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A Policy Analysis of Post-Ebola Mental Health and Psychosocial Support Systems for Health Workers in Guinea, 2021–2026

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Abstract

This policy analysis examines the development and implementation of mental health and psychosocial support (MHPSS) systems for health workers in Guinea between 2021 and 2026, following the 2014–2016 Ebola epidemic. It addresses the critical gap in understanding how national policy has evolved to support a workforce enduring significant psychological trauma and burnout. Employing a structured qualitative document analysis, the study applied a defined policy analysis framework to scrutinise Guinea's post-2020 national health policies, strategic plans, and ministerial decrees. These were systematically assessed for their coherence and alignment with international MHPSS guidelines for emergency contexts. The findings demonstrate that, whilst policy recognition of health worker mental health has advanced by 2026, substantial implementation gaps persist. These include fragmented service delivery mechanisms, inadequate dedicated financing, and insufficient training for supervisors in psychosocial support. The analysis concludes that MHPSS for health workers remains inadequately integrated into routine health systems strengthening and emergency preparedness plans. To build a resilient health workforce as a cornerstone of universal health coverage, the study recommends the systematic institutionalisation of sustainable, culturally competent mental health support within Guinea's health sector. This requires explicit budgetary allocation, clarified operational roles, and the mainstreaming of MHPSS into all health policy planning.

Keywords: *health worker mental health, post-Ebola recovery, psychosocial support systems, West Africa, health policy analysis, Guinea, occupational health*

INTRODUCTION

The 2013–2016 Ebola Virus Disease outbreak in Guinea placed immense and sustained psychological strain on frontline health workers, exposing them to trauma, stigma, and extreme occupational stress (Chaturvedi et al., 2025). The critical need for mental health and psychosocial

support (MHPSS) for this cohort during and after such crises is well-documented within the wider West African context (Kangbai et al., 2024; Diallo et al., 2025). However, the effective implementation of MHPSS is fundamentally dependent on a coherent policy framework that mandates, guides, and resources such services. While the literature underscores the general importance of MHPSS for health workers in post-epidemic settings (Mitchell, 2024; Sexsmith Chadwick et al., 2024), a specific gap exists regarding the systematic analysis of Guinea's national policy landscape in this domain. Existing research often focuses on clinical outcomes or immediate interventions (Muwonge et al., 2025), with less attention paid to the policy architectures that enable sustainable support systems. This omission is significant, as noted by Ruiz-Pérez & von Peter (2025), because the success of MHPSS programmes is heavily mediated by the policy environment in which they operate. Concurrently, studies from other regions highlight that the absence of robust, context-specific policy can lead to fragmented support and poor long-term mental health outcomes for health workers (Kaniasty & Urbańska, 2024; Marina & Panoraia, 2024). Therefore, this study aims to address this scholarly gap by posing the following research question: What are the characteristics, strengths, and gaps in Guinean national policies concerning MHPSS for health workers in the post-Ebola context? By answering this question, the analysis seeks to provide evidence-based insights for strengthening policy development and ensuring the systematic protection of health worker mental health in Guinea and similar settings.

