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# Mental Health Matters:

Progress Report on Mental Health and Psychosocial Support Activities  
within the International Red Cross and Red Crescent Movement

October 2021



**+CIFRC**

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Psychosocial Centre

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## Executive Summary

This year's Movement-wide Mental Health and Psychosocial Support survey has been conducted to follow up on the [Mental Health and Psychosocial Support survey of 2019](#), which, for the first time, provided a dataset and baseline for mental health and psychosocial support (MHPSS) activities carried out by the components of the Movement. A total of 163 National Societies (NS), the International Federation of the Red Cross and Red Crescent Societies (IFRC) and the International Committee of the Red Cross (ICRC) participated in the survey. **This report presents the results of the 2021 survey compared to the results of the survey conducted in 2019.**

In 2021, **94% of respondents (155 NS, the IFRC and the ICRC) provide mental health (MH) and/or psychosocial support (PSS) activities.** As in 2019, psychological first aid (PFA) was one of the activities most frequently carried out, with 79% of respondents (130 NS and the IFRC) reporting its use compared to 74% in 2019 (121 NS and the IFRC), representing a 7% increase over the two years. **New in 2021 is the high number of activities centred around caring for staff and volunteers** (79%: 130 NS, the IFRC and the ICRC) followed by 68% (110 NS, the IFRC and the ICRC) of the respondents who reported carry out activities addressing the basic needs of volunteers.

The MH activities ranked amongst the highest by the respondents are:

psychological support, at 63% (102 NS, the IFRC and the ICRC) versus only 20% (33 NS, the ICRC) in 2019; the provision of training of community actors in basic psychological support (46%: 74 NS, the IFRC and the ICRC) which is roughly the same frequency as two years before (45%: 72 NS, the IFRC and the ICRC); and counselling (42%: 69 NS, the ICRC). Volunteers and staff are being given significant focus and have risen as the most significant groups for MH activities by 20% and 13% respectively.

Two percent more of the respondents (from 68% (109 NS, the IFRC and the ICRC) in 2019 to 70% (113 NS, the IFRC and the ICRC) refer persons in need of specialized care to other service providers. **During emergency situations 87% of respondents (141 NS, the IFRC and the ICRC) provide MHPSS activities.**

In 2019, 74% (120 NS, the IFRC and the ICRC) reported that they had at least one focal point for MH and/or PSS in their organisation. **In 2021 however, a rise in focal points is noted.** 81% (132 NS, the IFRC and the ICRC) of respondents stated having appointed one or more focal points.

Collectively, **around 40.000 staff and volunteers are reported to have been trained in basic psychosocial support** within the 163 NS and the IFRC in the last year. **The number of trained staff and volunteers in PFA has risen significantly from 42.000 in 2019 to around 88.000**

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**in 2021.** Further, **8% more respondents than in 2019** (141 NS, the IFRC and the ICRC) **state that they have a system in place to monitor the MH and/or PSS activities** of their organisation.

25% of respondents (42 NS) report having no budget dedicated for MHPSS activities, while 76% of NS and the IFRC report that a **lack of funds or limited funds is an obstacle for delivering MH and/or PSS activities.** Further, 42% of respondents **report challenges within the components of the Movement as an obstacle for providing PSS or/and MH,** followed by 41% of respondents **reporting lacking or limited technical expertise,** which prevents them from addressing needs.

Looking towards the future, **50%** (81 NS, the IFRC and the ICRC) **plan to expand their MHPSS activities,** 39% (64 NS) want to integrate or mainstream MHPSS within their current programming, 12% (20 NS and the ICRC) plan to maintain the same level of MHPSS activities, while only one NS reported expecting to reduce its activities in this domain.

Finally, this report does not include specific information about the delivery of MH and/or PSS activities in relation to the COVID-19 pandemic. We acknowledge that the pandemic possibly has had an impact on the services provided. However, to maintain validity, the survey questions informing the report remained essentially the same as in 2019, with the exception of the questions introduced by the Working Groups of the MHPSS Roadmap implementation (please see the annex).

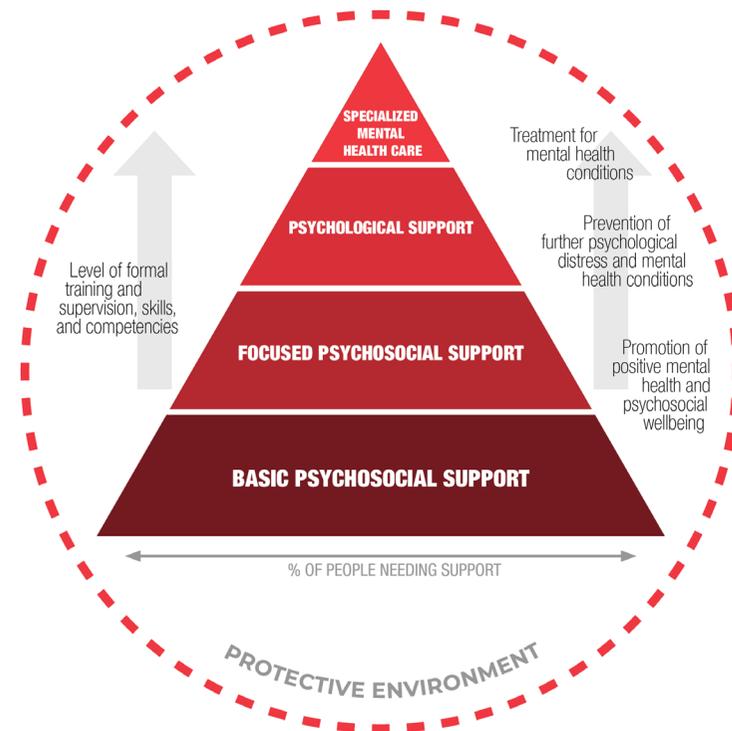
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## Introduction

Throughout the world, every day the International Red Cross and Red Crescent Movement (the Movement) witnesses the extensive unmet mental health and psychosocial support needs that populations endure. Needs that increase dramatically during armed conflicts, natural disasters and other emergencies. One of the most prominent examples is the COVID-19 health emergency, which sheds light on how crucial mental health and psychosocial support (MHPSS) is.

In the Movement, MHPSS continues to be high on the agenda. The different components of the Movement - the 192 National Societies (NS), the International Federation of Red Cross and Red Crescent Societies (IFRC) and the International Committee of the Red Cross (ICRC) - respond to mental health and psychosocial needs through a variety of activities. These activities cover the spectrum of MHPSS from basic psychosocial support, to focused psychosocial support, psychological support and specialized mental health care. Psychosocial wellbeing and mental health support exist on a continuum, and therefore different people need different levels of care, from prevention and promotion of positive mental health, to treatment of mental disorders.

The Mental Health and Psychosocial Support survey was conducted by the International Red Cross and Red Crescent Movement in 2021 to assess and monitor areas of improvement as well as areas that need further strengthening in regards to the activities addressing mental health and



**The Movement's mental health and psychosocial support framework. Read more: <https://pscentre.org/what-we-do/the-mhpss-framework/>**

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psychosocial needs. The survey also provides a method of tracking progress in implementing the Movement's policy of addressing mental health and psychosocial needs and [resolution 2](#) of the 33rd International Conference "Addressing mental health and psychosocial needs of people affected by armed conflicts, natural disasters and other emergencies".

This report therefore includes questions specifically related to the six Priority Action Areas, as defined in the [Roadmap for Implementation 2020-2023](#). This Roadmap specifies the Movement's collective commitments and ambitions in responding to the mental health and psychosocial needs of the populations we serve, by translating those into activities and outputs that both the Movement as a whole and NS, the IFRC and the ICRC individually should work towards. The Priority Action Areas have guided the creation of working groups (WG) which facilitate the roll-out of the specific commitments, as defined in the Roadmap. Each WG contributed to the survey by providing additional questions or amendments to past questions, to ensure an efficient follow-up of the progress on the Priority Action Areas. (Please see the annex for the WGs' focus and Priority Action Areas and a detailed list of the questions which were added or edited.)

The additional questions provided by the WGs are the only significant change compared to the [survey conducted in 2019](#). The survey in 2019 established a dataset and a baseline of MHPSS activities carried out by NS, the IFRC and the ICRC. This report presents results from the 2021 survey and compares them with those from the previous report to document developments over the past two years.

To summarize, this report contains an overview of the survey results in 2021 compared to the results from the 2019 survey. It presents what respondents – made up of 163 NS, the IFRC and the ICRC – have done in the last 12 months and what they continue to do in the field of MHPSS. The focus is on the development in the delivery of MHPSS activities by respondents as well as the challenges encountered when delivering MHPSS activities.

The survey represents a snapshot of current activities but does not provide information about the quality of services being provided or about potential variation in approaches used across the Movement.

### **Key terminology**

**Mental health activities:** *counselling, group therapy, psychiatric or psychological assessments and treatments, often delivered by persons with professional training in mental health or psychology, or highly skilled, trained and supervised volunteers.*

**Psychosocial support activities:** *e.g. psychological first aid, psycho-education, awareness-raising, community-based activities and other activities usually delivered by trained volunteers but often supervised by someone with a more advanced background in psychology/social work/health.*

**Source: Movement-wide MHPSS survey 2021**

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## Methods: How was the survey conducted?

The survey was shared in Arabic, English, French and Spanish and disseminated to all 192 NS, the IFRC and the ICRC in June 2021. Follow up on submissions took place between June and August 2021.

The survey requested each component of the Movement to provide information on their mental health (MH) and/or psychosocial support (PSS) activities related to both national and international work. Only one response was accepted per NS. In cases where more than one answer was submitted from the same NS, respondents were given the opportunity either to consolidate their response and resubmit a joint answer or to choose which of the submitted responses should be considered.

Regarding the IFRC, a response was received from each of the five IFRC Regions - Africa, Americas, Asia Pacific, Europe and Central Asia (CA), and the Middle East and North Africa (MENA) - together with a response from the IFRC Reference Centre for Psychosocial Support (PS Centre). These separate responses were merged into one response covering all the work undertaken by the IFRC. Similar to the IFRC, the ICRC also provided regional breakdowns for the regions - Americas, Africa, Eurasia, North Africa and Middle East (NAME) and Asia Pacific in addition to information on their MHPSS activities worldwide.

As in the [MHPSS baseline survey in 2019](#), the 2021 survey included respondent specific questions and contact information. Instead of 27 questions, this year's survey contained 33 questions. The additional questions stem from the Roadmap for Implementation 2020-2023 working groups' (WG) specific interest in their Priority Action Areas. Each WG contributed with amendments to the existing questions or added one to two questions. The survey was divided into two sections: existing MH and/or PSS activities, and MH and/or PSS activities moving forward.

Although the COVID-19 pandemic has significantly affected the context of MHPSS activities in the past year it was decided because of reasons of validity to not further modify the initial survey of 2019. As the goal of the Movement-wide MHPSS surveys is to deliver coherent information from the commencement of resolution 2 in 2019 until the end of the Roadmap for Implementation in 2023, the survey needs to remain comparable. The impact of COVID-19 on MH and/or PSS activities and services will be reported on in other appeal reports and publications.

A total of 163 NS out of 192, the IFRC, and the ICRC responded to this survey. This accounts for a total response rate of 84%, compared to a similar response rate of 85% (162 out of 191 NS, the IFRC and the ICRC) in 2019. Looking at the regional response rates, the 2021 levels

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are 90% in Africa, 89% in Americas, 71% in Asia Pacific, 87% in Europe and CA, and 83% in MENA compared to 82% in Africa, 86% in Americas, 90% in Asia Pacific, 89% in Europe and Central Asia and 68% in MENA in 2019.

