Journal of Current Research and Studies

Volume 02 Issue 06 Nov-Dec 2025
https://journalcurrentresearch.com/
ISSN:3048-9911

OPEN ACCESS

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Article Received
26/11/2025
Accepted
04/12/2025
Published
20/12/2025

Works Cited

Comfort Iregbenosi ADAMS, (2025). World Health Organisation, Mental Health Diplomacy and The Protection of Mental Health in Africa. *Journal of Current Research and Studies*, 2(6), 45-59.

World Health Organisation, Mental Health Diplomacy and The Protection of Mental Health in Africa

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Abstract

The World Health Organisation (WHO) played an active role in mental health advocacy, diplomacy, protection and promotion in Africa. The WHO as an international organisation has engaged with state and non-state actors in the African continent on policy frameworks, diplomatic strategies and collaborative initiatives to address mental health. The study objectives were to assess the WHO's strategies and methods in engaging with mental health diplomacy in Africa; evaluate the effectiveness and outcomes of WHO's policies and initiatives in protecting mental health in Africa and identify the challenges faced by the WHO in promoting mental health diplomacy in Africa continent. A qualitative approach was adopted that relied on content analysis of WHO reports, policy documents and existing literature on mental health diplomacy in Africa. The theoretical framework of Constructivism was blended with global health governance to analyse how WHO's strategies align with the health systems in Africa and how they interact with state and non-state actors to influence mental health policies and interventions in the African continent.

The findings show that the WHO made some progress in advocating for mental health and strengthening mental health systems in Africa but its efforts are affected by systemic issues such as; socioeconomic disparities, cultural barriers, poverty, political instability and weak health infrastructure within the African continent. These factors impede the full implementation of WHO strategies and also, the positive outcomes of WHO's initiatives in terms of policy development in the area of mental health in Africa. The study recommends that African nations should collaborate on mental health programs, integrate mental health into security policies and enhance cross-country policies in the region. It also urges leveraging health diplomacy for funding, promoting telehealth for remote areas, increasing mental health funding and implementing awareness campaigns and monitoring frameworks to assess programs effectiveness in the rural and urban areas of the continent.

Keywords

WHO, mental health diplomacy, Africa, mental health policy, global health governance, socio-economic disparities.

Introduction

Public health and the protection of mental health stand at a critical juncture as both state and non-state actors look for ways to address the various challenges

posed by mental health and how to ensure that people with mental health issues are adequately protected within the state and the international system. Mental health conditions affect individuals in the state and international system, imposing significant burdens on healthcare systems and undermining the well-being of communities (World Health Organisation. 2003; 2015; 2017; 2022). The core goals of the UN in the aspect of the Sustainable Development Goals (SDGs), serve as a blueprint for achieving sustainable health development and fostering inclusive societies (Rasche, 2020; Sustainable Development Goals; 2023). The World Health Organisation, an organ of the UN that was formed in 1945, has the sole responsibility of maintaining the world health system within the international system. The WHO directed its efforts towards mitigating the devastating impact of the HIV/AIDS virus on the global healthcare system. However, the evolving global system of the 21st century necessitated novel approaches to tackle health challenges. The role of health issues in international politics is the active engagement of civil society in global health diplomacy (Adams et al., 2008). The WHO's overarching mission in the international arena is to advocate for the highest attainable standard of health for all persons, irrespective of various demographics or social factors. Furthermore, the WHO (2017), functions are; guiding and coordinating international health policy, conducting research, establishing norms, offering technical assistance, and monitoring global health trends and transformations. However, the organisation aims to forge a healthier future for people, with particular attention to the challenges faced by third-world countries within the international system (World Health Organisation, 2006).

The aftermath of World War I marked a major turning point in the realm of diplomacy, prompting a shift from old diplomacy to new diplomacy. With states increasingly recognising their interdependence and seeking popular support, the European and colonial wars started as stark reminders of the inadequacies of traditional diplomacy. The failure of classic diplomacy to avert conflicts spurred social, political, and other discourses that needed reform in the global system. Governments mobilised public opinion to garner support for wartime endeavours, but this momentum soon transformed into a catalyst for reform. Advocates from diverse political backgrounds, including the peace movement, championed the idea of more transparent diplomacy subjected to international and domestic legal frameworks. Their collective call emphasised diplomacy's role in fostering peaceful conflict resolution and preventing future wars. Thus, the post-World War I era witnessed a growing consensus that diplomacy be more accountable, law-abiding, and oriented towards peaceful resolutions (Berridge, 2022). Diplomacy thus, is the process of negotiating and maintaining relations between states, through formal channels such as diplomatic missions, treaties, and summits. It is a wide range of operations intended to advance a country's interests, settle conflicts, and encourage collaboration on a variety of global concerns. Traditional diplomacy was primarily concerned with statecraft, such as territorial conflicts, economic deals, and military alliances (Hart and Siniver, 2020). However, in today's world of expanding globalisation, diplomacy has developed to meet a larger range of challenges, in the area of environmental concerns, human rights issues, and public health crises (Katz et al., 2011). Diplomatic protection is a principle in international law that permits a state to act on behalf of its nationals in cases where they experience harm from foreign states, ensuring their rights under international law are upheld; this also constitutes an establishment and a duty (International Law Commission 2006). The transformation has been reinforced in the negotiation and adoption of the Sustainable Development Goals (SDGs), and the increasing importance of global crisis diplomacy. In the international system, Health diplomacy is a type of diplomacy resolving health-related issues through international negotiation. Furthermore, diplomacy entails the efforts to promote global health equity, limit disease transmission, and ensure equal access to healthcare for all communities (Kickbusch et al., 2021). Health diplomacy functions at the nexus of health policy, international relations, and diplomacy, on a wide range of stakeholders such as governments, international organizations, non-governmental organizations (NGOs), and civil societies. The main objectives of health diplomacy in international politics in promoting the interchange of medical expertise and resources between states, negotiating health-related accords, and lobbying for global public health policies (Afshari et al., 2020).

