Greener Journal of Biomedical and Health Sciences

Vol. 8(1), pp. 44-63, 2025

ISSN: 2672-4529

https://gjournals.org/GJBHS

DOI: https://doi.org/10.15580/gjbhs.2025.1.052725099

Assessing the Mental Health Needs of Patients with Chronic Diseases in Cameroon Baptist Convention Health Services Facilities: A Cross-Sectional Study

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ARTICLE'S INFO

Article No.: *052725098*
Type**:** *Research*
Full Text: *PDF, PHP, EPUB, MP3*
DOI: *10.15580/gjbhs.2025.1.052725099*

Accepted: *03/06/2025*
Published: *10/06/2025*

Keywords: *Mental health, chronic diseases, HIV/AIDS, diabetes, hypertension, psychological distress, integrated care, faith-based health systems, Cameroon Baptist Convention Health Services (CBCHS), cross-sectional.*

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Article's QR code

ABSTRACT

A key factor of navigating the health journey in many low-resource settings comes in the form of patients receiving care for chronic conditions such as HIV/AIDS, diabetes and hypertension who often confront very high levels of psychological distress. This article describes an often-neglected dimension of chronic disease care in Cameroon Baptist Convention Health Services (CBCHS) facilities with respect to mental health. We conducted a cross-sectional survey of 400 patients in four major CBCHS hospitals using validated mental health screening instruments. Results show that around 38% of participants showed moderate to severe symptoms of depression or anxiety which often fell under the radar and were left untreated. The burden was greatest among people living with HIV. Such findings highlight the urgent need for integrated-care approaches that take a more holistic perspective on patients, considering their physical and mental health together, especially in faith-based health systems that deliver care in resource-constrained settings.

INTRODUCTION

In Cameroon, many people are dealing with chronic conditions like HIV/AIDS, diabetes, and good ol' hypertension. It's honestly more common than most people realize almost like these illnesses are just lurking in the background of everyday life. These conditions have an impact not just on their bodies but also on their state of mind and overall wellbeing. Patients regularly grapple with sadness, fear, and stress as they cope with their health, but mental health support is seldom provided as part of their treatment. Most healthcare interventions are focused only on treating physical symptoms.

Set up by the Cameroon Baptist Convention, the Cameroon Baptist Convention Health Services (CBCHS) is the largest faith-based health system and one of the key providers of health services across the country, particularly in rural settings. CBCHS already has a solid presence in the community, and let's be honest its spiritual backbone gives it a unique edge when it comes to caring for the whole person, not just patching up physical stuff. We're talking body, mind, and spirit here. But even with all that potential, their mental health services is still kind of basic. Honestly, they rarely show up as part of the regular care routine, which is a bit of a missed opportunity.

Globally, researchers have been shouting this from the rooftops that mental and physical health are like two sides of the same coin. If someone's battling a chronic condition maybe diabetes, heart stuff, or even sickle cell there's a pretty good chance they're also dealing with anxiety or depression on the low (Ngasa et al., 2021; Aroke et al., 2020). And it's not a one-way street. Poor mental health can make it super tough for people to stay on top of their treatments. It's like trying to climb a hill while carrying emotional baggage and that is not easy.

Now here's the thing, in Cameroon, there's not a whole lot of solid research documenting this mental–physical health link. And when you zoom in to just CBCHS hospitals it is even less. This study is hoping to chip away at that gap and wish to see just how common mental health struggles are among people living with chronic diseases in the CBCHS system, and more importantly, whether the current mental health support (as sparse as it might be) is actually helping them cope.

Background of the Study

Chronic illnesses like HIV/AIDS, diabetes, and hypertension are becoming a bigger and bigger deal in Cameroon. They're not just random health hiccups they stick around for the long haul and can really mess with someone's physical health, emotions, and even their social life. It's a tough ride. And honestly, a lot of folks battling these conditions also deal with mental health struggles like depression or anxiety but those often fly under the radar.

In most health centers especially in faith-based ones like the Cameroon Baptist Convention Health Services (CBCHS) the spotlight tends to stay on the physical stuff. Which makes sense but the mental side of things kind of gets left in the shadows. There aren't enough trained mental health pros, and to be real, mental wellness just isn't treated like its part of the chronic care package. But it should be, right? This means that patients who suffer from emotional or psychological problems often do not receive the help they need.

The CBCHS provides care to a large number of people living with chronic diseases. These services are available in rural and urban areas and are trusted by many communities. Although CBCHS believes in holistic care, mental health is still not included in a structured or consistent way. Many patients silently suffer from mental health issues without diagnosis or treatment. This leads to poor treatment outcomes, especially among people living with HIV.

Problem Statement

Even though patients with chronic diseases often experience mental health problems, CBCHS facilities do not have clear systems to screen for or manage these issues. Most patients are not asked about their mental well-being during visits, and healthcare workers are not trained to handle such concerns. As a result, mental health needs remain unnoticed, and untreated, making it harder for patients to manage their physical illnesses.

Research Objectives

1. Assess the level of mental care awareness among patients with chronic illnesses in CBCHS facilities.
2. Identify the effects of limited mental care awareness on the mental well-being of patients with chronic illnesses.
3. Explore the key factors contributing to poor mental health awareness and care among chronically ill patients.
4. Examine effective strategies and interventions that can be used to improve mental care awareness and promote mental well-being within CBCHS health facilities.

Research Questions

1. What is the current level of mental care awareness among patients with chronic illnesses in CBCHS facilities?
2. How does limited mental care awareness affect the mental well-being of patients with chronic illnesses?
3. What are the main factors contributing to poor mental health awareness and care among patients in CBCHS?
4. What strategies and interventions can improve mental care awareness and promote mental well-being in CBCHS settings?

LITERATURE REVIEW

Overview of Mental Health and Chronic Illness in Low-Resource Settings

People are finally starting to pay attention to how physical illness and mental health are linked especially in places like low- and middle-income countries (LMICs), where healthcare systems tend to focus more on stuff like infectious diseases and emergencies, and kind of forget that long-term mental well-being is a thing too.

Now, chronic illnesses like HIV/AIDS, diabetes, and hypertension aren't just about the body breaking down. They mess with your head, your heart (not just the physical one), and your whole vibe. Living with these conditions' day in and day out? That takes a serious mental toll. Studies show that folks dealing with these kinds of diseases are way more likely to end up battling depression or anxiety too (Ngasa et al., 2021; Aroke et al., 2020). And if nobody's addressing that side of things it just makes everything harder sticking to meds, staying motivated, even feeling like life's worth the hustle.

Van Rensburg and Tema (2019) talk about this deep mind–body connection and point out that in Sub-Saharan Africa, its super common for people to carry emotional weight they've never even named let alone gotten help for. So, it really drives home the need for care models that treat people as whole humans, not just a collection of symptoms.

Now here's the kicker, in Cameroon, mental health is still pretty low on the priority list when it comes to managing chronic illness. And in places like CBCHS which, by the way, handles a huge chunk of healthcare in rural areas that gap is even more obvious. They've got the spiritual and physical care down, no doubt, but the mental health side still playing catch-up.

Mental Health Awareness Among Patients with Chronic Illnesses

Understanding mental health like, what the symptoms even are, why they matter, and where to get help is the first real step toward healing. But here's the truth: a lot of folks in Sub-Saharan Africa, Cameroon included, are still in the dark when it comes to mental health basics. We're talking super low mental health literacy.

A national study by Siewe Fodjo et al. (2021) showed that during the chaos of COVID-19 when pretty much everyone was stressed out only a small number of people could even recognize signs of depression or anxiety in themselves or others. Wild, right? And it's not just a fluke. Toguem et al. (2022) found that over in Cameroon's West Region, mental health services are struggling. Why? Because people don't really get what mental health is, it's barely built into regular healthcare, and there aren't nearly enough professionals who specialize in it.

Now, this gap hits even harder if you're someone living with a chronic illness. Aroke et al. (2020) found that nearly 27% of type 2 diabetes patients at a Cameroonian reference hospital were dealing with depression but here's the kicker: fewer than 10% had ever talked to a doctor about how they were feeling emotionally. That's not just sad, it's scary. Same story in Nicolet et al. (2021)'s study teenage moms in Yaoundé were dealing with serious perinatal depression, but because of stigma and just not knowing better, most of it went unspoken and untreated.

It's like people are silently suffering, thinking it's normal to feel that way when help could actually make a world of difference.

Effects of Limited Mental Health Support in Chronic Disease Care

When mental health awareness and care are lacking, the consequences can be pretty rough. It's not just about

feeling down; it can actually make things worse physically. Take the study by Ngasa et al. (2021) as an example they pointed out that untreated depression and anxiety in patients hospitalized with COVID-19 didn't just make them feel worse, but it actually prolonged their stay and upped the risk of complications. This isn't just some isolated case either. If we look at it broadly, it makes sense that if we ignore mental health in chronic care settings, it could mess with how motivated patients are, how they make decisions, and even whether or not they stick to their treatment plans.

Adama et al. (2015) did a study on postpartum depression in Cameroonian women and found that when mental health problems go undiagnosed, it can lead to women delaying treatment, which ends up with worse outcomes for both mom and baby. It's like this vicious cycle where unaddressed mental health issues make everything else harder. This idea is echoed by Lyman (2025), who says that chronic physical pain can actually get worse or drag on longer if there's mental distress hiding behind it. And Nord (2025) agrees, stressing that to properly manage illness, you can't just focus on the physical side you need to balance it out with a strong understanding of what's going on mentally too.

