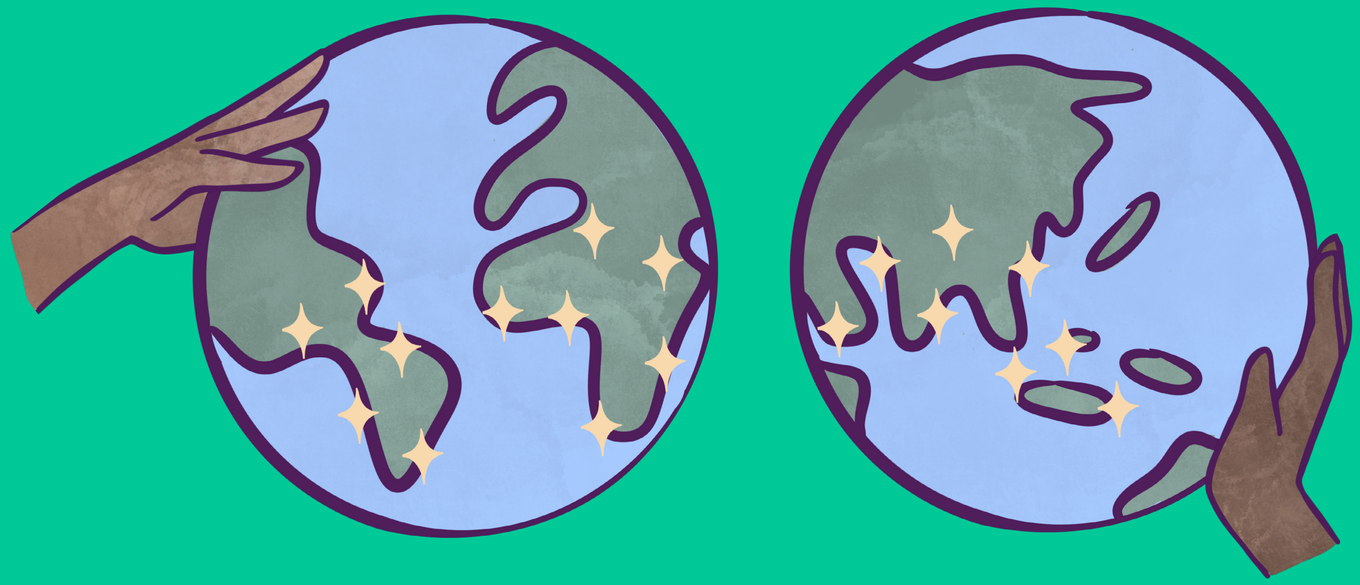
ember

the SHM foundation



Community-led Mental Health Innovation Exists!

Let’s Support It

Insights from the Ember 2024 Call-Out

Acknowledgements

The Ember Team would like to thank all those who applied to the Ember 2024 Call-Out, for their stories of innovation and impact that allowed this work to be possible.

We are grateful for their time spent in conversation with us and willingness to share the success, challenges, and hopes they have in service to their communities. Thank you to organisations **Alternatives Madagascar**, **Centro 32**, and **Yes Theatre for Communication Among Youth** for your participation as case studies of innovation. We are grateful to **Centre for Arts Based Methodologies & Wellbeing**, **Dlalanathi**, **Jan Sahas Social Empowerment Society**, and **Um pouco d'arte** for allowing us to share your quotes on why community-led mental health work matters.

The preparation of this report was a collaborative effort across the SHM Foundation and Ember team. Thank you to the team for the hours spent reading and assessing applications, interviewing organisations, coding and analysing data, writing, and workshopping the report (in alphabetical order):

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Thank you to Jara Lindsay & Joshua Olins for the beautiful design of this report. Thank you to the **Vitol Foundation** and **the SHM Foundation** for supporting this work.

Table of contents

Introduction & Context

Community-led mental health initiatives (CLMHIs) provide essential mental health care, particularly in low-and-middle-income countries (LMICs).

Deeply embedded in the communities they serve, these initiatives provide tailored and holistic support that is responsive to the unique needs of their community.

Despite calls to leverage community-led solutions in this space, these organisations remain underfunded and lack necessary support both at the level of individual innovations and the systems levels.

CLMHIs provide solutions adapted to the unique mental health needs of their communities, often in creative and unprecedented ways to suit their local context. Yet global mental health prioritises a narrow set of scalable, 'silver-bullet' solutions, often overlooking the innovative solutions emerging from communities themselves.

Although these organisations are arguably best placed to understand and respond to the mental health needs of their communities in relevant and culturally appropriate ways, they are persistently challenged by restrictive and unstable funding; difficulties capturing impact; limited opportunities to invest in technical and organisational capacity; and inadequate recognition by governments and within global mental health agendas[1].

Recognizing the essential role of community-led organisations in the provision of quality and culturally competent mental health services, **Ember Mental Health finds, mentors, and funds excellent community-led mental health innovations in LMICs[2] through its various partnership packages.**

With expertise in supporting CLMHIs around the world, Ember defines community as collectives who have acknowledged shared experiences and innovation as creative solutions that address unmet needs.

[1] Larrieta, J., et al. (2023). Equitable and sustainable funding for community-led organisations in global mental health.The Lancet Global Health, 11(3), e327–e328. https://doi.org/10.1016/S2214-109X(23)00015-3

[2] Organisation for Economic Co-operation and Development. (2024). DAC list of ODA recipients [List is revised by OECD every three years; Ember selections are based on 2024 categorisations]. https://www.oecd.org/en/topics/sub-issues/oda-eligibility-and-conditions/dac-list-of-oda-recipients.html

Ember 2024 Call-Out

In 2024, Ember held an open call for the 2025-2026 partnership cohort. The partnership is a yearlong tailored support package that combines funding with mentorship around critical areas such as impact, strategic direction, and wellbeing to enable initiatives to grow and thrive.

The open call received an exceptional response, with over 1800 self-identified community-led mental health organisations applying from 93 countries. This is over ten times the number received during Ember's 2021 call-out.

Recognising this as an opportunity to deeply listen, we endeavoured to interview all organisations that met our application criteria, spending over 650 hours in conversation with 932 CLMHIs over the entire process.

The combined applications and interviews from the 2024 Ember Call-Out have provided unprecedented insight into the landscape of CLMHIs. It presents a unique opportunity to inform the global mental health ecosystem and for stakeholders to hear directly from these initiatives on successes, opportunities, needs, and gaps in supporting them to scale and strengthen their impact.

The insights work shows us that innovation is happening; we need to recognize and support it.

Um pouco d'arte addresses the critical gap in access to mental health care by providing a safe, stigma-free space for individuals to express their trauma through art. By integrating creative expression with psychological support, we offer a vital alternative for those who would otherwise remain without help.

Our work is essential in shifting the conversation around mental health in Mozambique, making support more accessible and helping to reduce the devastating impact of untreated mental illness.

UM POUCO D'ARTE – Mozambique
ember 2025-2026 Innovator

This work is needed to shift from a treatment-oriented, expert-driven model of mental healthcare to one that is community-based, trauma-informed, and centred on well-being.

By elevating the knowledge, resilience, and leadership already present within these communities, we can foster collaborative, inclusive mental health practices that respect and respond to their unique lived experiences.

JAN SAHAS SOCIAL EMPOWERMENT SOCIETY – India
ember 2025-2026 Storytelling Fellow

Through our combined work in the arts and wellbeing spaces we weave the frayed strands of our heritage, culture, and identity into a new, rich tapestry that preserves, comforts, and provides wisdom, hope and direction for the future.

CENTRE FOR ARTS BASED METHODOLOGIES AND WELLBEING – Pakistan
ember 2025-2026 Innovator

Our community development approach believes that families and communities hold the key to real change and that an invitation to participate in creating safe spaces, safe people and safe practices for children to play, grow and thrive will create a safer world for children to live in.

