

## **Essay**

Dawn Opert

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Katya Kee-Tui

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## Introduction

Depression is a serious concern in Africa, and it is necessary to have a clear idea about how countries across the continent are engaging with it, and what Interventions can be effectively deployed to minimise it's impact on the mental health burden. This essay will first discuss the prevalence of depression in African countries. Next, this essay will discuss what Interventions have been tested, whether they have been effective, and where they have been effective. The quality of the evidence for these Interventions will be analysed, before a final reflection will be made on the state of depression Interventions and possible future directions for research and policy makers.

Depression and anxiety are among the most common mental disorders globally, and cause a disproportionate amount of the global disability based healthcare burden, a major contributor to morbidity, and a contributor to lower standard of life (Chibanda et al., 2015; Chibanda et al., 2016; Doukani et al., 2021; Fernando et al., 2021; Lofgren et al., 2018; Lund et al., 2014).

Africa bears the brunt of the burden of common mental disorders, with countries across sub-Saharan Africa alone accounting for at least 19% of the global mental health burden (Lund et al., 2015). In specific countries, at least 16.5% of adults in South Africa present with a common disorder (Lund et al., 2014), and at least 30% of people attending primary healthcare facilities in Zimbabwe present with depression and anxiety symptoms (Chibanda et al., 2011; Chibanda et al., 2015).

Further, Africa has the highest rates of people living with HIV/AIDS, a population that is especially vulnerable to depression as compared to a general population, and the highest rate of people living with HIV related depression (Lofgren et al., 2018; Petersen et al., 2014). This is a serious problem because depression is strongly associated with lower rates of antiretroviral therapy adherence which is necessary for good management of HIV/AIDS (Lofgren et al., 2018; Lund et al., 2014; Petersen et al., 2014). On a similar front, depression severely affects young and expecting mothers, increasing the risk of complications during pregnancy, impairing caregivers' ability to create an environment suitable for a child, and limiting caregivers'

ability to cope with parenthood (Fernando et al., 2021; Nyatsanza et al., 2016).

Despite the high prevalence of depression and other common mental disorders across Africa, there is a serious lack of access to treatment and support (Chibanda et al., 2011; Chibanda et al., 2015; Chibanda et al., 2016; Doukani et al., 2021; Fernando et al., 2021; Lofgren et al., 2018). This is exacerbated by the fact that only half of African countries have a mental health policy to speak of (Lund et al., 2014; Lund et al., 2015), and most governments do not have the ability to allocate the necessary funds to implement one if they had it (Doukani et al., 2021; Lofgren et al., 2018). The general lack of resources and infrastructure for providing effective treatments means that there is an urgent need to develop interventions that work, that have lasting effects, and that can be deployed cheaply and efficiently (Doukani et al., 2021; Lund et al., 2014; Lund et al., 2015; Osborn, Wasil, et al., 2020; Osborn, Venturo-Conerly, et al., 2020; Osborn et al., 2021).

### **Interventions**

For an intervention to be considered evidence-based, it must be able to show that they can effectively reduce a measure of symptoms for the target disorder in a controlled trial (Cook et al., 2017). Most interventions that are studied in this way, and therefore fulfil this condition, are CBT-based and manualized interventions (Cook et al., 2017; Shedler, 2018). Because manualized therapies tend to require a lower threshold of training in order to be implemented, they are particularly suited to fulfil the needs of African governments and health practitioners in bridging the treatment gap (Cook et al., 2017; Doukani et al., 2021; Lund et al., 2014; Osborn, Wasil, et al., 2020).

Generally, most of the data on low-cost interventions for low and middle income countries comes from outside Africa, and while studies have been done more recently in Africa, they are almost all from sub-Saharan Africa (Lofgren et al., 2018). Most of the readily available studies discuss interventions based on some form of cognitive behavioural therapy (CBT), are deployed by lay health workers, and are low-intensity and rather short interventions (Chibanda et al., 2011; Fernando et al., 2021; Lofgren et al., 2018; Lund et al., 2014). Out of all the articles reviewed, only Lofgren et al.

(2018) presented data on interventions other than psychotherapies.

Something important to note, most of the interventions discussed were not targetting depression alone. Rather, some interventions targetted depression alongside other common mental disorders (Abas et al., 2016; Chibanda et al., 2011; Chibanda et al., 2015; Chibanda et al., 2016; Doukani et al., 2021), depression specifically tied to living with HIV/AIDS (Lofgren et al., 2018; Petersen et al., 2014), or otherwise targetted peri- and post-natal depression (Lund et al., 2014; Nyatsanza et al., 2016). This means that the studies might not be as generalizable to other contexts, because the effect of the interventions are not isolated to depression. However, real-life people live complex lives. As established above, the prevalence of depression is high in African countries. Furthermore, the link between depression and the other facets of peoples' lives is intricately linked. The bi-directional relationship between poverty and mental illness is very well supported (Lund et al., 2010; Lund, 2012; Ridley et al., 2020; Wahlbeck et al., 2017).

## **Quality of Evidence**

### **Reflection**

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