It's kind of wild, right? We've got this clear link between mental and physical health, but a lot of the time, we're still kind of playing catch-up on recognizing how intertwined they really are. It's not just about "feeling better," it's about overall wellness.

Structural and Cultural Barriers to Mental Health Integration

When we look at what's keeping mental health care in Sub-Saharan Africa from being where it needs to be, a few big issues pop up. First off, there's just not enough trained mental health professionals. Add that to cultural stigmas around mental health, policy gaps, and weak institutional support, and it's easy to see why things aren't improving as quickly as they should be (Skuse, 2008; Kalipeni & Thiuri, 1998). Take Cameroon, for example. There, mental illness is often viewed through a spiritual lens due to deep religious and cultural beliefs. People tend to go to prayer houses or traditional healers instead of seeking help in clinical settings (Metzl, 2010; CBCHS, n.d.). It's tough to shift those long-held beliefs, so patients are stuck in this cycle of not getting the right care.

Now, within CBCHS (the Catholic Diocese of Buea's Community Health Services), the idea is that care should be holistic, but in practice, mental health services are all over the place. There's some psychosocial support, sure, but it's often underfunded and doesn't really mesh with the regular management of chronic diseases (CBCHS, n.d.). Vaughan et al. (2021) makes a key point here: if we want real healthcare reform in the region, we can't just focus on the clinical side of things. We've got to take into account the bigger picture the history, the culture, and everything else that shapes how people engage with their health. It's not just about the treatment; it's about how society views mental health and the barriers that come with that.

Toward an Integrated Model of Care: Evidence-Based Interventions

When you think about the challenges faced by chronically ill patients, it's clear that the traditional way of treating illnesses in separate boxes isn't cutting it anymore. O'Rourke (2022) argues that we need health systems that get the full picture acknowledging not just physical pain, but the emotional and mental toll that often comes with it. In places like Cameroon, there's actually been some success with combining chronic care and psychosocial counseling, and the results have been encouraging (Nicolet et al., 2021; Ngasa et al., 2021).

The WHO-AIMS framework, as applied in Cameroon by Toguem et al. (2022), lays out a solid plan for improving mental health systems. It's all about training health workers who are on the frontlines, creating clear pathways for referrals, and running public campaigns to break down the stigma around mental health. If CBCHS were to implement these ideas, we could see a huge shift. Things like community mental health outreach, using quick screening tools in chronic care units, and teaming up with faith leaders to spread mental health awareness could make a real difference. It's about taking mental health out of the shadows and making it a part of everyday healthcare conversations.

Importance of Mental Care Awareness

Mental health awareness is a game-changer when it comes to holistic healthcare, especially for chronic conditions like HIV/AIDS, diabetes, and hypertension. In places like Cameroon, where people are juggling both infectious and chronic diseases, understanding mental health is more important than ever. Mental health literacy isn't just about knowing the symptoms or signs of mental illness. It's about realizing how crucial it is to get help early, knowing where to turn for support, and breaking down the stigma that still surrounds mental health.

In low-resource settings like this, the lack of awareness can be a huge barrier to better health outcomes. If people don't know the signs or feel too ashamed to seek help, it just makes managing these diseases even harder. Building mental health literacy can literally change the game by making it easier for patients to recognize when they need help and encouraging them to get the support they deserve. The sooner that mental health is recognized as a key part of healthcare, the better the results will be for everyone.

1. Early Detection and Timely Intervention

One of the biggest perks of mental health awareness is its ability to help catch mental health issues early. Wang et al. (2005) point out that when people are clued in about mental health, they're more likely to spot the signs in themselves and others, which leads to quicker

intervention. This is super important for folks dealing with chronic conditions like HIV, diabetes, or hypertension because mental health problems that go unnoticed can make everything worse. If depression or anxiety shows up alongside physical illness, it can make the disease progress faster, mess with a person's ability to stick to their treatment plan, and even raise the risk of dying (Ngasa et al., 2021; Aroke et al., 2020).

CBCHS, even though it's focused on community-based care, doesn't always have the systems in place to spot mental health issues early. This is especially true for HIV patients who might quietly deal with depression or anxiety without anyone noticing. If those symptoms aren't picked up, the person might not get the help they need, and their overall health can suffer as a result. A stronger system that integrates mental health checks could really make a difference, giving those patients a better shot at both their physical and emotional well-being.

2. Preventive Approaches to Mental Health

Mental care awareness also contributes to preventive mental health strategies, enabling individuals and communities to adopt behaviors that protect mental well-being. Herman et al. (2019) highlights the importance of early education, coping strategies, and community-based initiatives in mitigating mental health risks. In resource-constrained settings like CBCHS hospitals, prevention is not only cost-effective but also vital for sustainability. Nord (2025) emphasizes that when individuals understand how psychological stress interacts with chronic pain or disease, they are more likely to engage in preventive behaviors such as stress management, exercise, and peer support participation measures that can be institutionalized within CBCHS's holistic care model.

3. Enhanced Help-Seeking Behaviors

Mental health awareness is also a key player in preventing mental health issues before they even start. When people and communities know what to look for and how to manage their mental well-being, it can lead to healthier, more proactive behaviors. Herman et al. (2019) make a solid point here: early education, coping strategies, and community-based efforts are all crucial in reducing the risks associated with mental health problems. In places like CBCHS hospitals, where resources are tight, focusing on prevention isn't just cost-effective it's actually essential for long-term success.

Nord (2025) takes it a step further, saying that when people understand how mental stress interacts with chronic pain or illness, they're more likely to take action. Simple things like managing stress, staying active, or getting support from others can have a huge impact. And these aren't just good practices they can be woven right into CBCHS's holistic care approach. By making prevention a part of everyday care, CBCHS can help people stay healthier for longer, both mentally and physically. It's a win-win, especially in settings where the stakes are so high.

4. Combating Mental Health Stigma

Stigma is still one of the biggest roadblocks when it comes to mental health care in sub-Saharan Africa. Thornicroft et al. (2007) hit the nail on the head when they say that society often sees mental illness as a weakness or moral failure, which leads to discrimination and a general lack of care. Within CBCHS, this stigma is even worse because mental health professionals aren't always visible, and the focus tends to be more on physical health issues. So, people who need mental health support might not even know where to go, or feel like they shouldn't ask for help in the first place.

Vaughan et al. (2021) suggest that changing how people think about mental illness requires a shift in the narrative one that's rooted in local culture and moves away from colonial-era health messaging. CBCHS, with its strong religious and community focus, is in a good position to take this on. They could use faith-based values like compassion, healing, and inclusion to reframe mental health in a way that feels more acceptable and relevant to the community. If we can change how people view mental health, it could open up more pathways for care and understanding, ultimately reducing stigma and helping more people get the support they need.

5. Holistic and Integrated Care Models

One of the best things that can come from increasing mental health awareness is the chance to develop integrated care models, where both physical and psychological health are tackled at the same time. This isn't just a nice idea; it's something that experts, both locally and globally, say is crucial for managing chronic diseases (van Rensburg & Tema, 2019; Ngasa et al., 2021). The WHO-AIMS assessment in Cameroon pointed out how mental health services are often fragmented and how urgently we need more coordinated care pathways (Toguem et al., 2022).

CBCHS, thanks to its deep roots in the community and broad service reach, is in a prime position to really push this integration forward. They could make a huge impact by weaving mental health into the routine management of chronic diseases, training frontline staff to recognize and address mental health issues, and setting up systems where patients and counselors can give and receive feedback. This approach could help break down the silos that separate physical and mental health care, offering a more holistic, effective solution for those dealing with chronic illnesses. It's the kind of change that could truly transform healthcare in the region.

6. Societal Well-being and Productivity

On a larger scale, boosting mental health awareness can make a big difference in public health, economic

productivity, and family dynamics. When the psychological distress of chronically ill individuals is left unchecked, it often leads to absenteeism, lower participation in the workforce, and more strain on caregivers (Kalipeni & Thiuri, 1998; O'Rourke, 2022). In the case of CBCHS, awareness programs could play a dual role not only improving the well-being of patients but also helping to build stronger, more resilient communities. As Lyman (2025) points out, healing isn't just about what happens in a clinic it's a social process too. It requires everyone to be aware and empathetic, so the whole community can contribute to the healing journey, making it more sustainable and far-reaching.

7. Intersectionality and Vulnerable Populations

Mental health awareness becomes even more critical when we look at marginalized groups like women, adolescents, and the elderly—who are living with chronic diseases. Research by Adama et al. (2015) and Nicolet et al. (2021) shows how perinatal depression and mental health challenges in adolescents often get missed in general care, leaving these vulnerable groups without the support they desperately need. For CBCHS, focusing awareness efforts on these groups can make sure that mental health services reach those who are doubly vulnerable due to both their social position and their chronic health issues.

To wrap it all up, mental health awareness isn't just an add-on; it's at the heart of effective chronic disease management. Promoting it within CBCHS is not just urgent—it's absolutely necessary, especially with the rising mental health issues among chronically ill patients in Cameroon. By integrating care, reducing stigma, catching problems early, and using preventive strategies, CBCHS has the chance to shift from simply treating illness to really promoting overall wellness. This change is crucial for making healthcare more sustainable, especially in faith-based and resource-limited settings. It's not just about fixing the problems that already exist—it's about creating a healthier, more resilient future.

