Essay Assignment

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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).

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 based on Cognitive Behavioural Therapy (CBT) and are 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).

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). As expected, most of the readily available data is on CBT based 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: six anti-depressant based interventions, a novel drug, an exercise

intervention, and three psychosocial interventions.

One of the key themes across these interventions was testing interventions that could be delivered by minimally trained lay healthcare workers (LHWs) already deployed in the field. Almost every single one of the psychotherapy interventions followed this approach (Abas et al., 2016; Chibanda et al., 2011; Chibanda et al., 2015; Chibanda et al., 2016; Doukani et al., 2021; Fernando et al., 2021; Lofgren et al., 2018; Lund et al., 2014; Nyatsanza et al., 2016; Petersen et al., 2014). Lofgren et al. (2018) also reported on three anti-depressant interventions delivered by LHWs.

The reason given for this approach is that LHWs are already deployed across primary healthcare clinics, and can therefore cheaply and efficiently deliver interventions that act as a preventative measure for serious mental disorder that would otherwise require (costly) hospitalization (Abas et al., 2016; Doukani et al., 2021; Fernando et al., 2021; Lund et al., 2014). Nyatsanza et al. (2016) also suggested that LHWs provide a built-in way to ensure interventions are localized to and respect the cultural context where they are being delivered.

The *Friendship Bench Project*, initially developed for Zimbabwe, has by far the most data out of any of the reviewed interventions. Three trials are reviewed here (Chibanda et al., 2011; Chibanda et al., 2015; Fernando et al., 2021), the project is one of the oldest interventions tested in an African context (Abas et al., 2016; Chibanda et al., 2011; Fernando et al., 2021). The project uses LHWs who are already known and respected in the community to deliver a low-intensity counselling program based on Problem Solving Therapy (PST) (Abas et al., 2016; Chibanda et al., 2011; Fernando et al., 2021). The LHWs were trained generally for five to six days in basic counselling techniques and in the intervention's specific program, and were based out of primary healthcare clinics (Abas et al., 2016; Fernando et al., 2021). PST was chosen because it could it could very easily be adapted to a task-shifted intervention, and because it proved to be both effective and flexible in the intervention studies (Abas et al., 2016; Chibanda et al., 2011; Chibanda et al., 2015; Fernando et al., 2021). Over the course of up to six sessions, LHWs and clients would identify the problems that the client faced,

discuss the problems in a safe and non-judgemental space, then collaboratively break down the problems into manageable steps and develop step-by-step solutions to those problems (Abas et al., 2016; Chibanda et al., 2015; Fernando et al., 2021). The intervention was also accompanied by a group peer-support program, wherein clients of the *Friendship Bench* project met together regularly to support each other emotionally, and to participate in income generating activities (Abas et al., 2016; Fernando et al., 2021).

This project is important for a number of reasons. Firstly, the *Friendship Bench* has been very succesfully upscaled in Zimbabwe, and has generlly been well received by both clients and LHWs (Abas et al., 2016; Fernando et al., 2021). This is important because it the lessons learned from this can hopefully be applied to other projects in Africa. Secondly, this is one of the few interventions that intentionally attends to the economic factors that cause depression (Fernando et al., 2021).

One of the first interventions developed based on the lessons of the *Friendship Bench* is the *Inuka Coach* program developed for use in Kenya (Doukani et al., 2021). The program is based on the use of the *Friendship Bench*'s PST program, and it is also intended to be delivered by LHWs as a low-intensity intervention. However, this program is being developed to be delivered via a mobile application rather than in-person (Doukani et al., 2021). This delivery method is an attempt to address accesibility issues by allowing clients to access the program from anywhere they have access to a smart device and an internet connection (Doukani et al., 2021). However, the team behind this intervention reported some added difficulties introduced by this method. LHWs required extra training in use of the application, and often did not have access to smart devices capable of running the application; the LHWs also often used their smart devices for personal business, which would distract them from their client and run down their batteries (Doukani et al., 2021). Additionally, there could be no guarantee that clients would have access to a smart device, a stable internet connection, or that the application would be user-friendly (Doukani et al., 2021). Lastly, mobile based interventions are potentially very useful, such as Osborn et al.'s (2020)

Shamiri-Digital intervention which seemed to succesfully teach students skills which would help them navigate stress and depression. However, this specifically intended to target prevention skills, it was not an intervention for already existing depression, and more data is necessary on how effective this approach can be.

