the
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Decolonising mental health interventions in the humanitarian system

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CENTRE FOR HUMANITARIAN LEADERSHIP

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A Child Friendly Space in an informal camp in Ethiopia allows children to play, learn and access psychosocial support. © Sacha Myers / Save the Children

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Abstract

Mental health is an increasing concern around the world, but there is a substantial gap between Western and non-Western countries in terms of access to quality mental healthcare. To help close this gap and improve the delivery of mental health and psychosocial support services (MHPSS), the UN's 2016 Grand Bargain declared a new approach of prioritising the localisation of these services. This paper examines the effects of the Grand Bargain on the localisation of mental health and psychosocial support services in non-Western countries, as a means to decolonise mental health.

An outcome evaluation was carried out to measure the amount of funding received by local and national agencies that provide MHPSS services in less economically developed countries. All data was gathered from the UN Financing Track System (FTS) and looked at financial contributions over time in six humanitarian sectors: health; water, sanitation and hygiene (WASH); gender-based violence; nutrition; protection, and shelter. The results show that local and national agencies received only 3% of international donors' MHPSS-related humanitarian funding between 2017 and 2021. Most localised MHPSS-related funding is driven by country-based pooled funds, with Middle Eastern countries as the primary beneficiaries, and localised MHPSS funding predominantly went to the health, WASH, and protection sectors. The study found limited localisation of MHPSS services in less economically developed countries, and a limited focus on community capacity building through associated humanitarian sectors. Based on this study, it is recommended that humanitarians should advocate for increased localisation and culturally competent practices in the MHPSS space.

Leadership relevance

Community leaders and local service providers are essential in the aftermath of a humanitarian crisis, both in terms of giving immediate aid and building the framework for a sustainable recovery, yet many local and national agencies that focus on MHPSS and child protection services suffer from a lack of funding. They are sometimes hampered by an imbalance of power that places funders, rather than local leaders, in charge of making important decisions regarding the strategic allocation of limited resources. Through shedding light on funding disparities, this paper informs humanitarian leadership practitioners of our responsibility to make MHPSS and child protection services localised, accessible and culturally appropriate.

"National liberation, the struggle against colonialism, the construction of peace, progress and independence are hollow words devoid of any significance unless they can be translated into a real improvement of living conditions"—Amílcar Cabral (1979).

Introduction

The suffering of people from mental illnesses is an increasing problem across the world. The World Health Organisation (WHO) anticipates that one in every four people will experience a mental health issue during their lifetime (WHO, 2021). Depression, for example, is known to be one of the primary causes of disability, while suicidality is the fourth highest cause of mortality among 15 to 19-year-olds (ibid.). Individuals and communities coping with mental health conditions are frequently subjected to serious human rights abuses, particularly discrimination and interpersonal violence (Lund, 2020). However, mental illness, and specifically accessibility to adequate care, is manifested differently in various parts of the world. For instance, about 42% of the individuals coping with mental illnesses in Western countries receive no formal treatment, while this figure is nearly double in non-Western countries (Bedi, 2018).

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Despite the need for mental health services across communities worldwide, treatment disparities persist because the current approach to delivering these services has been Western-oriented and fails to embrace cultural contexts and integrate local practitioners (Tay et al., 2019; Tefera, 2022). This approach not only fails to leverage the practices, knowledge, and beliefs of local communities, which leads to apprehension about treatment, but the imposition of a Western-based approach is also seen as an extension of colonialism (Cullen et al., 2021). To narrow these treatment disparities, public health and humanitarian experts have been encouraged to examine how the delivery of mental health services can be more responsive to local sociocultural contexts.

In May 2016, the United Nations conducted the World Humanitarian Summit (WHS), during which possible approaches to providing more funding to local organisations in humanitarian emergencies were discussed (Gómez, 2021). Following this conference, the 'Grand Bargain' was launched, and by 2019, its signatories represented 84% of all donor humanitarian contributions worldwide (Esmail, 2022)—making it a substantial guideline for enhancing equality in funding of humanitarian missions. The main purpose of the agreement was to strengthen local and national capacities by reinforcement rather than by replacing them with international organisations (Metcalfe-Hough et al., 2021). The Grand Bargain presents this goal as the basis of localisation. One of the ways in which the goals of the Grand Bargain can be accomplished is by localising mental health services (Esmail, 2022; Gómez, 2021).

