Cameroon Has Built Mental-Health Capacity Through Crisis. Will It Survive the Humanitarian Funding Crisis?

From humanitarian response to sustainable mental-health systems

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Final edition and publication 26th November 2026 , Yaoundé Cameroon

There is a mental health revolution happening in Cameroon (Demassosso,2021). In June 2025, the Norwegian Refugee Council (NRC) named Cameroon the **world's most neglected displacement crisis**. NRC's ranking considers not only humanitarian funding, but also media attention and political and diplomatic engagement. Cameroon had already appeared near the top of the ranking for several years. (NRC)

The warning was stark: Cameroon was experiencing enormous humanitarian needs while receiving insufficient international attention and resources.

But there is another dimension to this crisis that deserves greater attention.

Over more than a decade of humanitarian response, Cameroon has also accumulated significant mental-health and psychosocial support (MHPSS) capacity.

Humanitarian organisations, the Ministry of Public Health, United Nations agencies, NGOs, community organisations and other partners have trained frontline workers, established community-based MHPSS services, developed referral pathways, strengthened supervision and built coordination mechanisms.

Now the humanitarian financing environment is deteriorating.

And that creates a critical question:

Will the mental-health capacity built during more than a decade of humanitarian response become part of Cameroon's health system—or disappear when humanitarian projects and funding disappear?

My exploratory poll among members of three MHPSS Technical Working Groups suggests that the answer is neither simple nor reassuring.

Some capacity is clearly being retained. But the transition from humanitarian capacity to nationally owned and financed mental-health services remains incomplete.

The warning from NRC

The NRC's 2025 assessment is important because it puts Cameroon's humanitarian situation into a global perspective.

In its 2025 report, NRC identified Cameroon as the **world's most neglected displacement crisis**, using three dimensions of neglect: humanitarian funding, media attention and political engagement. (NRC)

The situation did not improve sufficiently in 2025.

NRC's subsequent assessment, published in 2026 and examining the situation during 2025, reported that Cameroon had **more than 1.5 million displaced people by June 2025**, while its humanitarian response for 2025 was only **24 per cent funded**. (NRC)

This is an important distinction.

The 2025 NRC report said Cameroon was the world's most neglected displacement crisis.

The subsequent assessment shows that the underlying funding problem continued: **only 24 per cent of the 2025 humanitarian response was funded**. (NRC)

For mental health, this matters enormously.

Because humanitarian funding does not only pay for counselling sessions.

It also supports the less visible infrastructure around MHPSS:

- trained personnel;
- community facilitators;
- supervision;
- referral pathways;
- technical specialists;
- coordination;
- information management;
- monitoring and quality assurance.

When funding disappears, these capacities can disappear with it.

And that is the real concern.

Cameroon has built something during the crisis

When people hear "humanitarian mental-health response", they may imagine a psychologist sitting with a person who has experienced trauma.

But MHPSS in Cameroon has evolved considerably beyond individual counselling.

Humanitarian programmes have trained frontline actors in psychological first aid, basic psychosocial support, communication, stress management and self-care.

Community facilitators have been supported to identify people experiencing psychological distress and connect them with services.

Referral systems have been developed.

Traditional therapists have been engaged as potential entry points for people seeking support.

Community-based interventions have expanded.

These are not simply humanitarian activities.

They are building blocks of a mental-health system.

The scale is significant.

UNICEF reported that, in 2024, it and its partners reached **113,631 children, adolescents and caregivers with community-based mental-health and psychosocial support** in Cameroon. (UNICEF Cameroon)

That represents more than 113,000 people receiving support.

But it also represents years of operational learning:

How do you deliver MHPSS in communities where specialist professionals are scarce?

How do you reach displaced populations?

How do you identify people requiring specialised care?

How do you create referral pathways?

How do you work through community structures?

How do you provide psychosocial support during insecurity?

This is knowledge.

And knowledge is a health-system asset.

The question is: who owns this capacity?

This is where the humanitarian story becomes a health-system story.

A humanitarian organisation can train 100 community workers.

Those workers acquire skills.

That is **capacity building**.

The organisation can then supervise them.

That makes the capacity stronger.

Some workers may remain with their organisation after the project ends.

That is **retention**.

But what happens when the humanitarian organisation withdraws?

Who supervises the workers?

Who pays them?

Who trains new workers?

Who maintains the referral system?

Who collects the data?

Who ensures quality?

Who finances the services?

If the answer is still "the humanitarian project", then the capacity has not yet become fully institutionalised.