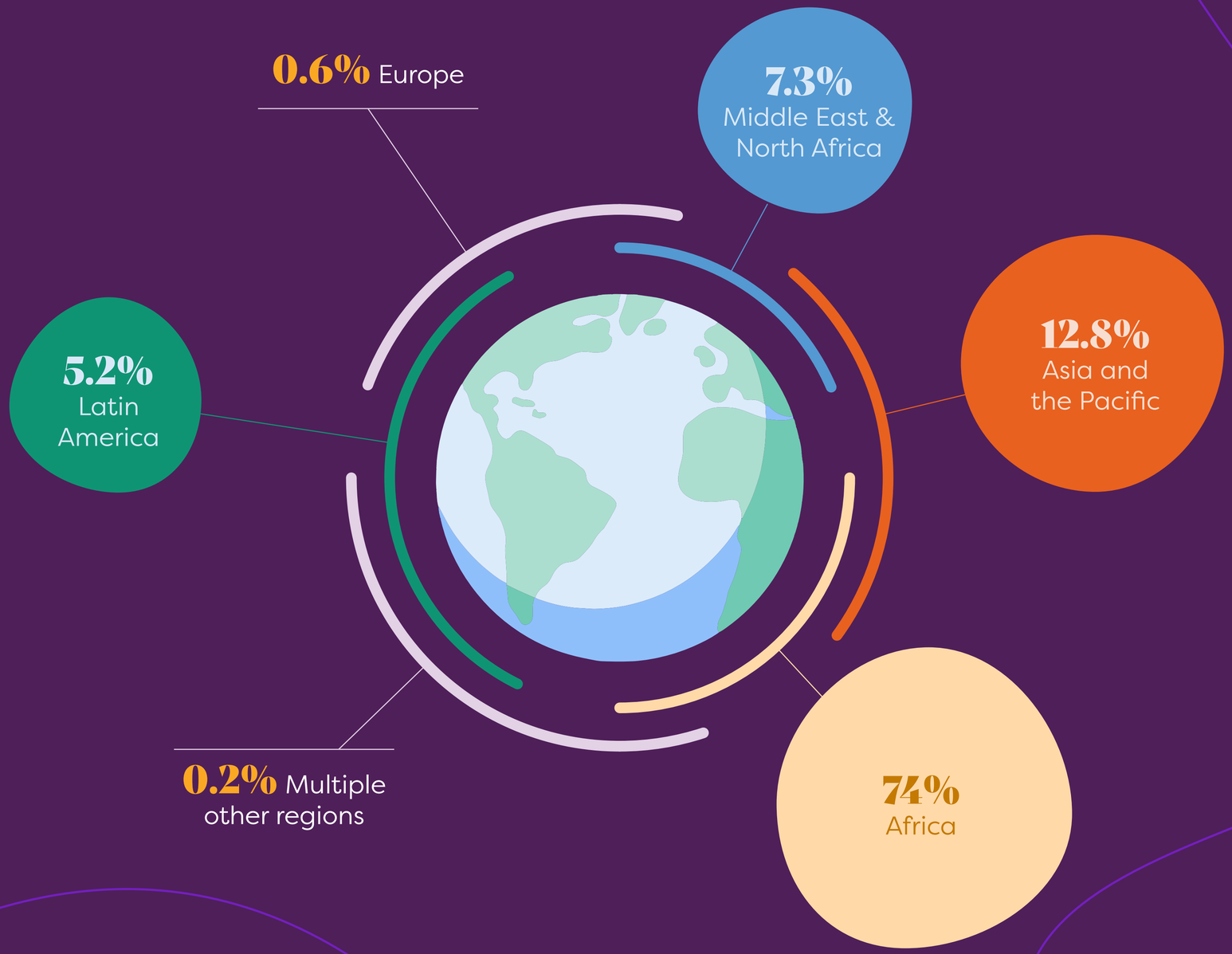
DLALANATHI – South Africa
ember 2025-2026 Innovator

Who applied?

CLMHIs from LMICs were invited to apply to the Ember Call-Out between June and August 2024. Data were collected through an online application form on each organisation's context of operation (country, region), organisational make-up (date founded, registration status, team size, volunteers, staff), finances (annual income, date financial support ends), activities, rationale for their activities, and challenges.

A total of 1806 organisations self-identifying as working in community-led mental health applied to the call-out; **after data-cleaning the final count was 1797 applications from 93 countries.**

Applications were accepted in Spanish, English and Arabic, languages in which the Ember team currently offers native-level support and guidance. Most applications were received in English (**91.9%**), followed by Arabic (**3.7%**), and Spanish (**3.7%**). An additional 12 applications were excluded from the pool for interview as they were not in Ember's working languages.



Applications were screened and those that met Ember's initial application criteria were invited for a semi-structured interview to further explore their vision, activities, and challenges.

Organisations were excluded from interview if they lacked a clear mental health focus, were not operating in a LMIC or were solely research or advocacy focused without a service delivery component. Interviews were conducted by one of 22 members of the Ember team, and notes were taken on a standardised template.

Of those who applied, 999 met Ember's initial eligibility criteria and were invited for interview.

Interviews were successfully conducted with 932 organisations.

^ *Centro 32 - Mexico*

Application and interview data were analysed both qualitatively and quantitatively. Five team members, with expertise in data analysis and language proficiency in Spanish, English, and Arabic participated in the analysis process.

Quantitative data from the applications were summarised using basic descriptive statistics. The qualitative data from the application and interview were analysed through a tagging (coding) process to group and analyse organisations according to their primary (main) and secondary thematic areas of work in mental health. A total of 128 organisations were eliminated from the pool for analysis as they did not meet Ember's inclusion criteria based on information acquired during the interview *(Appendix A)*.

A final pool of 804 organisations was included for analysis[3].

[3]The criteria used in this analysis do not reflect the entirety of the criteria used in the selection of the Ember cohorts.

See Appendix A →

Ember's application criteria

Not discriminate on the basis of religion, gender, sexuality, ethnicity, race or ability

Work in the field of mental health

Have a mental health support programme or project that is already implemented, currently operational, and has had some impact

Have a team of more than one person

Be based in a low-income country

Engage directly with communities

Have at least one team member who speaks an Ember official language

Be locally led – projects should be created and implemented by local leadership teams, or/ and with members of the community they serve

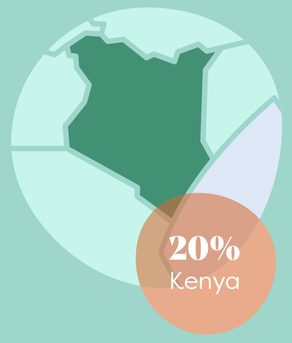
The landscape of community-led mental health in low-and-middle income countries

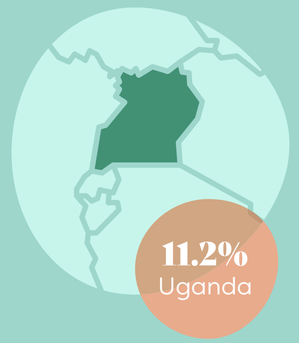
Community-led global mental health in numbers

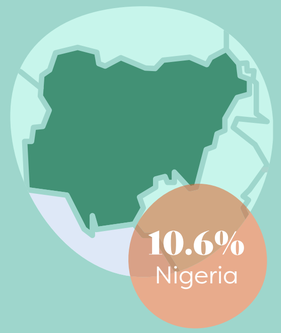
804

ember eligible organisations applied from 71 countries all over the world, spanning from newly founded initiatives to well-established organisations over 10 years old.

