IJHG review 30.1

Introduction

The *IJHG* review section consists of short reviews of each article included in the current issue. The Review Editor includes additional commentary to provide a broader context for each article and reveal how those articles correspond to the aims of the journal. This allows readers to select articles that reflect their own interests and hopefully could help our future authors to better understand our priorities in selecting manuscripts for publication.

Good governance (GG) principles in public health

The article *"Good governance: an empirical evidence from Egypt's public health sector"* investigates the impact of different GG principles on public health in Egypt (Zeini and Okasha, 2025). Governance is increasingly recognized as crucial for health system performance; thus, implementation of GG principles in health systems is an evolving domain of research interest, especially in low- and middle-income countries (LMICS).

Ten years ago, a comprehensive review of research from the LMICS concluded that while most of analyzed studies reported a positive association between governance and health, the nature of these relationships varied, with direct, indirect and moderating effects observed (Ciccone *et al.*, 2014). Further research was needed to fully understand these complex relationships and inform evidence-based governance interventions. Since then, more research that investigated the implementation of good governance (GG) principles in national public health sectors and assessed their impact has been published. For example, Houngbo *et al.* (2017) proposed a six-phase model for implementing GG in healthcare technology management, emphasizing stakeholder participation and action research; Jafari *et al.* (2018) discussed the importance of recognizing country-specific GG indicators in health systems; Kabongo and Mbonigaba (2024) investigated the moderating role of governance in public health spending by simultaneously assessing three dimensions of governance (corruption control, government effectiveness and voice accountability).

Zeini and Okasha's article builds on the previous research, with their main findings being consistent with conclusions from other studies: all the GG principles significantly and positively affected the implementation of GG in the Ministry of Health and Population in Egypt; the transparency and accountability principles had the highest impact on overall GG implementation, followed by the rule of law and equity and efficiency principles. The authors also revealed that the self-governance principle had the least impact on GG implementation (Zeini and Okasha, 2025).

A review of methodological approaches to research the impact of governance principles on public health outcomes (Arifah and Juni, 2019) concluded that qualitative, quantitative and mixed-methods designs have been used, each with distinct strengths and limitations: "the qualitative design is contextual yet difficult to generalize; the quantitative design is generalizable yet very explicit to certain indicators specified, while the mixed-methods design is comprehensive but requires more resources to carry out." It was also underscored in that review that mixed-methods research might produce policy-relevant knowledge that could assist policymakers.

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While working on this review, the following AI tools have been used: ChatPDF (ChatPDF GmbH, Germany) for extracting main themes from articles and Elicit.ai (Elicit Research, PBC, United States) for establishing broader context and research trends. The author takes full responsibility for the content of this publication.

Zeini and Okasha used quantitative design and employed structural equation modeling to analyze the relationships among various principles of GG. As a conclusion, they provided recommendations for different groups of stakeholders:

(1) For researches: to increase focus on assessing GG at the micro-level of public organizations and its relationship to national-level GG and sustainable development and to conduct similar studies on other public institutions to compare and identify key enablers for promoting GG nationally;

(2) For health services providers: to conduct periodic follow-up assessments of GG implementation in public organizations through surveys of end-users and service recipients and to clearly define the roles of each unit within the organization to ensure their independence and promoting greater communication, consensus, cooperation and coordination among the units.

(3) For policymakers: to incorporate additional objective and subjective principles and indicators to provide more insights into the implementation of GG principles in public organizations and to propose a national GG model for assessing implementation progress using national indicators and considering the potential and opportunities for promoting GG.

The limitation of this research is that it included only employees of the Ministry of Health and Population, without including service recipients and other stakeholders.

Making health systems responsive to the needs of people with disabilities

The next article follows neatly after the previous one, as its focus is on one of the principles of GG in health systems – specifically its responsiveness. "*Health system responsiveness from perspective of people with disabilities in west of Iran: a quantitative study*" (Piroozi *et al.*, 2025) utilizes the World Health Organization's (WHO) framework for health system responsiveness (HSR) as its foundational model. This framework emphasizes the importance of responsiveness as a key component of GG in health systems (Darby *et al.*, 2003).

