



Partnerships for Sustainable Development Goals (SDGs) in implementation of scientific-based preventive methods to improve global mental health

Introduction

With major advances in the science of mental health, one would expect mental health to be widely accessible to everyone. Evidence-based tools and training have been developed and implemented in most countries, and global commitment to mental health, through multiple Sustainable Development Goals (SDGs), has never been more explicit. Yet, in the circumstances where the need is most acute, mental health prevention systematically fails to be effectively delivered to those who require it the most. In 2026, this failure is evident, as armed conflicts have been breaking out across multiple regions of the globe over the past 4 years. Millions of civilians across Ukraine, Gaza, Sudan, and other parts of the world are currently suffering the greatest vulnerability to mental health crises.

The question this essay addresses is not whether established mental health prevention measures work; science-based evidence supports these measures. The question is why, despite identical tools, funding, and need, science-based mental health prevention is effective in some conflict-affected areas and collapses in others. The quality of partnerships delivering mental health care is not in question; however, the architecture of these partnerships might hold the answer to the question raised.

A comparative examination of the World Health Organization's Mental Health Gap Action Programme (mhGAP) in five conflict-affected regions — Ukraine, Ethiopia, Lebanon, Gaza, and Sudan — uncovers three recurring structural deficiencies that influence results regardless of the availability of resources or established protocols.

The Scale of the Issue and the Hope of Prevention

In conflict-affected areas, one in five individuals suffers from mental disorders ranging from anxiety, depression, and post-traumatic stress disorder (PTSD), a proportion significantly higher than the global average¹. Nonetheless, prior to any conflict, in low- and middle-income countries (LMICs), there is a treatment gap exceeding 75%, reflecting the fact that the majority of the affected individuals lack mental health care². This already existing gap is significantly increased by war.

The conversion of acute trauma to chronic mental illness can be avoided if appropriate care is provided during a duration known as the prevention window. Reversing the trajectory can be achieved through early psychological support, community-based mental health interventions, as well as the training of non-specialist healthcare providers to effectively identify and respond to various mental presentations. This resonates with the goal of the World Health Organization's (WHO) mhGAP, which is to create a well-architected, evidence-based program that equips non-

specialist healthcare providers with the necessary skills to deliver first-line mental healthcare, having a greater impact in third-world and war-affected regions³. This program, implemented in over 90 countries, has had great success in some, while in others it has not found the same success. The difference between the two situations is, as will be discussed, mostly structural.

The Ukraine Model: A Success Story

Ukraine illustrates the clearest case study of the relationship between partnership architecture and mental health outcomes. In Ukraine, an internally displaced population numbering around 1.4 million people has been recorded due to the occurrence of a sustained low-intensity conflict that began in 2014, which was later intensified into a full-scale war in 2022. Along with this, internal displacement has come an increased psychological burden in terms of prevalence figures for depression of 5.18% and alcohol use disorder of 5.47%, which is more than LMIC averages². The efforts of Ukraine aimed at addressing the crisis through the UNA Partnership resulted in creating a sustainable prevention infrastructure. Specifically, through the UNA Partnership, it became possible to successfully integrate the mhGAP-Intervention Guide into the undergraduate and postgraduate courses taught in different universities². Some examples include adopting the mhGAP curriculum in the Kyiv Medical University in August 2019, with the involvement of over 700 participants, including not only students and residents but also practitioners, as well as not only medical professionals but also psychologists, social workers, and legal advisers of orphanages². In a similar vein, participating in the UNA Partnership, Kyrgyzstan managed to achieve a 17% increase in identifying depression and suicidal cases among people under the care of the trained practitioners. Moreover, the country also incorporated the mhGAP modules dealing with PTSD, acute stress, and grief from the mhGAP Humanitarian Intervention Guide. As a result, when a conflict arose, Ukraine was ready and resilient because a proper prevention infrastructure had been put in place beforehand. Therefore, prevention infrastructure might be the core principle that the other later discussed cases lack.

Ethiopia: Incomplete Partnership Architecture

Ethiopia was widely recognized as a successful mhGAP scale-up in sub-Saharan Africa prior to the Tigray conflict. The program was founded on five core principles: country ownership, community ownership, scaling to achieve meaningful impact, integration into existing health systems, and a structured multi-partner collaboration involving the Federal Ministry of Health, WHO, the European Union, and Fondation d'Harcourt⁴. This resulted in 244 health centers participating in the mhGAP training. The program benefited from national strategic support, integration into primary care, and true government co-leadership. All the above factors, supported by scientific data, would have ensured that the success of the program became a reality.