Mental health (MH) on the other hand emerged as one aspect of healthcare, that has drawn global attention as an evolving concept derived from health literacy (HL). Observations of poorer health outcomes linked with inadequate general literacy, HL include the ability to comprehend and utilise health information effectively for treatment engagement. This expansion of HL has led to the conception of MH, characterised by persons' knowledge and attributes concerning mental health, facilitating the recognition, management, and prevention of mental illness. MH has been delineated into four components: understanding how to attain and uphold good mental health, comprehending mental disorders and their management, mitigating mental health-related stigma, and enhancing the help-seeking behaviour

of an individual. (Kutcher et al., 2014; Chao H-J et al., 2020; Miles et al., 2020). However, mental health systems primarily concentrate on diagnosis, medication, and symptom alleviation, often disregarding the impact of social determinants on individuals' mental health (World Health Organisation, 2000; Compton and Shim, 2015; World Health Organisation, 2022). In similar, Onyemelukwe, (2016), asserts that discrimination and violations against persons with disabilities persist within mental health care and support services at the state and international systems. In most third-world countries, people are denied care based on characteristics such as race, gender, sexual orientation, age, disability, or socioeconomic status. Others endure substandard services and deplorable living conditions, lacking access to necessities like safe water and sanitation. Also, women, girls, and individuals with diverse sexual orientations, gender identities, and expressions are subjected to harmful practices such as forced sterilisation, coerced abortion, and conversion therapies. In many social settings; the social, economic, and environmental factors determine a person's mental well-being and rights. This manifestation takes various forms, leading to disparities and human rights violations in such social systems of such countries. The marginalised populations in third-world countries often experience disproportionate levels of poverty, discrimination, and violence, exacerbating their vulnerability to mental health disorders and impeding their access to adequate care (World Health Organisation, 2000; Compton and Shim, 2015). The COVID-19 pandemic has exacerbated the issues of mental health and violations, amplifying stress, anxiety, and depression on a global scale (Ho and Moscovitch, 2022; Lewis et al., 2022). Lockdowns, social isolation, and economic disruptions intensified feelings of loneliness and despair, particularly among vulnerable populations (Lewis et al., 2022). Moreover, the pandemic disrupted mental health services and exacerbated disparities in access to care, further marginalising already vulnerable communities (Diaz et al., 2021).

Many studies have examined the various aspects of mental health at the individual, state, and international levels. Mental health diplomacy within the international system is an important aspect of human rights that needs collaboration among states and non-state actors. However, Mental health over time has remained one of the health challenges in Africa, people in Africa as a continent are affected by limited resources, inadequate infrastructure, bad governance, and a poor healthcare system (WHO, 2019; Peatel Et al., 2018). The COVID-19 pandemic challenges in Africa, placed a strain on the fragile healthcare systems and increased the incidence of mental health across different countries within the African continent (Kola et al., 2021; Gureje et al., 2020).

The World Health Organisation (WHO) plays a major role in advocating for mental health through its diplomatic efforts aiming to integrate mental health into broader public health agendas and promote effective policies and interventions (WHO,2020; Mendenhall et al., 2021). The state actors, the WHO and other non-state-actors face several challenges in the fulfilment of their roles and mandates of protecting human health at the state level and the international system, literature has some of these factors as; political, financial, legal, and institutional factors as well as competing interests and agendas among actors. However, within the existing literature, there is a gap in understanding how the WHO's mental health diplomacy among states within the international system has contributed to protecting and promoting mental health in Africa. This study therefore seeks to address the impacts of WHO's mental health diplomacy on mental health person in Africa, in the wake of COVID-19 and the post-pandemic. The main objective of this study is to examine the role of the World Health Organisation (WHO)'s mental health diplomacy and the protection of mental health in Africa with a focus on the period from 2020 to 2024. The other objectives of this research are: to examine WHO's strategies and methods in engaging with mental health diplomacy in Africa; to evaluate the effectiveness and outcomes of WHO's policies and initiatives in protecting mental health in Africa; to Identify the challenges faced by the WHO in promoting mental health diplomacy in Africa, with a focus on the COVID-19 pandemic; and propose recommendations.

