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THE GLOBAL STATE OF MHPSS IN THE RED CROSS RED CRESCENT MOVEMENT: 2025 FINDINGS

The Global State of MHPSS in the Red Cross Red Crescent Movement: 2025 Findings
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Abbreviations

GBV / SGBV – Gender-Based Violence / Sexual and Gender-Based Violence

HR – Human Resources

ICRC – International Committee of the Red Cross

IFRC – International Federation of Red Cross and Red Crescent Societies

MEAL – Monitoring, Evaluation, Accountability and Learning

MENA – Middle East and North Africa

MHPSS – Mental Health and Psychosocial Support

NS(s) – National Society (Societies)

PFA – Psychological First Aid

Movement – Red Cross Red Crescent Movement

SOGIESC – Sexual Orientation, Gender Identity and Expression, and Sex Characteristics

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Executive Summary

The 2025 Global MHPSS Survey provides a comprehensive overview of the status, capacity, and future direction of MHPSS across the Red Cross Red Crescent Movement (Movement). Based on responses from 118 National Societies (NSs), together with the International Federation of Red Cross and Red Crescent Societies (IFRC) and the International Committee of the Red Cross (ICRC), and reaching a 62% global response rate, the survey offers a robust picture of how MHPSS is being implemented and strengthened across diverse humanitarian contexts.

The findings confirm that MHPSS is now firmly established as a core pillar of humanitarian action. An overwhelming 95% of responding organisations report delivering MHPSS activities, supported by a workforce of an estimated 110,000 to 125,000 staff and volunteers. More than 254,000 personnel have been trained in basic psychosocial support and Psychological First Aid (PFA), and 92% of organisations have designated MHPSS focal points. These figures reflect sustained investment in capacity building and strong organisational commitment across the Movement.

At the same time, MHPSS is entering a new phase of expansion and integration. A majority of organisations report plans to scale up activities, while nearly two-thirds aim to mainstream MHPSS across sectors such as health, disaster management, and protection. This shift signals growing recognition of MHPSS as a cross-cutting priority, although institutionalisation remains uneven. While over half of organisations include MHPSS in their broader strategies, fewer have formal policies or dedicated frameworks in place, highlighting the gap between implementation and governance.

Service delivery across the Movement spans the full continuum of care but remains concentrated at the community level. Most organisations focus on basic and focused psychosocial support, with fewer providing specialised mental health care. This reflects a strategic emphasis on scalable, high-reach interventions such as PFA, awareness raising, and community-based support, while also pointing to ongoing gaps in specialised services and referral systems.

Supporting the well-being of staff and volunteers continues to be a priority across the Movement. The majority of organisations report offering well-being activities, primarily through self-care, peer support, and psychological support. However, these efforts are not yet consistently embedded within formal systems, with less than half of respondents reporting the existence of policies or structured frameworks for staff and volunteer care.

Despite the expansion of MHPSS programming, systems for monitoring, evaluation, and research remain underdeveloped. Less than half of organisations report regularly monitoring MHPSS activities, and only a quarter are engaged in research. Limited funding, technical capacity, and dedicated staffing continue to constrain evidence generation and learning, reducing the ability to demonstrate impact and inform strategic decision-making.

Humanitarian Diplomacy and Advocacy for MHPSS are widely practiced, with strong participation in coordination mechanisms and public engagement. However, this operational visibility is not yet fully matched by institutional recognition. Only a minority of organisations report inclusion in national policies or access to dedicated government funding, underscoring persistent gaps in formal integration and sustainable financing.

Overall, the survey highlights a Movement where MHPSS is widely implemented, increasingly integrated, and strongly prioritised, yet still constrained by gaps in institutionalisation, evidence systems, and long-term financing. Moving forward, strengthening policy frameworks, embedding MHPSS across sectors, investing in monitoring and research, and advancing strategic humanitarian diplomacy will be critical to ensuring that MHPSS services can be delivered at the scale, quality, and sustainability required to meet growing global needs.

Introduction

Mental health and psychosocial support (MHPSS) continues to be a core priority across the Movement, reflecting both increasing global needs and sustained Movement-wide commitment. Across its three components—the 192 NSs, the IFRC and the ICRC—the Movement delivers a wide range of MHPSS activities and services to protect and promote well-being, alleviate human suffering, and support the dignity of people affected by crises, as well as staff and volunteers.

MHPSS programming across the Movement spans the full continuum of care, from prevention and promotion of psychosocial well-being, through focused and psychological support, to specialised mental health care. This approach is grounded in the Movement MHPSS Framework[1] (see figure 1), which recognises that mental health needs are diverse and dynamic, requiring complementary and layered responses tailored to the needs of individuals, families,and communities in all cotexts. These efforts are guided by the Movement Policy on Addressing Mental Health and Psychosocial Needs (2019) [2]and reinforced by Resolution 2 of the 33rd International Conference[3], affirming the collective Movement-wide commitment to addressing mental health needs in humanitarian settings.

The 2025 Global MHPSS Survey confirms that MHPSS is firmly embedded across the Movement, with continued progress in the implementation of policy commitments and the expansion of services. These developments are closely aligned with the priorities set out in the new MHPSS Hub Strategy 2026–2030[4], which emphasises strengthening quality, scale, integration, and systems of care, while advancing MHPSS as a fundamental humanitarian priority and an essential component of health and well-being.

The survey was conducted in a context of intensifying global polycrises, including armed conflicts, climate-related disasters, public health emergencies, and displacement, combined with a broader humanitarian reset marked by funding constraints and operational pressures. These dynamics are driving increasing and more complex mental health needs, while simultaneously limiting the ability to deliver sustained and scalable MHPSS support.

Against this backdrop, the 2025 Global MHPSS Survey aims to:

- Monitor progress in implementing the Movement's MHPSS Policy since the 2023 Global MHPSS survey
- Identify emerging priorities, opportunities to strengthen MHPSS capacity, and MHPSS programming needs across regions
- Inform Movement-wide learning, advocacy, and resource mobilisation efforts
- Provide the baseline for the MHPSS Hub Strategy 2026–2030

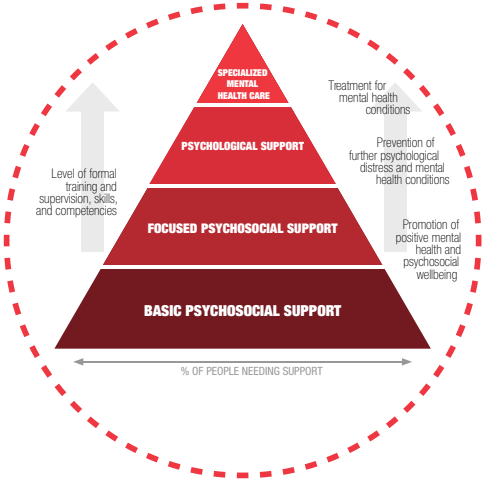


Figure 1: The Movement MHPSS Framework

1 Read more: The MHPSS Framework - MHPSS Hub
2 The International Red Cross and Red Crescent Movement policy on addressing mental health and psychosocial needs; 2019
3 Resolution 2: Addressing mental health and psychosocial needs of people affected by armed conflicts, natural disasters and other emergencies; 2019
4 The Red Cross Red Crescent Movement MHPSS Hub strategy 2026-2030; 2026

Methodology

The 2025 Global MHPSS Survey was developed to capture a comprehensive overview of MHPSS capacity, activities, systems, and priorities across the Movement. The survey was structured around five thematic areas: 1) Organisational capacity, human resources, and integration of MHPSS; 2) MHPSS activities and programmes; 3) Caring for staff and volunteers; 4) Evidence building and learning for MHPSS: MEAL (Monitoring, Evaluation, Accountability and Learning) and Research); 5) Humanitarian Diplomacy and Advocacy for MHPSS.

The survey was disseminated in Arabic, English, French, and Spanish to all 189 NSs, the IFRC, and the ICRC in November 2025. Follow-up with respondents took place between November 2025 and February 2026 to support completion and validation of submissions.

Each component of the Movement was requested to provide one consolidated response, covering both domestic and international MHPSS activities implemented within the reporting period (January 2024 to December 2025).

The analysis is based on responses from 118 NSs, the IFRC and the ICRC, representing an overall response rate of 62%. Regional response rates vary as shown in the table below:

These responses provide a substantive and representative overview of MHPSS implementation across the Movement, while also reflecting regional variations in participation.

Data considerations and limitations

Findings presented in this report are based on self-reported data provided by respondents, which may be subject to differences in interpretation, reporting practices, and data availability across organisations.

In addition, aggregation and comparison with previous Global MHPSS survey cycles (2019-2021-2023)[5] should be interpreted with caution, as the questionnaire has evolved and the scope and purpose of the survey have been further refined. As a result, some indicators are not directly comparable over time.

Data gaps were also identified in some areas, where respondents indicated "don't know" or reported zero values which can be attributed to the diversity of organisational structures across NSs and the lack of access and tracking HR-related data for MHPSS focal points. This suggests that certain figures—particularly related to human resources and systems—may represent minimum estimates rather than complete coverage.

Overall, while the survey provides a robust basis for identifying global trends, patterns, and gaps, the findings should be understood as indicative of the current state of MHPSS across the Movement, rather than exhaustive.

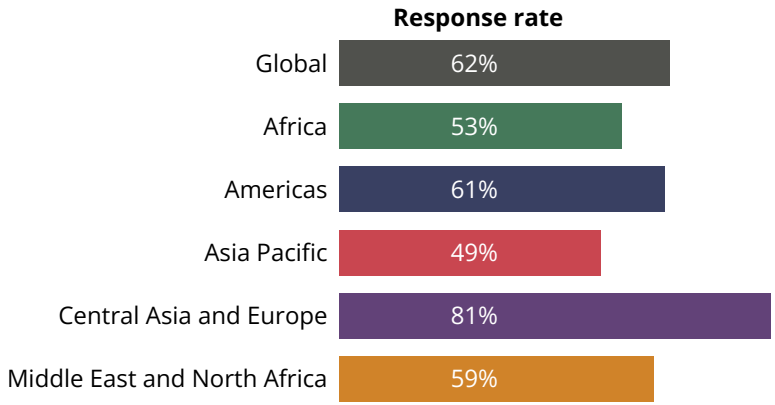


Figure 2: Percentages of respondents global and per region

5 Previous MHPSS survey reports. Read more: https://mhpsshub.org/about-us/focus-areas/the-mhpss-roadmap-project/mhpss-progress-in-the-movement/

Results: State of MHPSS Across the Movement

Global Overview of Organisational MHPSS Capacity and Human Resources

95% of reporting NSs, the IFRC and the ICRC provide MHPSS activities

56% have integrated MHPSS into their general strategy

254,869 staff and volunteers are trained in basic psychosocial support and/or psychological first aid skills

32% have a formal policy, framework, or strategy dedicated to MHPSS

92% have a designated MHPSS Focal Point

46% are currently developing or planning to develop an MHPSS strategy

Movement staff engaged in MHPSS

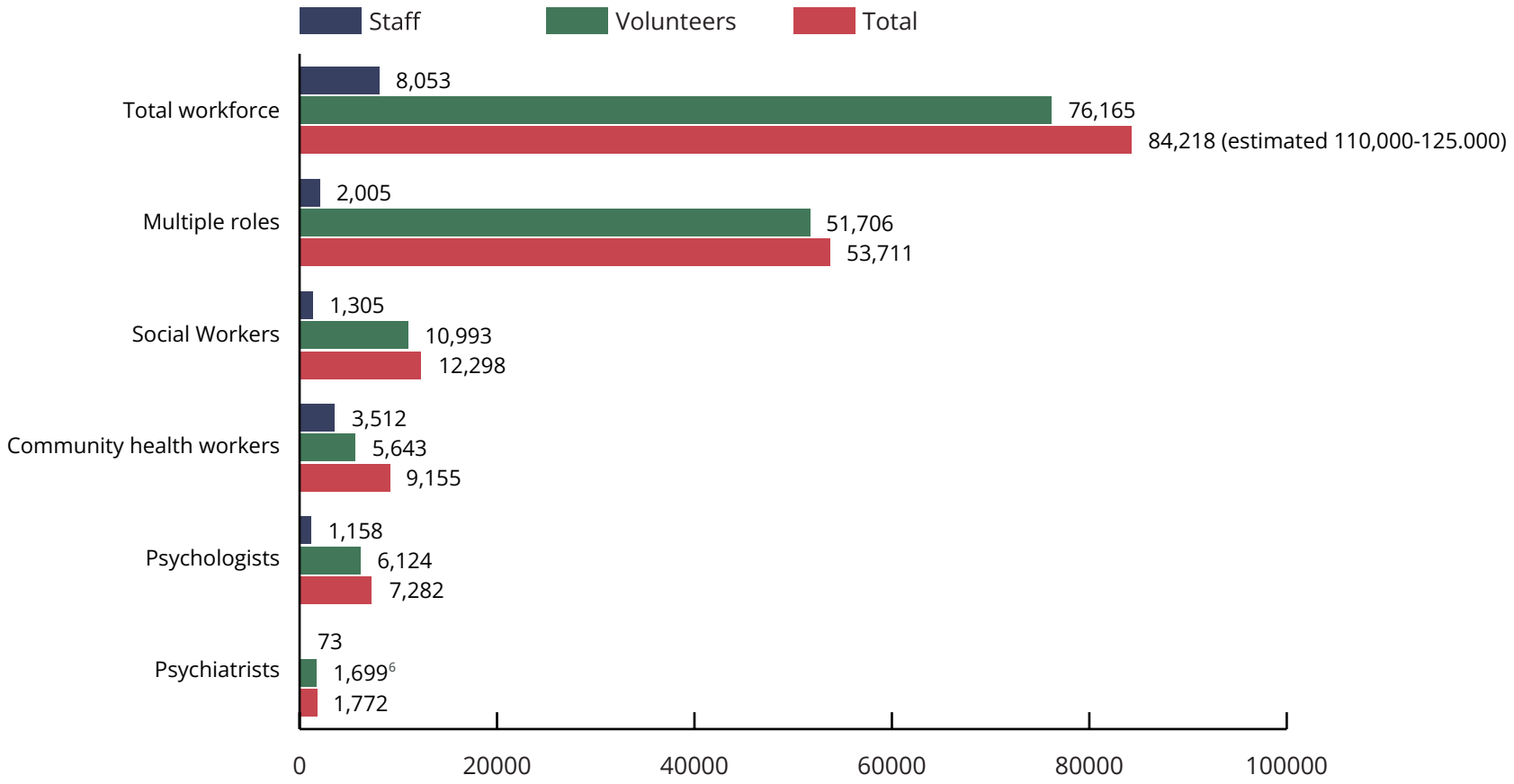


Figure 3: MHPSS workforce in the Movement

6 1,624 volunteer psychiatrists were reported by Spanish Red Cross

Future Trends and MHPSS Integration

71% of National Societies plan to expand standalone MHPSS activities

64% plan to integrate/mainstream MHPSS across other sectors (e.g., health, wash, protection)

3% anticipate to reduce MHPSS activities

Caring for Staff and Volunteers

69% provide activities/resources to support staff and volunteer well-being

41% have a formalised, written policy on staff/volunteer mental health

Evidence Building, MEAL, Research and Advocacy

66% engage in MHPSS Humanitarian Diplomacy and Advocacy

42% regularly monitor and collect data on MHPSS activities

25% are actively involved in MHPSS research initiatives

Key Findings

Strong and continued commitment towards MHPSS across the Movement

The 2025 survey findings demonstrate a continued commitment to implementing the Movement Policy on MHPSS.

95% of responding NSs, the IFRC and the ICRC deliver MHPSS activities, confirming that MHPSS is a core and well-established programmatic area across the Movement

This commitment is supported by a wide and predominantly community-based workforce:

84,218 staff and volunteers reported, with an estimated 110,000–125,000 actively engaged globally

Workforce is heavily driven by community-based volunteers, particularly social workers and community health workers

92% of respondents report a designated MHPSS focal point, indicating strong organisational structures supporting MHPSS.

Over **225,000** staff and volunteers have been trained in basic psychosocial support and PFA, demonstrating a significant expansion of MHPSS capacity. The number of trained personnel has increased steadily over time, from 42,000 in 2019 to around 88,000 in 2021, and over 202,000 in 2023.

Overall, delivery of MHPSS activities remains anchored at basic levels of care, reflecting a Movement-wide focus on scalable, community-based approaches.

Continued expansion and integration of MHPSS

The data points to sustained growth and future ambition:

71% of respondents plan to expand MHPSS activities

64% of respondents aim to integrate or mainstream MHPSS across sectors such as health, disaster management, and protection

This indicates a transition from stand-alone programming towards holistic, integrated approaches, and cross-sectoral programming consistent with trends observed in earlier MHPSS Progress report.[7]

7 ibid

Key Findings

Progress in implementing caring for staff and volunteers activities with opportunities to strengthen the policy

Supporting the mental health and well-being of staff and volunteers remains a clear priority:

- **69% of respondents provide activities or resources for staff and volunteer well-being**
- **41% have a formal policy on caring for staff and volunteers in place**

This highlights a shift from ad hoc or activity-based support towards acknowledging the need for institutionalised protective systems, ensuring consistency, sustainability, and accountability.

Limited progress in MHPSS evidence building, MEAL and research

While monitoring is increasingly recognised as essential, only:

- 42% of respondents regularly collect and monitor data on MHPSS activities
- 25% are engaged in research

This suggests that while implementation is scaling up, systems for evidence building and research are still developing, with opportunities to further strengthen the Movement's ability to demonstrate impact, support quality improvement, and contribute to global research and practice in MHPSS.

Growing advocacy engagement with opportunities to strengthen strategic positioning

The Movement continues to play an active role in Humanitarian Diplomacy and Advocacy:

- 66% of respondents engage in MHPSS advocacy, primarily through events, coordination platforms, and communication channels
- 56% report inclusion of MHPSS in organisational strategies, reflecting increasing institutionalisation
- 32% report the existense of formal policies or frameworks (with 46% developing them)

This highlights the need to further strengthen MHPSS as a strategic priority across all Movement components, both internally, and in their respective engagements with governments and external partners.

Global Analysis

The 2025 Global MHPSS Survey was conducted in a period marked by intensifying global challenges and increasing funding constraints on humanitarian action, shaping both the demand for, and the delivery of, MHPSS services. The global context is defined by a convergence of interconnected crises—armed conflicts, public health emergencies, climate-related shocks and natural hazards, and rising levels of displacement and migration—which continue to compound vulnerabilities and contribute to increasing and evolving mental health and psychosocial needs.

Across all regions, these overlapping polycrises are contributing to a significant increase and diversification of mental health needs, affecting not only communities experiencing acute emergencies but also those living in protracted and increasingly unstable contexts. At the same time, access to MHPSS services remains uneven and insufficient, with persistent gaps in coverage, inclusion, and continuity of care.

Data from the IFRC[8] databank highlights a significant decline in the number of people reached with MHPSS services, decreasing from 16.7 million people in 2023 to 8.5 million in 2024, representing a reduction of more than 50%.

This decline reflects the combined effects of growing operational complexity, increasing demand, and constrained funding for MHPSS, rather than reduced needs.

These challenges are taking place in the context of a profound and prolonged funding crisis affecting the humanitarian sector, where MHPSS remains significantly underfunded relative to the growing needs of populations. Chronic underinvestment in MHPSS continues to undermine service continuity, weaken national and community-level systems, and limit the ability to scale or sustain responses, particularly in fragile and resource-constrained settings.

Together, these dynamics frame the findings of this thematic analysis. They highlight a growing disconnect between increasing needs and shrinking resources and underscore the importance of strengthening system-wide capacity, integration, and evidence-informed approaches to ensure that MHPSS services can be delivered at the scale, quality, and sustainability required.

8 IFRC - Network Databank

Organisational MHPSS Capacity

Human resources for MHPSS

Survey data indicates that MHPSS service delivery across the Movement is supported by a large and diverse workforce of both staff and volunteers, with a notable reliance on volunteer capacity. Distribution data shows clear reliance on a volunteer- based activities, with 46% of responding NSs reporting more than 100 volunteers engaged in MHPSS, while a further 28% report between 20 and 99 volunteers. Smaller volunteer groups are less frequently reported, indicating that MHPSS activities are often implemented at scale within many NSs.

In contrast, the distribution of staff is more varied and generally smaller in scale. Most respondents report between 1 and 19 staff involved in MHPSS (60%), although a notable proportion (17%) report more than 100 staff, reflecting the presence of larger, more institutionalised programmes in some contexts.

Key figures

Estimated **110,000** to **125,000** staff and volunteers engaged in MHPSS

254,869 volunteers and staff trained in basic psychosocial support and/or PFA

How many volunteers are involved in MHPSS activities in your organisation?

More than 100: 46% | 50-99: 11% | 20-49: 17% | 6-19: 9% | 2-5: 4% | 1: 3% | Don't know: 10%

Figure 4: Volunteers involved in MHPSS activities

How many paid staff members are involved in MHPSS?

More than 100: 17% | 50-99: 5% | 20-49: 12% | 6-19: 22% | 2-5: 20% | 1: 18% | Don't know: 6%

Figure 5: Staff involved in MHPSS activities

The Venezuelan Red Cross volunteers are providing critical psychosocial support to the people affected by the earthquakes.

Photo: Venezuelan Red Cross

Reported figures indicate that over 8,000 staff and 76,000 volunteers are engaged in MHPSS across the Movement. However, these figures likely underestimate the true workforce, as respondents frequently reported zero or "I don't know" in cases where data was unavailable. Adjusting for underreporting, the total MHPSS workforce is estimated at 110,000–125,000 staff and volunteers engaged in MHPSS activities.

Compared to the broader IFRC databank figures—approximately 18.3 million volunteers and over 560,000 staff globally[9] —the MHPSS workforce represents a relatively small but strategically critical subset. This highlights both the dependence on a limited pool of human resources and the significant potential to scale MHPSS capacity across the wider Movement workforce. At the same time, available data suggest that the workforce is predominantly concentrated at the basic levels of the MHPSS Framework, with a strong emphasis on PFA and basic psychosocial support, while capacity at higher, more specialised levels remains limited.

In 2025, 92% of responding NSs, the IFRC, and the ICRC reported that they had at least one focal point[10] for MHPSS in their organisation. This is a continuous rise in the number of focal points from 2023, where 74% stated to have appointed one or more focal points.

9 IFRC databank

10 A 'focal point' is defined as a representative of the Movement component which is responsible for MHPSS within their organisation (either alone or in collaboration with another/others) and should be appropriately resourced and enabled by the NS/Movement component that they represent.

MHPSS in Organisational Structure

Patterns of cross-sector integration show that MHPSS is most frequently embedded within health programmes (60%) and disaster management structures (56%), often implemented through by project-based/restricted grant funded approaches (42%). More formalised system-wide mechanisms—such as dedicated MHPSS units (36%) or the use of a guiding MHPSS framework (23%)—are reported less consistently, suggesting that while MHPSS is widely operationalised, institutional integration remains uneven across the Movement.

Looking ahead, responses suggest continued scaling of MHPSS activities and increasing efforts towards integration, with 71% planning expansion and 64% aiming to mainstream MHPSS across sectors. Only a small proportion expect to maintain current levels (16%) or reduce activities (3%), highlighting a broadly shared direction towards growth and deeper institutionalisation of MHPSS across the Movement.

How are the MHPSS activities integrated into your organisational structure ?

