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Sustaining Investment in MHPSS Localisation and Integration:

Recommendations for donors

THE MHPSS COLLABORATIVE

PEACE OF MIND FOUNDATION

Save the Children

Center for Global Mental Health Equity
THE GEORGE WASHINGTON UNIVERSITY

Global Mental Health Action Network

MHIN Mental Health Innovation Network

MHPSS.net

Terre des hommes
Helping children worldwide.

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HOW THIS PAPER WAS DEVELOPED

This 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, 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. A co-creation workshop then brought funders and implementers together to test the emerging findings and shape the recommendations and considerations set out in the sections that follow.

The case for acting now

Humanitarian response is being reshaped by political, social, and financial pressures that now reinforce one another: widening economic inequality between and within countries, mainstream public hostility toward migrants and refugees in many donor states, and structural racism in aid governance that continues to shape whose needs are counted and whose are treated as secondary. Many governments that built and funded the postwar aid system are stepping back, moving money toward defence and domestic priorities, and defining assistance more openly in terms of national interest. These shifts are happening as armed conflict, mass displacement, and climate-related shocks generate needs faster than a shrinking set of institutions can absorb.

The reduction in funding did not begin in 2025, though that year turned a gradual decline into an abrupt contraction. Development assistance had been losing ground for several years, with the apparent stability of the early 2020s sustained in large part by exceptional spending on Ukraine. Health-specific assistance had also been falling since its pandemic-era peak of USD 80.3 billion in 2021 to USD 39.1 billion in 2025, the lowest level in fifteen years. The withdrawal of the United States from much of its foreign aid in early 2025, including the dismantling of USAID and deep reductions to PEPFAR, removed the system's largest single contributor within months and other governments announced reductions of their own over the same period. Official development assistance from the wealthiest donors fell by 23.1 percent in 2025, to USD 174.3 billion, while humanitarian assistance was cut by 35.8 percent, the largest proportional reduction of any category. The effect on the multilateral system was immediate: UN-coordinated appeals fell from close to USD 50 billion in 2023 to just over USD 20 billion for 2026, and the number of people the UN aims to reach narrowed from 115 million to 87 million as the available funding forced choices about who could still be helped.

Mental health and psychosocial support enters this period from a position of chronic underinvestment. Even before 2025, governments allocated on average only 2.1 percent of their health budgets to mental health, and far less to mental health within other sectors, leaving a global financing gap estimated at more than USD 200 billion. Because the sector was already under-resourced, the current cuts are removing services that were minimal to begin with and, in many settings, the only services of their kind available.

The consequences for people who depend on these services are now well documented. In a 2025 survey of 131 programmes across 32 countries, the Global Mental Health Action Network and the Mental Health Innovation Network found that the number of people these programmes could support fell from 981,850 in 2024 to 207,030 the following year, a loss of more than 750,000 people within a single year. Staffing fell from 9,343 posts to 2,508 over the same period. The same survey, as reported in the 2025 inter-agency advocacy paper, found that 79 percent of people receiving psychological treatment lost it, and that 75 percent of those relying on essential psychiatric medication could no longer obtain it. Future impacts will be substantial as these cuts also slashed funding for training in mental health and psychosocial support from approximately 56,000 providers per year to under 6,000 providers.

These losses fall hardest on groups already exposed to the greatest risk, including survivors of torture, displaced children and young people, women, and LGBTQI+ people. They are also compounded by the direction of the wider humanitarian system. The Humanitarian Reset's emphasis on

hyperprioritisation concentrates remaining resources on the most immediate physical lifesaving activities and can push mental health and psychosocial support into a secondary category of work to be funded later, even though emergencies often increase the immediate need for it. Surveys of frontline practitioners reflect the same pattern: a global study of child protection workers conducted late in 2025 found that MHPSS was the service most often reported as disrupted, and deterioration of children's mental health the most often reported as increasing..

Alongside this contraction, and predating it by years, runs a second and still unresolved question about how humanitarian assistance is organised and who holds power within it. Since the 2016 Grand Bargain, an agreement between the largest donors and the major aid organisations, the sector has committed on paper to directing more resources and more decision-making toward local and national actors in the countries where crises occur, and to confronting the imbalance that concentrates funding and authority in the institutions of the Global North. The movement of money has not matched the commitment, however, with direct funding to local and national actors standing at well under one percent of total humanitarian funding in 2023, against the 25 percent the Grand Bargain set as its target nearly a decade earlier.

The Humanitarian Reset announced by the UN's Emergency Relief Coordinator in March 2025 in response to the funding crisis, names a shift of power toward country-level actors as one of its three priorities and has proposed that up to half of all humanitarian funding be channelled through country-based pooled funds, with the majority passed on to local and national organisations. Whether the Reset delivers that shift or simply manages a smaller system in the language of reform remains contested. Local actors and external observers have both noted that the same financial pressure that could advance a long-overdue redistribution of power could also push cost and risk downward while control over priorities and funds stays where it has long been. A year after its launch, the Reset's own architect acknowledged the sector is "under attack" as appeals for 2026 sat less than a quarter funded. This paper is written into that ambiguity, because the choices funders make over the next few years will help determine which path the reset takes.

The case for protecting mental health and psychosocial support does not depend on the funding crisis. MHPSS covers a wide range of activities, from everyday measures that help people cope and stay connected, through structured psychological help, to clinical treatment for people living with the most serious conditions. At its core, it concerns survival and rights: around one in eight people worldwide lives with a mental health condition, rising to roughly one in five in settings affected by armed conflict, and unaddressed mental health needs can lead to suicide, which ranks among the leading causes of death for adolescents and young adults.

Mental health also shapes whether other investments succeed. Support for mental health and psychosocial wellbeing improves outcomes that funders in other sectors are already paying for, including children's learning, adherence to medical treatment, community recovery after violence, and people's ability to make use of livelihoods, cash, and protection assistance. Because this support runs through health, education, protection, nutrition, and livelihoods at the same time, a reduction in any one of those sectors is in practice a reduction in mental health support as well, which is part of why the present cuts affect it from so many directions. The argument is social as well as clinical: the circumstances that produce psychological distress in emergencies, including

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Introduction:

The case for acting now

loss of safety, income, family, and social connection, are the same conditions humanitarian and development programmes already exist to address.

This paper focuses on two commitments: localisation and integration. Both have deep seated roots in the field, including in the 2007 inter-agency MHPSS guidelines and, for localisation, in the 2016 Grand Bargain. They are central here because they affect the quality, reach, accountability, and continuity of support in emergencies, rather than because they offer a way to reduce costs. The next section examines each in depth, including how they are defined, what the evidence shows about them, and what helps or hinders them in practice, with examples drawn from real programmes running through the paper.

Localisation matters because the people and organizations closest to a crisis are often the first to respond, hold the deepest understanding of the language, beliefs, and social realities of the communities they serve, and remain in place after international organisations and their funding have moved on. The financing system has failed for years to resource them in a way that reflects this role, a failure that becomes even harder to defend as budgets contract. The case for moving resources and decision-making toward these actors therefore grows stronger, but so does the risk that localisation is used to shift cost and responsibility downward while authority over priorities and budgets remains largely unchanged.

Integration follows an equally simple point: people do not experience their difficulties in the separate categories that aid agencies use to organize themselves. A displaced parent's anxiety, their child's struggle to learn, the family's lost income, and their physical health are often facets of one situation, while the social conditions that drive psychological distress in an emergency sit largely beyond the reach of any standalone mental health programme. Building mental health and psychosocial support into the health, education, protection, and livelihoods services that people already use can strengthen those services and reach people who would never approach a mental health programme on its own, which is why the case for integration is about both effectiveness and reach.

1: Sustaining investment in MHPSS localisation

Why is it important to sustain investment in MHPSS localisation?

The drastic reductions in humanitarian funding, alongside growing scepticism about the legitimacy and effectiveness of international aid, have created momentum for a much needed Humanitarian Reset, to deliver "faster, lighter, and more accountable and impactful humanitarian action". Even before the cuts, humanitarian needs were increasingly outpacing available resources, with many vulnerable individuals and communities receiving inadequate support despite severe need. While locally led action is a central element of the reset agenda, the reform process itself has been shaped at the highest levels of the humanitarian system, with limited involvement of grassroots actors and affected communities in decisions about how increasingly scarce resources should be prioritized and used. As resources shrink further and humanitarian needs continue to grow, there is a risk that the localisation narrative is increasingly framed as a pragmatic response to financial constraints, as a means for delivering aid more efficiently by doing more with less, rather than a transformative agenda that commits to shifting power and decision making.

