry at least once in the previous week. Eighty-eight percent were caring for younger siblings, and 28 percent had lost their father. When the programme began in 2019, three health centres served the settlement and surrounding host communities, while the number of trained counsellors was far below what the scale of need required.

A response built mainly around funded external staff would have reached only a fraction of young people needing support. The settlement also brought together nine nationalities, with different languages, social norms, and ways of understanding distress, which meant that trust had to be built within and across communities rather than assumed.

Approach

REPSSI built the peer champion model from capacities already present in the settlement. The programme identified refugees who were already supporting others informally, then strengthened their role through training, supervision, peer learning, and referral links.

The model invested in the community base of the MHPSS pyramid, where everyday support, social connection, and early identification can reduce pressure on more specialised services. Peer champions were trained to provide community-level support, share psychosocial and sexual and reproductive health information, facilitate group activities, and refer cases beyond their role to trained staff.

In a settlement with several nationalities and languages, the programme depended on champions who could reach young people and families through trusted community relationships. REPSSI later had to adapt this approach

when it became clear that trust within one ethnic or language group did not automatically transfer to another.

CASE

03

REPSSI Peer Champions

What it looked like on the ground

The programme unfolded over six years, beginning in 2019 with asset mapping. REPSSI worked with community members to identify existing skills, knowledge, networks, and leadership, including teachers, healthcare workers, traditional healers, religious leaders, entrepreneurs, and informal care networks. The process helped the programme locate existing support structures and helped community members see themselves as part of the response.

From 2019 to 2021, REPSSI trained an initial cohort of peer champions selected through community nomination and self-selection. The training covered psychosocial life skills, basic counselling, sexual and reproductive health education, and facilitation. Champions also took part in ongoing supervision, peer learning circles, and case consultation with technical staff.

Between 2022 and 2024, the champions expanded their work through eleven peer-to-peer social connectedness clubs reaching 283 young people. They also co-facilitated community conversations with 406 parents and caregivers and worked as peer educators within adolescent health services in the settlement.

By 2025, 89 percent of trained champions were still providing community-based MHPSS and sexual and reproductive health education independently, without direct REPSSI facilitation. Some had begun recruiting and mentoring new champions themselves. The God is Able women's group, formed through champion-facilitated community conversations, had also become a training hub for new women's economic groups.

What supported the work

Beginning with asset mapping gave the programme a stronger basis for community ownership, because the process identified what people already knew, did, and held together before training began. The communities mapped as resource-rich in 2019 were, by 2025, demonstrating that capacity through peer clubs, caregiver conversations, adolescent health education, and women's groups operating with less direct REPSSI involvement.

Support for champions' wellbeing was built through peer learning circles, certificate recognition, supervision, and organisational backing, alongside the technical training they received. For many champions, the role offered recognition, purpose, and a way to support their peers while also strengthening their own confidence.

The tiered MHPSS structure helped keep the role safe and manageable. Champions provided community-level support and education, while cases beyond their competence were referred through warmer and more defined pathways to trained staff. This allowed peer champions to contribute meaningfully without being expected to carry needs they were not equipped to manage.

The years REPSSI staff spent attending community gatherings, learning languages, and participating in cultural events helped make the peer-led model acceptable across parts of the settlement. The work depended on those relationships as much as on the formal training package.

CASE

03

REPSSI Peer Champions

What made it difficult

REPSSI initially underestimated the inter-ethnic complexity of a settlement made up of nine nationalities. Champions from one ethnic or language group were not automatically trusted by another, which meant the programme had to invest additional, initially unbudgeted resources in multi-ethnic champion cohorts and shared learning spaces.

Where funding gaps opened before champion networks were fully established, engagement declined and some groups dissolved. Rebuilding those groups later required more time and trust than it would have taken to maintain them between grants.

Early cohorts that received less ongoing supervision had higher attrition and weaker quality, showing that one-off training could not sustain the model on its own. Continued accompaniment became the minimum workable model because training could start the process, while supervision, peer support, recognition, and referral links were needed to keep it functioning.

