

Doing more with less?

Sustaining mental health and psychosocial support for refugees in low-resource settings amidst declining resources

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Spirit Symposium, University of Zurich, 30 Jan 2026



Mental health and psychosocial support in humanitarian settings

Major growth of MHPSS since 2007

- Consensus among UN agencies, INGOs, donors
- Proliferation of tools
- Standardisation
- Professionalisation
- Task-sharing/ systems of care

From exception to the norm: how mental health interventions have become part and parcel of the humanitarian response

Humanitarian psychiatry is the provision of services for mental health and psychosocial support in a humanitarian context – that is, to populations exposed to collective violence, forced displacement or natural disasters. Unfortunately, humanitarian needs have grown: nearly 80 million are forcibly displaced in the world today, that is one in a hundred people, with diminishing numbers returning home. These figures do not include those with humanitarian needs who are not displaced, but who are also in danger, as for example in Yemen at this time.

When the first author of this paper began her career in humanitarian psychiatry 30 years ago, during the Balkan wars, psychiatry in humanitarian settings focused largely on one diagnosis (post-traumatic stress disorder, PTSD) and individualized medical interventions to prevent and/or address it. She encountered the same approaches in Iraq in 2003, and after the 2004 South-East Asian tsunami¹.

The publication in 2007 of the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings heralded a new understanding and a new approach. Namely, that tightly defined psychiatric problems are only part of a spectrum of mental health and psychosocial needs. These may be prevented or mitigated if people's basic needs for food, shelter and security, and their social needs for connection and justice, are addressed in a dignified and equitable manner that respects human rights (see Silove² in this issue of the journal).

This requires multi-sectoral action, with different levels of in-

tensity and specialization. Clinical services constitute a modest part of the pyramid of multi-layered mental health and psychosocial services and supports, the others being: a) focused non-specialized psychosocial support, b) strengthening the capacity of individuals, families and communities to support themselves, and c) embedding social and psychological considerations into the way basic needs and security are delivered.

That is not to say that clinical needs are insignificant. The latest World Health Organization (WHO) figures show that more than one in five people in post-conflict settings have depression, anxiety disorder, PTSD, bipolar disorder or schizophrenia³. Fortunately, certain barriers to addressing psychiatric disorders in emergency settings have been removed. Prior to 2009, mental health problems were not included in the health information system of the United Nations High Commissioner for Refugees (UNHCR), which meant they were invisible. Since then, the inclusion of seven, and currently nine, mental and neurological categories has highlighted the significance of these conditions⁴. Another problem was that only three psychiatric medications were included in WHO essential drug kits for emergencies. The increase to five in 2011, continued in 2017, has meant that pharmacological treatments are now available in emergencies⁵.

The first most significant development of the last decade is the recognition that the provision of essential mental health services is not the exclusive realm of mental health specialists. It can be done by non-specialized health workers, particularly in primary care, if they are well trained and supervised. The development

(Jones & Ventevogel World Psychiatry 2022)

Mental health and psychosocial support in humanitarian settings



2024
Strengthening Mental
Health and Psychosocial
Support in UNHCR
Annual Report

Public Health Section | Division of Resilience and Solutions, UNHCR, Geneva

In 2024

- 1.2 million MHPSS consultations
- 498 health staff trained in identification and management of priority mental, neurological and substance use disorders using the mhGAP approach;
- 922 people to deliver scalable psychological interventions;
- 8,265 community health volunteers and other volunteers in Psychological First Aid or Basic Psychosocial Skills.



