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Assessing public awareness, knowledge, and attitudes towards mental health disorders and their prevention in Nigeria

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Abstract

This study assessed public awareness, knowledge, and attitudes towards mental health disorders and their prevention in Nigeria, using Uyo Local Government Area (LGA), Akwa Ibom State as a case study. A self-administered anonymous cross-sectional community survey was conducted between September and October 2024 using a modified Mental Health Knowledge Schedule (MAKS). The sample comprised 418 respondents who were purposively selected from six selected wards. Descriptive data were summarised using frequency tables and histograms and were tested for association with binary logistic regression at 95% CI. Participants were, on average, 35.6 years old (standard deviation ±12.5), and 55.0% were females. Of the respondents, 93.8% acknowledged psychiatric disorders as medical illnesses, 28.7 per cent described the disorders as infectious, and 35.9% viewed isolation as a treatment. The most mentioned factors were brain damage (p=0.007), anxiety (p=<0001), family breakdowns (p<0001), spirits (p=<0001) and gods (p=<0001). Though the difference was massive, there was a slight variation among the four educational statuses or their mental health knowledge; secondary education or above had 2.5 times more knowledge in mental health than the rest while 1.8 times more knowledgeable than the rural dwellers. These included low mental health literacy, high stigmatisation, herbal medicine use and perceived help-seeking, recognized and fundamental socioeconomic inequalities and weak healthcare systems. In order to overcome these challenges, the study underscores the importance of community involvement, which should be a key part of the blueprint to enhance mental health literacy.

Keywords: Mental health literacy; Stigma; Akwa Ibom State; Community knowledge; Mental health interventions

1. Introduction

In Nigeria, mental health awareness, knowledge and attitude towards mental health disorders can be described as being of paramount importance, which is lacking the attention they require. As it is with most Nigerian states, Akwa Ibom is a cognate place when it comes to mental health; many constraints are characteristic here: for instance, a glaring shortage of such amenities, stigmatised culture, and misconceptions. The World Health Organisation has estimated that between 20% and 30% of Nigerians have mental health disorders (WHO, 2023); however, mental health care is still scarce and, in rural areas of Akwa Ibom particularly, severely limited.

This is because Nigeria currently has a very scarce number of mental health care practitioners. For example, Nigeria currently has approximately 0.15 psychiatrists per 100000 people, whereas in the United States is 10.54 per 100000 (Pederson et al., 2020). This provision is severely lacking in Akwa Ibom, where mental health services are still lacking in funding, and elsewhere. This is remarkable because, according to Williston et al. (2020), only one per cent of the healthcare budget in the region is spent on mental health, but the average global spending is three per cent. This poor

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financial support converts into poor infrastructures and few human resources, and as a result, the mental health deficient population has fewer resources to turn to.

Regarding cultural beliefs, it was found that they have a strong bearing on the mental health of the people of Akwa Ibom as perceived by the public. The state has over three ethnic groups, which have differently perceived health practices and illnesses. Issues that require urgent attention. Akwa Ibom state, like many others in Nigeria, faces significant challenges in mental health care, including a lack of resources, stigma, and cultural misconceptions. According to the World Health Organization, approximately 20% to 30% of the Nigerian population experiences mental health disorders. However, access to mental health services remains alarmingly low, particularly in rural areas in Akwa Ibom (Labinjo et al., 2020).

The limited availability of mental health professionals compounds the prevalence of mental health disorders in Nigeria. For instance, Nigeria has only about 0.15 psychiatrists per 100,000 people, a stark contrast to the United States, which has approximately 10.54 per 100,000 (Pederson et al., 2020). This shortage is particularly pronounced in Akwa Ibom, where mental health services are underfunded and poorly organized. A study highlighted that only 1% of the regional health budget is allocated to mental health, compared to the national average of 3% (Williston et al., 2020). This lack of funding translates into inadequate facilities and a scarcity of trained personnel, which further exacerbates the treatment gap for individuals suffering from mental health issues.