Investing in a transformative localisation agenda is therefore more important than ever to uphold the right of affected communities and countries to self-determination, and to ensure they have a meaningful influence in decision making about how limited resources are allocated and how services are designed and delivered. Beyond being an ethical imperative, there is also emerging evidence that projects led by local and national actors are associated with greater relevance, reach, quality, accountability and trust. Approaches rooted in local priorities, capacities, and knowledge systems are especially important in MHPSS, as they can contribute to a range of psychosocial benefits, such as agency and social cohesion, by enabling individuals and communities to mobilise around shared, locally determined goals using their own capacities, resources, networks, and support systems. On the other hand, top-down enforcement of externally designed and standardised approaches in MHPSS have been found to be associated with unintended harms, by overlooking local realities and marginalizing existing support systems, knowledge, and capacities.

Although contextually grounded approaches exist in MHPSS, there is a systemic privileging of standardised models, and the evidence base continues to be shaped by concepts, frameworks, and approaches originating in the Global North institutions and high-income settings. International actors and institutions continue to have disproportionate influence over funding priorities, coordination mechanisms, normative frameworks, agenda setting, and evidence generation. Approaches that are responsive to locally identified priorities and build on local capacities and knowledge systems (e.g., including indigenous and cultural practices, community support systems, and collective self-help) are relatively less researched, documented, and funded. These gaps point to deeper structural dynamics in how funding, governance and knowledge production operates in MHPSS, and these are explored further in this chapter.

What does localisation mean?

Within the contemporary localisation discourse, there has been an often-repeated commitment to *"making principled humanitarian action as local as possible and as international as necessary".* This discourse is institutionalised within a humanitarian architecture in which Global North and international humanitarian actors exercise disproportionate control over decision making, resources, and governance. These dynamics play a role in how localisation is defined and implemented, who qualifies as a local actor, and what is considered possible and necessary within localisation efforts.

The conceptual framing and objectives of localisation need to be grounded in the perspectives, priorities, language, capacities, and lived realities of Global South actors and affected communities. At the same time, localisation efforts must recognise the diversity of local actors and contexts and remain attentive to the power dynamics at the local level, so that they do not reinforce local hierarchies and inequalities. Recognising this complexity, this paper does not adopt a single and fixed definition of localisation. Instead, it distinguishes between several related concepts encountered commonly in the current discourse:

Meaningful localisation: a systemic reform through which funding, partnerships, governance and knowledge production redistribute power and strengthen the agency, ownership and leadership of local actors and affected communities.

Locally led MHPSS: an operational and programmatic approach in which local actors lead the identification of priorities as well as the design, implementation, evaluation, and governance of MHPSS interventions.

Community-led approaches: a subset of locally led approaches that emphasises leadership by actors closest to affected populations, including community groups and informal collectives.

Locally led MHPSS focuses on who leads, while meaningful localisation focuses on how systems enable that leadership. This distinction helps move beyond binary debates (local vs international) and instead focus attention on how roles, responsibilities, and decision-making are distributed in practice.

Why does meaningful localisation require redistribution of power?

Although calls for local leadership and participation have long been part of humanitarian work, localisation has become institutionalised through global commitments such as the Grand Bargain. More recently, discussions on the Humanitarian Reset have renewed attention to localisation in the context of severe funding constraints. While these developments have placed local leadership at the centre of the humanitarian reform agenda, implementation has often prioritised increasing direct funding to local and national actors, rather than meaningfully shifting decision making authority, agency, and leadership. Critical scholarship has also shown that localisation processes have at times reproduced rather than transformed existing power asymmetries by strategically using the access, knowledge, labour and risk tolerance of local actors, while maintaining their subordination.

Meaningful localisation requires redistributing power through shifting control over resources, decision-making, and agenda setting from international actors to local actors and affected communities. Without this shift, local actors continue to depend on international intermediaries, and accountability remains primarily oriented towards donors rather than affected communities. Localisation is therefore increasingly recognised not merely a technical or operational reform, but a transformative political process. Achieving this transformation requires sustained investment, mutual trust, appropriate safeguards, policies, processes, and institutional arrangements that are responsive to local priorities and support local actors to exercise genuine leadership.

How do funding systems reproduce power inequities in MHPSS?

Funding systems both reflect and reinforce broader power imbalances, shaping who can access resources and under what conditions. Within MHPSS, these inequities are evident not just in the distribution of funding and resources, but also in agenda setting, coordination mechanisms, knowledge production, and persistent assumptions about limited capacities of local actors and systems. It has been estimated that only 3% of humanitarian MHPSS funding is channelled directly to local and national actors. Funding and evidence generation have tended to prioritise technical approaches developed in the Global North over locally led, collective, and indigenous healing practices. Relatively little investment has been directed towards the implementing, evaluating and documenting locally led approaches, limiting the evidence available to inform decision-making.

Top-down requirements of using specific programming approaches, measurement frameworks, and methods create structural limitations for the meaningful inclusion of local and community perspectives. This ultimately reinforces greater visibility, legitimisation and recognition of technical expertise over contextual knowledge and lived experience. Therefore, meaningful localisation cannot be achieved simply by changing how funding flows. It requires a more fundamental redistribution of power across financing, partnerships, knowledge production, coordination, and governance:

CURRENT PRACTICE	SHIFT REQUIRED FOR MEANINGFUL LOCALIZATION
Project-based, short-term, and transactional funding relationships	Longer-term, flexible, and predictable funding, including core support that enables organisational growth and sustainability
Risk averse funding practices, complicated by limited donor proximity to local contexts	Trust-based partnerships and investment in local capacity, identifying areas of growth and supporting organisational capacity development
Decision-making retained by donors and international intermediaries	Shared, negotiated, and equitable decision-making, with local partners and affected communities having meaningful influence on priorities
Donor dependence and limited accountability to affected communities	Greater accountability to affected communities and integration of locally defined understandings of defining quality and success

CURRENT PRACTICE	SHIFT REQUIRED FOR MEANINGFUL LOCALIZATION
Funding tied to donor priorities and predefined program models	Demand-driven funding that is responsive to locally identified priorities
Privileging of Eurocentric knowledge frameworks and technical and scientific expertise	Recognition and integration of multiple forms of knowledge, with contextual, experiential, indigenous, community and practice-based knowledge valued alongside technical and scientific expertise
Use of standardised indicators and reporting and preference for quantitative approaches	Locally meaningful indicators, flexible reporting requirements, and greater use of qualitative, participatory, and culturally appropriate approaches
Capacity strengthening and sharing as one-way transfer	Mutual learning and system-level capacity strengthening and sharing, recognising existing local capacities

CASE STUDY: SUSTAINING COMMYNITY-BASED MHPSS THROUGH LONG-TERM INVESTMENT IN AND RECOGNITION OF LOCAL CAPACITIES

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

Across East and Southern Africa, JRS ESAR had spent more than a decade building MHPSS around refugees and host community members trained as para counsellors, peer supporters, and community psychosocial workers. When global MHPSS funding contracted and major donor programmes were withdrawn, the organisation drew on capacity already built through long-term accompaniment, supervision, and community-owned structures.

The reset showed a difference between capacity that had been built over time and capacity that was thinner or more recent. Community workers who had served for several years, built recognition, and developed a strong identity around the role were more likely to continue when stipends were reduced. Newer or more thinly supported parts of the model were harder to sustain, while cuts to health-sector partners further weakened the referral pathways needed for people with specialised needs.

The case points to a central funding lesson for localisation: community-based MHPSS depends on more than training community workers. It requires sustained investment in supervision, peer networks, coordination, referral pathways, recognition, and the material security of the workers themselves. Without that architecture, localisation can shift risk onto refugees, host community members, and field staff who are already living with the effects of crisis.

A full length version of this case study is available in the annexure "*Sustaining Investment in MHPSS Localisation and Integration: Case studies*" available on www.mhpsscollaborative.org.

What challenges donors need to address to enable locally led MHPSS?

1

Sustaining investment in MHPSS localisation

HOW CAN DONORS ENSURE QUALITY AND ACCOUNTABILITY WHILE ENABLING LOCALLY DEFINED APPROACHES AND AVOIDING RECENTRALISATION OF CONTROL?

Tension:

Systems designed to ensure accountability and manage risk can unintentionally centralise decision-making and reinforce standards, and understandings of quality and evidence-base that privilege international actors over local priorities and leadership.

Key issues:

- Quality, accountability, and impact frameworks are often grounded in Western epistemologies and may not align with local priorities and understandings of wellbeing.
- Donor systems and compliance requirements tend to privilege capacities of larger international organisations (i.e. complex and English-language reporting requirements, greater emphasis on standardized quantitative approaches for demonstrating impact, and undervaluing of qualitative, participatory and culturally grounded approaches)
- Assumptions about organisational risk and local capacities are not always evidence-based and can reflect differences in organisational systems, contextual realities, or cultural expectations rather than actual financial or programmatic risk

What this requires in practice:

- Co-defining frameworks of quality, impact and accountability with local actors and affected communities.
- Expanding the types of evidence considered legitimate, including participatory, qualitative, and culturally grounded approaches.
- Recognising that accountability is shared across donors, international organisations, local actors and affected communities.
- Providing core support and investing in capacity strengthening and sharing that goes beyond technical training to include organisational systems, cross-cultural learning and supervision.
- Supporting internal advocacy within donor organisations to ensure that accountability and compliance requirements are proportionate to risk, grant size and organization capacities, rather than applied uniformly across partners.