Funding

REPSSI's Uganda programme was funded over six years by Sida and bilateral development partners, with individual grants usually running between one and three years. The programme did not face the acute cuts that affected many MHPSS programmes after 2024, although it still had to manage the mismatch between short grant cycles and a model that depends on long-term investment.

The most useful funding relationships allowed REPSSI to invest in process-oriented work, including relationship-building, asset mapping, champion training, supervision, and peer learning. They also allowed REPSSI to report on community capacity built, not only on the number of people reached.

The main constraints came from short cycles, often twelve to eighteen months, and from compliance requirements focused on disaggregated service-delivery data. Those requirements could push the programme toward direct service provision, even when the stronger localisation outcome was the slower work of building and sustaining community capacity.

REPSSI's experience suggests that this kind of model needs a three-to-five-year horizon, reporting frameworks that value capacity built alongside people reached, and bridge funding between cycles to protect champion networks before they dissolve.

What this suggests for funders

First, funders should commit to a three-to-five-year horizon for peer-led community MHPSS, because the movement from asset mapping to training, mentoring, supervision, and independent community action takes time. REPSSI found that communities could move toward self-sufficiency within three years when funding was stable, while interruptions made recovery slower and more costly.

Second, funders should use reporting frameworks that value community capacity built, not only beneficiaries reached. Compliance systems centred on service-delivery counts can push organisations toward direct provision and away from the relationship-building, supervision, and mentoring that localisation requires.

CASE

03

REPSSI Peer Champions

Third, bridge funding between project cycles should be treated as protection for community infrastructure. Champion networks often weaken in the gaps between grants, and the cost of rebuilding trust, groups, and routines is higher than the cost of maintaining them.

Fourth, funders should support localisation as a long-term investment in community systems, not as a cheaper substitute for professional services. The value of the peer champion model lies in a community support structure that can continue beyond direct project facilitation, while still needing supervision, referral links, and investment to remain safe and effective.

CASE

04

JRS ESAR

Case 04: Jesuit Refugee Service Eastern and Southern Africa Region (JRS ESAR)

Jesuit Refugee Service Eastern and Southern Africa | Uganda, South Sudan, Ethiopia, Kenya, and the wider region | Multiple donors across more than a decade, with Ethiopia MHPSS previously funded through US PRM

Before the humanitarian funding reset of 2024 and 2025, JRS ESAR had spent more than a decade building MHPSS around community psychosocial workers, peer support networks, community-owned structures, and accompaniment. Across Uganda, South Sudan, Ethiopia, and Kenya, refugees and host community members were already trained and supported to provide psychosocial support within their own communities. When global MHPSS financing contracted and major donor programmes were withdrawn from East and Southern Africa, the organisation was drawing on capacity built over years rather than trying to create it after the shock had already arrived.

The funding reset showed that long-term investment mattered. Parts of the model that had been supported over several years, with supervision, community recognition, and clear roles, were more likely to continue under pressure, while newer or thinner parts of the model weakened more quickly.

Context

JRS ESAR runs MHPSS programming across refugee settlements and host communities in Uganda, South Sudan, Ethiopia, Kenya, and the wider region, in settings shaped by displacement, poverty, and, in several locations, persistent insecurity. The 2024 to 2025 funding reset reduced global MHPSS financing, withdrew major donor programmes, and placed pressure on frontline services across several countries at the same time.

The pressure was especially acute in South Sudan, including Maban, Renk, and remote communities along the Nile corridor, where seasonal access constraints, insecurity, and limited public services already made MHPSS delivery difficult. In areas with little clinical infrastructure and few functioning referral pathways to secondary mental health services, community-based support remained the most stable platform available.

Approach

For JRS ESAR, localisation meant structuring MHPSS through community actors, community-owned structures, and community decision-making as the normal way of working. The approach predates the funding reset and is rooted in JRS's accompaniment model, which keeps staff and partners close to the communities they serve over time.

