

Barriers to Seeking Mental Health Support Among Nurses and Midwives in Sub-Saharan Africa: A Scoping Review

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Abstract

Introduction: Psychological distress is widespread among nurses and midwives, especially in sub-Saharan Africa (SSA), where evidence primarily reports on the prevalence and not on the situation of seeking help. This scoping review identified barriers reported to seeking mental health-related support among nurses and midwives in SSA, and the strategies reported to facilitate the help-seeking process.

Methods: The review was carried out following the Arksey-O'Malley framework and was reported using the PRISMA-ScR. The following criteria applied to the studies: Eligible studies were peer-reviewed articles published in English from 2020 to 2026. Records were independently screened by two reviewers, and data were charted on a standardised form, with findings thematically aggregated on the individual, organisational, and socio-cultural levels.

Results: Sixty-two-three records were identified, of which 598 were not duplicates, and 20 studies were selected. Less attention was directed at help-seeking. Personal factors such as low self-identification with symptoms, low awareness and utilization of services available, and informal coping were identified as individual barriers. The organisational barriers were limited workplace support, heavy workloads, and, in one study, counselling related to increased resilience. Socio-cultural barriers involved were stigma, neglect, and isolation, mostly associated with COVID-19 and psychiatric nursing, and not psychiatric nurses' mental health itself. There was no study that appraised an intervention to encourage help-seeking.

Conclusion: There is limited evidence of help-seeking among nurses and midwives in SSA, and evidence is often indirect. There is a need for workplace support for mental health to be strengthened and for more people to be aware of services; future studies should directly explore help-seeking, take a case-by-case approach to including nurses and midwives, assess interventions, and incorporate under-represented areas

INTRODUCTION

There is good evidence of psychological distress in nurses and midwives globally. The prevalence rates nurse burnout from an umbrella review of 14 meta-analyses were pooled at 33.5% for high emotional exhaustion, 25.0% for depersonalization, and 33.5% for low personal accomplishment among the nurses (1). Moreover, a meta-analysis of 94 studies conducted in more than 30 countries reported the nursing burnout rate as 30% (2). Burnout has been found to impact 52% of healthcare staff during COVID-19 with focus on physicians and/or nurses at 66% (3), while 34% of nurses experienced emotional exhaustion (4). Most of this literature, however, measures distress and does not measure help-seeking among nurses and midwives. In the few studies conducted on help-seeking, three levels of barriers have been identified: sociocultural, individual, and organizational factors that can either reinforce or mitigate stigmatization barriers.(5). In retrospective quantitative study 25% of healthcare workers preferred to self-manage, while 13% did not know where to seek help, with 57% of healthcare workers reported they did not seek mental health support last year, 28% reported seeking help, and 15% felt the need to seek help but did not (6). Confidentiality issues, perceived career implications, time constraints, stigma, doubts about the effectiveness of psychological services, limited knowledge, perceived professional role conflicts, and licensure concerns regarding mental health hinder disclosure of these nurses' and midwives' mental health problems (7, 8). The socio-cultural aspects are inconsonant with the nurse as a caregiver, as a pervasive form of stigma dictates that nurses/midwives must be completely self-sacrificing, emotionally bulletproof, and able to "just deal with" extreme workplace stress found in the professional culture this limiting them to seek mental health support(9).

The evidence base is less robust in Africa, with most studies being prevalence studies from the pandemic era. However, a global meta-analysis indicated that health workers in Africa had the highest prevalence of depression (82.4%), followed by those in North America (33.4%), in Europe (31.3%) and in Asia (19.1%) (10). Anxiety (45.3%), depression (39.4%), and insomnia (15.3%) have been synthesized across general populations and healthcare workers (11) or across five meta-analyses of healthcare professionals (12) in Africa. Both were not focused on seeking help. Evidence from the general population is thus used to a high degree to infer barriers. People have wrong beliefs and prejudices about nurses and/ midwives having mental illness (13). From a socio-cultural perspective, stigma and culture help to discourage help-seeking (9). More specifically, the system level of services is located mainly in urban areas and is poorly connected to primary care (14). Service user interventions such as integration of mental health into primary health care, community-based approaches, and awareness campaigns have been reported as strategies, but not for the health workforce.