Consequences of Insufficient Mental Care Awareness

1. Rising Prevalence of Undiagnosed Mental Health Disorders

When it comes to managing chronic illnesses, the lack of mental health awareness is a huge factor in the growing number of undiagnosed and untreated mental health issues. As Ngasa et al. (2021) point out, people with chronic infections like COVID-19 often show symptoms of anxiety and depression that are just as intense as those found in chronic conditions like HIV/AIDS. Aroke et al. (2020) also found that 34.5% of patients with type 2 diabetes in Cameroon met the criteria for depression but had no access to mental health care. This kind of situation is common across CBCHS facilities, where both patients and healthcare providers are often not equipped with the knowledge to identify the early signs of psychological distress.

In CBCHS settings, this lack of awareness leads to serious underdiagnosis, particularly among HIV-positive patients. When symptoms like fatigue, hopelessness, or panic attacks show up, they're often misunderstood as just part of the physical illness, rather than being recognized as potential signs of mental health issues (van Rensburg & Tema, 2019). This misinterpretation delays care and allows mental health problems to get worse over time.

2. Impaired Disease Management and Health Outcomes

Not only does a lack of mental health awareness make it harder to diagnose conditions, but it also messes with how chronic diseases are managed. When depression or anxiety goes untreated, patients often have a hard time sticking to their treatment plans, showing up for appointments, or making the necessary lifestyle changes (Nord, 2025). The connection between mental distress and poor health outcomes is clear: when mental health symptoms are ignored, it leads to faster disease progression, more hospitalizations, and higher long-term healthcare costs (Lyman, 2025; Skuse, 2008).

At CBCHS, where chronic care depends heavily on the patient's own involvement in managing their condition, the lack of mental health support seriously affects the effectiveness of physical treatments. Nicolet et al. (2021) showed in their study on perinatal depression that when mental health conditions go undetected, it diminishes a person's ability to function socially and emotionally, which impacts their willingness to seek medical help. This means that without addressing mental health, chronic disease management becomes much harder, leaving patients with fewer chances for improvement and healing.

3. Educational Disruption and Reduced Productivity

If mental health challenges aren't addressed early on, they can mess with a person's ability to think clearly, concentrate, and remember things—skills that are essential for success in both education and the workplace. For younger people living with chronic conditions, this can lead to disengagement from school or poor job performance (O'Rourke, 2022; Lee et al., 2014). Within faith-based organizations like CBCHS, where holistic care is central, this is a major missed opportunity. Spiritual care could be paired with psychosocial support to build resilience in a way that empowers individuals to manage their mental health and improve their productivity in school, work, and beyond.

4. Isolation and Social Dysfunction

When people don't have a strong understanding of mental health, they often struggle with emotional regulation and communication. This makes it harder for them to maintain healthy relationships, which can lead to

social isolation and stigma two things that only make chronic illness worse (Rigby et al., 2007; van Harmelen et al., 2017). In CBCHS communities, where support from family and peers is crucial for ongoing care, this breakdown in social connections can really hold patients back. Without strong relationships, it's harder for individuals to stick to their treatment plans or find the support they need to recover. It's a vicious cycle that can keep people stuck in a place where their physical and mental health both deteriorate.

5. Systemic Consequences in Resource-Constrained Settings

In resource-limited environments like those served by CBCHS, the impact of poor mental health awareness doesn't just hurt individual patients but it puts a huge strain on the entire health system. Clinics often deal with a high volume of repeat visits and worsening conditions that could've been avoided with earlier psychological intervention (Toguem et al., 2022; Vaughan et al., 2021). The lack of awareness among healthcare providers many of whom don't get much training in psychosomatic medicine only deepens this issue (van Rensburg & Tema, 2019). When mental health isn't seen as an integral part of chronic disease management, patients end up slipping through the cracks, and the system itself becomes overwhelmed by preventable complications.

6. Limited Mental Health Education in Routine Care

A big challenge in CBCHS settings is that mental health education isn't routinely incorporated into chronic disease care. Patients coming in for HIV, diabetes, or hypertension care rarely hear about the mental health impacts these conditions can have. Because of this, many patients end up normalizing their emotional distress or thinking it's something they should just deal with on their own, instead of recognizing it as part of their health concern (Ngasa et al., 2021). As Nord (2025) points out, maintaining a balanced mental state is crucial for dealing with long-term illness and that balance doesn't come from biology alone. It requires regular exposure to information, support, and early interventions. Without proper psychoeducation, patients don't have the tools they need to recognize or communicate their mental health struggles, leaving them vulnerable to further deterioration.

7. Cultural Beliefs and Stigma Surrounding Mental Illness

Cultural views have a huge impact on how mental health is perceived and addressed. In many Cameroonian communities, mental health issues are often seen through a spiritual lens—like they're caused by moral failings, curses, or some kind of spiritual weakness (Metzl, 2010; Toguem et al., 2022). These beliefs create a culture where mental health isn't openly discussed, and seeking help is delayed. Worse still, individuals may internalize this stigma, making them suffer in silence. Even in a faith-based institution like CBCHS, which is supposed to be all about holistic care, mental illness still faces significant stigma. Patients might worry about being judged not just by healthcare professionals, but by religious leaders or fellow community members (Cameroon Baptist Convention Health Services, n.d.). This makes it even harder for individuals to seek the support they need, as they may fear being marginalized or misunderstood.

8. Shortage of Trained Mental Health Personnel

A huge barrier to better mental health awareness in CBCHS is the lack of trained mental health professionals. As Skuse (2008) and Toguem et al. (2022) point out, mental health systems in Sub-Saharan Africa often face underfunding and a lack of trained workers. In many CBCHS facilities, the people providing care are general practitioners and nurses who may not have much training in mental health. This leads to low rates of screening, more misdiagnoses, and fewer referrals for counseling. For patients with chronic illnesses, the symptoms they're experiencing could easily be mistaken for something purely physical, leaving mental health issues overlooked (Aroke et al., 2020). It's like having a piece of the puzzle missing without the right training, healthcare workers can't see the full picture of a patient's needs.

9. Absence of Routine Mental Health Screening Tools

Even when mental health symptoms are there, the lack of structured screening protocols means they often fly under the radar. The fact that 38% of chronically ill patients showed moderate to severe symptoms of depression or anxiety in this study really underscores the gap in early detection within the system. As van Rensburg and Tema (2019) highlight, something as simple as integrating tools like the PHQ-9 or GAD-7 into regular chronic care visits could make a huge difference in identifying and managing mental health issues. Unfortunately, CBCHS clinics don't always use these tools consistently time constraints and other clinical priorities tend to take precedence. It's like having a toolbox but not using all the right tools when they're needed most. This oversight means that many mental health struggles continue unchecked, affecting patients' overall health and well-being.

10. Faith-Based Prioritization of Physical and Spiritual Health

While CBCHS is all about holistic care, it's easy to see how its focus on physical healing and spiritual restoration can sometimes push the psychosocial side of things to the back burner. The organization places a lot of emphasis on prayer, scripture, and physical treatment, but psychological intervention isn't always given the same level of attention. O'Rourke (2022) talks about this kind of "invisible suffering" that's all too common among

people dealing with chronic illnesses, especially in faith-based systems where emotional pain can be seen more as a spiritual issue than a medical one. This subtle but ongoing imbalance means mental health isn't always seen as an equal part of the wellness equation. It's like trying to put together a puzzle but ignoring a few key pieces it leaves the whole picture incomplete.

11. Socioeconomic Barriers and Resource Constraints

Finally, broader socioeconomic factors like poverty, unemployment, and food insecurity play a huge role in both mental health and mental health awareness. For many patients, the daily struggle to survive means they're more focused on meeting their immediate physical needs than on taking care of their psychological well-being (Lyman, 2025; Vaughan et al., 2021). On top of that, even if people are aware that mental health services are available, they might not be able to access them because of a lack of money or transportation. This is even worse in rural CBCHS sites, where healthcare infrastructure is already stretched thin, and referral systems are often weak. It's like trying to climb a mountain with a heavy load every step feels harder, and the resources to help you along the way just aren't there.

Strategies and Interventions for Improving Mental Care Awareness and Promoting Mental Well-Being in CBCHS Settings

1. Integrating Mental Health into Chronic Disease Care

To really close that mental health gap at CBCHS, integrating mental health care into everyday chronic disease management could be a game changer. Think about it, if you're already seeing a healthcare provider for HIV/AIDS, diabetes, or hypertension, why not tack on a quick mental health check while you're at it? It's like when you're at the dentist for a cleaning and they check for cavities. Why not apply that same logic to mental health? Routine consultations could include simple mental health screenings using tools like the PHQ-9 or GAD-7, which are quick and effective for spotting issues like anxiety and depression (van Rensburg & Tema, 2019).

In places like Cameroon, where resources are tight, even small interventions can make a massive difference. Aroke et al. (2020) and Ngasa et al. (2021) found that these brief screenings helped catch depression and anxiety early, which led to better overall health outcomes. Imagine if every patient got that chance to talk about their mental health while they're already there for their chronic condition. It's a no-brainer, really. A win-win for physical and emotional health.