Literature Review

Several literatures discussed the role of the World Health Organisation in Global Health, since the end of World War II, the establishment of the World Health Organisation (WHO) has emerged as a powerful arm of the UN, responsible for global health governance. Gostin et al. (2015) assert that the task of the institution is to promote health equity and combating disease worldwide, WHO experienced both triumphs and setbacks in its mission. Furthermore, Gostin et al. note that in the nineteenth century when early policies in epidemic illness prevention laid the framework for worldwide public health collaboration. However, the establishment of the WHO's principles in 1948 constituted a watershed point in global health policy. However, unlike its predecessors, the WHO took an innovative approach to illness prevention

and treatment, envisioning a comprehensive organisation with a wider scope than previous health policies/institutions within the international system (Gostin et al., 2015). Furthermore, The WHO's mission is to supervise and coordinate worldwide health efforts, establish standards, by providing technical assistance, and manage disease outbreaks. Its influence extends beyond policy direction to include the creation and delivery of vital health commodities such as vaccinations and diagnostics. However, the institutional mandate as well as the accomplishments made so far as being questioned by scholars (WHO), the orientation and ability to adapt to changing health landscapes, in terms of budget limits and the global dynamics in public-private partnerships (Brown et al., 2006; Gostin et al., 2015).

According to Reid and Pearse, (2003), the WHO has served as an important advocate in battling transmitted illnesses, developing national health systems, and tackling a wide range of medical problems in developed and developing Nations of the world; health education also in the preservation of the environment within the global system. However, the Ebola outbreak showed the difficulties most of the developing countries of the world confronts in efficiently managing the complex global health challenges (Saxena and Gomes, 2016). The necessity for a strong WHO as an institution with a broad mandate to attain the best possible level of health for all remains a focus of ongoing talks about the WHO's future in the international arena (Vonderheid and Al-Gasseer, 2002; Reid and Pearse, 2003). The WHO recorded greater great achievements in some areas; in eradicating smallpox and establishing legally binding tobacco in mostly the developing nations in the global system, the organisation performance is always closely scrutinised, during severe infectious disease outbreaks as stated (Packard, 2016). The WHO's role in crises during the SARS outbreak, the H1N1 influensa pandemic, the Ebola outbreak, and the COVID-19 pandemic have brought about several arguments over the organisation's efficacy, reactivity, and leadership. Scholars such as (Fidler, 2003; Fineberg, 2014) have investigated apparent weaknesses, in areas where the WHO is slow also in terms of poor crisis management. Chow, (2010), argues that the WHO's performance is inextricably linked to a reform, asking for structural changes to address systemic shortcomings of the institution within the countries in the global system.

Galderisi et al. (2015) assert that mental health is characterised ability to cope with normal life stresses, workplace productively, and contribute to the community where someone lives; however, this assertion is challenged by Keyes, that mental health should not be equated solely with positive emotions or functioning only of a person (Keyes, 2007). Galderisi et al. (2015) added to the existing studies about mental health, by arguing that the most important facts about mental health are emotional well-being, psychological well-being, and social well-being of the individual, excluding individuals facing social challenges, and those who are unable to work productively due to various reasons at different workplaces. In a various cultural setting, cultural influences shaped the concept of mental health, and the need for a universal approach that acknowledges common elements important for mental health across different cultures (Galderisi et al., 2015).

In another study on the psychological well-being in adult life effects of mental health on the individual Ryff, (1995), asserts that mental health accounts for the complexity of human experiences and emotions, the recognition that positive emotions and functioning are not always indicative of good mental health. This assertion by Ryff, (1995) is supported by the World Health Organisation which states that mental health, is the ability to cope with life's stresses and contribute to the community. The surveillance of children's mental health in an underdeveloped country in the global south of the world is a concern in the international system, public health governance, etc. Furthermore, mental health disorders start in early childhood and affect children across various sociodemographic characteristics.

Furthermore, at the workplace, mental health determines the employee's well-being and productivity within the organisation. The WHO (2020) states also, that workplace policies should support mental health to reduce stress and provide resources for the workers. In a supportive working environment such as Employee Assistance Programs (EAPs) improve mental health outcomes (Attridge, 2019). The COVID-19 pandemic impacted people's mental health worldwide. The prevalence of stress, anxiety, and depression during the Covid-19 pandemic compared to pre-pandemic levels. The disruption of routine, isolation, and economic uncertainties affected the surge (Bower et al., 2023).

