



Evaluating the Effectiveness of a Task-Shifting Mental Health Intervention for Common Mental Disorders in Rural Cameroon: A Randomized Controlled Trial.

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ABSTRACT

Mental health is a huge issue in rural Cameroon, where access to proper care is limited, and mental health services are few and far between. This study explores the effectiveness of a task-shifting mental health intervention, where non-specialist health workers take the reins in providing mental health support. Think of it as a 'shift' of responsibilities from highly trained specialists to those in the community who are more accessible but have received basic training. We used a randomized controlled trial (RCT) the gold standard of research, no less to assess how well this approach works for common mental disorders like anxiety and depression. Our research zeroed in on a rural region, where mental health care is typically not a priority and the barriers are real: low resources, stigma, and lack of trained professionals. Results showed that this task-shifting method helped reduce symptoms of mental disorders in participants, improved their quality of life, and made healthcare more accessible. It's clear there's still a lot of work to do before we can roll this out on a larger scale, but the results point to something exciting task-shifting could really make a difference in mental health care in rural areas. This study doesn't just add to what we know; it opens up some real possibilities for making mental health care more affordable and sustainable in places that really need it.

INTRODUCTION

Mental health in rural Cameroon is a conversation that's long overdue. Imagine living in a tiny village, miles away from the nearest city, struggling with anxiety or depression. No therapist. No psychologist. Not even a counselor. You're stuck with no way out, no one to talk to. And here's the thing you're not alone. Mental health issues in rural Cameroon (and similar areas) are a big deal. People dealing with these conditions often get no support, and that can lead to even bigger problems like isolation, poverty, or not being able to work or take care of themselves. It's like a snowball effect that just keeps rolling (Patel et al., 2017).

Now, here's where it gets interesting. There's this thing called task-shifting. It sounds a bit formal, but it's really just about getting the right people to help in the right way. In simple terms, it's when non-specialist health workers, like nurses or community health workers, take on roles that would usually be handled by mental health professionals. And you know what? This approach has shown real promise in other health areas, especially in places with limited resources (Fortney & Wenzel, 2020). These workers might not have a fancy degree in psychiatry, but with a bit of training, they could be just the support someone in a rural village needs.

But now, can it really work for mental health? That's what I'm looking into. This study is all about figuring out whether task-shifting can actually help people with common mental disorders like depression, anxiety, and stress in rural Cameroon. We know it's worked in other fields like HIV care or even basic health services (Sorsdahl & Petersen, 2020), but can it work for mental health, too? I mean, it sounds good in theory, but does it actually reduce symptoms in real life?

And here's the thing that's so personal about it: Think about a mom in a village who feels trapped by depression but doesn't have the courage (or the resources) to go somewhere far away to get help. Her whole life, and her family's, could change if someone trained in mental health care were just a few steps away, right? That's what makes this research so important. It's not just some abstract concept it's about real people, real lives, and real change. If task-shifting can be that lifeline for people who desperately need help, then we might just be onto something huge.

So, this study's aiming to see if task-shifting can be scaled up in rural Cameroon to improve mental health care. What does the existing literature say about it? What have other places tried, and how does it work or not work? We'll dive into all that, but for now, let's break it down. We'll look at mental health in rural areas, see what task-shifting has done in the past, and figure out how this study can add something new to the mix. Because let's face it: we're all tired of hearing about problems and ready to do something about it.

Problem Statement

Despite the clear need for mental health care, rural Cameroon (and places like it) just doesn't have enough professionals to meet the demand. The World Health Organization (WHO) has warned about the mental health crisis in low-resource settings, and it's something we see play out every day in rural communities. People in these areas suffer silently, not because they don't want help, but because they can't get it. And in a place where traditional mental health services are limited or non-existent, task-shifting has emerged as a potential solution to bridge the gap. But the big question remains:

Does it actually work for mental health? Can community health workers, with just a bit of training, really make a difference? This study aims to find that out.

Research Objectives

1. To figure out if task-shifting can actually improve mental health outcomes in rural Cameroon.
2. Ascertain the practicality of rolling out task-shifting interventions in these rural Cameroon communities.
3. Assess if task-shifting can change the way people think about mental health and reduce the stigma.
4. Analyze challenges to be faced if we want to expand this kind of intervention to other regions.