It remains **project-dependent capacity**.

What did our exploratory poll find?

To better understand this question, I conducted an exploratory poll among members of three MHPSS Technical Working Groups:

- the **National MHPSS Technical Working Group**;
- the **Far North MHPSS Technical Working Group**; and
- the **North-West/South-West MHPSS Technical Working Group**.

Together, these groups had **989 members**.

There were **42 responses**:

Technical Working Group	Members	Responses
National	39	2
Far North	160	8
North-West/South-West	790	32
Total	**989**	**42**

The response rate was approximately **4.2 per cent**.

This is important to acknowledge.

The poll is **not representative** of all MHPSS actors in Cameroon. It was an exploratory exercise intended to provide an initial picture of whether humanitarian-generated capacities are being retained and transferred.

Nevertheless, the responses provide some interesting signals.

Some capacity is clearly surviving

Among the 42 respondents:

18 reported having been supervised.

This is important because training alone is rarely sufficient to sustain competence.

Supervision helps workers apply knowledge, discuss difficult cases, receive feedback and maintain quality.

It is therefore one indicator that humanitarian MHPSS programming has sometimes gone beyond one-off training.

Trained people are being retained—but mostly at organisational level

10 respondents reported that trained personnel were retained within their organisation.

This is encouraging.

It suggests that humanitarian investment in human capital is not necessarily lost when a training activity ends.

But there is an important distinction between **organisational retention** and **national retention**.

A trained person remaining with an NGO is still valuable.

But if the NGO depends entirely on humanitarian funding, that person's position may disappear when the funding disappears.

The real system question is:

How many humanitarian-trained people are being absorbed into permanent national structures?

Our poll could not answer that question.

That is an important area for further research.

Some referral systems survive humanitarian withdrawal

One of the most interesting findings was that **11 respondents reported continuing to use referral systems even after humanitarian partners withdrew**.

This provides preliminary evidence that some humanitarian-generated functions can survive the departure of humanitarian organisations.

That is an important sign of institutionalisation.

But it also raises a deeper question.

A referral pathway is only useful if there is somewhere to refer people.

A community worker may identify someone with a serious mental-health condition.

But then:

Where does the person go?

Who receives them?

Is specialist care available?

Are medicines available?

Who pays for transportation?

Who pays for treatment?

Who follows up?

Who records the outcome?

Who supervises the community worker?

These are not simply humanitarian questions.

They are health-system questions.

Humanitarian experience is accumulating

Another finding deserves attention.

26 respondents reported having other humanitarian experiences beyond those specifically examined in the poll.

And **nine respondents reported having two or more humanitarian experiences**.

This is potentially one of the most important hidden assets created by protracted crises.

Over years of humanitarian programming, practitioners accumulate knowledge.

They learn how to work in difficult environments.

They learn how to engage communities.

They learn how to identify psychological distress.

They learn how to establish referral pathways.

They learn how to coordinate across organisations.

They learn how to provide services when specialists are scarce.

This creates a form of **humanitarian institutional memory**.

But there is a risk.

If this expertise remains attached to individual projects or organisations, it can disappear when funding ends.

If it is captured, documented, transferred and incorporated into national training and health structures, it can become a permanent national asset.

Data is another unfinished transition

Only **seven respondents reported that MHPSS data belonged to their organisation**.

This finding needs careful interpretation, but it points toward an important issue: **who owns the information generated by humanitarian MHPSS?**

Humanitarian organisations often develop their own monitoring systems.

These systems are necessary for programme management and donor reporting.

But humanitarian information does not automatically become national health information.

A sustainable mental-health system needs to know:

- where services are available;
- how many people receive care;
- what conditions are being treated;
- how many people are referred;
- whether referrals are completed;
- where the biggest service gaps are;
- how many trained workers remain active; and
- how much essential MHPSS costs.

Without this information, national mental-health planning becomes difficult.

The biggest warning sign is financing

The most striking result from the poll may be this:

Only four respondents reported that their organisation had received national funding.

This should not be interpreted as saying that only four organisations in Cameroon receive national funding. The poll was small and non-representative.

But it raises an uncomfortable question.

Humanitarian actors can create capacity.

Who will finance it after they leave?

This is especially important given the current funding environment.

IOM's current Cameroon Crisis Response Plan identifies **US$1.2 million in MHPSS requirements** and continues to describe MHPSS as part of the humanitarian response, including community-based support, referral of people with severe mental-health problems and capacity strengthening for frontline actors and traditional therapists. (Cameroon Crisis Response Plan 2026)

At the broader humanitarian level, the funding situation remains extremely constrained.