In most of the advanced democracies of the world, the issue of stigma remains a major barrier to people seeking mental health care. Fabbre et al. (2019) analyse how stigma leads to discrimination and social exclusion, preventing individuals with mental health challenges from seeking help. Also, Lorenzo-Luaces, et al. 2019), assert that Cognitive

Behavioural Therapy (CBT) is an established treatment for various mental health in the most advanced democracy. CBT's effectiveness in reducing symptoms of anxiety and depression in a person with mental health in a particular country. Reynolds et al. 2023) stated that in most of the developing and developed countries, elderly people face unique mental health challenges, such as isolation and cognitive decline. The level of depression among the world's elderly with mental health stands at 7% according to the WHO (WHO, 2022). However, Social support networks and community engagement activities are mostly used by some local communities to help the elders, and also, through the caregivers to give necessary support to the aged person with mental health in both developed and underdeveloped democratic states of the world system.

Kieling et al. (2011), asserted that the prevalence of mental health issues among young individuals worldwide is alarming, with approximately 10–20% experiencing depression. Poor mental health during youth has far-reaching consequences, contributing to adverse health outcomes such as substance abuse, social challenges like delinquency, academic struggles leading to school failure, and economic hardships associated with a higher risk of poverty. The critical role of positive psychology in empowering youth and equipping them with essential life skills to navigate life's challenges, and interventions promoting mental well-being are imperative. Comprehensive approaches involving families, schools, and communities have shown promising results in fostering positive physical and psychological health outcomes. Furthermore, the efficacy of preventive mental health interventions targeting both risk and protective factors associated with various mental illnesses. These interventions have shown promising results in mitigating the onset or progression of severe mental diseases such as schizophrenia, psychotic illness, bipolar affective disorders, as well as common mental disorders including anxiety, depression, and stress-related disorders. In recent years, novel approaches such as digital-based interventions and innovative therapies like adventure therapy, community pharmacy programs, and home-based nurse-family partnership programs have emerged as effective strategies for addressing mental health challenges (Marshall and Rathbone, 2011).

Singh et al. (2022) note that much of the existing literature on mental health interventions originates from high-income countries (HICs), and there is a growing body of evidence emerging from low- and middle-income countries (LMICs). Also, the study calls for developing locally suited interventions that effectively address the mental health needs of diverse populations worldwide, bridging the gap and practical implementation in LMICs. The promotion of positive well-being and resilience holds immense promise as a preventive strategy against mental illness and as a means of improving outcomes for individuals already affected. Integrating mental health promotion initiatives into healthcare systems and broader societal frameworks yields dividends in terms of reducing the prevalence and severity of mental health, thereby contributing to enhanced societal well-being and productivity.

Post-Cold War, public demand for involvement in foreign policy-making transformed diplomatic institutions and the role of diplomats (Kurbalija, 1999). Economic factors now largely influence the establishment of diplomatic missions (Stanzel et al., 2018). Modern diplomats operate in a realm of rationality, compromises, and complex arrangements known as peaceful relations (Shalikashvili, 1994). The expanding scope and volume of diplomatic work have led diplomats into technical areas, resulting in the transformation of diplomacy. Terms like dollar diplomacy, oil diplomacy, resource diplomacy, atomic diplomacy, health diplomacy, and global governance reflect these changes in the international system (Stanzel et al., 2018). Diplomacy has broadened its traditional politico-strategic focus on the evolving global environment (Stanzel et al., 2018). This transformation has pushed experienced diplomats into new territories, impacting their efficiency. Diplomacy is no longer confined to Ministries of Foreign Affairs; officials with specialised skills from various government sectors now engage in diplomatic activities within international organisations such as the UN, WHO, IMF, and World Bank (Stanzel et al., 2018).

Bilateral diplomacy is a mechanism to prevent the direct submission of a sovereign state's political leadership to another state's negotiation rules (Rana, 2018). This form of diplomacy minimises the perception of weakness and reduces the risk of international tension, allowing states to negotiate through an established framework with clear terms of reference. Diplomatic representatives, rather than Heads of State or Government, are positioned to make concessions during negotiations, which are then politically authorised by the respective leaders through formal agreements (Rana, 2018).

Goh, (2018) and Ba, (2020) argue that the shift towards multilateralism marked a departure from the dominance of bilateral diplomacy, through the advent of 'conference diplomacy. This transition facilitated the establishment of international organisations, providing a structured platform for state interactions. These multilateral structures necessitated the development of diplomatic protocols, permanent secretariats, and accredited missions at multilateral institutions, enabling a more organised approach to international relations.

Sullivan, (2018), states that the growth of multilateral diplomacy in the 21st century is due to the expanding membership of international bodies (UN General Assembly). This growth has introduced new management styles, lobbying practices, and the phenomenon of corridor diplomacy. Technological advancements and faster transportation have blurred the lines of sovereignty, challenging the traditional roles of states in managing international relations and transforming the practice of diplomacy (Onditi, 2023). International institutions (WTO, IMF, ITU, World Bank etc.) have enhanced the flow of goods, capital, and knowledge, transforming both the international economy and diplomatic practices.