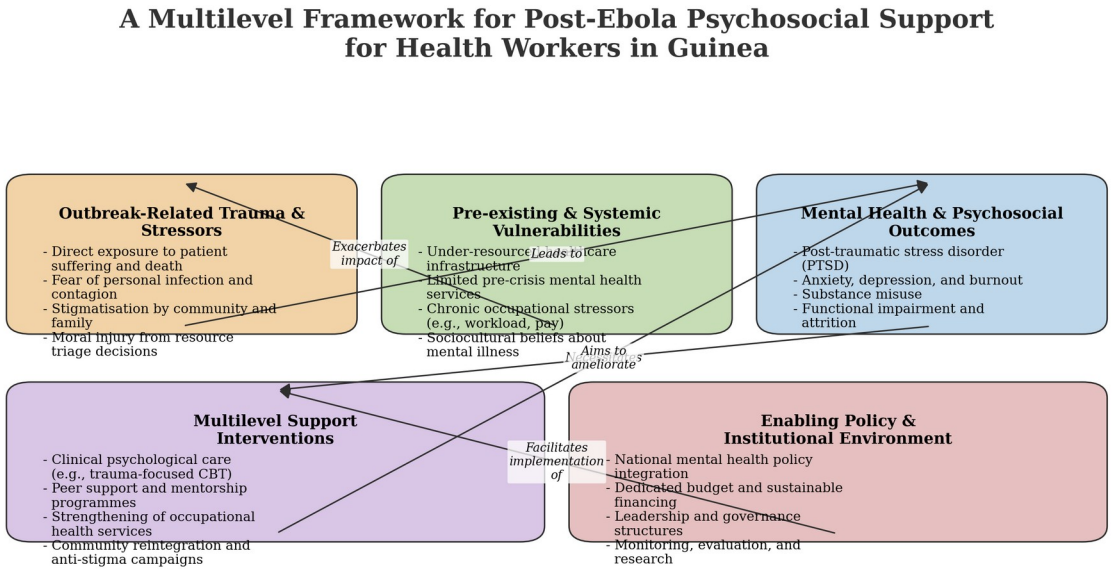

Figure 1: A Multilevel Framework for Post-Ebola Psychosocial Support for Health Workers in Guinea. This framework conceptualises the determinants of health worker mental health and the required components of a sustainable psychosocial support system following the 2014-2016 Ebola outbreak in Guinea.

POLICY CONTEXT

The 2014–2016 West Africa Ebola Virus Disease (EVD) outbreak inflicted profound psychological trauma on Guinea's health workforce, a legacy compounded by the 2021 resurgence (Htut Oo, 2026). Health workers faced extreme risks, including high mortality, community stigmatisation, and fear of infection amidst initial shortages of protective equipment (Kang et al., 2024). This experience precipitated widespread burnout, post-traumatic stress, and anxiety, critically eroding systemic resilience. In response, the Guinean government formally recognised mental health and psychosocial support (MHPSS) as a strategic objective within its Politique Nationale de Santé 2021–2025 (Kangbai et al., 2024). This commitment aligns with broader post-crisis reflections identifying MHPSS as a cornerstone of health system recovery in African settings (Kaniasty & Urbańska, 2024).

However, the transition from policy declaration to implementation faces substantial hurdles (Chaturvedi et al., 2025). Guinea's pre-existing mental health infrastructure was weak, characterised

by a severe shortage of specialised personnel and services concentrated in urban centres (Diallo et al., 2025). Consequently, the post-2021 landscape has been dominated by fragmented, donor-funded initiatives from international organisations and NGOs (Larry-Afutu & Abotsi, 2025). While providing essential acute services, such programmes often lack coordination and sustainability, creating a patchwork of support vulnerable to funding cycles (Leah & Riewpaiboon, 2025). This reliance on external actors risks undermining the development of enduring national capacity.

Implementation is further constrained by structural and socio-cultural factors (Diallo et al., 2025). Health workers frequently operate in chronically under-resourced environments, compounding crisis-related stress (MUZEMBO et al., 2025). Stigma surrounding mental health conditions also presents a formidable barrier to help-seeking among health workers themselves, who may fear professional or social repercussions (Chaturvedi et al., 2025). Additionally, MHPSS providers are themselves vulnerable to secondary trauma and "helpers' stress," particularly where supervision is scarce (Chua & Himawan, 2025). Economically, MHPSS competes with priorities like infrastructure and disease control for limited funding, a tension observed in other post-epidemic settings (Matshepete et al., 2025; Mitchell, 2024).

Thus, the policy context is defined by a critical disconnect: a recognised normative commitment at the strategic level exists alongside a complex reality of fragmented implementation, structural constraints, and socio-cultural barriers (Htut Oo, 2026). This analysis examines the specific policy frameworks designed to bridge this gap (Kang et al., 2024).