NRC's assessment of 2025 found that only **24 per cent of Cameroon's humanitarian response was funded**. (NRC)

This creates a critical timing problem:

Humanitarian funding is shrinking at the same time that Cameroon is being asked to sustain and transition capacities developed through humanitarian programming.

The real risk is not simply fewer services

When funding is reduced, it is easy to think about the immediate consequences:

Fewer beneficiaries.

Fewer counselling sessions.

Fewer community activities.

Fewer outreach visits.

But there is a deeper risk.

Funding cuts can also affect:

- supervision;
- trained personnel;
- technical expertise;
- community facilitators;
- referral mechanisms;
- coordination;
- data systems;
- monitoring;
- institutional memory.

In other words, **funding cuts can destroy the infrastructure that makes future services possible**.

That is why the sustainability question matters.

The humanitarian-to-system transfer gap

I would describe this challenge as the **humanitarian-to-system transfer gap**.

Over more than a decade, humanitarian actors have contributed:

People.

Skills.

Knowledge.

Community structures.

Referral systems.

Coordination mechanisms.

Data.

Experience.

But these assets do not automatically become part of the national health system.

There is a progression:

Training → supervision → retention → functional continuity → institutionalisation → national financing

Cameroon appears to have made progress along this pathway.

But not all elements have progressed at the same speed.

The poll provides evidence of supervision, retention, referral continuity and accumulated humanitarian experience.

But evidence of national financing remains limited.

That is why I would describe the current situation as **partial and uneven institutionalisation**.

The Health Cluster transition could be a turning point

This issue is becoming even more relevant as Cameroon moves toward nationally led humanitarian health coordination.

WHO has described a transition of the Cameroon Health Cluster toward national leadership, with the objective of full national assumption of health-emergency coordination by 2027.

This creates an important opportunity for MHPSS.

But the transition should not simply ask:

Who will chair the MHPSS coordination meeting?

The more important questions are:

Who owns the system?

Who trains?

Who supervises?

Who collects the data?

Who maintains referral pathways?

Who monitors quality?

Who coordinates nationally and regionally?

And, above all:

Who pays?

That is what will determine whether humanitarian MHPSS capacity becomes health-system capacity.

We do not need to preserve every humanitarian project

There is a danger of thinking that sustainability means government must simply take over every humanitarian project.

That is neither realistic nor necessarily desirable.

The objective should instead be to identify the **functions that must survive**.

For example:

1. MHPSS coordination at national and decentralised levels.
2. Training and supervision of frontline workers.
3. Community-based identification and referral.
4. Integration of MHPSS into primary healthcare.

5. Links with education, child protection and GBV services.
6. MHPSS information within national health-information systems.
7. Access to specialised mental-health services.
8. Sustainable financing of essential MHPSS services.
9. Quality assurance and monitoring.
10. Preparedness for future emergencies.

This is the difference between **transferring projects** and **transferring functions**.

A project can end.

A health-system function must continue.

The three humanitarian regions are a natural test

The Far North, North-West and South-West regions have experienced different humanitarian dynamics.

But all three have accumulated years of MHPSS experience.

This creates an opportunity for a systematic comparison.

For each region, we should ask:

Who currently coordinates MHPSS?

Who trains frontline workers?

Who supervises them?

Who owns the data?

Who manages referrals?

Who finances community-based services?

Which humanitarian-trained competencies have moved into government structures?

What would happen if the major humanitarian MHPSS partner withdrew tomorrow?

That last question may be one of the most powerful measures of sustainability.

Cameroon has a humanitarian dividend—but it must be capitalised

The crises themselves are not a benefit to Cameroon.

The suffering they have caused should never be described as one.

But the response has created something valuable.

Years of humanitarian investment have generated:

- experienced practitioners;
- trained frontline workers;
- community networks;
- referral mechanisms;
- supervision experience;
- technical knowledge;
- coordination experience;
- institutional relationships; and
- practical knowledge about delivering MHPSS in difficult environments.

This is a **humanitarian dividend**.

The challenge is to transform it into a **national health-system dividend**.

What should happen now?

Cameroon could begin with a national **MHPSS capacity capitalisation exercise**.

It should ask:

Who has been trained?

Where are they now?

Which humanitarian-trained personnel have moved into government structures?

Which skills have been retained?

Which humanitarian competencies should become part of routine health-worker training?