Healthcare workers (HCWs) in sub-Saharan Africa (SSA) had been the subject of a systematic review (SR) of 69 studies across 27 countries, which reported a range of depressive symptoms (2.1%–75.7%), anxiety symptoms (4.8%–96.5%), and post-traumatic stress symptoms (11.7%–78.3%) (10). A total of eight studies concerned nurses, and one study concerned midwives. The majority were from Ethiopia, Nigeria, and South Africa, and all examined prevalence and correlates rather than help-seeking (10). Studies among nurses reported depressive symptoms in 38.5%–55.3% and anxiety in 46.6%–69.6% (15, 16). The knowledge and attitudinal barriers are smaller in isolation in terms of access to services (17). In terms of organisation, Ghanaian health workers reported that support for mental health at work was either not present or that it was inadequate (18). From a socio-cultural perspective, mental health is marginalized and stigma even becomes a problem for nurses (19). This review thus rectified the lack of mapping of evidence regarding mental help-seeking by nurses and midwives in SSA.

The ideal workplace for a nurse or midwife would be one that safeguards their mental health and enables them to identify distress in themselves and others, and to access support without fear of stigma, breaches of confidentiality or professional consequences, a feature of nurse burnout that has been associated with poorer patient and organization outcomes (20). However, approximately one-third of nurses around the world report high emotional exhaustion (33.5%) and low personal accomplishment (33.5%); one in four reports depersonalization (25.0%) (1). Burnout affected 52% of healthcare workers during COVID-19 (3). In sub-Saharan Africa, healthcare workers report depressive symptoms (2.1%–75.7%), anxiety (4.8%–96.5%), and post-traumatic stress symptoms (11.7%–78.3%) (10). Among nurses, depressive symptoms reach 38.5%–55.3% (15, 16). Stigma remains a problem even among nurses in Ghana (18), and a lower level of resilience correlates with greater depressive and anxiety symptoms (21).

Interventions suggested in the literature include targeted workplace interventions (22) and education and mental/coping support for nurses in South Africa (23). However, challenges around mental health, stigma, burnout, and poor resilience continue. These interventions are primarily focused on stress reduction or symptom management, not on understanding why distressed nurses and midwives might not seek help. Prevalence studies prevail in SSA, with only a few studies on nurses and one on midwives. To our knowledge, there is no review that has traced the barriers and/or facilitators to help-seeking among them. This scoping review thus aimed to draw a map of these barriers at the individual, organizational, and socio-cultural levels and also map the strategies that enable help-seeking among nurses and midwives in SSA.

METHODS

This scoping review was conducted in line with the framework of Arksey and O'Malley (2005), modified by Levac et al. (2010) and the Joanna Briggs Institute (Peters et al., 2020), and reported in accordance with the PRISMA-ScR guidelines (Tricco et al., 2018). The framework consists of five stages: (1) defining the research question; (2) finding relevant studies; (3) screening studies based on predetermined criteria; (4) charting the data; and (5) collating, summarizing, and reporting the results. Prior to the search, a protocol was developed that outlines the search strategy, screening process, and synthesis approach. The choice of this design was made due to the aim of the review to map the extent of evidence relating to the barriers to mental health seeking among nurses and midwives in Sub-Saharan Africa (SSA). It also seeks to outline strategies that support help-seeking and gaps to inform health policy and nursing practice as well as future research.

Peer-reviewed articles published in PubMed/MEDLINE, CINAHL, Scopus, PsycINFO, Web of Science, African Journals Online (AJOL), and African Index Medicus were searched. The websites of the World Health Organization, the International Council of Nurses, and the International Confederation of Midwives were searched for grey literature. Hand searching of reference lists of included studies was also conducted. Four concepts (nurses and midwives, mental health, help-seeking (barriers, facilitators, interventions), and SSA) were coded with free-text terms, connected with Boolean operators AND and OR. For example, a PubMed search would look like this: ("Nurses" OR "Midwifery" OR nurs* OR midwi*) " AND ("Mental Health" OR "Mental Disorder*" OR "Burnout" OR "psychological distress" OR anxiety OR stress) AND ("Help-Seeking Behavior" OR "help-seeking" OR "seeking help" OR stigma OR barrier* OR facilitator* OR "mental health services" OR "peer support" OR counsel) AND ("Africa South of the Sahara" OR "sub-Saharan Africa"