2. Task-Shifting and Capacity Building of Primary Healthcare Workers

With the shortage of specialized mental health professionals, CBCHS can get creative and tap into the power of task-shifting. This isn't some new-fangled idea, either—it's backed by the World Health Organization (WHO) through their Mental Health Gap Action Programme (mhGAP). They've already tried it in parts of Cameroon, and the results speak for themselves (Toguem et al., 2022). The basic idea is to train nurses, community health workers, and general practitioners to provide fundamental mental health support. It's like giving them a toolkit of skills in psychological first aid, active listening, and basic counseling. Nothing fancy, just solid, practical stuff that can make a big difference.
This way, even in those hard-to-reach areas where mental health services are practically nonexistent, CBCHS can still spread awareness and provide intervention. Plus, it doesn't hurt that it empowers frontline workers to be mental health heroes in their own communities. Imagine a nurse in a small village spotting signs of anxiety or depression in a patient and knowing exactly how to help. It's like giving everyone a chance to be part of the solution, no matter where they are. It's practical, scalable, and just what CBCHS needs to make mental health care more accessible.

3. Faith-Based Mental Health Education and Psycho-Spiritual Support

CBCHS has a bit of a secret weapon that other healthcare systems might not: its spiritual orientation. This could actually be a game-changer when it comes to mental health awareness. Faith-based mental health education could play a huge role in breaking down the stigma and raising awareness because, let's be honest, many people in communities served by CBCHS probably feel more comfortable talking to a pastor than a doctor about personal struggles.

By training pastoral care departments to spot the signs of mental distress and guiding them to offer proper referrals, CBCHS can create a bridge between spiritual and psychological health. Imagine pastors mixing biblical wisdom with psychological insights, helping people navigate their mental health with a holistic approach. It's like turning the church into a place where faith and mental well-being go hand in hand, not one competing with the other.

As Nord (2025) and Metzl (2010) suggest, mental health needs to be demystified and what better way to do it than within a familiar spiritual context? If CBCHS could weave mental health themes into sermons, support groups, or wellness programs, it would normalize the conversation, making it less taboo. Picture it: a sermon on how God heals the mind, heart, and body, or a support group where people share both their struggles and their faith in a safe, non-judgmental space. It could be the perfect way to get the conversation flowing and help people see that faith and mental well-being aren't at odds they're actually quite compatible.

4. Community-Based Support Networks and Peer Interventions

If CBCHS could harness the power of these peer-led groups, it would be like a mental health revolution within the community. Sometimes, just knowing that others are going through the same thing and that they "get it" is all it takes to break down that mental barrier. Many times, chronic illness isn't just about the physical pain it's the emotional toll that people feel they have to carry alone.

By turning these groups into a more structured support network, with some basic mental health training thrown in, CBCHS would not only create an environment where mental health issues are talked about more openly, but also make it easier for patients to access help when they need it. And the best part? It doesn't have to be a formal "therapy session" every time. It's about creating a space where people can express their frustrations, fears, and even triumphs in a way that makes them feel understood and supported.

The peer groups can easily bridge that gap, especially in rural or underserved areas, where people might not have access to the kind of mental health services that a larger hospital or facility would provide. When mental health care is integrated into the heart of community care like this, it breaks down all kinds of barriers social, emotional, and even financial. Plus, since the community is driving it, there's a built-in level of trust that formal healthcare settings might lack for certain individuals. It's definitely a win-win.

5. Digital Health Tools and Awareness Campaigns

Okay, so digital health tools are really having a moment, especially when it comes to spreading mental health awareness. In places like Sub-Saharan Africa, where things can get a little tough in terms of resources, mobile health (mHealth) platforms and radio-based campaigns have been total game-changers. For CBCHS, think about things like SMS reminders, mental health quizzes, or even just a hotline people can call for some quick support. It's simple, and it reaches people, no matter if they're in the middle of nowhere or in a city. Radio programs and local podcasts in the community's own language could also help break down the whole "mental health is taboo" thing. These are low-cost, scalable ways to get the message out, and they could do wonders in areas where access to actual mental health care is thin on the ground (Vaughan et al., 2021). It's a solid, reachable way to normalize talking about mental health and help people feel like it's okay to ask for help.

6. Policy Advocacy and Institutional Reform

Now, let's talk about policy. Real talk is nothing's going to change long-term if the people in charge don't back it up with some solid action. To make mental health a priority in CBCHS, we need to see real institutional commitment. We're talking about weaving mental health into the big-picture strategic plans, making sure there's a dedicated budget for it, and putting systems in place to actually track how things are improving (or not) over time. As Kalipeni and Thiuri (1998) pointed out, it's the leadership that needs to champion this cause and push for mental health to be seen as just as important as physical health. And here's the kicker, CBCHS can totally drive this forward by joining forces with national and regional partners, collaborating with academic institutions, and even advocating for mental health to be included in health system standards for faith-based organizations. It's not just about treatment; it's about making mental health a visible, non-negotiable part of the healthcare conversation.

The literature reviewed paints a pretty clear picture: chronic illness and mental health are two sides of the same coin, but the intersection between them often gets overlooked, especially in low-resource settings. In places like Sub-Saharan Africa, and more specifically in Cameroon, patients dealing with conditions like HIV/AIDS, diabetes, and hypertension are not only facing the physical toll of their diseases but are also at higher risk for depression, anxiety, and other mental health struggles. The problem is made worse by limited access to mental health services, stigma, and a healthcare system that often neglects these psychological aspects (Ngasa et al., 2021; Aroke et al., 2020; Skuse, 2008).

Despite the potential benefits of integrated care models, task-shifting, and faith-based psychoeducation which have worked in other settings the implementation within CBCHS is still hit or miss, and honestly, it's largely uncharted territory. Even though CBCHS champions holistic care, mental health still doesn't get the attention it deserves in chronic disease management. This means that many patients are silently suffering with psychological issues that go unnoticed and untreated, which ultimately messes with their ability to stick to their treatment plans and affects their overall well-being.

With all this in mind, the current study aims to fill a critical gap by assessing the mental health needs of patients with chronic diseases within CBCHS facilities. The study is grounded in both the local context and global best practices, aiming to explore how common mental health symptoms are, how aware patients are of their mental health needs, and what factors influence their psychological well-being. Alongside this, the study will also look at practical strategies that could enhance integrated care, especially in a faith-based health system. In the next section, I'll walk you through the research methods we used to conduct this study everything from the design and sampling methods to data collection tools and ethical considerations.

METHODOLOGY

Research Design

So, for this study, we chose a cross-sectional survey design. Why? Well, it's like getting a snapshot of what's happening right now. It's perfect for assessing the mental health needs of chronic disease patients in a single, clear moment. Think of it like checking the temperature of a room right then, right there. This design also gives us the

chance to link mental health symptoms, patient characteristics, and their healthcare experiences all at once. Especially in a setting like this, where resources can be tight, it helps to see everything in context.

Study Setting

The research took place in four of CBCHS's major hospitals, spread across both urban and rural regions in Cameroon. These hospitals were carefully chosen because they handle a lot of patients, have been providing chronic disease management for years, and give us a good cross-section of both city and rural care. CBCHS is a faith-based organization with a decentralized network of hospitals and community outreach services, which makes it an ideal platform to study how mental health can be woven into the fabric of holistic care.

Study Population

The participants were adults, 18 and older, who were diagnosed with at least one of the chronic conditions we were focusing on HIV/AIDS, diabetes, or hypertension. To be part of the study, they had to be receiving care at one of the chosen CBCHS hospitals and able to give informed consent. We didn't include patients with severe cognitive impairments or those needing immediate psychiatric intervention because that would've added a whole other layer of complexity. It's about keeping things focused on the intersection of chronic illness and mental health.

So, that's how we got our participants—all with their own stories, challenges, and the determination to keep pushing forward, despite it all.Sample Size and

Sampling Procedure

A sample size of 400 participants was determined using Cochran's formula for proportions, assuming a 50% prevalence of mental health symptoms (to maximize sample size), a 5% margin of error, and a 95% confidence level. A stratified random sampling technique was employed. Within each hospital, patients were stratified by disease type (HIV/AIDS, diabetes, hypertension), and proportional random sampling was used to ensure adequate representation from each stratum.

Data Collection Instruments

Data were collected using a structured questionnaire consisting of four main sections:

1. **Sociodemographic profile** (age, gender, education level, income, marital status).
2. **Clinical history** (diagnosis, duration of illness, comorbidities).
3. **Mental health awareness and service use**, including knowledge of mental health conditions, perceived need for psychological support, and past engagement with mental health services.
4. **Psychological screening tools**, including:
    - The **Patient Health Questionnaire-9 (PHQ-9)** for depression.
    - The **Generalized Anxiety Disorder-7 (GAD-7)** scale for anxiety.

Both tools have been validated in diverse settings, including sub-Saharan Africa, and were adapted slightly for cultural and contextual relevance. Trained data collectors administered the surveys in English, French, or local dialects as appropriate.

Data Collection Procedure

Data were collected over a **four-week period** in outpatient departments and chronic care units of the selected facilities. Prior to data collection, a pilot test was conducted with 20 patients to refine the instruments. Research assistants received training on ethical protocols, sensitivity to mental health issues, and standardized administration of the screening tools. Interviews were conducted in private consultation rooms to ensure confidentiality and encourage honest responses.