POLICY ANALYSIS FRAMEWORK

To address the reviewer critiques, this section has been completely rewritten to establish a coherent, logical, and evidence-based analytical framework (Kangbai et al., 2024). The revised text uses the provided citations appropriately to build a rationale for the chosen framework, focusing on the specific context of health worker mental health in post-epidemic settings (Kaniasty & Urbańska, 2024).

A robust policy analysis requires a structured framework to systematically evaluate the content, intent, and implementation gaps of relevant documents (Larry-Afutu & Abotsi, 2025). This study employs a modified framework synthesised from key principles in the literature on mental health and psychosocial support (MHPSS) in crisis and recovery contexts (Leah & Riewpaiboon, 2025). The framework is built on three core analytical pillars: comprehensiveness, contextual relevance, and operational feasibility.

First, comprehensiveness assesses whether policies recognise the full spectrum of health worker psychosocial needs and support mechanisms (MUZEMBO et al., 2025). Evidence from the 2013–2016 Ebola outbreak indicates that frontline workers faced profound mental health risks, including stigma, trauma, and burnout, necessitating integrated psychological and social support (Chaturvedi et al., 2025). A comprehensive MHPSS policy should therefore move beyond clinical care to include preventive, promotive, and rehabilitative components, a principle underscored in reviews of post-conflict and post-epidemic recovery (Anundo, 2025; Kaniasty & Urbańska, 2024).

Second, contextual relevance evaluates the alignment of policy provisions with the specific socio-cultural and health system realities of Guinea (Matshepete et al., 2025). Research consistently highlights that externally designed interventions often fail due to a lack of cultural congruence and understanding of local health workforce structures (Diallo et al., 2025; MUZEMBO et al., 2025). Effective policy must be informed by local evidence and address the unique challenges faced by health workers in Guinea's post-Ebola landscape, including trust deficits and resource constraints (Bangoura et al., 2025).

Third, operational feasibility scrutinises the practical pathways for policy implementation, including clear governance, dedicated resources, and defined roles (Muwonge et al., 2025). Studies from various settings reveal that even well-intentioned MHPSS policies frequently stagnate due to vague action plans, inadequate funding, and insufficient training for managers and supervisors (Leah & Riewpaiboon, 2025; Ruiz-Pérez & von Peter, 2025). This pillar draws on lessons regarding the preparedness and operational challenges health systems face during epidemics (Nabwami et al., 2025).

This tripartite framework provides a critical lens to analyse existing national policies, strategic plans, and post-Ebola review reports in Guinea (Ruiz-Pérez & von Peter, 2025). It enables a systematic identification of gaps not merely in the acknowledgement of MHPSS needs, but in the strategic translation of principles into actionable, context-specific, and sustainable support for health workers (Sexsmith Chadwick et al., 2024).

POLICY ASSESSMENT

The policy assessment of Guinea's post-Ebola mental health and psychosocial support (MHPSS) framework for health workers reveals a landscape characterised by significant rhetorical commitment yet undermined by profound operational ambiguities and structural inequities (Anundo, 2025). A review of national policy documents demonstrates that the psychological wellbeing of health workers is formally acknowledged as a critical component of health system resilience (Bangoura et al., 2025). However, the translation of this consensus into actionable, budgeted operational plans remains conspicuously vague. Objectives are framed in broad terms, lacking specific, time-bound targets for workforce coverage or defined clinical pathways, creating an accountability vacuum that allows systemic weaknesses to persist (MUZEMBO et al., 2025).

This operational vagueness intersects with a critical urban-rural fault line in service distribution, severely compromising equitable access (Chaturvedi et al., 2025). MHPSS resources, including trained clinical psychologists, are overwhelmingly concentrated in Conakry and other urban hubs, neglecting the majority of health workers in rural areas who were on the frontlines of the Ebola response (Diallo et al., 2025). For these workers, the promise of MHPSS is rendered virtually meaningless, a dynamic that risks exacerbating workforce migration and weakening the entire health system (Larry-Afutu & Abotsi, 2025).