Key concepts

To lay out the theoretical basis for this analysis of localisation and its role in the decolonisation of mental health and psychosocial support, six key concepts will be briefly explored: MHPSS, decolonisation, cultural relativism, therapeutic governance, localisation and the UN cluster system.

Mental health and psychosocial support services

Mental health and psychosocial support services (MHPSS) integrate interventions that individuals, groups and communities receive to care for or enhance their mental health and psychosocial wellbeing (Tol et al., 2015). MHPSS approaches include treatment and prevention of mental health disorders such as depression, anxiety and post-traumatic stress disorder (Rehberg, 2015). In the past several decades, international organisations such as the WHO, UNICEF and Save the Children have prioritised psychosocial issues in humanitarian emergencies (Williamson and Robinson, 2006). MHPSS departments have been established across the globe, often cooperating with local mental health agencies to promote both short and long-term interventions to alleviate emotional suffering in times of crisis (Tol et al., 2015).

Such programs are critical, as war and conflict fragment societies and damage their capacity for recovery (Rokhideh, 2017). The negative impacts of war and conflict affect future generations, as the memory of trauma and violence is transmitted across generations. This intergenerational trauma erodes the cultural, physical, and socio-emotional conditions of a society (Lehrner and Yehuda, 2018). Research has shown that the effects of post-conflict trauma on communities include high levels of social fragmentation; broken families and warring communities; violence and aggression; gender-based violence; negative economic productivity trends; alcohol and drug abuse, and depression and suicide (Tinari and Fürst, 2020).

Paying attention to psychiatric illnesses and emotional wellbeing—from biological, sociological and psychological perspectives—is evidently important. MHPSS programs are developed on mass scales and international NGOs strive to provide adequate services

to individuals, groups and communities in complex humanitarian situations. However, medical anthropology has begun to question the utility of imposing Western-based MHPSS programs and interventions on communities across the world (Roepstorff, 2020). On one hand, MHPSS interventions might be valuable in bringing attention to humanitarian problems. On the other hand, these efforts might be considered as another form of modern colonisation. Specifically, growing critiques from the international humanitarian community have been made regarding the overly medicalised approach used in assessing and treating individuals in humanitarian emergencies (Roepstorff, 2020; Watters, 2001). Watters (2001) argues that attention should be given to the socio-ecological factors that affect individuals in those settings, rather than focusing on bio-medical treatment which often portrays them as "passive victims" (p. 2).

The field of MHPSS uses an approach called the Inter Agency Standing Committee (IASC) MHPSS Pyramid of Interventions, which was created by the IASC in 2006 (O'Connell et al., 2021). It aims to categorise interventions that target both recovery and prevention phases. Recovery interventions include creating community resilience, strengthening the social fabric that was destroyed, or creating a new one to be ready for following adversities (Tol et al., 2015). Prevention interventions include psychosocial support to help people affected by crises to recover and help communities to get up on their feet, and aims to prevent certain symptoms developing into pathology (e.g., Post Traumatic Stress Disorder) (Tol et al., 2015; O'Connell et al., 2021).

Decolonisation

Andreotti et al. (2015) discuss the term decolonisation in relation to the right to self-determination and as a process that seeks to challenge white supremacy. Decolonisation, according to Tomaselli (2016), is achieved through developing forms of autonomy for indigenous people, including self-governance and economic independence. The process of decolonisation becomes more complicated in times of crisis and humanitarian emergencies (Andreotti et al., 2015).