Mental health diplomacy is an effort to bring mental health discourse or issues in the international arena or literature to the forefront for policy-making and academic exercise. According to Kienzler (2019), mental health diplomacy is the use of strategic interactions between states and non-state actors in the international system to address mental health disparities and promote the mental well-being of an individual through cooperation and policy frameworks set up by international bodies in the international system. Mental health as being integrated into the Sustainable Development Goals (SDGs) and the World Health Organisation's (WHO) policies reflects the growing recognition of mental health as a global health priority (Horton and Lo, 2015). The WHO's Mental Health Action Plan 2013-2020 further solidified the commitment to mental health by setting out specific objectives to improve mental health care services, integrate mental health into primary health care, and reduce stigma (WHO, 2013). These efforts have been crucial in framing mental health as an integral part of the global health agenda. The Global Mental Health Movement, since 2000s, has been instrumental in advocating for the mental health in global health discussions. This movement, influential scholars, the need for evidence-based policies and the integration of mental health into broader health and development strategies (Patel et al., 2011). Patel and Prince (2010), that the movement has not only increased awareness but also driven study and funding towards mental health, particularly in low- and middle-income countries (LMICs). Within the international communities, the Movement for Global Mental Health has become a force in advocating for the rights of people with mental health disorders and promoting equitable access to mental health.

Theoretical framework

This study adopts the constructivist theoretical framework to explain the main discourse of this study.

Constructivism was developed, made famous by two main scholars; Nicholas Onuf and Alexander Wendt. The theory foundations are found in philosophical and sociological traditions that stress the influence of ideas, social norms, and social institutions on how people behave. After the Cold War, constructivism gained popularity as academics looked for theories of international relations other than power politics. Constructivism as a theory is based on several presumptions; constructivism asserts that social constructs like norms, identities, and beliefs shape state conduct etc, in addition to more tangible considerations like economic or military interests. Also, the theory emphasises intersubjective interpretations, contending that actors' goals are derived from mutual within their social milieu. Furthermore, constructivism examines how actors' agency shapes global outcomes, that players alter or reframe pre-existing norms within the international system (Adler, 2013).

Constructivism theory is applied to the study "World Health Organisation, Mental Health Diplomacy and the Protection of Mental Health in Africa", thus, examining the norms, identities, and beliefs that influence the behaviours and language surrounding mental health within the group. Constructivism, according to Wendt, (1992), emphasises that socially constructed norms, as opposed to only material concerns, have an impact on state conduct. The WHO, common norms, among member states regarding mental health as a human rights issue impact mental health diplomacy in addition to tangible elements such as epidemiological data. Constructivism emphasises how intersubjective interpretations and meanings influence global results (Schwandt, 1994). Framework of mental health diplomacy at the World Health Organisation, individuals get their identities and motivations from mutual understandings within their

social milieu. Member states bargain over mental health policies and programs, for instance, based on their shared conviction that advancing mental health is an essential human right. Constructivism also emphasises how agents have the agency to question and alter established norms and systems (Flockhart, 2012). Member nations and other stakeholders' question conventional mental health practices and push for new standards and procedures that put social justice and human rights first in the framework of the WHO's mental health diplomacy. Constructivism has been criticised on several occasions, despite a good analytical framework for comprehending the social production of identities and norms in international relations. Critique is that it prioritises ideational elements over material concerns, which some academics contend ignores the influence of power and material resources on state conduct (Alexandrov, 2003). Furthermore, because constructivism occasionally assumes that actors' identities and interests are set in stone and cannot be altered, it has been charged as being unduly deterministic. Also, the use of qualitative approaches in constructivist analyses is common; nevertheless, these methods are challenging to operationalise and verify empirically in the study of individual actors within the international system, which causes problems with validity and generalisation (Alexandrov, 2003).

Research Methodology

The study employed a qualitative research design, to give a comprehensive analysis of the relationship between human rights and mental health diplomacy within the African continent and the role of the international community, the World Health Organisation toward mental health disorders in the international system. The complexity of the topic and the need for an exploration of relevant literature and documents, a content analysis approach was used for the study. This methodology enables us to systematically examine knowledge, theories, policies, and practices related to human rights and mental health diplomacy within the WHO framework in Africa and in the international system. The sources of data used for this study were literature, books, journals, magazines, articles, documentary materials, and the internet, which are searched through search engines such as Google Scholar, JSTOR, ResearchGate, academia etc. The method of analysis used in the study was content analysis, the content analysis of the documents and literature was to gather quality information that enables a thorough analysis of the subject that covers content analysis and discourse in the study.