Study Selection

The selection process consisted of two phases. Titles and abstracts were initially screened, and then full-text articles of those deemed potentially eligible. Two reviewers independently screened using a set of inclusion/exclusion criteria. Disagreements were discussed and voted on to reach consensus; a third reviewer was consulted if necessary. Studies were included if they: included the presence of nurses and/or midwives; evaluated barriers or facilitators to seeking mental health support, or strategies and interventions that facilitate it; took place in one or more SSA countries; and were published in English during the review period. Studies that primarily addressed other healthcare workers but did not provide data for nurses or midwives, concerned patients' help-seeking rather than providers' help-seeking, were conducted outside of SSA, or were editorials/commentaries lacking empirical evidence were excluded.

Table 2.1
Eligibility Criteria of the Studies

Criterion	Inclusion	Exclusion
Population	nurses and midwives	Other healthcare workers without separate nurse or midwife data
Concept	Barriers and facilitators to seeking formal or informal mental health support, and strategies or interventions that promote help-seeking	Studies reporting only prevalence of distress, with no data on help-seeking, support, or related strategies
Context	Studies conducted in one or more SSA countries	Studies outside SSA
Time frame	Published between 2020 and 2026	Published outside this period
Language	English	Other languages
Study design	Qualitative, quantitative, mixed-methods studies, and reviews	Editorials and commentaries without empirical data
Publication type	Peer-reviewed articles and credible grey literature (WHO, ICN, ICM reports)	Blogs, non-scientific sources, and unpublished theses

Data Extraction and Synthesis.

The following information was extracted using a standardized charting form: author(s), year, country, study design, study population (cadre), sample size, mental health health issue studied, barriers reported, facilitators/strategies reported and key findings. There was an iterative process in charting and categories were developed and updated as knowledge of the studies increased. As part of the scoping review process, no quality appraisal was performed. The barriers were divided into three levels. Self-stigma, low mental health literacy and denial were individual barriers. Workplace barriers were the lack of workplace programmes, confidentiality issues, workload, and fear of consequences on the job. Socio-cultural barriers were stigma within the community, spiritual explanations for illness, gender norms and professional culture. A separate map for strategies and interventions was drawn up. Descriptive thematic analysis was employed to discover patterns, differences in context and gaps.

Presentation of Results

Results are reported in narrative and tabular format as a summary of distribution of studies, key results and new trends. Selection process is presented in a PRISMA-ScR flow diagram (Fig. 2.1) containing the number of records identified, screened, included and excluded with reasons for exclusion. The data analysis method used is a mixed method, which includes numerical analysis and thematic analysis. The distribution of the included studies by country, year, design, population, and domain are described numerically and is expressed in tables. The barriers, facilitators, and strategies extracted from the literature were read by two reviewers, coded, and reflexive memos were documented in an iterative process. A codebook was created and developed in a team discussion. Codes were organised into categories (individual, organisational, and socio-cultural), and themes and findings matched the review objectives.

Ethical Considerations

Ethical approval was not needed as only published secondary data was used for the review. Academic integrity is ensured through citations of all the sources.