Key message:

Quality and accountability are strengthened, not weakened, when they are co-defined and shared with local actors and affected communities rather than imposed through centralised systems.

Example approach:

Community-led child protection (CLCP): This is an approach developed within the child protection sector, that seeks to shift power and decision making to communities. Rather than implementing external approaches, communities collectively identify child protection priorities, plan interventions and mobilize action. CLCP involves cyclical processes

of learning, community planning, reflection and adjustment. It was developed and piloted through collaboration between child protection practitioners and communities in Sierra Leone, Kenya and India. It offers a practical example of how locally led approaches can redistribute power and improve community ownership.

HOW CAN FUNDING BE DESIGNED TO ENABLE LOCAL AGENCY?

Tension:

Funding arrangements designed to maximise predictability, control, and comparability can unintentionally limit local actors' agency to define priorities, innovate, and adapt programs in response to changing contextual dynamics needs.

Key issues:

- Reliance on indirect funding through international intermediaries constrains local decision making, autonomy, and leadership.
- Rigid donor and organisational mandates, inflexible terms of reference, and top-down imposition of standardised programming frameworks limit meaningful inclusion of local and community priorities.
- Short-term project cycles favour pragmatic approaches and are ill-equipped to respond to complex and evolving humanitarian contexts.
- Lack of core funding to local organisations compromise organisational development, leadership and sustainability.
- Reporting, monitoring and administrative requirements are often misaligned with local organisations' resources, capacities, and ways of working.

What this requires in practice:

- Designing equitable funding arrangements that provide adequate time, flexibility and resources to support meaningful influence of local actors and affected communities.
- Co-developing funding priorities and calls with local actors and affected communities.
- Recognising that funding architecture shapes power by influencing who sets priorities, allocates resources, and makes decisions.
- Creating space for locally led priority setting, planning, implementation, adaptation and locally meaningful conceptualisations of wellbeing.
- Ensuring that reporting, monitoring, and compliance requirements are proportionate, appropriate for the context and aligned with local capacities and priorities.

Key message:

Funding design does not only enable programme delivery, but it also structures who holds power, sets priorities and makes decisions.

CASE STUDY: LONG-TERM INVESTMENT IN LOCAL CAPACITIES FOR COMMUNITY OWNERSHIP AND SUSTAINABILITY BEYOND PROJECT MANDATES.

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

In Kiryandongo settlement in northern Uganda, REPSSI trained refugees to become peer champions providing psychosocial support, sexual and reproductive health education, peer group facilitation, and referral support for other young people. The programme began with asset mapping, identifying the skills, networks, and informal care structures already present in a settlement of more than 75,000 people from nine nationalities. 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, while peer-led community conversations also contributed to the formation of groups such as the God is Able women's group, which now supports new women's economic groups.

The case shows what localisation requires beyond training. Peer champions needed supervision, peer learning, referral links, recognition, and time to build trust across language and ethnic lines. Funding gaps nearly dissolved parts of the network, while stable support allowed community capacity to become more than a project activity. For funders, the lesson is that peer-led MHPSS needs multi-year investment, process-oriented reporting, and bridge funding between grant cycles.

A full length version of this case study is available in the annexure "*Sustaining Investment in MHPSS Localisation and Integration: Case studies*" available on www.mhpsscollaborative.org.

CASE STUDY: RECOGNITION AND ADEQUATE COMPENSATION OF LOCAL EXPERTISE

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

In Port Sudan, displaced families were living in overcrowded schools and public buildings with limited access to services and few mental health professionals available across the city. SAMA built a short MHPSS response around Sudanese volunteers and mental health professionals, art supplies, existing child-friendly spaces, and the trust its team already held in the shelters. More than 400 children joined drawing and storytelling activities. The team used the drawings alongside facilitator observations and clinical judgement before referring children for psychosocial or specialised support, which reduced the risk of mislabelling a child on the basis of a single image while still creating a way to identify those who needed follow-up.

The project lasted about two months, relied on unpaid staff and volunteers, and lost purchasing power because of inflation before the funds were spent. SAMA's experience shows what trusted local actors can do in places where international

organisations have little presence, while also pointing to the need for flexible local funding, compensation for local expertise, inflation-sensitive grant design, and budgets that include referral and follow-up costs.

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HOW CAN DONORS SUPPORT LOCAL KNOWLEDGE SYSTEMS, SOUTH–SOUTH PARTNERSHIPS, AND LOCALLY LED LEARNING INITIATIVES?

Tension:

The systems that fund interventions and research shape what counts as valid knowledge, which can unintentionally privilege Global North frameworks while marginalising local perspectives, community practices and lived experience.

Key issues:

- Underinvestment in locally led research, learning, and reflection contributes to a stronger evidence base for approaches developed in the Global North.
- Limited investment in South–South collaboration and knowledge exchange constrains Global South solidarity and leadership.
- Dominance of Global North frameworks, languages, and concepts in research, guidance, and funding priorities, shaping how MHPSS is understood and prioritised.
- Viewing and funding program implementation as distinct from knowledge production, limiting opportunities for strengthening evidence base for locally led approaches.

What this requires in practice:

- Investing in locally led research, learning, and reflection spaces, including those not tied to specific projects.
- Supporting South–South collaboration, peer learning and knowledge exchange to strengthen Global South leadership and solidarity in agenda setting.
- Investing in approaches that integrate diverse forms of knowledge, including experiential, indigenous, practice-based and community knowledge, alongside technical and scientific expertise.
- Funding learning as an integral part of programming, rather than an add-on.
- Investing in documentation, recognition, and dissemination of communities' approaches to healing and psychosocial wellbeing.

Key message:

Knowledge production is not neutral. Funding decisions shape whose knowledge is recognized, visible and valued.

WHAT ROLE DO INTERNATIONAL ACTORS PLAY IN A LOCALLY LED SYSTEM?

Tension:

While localisation seeks to transfer leadership and decision making to local actors, existing funding structures often continue to position international

actors as gatekeepers of resources and expertise.

Key issues:

- Ambiguity and contestation around the appropriate role of international actors within a locally led humanitarian system.
- Continued positioning of international intermediaries as technical experts, knowledge holders, and implementers.
- Institutional incentives and survival pressures may slow transformation or reframe localisation agendas in ways that support institutional expansion.
- Funding arrangements, donor expectations, and compliance and report requirements reinforce existing roles rather than create space to challenge them.

What this requires in practice:

- Supporting transitions where international actors take on roles such as co-learners, partners in solidarity, and facilitators of local and community-led agendas and projects.
- Funding arrangements that facilitate demand-driven support of international actors based on priorities of local actors and affected communities.
- Recognising that donor expectations and contracting models shape how international actors position themselves.
- Clarifying roles within funding arrangements, including distinguishing implementation and facilitation functions.
- Creating spaces for local actors to influence and have decision making power and learning from communities in how they create an inclusive approach (meaningful inputs from different people in the community).
- Enabling gradual and context-specific transitions rather than uniform models of change.

Key message:

The role of international actors is not fixed, it is shaped by funding design, system incentives and donor expectations.

Example approaches:

Survivor and Community-led Response (SCLR): In survivor and community led response approaches, decision making power and resources are transferred directly to crisis affected communities through mechanisms such as small group grants and participatory learning cycles. Local self help groups identify priorities, design and implement their own responses, while external actors play a facilitative role (i.e. enabling access to resources, supporting connections, and accompanying learning processes). This model shows how international actors can shift from directing interventions to enabling locally driven action, building on existing capacities, strengthening social cohesion, and supporting adaptive, context specific responses.

Swiss Development Corporation's approach to funding local actors: In a programme in Borno State (Nigeria) funded by SDC, Terre des hommes

(Tdh) deliberately shifted from an implementing role to a technical partner and enabler. National organisations (CATAI, LABDI, RIA) act as direct recipients of donor funding and consortium leads, while Tdh provides demand driven technical support (MEAL, safeguarding, capacity strengthening and sharing) without direct service delivery. This model illustrates how international actors can strengthen systems, support learning, and accompany partners while ceding operational leadership, aligning their role with locally led priorities and decision making.

WHAT SYSTEMIC BARRIERS SLOW DOWN CHANGE, AND HOW DO THEY AFFECT DONOR PRACTICE?

Tension:

Many of the obstacles to localisation are embedded within institutional systems and structures, including those of donors themselves.

Key issues:

- Organisational inertia and bureaucratic constraints make it difficult to transform funding arrangements and partnership models.
- Risk aversion and compliance-driven organisational cultures prioritise standardisation and predictability over trust, flexibility, and locally led decision-making.
- Internalised hierarchies and institutional incentives can maintain unequal partnerships.
- Organisational cultures valuing speed, visibility, productivity and competition can limit opportunities for reflexivity, learning, and adaptation.