The model is organised around the lower three levels of the IASC pyramid, with community-based psychosocial activities woven through education, economic inclusion, protection, and reconciliation. Community-based paracounsellors, including refugees and host community members recruited, trained, supervised, and supported by JRS, provide support within their own communities, while trained staff under expert supervision provide focused, non-specialised care.

Community actors help set priorities, identify needs, and decide which activities can continue when resources are constrained. Their role is therefore part of programme design and decision-making, rather than only implementation.

What it looked like on the ground

In the South Sudanese refugee settlements of Adjumani in Uganda, JRS has trained and sustained a network of community-based paracounsellors embedded in daily community life. They are trained in psychological first aid, foundational helping skills, active listening, grief support, and referral navigation.

When stipends were reduced during the reset, paracounsellors' ability to continue depended partly on the depth of earlier investment. Those who had served for several years, built community recognition, and developed a strong identity around the role were more likely to remain engaged, while those trained more recently or connected to the role mainly through short-term incentives were harder to retain.

In South Sudan, the reset pushed JRS to involve communities more directly in decisions about what should continue. Community members were retained as psychosocial workers and brought into discussions on prioritisation, including in the high-intensity Renk emergency. They helped identify which activities mattered most, how scarce resources should be allocated, and where the programme should concentrate its remaining capacity.

The priorities named by communities did not always match external programme assumptions. Communities placed value on dialogue around harmful coping, work on loss and social reconstruction, and traditional activities they described as producing "pure joy." The funding constraint made the gap between programme frameworks and community priorities more visible, giving JRS and community members a clearer basis for adjusting the response.

In Ethiopia, where JRS had worked in the five Somali refugee camps of Dollo Ado since 2011, the loss of PRM-funded MHPSS staff accelerated a shift toward Refugee Volunteer Workers. These community members were trained and supervised to deliver structured psychosocial activities and peer support. Because task-sharing can increase secondary trauma and blur role boundaries, JRS strengthened supervision where staff remained, clarified roles, and spoke explicitly with volunteers about the heavier burden they were carrying.

The reset did not create conditions for systematic outcome data collection. What it did provide was a practical stress test of the model: experienced community workers with stronger support histories were more likely to continue, while thinner parts of the system were more likely to weaken.

What supported the work

Long-term investment in community workers shaped how the model held under pressure. Paracounsellors who had served for three or more years had often built social standing, confidence, and a sense of identity around the role, which made them more likely to continue when stipends were reduced.

JRS's accompaniment approach also supported continuity because staff presence within communities over time had created relationships that could be

drawn on when external funding reduced. Trust of that kind could not have been built quickly once the reset had already begun.

Honest communication with communities helped maintain trust during the funding shock. JRS staff explained the resource constraints directly, rather than presenting reductions as routine programme pauses. Communities that understood why activities were being reduced were better able to take part in decisions about what should continue.

For some experienced workers, community recognition provided motivation that stipends had supported but had not created. That recognition helped sustain engagement, although it could not replace income for workers who relied on stipends to meet basic needs.

What made it difficult

Community psychosocial workers were themselves refugees and host community members living with poverty, displacement, and insecurity. When stipends were reduced, those who depended on them for basic needs faced additional strain. Some of the most experienced workers in Uganda and South Sudan reduced their engagement or withdrew, and their departure had a double cost because long tenure had made them both skilled and difficult to replace.

The ethical burden of asking community members to absorb the consequences of a global funding failure weighed heavily on JRS field teams. Localisation became fragile where it depended on people continuing to support others while their own material security deteriorated.

Community-based MHPSS also reached its designed limit when people needed specialised care. JRS's work covers the lower levels of the IASC pyramid and was never intended to replace clinical services. As health-sector partners reduced operations under the same funding cuts, the referral pathways needed for acute cases contracted further.

Many field staff were also managing their own employment uncertainty while supporting communities in distress. The secondary trauma and wellbeing risks were significant, while JRS's ability to support staff wellbeing was constrained by the same funding pressures affecting programme delivery.