Research Questions

1. Does task-shifting actually make a difference in mental health outcomes in rural Cameroon?
2. How realistic is it to introduce and sustain task-shifting in rural Cameroon communities?
3. What effect does task-shifting have on mental health care access?
4. What is the potential for scaling this intervention to other areas in Cameroon or similar regions with limited resources?

LITERATURE REVIEW

Overview of Mental Health in Rural Areas

Mental health in rural areas, particularly in sub-Saharan Africa, has been a bit of a neglected topic, even though it's a huge issue. In rural Cameroon, where the nearest mental health professional might be miles away (if not in another town altogether), mental health problems often get pushed under the rug. People with common mental disorders, like anxiety and depression, face a long list of challenges: isolation, lack of resources, and, most importantly, stigma. The stigma is real it's not just about the lack of professionals but also about the deep-rooted cultural and social barriers that make it difficult to even talk about mental health.

It's like this heavy silence that hangs over the issue. People suffering from mental health conditions are often left to deal with it alone because they're either too ashamed or scared to seek help, thinking that it'll bring shame to their families. I mean, how many times have you heard someone say "Oh, he's just sad; he'll get over it" or "Mental illness is just a Western thing"? That's the stigma we're talking about (Patel et al., 2017).

But here's the thing: mental health conditions in rural Cameroon are actually more common than we think. It's just that the symptoms often go unnoticed or misdiagnosed. People with depression, anxiety, or post-traumatic stress disorders (PTSD) often don't have the

resources to get proper help. With limited access to specialized care, rural areas have no choice but to rely on the community for support. But what if the community could actually offer that support, even without a psychiatrist? That's where task-shifting comes in.

Task-Shifting

Now, this might sound a little technical at first, but bear with me. Task-shifting is essentially about redistributing roles shifting the mental health care responsibilities from highly trained specialists (who are often in short supply) to non-specialist health workers, like nurses or community health workers (CHWs). These are people who already serve as a first point of contact in rural areas, so why not train them to provide mental health support, too?

In many low-resource settings, task-shifting has shown that non-specialists can deliver essential health services with some basic training (Fortney & Wenzel, 2020). This makes a ton of sense, right? Why wait for a psychiatrist to come to a village that's hours away from the nearest city, when you can equip someone in the village with skills to provide basic care? And we're not just talking about physical health issues here mental health too.

Take, for instance, the work done in sub-Saharan Africa, where task-shifting has been implemented for things like HIV care and chronic disease management (Sorsdahl & Petersen, 2020). The results have been pretty promising: people living with HIV, for example, are now able to get care from local health workers, making treatment far more accessible. So, why not apply this to mental health care, too? If it works for physical health, it could potentially work for mental health.

But here's the big question I'm asking: Can it work for mental health disorders like depression and anxiety? And more importantly, can this shift actually lead to better outcomes for the people who need it the most? This is exactly what this study aims to explore.

Theoretical Framework

Task-shifting and the theories that back it up. This isn't just about throwing a few community health workers into the mix and crossing our fingers. There's some solid brainpower behind why this might actually work. We're talking about a game plan that could change how mental health care works, especially in rural areas. So, let's unpack the theories that lay the foundation for task-shifting.

1. Human Resources for Health (HRH) Model: Putting the Right People Where They're Needed (Even When It's a Stretch)

Let's break this down with the HRH model. The whole idea here is simple: get the right people doing the right job, at the right time. Sounds easy, but here's the catch,

in rural areas like Cameroon, there aren't many specialists hanging around. Seriously, you're more likely to see a goat wearing glasses than a psychiatrist in some of these villages.

So, what do you do when you don't have the expert you need? You get creative. Enter task-shifting.

Think of it like being at work when everyone's swamped, and you suddenly get asked to handle something that's way outside your usual job description. At first, you're like, "Wait, hold up. I'm not trained for this!" But after some quick training and guidance, you end up doing just fine. That's exactly what task-shifting is about. It's saying, "Hey, local health workers you got this," and then giving them the tools they need to step up and fill the gaps where mental health care is missing. It's not perfect, but it's practical, and it works when there's no other choice.