While the program proved to be effective in peacetime, it was not built to operate under conditions of war, which became clear from the Tigray conflict of November 2020. It lacked an existing set of protocols indicating the responsible party for providing support to individuals suffering from mental distress, the pre-existing inventory of educational material for conflict-hit zones, and the activation protocol for triggering the program when the government-partner became part of the conflict situation.

WHO's response to the conflict, by initiating training-of-trainers on the mhGAP Humanitarian Intervention Guide, came in May 2021, six months after the conflict began⁵. And by March 2023, 2750 mhGAP manuals had been distributed, and 1230 health workers were trained across three

affected regions⁵. These represent important achievements; however, they may constitute a reactive scramble rather than a planned prevention response. In the 6-month delay of intervention, and without any organized psychosocial support, a large population was accumulating trauma with the potential of evolving to chronic mental illness that may persist for decades.

The model of Ethiopia does not portray partnership failure; it represents partnership incompleteness.

Lebanon: The Coordination Vacuum

The mental health landscape in Lebanon reveals a different aspect of failure: a lack of a coherent system to begin with, rather than the breakdown of an established one. Lebanon hosts more than 1.5 million Syrian refugees, constituting the highest refugee-to-host ratio in the world, while Lebanon had been simultaneously suffering from economic collapse, the aftermath of the COVID-19 pandemic, and the catastrophic Beirut Port explosion in August of 2020⁶, in addition to the wars in September 2024 and March 2026, displacing and affecting millions across the country. This implied an acute need for mental health care. Although funding and international attention were evident, mhGAP implementation has remained partial, inequitable, and unable to reach the most vulnerable.

In a qualitative analysis, key Lebanese stakeholders indicated that the reasons for this inefficacy are structural⁶. Multiple actors, among which are the WHO, the National Mental Health Programme, UNHCR, international non-governmental organizations (NGOs), and bilateral aid implementers, operated with overlapping mandates and a lack of a true leader. Training was delivered without any systematic rationale to some medical facilities and not others. Even trained primary care workers could not act on their training because referral pathways for patients requiring specialist care were inconsistent or absent.

Lebanon's model highlights the importance of coordination, as its absence can be as lethal as the complete lack of a program.

Gaza: The Outcome of Absent Infrastructure

Gaza pinpoints the consequences of the lack of mental health partnership infrastructure prior to conflict escalation. Even before October 2023, Gaza had fewer than 1 psychiatrist per 100,000 people⁷, in addition to only having 38 psychiatric beds for a population of 2 million people⁶, making it among the most psychiatrically under-resourced places on earth. This stems from the use of mhGAP in Gaza's community mental health services without formal evaluation, without a structured multi-actor partnership framework, nor the institutional embedding that gave Ukraine's model its durability. By mid- 2024, with only 16 of 36 public hospitals remaining functional⁷, the consequences of this absence were already devastating, as rates of PTSD and depression reached 54% and 41% in children, 40% and 45% in adults, respectively, while 34% of children and 37% of adults also suffered from anxiety⁷. A first-hand clinical account from a primary care facility in Gaza in late 2025 describes the total unpreparedness of routine primary health care facilities to manage cases of mood disorders, complex grief reactions, sleep disorders, PTSD, and suicidal ideation⁸. The same account calls for the implementation of the mhGAP training for primary healthcare staff, establishment of referral pathways for severe mental illness, as well as the consistent supply of

essential psychotropic medications through humanitarian corridors⁸. Had these measures pre-existed, the documented catastrophic outcomes could have been avoided.

It is worth mentioning that the ceasefire of early 2025 represented a prevention window that could have interrupted the trajectory from acute trauma to chronic mental illness for over one million people assessed by WHO as requiring mental health care⁸. However, with the lack of pre-existing infrastructure, this opportunity closes before it can be effectively used.

Sudan: The Null Case

While Gaza's model portrays under-preparedness, Sudan depicts its complete absence. Sudan suffered from the destruction of medical infrastructure, widespread shortage of trained mental health professionals, as a result of the ongoing conflict, and a limited presence of mhGAP in primary health systems prior to conflict onset⁹. Moreover, Sudan introduces a different overlooked dimension: stigma. Stigma is so deep-rooted in the culture that even the limited care available is not sought. Furthermore, emergency humanitarian responses have systematically prioritized physical trauma and infectious diseases, treating mental health needs as a secondary concern⁹. Simply, evidence-based prevention could not be delivered without a pre-existing partnership framework, infrastructure, and local workforce.

The unfortunate null case of Sudan, by contrast, confirms the value of the measures built in the previously discussed cases.

Three Structural Failures: The Blueprint in Negative

Across the five settings discussed above, three structural failure modes appear consistently. These are not characteristic of a particular nation, but recurring architectural flaws that emerge wherever partnership design is inadequate. Taken together, they point directly to the fundamental elements that any effective blueprint for partnership must include.