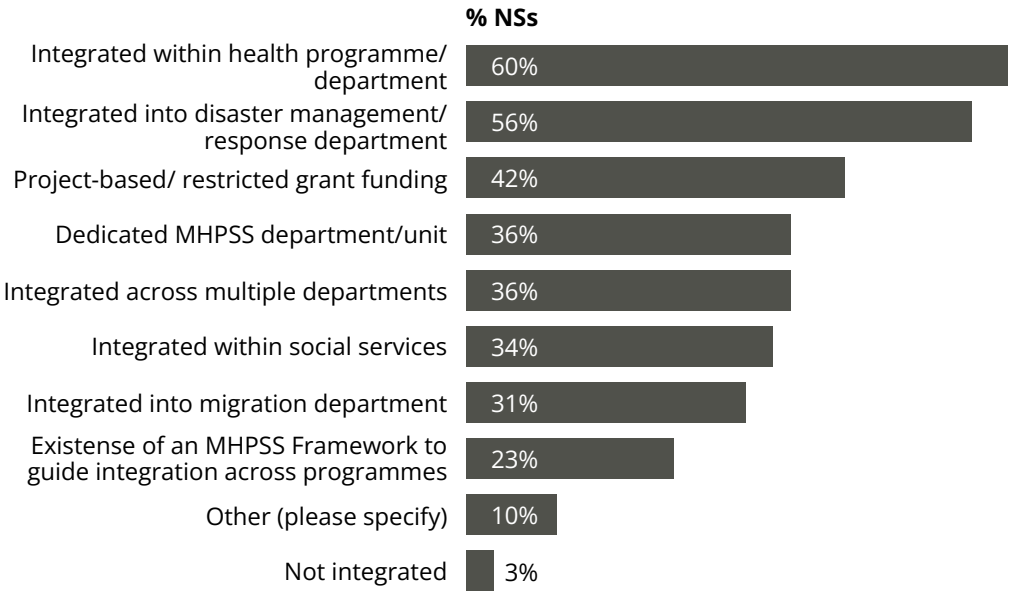


Figure 6: MHPSS integration

How do you anticipate the volume of MHPSS activities to change in your organisation? ?

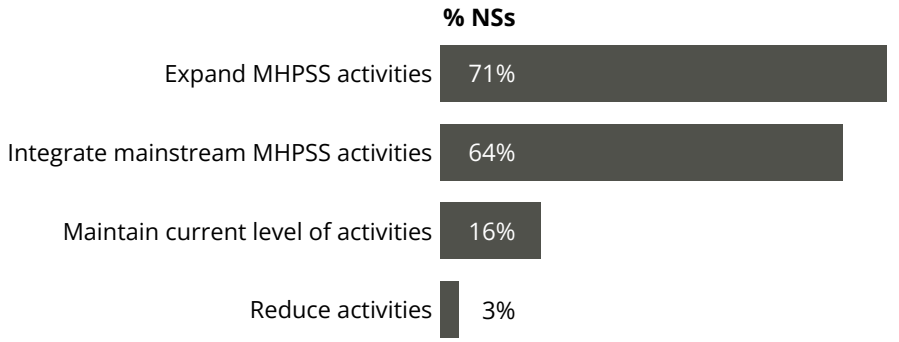


Figure 7: Anticipated volume of MHPSS activities

MHPSS Activities and Programmatic Focus

MHPSS service delivery across the Movement is primarily concentrated at the two first layers of the RCRC MHPSS Framework, with 93% of responding NSs, the IFRC and the ICRC providing basic psychosocial support, followed by focused psychosocial support (72%). Fewer organisations report delivery at higher levels, with psychological support provided by 55% of respondents and specialised mental health care by 24%, reflecting a strong emphasis on scalable, community-based interventions over more specialised services.

Key figures

95% of NSs, the IFRC, the ICRC provide MHPSS activities globally

93% of NSs, the IFRC, the ICRC deliver basic psychosocial support

24% of NSs, the IFRC, the ICRC deliver specialised mental health care

73% of NSs, the IFRC, the ICRC provide referral to specialised mental health services

87% of NSs, the IFRC, the ICRC providing MHPSS activities during emergency response

40% of NSs, the IFRC, the ICRC are using digital MHPSS interventions and **18%** are planning to

23% of NSs, and the IFRC implement activities that address both climate change and MHPSS

Survey data indicates very high levels of implementation across core MHPSS activities globally, with PFA (87%), awareness campaigns (81%), and psychological support (72%) emerging as the most widely delivered interventions. A second tier of activities—such as information activities (70%) and various community-based approaches (around 69%)—also show consistently strong uptake, reflecting a broad and well-established operational base.

Specialised and more resource-intensive interventions—such as psychiatric treatment (14%), family therapy (14%), and trauma treatment centres (5%)—are implemented by a smaller proportion of respondents, indicating a continued concentration of efforts on basic and community-level support rather than specialised care.

At which level(s) within the MHPSS Framework does your organisation deliver MHPSS

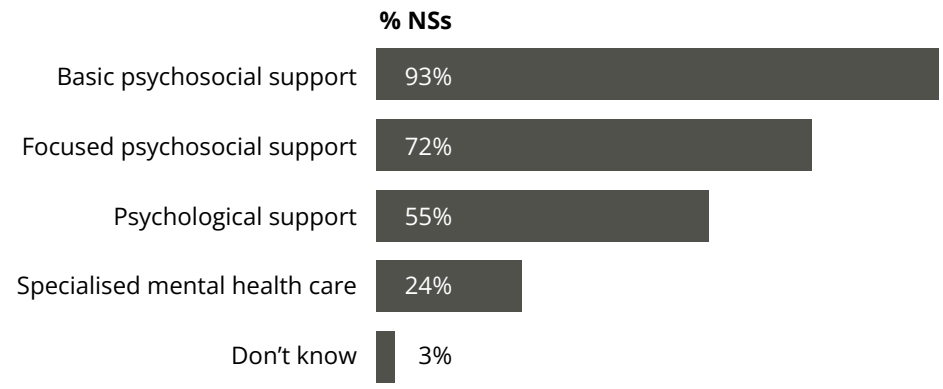


Figure 8: MHPSS activities within the MHPSS Framework

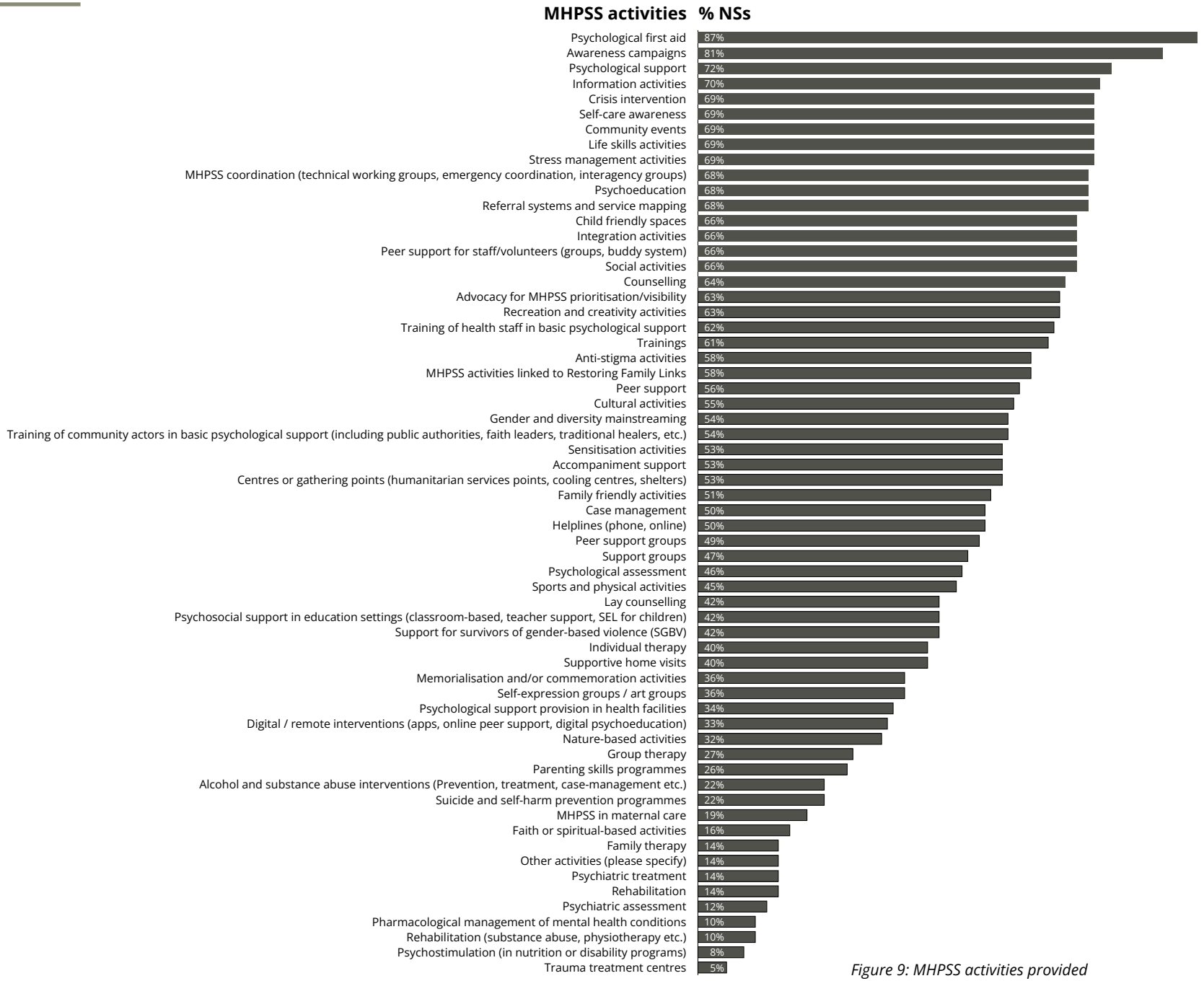


Figure 9: MHPSS activities provided

Thematic areas of focus

Survey results suggest that MHPSS programming is strongly concentrated in emergency-related areas, with highest levels of engagement in disaster response and emergency management (83%), Caring for Staff and Volunteers (82%), and first aid (78%). These areas reflect a clear prioritisation of emergency response capacities and staff and volunteer well-being within MHPSS programming.

In contrast, lower levels of engagement are observed in more specialised or context-specific areas such as climate change (33%), armed conflict (40%), and particularly detention settings (19%) (facility/ institution-specific settings), suggesting that these thematic areas remain less systematically integrated into MHPSS programming across responding organisations.

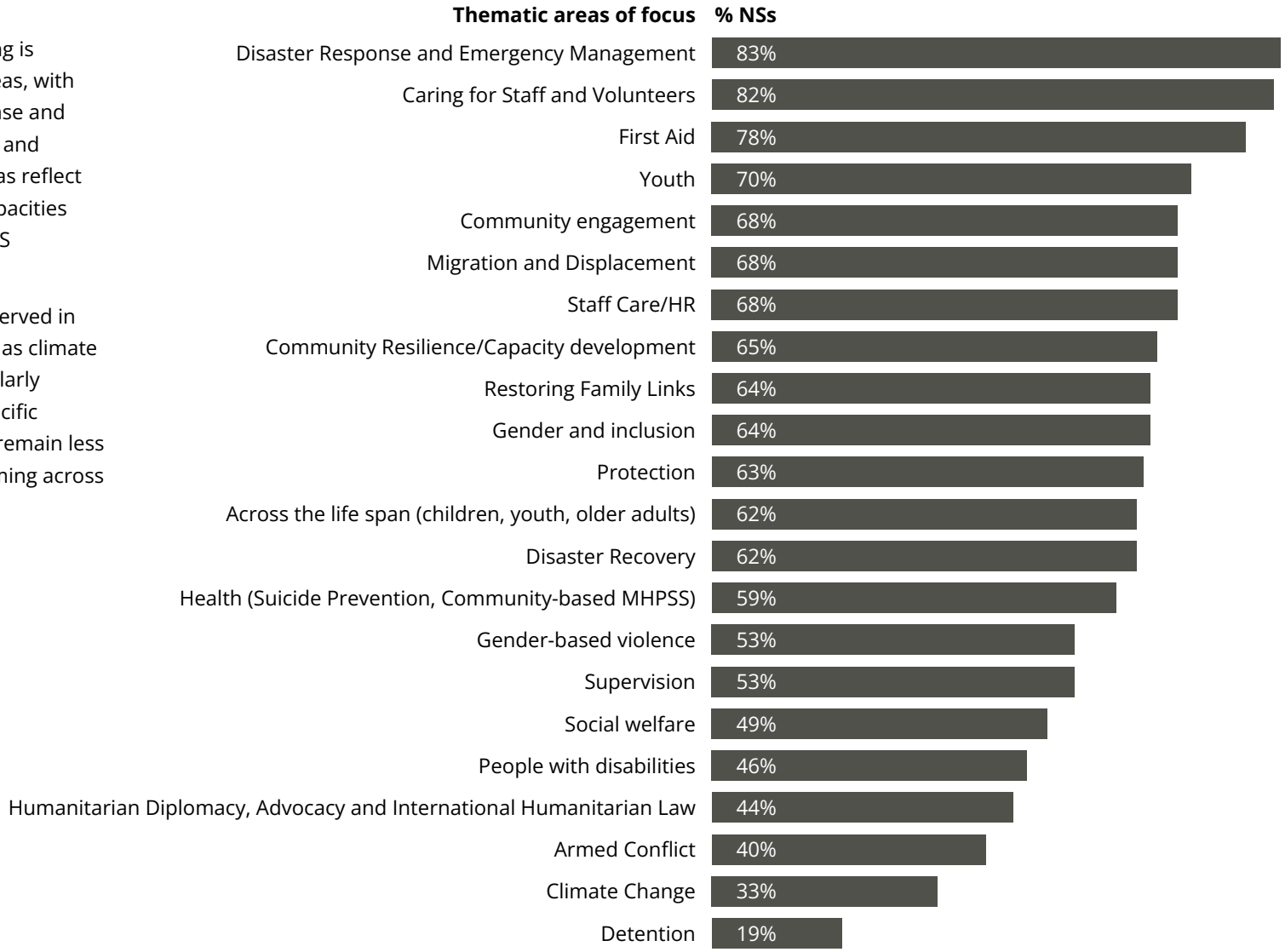


Figure 10: Thematic areas of focus

Target groups

Survey data reveals that MHPSS activities most frequently target core operational and directly affected populations, with highest levels of engagement among volunteers (80%), people affected by disasters (79%), and staff (77%). This highlights a strong focus on both responders and crisis-affected communities.

At the same time, lower levels of engagement are reported for more specific or marginalised population groups, including prisoners and their families (19%), post-release detainees (18%), and people living with addictions (23%), indicating that while programming is broadly inclusive, certain high-risk or less visible groups remain less consistently reached.

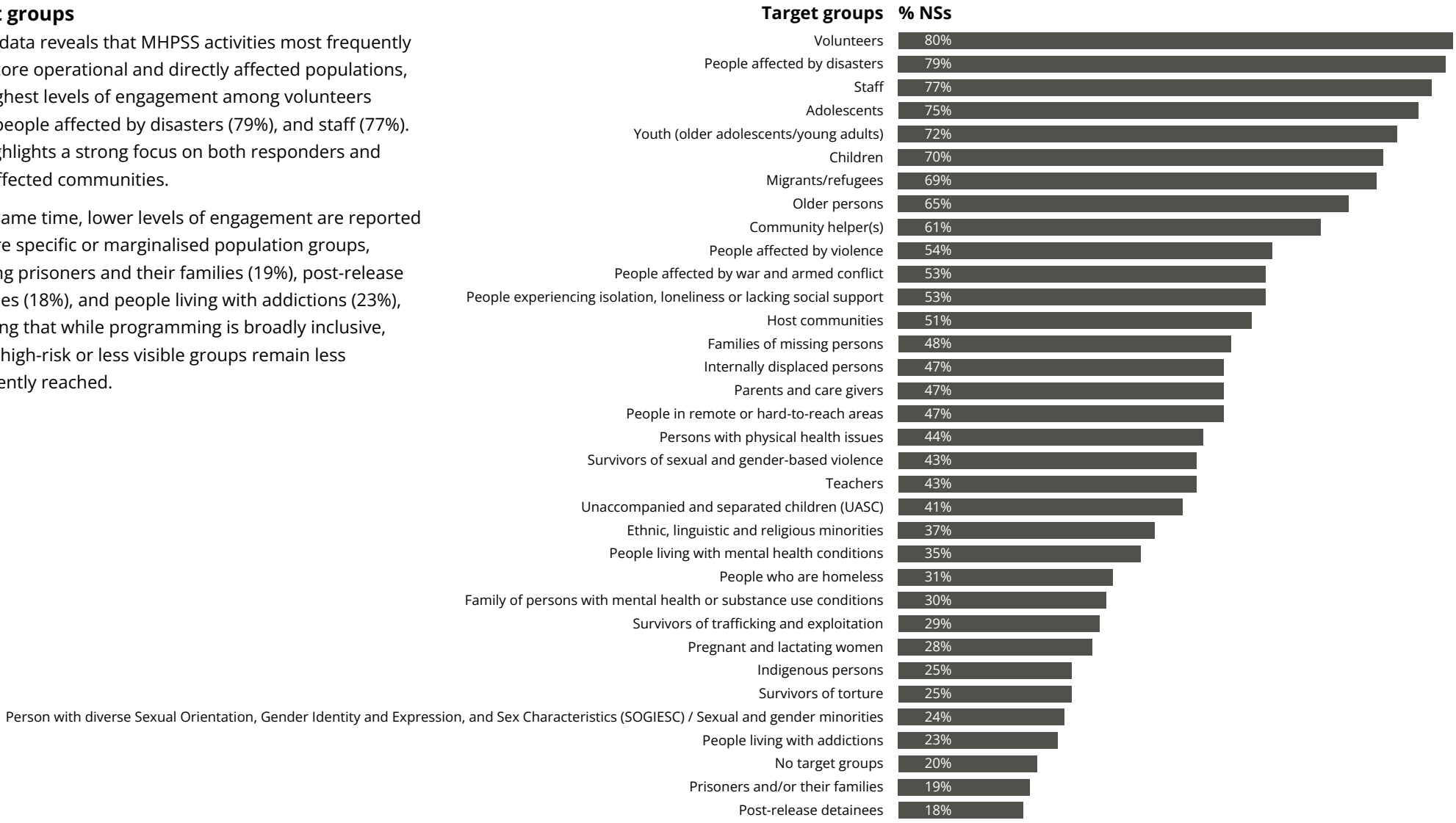


Figure 11: Groups targeted for MHPSS activities

Analysis: Key global trends

- **Widespread provision of MHPSS activities:**
  MHPSS is widely implemented across the Movement, with 95% of responding NSs, the IFRC and the ICRC reporting provision of activities. The small proportion (5%) not providing MHPSS primarily mention limited funding, human resources, and technical expertise as main constraints. Building of basic psychosocial skills such as through PFA training (87%) play a central role, with evidence of steady growth over time. However, it should be noted that 38% of NSs did not respond to the survey and therefore the status of MHPSS activities of these NS is not known.
- **High demand for technical support:**
  A large majority of respondents (81%) express the need for external technical support, particularly in the form of training (61%) and mentoring and supervision (41%), indicating opportunity to strengthen the capacity in both MHPSS implementation and quality assurance.
- **Strong growth trajectory of MHPSS programming:**
  MHPSS activities are expected to continue expanding, with 71% of respondents planning to scale up services and 64% aiming to integrate or mainstream MHPSS within their programmes. Only a small proportion (3%) anticipate maintaining current levels or reducing activities.
- **MHPSS provision across the continuum of care, with a focus on lower levels of the Framework:**
  Movement components provide MHPSS services across all levels of care, but delivery is most heavily concentrated at basic psychosocial and focused psychosocial layers of the MHPSS Framework, highlighting a prioritisation of high-reach, community-based approaches over specialised mental health services.
- **Increasing emphasis on MHPSS integration across sectors:**
  Efforts to integrate and mainstream MHPSS (64%) are expanding, particularly within health and disaster response sectors. This is reflected in a growing number of NSs reporting formal engagement with health and disaster management authorities through agreements and other mechanisms linked to their auxiliary role. Together, these developments point to increasing recognition of MHPSS as a cross-cutting component of humanitarian action. This marks a notable increase compared to 2023, when 40% of NSs and the ICRC reported plans to integrate MHPSS services, although the systematisation of this remains uneven.

Caring for Staff and Volunteers

Staff and volunteers well-being activities and systems

Responses indicate that support for staff and volunteer well-being across the Movement is widely implemented through a diverse range of activities, with a stronger emphasis on accessible and preventative approaches than on formalised institutional "duty of care" systems and policies.

Respondents most frequently report activities such as self-care activities (67%), psychological support (65%), and self-care training (65%), alongside peer support mechanisms (61%), indicating strong uptake of individual and peer-based support models. A second tier of activities—including crisis interventions, referral systems, and supervision (around 53–54%)—is also widely reported, suggesting increasing adoption of more structured support mechanisms.

At the same time, survey responses indicate that system-level approaches remain less consistently implemented, with fewer respondents reporting regular needs assessments (31%), approved well-being action plans (23%), and the existence of formal policies (19%). Taken together with the relatively low proportion of respondents reporting leadership training (40%), these findings suggest that while well-being support is operationally embedded, institutionalisation and governance structures remain uneven across responding organisations.

Responsibility for staff and volunteers' well-being support

Responses to the question on who holds the responsibility for caring for staff and volunteers indicate that support for staff and volunteer well-being is most often distributed across multiple departments, rather than centralised within a single function.

Respondents frequently indicate shared responsibility across MHPSS units, HR, and operational departments, reflecting the cross-cutting nature of caring for staff and volunteers' activities and systems. MHPSS teams and programmes are often reported as providing technical leadership and guidance, particularly for first responders, while HR departments are more commonly associated with policies, staff well-being frameworks, and internal procedures.

In addition, respondents indicate that health, social services, protection, and disaster management departments often play a key role in implementation, particularly in operational and emergency contexts. While this multi-departmental model supports a holistic approach to staff and volunteer care, responses also suggest variability in how responsibilities are structured across organisations, with some respondents noting unclear or shared accountability.