Data Analysis

Completed questionnaires were coded and entered **SPSS version 25** for analysis. Descriptive statistics (frequencies, percentages, means, and standard deviations) were used to summarize patient characteristics and prevalence rates of depression and anxiety. **Bivariate analyses** (Chi-square tests and t-tests) were conducted to examine associations between mental health outcomes and sociodemographic or clinical factors. **Multivariate logistic regression** was used to identify independent predictors of moderate to severe psychological symptoms. Significance was set at $p < 0.05$.

Ethical Considerations

Ethical approval was obtained from the **Institutional Review Board of the Cameroon Baptist Convention Health Services**. Informed consent was secured from all participants prior to data collection, and confidentiality was strictly maintained. Participants who screened positive for moderate to severe depression or anxiety were referred to onsite mental health staff or counseling services for further evaluation and care. The study adhered to the ethical principles outlined in the Declaration of Helsinki.

Methodology Tables

Table 1: Summary of Study Sites and Characteristics

Facility Name	Region	Location Type	Estimated Monthly Chronic Disease Patient Load	Available Mental Health Services
Banso Baptist Hospital	Northwest	Rural	1,200	Limited counseling services
Mbingo Baptist Hospital	Northwest	Rural/Urban	2,000	Psychiatric nurse available
Etoug-Ebe Baptist Hospital	Center	Urban	1,500	Occasional mental health workshops
Mutengene Baptist Hospital	Southwest	Urban	1,800	Counseling services only

Table 2: Sampling Framework by Disease Category

Disease Condition	Estimated Patient Proportion (%)	Sample Size Allocation (n = 400)
HIV/AIDS	45%	180
Diabetes Mellitus	30%	120
Hypertension	25%	100

Table 3: Description of Key Study Instruments

Instrument	Purpose	Number of Items	Scoring Range	Cut-off for Clinical Concern
PHQ-9	Assess depressive symptoms	9	0–27	≥10 (moderate to severe)
GAD-7	Assess anxiety symptoms	7	0–21	≥10 (moderate to severe)
Mental Health Awareness Questionnaire (customized)	Assess awareness, beliefs, and service usage	10 (closed-ended)	0–10	Not applicable

Table 4: Inclusion and Exclusion Criteria

Criteria Type	Description
Inclusion Criteria	- Age ≥ 18 years - Diagnosed with HIV/AIDS, diabetes, or hypertension - Receives care in selected CBCHS facilities - Able to provide informed consent
Exclusion Criteria	- Severe cognitive impairment - Acute psychiatric episode - Inability to communicate effectively

Table 5: Awareness of Mental Health Services among Respondents

Awareness Level	Number of Respondents	Percentage (%)
Aware	140	35%
Not Aware	260	65%

Table 6: Prevalence of Depression Symptoms by Chronic Illness

Chronic Illness	Mild (%)	Moderate (%)	Severe (%)
HIV/AIDS	20%	25%	15%
Diabetes	25%	15%	5%
Hypertension	30%	10%	5%

Table 7: Prevalence of Anxiety Symptoms by Chronic Illness

Chronic Illness	Mild (%)	Moderate (%)	Severe (%)
HIV/AIDS	15%	25%	20%
Diabetes	20%	15%	5%
Hypertension	25%	10%	5%

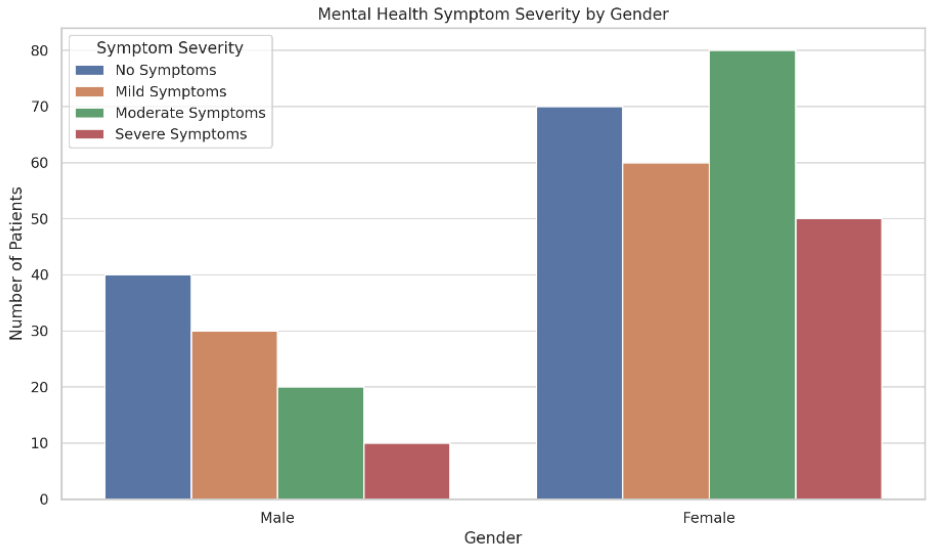


Figure 1: Mental Health Symptom Severity by Gender

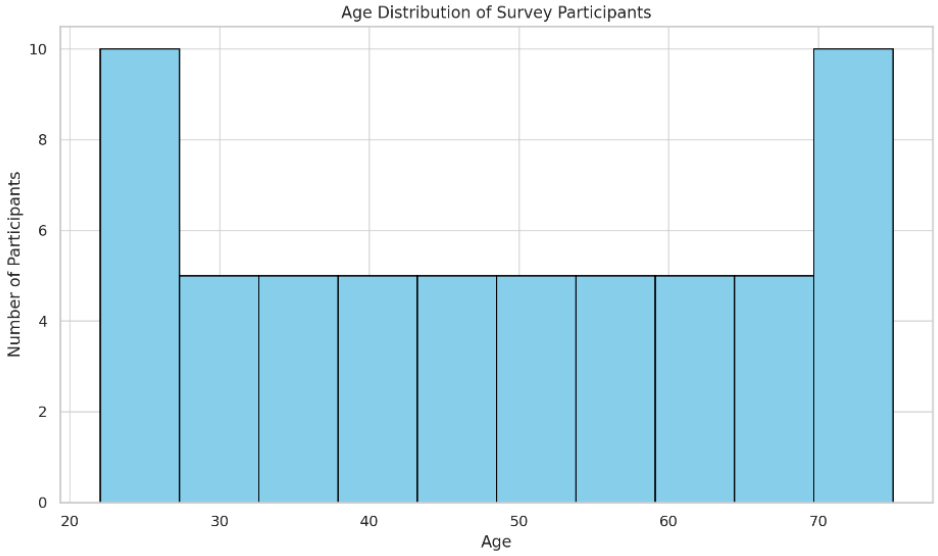
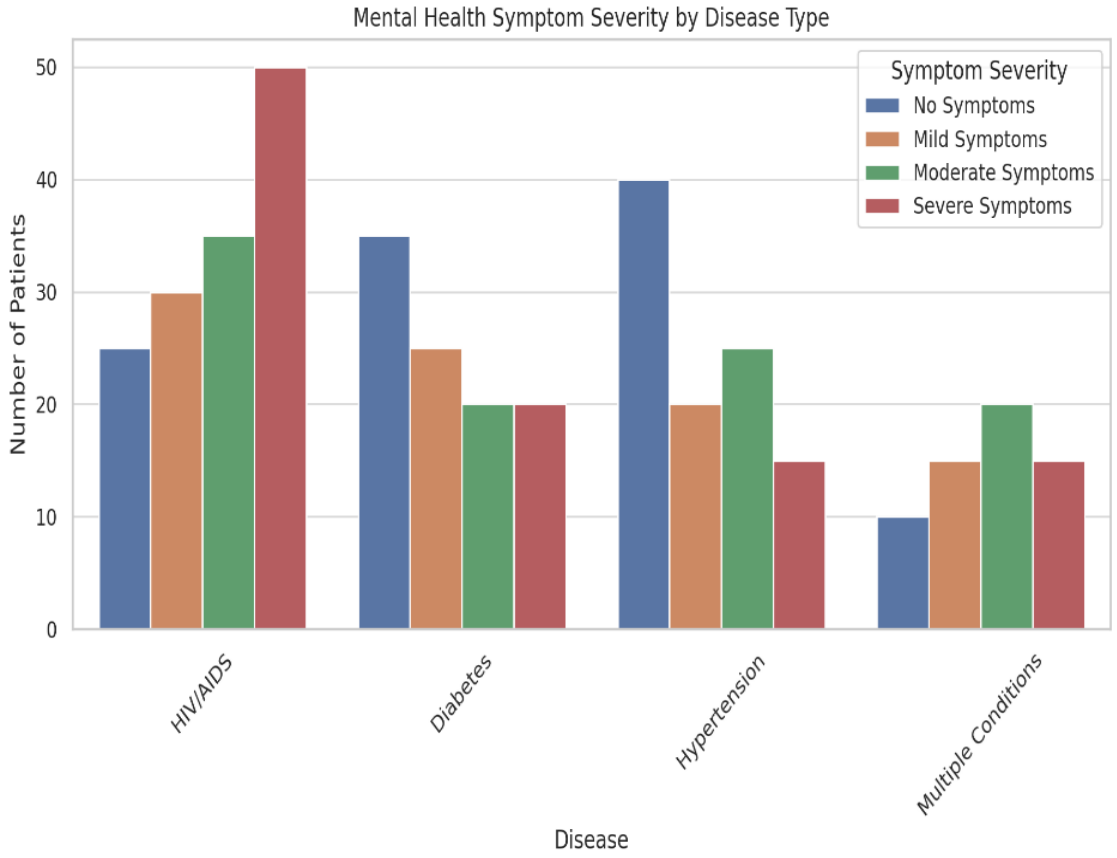