**Number of respondents per region**

Year	Africa	Americas	Asia Pacific	Europe & CA	MENA/ NAME	Total
2019	82%	86%	90%	89%	68%	85%
2021	90%	86%	71%	87%	83%	84%

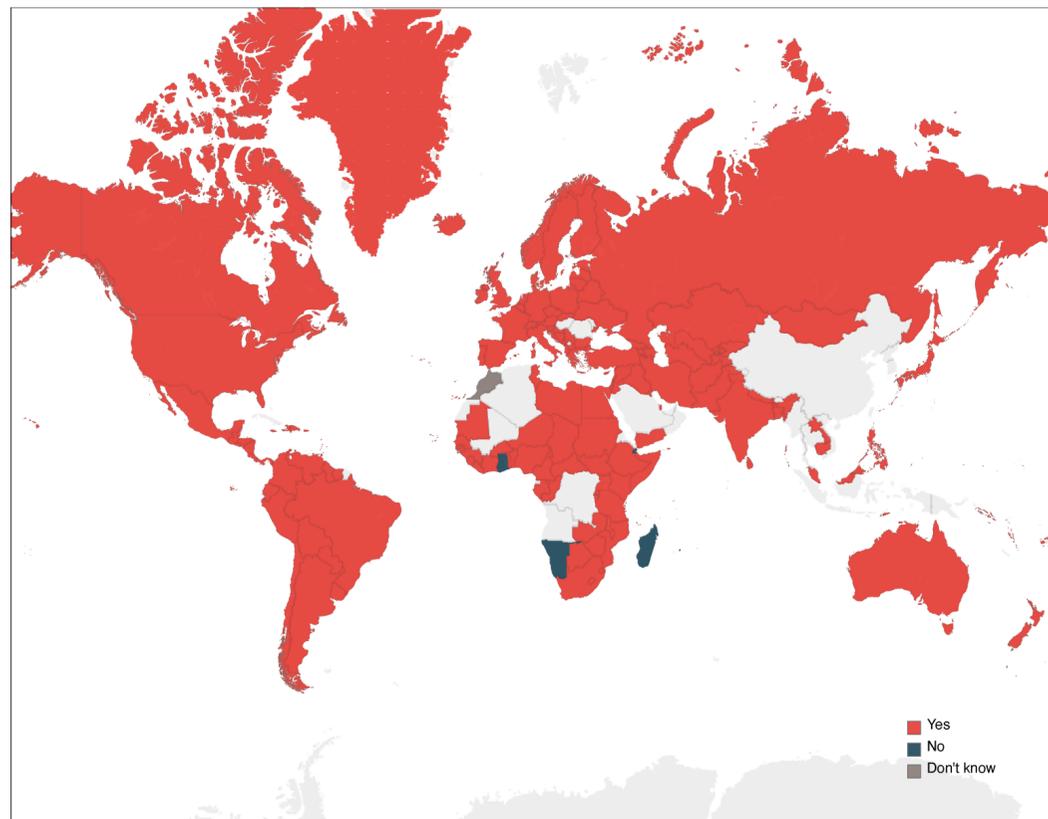
**Table 1: Percentages of respondents per region**

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## Results

### Mental health (MH) and/or psychosocial support (PSS) activities

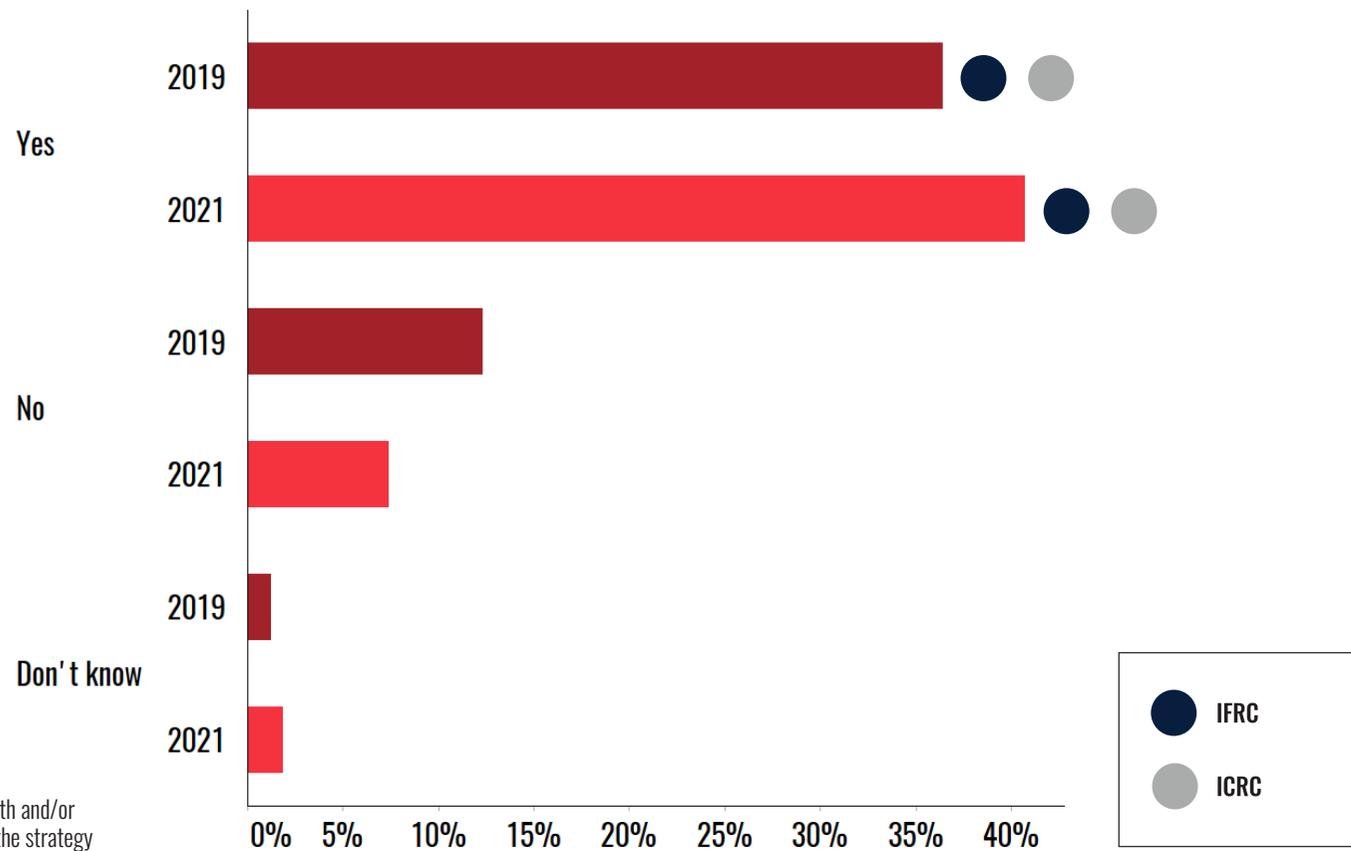
The different components of the Movement identify mental health and psychosocial needs in every community and society around the world and do important work to address and meet these needs.



**Figure 1:** NS providing mental health and/or psychosocial support services

The delivery of MH and/or PSS activities has remained high since 2019. In 2021, 94% (153 NS, the IFRC and the ICRC) indicate that their organisation has provided MH and/or PSS activities, as shown on the map (figure 1), compared to 96% (156 NS, the IFRC and the ICRC) in 2019.

A rise in the number of NS having a MH and/or PSS focus in their organisation strategy is observable, from 73% (118 NS, the IFRC and the ICRC) in 2019 to 81% (132 NS, the IFRC and the ICRC) in 2021 (figure 2).



**Figure 2:** Provision of mental health and/or psychosocial support is a focus in the strategy

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## Provision of psychosocial support (PSS) activities

When looking solely at PSS activities, close to every respondent (98%) that participated in the survey (159 NS, the IFRC and the ICRC) reported having carried out at least one activity defined as psychosocial support in the last year. This is the same number (159 NS, the IFRC and the ICRC) as in 2019.<sup>1</sup>

The different PSS activities are shown in figure 3. Figure 3 includes a comparison of the activities carried out by the NS, the IFRC and the ICRC in 2019 and 2021. The top four activities in 2019 were the following:

- **psychological first aid (PFA) (74%: 121 NS and the IFRC)**
- **activities related to restoring family links (73%: 117 NS, the IFRC and the ICRC)**
- **caring for staff and volunteers (73%: 119 NS)**
- **held community events (64%: 104 NS and the IFRC)**

In 2021, the three most utilized activity approaches were:

- psychological first aid (PFA) (79%: 130 NS and the IFRC)
- activities around caring for staff and volunteers (79%: 130 NS and the IFRC)
- addressing the basic needs of volunteers (68%: 110 NS, the IFRC and the ICRC)
- awareness campaigns (65%: 106 NS, the IFRC and the ICRC)

Figure 4 shows a comparison of the target groups for these activities for 2019 and 2021. Most respondents have focused on supporting volunteers (85%: 138 NS, the IFRC, the ICRC) and staff (66%: 107 NS, the IFRC and the ICRC), older persons (65%: 106 NS, the IFRC and the ICRC), adolescents (63%: 102 NS, the IFRC and the ICRC), children (56%: 91 NS, the IFRC and the ICRC) and migrants (53%: 85 NS, the IFRC and the ICRC).

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<sup>1</sup> There is a discrepancy in the reporting from NS, as 159 NS reported to have provided psychosocial support activities in the past year while only 156 NS (in 2019) and 153 (in 2021) answered generally yes to the question whether they provide MH and/or PSS activities. A possible reason for this might be that these NS have provided PSS activities in the past year as part of a certain programme or project which by the time of participating in the survey ended and the NS do not provide these activities anymore.

