Finding the Middle Space: Strategies and Interventions to Support Mental Wellness in Sub-Saharan Africa

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Abstract

The World Health Organization[WHO], 2023 reports that approximately 280 million people worldwide are depressed. Many may have been adversely impacted by the onset of Covid-19 and the struggle to cope with the devastating disease. Vulnerable people without a clear identification of the pandemic's existence or how to access treatment may also have been affected. Cultural conceptualization of mental illness, self-concealment, social and other structural-policy barriers may prevent many from seeking help. Mental health issues such as depression, anxiety, and traumatic life events also impact sub-Saharan Africans. However, the way in which these individuals seek and access help for their concerns is uncertain. Additionally, mental health is conceptualized in such a manner that there seems to exist a profound gap between emotional wellness and severe mental illness. In this case, individuals are described as either healthy or severely ill. In response to the call to re-engineer the future of work in a post-covid era, we discuss how to intervene and maintain overall mental wellness.

Keywords: Depression, anxiety, mental wellness, intervention, help-seeking, Sub-Saharan Africa

Introduction

According to the World Health Organization (WHO), mental health is defined as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make contribution to his or her own community" (WHO, 2004, p.1). However, WHO (2023) approximates that 280 million people are impacted by depression worldwide. In a study on the global prevalence of mental disorders, approximately 75% of severe cases in Low-and-Middle Income Countries (LMIC) in sub-Saharan Africa (SSA) went untreated, partly due to a lack of mental health education and services, which are unavailable, especially in the rural areas (Demyttenaere et al., 2004). The WHO executive board 130th session (2012) discussed the Global Burden of Mental Disorders and identified depression and anxiety as common mental health problems, among other disabling conditions such as alcohol and substances, schizophrenia, and bipolar disorders. Depression and anxiety are reported to contribute to 13% of the total Global Burden of Disease; accounting for 4.3% and an estimated 3.2% for LMIC, with predictions of depression being the

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leading cause of disease burden globally in 2030 (WHO, 2011).

Despite the high prevalence of mental health problems in sub-Saharan African countries, there is a paucity of studies informing the effort made toward mental health literacy, making mental health services available and affordable to individuals impacted by these problems. This conceptual paper aims to bring awareness and expand the knowledge that will assist individuals in seeking help. Thus, we theorize and assume that despite the reality that many people are living with mental health problems, they may be hindered from seeking help due to certain factors such as (a) failure to recognize and identify their mental health problems; (b) cultural conceptualization of mental illness; (c) perceived self-stigma; and (d) structural and policy barriers, among other factors. Contextual and cultural interventions are discussed that may lead to the enhancement and maintenance of mental wellness.

The barriers to treatment may be compounded by the recent Covid-19 pandemic which has impacted and caused loss and disruptions in families and the workplace. In this case, however, individuals unfamiliar with the prevalence of mental health problems may deny having mental health problems and be likely to assume a dichotomous approach in describing mental wellness. Hence individuals are described as either well or severely sick, with little room for a continuum to address optimization of mental wellness. We seek to fill the middle space – between wellness and severe illness - by highlighting the need to identify mental health problems. We emphasize the need to acknowledge the pervasive nature of mental disorders, the need to seek help, find effective intervention strategies, and support individuals living with mental health problems.

Identification of Mental Health Concerns

Depression and anxiety are common mental health concerns in sub–Saharan Africa that have been especially notable during the Covid-19 crisis. In a meta-analysis and review of articles published during the first year of the pandemic, Chen et al. (2021) determined that the prevalence of depression across 12 African countries was 45% while the prevalence of anxiety was 37%. In research completed before the pandemic began (Duthé et al., 2016), data indicated that the occurrence of major depressive episodes in an urban sub-Saharan environment was 4.3%. The researchers also found strong relationships between depression and factors such as chronic disease, food shortages, experience of physical violence, and regular alcohol intake (Duthé et al.). Sweetland, Belkin, and Verdeli (2014) noted that although depression is a leading cause of disability worldwide, only 10% of individuals in low-resourced countries have access to appropriate treatment. Via a systematic review of screening instruments, they determined there are nuances in symptom manifestation and expression of depression and anxiety in sub-Saharan Africa that warrant

adaptation of these assessments to the local culture (Sweetland et al., 2014).

