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Examining the Perception and Expectations of African Adults towards Mental Health Matters

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Abstract**—** *This study evaluates and clarifies the perceptions and expectations of African men and women towards mental health issues. The cross-sectional online survey consisted of the domains of demographics, mental health perception, and mental health expectations. A descriptive analysis was done on the data of 114 participants from Nigeria and Zimbabwe. The gender gap in the responses points to an unwillingness of the male population to engage in studies regarding mental health. Also, most of the respondents stated that they were not aware of any mental health resources in their countries. Respondents admitted to experiencing changes to their mental health in their daily lives due to stressors such as work and studying, and needing support to deal with the challenge. A holistic approach to mental healthcare would be most effective in addressing mental healthcare in African countries. For this to happen, mental health needs to be prioritized and properly financed.*

Keywords**— *African, Gender, Mental Health Expectations, Mental Illness, Mental Health Perception.***

I. INTRODUCTION

Mental health entails an individual's emotional, psychological, and social well-being. It impacts a person's feelings, thoughts, and behavior. According to Carter and Goldie [1], it is a state of well-being in which the person recognizes their potential, manages daily stressors, works effectively and efficiently, and can give back to the community. The capacity to find balance between one's daily activities and attempts to develop psychological resilience is another aspect of mental health. Mental diseases are a prominent source of impairments worldwide [2]. The lifetime prevalence of mood disorders varied from 3.3% to 9.8%, anxiety disorders from 5.7% to 15.8%, drug use disorders from 37% to 13.3%, and psychotic disorders from 0% to 4.4% in Africa, according to Greene et al. [3]. Research undertaken outside of Africa has indicated a reduced prevalence of anxiety and mood disorders [3]. Given that the problem of mental illnesses in Africa necessitates

additional gender-based study, this primary research exposes the deficit in mental health research in Africa to better the knowledge of mental health concerns. People's understanding of mental health and the disorders that are related to it is comparatively low [4; 5; 6]. The perception of mental health disease follows a similar trend around the world. The negative opinions of the general public and mental health experts contribute to stigma and prejudice and are a major barrier to care and treatment options in many nations and cultures. Proper health-seeking is predicated on the recognition of mental problems, the display of the right attitudes, and the implementation of appropriate preventative actions. Subu et al. [7] explained that the stigma associated with mental illnesses, particularly those originating from traditional beliefs, keeps those who are affected from coming forward and seeking or receiving the necessary care because they fear rejection, even from family members who might choose to ignore them or abandon them completely to avoid the so-called "embarrassment." As mental health stereotypes have become older, so too have people's expectations and views about mental health concerns, which has led to the avoidance of mental health issues in African countries. Because of this, individuals frequently do not seek help until it's too late and their mental health has severely worsened, at which point there is nothing that can be done to reverse the condition. Thus, raising public awareness and fostering a positive picture of mental health and sickness will help the affected feel more included in society and raise expectations for mental health issues.

According to the World Health Organization, African nations have conflicting goals for mental development and health, and there are not enough resources to meet them all [8]. The absence of mental health data from health management systems leads to an underestimation of the illness burden in nations throughout the continent [9]. Policymakers are unable to fully understand the scope of the issues that nations are experiencing due to a lack of data and information. It is with these in consideration that this study evaluates African men's and women's perceptions of mental health issues. This study also aims to clarify African men and women's expectations regarding mental health issues in their nation. The investigation is to raise public awareness of mental health in general and provide an updated set of data concerning mental health in the African countries of Nigeria and Zimbabwe. Examining the expectations around mental health will also assist in identifying areas in which public health interventions, such as mental health education, may be implemented to lessen the stigma and burden of the illness.

1.1 Social construct theory

There is no one definition of the social construct theory. It is a theory of knowledge which examines people's perceptions and comprehension of the world. The social construct theory posits that ideas or notions are created because of human interaction and acceptance of these ideas or notions in the process of this interaction [10]. What is known is not a result of objective interpretations but is rather influenced by history and culture. New generations of people accept what is known as truth because they are born into it, and it is what is socially acceptable. Furthermore, a more powerful group of actors in society can determine what idea or concept is true [11]. This infers that if a group of powerful actors view a certain thing as bad, even if it is not inherently bad, then all of society will view it as bad [12]. Additionally, communication between people is seen as meaningless unless there is meaning assigned to it. This meaning is determined by interactions among people. What can be concluded from the social constructionist view is that different societies can assign different meanings to mental health and view it differently based on their norms, beliefs, histories, language, and what is viewed as knowledge at a certain point in time [12]. It is not just a biomedical issue but is also influenced by social, environmental, and cultural processes [13]. In the African context, at one point, mental illness was seen because of witchcraft, with this belief persisting until today in some places [14]. Social constructs can reinforce negative connotations attached to mental health and limit people's understanding of the issue. Stigma, for instance, is a real-world consequence of social constructionism [16]. People hide that they are facing mental health issues because it can be socially isolating to admit being mentally ill. Certain words used to describe mentally ill people have a shared negative meaning and might also contribute to deterring people from seeking help with mental health issues. Society, in its interactions, norms, and accepted knowledge, can determine how much it addresses mental health issues. Resources to address mental health issues might also not be prioritized due to stigmas [17]. Africa is lagging in addressing mental health issues due to persistent beliefs and unchallenged knowledge that hinder progress in mental health care [17]. Having this view of mental health

