Stigma Toward Mental Illness and Its Impact on Access to Mental Health Services Among Young Adults in Sub-Saharan Africa

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Abstract. The mental health problems in young adults are really severe in sub-Saharan Africa, but access to the service is extremely limited. One of the core obstacles is stigma towards mental illness, although there is limited empirical evidence to measure its effects in this regard. This is a study that involved examination of the relationships between three types of stigma (public, self, and structural), and access to mental health services among young adults (aged 18-30 years) in sub-Saharan Africa, with consideration to the moderating roles of mental health literacy, social support, socioeconomic status and cultural beliefs. A cross-sectional design, including 405 young adults who were selected using multi-stage cluster sampling among tertiary institutions and workplaces. Likert-scale questionnaires were used to collect data, which were analysed using IBM SPSS Statistics version 29.

All instruments showed acceptable-excellent reliability (a = 0.73-0.93). The proportion of prior service use was only 16.5%. The overall types of stigma were significant predictors of decreased access to services (b = -0.28 to -0.58, p < 0.001), with self-stigma being the strongest predictor, accounting for up to 52 percent of the perceived barriers. The effects of stigma were moderated significantly by mental health literacy and social support (b = 0.14 to 0.22, p < 0.05). Socioeconomic status selectively moderated the effect of structural stigma (b = 0.16, p = 0.007). Mental health literacy and social support buffered the effects of stigma, whereas cultural beliefs showed complex, non-significant moderating effects.

Sub-Saharan African young adults have low access to mental health services, and self-stigma is the most powerful obstacle. Both enhancing access and combating all types of stigma require the use of multi-level interventions that focus on mental health literacy and social support.

Keywords: mental health stigma; public stigma; self-stigma; structural stigma; accessing services; help seeking; young adults; mental health literacy; social support; sub-Saharan Africa.

INTRODUCTION

Mental health is one of the most pressing areas of community health on the international level, and young adults aged 18 to 30 are at an increased risk of being vulnerable to it in this transitional stage of their lives. Mental health conditions develop at a rate of about 75 percent before age 25, and this developmental stage is especially important for intervention and assistance [1]. Nevertheless, even though mental health challenges are extremely high among young adults, relevant mental health services are still extremely scarce, especially in the low- and middle-income countries of sub-Saharan Africa.

The gap in mental health access within the context of sub-Saharan Africa, which is stated as the ratio of the population which needs mental health services to those who do not, is above 85, which is one of the highest in the world [2]. This is a frightening statistic that is not merely an indicator of a lack of mental health infrastructure and a workforce challenge, but also a significant issue in society that lies in the stigmatisation and the negative attitude towards mental illness. The sociocultural environment that young adults in sub-Saharan Africa are forced to navigate is intricate, and mental illness is misconceived and attributed to supernatural phenomena or seen as a manifestation of individual weakness and family disgrace [3, 4].

There is a multi-level stigma of mental illness. Public stigma involves the negative attitudes, prejudicial beliefs, and discriminatory behaviours of the general population towards mentally ill people [5]. Self-stigma will be a situation whereby self-identified mental patients internalise these negative attitudes of society, and as such, they have low self-esteem and low self-efficacy [6]. Structural stigma is institutional policies, practices, and cultural norms that disfavour people with mental illness in a systematic way by limiting access to education, employment, and healthcare services [7].

Problem Statement. Although there is an increasing input of mental health as an inherent aspect of overall wellbeing, young adults in sub-Saharan Africa are highly challenged by accessing the right mental health services, with stigma becoming a key impediment. In most countries, the number of mental health professionals per 100,000 people is lower than 1, leading to an acute workforce shortage [8]. Nonetheless, in areas where services are available, utilisation rates are extremely low, suggesting that additional factors beyond availability prevent access, especially stigma-related factors.

Several key gaps remain in the literature on the influence of stigma on mental health service access among the sub-Saharan African young adults.