Key figures

41% have a policy on support for staff and volunteers' mental health and psychosocial well-being

40% of management and leadership received training on MHPSS and well-being of staff

31% report regular needs assessments on staff and volunteer well-being

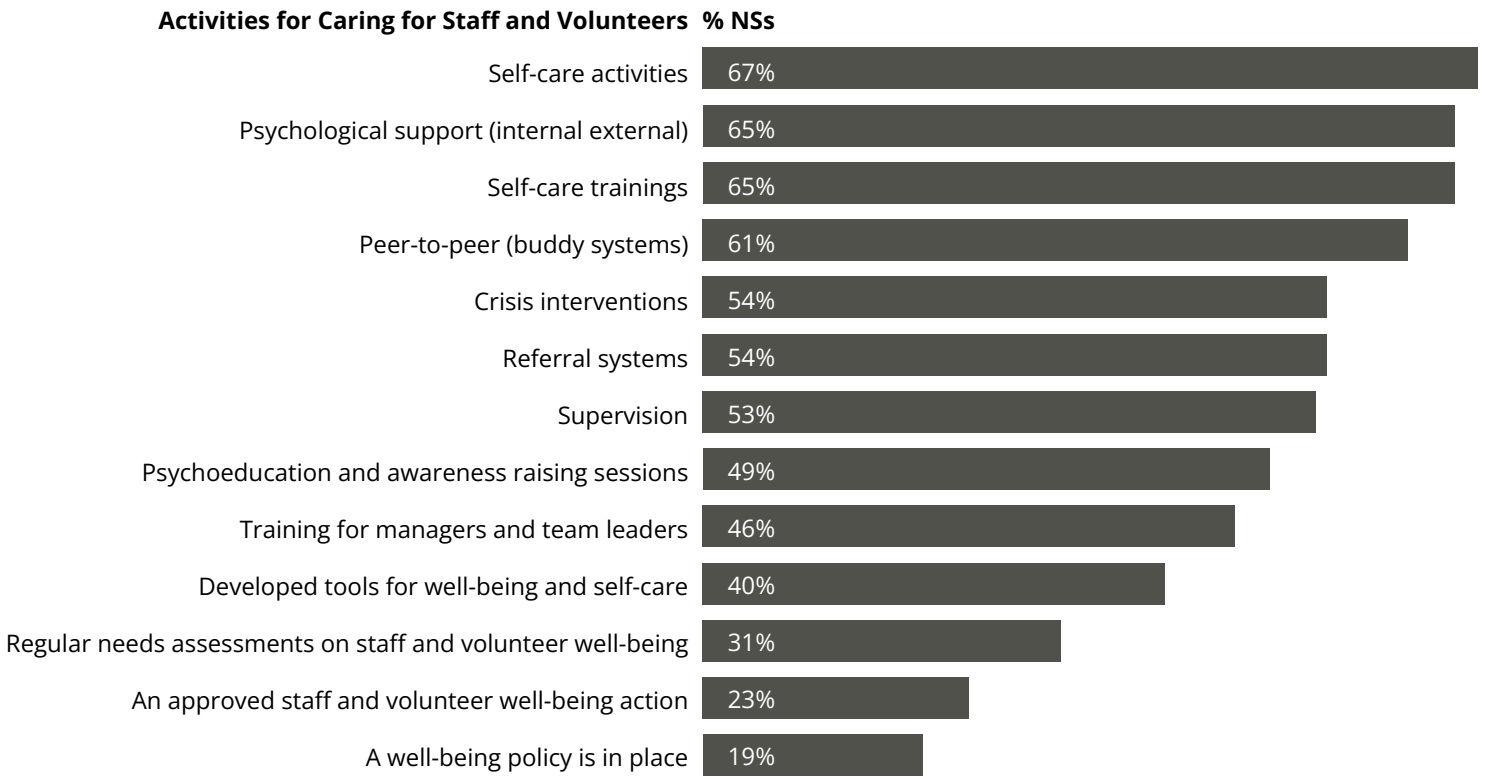


Figure 12: Staff and volunteers well-being activities and systems

Analysis: Key global trends

- **Strong operational provision, with uneven institutionalisation:** Staff and volunteer well-being support is widely implemented across NSs, the IFRC and the ICRC through a range of activities, particularly self-care, peer support, and psychological support, while more formalised systems—such as policies (19%) and action plans (23%)—are less consistently reported.
- **Emphasis on accessible and self-care approaches:** The most frequently reported activities focus on individual, peer-based, and awareness-driven interventions, indicating a strong orientation towards low-threshold, scalable support models.
- **Emerging but uneven structured systems:** A substantial proportion of respondents' report supervision, crisis interventions, and referral systems (~53–54%), suggesting progress towards more structured approaches, although these are not yet uniformly embedded.
- **Distributed responsibility across departments:** Responses highlight that responsibility is typically shared across MHPSS, HR, and operational units, enabling a cross-cutting approach but also pointing to potential fragmentation and a lack of clear ownership.
- **Opportunities to strengthen the governance and leadership engagement:** Lower levels of reported policy frameworks (41%) and leadership training (40%) suggest a need for stronger commitment and leadership involvement in staff and volunteer well-being to drive organisational change.
- **Strengthening staff and volunteer well-being systems starts with understanding their needs:** Regular needs assessments are not yet consistently embedded (31%), limiting organisations' ability to identify and respond to the evolving priorities of staff and volunteers. More systematic approaches to gathering and acting on staff and volunteer feedback are needed to ensure well-being action plans and policies are relevant, responsive, and evidence-based.
- **A rising number of International Humanitarian Law violations**: Including attacks on health care and aid workers, is a worrying trend that underscores the urgent need to strengthen protection measures and support the safety and well-being of staff and volunteers.

MHPSS Evidence Building and Learning: MEAL and Research

Monitoring, evaluation, accountability and learning (MEAL) systems

Survey responses suggest that MEAL systems are partially established in MHPSS programmes across the Movement, but not yet consistently applied. A proportion of respondents report regular monitoring (42%) and programme evaluation (29%) of MHPSS programmes, suggesting that elements of MEAL are in place, though not yet systematically embedded across the Movement.

In addition, 24% of respondents report that they do not currently monitor MHPSS activities, or only plan to do so, highlighting an opportunity to strengthen MEAL systems and evidence building for MHPSS. The greatest barriers limiting monitoring and evaluation of MHPSS activities and programmes include limited financial resources, insufficient technical expertise, and a lack of dedicated staff capacity for data collection and analysis.

Research engagement and partnerships

Responses indicate that engagement in MHPSS research is diverse but uneven, with 25% of NSs relying on external partnerships. Respondents most frequently report collaboration with academic institutions and research centres, indicating that research is often externally driven and academically supported.

In addition, respondents highlight collaboration with Movement partners (the IFRC, the ICRC, the MHPSS Hub) and international organisations such as WHO and UNICEF, suggesting growing levels of inter-agency coordination and knowledge sharing comparing to the previous Global Surveys. However, several responses indicate limited or no direct involvement in research, or engagement through ad hoc, project-based collaborations, pointing to uneven internal research capacity across the Movement.

Research topics reported by respondents are wide-ranging but show clear patterns. A significant proportion focus on MHPSS in emergency contexts, including trauma, crisis response, preparedness, and the impact of epidemics. Other commonly reported areas include the effectiveness of MHPSS activities and interventions (e.g. PFA, programme evaluations) and staff and volunteer well-being systems.

Key figures

42% of NSs, the IFRC, the ICRC regularly monitor MHPSS activities /projects /programmes

29% of NSs, the IFRC, the ICRC regularly evaluate MHPSS projects /programmes

25% of NSs, the IFRC, the ICRC are engaged in MHPSS research

Additional areas of focus align with priority research questions on understanding MHPSS problems and determinants across different population groups—such as migrants, children and adolescents, and older persons—as well as on resilience and the intergenerational impacts of adversity. They also reflect emerging priority topics, including the mental health impacts of climate change and the role of digital technologies in MHPSS. Overall, these findings point to a broad yet practice-oriented research agenda, consistent with the identified emphasis on implementation, effectiveness, and application to humanitarian policy and practice within the MHPSS-SET2 priorities (Research Priority Setting 2)[11].

11 IASC Reference Group on Mental Health and Psychosocial Support, 2023. Mental health and psychosocial support in humanitarian crises: Setting consensus-based research priorities for 2021–2030 (MHPSS-SET 2). Elrha

Egyptian Red Crescent Society (ERCS) providing comprehensive assistance—incluing MHPSS—to Palestinian medical evacuees and their accompanying family members in Egypt.

Photo: Egyptian Red Crescent Society

Analysis: Key global trends

- **Partial but uneven development of MEAL systems:**
  Responses indicate that monitoring (42%) and evaluation (29%) are in place in a number of NSs, the IFRC and the ICRC but remain inconsistently applied across the Movement.
- **Significant barriers to evidence building:**
  17% of respondents report limited monitoring or plans to introduce it, stating financial, technical, and human resource constraints as key challenges.
- **Limited and uneven engagement in research:**
  With only 25% of respondents engaged in research, evidence building remains concentrated in a subset of Movement components, with others relying on external actors.
- **Strong reliance on external partnerships:**
  Research is largely driven through collaboration with academic institutions and international partners, reflecting both the strength of partnerships and limited internal research capacity.
- **Operationally driven research agenda:**
  Reported research topics are closely aligned with practice, focusing on emergency response, intervention effectiveness, and well-being, with increasing attention to specific populations and emerging risks.
- **Need to strengthen system-wide evidence and learning:**
  Responses highlight the need to strengthen MEAL systems and institutionalise research capacity, to support more consistent, evidence-based and impact-driven MHPSS programming across the Movement.

Mongolian Red Cross providing a series of humanitarian assistances including MHPSS as a response to the Drud (extreme cold temperatures and weather) affecting more than 185,000 herder families.

Photo: IFRC

MHPSS Humanitarian Diplomacy and Advocacy

Humanitarian Diplomacy and Advocacy for MHPSS

Humanitarian Diplomacy and Advocacy for MHPSS needs and programming are increasingly embedded across the Movement, supporting efforts to raise awareness, influence policy, and mobilise resources, while also drawing on evidence and research to strengthen positioning and practice.

Responses indicate that engagement in Humanitarian Diplomacy and Advocacy is relatively widespread across the Movement, with a majority of respondents reporting (66%) participation in at least one form of advocacy activity.

The most common forms of engagement include participation in advocacy events (61%), involvement in technical working groups and coordination mechanisms (52%), and social media advocacy (52%). This reflects a strong emphasis on collective advocacy and visibility-raising efforts. More targeted approaches—such as bilateral engagement with governments (42%) and organizing advocacy events (36%)—are also reported, while more technical contributions to policy development (25%) are less frequent.

Key figures

56% of NSs, the IFRC, the ICRC include an MHPSS focus in their general strategy

32% of NSs, the IFRC, the ICRC have a formal MHPSS policy, framework or strategy

66% of NSs, the IFRC, the ICRC work with MHPSS advocacy

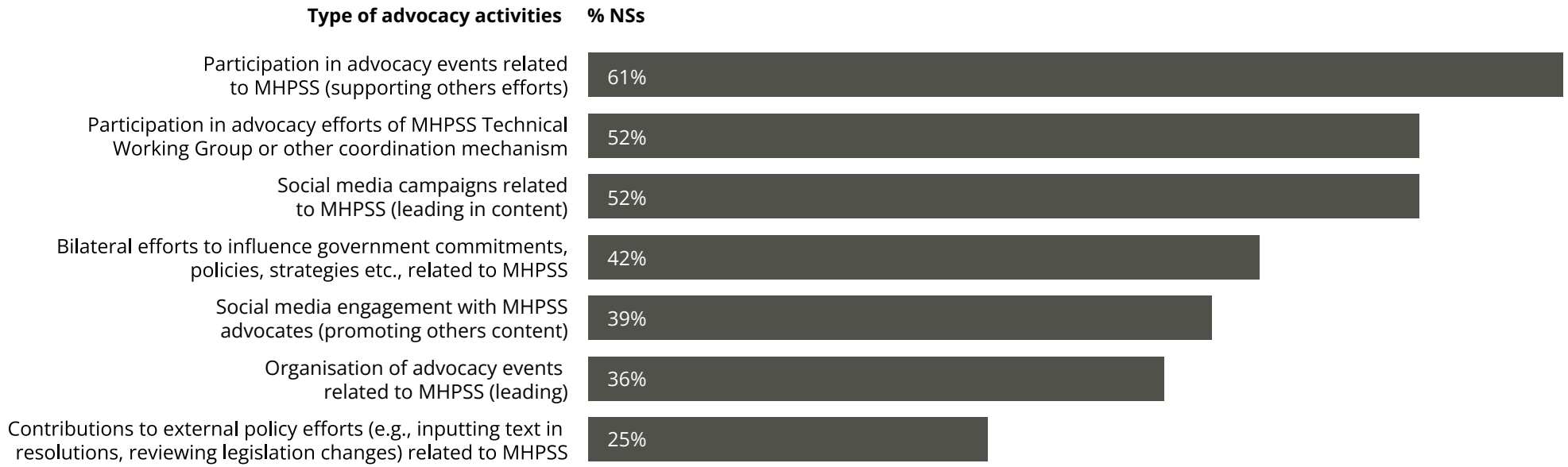


Figure 13: Types of advocacy and humanitarian diplomacy activities

Auxiliary role: Recognition of MHPSS in national systems

Survey findings indicate that recognition of the NS auxiliary role in MHPSS differs across operational, institutional, and financial levels.

Respondents from NSs most commonly report recognition through operational and coordination mechanisms, with 63% included in relevant humanitarian inter-agency platforms (e.g. clusters and technical working groups) and 59% integrated within national public health or disaster management systems. A substantial proportion also indicate participation in government committees (45%) and the existence of formal agreements with public authorities (42%), reflecting relatively strong engagement in implementation and coordination structures.

However, fewer respondents report recognition through more formalised and institutional mechanisms, with only 29% indicating inclusion in national laws or policies, and 19% reporting access to dedicated government funding for MHPSS activities.

These findings suggest that while the auxiliary role of NSs in MHPSS is widely recognised in practice and coordination settings, it is less consistently embedded within formal policy frameworks and financing structures. This points to a gap between operational engagement and institutional recognition, has implications for the sustainability, scaling, and long-term positioning of MHPSS within national systems.

Is your organisation's auxiliary role, in providing MHPSS services, expressly recognised by

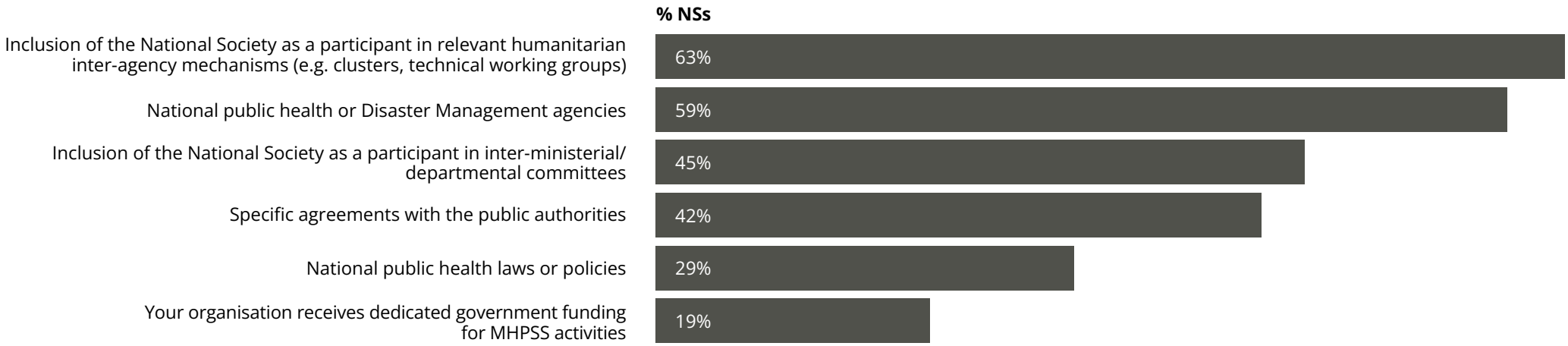


Figure 14: Recognition of MHPSS in national systems

Challenges and gaps in MHPSS service provision

Responses from NSs, the IFRC and the ICRC indicate three consistent and interrelated gaps affecting the delivery, scale, and sustainability of MHPSS services globally.

Respondents state that challenges in delivering MHPSS are consistent across contexts but vary in intensity, with most organisations facing a combination of resource, capacity, and system-level constraints.

A large proportion of respondents highlight limited and unstable funding as a primary barrier, often linked to reliance on short-term, project-based financing. This constrains the ability to plan long term, sustain services, and retain trained staff and volunteers, while also limiting opportunities to scale interventions in line with growing needs.

In parallel, responses frequently point to insufficient human resources and technical capacity, including shortages of trained staff and volunteers, particularly for more specialised services. Many NSs report reliance on a small pool of trained individuals, with limited access to continuous training, supervision, and mentoring, resulting in challenges in ensuring consistent quality and coverage.

A third common pattern relates to weak institutionalisation and integration of MHPSS, with respondents noting limited availability of policies, strategies, and dedicated structures, as well as low prioritisation within organisational leadership. MHPSS is often not fully integrated into core sectors such as health and disaster management, and coordination mechanisms—both internally and with external actors—are described as inconsistent.

Analysis: Key global trends

- **Operational and collective advocacy dominates over policy influence:** The most reported activities—such as participation in advocacy events (61%), technical working groups (52%), and social media engagement (52%)—indicate a strong focus on awareness-raising and collaborative efforts. In contrast, lower levels of engagement in policy development and legislative processes (25%) suggest that advocacy is less frequently translated into system-level influence.
- **Strong operational recognition of the auxiliary role, with limited institutional support:** Respondents report relatively high engagement in coordination mechanisms (63%) and integration into national health and disaster management systems (59%), reflecting operational recognition of the auxiliary role. However, this is less consistently reflected in formal policies (29%) and dedicated government funding (19%), highlighting gaps in institutional and financial support for MHPSS.
- **Advocacy constrained by broader system-level challenges:** Responses on delivery challenges highlight that limited funding, insufficient human resources, and weak institutionalisation continue to constrain both MHPSS services and advocacy efforts. These factors reduce the ability of the Movement to position MHPSS strategically and influence decision-making at higher levels.
- **Strengthening strategic advocacy and enabling environments:** Stronger engagement requires greater leadership prioritisation, leveraging the NS auxillary role, clearer policies and strategies, improved evidence and technical capacity, better coordination, and enhanced resource mobilisation for MHPSS.

Regional Analysis

Overview across the regions

		GLOBAL (IFRC, ICRC, NSs)	AFRICA	AMERICAS	ASIA PACIFIC	CENTRAL ASIA & EUROPE	MENA
	Response rate	**62%**	**53%**	**61%**	**49%**	**81%**	**59%**
General trends	% of NS, the IFRC, the ICRC providing MHPSS activities	95%	92%	100%	83%	98%	100%
	Staff and volunteers trained in basic psychosocial support and PFA	256.078	7.412	8.046	18.050	215.768	6.802
	% of NSs, the IFRC, the ICRC with an MHPSS focal point	92%	85%	100%	83%	91%	100%
	% of NSs, the IFRC, the ICRC with plans to expand MHPSS activities in future	71%	81%	75%	78%	72%	90%
	% of NSs, the IFRC, the ICRC with plans to integrate / mainstream MHPSS into other sectors	64%	77%	65%	56%	53%	30%
Caring for staff and volunteers	% NSs, the IFRC, the ICRC have activities /resources to support staff and volunteers' well-being	69%	52%	70%	50%	88%	60%
	% NSs, the IFRC, the ICRC have a policy on support for staff and volunteers' mental health and psychosocial well-being	41%	38%	25%	39%	50%	40%
MHPSS MEAL and research	% NSs, the IFRC, the ICRC that regularly monitors data on MHPSS activities	42%	27%	26%	28%	57%	70%
	% NSs, the IFRC, the ICRC involved in MHPSS research	25%	24%	11%	11%	36%	30%
Humanitarian Diplomacy and Advocacy	% NSs, the IFRC, the ICRC include an MHPSS focus in its general strategy	56%	62%	26%	50%	67%	60%
	% NSs, the IFRC, the ICRC have a formal MHPSS policy, framework or strategy	32%	24%	16%	24%	45%	40%
	% NSs, the IFRC, the ICRC planning on developing MHPSS strategy in the future or is currently developing one	46%	60%	63%	36%	33%	60%
	% NSs, the IFRC, the ICRC who work with MHPSS advocacy	66%	73%	74%	39%	71%	60%

Regional Analysis: Africa

Regional data presented in this section primarily reflects responses from NSs. Contributions from the IFRC and the ICRC are included in the global analysis and, where relevant, are referenced in the narrative for each region.

Across Africa, the IFRC and the ICRC supported NSs and their partners in line with their respective mandates. The IFRC provides coordination, financial, and technical support for disaster operations and longer-term development programmes, while the ICRC supports populations affected by armed conflict and other situations of violence, through protection services as well as access to essential services.

The IFRC and the ICRC supported NSs across Africa through large-scale disaster response, and community health programmes.

Organisational Capacity and MHPSS Integration

Survey data indicates that MHPSS is well established across the Africa region, with a large majority of responding NSs reporting provision of MHPSS activities (92%) and the presence of designated focal points (85%). A similarly strong proportion report plans to expand MHPSS activities (81%) and integrate or mainstream MHPSS into other sectors (77%), pointing to both continued scaling and increasing institutional embedding of MHPSS across programmes.

Snapshot

(Percentages refer to responding National Societies in the region)

53% response rate

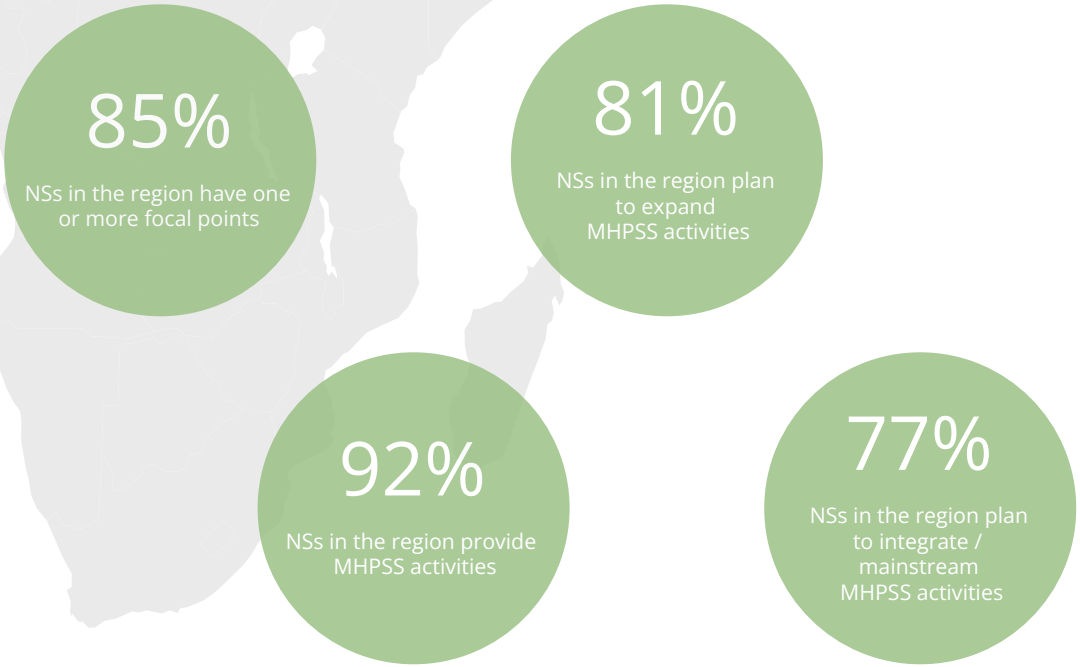
92% of NSs in the region report providing MHPSS activities

7,412 staff and volunteers trained in basic psychosocial support and PFA

85% of NSs in the region report having a designated MHPSS focal point

81% of NSs in the region reports plans to expand MHPSS activities

52% of NSs in the region report providing support to staff and volunteers' mental health and psychosocial well-being



MHPSS Activities and Programmatic Focus

NSs from the Africa region reported strong implementation of foundational MHPSS activities, particularly PFA (85%), awareness and psychological support (81%), and community-based activities (73%). Survey findings further indicate that programmatic efforts are most frequently focused on caring for staff and volunteers (81%) and disaster response and emergency management (77%), while first aid (69%) remains an important complementary area.