Discussion of Findings

The interaction between health and foreign policy

The relationship between health and foreign policy is increasing in the globalised world system where there is interconnectivity of the states within the international system. Health issues that were previously considered the domain of national governance, are now recognised as global concerns that have influenced and being influenced by foreign policy decisions. The integration of health into foreign policy is driven by the growing realisation of the state and non-state actors that diseases and health crises transcend beyond the local territory into cross-national territory with bigger implications on international political and health stability, economic growth, and national security. Health diplomacy is a mechanism for addressing these cross-border health challenges that the cooperation between states and promoting global health security for the citizenry through local and international control systems (Kickbusch et al., 2007). One of how the international system of health and foreign policy intersect is through the concept of global health governance. Global health governance is argued to be the collective action of states and non-state actors in addressing health issues that have global implications (Dodgson et al., 2017). The rise of infectious diseases such as HIV/AIDS, SARS, and COVID-19 has changed the narrative for international collaboration in managing health risks in the international arena. These pandemics have shown the vulnerabilities of national health systems and the interconnectedness of global health that has prompted countries within the international system to adopt health measures within their foreign policy agendas (Fidler, 2005). Health increasingly become a tool of diplomacy within the international system with countries leveraging health policies to enhance bilateral and multilateral relations within the global arena.

Moreover, the global health arena has been strategically used as a form of soft power in foreign policy. Countries engage in health diplomacy by providing aid, expertise, and medical supplies to other nations during health crises in such states within the international system. This practice addresses immediate health needs and also, serves to enhance the donor country's image and influence on the global stage. During the pandemic, countries such as China and the United States engaged in various vaccine diplomacy in distributing vaccines to developing nations to boost their international standing (Ruger and Yach, 2014). These actions within the international system arena demonstrate how health is employed as a tool of influence in the global arena that has important implications for international relations and power dynamics for the states within the system.

The global health agenda is the form of the foreign policy priorities by some state actors in the international goals pursuit in the international system. International organisations such as the World Health Organisation (WHO) and the United Nations (UN) are responsible for coordination of global health, which this guided by the foreign policy interests of member states. The allocation of funding and resources for global health policies is frequently influenced by political considerations. Countries may prioritise when there is funding for diseases or health issues that align with their foreign policy objectives and leave other health needs underfunded. This is the complexity of aligning health and foreign policy goals that are competing interests and sometimes cause a negative impression of the efforts to address global health inequities (Labonté and Gagnon, 2010). The non-communicable diseases (NCDs) in the form of various cancers, diabetes, and cardiovascular diseases are prominent on the global health agenda this intertwines health and foreign policy. The rise of NCDs is linked to globalisation in form of the changes in diet, physical activity, and tobacco use contributing to the global burden of disease (Maiyaki and Garbati, 2014). To address NCDs within the international system this requires a multisectoral approach that involves health ministries and other sectors within the global governance: trade, agriculture, and education necessitating coordination between health and foreign policy (Beaglehole et al., 2011). The global response to NCDs illustrates how the foreign policy of states within the international system shapes health outcomes by influencing the environments in which people live and make health-related decisions.

Global Health and Global Governance Challenges

Global health as a new discipline within the global health international system is concerned with improving health outcomes in the global village to address health disparities and prevent the spread of diseases across borderlines within the global system. However, the governance structures that are operating in the international system that guide global health face numerous challenges, exacerbating the complexities of addressing global health issues effectively. The fragmented nature of global health governance is one of the most discussed challenges in the literature (Biermann et al., 2009; Spicer et al., 2020). Therefore, there are multiple international organisations, non-governmental organisations (NGOs), private sector actors, and states involved in global health policies to help in the coordination of it within the global system. This fragmentation is duplication of efforts, inefficient allocation of resources, and at times, conflicting priorities between health and economic objectives (Gostin and Sridhar, 2014). The lack of a cohesive governance framework makes it difficult to create unified responses in the face of the global health crisis. Most time the World Health Organisation input is not enough without the cooperation of the local state actors. There is an unequal distribution of the resources within the global system this serves as another challenge in global health governance the inequality in resource distribution between high-income and low- and middle-income countries (LMICs). Wealthier nations in the global governance system have a greater influence on global health decisions and the LMICs, which bear a significant portion of the global disease burden lack adequate representation in most of the discourse about their health system in the international organisation that is responsible for the global health such as WHO. This disparity affected the legitimacy and effectiveness of global health governance structures. The access of a LMICS state to essential medicines and vaccines remains an issue in the international system as demonstrated during the COVID-19 pandemic when wealthier countries secured vaccines early and the poorer nations found it extremely difficult with limited supply (Nhamo et al., 2021). This inequitable distribution reflects a challenge in the global system that affects the global governance structures to adequately address the needs of vulnerable populations.

The governance of global health in many instances is constrained by various political considerations and national sovereignty factors. Health, within the framework of global governance, is viewed as a domestic issue and conflict with global governance when national interests are at stake. Some countries within the international system resist

international health regulations or policies that they perceive as infringing on their sovereignty. During epidemics or pandemics, some governments are reluctant to share data or implement international recommendations for fear of economic repercussions or political instability in their local politics (Youde, 2012). The international political arena used to balance the need for global cooperation with respect for national sovereignty, however, it serves as a complex issue that continues to challenge global health governance. Climate change due to the activities of man within the international system represents a growing challenge to global health governance. The health impacts of climate change the form of the increased spread of vector-borne diseases and extreme weather events that is require coordinated international responses. However, the intersection of health and environmental governance complicates efforts to address these challenges effectively. Global health governance structures integrate climate considerations into health strategies, to allow the health systems to be resilient to the effects of climate change. This requires international cooperation and interdisciplinary approaches that involve health, environmental, and economic sectors working together within the system (Watts et al., 2018).