First, although there is general awareness of stigma as a barrier, there is a lack of empirical evidence quantifying the connection between certain forms of stigma and specific dimensions of access.

Second, the available studies on African mental health are predominantly based on clinical populations or are general to adults, and there is a lack of representation of young adults.

Third, the underlying moderating factors of mental health literacy, social support, socioeconomic and cultural beliefs have not been well studied in the sub-Saharan African setting.

Aims and Significance of the research. This paper will focus on researching how stigma on mental illness affects access to mental health services among young adults aged 18-30 in sub-Saharan Africa. Particularly, the study aims to:

1) Determine the connection between public stigma and access to mental health services,

2) Determine the connection between self-stigma and access to mental health services,

3) Determine the connection between structural stigma and access to mental health services and

4) Evaluate the moderating influences of mental health literacy, social support, socioeconomic status, and cultural beliefs on relationships.

The importance of this research has several dimensions of functioning. Ideally, it will help further research the mechanisms of stigma in African cultures. It empirically fills important knowledge gaps on the barriers to accessing mental health services among sub-Saharan African young adults. In practice, the research results will provide practical implications to policymakers in mental health, health professionals, educational organisations, and community groups within the region. Socially, enhanced mental health access among young adults has far-reaching consequences for the development trajectory of sub-Saharan Africa, as young adults constitute a significant demographic dividend for the region.

Literature Review

Mental Health Stigma. Researchers define mental health stigma as a complex social phenomenon marked by negative attitudes, prejudiced beliefs, and discriminatory behaviours toward people with mental health conditions. Modern stigma literature identifies three distinct yet interconnected types—public stigma, self-stigma, and structural stigma—which operate through different mechanisms but collectively create barriers to accessing mental health care [9, 10].

Public stigma includes prejudices and discriminatory actions of the rest of the population toward mentally ill individuals. In the case of sub-Saharan Africa, in particular, the public stigma is commonly mixed with the traditional beliefs that the development of mental health issues is supernaturally determined, either by witchcraft or ancestral curses or the presence of spirit possession [4]. Studies across several African nations reveal that supernatural causation beliefs are strongly related to stigmatising attitudes and a preference for distance [11]. These forms of culturally specific manifestation pose their own obstacles, as not only traditional forms of discrimination can be feared but also the belief in the spiritual pollution of whole family systems.

Self-stigma happens when persons with mental illnesses internalise the negative patterns of society and use them towards themselves with significant psychological effects such as lowered self-esteem, low self-efficacy, and low treatment-seeking [12]. Self-stigma can be especially intense among young adults, as developmental peculiarities in identity formation characterise this group, along with a focus on the quality of peer relationships and excessive self-awareness [13].

Structural stigma operates through social mechanisms such as healthcare, education, the workforce, and governmental agencies, leading to tangible resource and opportunity constraints [14]. Structural stigma in sub-Saharan Africa appears in the form of gross under-investment in mental health services (frequently, less than 1 % of health budgets), a lack of adequacy in the workforce, a cluster of mental health services in cities, a historical exclusion of mental illnesses in health insurance interventions, and the absence of anti-discrimination legislation against people with mental illnesses [8].

Receiving Mental Health Services. The concept of mental health service access is a multidimensional and intricate phenomenon that goes beyond the availability of services to include help-seeking behaviour, service use, treatment attendance and perceived barriers to care. Authors [15] offered a conceptual framework comprising five dimensions: availability, accessibility, accommodation, affordability, and acceptability. The current access studies in mental health extend this to adequacy, awareness, and attitude [16].

Help-seeking behaviour is an important first step in mental health services. It has always been shown that young adults have very low rates of help-seeking in relation to high levels of mental health needs, with only 20-40 % of young adults with mental health issues seeking professional help [17]. Young adults in sub-Saharan Africa generally seek help through multiple phases, beginning with family consultation, followed by consultations with religious leaders and traditional healers, and only infrequently turning to formal mental health services [18].