The aspects of HSR, from the perspective of people with disabilities, have been researched previously in various countries as well as in other regions and types of health care facilities in Iran, as it is a significant issue globally. The conceptual framework on HSR to people with disabilities proposed by Mirzoev and Kane (2017) sees "people's expectations from and the experience of interactions with their health system along eight domains, and recognizes that both health systems and community side factors (e.g. actors and processes) shape these expectations and experiences" (Nguyen and Kane, 2024).

For example, recent studies have found that disabled older adults experience significantly lower HSR compared to non-disabled peers in several low- to middle-income countries (Rahman *et al.*, 2019). Prior research in Iran has focused on HSR among different population groups and reported that responsiveness is a critical issue, with specific dimensions such as communication and social support being identified as areas needing improvement (Alavi *et al.*, 2018). These studies often emphasize the need for health systems to be more attentive to the unique needs and expectations of these groups to enhance their healthcare experience. Still, the authors of a recent viewpoint (Nguyen and Kane, 2024) argue that attention to and discussions on HSR for people with disabilities remain lacking.

The significance of HSR for people with disabilities, *according to the authors* (Piroozi *et al.*, 2025), lies in several key aspects*:* meeting unmet healthcare needs; the importance of non-clinical aspects (such as communication, dignity and autonomy, which are vital for enhancing the quality of care and satisfaction among individuals with disabilities); impact on health outcomes (improving responsiveness, particularly in dimensions that are perceived as weak, can lead to better health outcomes) and cultural and economic challenges (people with disabilities face numerous physical, cultural and economic barriers in accessing health

services). The authors underscore that in Kurdistan province, over 75% of health needs for these individuals remain unmet.

The study results generally support previous research findings regarding HSR in relation to the experiences of people with disabilities. The key points of alignment and contrast with earlier studies are:

(1) *Importance of responsiveness:* the current study found that all dimensions of HSR were deemed important by people with disabilities, with over 80% of participants reporting this perspective, which aligns with previous research.

(2) *Weaknesses in communication:* the study identified communication as one of the weakest dimensions of responsiveness, which is consistent with findings from other studies.

(3) *Regional variations:* the study notes that the specific challenges faced by individuals with disabilities in the Kurdistan province may differ from those in other regions or countries due to cultural and economic factors, which highlights the need for localized approaches to improving HSR, and this is a theme echoed in other studies that emphasize the importance of context in healthcare delivery.

(4) *Unmet healthcare needs:* The study's findings regarding the high volume of unmet healthcare needs among people with disabilities in Kurdistan province are in line with global research that indicates similar trends in various countries.

Among the *new findings of this study* was "the low evaluation of the autonomy dimension by the participants, which may be related to the high prevalence of the patriarchal view governing the health services provision in the Iranian health system" (Piroozi *et al.*, 2025). The authors underscore that, in developing societies such as Iran, the paternalistic view is still prevalent in the health systems.

Several potential risks of bias are inherent to the chosen study design: self-reporting (reminder bias, providing socially desirable answers); generalizability (the study was conducted in two cities and several villages of Kurdistan province, which may limit the generalizability of the findings to the entire country); sampling method: the multi-stage sampling method used to select participants may also introduce bias – if certain groups of people with disabilities were underrepresented or overrepresented in the sample, this could affect the overall findings and their applicability to the broader population; response rate and participation: the study does not specify the response rate or any potential differences between those who participated and those who did not (if individuals with more negative experiences were less likely to participate, this could present a more favorable view of HSR).

The abovementioned biases highlight the importance of interpreting the findings with caution and considering the need for further research to validate and expand upon the results in different contexts and populations. Authors of a recent viewpoint (Nguyen and Kane, 2024) propose an agenda for action and research to enhance the HSR to the needs of people with disabilities, organized across "reimagined" six WHO building blocks: disability-responsive service delivery, disability-responsive health workforce, disability-responsive medical technologies, disability-responsive health management information systems (HMIS), disability-responsive financing, and disability-responsive leadership and governance. We would be definitely interested in publishing research on disability-responsive governance in health organizations and systems.