Target group coverage includes many different groups, with similar proportions of respondents reporting activities for adolescents, people affected by disasters, and staff (each 69%), followed by children (65%) and volunteers (62%).

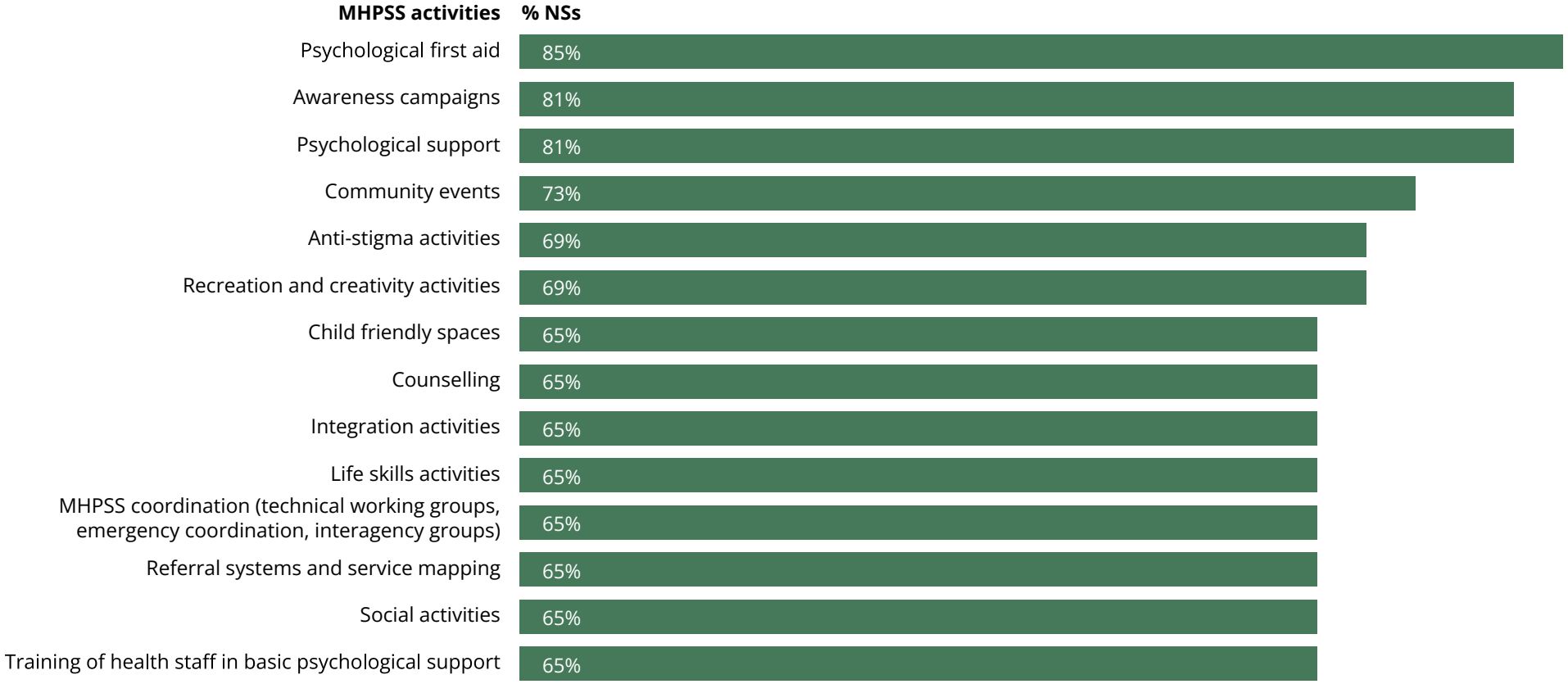


Figure 15: Africa: MHPSS Activities

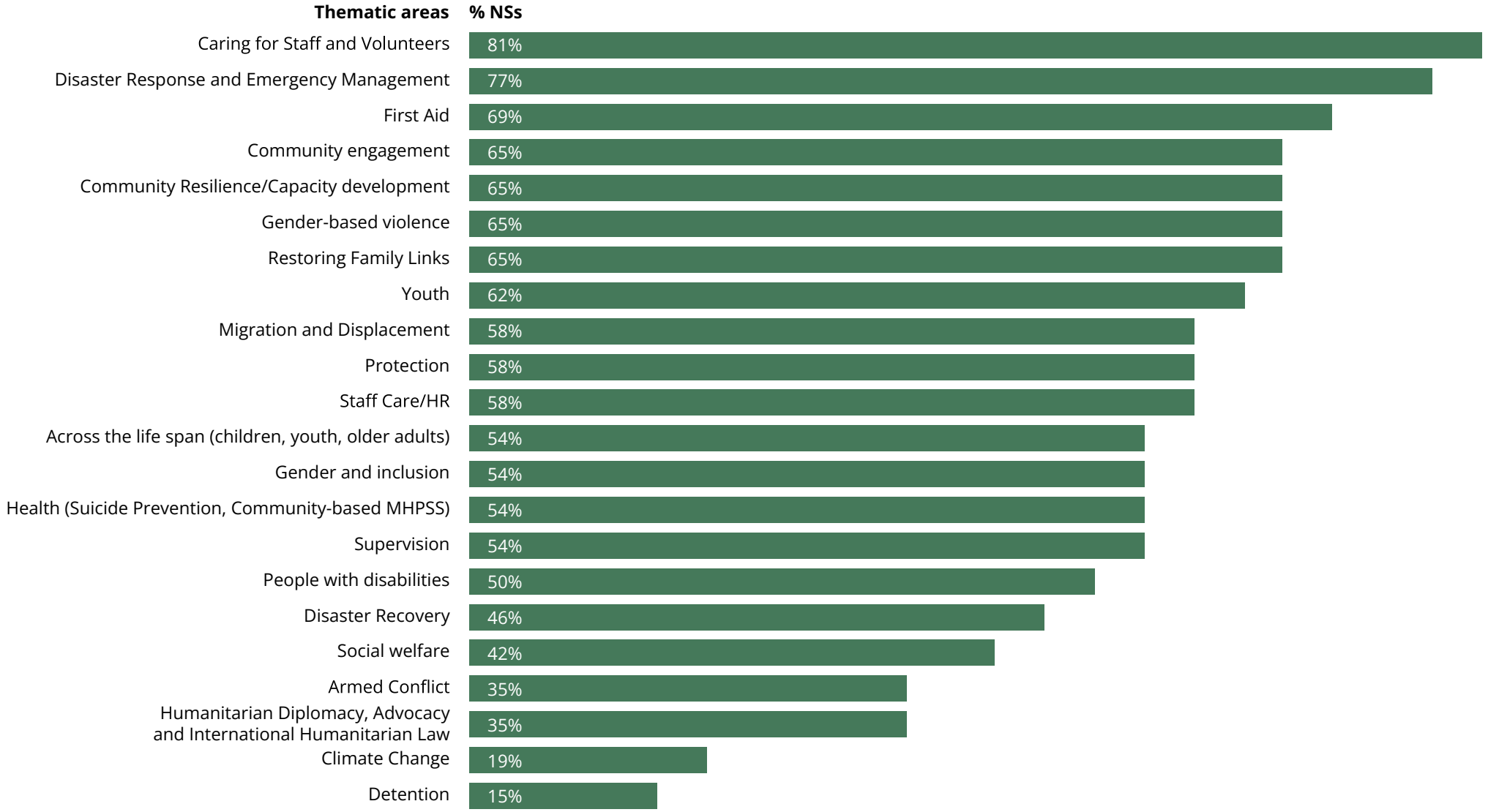


Figure 16: Africa: Thematic areas of focus

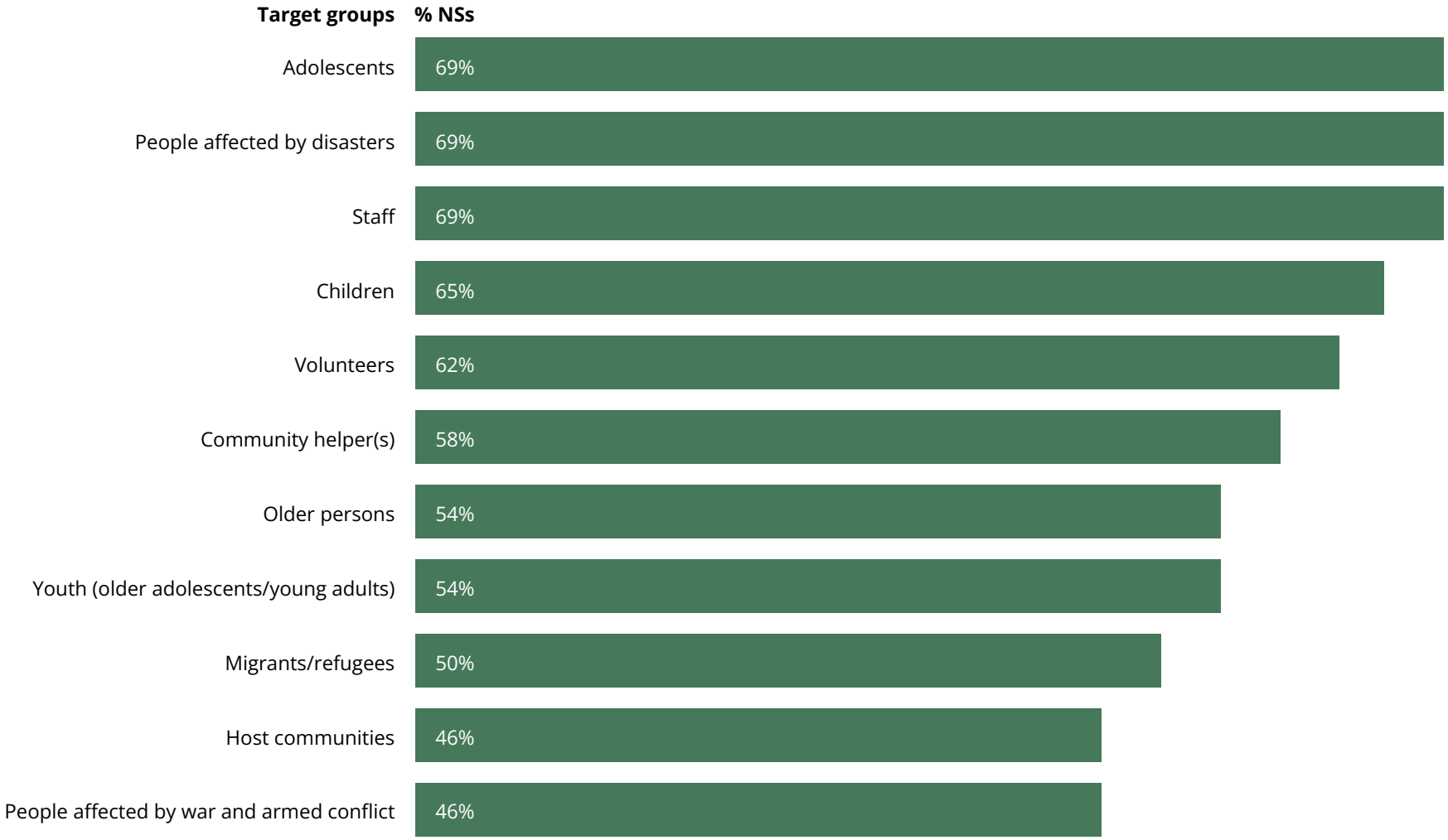


Figure 17: Africa: Target groups

Caring for Staff and Volunteers

Survey data indicates that respondents from the Africa region report a broad range of activities to support staff and volunteer well-being, with a strong emphasis on accessible and preventative approaches. The most reported interventions include psychological support, self-care activities, and self-care training (each 69%), followed by referral systems (65%) and training for managers and team leaders (62%), reflecting a strong operational focus on frontline, peer-based support and investment in leadership skills.

At the same time, fewer respondents report the use of more structured and system-level approaches, such as regular needs assessments (23%), development of well-being tools (19%), and the existence of formal action plans (15%) and policies (12%). This suggests that while well-being support is widely implemented, it remains less consistently institutionalised across responding NSs in the region.

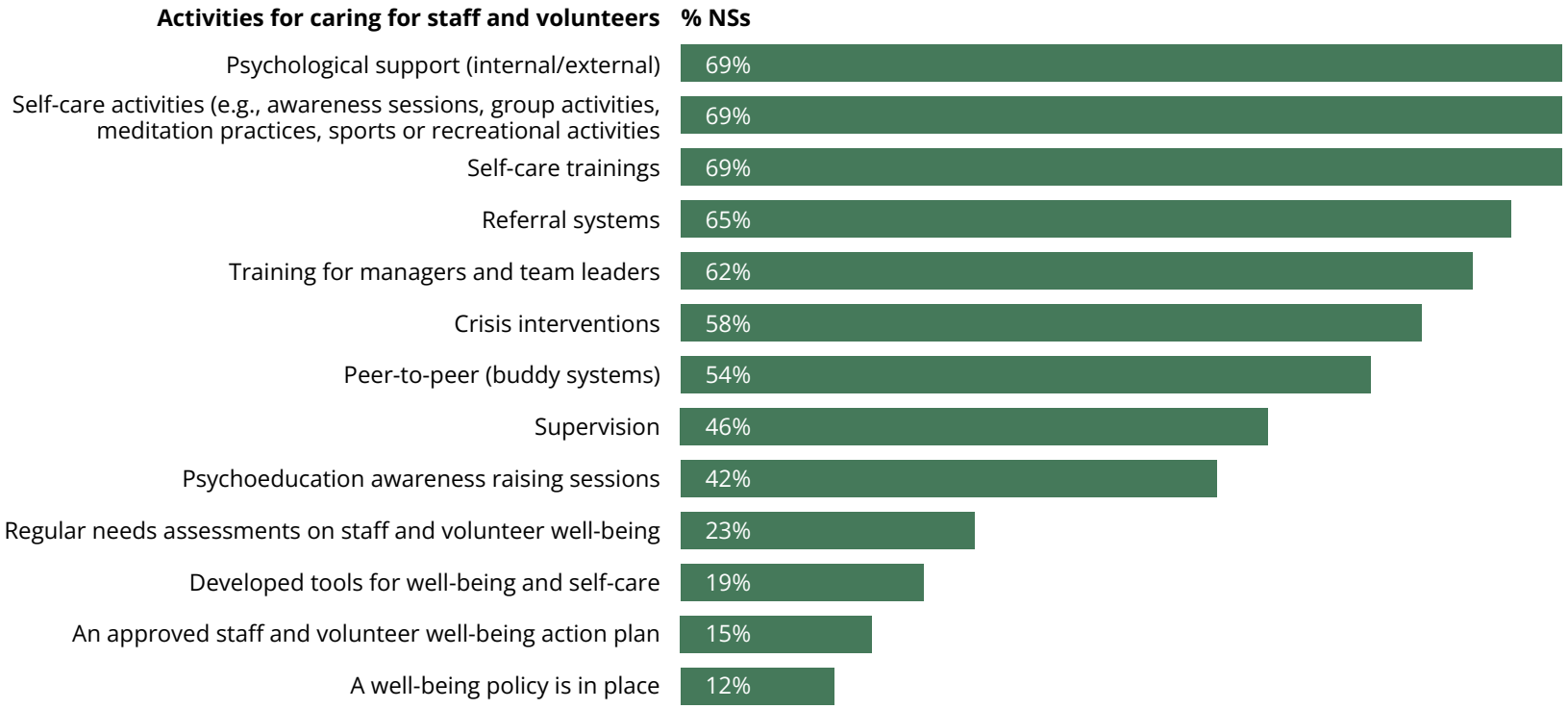


Figure 18: Africa: Caring for staff and volunteers' activities

Key gap

52% of responding NSs provide activities/resources to support mental health and well-being of staff and volunteers

12% of responding NSs have a formal policy

MHPSS MEAL and Research

NSs located in the Africa regionreport limited but emerging systems for MHPSS evidence building, with only 27% reporting regular monitoring of MHPSS activities and 23% engagement in research.

These findings suggest that while MHPSS implementation is well established in the region, systems for monitoring, learning, and evidence generation are not yet fully embedded, pointing to a gap between programme delivery and systematic tracking of outcomes and impact.

Key figures

27% of NSs, the IFRC, the ICRC regularly monitor MHPSS activities and conduct MHPSS research

23% of NSs, the IFRC, the ICRC engage in research

The Democratic Republic of the Congo Red Cross volunteers providing psychsocial support to people affected by Ebola

Photo: DRC Red Cross

Humanitarian Diplomacy and Advocacy

Findings from the Africa region indicate that recognition of NS auxiliary role in providing MHPSS services is primarily operational and participation-based, rather than formalised in policy or financing frameworks. A significant majority of respondents report that their role is expressly recognised through inclusion in humanitarian inter-agency coordination mechanisms (i.e. clusters, technical working groups) (77%) and through integration within national public health or disaster management systems (77%). In addition, 62% of NSs indicate recognition through participation in inter-ministerial or government technical committees addressing MHPSS-related issues.

However, this recognition is less consistently institutionalised. Only 35% of respondents report explicit recognition in national public health laws or policies, and 31% have formalised this role through specific agreements with public authorities. Most notably, just 8% report receiving dedicated government funding for MHPSS activities.

Is your organisation's auxiliary role, in providing MHPSS services, expressly recognised by: ?

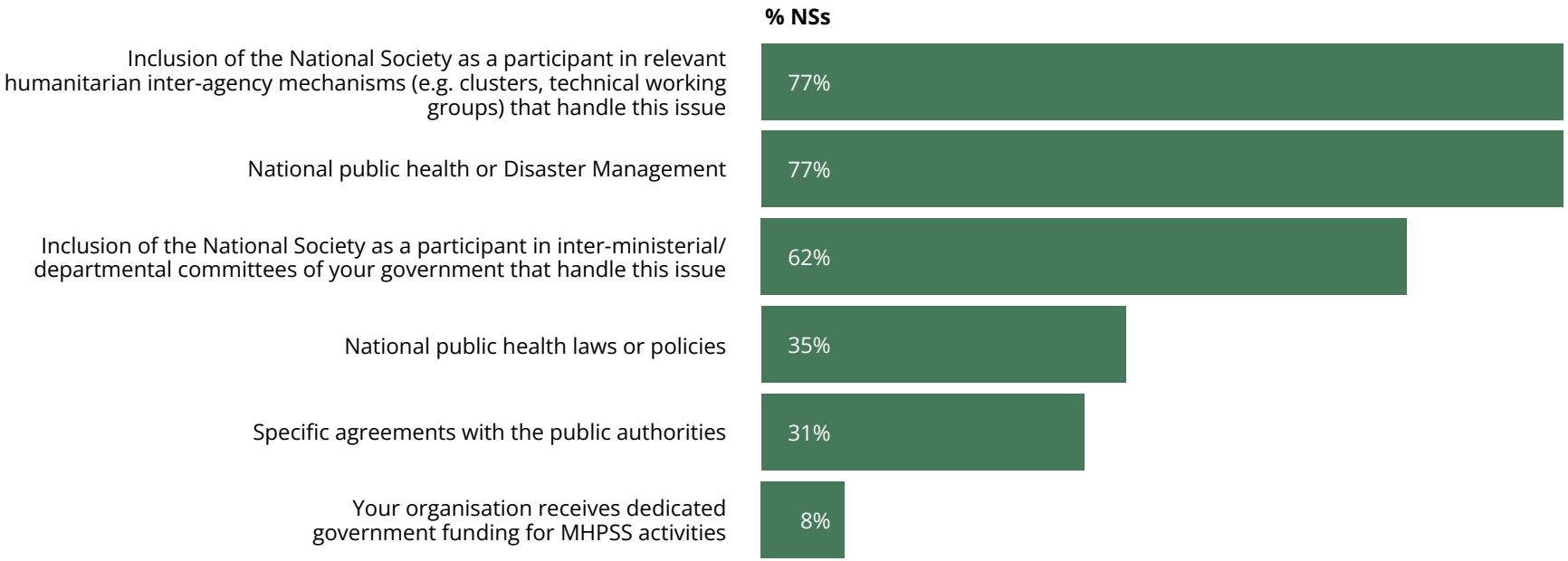


Figure 19: Africa: MHPSS recognition in national systems

Key Messages and Priority Actions

- **Strong operational delivery with growing institutional anchoring**
  MHPSS is widely implemented across the Africa region (92%), supported by strong engagement in staff and volunteer care (81%) and a clear focus on emergency response (77%). At the same time, institutional frameworks—such as policies, strategies, and formal systems (12–15%)—are still developing, presenting an opportunity to further strengthen long-term sustainability and system coherence.
- **Strong commitment to expansion and integration of MHPSS**
  NSs in the region report plans to expand MHPSS activities (81%) and integrate or mainstream them across sectors (77%), demonstrating a clear and region-wide commitment to scaling services and embedding MHPSS within broader programming.
- **Staff and volunteer well-being widely implemented with scope to strengthen systems**
  Many NSs report providing psychological support and self-care activities (69%), reflecting strong engagement in staff and volunteer well-being. Strengthening policy frameworks, action plans, and monitoring systems would help ensure greater consistency, sustainability, and accountability of these efforts.
- **Operational recognition of the auxiliary role with scope to strengthen policy and financing frameworks**
  NSs are well recognised as operational partners, particularly through participation in coordination mechanisms and national systems (77%). Further strengthening formal recognition in policies (35%), agreements (31%), and sustainable financing mechanisms (8%) presents an opportunity to enhance long-term positioning and support.
- **Opportunity to strengthen evidence and learning systems**
  Monitoring (27%) and research (23%) are present but not yet widely embedded, suggesting an opportunity to further develop MHPSS evidence building and MEAL systems to support quality, accountability, and advocacy.

Regional Analysis: Americas

Regional data presented in this section primarily reflects responses from NSs. Contributions from the IFRC and the ICRC are included in the global analysis and, where relevant, are referenced in the narrative for each region.

Across the Americas, the IFRC and the ICRC supported NSs and their partners in line with their respective mandates. The IFRC provides coordination, financial, and technical support for disaster operations and longer-term development programmes, while the ICRC supports populations affected by armed conflict and other situations of violence, through protection services as well as access to essential services.

Organisational Capacity and MHPSS Integration

Respondents from the Americas region report full coverage of MHPSS activities, with all responding NSs reporting both service delivery (100%) and designated MHPSS focal points (100%).

A vast majority of respondents also report plans to expand MHPSS activities (75%) and integrate MHPSS into other sectors (65%), reflecting continued efforts to grow and embed MHPSS across programmes. However, while MHPSS service delivery is already highly established, efforts to expand and integrate MHPSS are continuing to build on this strong foundation.