Of the total number of applications, most came from three countries:







Age of Ember eligible applicants

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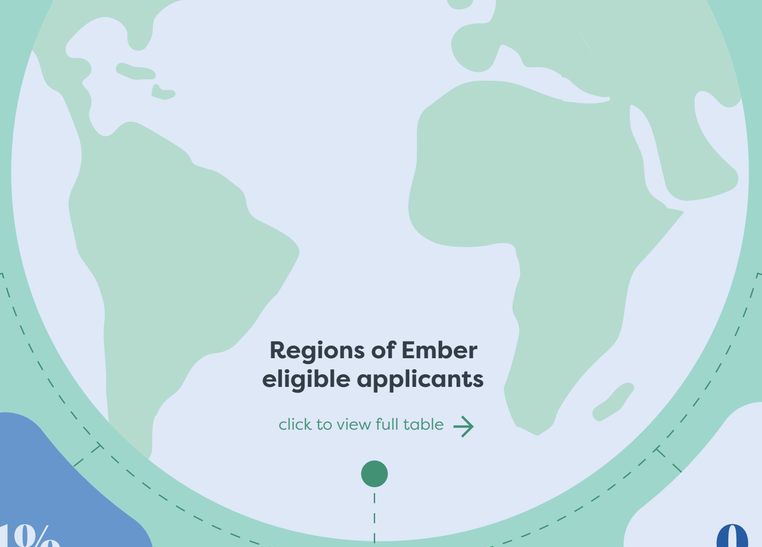
0.6%	57.8%	23.6%	17.5%
1 year	1-5 years	6-10 years	+10 years



Regions of Ember eligible applicants

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- **73.8%** Africa
- **13.1%** Asia & the Pacific
- **6.3%** Latin America
- **5.8%** Middle East & North Africa
- **0.6%** Europe
- **0.4%** Other regions

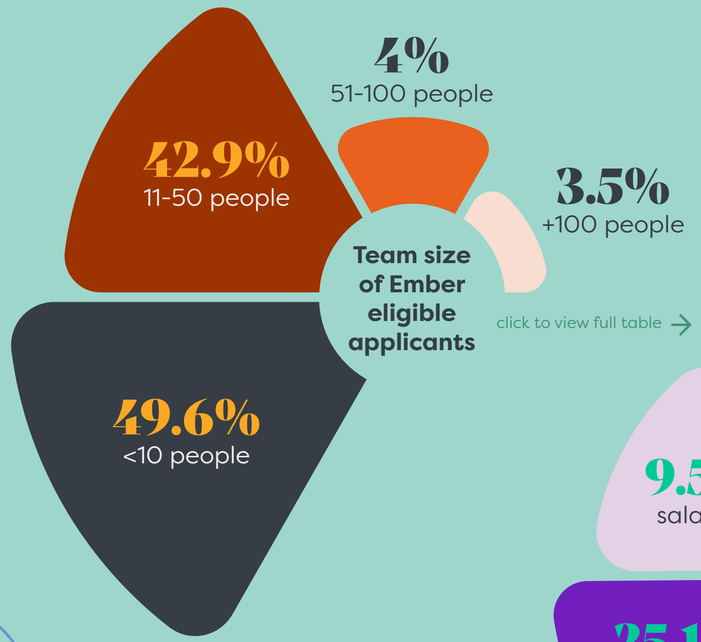
Registration status of Ember eligible applicants in their country of operation

85.6% registered status

14.1% unregistered

0.4% unspecified

Team size of Ember eligible applicants



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Annual income of Ember eligible applicants

click to view full table

<5,000USD
median income

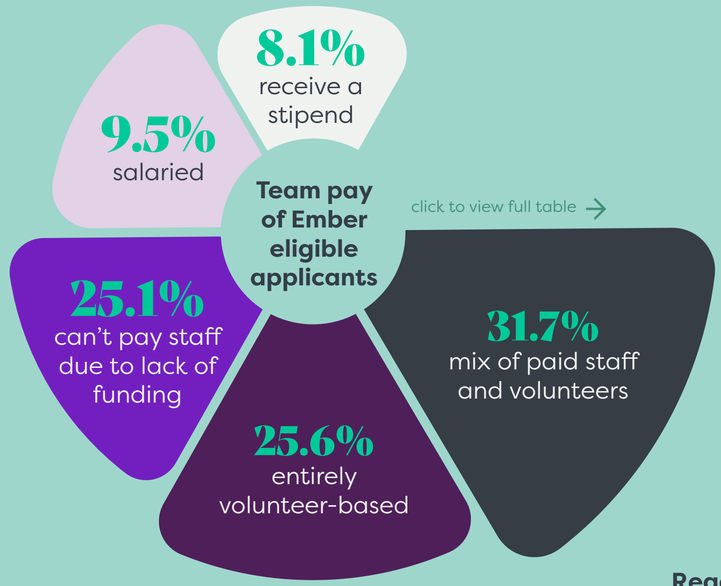
34.2%
no annual income

75%
income is <15,000USD

10%
income is +100,000USD

2.5%
income is +500,000USD

Team pay of Ember eligible applicants



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Operational challenges indicated by Ember eligible applicants

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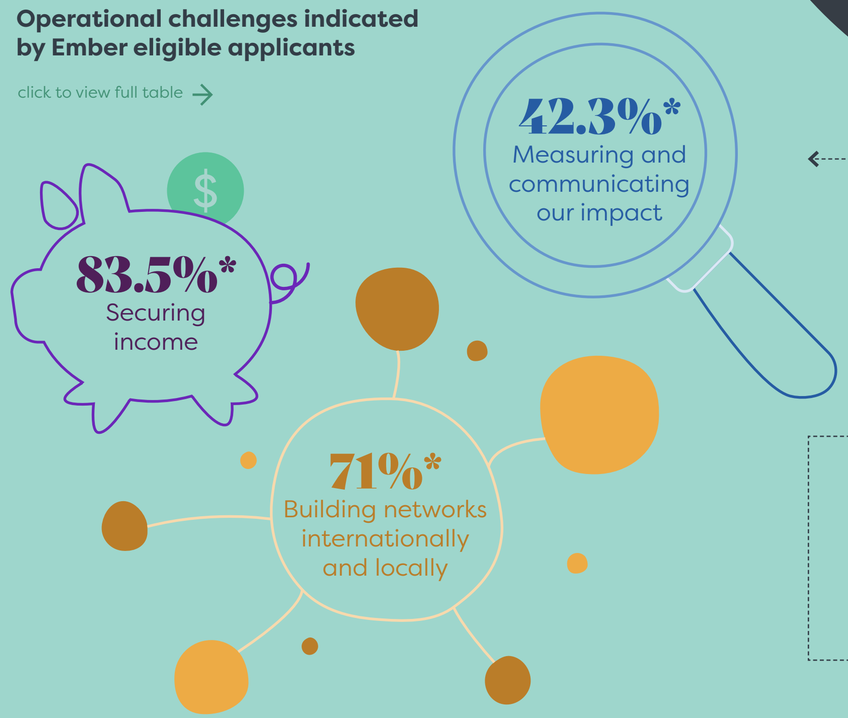


* Organisations were asked to select three challenges from a drop-down list and elaborate in an open text box.

Reach of Ember eligible applicants

click to view full table

70.2%
of organisations reported reaching <1,000 people

27.6%
100-500 people

Areas of work and approaches to community-led mental health innovation

* Organisations could be coded as focusing on more than one life stage and gender.