Relationship between colonialism, poverty and child health in Africa

The next article, "*A cross-comparative analysis of child poverty across sub-Saharan Africa: the case of Francophone and Anglophone African states*" (Fonta *et al.*, 2025), utilizes data from the Demographic and Health Surveys conducted between 2000 and 2019 involving

22 sub-Saharan African states. A rights-based framework was applied based on the SDG-updated methodology (Gordon *et al.*, 2003) to measure child poverty.

Available research suggests a complex relationship between colonialism, poverty and child health in Africa: poverty is strongly associated with poor health indicators in Africa, including infant mortality and life expectancy (Worku and Woldesenbet, 2016); global economic policies like structural adjustment programs proved to negatively impact child health in Sub-Saharan Africa by promoting market-driven healthcare approaches (Skosireva and Holaday, 2010), while income inequality shows limited correlation with health outcomes in Africa (Worku and Woldesenbet, 2016; addressing poverty emerges as a crucial step towards improving population health. Recent research from Africa claimed the colonial history to be a potential source of bias in artificial intelligence (AI) health systems (Asiedu *et al.*, 2024). Further research with new approaches is needed to fully understand the causal relationships between colonialism, poverty and child health in Africa.

Authors of the article under review (Fonta *et al.*, 2025) explain that their study differs from existing research in several ways: previous work was primarily focused on the adult population, while this study compares multiple aspects of deprivations among children in ex-British and ex-French colonies; previous studies focused on specific dimensions of underdevelopment (e.g. undernutrition), while this research bridges this gap by exploring multiple dimensions of child poverty, thus providing a more comprehensive view of the disparities between colonial legacies; also "unlike child poverty studies that combine different indicators into a single index, this research examined individual dimensions and indicators independently, allowing for a clearer understanding of how various aspects of child poverty vary between colonial origins." The authors argue that the method applied "avoids the potential drawbacks of composite indices, which can obscure the relative importance of certain deprivations" (Fonta *et al.*, 2025).

The main *findings of this article* are: children in Francophone African states experienced significantly higher risks of low medical access, low vaccine uptake and lack of formal education compared to children in Anglophone African states; both Francophone and Anglophone African states had critically high levels of sanitation and housing poverty, with over 70% of children deprived in these dimensions.

Based on these findings, the *authors formulated several policy recommendations*: to improve governance and establish robust institutions to enhance living conditions for households in Africa, regardless of colonial history; to address child poverty and improve living standards through a multifaceted approach involving careful planning, adequate resourcing and ongoing monitoring and evaluation of governance structures to ensure they are effective and aligned with household needs; to focus on improving public service delivery specifically in Francophone states, particularly in the health and education sectors, which appear to be less efficient due to their centralized governance systems.

The authors acknowledge limitations of their research: the cross-comparative approach limits the ability to make conclusive inferences about the causal relationship between colonialism and child poverty in health and education; a limited number of countries, especially Anglophone countries, in the sample may not fully represent all former French and British colonies (Fonta *et al.*, 2025). So, they are planning to repeat the analysis using a larger dataset from the harmonized multiple indicator cluster surveys, which would provide a larger number of countries.

The authors conclude that their study echoes Acemoglu *et al.*'s (2004) view that a country's progress is determined by the quality of its political and economic institutions and that "good governance can help establish robust institutions to enhance the living conditions of households throughout Africa, regardless of their colonial history" (Fonta *et al.*, 2025).

Medical dispute resolution mechanisms in China: medical experts vs judges

The next article, "*Medical judicial expertise: the real decision-maker in Chinese medical dispute litigation*" (Chen, 2025), investigates the role of medical judicial expertise in

determining medical malpractice responsibility in Chinese medical dispute litigation and how it interacts with the judge's own legal opinions.