Identifying Symptoms of Depression

According to the American Psychiatric Association (Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5-TR®, 2022), symptoms of depression include depressed mood; loss of interest or pleasure; weight loss or gain; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue; feelings of worthlessness or inappropriate guilt; decreased concentration; and thoughts of death or suicide. Haroz et al. (2017) found that the three most common features of depression worldwide are sadness and depressed mood, fatigue and loss of energy, and difficulty with sleep. The DSM-5 does have potential limitations, including unlisted symptoms such as isolation, crying, anger, and pain, that may be present for some individuals (Haroz et al., 2017).

It is especially important to remember that manifestations of depression may vary across cultures. In a thematic synthesis of qualitative studies, Mayston, Frissa, Tekola, Hanlon, Prince, and Fekadu (2020) reviewed different models of depression in sub-Saharan Africa and found similarities in experiences of deep sadness, mental disturbance, sickness of the soul, and burdened heart. Physical symptoms such as head, chest, and stomach pain were also noted. Possibly due to the stigmatization of mental illness in many African societies, variations were seen between the language used by healthcare workers to describe concerns (stress and depression) and that used by female patients, which included a distinction between problems of the mind and physical problems (Mayston et al., 2020).

Gbadamosi et al. (2022) acknowledged the cultural and social stigma associated with the identification and assessment of depressive disorders and pointed out the dearth of practitioners in sub-Saharan Africa qualified to administer diagnostic tests. Sweetland et al. (2014) also noted the lack of mental health specialists in low-resourced locations and stated that screening tools should be assessed for cross-cultural validity. Several well-known instruments for screening depression have been validated for use in cross-cultural settings, including the Beck's Depression Inventory (Beck et al., 1961), the Patient Health Questionnaire (Kroenke & Spitzer, 2002), and the Mini International Neuropsychiatric Interview (Sheehan et al., 1998). However, despite the validation of several screening tools for cross-cultural use, methods of determining validity have varied. There continues to be a lack of consensus about what constitutes cross-cultural similarity (Gbadamosi et al., 2022). Sweetland et al. (2014) noted the value of brief screening instruments in low-resourced areas while acknowledging that symptom expression may vary in different contexts; they suggested that locally adapted instruments may be most effective.

Identifying Symptoms of Anxiety

The American Psychiatric Association Diagnostic and Statistical Manual of

Mental Disorders-5 (DSM-5-TR®) (2022) lists several anxiety conditions. One category, known as Generalized Anxiety Disorder, includes symptoms such as restlessness or feeling keyed up or on edge; being easily fatigued; difficulty concentrating or mind going blank; irritability; muscle tension; and sleep disturbance. The World Health Organization (2022) noted that globally, anxiety and depression increased by 25% during the first year of the Covid-19 pandemic. Given the overlap of anxiety symptoms with symptoms of depression in sub-Saharan Africa (and elsewhere), it is vital to consider the two diagnoses together (Patel & Stein, 2015).

Bello et al. (2022) found in a metanalysis that prevalence rates for anxiety and depression in Africa during the pandemic were 47% and 48% respectively and that risk factors for these conditions included female sex and chronic medical problems. They also demonstrated an association between anxiety and depression. Specific anxiety symptoms in the study included insomnia, fear of Covid, psychological distress, worry, and fear of getting sick (Bello et al., 2022). Beyond gender and medical concerns, other risk factors for anxiety included urban residency, living alone, lower SES, younger age, and being widowed, single, unemployed or a student. Bello et al.'s systematic review also revealed that anxiety was highest among Africans infected with the virus that caused Covid-19 and was associated with having a friend or relative with Covid. The authors concluded that the pandemic considerably impacted anxiety and depression in Africa, although they did not make causal interpretations (Bello et al., 2022).