means that interventions need to consider cultural and societal norms, beliefs, and experiences to maximize effectiveness.

1.2 Intersectional theory

The intersectionality theory emerged in 1989 and is credited to Kimberley Crenshaw, whose main interest was the effects of certain social factors on the employment of black women in America [18]. The theory states that there is the interdependence of markers such as age, physical ability, sexuality, race, and gender affect people's experiences [18]. These markers do not act independently but jointly determine social biases [19]. This is an interconnected network of identifiers that mold people's experiences [20]. It is important to note that power dynamics come into play in this theory in that people who feel oppressed or experience biases based on their social identities tend to resist these oppressions, and in doing so, it can affect their health [21]. According to Collins [19], individuals' experiences are influenced by societal processes and structural biases such as racism. The intersectionality theory's main views state that various identities intersect with each other within a power dynamic and socio-cultural context to give people certain experiences [20]. Based on the perspective given by this theory, mental health care needs to be understood from how different identities interact with each other and how historical biases and social and cultural experiences affect a person's mental health.

Because mental health is affected by many factors, including race, gender, and sexuality, it makes sense to approach mental health care from an understanding of how these factors affect how people experience and navigate mental health [22]. The social identifiers in the intersectionality theory can affect people's mental health in subtle ways, necessitating a need to understand the impact of these social markers on mental health [22]. Social identifiers are usually associated with certain biases that impact people's mental health. Some cultures have gender biases that can affect the quality of life of those affected, and addressing these issues requires that mental health care be aware of these cultural and social biases if care is to be effective [23; 24]. These cultural and social biases can affect how people view mental health and whether they seek treatment [24]. This implies that to provide optimal healthcare, mental health interventions should take into consideration people's experiences and interactions with bias, as well as the mental healthcare providers themselves resisting passing judgments on people based on their identities [25].

1.3 Labeling theory

Labeling theory gained a lot of traction in the 1960s, 1970s, and even now. The book "suicide" by French sociologist Emile Durkheim (1858–1957) served as the inspiration for labeling theory. The labeling hypothesis suggests that people are assigned labels according to how other people perceive their tendencies or behaviors. In addition, the theory of self-identification and behavior holds that people can be influenced negatively by the terms used to categorize or characterize them. Thomas J. Scheff introduced the term "mentally ill" to the labeling theory in 1966. According to Scheff, mental disease is only a symptom of social influence, and when the public perceives some behaviors as aberrant, it is common to associate those behaviors with mental illness in persons who engage in them. Research has indicated that label expectations may have a significant negative impact. Patients may retreat from society as a result of it. They learn to anticipate and identify unwanted social reactions to them, which may diminish the worth of life.

The labeling theory is a useful tool for assessing Africans' mental health issues, particularly those that impact both men and women. In Africa, mental illness is typically classified as deeply spiritual. A woman may believe that her illness is the result of divine retribution for her transgressions, such as witchcraft or promiscuity, or because she refuses to participate in cultural or traditional rituals that her family may have requested of her. This term always explains why women are more likely to receive the correct diagnosis because of the way that mental illness has historically been classified, which itself reflects societal perceptions, attitudes, and cultural views. It has also been shown that women may receive mental health designations related to conception and pregnancy. Since depression and anxiety have been identified as the most prevalent mental health issues after pregnancy, some of the designations include post-partum depression and perinatal depression and anxiety. Conversely, men have historically been acknowledged as the more physically fit members of society and have been informed that they are not supposed to be weak. They are unable to bear labels.