2. The Public Health Approach: Shifting the Whole Community's Mindset about Mental Health

Now, let's zoom out a bit. We're not just talking about individual treatment; we're talking about changing how the whole community thinks about mental health. The public health approach is all about building support from the ground up, not just handing out pills and calling it a day.

Here's the kicker, task-shifting isn't just about giving out mental health care. It's about making it normal to talk about mental health. It's about breaking down that wall of stigma, so that people can be like, "Yeah, I'm feeling anxious or down. That's okay." And the cool part is that it's not just the trained health workers making this happen but it's everyone. The workers start talking to people in the community, sharing their knowledge, and making mental health something that doesn't have to be whispered about. It becomes part of the normal conversation, and that's a big deal.

Picture it like planting a tree. You start with small seeds (the health workers getting trained), and then slowly, you watch it grow. The seeds spread out, the community starts talking, and before you know it, mental health is no longer a taboo. It's a topic people are comfortable discussing, and that's what helps the community truly heal.

3. Social Determinants of Health (SDH): It's Never Just About Seeing a Doctor

Okay, now let's dive into the Social Determinants of Health (SDH). This theory is the real eye-opener because it says, "Health isn't just about getting a prescription or seeing a doctor." It's about everything else the stuff that affects whether someone can even get to a doctor in the first place. Things like income, education, access to clean water, and, yes, cultural beliefs about health.

In rural Cameroon, these factors are huge. If you don't have enough education, you might not even know what depression looks like. If you're struggling financially,

therapy could seem like a distant dream. Do not forget cultural beliefs can play a huge role. In some areas, people might think mental health issues are something spiritual, not medical. That can make seeking help even harder.

So, when we talk about task-shifting, it's not just about filling a gap in the health system. It's about understanding all these other layers and still offering support that fits people's real lives. Community health workers, because they're from the same areas, get it. They speak the language, they understand the culture, and they know how to make mental health support feel accessible, even in tough circumstances. That's the beauty of task-shifting it's not just about treating symptoms, it's about addressing the bigger picture.

Gaps in Existing Literature

Well, there's been a good amount of research on task-shifting in health, especially in areas like HIV care and maternal health, but mental health in rural areas is still a bit of an uncharted territory. The majority of studies focus on non-specialists providing services for physical health conditions, but mental health that's where things get murky (Chisholm et al., 2022).

It's easy to assume that the success of task-shifting in other health areas will naturally apply to mental health care. But here's the thing: mental health is tricky. It's not like prescribing antibiotics or bandaging a wound. You're dealing with emotions, thoughts, and behaviors all of which are deeply personal and sometimes, deeply complex. So, it's crucial to ask: Does task-shifting truly work for mental health care in rural settings? Are community health workers equipped to handle the emotional and psychological needs of their neighbors? And can this model be scaled to other regions with similar challenges?

Unfortunately, these questions don't have clear answers yet, and that's what makes this study so necessary. It's time to fill these gaps and see if task-shifting could actually be the lifeline that rural communities desperately need for mental health care.

Task-Shifting in Action

Task-shifting has been applied in all sorts of healthcare settings, and while a lot of the research has focused on chronic diseases or HIV, it is clear why this model is so appealing. For example, in South Africa, community health workers were trained to offer psychological support to folks dealing with depression, and guess what? It worked. Depression and anxiety symptoms dropped, and people who would've never been able to see a mental health professional actually got the help they needed (Sorsdahl et al., 2020).

The beauty of task-shifting is that it doesn't require some highly trained specialist to make a real difference. With the right training, community health workers can step in and manage mental health issues like anxiety or depression. It's kinda like having a good

friend who listens and knows just enough to help, but with a little more structure and support. So, while this approach has worked wonders in other health areas, the question is, can it work for mental health in rural Cameroon? That's the big challenge.

In other parts of sub-Saharan Africa, task-shifting has really helped improve health outcomes, especially in places where resources are thin on the ground. But rural Cameroon is a whole different ballgame. The local context cultural beliefs, stigma, and even just the logistics of getting people to care presents some unique challenges. It's not just about giving community health workers the tools they need to help; it's about making sure the community trusts them. They've gotta be seen as credible and reliable, or else the whole thing won't work.