As noted above, several commonly used screening instruments have been validated for cross-cultural use. In a review of validated screening tools for anxiety disorders in low to middle-income countries, Mughal et al. (2020) identified 46 validated instruments designed to screen for anxiety. The Kessler-10 and the Generalized Anxiety Disorder-7 were shown to have been validated most often in the Mughal et al. (2020) study. The authors pointed out that brief screening tools are important and can help to identify and manage anxiety disorders. Still, they commented that many of the instruments that have been locally validated need further validation to determine their efficacy.

Barriers to Seeking Care for Depression and Anxiety

Religious and Cultural Beliefs

One of the major cultural barriers to seeking mental health care among sub-Saharan Africans is the failure to recognize mental health as an important feature of overall wellness. This may be due to a lack of understanding within African cultures about the causes of mental illness. The traditional and cultural perception of mental disorders among sub-Saharan Africans is synonymous with the supernatural and possession by evil spirits (Comaroff, 1980). Comaroff conducted an ethnographic study among the Barong boo Ratshidi ethnic group in

Southern Africa that explained the basic beliefs of health and affliction. Affliction is interpreted as "the dislocation of the self and its social and cosmic context"; therefore, "healing entails the manipulation of the multi-vocal symbolic media, seeking to reintegrate the physical, conceptual, and social universe of the sufferer and the community, objectification and restructuring of the dislocation" (Comaroff, 1980, p. 637).

As a result, especially in Kenya as in many other African communities, mental illness is deeply stigmatized, and there is discrimination against people with mental health concerns. For instance, derogatory epithets are used for people with mental illness, such as *mwenda wazimu* (Kiswahili); *mundu wa ngoma* (Kikuyu); *omulala* (Luhya); and *janeko* (Dholuo), which in all these ethnic groups connotes a mentally ill person as possessed and belonging to the spirit world (Kweyu, 2012). A person who is mildly depressed and one who is severely mentally ill are categorized the same, and therefore no one wishes to be associated with suffering from mental health problems. To confirm the inherent prejudices and insidious effect against mental illness, a recent live Kenyan parliamentary proceeding recorded a Member of Parliament overtly castigating a colleague by asserting "*we are not mental to raise issues,*" thus disassociating from those who struggle with mental illness (Nation Africa, 2022). The adverse inferences and associated prejudices will likely discourage many sub-Saharan Africans from acknowledging their vulnerability to mental health concerns and seeking help.

Further, Makanjoula et al. (2016) investigated the explanatory models of psychosis and the impact on perception of self-stigma by patients in the sub-Sahara African cities. The study utilized a mixed-method approach to explore respondents' explanatory models of the causation of psychosis and a questionnaire assessment of the level of internalized stigma. Drawing respondents mainly from Nigeria, Ghana, and Kenya, the authors contrasted those with a biopsychosocial explanatory model with those with supernatural attribution. The study found that the respondents endorsed both supernatural and biopsychosocial explanatory models of the causation of psychosis. Most of the respondents with severe forms of self-stigma held supernatural attribution. However, some respondents with low self-stigma embraced a supernatural model, while others with high self-stigma gave a biopsychosocial explanation. The study suggested programs that generically promote biopsychosocial intervention or discourage supernatural models may not be ideal, rather individualizing treatment to minimize stigma may be a better intervention approach to treatment among sub-Saharan Africans (Makanjoula, 2016).

Social Stigma

The indignity associated with mental illness may be a deterrent to help-seeking. A study about stigma and discrimination against mentally ill people in Zambia, South Africa, Katotonka (2007) found

that people with mental health disorders are not treated with respect, neglected, and denied growth opportunities. Cultural beliefs and practices such as bewitchment, sorcery, demonic possession, and ritual cleansing have far-reaching implications for conceptualizing mental health. Therefore, the problem of stigma associated with mental illness may cause delay or interfere with help-seeking practices thus contributing to continued suffering of families and patients living with mental illness. Ndetei (2001) corroborates with the Zambian study and found that mentally ill patients are severely stigmatized among Kenyans. Therefore their traditional conceptualization and help-seeking attitudes could have critical implications for their overall mental health especially for those most in need of counseling services.