Gender focus of beneficiaries

3.6%
Men's mental health needs

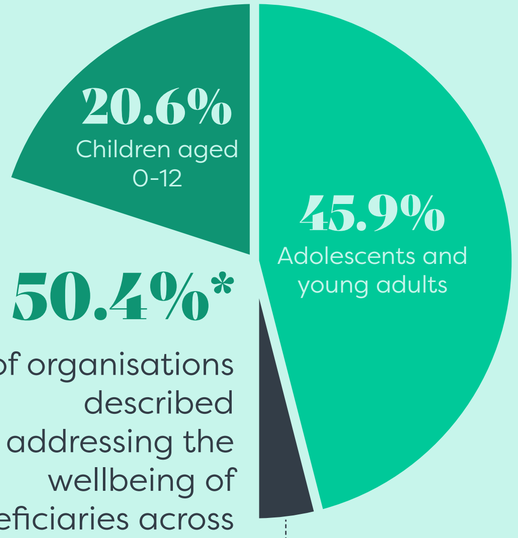
1.2%
Transgender mental health needs

83.3%*
of CLMHIs mostly served all genders without a specific focus

0.7%
Non-binary/ gender non-conforming mental health needs

15.3%
Women's mental health needs

Age focus of beneficiaries



20.6%
Children aged 0-12

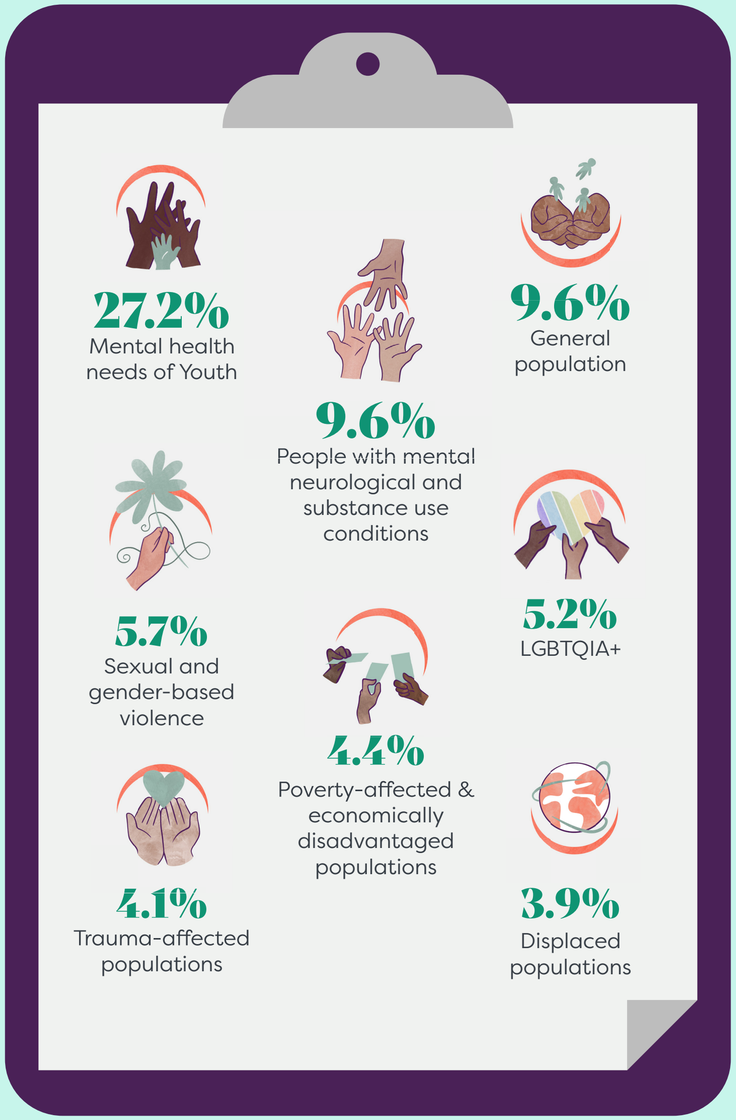
45.9%
Adolescents and young adults

50.4%*
of organisations described addressing the wellbeing of beneficiaries across all life stages