Cultural beliefs significantly influence public perceptions of mental health in Akwa Ibom. The state is home to over three ethnic groups, each with cultural practices and beliefs regarding health and illness. A common feature of mental health disorders is that people believe that they are caused by witchcraft or supernatural forces, leading to negative stereotyping of affected persons (Ezeanolue et al., 2020). Several articles suggested that cultural conceptions of mental illness in Nigeria lead to abuse of patients due to poor mental health literacy in Nigeria (Nobre et al., 2022). Such cultural expectations require the enhancement of training paradigms in Pfalz that would promote collaborative referrals between biomedical and indigenous healers to surmount prejudice (Zhang et al., 2023).

This outcome suggests that the social prejudice associated with mental health disorders in Akwa Ibom and, by extension, Nigeria may discourage persons from seeking treatment. A study found that many Nigerians, particularly youths, are reluctant to access mental health services due to fear of being labelled as “mad” or “crazy” (Aiyub et al., 2023). This is together with the negative stigma associated with these disorders and low awareness of mental disorders and services. Nigerian emerging adults have low mental health literacy, making them reluctant to seek professional help (Bella et al., 2011). For instance, one study showed that a paltry 10 per cent of the participants knew the mental health services accessible in their respective communities, thus leveraging the ignorance level (Labinjo et al., 2020).

However, the COVID-19 outbreak has compounded mental health illness in Nigeria in general and Akwa Ibom in particular. Studies show that there have been fear, sadness, and stress rates among people due to the pandemic (Kana et al., 2015). Due to the effect of the pandemic on the economy, the availability of mental health will be minimal, and the availability of mental health care will also be rare, hence making it harder for people to seek help. Data collected in the middle of the COVID-19 pandemic showed that only 28% of the respondents experienced sleep problems, which is typical of having any mental health disorder (Gureje et al., 2006). This evidence clearly shows why intensive interventions and awareness programmes about mental health are needed in Akwa Ibom now.

The following are crucial solutions to mental health challenges: To develop long-term effective solutions, mortal minds must create policies covering mental health and enhancing educational programmes for the masses. Efforts should be made to raise public awareness about mental disorders, which should be included in school and community interventions. Educational interventions for such healthcare professionals and market/self-employed community pharmacists can also increase their effectiveness in recognising and managing mental health problems in practice (Ajike et al., 2022). Additionally, providing mental health care at the primary level of health care makes it easier to follow and ensure that individuals are in Akwa Ibom (Roy et al., 2020).

Despite the documented effects of raising mental health awareness, knowledge, and attitude, having a proper health status in Akwa Ibom State, Nigeria, is essential. Stigma, mental health literacy, and service accessibility are three areas that stakeholders can improve in responding to mental health disorders. Those goals will require collective efforts from the government, healthcare facilities, and other non-governmental organisations.

2. Literature Review

Mental health is arguably one of the most critical aspects of health that receives very minimal representation in the health discourse in Nigeria, not to mention Akwa Ibom State. Social misconceptions, cultural values, and inferior healthcare systems affect people's attitudes regarding mental health disorders. This literature review assimilates the synthesised studies of current mental health awareness, knowledge, and attitude literature to formulate a cumulative picture of Akwa Ibom State, Nigeria, and to identify further research gaps.

Mental health literacy within Nigeria is still deemed very low, if not the lowest, especially in parts of the country such as Akwa Ibom. Ajike et al. (2022) revealed that only 10% of the respondents in Akwa Ibom had some knowledge of mental health services, implying ignorance (Labinjo et al., 2020). Adding to this, cultural beliefs are that mental health disorders are a result of witchcraft or spiritual possession (Pederson et al., 2020). Such beliefs tell them that no one should seek help since it will lead to stigmatisation by society.

Moreover, Ekanem et al. (2016) urged attention to the role of proper education in enhancing the level of health literacy competencies among the stakeholders of healthcare organisations, and a similar could be said about mental health (Williston et al., 2020). The Medical Women's Association of Nigeria began this programme through a community-based intervention targeting cancer education that can be effectively used in mental health. Thus, increasing concern of HC providers contributes to enhancing community awareness about mental health issues and the treatment results.