Quality of Evidence

One of the most salient limitations of many interventions studies is that the strict conditions of evidence gathering do not map onto their practical, real world applications by their very nature (Doukani et al., 2021; Kazdin, 2014; Shedler, 2018).The *Inuka Coach* program ran into this issue directly. For a variety of pragmatic reasons that Doukani et al. (2021) explain, they required the clients in the study to be present in the clinic during the intervention, which if very different to the intended use of the *Inuka* application once it is fully launched. This was noted in the study, but it does mean that there must still be intensive testing of the intervention before it can really be called effective for use in the privacy of clients' own homes.

On a similar note, studies for interventions often have incredibly strict exclusion criteria, in order to experimentally isolate the effect of the intervention on a single target, depression for example (Kazdin, 2014; Shedler, 2018). While this is part of good experimental practice, such as in a chemistry experiment, it reinforces the above discussed problem of preventing intervention evidence from being useful in real life contexts where depression rarely manifests alone, and where multiple CMDs often have complex interactions with each other (Shedler, 2018). Importantly, none of the interventions discussed targeted depression alone. Rather, some interventions targeted 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 targeted 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, but acknowledges that real-life people live complex lives.

Some of the interventions did still exclude clients who were suicidal or otherwise severely depressed as measured by the intervention's depression scale. Chibanda et al. (2011; Chibanda et al., 2015) and Nyatsanza et al. (2016) both explained that for the *Friendship Bench* they simply were not equipped to help people with very severe symptoms and instead referred these clients to better equipped clinics.

Something that is worrying in this pool of studies is that many of them are only research proposals (Chibanda et al., 2015; Lund et al., 2014), or otherwise only measured the effects of the interventions right after and after only a brief three or six month follow-up (Chibanda et al., 2011; Chibanda et al., 2016; Doukani et al., 2021; Fernando et al., 2021; Nyatsanza et al., 2016; Petersen et al., 2014). 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). People living with HIV/AIDS are also more likely to develop depression (Lofgren et al., 2018). This means that without treating the root causes of depression and other CMDs, even if six months after the intervention there is still a positive effect, this effect will not last (Kazdin, 2014; Shedler, 2018).

Similarly, the measures that are used to see how effective an intervention is do not properly map onto anything useful for clients (Kazdin, 2014; Shedler, 2018). Generally the studies used measures that were developed for European and American contexts, but were validated for use in southern Africa (Lund et al., 2014; Nyatsanza et al., 2016; Petersen et al., 2014). While it is good that these measures seem to work in Africa, there is still a concern that there is a mismatch between the items in the measures and the real world context, and whether these items actually mean that clients have experienced tangible benefits from the intervention(Kazdin, 2014; Lund et al., 2014; Nyatsanza et al., 2016; Shedler, 2018). Only the *Friendship Bench* studies addressed this issue. First, they used the Shona Symptom Questionnaire, a measure that was actively created for the Zimbabwe context, using local idioms for various aspects of depression and other CMDs. Second, these studies all supported their

quantitative data with very robust qualitative data that showed directly how much of an impact the program has had on clients' lives (Abas et al., 2016; Chibanda et al., 2011; Chibanda et al., 2015; Chibanda et al., 2016; Fernando et al., 2021).

Reflection

One of the things that struck me when I began research for this essay was how little attention many interventions seem to pay towards root causes of CMDs. Despite the relationship between poverty and mental health being very well documented, as discussed above, and despite how relevant poverty is across all African contexts. While psychotherapy interventions can only do so much outside the treatment of CMDs themselves, there should be at least an acknowledgment of the effects of poverty, if not some attempt to address part of the problem. As I mentioned above, without something in place to treat causal factors of depression, any effects of an intervention can only have a limited effect.

The *Friendship Bench* project seems to be incredibly promising because of this. It was the only intervention I found that did attempt to give clients tools that they needed in order to minimise the effect of poverty on their lives. The program also seems very good for the reasons discussed above, with regards to how effective it is and how well clients respond to it.

There was definitely a lack of studies for interventions in Africa from the beginning of the last decade. However, much more recently there has been an increase in interventions piloted for an African context, such as Doukani et al (2021), Fernando et al (2021), Nyatsanza et al (2016).

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