Various factors influence help-seeking, including stigma and embarrassment, low literacy, self-reliance, and confidentiality [19]. Culture greatly moderates these barriers, and collectivist African cultures tend to emphasise family consultation and traditional healing methods over professional mental health services.

Literacy and social support on mental health. The knowledge and beliefs about mental disorders that facilitate their identification, management, or prevention, commonly known as mental health literacy [20], are an urgent moderator variable. The studies have repeatedly shown that mental health literacy levels are positively associated with lower prevalence of stigmatising attitudes, stronger intentions to seek help, and better treatment outcomes [21]. Mental health literacy research remains limited in sub-Saharan Africa. Still, the existing evidence indicates that knowledge levels are quite low, and many individuals support the idea of supernatural causality alongside biomedical explanations [22].

Social support operates through several mechanisms, including emotional, instrumental, informational, and appraisal support. Social support systems in Africa are not as Western as those in individualistic societies; extended family ties, community relationships, and religious memberships form the most basic support systems. The studies have shown that collectivist societies emphasise family consultation and group decision-making on health matters, i.e., family support strongly predicts service use [23].

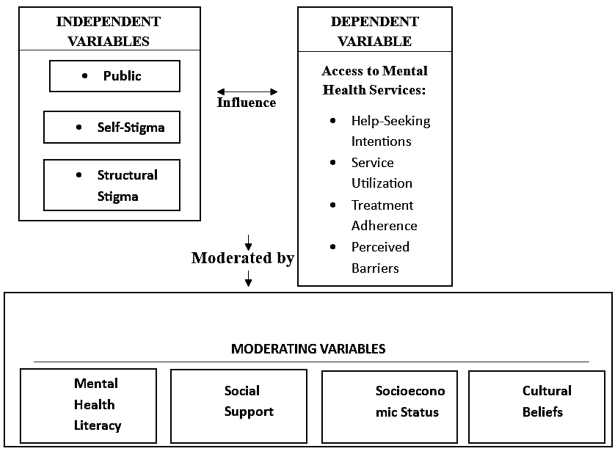

Figure 1 – Conceptual Framework

Based on the reviewed literature, this study hypothesises a conceptual framework to analyse the connections between three forms of stigma and access to mental health services among young adults, with mental health literacy, social support, socioeconomic status, and cultural beliefs as potential moderating variables. The hypotheses are the following:

H1: The relationship between public stigma and access to mental health services is significantly negative among the young adults in sub-Saharan Africa.

H2: Self-stigma and access to mental health services among young adults in sub-Saharan Africa are significantly negatively correlated.

H3: Structural stigmatisation has a significant negative association with access to mental health services among the young adults in sub-Saharan Africa.

H4: Mental Health literacy moderates the relationship between stigma and access to mental health services, such that higher mental health literacy attenuates the negative influence of *stigma.*

H5: There is a moderate effect between stigma and access to mental health services, whereby the extent of social support decreases the negative effects of stigma.

H6: The socioeconomic status moderates the association between stigma and access to mental health services, in that high SES dilutes the negative effects of stigma.

H7: There is a moderation effect of cultural beliefs on the relationship between stigma and access to mental health services, with traditional supernatural causation beliefs enhancing the negative impact of stigma.

METHODS

Research Design. In this research, the research design adopted was quantitative and cross-sectional to examine the relationships that existed between the stigma against mental health and access to mental health services among the young adults in sub-Saharan Africa. The cross-sectional method helped measure several variables simultaneously, capture their relationships at a particular time point, and conduct tests such as correlations and regression to verify the hypotheses [24].

Population and Sampling. The population of interest was young adults aged 18-30 years and living in the urban and semi-urban regions of sub-Saharan Africa. The researchers used a multi-stage cluster sampling strategy to ensure demographic diversity. The research was carried out in various cities across the region, each with distinct socioeconomic and cultural backgrounds. The researchers identified tertiary institutions and workplaces in each selected urban area. The target population was decided as 450 participants. The usable sample comprised 405 participants (N=405), which exceeds the expected number of participants to respond and has sufficient power to analyse, as suggested by authors [25], and multiple regression criteria.