Funding

JRS ESAR's MHPSS work has been financed by multiple donors over more than a decade. In Ethiopia, the MHPSS component had been funded largely through the United States Bureau of Population, Refugees, and Migration, which supported staff and supervision infrastructure across the Dollo Ado camps.

When PRM portfolios across the Horn of Africa were cut, the Ethiopia operation lost staff, saw funding reduced, and faced rising demand at the same time. The impact reached beyond the activities counted in project reports, affecting the supervision systems, peer networks, community recognition mechanisms, and coordination platforms that allow community-based MHPSS to function.

These systems rarely appear in grant reports as outputs, although they are the foundation on which many outputs depend. JRS ESAR's resilience during the reset rested on this architecture having been built over years through modest but sustained investment. The community workers who continued through the reset were the result of that long investment, not something a crisis-era budget

could have created quickly.

What this suggests for funders

First, funders should invest in duration, supervision, and recognition, rather than only activity delivery. A community worker supported over several years through training, accompaniment, peer networks, and community recognition is not in the same position as someone trained within a short project cycle. The ability of community workers to continue during a funding shock depends heavily on the depth and length of prior investment.

Second, funders should pay for the architecture that makes community-based MHPSS possible. Supervision systems, peer networks, coordination platforms, role clarity, and community recognition mechanisms are often treated as support costs, even though they are the infrastructure that allows localised MHPSS to function.

Third, specialised and clinical referral pathways need to be protected alongside community-based models, because localised work at the lower levels of the IASC pyramid cannot compensate for the loss of clinical services when people have acute or specialised needs. Community-based support becomes more exposed when the referral ecosystem around it contracts.

Fourth, the material security and wellbeing of community workers and field staff should be treated as part of responsible localisation. A model that relies on refugees and host community members to absorb funding shocks without protecting their own livelihoods carries practical and ethical costs, including the loss of experienced workers when support is withdrawn.

CASE

05

SAMA

Case 05: SAMA

SAMA (Sudanese Association for Mental Health and Awareness) | Port Sudan, Red Sea State, Sudan | 2024 | Funded through local donations and a sub-grant routed via SORD, a national intermediary | Approximately two months of funded activities

By mid-2024, more than a year after armed conflict broke out in Sudan, displaced families were living in overcrowded schools and public buildings across Port Sudan. In some of those shelters, children joined drawing and storytelling activities using crayons and paper. For SAMA, art provided a way to engage children who had experienced violence, loss, displacement, and interrupted schooling without asking them to begin with direct disclosure. Some drawings showed scenes of violence, dark colours, or distorted human figures that suggested a need for follow-up, while others showed flowers, birds, and sunlight. The work used creative expression as an entry point for MHPSS in a setting where formal mental health services were scarce and international actors had little presence in the shelters where families were living.

Context

Sudan's conflict, which began in April 2023, displaced families into Port Sudan and placed many in informal shelters with limited access to basic services. Children in these shelters had experienced violence, family separation, loss, and interrupted education, while a small number of psychologists and psychiatrists across the city were expected to serve thousands of displaced people.

The response had to be built around what was available: Sudanese volunteers and mental health professionals, art supplies, existing child-friendly spaces, shelter routines, and the trust held by people already known to the displaced communities.

Approach

SAMA designed and delivered the response through a Sudanese team made up of medical students, recent graduates, a psychologist, a psychiatrist, and community mobilisers from displaced communities. Activities were delivered in Arabic, and facilitators were assigned in line with community gender norms.

Because some caregivers associated mental health support with shame or social risk, the team presented the activities as creative expression rather than therapy. Drawing and storytelling gave children an acceptable way to participate, while allowing facilitators to observe behaviour, expression, and interaction over time.

More than 400 children took part voluntarily in activities held in child-friendly spaces already operating in the shelters. An art-based psychological analyst reviewed the drawings for signs of distress, facilitators recorded children's behaviour during the sessions, and a psychologist working in the shelters made referrals based on direct observation.