Table 2.2
Data Extraction and Synthesis

Study	Design/method/location/population	Objective	Opportunities identified (facilitators, supports, strategies)	Challenges identified (barriers, stressors)
(24)	Qualitative; interpretive and descriptive phenomenological design; 3 focus group discussions + 10 in-depth interviews; thematic analysis (SICMS, transactional stress model, JD-R framework). Hospitals in central and southern Ethiopia; physicians, nurses, midwives, laboratory technologists, pharmacists, other paramedical staff.	Explore how health workers perceive the link between inadequate water, sanitation and hygiene (WASH) stressors and common mental symptoms.	Recommends integrated WASH and mental health services for health workers: individual-level interventions and better WASH around care areas, with administrators, health systems and water/sewerage services. Participants believed they could reduce impact mainly by avoiding the problem.	Inadequate water supply, hand hygiene, environmental cleaning and waste management raised perceived risk of occupational stress, job anxiety and occupational depression; low self-identification with mental symptoms but high perceived vulnerability; individual, organizational and system-level barriers to coping and to seeking mental health support.
(25)	Cross-sectional; West Rand District, Gauteng, South Africa; 2021–2022 (COVID-19). Healthcare professionals: doctors, nurses, clinical associates, dentists. Measures: alcohol use disorder, depression, GAD-7 anxiety, PSS-3 suicidality, COVID anxiety, awareness/utilization of support services.	Describe prevalence and correlates of alcohol use and mental disorders and assess awareness and utilization of support services.	Multiple wellness/support services existed. Recommends interventions to raise awareness and uptake, plus screening, brief intervention and referral to treatment.	20.9% harmful alcohol use (higher in males); mental disorders common among females; awareness and use of support services overall poor, with few professionals using them.
(26)	Qualitative, embedded in a larger cross-sectional mixed-methods study; socio-ecological model; N = 29; data collected 17 April 2020 to 8 March 2021 across all 16 regions of Ghana; nurses, physicians and allied health workers.	Examine multilevel factors influencing health workers' mental health during COVID-19 and their coping strategies.	Protective factors: social support (family) and workplace support. A minority received adequate institutional support.	Fear and anxiety most reported, then stress and depression; institutional and societal factors; mental health 'downplayed' in Ghana; pay seen as inadequate; stigma toward nurses who contracted COVID-19. Conclusion: inadequate resources to address distress.
(27)	Integrative review; PubMed, EBSCOhost, Web of Science, Google Scholar plus supplementary searching; 9 studies; sub-Saharan Africa; multiple health worker cadres.	Identify, map and synthesize strategies used to manage burnout among health workers in SSA.	Strategies described as coping strategies, interventions and management approaches; classed as adaptive and maladaptive.	Burnout management research in SSA described as limited and fragmented; database searching yielded few eligible studies.
(28)	Scoping review; South Africa; postgraduate nursing students with probable anxiety and depression. Part of a doctoral thesis, University of Limpopo.	Identify available support strategies for postgraduate nursing students with probable anxiety and depression.	First review to document such strategies in South Africa.	Significant gaps in the literature; current support strategies poorly structured; need for observational and mixed-methods studies.
(29)	Qualitative phenomenological; 6 focus groups; AIC Kijabe Hospital (level 5B tertiary referral), Kenya; nurses.	Explore factors influencing reactions to patient death, perceived adequacy of training, coping strategies chosen, and nurses' recommendations for support.	Nurses advocated psychological support.	Hospital provided no support or guidance in selecting coping mechanisms; working conditions increased the emotional burden of coping with patient death.
(30)	Phenomenological qualitative; Dodoma, Tanzania; first COVID-19 surge; 23 midwives; semi-structured interviews and 5 focus groups.	Explore midwives' experiences and challenges providing maternity care during COVID-19.	Midwives also described 'silver linings' of providing care during the pandemic.	3 themes, 8 subthemes: mental health distress (fear of infection, unexpected deaths, anxiety over positive cases, stressful workload), work-environment challenges (including PPE), and isolation of midwives.
(31)	Qualitative; purposive sampling; primary health care nurses (at least 1 year	Explore challenges PHC nurses faced	Outreach, telehealth, mental health awareness	Challenges in delivering mental healthcare