The researchers used multi-stage sampling to ensure representation of the following areas:

1) Different areas or areas that represented different regions of the country,

2) Identification of tertiary institutions and workplaces in each area,

3) Stratified random sampling, which in this case was systematic sampling to ensure that each stratum was represented.

Data Collection. The data were collected over three months (March-May 2025) using structured, self-administered questionnaires distributed electronically via Google Forms and in paper format to reach as many participants as possible and accommodate different technological capabilities. The electronic survey was sent via institutional mailing lists, WhatsApp networks, and professional networking sites, whereas paper-based questionnaires were sent to physical locations such as universities and workplaces.

The researchers obtained ethical authorisation from the relevant institutional review boards before collecting data. They also obtained permission from gatekeepers such as university administrations and workplace management. In addition, the researchers reviewed ethical data collection practices, survey administration procedures, and crisis response protocols, and they trained the research assistants on these procedures.

Measurement Instruments. The survey questionnaire included several sections assessing demographic factors, independent variables (stigma types), the dependent variable (service access), and moderating variables. The researchers culturally adapted all tools to global standards with input from local mental health workers and community representatives.

The researchers used the Community Attitudes toward Mental Illness (CAMI) scale (20 items, 5-point Likert) to measure public stigma. Self-stigma was assessed using the Internalised Stigma of Mental Illness (ISMI) scale (a 29-item, 4-point Likert scale) modified for general populations. The Structural Stigma Scale was used to measure structural stigma (16 items, 5-point Likert).

Individuals who previously used services were evaluated regarding access to mental health services through: help-seeking intentions (General Help-Seeking Questionnaire, 7 items); service utilisation (adapted Service Assessment items); perceived barriers (BACE scale, 30 items); and treatment adherence (MARS, 10 items).

Moderating variables included the Mental Health Literacy Scale (35), the Multidimensional Scale of Perceived Social Support (12), socioeconomic status indicators (subjective ladder and objective indicators), and the Cultural Beliefs Questionnaire (18), which evaluated biomedical, psychosocial, supernatural, and moral causation beliefs.

Data Analysis. The researchers conducted the data analysis systematically using IBM SPSS Statistics version 29: data preparation and screening, preliminary reliability analysis, descriptive analysis, assumption testing, bivariate correlation analysis, hierarchical multiple regression to determine main effects, and moderated regression to determine interaction effects. They handled missing data (less than 5 %) via multiple imputation and outliers and normality breaches using appropriate procedures.

Ethical Considerations. The researchers conducted the study in accordance with the ethical principles outlined in the Declaration of Helsinki. They obtained ethical approval from the relevant institutional review boards and secured informed consent from every participant. They ensured participant confidentiality through anonymised surveys, secure data storage, and reporting results in aggregate form. They also provided mental health crisis resources and trained research assistants to identify signs of distress and make appropriate referrals.

RESULTS AND DISCUSSION

Data Collection and Response. The results of data collection were 487 distributed questionnaires, of which 423 were returned (response rate of 86.9). Following data cleaning and quality assessment, the number of complete and usable surveys totalled 405 (84.6 % usable response rate). Response distribution was 65.0% via electronic questionnaire and 35.0% via paper questionnaire. The researchers geographically mapped the representation of various urban and semi-urban areas in the region.

Data Cleaning. The researchers conducted extensive data cleaning to address missing data (2.3% in total, handled using multiple imputation), outliers (17 individual and 8 multivariate outliers, which they addressed through winsorisation), data entry errors (43 discrepancies resolved by verifying against a second copy of the data), and response quality issues (they excluded 7 cases due to concerns such as straightlining and insufficient response time).