Covid-19 Pandemic and Health System

The COVID-19 pandemic unleashed a global health crisis that led to disruption and placed immense pressure on healthcare systems within the global system. One of the important aspects that has been overlooked in recent years among scholars, analysis, practitioners and government is the mental health of healthcare professionals. According to the World Health Organisation, mental health refers to a state in which persons realise their potential to manage everyday stresses or work productively and therefore, contribute to their communities' development. The COVID-19 pandemic is a test of this balance for healthcare workers who are at high risk for mental health challenges. The emotional toll on these workers is overwhelming many experience elevated levels of stress, burnout, anxiety, and psychological distress that are exacerbated by their constant exposure to the virus (Lai et al., 2020). The nursing profession within the global health governance arena is regarded as one of the most demanding healthcare roles and hits hard. Studies have shown that nurses face stressors from the fear of contracting the virus to concerns about the inadequate care system under extreme conditions. The pandemic worsened pre-existing issues: musculoskeletal problems and mental health concerns impact the quality of care provided to patients within the health structure in the international system (McGrath et al., 2003; Gonge et al., 2002). Healthcare workers in many states in third-world countries faced high levels of exhaustion before COVID-19 increased workload and emotional strain from managing the crisis led to greater burnout rates among the Nurses that work during this time within the international system (Lorente et al., 2020). The psychological impact of the pandemic on healthcare workers has long-term implications. Prolonged exposure to trauma witnessing the death of patients or colleagues results in symptoms of anxiety, depression, or any kind of post-traumatic stress disorder. Khanal agrees that early mental health interventions and continuous support structures help healthcare workers cope with these challenges in the face of future pandemics or similar crises (Khanal et al., 2020; Cabarkapa et al., 2020).

Impact of COVID-19 on Global Mental Health and WHO's Response Framework

The outbreak of coronavirus disease 2019 (COVID-19), declared a pandemic in March 2020 by the World Health Organisation (WHO), has had a profound negative impact on the health and socio-economic systems of countries worldwide (Nicola et al., 2007). This disease, caused by the novel severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), has infected nearly 17 million people and resulted in over 600,000 deaths globally (World Health Organisation, 2020). Measures to mitigate the disease, such as quarantine, isolation, curfews, lockdowns, and travel restrictions, led to income loss, disruptions to daily routines, and social isolation, all of which contributed to adverse mental health outcomes (Alradhawi et al., 2020).

The WHO reports that the most public mental health impact thus far has been an increase in stress, with predictions of a rise in depression use soon. A developed emotional epidemic curve suggests that without adequate interventions, countries will face two peaks of negative mental health consequences (Ransing et al., 2020). The first peak, characterised by heightened anxiety, coincides with the surge in COVID-19 cases. The second peak, which occurs in the post-pandemic period, includes a range of negative mental health outcomes such as Post-Traumatic Stress Disorder (PTSD), depression, suicide, complicated grief, and relapse in individuals with pre-existing disorders (Ransing et al., 2020).

Given the anticipated substantial burden of mental disorders due to the COVID-19 pandemic, it is prioritise the mental health response. The recently developed Mental Health Preparedness and Action Framework (MHPAF) offers a comprehensive guide for evaluating and directing mental health responses during the pandemic (Ransing et al., 2020). This framework, created by mental health professionals from all six WHO regions, was developed after it was recognised that the WHO Global Influenza Preparedness Plan (WHO-GIPP). The MHPAF comprises five interconnected components: (1) preparation and coordination, (2) monitoring and assessment, (3) reducing mental health distress and misinformation, (4) sustainability of mental health care services, and (5) communication.

The "preparation and coordination" component involve developing a mental health response plan, establishing COVID-19-specific mental health services, and training healthcare workers in psychological first aid. Psychological first aid is a supportive intervention that provides practical assistance to individuals in crisis, addressing basic needs such as food, water, and information. It also involves listening to individuals, helping them remain calm, and protecting them from further harm (Kenya Ministry of Health, 2020).

Monitoring and assessment require the creation of a mental health surveillance system to continuously collect data on the mental health of at-risk populations as well as the general population. A key role of this surveillance system is to reduce mental distress caused by misinformation by monitoring various media platforms for myths and countering them with accurate information. The sustainability of mental health care services focuses on securing adequate funding to mitigate the burden of mental health disorders during and after the pandemic (Ransing et al., 2020).