Study	Design/method/location/population	Objective	Opportunities identified (facilitators, supports, strategies)	Challenges identified (barriers, stressors)
	experience) providing mental healthcare in Durban, South Africa.	providing mental healthcare to patients during COVID-19 and innovative approaches used.	for patient care.	services; vaccine hesitancy.
(32)	Qualitative; district hospital, Ghana; nurses.	Explore occupational hazards faced by nurses, their psychological outcomes, and how emotional labour mediates nurses' behaviour.	Coping through emotional labour: surface acting, deep acting, spiritual coping, peer support, emotional detachment. Recommends comprehensive support systems, such as psychotherapeutic counselling during and after nursing school.	Two hazard categories: unavoidable (patient deaths, ubiquity of sickness, unpleasant sights) and escapable (work-related injuries, shift-work maladaptation); grief, disgust, fear, anxiety, fatigue; reliance on individual coping unsustainable without institutional support.
(33)	Cross-sectional; Nigerian tertiary hospital; 194 nurses.	Assess coping strategies and emotional impact of grief after patient loss.	Most used coping strategies: peer support, spiritual practices, relaxation techniques.	Emotional exhaustion, anxiety, sleep disturbance and burnout concerns after patient loss; female nurses scored higher on coping, emotional response and mental health impact.
(34)	Qualitative exploratory, descriptive, contextual; psychiatric nurses in child mental health settings, North West Province, South Africa.	Explore coping mechanisms of psychiatric nurses in child mental health environments.	Services should enable nurses to deal with service demands; coping mechanisms.	Scant, poorly defined child mental health services; few specialist nurses; limited understanding of child mental health challenges.
(35)	Qualitative; 20 nurses and midwives (11 nurses, 9 midwives per the companion paper) caring for advanced cervical cancer patients for at least 1 year; national referral hospital, Ghana.	Explore personal and workplace factors influencing resilience.	Personal factors supporting resilience: experience as a 'safety toolkit', desire to care, emotional numbness, professional outlook; longer service and intrinsic motivation. Companion paper (Oware et al. 2024, BMC Palliative Care 23:174) reports most had no workplace support, relying on family and friends.	Heavy caregiving demand in a resource-constrained setting.
(36)	Cross-sectional; N = 400 health workers; Mubende and Kassanda districts, Uganda (2022 Sudan virus outbreak epicentre); resilience scale; stigma-related risk perception items.	Assess resilience and associated factors among health workers.	Higher resilience with age over 40, 10 or more years' experience, permanent employment, long hours, and receiving counselling (adjusted OR 3.3, 95% CI 1.7–6.5). Recommends targeted mental health support.	Most had low resilience; 89% feared infection and workplace stigma; 80% felt families would avoid them if infected; 68% felt PPE was inadequate.
(37)	Cross-sectional; convenience sampling; N = 563 health workers; Sudan; 4–30 Nov 2024; PHQ-9, GAD-7; coping mechanisms.	Assess depression, anxiety and coping among health workers during the 2023 conflict.	Most common coping: support from family and friends.	More than half had anxiety symptoms (28.1% severe); about one-third depressive symptoms; higher in women; administrative staff, nurses and laboratory staff had higher depression; About 42% rated mental health support as insufficient (35.7% 'insufficient but manageable'; 5.9% 'extremely insufficient'); access to support was not significantly

Study	Design/method/location/population	Objective	Opportunities identified (facilitators, supports, strategies)	Challenges identified (barriers, stressors)
				associated with depression or anxiety.
(38)	Quantitative survey; 209 nurses; various facilities, Uganda; PLS-SEM.	Examine resilient leadership, nurses' well-being and organizational resilience.	Nurse well-being mediates the link between resilient leadership and organizational resilience; recommends well-being initiatives within leadership strategies.	None directly about help-seeking.
(39)	Qualitative; remote semi-structured interviews; 14 registered psychiatric nurses; Ankaful Psychiatric Hospital, Cape Coast, Ghana; referral recruitment; NVivo 12.	Explore interpersonal and structural stigma experienced by psychiatric nurses and its impact on mental healthcare.	None reported.	Social stigma makes psychiatric nursing a difficult career choice; structural stigma through government neglect; lack of basic equipment and improvisation.
(40)	Descriptive phenomenological; 7 maternal healthcare providers; quasi-government hospital, Ghana; face-to-face interviews.	Explore lived experiences of maternal healthcare providers who contracted COVID-19.	Support from family, colleagues who also had COVID-19, and superiors; psychological adjustment.	Shock and grief; stigmatization and neglect by family and colleagues; psychological distress (fear of dying, infecting others).
(41)	Qualitative; two PHC facilities, rural KwaZulu-Natal, South Africa; PHC practitioners.	Explore perceptions and understanding of COVID-19.	Interventions to support practitioners are needed.	Negative perceptions from social-media misinformation; potential effects on service delivery and mental health.
(42)	Qualitative, descriptive cross-sectional; two PHC facilities, rural KwaZulu-Natal; PHC practitioners.	Explore experiences of the COVID-19 pandemic.	None reported.	Staff infections, courtesy stigma, resource constraints, poor information dissemination.
(43)	Protocol; mental health institutions, Limpopo, South Africa; nurses caring for mental healthcare users.	Develop and validate a model to promote nurses' mental health.	A model is planned; no findings yet.	Nurses susceptible to harm from patients' hostile behaviour.