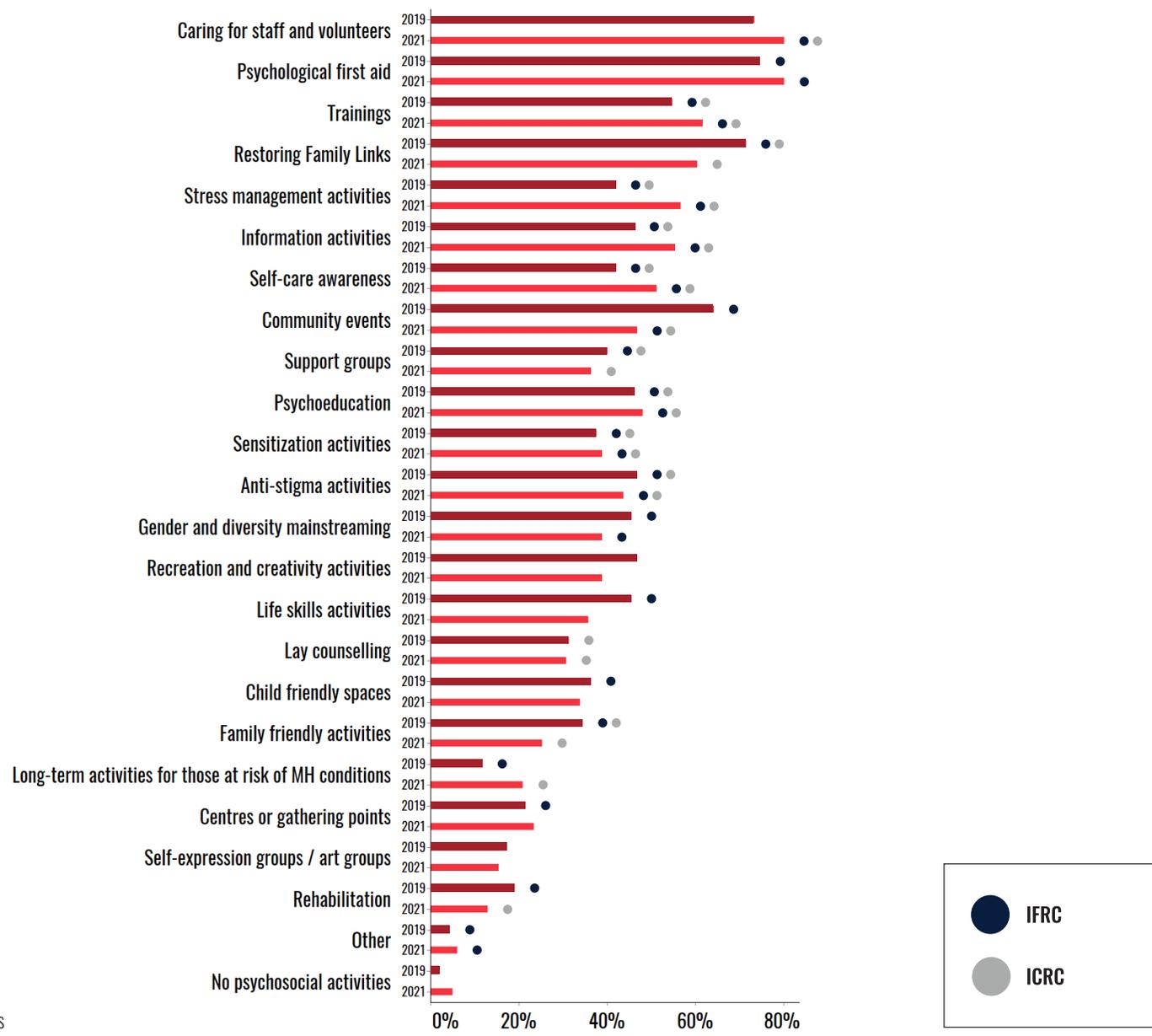


Figure 3: Provision of psychosocial support activities

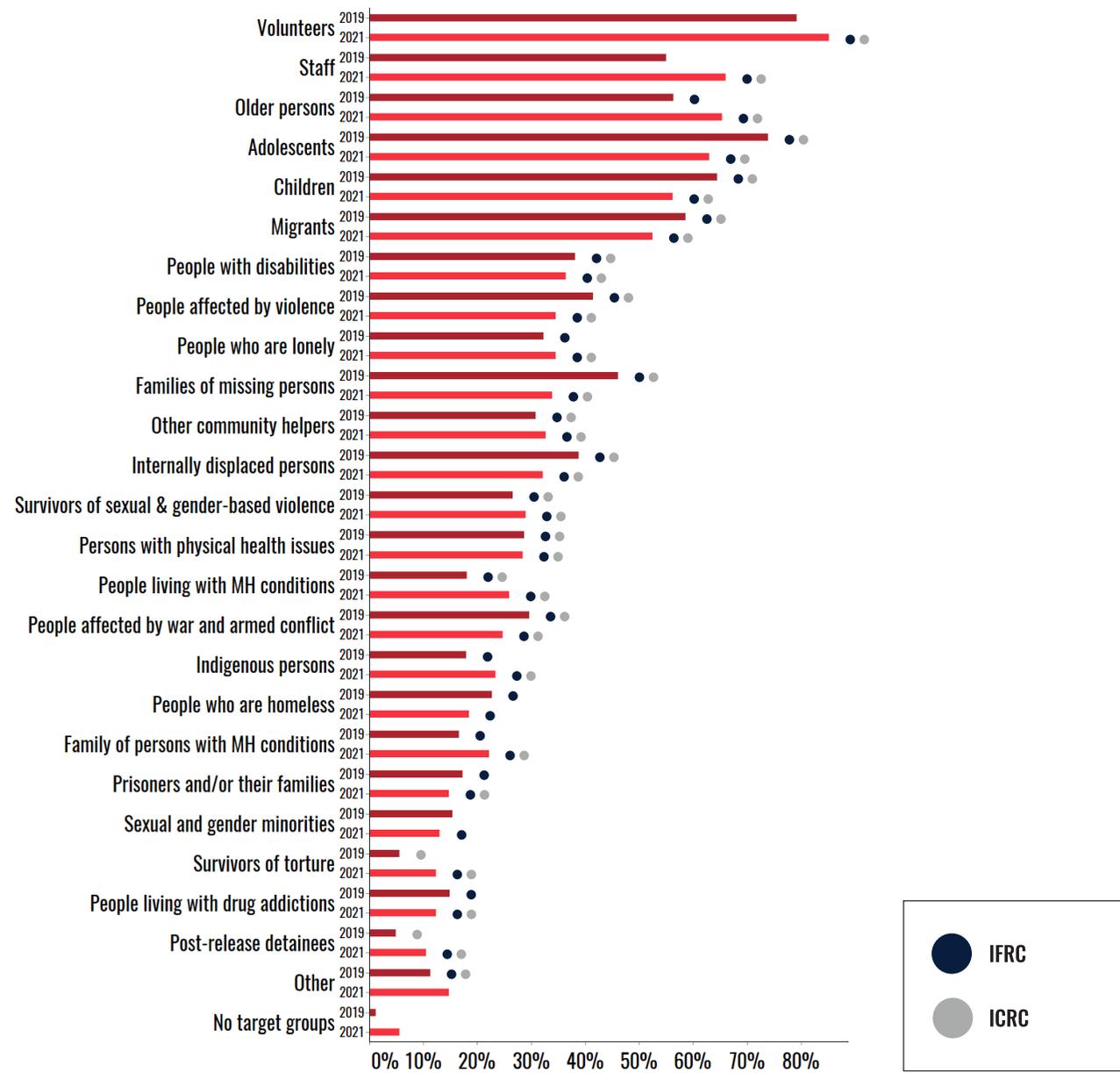


Figure 4: Groups targeted for psychosocial support activities

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## Provision of mental health (MH) activities

Turning to MH activities carried out in the past year, 84% of respondents (137 NS, the IFRC, and the ICRC) in comparison to 78% of respondents (126 NS, the IFRC and the ICRC) in 2019, report that they have provided at least one activity defined as a MH activity.

The different MH activities are shown in figure 5. The first, most frequent activity is psychological support (63%: 102 NS, IFRC and ICRC in 2021, compared to only 20%: 33 NS and ICRC in 2019). The second most frequent type of mental health activity in 2021 is the provision of training of community actors in basic psychological support (46%: 74 NS, the IFRC and the ICRC), which is almost the same frequency as two years before (45%: 72 NS, the IFRC and the ICRC). This is followed by 42% of respondents providing counselling (69 NS, the ICRC) and the training of health staff in basic psychological support (67 NS, the IFRC and the ICRC). In contrast, in 2019 counselling (38%: 61 NS, the IFRC and the ICRC) and psychological support home visits (35%: 55 NS, the IFRC and the ICRC) were the most frequent MH activities offered.

Volunteers (62%: 102 NS, the IFRC and the ICRC) by 19% and staff by 13% (50%: 83 NS, the IFRC and the ICRC) rose significantly as a target group of the Movement in 2021, in regards to provision of MH services. In 2019, however, respondents targeted mostly adolescents (51%: 82 NS, the IFRC and the ICRC), older persons (42%: 68 NS and the IFRC) and children

(39%: 62 NS, the IFRC and the ICRC). Please see figure 6 for more detailed information about targeted groups of MH activities.

In 2021, 70% of respondents (113 NS, the IFRC and the ICRC) stated that they make referral(s) to more specialized mental health services such as psychiatrists and psychologists, compared to 68% (109 NS, the IFRC and the ICRC) in 2019. This number includes 12 NS which had not carried out any mental health activities in the past year and therefore relied on referrals to other specialized MH care.