1.4 Concept of mental health in Africa

Africa is a big continent with a history of conflict. Low life expectancy, a high incidence of communicable illnesses and malnutrition, low wages, and understaffed healthcare facilities are the hallmarks of the majority of its member nations [26]. When it comes to policymakers' priority, mental health concerns frequently rank last [27]. In a world where infectious illnesses and starvation continue to be the leading causes of death, the government pays very little attention to the morbidity and disablement caused by mental illness. In most African nations, social services related to health are still underfunded, and mental health services are underdeveloped in comparison to other health-related services [28]. Most African nations lack action plans, programs, or policies about mental health [29]. Before the coronavirus epidemic, the WHO projected that over 116 million individuals in the African region suffered from mental health issues. However, the primary obstacle that hinders efforts to increase the number of mental health professionals in Africa is still inadequate funding for mental health services. Psychiatric nurses and mental health nursing assistants make up the majority of the currently underemployed workforce of less than two mental health professionals for every 100,000 individuals [30]. People receiving primary and community treatment are severely neglected as a result of the limited resources being focused at sizable mental hospitals in urban locations. Due to the numerous conflicting objectives that the continent faces, including poverty, economic crises and corruption, infectious illnesses, and internal conflicts, mental health treatment and literacy are not always regarded as crucial in certain African countries [31]. People may find themselves in situations that are detrimental to their mental health, and this is made worse by the fact that many do not have the support of their communities, families, or the medical community as a whole. African cultural conceptions of the individual have an impact on several mental health issues, including awareness of mental illness, behavior related to seeking care, and expectations for recovery [32; 33]. To effectively treat African clients, therapists must be cognizant of these cultural ideas. Patients may feel alienated and misinterpreted if the internalized notion of the patient is ignored throughout therapy, which highlights the need to take note of cultural perspectives in mental health treatment in Africa.

1.5 Gender and Mental Health in Africa

Gender norms are deeply ingrained beliefs about proper conduct and activities based on one's gender categorization. Breaking these norms can be dangerous for men, as they are often the foundation of masculine social standing [34]. According to Freiberger et al. [34], men who display a high degree of conventional masculinity may see talk therapy and individual and group counseling as forms of depression treatment that are emotionally intrusive and inappropriate. Because gender stereotypes form the foundation of masculine gender norms, these biases probably affect the capacity of others to identify depression in men and inform suggestions for depression treatment [36]. Certain depressive symptoms, such as furious outbursts, are often misdiagnosed in diagnostic exams as typical male behaviors. As a result, these cues may go unnoticed as signs of sadness in males. Furthermore, it may be necessary for males to exhibit more severe symptoms to overcome their perceived resistance to depression, even if they exhibit conventional symptoms such as social disengagement [35].

In addition, while talking about experiences, those who believe that depression has a strong stigma may place more emphasis on physical symptoms such as fatigue, headaches, and backaches [37] than on psychological ones [37]. Men may thus emphasize physical symptoms when talking to peers about mental health difficulties because they have greater rates of depression and self-stigma than women [38]. In order to determine whether there are gender variations in the recognition of depression, Freiberger et al. [35] evaluated the shifting standards model (SSM). According to the SSM, differing judgments of people are based on mental associations of groups and their related traits, or stereotypes, since observers assess different individuals based on different reference points [39]. Mental images of a social category, such as a person's gender, known as stereotypes, affect how various associations and attitudes towards (i.e., bias) members of such categories are formed and maintained [40]. Both perceivers and performers are influenced by stereotypes. Per the SSM, individuals are involved in both subjective and objective assessments of other individuals. This study will examine whether the preconceived notions regarding a person's gender might influence how that person is seen when it comes to a mental health issue.

1.6 Mental Health Expectations

According to Rief and Glombiewski [41], expectations are future-focused thoughts that center on the occurrence or non-occurrence of a certain experience or event. Examining and altering patients' expectations is talked about as a key change mechanism in the treatment of mental illnesses. This expectation-based approach does not discount the importance of past experiences; rather, it views them as relevant only to the extent that they may be used to forecast future occurrences. The study of perception and mental health are related fields of inquiry. Although this study primarily looks at how Africans view mental health issues, looking at expectations will also assist in understanding how Africans see their chances for mental health promotion and prevention.

Forouzan et al. [42] conducted a qualitative study to investigate the expectations of both providers and recipients of mental health services. The expectations linked to mental health and mental health services were found to be shared by all participant groups in five common domains: continuity of treatment, involvement in decision-making, quality of interpersonal connections, suitable infrastructure, and accessibility. It was only service users that brought up the significance of culturally appropriate treatment as a requirement for the perfect mental health service. Although designations like consumers or providers are taken into consideration, this research takes into account this method of understanding mental health expectations while taking into account the number of persons living with untreated mental health conditions and receiving treatment.

Mental healthcare providers need to be aware of patient expectations to build a lasting relationship with patients. Mental health practitioners should encourage patients to vocalize their views on mental health as well as their preferences so that care plans are formulated to meet patients' needs. This can help to increase satisfaction levels and effectiveness of care plans. There is very little evidence to suggest that there are efforts to identify the expectations of both patients and mental healthcare providers and this suggests that there is a need to study Africa's' expectations when it comes to mental healthcare provision and the perspectives of care providers in Africa as well.