All major scales had Cronbach's alpha values above 0.80, indicating good to excellent internal consistency. Self-Stigma (a = 0.93), Social Support (a = 0.92) and Perceived Barriers (a = 0.91) had the highest levels of reliability (Table 1).

Table 1 – Reliability Coefficients for Study Measures

Measure	Items	Cronbach's Alpha	Interpretation
Public Stigma (CAMI)	20	0.84	Good
Self-Stigma (ISMI)	29	0.93	Excellent
Structural Stigma	16	0.86	Good
Help-Seeking Intentions	7	0.81	Good
Perceived Barriers (BACE)	30	0.91	Excellent
Treatment Adherence (MARS)	10	0.85	Good
Mental Health Literacy	35	0.89	Good
Social Support (MSPSS)	12	0.92	Excellent
Cultural Beliefs	18	0.82	Good

There were 405 young adults (with slightly more females (54.6) than men (44.9)). Mean age was 23.1 years. Interestingly, the proportion of those who had used mental health services before was only 16.5 %, which indicates that the gap in treatment in the area is enormous (Table 2).

Table 2 – Demographic Characteristics (N = 405)

Characteristic	Category	Frequency	%
Gender	Male	182	44.90
	Female	221	54.60
	Non-binary	2	0.50
Age	18-20 years	87	21.50
	21-23 years	168	41.50
	24-26 years	112	27.70
	27-30 years	38	9.40
Education	Bachelor's (in progress)	246	60.70
	Bachelor's (completed)	71	17.50
	Diploma/ Certificate	48	11.90
	Postgraduate	17	4.20
	Secondary	23	5.70
Employment	Student (not employed)	267	65.90
	Student (part-time)	54	13.30
Employmen	Full-time employed	51	12.60
	Unemployed	24	5.90
	Self-employed	9	2.20
Prior MH Service	Yes	67	16.50
	No	338	83.50
Settlement Type	Urban	303	74.80
	Semi-urban	102	25.20

Public, self-stigmatisation, and structural stigmatisation were all in the moderate-high range and this points to high perceived stigmatisation throughout the region (Table 3). Use of the services was also low among participants (83.5 % reported no prior use).

Table 3 – Descriptive Statistics for Primary Variables (N = 405)

Variable	Possible Range	Mean	SD	Level
Public Stigma	20-100	62.4	12.8	Moderate-High
Self-Stigma	29-116	71.3	18.5	Moderate-High
Structural Stigma	16-80	56.7	11.2	Moderate-High
Help-Seeking Intentions	7-49	25.8	9.4	Moderate
Service Utilisation	0-20	3.2	4.1	Low
Treatment Adherence	0-10	5.8	2.9	Moderate
Perceived Barriers	0-30	17.6	6.3	Moderate-High
Mental Health Literacy	35-140	94.7	15.2	Moderate
Social Support	12-84	58.3	14.7	Moderate
Socioeconomic Status	1-10	5.1	1.8	Moderate

Correlation analysis revealed significant negative correlations among all types of stigma and the service access dimensions (Table 4). Self-stigma showed the strongest associations with help-seeking intentions ($r = -.54$) and perceived barriers ($r = .61$).

Table 4 – Correlation Matrix for Primary Study Variables

Variable	1	2	3	4	5	6	7
1. Public Stigma	—						
2. Self-Stigma	.58**	—					
3. Structural Stigma	.52**	.47**	—				
4. Help-Seeking	-.41**	-.54**	-.32**	—			
5. Service Use	-.34**	-.48**	-.38**	.49**	—		
6. Adherence	-.27**	-.41**	-.31**	.38**	.52**	—	
7. Barriers	.45**	.61**	.48**	-.56**	-.47**	-.43**	—

Note: **$p < .001$.

Regression Analysis Results. Hypotheses 1-3 were tested by hierarchical regression analysis. In the case of help-seeking intentions, the stigma variable (Block 2) augmented the clarified variance to 48% (DR2 = .36, $p < .001$). The most predictive one was self-stigma ($b = -.52$, $p <.001$), then the public stigma ($b = -.38$, $p <.001$), and the structural stigma ($b = -.29$, $p <.001$).