3.4%
+65 years old

Contextual issues within mental health

See Appendix B for codes and definitions →



27.2%
Mental health needs of Youth

9.6%
People with mental neurological and substance use conditions

9.6%
General population

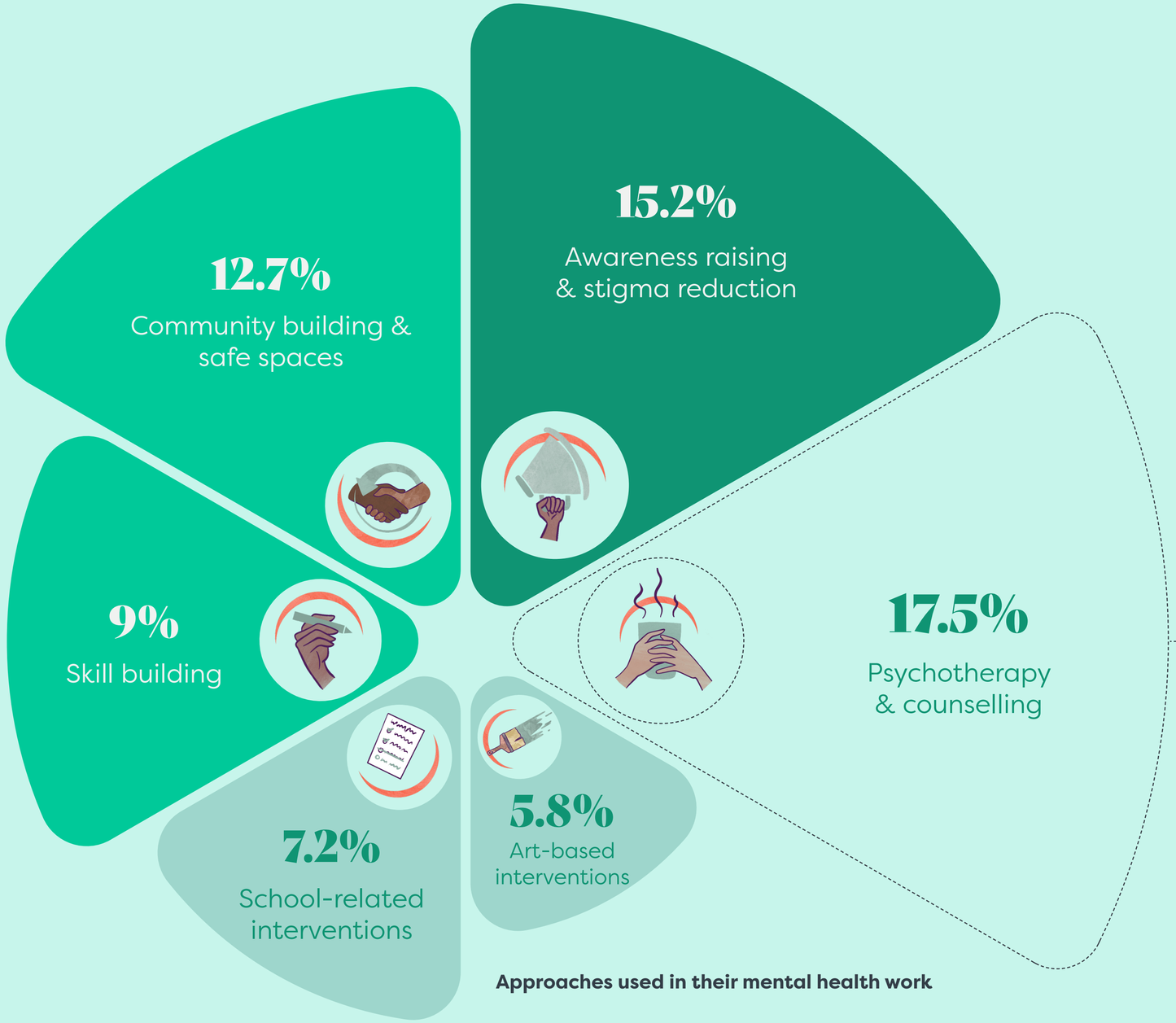
5.7%
Sexual and gender-based violence

5.2%
LGBTQIA+

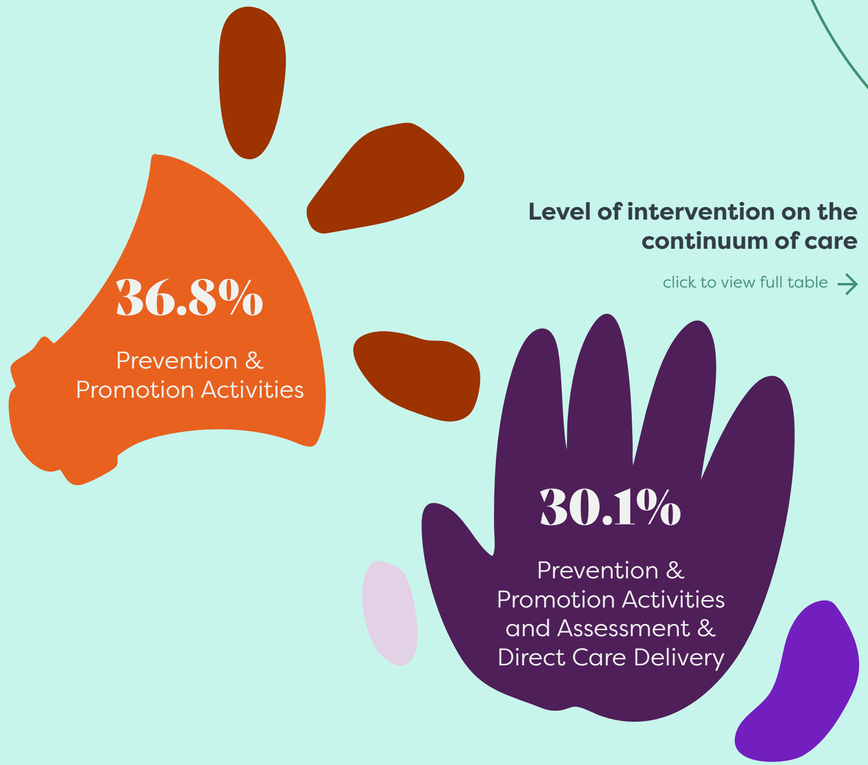
4.4%
Poverty-affected & economically disadvantaged populations

4.1%
Trauma-affected populations

3.9%
Displaced populations



Approaches used in their mental health work



Level of intervention on the continuum of care

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Organisations rarely used one approach to their care, with those focusing on Psychotherapy & counselling most commonly combined their efforts with:

Psychotherapy & counselling + Awareness raising & stigma reduction
= **33.3% of organisations**

Psychotherapy & counselling + Training & capacity-building for MH service providers and lay-carers
= **23.4% of organisations**

Psychotherapy & counselling + Socio-emotional Skill-building
= **15.6% of organisations**

What we heard

Over the hundreds of hours of dialogue with global mental health innovators as part of this process, common themes emerged across organisations.

From Bhutan to Mozambique, we heard similar messages and have distilled these into key points for anyone aspiring to support community-led innovation in mental health.

^ *Centro 32 - Mexico*

< *Alternatives Madagascar - Madagascar*

When asked for their vision and what they would like to achieve long-term, a theme emerged around organisations aspiring to ground their work in a physical space, where the community can engage and interact in-person.

This vision contrasts with trends in global health in the last two decades, which have often focused on digital service delivery as the most affordable and scalable way forward. Whilst tech-based solutions and virtual spaces are central tools for many organisations, CLMHIs also reported visions for centres, institutes, homes, and other real safe spaces where people can gather, learn, and heal together. **Real spaces appear to be essential to building trust, feeling established as an organisation, and perception as a truly community-owned organisation.**

CLHMIs consistently frame schools and universities as critical entry points for mental health promotion, with aspirations to expand and integrate mental health into curricula and everyday learning. Outside of formal educational institutions, organisations reiterate the desire to make mental health resources widely and easily accessible to all, envisioning themselves not only as providers of care but also as educators and trainers in their communities, and critical agents for stigma reduction in this capacity.

Given that educational institutions are typically youth-centric spaces, this links to the recurrent expressed goal that organisations have around empowering youth as champions for mental health promotion and prevention in their communities.

Organisations see it is as critical that there is youth ownership of mental health promotion as they are best positioned to shape and lead future outcomes - **the desire to platform young voices in this space is not only one of principle but one of necessity.**

A consistent message around impact emerged from innovators around the world: **many feel they lack the tools and skills to effectively capture and communicate their impact** in ways that are both meaningful to them and valued by their networks and funders. This discrepancy has left many organisations feeling that their work is unheard and misunderstood, often falling short when measured against traditional metrics of success.v There is therefore a clear need to expand definitions around what counts as impact, an approach still uncommon among funders and policymakers.

Wellbeing challenges also emerged as a core concern. Data indicated that **more than 20% of organisations were affected by burnout and overstretched team members**, as many organisations rely on small, volunteer-based teams and are unable to renumerate staff. These pressures are further compounded by the high levels of need from the community, particularly in contexts where these organisations are among the few – or the only – providers of mental health care.

^ Centro 32 - Mexico

This is especially true for innovators working in conflict settings and protracted crises, where navigating security risks and political instability takes a profound toll on wellbeing and resilience. These findings highlight **a clear need for dedicated wellbeing support as a core component of support packages** for these organisations if we are to support those best placed deliver this care.

CLMHIs consistently express **a desire to expand their reach through stronger networks** and partnerships locally, nationally, and internationally. Organisations do not want to work in silos - they envision a robust, interconnected ecosystem of community-led mental health, where knowledge, resources, and experiences are shared openly.

Securing **long-term funding remains the major challenge identified by organisations** in the sustainable delivery of care to their communities. These difficulties are marked by restricted, often project-based, pools of funds that dilute the scope of work that they are able to deliver in order to meet funding requirements that are often stringent, bureaucratic, and do not cover essential costs of day-to-day operations. Further exacerbating this is steep competition for limited (or sometimes non-existent) viable funding streams for their areas of work. **Access to unrestricted funding that covers overhead costs and allows organisations to care of their communities on their own terms is essential.**

Case studies: stories of innovation

We've selected three organisations from the 2024–2025 partnership cohort to showcase as case studies, highlighting the diversity of approaches to community healing that exist in this space - from the use of creative tools to address unmet community needs, to service delivery models designed to meet communities exactly where they are.

In sharing their purpose and impact, these organisations demonstrate how culturally embedded, community-driven approaches can fill critical gaps in access to mental health care around the world.

Alternatives Madagascar

Antananarivo, Madagascar

Website

Established in 2019

Target audience

Children; youth; sex workers

Type of support

Sexual and reproductive health; mental health care; life skills training; economic empowerment

> **I'm most proud of creating this organisation and keeping it alive. Seeing our achievements makes me really proud.**

Alternatives Madagascar is a youth-led organisation supporting some of the country's most underserved young people, including sex workers and incarcerated youth. In the context of Madagascar where over 70% of the population lives in extreme poverty and access to basic services is limited, mental health is often treated as a luxury.

Adolescents face particularly profound challenges, with fewer than 1% receiving the care they need during this critical stage of life. Among incarcerated youth, trauma from harassment and sexual violence is widespread, yet often ignored or normalised by prison officers. These realities underscore the urgent need to support young people in developing the skills and stability needed to build their futures and to ensure that mental healthcare in prisons is treated as an essential service, not an afterthought.

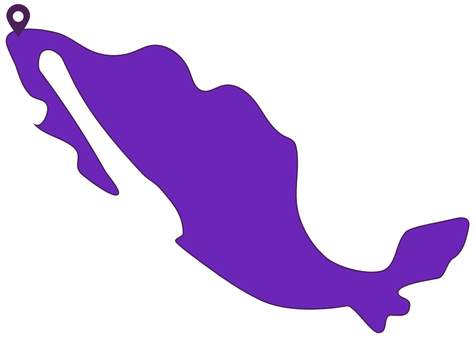
Alternatives Madagascar envisions a society where youth can access holistic support. As one of the few organisations in Madagascar addressing the needs of incarcerated youth, they provide life skills, sexual and reproductive health services, economic empowerment, and quality mental health care. Through their youth-led model, they step into gaps left by the system, empowering young people to transform their lives and communities with dignity and equity. Their creativity also shines through in unexpected ways: they designed a board game that encourages self-expression among children, turning play into a powerful tool for building resilience.