II. MATERIALS AND METHODS

2.1 Participants and procedure

Participants were recruited for this study through social networking networks like WhatsApp, Instagram, and emails, among others. The eligibility criteria included Africans from Zimbabwe and Nigerian Africans residing in these countries. These residents include students, the working class, and those not currently employed. This study was conducted amongst African men and women who were between the age range of 17 and above 40. The study population excluded those people who had not undergone any form of education. Teenagers/adolescents were also excluded from the study. The participants, after consenting to participate in the study, were permitted to invite others that are eligible to participate in the study. Participants who did not consent to the study were allowed to withdraw from the study as participation was voluntary. The participants for the study were Africans from two regions, Zimbabwe and Nigeria. Harare (the capital city of Zimbabwe) and Bulawayo were considered for this study as the most populated regions in the country [43], and with the consideration that the majority of the population is rural, these regions have more access to amenities such as internet. Lagos and Ogun are regions in Nigeria that are considered for this study because they are the most industrialized regions in the country [44]. Lagos is also one of the most populated regions in the country [45].

2.2 Measures

The cross-sectional online survey consisted of the domains of the demographic domain, the mental health perception domain, and the mental health expectations domain. Mental health Perception was examined with a 15-item scale adopted from Mojiminiyi [46] and St Louis and Roberts [47]. The items were measured on a 5-point scale (1 = Strongly Disagree to 5 = Strongly Agree). The mental health measuring items were adopted from Kanika [48]. The final section of the measure comprised sociodemographic items, including age, gender, educational qualification, and others.

2.3 Data Analysis

The data collected from the forms were then converted to a spreadsheet and analyzed with the use of Jamovi statistical software version 2.5.6. A descriptive analysis was done using this statistical software.

Ethical Statement

Participants were recruited online and only participated after consenting to be a part of the study. A consent form and a brief description of the study was attached to the survey making it vital for them to consent before participating in the study. The participants were informed that the data collected was solely for research purposes and confidentiality would be strictly observed. It is also important to state that the online survey does not contain any item or question that will distinctively identify any of the participants.

III. RESULTS

This study assesses the perspectives of African men and women on mental health concerns, clarifying what African men and women anticipate from their country in relation to mental health concerns. The mental health perceptions and expectations of Africans were investigated, and the results obtained from a total of 114 analyzed responses are discussed in sections.

3.1 Demographics

A total of 114 responses were analysed from Nigeria and Zimbabwe, with 83 of the respondents being Nigerian and 31 of the respondents being Zimbabwe. The large gap is due to convenience and the willingness of the African population to participate in mental health-related research.

Table 1: Age Demographics

Age	Counts	% of Total	Cumulative %
18- 25=1	52	45.6 %	45.6 %
26-33=2	51	44.7 %	90.4 %
34-41=3	7	6.1 %	96.5 %
Older than 41=4	3	2.6 %	99.1 %
younger than 18=5	1	0.9 %	100.0 %

Table 1 shows that from the responses, the age of majority of the respondents were between 18 and 33 with a total of 90.3% and the remaining of the respondents comprising of those younger than 18 (<18) and other between 34 and older than 41 (>41).

Table 2: Gender demographics

Gender	Counts	% of Total	Cumulative %
Female=1	77	67.5 %	67.5 %
Male=2	37	32.5 %	100.0 %

Table 2 shows that from the responses, the gender of majority of the respondents were female (67.5%) as compare to the minority of the gender being male with 32.5%.

3.2 Mental Health Inquiry

Table 3: Have you ever experienced a mental health challenge?

	Gender	Counts	% of Total	Cumulative %
No=1	Female	34	29.8 %	29.8 %
	Male	22	19.3 %	49.1 %
Yes=2	Female	43	37.7 %	86.8 %
	Male	15	13.2 %	100.0 %

Table 3 above shows a close range between those that have experienced mental health challenges and those who have not. 56 of the respondents have never experienced a mental health challenge, while, 58 have experienced a mental health challenge. Also, from responses of Yes and No, the highest counts were for female, and most importantly, 43 female respondents have experienced mental health challenges, while more male respondents(22) have not experienced mental health challenges.