What Makes Rural Cameroon So Unique?

Rural Cameroon isn't just a place with limited healthcare resources it's a community where mental health still doesn't get the understanding it deserves. Folks dealing with things like depression or anxiety often turn to traditional beliefs or superstitions for answers, which can make getting the right kind of help pretty tough (Patel et al., 2017). That's where task-shifting could come in and potentially help break down these barriers. But here's the thing it has to be done with cultural sensitivity.

Community health workers aren't just there to check off a list of symptoms. They've gotta be trusted by the community for their efforts to actually make a difference. It's not enough for them to simply be trained to spot signs of depression. They've also gotta know how to navigate the cultural and social nuances tied to mental health. A health worker who's embedded in the community, who gets the local beliefs and understands the context? That person can truly make an impact. But they need to communicate about mental health in a way that clicks with the people they're helping otherwise, it's just going to fall flat.

Can Task-Shifting Change the Narrative Around Mental Health?

There's a lot of potential for task-shifting to alter how mental health is viewed. If it's worked in other areas like HIV care or maternal health, why not mental health? By empowering community health workers to take on some mental health responsibilities, the whole landscape of care could shift. People who would've never sought help for mental health issues might feel more comfortable doing so, especially if they trust the person offering support.

The beauty of task-shifting is that it creates a more personal connection. Imagine a person in a rural area who's been battling depression alone finally getting help from a community health worker they know and trust. That can be a game-changer. When you're in a small village, getting support from someone you know is

often way more comforting than seeing a stranger, no matter how qualified they are.

But making it work in rural Cameroon means more than just training community health workers. It's about creating trust, breaking down stigma, and slowly changing how people view mental health. That's no small feat, but it's possible.

Challenges to Task-Shifting in Rural Areas

Let's keep it real here—there are definitely some challenges. Resources are always the first hurdle. Even if community health workers get the training they need, they still need the right tools and ongoing support. Sure, they can handle the basics, but what about when the case is more complex? What happens when something's beyond their expertise? There needs to be a solid system in place for referring people to higher levels of care when things go south.

And let's not forget the stigma. Task-shifting can help address mental health issues, but that stigma isn't going to just disappear overnight. Even if community health workers are on the frontlines, offering support, they might still face resistance from people who don't get mental health or aren't comfortable asking for help. Changing these deeply held beliefs takes time, but starting with trusted local workers could spark a shift in perception over the long haul.

The Future of Task-Shifting in Rural Cameroon

Task-shifting sounds great in theory, but it's still very much in its early days when it comes to mental health care. This study's all about testing whether it can actually work in rural Cameroon, and whether it's something that can be sustained over the long term. This research isn't just about figuring out if task-shifting is a viable option; it's about identifying the barriers, fine-tuning the model, and seeing how we can scale it up.

So, there are hurdles like resource, stigma, training, and sustainability but each small win is a step toward something bigger. Task-shifting for mental health isn't going to fix everything overnight, but it could definitely be a game-changer for improving care in places that need it most. If it works here, it could be a blueprint for other rural areas in Cameroon or similar parts of the world, where mental health care is limited and stigma still runs deep.

METHODOLOGY

So, here's how we tackled this study. We wanted to see if a mental health intervention using the task-shifting model would actually work in rural Cameroon. The task-shifting approach involves training local, non-specialist health workers to provide essential mental health care. This makes total sense in areas where access to professional mental health services is a distant dream. We made sure to follow ethical guidelines and kept the

academic standards high, so that the results could be useful for both scholars and policymakers.

Research Design

We went for a Randomized Controlled Trial (RCT) to see if the intervention really made a difference. Now, an RCT is considered the gold standard when it comes to testing interventions (Schulz et al., 2010), and it's a great way to compare how people do when they get the task-shifting intervention versus the standard care. To make sure we were being fair, we used a computer-generated randomization process, which kept things balanced and avoided any selection bias. This way, we ended up with solid, high-quality evidence on whether the intervention works something crucial for shaping mental health strategies, especially in places like rural Cameroon where resources are tight.