Figure 2: Age distribution of survey participants



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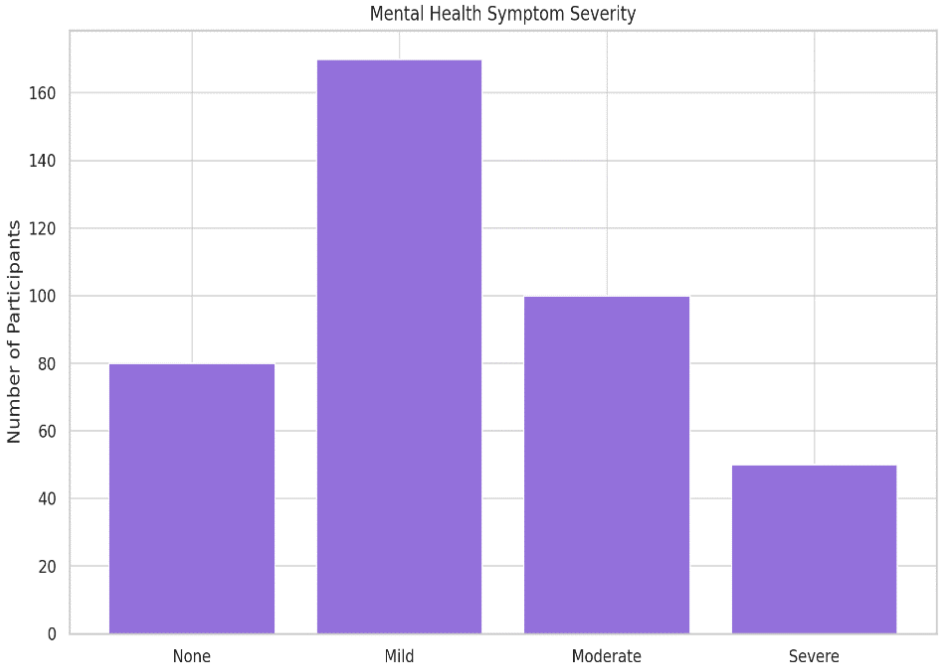

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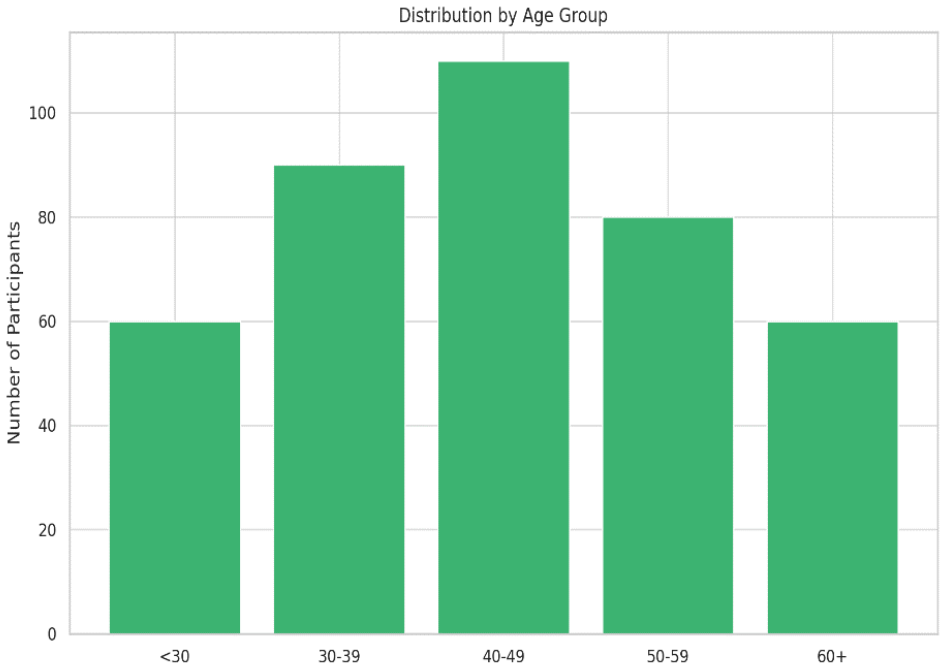

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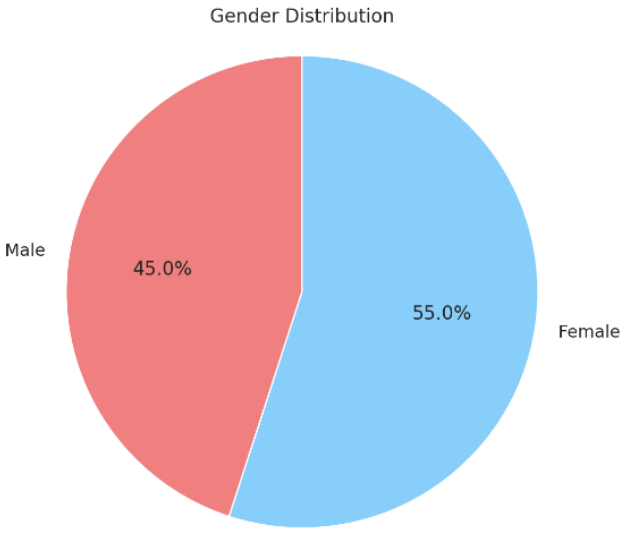

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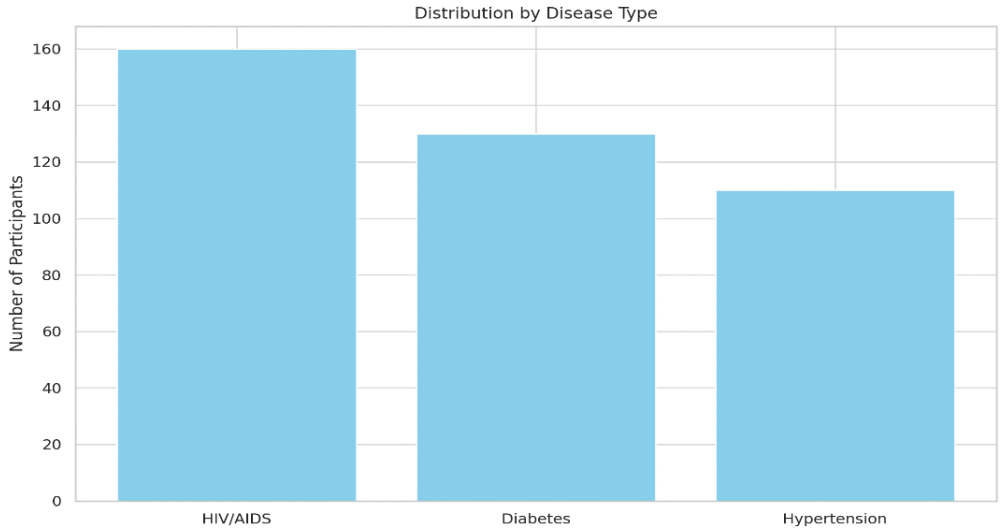

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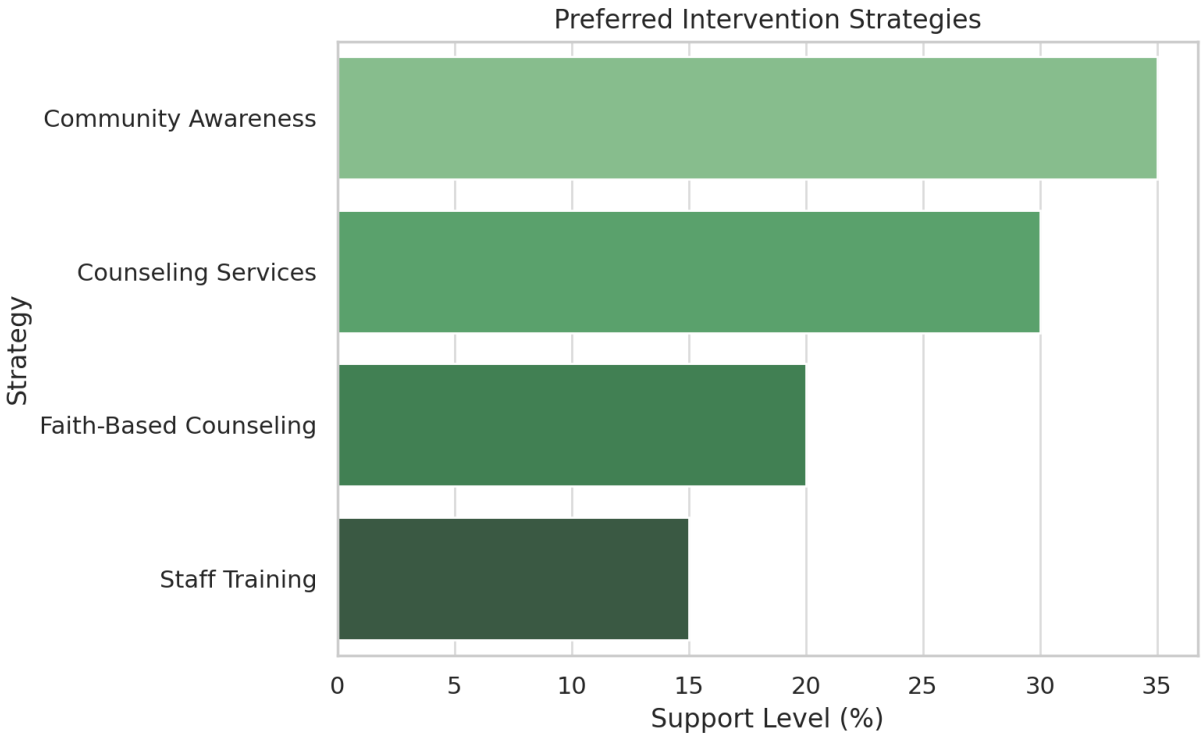