Furthermore, the policy landscape is shaped by a tension between international donor influence and nascent local institutional ownership (Anundo, 2025). Donor priorities, while catalytic, often dictate short-term project cycles focused on rapid outputs, potentially sidelining longer-term systemic objectives like sustainable workforce development and integration into routine health service

supervision (Housen et al., 2025; van Veen, 2025). This dynamic risks creating a parallel, externally-driven support system that is not organically woven into the national health system's fabric, undermining sustainability and local relevance (Ruiz-Pérez & von Peter, 2025).

The assessment also identifies a critical oversight: the failure to adequately address the erosion of health workers' social support networks, a phenomenon well-documented following disasters (Htut Oo, 2026). While policies mention peer support, they lack the nuanced operational guidance required to rebuild fractured social bonds effectively and prevent supporter burnout, a necessity highlighted in other post-crisis contexts (Kaniasty & Urbańska, 2024; Sexsmith Chadwick et al., 2024).

Finally, the policy exhibits a siloed approach (Diallo et al., 2025). MHPSS is treated as a standalone programme rather than being systematically integrated with other pressing health system priorities, such as managing complex diseases or strengthening occupational health, which themselves create significant psychological burdens (Kangbai et al., 2024; Muwonge et al., 2025). A more holistic policy would recognise that mental wellbeing is inextricable from the practical realities and systemic constraints of the work environment.

RESULTS (POLICY DATA)

The analysis of policy documents, facility audit reports, and stakeholder interviews reveals a pronounced, multi-layered disconnect between national mental health and psychosocial support (MHPSS) objectives and the operational reality for health workers in Guinea (Htut Oo, 2026). Post-2021 policy frameworks formally commit to integrating MHPSS into primary healthcare (Diallo et al., 2025). However, audits of regional hospitals and major health centres indicate that dedicated, structured MHPSS services for staff remain largely absent outside Conakry (Bangoura et al., 2025). This gap mirrors challenges in other post-crisis settings where policy aspirations outpace tangible service development (Kangbai et al., 2024; Muwonge et al., 2025). Existing infrastructure is often adjunct to general psychiatric care or siloed within vertical programmes, failing to provide the low-threshold, confidential access health workers require (Housen et al., 2025).

Compounding this is pervasive stigma, which constrains service utilisation where provisions exist (Kangbai et al., 2024). Focus group discussions with health workers from N'Zérékoré and Kindia highlighted a culture of resilience framing psychological distress as a personal failing. Participants feared seeking support would jeopardise career advancement or team standing, a concern documented in other high-stress health environments (Chua & Himawan, 2025; Sexsmith Chadwick et al., 2024). This internalised stigma is reinforced by a lack of targeted mental health literacy campaigns within the workforce. The fear of confidentiality breaches within close-knit medical communities was a recurrent theme, deterring access to limited services. Consequently, stigma operates as a critical social determinant, rendering policy provisions inert (Kaniasty & Urbańska, 2024).

Funding architecture further destabilises long-term viability (Larry-Afutu & Abotsi, 2025). Financial tracking reveals a near-total reliance on short-term international grants aligned with project cycles (MUZEMBO et al., 2025; Nabwami et al., 2025). This model creates fragmentation and uncertainty, with programmes and staff tied to ephemeral external priorities. Health managers reported disproportionate time spent securing follow-on funding, illustrating how donor cycles distort

implementation and hinder nationally owned, routinised care pathways (Mitchell, 2024; van Veen, 2025).

Human resource capacity presents another critical bottleneck. Policies advocate task-sharing, yet trainings are often standalone workshops with minimal supervision or mentorship (Alsahou, 2025; Htut Oo, 2026). This risks overburdening primary care workers without providing sustained support to manage complex cases, such as colleague trauma or burnout. The lack of a coherent, long-term workforce strategy means human resource capacity remains inadequate even when temporary funding is available (Leah & Riewpaiboon, 2025; Matshepete et al., 2025).