Humanitarian work affected by funding cuts

- Less funds for humanitarian programming
 - Many agencies affected: WHO, UNICEF, UNFPA
 - UNHCR; less funds. Accelerated phasing out for health in some countries
 - NGOs that were directly funded by Govts especially US
 - Others e.g. MSF less affected but have to deal with enormous increase in demands so they also need to make sharp choices
- Restructuring of the humanitarian system
 - “Hyperprioritisation”

Mental health and psychosocial support disproportionately affected

- Not life saving
- E
- N
- M
- les
- govt donors

“Mental health only becomes a humanitarian need in situations where people’s distress, sadness, uncertainty and anger is not sufficiently resolved by community-led caring, or the healing that comes from their own agency in their wider socio-economic recovery.” (Slim, 2023)

London
 Cite this as: BMJ 2025;389:r1215
<http://doi.org/10.1136/bmj.r1215>
 Published: 12 June 2025

Global aid cuts are straining mental health services for refugees, says UN

Sally Howard freelance journalist

Cuts to funding for foreign aid have strained mental health services for refugees, the UN says. Other forcibly displaced people are also affected.

primary care facilities relating to mental, physical, and substance misuse conditions in 2024.

ing care

the UNHCR is supporting the Ministry of Health to train 1260 community health workers to address mental health conditions and non-communicable metabolic diseases, supported by a community awareness campaign targeting internally displaced people. In Chad, the arrival of more than 700 000 new refugees from conflict wrought neighbour Sudan has provided 29 550 consultations for mental health, physical, and substance misuse

work in low-income and middle-income countries, the consultations also served as a forum for reciprocal innovation, where shared global challenges were addressed collaboratively and the lessons learned were adapted to meet the needs of all countries, including high-income countries, such as the USA.

The position paper presents a bipartisan approach to addressing mental health needs by addressing macro-level issues often overlooked by governments, institutions, and organizations; promoting a comprehensive and principled approach to addressing global mental health needs. As the highlight of a broader ecosystem of mental health documents, including several toolkits for population-specific mental health issues, the position paper calls for stronger human rights, ethics, and do-no-harm principles; better partnerships with local communities; more robust contextualization of mental health interventions; and a stronger focus on creating an enabling environment that supports improved mental health. USAID’s approach included population health methods to address the social determinants of mental health, supporting the professionalization of service providers, and reducing stigma, as well as approaches across multiple levels (community, relational, and individual) that strengthens early intervention services, improve regulatory environments, and increase access to family and individual services.

To operationalize the Mental Health Position Paper, USAID also issued a Mental Health Framework² used to identify gaps and opportunities in any context. The Framework details the components of enabling multilevel environments that promote better mental health, examining components encompassing prevention across populations, community, relational, and individual levels; supporting elements, systems; strengthening policies; mental health literacy building; and treatment. Alongside the Framework, ten Mental Health Sector Briefs were designed to summarize the complex, multidirectional relationships between mental health and Sustainable Development Goal-related sectors. The aim was to promote mental health integration into these areas to improve outcomes and prompt additional research to identify what works. Unfortunately, only three mental health sector briefs—health, education, and gender—were published before the Agency’s closure³.

NCHS PAPER 15 | NOVEMBER 2023

HOW SHOULD WE DEFINE AND PRIORITISE HUMANITARIAN NEED?

AN ETHICS-BASED PERSPECTIVE FOR IMPACT INITIATIVES

AUTHOR
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NORWEGIAN CENTRE FOR HUMANITARIAN STUDIES

Example Gambella (Ethiopia)



2024

- 380,000 refugees
- MHPSS in health (ex: IMC, ARRA) and with standalone programmes (ex:CVT) in child protection and education (Bethany, Save the Children)
- 38 MHPSS staff (27 nationals/ 11 refugees)
- Active TWG: NGOs, UN agencies

2026

- 450,000 refugees (new emergency)
- Almost all MHPSS services stopped
 - No psychologists left
 - No psychiatric staff
 - Community centres closed.
 - Volunteers not supported
- Some mental health in primary care but almost no medication
- Coordination group collapsed
- Deployee MHPSS Surge Support.
- Some support for new influx

What now???

Can MHPSS survive?