Although mental health is not considered a life-threatening problem and is therefore seen as insignificant and unworthy of attention, it continues to present a stigma and discrimination problem. For instance, stigma associated with poor mental health has been compounded by the public perception and attitudes, especially toward individuals treated in a psychiatric hospital such as Mathari Mental Hospital. Historically, this hospital has been associated with patients who have severe psychosis, hence the avoidance of being associated with such a mental health facility. Ndetei (2001) noted that treatment at the hospital may complicate social acceptance and friendships and that clients struggle with social acceptance and integration into society once discharged from the hospital.

Similar stigma and social distancing toward people with mental illness was found to be prevalent among Nigerian university students. For instance, participants in a 2005 study acknowledged they would feel ashamed if people knew there was someone in their family with mental illness and 79.0% will "probably"/ "definitely" not marry someone who has mental illness (Adewuya & Makanjuola, 2005). In contrast, the Western view explains mental health from a biological and psychosocial perspective. For instance, Angermeyer and Matschinger (2005) examined the public's beliefs about the causes of schizophrenia between 1990 and 2001, drawing data from two population surveys in Germany. The study found that belief about the causes of schizophrenia could be attributed to psychosocial stress (ranked first) and chronic stress (second). Also, biological factors such as brain disease ranked fifth while hereditary factors ranked sixth.

Along with schizophrenia, brain disease was attributed to be the main cause for depression. Leiderman et al. (2011) examined public knowledge, beliefs, and attitudes toward patients with schizophrenia in Buenos Aires. They found that although the general population believed that patients with schizophrenia suffer from a split personality, those directly related to patients with schizophrenia were more knowledgeable about the illness (Leiderman et al., 2011).

Structural Barriers

Similarly, the lack of coverage of mental health services through health insurance poses a major structural barrier that may discourage many from accessing services. Although this critical concern has been addressed in the Kenya Mental Health Policy 2015-2030 report (2015) there remain important issues to be addressed to make services available to the people. Many African governments fail to recognize mental health as an important component of overall wellness, which results in poor funding, hence treatment becomes unaffordable and unavailable to many who would benefit from such services. This is further compounded by the lack of adequate treatment facilities and skilled human resources to address mental health problems. Previously, in Kenya, as demonstrated in many other sub-Saharan African governments, mental health services were concentrated and provided from centralized psychiatric mental hospitals.

A focus on mental health and psychological counseling education is developing gradually, and therefore supplementing the psychiatric-medical model that has dominated the field. Furthermore, the cost of treatment for mental health in Kenya has been exorbitant, estimated at between Sh50,000 to Sh100,000 ($500 to $1,000) excluding "down payment" of Sh10,000 and additional doctor's consultation fee of Sh10,000 and additional fee of between Sh3,000 to Sh5,000 per every psychiatric follow-up visit (The Standard, 2018). To this end, the Kenyan government agreed to recognize and include mental disorders coverage in the National Health Insurance Fund (NHIF) beginning June 2022, therefore allowing clients to be treated in local health facilities without self-pay (The Standard, 2018).

Confidentiality, privileged communication, and privacy are basic elements in providing mental health treatment. According to the American Counseling Association code of ethics (2014) "confidentiality is a right granted to all clients of mental health counseling services. From the onset of the counseling relationship, mental health counselors inform clients of their rights including legal limitations and exceptions" (1.A.2.a.). The concept of confidentiality in the delivery of mental health services is well-delineated in most high-income countries. Comparably, although the Kenya Counseling and Psychological Association (KCPA) lists professionalism, confidentiality, integrity, and commitment to the profession as its core values; it is unclear whether the scope of confidentiality, privileged communication, and privacy of mental health clients' information is legally defined and binding under the Kenyan law. Also, many people may fail to self-disclose to their counselors or pastors if they are not sure how their confidential information will be protected. It is common for inexperienced clergy to discuss private information shared by their parishioners from the pulpit, thus exposing vulnerable church members to the public.