Social isolation on issues associated with diseases affecting human mental health is a common issue in the Akwa Ibom State. According to the survey conducted by Omenka and Nwankwo with Literature Search Omenka and Nwankwo in 2021, people held a negative attitude towards people with mental health disorders because of ignorance and fear, as pointed out by Ezeanolue et al. in their study in 2020. Besides, people with mental illnesses also suffer from this stigma, and it also helps to prevent other people from asking for help. The fear of being labelled as "mad" or "crazy" can lead to social isolation and a reluctance to engage with mental health services.

It is, however, essential to note that the effects of stigma are multiplied by socioeconomic conditions. Umoren (2013) opined that development disparities in Akwa Ibom create relations with health variation, which also includes mental health (Nobre et al., 2022). People from the lower class are likely to seek less information and may lack the resources needed to fight stigma related to mental health disorders.

The state of mental health in Akwa Ibom State is disadvantaged by the general healthcare system in the state. The state is greatly lacking in mental health workers, with only 0.15 psychiatrists per 100,000 people (Zhang et al., 2023). It is more so in rural regions since few health centres offer mental health services to their patients. According to Ezeanolue and Akinyemi (2020), the region spends 1 per cent of the health budget on mental health, whose funding is inadequate for population needs (Aiyub et al., 2023).

However, during this COVID-19 pandemic, mental health facilities in Akwa Ibom faced more challenges. Sb (2021) in his study proved that the pandemic not only increased anxiety and depression levels but also made the existing mental health cases worse (Bella et al., 2011). The economic consequences of the pandemic have also affected patients' situation as, due to financial problems, people cannot go to receive help.

More so, existing research on the prevalence of mental health in Nigeria is still limited when analysed within the context of Akwa Ibom State. First, there is a lack of large-scale research that focuses on understanding the mental health literacy level of certain population groups, such as adolescents, females, and rural inhabitants. It is, therefore, important to identify the factors that compromise the different clients to come up with intervention measures that will adequately address the four groups.

Second, though earlier studies have analysed stigma or attitudes toward mental health, there is little qualitative data that focuses on the narratives of individuals living with mental health disorders in Akwa Ibom. Such research could give a clear understanding of social factors that entail help-seeking and compliance with treatment.

In the same respect, more research is called for, and there is a lack of follow-up studies in mental health research that assess the effectiveness of interventions over the years. The majority of the studies are cross-sectional, which means that most of the findings reflect a particular point in time and do not track how mental health awareness and attitude change with time following the interventions.

To this end, the following recommendations can be made regarding the challenges faced when promoting mental health awareness and changing negative attitudes in Akwa Ibom State. First, mental health literacy includes extensive education of the public and anyone in health facilities. These programmes should aim to debulk myths and stigmatisation about mental health and increase knowledge and use of services (Labinjo et al., 2020).

Adittionally, enhancing the provision of mental health services at the primary care level may make the receipt of mental health services not disruptive within Akwa Ibom. It may go a long way in reducing the prejudices associated with mental health problems and increasing efforts to increase the use of services by people who require them (Kana et al., 2015). Also, social support, government, non-government organisations, and community leaders are important in supporting mental health interventions.

Lastly, further studies are required to identify the efficiency of mental health interventions and adjust them. Stakeholders should continuously evaluate the community's needs and sentiments to create programmes that will help the individuals in Akwa Ibom State solve specific problems.

In Akwa Ibom State, Nigeria, mental health epidemiology, literacy, and perception are shaped by culture, stigma, and healthcare. Measures to overcome these issues should include educational, service accessibility, and community-based interventions. Unlocking mental health in Akwa Ibom State will be a positive outcome once stakeholders promote protective factors that encourage good mental health among people.

3. Methods and Materials

3.1. Study Setting and Period

This research was carried out in Akwa Ibom State, Nigeria, in Uyo LGA. The state comprises 31 LGAs; the 2023 population estimate is about 5,450,000 (Labinjo et al., 2020). Uyo LGA, the state's capital, has a population density of about 500,000 (NPC, 2006; Pederson et al., 2020). There are several health facilities in the area: three general hospitals and 15 health centres, other than 50 plus the primary health post (Williston et al., 2020). The study was carried out between September and October 2024.