Table 4: Rate your current mental health status

	Gender	Counts	% of Total	Cumulative %
1	Female	2	1.8 %	1.8 %
	Male	3	2.6 %	4.4 %
2	Female	2	1.8 %	6.1 %
	Male	2	1.8 %	7.9 %
3	Female	7	6.1 %	14.0 %
	Male	2	1.8 %	15.8 %
4	Female	10	8.8 %	24.6 %
	Male	1	0.9 %	25.4 %
5	Female	10	8.8 %	34.2 %
	Male	6	5.3 %	39.5 %
6	Female	8	7.0 %	46.5 %
	Male	5	4.4 %	50.9 %
7	Female	11	9.6 %	60.5 %
	Male	3	2.6 %	63.2 %
8	Female	13	11.4 %	74.6 %
	Male	7	6.1 %	80.7 %
9	Female	6	5.3 %	86.0 %
	Male	2	1.8 %	87.7 %
10	Female	8	7.0 %	94.7 %
	Male	6	5.3 %	100.0 %

Table 4 above contains the self-rating value of the respondents' mental health. One each count of the rates from 1-10, the female mostly rated their mental health 4, 5, 7 and 8 out of 10. For male, their mental health was mostly rated 5, 6, 8 and 10. It can also be depicted that 45 of 114 respondents rated their mental health to be within the range of 1-5 out of 10 of which only 11 of them are male. Also, from the rate of 6-10, 46 were female, while, 23 of the respondents who rated their mental health within 6-10 were male.

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3.3 Descriptive Analysis Results for Mental Health Perception

114 responses were analyzed to investigate the mental health perception of Africans in Nigeria and Zimbabwe. The perceptions of respondents when it comes to making a decision to advise anybody with a mental disorder to visit a psychiatrist is displayed in table 5 (see appendix). Majority of the respondents (89/114) would advise anybody with a mental health disorder to visit a psychiatrist. From table 6, 50.9% believed it is not easy to tell when one has a mental challenge, while 21.9% disputed this and agreed that it easy to tell when one has a mental challenge. Table 7 shows that when asked if they would be ashamed to mention that someone in their families has a mental disorder, the respondents majorly disagreed (63.2%) (See appendix). However, 17.6% agreed that they would be ashamed with up to 19.3% of them saying they neither agree nor disagree with the statement. According to table 8, more than 50% of the respondents disagreed to the statement that 'mental health facilities are improving in their country'. Those that agreed were the minority and were only 17% of the respondents. The questionnaire item depicted in table 9 (see appendix) is to understand the level of awareness of Africans about mental health resources available in the countries. Only 21.9% are aware of the mental health resources in their country. 43% had no awareness of the available mental health resources. Table 10 shows 29.8% of the respondents were neither satisfied nor unsatisfied with the quality of their life and wellbeing, and 48.3% are satisfied with their quality of life and wellbeing (see appendix). Only 21.9% of the respondents were not satisfied with the overall quality of their lives and wellbeing. To understand if the respondents experience changes which impacts their mental health in their daily life, the question depicted in the table 11 was asked. 74.6% of them attested to experiencing these changes, while only 6 of the respondents mentioned they do not experience significant changes in their mental health while working or studying. As depicted in the table 12 (see appendix), 53.5% of the respondents are able to open up about their concerns, while 21.1% of the respondents disagreed. Table 13 (see appendix) shows that 39.5% of the respondents have the need support to manage stress effectively. 29.8% do have the needed support, and up to 30.7% were not able to state if they have the support or not. In table 14, 61.4% feel supported by their families in relation to their mental health, while the minority (11.4%) didn't feel supported by their families (see appendix). It is important to note that up to 27.2% of the respondents neither agreed nor disagreed about being supported by their families. In table 15, 82.5% of the respondents agreed that they engage in self-care activities to support mental wellbeing while 6.1 % said they did not engage in self-care activities (see appendix).

3.4 Descriptive Analysis Results for Mental Health Perception

In order to have a grasp of the mental health expectations of Africans in Nigeria and Zimbabwe, the following questions were asked.

Table 16

Who do you expect to provide the most support for your mental health needs?	Counts	% of Total	Cumulative %
Family	45	39.5 %	39.5 %
Government	11	9.6 %	49.1 %
Health Professionals	15	13.2 %	62.3 %
Other (Yourself and all the above options)	43	37.7 %	100.0 %

Table 16 above shows that the respondents mostly expect that family should provide the most support for their mental needs. While 37% of these respondents believe that it is not only the responsibility of the family, but other actors like the government, health professionals and oneself is important when it comes to providing adequate support for mental health needs.

Table 17

What would make mental health services more accessible	Counts	% of Total	Cumulative %
Standardized mental health facilities	30	26.3 %	26.3 %
Provision of mental health councilors/personnel	20	17.5 %	43.9 %
Adequate financial support	12	10.5 %	54.4 %
more mental health groups	10	8.8 %	63.2 %
online support	7	6.1 %	69.3 %
mental health insurance	8	7.0 %	76.3 %
Building a Clients-personnel relationship	11	9.6 %	86.0 %
Community mental support	16	14.0 %	100.0 %

Table 17 above shows that most of the respondents believe that standardized mental health facilities and community health support are the most important factors that would make health services more accessible. Other factors stated include provision of mental health counsellors, financial support, mental health support groups, online mental health support, mental health insurance, and building clients-personnel relationship.