Since their first intervention in 2022, Alternatives Madagascar has reached hundreds of youth, supporting many of them in rebuilding their lives. They developed a tailored programme for children, guided by direct engagement and surveys to understand their needs. With an eye for impact, they began tracking individual progress and have strengthened ongoing access to children in prisons, creating opportunities to deepen their support as their programs continue to expand.

By youth for youth, Alternatives Madagascar demonstrates how intentional care can transform lives that are often overlooked, even amidst significant barriers and adversity.

Centro 32

Tijuana,
Mexico



[Website]

Established in 2020

Type of support

Displaced populations & migrants; children & adolescents; women; LGBTQI+

Type of support

Humanitarian aid; physical & mental healthcare; education programs

> **Our overall goal is to contribute to the psychosocial well-being of the migrant population by strengthening their capacities and coping skills in the face of the adversities of their context.**

At the border city of Tijuana, Mexico, where thousands of migrants arrive every year, Centro 32 stands as a refuge of care and dignity. Founded in 2020, this non-profit organisation provides support to women, children, adolescents, LGBTQI+ individuals, and migrant communities in forced displacement. This includes refugees escaping violence and political instability, asylum seekers waiting for legal processes, deported individuals, and unaccompanied minors facing vulnerable conditions.

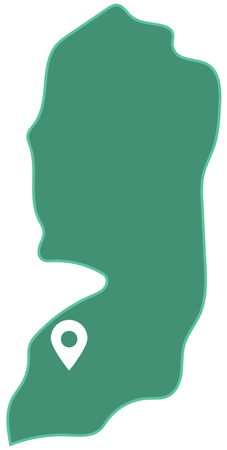
In Tijuana, migrants are forced to navigate severe hardships. They often lack housing, medical care and basic needs, while also confronting significant legal and bureaucratic obstacles that limit their ability to find employment or rebuild their lives. Yet, few organisations in this context focus on their mental wellbeing - an often-overlooked dimension of humanitarian response. Centro 32 was created to fill this gap, offering humanitarian aid, healthcare, and education to people in mobility contexts.

Centro 32 stands out in its ability to combine immediate assistance with long-term psychosocial care. By connecting basic needs, education, and creative activities with mental health strategies, they transform basic help into tools for resilience, empowerment, and healing. Their multidisciplinary team includes psychologists, social workers, educators, and volunteers, all working together to restore dignity and foster social inclusion among the people they serve. Through initiatives like the mobile mental health clinic (Psicomóvil), they remove barriers by bringing therapy and workshops directly into shelters.

In 2023 alone, Centro 32 supported more than 20,000 people through their different programs. Many continue to stay in contact even after resettling, sending messages and small gifts of gratitude - a testament to the lasting bonds the organisation builds. The Psicomóvil has also been recognised as a model for other communities, creating a ripple effect of their impact. At its heart, Centro 32 embodies hope at the margins, proving that compassion, creativity, and care can travel just as far as any border.

Yes Theatre

Hebron,
Palestine



Website

Established in 2008

Target audience

Youth

Type of support

Drama & Art Therapy; Theatre

> **The importance of arts in society is undeniable, it communicates across all cultures, tells the stories of the past and present, and inspires minds, both young and old, to do beautiful things.**

Yes Theatre is a Palestinian cultural institution based in Hebron that uses drama, storytelling, and the arts as tools for empowerment, psychosocial support, and social change. Its name reflects a deep commitment to saying Yes! – to hope, creativity, and life itself – even amid the reality of living under occupation and escalating violence in the West Bank.

Through theatre productions, workshops, and community programs, Yes Theatre helps children and youth build life skills, find relief from trauma, and reclaim spaces for expression and healing. In a context where more than 80% of Palestinian children experience trauma and access to mental health care is severely limited, their work fills a critical gap. By integrating cultural development with psychosocial support, Yes Theatre turns drama and the arts into therapeutic and transformative practices.

Their work extends beyond the walls of their theatre to reach marginalised and hard-to-access communities, such as Bedouin tribes and families living near the separation wall. They also work in schools through partnerships with the Ministry of Education and UNRWA, while engaging the wider community through public performances and outreach activities. Social entrepreneurship initiatives like “Puppets for Kids” generate income while expanding cultural access, and innovations such as the “Healing through Art Bus” enable access to communities wherever they are. Over the past two years, Yes Theatre has also adapted its work to support people on the ground during the ongoing genocide in Gaza, mobilising its networks for material and psychosocial aid and solidarity.

Having directly reached more than 250,000 people through workshops, performances, and community activities, Yes Theatre continues to nurture resilience, resistance, and imagination among Palestinian youth – standing as a powerful testament to creativity and collective healing in the face of profound injustice.

Key take-aways for collective action

Our main conclusion from this process is that there is a huge diversity of innovation happening in communities across the globe.

We need to move away from searching for the silver-bullet, one-size fits all solution and instead put our efforts towards creating an ecosystem that can support a large number of innovations to flourish.

Innovators, funders, policy makers, academics, and friends of CLMHIs should reorient towards investing in diversity, and in the supporting structures that allow these organisations to grow and thrive. These structures are wide ranging and might include shared administrative services to reduce costs for individual organisations; platforms that help innovations connect and avoid operating in silos; and structures that prioritise the wellbeing of leaders and mitigate burnout.

The stories we heard through this process point to six key recommendations.

01 Prioritise deep listening

Through this Call-Out, Ember engaged in **over 650 hours of conversation with 932 organisations around the world**, taking the opportunity to deeply listen to those at the heart of community-led care. While this level of engagement is not feasible for every Call-Out, a crucial lesson learned is that in order to deliver meaningful support, funders and other stakeholders must take the time to understand who they are trying to work with, hear directly from them about what they need, and be responsive in the support provided. This means tailoring any support offered directly to the experiences shared.

For example, this year **Ember launched the Caring for Carers award, a dedicated pool of funds for team wellbeing**, reflecting the documented pressures of overstretched teams, burnout, and extensive work ongoing in contexts of crises. Or, in 2021 at the height of the COVID-19 pandemic, **Ember launched its Transformation Fund, responding to innovators who asked for support in adapting their services within the context of global lockdowns**, when their communities needed them more than ever. Being responsive means staying abreast of the ever-evolving realities on the ground – which means asking, listening, and then responding.

Not only did this exercise provide unprecedented insight into the global mental health landscape, but it was also positively received by applicants.

Innovators, including those not selected for partnership, told us that they felt centred and valued by the interview process. Moving forward, stakeholders should prioritise creating opportunities for direct engagement with initiatives, prioritise active listening, and design simple, accessible processes across funding, implementation, evaluation and collaboration to keep support responsive to community needs.

^ Dlalanathi - South Africa

02
Embrace diverse forms of innovation

It is clear from this analysis that innovation in community-led mental health *is* happening and comes in many diverse forms.

Every community has different needs and approaches - over 25 different primary areas of work and 22 approaches were identified through this work. **By prioritising a select few "silver bullet solutions", the sector risks sidelining communities who require alternative forms of support.**

As members of the communities they serve, CLMHIs understand that communities are dynamic - constantly changing, growing, and evolving. They adapt their models to reflect these shifts, ensuring that their services remain relevant and responsive. In contrast, a one-size-fits-all model is static, unable to keep up with the evolving landscape of need. **True scale and universal mental health coverage can be achieved by supporting a wide variety of community-led solution.**

^ Yes Theatre - Palestine

Diversity should not be seen as an added complexity, but rather the foundation for an inclusive, responsive, and sustainable global mental health ecosystem.

03
Recognise underserved groups as embedded in their communities

A dedicated pool organisations we heard from through this Call-Out support the mental health needs of often under-recognised groups, including LGBTQIA+ communities, displaced and conflict-affected populations, people with disabilities, and older adults, amongst others.

Already uniquely vulnerable to mental health challenges, these groups often face compounded barriers such as stigma, persecution, security-risks, and neglect. CLMHIs recognise these groups as an integrated part of their broader community and make the intentional effort to meet them where they are.