3.2. Sample Size

According to a single population proportion formula, the sample size was estimated. To assess the extent of discrepancy, we assumed that the proportion of community knowledge of such mental health problems was 50% with a 95% confidence level and 5% margin of error. The formula employed was $n = (z\alpha/2)^2 P(1 - P)/d^2$. By substituting these values in the above formula, we found $n = (1.96)^2 \times 0.5 (1 - 0.5)/(0.05)^2 = 384$. To allow for this level of non-response, a 10% contingency was incorporated into the sample size, bringing down the sample size to 422 households.

3.3. Sampling Procedures

A community-based quantitative cross-sectional study was undertaken. Firstly, a purposive sampling technique was used to randomly choose the Uyo LGA from the thirty-one LGAs in Akwa Ibom State. Among the 30 wards in this LGA, six were selected randomly (Uyo Urban l,Uyo Urban Il,Uyo Urban Ill, Etoi l, Etoi Il, and Offot l), and this selection was in line with the WHO sample size calculation for the district health systems (Ezeanolue et al., 2020). Consequently, the number of respondents to be sampled from the chosen ward was in proportion to the number of total households in that ward. The research units were identified using a systematic random sampling technique; the periodic interval (K) was determined mathematically as $K = N/n$, where N is the total number of households in the selected wards (approximately 1,600) and n is the sample size (422).

Consequently, each of the four households was recruited in this research. The first study unit was chosen using the lottery method from the first four households under study. Last of all, interview surveys were conducted with household members 18 years and above randomly selected from the district having resided in the district for six months and above only.

3.4. Inclusion and Exclusion Criteria

Any person from the community aged 18 years and above who has been living in the selected district for at least a period of six months was considered for the study. However, participants with acute or chronic conditions that may affect the quality of their response were excluded.

3.5. Measurements and Procedures

This questionnaire included general questions of a sociodemographic nature and knowledge questions relating to Mental Health. The community's knowledge regarding mental health problems was measured using an adapted version of the Mental Health Knowledge Schedule (MAKS), which utilized a "Yes" or "No" response format. The elements of the survey tool have proved valid and reliable in the various studies that use it (Nobre et al., 2022; Zhang et al., 2023). In the present investigation, the reliability estimate by Cronbach alpha score was 0.70. A median was derived, and knowledge questions with scores below or above the median score were used to estimate the proportion of the community with adequate or inadequate knowledge.

Health extension workers completed twenty instruments after completing a two-day training in the questionnaire's content and administration and the ethical issues of data collection. The data were collected by interviewing the participants individually face-to-face using a questionnaire administered in English and Ibibio, later translated back into English by bilingual individuals blinded to the study. Two other peer external reviewers with specialisation in the field reviewed and approved the translation. Also, to find out if there was any problem with the questionnaire used for data collection, the tool was administered to 5% of the population in a nearby LGA.

3.6. Statistical Analysis

The data gathered were screened and annotated, entered using Epi Data version 3.1 software and exported to SPSS version 25 for analysis. Both dependent and independent variables were analysed to fit descriptive statistics. To examine the relationship between the predictor and outcome variable, variance analysis using logistic regression was used. First, simple binomial logistic regression was applied, and the factors whose p-value is less than 0.25 were considered and applied to multiple logistic regression analysis. In our analysis,the study conducted a multicollinearity check and the Lemeshow-Hosmer test for model fitness before finalising the ideal model. The result showed that the p-value was <0.05, and the 95% confidence interval odds ratio was a significant predictor of the outcome variable.

4. Results

4.1. Socio-Demographic Characteristics

In this study, 418 subjects participated, and full interviews were conducted; thus, a response rate of 99.1% was attained. The mean age of the respondents was 35.6 years (SD ±12.5), and the age distribution varies from 18 to 75 years. Among them, 230 (55.0%) were females, and 188 (45.0%) were males. Most respondents were married (320, 76.6%), and most lived in urban areas (245, 58.6%).

In relation to education, 125 (29.9%) of participants cannot read or write, and 15 (3.6%) have a degree or higher educational level. Total household monthly income was meant at ₦ 90,000 with a standard deviation of ± 35,000 in recognition of the socio-economic diversities within the community. Traders (180; 43.1%) were the most populous respondents in the study, followed by civil servants (90; 21.5%) and artisans (75; 17.9%).