The first challenge is the coordination vacuum, as depicted by the models of Lebanon and, to a lesser extent, Ethiopia. During the conflict phase, overlapping mandates resulted in duplication in some areas and gaps in others. Thus, multi-sector coordination is imperative before crises occur, with a clear assignment of roles, in addition to well-established escalation and handover protocols. This framework may be found in the WHO/IASC MHPSS (Inter-Agency Standing Committee Mental Health and Psychosocial Support) Coordination Handbook, launched in 2022 and successfully implemented in Syria, Gaza, Ethiopia, and Yemen¹⁰. A case that demonstrates this is Syria's 2023 earthquake response. Coordinated MHPSS services across 450 locations were provided by 37 partner organizations, with over one million service contacts. This example is proof that a well-established coordination structure is effective when built before crises¹⁰.

The second challenge is the local ownership gap. This was evident in the models of Gaza and Sudan, as international actors arrived to provide care, but left when funding ran out or security deteriorated. Nonetheless, there was no local institution to take the lead. This contrasts with the models of Ukraine and Armenia, where mhGAP was integrated into university curricula and local institutions². This is the structural mechanism that enabled prevention capacity to survive during armed conflicts when external support disappeared.

The third challenge is the prevention squeeze. Acute episodes, such as suicide attempts, psychosis, and PTSD, tend to receive more attention than prevention in emergency situations. While it is impossible to ignore this prioritization in clinical terms, it is nevertheless self-defeating since the very activities that prevent a patient from transitioning from trauma to chronic disorder are the ones that stop the chain reaction. Thus, assigning specific individuals the task of prevention and allocating resources for it could be considered a good course of action.

A Replicable SDG 17 Blueprint

From these challenges, three partnership principles can be extracted to form the core of an SDG 17 blueprint suitable for conflict-affected environments.

First, pre-crisis partnership mapping, meaning formal agreements between the WHO, national Ministries of Health, medical schools, and local NGOs, should be operationalized before crises occur. These agreements should clearly designate a lead figure and other roles in times of emergency, and provide adequate training and medication stockpiles in preparation for any emergency.

Second, the requirement of local co-ownership. Local medical schools and NGOs should not be passive recipients of training. On the contrary, they must be formal co-leaders of mhGAP partnerships. This can be accomplished through co-developing curricula and co-training future trainers. The local institutions must be capable of sustaining the program independently.

Third, “ringfencing” of prevention within partnership agreements. This implies sparing at least one partner in every SDG 17 partnership to carry a preventive mandate exclusively, protecting it from reallocation to acute care. Prevention-specific data, such as funding lines, numbers trained in psychological first aid, support sessions delivered, and early presentations screened, must be independently tracked and reported.

Feasibility and Limitations

These principles are extensions of existing WHO frameworks. The UNA partnership, the MHPSS Coordination Handbook, and Ethiopia’s pre-conflict national mental health strategy all showcase that the components of this blueprint can be assembled within existing institutional landscapes. Medical schools are legitimate initiators of the local co-ownership component. The World Psychiatric Association (WPA) Medical Students Special Interest Group is an example of a multi-institutional partnership through which mhGAP training can be embedded in education at scale.

However, some limitations must be mentioned. Effective partnership mapping requires sufficient political stability to form multi-actor agreements, a condition Sudan, for example, has not met for years. Local institutional capacity must be adequate

to meet local co-ownership demands. In settings such as Gaza, the capacity was catastrophically depleted by the conflict itself. The absence of independent monitoring mechanisms exposes prevention ringfencing to the risk of becoming a nominal commitment rather than an operational reality.

Conclusion

Ukraine, Ethiopia, Lebanon, Gaza, and Sudan depict a gradient that maps almost perfectly onto partnership quality, with the same program yielding five dramatically different outcomes. Science-based mental health prevention is effective only when paired with partnerships that are formally constituted before any conflict, locally co-led by medical schools and civil society, and structurally protect preventive activities from being consumed by acute response.

SDG 17 is an essential framework. The ceasefire in Gaza in 2025, described by a clinician working in primary care as a window that must not be missed⁸, is a manifestation of every post-conflict situation: a brief duration in which the trajectory of an entire population's mental health can be redirected, if the partnership infrastructure to act is already prepared. The examined cases portray with painful clarity the consequences of unpreparedness. The derived blueprint is not theoretical; it is supported by evidence from the most extreme conditions on earth, and is actionable by medical students, universities, and WHO partnerships, which are the legitimate initiators of this change.

Future research should focus on developing standardized metrics for evaluating the quality of partnership architecture in conflict settings, allowing for the detection and rectification of structural deficiencies before the outbreak of the crisis, not in its aftermath.

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