Snapshot

(Percentages refer to responding National Societies in the region)

61% response rate

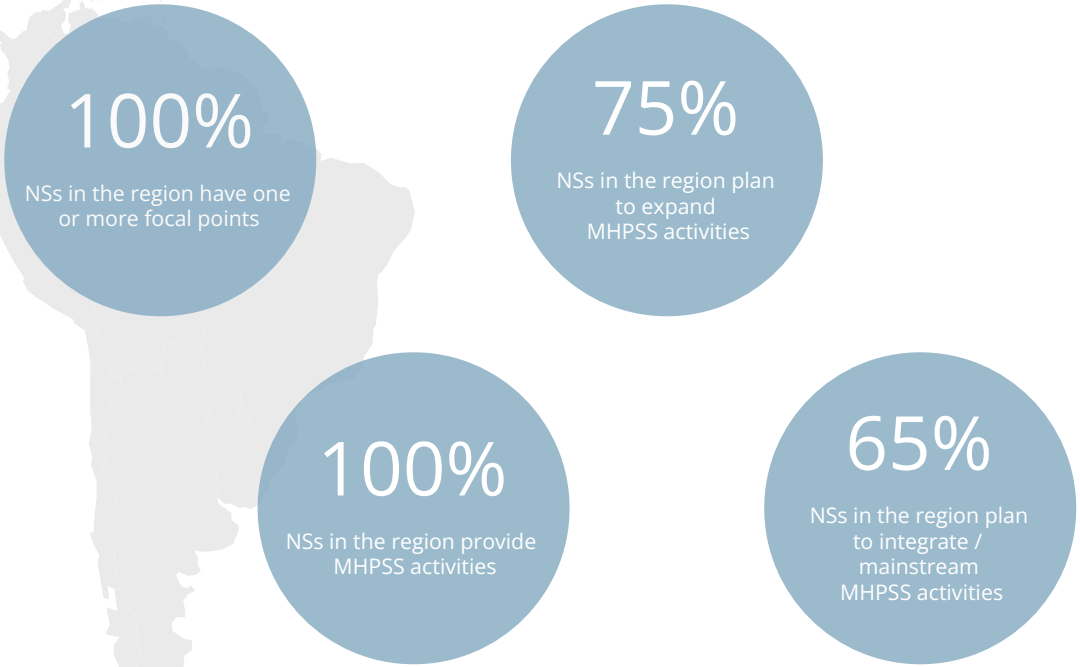
100% of NSs in the region report providing MHPSS activities

8,046 staff and volunteers trained in basic psychosocial support and/or PFA

100% of NSs in the region report having a designated MHPSS focal point

75% of NSs in the region report plans to expand activities

70% of NSs in the region report providing well-being support



MHPSS Activities and Programmatic Focus

NSs located in the Americas region report consistently high levels of implementation across a wide range of MHPSS activities, with particularly strong engagement in information activities and PFA (both 95%), as well as awareness campaigns and referral systems (90%). A broad set of additional interventions—such as self-care awareness (85%) and psychological support, stress management, and integration activities (around 80%) are also implmented.

Programmatic focus is strongly centred on disaster response and emergency management (95%), followed by staff and volunteer care (80%) and Restoring Family Links (80%), while maintaining consistent engagement across other thematic areas, including migration, gender and inclusion (~75%).

Target group coverage is broad and inclusive, with strong reach among volunteers (85%), adolescents and people affected by disasters (80%), and youth (80%), alongside sustained engagement with migrants and refugees, community helpers, and staff (around 75%).

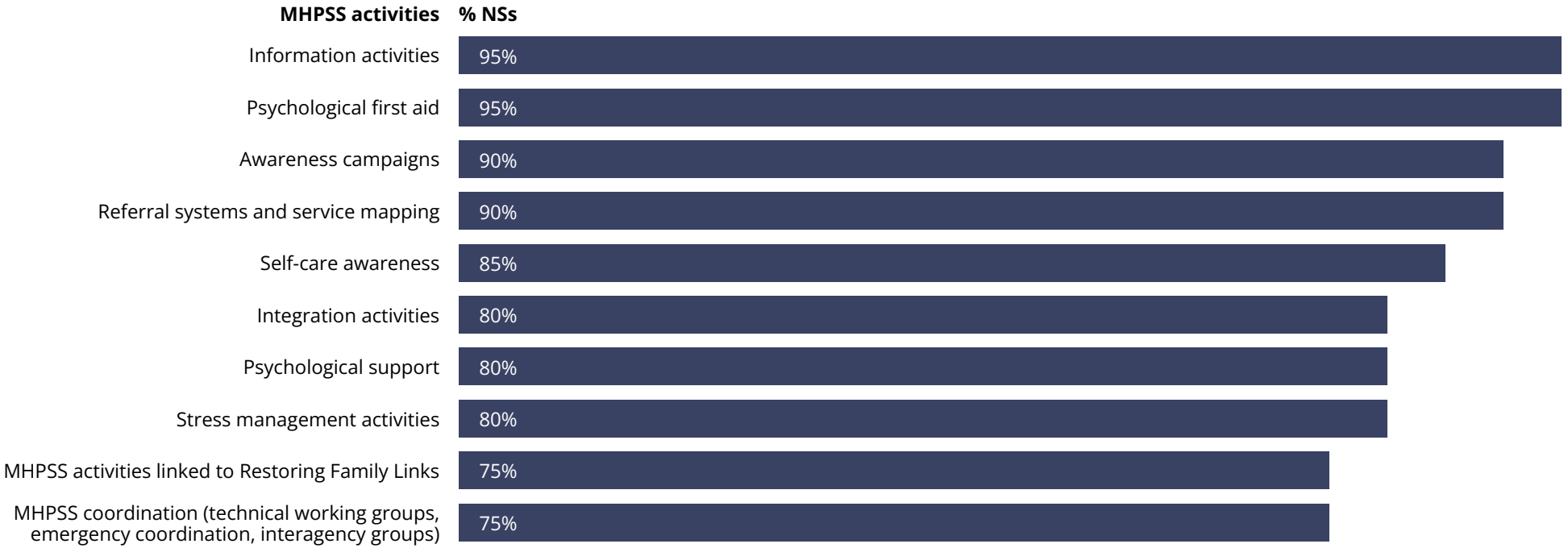


Figure 20: Americas: MHPSS Activities

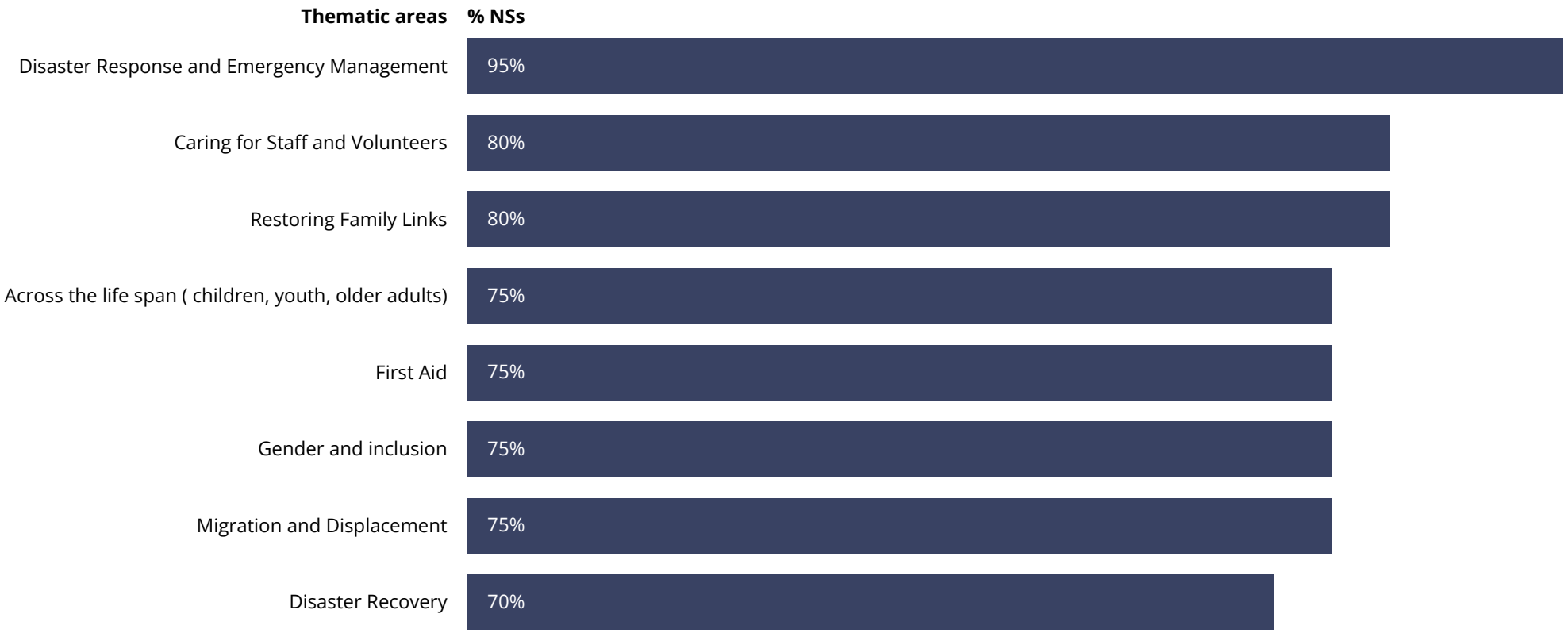


Figure 21: Americas: Thematic areas of focus

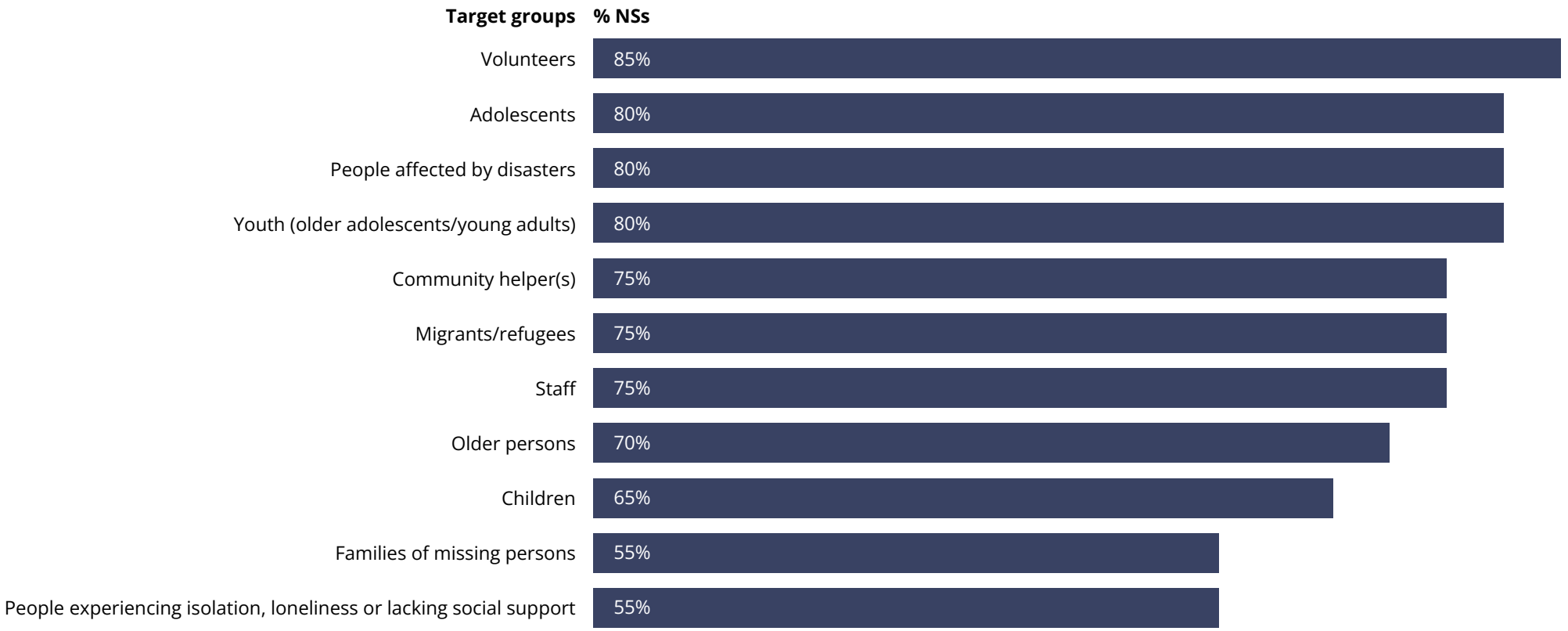


Figure 22: Americas: Target groups

Caring for Staff and Volunteers

NSs report a widespread implementation of staff and volunteer well-being activities, with a vast majority of respondents reporting provision of support (70%). The types of support reflect a mixture of reactive and preventative approaches, including crisis interventions (75%), psychological support (74%), and peer-to-peer systems (70%), alongside moderately implemented self-care training (65%), referral systems (60%), and self-care activities (60%).

More structured and system-oriented approaches are less consistently reported, with lower uptake of supervision systems (55%), well-being tools (45%), and regular needs assessments (30%) and management training (30%). Formalisation remains limited, with only 20% reporting approved well-being action plans and 15% reporting the existence of policies, highlighting the opportunity to further invest in consistent and system-level approaches to staff and volunteer well-being.

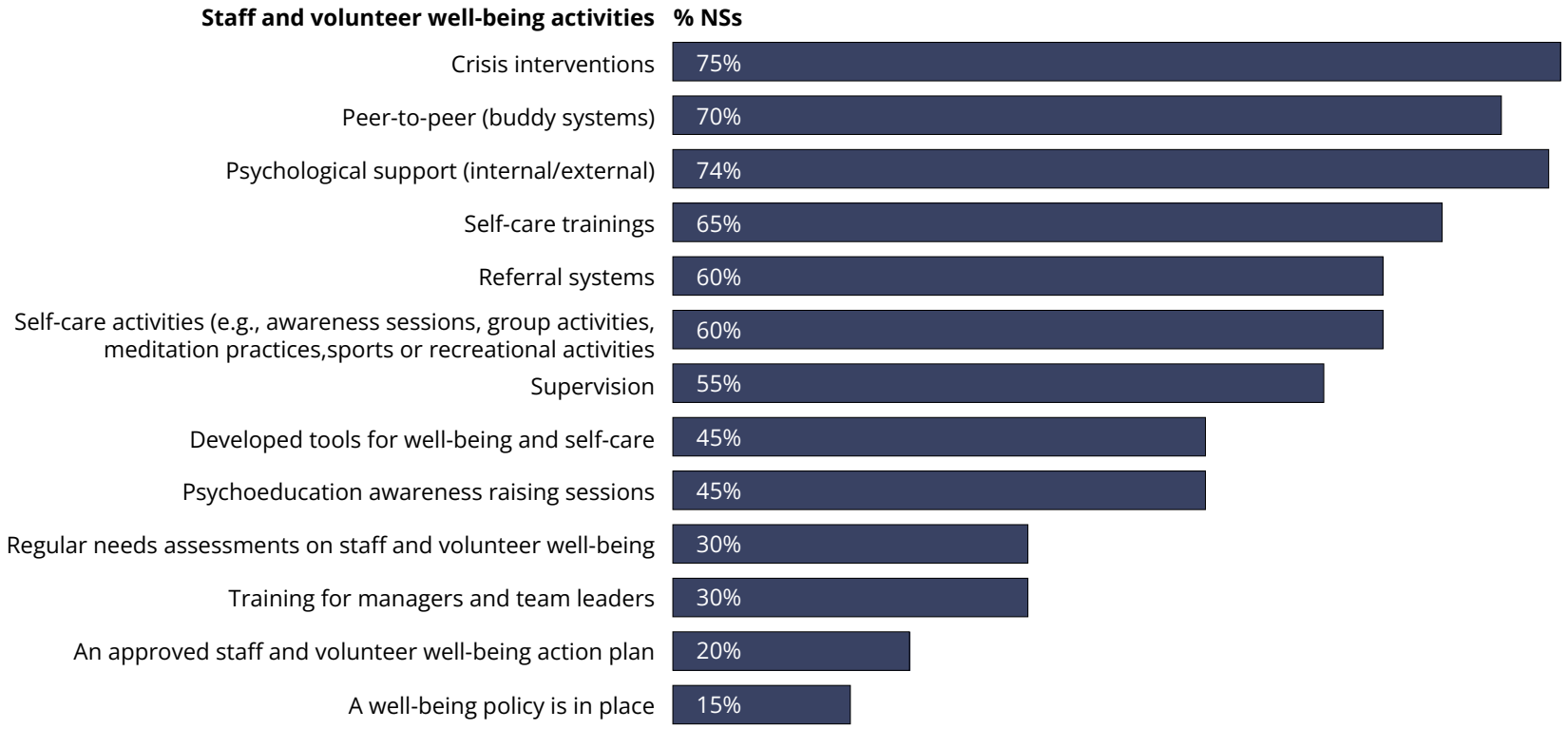


Figure 23: Americas: Caring for staff and volunteers' activities

MHPSS MEAL and Research

Responses from the Americas region suggest that monitoring (26%) and research engagement (11%) remain areas for further development.

Key figures

26% of NSs, the IFRC, the ICRC regularly monitor MHPSS activities and conduct MHPSS research

11% of NSs, the IFRC, the ICRC engaged in research

Venezuelan Red Cross providing psychosocial support at Field Hospital in La Guaira.

Photo: Venezuelan Red Cross

Humanitarian Diplomacy and Advocacy

Findings from the Americas region indicate strong engagement in MHPSS Humanitarian Diplomacy and Advocacy, with 74% of responding NSs reporting involvement in advocacy activities. This reflects a high level of operational engagement and participation in coordination and advocacy processes.

Respondents also report active recognition of the NSs auxiliary role in practice, particularly through participation in inter-agency coordination mechanisms (55%), government committees (45%), and integration within national public health and disaster management systems (40%). These findings highlight well-established collaboration with national systems and partners at the operational level.

At the same time, fewer respondents report formal recognition through institutional and policy frameworks, including national policies (20%), formal agreements (10%), and dedicated government funding (10%).

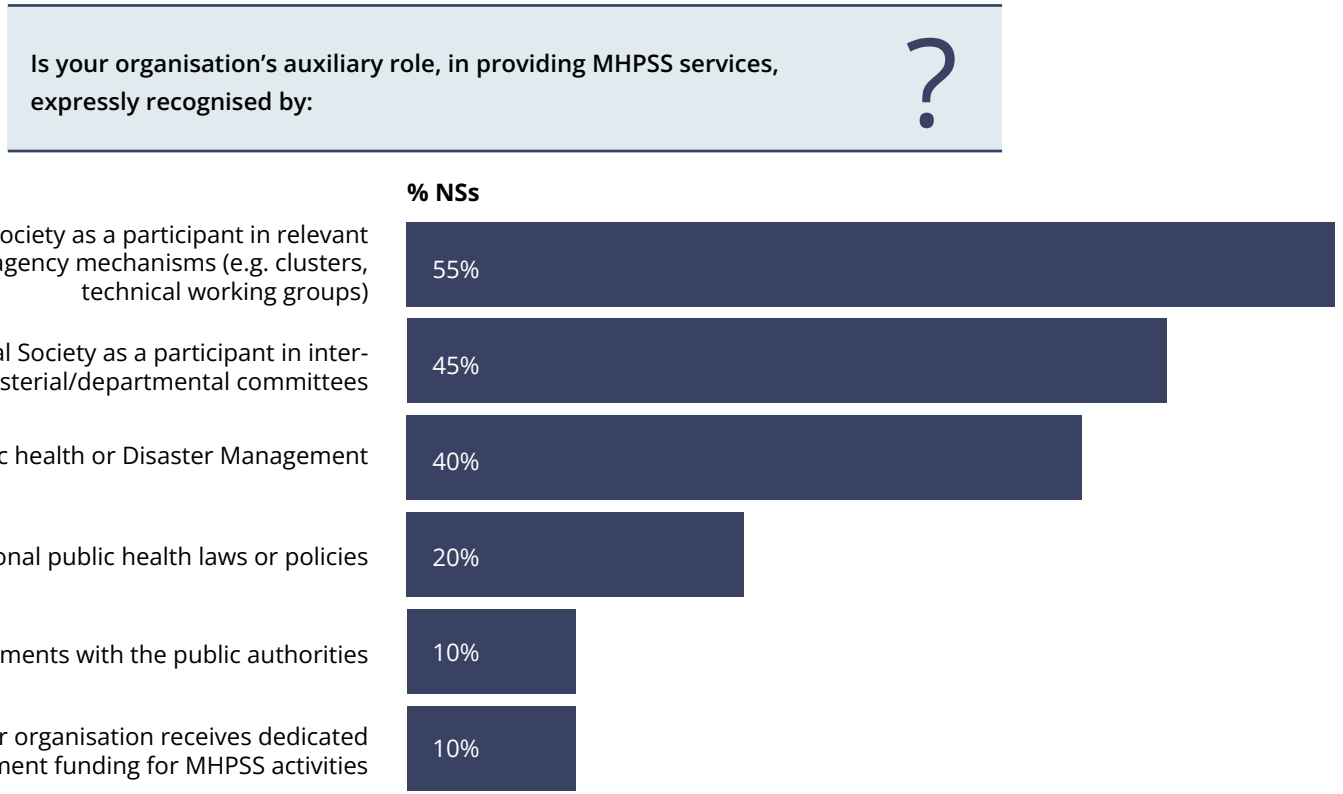


Figure 24: Americas: MHPSS recognition in national systems

Key Messages and Priority Actions

- **Very strong MHPSS service delivery with well-established systems in place**
  MHPSS is fully implemented across responding NSs (100% provision), supported by designated focal points (100%) and consistently high engagement across a wide range of activities.
- **Sustained commitment to expansion and integration of MHPSS**
  A substantial proportion of NSs report plans to expand MHPSS activities (75%) and integrate or mainstream MHPSS across sectors (65%), demonstrating continued efforts to scale services and strengthen cross-sectoral programming.
- **Caring for staff and volunteers' activities widely implemented with scope to strengthen systems**
  A majority of NSs report providing well-being support (70%), particularly through crisis interventions, psychological support, and peer-based approaches. Strengthening policies (15%), action plans (20%), and monitoring systems would further support consistency, sustainability, and system-wide application.
- **Strong operational recognition of the auxiliary role with potential to strengthen formal policy frameworks**
  NSs are actively engaged in coordination and advocacy mechanisms, reflecting strong operational recognition of their role. Formal recognition through policies (16–26%), agreements, and sustainable funding (10%) presents an opportunity to enhance long-term positioning and support.
- **Opportunity to strengthen evidence and learning systems**
  While implementation is highly developed, monitoring (26%) and research (11%) remain more limited, indicating an opportunity to further invest in evidence generation and learning systems to support quality, accountability, and advocacy.

Regional Analysis: Asia Pacific

Regional data presented in this section primarily reflects responses from NSs. Contributions from the IFRC and the ICRC are included in the global analysis and, where relevant, are referenced in the narrative for each region.

Across the Asia Pacific, the IFRC and the ICRC supported NSs and their partners in line with their respective mandates. The IFRC provides coordination, financial, and technical support for disaster operations and longer-term development programmes, while the ICRC supports populations affected by armed conflict and other situations of violence, through protection services as well as access to essential services.

Organisational Capacity and MHPSS Integration

Respondents from the Asia Pacific region report moderately strong MHPSS coverage and institutional anchoring, with 83% reporting provision of services and 83% reporting designated MHPSS focal points.

A substantial proportion of respondents also report plans to expand MHPSS activities (78%), alongside integration into other sectors (56%), reflecting a positive momentum in scaling and embedding MHPSS across programming areas.