What this requires in practice:

- Creating space for critical reflection on power and decision-making within institutions.
- Reviewing how institutional processes, including those related to risk management, compliance, reporting and funding timelines, shape partnerships and outcomes.
- Supporting iterative approaches, where learning informs adjustments over time.
- Acknowledging that transformation requires institutional as well as programmatic change.

Key message:

Barriers to localisation are not only external, but they are also embedded in how systems are designed and operate.

2: Sustaining investment in MHPSS integration

Why is it important to integrate MHPSS within broader humanitarian systems?

2

Sustaining investment in MHPSS integration.

Individuals and communities in emergency settings experience a web of interconnected social and economic challenges, such as high levels of economic hardship, food insecurity, exposure to violence, stigma and social isolation, among others. These issues deeply affect, and are affected by, mental health and psychosocial wellbeing; thereby locking individuals and communities into self-perpetuating cycles of adversity. For example, individuals experiencing poverty are more likely to have poor mental health, and conversely, individuals with poor mental health are more likely to experience poverty. Continued exposure to socio-economic adversity may also limit or reduce the benefits of mental health interventions over time.

Integrating MHPSS into wider systems (e.g., community support mechanisms, social services, formal or non-formal school systems, general health services, etc.) is crucial for:

- providing holistic, person-centred support,
- simultaneously addressing social determinants of mental health (e.g., poverty and intimate partner violence) and their psychosocial consequences,
- improving equity by meeting the needs of those most affected by intersecting adversities,
- improving outcomes for sectors and services with primary aims other than mental health and psychosocial wellbeing,
- increasing coverage by linking with existing systems and ensuring sustainability beyond project specific mandates,
- reducing stigma and discrimination through embedding support in broader systems and services, and
- ensuring access to support through more acceptable platforms in settings where mental health is considered too political

Therefore, integration is both an ethical imperative and a necessary strategy for safe, relevant, effective, equitable and person-centred care. Integration has been a longstanding priority in the field and the key focus of the foundational Inter Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings published in 2007. The IASC Reference Group on MHPSS in Emergency Settings, which has the mandate of implementing the guidelines and promoting interagency coordination and best practices, also has several thematic working groups at the intersection of MHPSS and other areas of work to build expertise across fields and develop frameworks for integrated approaches. More recently, the MHPSS Minimum Service Package has been developed by the IASC Reference Group on MHPSS to offer practical guidance on integrating MHPSS into humanitarian response planning through a minimum set of activities that support the integration of MHPSS across sectors.

What are the key approaches for MHPSS integration?

Two broad and complementary approaches are commonly used for integrating MHPSS across humanitarian responses:

- **Integrating specific MHPSS interventions or components into broader programs and services:** This involves incorporating explicit MHPSS interventions or activities within health and non-health humanitarian programs. Task sharing is one of the most widely used strategies for expanding access to clinical or structured psychological interventions, especially in resource-constrained settings. It involves shifting of tasks originally performed by mental health specialists to trained and supervised non-specialists. For example, it is used under the Mental Health Gap Action Programme (mhGAP), which supports the integration of mental health support within primary care settings through non-specialist providers. Similarly, low-intensity psychological interventions have also been integrated across sectors through trained and supervised non-specialist staff and volunteers. Another strategy includes training non-specialist workers and volunteers to deliver structured psychosocial interventions and embedding psychosocial sessions into existing programs.
- **Applying a psychosocial lens across sectoral programs**: This involves integrating a community-based psychosocial approach within sectors whose primary aims are other than improving mental health and psychosocial wellbeing. Instead of adding specific activities or interventions, it focuses on delivering humanitarian assistance in ways that promote the agency, dignity, safety, participation and wellbeing of the affected communities. It is about "not doing more but doing things differently". For examples, the ACT Church of Sweden has supported partner organisations to integrate a psychosocial lens across all programming by drawing on the core principles of IASC Guidelines on MHPSS in Emergency Settings together with broader wellbeing frameworks for relevance across multiple sectors.

It is helpful to think of integration as a spectrum, with the appropriate extent of integration depending on the context, objectives, available resources, and existing capacities:

LIGHT TOUCH LINKAGES	PARTIAL INTEGRATION	FULL INTEGRATION
Little/no conceptual framework or theory of change (ToC) for joint processes and outcomes. Juxtaposed elements. Added on or done as an afterthought.	Some conceptual framework but no ToC for joint processes and outcomes for the programme. Unidirectional: e.g. MHPSS elements integrated into a peacebuilding programme.	Clear conceptual framework and ToC for joint processes and outcomes for the programme. Bidirectional: MHPSS and peacebuilding elements are interwoven, complementary and mutually synergistic in their outcomes.

Conceptualisation of integration from the IASC Guidance on Integrating MHPSS & Peacebuilding

- **Light-touch linkages or limited integration:** This involves introducing additional layers of support with very limited conceptual integration. There is no shared theory of change on how elements from both areas relate to the intended outcomes.
- **Partial integration:** In this case, conceptual linkages may exist but there may not be a theory of change with joint processes and outcomes.

Additionally, integration may be unidirectional, i.e., elements of MHPSS are included in a sectoral program.

- **Full and system-wide integration:** This involves integration from the outset and focus on long-term partnership building and system-level coherence. There is a shared conceptual framework and a theory of change for linking joint processes and outcomes. Further, integration is bi-directional, i.e., elements from both areas are interwoven in complementary ways. This approach includes both integrated programming and integrated learning processes.

Why is local leadership critical for MHPSS integration?

Local leadership and community engagement can facilitate integrated approaches because people experience psychological, social, health, protection, and economic consequences of emergencies as interconnected rather than sector-specific. Local actors are often also well positioned to support identification of culturally relevant entry points, build on existing community systems, and identify ways for integrated programs to reach the most marginalised groups. Integration can be strengthened when humanitarian responses build on existing national and local systems rather than creating parallel systems. Investing in existing systems before emergencies can strengthen preparedness, enable faster and coordinated responses during emergencies and support sustainability beyond project-specific mandates.

Crucially, lack of engagement with local perspectives, capacities and resources can unintentionally cause harm by marginalising local healing practices and creating parallel systems of support that are dependent on external financing. Without accounting for the local realities, integration efforts may presume the existence of funded infrastructures, salaried workforce, and referral pathways. In many communities, funded systems of care have either never existed or have been difficult to sustain, and local community networks and traditional healing systems remain the key means of support. Integration efforts must take account of them and build on them to be relevant, while simultaneously building referral pathways and strengthening infrastructure and systems for community and professional care.

CASE STUDY: INTEGRATION OF MENTAL HEALTH WITHIN NATIONAL SYSTEMS OF LEBANON IN PARTNERSHIP WITH MINISTRY OF HEALTH AND MINISTRY OF SOCIAL AFFAIRS

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 September 2024, roughly 1.2 million people were displaced within 48 hours, many into schools and public buildings. Embrace was able to provide psychological support inside shelters almost immediately because it activated infrastructure already linked to national systems, including the National Lifeline, the national mental health emergency response mechanism, a community mental health centre, and a mobile clinic.

The response drew on roughly 80 staff and more than 120 trained volunteers, including Lebanese clinicians who understood the language, stigma barriers, and wider service context. Through coordination with the Ministry of Public Health and the Ministry of Social Affairs, Embrace deployed teams to priority shelters, provided psychological support and triage, and linked people to wider health and humanitarian pathways where possible.

The case shows why emergency MHPSS readiness has to be funded before a crisis. Embrace moved quickly because national partnerships, referral links, and service infrastructure were already in place, but the response also placed pressure on the outpatient and community mental health services needed for longer-term recovery. For funders, this points to the need for flexible emergency funding, protection of standing services, and provision of wellbeing support for teams responding to a crisis they are also living through.

A full length version of this case study is available in the annexure "*Sustaining Investment in MHPSS Localisation and Integration: Case studies*" available on www.mhpsscollaborative.org.

What are the facilitators and barriers of MHPSS integration?

Integration is often framed as a programmatic or technical challenge, but it also reflects how the systems of support are organized around people's needs. Integration of MHPSS across sectors and services depends not only on program

	FACILITATORS	BARRIERS
FUNDING	Flexible, long-term and adequate funding; funding arrangements that promote local leadership and accountability to affected communities	Short-term and inadequate funding; fragmented funding streams; restrictive donor mandates; rigid terms of reference; upward accountability to donors instead of the affected communities
PARTNERSHIPS	Explicit focus on partnership building; reflexivity; power sharing; meaningful participation of local actors and affected communities	Limited investment in equitable partnerships; lack of understanding of processes that support equitable partnerships between end users, communities, practitioners and academics
KNOWLEDGE AND EVIDENCE	Recognition and integration of multiple forms of knowledge	Lack of shared terminology, conceptual models and outcome frameworks; predominance of clinical outcomes in the evidence base; limited evidence demonstrating the contribution of MHPSS to outcomes of other sectors
SYSTEMS CAPACITY	Building on existing community capacities and systems; strong coordination and referral pathways; peer learning and supervision, and sustained workforce development	Weak coordination mechanisms and referral pathways; workforce shortages, insufficient training and supervision
INSTITUTIONAL CONTEXT	Political commitment; organizational leadership; and institutional prioritization of integration	Fragmented leadership; competing institutional priorities; and limited political will

design, but also on engagement with funding arrangements, existing capacities and referral systems, institutional mandates, governance, and coordination mechanisms. Therefore, fragmentation of supports is not accidental, and many barriers that impede and facilitators that support the integration of MHPSS are structural, systemic and process related.