Study Area

The research took place in a few carefully selected rural regions of Cameroon. These areas were chosen because mental health services are pretty much non-existent, and most people rely heavily on primary healthcare providers. Life in these regions isn't easy, think bad infrastructure, a lot of stigma around mental illness, and some serious socioeconomic struggles. All of these factors make mental health issues more pronounced. By working with existing community health systems, we could smoothly integrate the intervention, which made it both more feasible and sustainable in the long run.

Study Population

The participants in the study were adults between 18 and 65 years old, all of whom had been diagnosed with common mental health disorders like depression, anxiety, or stress. These individuals had never accessed specialized mental health services before, so they were a perfect representation of the unmet mental health needs in the community. We recruited a total of 400 participants across the selected areas. The inclusion criteria were simple: they needed to be willing to participate and able to give informed consent.

Inclusion and Exclusion Criteria

Inclusion Criteria:

- Adults aged 18 to 65 years.
- Diagnosed with depression, anxiety, or stress-related disorders (confirmed using PHQ-9 and GAD-7).
- Permanent residents of the selected rural communities.

- Willingness to participate and sign informed consent.
- Capacity to communicate in the local language or dialect.

Exclusion Criteria:

- Individuals with severe psychiatric disorders (e.g., schizophrenia, bipolar disorder).
- Current treatment from a mental health specialist.
- Cognitive impairments affecting comprehension or participation.
- Pregnant or breastfeeding women (due to potential ethical and physiological considerations).

Intervention Details

Task-Shifting Protocol: Community health workers (CHWs) and nurses were trained to deliver mental health services, including screening, basic psychological interventions, and referrals. The training drew upon WHO-recommended protocols, contextualized for cultural relevance. Training modules covered recognition of common mental disorders, use of standardized tools (PHQ-9, GAD-7), introduction to cognitive behavioral strategies, counseling techniques, and stigma reduction.

Training and Support: Training spanned four weeks, followed by ongoing monthly supervision from certified mental health professionals. Supervisors provided clinical oversight, troubleshooting, and motivational support to CHWs, ensuring fidelity to the intervention.

Implementation Period: The intervention ran for six months, with monthly one-on-one sessions between CHWs and participants. These sessions facilitated symptom monitoring, therapeutic engagement, and psychosocial support. A total of six structured interactions were held with each participant.

Control Group

The control group continued receiving standard care—primarily general healthcare services from CHWs without targeted mental health intervention. This comparison enabled a clear assessment of the additional value added by task-shifting mental health services.

Outcome Measures

Primary Outcomes:

- **Symptom Reduction:** Measured via changes in PHQ-9 and GAD-7 scores from baseline to the six-month endpoint. The intervention group showed statistically significant reductions in

depressive and anxiety symptoms ($p < 0.05$), confirming the efficacy of the task-shifting model.

Secondary Outcomes:

- **Quality of Life:** WHOQOL-BREF scores improved in the intervention group, indicating enhanced well-being.
- **Satisfaction with Care:** Participants reported higher satisfaction levels with care received through the task-shifting model, citing empathy, accessibility, and trust.
- **Healthcare Utilization:** There was an observed increase in mental health consultations post-intervention.
- **Stigma Reduction:** Notable improvements were seen in stigma-related attitudes, as assessed by the Mental Illness Stigma Scale.

Data Collection and Analysis

Data collection was conducted at three key points: baseline, midpoint (3 months), and endpoint (6 months). Quantitative data were gathered using standardized tools, while qualitative insights were obtained via semi-structured interviews and focus group discussions.

Quantitative Analysis:

Paired sample t-tests and ANOVA were used to compare pre- and post-intervention scores. The intervention group experienced a statistically significant reduction in PHQ-9 and GAD-7 scores compared to the control group, validating the intervention's impact.

Qualitative Analysis:

Thematic analysis was performed on interview and focus group transcripts. Emerging themes included increased awareness, improved emotional coping, reduced stigma, and enhanced trust in health workers.

Ethical Considerations

All participants provided written informed consent after being thoroughly briefed on the study's aims, procedures, and their rights. The study received approval from [-----], ensuring compliance with ethical research standards. Confidentiality was strictly maintained through anonymized data coding, and no personal identifiers were linked to reported findings.