Snapshot

(Percentages refer to responding National Societies in the region)

49% response rate

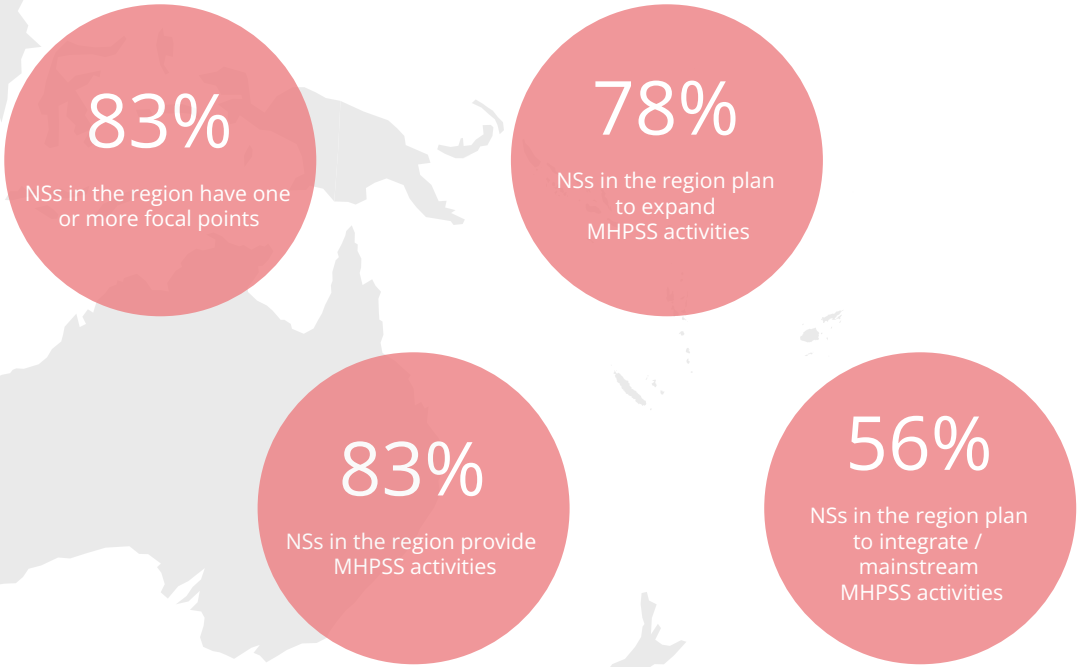
83% of NSs in the region report providing MHPSS activities

18,050 staff and volunteers trained in basic psychosocial support and/or PFA

83% of NSs in the region report having a designated MHPSS focal point

78% of NSs in the region report plans to expand activities

50% of NSs in the region report providing well-being support



MHPSS Activities and Programmatic Focus

MHPSS activities in the Asia Pacific region are reportedly implemented across a wide range of areas, with relatively even coverage rather than a strong focus on a few specific interventions. PFA (78%) is widely provided, alongside a broad group of activities—such as awareness campaigns, life skills activities, psychological support, and stress management (each 67%)—indicating a balanced approach to service delivery.

Programmatic focus follows a similar pattern. Activities are concentrated in disaster response (83%), staff and volunteer care (78%), and first aid (78%), while a wide range of other areas—such as community resilience, protection, youth, gender-based violence, and recovery (~61%)—are also consistently implemented. Engagement is somewhat lower in areas like community engagement, migration, gender inclusion, and staff systems (~56%).

Target group coverage is broad and inclusive, with the highest engagement among people affected by disasters (83%), volunteers (78%), and staff and youth (72%). Many other groups—including adolescents, migrants and refugees, and older persons (~67%)—are also regularly reached. Coverage is lower for other specific groups, such as children, internally displaced persons, and people affected by conflict or violence (~56%).

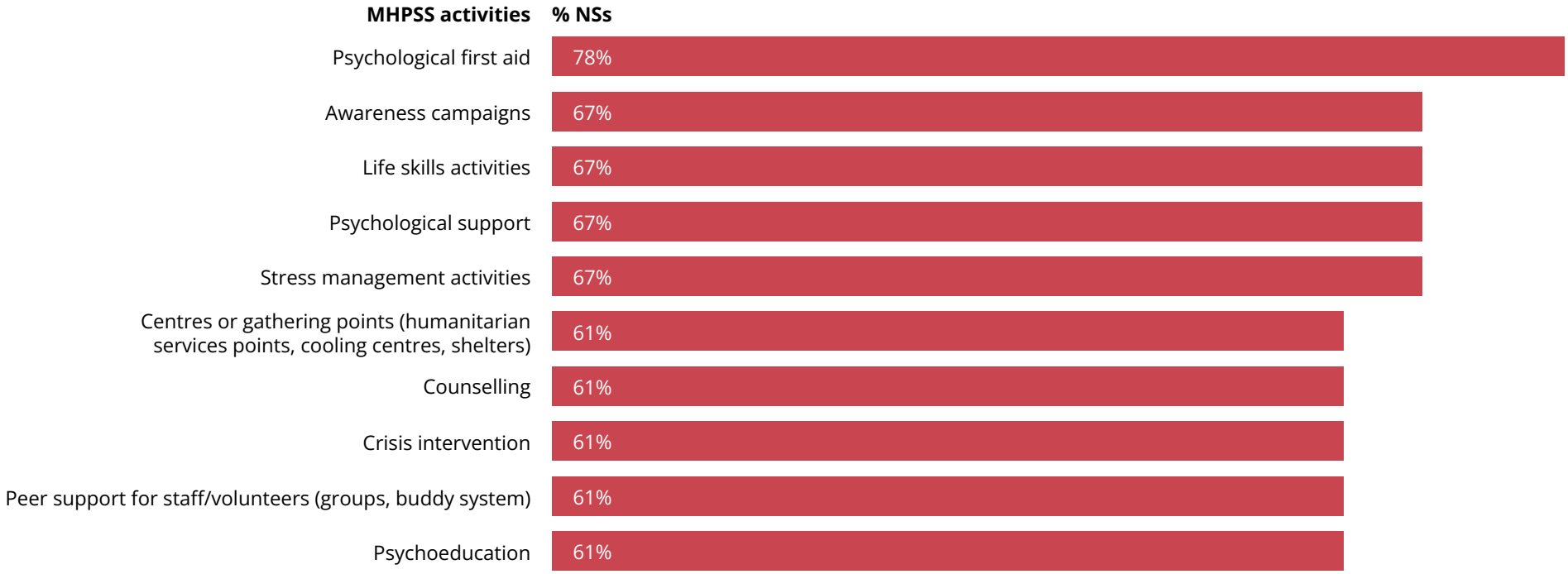


Figure 25: Asia Pacific: MHPSS Activities

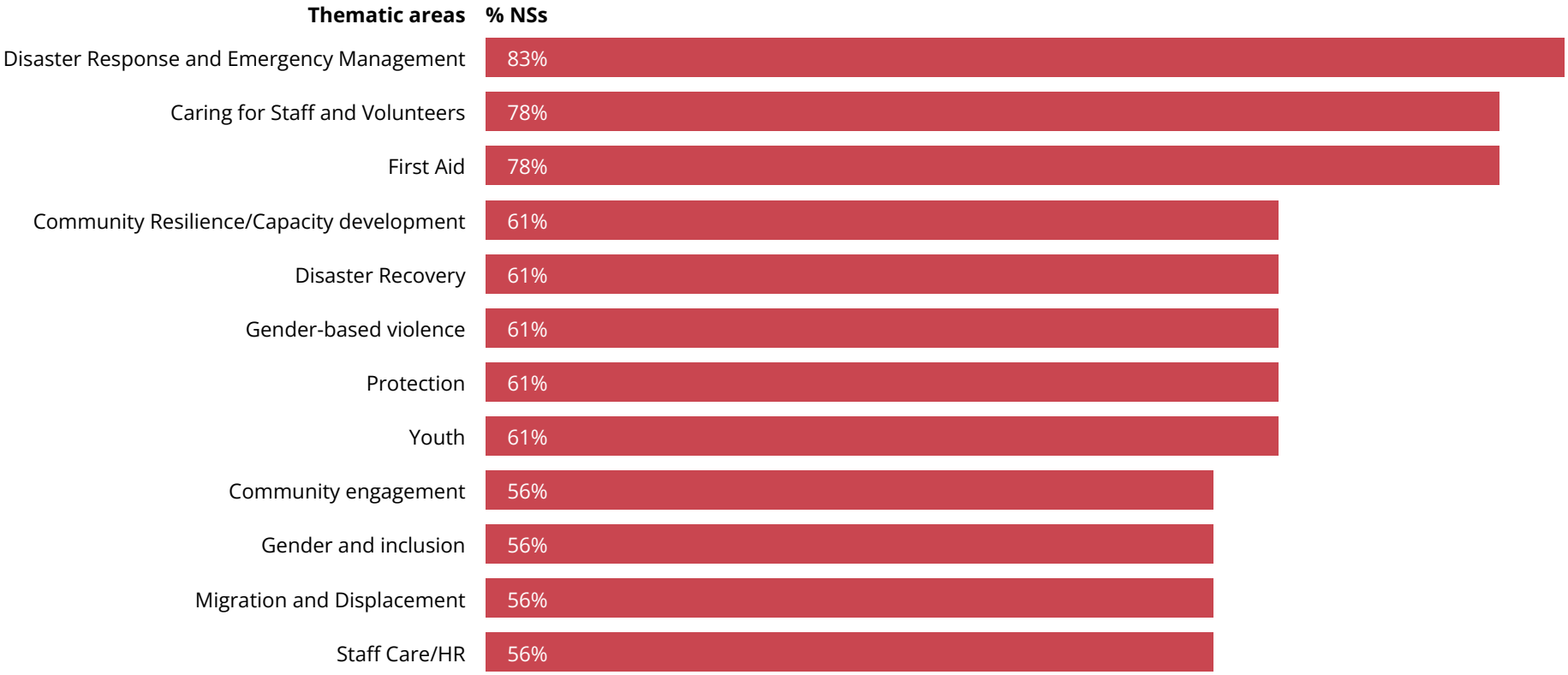


Figure 26: Asia Pacific: Thematic areas of focus

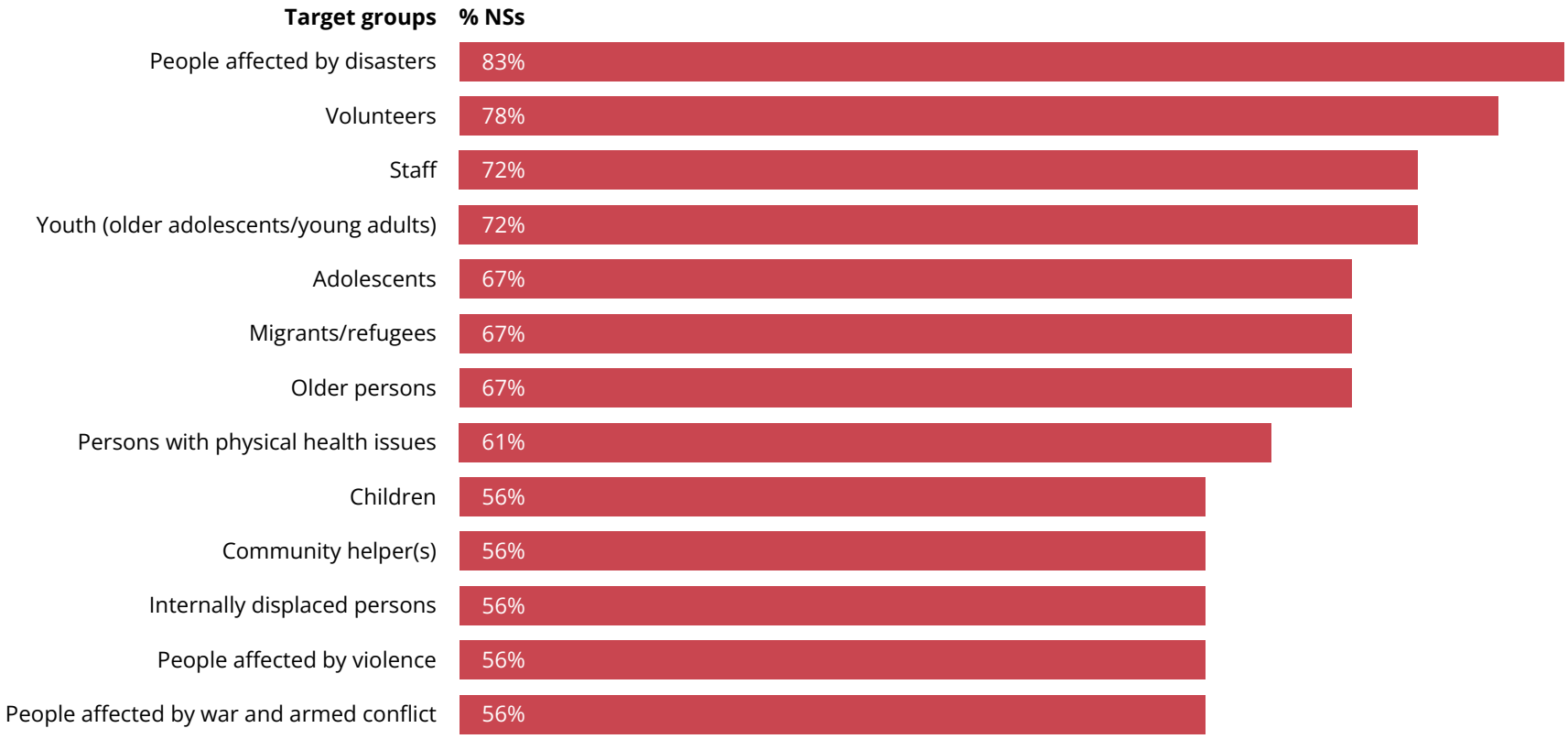


Figure 27: Asia Pacific: Target groups

Caring for Staff and Volunteers

Reported data from responding NSs in the Asia Pacific region show moderate provision of staff and volunteer well-being support (50%), with a range of activities implemented across both preventative and reactive approaches.

Respondents most frequently report self-care activities (67%), alongside peer support systems and psychological support (each 50%), indicating a strong reliance on accessible, peer-based and awareness-driven approaches. A second group of activities—such as self-care training (50%) and manager training (44%)—suggests some investment in capacity building, while more structured support mechanisms, including referral systems and well-being tools (each 39%) and supervision (33%), are less widely implemented.

Lower levels of implementation are reported for more specialised and system-based approaches, such as crisis interventions (28%), regular needs assessments (17%), and formal well-being action plans (11%), while 22% of respondents report the existence of formal policies. These findings highlight opportunities to further strengthen system-level approaches to staff and volunteer well-being.

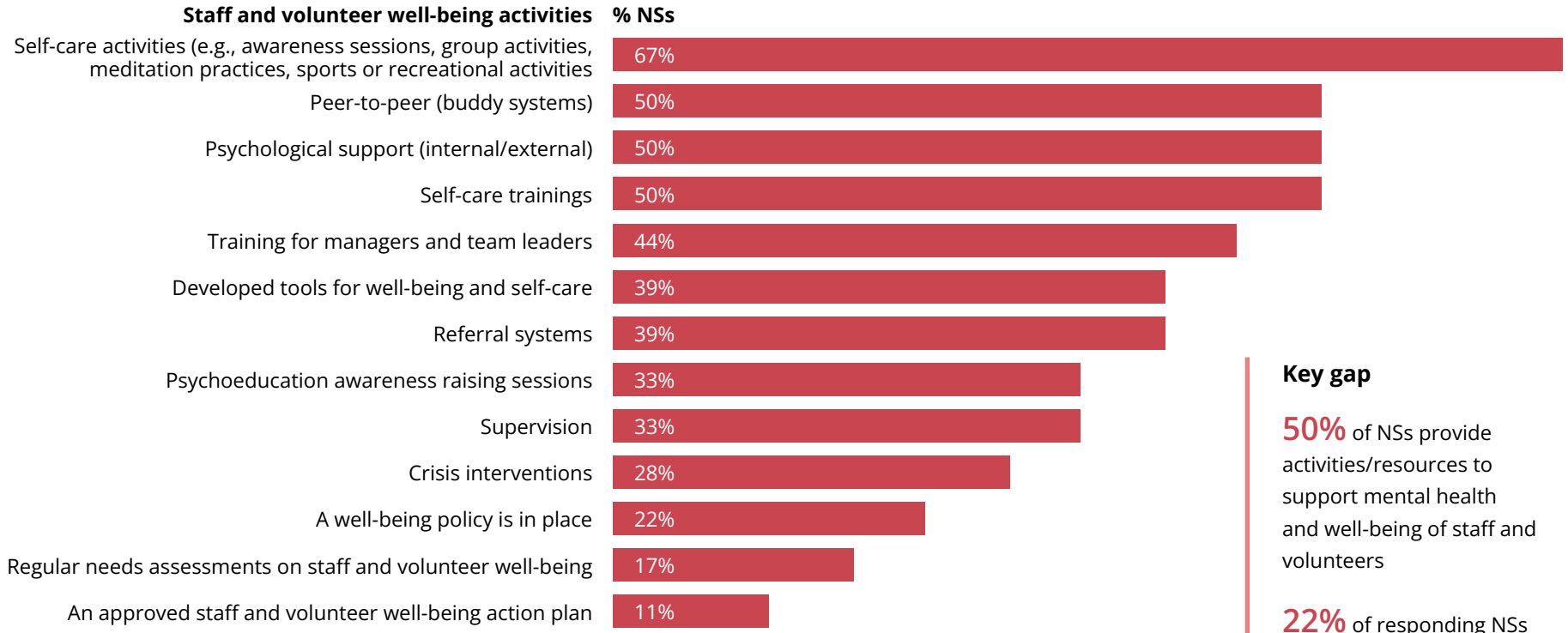


Figure 28: Asia Pacific: Caring for staff and volunteers' activities

Key gap

50% of NSs provide activities/resources to support mental health and well-being of staff and volunteers

22% of responding NSs have a formal policy

MHPSS MEAL and Research

Responses from NSs in the Asia Pacific region suggest that systems for evidence generation are emerging across the region, with 28% of respondents reporting regular monitoring and 11% are engaged in research. This indicates a growing foundation for systematic learning and evidence-based programming.

Key figures

28% of NSs, the IFRC, the ICRC regularly monitor MHPSS activities and conduct MHPSS research

11% of NSs, the IFRC, the ICRC engage in research

Child friendly space set up by Myanmar Red Cross Society in Kyauk Tar village in Sagaing Township, february 2026.

Photo: IFRC

Humanitarian Diplomacy and Advocacy

NSs in the Asia Pacific region report a moderate engagement in MHPSS Humanitarian Diplomacy and Advocac and humanitarian diplomacy, with recognition of the auxiliary role primarily reflected through participation in coordination mechanisms and inclusion of MHPSS in organisational strategies (50%).

Respondents report participation in inter-agency coordination mechanisms (44%), engagement in national public health and disaster management systems (39%), and involvement in government committees (28%), highlighting active collaboration with national systems at the operational level.

At the same time, fewer respondents report formal recognition through policy frameworks and institutional mechanisms, including national laws or policies (28%), formal agreements (22%), and dedicated government funding (11%).

Overall, these findings suggest that the auxiliary role of NSs in MHPSS is increasingly recognised in practice, with opportunities to further invest in formal policy integration, institutional frameworks, and sustainable financing to support long-term positioning and scale.

Is your organisation's auxiliary role, in providing MHPSS services, expressly recognised by: ?

Figure 29: Asia Pacific: MHPSS recognition in national systems

Key Messages and Priority Actions

- **Solid MHPSS operational delivery with scope to strengthen systems**
  MHPSS is widely implemented (83%) with strong engagement in disaster response (83%), staff care (78%), and first aid (78%), reflecting broad and balanced programming.
- **Strong commitment to expansion with continued progress in integration**
  A large proportion plan to expand activities (78%) and integrate MHPSS (56%), indicating continued efforts to scale and embed MHPSS across sectors.
- **Broad and inclusive MHPSS programming coverage**
  Activities and target groups are widely covered, including people affected by disasters (83%), volunteers (78%), and staff and youth (72%), reflecting a diverse and inclusive approach.
- **Staff and volunteer well-being established, with opportunities to strengthen "duty of care" systems**
  Around 50% of respondents report provision of well-being support, primarily through self-care, peer support, and psychological support approaches. Strengthening policies (22%), action plans (11%), and structured systems such as supervision and monitoring would further enhance consistency and sustainability of well-being support.
- **Operational recognition of the auxiliary role with potential to strengthen formal frameworks**
  NSs are engaged in coordination mechanisms and national systems, reflecting recognition of their auxiliary role in practice. Further strengthening formal policy frameworks (24%), agreements, and sustainable financing (11%) would support more consistent institutional recognition and long-term positioning.
- **Opportunity to strengthen evidence and learning systems**
  While MHPSS delivery is well established, monitoring (28%) and research (11%) are less widely implemented, indicating an opportunity to further develop evidence generation, learning, and accountability systems to support programme quality and advocacy.

Regional Analysis: Central Asia and Europe

Regional data presented in this section primarily reflects responses from NSs. Contributions from the IFRC and the ICRC are included in the global analysis and, where relevant, are referenced in the narrative for each region.

In Central Asia and Europe, the IFRC and the ICRC supported NSs and their partners in line with their respective mandates. The IFRC provides coordination, financial, and technical support for disaster operations and longer-term development programmes, while the ICRC supports populations affected by armed conflict and other situations of violence, through protection services as well as access to essential services.

Organisational Capacity and MHPSS Integration

Responses from Central Asia and Europe show very strong MHPSS capacity, with almost full coverage of MHPSS provision (98% of NSs) and a high proportion of NSs having designated MHPSS focal points (91%).

The majority of respondents plan to expand MHPSS activities (72%) and further integrate MHPSS into other sectors (53%), reflecting continued efforts to strengthen and embed MHPSS within broader NS programming.

Snapshot

(Percentages refer to responding National Societies in the region)

81% response rate

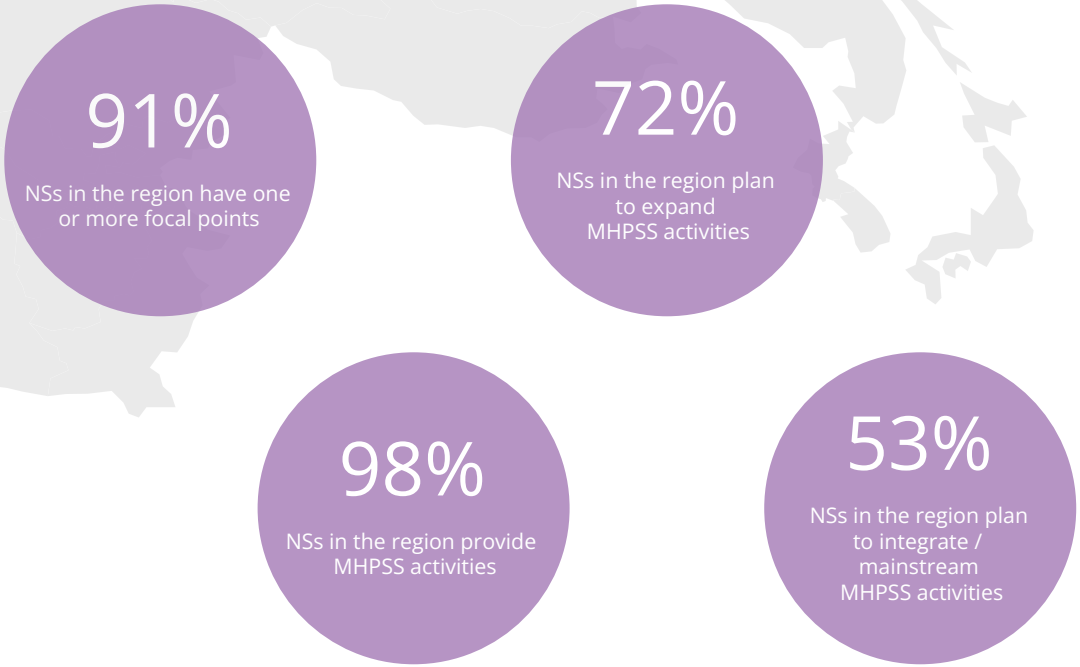
98% of NSs in the region report providing MHPSS activities

215,768 staff and volunteers trained in basic psychosocial support and/or PFA

91% of NSs in the region report having a designated MHPSS focal point

72% of NSs in the region report plans to expand activities

88% of NSs in the region report providing well-being support



MHPSS Activities and Programmatic Focus

Respondents from Central Asia and Europe report very high implementation across key MHPSS activities, with consistently strong uptake across core activities and services. Providing PFA (93%) is the most widely provided activity, alongside awareness campaigns and crisis interventions (81%), and a range of community-based approaches—such as community events, psychoeducation, and social activities (around 79%)—reflecting strong and consistent service delivery.