The World Bank estimates based on the United Nations Population Division's World Urbanization Prospects of 2018

reports that the annual percentage of sub-Saharan Africa rural population has been declining from 85% in 1960 to 58% in 2021 (World Bank Group, 2021). Thus, most SSA still live in rural-agrarian communities, which may still be influenced by strong cultural and agrarian values. Although many studies have been conducted on rural-urban migration, examining some factors that may impact or inhibit mental health help-seeking attitudes among the SSA rural communities is still important.

For instance, Judd (2006) examined the impact of agrarian values among young adults regarding the help-seeking process for mental health problems. Agrarian values are generally found to be more commonly practiced and prevalent in rural populations than in urban areas. A major characteristic of agrarian values is stoicism, which emphasizes self-reliance and personal responsibility when dealing with one's own problems. Individuals are likely to suffer from their own problems or turn to their immediate family members than seek professional help and support. Stoicism could inhibit individuals from seeking help, especially for those who consider being healthy as one's ability to be productive member of society. Agrarian communities tend to deny, suppress, self-conceal, and control their emotions, denying having or experiencing symptoms of mental health-related problems. In this case, however, agrarian communities were found to have higher degrees of stoicism and are less likely to seek help for their mental health problems (Judd, 2006).

Contextual and Cultural Interventions

The rural-urban migration continues to destroy family ties and social fabric, thus creating anonymity among communities. This trend will likely destroy collectivism, existing social network, and support for each other. Assari (2017) examined the association between social capital and depression among adults living in a suburban city in a High-Income Country (HIC). The social capital had six dimensions as follows: (a) groups and networks, (b) trust and solidarity, (c) collective action and cooperation, (d) information and communication, (e) social cohesion and inclusion, and (f) empowerment and political action. The study found that among the 1212 subjects, 24.4% reported a diagnosis of depression and Trust and Solidarity, Social Cohesion and Inclusion dimensions were significantly associated with the diagnosis of depression and experience of depressive symptoms (Assari, 2017).

Whereas the study cited above was conducted within a high-income country, it is important to consider how the social capital dimensions would impact individuals living in Low-and-Middle Income Countries (LMICS) mostly found in sub-Saharan Africa. As aforementioned, individuals living in urban areas are likely to experience a breakdown of family ties and community social network that was previously experienced in the rural areas prior to their migration to urban centers. The gradual detachment from the rural areas and closely-knit familiar village life may lead to isolation and

anonymity. As stated, it is important to investigate how their mental health is impacted by urbanicity and perceived limited interaction with their families and social network. In this paper, we argue that urban populations are likely to experience isolation and consequently be left to deal with their physical and emotional burdens. Other environmental and psychosocial difficulties may further exacerbate their livelihood, thus leading to stress, anxiety, and depression. It is important therefore for individuals who migrate to urban centers to maintain family and social connections; increasing social capital and support for each other to ease the burden of depression.

Maintaining Mental Wellness

Given the stigmatization of mental health concerns in much of sub-Saharan Africa, disparities in access to treatment, and the prediction that mental disorders will more than double there by 2041, the time is nigh to address the situation (Meffert et al., 2021). Strategies that were utilized for HIV response, including advocacy with policymakers may be helpful (Meffert et al., 2021). It is important to note that while the HIV response in sub-Saharan Africa also involved advances made possible by scientific research and funding that supported testing and treatment, the response to the mental health crisis has primarily focused on acute care and hospitalization (Meffert et al., 2021). According to the World Health Organization (WHO, 2013), 76-85% of people in low- and middle-income countries who have mental health concerns are never treated, clearly indicating an unmet need. Even for depression, which results in the most mental health-related disability worldwide, there is little available outpatient help for individuals who suffer from this disorder in sub-Saharan Africa (Merfert et al., 2021). Given the severity of the mental health problem in sub-Saharan Africa, it may be helpful to consider the use of a variety of interventions, including those that originated in other locations. In these circumstances, it will be imperative to keep in mind the cultural context and always adapt the intervention to local circumstances.