Table 18

What mental health intervention do you find to be most helpful	Counts	% of Total	Cumulative %
Counseling and medication	55	48.2 %	48.2 %
Exercise and physical activities	20	17.5 %	65.8 %
Self-help book/online resources and spiritual support	16	14.0 %	79.8 %
Friends and Family support	23	20.2 %	100.0 %

Finally, this study asked the respondents about the mental health interventions that they deemed to be the most helpful. In table 18 above, counseling and medication were the most helpful (55%) to the respondents. In addition, up to 20% of them agreed that friends and family support is the next intervention that is very helpful while closely followed by other interventions like exercise and physical activities (17.5%) as well as self-help resources (14%).

IV. DISCUSSION

This study sought to shed light on how African men and women perceive mental health and its associated concerns. Issues addressed included awareness of mental health, expectations of people regarding mental health interventions, perceptions of mental health support and people's experiences regarding mental health. An important conclusion from the findings is the proportion of men to women respondents in the study. The respondents were predominantly female at 67.5% compared to males at 37.5%. This could point to an unwillingness from the male population to engage in studies regarding mental health. It is possibly due to a societal norm in Africa where men are discouraged from exhibiting emotions or perceived weakness [48], thereby limiting the number of male respondents. The prevalence of respondents who have experienced a mental health challenge was almost equal to the number of respondents who have not experienced it. This could point to an inability to identify or acknowledge a mental health challenge, also prevalent among African communities [17]. Respondents stating, overwhelmingly, that they would not be ashamed to mention that someone in their family has a mental health challenge points to a shift in perceptions in favor of addressing mental health. This is supported by Burr [11]'s study that explained that more powerful societies can influence

those deemed less powerful into accepting different norms and beliefs. Western societies tend to acknowledge, address and prioritize mental health more than African societies. Their influence on African beliefs on mental health can be seen in a shift in perceptions. Furthermore, majority of the respondents were satisfied with their quality of life followed closely by people who were indifferent about their quality of life as well as people who were not satisfied.

African countries invest less than 50 cents (US) in mental healthcare [8]. This is because financial resources are scarce and have competing needs, with governments allocating more funds to development issues and less on mental health care [8]. This is reflected in this study as most of the respondents stated that they are not aware of any mental health resources in their countries. This is because there are limited resources to raise awareness as well as treat the mental health illnesses in Africa, with most countries having less than 2 health care workers per 100 000 people [49]. Respondents admitted to experiencing changes to their mental health in their daily lives due to stressors such as work and studying as well as needing support to deal with the challenge. Most rely on their families and friends for support and engage in self-care activities. This points to a lack of professional resources to address mental health issues.

Traditionally Africans tend to consult traditional healers and spiritualists to treat mental health illnesses [50]. This is because of the prevalence of the belief that mental health illnesses are caused by witchcraft and other supernatural causes [14]. The respondents majorly expect assistance from family and self-care to combat mental health challenges, while few (22.8%) of them expect assistance from the government and or health professionals. The lack of adequate mental healthcare facilities leads to people not expecting assistance from the government but rather turning to relations for support. In most African countries mental healthcare can only be accessed in large hospital usually located in the biggest cities [49]. The ratio of mental healthcare workers to the population is too high, making quality mental healthcare inaccessible for most Africans. In such a situation, patients would not even be able to identify where they can access help and therefore, fall back on what is easily accessible to them, which in this case would be traditional healers.

While respondents looked to relations and traditional healers for support, 30% still believe that standardized mental health facilities would make it easier to access mental healthcare. Standardized mental health facilities would consist of community based mental healthcare workers who work on a local level and can be a first point of contact for mental health patients. These teams comprise of psychiatrists, psychologists, social workers as well as nurses among others [50]. This was also stated by respondents who felt that having professional healthcare workers in proximity would make access to mental healthcare easier. This might prove difficult in African settings due to a shortage or mental healthcare personnel and government resources to make such services easily accessible. Furthermore, the healthcare workers who work in communities in Africa tend to provide basic health support and are not equipped to deal with mental health illnesses [49]. Respondents also stated that mental health groups and online support would help alleviate the issue of access. Additionally, respondents stated that financial assistance and mental healthcare insurance would help to improve ease of access to care. Most people in Africa generally pay for their healthcare themselves, making it even more difficult for people to access medical care. It puts the scarce financial resources that families have under immense pressure, causing mental healthcare to not be prioritized. Overall, respondents expect an approach in which the barriers to healthcare access are reduced enough to make it easier for all people to easily access mental healthcare.