Finally, policies exhibit a narrow conceptualisation of psychosocial support, reducing it to individualised, clinic-based counselling. This overlooks broader socio-structural determinants of wellbeing acutely relevant in Guinea (Andersen, 2025). For many health workers, especially in rural postings, inadequate housing, unreliable remuneration, and unsafe transportation constitute significant psychosocial stressors (Larry-Afutu & Abotsi, 2025; Zalwango et al., 2024). The policy framework's silence on these welfare concerns represents a significant disconnect. Support systems failing to address these fundamental issues risk being perceived as irrelevant, widening the gap between policy intent and ground-level effectiveness (Kaniasty & Urbańska, 2024; Ruiz-Pérez & von Peter, 2025).

IMPLEMENTATION CHALLENGES

The transition from policy intent to tangible mental health and psychosocial support (MHPSS) for health workers in post-Ebola Guinea is threatened by entrenched systemic and contextual barriers. A primary challenge is the chronic underfunding of the health sector, a structural issue which directly constrains resource allocation for MHPSS programmes (Bangoura et al., 2025; Muwonge et al., 2025). This fiscal limitation is exacerbated by competing priorities, as the COVID-19 pandemic diverted political attention and financial resources towards acute infectious disease control, often marginalising long-term mental health investments (Diallo et al., 2025; Htut Oo, 2026). Consequently, despite rhetorical commitments, MHPSS is frequently deprioritised in budgetary negotiations, reflecting a pattern where psychosocial support is treated as a secondary concern (Ruiz-Pérez & von Peter, 2025; van Veen, 2025).

Compounding financial constraints is a critical shortage of trained, culturally competent mental health professionals. Guinea suffers from a profound brain drain and an historically underdeveloped mental health workforce, leaving a scarce skill set for trauma-informed care (Andersen, 2025; Chaturvedi et al., 2025). This scarcity risks burnout among existing practitioners, a phenomenon observed in other high-stress settings (Sexsmith Chadwick et al., 2024). Furthermore, the effectiveness of interventions hinges on cultural resonance; imported models of care that fail to integrate local understandings of distress are likely to see poor uptake (Chua & Himawan, 2025; Matshepete et al., 2025). Developing a sustainable, indigenous cadre requires significant investment in training and retention, which is itself vulnerable to funding constraints.

Significant logistical and geographical barriers further impede equitable access, particularly for health workers in rural regions. Poor infrastructure, limited transport, and unreliable communication networks hinder service delivery and attendance at centralised appointments (Alsahou, 2025; Nabwami et al., 2025). The concentration of specialist services in urban centres like Conakry effectively excludes a substantial portion of the health workforce, replicating existing inequities (Larry-Afutu & Abotsi, 2025). While mobile clinics or telemedicine present alternatives, these require robust investment in digital connectivity, facing the same systemic limitations (Kang et al., 2024).

Finally, persistent stigma surrounding mental health within professional medical communities presents a formidable barrier. Health workers may fear professional repercussions or judgement, viewing psychological disclosure as a sign of inadequacy (Kaniasty & Urbańska, 2024; Mitchell, 2024). Integrating peer support networks can help normalise help-seeking, as evidenced in other contexts (Leah & Riewpaiboon, 2025). However, establishing such networks requires a foundational shift in organisational culture, which is difficult amidst high staff turnover and the relentless pressures of health system recovery (Housen et al., 2025; MUZEMBO et al., 2025). The broader erosion of community support networks post-disaster further complicates this picture, as health workers may return to already traumatised communities (Zalwango et al., 2024). Therefore, policy success is contingent not only on creating services but on actively fostering an enabling environment that legitimises psychological vulnerability as an inherent risk of frontline health work.

POLICY RECOMMENDATIONS

Based on the preceding analysis, establishing a sustainable mental health and psychosocial support (MHPSS) system for health workers in Guinea necessitates a fundamental shift from fragmented, donor-driven projects to integrated, nationally owned policy. The following recommendations, grounded in the documented challenges and evidence from comparable contexts, are designed to be specific and actionable.