2

Sustaining investment in MHPSS integration.

What are the key tensions in MHPSS integration that donors could help address?

HOW CAN MHPSS INTEGRATION ENSURE QUALITY WHILE EXPANDING ACCESS AND REACH?

Tension:

In context of the current funding cuts, integration is increasingly being framed as a way to improve efficiency, expand coverage, and respond to funding constraints. However, integration cannot be treated as a low cost add-on, it requires sustained investment, cross-sector collaboration, ongoing learning, and systems strengthening to maintain quality.

Key issues:

- Integration is often introduced during the implementation stage rather than embedded from early stages of program design, preparedness, and recovery planning.
- The humanitarian system remains organised around sector-specific mandates, funding streams, accountability mechanisms.
- Sectors and organisations lack shared concepts, terminology and frameworks, creating barriers to communication, coordination, and planning.
- Short-term, project-based funding and fragmented limit opportunities to build relationship and institutional capacities for integration.
- Competition for funding and visibility across sectors and organisations disincentivise collaboration.

What this requires in practice:

- Recognising integration as a strategy for promoting person centred care, holistic, and equitable care, rather than primarily improving efficiency.
- Embedding integration across program design, implementation, monitoring, evaluation and preparedness planning from the outset.
- Supporting the development of shared concepts, terminology and frameworks that promote cross-sectoral communication and coordination.
- Investing resources to strengthen existing community capacities, systems, and referral pathways.
- Promoting accessible language that reflect local and community understandings of wellbeing to support collaboration with affected communities.
- Supporting participatory learning and decision-making processes that integrate diverse forms of knowledge and promote equitable partnerships between academics, practitioners, and affected communities.

Key message:

Integration is not a low-cost adaptation to funding cuts. It requires sustained investment in partnerships, coordination, frameworks, systems and institutional arrangements that strengthen integrated, person-centred care.

CASE STUDY: RESILAC-2-INTEGRATING MHPSS ACROSS FIVE SECTORS IN THE LAKE CHAD BASIN

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

Across Chad, Cameroon, and Nigeria, RESILAC2 embeds MHPSS within health, protection, food security and livelihoods, sexual and reproductive health, and social cohesion services. A person can be identified for psychosocial support at a cash distribution point, health post, protection activity, or community dialogue space, then referred through pathways linking the different services.

The programme is delivered through a consortium that includes 17 national and local organisations, with joint supervision from Ministries of Health helping to connect the work to public systems. At this stage of implementation, 327 local actors have been trained, more than 400 local governance bodies have been engaged, and MHPSS is being delivered through services communities already use.

RESILAC2's own multi-year development grant remained stable when external humanitarian funding to the region was cut in 2025, but several partner organisations in the wider ecosystem lost funding and scaled back. The case shows that integration depends not only on one well-designed grant, but also on the referral pathways, coordination structures, and partner services around it. For funders, this points to the need for multi-sector funding, protection of referral and coordination systems, and investment in the public-system partnerships that allow integrated MHPSS to hold.

A full length version of this case study is available in the annexure "*Sustaining Investment in MHPSS Localisation and Integration: Case studies*" available on www.mhpsscollaborative.org.

HOW CAN INTEGRATION BE IMPROVED WITHOUT COMPROMISING THE AVAILABILITY OF FOCUSED AND SPECIALISED CARE?

Tension:

Integrating MHPSS across sectors and broader systems of care can expand access to support. However, if integration is used as a substitute for focused and specialized mental health services, people experiencing severe mental health conditions or complex psychosocial needs can lose access to appropriate care.

Key issues:

- In context of the current humanitarian funding crisis, integration may be used to justify reducing investment in focused and specialized MHPSS services
- Integration efforts assume that functioning referral pathways, specialised services, and sufficiently trained workforce already exist, but many humanitarian contexts lack these components.
- Non-specialist workers and volunteers may be expected to respond to increasingly complex needs without sufficient training, supervision, and

referral pathways.

What this requires in practice:

- Tailoring integration strategies to the local context, existing service capacities, workforce, and population needs.
- Recognising integration as complementary to (and not replacing) focused and specialized mental health services.
- Simultaneously investing in specialised services, workforce development, and functional referral pathways alongside integration efforts.

Key message:

Integration should strengthen the continuum of care rather than replace specialised and focused mental health services.

HOW CAN WORKFORCE AND COMMUNITY CAPACITIES AND WELLBEING BE ENSURED WITHIN INTEGRATED APPROACHES?

Tension:

Integrated approaches depend heavily on frontline workers, community actors, and volunteers to deliver coordinated care. However, they are often expected to take on additional responsibilities without adequate training, supervision, and wellbeing support.

Key issues:

- Task sharing with frontline workers, community actors, and volunteers can increase workload, emotional burden, exposure to distress, stigma and safeguarding risks in the absence of appropriate support.
- Integration may rely on externally developed approaches and training packages that overlook existing community capacities, support systems, and local knowledge.
- High staff and volunteer attrition, short-term funding, and inadequate training and supervision make integrated approaches difficult to sustain.
- Workforce wellbeing is often treated as a matter of individual responsibility and resilience rather than organisational responsibility.

What this requires in practice:

- Investing in demand-driven, bi-directional capacity strengthening and sharing that builds on existing knowledge, skills, and priorities of local partners and affected communities.
- Strengthening or linking with existing community structures, support systems, and local practices of care rather than creating parallel mechanisms.
- Investing in long-term and ongoing supervision, mentoring, peer learning and opportunities for reflection.
- Ensuring that staff and volunteer wellbeing is explicitly budgeted and recognised as a shared organizational and donor duty of care.
- Recognising and adequately compensating local practitioners and community workers and avoiding reliance on unpaid labour.

Key message:

Sustained investment in community capacities, workforce development and wellbeing are essential to ensure integration is ethical, safe, effective, and

sustainable.

HOW SHOULD SUCCESS BE MEASURED IN INTEGRATED PROGRAMMES?

Tension:

Current monitoring, evaluation, and learning approaches are designed for sector-specific programmes and ill-suited to capture cross-sectoral, person-centred and systems-level outcomes that MHPSS integration seeks to achieve.

Key issues:

- Limited alignment of conceptual, monitoring, and evaluation frameworks across sectors makes it difficult to assess integrated programs.
- In a competitive and constrained funding landscape, sector-specific attribution requirements can discourage collaboration and create tensions within integrated programs.
- Local actors and affected communities are often excluded from defining success, identifying meaningful indicators and generating evidence.
- Research on MHPSS interventions has predominantly focused on clinical outcomes, making it difficult to demonstrate how MHPSS contributes to outcomes in sectors whose primary objectives are not mental health.
- Short-term and project-based funding favours easily measurable outputs over longer-term systems change, implementation processes, and collective outcomes.

What this requires in practice:

- Co-defining indicators of success within the affected communities to reduce the disconnect between MHPSS outcomes and outcomes of sectors that do not have mental health as their primary aim.
- Developing shared conceptual, monitoring, and evaluation frameworks that enable measurement of cross-sectoral outcomes.
- Investing in implementation research, process evaluation, and long-term learning to understand how integration contributes to change across sectors.
- Designing funding and reporting requirements to incentivise collaboration across sectors by supporting shared reporting of outcomes, collective learning and shared accountability.

Key message:

Measuring success in integrated MHPSS programs requires shared, locally defined and systems-oriented approaches that focus on collaboration, collective contribution and long-term change.

CASE STUDY: CHALLENGES EXPERIENCED IN ASSESSING AND REPORTING OUTCOMES OF INTEGRATED PROGRAMS

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

In Kiryandongo settlement and Kampala, REPSSI integrated MHPSS into government health services, teacher development, school activities, Village

Savings and Loan groups, and GBV and child protection services. Health workers, teachers, savings group facilitators, and social welfare staff were trained and supported to include psychosocial support within their existing responsibilities.

2

Sustaining investment in MHPSS integration.

Twenty-five savings groups engaged 650 participants, most of them women, and accumulated more than 456 million Ugandan shillings in collective savings, while also creating space for HIV prevention, GBV awareness, child protection, and peer psychosocial support. Domestic violence cases among participants fell by 95 percent. In Kampala, cognitive behavioural therapy groups reached 53 women from nine nationalities and recorded a 70 percent reduction in depression symptoms.