Task Shifting

Galvin and Byansi (2020) pointed out the lack of access to services for mental healthcare in low- and middle-income countries. They reviewed studies from sub-Saharan Africa to explore the effectiveness of task shifting (training of lay workers in the provision of mental health treatment) to expand treatment options. They concluded that task shifting is beneficial in settings where there are not enough professionals to cover mental health service needs, but that some of the studies they reviewed lacked methodological rigor and did not use control groups (Galvin & Byansi, 2020). Nevertheless, the authors determined that most of the studies in their review demonstrated positive improvements for mental health outcomes. They also noted that strategies from higher income countries outside of sub-Saharan Africa were incorporated into the treatment plans and efforts were made to adapt

them to the local cultural setting (Galvin & Byansi, 2020).

Group Work

Group work may be efficacious in treating depression and anxiety in sub-Saharan Africa. Osborn et al. (2020) trained lay providers to implement exercises that focused on growth mindset, gratitude, and value affirmation in groups of Kenyan adolescents with anxiety and depression. Compared to the control group (which focused on study skills), adolescents in the treatment group experienced reduced anxiety and depression, as well as increased academic performance. The treatment group also experienced more feelings of social support from friends than did the control group (Osborn et al., 2020) The study authors acknowledged the limited options that are available for adolescents in sub-Saharan Africa who suffer from depression and anxiety and pointed out the need for alternative approaches that are brief, focused, and intended to destigmatize mental health concerns.

Cognitive Behavior Therapy and Medication

In parts of the western world, cognitive behavior therapy (CBT) and medication may be the initial interventions for concerns related to anxiety and depression. Feurer et al. (2021) designed a study to ascertain whether CBT and selective serotonin reuptake inhibitors (SSRIs) alleviated the symptoms of internalizing disorders such as anxiety, depression, and posttraumatic stress disorder. When they examined the impact of the interventions on emotion regulation (ER) strategies and repetitive negative thinking (RNT), they found that symptoms were improved. However, individuals in the CBT cohort reported more remarkable improvement in emotion regulation strategies than did those in the SSRI group.

A combination of CBT and SSRI treatment has been shown to be more effective for internalizing disorders in children and adolescents than either CBT or SSRI treatment alone (Strawn et al., 2022). Strawn et al. (2022) wanted to find out whether this outcome would vary across the different types of internalizing disorders and thus evaluated the results of several large National Institutes of Health funded trials. They concluded that their data supported previous work indicating that combined treatment is most efficacious for both anxiety and depression in children and adolescents. However, they noted that younger patients with less severe symptomatology had the fastest response to the combined treatment. Additionally, the benefit of CBT was seen to occur late in the combined therapy (Strawn et al., 2022).

Confidentiality

As practitioners in the mental health field, members of professional counseling organizations and other healthcare groups are often required to adhere to specific codes of ethics (e.g., American Counseling Association, 2014). One ethical directive particularly dear to professional counselors is the concept of confidentiality, which necessitates holding

private clients' personal information except under specific circumstances (e.g., abuse of a child, elder, or anyone who cannot speak for themselves; harm to self or others; legal requirement to disclose information, etc.). Considering the stigma that has been associated with mental health concerns in sub-Saharan Africa, it would be critical to help individuals with anxiety and/or depression understand through the process of informed consent that their private information will not be shared outside of counseling sessions, except according to the limits of confidentiality described above. Some populations may be especially vulnerable to these concerns. For example, men may feel it is a weakness to suffer in this way and be reluctant to accept assistance for fear their troubles could be shared outside of the counseling session and shame brought upon them and their families.