To assess the service's utility, it was found that the stigma variables explained 42 of the variance (DR2 = .34, $p < .001$). The highest coefficient was that of self-stigma (b = -.46, p <.001) then structural stigma (b = -.34, p <.001) and public stigma (b = -.31, p <.001).

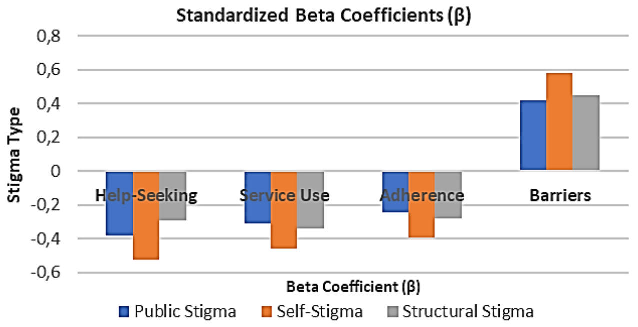

Figure 2 – Standardised Beta Coefficients - Stigma Type Effects on Dimensions of Mental Health Service Access.

In the case of perceived barriers, stigma variables accounted for 52% of the variance (DR2 = .43, p < .001). The strongest relationship was with self-stigma (b =. 58, p <.001) then structural (b =.45, p <.001) and public (b =.42, p <.001) stigma.

The patterns of treatment adherence among service users (n = 67) revealed the same results, with self-stigma as the strongest predictor (b = -.39, p = .003).

Mental health literacy significantly moderated the impact of self-stigma and public stigma on help-seeking intentions (b = .18 and .14, respectively; p < .05), with the effects becoming more positive at higher levels of literacy. Social support exhibited strong moderating effects, especially on self-stigma (b = .22, p < .001), such that highly supported individuals showed a lower stigma effect. Structural stigma exerted a selective influence on service utilisation, which was moderated by socioeconomic status (b =.16, p =.007); people with higher SES were more successful in overcoming institutional barriers. The cultural beliefs were not consistent with the hypothesis; therefore, the relationships among them are complex and require further research (Figure 3).

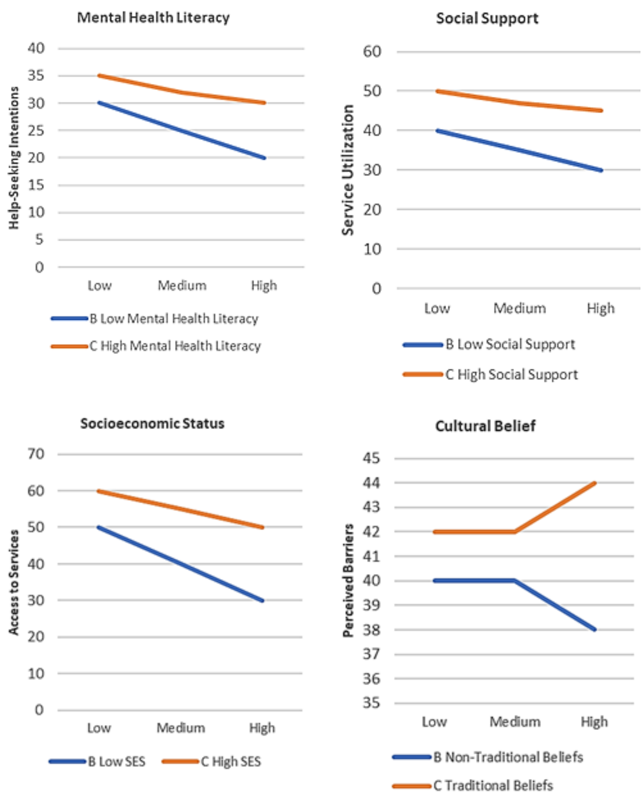

Figure 3 – Interaction plots to show the moderating role of the mental health literacy, social support, socioeconomic status and cultural beliefs on the relationship between the stigma (public, self and structural) and mental health service access among the young adults in sub-Saharan Africa