The team considered drawings, facilitator observations, and clinical judgement together before identifying a child for follow-up. This reduced the risk of reading too much into a single drawing, while still giving the team a structured way to identify children who might need psychosocial or specialised support.

Children identified for support were referred to on-site psychosocial workers

or to the small network of private mental health professionals in Port Sudan. Caregivers were involved in the referral process where appropriate. Some children also needed physical health checks before psychological support could proceed, and the team coordinated with available medical services when possible.

What supported the work

Because the facilitators were Sudanese, spoke Arabic, and understood the displacement context from within, families who might have hesitated to engage with an external organisation or a service labelled as mental health were more willing to allow their children to join the art and storytelling activities.

The grant's light reporting requirements gave the team space to adjust activities, move children between sessions, change facilitator assignments, and adapt caregiver engagement as they learned what worked in the shelters. Holding the activities in existing child-friendly spaces also meant that children could participate without being singled out as mental health service users.

The use of drawings as one part of a wider identification process was important for safeguarding. Art-based screening can be misused when images are interpreted in isolation, especially in a crisis where many children are distressed, so SAMA required convergence between drawings, behaviour observed during sessions, and clinical judgement before a referral was made.

What made it difficult

The psychologists, psychiatrist, coordinators, and facilitators worked unpaid throughout the project, while many were themselves displaced or under severe economic pressure. Their commitment made the response possible, but the reliance on unpaid work also made burnout one of the main threats to continuity and showed the limits of treating local capacity as a substitute for properly funded delivery.

Some children needed medical assessment before psychological support could begin, yet the grant did not include funds for investigations, referrals, or related health costs. This left some cases unresolved, particularly where physical health concerns had to be addressed before psychosocial or psychological support could continue.

Specialised follow-up was difficult because the number of mental health professionals in Port Sudan was small in relation to the scale of need. Even when children were identified for specialised support, referrals could involve long waits or remain incomplete.

The framing of the activities as creative expression helped children enter the programme, but stigma around mental health still required more sustained work with caregivers than the project could provide. Deeper engagement with caregivers around children's wellbeing would have needed more time, staffing, and follow-up resources.

Funding

SAMA's activities were supported through a sub-grant routed via SORD, a national intermediary, and supplemented by small local donations. Funded activities lasted approximately two months.

The light reporting requirements gave SAMA room to adapt the response,

although the grant offered little institutional support and no clear path for continuing the work beyond volunteer commitment. The grant amount was fixed months before disbursement, and inflation reduced its value by the time the money was received and spent, forcing the team to ration supplies.

The budget assumed a fixed number of sessions per child and did not include medical referral costs. It also covered operational costs only, with no stipends or incentives for the staff and volunteers delivering the work, even though they were carrying out the response in a context of displacement, insecurity, and economic strain.

What this suggests for funders

First, locally led work needs to be costed properly. Local expertise, volunteer coordination, facilitation, clinical supervision, and follow-up all require funding, especially when local staff and volunteers are living through the same crisis as the people they support. Compensation for local expertise should be treated as part of delivery, not as an optional addition.

Second, grants in volatile economies need protection against inflation and delayed disbursement. Fixed nominal amounts can lose value quickly, making it difficult for local organisations to deliver what was agreed. Indexation, currency protection, quicker disbursement, or staged budget adjustments can help preserve the value of small grants.

Third, flexible local funding can reach spaces where international actors have little or no presence. SAMA was able to work in informal shelters because the team already had language, trust, and access, and because the model could be adapted to the resources available.

Fourth, community-led MHPSS in crisis settings may use forms of support that differ from standard clinical models. In this case, art-based group activities, observation, caregiver engagement, and referral links formed a practical response within the limits of the setting. Funding should allow such models to be used carefully, with safeguards against over-interpretation and with referral options for children who need more specialised support.