Counselling and medication were identified as the most helpful mental health intervention by respondents. Whilst respondents generally look to family and traditional healers for support, they still are of the notion that professional counselling and medication are the most helpful interventions. Other interventions were of a self-help nature and seeking spiritual and familial support. A holistic approach to mental healthcare that combines professional healthcare, community healthcare, familial and spiritual support as well as self-care activities would be most appropriate to address the needs of mental health patients.

4.1 Strengths and Limitation

This study is the first to investigate mental health perception and expectations of Nigerians and Zimbabweans side by side. Other studies have only investigated African countries individually, this study considers examining two African countries, in an attempt to have a solid report of the perceptions of

Africans considering two of the more populated regions in the countries. Investigating these two countries will also contribute to increased diversity in research information, ideas and as well bring value. Given that the participants of the study were recruited through social networking sites such as Whatsapp, there were concerns of privacy breach and lack of confidentiality, but this study ensures that demographics required in the study instrument were not invasive. The demographics asked were majorly age, gender, occupation, and nationality. There were no direct identifiers asked in the questionnaire, and the participants were allowed to recruit others that are eligible.

4.2 Conclusion

Mental health in Africa is a complex issue that is influenced by cultural and spiritual beliefs. In many instances, it is overlooked and not acknowledged as there are stigmas attached to mental health illnesses. Furthermore, mental healthcare is not easily accessible in Africa as there are scarce resources due to a lack of adequate funding. People generally seek the support of families, friends, and spiritualists to address mental healthcare. They also expect government assistance in the form of standardized care and policies that will make access to healthcare easier. A holistic approach to mental healthcare would be most effective in addressing mental healthcare. In order for this to happen, mental health needs to be prioritized and properly financed.

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AUTHOR CONTRIBUTIONS

The authors Tolulope OO and Jaqueline K contributed to writing the manuscript. The author Joy JA worked on the methodology aspect of the work. Author Japheth AN carried out the data analysis for this research with the use of Jamovi statistical software version 2.5.6. Author Blessing OO proofread and edited the manuscript. Authors Tolulope OO and Blessing OO prepared the manuscript for submission.

ETHICAL APPROVAL AND INFORMED CONSENT STATEMENTS

Participants were recruited online and only participated after consenting to be a part of the study. A consent form was attached to the survey making it vital for them to accept to participate before proceeding.

DECLARATION OF CONFLICTING INTEREST

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

DATA AVAILABILITY STATEMENT

The datasets generated and analyzed during the current study are available from the corresponding author on reasonable request.