1. Strengthen the capacities of local communities and refugee led organisations

Problem

- MHPSS remains dominated by international actors, funding structures favour Global North organisations (expensive)

Solution

- Community-driven models. Participatory and locally owned approaches with local and refugee-led organisations

Challenge

- Capacity strengthening takes time and funds
- “Task dumping”

Example: Rohingya para counsellor Monowara in Bangladesh

- Monowara, a Rohingya refugee lives on Bhasan Char, an island designated by the government to host Rohingya refugees
- She speaks about her work as a community para-counsellor and briefly explains how she supports both adults and children.
- Monowara has been trained in scalable psychological interventions such as Integrative Adapt Therapy (IAT) and Early Adolescent Skills for Emotions (EASE).
- She speaks in the Rohingya language, with English subtitles.



we also learned how mental health changes affect the body physically

2. Integrating MHPSS into national service delivery systems

Problem

- Emergencies are often protracted, requiring long-term responses
- Parallel NGO-led MHPSS services address needs but ultimately unsustainable

Solution

- Shift from fragmented interventions to government-led approaches
- Development actors and multilateral banks can support system resilience. Example: World Bank Window for Host Communities and Refugees.

Challenge

- National MHPSS systems are often weak

Example: Kurdistan Region Iraq

- Integrating mental health into health facilities
- Link community volunteers to the health centres
- Supervision by psychiatrists/psychologists from national system
- Progressive handover Sulaymania – Erbil - Dohuk
- PM+ training of PS staff in clinics
- Transition plan accelerated due to funding cuts



3. Integration of MHPSS into all sectors

MINDFUL SHELTERING



Recognising and Enhancing the Impact of Humanitarian Shelter and Settlements on Mental Health and Psychosocial Well-Being

Proceedings of the Shelter and Mental Health Learning Event, May 2021

care | OXFORD BROOKES UNIVERSITY | CENDEP

INEE Background Paper on **Psychosocial Support and Social and Emotional Learning for Children and Youth in Emergency Settings**



INEE An international network for education in emergencies.
 Un réseau international pour l'éducation en situations d'urgence.
 Una red internacional para la educación en situaciones de emergencia.
 الشبكة العالمية لتعليم في حالات الطوارئ.

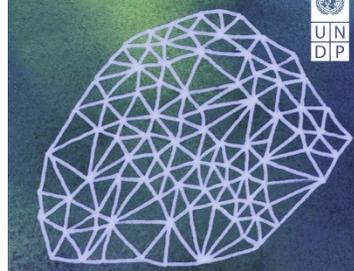
WORKING TOGETHER



How integration and cooperation between Shelter & Settlements, WFP & NFPSS will benefit well-being and health for people living through crises

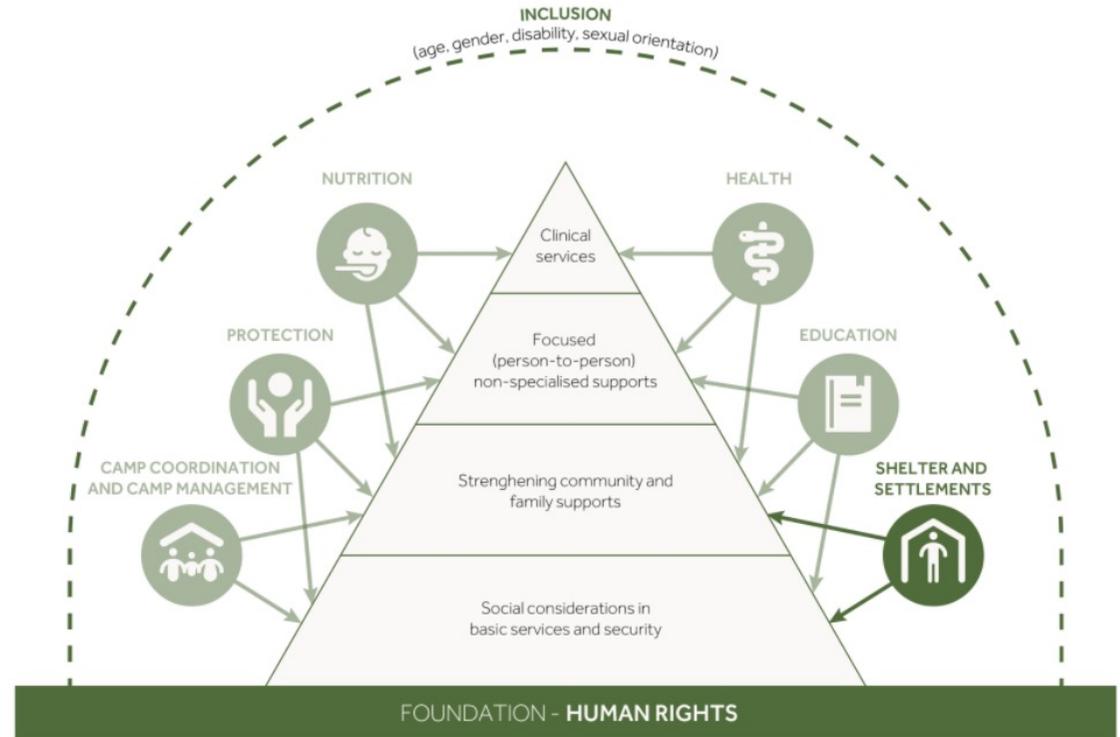
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UNDP