CASE

06

EMBRACE

Case 06: Embrace

Embrace, national mental health NGO | Lebanon: Beirut, Mount Lebanon, and conflict-affected communities | War escalation September 2024 | Funded through short-term humanitarian grants, emergency donor support, Embrace's own institutional resources, and volunteer contributions | Partner: National Mental Health Programme, Ministry of Public Health, with coordination through the Ministry of Social Affairs

When the conflict in Lebanon escalated in late September 2024, roughly 1.2 million people were displaced from the south, the Bekaa, and the southern suburbs of Beirut within 48 hours. Many arrived in schools and public buildings that had never been designed to house families. Embrace was able to provide psychological support inside shelters almost immediately because it could activate infrastructure already connected to national systems: the National Lifeline for emotional support and suicide prevention, the national mental health emergency response mechanism, a community mental health centre in Beirut, and a mobile clinic serving underserved areas across the country. The speed of the response came from years of integration before the emergency began.

Context

The escalation unfolded in a mental health system that was already overstretched, with around 1.3 psychiatrists per 100,000 people and most services concentrated in urban areas. Lebanon's wider economic collapse had also weakened access to care, while about 40 percent of hospitals and a fifth of primary health care centres were damaged or destroyed, reducing access to basic health services as displacement increased.

People in shelters reported anxiety, insomnia, panic, and acute stress, while those already living with mental health conditions lost access to medication and follow-up care. One patient described displacement as losing not just a home, but "the tools that kept me standing." With no dedicated national MHPSS resources available at the scale required, the response had to draw on infrastructure, relationships, staff, and volunteers already in place.

Approach

Embrace's emergency response was linked to Lebanon's wider emergency architecture. The National Lifeline was included in the national response plan and promoted through official platforms, while National Mobile Crisis Teams accessed shelters through coordination with the Ministry of Social Affairs and the Ministry of Public Health.

Care was provided by Lebanese psychiatrists, psychologists, and other mental health professionals whose language, contextual knowledge, and community trust helped make the service usable. The response also stayed connected to wider health and humanitarian pathways, since psychological distress in the shelters was closely tied to interrupted medication, family separation, insecurity, lack of privacy, and unmet basic needs.

Mental health support was therefore treated as one part of a wider continuum of care. A person who had spent days sleeping on the street, lost medication, or been separated from family could not be supported through coping strategies alone, so the teams worked alongside medical, social, and protection actors where possible.

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What it looked like on the ground

The Ministry of Public Health and the Ministry of Social Affairs helped identify priority shelters, including sites in Beirut and Mount Lebanon where displaced people had the least access to services. Through this coordination, Embrace deployed teams into shelters and other non-traditional service settings.

The response drew on roughly 80 staff and more than 120 trained volunteers, including many clinicians who volunteered during the crisis. Their familiarity with the language, health system, stigma barriers, and patterns of help-seeking shaped how they approached care inside crowded shelters.

Clinical work included psychological first support, triage, referral, medication-related support where possible, and more intensive intervention for high-risk cases. Trust-building and stigma reduction were part of the work, with clinicians normalising help-seeking and addressing fears about psychiatric care. One woman said the sessions made her feel seen and heard for the first time since displacement.

What supported the work

Embrace's long-standing partnership with the National Mental Health Programme gave the response a basis for rapid alignment with national structures. Since 2017, that partnership had included the Lifeline, the emergency response mechanism, a digital mental health programme, and work to integrate mental health into primary care. When the escalation occurred, those relationships already existed.

The availability of a trained Lebanese workforce also shaped the response. Clinicians who spoke the language and understood local barriers to help-seeking were able to work in shelters where stigma, fear, and uncertainty affected whether people would accept support.

Embrace's existing mix of services helped the organisation adapt quickly. The Lifeline, community mental health centre, mobile clinic, and emergency response mechanism gave the organisation several entry points for reaching people, while coordination with medical, social, and protection actors helped position MHPSS within a wider support system.