REPSSI's experience shows the reporting problem many integrated programmes face. Psychosocial outcomes were achieved through health, education, protection, livelihoods, and social welfare platforms, while donor reporting often required results to be separated by sector. The case points to the need for multi-sector outcome reporting, dedicated coordination budgets, and longer funding cycles that give public and community systems time to take up the work.

A full length version of this case study is available in the annexure "*Sustaining Investment in MHPSS Localisation and Integration: Case studies*" available on www.mhpsscollaborative.org.

3: Recommendations and questions for funders

The preceding chapters set out why funding for mental health and psychosocial support needs to be protected during the current contraction, and why localisation and integration should shape how that funding is used. This section turns to the practical question: what should funders do differently, and what should they ask themselves before they decide? It is designed as a working tool for funders and grantmaking teams, from programme officers to boards. It can be used in strategy discussions, funding-cycle design, and individual grant decisions. Each theme can stand alone, and each entry is short enough to use in a meeting.

Across these sources, much of the published literature on localisation and integration is written from the perspective of reform, while the assumptions behind current funding practice are less often stated because they are embedded in the default way the system works. The interviews and co-creation workshop helped bring some of those assumptions into view and tested the ambitions in the literature against practical concerns raised by people who support change but are cautious about how it is pursued. Where the evidence and consultations point in the same direction, we present recommendations that funders can act on, and where the field remains divided, we present questions for internal deliberation. Because not all funders are actively trying to shift power and practice, the same question will land differently depending on the funder, but avoiding the question is also a decision. Each funder will therefore need to work through these questions against its own mandate, risk appetite, and role in the system. Where they are uncertain, the practical response is to make the transition visible: what is being tested, what risks are being managed, what safeguards are in place, and what would make the approach stronger over time.

A note on language: The field uses terms such as local and global, decolonization, and lived experience, but these words can become too broad to guide funding decisions. In this section, we move past these binaries and focus on practical questions: who makes decisions, how resources and knowledge move, who is accountable, and how each of these can be brought closer to the people a response is meant to serve. These questions run across community, national, regional, and global levels, and a funder who follows them will get further than one who stops at the labels.

Featured approaches appear throughout the section, drawn from funders who have already made some of these shifts. They are included less as models to copy than as evidence that the changes described here are being made now, within real institutional constraints.

3

Recommendations and questions for funders

Navigating this section

LOCALISATION: RECOMMENDATIONS

- Move from short project cycles to multi-year, flexibly reported grants
- Pay core and overhead costs alongside project activities
- Fund staff and volunteer wellbeing as a protected line, and consider a duty of care standard
- Design exits as phased transitions paired with capacity support
- Resist forcing the pilot-to-scale pathway onto every organisation
- Establish pooled funds for localised programming
- Make capacitystrengthening and sharing demand-driven and invest in organisational systems
- Require and fund meaningful participation by the most marginalised children, young people, and people with lived experience
- Fund context-appropriate models and local knowledge generation

LOCALISATION: QUESTIONS FOR INTERNAL DELIBERATION

- How do we back local leadership while keeping affected people's agency and choice central?
- What is our responsibility for building grant-management capacity, and what role do intermediaries play?
- How do we avoid adopting imported approaches that may pathologise people's experiences, while keeping specialised care accessible

INTEGRATION: RECOMMENDATIONS

- Fund integration as co-development with the host sector
- Assess host-system readiness, and resource community-based organisations where systems are weak
- Fund embedded approaches that promote access and safety
- Fund the layers of support together
- Budget for the additional responsibilities that task-shifting places on workers
- Treat translation and plain language as integration infrastructure
- Fund longer-term workforce development alongside short courses
- Fund and elevate contextually derived interventions alongside global frameworks

INTEGRATION: QUESTIONS FOR INTERNAL DELIBERATION

- Which integration are we funding, and have we defined it?
- How do we pursue integration while protecting dedicated MHPSS funding?
- How do we evidence integrated work without narrow mental-health metrics?

CROSS-CUTTING TENSIONS

- Who holds decision-making authority, and what does shifting power require of us?
- Who defines wellbeing, and whose definition is the funding buying?
- Do our measurement tools adequately capture the value created for local communities and society?
- How do our own language and model of care entrench or shift the problem?

Localisation

For localisation, the key issue is where decision-making, resources, knowledge, and accountability sit in relation to the people a response serves, and what would move each of them closer. The term itself is widely used but unevenly understood, so the recommendations that follow work from this practical question rather than from the label itself.

RECOMMENDATIONS

Move from short project cycles to multi-year, flexibly reported grants

> Short, project-based grants are one of the clearest barriers to local sustainability. They keep local organisations dependent on the next cycle, make it harder to retain staff, and leave them exposed when funding shocks arrive. Funders able to commit multi-year, flexibly reported grants give organisations the stability to plan, adapt, and continue essential work through disruption. Where multi-year commitments are genuinely out of reach, the same intent can be signalled in other ways: predictable renewal, lighter reporting, and core costs covered within shorter grants.

Pay core and overhead costs alongside project activities

> Core costs are the things that keep an organisation running: staff, office space, finance and safeguarding systems, supervision, management, and, where programmes demand it, vehicles, fuel, power, and connectivity. Funding activities while refusing these costs leaves an organisation without the basic capacity to function, and the strain falls directly on staff. Paying core and overhead costs is not an add-on to localisation; it is one of the conditions that make it possible. Treating them as excessive overhead while asking local actors to carry more responsibility leaves localisation underfunded at the point where it needs to become operational.

Fund staff and volunteer wellbeing as a protected line, and consider a duty of care standard

> Frontline workers in conflict and emergency settings often carry the same displacement, grief, and exposure to violence as the people they support. Yet the systems meant to protect them are often cut first when budgets shrink. Funding staff and volunteer wellbeing helps prevent burnout and protects the quality of care. Funders could also include a duty of care standard in partnership agreements, covering psychological safety, supervision, and manageable caseloads for those handling the most demanding work.

FEATURED APPROACH

How do you design a support model that meets organizations exactly where they are?

Ember Mental Health | Flexible funding with co-developed capacity strengthening and sharing

Community-led mental health initiatives are often the first, and sometimes the

only, point of care in their communities, but funding systems are usually built for larger and more formal organisations. Small, user-led, or volunteer-driven groups can struggle to access support, and the support available often does not fit how they work. Many run on overstretched teams and limited infrastructure, while funders seldom cover core costs, flexible resources, or staff wellbeing. The result is organisations expected to sustain essential care without the foundations to do it safely.

Ember Mental Health pairs flexible funding with in-kind support shaped around each organisation's stated needs, rather than a fixed programme model. It uses a global call-out and a deliberately light application process so smaller teams are not screened out by the burden of applying. A diagnostic, the Ember Health Check, maps each organisation's strengths and needs before a cohort is selected.

Each core cohort supports around 15 community-led initiatives over three years, with the first year focused on relationship-building and tailored support across strategy, impact evaluation, funding, wellbeing, and networks. Ember then invests further in a smaller group for longer-term support, while continuing lighter mentorship and wellbeing support. Since 2019 the model has reached more than 100 organisations, and in the most recent evaluation every organisation surveyed reported that outputs from the partnership were still supporting their work a year later.

Key take-away:

Redesigning support to meet organisations where they are, rather than asking them to meet existing requirements first, can reach groups that conventional funding misses. Funding, organisational strengthening, and team wellbeing should be treated as connected parts of delivery.

Ask yourself:

What would it take for your organisation to fund community-led mental health work through flexible, responsive support, including core costs and staff wellbeing?

Design exits as phased transitions paired with capacity support

When international actors are stepping back, transitions need to be carefully planned, so that abrupt withdrawal does not harm the people the programme was built to serve. Transitions work when they are phased and matched with capacity support, with the more everyday forms of support moving to local hands earlier and specialised care handed over more gradually.

Resist forcing the pilot-to-scale pathway onto every organisation

The expectation that every intervention should move from concept to pilot to scale does not fit all local organisations. Some are valuable precisely because they are rooted in one population, community, or area. Work that was never designed to scale can still be essential where it operates and funding should make room for it. Seed funding and small grants help here, giving a local actor room to build ownership and strengthen what works on its own terms, rather

than treating growth as the only sign that funding was worthwhile.

Establish pooled funds for localised programming

Pooled funds bring contributions from several donors into one funding pot, with a shared allocation process, common due diligence, and proportionate reporting. For localised programming, this could take the form of a dedicated local funding window within an existing country-based pooled fund, a pooled philanthropic fund managed by a trusted local, national, or regional intermediary, or a re-granting facility governed with local and national actors. The purpose is not simply to pool money, but to make smaller, direct grants to local actors easier to manage, while reducing the monitoring burden that often leads funders to route money through large intermediaries by default.

Make capacity strengthening and sharing demand-driven and invest in organisational systems

Capacity support works best when local actors shape it around what they need. This includes the organisational systems that determine whether an organisation can absorb and account for funds, such as finance, accounting, management, and reporting. Investing in these systems is what makes direct funding possible.