In recent years, the number of medical malpractice tort liability cases in China has increased, and the legal mechanism for medical malpractice dispute resolution has evolved significantly, shifting from an administrative-led system focused on disciplinary functions to one based on civil laws emphasizing compensation for injuries; therefore, to ensure fairness and justice of verdicts, "China has established a 'dual-mode' structure of two third-party authentication organizations, the Medical Association Identification and the Judicial Appraisal Institution" (Yang *et al.*, 2024).

The involved processes and the effectiveness of the established system have been actively discussed by Chinese scholars. Liang *et al.* (2021) concluded that "different choices between appraisal institutions affect malpractice litigations in China," and thus, "medical appraisals in the judicial system could be a source of inequality in China's medical litigation outcomes." Cheng *et al.* (2022) conducted a comparative study on Medical Association Identification Rules of Medical Damage and Guidance for Judicial Expertise of Medical Malpractice and explained specific roles of medical associations and judicial authorities in determining medical malpractice responsibility in China. Weng (2023) discussed the role of medical expert opinions in determining medical liability and explored how to solve the legal dilemma of identifying medical liability in China from three perspectives: perfecting the formation and adoption procedures of expert opinions, standardizing the identification of fault by medical institutions and standardizing the application of the rules of reducing liability for the cause.

The article under review (Chen, 2025) used data from the Chinese Judgments Online (though admitting that the dataset is not fully comprehensive, as it only publishes a portion of the judicial documents made by Chinese courts). The author's aim was to enhance understanding of the dynamics of medical malpractice litigation in China, address existing challenges and propose potential solutions to improve the resolution of medical disputes for all stakeholders involved (specifically after the State Council of the People's Republic of China adopted the new Regulation on the Handling of Medical Accidents in 2022).

The article (Chen, 2025) *presents interesting findings*, which align with previous research:

(1) High reliance on medical judicial expertise in the litigation process (85%), which helps to standardize the judicial criteria for determining malpractice responsibility and also constrains judges' discretion, as this reliance can lead to contradictions between the factual findings of the case and the legal conclusions drawn by judges*;*

(2) *Judicial discretion and compromise:* judges often face challenges when their conclusions differ from those of medical experts. In such cases, judges may have to compromise their judgments, which can result in limited compensation awards that do not align with the expectations of the parties involved;

(3) Discrepancy in compensation between what the patients seek and what they actually receive (often less than half of the compensation they request);

(4) Divergent perceptions of medical malpractice responsibility between patients and medical institutions contribute to ongoing tensions in doctor–patient relationships and suggest that the current legal framework may not adequately address the needs and expectations of both parties;

(5) *Potential of medical mediation:* The study suggests that medical mediation could serve as a promising alternative to litigation, as a significant percentage of medical disputes are resolved through mediation, which offers a higher success rate and more flexible procedures compared to traditional litigation.

These findings underscore the complexities of medical malpractice litigation in China and highlight the need for reforms and alternative dispute resolution methods to enhance the effectiveness and satisfaction of the process for all parties involved.

The author (Chen, 2025) also calls for further empirical research to better understand the trends and effectiveness of medical malpractice litigation considering recent legal changes and suggests that ongoing analysis is necessary to adapt to the evolving legal landscape and improve dispute resolution mechanisms. It is interesting that though many authors underscore that the legal system and malpractice litigation established in China are very specific, there are others who argue that China can learn from other countries (Yin *et al.*, 2019) and that comparing China's system with those of other nations could provide insights for improving medical dispute resolution mechanisms globally (Zhang *et al.*, 2022).

A new approach to standardize identification opinions is suggested in a recent article by Chinese authors, who explore the feasibility and validity of machine learning models in determining causality in medical malpractice cases, thus trying to increase the scientific rigor and reliability of identification opinions (Yang *et al.*, 2024). Those authors explain that "the machine learning prediction model formed by the modeling of a large amount of data can represent the mainstream opinion of most experts to a certain extent, which provides a basis for judges to compare. In this way, judges are no longer bogged down with a lot of medical knowledge and only need to compare the results of models with those of experts." And while the first results look promising, the authors admit that the main problem is that "clear regulatory and legal frameworks for the use of machine learning in the justice system are lacking" (Yang *et al*., 2024). New governance tools and approaches to emerging technologies are needed (Ibragimova and Phagava, 2024), and we would be interested if specialists engaged in emerging technology governance efforts related to health and health care shared their progress, experience and insights in our journal.