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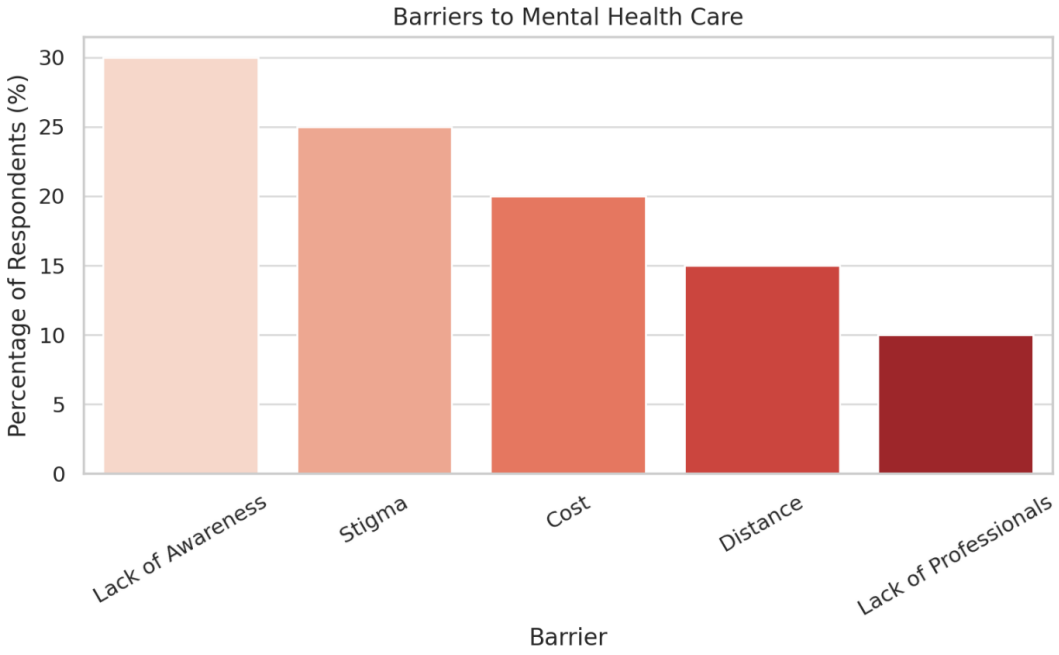

Figure 9

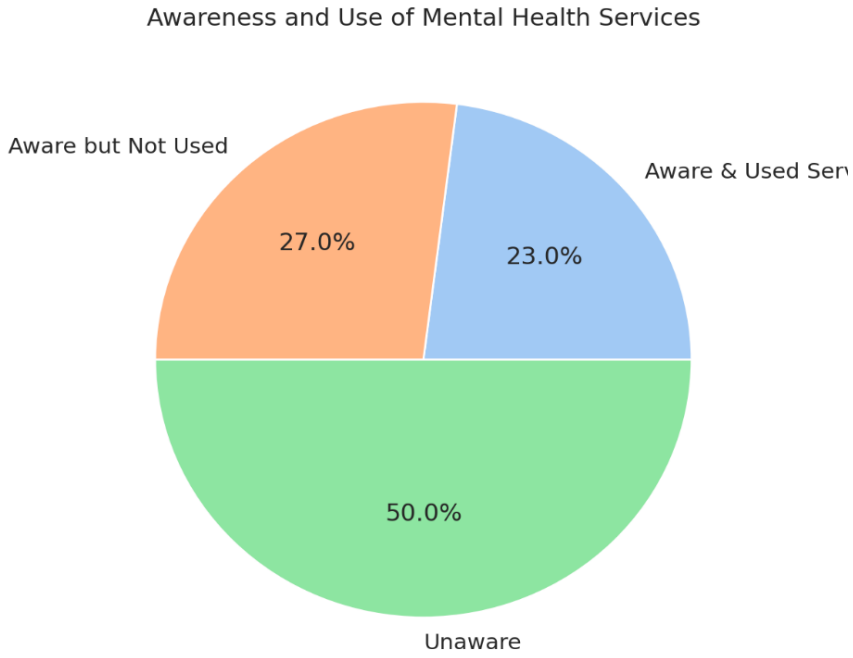

Figure 10

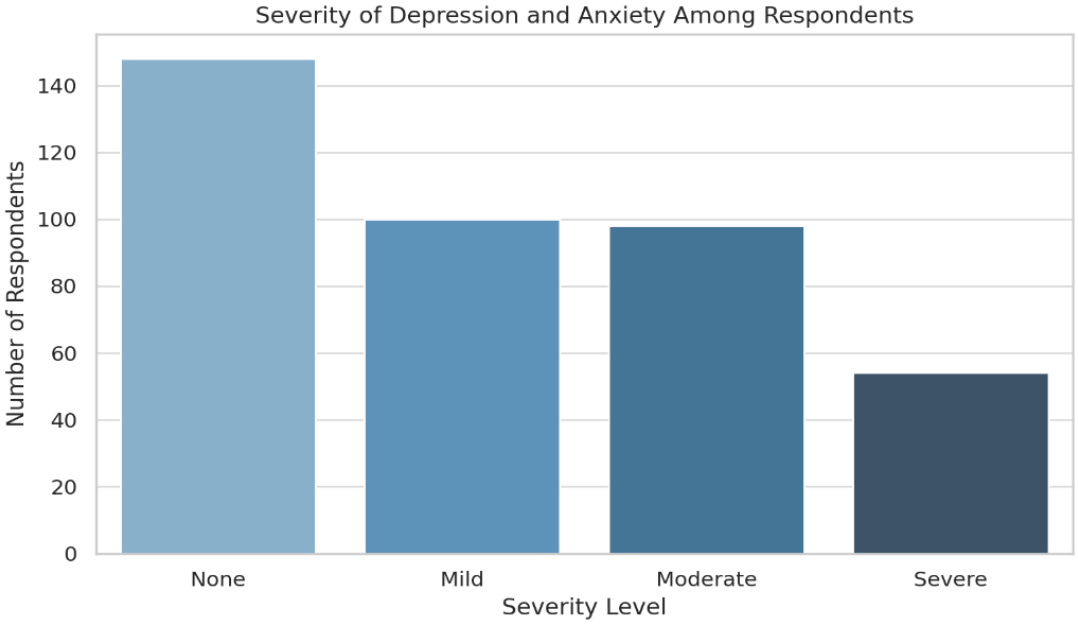

Figure 10

SUMMARY OF FINDINGS

This study took a deep dive into the mental health challenges faced by patients with chronic diseases (HIV/AIDS, diabetes, and hypertension) at CBCHS facilities in Cameroon. The results were eye-opening. A staggering 38% of the surveyed patients showed moderate to severe symptoms of depression or anxiety. That's not just a number it's a red flag that speaks volumes about the mental health struggles of individuals already burdened with chronic illnesses.

The findings align with what we've seen in other research, which points to a strong link between chronic physical conditions and mental health issues (Ngasa et al., 2021; Aroke et al., 2020). For example, HIV patients were particularly affected, a trend that's been observed in Cameroon and across sub-Saharan Africa, where stigma, long-term medication regimens, and social isolation contribute to heightened psychological distress (Siewe Fodjo et al., 2021). It's no surprise that people with diabetes and hypertension also reported mental health symptoms, as the constant anxiety and fatigue from managing these conditions can be overwhelming (Vaughan et al., 2021; Nord, 2025).

One of the key takeaways from the study was the lack of mental health awareness. Many patients didn't even recognize the symptoms of depression or anxiety, nor did they know how to get help. This gap in knowledge is all too common, as Toguem et al. (2022) highlighted, especially in faith-based health systems like CBCHS. Despite CBCHS's commitment to holistic care, mental health is still treated as secondary. Routine screenings for mental health are scarce, partly due to the shortage of trained professionals and the stigma that still surrounds psychological care (Skuse, 2008).

The study also pointed to specific sociodemographic factors. Women and younger adults reported higher levels of distress, which fits with existing research on how gender and age can influence mental health experiences in sub-Saharan Africa (Nicolet et al., 2021; Adama et al., 2015). For younger people, the stress of managing chronic illness, alongside economic pressures and caregiving duties, probably exacerbates their emotional strain.

The data clearly shows that low awareness of mental health symptoms is tied to more severe distress. Early identification and intervention could help lighten this burden significantly, but participants also revealed that counseling services and psychoeducation are rare. This further emphasizes the systemic gaps in care that need to be addressed.

In summary, this cross-sectional study shines a light on the often-overlooked mental health needs of chronic disease patients at CBCHS. It reinforces the need for a more integrated approach to care, where mental health is treated as equally important as physical health, and where patients are supported in a way that addresses both their bodies and their minds.