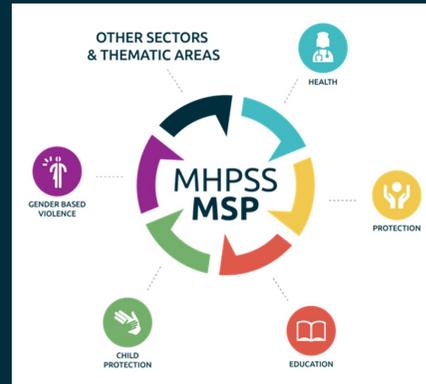
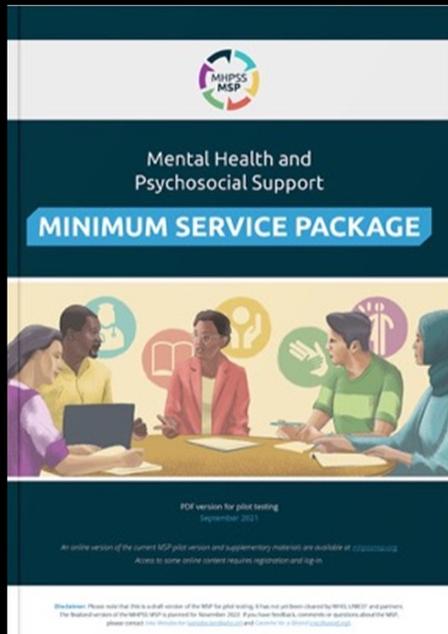