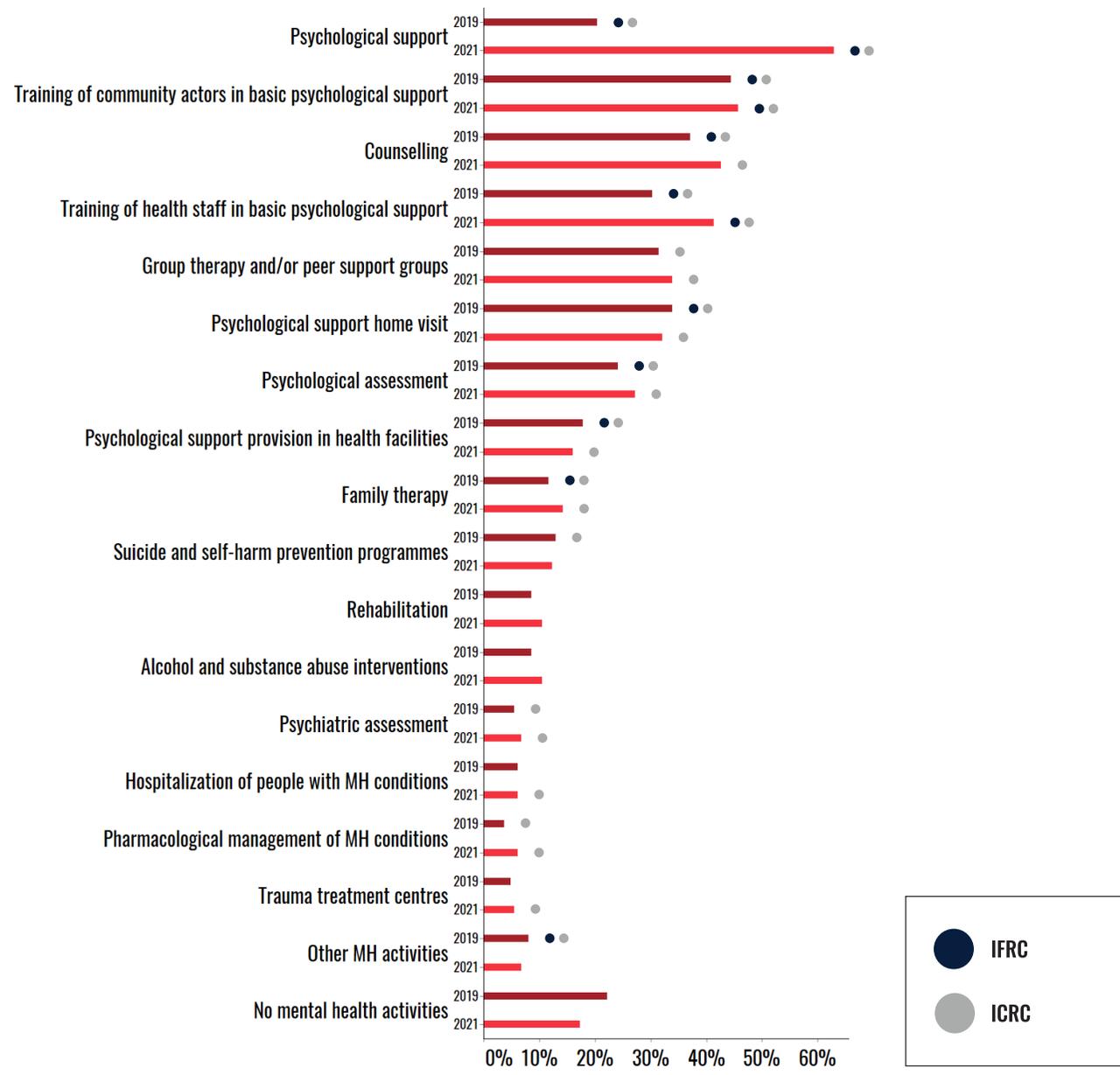


Figure 5: Provision of mental health activities

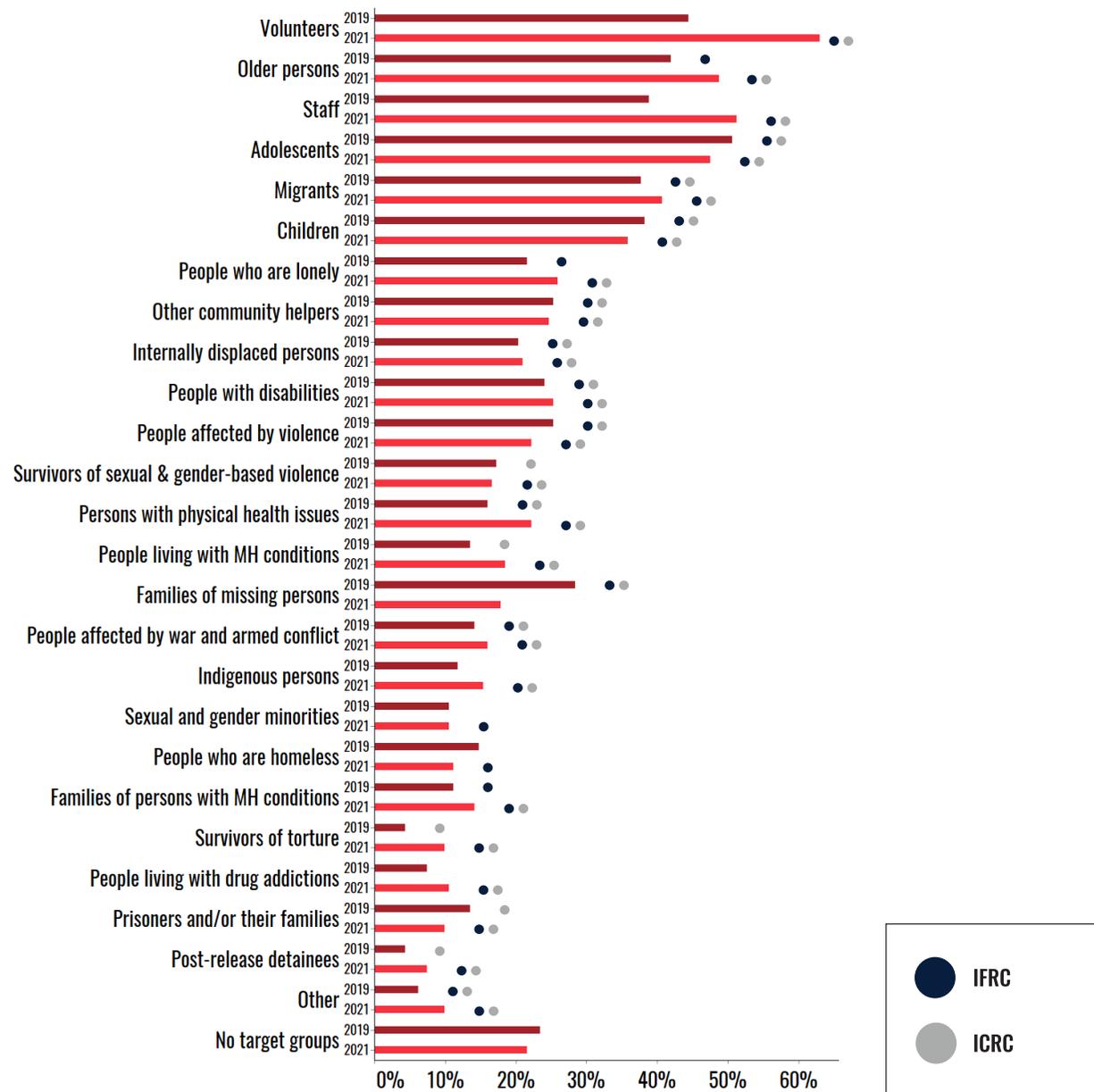


Figure 6: Groups targeted for mental health activities

## Approach used when delivering MH and/or PSS services

The components of the Movement use different approaches when they deliver MH and/or PSS services: a stand-alone approach, an integrated or mainstreaming approach or a combination of both. The survey results indicate that the Movement respondents deliver MH and/or PSS activities using all these approaches. However, we can identify a much higher

preference for the integrated or mainstreaming approach (2019: 43% (70 NS and the ICRC); 2021: 39% (65 NS)) or a combination of that with stand-alone programmes, over the stand-alone approach on its own, as shown in figure 7.

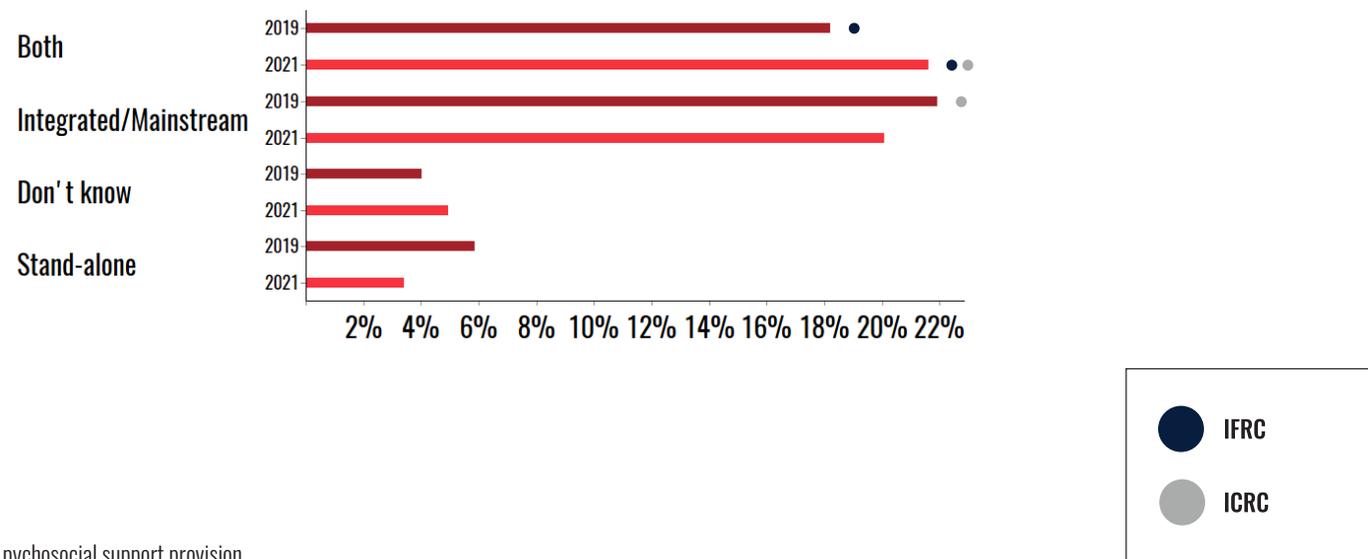
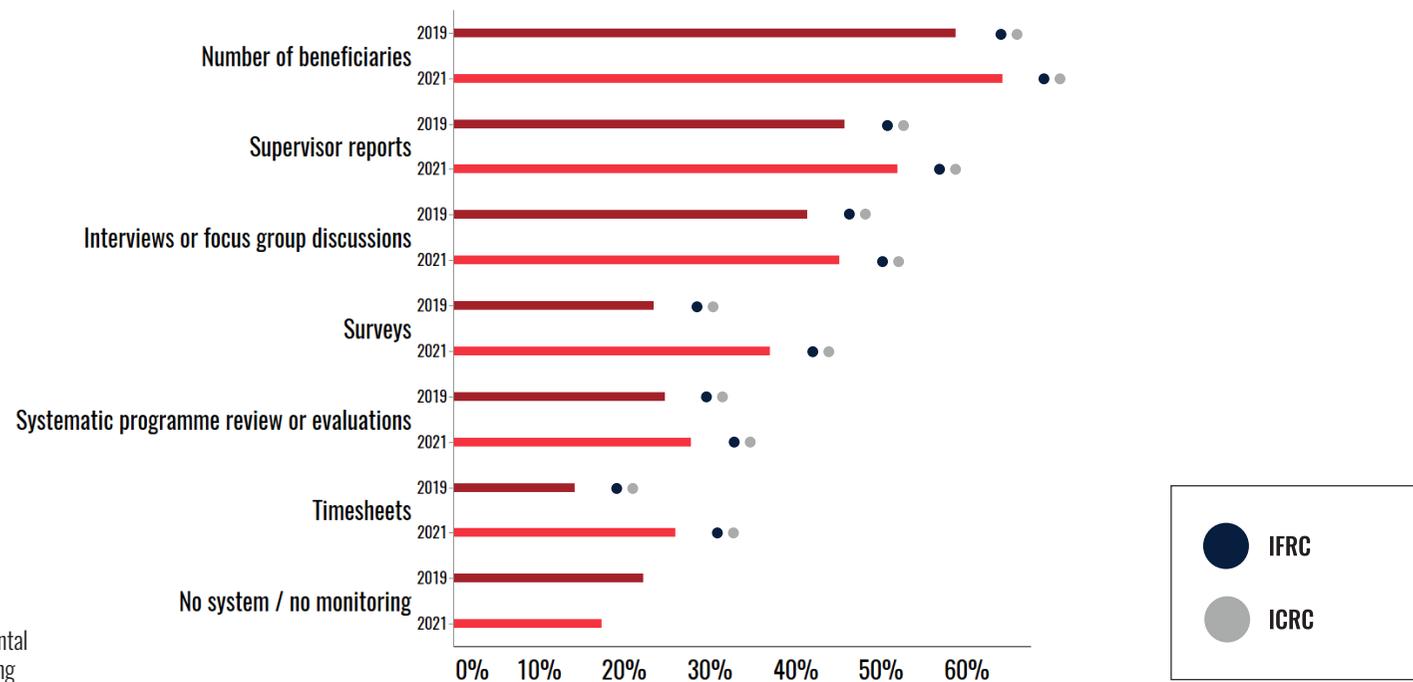


Figure 7: Approaches used in mental health and/or psychosocial support provision

## Systems in place to ensure quality

The Movement invests in ensuring that quality support is provided. 59% (96 NS, the IFRC and the ICRC) of respondents, in contrast to 48% of respondents (77 NS, the IFRC and the ICRC) in 2019 have supervision mechanisms in place to ensure the quality of the MHPSS activities they provide. This is a positive development and represents an increase of 9% in this area.

85% (141 NS, the IFRC and the ICRC) state that they have a system in place to monitor the MH and/or PSS activities of their organisation. Figure 8 shows the tools used in the Movement to monitor MH and/or PSS activities in comparison to the tools used two years ago. As in 2019 (59%: 95 NS, the IFRC and the ICRC), documenting the number of beneficiaries engaged in an activity was the most used tool in 2021 (64%: 104 NS, the IFRC and the ICRC).



**Figure 8:** Type of tools/guidance used for mental health and/or psychosocial activities monitoring



## Mental health and psychosocial wellbeing of staff and volunteers

The mental health and wellbeing of staff and volunteers is critically important to the Movement. Staff and volunteers are therefore of particular focus when it comes to MHPSS activities. Three quarters of respondents (120 NS, the IFRC and the ICRC) indicate having systems in place to support staff and volunteers' mental health and psychosocial wellbeing (figure 10).

Most of the NS, the IFRC and the ICRC (60%: 98 NS, the IFRC and the ICRC) offer staff and volunteers psychological support (internal and/or external), 52% (85 NS, the IFRC and the ICRC) conduct self-care trainings and capacity building and 47% (77 NS, the IFRC and the ICRC) organize self-care activities, which include, for instance, awareness sessions, group activities, mediation practices, sports or recreational activities.