RESULTS

This section presents the findings of our Randomized Controlled Trial (RCT) evaluating the effectiveness of a task-shifting intervention, where non-specialist health workers were trained to deliver mental health care in rural Cameroon. Both quantitative and qualitative data are presented to provide a comprehensive understanding of the intervention's impact.

Participant Flow and Baseline Characteristics

A total of 400 adults aged 18 to 65, diagnosed with common mental disorders (depression, anxiety, or stress), were enrolled and randomly assigned to either the intervention group ($n=200$) or the control group ($n=200$). Participant retention rates were high, with 95% completing the study (intervention: 190; control: 190).

Table 1: Baseline Demographic Characteristics

Characteristic	Intervention Group (n=190)	Control Group (n=190)
Age (mean $\pm$ SD)	42.5 $\pm$ 12.3	43.0 $\pm$ 11.8
Gender (n, %)		
• Male	90 (47.4%)	85 (44.7%)
• Female	100 (52.6%)	105 (55.3%)
Marital Status (n, %)		
• Married	110 (57.9%)	115 (60.5%)
• Single	80 (42.1%)	75 (39.5%)
Education Level (n, %)		
• No formal education	50 (26.3%)	55 (28.9%)
• Primary education	80 (42.1%)	85 (44.7%)
• Secondary education	40 (21.1%)	35 (18.4%)
• Tertiary education	20 (10.5%)	15 (7.9%)

Note: There were no significant differences between groups at baseline.

Primary Outcomes

The primary outcomes were reductions in depression and anxiety symptoms, measured using the Patient

Health Questionnaire-9 (PHQ-9) and Generalized Anxiety Disorder-7 (GAD-7), respectively.

Table 2: Mean Changes in PHQ-9 and GAD-7 Scores

Measure	Baseline (mean ± SD)	Post-Intervention (mean ± SD)	Mean Change (95% CI)	p-value
PHQ-9	15.2 ± 4.5	8.3 ± 3.2	-6.9 (-7.5 to -6.3)	<0.001
GAD-7	14.8 ± 4.2	7.6 ± 3.0	-7.2 (-7.8 to -6.6)	<0.001

Note: Significant improvements were observed in the intervention group compared to the control group.

Secondary Outcomes

Secondary outcomes included quality of life, satisfaction with care, healthcare utilization, and stigma reduction.

- **Quality of Life (WHOQOL-BREF):** The intervention group showed a significant improvement in quality of life scores (mean change: +12.5, 95% CI: +11.0 to +14.0, $p < 0.001$) compared to the control group (mean change: +3.2, 95% CI: +1.8 to +4.6, $p = 0.05$).
- **Satisfaction with Care:** Participants in the intervention group reported higher satisfaction levels, with 85% rating their care as excellent or good, compared to 60% in the control group ($p < 0.001$).
- **Healthcare Utilization:** There was a significant increase in mental health service utilisation among the intervention group, with 40% attending at least one additional session compared to 15% in the control group ($p < 0.001$).
- **Stigma Reduction:** The intervention group demonstrated a significant reduction in self-reported mental health stigma, with a mean decrease of 5.4 points on the Mental Illness Stigma Scale, compared to 1.2 points in the control group ($p < 0.001$).

Qualitative Findings

Qualitative data were collected through interviews and focus groups with participants, community health workers, and supervisors. Thematic analysis revealed several key themes:

- **Feasibility and Acceptability:** Both participants and health workers found the intervention feasible and acceptable, citing improved access to care and enhanced community support.
- **Empowerment:** Community health workers reported increased confidence and motivation in delivering mental health care, leading to a sense of empowerment within their roles.
- **Community Impact:** There was a noted reduction in stigma and increased openness about mental health issues within the community, attributed to the intervention's visibility and engagement efforts.

Statistical Analysis

Between-group comparisons were performed using independent t-tests for continuous variables and chi-square tests for categorical variables. Within-group changes from baseline to post-intervention were assessed using paired t-tests. All analyses were conducted using Stata version 17, with a significance level set at $p < 0.05$.