Programmatic focus is particularly strong in staff and volunteer care and first aid (both 91%), followed by disaster response (88%) and areas such as community resilience and youth (84%). Other thematic areas—including migration, community engagement, and staff systems (around 81%)—are also widely implemented, indicating a well-developed and integrated programme structure.

Target group coverage includes a wide range of different groups, with strong engagement among volunteers (93%), people affected by disasters (88%), staff (88%), and children (86%), as well as adolescents (84%) and migrants and refugees (81%). Coverage also includes more specific groups, such as people affected by violence (70%) and conflict-affected populations (67%), showing that MHPSS activities reach both general and higher-risk populations.

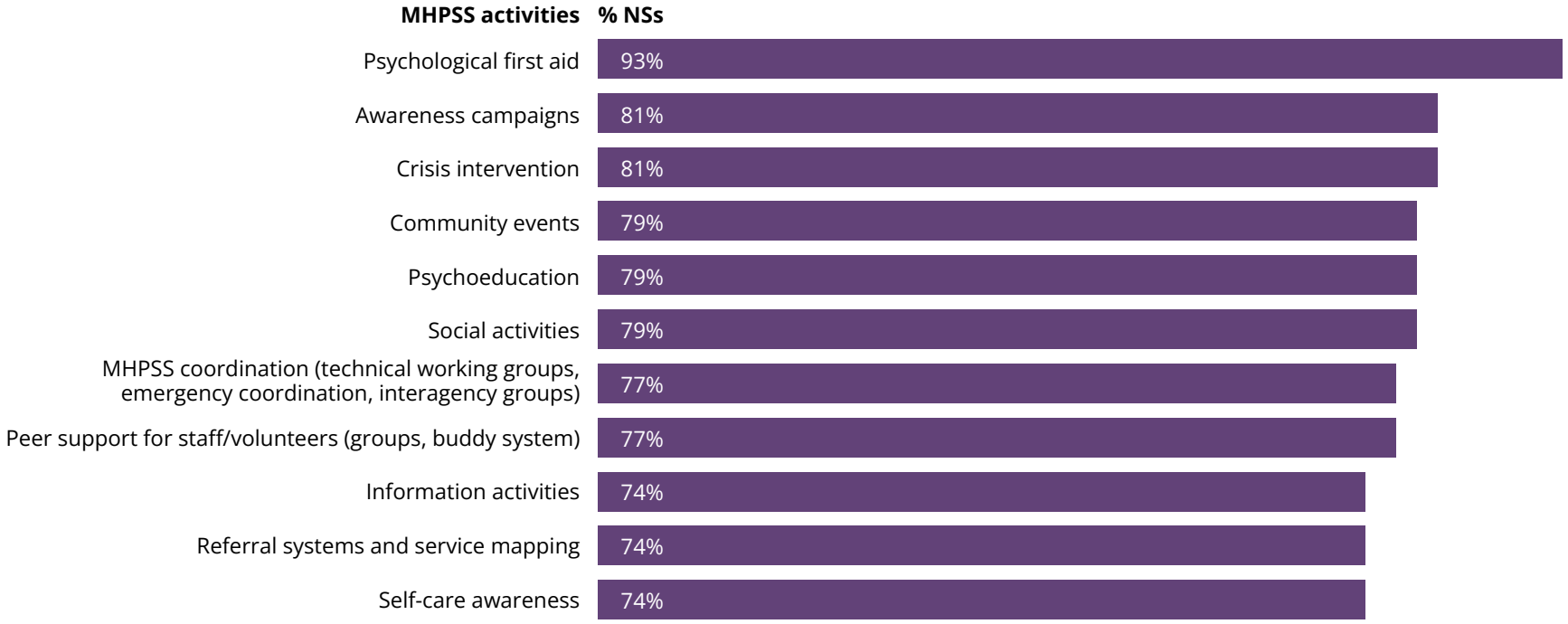


Figure 30: Central Asia and Europe: MHPSS Activities

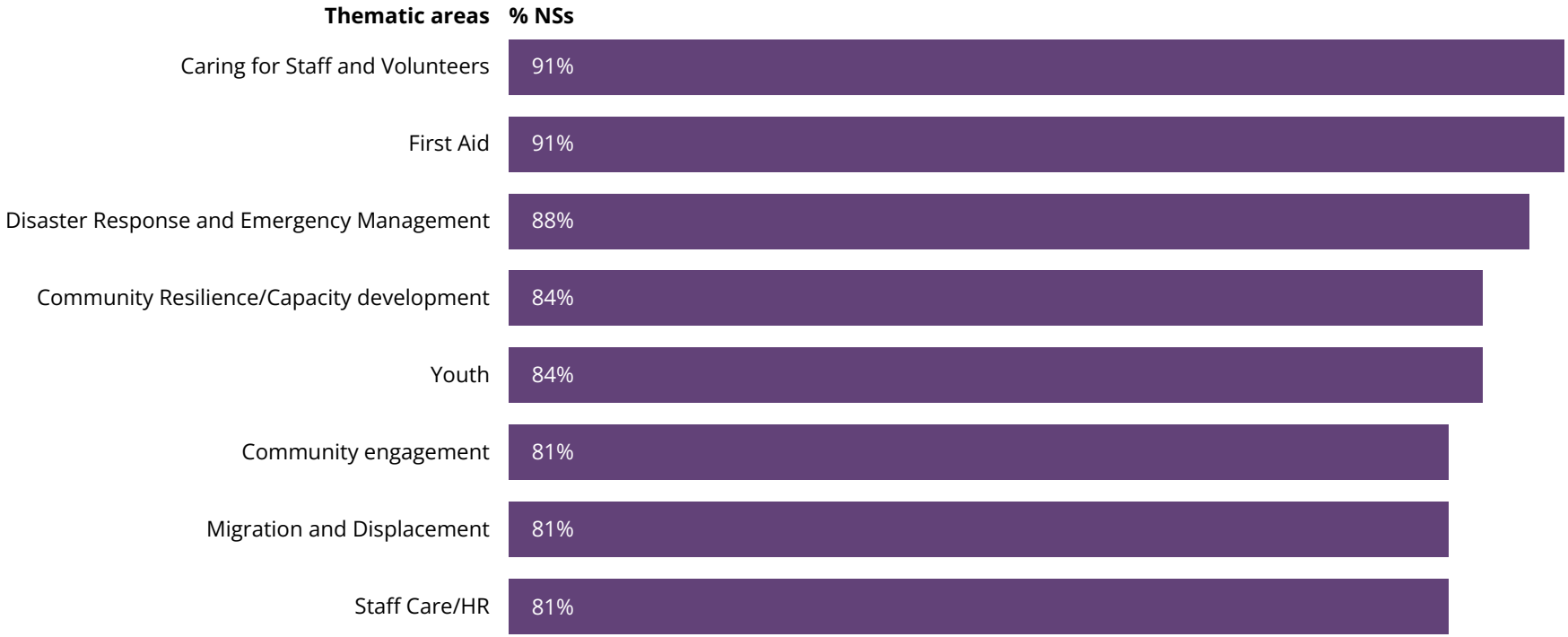


Figure 31: Central Asia and Europe: Thematic areas of focus

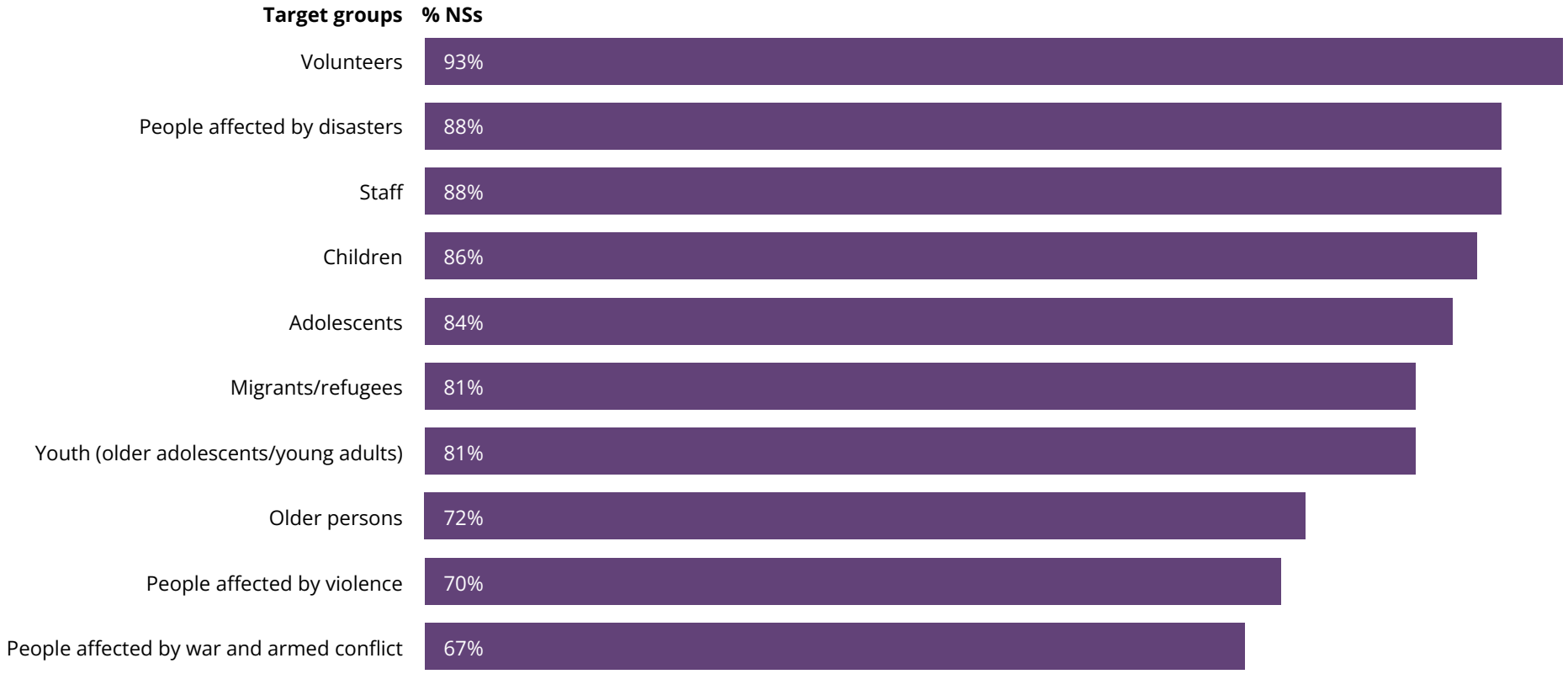


Figure 32: Central Asia and Europe: Target groups

Caring for Staff and Volunteers

Respondents from Central Asia and Europe report well-developed support for staff and volunteer well-being, combining strong implementation of activities with more established systems.

Common approaches include self-care activities and training (74%), peer support (72%), and psychological support and psychoeducation (around 70%), reflecting strong use of both preventative and supportive measures. More structured approaches—such as supervision (67%), crisis interventions (63%), and referral systems (60%)—are also widely in place.

Higher levels of system-based practices are also reported, including well-being tools (56%), regular needs assessments (44%), and action plans (33%), while 26% report formal policies.

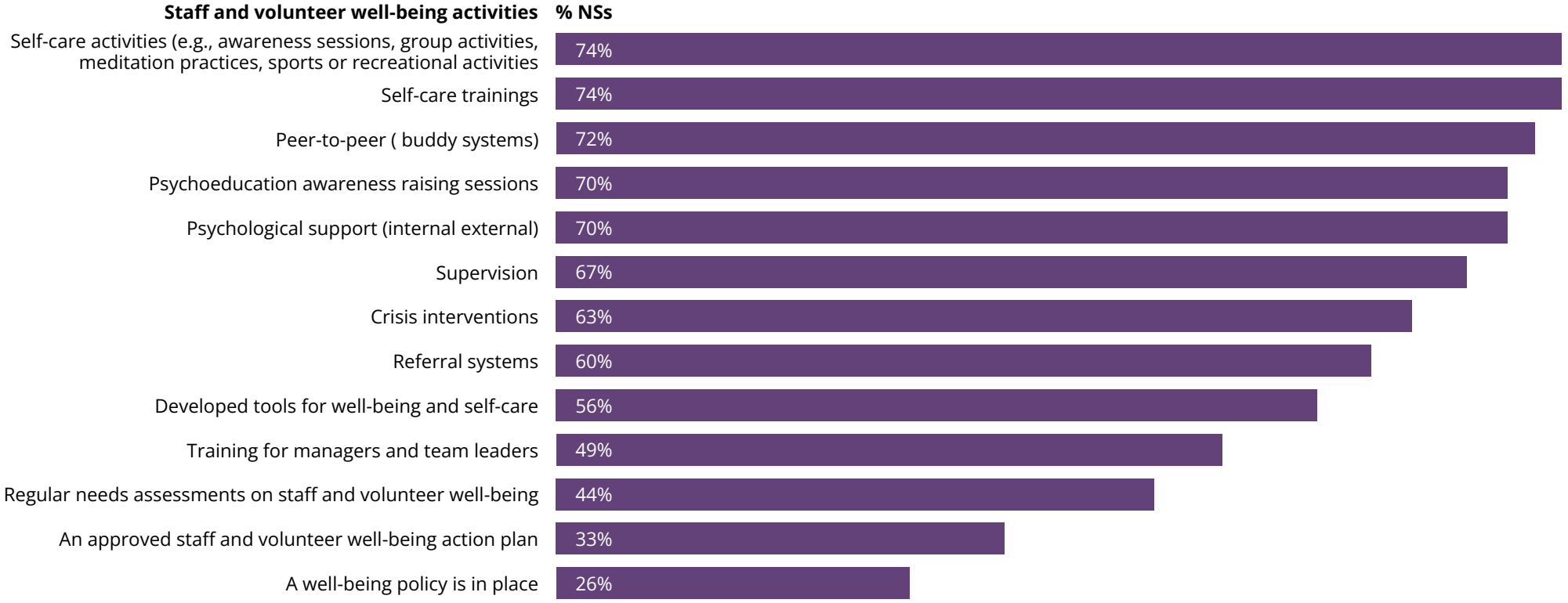


Figure 33: Central Asia and Europe: Caring for staff and volunteers' activities

MHPSS MEAL and Research

Respondents from Central Asia and Europe report strong engagement in MHPSS evidence building, with over half indicating regular monitoring of activities, projects, and programmes (57%), and a relatively high level of engagement in MHPSS research (36%).

Key figures

57% of NSs, the IFRC, the ICRC regularly monitor MHPSS activities and conduct MHPSS research

36% of NSs, the IFRC, the ICRC engage in research

Yoga class in the Portuguese Red Cross Coimbra branch.

Photo: The MHPSS Hub

Humanitarian Diplomacy and Advocacy

Respondents from Central Asia and Europe report a strong recognition of the NS auxiliary role, reflected through both operational engagement and formal mechanisms. A high proportion indicate recognition through formal agreements with public authorities (72%), as well as active participation in inter-agency coordination mechanisms (67%) and integration within national public health and disaster management systems (67%).

Respondents also report participation in government and inter-ministerial committees (42%), indicating a strong level of involvement in national decision-making processes. Compared to other regions, a relatively higher proportion report access to dedicated government funding (35%), reflecting more established institutional support.

At the same time, fewer respondents report recognition through national laws and policy frameworks (28%), suggesting opportunities to further invest in formal policy integration and long-term institutional positioning of MHPSS within national systems.

Is your organisation's auxiliary role, in providing MHPSS services, expressly recognised by: ?

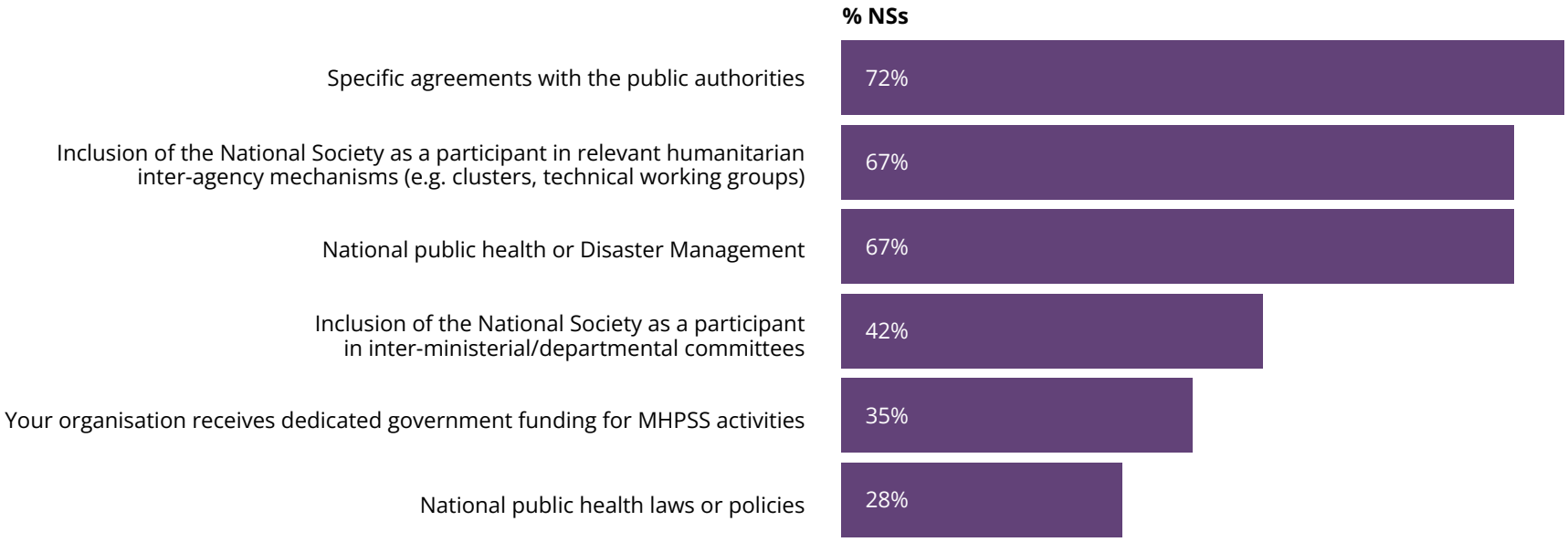


Figure 34: Central Asia and Europe: MHPSS recognition in national systems

Key Messages and Priority Actions

- **Very strong operational delivery with well-established systems**
  MHPSS is almost universally implemented (98%) with strong coverage across key areas, particularly staff care and first aid (91%) and disaster response (88%).
- **Continued expansion with opportunities to strengthen MHPSS integration across sectors**
  A majority of responding NSs plan to expand activities (72%) and integrate MHPSS (53%), supporting further embedding across programmes.
- **Advanced staff and volunteer well-being systems with continued development of policies**
  Well-being support is widely in place (88%), with strong use of tools and systems, and opportunities to further expand formal policies (26%).
- **Strong recognition of the auxiliary role with solid institutional support**
  Recognition is well established through agreements (72%), coordination (67%), and government funding (35%), with scope to invest in policy recognition (28%).
- **Well-established evidence and learning systems**
  Strong engagement in monitoring (57%) and research (36%) supports continued learning and evidence-based programming.

Regional Analysis: Middle East and North Africa

Regional data presented in this section primarily reflects responses from NSs. Contributions from the IFRC and the ICRC are included in the global analysis and, where relevant, are referenced in the narrative for each region.

Across the Middle East and North Africa, the IFRC and the ICRC supported NSs and their partners in line with their respective mandates. The IFRC provides coordination, financial, and technical support for disaster operations and longer-term development programmes, while the ICRC supports populations affected by armed conflict and other situations of violence, through protection services as well as access to essential services.

Organisational Capacity and MHPSS Integration

Respondents from the MENA region report full operational coverage and strong institutional anchoring, with all responding NSs reporting both provision of MHPSS activities (100%) and the presence of designated focal points (100%).

A large majority also report plans to expand MHPSS activities (90%), reflecting a clear commitment to scaling up MHPSS services. At the same time, fewer respondents report integration across sectors (30%), suggesting opportunities to further embed MHPSS within broader NSs programmes and systems.

Snapshot

(Percentages refer to responding National Societies in the region)

59% response rate

100% of NSs in the region report providing MHPSS activities

6,802 staff and volunteers trained in basic psychosocial support and/or PFA

100% of NSs in the region report having a designated MHPSS focal point

90% of NSs in the region report plans to expand activities

60% of NSs in the region report providing well-being support

100%
NSs in the region have one or more focal points

90%
NSs in the region plan to expand MHPSS activities

100%
NSs in the region provide MHPSS activities

30%
NSs in the region plan to integrate / mainstream MHPSS activities

MHPSS Activities and Programmatic Focus

Respondents report implementation across a range of MHPSS activities, with stronger emphasis on community-based and awareness-oriented approaches. The most reported activities include awareness campaigns and life skills (80%), followed by PFA and peer support (70%), reflecting a focus on accessible and community-level support. More structured interventions—such as counselling, information activities, and child-friendly spaces (60%)—are also reported, though less consistently.

Programmatic focus is more evenly distributed, with highest engagement in staff and volunteer care (50%), while core humanitarian areas such as disaster response, first aid, migration, and youth (around 40%) are moderately covered. Other thematic areas—including community engagement, protection, recovery, and social welfare (around 30%)—are less widely implemented.

Target group coverage is broad but relatively even, with most groups—including migrants, volunteers, staff, and disaster-affected populations—reported at around 50%, while others, such as children and adolescents (40%), are less frequently reached.