Arthur Kleinman's *Social Suffering* (1997) offers a critical analysis of interventions for social problems that are influenced by power and colonisation. In the growing field of MHPSS, it is inevitable that the intentions behind mental health and psychosocial interventions in humanitarian emergencies are questioned, especially when they are coordinated by international NGOs. Recent research has examined the relationship between global mental health and the preservation of global power dynamics (Kola et al., 2021), however practical responses to these critiques have been widely avoided by most international agencies. Perhaps philanthropists and donors do not appreciate seeing the word 'colonising' in a grant proposal; however, programs that do not involve a critical lens will not be able to offer a culturally respectful approach to the delivery of critical mental health services.

According to Bojuwoye and Sodi (2010), MHPSS colonisation is grounded in Euro-American oriented approaches to mental health services, which usually include the use of conventional Western psychotherapy. Despite the limitation of Western body-mind practices evident in many non-Western countries, where the integration of holistic approaches is often embraced within traditional healing practices, MHPSS programs often miss integrating local practitioners, claiming that their practices are not evidence-based (Finnstrom, 2008).

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Since its formation as an international development and humanitarian aid practice, MHPSS has been coping with these tensions within the world of community work. This is because, in part, the framework that guides MHPSS does account for varying cultural and socio-political contexts across the communities in which it is implemented. Bojuwoye and Sodio (2010) emphasise the importance of implementing traditional healing and therapeutic practices into local psychotherapy work in humanitarian emergencies. As the world of aid covers events where high exposure rates to trauma are evident, there is a need for practitioners who use local healing practices and methods, and for programs that take into consideration the stigma many communities have towards mental health conditions.

Cultural relativism

The term cultural relativism is defined by Swartz (1996) as the ability to comprehend a certain culture and its social norms according to its own people. The goal of this approach is to promote an understanding of cultural practices as well as enable others to live according to their own norms and beliefs. In relation to mental health, the concept of cultural relativism might be adopted by understanding that a society's practices and traditions could affect how therapy is conducted, or by choosing to approach mental health issues differently and with respect to local cultures.

Therapeutic governance

Therapeutic governance is defined by Pupavac (2001) as a means of control through which non-profit organisations and other international agencies represent 'Western' values and interests and seek to manage global risk in emergencies. Therefore, according to Rehberg (2015), psychosocial programs might be seen as dehumanising less-economically developed countries and non-Western cultures. Rehberg also suggests that therapeutic governance in relation to psychosocial interventions and other well-being programs could affect the way psychosocial professions (social workers, psychologists, mental health practitioners) perceive what seems to be the appropriate intervention in cases of emergency.

Localisation

Research and academia have not yet established one explicit definition of localisation. However, the International Federation of Red Cross and Red Crescent Societies (IFRC) define localisation as "a process of recognising, respecting and strengthening the independence of leadership and decision making by national actors in humanitarian action, in order to better address the needs of affected populations" (IFRC, 2018, p. 2). The predominant goal of localisation is to make aid response better through ensuring access to reliable, affordable, inclusive, and tailor-made humanitarian services for all populations in need (Van Brabant and Patel, 2018).

Local agencies and humanitarian NGOs are vital for this aim and carry distinct, meaningful strengths, mostly because they play a critical role in guaranteeing early response and understand the socio-cultural and religious contexts of affected populations in emergencies. Therefore, localisation comes from the understanding that a multidisciplinary approach is needed in humanitarian work to navigate between immediate responses to development and recovery (Van Brabant and Patel, 2018). In MHPSS, the main goal of localisation would be to maximise not only the interests of local stakeholders but maximise collaborations between international and national providers (Tol et al., 2015).

The cluster system

The UN cluster system is a mechanism used by the UN to coordinate services that are made to serve individuals during and after an emergency (Abaya et al., 2020). In 2020, more than 36 countries have been recognised as 'clustered countries'—those that use the system. Clusters include different thematic areas such as nutrition, water and hygiene, gender-based violence and health. Each cluster coordinates between the different humanitarian interventions that provide services in a specific setting and are usually overseen by UN agencies (Abaya et al., 2020).