RESULTS

Out of the 623 records were found in the database search. Of the 598 titles and abstracts, 578 were rejected after 25 were duplicated. The full texts of 20 articles were evaluated and all 20 articles were found to meet the inclusion criteria and were included in the review (Fig. 2.2). Table 2.2 summarises their characteristics.

As per the objectives of the review, the barriers of seeking mental health support identified were divided into 3 broad areas, namely, individual, organizational, and socio-cultural domains along with strategies and interventions to curb those barriers. The 20 studies were finally summarized in Table 3.1.

Table 3.1
Barriers and Facilitators to Seeking Mental Health Support by Nurses and/or Midwives in SSA

Domain	Context	Nature	Explanation / evidence summary
Individual	Low awareness and use of available support services	Barrier	Awareness and use were overall poor among healthcare professionals despite several services existing.
	Low self-identification with mental symptoms and avoidance-based coping	Barrier	Health workers identified little with having symptoms despite high perceived vulnerability, and individual-level barriers to seeking support were reported.
	Low resilience driven by fear of infection and stigma	Barrier (indirect)	89% feared infection and workplace stigma; most had low resilience.
	Reliance on informal coping	Mixed	Peer support, spiritual practices and relaxation; family and friends and individual coping is unsustainable without institutional support.
Organizational	Limited workplace mental health support	Barrier	Only a minority of Ghanaian health workers reported adequate institutional support; Kenyan nurses reported no hospital guidance on coping after patient deaths.
	Heavy workload and caregiving demand	Barrier	Caregiving demand reduced resilience; midwives described stressful workloads.
	Access to counselling	Facilitator	SVD-specific counselling was associated with higher resilience (AOR 3.3, 95% CI 1.7–6.5).
Socio-cultural	Mental health downplayed in society	Barrier	A few Ghanaian health workers said so.
	Stigma attached to mental healthcare	Barrier (indirect)	Psychiatric nurses reported social and structural stigma.
	Stigma, neglect and isolation	Barrier (indirect)	Providers who had COVID-19 faced neglect from family and colleagues; 80% expected families to avoid them; midwives reported isolation.
Strategies and interventions	Social support	Facilitator	Family and workplace support were protective; family, colleagues and superiors supported providers with COVID-19.
	Psychological support and counselling (recommended)	Facilitator	Nurses advocated psychological support; recommendations included counselling and integrated mental health and workplace services.
	Burnout management strategies	Not evaluated	Support recommended but rarely evaluated. Evidence limited and fragmented.

DISCUSSION

This scoping review documented what is known about barriers to mental health care seeking among nurses and midwives in sub-Saharan Africa and the strategies reported to be effective in helping them to seek mental health care. Our main result is the evidence that focuses on help-seeking directly. Only a few of the 20 studies focused specifically on awareness, use, or barriers to access of support as an explicit focus. The nature of the reported distress and coping seems to be related to the identified barriers. This is similar to broader SSA literature, where a systematic review of 69 studies revealed that nearly all of the studies measured prevalence of depression, anxiety, and post-traumatic stress, and only eight measured that of nurses and one of midwives (16). It is well known that there is a problem. It is estimated that 30% of nurses are burned out globally saying that they experience high levels of emotional exhaustion (2). There is less evidence regarding why distressed nurses and midwives don't seek help.

Evidence was also gathered at a specific location. 12 of the 20 studies were in South Africa, and none in Central Africa or French- or Portuguese-speaking countries as shown in Fig. 2.3. This compares with the distribution where over half of the studies were from Ethiopia, Nigeria, and South Africa (10). This may have been exacerbated by our English-only criterion. In several studies, however, the data included mixed groups of health workers, which precluded analyses of nurses and midwives, and midwives were only found in a small number of studies.