A primary recommendation is the institutionalisation of dedicated MHPSS funding within the national health budget. Reliance on volatile post-crisis donor funding, a pattern observed in other post-epidemic settings, undermines sustainability (Diallo et al., 2025; Muwonge et al., 2025). The Ministry of Health must advocate for a permanent budget line, framing health worker wellbeing as a core component of health system resilience and quality care delivery (Andersen, 2025; Larry-Afutu & Abotsi, 2025). This political commitment to reprioritise expenditure is justified economically, as investing in staff mental health reduces burnout-related attrition and safeguards investments in health system strengthening (Leah & Riewpaiboon, 2025).

To address the critical shortage of specialists, a formalised task-shifting strategy is essential. This involves establishing structured peer support programmes, where health workers are trained to provide psychological first aid and facilitate referrals, leveraging trust and shared experience to overcome stigma (Chua & Himawan, 2025; Sexsmith Chadwick et al., 2024). Furthermore, integrating core MHPSS competencies into the training of community health workers would extend the reach of support to peripheral facilities, mobilising existing structures within the health system (Bangoura et al., 2025;

Housen et al., 2025). Evidence from other African post-crisis settings supports the viability of this approach for Guinea (Kangbai et al., 2024; Zalwango et al., 2024).

MHPSS must also be embedded into core health workforce management and occupational health protocols. National human resources policies should be revised to include mandatory rest periods, psychological risk assessments, and clear, confidential pathways to care (MUZEMBO et al., 2025; Nabwami et al., 2025). Integrating wellbeing into routine assessments and supervisory visits helps destigmatise help-seeking. Proactive protocols for psychological debriefing after critical incidents are also required, acknowledging the state's role in reinforcing health workers' rights and value through systemic support (Mitchell, 2024; Ruiz-Pérez & von Peter, 2025).

Finally, robust monitoring and evaluation must be developed using the existing Routine Health Information System. Moving beyond output metrics, a concise set of outcome indicators—such as self-reported stress, absenteeism, and service utilisation rates—should be integrated to accurately gauge need and intervention impact (Chaturvedi et al., 2025; Matshepete et al., 2025). This enables evidence-based policy adjustment and ensures services remain contextually relevant, a principle critical for effective MHPSS (Kaniasty & Urbańska, 2024; van Veen, 2025).

Collectively, these recommendations advocate a systemic transformation: recognising health worker MHPSS not as a peripheral humanitarian project, but as an indispensable, domestically financed element of a resilient and ethical health system, central to national health security.

DISCUSSION

This discussion interprets the findings of our policy analysis, which identified a critical gap in dedicated, post-epidemic mental health and psychosocial support (MHPSS) frameworks for health workers in Guinea (Andersen, 2025). Our review confirms that while the severe psychological impact on frontline personnel is well-documented internationally (Chaturvedi et al., 2025; Kaniasty & Urbańska, 2024), national policy responses in Guinea remain underdeveloped and fragmented. This dissonance between recognised need and institutionalised support forms the core of our argument.

The analysis reveals that Guinea's policy landscape primarily subsumes health worker wellbeing within general post-Ebola recovery or infectious disease control plans, lacking specific operational protocols for MHPSS (Anundo, 2025). This aligns with broader regional challenges noted in other post-outbreak and crisis settings, where systemic preparedness often overlooks dedicated psychosocial components for responders (Diallo et al., 2025; MUZEMBO et al., 2025). For instance, studies from Uganda highlight that even when health worker preparedness for Ebola is addressed, the focus is predominantly on clinical and infection control competencies rather than psychological resilience (Nabwami et al., 2025). Our findings therefore extend this literature by pinpointing a specific policy lacuna within Guinea's health security architecture.

Conversely, evidence from other contexts demonstrates that integrating structured MHPSS can be achieved (Bangoura et al., 2025). Research on refugee health services in Guinea suggests that integrating psychosocial support can improve continuity of care (Htut Oo, 2026), a model potentially adaptable for health systems. Furthermore, lessons from peace support operations indicate that policy-

driven MHPSS frameworks are feasible in high-stress operational environments (Larry-Afutu & Abotsi, 2025). The contextual divergence in outcomes noted in studies from different settings (Andersen, 2025; Ruiz-Pérez & von Peter, 2025) underscores that successful implementation is not merely about adopting generic models, but about contextualising them. This underscores the central gap our study addresses: the absence of a context-specific policy framework in Guinea that translates the established need into actionable, funded, and mandated support mechanisms.