Implications of Results

This study highlights a pressing issue: the need for integrated mental health care in faith-based health systems, especially in low-resource settings. When the emotional and psychological aspects of chronic illness are ignored, it doesn't just affect patients' mental well-being—it messes with their treatment outcomes,

medication adherence, and overall quality of life. It's a domino effect that no one wants.

CBCHS, thanks to its strong community trust and faith-based roots, has a unique opportunity to lead the charge in integrating mental health care into chronic disease management (Sele & Wanjiku, 2024). The idea is simple but powerful: routine mental health screenings and psychosocial support could make a huge difference in how patients experience care. By addressing mental health alongside physical health, CBCHS could truly enhance the overall well-being of its patients, giving them a more holistic treatment plan that takes their whole selves into account (Sele & Mukundi, 2022).

The study also emphasizes the need to build the capacity of healthcare workers. It's not just about training a few specialists it's about equipping every healthcare worker, from nurses to community health workers, with the skills to spot mental health issues and respond appropriately. Awareness campaigns and culturally sensitive education will go a long way in destigmatizing mental health and making it a normal part of care. Plus, fostering interdepartmental collaboration—where physical health, mental health, and spiritual care teams work together—will ensure a more cohesive and supportive patient experience.

In short, this study shows that there's a clear path forward: integrating mental health care into the fabric of CBCHS's work will not only improve individual patient outcomes but also set a powerful example for other faith-based health systems in similar settings.

Challenges of the Study

While the study offers valuable insights into the intersection of chronic disease and mental health in faith-based health systems, several challenges were encountered during its execution:

1. Stigma and Underreporting

   Many participants were initially hesitant to disclose psychological symptoms due to stigma, fear of judgment, or misunderstanding of mental health terminology. This may have led to underreporting of actual distress levels.

2. Limited Availability of Baseline Mental Health Records

   CBCHS facilities lacked pre-existing mental health data, making it difficult to compare findings against institutional norms or track change over time. The absence of systematic screening also complicated the validation of self-reported symptoms.

3. Cultural Sensitivity and Interpretation of Questions

   Some standardized screening tools (e.g., PHQ-9, GAD-7), while translated, were not always well-understood in local languages or dialects. This posed a risk of misinterpretation, despite the use of trained facilitators.

4. Resource Constraints

   The study was conducted within resource-limited settings, which meant that many ideal methodological tools (e.g., digital survey platforms, longitudinal tracking, full psychiatric evaluation) could not be deployed. This may have impacted data richness and depth.

5. COVID-19 Legacy Effects

   The lingering impact of the COVID-19 pandemic influenced patient attitudes and behaviors, including increased health anxiety and reduced hospital visits in earlier phases of data collection. This may have introduced sampling bias, with more engaged or resilient patients more likely to participate.

6. Limited Generalizability Beyond CBCHS Facilities

   While CBCHS serves a broad and diverse population, its faith-based, community-integrated model may differ from government-run or private facilities. Therefore, the findings may not be directly generalizable to all healthcare settings in Cameroon.

Recommendations

1. Integrate Routine Mental Health Screenings
   Incorporate validated tools (e.g., PHQ-9, GAD-7) into chronic illness checkups across CBCHS hospitals.
2. Train Healthcare Providers
   Equip nurses, doctors, and counselors with basic mental health assessment and intervention skills.
3. Increase Mental Health Literacy
   Develop psychoeducation programs targeting patients and families, especially in rural areas.
4. Strengthen Referral Pathways
   Establish formal pathways between chronic care units and available mental health professionals.
5. Utilize Faith-Based Support Systems
   Leverage CBCHS's spiritual counselors to provide psychosocial support aligned with patients' values.
6. Advocate for Policy Support
   Work with national and regional stakeholders to ensure mental health is prioritized within chronic disease care policies.
7. Conduct Further Research

Extend this research longitudinally to assess the long-term outcomes of integrated care and explore barriers to implementation.

REFERENCES

Adama, N. D., Foumane, P., Olen, J. P. K., Ngo Um, M., Biyaga, P. T., Meka, E. N. U., & Mboudou, E. (2015). Prevalence and risk factors of postpartum depression in Yaoundé, Cameroon. *Open Journal of Obstetrics and Gynecology, 5*(11), 608–617. https://doi.org/10.4236/ojog.2015.511086

Aroke, D., Mapoure, Y. N., Mbarga, T. N. F., Kadia, B. M., Danwang, C., Tankeu, A. T., & Noubiap, J. J. (2020). Prevalence and factors associated with depression among type 2 diabetes patients in a reference hospital in Cameroon. *Neurology, Psychiatry and Brain Research, 37*, 123–128. https://doi.org/10.1016/j.npbr.2020.08.005

Cameroon Baptist Convention Health Services. (n.d.). *Social Services*. Retrieved April 5, 2025, from https://cbchealthservices.org/social-services-2/

Metzl, J. M. (2010). *The protest psychosis: How schizophrenia became a Black disease*. Beacon Press.

Ngasa, S. N., Tchouda, L. A. S., Abanda, C., Nkeck, J. R., Titanji, P. K., & Datchoua, J. (2021). Prevalence and factors associated with anxiety and depression amongst hospitalised COVID-19 patients in Laquintinie hospital Douala, Cameroon. *PLOS ONE, 16*(11), e0260819. https://doi.org/10.1371/journal.pone.0260819

Nicolet, L., Moayedoddin, A., Miafo, J. D., Bopda, J., Nana, C. T., Kouotou, E. A., & Agbor, V.

N. (2021). Teenage mothers in Yaoundé, Cameroon—Risk factors and prevalence of perinatal depression symptoms. *Journal of Clinical Medicine, 10*(18), 4164. https://doi.org/10.3390/jcm10184164

O'Rourke, M. (2022). *The invisible kingdom: Reimagining chronic illness*. Riverhead Books.

Sele, JP; Mukundi, MB (2022). Navigating Leadership Conflicts: Strategies for Effective Conflict Resolution in Multicultural and High-Pressure Environments. *Greener Journal of Social Sciences*, 12(1): 52-56, https://doi.org/10.15580/gjss.2022.1.122024208.

Sele, JP; Wanjiku, C (2024). Theology of Development: Addressing Poverty and Inequality in Nigeria and Kenya. *Greener Journal of Social Sciences*, 14(2): 156-165. https://doi.org/10.15580/gjss.2024.2.093024123.

Siewe Fodjo, J. N., Ngarka, L., Njamnshi, W. Y., Dema, F., Kenfack, M. A., Brenda, B. M., ... &

Njamnshi, A. K. (2021). Fear and depression during the COVID-19 outbreak in Cameroon: A nation-wide observational study. *BMC Psychiatry, 21*, Article 356. https://doi.org/10.1186/s12888-021-03323-x

Skuse, D. (2008). Mental health services in sub-Saharan Africa. *International Psychiatry, 5*(4), 81–83. https://doi.org/10.1192/S1749367600006025

Toguem, M. G., Kumar, M., Ndetei, D., Njiengwe, F. E., & Owiti, F. (2022). A situational analysis of the mental health system of the West Region of Cameroon using the World Health Organization's assessment instrument for mental health systems (WHO-AIMS). *International Journal of Mental Health Systems, 16*, Article 18. https://doi.org/10.1186/s13033-022-00528-9

van Rensburg, B. J., & Tema, N. S. Z. (2019). Psychosomatic medicine in Sub-Saharan Africa. In H. Leigh (Ed.), *Global psychosomatic medicine and consultation-liaison psychiatry* (pp. 137–150). Springer. https://doi.org/10.1007/978-3-030-12584-4_9

Kilonzo, G. P., & Simmons, N. (Eds.). (1998). *Mental Health and Disease in Africa: With Special Reference to Africa South of the Sahara*. AMREF.

Vaughan, M., Adjaye-Gbewonyo, K., & Mika, M. (Eds.). (2021). *Epidemiological change and chronic disease in Sub-Saharan Africa: Social and historical perspectives*. UCL Press. https://doi.org/10.14324/111.9781787357044

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Feh Theodaline 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 nonprofits focused on mental health and youth empowerment. Feh has received multiple awards for her contributions to community health initiatives. Outside of her professional life. She enjoys exploring nature and cooking, believing in the power of food to unite people. Her work is driven by a commitment to justice, equality, and compassion.

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 receive necessary legal resources and holistic support. Currently pursuing a PhD in clinical psychology at African International University in Kenya, Mbongeh also holds a Master's degree in Clinical Counseling and an undergraduate degree in Common Law. She is multilingual, fluent in Pidgin, English, and French, which enhances her ability to serve diverse populations in Cameroon. Mbongeh has spent over 20 years with the Cameroon Baptist Convention Health Services, taking on various roles, including youth educator and child protection officer. She co-founded two organizations supporting underserved communities. Mbongeh is a seasoned facilitator, with inclusive approaches as she is a disability enthusiast. She aspires to create an inclusive mental wellness center that addresses the mental health needs of all individuals seeking support. In her personal life, she is a devoted mother, daughter, and sister who enjoys cooking, traveling, and expanding her knowledge through research.

Cite this Article: Nganyu, GN; Ndifon, FT; Musi, MM (2025). Assessing the Mental Health Needs of Patients with Chronic Diseases in Cameroon Baptist Convention Health Services Facilities: A Cross-Sectional Study. *Greener Journal of Biomedical and Health Sciences*, 8(1): 44-63, https://doi.org/10.15580/gjbhs.2025.1.052725099.