Although underserved groups may require tailored care and support, funders and other stakeholders should avoid support packages that narrowly target specific groups, so organisations addressing community needs in an integrated way are not inadvertently excluded from accessing resources.

^ Jan Sahas Social Empowerment Society - India

04

Youth-focused projects are driving community-led mental health. Let's support them!

Over a quarter of all initiatives that applied to the Ember call-out focused primarily on youth and many organisations prided themselves on being youth-led.

. With 50% of mental health conditions starting before the age of 18 and suicide being the leading cause of death amongst young people, this is a direct reflection of urgency of the situation but also an opportunity for action given the well-known treatment gaps in youth mental health globally[4].

With the necessary recognition and support, there is huge potential for these youth-focused solutions, which are tailormade for their communities, to make significant strides towards closing this gap.

^ Dlalanathi - South Africa

[4] World Health Organization. (2025). Mental health of adolescents: Fact sheet. https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health

05 Capture meaningful impact

Almost half of organisations reported that measuring and communicating impact is a significant challenge. **The global mental health field continues to prioritise one-size-fits-all approaches to impact measurement** and often imposes standardised frameworks on grantees, typically driven by a desire to reduce perceived ‘risk’.

However, **what impact looks like will be as diverse as the settings, themes, and activities that organisations are engaged in.** Adhering to these standardised frameworks of impact measurement also often means compromising on important areas of service delivery or overlooking forms of impact that deeply matter to the organisation and the communities they serve but are not captured in the framework.

Funders and other partners should begin by asking organisations what impact means to them, and then provide the skills, resources, and time required to capture and communicate this meaningfully.

Enabling community-led organisations to lead this process builds trust and confidence within teams, ensures relevance, and champions the diversity of pathways that people take towards mental wellbeing.

^ Centro 32 - Mexico

06
Foster an environment of collaboration and peer-support

Interviews highlighted **a strong desire to expand networks and connect with other organisations doing community-led mental health work both locally and internationally.**

Many expressed not knowing many others in the field, limiting their opportunities for collaboration, visibility, resource-sharing, and sharing of lessons learned.

Stakeholders need to act as bridge builders between CLMHIs, creating opportunities for connection, collaboration, and peer support.

Such an environment builds solidarity and resilience in the community mental health ecosystem, strengthening collective impact.

^ Centre for Arts Based Methodologies and Wellbeing - Pakistan

Appendix

Appendix A: Exclusion criteria for this analysis

Reason for exclusion	Count
Lack of mental health focus	55
Organisation/ project not operational	33
Did not attend interview	67
Lack of information/ conflicting information between interview and application	14
Not a community-led organisation	10
Interview notes lost/ corrupted	16
Total	**195**

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Appendix B: Codes for contextual issues/ focus areas in mental health

Code title	Description
Climate and MH	Programmes that mention climate affected populations or the impact of climate on mental health the focus of their activities.
Conflict-affected populations	Programmes that address the needs of those currently or previously affected by conflict - includes survivors of war, genocide, etc.
Depression & anxiety	Programmes that specifically mention anxiety/ depression as the target of their work – includes a broad spectrum of activities (e.g. prevention, assessment, support, advocacy, treatment etc.)
Displaced populations	Programmes working to address the needs of displaced people, includes refugees, migrants, IDPs, asylum seekers, etc.
Family & caregivers	Programmes that specify the mental health of family and caregivers as the main focus of their activities.
General population	Programmes with a broad focus or target population.
HIV/ AIDS	Programmes that focus on people living with or affected by HIV/ AIDs.
Homelessness	Programmes that meet the needs of people experiencing homelessness, including those living on the streets, in shelters, or in unstable housing situations.

Code title	Description
Incarcerated individuals	Programmes that address the needs of those currently or previously incarcerated.
Indigenous populations	Programmes that focus on populations who self-identify as having collective ancestral ties to the lands and natural resources of a specific region.
Intersecting identities	Programmes that address individuals with identities that result in people being at greater risk of experiencing a mental health problem. This might be due to marginalisation, stigma, or other (e.g. disability, sexuality, etc.). Also, organisations that address the needs of multiple groups at once.
LGBTQIA+	Programmes working with sexual minorities and gender diverse groups.
Neurodivergence	Programmes that are self-described as focusing on neurodivergence. Typically includes autism, ADHD, and other neurodevelopmental conditions. Includes a broad spectrum of activities (e.g. assessment, support, advocacy, treatment etc.)
People with disabilities	Programmes that focus on individuals with physical, intellectual, sensory, or cognitive disabilities.
People with MNS conditions	Programs that broadly cater to groups of people affected by different mental, neurological and substance use conditions.

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Cont.

Code title	Description
Poverty affected & economically disadvantaged populations	Programmes that address the needs of communities who are economically disadvantaged, may lack access to basic necessities and opportunities for employment. Often intersects with marginalisation/ social exclusion.
Pregnancy & motherhood	Programmes that focus on pregnancy, including the perinatal and postpartum periods. Includes perinatal loss (stillbirth, miscarriage, etc) and motherhood generally.
Psychosis & schizophrenia	Programmes that specifically mention and focus on psychosis & schizophrenia – includes a broad spectrum of activities (prevention, assessment, support, advocacy, treatment etc.).
Remote/ rural populations	Programmes that focus on people living in areas with limited access to services and resources. This may be due to geographic isolation, living outside urban centres, or other factors that make it more difficult for them to access or be reached by services.
Service providers	Programmes that focus on service providers (e.g. healthcare professionals, social workers, community health workers etc.) as the target of their work. Also includes informal service providers such as police officers, teachers, community development practitioners, faith leaders etc. Includes both care, support, training, and capacity building.
Sexual and gender-based violence (SGBV)	Programmes that focus on preventing, advocating, or supporting populations affected by violence that is a result of their gender or sex. Includes physical violence, sexual violence, domestic violence, female genital mutilation, etc.
Substance use conditions	Programmes focused on substance use conditions only. Includes those with or affected by substance use conditions, education or sensitisation programs, advocacy, harm reduction, rehabilitation etc.
Suicide	Programmes that specifically mention suicide as the focus of their work. Includes a broad spectrum of activities (prevention, crisis support/ intervention, advocacy, stigma reduction etc.)
Trauma affected populations	Programs that focus on individuals and communities impacted by trauma, including experiences of violence, abuse, and disasters. Includes programmes that specifically mention PTSD as the focus of their work. Often intersects with other forms of marginalisation and social exclusion. Includes a broad spectrum of activities (e.g. prevention, assessment, support, advocacy, treatment etc.)
Youth	Programmes that specifically mention youth as the focus of their activities or describe those aged 15-24 as their focus.
Other physical health conditions	Programmes that address the mental health needs of people with other physical health conditions.
Other	Programmes that are not addressed in any of the above categories. Includes: • Other mental health conditions • Other vulnerable groups (widows, orphans, homeless, sex workers).
None	Only use for secondary contextual issue if there are no additional themes to consider.

Appendix C: Codes for primary and secondary approaches to the delivery of mental health care

Code title	Description
Advocacy	Programmes focusing on influencing decisions within political, economic, and social institutions.
Arts-based interventions	Programmes using a creative art form, not limited to theatre, music, photography, art-based therapies, journalling, animation, or tech-based art forms.
Awareness raising & stigma reduction	Programmes that focus on increasing public understanding of mental health and reducing stigma, discrimination, and misconceptions. Includes campaigns, community engagement, advocacy efforts, and initiatives aimed at fostering more supportive/ inclusive attitudes toward mental health.
Basic needs	Programmes that provide essential services and resources to address the fundamental needs of individuals, such as access to food, housing, healthcare, etc.
Clinical care	Programmes where care is provided through a medical approach, typically within a hospital or clinical setting. These programmes might involve licensed mental health professionals, such as psychiatrists, psychologists, and clinical social workers, offering assessments, therapy, medication management, and specialised treatment for individuals.
Community building & afe spaces	Programmes that create inclusive environments where individuals feel supported, heard, and valued. Aim to foster connection, instil a sense of safety/ acceptance, reduce stigma, and promote a sense of belonging through shared physical spaces or community activities.