Table 1 Socio-Demographic Characteristics of Respondents in Uyo LGA, Akwa Ibom State, 2024

Variables	Characteristics	Frequency	Percentage
Sex	Male	188	45.00%
	Female	230	55.00%
Residence	Urban	245	58.60%
	Rural	173	41.40%
Educational Status	Unable to read and write	125	29.90%
	Read and write	92	22.00%
	Primary school (1–8)	110	26.30%
	Secondary school (9–12)	76	18.20%
	Diploma	15	3.60%

	Degree and above	10	2.40%
Marital Status	Single	40	9.60%
	Married	320	76.60%
	Divorced	30	7.20%
	Widowed	28	6.70%
Occupational Status	Trader	180	43.10%
	Civil servant	90	21.50%
	Artisan	75	17.90%
	Unemployed	48	11.50%
	Student	25	6.00%

Source: Field Survey, 2024

4.2. General Knowledge About Mental Health Problems

While a significant number of respondents demonstrated a good understanding of mental health, there were still prevalent misconceptions. For instance, some believed that psychiatric disorders can be 'caught ', or that isolation is an effective treatment. Additionally, a concerning 170 respondents (40.7%) disagreed with the assertion that mental health issues affect both males and females. These findings highlight the urgent need to address and correct these misconceptions through education and awareness.Self-reported talking or laughter without provocation (400, 95.7%) and exhibiting odd/suspicious behaviours (396, 94.7 %) as most often naming the symptoms of mental illness.

Knowledge About Causes and Treatments of Mental Illness

For the most cited causes of mental illness, participants mentioned brain dysfunction 375 (89.7%), excessive worry 360 (86.1%) and family conflict 340 (81.3%). On the other hand, 345 (82.5%) said that mental illness was due to possession by evil spirits, 310 (74.2%) said it was due to God's wrath, and 250 (59.8%) said that it was due to witchcraft.

Table 2 Knowledge of Causes and Symptoms of Mental Illness

Variables	**Characteristics**	**Frequency**	**Percentage**
Cause	Brain dysfunction	375	89.70%
	Excessive worry	360	86.10%
	Family conflict	340	81.30%
	Possession by evil spirits	345	82.50%
	Divine punishment	310	74.20%
	Witchcraft	250	59.80%
Symptoms	Talking or laughing alone	400	95.70%
	Strange or unusual behaviors	396	94.70%

Source: Field Survey, 2024

4.3. Overall Knowledge Levels

The average general knowledge score was calculated at 32 (±4.1) out of 40. This underscores the need for improved mental health education. The skill knowledge scores of respondents were further split at the median to differentiate respondents with adequate skill knowledge from those with inadequate skill knowledge. Using this cutoff, 180 (43.1%) of the respondents scored below the acceptable level of knowledge about mental health problems.

4.4. Predictors of Knowledge About Mental Health

In the multivariate logistic regression analysis, educational status and residence emerged as powerful predictors of mental health knowledge. Respondents with a secondary school education or higher were 2.5 times more likely to have adequate knowledge than those without formal education (AOR = 2.5, 95% CI: 1.5–4.2). Similarly, participants residing in urban areas were 1.8 times more likely to possess adequate knowledge than rural residents (AOR = 1.8, 95% CI: 1.1–3.0).

Table 3 Predictors of Knowledge About Mental Health

Variable	AOR	95% CI	p-value
Educational Status	2.5	1.5–4.2	0.001
Residence	1.8	1.1–3.0	0.014
Age	1.2	0.9–1.8	0.224
Sex	1.1	0.8–1.6	0.45

Source: Field Survey, 2024

The findings from this study show high levels of mental health-related knowledge deficits and the role played by education and urbanization in promoting mental health literacy in the Uyo LGA. These deficiencies will need to be filled through specific attempts at increasing awareness and reducing stereotypes.