The cluster system and its coordination are complex and bureaucratic (Olu et al., 2015). Between the UN agencies in Geneva and New York, and between the individuals and communities who end up receiving MHPSS services, there are multiple layers of stakeholders and organisations, each with their own motives, including political power, funding and prestige (Roepstorff, 2020). Each layer contains professionals and non-professionals who, due to globalisation and the high number of NGOs providing psychological support, come from different backgrounds and have different motivations and understanding. When guidelines are written in an office in Geneva to cope with, for example, adolescents who are survivors of sexual abuse, it is inevitable that cultural nuances will be missed and that the guidelines will lack deep understanding of local mental health issues.

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Increasing the influence, decision-making and access to financial resources of local stakeholders leads to a quicker, more efficient, and sustainable humanitarian response (Manis, 2018). These advantages can be due to the better awareness of local MHPSS service providers to the local government, political and social dynamics, which often leads to a more culturally appropriate approach to fulfilling the needs of a community (Chan and Shaw, 2020). Such advantages are particularly valid with respect to child-protection programs, especially when looking at multi-sectoral work. The multi-sectoral approach is based on the belief that cooperation between different UN clusters during an emergency strengthens interventions and enables clients to receive adequate and accessible services (Chan and Shaw, 2020).

An example of the implementation of this approach could be through an education cluster working together with a protection cluster to provide adequate MHPSS services that tackle both emotional support in schools and adequate access to prescribed medications (UNICEF, 2018). As children around the world depend on psychosocial care, the localisation—and ownership of—accessible MHPSS services is needed. Therefore, a localised approach provides an opportunity to enhance access to services, and increase their quality and effectiveness, while acknowledging a region's or country's essential duty to protect its citizens—even in places where adequate access to mental health care is less approachable (Roepstorff, 2020).

The current study

Based on the theoretical frameworks presented so far in this paper, there is an urgent need to bridge the gaps between the continuous colonisation of Western-based therapy modalities and the ambition of the UN to localise services. This paper aims to answer specific questions to provide a coherent, evidence-based picture of the funding and localisation efforts of MHPSS services, including:

1. What financial contribution did the UN make to support the localisation of humanitarian MHPSS services in less economically developed countries between the years 2017-2021?
2. What were the primary sectors with localised humanitarian MHPSS-related funding in less economically developed countries between the years 2017-2021?

Methodology

Design

An outcome evaluation was conducted for this paper. The assessment measured the funding of local grassroots organisations in the provision of MHPSS services in less economically developed countries, to determine whether and how well the objectives of localising MHPSS services—an objective set by the UN's Grand Bargain—have been met.

Quantitative methods of analysis were selected in order to have a clear picture of how much funding has been dedicated to localising MHPSS services since the Grand Bargain. For this reason, an analysis of cash transference has been done. This research could catalyse donors and UN agencies to fund localisation and capacity building efforts, through providing an overview on where it is lacking.

Sample

All data was collected from the UN Funding Track System (FTS) to evaluate how localisation was enhanced in developing countries through prioritisation in the humanitarian funding arena. The study includes data from 40 international agencies and governments that fund humanitarian MHPSS activities in less economically developed countries. This data includes information on the amount of cash transferred from donors and international organisations to local agencies in less economically developed countries between the years 2017-2021. The feasibility of this evaluation is high since FTS includes most of the funding in this arena that governments and funds report to the United Nations.

The sample included the following organisations:

- Local organisations—registered in the one country only, with headquarters in the same country activities are provided
- Organisations providing MHPSS services
- Organisations receiving direct funding from international organisations
- Organisations registered in the UN Funding Track System

Measures

The outcome variable was money, or financial contribution, in dollars, per year (2017-2021) allocated for one of the following services: mental health interventions that include psychotherapy or psychotropic medications; the creation of informal child-friendly spaces in humanitarian settings; mental health and psychosocial support trainings for service providers; and/or any direct case management with individuals in less economically developed countries. As MHPSS is not a standalone sector, the outcome variable of financial contributions over time were analysed in six humanitarian sectors: health; water, sanitation and hygiene (WASH); gender-based violence; nutrition; protection, and shelter.