Reports from studies showed low self-identification with mental symptoms, avoidance as a coping mechanism, poor awareness and utilization of services available, and informal coping mechanisms with peers, family, and spiritual practice were the noted individual barriers hindering the nurses and/or midwives from seeking professional mental health support. Moreover, results indicated that informal coping is widespread when dealing with distress. This cannot be distinguished from preference, lack of awareness, or lack of access from the studies included, as

none of these studies were designed for comparison of these explanations. Interestingly, one study identified that few professionals made use of services where they are offered and that availability alone was not enough.

Lack of or minimal support in the workplace was found consistently across the organization in Ghana, Kenya, and Sudan. In addition, heavy workload and insufficient resources were reported. There was an association between counselling and higher resilience in Uganda, but this was a cross-sectional association and cannot demonstrate that counselling led to better resilience. There is mixed evidence on counselling in Sudan, as there was no association between access to support and depression or anxiety in the country. Some issues that were salient in studies conducted elsewhere in the country, including privacy and professional license issues [add citation] were not found in the studies included. The lack of these in the measures may be due to what was measured, not that they are not present.

Stigma, mental health being overlooked, neglect, and isolation were reported. Much of the stigma mentioned above was related to COVID-19 infection and/or the psychiatric nursing profession, rather than to mental illness among nurses themselves, and therefore is indirectly relevant to help-seeking. This is important to note, and there are few primary studies asking nurses and midwives themselves about stigma toward their mental health needs.

None of the included studies assessed an intervention to encourage help-seeking. Strategies were most commonly found in the form of recommendations, including counselling, targeted support, awareness and screening, and integrated services, or in the form of reviews of the fragmentation of burnout management strategies. A few other studies indicated that targeted workplace interventions may be beneficial in improving the mental health of health workers and that there is support for psychiatric nurses in South Africa that includes educational, interpersonal, psychological and coping aspects. The effect of such strategies on the seeking of help by SSA nurses/midwives has yet to be evaluated.

The results highlight the need for support within the workplace, both for practice and for policy, and suggest a focus on awareness and utilization of existing support services, as this would benefit hospital managers and ministries of health. For research, the priorities are primary studies where the help-seeking behaviours of nurses and midwives are directly queried, studies that split the two cadres, intervention studies with outcome evaluation, and studies from under-represented regions and languages.

Strengths and limitations

To our knowledge, this is the first review that maps this question for nurses and midwives in SSA. A published framework was used for the review and a structured and transparent search. Some limitations are English-only search and only PubMed. We did not perform a quality. The journals extracted were from abstracts and open access text / full text from, and some studies combined health worker cadres. Lastly, our arrangement of findings within the domains of judgment was also subjective, as very few studies had a direct measure of help-seeking.