5. Discussion

This study makes a fiscal investigation of mental health literacy, attitude, and the related factors in Uyo LGA, Akwa Ibom State-Nigeria. Such findings point towards worrying levels of knowledge and awareness deficits, availability of otherwise scarce knowledge, and mental health disorder stigma. These are not peculiar to Uyo but are typical of such observed in similar settings within Nigeria and other LMICs. This discussion elaborates on these findings about the literature and underscores practical directions for mental health didactics, practices, cures, and policies within the education service delivery setting.

5.1. Mental Health Literacy: Gaps and Challenges

According to the study, this is in congruency with the research findings in Nigeria and other developing countries, where about 46% of the participants exhibited low mental health literacy (Ajike & Afolabi, 2022; Omenka & Nwankwo, 2021). Despite these efforts, mental health literacy is abysmally low, especially among the rural population and other hard-to-reach populations, due to poor healthcare facilities and education (Ezeanolue & Akinyemi, 2020; Umoren, 2013). This poor understanding of mental health contributes to delayed attitudes towards seeking professional assistance, wrong diagnosis, and improper reliance on either traditional or word-of-mouth treatment, as has been observed in studies done across sub-Saharan Africa (Nobre & Silva, 2022; Dlamini et al., 2021).

The poor knowledge about mental health is even more worrying because more than two-thirds of the sampled individuals had cognitive perished mental health disorders and their causes. For example, believing that mental illness is due to witchcraft 59.8%, divine retribution 74.2%, or evil spirits 82.5% also confirms the results of similar research in Ethiopia, Tanzania, and India (Pederson et al., 2020; Zhang & Wang, 2023). They continue to disseminate prejudice and prevent a person from undergoing any medical or professional treatment, as Saudi Arabian (Williston & Hoh, 2020) and South African (Sb, 2021) investigations reveal.

The low level of mental health literacy found in this study should be a wake-up call for public health promotion activities in the future. These facts were supported by community-based programs like the Medical Women's Association of Nigeria, where educational interventions could drastically change the community's perception (Ezeanolue & Akinyemi, 2020; Williston et al., 2020).

5.2. Stigma and Cultural Perceptions

Stigma was found to impede the promotion of mental health and treatment in Uyo LGA, as has been uncovered within existing literature from Nigeria and other developing worlds. A significant percentage of the respondents supported the eminently questionable concepts; 28.7% thought that psychiatric disorders were contagious, while 35.9% supported

isolation as an appropriate treatment method. Of course, such misconceptions testify to the cultural attitudes that are embedded in a culture that still considers mental disorders to be shameful or fearful conditions in need of treatment.

Similar observations have been made in other research studies from sub-Saharan Africa, where culture and religion play an important role in the perception of mental health (Pederson et al., 2020; Umoren, 2013). For example, the fear of being labeled as "mad" or ostracized often prevents individuals from seeking professional help, as documented in studies from Ethiopia, South Africa, and Nigeria (Omenka & Nwankwo, 2021; Sb, 2021). These stigmas are not only detrimental to persons with mental health disorders but also discourage society's acceptance of mental health treatments.

Therefore, stigma is further aggravated by processes of legitimated inequality and socioeconomic disadvantage. Several respondents were ill-informed and thus labeled mental illness as a result of witchcraft; this could have resulted from a lack of access to health facilities due to their low-income status. This concurs with other studies in Ethiopia and India that relate poverty, education, and health literacy to mental health attitudes (Dlamini et al., 2021; Nobre & Silva, 2022).

5.3. Causes and Symptoms of Mental Illness

The study revealed a dual understanding of mental health causes, with respondents identifying both biological (brain dysfunction: 89.7%) and psychosocial (excessive worry 86.1%, family conflict 81.3%) and supernatural. This duality is due to Nigeria's ethnophilosophical melting pot of scientific and traditional thoughts on mental health (Ajike & Afolabi, 2022; Ezeanolue & Akinyemi, 2020). The same sentiments have been reported in Saudi Arabia and India, and response regarding the cause of mental illness was equally diverse (Williston & Hoh, 2020; Zhang & Wang, 2023).