Both research questions were measured via the use of the UN Funding Track System (FTS). All data supplied to FTS—including by local organisations who provide MHPSS services—is collected, curated, and published. This is referred to as "total reported funding" and indicates only direct funding. This database was utilised to examine humanitarian funding across all sectors between 2017 and 2021, in other words, funding across the last five years.

The funding analysis was based on extracting MHPSS keywords mentioned in the description of the funding in the FTS. In particular, the analysis focused on funding going to local and national actors (such as local NGOs, national NGOs, national governments) in respect to MHPSS. Keywords searched for in the funding description included: MHPSS, Mental Health, PSS, Psychosocial, CFS, Child Friendly Space. The French and Spanish equivalents of the above terms were also part of the keyword search. Data was extracted from FTS on 17 January 2022.

Data analysis

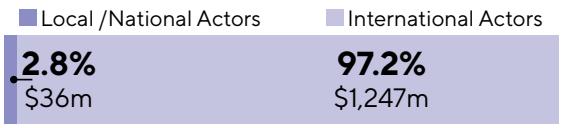
Data was analysed using Microsoft Excel and examined whether there was a specific trend for financial contributions over 2017-2021 within the main humanitarian sectors of health, WASH, gender-based violence, nutrition, protection, and shelter. The level of measurement is continuous. Descriptive statistics have been examined.

Results

The results of the quantitative analysis are described in this section.

The Big Picture: Money spent on MHPSS-related funding

Figure 1: Funding with an MHPSS keyword on FTS between 2017-2021



As can be seen in Figure 1, only $3 in every $100 of the funding identified as related to MHPSS activities in the last five years goes directly to a local or national organisation.

It was found that the international actors receiving over $30 million across the five-year period were: KfW Development ($341m), the International Organisation of Migration ($59m), the United Nations Relief and Works Agency ($49m), the International Rescue Committee ($40m), Save the Children ($39m), the United Nations High Commission for Refugees ($38m), International Red Cross and Red Crescent ($34m), and the United Nations Population Fund ($31m). Forty local and national actors shared the remaining $36 million dollars.

Overall MHPSS-related funding vs. local and national agencies

Figure 2: All funding with MHPSS keywords vs. specific local funding to local and national agencies (L/NA) between 2017-2021

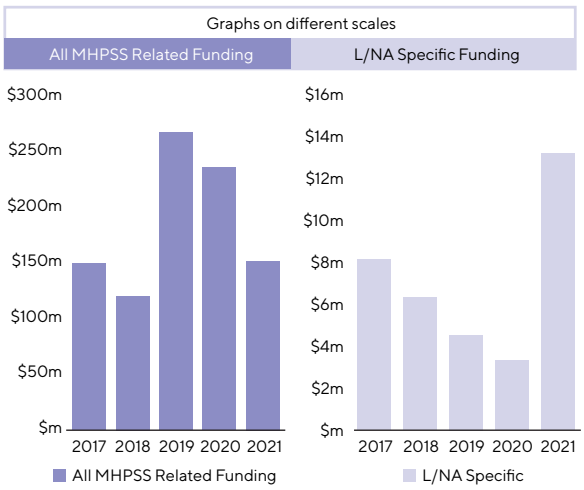
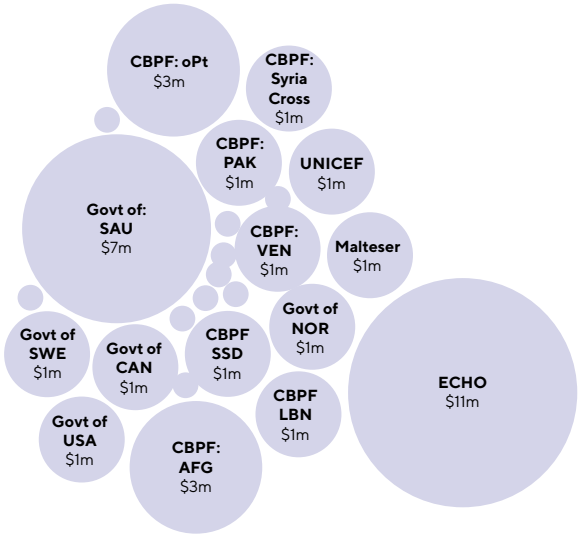


Figure 2 reveals that total MHPSS-related funding has fluctuated year-on-year, starting the period with $150 million in 2017, and ending it with $154 million in 2021. Specific funding directed towards local and national actors appears to be declining year-on-year, until 2021 when it reached a new high of $13 million (+150% increase on 2020).