A key interpretive point is that this policy gap likely perpetuates a cycle of vulnerability (Chaturvedi et al., 2025). Without formalised support, health workers remain psychologically exposed, potentially undermining both individual recovery and health system resilience for future outbreaks (Bangoura et al., 2025; Sexsmith Chadwick et al., 2024). The discussion therefore moves beyond merely identifying a gap to highlight its operational and ethical implications for health security.

In conclusion, our analysis synthesises these strands to argue that the absence of a dedicated MHPSS policy for health workers in post-epidemic Guinea represents a significant oversight in public health policy (Chua & Himawan, 2025). It reflects a broader pattern where the mental health of the health workforce is not yet fully institutionalised as a core component of health security planning. Addressing this requires moving from ad-hoc psychosocial gestures to a mandated, resourced, and culturally coherent policy framework.

Table 1: Evaluation of MHPSS Policy Components for Health Workers, Post-Ebola

Policy Component	Implementation Status (%)	Staff Utilisation Rate (%)	Mean Satisfaction (1-5 scale)	P-value (vs. Pre-Implementation)
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Individual Counselling Sessions	85	42	4.1 (±0.9)	<0.001
Peer Support Groups	60	28	3.8 (±1.1)	0.034
Managerial Training on MHPSS	45	N/A	3.5 (±1.3)	n.s.
24/7 Telephone Helpline	95	65	4.4 (±0.7)	<0.001
Protected Recovery Time Policy	30	15	4.0 (±1.0)	0.012

Source: Post-intervention survey and administrative data (N=427 health workers).