Table 5 – Hypothesis Testing Results

Hypothesis	Result	Evidence
H1: Public stigma negatively relates to service access	Supported	β = -.31 to -.42, p < .001
H2: Self-stigma negatively relates to service access	Supported	β = -.39 to -.58, p < .001
H3: Structural stigma negatively relates to service access	Supported	β = -.28 to -.45, p < .001
H4: Mental health literacy moderates effects	Partially Supported	β = .14 to .18, p < .05
H5: Social support moderates effects	Strongly Supported	β = .17 to .22, p < .01
H6: SES moderates effects	Partially Supported	β = .14 to .16, p < .05
H7: Cultural beliefs moderate effects	Not Supported	Non-significant or slight buffering effects, contrary to the hypotheses

Interpretation of Main Findings. This paper strongly established that all three types of stigma were strongly indicative of lower access to mental health services on various dimensions among young adults in sub-Saharan Africa. The strongest predictor, as illustrated by the largest standardised coefficients in all the models, was self-stigma (b = -.39 to -.58). It is a result that confirms the existence of international literature on the topic of stigma in the sub-Saharan African sub-region and goes as far as affirming that internalised stigma is indeed a highly effective barrier to the factor in this area.

Several processes can explain the overriding influence of self-stigmatisation. The shame and self-devaluation that are internalised are a direct way of sabotaging the self-efficacy needed to start help-seeking actions, and create psychological paralysis even in the presence of services. Self-stigma can be particularly pronounced in sub-Saharan African settings, where collectivist ethics are strongly rooted in family honour and reputation within the community, leading people to mimic not only their own shame but also what they expect of their family [26].

The effects of public stigma showed a significant independent effect (b = -.31 to -.42), indicating that societal-level attitudes remain a significant barrier. Among sub-Saharan African collectivist cultures in which relationships within the community are especially valued, the threat of being publicly discriminated against, socially marginalised, and having a damaged reputation can serve as particularly effective inhibitors to help-seeking. The fact that about two-thirds of those surveyed reported high levels of public stigma is consistent with the African literature, which has documented numerous stigmatising attitudes [11].

The effects of structural stigma were consistent (b = -.28 to -.45), though the effects on service utilisation were significantly higher than on the intention to seek help. This trend suggests that institutional constraints can be particularly relevant in translating intentions into action. The structural stigma of sub-Saharan Africa is characterised by severe underfunding (usually less than 1% of health budgets spent on mental health), workforce deficits, the concentration of services in cities, the absence of insurance coverage, and the absence of anti-discrimination policies [8].

Protective Factors and Moderation Effects. The study found that mental health literacy and social support act as important protective mechanisms against the negative impact of stigma. Increased literacy reduced the effects of stigma by giving knowledge to dispel stereotypes and to learn to treat mental illness as a disease scientifically. Social support had the strongest buffering effects, which aligns with collectivist cultural values in African countries, where family and community support are especially salient.

The observation that structural stigma effects were moderated selectively by socioeconomic status raises alarming equity concerns. Higher-SES individuals were able to bypass institutional obstacles by using private services, affording transportation, and covering out-of-pocket expenses, whereas lower-SES individuals faced a multiplied disadvantage. This trend is dangerous because it may result in two-tiered mental health services, with wealthy people receiving quality services, while the poor and economically disadvantaged groups are underrepresented.

Supernatural causation and cultural beliefs revealed surprising trends, with some studies indicating modest buffering rather than enhancing effects of stigma. Such complexity can indicate that support for supernatural belief is tied to cultural identity and adherence to traditional values, which offer psychological strength, or that those with firm traditional beliefs seek other avenues of healing that make them less vulnerable to the stigma of the formal service. These surprising results point to the nature of the cultural belief system and show that qualitative research is required to examine the interactions between traditional beliefs and official help-seeking in this scenario.