Country-based pooled funds (CBPFs) donations to MHPSS-related local and national agencies

Figure 3: Division of funding according to country-based pooled funds



Key:
CBPF: oPt = Country-based pooled funds Occupied Palestinian Territories
CBPF: Syria Cross = Syria Cross-border Humanitarian Fund
Govt of SAU = Government of Saudi Arabia
Govt of SWE = Government of Sweden
Govt of USA = Government of United States of America
CBPF: AFG = Country-based pooled funds Afghanistan
CBPF: SSD = Country-based pooled funds South Sudan
Govt of NOR = Government of Norway
CBPF: LBN = Country-based pooled funds Lebanon
ECHO = European Commission's Humanitarian Aid and Civil Protection (ECHO)
CBPF: VEN = Country-based pooled funds Venezuela
CBPF: PAK = Country-based pooled funds Pakistan
UNICEF = United Nations International Children's Emergency Fund

Figure 3 presents the largest donors of direct MHPSS funding to local and national actors. These were the European Commission's Humanitarian Aid and Civil Protection department (ECHO) and the Government of Saudi Arabia (all funds from both donors were for Syria and Yemen). However, if looking at the organisation type contributing funds to MHPSS-related activities, pooled funds come out on top, with 34% of all funding identified coming through pooled funds in Afghanistan, occupied Palestinian territories (oPt), Syria-Cross-border, South Sudan, Lebanon, Pakistan, and Venezuela—all of which contributed +$500K. Country-based pooled funds are seen to be a driver of MHPSS-related funding to local and national agencies.

Primary beneficiaries of MHPSS-related funding to local and national agencies

Figure 4: MHPSS-related funding to local and national agencies (L/NA) by context

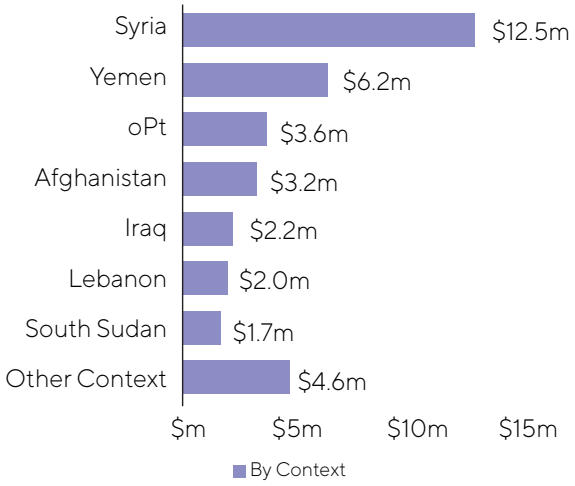
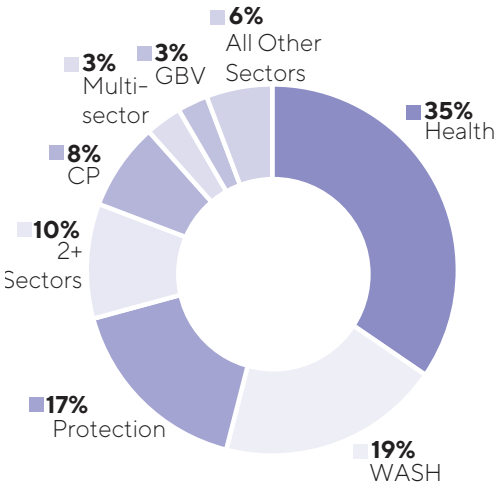


Figure 4 shows that of the contexts that received more than $1 million over the five-year period, six of the seven were in the Middle East. This is partly due to the high volume of funding to Syria and Yemen from ECHO and Saudi Arabia. However, it is also in part due to the country-based pooled funds. All localised MHPSS-related funding for Afghanistan came through the pooled fund, 85% of the identified occupied Palestinian territories funding came from the pooled fund, and the equivalent figure for Lebanon was 48%. Middle Eastern contexts were the primary beneficiaries of identified MHPSS-related funding to local and national agencies.