What happens after supervision ends?

Who takes responsibility for supporting community and frontline workers?

Which referral systems survive?

What makes the 11 reported continuing referral systems different from those that disappear?

Where does the data go?

How can humanitarian-generated information strengthen national mental-health planning?

Which functions depend on humanitarian funding?

And perhaps the most important question:

What would Cameroon lose if humanitarian MHPSS funding stopped tomorrow?

The answer should become the basis for a national transition plan.

The question is no longer whether Cameroon has capacity

Cameroon clearly has **some** MHPSS capacity.

The more important question is:

Where does that capacity live?

Is it in government?

In NGOs?

In UN agencies?

In individual practitioners?

In communities?

In project documents?

Or is it embedded in the national health system?

Our exploratory findings suggest that the answer is currently **all of the above—but unevenly**.

That is the challenge.

But it is also the opportunity.

Conclusion: Don't let the humanitarian dividend disappear

In 2025, the Norwegian Refugee Council called Cameroon the world's most neglected displacement crisis. Its subsequent assessment found that the country's 2025 humanitarian response was only **24 per cent funded**. (NRC)

At the same time, Cameroon has spent more than a decade building MHPSS capacity through humanitarian response.

Those two realities are now colliding.

On one side, there is accumulated capacity:

18 respondents reported supervision.

10 reported retention of trained personnel.

11 reported continued use of referral systems after humanitarian partners withdrew.

26 reported additional humanitarian experience.

9 reported two or more humanitarian experiences.

On the other side, there is a major financing question:

Only four respondents reported national funding.

The findings cannot tell us the precise scale of national MHPSS capacity in Cameroon. The poll was small, voluntary and exploratory.

But they do point toward an important conclusion.

Cameroon has not failed to capitalise on humanitarian MHPSS investment. It has begun to do so—but the process remains partial and uneven.

The country has accumulated human capital, practical knowledge, community experience and some functioning mechanisms.

The challenge now is to make those assets survive beyond the humanitarian project cycle.

The objective should not simply be to replace humanitarian organisations.

It should be to **retain, institutionalise and finance the functions they have helped develop**.

The ultimate measure of humanitarian MHPSS should therefore not be only how many people were reached during a project.

It should also be:

What remains when the project ends?

If trained people remain, if communities know where to seek help, if referral systems continue, if supervision is institutionalised, if data informs national planning and if essential services are financed domestically, then humanitarian action will have achieved something much greater than short-term crisis response. It will have helped build a stronger national mental-health system.

Cameroon has accumulated a humanitarian MHPSS dividend. The challenge now is to ensure that this dividend does not disappear when humanitarian funding does. Because if Cameroon loses this capacity, it will not simply lose projects. **It will lose years of accumulated knowledge about how to deliver mental-health care in crisis—and an opportunity to build a stronger mental-health system from the experience of those crises.**

Cameroon is officially undergoing a change in its humanitarian coordination mechanism this month of November. Today, 26th November is the retreat of the Inter-sectoral transition working group. Co-led with the directorate of civil protection at the ministry of territorial administration. The working group met to: assess the humanitarian transition and work on coordination orientation for 2027. Were present: cluster coordinators and heads of un agencies, government sectoral ministries, civil society and leads and co-leads of the MHPSS and SHR technical working groups. Knowledge about the localized transition Area Based Coordination (ABC) (North West and South west regions) and ABC + (Far north region) needs to be made accessible to humanitarian actors. Cameroon is one of eight countries selected globally for the UN's Global humanitarian Reset and Accelerated Humanitarian Transition

About the poll

The poll ran through the month of August 2026. It involved members of three MHPSS Technical Working Groups on WhatsApp with a combined membership of 989. Forty-two people responded, representing approximately 4.2 per cent of the combined membership. Because participation was voluntary and the response rate was low, the findings should not be generalised to all MHPSS actors in Cameroon. They are best understood as exploratory evidence supporting further investigation.

The next step should be a more systematic study involving **MINSANTE, regional and decentralised health authorities, humanitarian organisations, TWG members and frontline MHPSS practitioners**, particularly to examine national financing, retention of trained personnel, supervision, data ownership and referral continuity.

Sources: NRC's 2025 and 2026 neglected-displacement assessments;
UNICEF's 2024 Cameroon humanitarian dashboard, and IOM's 2025–2026 Cameroon Crisis Response Plan; Demassosso, B., D. (2021). Reflecting on Four Leaps In Mental Health Development in Cameroon | Global Mental Health
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