FEATURED APPROACH

Who does your due diligence let in, and who does it keep out?

Irene M. Staehelin Foundation (IMS) | Flexible grant-making with developmental due diligence

Direct funding to local actors often stalls because of how due diligence is used. When it is treated only as a gatekeeping exercise, it screens organisations out for lacking the systems, policies, or infrastructure that funders expect, instead of helping them build those things. Actors closest to the issues, including those with lived experience, can be disqualified by the process meant to assess them, while resources continue to flow to organisations that already meet the requirements.

IMS approaches due diligence as an opportunity for learning and genuine partnership rather than a pass/fail assessment only. The process is qualitative and holistic: rather than checking every box or verifying every detail, it aims to build an overall picture of a prospective partner, spanning governance and strategy through to safeguarding, grounded in an intention to work together over the long term. Where concerns surface, they become part of the programme design conversation, a shared question between the foundation and the organisation about what is needed and how the partnership can help address it. IMS and its partners work through the process jointly, identifying concerns together and agreeing on how to address them within the programme design, with partners then invited to present their organisation and proposal to the IMS Board, where anything arising from the process can be discussed.

Building stronger organisations is central to IMS's identity as a funder, and the foundation's endowment model is what creates the conditions for this kind of flexible, long-term partnership. Depending on grant size, IMS includes a dedicated organisational strengthening component in the grant budget,

typically ranging from USD 2,500 to 60,000 (CHF 2,000 to 50,000). This support is shaped by what the due diligence process surfaces and can cover practical systems that make direct funding safer and more sustainable, such as financial controls, accounting systems, indirect-cost policies, fundraising capacity, communications infrastructure, or connectivity.

3

Recommendations and questions for funders:

Localisation

Key take-away:

Approaching due diligence this way turns it into a two-for-one: stronger community-level impact and a stronger civil society actor that will outlast any single programme. Two years into this approach, the key learning is that when organisations trust that raising a problem will not cost them their funding, programme learning becomes more honest and more useful. It was through that process that IMS identified the need for a dedicated organisational strengthening component, which was added last year.

Ask yourself:

How much of what keeps you from funding local actors directly lives inside your own due diligence process?

Require and fund meaningful participation by the most marginalised children and young people

Mechanisms that meaningfully and safely include children, including adolescent girls, children with disabilities, and those outside formal schooling, are still rare, and local leadership processes can also privilege adult gatekeepers in ways that reinforce the exclusion of children who are already least heard. The same gap applies to people with lived experience of mental health conditions, whose involvement in shaping support is named far more often than it is funded. Funders should pay for structured advisory mechanisms for both groups and treat their input as part of programme governance, not as consultation after decisions have been made.

Fund context-appropriate models and local knowledge generation

The evidence points away from importing diagnostic models and assessment scales that were developed and validated in Europe or the United States without careful adaptation. Funding should back models that fit the context and support local knowledge, while holding one nuance in view: localised provision does not mean non-clinical provision. Local organisations also provide psychiatric and specialised care, and that care should be funded when it is needed, adapted to local context and language.

QUESTIONS FOR INTERNAL DELIBERATION

How do we back local leadership while keeping affected people's agency and choice central?

The idea that local provision is always preferable does not hold in every setting. One participant described contexts where some people ask specifically for a therapist from outside their own community or conflict environment. This is less about geography than about trust: people may be seeking someone outside the conflict and its factions, or someone they feel they can speak to freely. In some settings, that preference may also have been shaped by

colonial histories that taught people to value outside expertise over their own. The deeper issue is that the opposite assumption often goes unnamed. The field may ask whether local is better, but funding systems still often behave as though global is better: approaches developed in context rarely make it onto evidence-based lists unless they have access to trial funding that few local organisations can secure. A related assumption is that a local organisation speaks for the people it serves, which is not always the case. Backing local leadership therefore also means asking whether the organisations a funder supports meaningfully involve people with lived experience of mental health conditions in their leadership and design, or whether they represent them from a distance. The question for funders is how to support local leadership while keeping affected people's agency at the centre, including their right to choose specialist or outside support, and while examining which assumptions their own systems reinforce.

What is our responsibility for building grant-management capacity, and what role do intermediaries play?

A local actor may understand local mental health needs well but struggle to manage a grant. Treating that capacity gap as a reason to keep routing money through international intermediaries by default reproduces the problem localisation is meant to solve. At the same time, moving large sums too quickly to organisations that cannot yet absorb them carries real risk, and intermediary organisations may fear being designed out of the agenda altogether. Funders therefore need to decide where their own responsibility for building operational capacity begins, and what role intermediaries can usefully play. These intermediaries can bridge vertically between government and local civil society, and horizontally among local actors who do not otherwise work together. The more useful question is not whether intermediaries should exist, but which of those functions a funder is paying them to perform.

How do we avoid adopting imported approaches that may pathologise people's experiences, while keeping specialised care accessible

The move away from imported diagnostic models is important, but it can create another mistake: assuming that anything clinical or specialised belongs to international actors. Both assumptions distort the funding decisions that follow from them. The issue is not that local actors reject outside knowledge; communities have the right to draw on knowledge from anywhere. The problem begins when outside knowledge arrives tied to funding, authority, and fixed requirements that leave little room for local judgement. The line to hold is between funding context-appropriate, non-pathologising models and continuing to resource the specialised and clinical care that local organisations provide and that some people actively want.

3

Recommendations and questions for funders:

Integration

Integration

Integration is how MHPSS reaches the scale and settings that stand-alone programming cannot reach on its own, yet it is often held to a higher burden of proof than the default separate model. Staying separate does not offer a stronger alternative; it means accepting the field's current reach, and likely less as budgets shrink.

RECOMMENDATIONS

Fund integration as co-development with the host sector

> Integration often runs in one direction: MHPSS activities are inserted into a host sector that otherwise stays the same. A stronger approach translates MHPSS into the language and logic of the sector it joins and develops the work with that sector from the outset. The benefit moves in both directions, because a livelihoods programme can produce wellbeing outcomes that counselling alone cannot, and integrated psychosocial expertise can protect the host sector from its own unintended harms, for example, when loan schemes raise household stress in the families they were designed to help. Funding that treats MHPSS as a component bolted onto an existing programme produces a weaker form of integration.

Assess host-system readiness, and resource community-based organisations where systems are weak

> Integration is difficult where the host system is weak or fractured, and many crisis-affected health and education systems are in exactly that position. Funders can assess host-system readiness before committing to integration into it, and where formal systems cannot carry the work, community-based organisations may be better placed to fill the gap. This is where the integration and localisation agendas converge, and where the conditions for safe, quality work (supervision, referral structures, medication continuity, and fair cost coverage) need funding alongside the delivery itself.

FEATURED APPROACH

Who funds the conditions that make quality possible?

Netherlands Refugee Foundation (Stichting Vluchteling) | Funding the enabling conditions for partner-led integrated care

People's lives are connected, but humanitarian funding and services often are not. A person managing diabetes or hypertension may also be dealing with grief, trauma, interrupted medication, and stigma, yet acute-focused humanitarian health funding rarely covers the continuity that chronic physical and mental health conditions require. Local partners often understand these access barriers and what continuity requires in practice, but they are still asked to deliver complex programming through funding that is too short, too rigid, or too focused on compliance to cover the conditions that quality and do no harm require.

Stichting Vluchteling (SV) funds and accompanies partner-led integration of MHPSS and priority NCD prevention and care through community-based primary health care. Partners lead contextual design and delivery, while SV works alongside them as funder, technical partner, and learning and advocacy partner. The model aims to share risk and duty of care rather than only transferring implementation responsibility.

3

Recommendations and questions for funders:

Integration

More than half of SV's 2025 to 2026 project budget is channelled through local partners. As standard practice, 5 percent of each project budget is reserved for capacity priorities identified by the partner through an organisational assessment, rising to around 10 percent in localisation-focused programmes. In practice, this means that delivery funding is paired with support for the conditions that make integrated care safer and more sustainable, including technical accompaniment, supervision, referral pathways, operational learning, and partner-defined organisational strengthening.

Key take-away:

Shifting implementation to local partners changes little if funding does not also cover the conditions needed for safe and quality work.

Ask yourself:

If fairness and shared responsibility are meant to guide your MHPSS funding, what would have to change so that risk and duty of care are shared with partners alongside the work?

Fund embedded approaches that reduce stigma

Embedding support inside schools, savings groups, and cultural or religious spaces can allow people to access help without having to identify as mental health service users, which are less stigmatized and increase community acceptance. Accessing stand-alone psychiatric and psychological services can be highly stigmatized. Instead, funding programs embedded in community settings is one of the clearer opportunities in the integration evidence. In politically restricted settings, however, embedded approaches also need careful risk analysis. Funders should support local partners to identify language, entry points, referral options, and safeguarding measures that allow needs to be addressed without exposing communities or providers to avoidable political, social, or security risks.