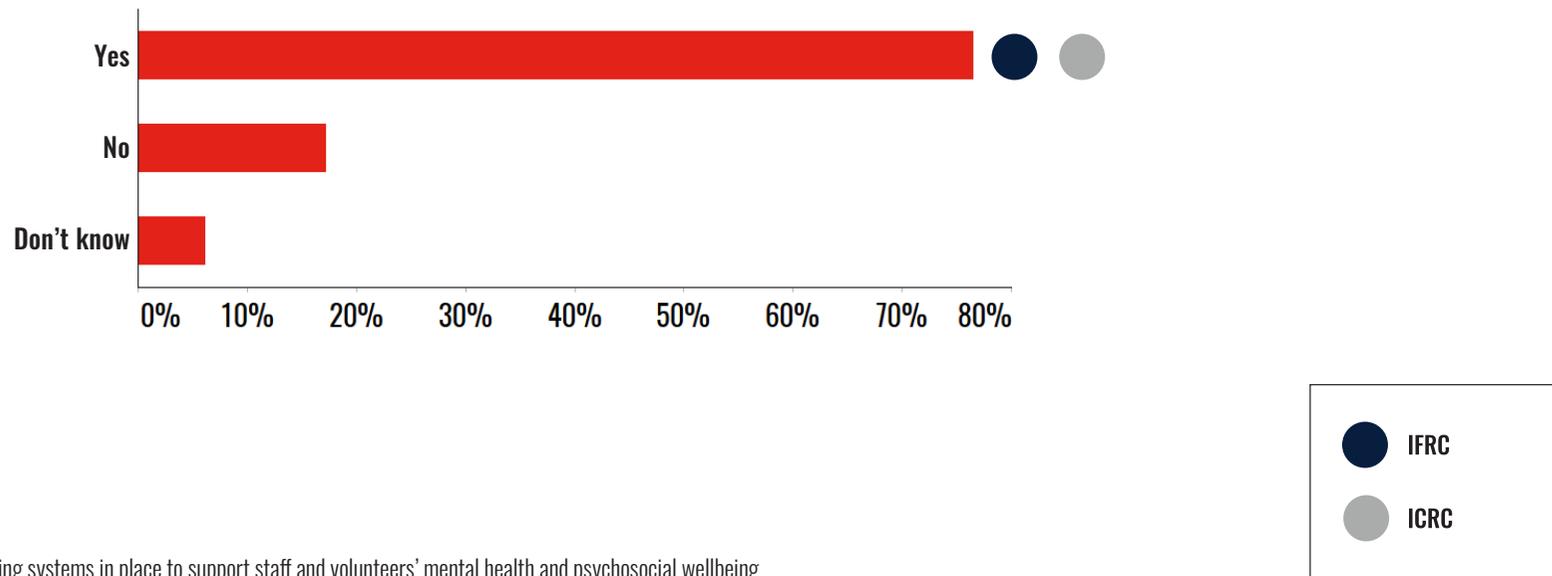


Figure 10: Components having systems in place to support staff and volunteers' mental health and psychosocial wellbeing

## Human resources for MHPSS

The Movement has both staff and volunteers involved in MH and/or PSS activities. In 2019, 74% (120 NS, the IFRC and the ICRC) reported that they had at least one focal point for MH and/or PSS in their organisation. In 2021, however, a rise in focal points is noted with 81% (132 NS, the IFRC and the ICRC) having appointed one or more focal points. As an amendment to the survey of 2019, this year's survey more clearly defined 'focal point' as a representative of the NS which is responsible for MH and/or PSS within their NS (either alone or in collaboration with another/others) and should be appropriately resourced and enabled by the NS/Movement component that they represent.

If the NS/Movement component indicated that they had one or more focal points, they were asked which focus this person had (programming or human resources related) as an additional question in this year's survey. The result is that the majority of the focal points (65%: 87 NS, the IFRC and the ICRC), focus on both staff and volunteers' mental health and psychosocial wellbeing and MHPSS

activities and programmes, whereas 19% (26 NS) focus only on staff and volunteers' mental health and psychosocial wellbeing, and 14% (19 NS) only on MHPSS activities and programmes.

As shown in figure 11 below, 34% of respondents (56 NS) have less than five staff members involved in MH and/or PSS activities, while 24% (40 NS) have between 5-19, 14% (22 NS and the IFRC) have between 20-49 staff, 7% (11 NS) have between 50-99, and 12% (19 NS and the ICRC) have more than 100 staff involved in these activities. ICRC staff provides MHPSS specifically to conflict-affected populations. 8% (14 NS) answered "Don't know".

Taking the profile and numbers of staff as a whole, the Movement has collectively close to 4.000 social workers, 1.500 psychologists, more than 80 psychiatrists, and close to 28.000 community health workers working in this field.

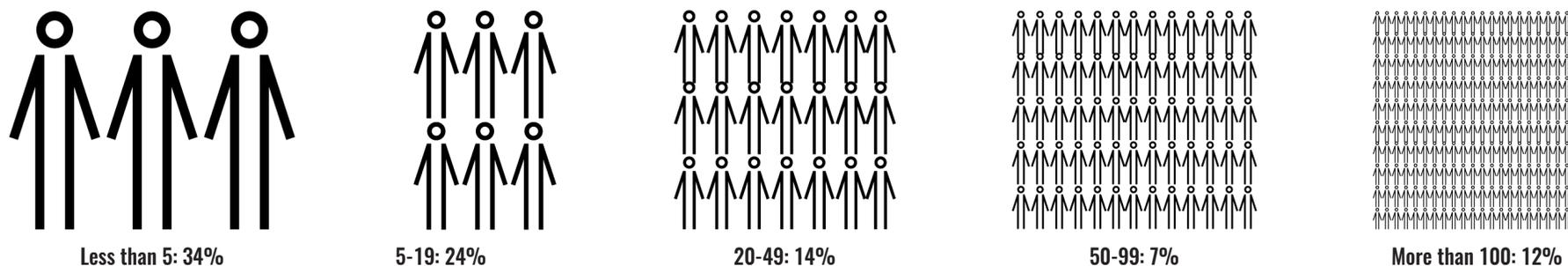
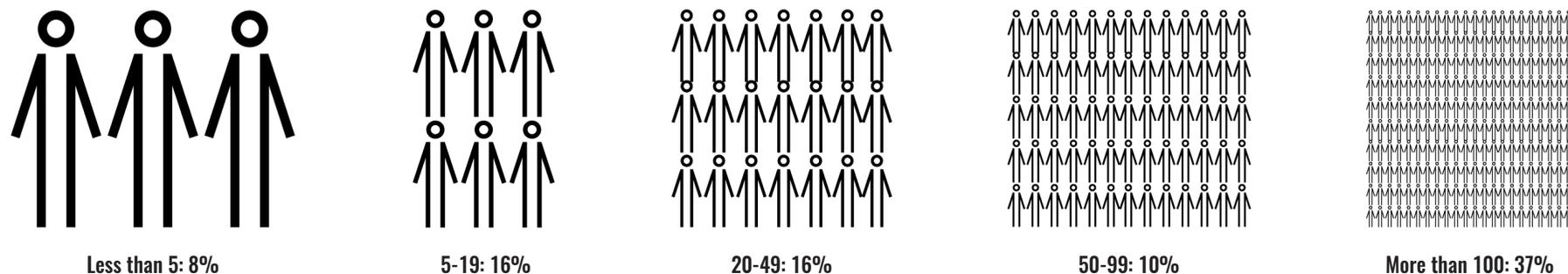


Figure 11: Staff involved in mental health and/or psychosocial support activities



**Figure 12:** Volunteers involved in mental health and/or psychosocial support activities

As shown in figure 12, 8% (13 NS) have less than five volunteers involved in MH and/or PSS activities, while 16% (26 NS) have between 5-19, 16% (26 NS) have between 20-49, 10% (17 NS) have between 50-99, while the majority, 37% of respondents (61 NS), have more than 100 volunteers. 12% (19 NS) answered “Don’t know”. The IFRC and the ICRC often collaborate with volunteers recruited through the hosting NS. In some cases, however, the IFRC and the ICRC work directly with volunteers.

163 NS indicated that around 5.300 social workers, 2.400 psychologists, 130 psychiatrists and close to 35.000 community workers work as volunteers in this field.

Collectively, among the 163 NS respondents, the IFRC and the ICRC, almost 40.000 staff and volunteers are reported to having been trained in basic psychosocial support in the last year, compared to almost 27.000 staff and volunteers in 2019. This is a growth of nearly 50%.

As explained in the Movement’s MHPSS Policy, the survey refers to basic psychosocial support as the first layer of the MHPSS Framework, addressed through activities that promote positive mental health and psychosocial wellbeing, resilience, social interaction and social cohesion activities within communities. Activities in this layer are often integrated into health, protection, and education sectors and should be accessible to the affected population. More information about the International Red Cross and Red Crescent Movement’s MHPSS Framework can be found in the [resource library of the IFRC Psychosocial Centre](#).

Furthermore, the number of staff and volunteers trained in PFA has risen significantly, from 42.000 in 2019 to more than 88.000 in 2021.

It should be noted that all specific numbers regarding staff and volunteers are likely to be higher than reported, as respondents typed zero in cases where the actual numbers were unknown.

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In the last 12 months, 45% (73 NS, the IFRC, and the ICRC) of respondents answered 'yes' to the question whether the management and other leaders in the Movement's components (e.g. board, branches) received training focused on the importance and benefits of mental health and psychosocial wellbeing of staff and volunteers. Frequently cited training topics included PFA, Basic Psychosocial Support, Caring for Staff and Volunteers (some specifically mentioned in relation to COVID-19), Stress Management, MHPSS Responses in Emergencies and Self-Care Trainings.

## Learning resources and needs for training staff and volunteers

The Movement has developed a range of learning resources such as manuals and courses for training staff and volunteers. As seen in figure 13, approximately the same number of respondents (58%: 90 NS and the IFRC) as in 2019 (55%: 90 NS and the IFRC), report in 2021 that they use learning resources from the IFRC Reference Centre for Psychosocial Support. The [IFRC Reference Centre for Psychosocial Support \(PS Centre\)](#) works under the framework of the IFRC, and supports NS in promoting and enabling the psychosocial well-being of beneficiaries, staff and volunteers. 52% of respondents (85 NS and the IFRC) use adapted materials from the IFRC Reference Centre for Psychosocial Support. 21% (32 NS, the IFRC and the ICRC) indicate that they use other Movement learning resources, and 32% (50 NS, the IFRC and the ICRC) use other learning resources in their trainings (e.g. from other agencies producing resources on MHPSS).

There is a strong request for more technical support regarding trainings and programme/ activity guidance. 79% (138 NS, the IFRC and the ICRC) express a need for this. More than half the respondents (59%: 102 NS, the IFRC and the ICRC) indicate new trainings or tools are required to tackle specific aspects of the MHPSS activities within their organisations.