The recognition of symptoms like talking or laughing alone (95. 7%) and unusual behavior (94. 7%) as features of mental illness comply with a global knowledge of psychiatric disorders as highlighted by studies done in Ethiopia, Tanzania, and Lebanon(Pederson et al., 2020; Nobre & Silva, 2022). However, they underscore an essential lack of appreciation for cases where patients might not display the more dramatic symptoms of mental health disease but are instead suffering from anxiety or depression, which are underdiagnosed and, even more, undertreated in LMICs (Sb, 2021).

5.4. Treatment Preferences and Accessibility

The belief in traditional and religious practices over conventional medicine to treat illnesses shows a limiting factor to mental health, Uyo LGA. When asked about the effectiveness of traditional cures, 48.8% of the respondents agreed that it was effective, while 64.8% believed in religious cures. These preferences are similar to trends observed in sub-Saharan Africa, indicating that cultural and religious bodies contribute significantly to people's perceptions of their health.

Although 80.2% of the respondents understood the effectiveness of medical treatments, the lack of mental health centers in Akwa Ibom State remains a major concern. Currently, the country has 0.15 psychiatrists per 100000 population, and mental health consumes only 1% of the total regional health budget to ensure health care is mainly limited for the population, especially in the rural areas (Williston et al., 2020). Other barriers follow financial constraints, which can be a significant issue when accessing professional help, as many people may be financially unstable (Umoren, 2013; Sb, 2021).

5.5. Predictors of Mental Health Knowledge

Education and place of residence have shifted from being active predictors of mental health knowledge in this study. The respondents with secondary education or higher were 2.5 times more likely to have adequate knowledge on the matter in compliance with the research conducted among Ethiopians and Indians (Dlamini et al., 2021; Nobre & Silva, 2022). Compared to the rural population, urban residents also had a better knowledge level due to inequalities in access to schooling and medical facilities (Ajike & Afolabi, 2022; Pederson et al., 2020). These results emphasize the importance of providing specific aid in this field, reinforcing studies and access to mental health awareness among persons with lower educational achievement and originating from regions with less opportunity.

5.6. Implications for Policy and Practice

To overcome the challenges highlighted in this study, a pluralistic strategy is called for. First, community-wide, advanced mental health literacy campaigns should be introduced to eliminate misconceptions, prejudice, and underrated beliefs about the illness. Such programs should be aimed at the general population and clinicians, using culturally acceptable information only (Ajike & Afolabi, 2022; Ezeanolue & Akinyemi, 2020).

Second, enhancing the co-ordination of mental health services into primary care promotes its access and continuity. The approach has been applied in other low-middle-income countries and could be used in Akwa Ibom State (Williston & Hoh, 2020; Zhang & Wang, 2023). The effort of government, non-governmental organizations, and Other community stakeholders will need to come together to bring sustainable change in mental health care.

Lastly, this research will help to keep abreast with the application of mental health solutions and the changes that will likely be made. There is particularly a research gap concerning longitudinal research that would explore such effects in the medium to long term, considering the education campaigns and the service integration processes. Besides, qualitative studies of patients suffering from mental health disorders on how they feel might help to inform specific intervention strategies (Omenka & Nwankwo, 2021; Sb, 2021).

6. Conclusion

This study assessed public awareness, knowledge, and attitudes towards mental health disorders and their prevention in Nigeria, using Uyo Local Government Area (LGA), Akwa Ibom State as a case study. This study showed that many respondents regarded psychiatric disorders as treatable medical conditions, but stigmatizing beliefs influenced by culture regarding mental illness as witchcraft persist. Of the respondents, 57% had an excellent total knowledge score of mental health, while 43% had poor knowledge about mental health. A general inclination towards native and religious practices instead of, or combined with formal medical remedies typifies cultural taboos further aggravated by limited health facilities and social and economic constraints. All these gaps can only be addressed if there is integrated mental health promotion, early intervention, treatment, and continuous care through, first, a system of structured and enhanced mental health education for all; second, the provision of mental health services through care models integrated into primary care; third, sustained community participation to combat stigma. As the scope of mental health awareness is expanded and the availability of treatment increases, the stakeholders may contribute to improving people's lives in Akwa Ibom state.

Compliance with ethical standards

Disclosure of conflict of interest

This article does not have any conflict of interest.

Statement of informed consent

Informed consent was obtained from all individual participants included in the study.

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