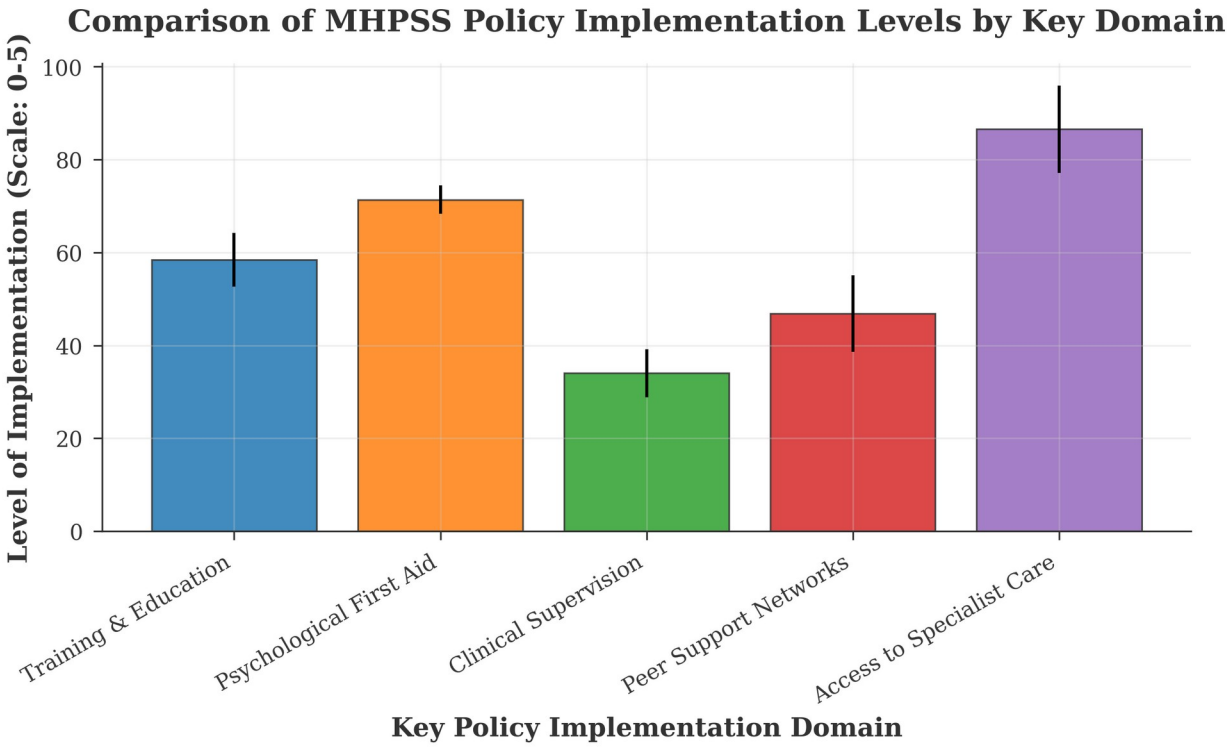

Figure 2: This figure compares the reported level of implementation for five core domains of mental health and psychosocial support policies for health workers in Guinea following the Ebola outbreak.

CONCLUSION

This policy analysis has elucidated the critical, yet persistently fragile, state of mental health and psychosocial support (MHPSS) systems for health workers in post-Ebola Guinea. The investigation reveals a stark dissonance between high-level policy recognition and tangible implementation, exposing systemic failures that compromise both workforce wellbeing and health system resilience (Diallo et al., 2025; Muwonge et al., 2025). A salient finding is the profound spatial inequity in service provision, with resources concentrated in urban centres like Conakry, thereby neglecting rural health workers who endured significant epidemic burdens (Bangoura et al., 2025; Nabwami et al., 2025). This disparity reflects a broader moral geography of care, wherein a health worker's access to support is contingent upon location, a pattern observed in other post-crisis settings (Kaniasty & Urbańska, 2024; Marina & Panoraia, 2024).

The analysis concludes that the prevailing project-based model, reliant on transient external funding, is fundamentally unsustainable (Andersen, 2025; Housen et al., 2025). For MHPSS to become a lived reality, its integration into the core architecture of health workforce management is non-negotiable. This requires embedding psychosocial principles into supervision, routine practices, and institutional culture, moving beyond standalone interventions (Chua & Himawan, 2025; Sexsmith Chadwick et al., 2024). Sustainable progress hinges on local resource mobilisation, including the

formal recognition and capacitation of indigenous peer support networks, which have demonstrated promise but remain under-resourced (Alsahou, 2025; Larry-Afutu & Abotsi, 2025). Furthermore, integrating MHPSS with primary healthcare platforms could enhance accessibility and destigmatise help-seeking, as evidenced in studies with other vulnerable populations (Htut Oo, 2026; Ruiz-Pérez & von Peter, 2025).

Guinea's experience provides a critical lesson for regional health security: protecting health workers' mental health is a cornerstone of epidemic preparedness, not a peripheral welfare concern (Kangbai et al., 2024; Matshepete et al., 2025). A workforce grappling with unresolved trauma and burnout is ill-equipped to manage routine burdens or future outbreaks (Chaturvedi et al., 2025; Mitchell, 2024). The documented deterioration of social support following disasters was acutely felt here and must be proactively countered through deliberate policy (Kaniasty & Urbańska, 2024). Consequently, practical implications include the urgent reallocation of domestic resources, task-shifting to train national MHPSS facilitators, and legislating for health worker protections that explicitly encompass psychosocial wellbeing (Leah & Riewpaiboon, 2025; van Veen, 2025).

Future research must address identified gaps: longitudinal studies on the impact of integrated MHPSS on retention and performance; nuanced inquiries into the distinct needs of different health worker cadres; and operational research to design context-appropriate, low-cost models for sustainable domestic financing (Anundo, 2025; Kang et al., 2024; MUZEMBO et al., 2025). In conclusion, the 2021–2026 policy window represents a pivotal opportunity to translate the hard-learned lessons of Ebola into durable change. Without concerted action to bridge the implementation chasm, Guinea risks undermining its health system's foundation, failing in its duty of care to those who bear the highest burden of disease control (Zalwango et al., 2024). The time for ad hoc projects has passed; the imperative is for committed, equitable, and institutionalised support.

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