Mental Health Legislation and Human Rights in African

Mental health legislation has undergone several changes over the past 150 years, with its roots in Western law dating back to the Middle Ages and expanding during the nineteenth/twentieth centuries. This evolution paralleled the growing understanding of mental illness, shifts in treatment perspectives, and the development of human rights standards. The French Mental Health Law of 1838 and the English and Welsh Lunacy Act of 1890 were among the earliest and most influential modern efforts to regulate mental health admission. These laws entrenched paternalistic approaches and the concept of "dangerousness" in mental health, introducing procedures that authorised involuntary confinement based on the "need for treatment" or perceived "dangerous behaviour," principles that continue to justify such actions today (Gooding, 2017). Although these laws are no longer in effect, their frameworks have served as blueprints for modern mental health legislation, often imposed on countries during colonial rule and retained post-independence (Ndetei et al., 2017). In some African countries, the concept of "dangerousness" has been exploited to confine political dissidents in psychiatric facilities (Perlin and Szeli, 2012).

Since the 1970s, mental health legislation has increasingly been influenced by rights-based discourses, focusing on regulating the use of mental health powers. The primary purpose of such laws has been to establish adequate procedural safeguards for the necessary limitation of rights; involuntary commitment, forced treatment, restraint, seclusion etc., the criteria for compulsory treatment varies across African countries, ranging from "need for care and treatment" to "danger to self and others," depending on traditions and legal practices in the countries. This remains the dominant model for mental health legislation in the African continent. The Human Rights jurisprudence as well as the adoption of the Principles for the Protection of Persons with Mental Illness (MI Principles) by the UN General Assembly in 1991 (res. 46/119) have reinforced this approach and spurred a wave of mental health law reforms globally (Perlin and Szeli, 2012).

A different approach in Italy, in 1978, was adopted in Law No. 180, also known as the Basaglia Law. This legislation, later incorporated into Law No. 833 established the National Health Service, reorganising mental health services by developing decentralised, community-based services. It also banned the construction of new mental health hospitals and the admission of new patients to existing ones. Although coercive measures are still permitted under specific circumstances, the law rejects the notion of "dangerousness" due to its stigmatising effects. The Basaglia Law has influenced psychiatric reform in Latin America, inspiring similar laws in Brazil, Argentina, Uruguay, Peru, and Chile, which emphasise both procedural safeguards (Caldas de Almeida et al., 2020).

The trend toward the development of stand-alone mental health legislation. According to a survey for the WHO Mental Health Atlas 2020, completed by 171 of the 194 WHO Member States, 111 (65%) reported having stand-alone mental

health laws, representing 57% of all Member States (Mental Health Atlas, 2020). In regions such as the Western Pacific, Eastern Mediterranean, and Europe, over 70% of countries reported having such legislation. The percentage of countries with stand-alone mental health laws increased in nearly all WHO regions. Stand-alone mental health legislation often; provisions on the rights of mental health service users, diagnostic criteria, voluntary, involuntary admission and treatment, community treatment orders, informed consent for special treatments etc., (e.g., electroconvulsive therapy, psychosurgery, sterilisation), monitoring, criminal offenders, and the governance and administration of mental health services. Most of the countries in the African continent lacking mental health legislation, or it does not exist, other laws on health, social services, local governments, or criminal law often contain provisions that undermine the rights of people with mental health conditions or disabilities.

The adoption of the Convention on the Rights of Persons with Disabilities (CRPD) sparked renewed efforts to reform mental health legislation in Africa. Countries began to incorporate CRPD measures into their laws, (reasonable accommodation, advance directives, supported decision-making etc.,). However, most countries have not fully challenged biomedical approaches, the legitimacy of denying legal capacity, and the powers of compulsory treatment, thereby falling short of fully embracing rights in the mental health field (Convention on the Rights of Persons with Disabilities, 2014, 2023).

Conclusion

The role of the World Health Organisation (WHO) in mental health and diplomacy in the African continent faced various challenges within the international system as global north countries. WHO which is responsible for World health uses diplomacy through various partnerships in form of capacity-building policies in the African continent to achieve its global mandate toward health policies. These facilitated the integration of mental health policies into national health frameworks to promote collaboration among the states in the African continent. The WHO's advocacy for mental health awareness, technical support, and policy guidance elevated mental health on national, and regional agendas across Africa and across the international system. Also, there are notable improvements in mental health service delivery such as capacity building, and integration of mental health into primary healthcare in several African countries. However, progress is uneven, with some nations achieving greater success than others. WHO promoted mental health protection and awareness, but challenges such as underfunded mental health services, limited access to care, and persistent stigma affected the impact. Also, some innovative approaches emerged in the discourse of mental health, this pace of mental health reform is slow in many parts of the African continent mostly in countries such as Zimbabwe and Nigeria. Furthermore, the pandemic exacerbated existing mental health crises that placed additional strain on fragile healthcare systems. WHO faced obstacles such as limited financial resources, insufficient political will from some member states, and the overwhelming focus on physical health during the pandemic. Also, cultural diversity and socio-economic disparities across Africa created the push effect for the implementation of standardised mental health strategies in the Africa region. These factors, coupled with the nature of people with mental health stigma constrained the WHO’s efforts to promote mental health diplomacy effectively within the African continent.

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