Code title	Description
Community outreach	Programmes that actively engage with individuals or groups outside of formal service settings to raise awareness, provide support, or connect people to mental health services and resources, such through as home visits.
Economic empowerment	Programmes focusing on supporting people with lived experience to gain the skills, resources, and opportunities to achieve financial independence.
Faith-based approaches	Programmes integrating religious or spiritual practices and beliefs into mental health support, using frameworks such as prayer, community support, and faith-based counselling.
Peer-to-Peer support	Programmes where individuals with a shared experience (peers) provide emotional, informational, and practical support or mentorship to one another.
Psychoeducation	Programmes providing care by facilitating information and support to service users and/or family members to better understand and cope with illness/ diagnosis for service users.
Psychotherapy & counselling	Programmes providing professional mental health support through one-on-one or group sessions with therapists or counsellors. These programmes typically use talk therapy, cognitive-behavioural techniques, or other therapeutic methods to help individuals manage their mental health.
Referrals	Programmes where linking individuals to further mental health care is a significant part of their activities.

Cont.

Code title	Description
Rehabilitation & Therapeutic Support	Programmes that provide support for recovery and reintegration, including services such as occupational therapy, speech therapy, and follow-up care. Also includes support for recovery after substance use, and activities that promote self-reliance and reintegration into society.
Research	Programmes focusing on advancing mental health through research.
School-related interventions	Programmes that are supporting the mental health of people going to school, university or engaging in other educational programmes. This does not mean that the programme necessarily takes place within the educational institution.
Skill-building	Programmes that provide education (outside of the school setting) or practical training to equip beneficiaries with essential life-skills, enhance coping skills, independence, and/or provide the competencies for personal and professional success. Includes mentoring and coaching.
Sports-based interventions & mind-body practices	Programmes using sports, mindfulness, yoga, breathwork or breathwork to advance the wellbeing of the community.
Technology	Programmes using digital tools and platforms, such as mobile apps, helplines, online therapy, or virtual support networks, to provide mental health resources and services.
Training and capacity building	Programmes focusing on educating and equipping various stakeholders, such as educators, caregivers, healthcare providers, and community leaders, with the skills and knowledge to better support mental health.
Youth-led	Programmes where young people are taking the lead in creating, organising, and running initiatives that address mental health issues within their communities.
Other	Any other programme that does not fit the categories above.

Appendix D: Codes for the level of intervention on the continuum of care

Code title	Description
Prevention & promotion	Programmes that aim to reduce the risk of mental health conditions and promote wellbeing. Raising awareness and promotion of positive mental health.
Assessment & direct care	Programmes providing care directly to address those conditions (clinical or other). Can also include assessment of needs and referrals. Activities that are aimed at maintaining a state of wellbeing.
Rehabilitation & recovery	Programmes focused on providing support after experiencing a mental health condition or stressor. Does not include treatment. E.g. reintegration, empowerment, training etc.
Continuum of Care (All)	Programmes that include all aspects of the continuum of care.

Appendix E: Notes on the analysis

There are several aspects of the analysis that should be considered when interpreting the data

To make sense of the large volume of information available, we developed a broad set of categories to tag and classify organisations. These were informed by the deep listening from interviews and the rich information provided in organisations' original applications. However, we recognise that it would have been most ideal for organisations to self-categorise their work. As the insights work was designed after the application process – in response to the overwhelming response to the Call-Out, it was not possible at this time. In future callouts, these data could be collected directly through the application form.

Additionally, some of the tags we used were necessarily broad. For example, the "psychotherapy" category covered a wide range of activities, from psychosocial support and psychological first aid to different forms of therapy. This approach was useful for grouping, but it also means that some of the nuance and specificity of organisations' may not have been captured. Further sub-analyses could be conducted at a later stage to explore these distinctions.

Organisations applied if they self-identified as being community led. When applications were reviewed by the Ember team, this was re-assessed against Ember's eligibility criteria. Ember's definition of community-led organisations are initiatives where implementers are part of the community they serve and have ownership over the project. If partners are involved, they play a supporting role - decision-making comes from the communities themselves.

Finally, very few organisations described their work as addressing specific mental health diagnoses in isolation. Instead, most identified as working in mental health more broadly, supporting people with a wide range of needs—even when their programmes focused on individuals experiencing anxiety, depression, or other specific conditions. As a result, most organisations were ultimately tagged under broader categories such as "people with MNS conditions." This pattern suggests that many community-led organisations do not naturally define their work, or the people they support, using clinical or diagnostic labels. Rather, they tend to describe their work in relation to the contexts and circumstances of people's lives.

TABLE 1 - Region of Ember eligible applicants

Region	Count	Percentage
Africa	593	73.8%
Asia-Pacific	105	13.1%
Latin America	51	6.3%
Middle East & North Africa	47	5.8%
Europe	5	0.6%
Multiple other regions	3	0.4%

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TABLE 2 - Age of Ember eligible applicants

Years in Operation	Count	Percentage
<1 year	5	0.6%
1-5 years	465	57.8%
6-10 years	190	23.6%
+10 years	141	17.5%

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TABLE 3 - Team size of Ember eligible applicants

Team size	Count	Percentage
Very Small (less than 10)	399	49.6%
Small (11-50)	345	42.9%
Medium (51-100)	32	4.0%
Large (over 100)	28	3.5%

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TABLE 4 – Team pay of Ember eligible applicants

Team pay	Count	Percentage
It is a mix of paid staff and volunteers	255	31.7%
No, we are all volunteers	206	25.1%
No, we don’t currently have the funding to pay our team but would like to	202	25.1%
Yes, the team are paid a salary	76	9.5%
Yes, the team are paid a stipend	65	8.1%

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TABLE 5 - Annual income of Ember eligible applicants

Income	Count	Percentage
0 USD	275	34.2%
0 USD–5,000 USD	175	21.8%
5,000 USD–15,000 USD	108	13.4%
15,000 USD–30,000 USD	64	8.0%
50,000 USD–100,000 USD	57	7.1%
100,000 USD–250,000 USD	45	5.6%
30,000 USD–50,000 USD	43	5.3%
250,000 USD–500,000 USD	17	2.1%
More than 500,000 USD	20	2.5%

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TABLE 6 - Reach of Ember eligible applicants

Number of people reached	Count	Percentage
0–25	51	6.3%
25–100	143	17.8%
100–500	222	27.6%
500–1,000	149	18.5%
1,000–5,000	158	19.7%
5,000–10,000	33	4.1%
Over 10,000	48	6.0%

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TABLE 7 - Operational challenges indicated by Ember eligible applicants

Challenges	Count	Percentage
Securing income	671	83.5%
Building networks internationally and locally	571	71%
Measuring and communicating our impact	340	42.3%
Getting people to know about our work and explaining our work to others	276	34.3%
Reaching beneficiaries or participants with our care	203	25.2%
Medium and long-term planning	178	22.1%
Heavy workloads and overstretched team members	163	20.3%
Retaining staff	109	13.6%
Recruiting staff with the right skills	98	12.2%
Other	77	9.6%

Organisations were asked to select three challenges from a drop-down list and elaborate in an open text box.

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TABLE 8 – Level of intervention on the continuum of care

Level of intervention	Count	Percentage
Prevention & promotio	296	36.8%
Prevention & promotion + Assessment & direct care	242	30.1%
Continuum of care (All)	113	14.1%
Assessment & direct care	92	11.4%
Rehabilitation & recovery	25	3.1%
Assessment & direct care + Rehabilitation & recovery	23	2.9%
Prevention & promotion + Rehabilitation & recovery	13	1.6%

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