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Figures

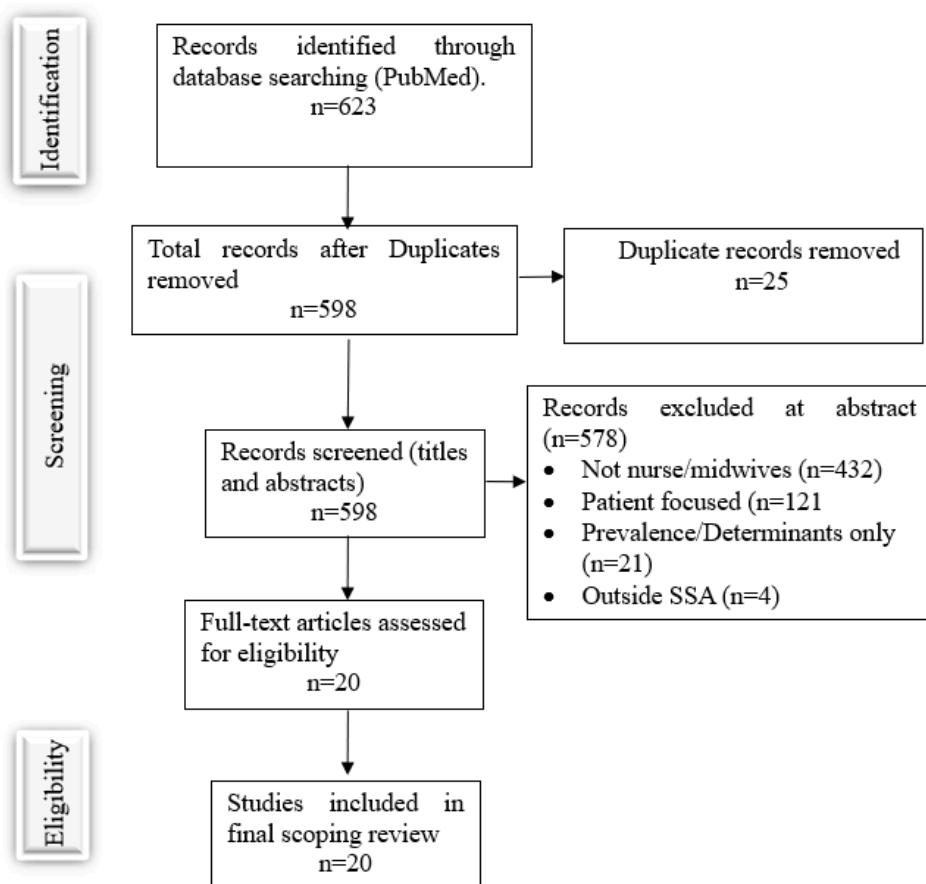


Figure 1

Figure 2.1: PRISMA-ScR flow Diagram Used in the Study

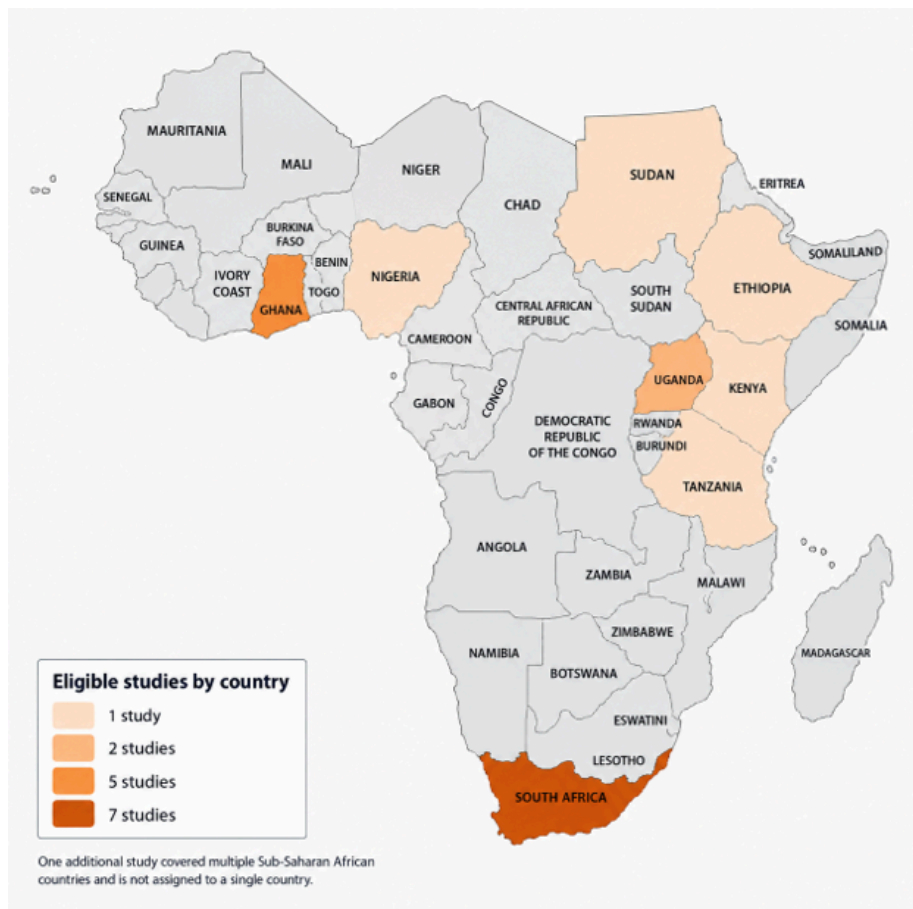


Figure 2

Figure 2.2: Geographical Distribution of Eligible Studies on Barriers to Seeking Mental Health Support Among Nurses and Midwives in Sub-Saharan Africa.

Supplementary Files

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