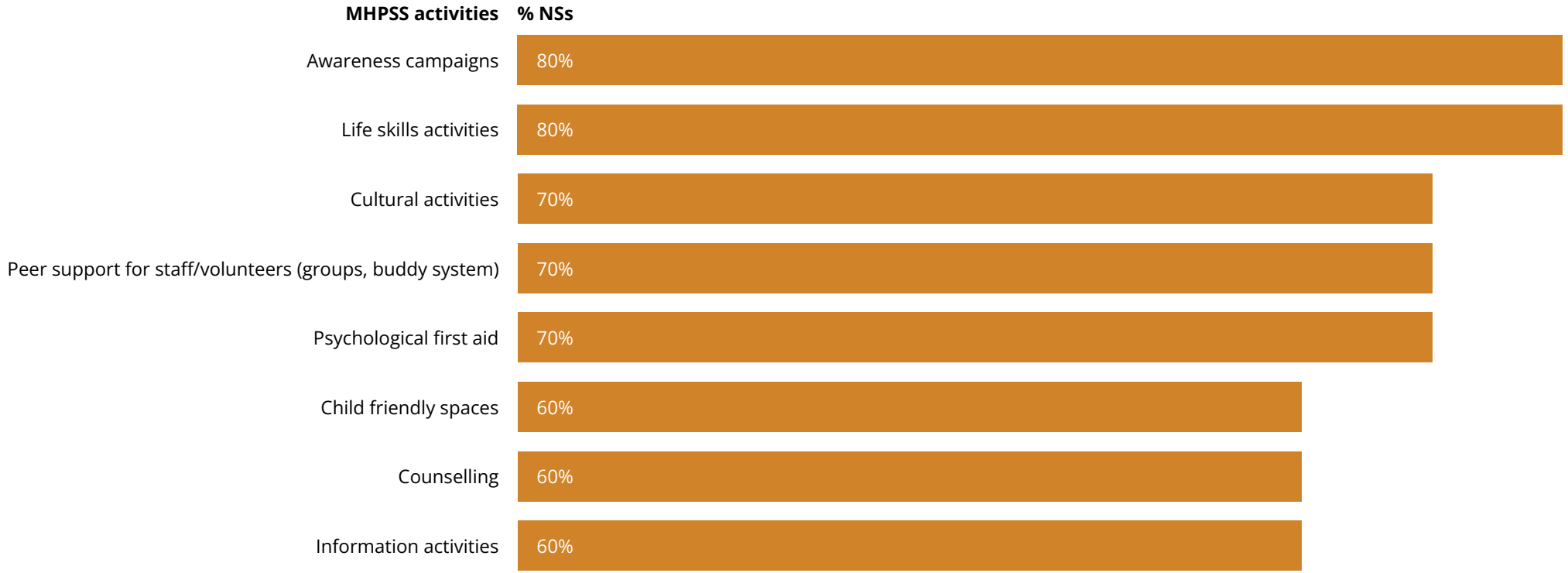


Figure 35: Middle East and North Africa: MHPSS Activities

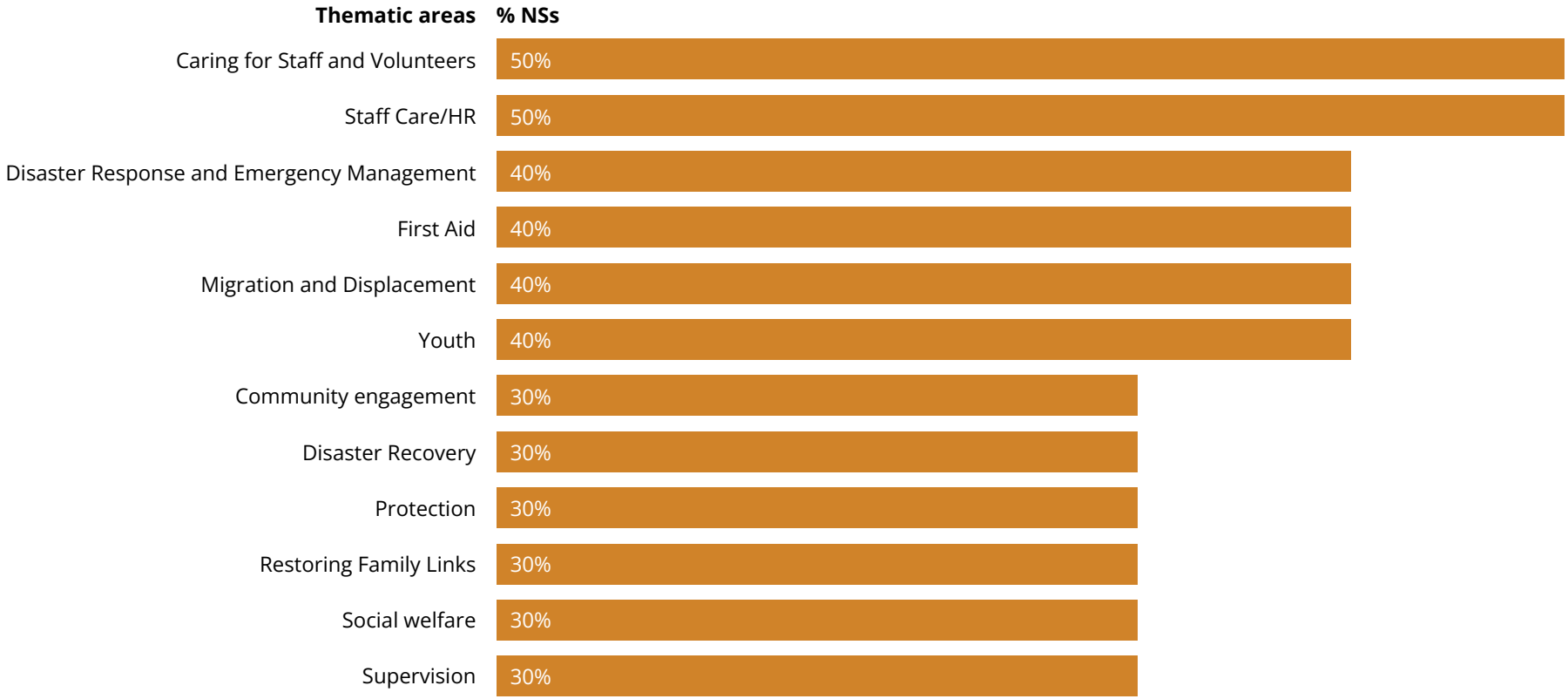


Figure 36: Middle East and North Africa: Thematic areas of focus

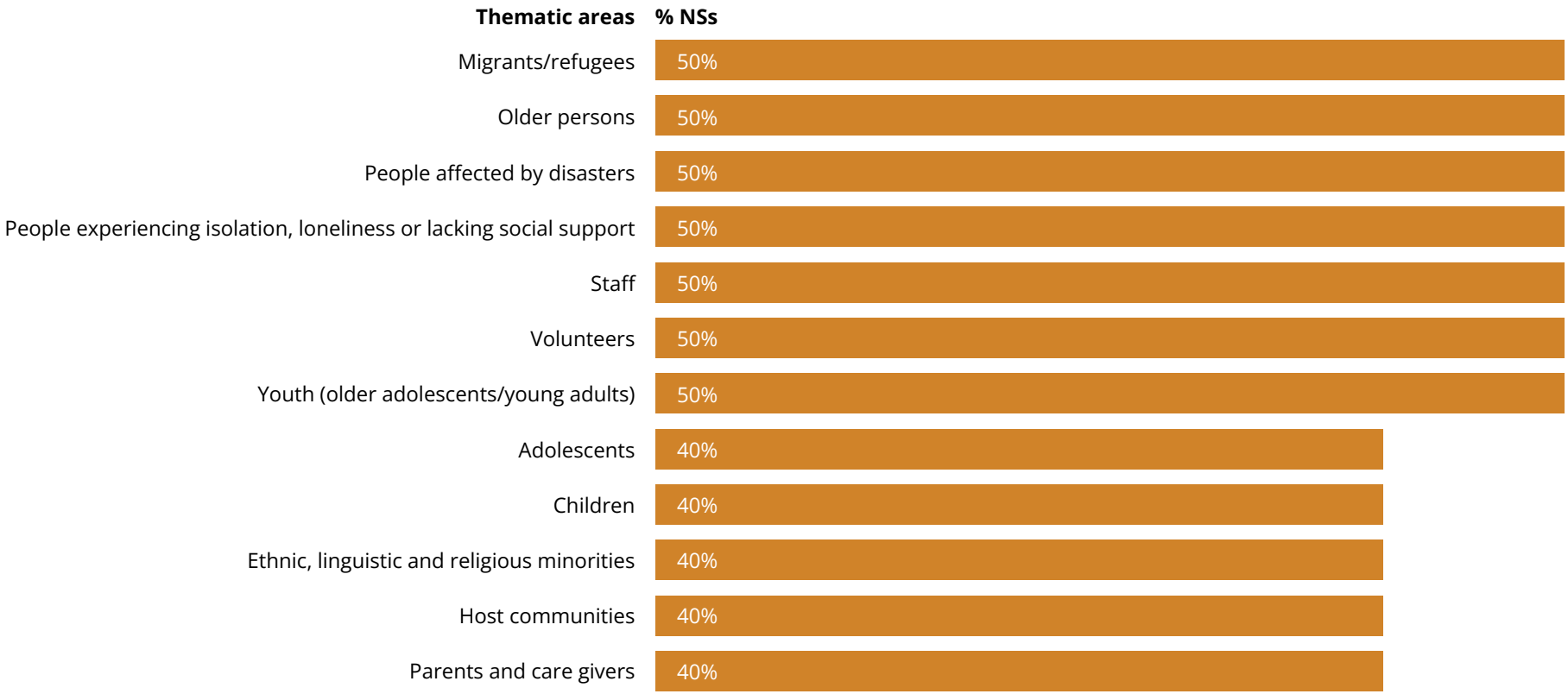
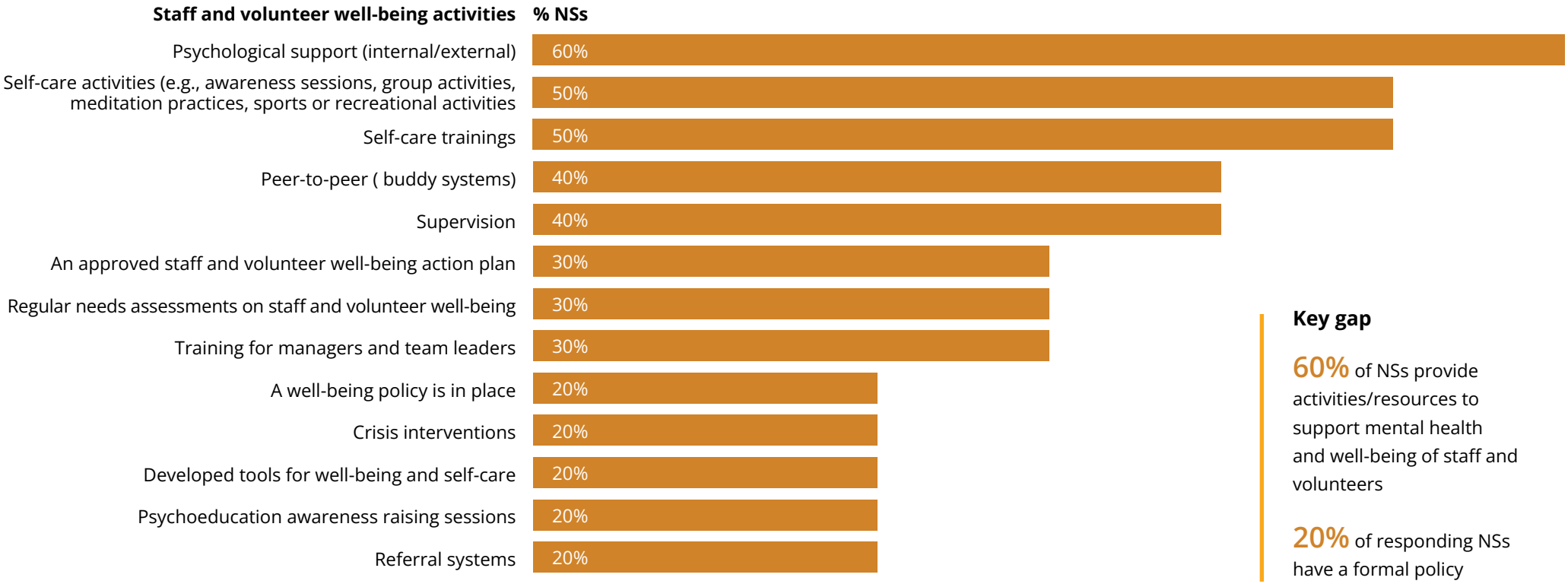


Figure 37: Middle East and North Africa: Target groups

Caring for Staff and Volunteers

Survey data indicates that respondents from the MENA region report moderate provision of well-being support (60%), with a combination of operational activities and emerging system-level approaches.

Common approaches include psychological support (60%) and self-care activities and training (50%), alongside peer support and supervision (40%), reflecting a combination of preventative and supportive measures. More structured systems—such as policies, tools, and referral mechanisms (around 20%)—are less widely reported, though slightly higher levels are seen for needs assessments and action plans (around 30%).



Key gap

60% of NSs provide activities/resources to support mental health and well-being of staff and volunteers

20% of responding NSs have a formal policy

Figure 38: Middle East and North Africa: Caring for staff and volunteers' activities

MHPSS MEAL and Research

Respondents report relatively strong monitoring systems (70%) and moderate engagement in research (30%), indicating a growing focus on evidence, learning, and data use.

Key figures

70% of NSs regularly monitor MHPSS activities and conduct MHPSS research

30% of NSs engage in research

Around 700 children taking part in an MHPSS activity in Al Mughayyir village, providing a safe space for play, expression, and connection.

Photo: Palestine Red Crescent

Humanitarian Diplomacy and Advocacy

Respondents from the MENA region report moderate to strong recognition of the auxiliary role, particularly through participation in coordination mechanisms (60%) and integration within national public health and disaster systems (60%). Participation in government committees (50%) further reflects engagement at national level.

In addition, policy frameworks and formal agreements (40%) are reported by a notable proportion of respondents, indicating progress towards institutional recognition. However, access to dedicated government funding (10%) remains limited.

Is your organisation's auxiliary role, in providing MHPSS services, expressly recognised by: ?

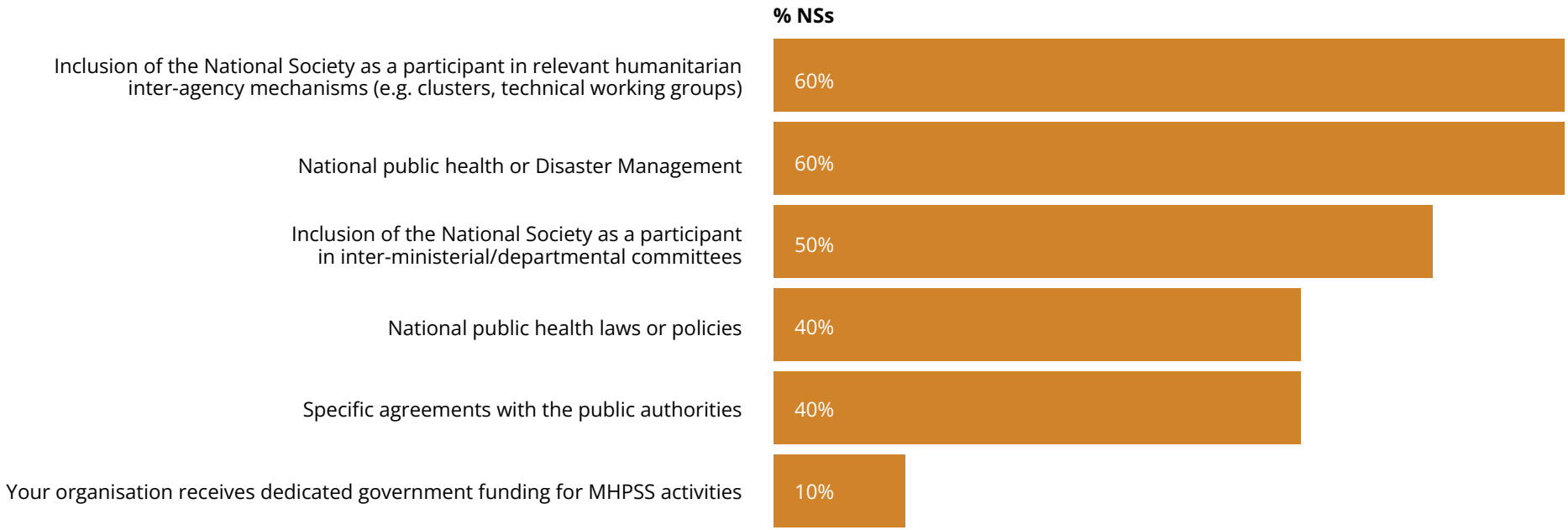


Figure 39: Middle East and North Africa:: MHPSS recognition in national systems

Key Messages and Priority Actions

- **Very strong operational delivery with full coverage**
  MHPSS is widely implemented (100%) with strong organisational capacity and consistent presence of MHPSS focal points.
- **Strong commitment to expansion with opportunity to increase integration**
  A large majority plan to expand activities (90%), with opportunities to further increase integration across sectors (30%).
- **Staff and volunteer well-being established with scope to invest in systems**
  60% provide well-being support, mainly through operational activities, with opportunities to expand policies and structured systems (~20–30%).
- **Operational recognition of the auxiliary role with opportunities to invest in institutional support**
  Engagement in coordination and national systems is strong, with further opportunities to expand policy frameworks (40%) and sustainable financing (10%).
- **Emerging evidence and learning systems**
  Strong monitoring (70%) and moderate research engagement (30%) provide a basis to further strengthen evidence and learning systems.

Concluding remarks

The findings of the 2025 Global MHPSS Survey confirm a continued and growing commitment across the Movement to implement the Movement Policy on Addressing Mental Health and Psychosocial Needs. MHPSS is increasingly recognised as central to protecting life, health, dignity, and well-being, and is now firmly embedded across Movement programming, with widespread delivery and sustained engagement from NSs, the IFRC and the ICRC.

Over recent years, MHPSS has evolved from a specialised area of work to a core component of humanitarian action, contributing to the Movement's broader objectives of alleviating human suffering and promoting mental health and psychosocial well-being, including for staff and volunteers.

Across regions, the survey highlights significant progress in expanding access to MHPSS, supported by a large and diverse workforce and strengthened foundational capacity, particularly at community level. This reflects an increasing focus on prevention, early support, and community-based approaches delivered by volunteers, as well as a shared commitment to integrated and multi-layered responses across the continuum of care.

At the same time, the findings point to the next phase in strengthening the Movement's response. While delivery is strong and continues to expand, further investments are needed to reinforce system-level approaches to ensure that MHPSS is comprehensive, integrated, and sustainable, including:

- investing in policy frameworks and organisational systems
- advancing integration of MHPSS across sectors and programmes
- enhancing monitoring, evaluation, learning, and evidence-based practice
- ensuring consistent duty of care for staff and volunteers
- strengthening Humanitarian Diplomacy and Advocacy, and sustainable financing mechanisms.

These priorities are especially important in the current context of protracted and overlapping crises, which are increasing mental health and psychosocial needs and placing growing pressure on humanitarian systems. Ensuring that MHPSS is not only delivered at scale, but also accessible, appropriate, and sustained over time, will be essential to maintaining quality and impact.

The findings also highlight the importance of formalising the link between operational engagement and the formal recognition of the auxiliary role of NSs, including within national systems, policies, and financing structures. Strengthening this alignment will support the positioning of MHPSS as a long-term priority within both humanitarian and public systems, in line with the Movement's role in complementing State responsibilities.

Looking ahead, the survey provides a strong evidence base to support the continued implementation of the Movement Policy and the priorities of the MHPSS Hub Strategy. It highlights both the significant progress achieved and the opportunities to further strengthen capacity, systems, and collaboration across the Movement.

Ultimately, the next phase of MHPSS development will require continued progress from scaling up activities to strengthening systems—ensuring that MHPSS is integrated across services, informed by evidence, grounded in principles of dignity and inclusion, and accessible to all people with mental health and psychosocial needs.

Acknowledgements

We extend our sincere thanks to all NSs, the IFRC, and the ICRC that contributed to the 2025 Global MHPSS Survey. Your participation, experiences, and insights have been essential in documenting the progress of MHPSS across the Movement and identifying priorities for future action. Your commitment to addressing mental health and psychosocial needs continues to strengthen the Movement's collective impact in communities around the world.

With thanks to the following for their participation in the survey (written in alpabetical order):

Afghan Red Crescent

Albanian Red Cross

Antigua and Barbuda Red Cross

Argentine Red Cross

Armenian Red Cross Society

Australian Red Cross

Austrian Red Cross

Bahrain Red Crescent Society

Bangladesh Red Crescent Society

Baphalali Eswatini Red Cross Society

Belgian Red Cross

Belize Red Cross Society

Bolivian Red Cross

British Red Cross

Bulgarian Red Cross

Burkinabe Red Cross Society

Cambodian Red Cross Society

Chilean Red Cross

Colombian Red Cross Society

Congolese Red Cross

Costa Rican Red Cross

Croatian Red Cross

Cuban Red Cross

Cyprus Red Cross Society

Czech Red Cross

Danish Red Cross

Dominica Red Cross Society

Dominican Republic Red Cross

Ecuadorian Red Cross

Estonia Red Cross

Ethiopian Red Cross Society

Fiji Red Cross Society

Finnish Red Cross

French Red Cross

Gabonese Red Cross Society

German Red Cross

Ghana Red Cross Society

Guatemalan Red Cross

Hellenic Red Cross

Honduran Red Cross

Hong Kong Branch of the Red Cross Society of China

Hungarian Red Cross

Icelandic Red Cross

International Committee of the Red Cross

International Federation of Red Cross Red Crescent Societies

Iraqi Red Crescent Society

Irish Red Cross Society

Italian Red Cross

Japanese Red Cross Society

Kazakh Red Crescent

Kenya Red Cross Society

Kiribati Red Cross Society

Kuwait Red Crescent Society

Lao Red Cross Society

Lebanese Red Cross

Lesotho Red Cross Society

Liberian Red Cross Society

Libyan Red Crescent

Liechtenstein Red Cross

Lithuanian Red Cross Society

Luxembourg Red Cross

Malawi Red Cross Society

Malaysian Red Crescent Society

Mali Red Cross

Mauritanian Red Crescent

Mexican Red Cross

Mongolian Red Cross Society

Moroccan Red Crescent

Myanmar Red Cross Society

Nepal Red Cross Society

Nigerian Red Cross Society

Norwegian Red Cross

Pakistan Red Crescent

Papua New Guinea Red Cross Society

Philippine Red Cross

Polish Red Cross

Portuguese Red Cross

Qatar Red Crescent Society

Red Crescent Society of Kyrgyzstan

Red Cross of Benin

Red Cross of Monaco

Red Cross of Montenegro

Red Cross of North Macedonia

Red Cross of the Democratic Republic of the Congo

Red Cross Society of Cote d'Ivoire

Red Cross Society of Georgia

Red Cross Society of Niger

Red Cross Society of Panama

Red Cross Society of the Republic of Moldova

Romanian Red Cross

Saint Kitts and Nevis Red Cross Society

Salvadorean Red Cross Society

Sao Tome and Principe Red Cross

Senegalese Red Cross Society

Singapore Red Cross Society

Slovak Red Cross

Slovenian Red Cross

South Sudan Red Cross

Spanish Red Cross

Swedish Red Cross

Swiss Red Cross

Syrian Arab Red Crescent

Tanzania Red Cross National Society

The Canadian Red Cross Society

The Comoros Red Crescent

The Guyana Red Cross Society

The Netherlands Red Cross

The Palestine Red Crescent Society

The Red Cross of Serbia

The Russian Red Cross Society

The South African Red Cross Society

The Thai Red Cross Society

The Uganda Red Cross Society

Turkish Red Crescent Society

Ukrainian Red Cross Society

Venezuelan Red Cross

Vietnam Red Cross Society

Yemen Red Crescent Society

Zambia Red Cross Society

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