What made it difficult

Clinicians often worked in overcrowded shelters with little privacy, frequent interruptions, power cuts, and continuing security threats. Waiting for better conditions would have delayed support, while providing care immediately meant working in spaces that were far from appropriate for confidential psychological support.

Demand rose faster than the supply of specialised providers. High-risk cases had to be prioritised for intensive intervention, while many others received briefer support than the teams would have preferred.

Redirecting staff and resources toward the emergency also placed pressure on outpatient psychiatric care and longer-term community mental health services. The emergency response depended on the same system that people would need for recovery, which meant that surge work could weaken standing services if additional resources were not provided.

The burden on providers was substantial. Many clinicians and volunteers were

living through the same war as the people they supported, facing insecurity, displacement, exhaustion, and concern for their own families. Embrace provided peer support, group debriefings, and supervision, although these measures could only reduce the strain, not remove it.

Funding

The response was financed through short-term humanitarian grants, emergency donor support, Embrace's own institutional resources, and substantial volunteer labour. Before the escalation, Embrace was already running several donor-funded mental health programmes, mostly through project-based grants with predefined activities, budgets, geographies, and timelines.

When the emergency began, some donors added support, and parts of existing projects were adapted in coordination with donors to meet displacement-related needs. This allowed a fast initial response by redirecting staff time and operational resources, although the limits of this arrangement became clearer as displacement patterns changed.

Most grants were tied to fixed locations and activities, which made it difficult to move resources as needs shifted. There were no flexible, dedicated emergency MHPSS streams at the scale required, so expansion depended on stitching together existing budgets rather than activating a purpose-built surge mechanism.

Even contingency provisions often required prior donor consultation, budget amendments, and formal approvals, which slowed deployment when speed mattered. Reporting and compliance obligations also remained largely unchanged, even as teams were responding to an active emergency.

The response relied heavily on clinicians and volunteers who continued working despite limited financial support. This showed the strength of local professional networks, while also exposing their fragility when essential services depend on short-term, inflexible funding and unpaid labour.

What this suggests for funders

First, funders should invest in the integration of MHPSS into national systems before crises arrive, because Embrace's response speed depended on infrastructure, partnerships, and trust built over several years. National lifelines, emergency response mechanisms, mobile services, primary care links, and working relationships with ministries cannot be assembled at the point of escalation.

Second, funders should protect the standing services that emergency responses draw on. When a surge response is financed by redirecting staff and resources from outpatient and community mental health care, the emergency response can weaken the system that people will need for recovery after the immediate crisis.

Third, flexible and multi-year funding is needed for local actors expected to respond as crises move. Grants tied to fixed locations, activities, and approval processes make it difficult to shift resources when displacement patterns change, while distress and demand often continue after active violence has subsided.

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Fourth, provider wellbeing should be funded as an operational requirement. Frontline workers delivering emergency MHPSS are often living through the same crisis as the people they support, and structured supervision, peer support, debriefing, and rest systems are necessary for keeping the workforce functioning.

ANNEX

Annex: List of abbreviations

01

List of abbreviations

ABBREVIATION	FULL TERM
GBV	gender-based violence
HADS	Hospital Anxiety and Depression Scale
HIV	human immunodeficiency virus
IASC	Inter-Agency Standing Committee
INGO	international non-governmental organisation
JRS ESAR	Jesuit Refugee Service Eastern and Southern Africa
KCCA	Kampala Capital City Authority
MHPSS	mental health and psychosocial support
NGO	non-governmental organisation
PRM	Bureau of Population, Refugees, and Migration (United States)
REPSSI	Regional Psychosocial Support Initiative
RESILAC	Résilience et Cohésion Sociale du Lac Tchad (Resilience and Social Cohesion in the Lake Chad Basin)
SAMA	Sudanese Association for Mental Health and Awareness
SIDA	Swedish International Development Cooperation Agency
SORD	Sudanese Organisation for Research and Development
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization
WHO-5	World Health Organization Five Well-Being Index
WHODAS	World Health Organization Disability Assessment Schedule