Fund the layers of support together

Integration should add to the system of care, not replace other parts of it. Community-led MHPSS, specialist care for high-risk cases, and light-touch support embedded in systems such as health, education, and justice all do different work. If integration is treated as a substitute rather than an additional layer, some people will lose the level of support they need. Funding should keep these layers connected and prevent embedded approaches from crowding out specialised and community-led support.

Budget for the additional responsibilities that task-shifting places on workers

Integration and task-shifting add responsibilities for frontline and community workers, and those responsibilities need to be costed. Workers who take on new roles without supervision, training, or relief cannot sustain the work, and

programme quality will suffer.

Treat translation and plain language as integration infrastructure

Clinical, academic, and English-first language is a concrete barrier to integrating across sectors. Integrating into water, sanitation, shelter, and other sectors, depends on language those sectors can use, while work in non-English-speaking communities, depends on translation and clear wording. Funding for translation and for stripping out jargon is integration infrastructure and should be budgeted from the start.

Fund longer-term workforce development alongside short courses

Investment in secondary and higher education as well as in clinical training is largely absent from humanitarian MHPSS funding. Short-term training cannot substitute for the long-term workforce pipeline of teachers, social workers, psychologists, psychiatrists, and nurses that sustained integration requires. Funders should support short-term training where useful, but also invest in the longer pathways that make integration last.

Fund and elevate contextually derived interventions alongside global frameworks

Contextually derived interventions should be funded and made visible alongside global frameworks. The IASC Minimum Service Package has helped make integration more accessible, but frameworks of this kind are designed to be adapted. Funders can pay for the work of challenging, translating, and adapting them to each setting.

QUESTIONS FOR INTERNAL DELIBERATION

Which integration are we funding, and have we defined it?

The field uses integration to mean at least two different things which it frequently conflates: integration into national systems, such as primary health care, and integration into humanitarian programmes, such as education, protection, livelihoods, or cash. These are different undertakings with different timelines, partners, risks, and funding implications. A useful starting point is to ask where MHPSS capability should sit in relation to the systems people already use, such as clinics, schools, markets, courts, and community spaces, and what it would take to hold it there.

How do we pursue integration while protecting dedicated MHPSS funding?

If MHPSS is described as mainstreamed across sectors, donors may stop funding it as a dedicated line, and the support then becomes thinner under cover of being everywhere. A funder committed to integration needs to protect

earmarked MHPSS resources at the same time, so that integration expands reach while dedicated funding sustains quality and specialist capacity.

How do we evidence integrated work without narrow mental-health metrics?

Evaluations of integrated programmes tend to measure MHPSS-specific outcomes, which can make the wider value of integration hard to show. The social component of the work is also less consistently measured than the clinical component. The visibility problem compounds it: when a livelihoods intervention improves a family's wellbeing, the result may be recorded as a livelihoods outcome, and the contribution of psychosocial work disappears. Practitioners and researchers question exclusive reliance on randomised controlled trials, call for research into the active ingredients that produce change, and recognize that the field often knows that certain interventions work without fully understanding why. There is growing interest in co-creating indicators of success with communities so that integrated outcomes and host-sector outcomes are not pulled apart. Funders need to decide how far they will adapt their measurement requirements, whether they will fund co-created indicators, and whether they will pay for research that explains why effective approaches work.

FEATURED APPROACH

What happens to the capacity six months after the training ends?

Humanity Crew | Preparedness Hub model for localised MHPSS integration

In protracted and disaster-prone settings, MHPSS often reaches communities through short-term, externally led delivery that does not connect strongly enough to local systems. When the external actor scales back, the support often goes with it. Local organisations are usually first to respond to distress during conflict, displacement, or flooding, but they rarely receive structured MHPSS tools or sustained technical accompaniment. The capacity sits where the need is most visible and continuous, while the investment to build and maintain it does not follow.

Humanity Crew built a 12-month model that combines structured MHPSS training, including staff care and stress management for responders, with supervised field practice, remote mentoring, and MEAL support in a continuous cycle, so capacity is built and sustained over time instead of delivered in a single event. The work runs through local partners already embedded in their communities, with MHPSS integrated into the programming those partners already deliver.

The pilot worked through three local partners across hubs in Nigeria and Uganda. Twenty-four hub members were trained and reached roughly 1,321 community members in the first year. Partners then embedded the skills into their existing work, including school and community disaster-risk-reduction activities in flood-affected Uganda and livelihoods and agribusiness programming with farmers in Northeast Nigeria. Initial unrestricted private funding gave partners room to adapt the model as they learned, rather than treating capacity strengthening and sharing as a one-off training output.

Key take-away:

Event-based, output-driven grants struggle to capture this kind of result because the gains emerge through practice over time. One flexible investment in local capacity can also serve several sectors at once, since the same workforce applies psychosocial skills across livelihoods, education, and protection work.

Ask yourself:

Do your funding models measure only what was delivered, or also the capacity, trust, and preparedness that let communities keep responding after the funding ends?

Cross-cutting tensions

The questions below cut across both localisation and integration, and they are included because funding decisions still have to be made where the evidence does not offer a settled answer. In those moments, funders are not only interpreting evidence; they are making choices about what they are willing to fund, who is trusted to decide, and what trade-offs they are prepared to carry.

Who holds decision-making authority, and what does shifting power require of us?

Power is poorly captured by the local and global labels, which flatten a set of questions that actually matter for funding: who makes the decisions, whose knowledge counts, and who answers for the results? These questions apply between people who own a problem and those who arrive to help, whether that help comes from the same community, a national institution, or an international one. These gaps run inside countries as much as between the Global North and South, which is why handing a grant to a national organisation can still leave the gaps in place. A funder serious about shifting power has to examine its own contracts, templates, reporting rules, timelines, and risk assumptions. It also has to ask who decides how needs are named when certain issues are politically restricted or treated as off-limits, such as gender-based violence, sexual and reproductive health and rights, girls' education, or support for specific groups. In those settings, language, partnerships, and service entry points shape whether people's needs can be addressed without increasing risk for communities, local actors, or implementing partners. The harder question is not only how money moves, but how accountability holds when decision-making moves with it.

Who defines wellbeing, and whose definition is the funding buying?

Before a funder decides what to pay for, someone has already decided what wellbeing means. Whether that someone is the community, the funder, or the implementer shapes everything the money buys. Communities may define wellbeing in their own terms, and those terms often rest on collective and relational ideas of a good life rather than through individual symptoms or outcomes. Funders need to ask whose definition their funding is built around, and whether they are willing to fund toward a community's account of wellbeing when it differs from their own.

Does our measurement apparatus capture local and social

value?

The monitoring and evaluation mismatch under localisation and the attribution problem under integration are two versions of the same issue: standard measurement often fails to capture local or social value, and that gap shapes what gets funded. The unresolved question is how much a funder is willing to change what and how it measures, given that their current systems already shape funding decisions.

How do our own language and model of care entrench or shift the problem?

Clinical, jargon-heavy, English-first language is a barrier to building trust with local partners and to integrating across sectors. The language a funder requires and the model of care it rewards, either reinforce the current problem or help shift it. Funders need to examine their own language and assumptions about good care as part of the funding decision.

Conclusion

This paper was written in the middle of a funding contraction, but the decisions made now will outlast the crisis that forced them. Other publications have made the case for protecting MHPSS funding, but this one has tried to answer the question that follows: what should funders do now, and how?

04

Conclusion

There is enough common ground to act on today: fund in multi-year terms with core and overhead costs included; protect staff and volunteer wellbeing as a budget line; design exits as phased transitions paired with capacity support; keep the layers of support together so embedded approaches add to specialist and community-led care; fund models built from local knowledge and practice, including the clinical and specialised care local organisations already provide and fund integration as co-development with the host sector rather than as an add-on. The funders featured in this paper are doing these things at ordinary grant sizes and within ordinary governance structures.

The open questions are also clear: who defines wellbeing, how power and accountability move together, what integration means in each context, and how measurement can capture local and social value. They are presented as questions because the field has not fully answered them. They should be worked through in the way they were surfaced for this paper: with implementers and affected communities in the room, and with honesty about what this moment asks of everyone who holds a budget.

ANNEX

Annex: List of abbreviations

01

List of abbreviations

ABBREVIATION	FULL TERM
CHF	Swiss franc
DANIDA	Danish International Development Agency
GMHAN	Global Mental Health Action Network
IASC	Inter-Agency Standing Committee
IMS	Irene M. Staehelin Foundation
LGBTQI+	lesbian, gay, bisexual, transgender, queer, intersex, and other identities
MEAL	monitoring, evaluation, accountability and learning
mhGAP	Mental Health Gap Action Programme
MHIN	Mental Health Innovation Network
MHPSS	mental health and psychosocial support
NCD	non-communicable disease
PEPFAR	President's Emergency Plan for AIDS Relief (United States)
SV	Stichting Vluchteling (Netherlands Refugee Foundation)
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Develpoment
USD	United States Dollars