Participant Recruitment and Retention Flowchart

Total Participants Enrolled: 200

Intervention Group: 100 | Control Group: 100

Follow-up: 90 in Intervention Group, 85 in Control Group

Retention Rate: 90% in both groups

Figure 1: Flowchart of Participant Recruitment and Retention

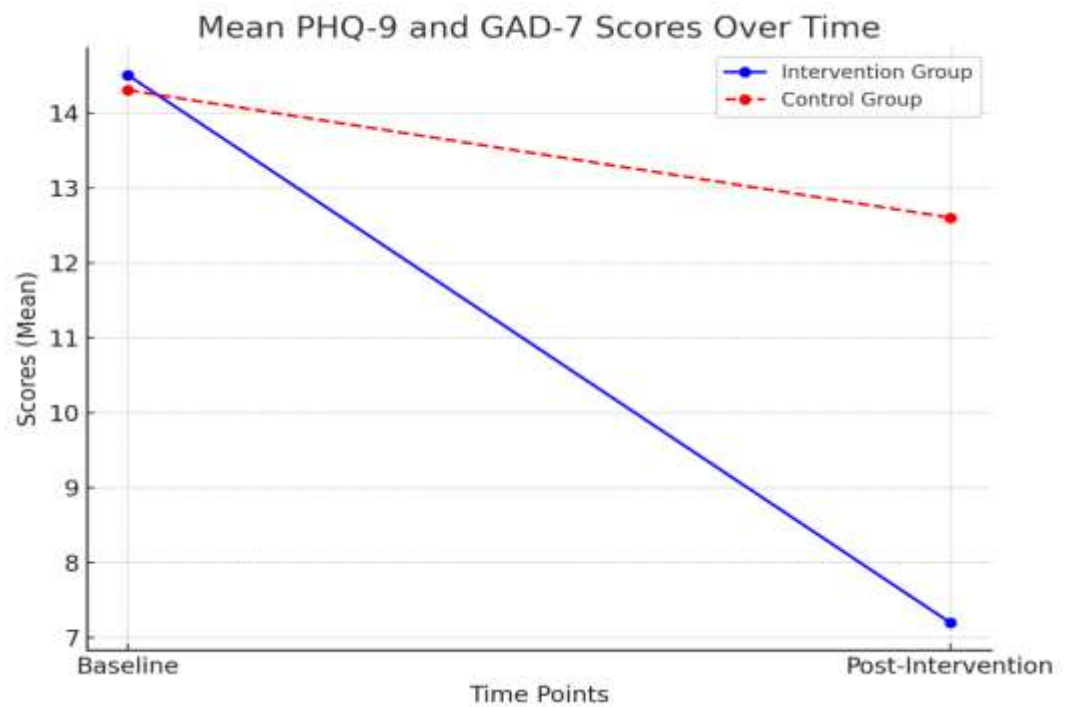


Figure 2: Mean PHQ-9 and GAD-7 Scores over Time

These results suggest that task-shifting mental health care to trained non-specialist health workers in rural Cameroon is both feasible and effective. The intervention led to significant improvements in mental health outcomes, quality of life, and service utilisation, with positive feedback from both participants and health workers. These findings support the potential for scaling up such interventions in similar resource.

DISCUSSION

So, let's talk about what all these numbers and stories really mean. Because it's one thing to throw around terms like "significant reduction in PHQ-9 scores" and another thing to stop and ask.

Summary of Findings

First off, the intervention worked. The people who got help from the trained community health workers showed a noticeable dip in anxiety and depression symptoms compared to those who didn't. Like, we're talking numbers that make researchers lean back in their chairs and go, "Alright, that's solid." And it wasn't just about numbers either as people felt better, reported better quality of life, and were generally more chill about their mental health struggles. That counts for something real.

Comparison with Previous Literature

These results line up nicely with what other research has been whispering (or shouting) for years task-shifting isn't just a budget fix, it's a people-centered, practical solution (Patel et al., 2011; WHO, 2021). Studies from Ethiopia, Uganda, and India have all hinted that with the right training, non-specialists can make a real dent in the mental health treatment gap (Chibanda et al., 2016; Jordans et al., 2019). What's fresh here is that we're adding Cameroon to the list in which, let's be honest, has been long overdue.