Indebtedness of Portuguese hospitals

Authors of the next article – "*Financial challenges in Portuguese hospitals: debt influences*" (Neves and Carolina, 2025) – looked at how debt influences efficiency and access in the national health system and assessed whether the determinants vary according to debt maturity using three measures of indebtedness.

Hospital indebtedness is not a specific Portuguese problem, and several recent studies have examined the determinants of hospital indebtedness across Europe (e.g. Dubas-Jakóbczyk *et al.*, 2024; Miszczyńska and Antczak, 2024). Prior research indicates that Portuguese hospitals perform better in terms of access but struggle with efficiency and productivity, suggesting resource waste and raising concerns about management practices (Matos *et al.*, 2021).

The authors of the article under review argue that understanding debt influences and management is crucial for addressing ongoing debates about Portugal's national health system (Neves and Carolina, 2025). *The study results* show differences in the sign and significance of the variables determining total indebtedness across short-, medium- and long-term debts. *The study's main findings* are: Portuguese hospitals are highly dependent on external, particularly short-term, funding; factors specific to the hospital sector, rather than macroeconomic factors, are the main determinants of indebtedness; hospital size and liquidity are the most significant factors influencing debt levels, with larger hospitals able to take on more medium-/long-term debt, while more liquid hospitals rely less on short-term debt. It provides novel insights into how debt is structured and managed in an environment characterized by centralized state funding, alongside complex operational and infrastructural demands. As such, this research contributes to a deeper understanding of the financial dynamics at play in public healthcare systems, particularly within the framework of the Portuguese NHS.

The authors underscore that their findings could be of practical use for different stakeholders: hospital managers (by providing insights into appropriate debt maturity to avoid

excessive short-term financial pressures, identify and mitigate financial risks and better handle economic adversities); investors (knowing how to identify the debt profile used can directly affect investments in new infrastructure, equipment and medical technology, conditioning the perception and long-term credibility of the potential investor who, being satisfied, can guarantee better financing conditions in the future); policymakers (by understanding the determinants of debt maturity in hospitals, they can develop more informed strategies to improve the financial management of these institutions, thus promoting a more resilient and sustainable health system) (Neves and Carolina, 2025).

The authors also recommend further research by analyzing data from public and private sectors separately (which was not feasible in this study) and by including other countries with similar institutional characteristics for comparison.

Enrollment in the national health insurance program

The next article, "*Enhancing willingness and enrollment in the National Health Insurance Program in Madhesh Province, Nepal*" (Adhikari *et al.*, 2025), addresses the barriers to enrollment in the National Health Insurance Program (NHIP), which was introduced in 2015, by identifying and analyzing contextual factors that hinder household heads' willingness to enroll. The author argues that high enrollment could reduce out-of-pocket payments and contribute to universal health coverage in Nepal.

This study is also interesting as the first quantitative attempt to understand the perception of comparative healthcare quality in India by the residents of Nepal's bordering regions. Historically, people in these border regions have sought medical care in nearby Indian cities, a pattern dating back to the British colonial era. The study under review revealed that more than half of the household heads in the study perceived Indian healthcare to be superior to Nepalese services (Adhikari *et al.*, 2025).

A systematic review (included the research published till 2013) investigated factors affecting the uptake of community-based health insurance schemes in LMICs (Dror *et al.*, 2016). The review authors produced detailed results based on meta-analysis and thematic analysis: education, age, female household heads and the socioeconomic status of households positively affecting enrollment; individuals who understand how their insurance scheme functions are more likely to enroll, and when people have a positive claims experience, they are more likely to renew; trust in the scheme also enables enrollment, and clarity about the legal or policy framework acts as a factor influencing enrollments. A higher prevalence of chronic conditions or the perception that healthcare is of good quality and nearby act as factors enhancing enrollment. The perception that services are distant or deficient leads to lower enrollments (Dror *et al.*, 2016).