Multi-sectoral work with localised MHPSS-related funding

Figure 5: Sector breakdown of localised MHPSS-related funding



A sector breakdown of the $36 million allocated to local and national agencies over the five-year period shows that health receives a plurality of funding (35%), followed by WASH (19%), and protection (17%). Child protection (CP) (8%) and gender-based violence (GBV) (3%) make up a combined 11% of the total. Together with protection, these three sectors combine 28% of the funding. 10% of the total relates to funding that includes more than one sector, while 3% relates to 'multi-sector' funding, which has historically been a catch-all term for refugee-related funding. Health, WASH, and protection are the primary sectors with localised MHPSS-related funding.

Discussion

The findings show a constant trend of continuing inequality when it comes to MHPSS funding for local and national agencies.

Finding 1: Overall MHPSS-related funding

Summary: As can be seen in Figure 1, the funding identified as related to MHPSS activities in the last five years was disproportionally split between international actors and local and national agencies. While more than 97% of the money funded international actors, a significantly smaller portion (less than 3%) was divided among 40 local and national agencies worldwide.

Implications and recommendations: Referring to Tomaselli's (2016) claim that economic independence is required to achieve decolonisation, this finding determines that economic independence has not been a main focus of the international humanitarian community, and questions its seriousness in regard to decolonising the humanitarian field. This implies that a thorough understanding among international donors about the importance or benefits of localisation has not been achieved, and that there is a gap between what was aimed for with the Grand Bargain and the engagement of the international philanthropic community. Therefore, it is recommended that the Grand Bargain Secretariat, together with the UN Office for the Coordination of Humanitarian Affairs (OCHA)—the official UN body in charge of strengthening the international response to complex emergencies and natural disasters (Keen, 2008)—should develop policies for international donors that indicate that a certain percentage of their financial contributions are donated directly to local and national agencies.

Plausible alternative explanations: Keyword searches only showed funding that had one of the selected terms in the description of the project. It is likely that there are projects that didn't include an MHPSS term in the description but do include MHPSS elements.

Finding 2: Localisation of MHPSS-related funding

Summary: Figure 2 indicates that total MHPSS-related funding has fluctuated year-on-year, but when comparing 2017 (one year following the Grand Bargain) and 2021 (five years after), there has been a slight increase. Looking at local and national agency-specific funding, there has been a significant increase in funding during 2021, after four consecutive years of declining funding.

Implications and recommendations: The increase in 2021 of specific local and national agency funding indicates a possible positive shift in trends, where more local and national agency interventions are funded. It is recommended that local and national agencies should connect donors with the organisation's objective and enable donors to directly fund certain areas of the organisation's work.

Plausible alternative explanations: Due to the increased needs of less economically developed countries for mental health interventions due to the eruption of COVID-19 in 2020, it is possible that funding was increased specifically for the following year, but does not yet indicate a positive trend.

Findings 3 and 4: Country-based pooled funds as drivers of MHPSS-related funding to local and national agencies, and focus on Middle East and North Africa (MENA) contexts

Summary: Donors can aggregate their contributions into a single, unrestricted fund to support local humanitarian operations through country-based pooled funds. This allows humanitarian partners in crisis-affected nations to provide timely, well-coordinated, and ethical aid. Figure 3 indicates that the largest donors were ECHO and the Government of Saudi Arabia, and that their donations were directed to support Syria and Yemen. In addition, Figure 4 shows a large focus on the Middle East and North Africa.