Spirituality

Spirituality may play an important role in the mental health of individuals in sub-Saharan Africa. In one study, older adults in Namibia who were living with HIV completed measures of social support, spirituality, and depressive symptoms (Kalomo et al., 2021). Analyses were done to understand the relationships between the variables and explore the impact of social support and spirituality on depressive symptoms. The researchers found that a higher level of social support from friends (not neighbors or family) predicted a lower level of depressive symptoms and that higher levels of spirituality were also related to lower levels of depressive symptoms (Kalomo et al., 2021). Based on this data, Kalomo et al. (2021) suggested that practitioners should include spirituality in their work with adults living with HIV.

In other research, Adong et al. (2018) studied the association between spirituality/religiousness and another mental health concern (unhealthy alcohol use) in adults living with HIV in Uganda. The findings revealed a correlation between higher scores on a spirituality/religiousness index and lower chances of unhealthy drinking, although the relationship was insignificant. The authors noted that individuals who identified as Muslim, Pentecostal, or Seventh-day Adventists were less likely to engage in unhealthy drinking and suggested that this might be due to the religions' discouragement of alcohol use and to the peer support that results from services and gatherings (Adong et al., 2018).

Self-Care Activities

Self-care activities have been employed in some settings to assist individuals struggling with depression and could potentially be utilized in sub-Saharan Africa if local adaptations are applied. In a Canadian study, McCusker et al. (2022) utilized trained lay coaches and various Cognitive Behavioral Therapy (CBT) tools (e.g., depression workbook and/or self-care website) to investigate depression in cohorts of individuals with chronic physical symptoms and in cancer survivors. The data indicated that the use of these modalities was associated with remission of depression in the first group but not the second. The authors

suggested that the lay-coaching model could be used as a first step in treating depression and would help ease problems of access to mental health care. In another study exploring the relationship between self-care agency and depression in Turkish older adults (Isik et al., 2020), investigators found that reported depression decreased as self-care agency increased. They concluded that a self-care agency increases self-care behaviors and that strengthening the self-care agency of older adults is therefore highly important (Isik et al., 2020).

Exercise

Some sub-Saharan Africans may exercise as part of their employment or daily activities. However, for others it may be beneficial to add a structured component that permits movement appropriate to the health and wellness level of the individual. Activities such as walking or running could be enjoyable depending on fitness level. A physician should be consulted before a new exercise program begins.

Time in Nature

Some U.S. doctors have prescribed time in nature as a means of treating anxiety and depression (Nature Connection Guide, 2020). In Canada, doctors may prescribe and provide free Parks Canada Discovery Passes for patients with various conditions, including anxiety and depression (CNN.com, 2022). For sub-Saharan Africans who work on farms, connecting with the soil and the earth intentionally may ease stress and offer satisfaction.

Mindfulness

Mindfulness activities may support mental wellness in clinical populations. For example, meta-analyses have indicated the efficacy of mindfulness-based therapy in treating various conditions, including anxiety and depression (Hofmann et al., 2010). Mindfulness may also protect against adverse mental health outcomes associated with the Covid-19 pandemic (Schachter et al., 2022; Liu et al., 2023). For example, Schachter et al. (2022) found that increases in mindfulness reduced rumination and Liu et al. (2023) demonstrated that the relationship between perceptions of pandemic severity and posttraumatic stress was moderated by state mindfulness.

Conclusion and Implications

We have attempted to highlight the prevalence of mental health problems especially in the sub-Sahara Africa. Evidently, mental health problems increased during the post-Covid-19 era, which has impacted many people. This paper has discussed the symptoms of common mental health problems such as depression and anxiety, which are likely to impact family relationships and productivity in the workplace. We focused on the invisible population that tends to avoid seeking help because of failure to identify and acknowledge their mental health problems. This population is likely to dismiss help-seeking as unnecessary or only reserved for those

who experience severe psychosis. There exists a middle space between failure to seek help and reaching out to address a crisis. Many people suffer mental illness due to self-neglect, which may impact their overall well-being. Therefore, It is imperative for sub-Saharan African policymakers to fast-track their effort in mental health advocacy, stump out stigma related to mental health illness and find effective treatment intervention strategies to enhance overall mental wellness. More research is needed to advance mental health literacy and find ways of serving each client's well-being in sub-Saharan Africa.

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