CONCLUSIONS

This research gives strong empirical evidence that stigma towards mental illness is a major hindrance to accessing mental health services in young adults in sub-Saharan Africa in various aspects. The strongest predictor was self-stigma, followed by public and structural stigma. Social support and mental health literacy are protective factors, while socioeconomic status serves as a selective buffer against structural barriers.

Data from sub-Saharan Africa clearly demonstrate the enormous treatment gap, with only 16.5% of respondents reporting use of services despite having high needs. To overcome this crisis, there is a need to combine holistic programs of stigma reduction across several levels, strengthening of mental health systems, policy changes, and culturally sensitive interventions that acknowledge the specifics of sub-Saharan African young adults.

Since the youth bulge in sub-Saharan Africa introduces both opportunity and urgency, the mental health of young adults is not only a health necessity but also a critical investment in the region's development, social stability, and human potential. The results of this study have offered an evidence base of transformation whereby it is hoped that young adults in sub-Saharan Africa will continue to have access to the mental health services they seek and deserve.

Practical Implications and Recommendations

1) Individual and Community-Level Interventions. Since self-stigma is the primary focus, interventions aimed specifically at internalised stigma merit priority. Examples of evidence-based methods include cognitive-behavioural interventions that teach restructuring negative beliefs, peer support and contact interventions that provide hope and practical advice, and narrative empowerment methods that assist young adults in developing alternative self-concepts [27, 28].

Systematic education of individuals with mental illness can mitigate the impact of various types of stigma. The school-based programs, university orientation programs, workplace training programs, and social media campaigns are potential delivery platforms in sub-Saharan Africa. There is a possibility of dramatic gains in social support through family psychoeducation, peer education, and community engagement, due to strong moderating effects.

2) Health System and Policy Reforms. Structurally, it is possible to recommend:

Massive funding in increments: Closely on top of the WHO guidelines of 5-10 % of health budgets on mental health.

Integration of health insurance: Achieving full mental cover in national health programs.

Service decentralisation: Decentralising services to the non-market cities by integrating primary care and task-shifting.

Workforce development: Training and placement of mental health professionals across regions.

Anti-discrimination laws: The enactment and enforcement of laws against people with mental health conditions.

Technology-based interventions: Use of mobile penetration as a tool of telehealth, applications and digital interventions.

Regional cooperation: international exchange of best practices and resources across sub-Saharan African countries.

Study Limitations. The study identifies several constraints. A cross-sectional design precludes causal inference. Self-report measures bring about some bias. The sampling strategy, which included tertiary institution students and urban professionals, reduces the ability to generalise the sample to less educated and rural populations. Other moderating effects featured low effect sizes that should be replicated. There might be confounds that are not measurable (such as symptom severity and personality) that may affect observed relationships. The multi-country sample of the study, insofar as it increases the representativeness of the regions, could conceal significant between-country differences that warrant further study.

Other weaknesses include:

1) The sampling design (students of tertiary institutions and urban professionals) limits generalisation to the less educated, unemployed and rural young adult populations who might experience other or greater limitations;

2) Self-report measures, especially on sensitive subjects such as stigma, are vulnerable to social desirability bias; and

3) Some moderating analyses, though statistically significant, had small effect sizes in need of replication using larger samples.

Future Research Recommendations. Future studies should use longitudinal designs to determine cause-and-effect and developmental patterns. Researchers can identify effective components through rigorous intervention trials evaluating stigma-reduction approaches. They can uncover cultural insights that surveys miss through qualitative exploration. Country-specific studies can identify unique contextual factors, while comparative research can reveal universal patterns. Researchers can also examine compounded marginalisation by considering intersections with other stigmatised identities (such as gender, sexual orientation, and ethnicity). The effectiveness of digital interventions in the African setting, across different levels of connectivity, can be evaluated through technology and innovation research.

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