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Appendix

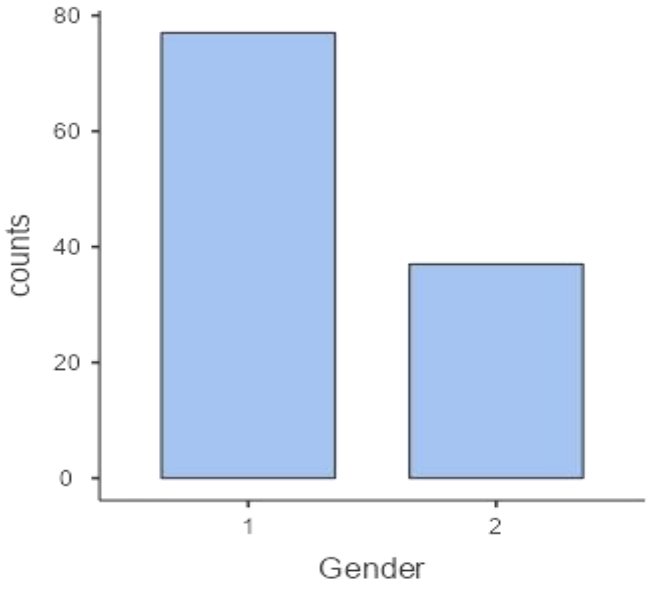

Fig.1: Gender Demographics

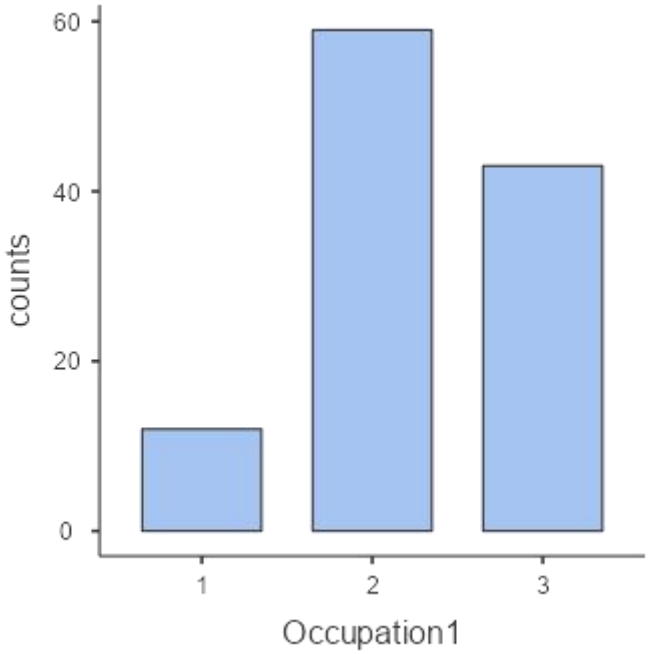

Fig.2: Occupation Demographics

Mental Health Perception

Table 5

I would advise anybody with a mental disorder to visit a psychiatrist.	Counts	% of Total	Cumulative %
Agree	37	32.5 %	32.5 %
Disagree	6	5.3 %	37.7 %
Neutral	12	10.5 %	48.2 %
Strongly agree	52	45.6 %	93.9 %
Strongly disagree	7	6.1 %	100.0 %

Table 6

It is easy to tell when one has a mental health challenge	Counts	% of Total	Cumulative %
Agree	21	18.4 %	18.4 %
Disagree	49	43.0 %	61.4 %
Neutral	31	27.2 %	88.6 %
Strongly agree	4	3.5 %	92.1 %

Table 5

I would advise anybody with a mental disorder to visit a psychiatrist.	Counts	% of Total	Cumulative %
Strongly disagree	9	7.9 %	100.0 %

Table 7

I would be ashamed to mention someone in your family that has a mental disorder.	Counts	% of Total	Cumulative %
Agree	19	16.7 %	16.7 %
Disagree	46	40.4 %	57.0 %
Neutral	22	19.3 %	76.3 %
Strongly Agree	1	0.9 %	77.2 %
Strongly Disagree	26	22.8 %	100.0 %

Table 8

Mental health facilities are improving in my country	Counts	% of Total	Cumulative %
Agree	18	15.8 %	15.8 %
Disagree	41	36.0 %	51.8 %
Neutral	34	29.8 %	81.6 %
Strongly agree	2	1.8 %	83.3 %
Strongly disagree	19	16.7 %	100.0 %

Table 9

I am aware of the mental health resources available in my community	Counts	% of Total	Cumulative %
Agree	21	18.4 %	18.4 %
Disagree	40	35.1 %	53.5 %
Neutral	40	35.1 %	88.6 %
Strongly Agree	4	3.5 %	92.1 %

Table 5

I would advise anybody with a mental disorder to visit a psychiatrist.	Counts	% of Total	Cumulative %
Strongly Disagree	9	7.9 %	100.0 %

Table 10

I am satisfied with my overall quality of life and well being	Counts	% of Total	Cumulative %
Agree	46	40.4 %	40.4 %
Disagree	19	16.6 %	57.0 %
Neutral	34	29.8 %	86.8 %
Strongly agree	9	7.9 %	94.7 %
Strongly disagree	6	5.3 %	100.0 %

Table 11

I have experienced significant changes in my mental health while studying/working	Counts	% of Total	Cumulative %
Agree	67	58.8 %	58.8 %
Disagree	6	5.3 %	64.0 %
Neutral	23	20.2 %	84.2 %
Strongly agree	18	15.8 %	100.0 %

Table 12

I am able to open up about my concerns	Counts	% of Total	Cumulative %
Agree	55	48.2 %	48.2 %
Disagree	22	19.3 %	67.5 %
Neutral	29	25.4 %	93.0 %
Strongly Agree	6	5.3 %	98.2 %
Strongly Disagree	2	1.8 %	100.0 %

Table 12

I am able to open up about my concerns	Counts	% of Total	Cumulative %

Table 13

I have adequate support and resources to manage my stress effectively	Counts	% of Total	Cumulative %
Agree	39	34.2 %	34.2 %
Disagree	29	25.4 %	59.6 %
Neutral	35	30.7 %	90.4 %
Strongly agree	6	5.3 %	95.6 %
Strongly disagree	5	4.4 %	100.0 %

Table 14

I feel supported by my family and friends regarding my mental health	Counts	% of Total	Cumulative %
Agree	57	50.0 %	50.0 %
Disagree	9	7.9 %	57.9 %
Neutral	31	27.2 %	85.1 %
Strongly agree	13	11.4 %	96.5 %
Strongly disagree	4	3.5 %	100.0 %

Table 15

I often engage in self-care activities to support my mental well-being	Counts	% of Total	Cumulative %
Agree	76	66.7 %	66.7 %
Disagree	7	6.1 %	72.8 %
Neutral	13	11.4 %	84.2 %
Strongly agree	18	15.8 %	100.0 %