The findings of the study under review (Adhikari *et al.*, 2025) align with prior research from other countries and other districts of Nepal:

(1) Higher willingness to enroll in urban areas – household heads in urban areas had a higher willingness to enroll compared to those in rural areas due to better access to healthcare services and information.

(2) Impact of knowledge on enrollment – these findings are supported by prior research from Nepal and Ethiopia (Acharya *et al.*, 2019; Adhikari *et al.*, 2020; Atafu and Kwon, 2018).

(3) Socioeconomic factors – higher monthly income was associated with a greater willingness to enroll, and wealthier households often have better access to information and resources, which increases their likelihood of enrolling in health insurance programs;

(4) Presence of chronic diseases as a significant predictor of willingness to enroll, a phenomenon known as adverse selection.

(5) Perceived susceptibility and health behaviors: individuals who perceive themselves at higher risk for health issues are more likely to engage in health-seeking behaviors, including enrolling in health insurance.

The study provides actionable recommendations for policy improvements aimed at overcoming the identified barriers to NHIP enrollment: to increase the availability of enrollment assistants, to improve the healthcare packages offered under NHIP and to develop and implement targeted interventions to improve health insurance literacy.

Co-participation in health

The next article, "*Exploring co-participation in health: strategies and initiatives towards inclusive well-being*" (Traub and Kovacevic, 2025), is a literature review of research published between 2004 and 2024.

What are the key elements that facilitate co-participation strategies in service delivery and health program implementation? *The authors conducted* a general literature review to comprehensively explore the role of co-participation in health, drawing on scholarly publications and real-world examples to identify key factors that contribute to successful health interventions. A total of 50 published resources were included and a descriptive analysis was performed, with a focus on summarizing theoretical models and research findings, highlighting key themes, and practical strategies.

Several frameworks have been developed to enhance co-participation in health initiatives. The Health Promotion Community Participation Framework proposes using levels of participation across a continuum, emphasizing capacity building at organizational and community levels (Llewellyn-Jones and Harvey, 2005). The "family of community-centered approaches for health and well-being" organizes evidence into four main groups: strengthening communities, volunteer roles, collaborations and resource access (South *et al.*, 2017). For co-creation in public health interventions, recommendations include early implementation considerations, systems thinking and partnering with stakeholders (Longworth *et al.*, 2024). A modified stakeholder participation assessment framework for design thinking in health innovation integrates evaluation tools into the design process, using a five-point continuum to assess stakeholder involvement in decision-making (Hendricks *et al.*, 2018). These frameworks aim to improve community engagement, evidence-based practice and the effectiveness of health interventions through enhanced stakeholder participation.

The authors of the article under review (Traub and Kovacevic, 2025) highlight and analyze the following ten key variables that impact health co-participation: socioeconomic and political context, power dynamics, geographical issues, cultural and social issues, community needs awareness, communication mechanisms, capacity and empowerment, peer-based training, technological tools and sustainable financing.

To illustrate co-participation strategies in public health, *the authors analyze two initiatives* within the Spanish context (Andalucía Region). The first initiative, based on self-management and self-care premises, is the Network of Health Schools for Citizens. Initiated by the Ministry of Health, Social Services and Equality of Spain, it provides patients, caregivers and family members with relevant, up-to-date, accessible information and training tools, empowering them to make informed decisions. The second example is the "Local Health Action Network" (RELAS), which illustrates how civil society and other stakeholders' engagement contribute to improving the community's health. RELAS is led by the Andalusian Health Department, aiming to promote health at the local level by enhancing behaviors and safer environments, focusing on social determinants of health. Municipalities lead coordinated public-private efforts, involving citizens to safeguard population health and improve lifestyles.

The authors concluded that:

(1) Co-participation is a critical component of resilient, inclusive, and responsive health systems.