Implications and recommendations: FTS data has not yet been released for 2022, and as ECHO is based in Europe, there is a possibility that more money will now go to support the current crisis in Ukraine which escalated in February (WHO, 2022). This possibility emphasises that although specific contributions have been donated to local and national agencies, there is a noticeable imbalance between regions and continents. For instance, although Ethiopia has experienced conflict in Tigray since 2020, it has not been a priority for country-based pooled funds. For this reason, OCHA is encouraged to monitor equitable donations to different parts of the world, to prevent potential political biases that affect financial support for local and national agencies.

Plausible alternative explanations: Funding to local and national agencies through an intermediary is often not captured on FTS. Therefore, there may have been more direct funding via country-based pooled funds that have not been tracked. In addition, data has not yet been released for 2022, and different trends may arise, given the escalation in conflicts in Ukraine and in Ethiopia.

Finding 5: Multi-sectoral work with localised MHPSS-related funding

Summary: Figure 5 shows that within local and national agency funding, health received the plurality of the MHPSS-related funding, followed by WASH, with protection, child protection and gender-based violence receiving a combined 28% of remaining funds.

Implications and recommendations: These results indicate a significant bio-medical approach in terms of the coordination of MHPSS services. As mentioned in the concept review, an overuse of a medical approach to MHPSS contributes to the portrayal of individuals in humanitarian settings as "passive victims" (Watters, 2001, p. 2). The results suggest that most of the funding supports the use of psychotropic medications and other medical treatments when coping with mental health issues, rather than following community-based interventions that use the capacities and assets of local communities as catalysts for healing and enhancing mental wellbeing. Therefore, it is recommended that OCHA uses its monitoring ability to create funding policies that support protection sector MHPSS-related interventions.

Plausible alternative explanations: As previously mentioned, funding to local and national agencies through an intermediary is often not captured on FTS, which might affect the results accordingly—there may have been more or less contributions to each sector. In addition, although the health sector widely uses medical treatments such as the use of psychotropic medications, co-sectorial interventions are difficult to track, and community-based interventions may also have been conducted by the health sector with no detected documentation.

Limitations and caveats

It is important to mention that there are several limitations and caveats on this research. A keyword search of funding descriptions will only show funding that has highlighted one of the selected terms in the short description of the project. However, it is likely that there are many more projects that didn't include a MHPSS term in the description but do include MHPSS elements. The inverse is also true. If a funding flow has

MHPSS in its description, it is likely that the funding is not 'MHPSS only' but that MHPSS components form part of a wider package of funding.

Given the methodological approach of using keywords, it is impossible to account for these two effects. Therefore, a high degree of caution should be exercised when interpreting the results. Specific numbers should not be interpreted as the definitive picture but should be interpreted as a hint towards the general situation. Another substantial caveat should be made regarding funding on FTS, which often only captures one part of the overall flow. For example, FTS may show that the US Government gave funding to UNICEF for child protection in Bangladesh, but in most cases, it is unlikely that FTS will show any flow of funding from UNICEF in Bangladesh through to a local partner that receives part of that funding for activities. In other words, funding local and national agencies through an intermediary is often not captured on FTS. Therefore, when interpreting the results, it should be considered that they more accurately reflect direct funding and not indirect funding, which is likely to be substantially higher.

Suggestions for further evaluation

Given the limitations of measuring indirect funding, further evaluation of financial contributions forwarded to local and national agencies through an intermediary is highly recommended. For this purpose, a collaboration between FTS, OCHA and the Grand Bargain Secretariat would be needed, to accumulate all possible sources of data on financial contributions. In addition, the cooperation of the largest donors, such as the Government of Saudi Arabia and ECHO is also needed, including the interpretation of their annual financial reports.

Further evaluation is required to assess what effects the funding of local and national agencies had on MHPSS services, and compare the results with local and national agencies that lack funding. It is recommended that Key Informant Interviews (KII) are held and are based on the six parameters for localisation produced by the UN to assess the Grand Bargain, which include quality of partnerships, funding, capacity, coordination, policy and local participation (Featherstone, 2019).

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