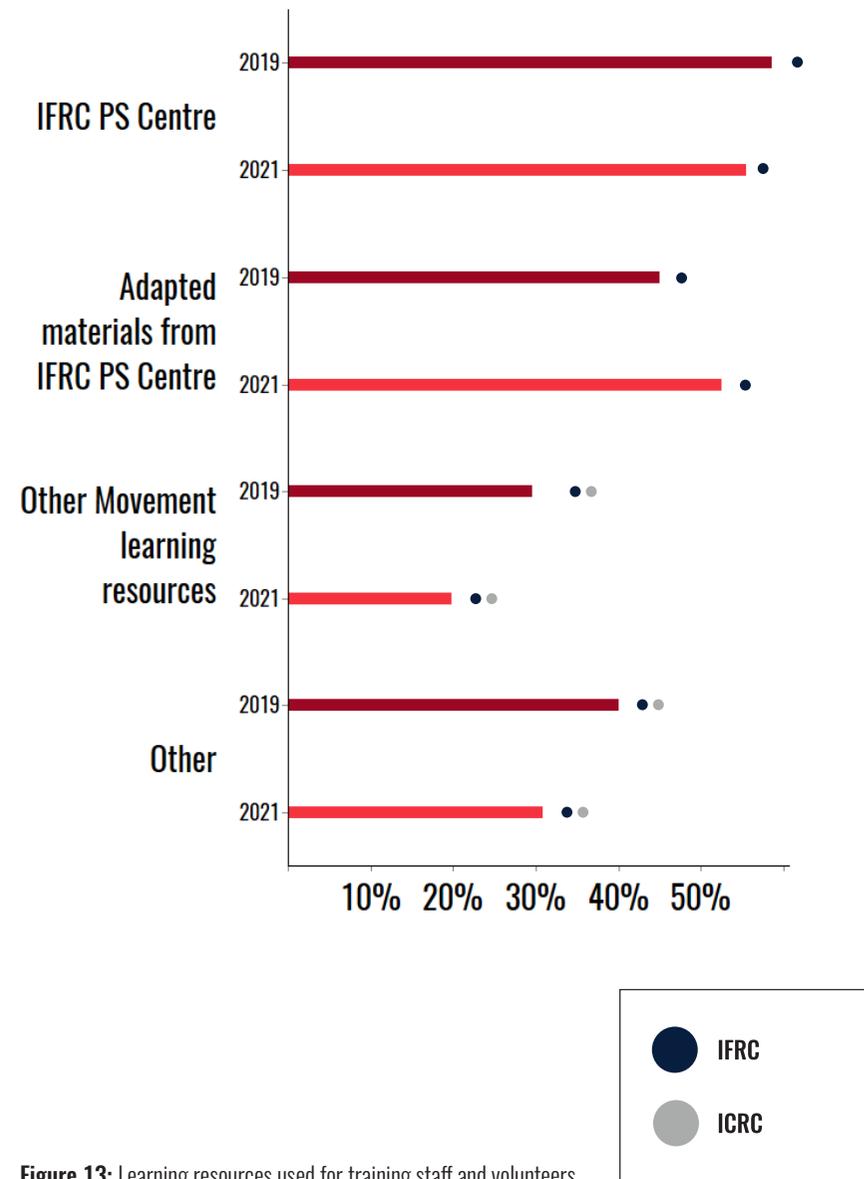


Figure 13: Learning resources used for training staff and volunteers

## Budget dedicated to MHPSS

Each component of the Movement is fully independent and responsible for its own budget plan. The budget for MHPSS is therefore very diverse. 25% of respondents in 2021 (42 NS), compared to 34% of respondents (55 NS) in 2019, have no budget dedicated to MHPSS activities, representing a majority of respondents. This may be due to the fact that many activities are delivered as an integrated approach and therefore the budget is not captured specifically under MHPSS, but is included in other sectors. 19% (31 NS) have a budget between 1-50.000 CHF, 7% (11 NS) have a budget between 50.001-100.000 CHF and 6% (10 NS) have a budget between 100.001-150.000 CHF. Four more NS (7%: 12 NS compared to 5%: 8 NS) state that they have the largest budget indicated, CHF 150.001-200.000. Moreover, the same number of respondents as in 2019, 13% of respondents (19 NS, the IFRC and the ICRC), have budgets different from the indicated intervals or have budgets which are included or based on other budgets. 22% (37 NS) of respondents reported that they do not know what budget is held for MHPSS activities in their organisations.

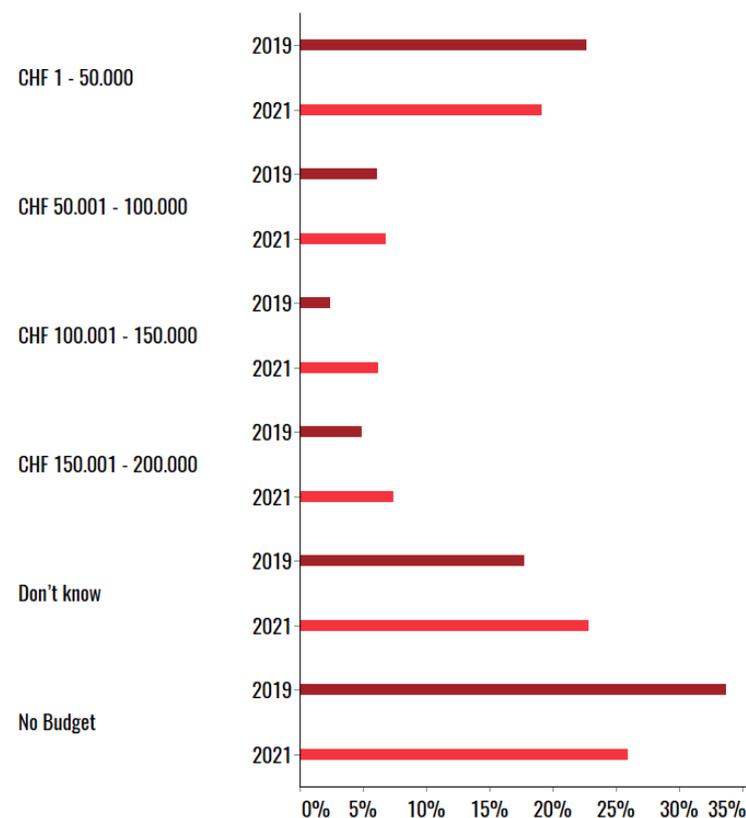


Figure 14: Annual budgets dedicated to mental health and/or psychosocial support activities

## Collaboration regarding MH and/or PSS

The Movement receives support from various stakeholders and of different kind. Survey data indicate that the support received by the Movement components is mostly of a technical kind, provided particularly by the IFRC (67%), Partner National Societies (PNS) (47%), respective governments (42%) and the ICRC (39%). The second most frequent type of support is

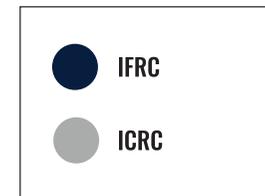
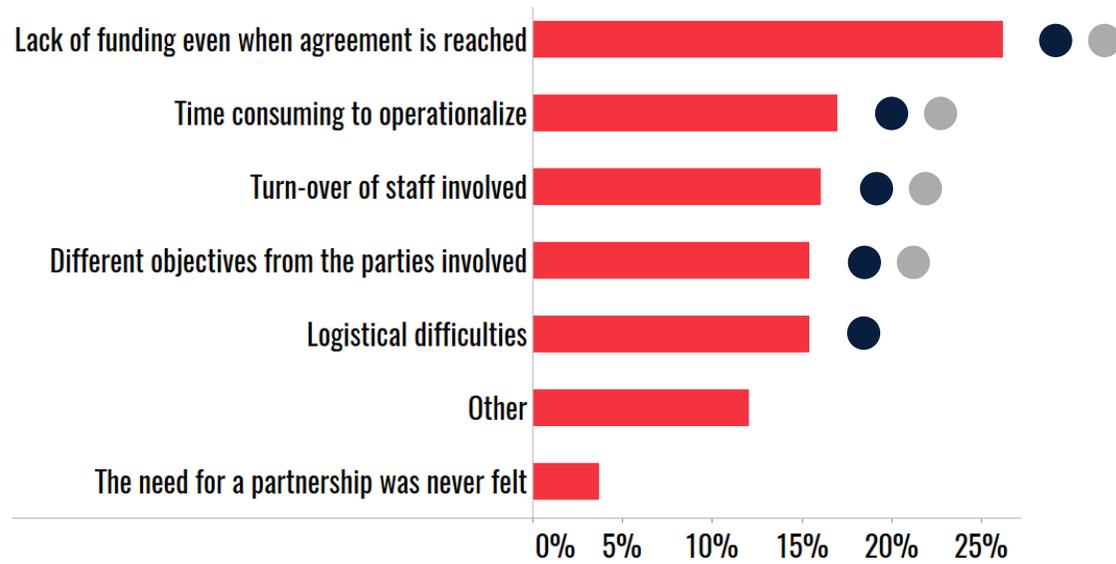
funding. NS report that the IFRC (53%), PNS (42%) and the ICRC (31%) contribute funding to their MHPSS service delivery and programming. However, collaboration is very limited in relation to individual donors, the private sector, United Nations agencies and universities.

	Funding	Human Resources	Technical	No collaboration
ICRC	31% (51 NS, IFRC)	15% (23 NS, IFRC)	39% (63 NS, IFRC)	33% (55 NS)
IFRC	53% (87 NS)	28% (46 NS)	67% (109 NS, ICRC)	10% (17 NS)
Partner National Societies	42% (68 NS, IFRC, ICRC)	24% (37 NS, IFRC, ICRC)	47% (75 NS, IFRC, ICRC)	28% (46 NS)
Government (e.g. ministry of social affairs, ministry of health)	19% (31 NS, IFRC)	16% (25, IFRC, ICRC)	42% (67 NS, IFRC, ICRC)	22% (37 NS)
Individual donors	23% (37 NS, IFRC, ICRC)	7% (10 NS, IFRC)	5% (8 NS, IFRC)	64% (105 NS)
Private sector	19% (30 NS, IFRC, ICRC)	5% (8 NS, IFRC)	13% (20 NS, IFRC, ICRC)	65% (106 NS)
United Nations Agencies	23% (37 NS, IFRC)	5% (7 NS, IFRC)	17% (26 NS, IFRC, ICRC)	56% (93 NS)
Universities	3% (4 NS, IFRC)	19% (30 NS, IFRC)	24% (38 NS, ICRC)	52% (85 NS)

**Table 2:** Type of support received, by component

Challenges that hinder or have already hindered collaboration between Movement partners are reported to be the lack of funding even when an agreement is reached (53%: 85 NS, the IFRC and the ICRC), the time consuming element of operationalization of activities (35%: 55 NS, the

IFRC and the ICRC) and the turnover in staff involved (33%: 52 NS, the IFRC and the ICRC). Figure 15 illustrates the range of challenges experienced by respondents when exploring collaboration possibilities.



**Figure 15:** Type of challenges presented by collaboration with different partners

## Challenges and gaps in delivering MH and/or PSS services

Budget constraints or limited budget availability are the year's major obstacle for delivering MH and/or PSS activities in 2021, as they were in 2019. 76% of respondents (123 NS, the IFRC and the ICRC) in 2021, compared to 83% of respondents (135 NS and the IFRC) in 2019, indicated these as challenges, followed by those within the organisation (42%: 68 NS, the IFRC and the ICRC). A lack of or limited technical expertise i.e. manuals, trainings, specialists, were also signalled as difficulties in the delivery of MH and/or PSS activities (41%: 66 NS and the ICRC). An overview of the different challenges can be seen in figure 16.