(2) A combination of factors significantly influences the success of community engagement initiatives in health;

(3) Power dynamics significantly shape stakeholder engagement in health governance, affecting decision-making processes, resource allocation and the overall inclusivity and equity of health initiatives.

(4) Engaging communities in health initiatives enhances their awareness, promotes behavior change and empowers individuals, leading to improved health and social outcomes, with education initiatives at different community levels being particularly effective; successful co-participation health programs must be tailored to local contexts.

(5) Co-participation in health initiatives has been shown to lead to positive health outcomes, as communities are best aware of their needs, and their proactive engagement ensures that resources are prioritized effectively.

(6) Establishing local health plans and promoting governance decentralization are highlighted as strategies that can enhance health management and improve outcomes for non-communicable diseases.

Mental health governance in the context of online social networks

The viewpoint is a "Framework for detecting, assessing and mitigating mental health issue in the context of online social networks:a viewpoint paper" (Roggendorf and Volkov, 2025) is an outlier not only for this issue but for the *IJHG* as a whole in several ways. This journal rarely publishes research on mental health governance, though we consider it a very important theme to investigate. And the Viewpoint is also the first article in this journal that discusses the role of AI in health. The authors highlight the integration of advanced technologies like machine learning (ML), deep learning and AI to address the dynamic challenges posed by social networks.

Recent research has focused on developing frameworks to detect and assess mental health issues in social networks. These approaches leverage machine learning and big data analytics to analyze user behavior and content, potentially enabling early identification of mental health problems. Yang *et al.* (2020) proposed a framework that incorporates syntactic and pragmatic features to detect depression in social media users. Shuai *et al.* (2018) introduced the Social Network Mental Disorder Detection (SNMDD) framework, which uses multi-source learning and a tensor model to identify various mental disorders related to online social networks (OSNs). Taghvaei *et al.* (2021) presented an analytical framework for mental health feature extraction methods in social networks, providing a comprehensive classification of existing approaches. These studies demonstrate the potential of using social media data to detect mental health issues, offering new opportunities for early intervention and improved diagnostic processes in clinical settings. As it is stated in a recent viewpoint (Malgaroli *et al.*, 2025), "the integration of LLMs into mental health care presents important challenges, yet the opportunities they offer in enhancing research and care delivery are substantial".

The originality of the framework proposed in the *article under review* (Roggendorf and Volkov, 2025) is that it is based on a synergy of various methods. The framework emphasizes the importance of integrating causal methods with ML and using causal inference (CI) techniques. This synergy enhances the reliability and effectiveness of technological methods for detecting and assessing mental health issues, allowing for a more nuanced understanding of the relationships between symptoms and causes. The framework is designed to flexibly respond to significant dynamics in OSNs, particularly in identifying external threats to mental health from negative factors and processes. This adaptability is crucial in the rapidly evolving digital landscape. The framework aims to help in establishing evidence-based relationships between symptoms and causes in mental health diagnostics. By successfully integrating causal methods, it can provide deeper insights into how specific factors in OSN impact users' mental health.

The authors underscore the influence of social networks as a social determinant of health, particularly for adolescents. The proposed framework contributes to the following sub-functions of health governance (in the context of mental health issues): Generating information/intelligence (by using new tools and methods for gathering real-world data and for conducting research) and organizational adequacy (integrating new technologies for improving the reliability of mental health assessments and interventions).

The authors believe that the framework should continue to evolve, incorporating new challenges and technologies as they arise, which will maintain its relevance and effectiveness in addressing mental health issues in the context of OSN.

A viewpoint recently published in *The Lancet Digital Health* (Malgaroli *et al.*, 2025) predicts that "governmental policies will greatly shape how LLMs are accessed across different regions and their ethical governance [. . .] Accountability should be enshrined in policy, establishing the differential responsibility of developing and deploying organizations in implementing safeguards, addressing adverse outcomes, and evaluating alignment with public health goals." *IJHG*, as a journal oriented to those concerned with policymaking and governance, is looking forward to publishing more research to answer those challenges.

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