GUIDANCE NOTE

Integrating Mental Health and Psychosocial Support into Peacebuilding



Mental Health & Psychosocial Support MINIMUM SERVICE PACKAGE



mhpssmsp.org

MHPSS MSP		The MHPSS MSP Goal: Reduced suffering and improved mental health and psychosocial well-being among populations affected by humanitarian crises		
Section 1. Inter-Agency Coordination and Assessment for the MHPSS Response				
1.1 Coordinate MHPSS within and across sectors	1 2 3 4 5	» The humanitarian MHPSS response is well coordinated and responsive to the context, needs and gaps		
1.2 Assess MHPSS needs and resources to guide programming	1 2 3 4 5			
Section 2. Essential Components of all MHPSS Programs				
2.1 Design, plan and coordinate MHPSS Programmes	1 2 3 4 5	» MHPSS programs are well designed, monitored and evaluated and workers are supported		
2.2 Develop and Implement an MSE System	1 2 3 4 5			
2.3 Care for staff and volunteers providing MHPSS	1 2 3 4 5			
2.4 Support MHPSS competencies of staff and volunteers	1 2 3 4 5			
Section 3. MHPSS Program Activities				
ORIENT HUMANITARIAN ACTORS AND COMMUNITY MEMBERS ON MHPSS				
3.1 Orient humanitarian actors and community members on MHPSS considerations and actions	1 2 3 4 5	» Humanitarian actors and community members are oriented to MHPSS and equipped with basic psychosocial support skills		
3.2 Orient frontline workers and community leaders in basic psychosocial support skills	1 2 3 4 5			
STRENGTHEN SELF-HELP AND PROVIDE SUPPORT TO COMMUNITIES				
3.3 Disseminate key messages to promote mental health and psychosocial well-being	1 2 3 4 5	» Affected communities have access to information and activities to promote their mental health and psychosocial well-being		
3.4 Support community-led MHPSS activities	1 2 3 4 5			
3.5 Provide early-childhood development (ECD) activities	1 2 3 4 5			
3.6 Provide group activities for children's mental health and psychosocial well-being	1 2 3 4 5			
3.7 Support caregivers to promote the mental health and psychosocial well-being of children	1 2 3 4 5			
3.8 Support education personnel to promote the mental health and psychosocial well-being of children	1 2 3 4 5			
3.9 Provide MHPSS through safe spaces for women and girls	1 2 3 4 5			
PROVIDE FOCUSED SUPPORT FOR PEOPLE IMPAIRED BY DISTRESS OR MENTAL HEALTH CONDITIONS				
3.10 Provide mental health care as part of general health services	1 2 3 4 5		» Persons impaired by distress or mental health conditions have access to care, protection and support	
3.11 Provide MHPSS as part of divol care for survivors of sexual violence and intimate partner violence	1 2 3 4 5			
3.12 Initiate or strengthen the provision of psychological interventions	1 2 3 4 5			
3.13 Provide MHPSS through protection case management services	1 2 3 4 5			
3.14 Protect and care for people in psychiatric hospitals and other institutions	1 2 3 4 5			
Section 4. Activities and considerations for specific types of emergency settings				
4.1 Integrate MHPSS considerations and support in clinical case management for infectious diseases	1 2 3 4 5	» MHPSS considerations and activities are appropriately integrated in specific types of emergency situations		
4.2 Provide MHPSS to persons deprived of their liberty	1 2 3 4 5			





  
**Atelier de Mobilisation Sociale et de Formation sur
l'Ensemble Minimum des Services de Santé Mentale
et Soutien Psychosocial**
Bujumbura, Donatus Conference centre
25-28 novembre 2025



Multistakeholder pledge (Global Refugee Forum 2023)



- Leadership of Group of Friends for Health and MHPSS: Govts of Germany & Netherlands, EC and Amal Alliance (NGO) + WHO/ UNHCR
- Multistakeholder pledge envisages to
 - *“make substantive progress towards the systematically integration of mental health and psychosocial support (MHPSS) in humanitarian, development, and peace-building programmes to foster access to quality services and support for all refugees and host communities in at least 15 refugee-hosting countries, enabled by financial, material and technical support”*
- 116 MHPSS pledges submitted by 95 entities
- More pledges being received **(Yes, this is an invitation!!!)**



New partnerships

- Operational research; with components for capacity strengthening and service delivery (ex: Uni of Wisconsin: KenTanBur)
- Academic involvement of local universities eg in Ethiopia (Addis/Toronto). Perhaps twinning with universities in HIC?
- Sponsorship of professionals to get training (Mental Health in Complex Emergencies course 75 hrs online synchronous/asynchronous)
- Private sector initiatives: Example: Greentree Collaboration

Multi stakeholder collaborations: Greentree Acceleration Plan

- Initiated by UN Deputy Secretary-General and Wellcome Trust.
- Collaboration among government, UN agencies, INGOs, nNGOs, private donors, refugee led organisations
- Sudanese refugees in eastern Chad

Three pillars:

1. Strengthen national mental health system through policy development and workforce capacity building
2. Widely delivering PM+ for all with an added livelihoods component for vulnerable women
3. Provide support to children and youth through the intervention 'Team Up', using structured play and psychosocial support





**Dr Tayseer Ibrahim,
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In conclusion:

1. Strengthen the capacities of local communities and refugee led organisations
2. Integrating MHPSS into national service delivery systems
3. Integration of MHPSS into all sectors

We need:

- Innovative partnerships (including private sector, academia and displaced populations)
- Collective and joint implementation