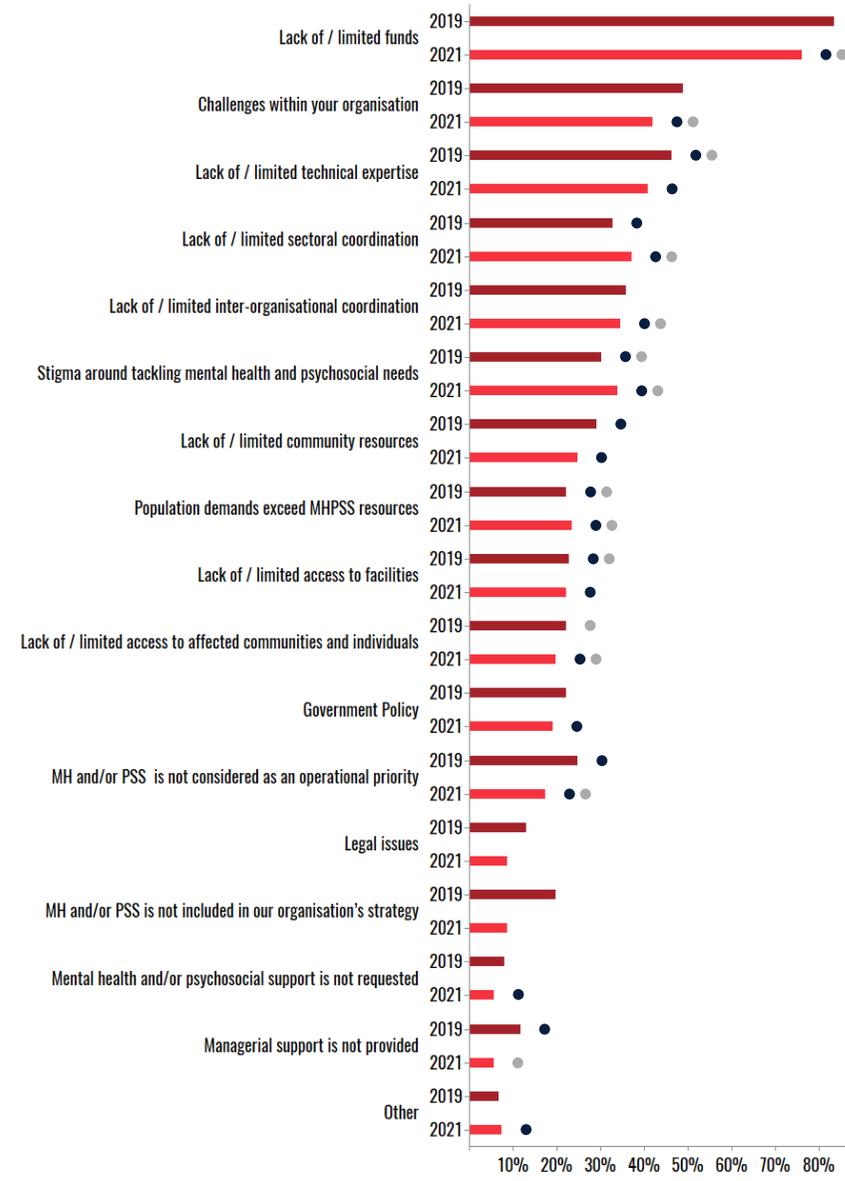
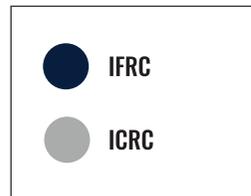


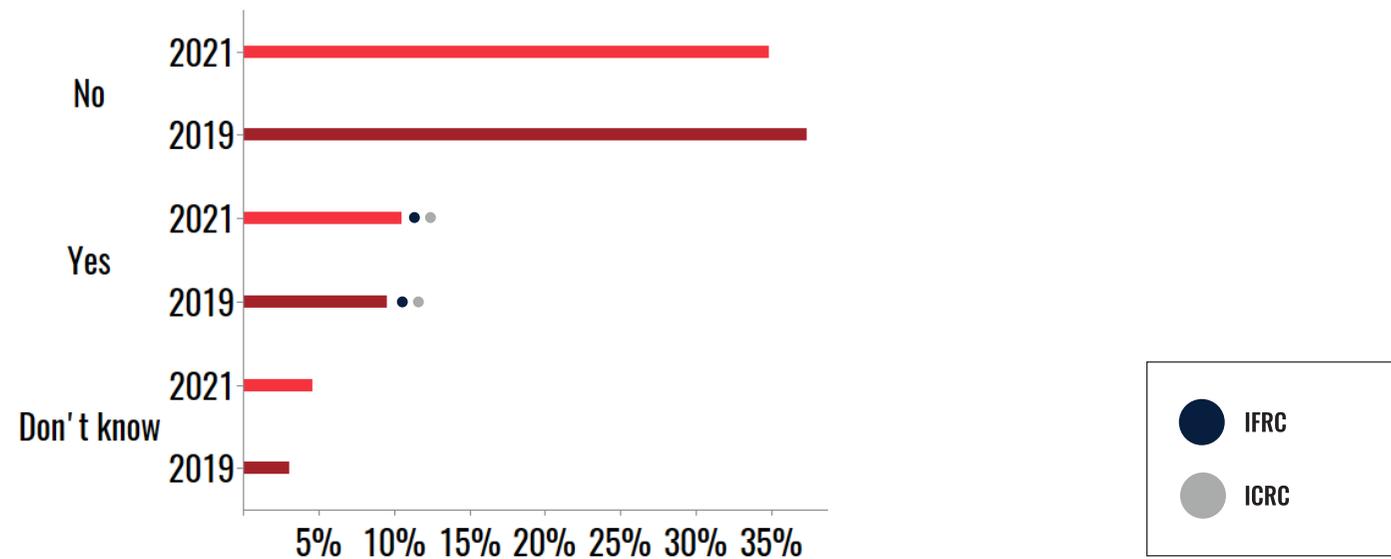
Figure 16: Perceived gaps in delivering mental health and/or psychosocial support activities

## MHPSS research, advocacy and the national role

The Movement is involved in humanitarian diplomacy and research, generating awareness and funding for mental health and psychosocial support services and documenting our work to inform the development of innovative approaches.

Almost two thirds of respondents (62%: 103 NS, the IFRC and the ICRC), work with humanitarian diplomacy on MHPSS related topics or issues.

In 2019, one in five (31 NS, the IFRC and the ICRC) reported that they were involved or had previously been involved in MH and/or PSS research, while in 2021, a slight increase can be reported, with 22% of respondents (34 NS, the IFRC and the ICRC) engaging in research.



**Figure 17:** Involvement in mental health and/or psychosocial support research

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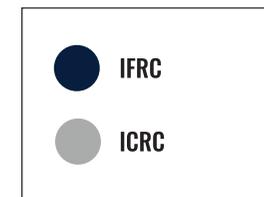
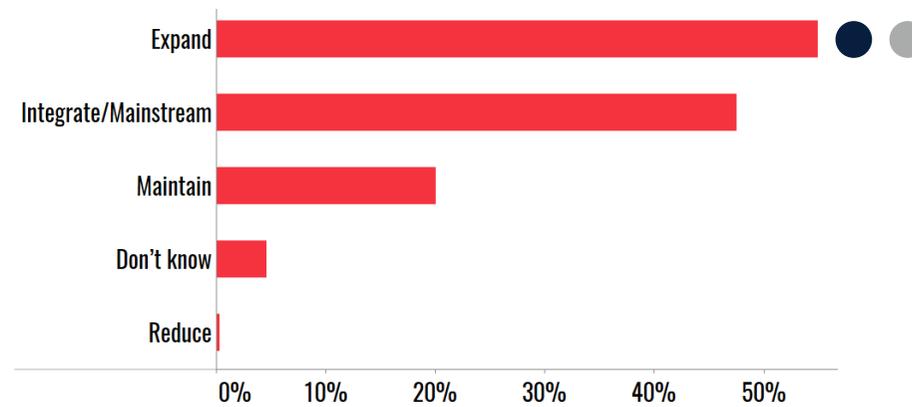
Nearly half of the NS (48%: 79 NS) indicate that their role in providing MH and/or PSS services is expressly mentioned in national public health laws and policies and that they have specific agreements with the public authorities (42%: 68 NS). More than a quarter (27%: 45 NS) of respondent NS are mentioned in the national public health or disaster management plans. Whereas the majority of NS (63%: 103 NS) are included as participants in relevant humanitarian inter-agency mechanisms, less than half (50%: 82 NS) are included in inter-ministerial/departmental committees.

As the NS work as auxiliaries to public authorities, it is key to understand if the public authorities recognize MHPSS as a component of their responses to disasters and emergencies. MHPSS is mentioned in pandemic preparedness and response laws, policies or plans by 64 (40% NS) governments. MHPSS also referred to in disaster risk management laws, policies or plans by 78 (48% NS) governments, while 77 (48% NS) governments point out MHPSS in plans for response to conflicts or violence. As the IFRC and the ICRC do not have auxiliary status, this is not applicable to them.

## Future plans

MHPSS activities appear to be on the rise. Around half of the respondents (81 NS, the IFRC and the ICRC) plan to expand their activities within this area, while only one NS intends to reduce its MHPSS activities. 45% (74 NS) also wish to integrate or mainstream their activities, which means including MHPSS in other programme activities. This includes an increase in the number of staff and volunteers who have a basic understanding of PSS

and know how to integrate the approach in their activities. 19% (32 NS) plan to maintain their level of activities in relation to MHPSS.



**Figure 18:** Future plans to expand, integrate, maintain or reduce mental health and/or psychosocial activities

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## **Concluding remarks**

Despite often limited resources and funds, the components of the Movement are delivering a wide range of MHPSS services and activities in accordance with their respective mandates, commitments and auxiliary roles.

The adoption of the policy on addressing mental health and psychosocial needs and resolution 2 of the 33rd International Conference “Addressing mental health and psychosocial needs of people affected by armed conflicts, natural disasters and other emergencies” provides the Movement and States with the framework, technical direction and political will to address unmet mental health and psychosocial needs. The data from the first Movement-wide MHPSS survey conducted in 2019 provided the critical baseline information against which we have been able to measure and track our progress in the operationalisation and implementation of the policy and the resolution. The report will also inform the Council of Delegates. A similar survey will be conducted by 2023 to monitor progress throughout the years of the Roadmap implementation from 2020-2023, drawing on the baseline set by the original survey of 2019.

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## Key takeaways:



**50%**

(81 NS, the IFRC and the ICRC) plan to expand their MHPSS activities



**88.000**

Volunteers and staff are trained in PFA



**48%**

(78 NS, the IFRC and the ICRC) have a system in place to ensure confidentiality and protection of personal data



**76%**

(123 NS, the IFRC and the ICRC) identify limited funds as a challenge



**87%**

(141 NS, the IFRC and the ICRC) provide MH and/or PSS activities in emergencies



**70%**

(113 NS, the IFRC and the ICRC) offer referral to more specialized mental health services



**22%**

(34 NS, the IFRC and the ICRC) are involved in MH and/or PSS research



**85%**

(138 NS, the IFRC and the ICRC) have a system in place to monitor MH and/or PSS activities



**62%**

(103 NS, the IFRC and the ICRC) work with MHPSS advocacy

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## Breakdown of Movement staff



**More than 4.000 social workers**



**More than 1.500 psychologists**



**Nearly 80 psychiatrists**



**Nearly 28.000 community health workers**

## Breakdown of Movement volunteers



**Nearly 5.300 social workers**



**More than 2.400 psychologists**



**More than 130 psychiatrists**



**More than 35.000 community health workers**

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## With thanks to the following for their participation in the survey:

Afghan Red Crescent Society	Dominica Red Cross Society	Lebanese Red Cross	Qatar Red Crescent Society	Spanish Red Cross
Albanian Red Cross	Dominican Red Cross	Lesotho Red Cross Society	RC of The Republic of N. Macedonia	Suriname Red Cross
American Red Cross	Ecuadorian Red Cross	Liberian Red Cross Society	RCS of Bosnia and Herzegovina	Swedish Red Cross
Argentine Red Cross	Egyptian Red Crescent Society	Libyan Red Crescent	RCS of Turkmenistan	Swiss Red Cross
Armenian Red Cross Society	Estonian Red Cross	Lithuanian Red Cross Society	RCS of Azerbaijan	Syrian Arab Red Crescent
Australian Red Cross	Ethiopian Red Cross Society	Luxembourg Red Cross	Red Crescent Society of Djibouti	Tanzania Red Cross National Society
Austrian Red Cross	Fiji Red Cross Society	Magen David Adom in Israel	Red Crescent Society of Islamic Republic of Iran	The Barbados Red Cross Society
Bahrain Red Crescent Society	Finnish Red Cross	Malagasy Red Cross Society	Red Crescent Society of Kyrgyzstan	The Canadian Red Cross Society
Bangladesh Red Crescent Society	French Red Cross	Malawi Red Cross Society	Red Crescent Society of Tajikistan	The Gambia Red Cross Society
Baphalali Eswatini Red Cross Society	Gabonese Red Cross Society	Malaysian Red Crescent Society	Red Crescent Society of Uzbekistan	The Red Cross of Serbia
Belarus Red Cross	Georgia Red Cross Society	Maldivian Red Crescent	Red Cross of Benin	The Russian Red Cross Society
Belgian Red Cross	German Red Cross	Marshall Islands Red Cross	Red Cross of Cape Verde	The Solomon Islands Red Cross
Belize Red Cross Society	Ghana Red Cross Society	Mauritanian Red Crescent	Red Cross of Chad	The Sri Lanka Red Cross Society
Bolivian Red Cross	Grenada Red Cross Society	Mauritius Red Cross Society	Red Cross of Monaco	The Comoros Red Crescent
Botswana Red Cross Society	Guatemalan Red Cross	Mexican Red Cross	Red Cross of Montenegro	The Netherlands Red Cross
Brazilian Red Cross	Guyana Red Cross Society	Micronesia Red Cross	Red Cross Society of Côte d'Ivoire	The Sudanese Red Crescent
British Red Cross	Haiti Red Cross Society	Mongolian Red Cross Society	Red Cross Society of Guinea	Timor-Leste Red Cross Society
Brunei Darussalam Red Crescent Society	Hellenic Red Cross	Moroccan Red Crescent	Red Cross Society of Guinea-Bissau	Togolese Red Cross
Bulgarian Red Cross	Honduran Red Cross	Mozambique Red Cross Society	Red Cross Society of Niger	Tonga Red Cross Society
Burkinabe Red Cross Society	Hungarian Red Cross	Namibia Red Cross	Red Cross Society of Panama	Trinidad and Tobago Red Cross Society
Burundi Red Cross	Icelandic Red Cross	Nepal Red Cross Society	Rwandan Red Cross	Tunisian Red Crescent
Cambodian Red Cross Society	Indian Red Cross Society	New Zealand Red Cross	Saint Lucia Red Cross	Turkish Red Crescent Society
Cameroon Red Cross Society	Iraqi Red Crescent Society	Nicaraguan Red Cross	Saint Vincent and the Grenadines RC	Tuvalu Red Cross Society
Central African Red Cross Society	Irish Red Cross Society	Nigerian Red Cross Society	Salvadorean Red Cross Society	Uganda Red Cross Society
Chilean Red Cross	Italian Red Cross	Norwegian Red Cross	Senegalese Red Cross Society	Ukrainian Red Cross Society
Colombian Red Cross Society	Jamaica Red Cross	Pakistan Red Crescent	Seychelles Red Cross Society	Uruguayan Red Cross
Congolese Red Cross	Japanese Red Cross Society	Palau Red Cross Society	Sierra Leone Red Cross Society	Vanuatu Red Cross Society
Cook Islands Red Cross Society	Jordan Red Crescent Society	Palestine Red Crescent	Singapore Red Cross Society	Venezuelan Red Cross
Costa Rican Red Cross	Kazakh Red Crescent	Paraguayan Red Cross	Slovak Red Cross	Yemen Red Crescent Society
Croatian Red Cross	Kenya Red Cross Society	Peruvian Red Cross	Slovenian Red Cross	Zambia Red Cross Society
Cyprus Red Cross Society	Kuwait Red Crescent Society	Philippine Red Cross	Somali Red Crescent Society	Zimbabwe Red Cross Society
Czech Red Cross	Lao Red Cross	Polish Red Cross	South African Red Cross Society	
Danish Red Cross	Latvian Red Cross	Portuguese Red Cross	South Sudan Red Cross	

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## Annex

Working Groups & their Priority Action Areas	Working Group Co-Leads (status October 2021)	Changes to the survey 2021 compared to the initial survey 2019
<p><b>Working Group 1</b></p> <p><b>Priority Action Area 1:</b>  <b>Guarantee a basic level of psycho-social support and integrate mental health and psychosocial support across sectors</b></p>	<p><b>British Red Cross:</b>  Sarah Davidson</p> <p><b>IFRC PS Centre:</b>  Sarah Harrison</p>	<p><b>Initial question (2019):</b> Are there one or more focal points for mental health and/or psychosocial support within your organisation?</p> <p><b>Addition to initial question is a definition of ‘Focal Point’:</b> “A Focal Point should represent the National Society and be responsible for mental health and psychosocial support within their National Society (either alone or in collaboration with another/others). The focal point should be appropriately resourced and enabled by the NS/ Movement component that they represent.”</p> <p><b>Question added to the survey:</b>  Please indicate their focus (and select all that apply for all of the focal points you have):</p> <ol style="list-style-type: none"> <li>1. MHPSS activities and programmes</li> <li>2. Staff and volunteers’ mental health and psychosocial wellbeing.</li> </ol> <p><b>Initial question (2019):</b> How many volunteers and staff are trained in basic psychosocial support?</p> <p><b>Addition to initial question is a definition of ‘basic psychological support’:</b> “Basic psychosocial support – the first layer of the pyramid – promotes positive mental health and psychosocial wellbeing, resilience, social interaction and social cohesion activities within communities. Activities in this layer are often integrated into health, protection and education sectors and should be accessible to 100% of the affected population, where possible. Examples of activities include psychological first aid (PFA) and recreational activities. Basic psychosocial support can be provided by trained Red Cross and Red Crescent staff and volunteers and/or trained community members.”</p>

**Working Group 2**

**Priority Action Area 2:  
Develop a holistic MHPSS approach  
between Movement components and in  
collaboration with other actors**

**Danish Red Cross:**  
Louise Steen Kryger

**ICRC:**  
Douglas Khayat Araujo  
Siqueira

**Initial question (2019):** If your mental health and/or psychosocial activities receive support, please specify from whom:

**Questions added to the survey:**

Does your organisation work in collaboration (this includes operational support, technical support and any form of coordination activities in the field) regarding MHPSS with other partners?

	Funding	Human Resources	Technical	Other	No collaboration
ICRC					
IFRC					
Partner National Societies					
Government (e.g. ministry of social affairs, ministry of health)					
Individual donors					
Private sector					
United Nations Agencies					
Universities					
Other					

What are the challenges that may (or have already) hinder collaboration between Movement partners (i.e. jointly develop and implement activities) – please select all that apply:

1. Time consuming to operationalize
2. Different objectives from the parties involved
3. Turnover of staff involved
4. Lack of funding even when an agreement is reached
5. Logistical difficulties
6. The need for a partnership was never felt
7. Other \_\_\_\_\_

### Working Group 3

**Priority Action Area 3:  
Protect and promote the mental health  
and psychosocial wellbeing of staff and  
volunteers**

**Swedish Red Cross:**  
Maite Zamacona

**IFRC HR:**  
Ines Hake

#### Questions added to the survey:

In the past 12 months, have management and other leaders in your organisation (e.g., board, branches) received training on the importance and benefits of mental health and psychosocial wellbeing of staff and volunteers? If yes, indicate what training they have received (at minimum one hour):

1. Yes \_\_\_\_\_
2. No
3. Don't know

Does your organisation have ways to support staff and volunteers' mental health and psychosocial wellbeing?

1. Yes \_\_\_\_\_
2. No
3. Don't know

Indicate which systems are in place:

1. Self-care activities (e.g., awareness sessions, group activities, meditation practices, sports or recreational activities, etc)
2. Peer-to-peer support (e.g., peer support groups, buddy systems)
3. Psychological support (e.g., it can be both internal and external)
4. Referral systems (e.g., supervision mechanisms for monitoring and/or directing staff and volunteers to the appropriate support groups/focal point)
5. Self-care trainings and capacity building (e.g., trainings or tools to tackle specific aspects of the MHPSS activities within your organisation)
6. Other \_\_\_\_\_

## Working Group 4

**Priority Action Area 4:**  
Demonstrate the impact of MHPSS interventions through research, evidence, monitoring and evaluation

**Swiss Red Cross:**  
Monia Aebersold

**IFRC PS Centre:**  
Michelle Engels

### Questions added to the survey:

What are the reasons for why your organisation does not have a system in place to monitor your mental health and/or psychosocial support activities in your organisation? Please select all that apply:

1. Lack of / limited funds
2. Lack of planning (e.g. not including monitoring and evaluation plans at the beginning of the project/activities)
3. Lack of staff who can collect data
4. Lack of staff who can analyse data
5. Lack of suitable tools
6. Lack of / limited technical expertise (e.g. to identify manuals, trainings, specialists)
7. Monitoring mental health and psychosocial support activities is not seen as a core priority for the organisation
8. Monitoring and evaluation is not requested
9. Practical monitoring and evaluation support is not provided
10. Legal issues (e.g. data protection and information security)
11. Other \_\_\_\_\_

What resources/guidance does your organisation use to monitor mental health and psychosocial support activities?

Please select all that apply:

1. IFRC Reference Centre for Psychosocial Support 'Monitoring and Evaluation Framework for Psychosocial Support Interventions – Toolbox / Indicator Guide'
2. ICRC 'Guidelines on Mental Health and Psychosocial Support'
3. IASC 'Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings'
4. IASC 'Mental Health and Psychosocial Support Assessment Guide'
5. WHO & UNHCR 'Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings'
6. IFRC 'Project/Programme Monitoring and Evaluation Guide'
7. We do not use any of the above listed resources/guidance (please specify why not and select all that apply):
8. We use other existing guidance/resources, please specify: \_\_\_\_\_

## Working Group 5

**Priority Action Area 5:**  
Strengthen resource mobilization for  
MHPSS in humanitarian response

and

**Priority Action Area 6:**  
Mobilize political support for MHPSS –  
humanitarian diplomacy and advocacy

**Danish Red Cross:**  
Jakob Harbo

**ICRC/POL**  
Barbara Jackson

**IFRC PSK:**  
Joy Muller

### Questions added to the survey:

Is your organisation's role in providing MH and/or PSS services expressly recognized by:

1. Mention in national public health laws or policies?  
 Yes     No     Don't know
2. Mention in national public health or DM plans?  
 Yes     No     Don't know
3. Specific agreements with the public authorities?  
 Yes     No     Don't know
4. Inclusion of the NS as a participant in inter-ministerial/departmental committees of your government that handle this issue?  
 Yes     No     Don't know
5. Inclusion of the NS as a participant in relevant humanitarian inter-agency mechanisms (e.g. clusters, technical working groups) that handle this issue?  
 Yes     No     Don't know

Is the role of MHPSS specifically mentioned in:

1. Your government's pandemic preparedness and response laws, policies or plans?  
 Yes     No     Don't know
2. Your government's disaster risk management laws, policies or plans?  
 Yes     No     Don't know
3. Your government's plans for response to conflicts or violence?  
 Yes     No     Don't know
4. Any other plans? Please specify: \_\_\_\_\_