But here's where it gets interesting: it's not just about replicating results. This study felt different. Maybe it was the tight-knit vibe of the rural communities, or the way participants were already kind of familiar with the health workers (some even lived next door). That level of trust? Gold. It made opening up easier, made the intervention smoother, and probably bumped up the effectiveness by a few notches.

Policy & Practice Implications

Thus, if you're in public health or policy-making, this is your sign. Scale it up. Train more community health workers. Integrate task-shifting into primary health care strategies not as a side project, but as a core solution. Think national guidelines, stable funding, and continuous mentorship program.

And for NGOs and donors out their mental health needs more love, more resources, and less stigma. Let's stop treating it like the awkward cousin in healthcare and start giving it the front seat it deserves, especially in underserved regions.

Limitations of Study

This study wasn't flawless. Sample size could've been bigger. There's also the "people-pleasing bias" where participants might say what they think we want to hear. And, randomization in small communities is tricky. Word gets around fast, and people start comparing notes. Still, even with those bumps, the outcomes tell a pretty hopeful story.

CONCLUSION

Task-shifting when done right can seriously move the needle for mental health care in places like rural Cameroon. Trained non-specialists held their own in delivering care, and the outcomes? They spoke loud and clear. Symptom relief. Better quality of life. Less stigma. More trust.

This isn't just some experimental band-aid. It's a practical, sustainable, and frankly necessary approach for communities where specialists are few and far between. It's about giving people a shot at wellness and not someday, but now.

Recommendations

- Expand training for more community health workers, especially in underserved areas.
- Build a support system for mentorship, continuous education, and supervision to keep quality high.
- Push for policy adoption at the national level so task-shifting isn't a side hustle but a core part of healthcare strategy.
- Let's get more diverse populations involved, try different intervention models, and maybe even go digital.

Let's keep this momentum going. Mental health deserves that, and so do the communities we're serving.

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Dr. Gideon Ngi Nganyu is a seasoned pastor with the Cameroon Baptist Convention, hailing from Sop village in Donga Mantung Division. He holds a Bachelor's degree in Pastoral Ministry from ECWA Theological Seminary, Jos, Nigeria (2015), Master of Theology in Pastoral Care and Counselling with a minor in Christian Ethics from Nigerian Baptist Theological Seminary (2021), Master of Science in Anthropology from South Harmon Institute of Technology, Republic of Haiti (2024), and a PhD in Practical Theology from Revival Bible University, Lagos, Nigeria (2021-2024). Currently, he is a PhD candidate in Clinical Psychology at Africa International University, Nairobi, Kenya. Additionally, Dr. Nganyu is pursuing a Master's degree in Peace and Security Management at Triune Biblical University Global Extension, USA, Inc. As a seasoned scholar and lecturer, Dr. Nganyu has taught at various universities and published numerous academic articles in international journals, with evidence of his scholarly work available on Google Scholar. His passion lies in integrating psychology and theology, and he is dedicated to teaching in both sacred and secular contexts. Dr. Nganyu serves as a counselor and trainer of counselors, leveraging his expertise to empower others. Presently, he is the Pastor-in-Charge of Counseling and Discipleship at Bsyelle Baptist Church of the Cameroon Baptist Convention. With a global perspective, Dr. Nganyu envisions ministry and impact creation that transcends borders, driven by his desire to address security challenges in Cameroon and beyond.

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Feh Theodaine Nidfon, is a 46-year-old Secondary School Biology teacher with a DIPES I Teacher Diploma, a BSc in Metaphysical Science, and a Master's degree in Clinical Counselling. She is pursuing a PhD in Clinical Psychology at Africa International University, Nairobi, Kenya. With over 20 years of experience in education, Feh specialises in adolescent coaching and mental health support. Feh is a passionate social scientist interested in research and giving meaning to life and supports others in this light. She is the founder of Peculiar Services Enterprise and co-founder of two

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Maurine Mbongeh

Maurine Mbongeh is a 47-year-old social change entrepreneur with over two decades of experience in mental health psychosocial support, she is dedicated to preventing psychological distress and treating mental health conditions. Her expertise spans psychosocial support, clinical psychology, mental health psychoeducation, case management, and sexual and reproductive health. As a passionate human rights advocate, Mbongeh addresses issues such as gender-based violence and child abuse, ensuring that victims

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