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Foundations For Change: Mapping Mental Health Knowledge And Attitudes To Guide Adolescent-Focused Programming In Sakubva, Zimbabwe

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Abstract:
Background*: Developing effective, community-based mental health programming for adolescents in low-resource settings requires a foundational understanding of their localised knowledge and attitudes. In Sakubva, a high-density suburb of Mutare, Zimbabwe, adolescents face significant psychosocial stressors, yet data to inform contextually relevant interventions remain scarce. This study aimed to map the mental health literacy and prevailing attitudes among adolescents in Sakubva to establish an evidence base for future intervention design.*
Materials and Methods*: A community-based, cross-sectional study was conducted using a mixed-methods approach. A survey assessing mental health knowledge, stigma, and help-seeking preferences was administered to a purposive sample of 77 adolescents (aged 14-19). This was supplemented by 4 focus group discussions to explore contextual nuances and lived experiences. Quantitative data were analysed descriptively, while thematic analysis was applied to qualitative data.*
Results*: Findings indicate a dual challenge: moderate awareness of common mental health conditions coexists with highly stigmatised attitudes, particularly towards depression and anxiety. Help-seeking is strongly preferred towards informal networks (friends, family) over formal services, primarily due to fears of confidentiality, cost, and social judgment. Qualitative themes reveal that mental distress is often somaticised or spiritualised, and a prevailing norm of resilience discourages the acknowledgement of psychological struggle.*
Conclusion: *A critical gap exists between mental health awareness and actionable help-seeking among Sakubva's adolescents. Effective programming must therefore address deep-seated stigma, strengthen informal supports, and improve formal service accessibility. This study provides the necessary empirical foundation for designing targeted and acceptable interventions.*
Keywords: *Adolescent mental health, Mental health literacy, Mental health stigma, Help seeking behaviour, Sakubva (Zimbabwe)****.***

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I. Introduction

The Global Burden and Critical Barriers in Adolescent Mental Health

Adolescence represents a critical period for mental health, with approximately half of all lifetime mental disorders emerging by age 14 (Kessler et al., 2005). Conditions like depression significantly increase risks for academic failure, substance use, and suicide, casting a long shadow over future life outcomes (Fergusson & Woodward, 2002). Despite this recognised burden, a profound treatment gap persists; an estimated 64% of adolescents with diagnosable conditions do not access formal help (Merikangas et al., 2011). A primary driver of this gap is low mental health literacy (MHL), where adolescents fail to recognise symptoms or understand available treatments, directly hindering help-seeking (Mental Health Foundation Scotland, 2018). Compounding this is pervasive stigma, with mental illness often associated with perceptions of weakness, danger, and incompetence across cultures, leading to social isolation and self-stigma that further deters care (Aggarwal, 2012; Kaushik et al., 2016).

Cultural Contexts and the African Reality

The manifestation of and responses to mental distress are deeply shaped by cultural context. In many African societies, explanatory models often spiritualise symptoms, attributing them to witchcraft or ancestral displeasure, while biomedical understandings may be viewed as Western impositions (Monteiro et al., 2014; Ventevogel et al., 2013). This fosters unique stigma, where individuals and their families face severe social exclusion (Kapungwe et al., 2010; Gureje et al., 2005). In Sub-Saharan Africa (SSA), adolescents face a

convergence of risks—including poverty, violence, HIV/AIDS, and rapid urbanisation—that exacerbate vulnerability to mental disorders (Jorns-Presentati et al., 2021). However, systemic resources are critically lacking, characterised by few mental health professionals, minimal dedicated funding, and scarce policies specifically protecting adolescent mental health (WHO, 2020).

The Zimbabwean Context and the Imperative for Community-Based Solutions

Zimbabwe mirrors and intensifies these regional challenges. Studies report high rates of psychological distress and suicidal ideation among youth, often conceptualised locally as *kufungisisa* ("thinking too much") (Verhey et al., 2020). The public health system is severely under-resourced, with a drastic shortage of specialised mental health practitioners (Chibanda et al., 2016). This stark reality necessitates a paradigm shift from under-resourced, clinical-centric models to innovative, community-embedded interventions. School-based programmes and community literacy initiatives, like Mental Health First Aid, have demonstrated promise in other settings by improving recognition, reducing stigma, and promoting early help-seeking within natural support systems (Kutcher et al., 2016; Talbot et al., 2017).

Identifying the Research Gap

While the high prevalence and systemic neglect of adolescent mental health in SSA are established, a critical gap remains in generating localised, contextual evidence to inform feasible interventions. Existing research in Zimbabwe has predominantly focused on Harare, leaving other urban centres like Mutare understudied. Specifically, there is a lack of nuanced data on the knowledge and attitudes that shape help-seeking behaviours among adolescents in high-density, high-stress suburbs such as Sakubva. This study aims to fill this gap by mapping mental health literacy and stigma in Sakubva, thereby providing the essential empirical foundation to design a culturally resonant, community-based intervention that is both acceptable and sustainable within this specific context.

II. Material And Methods

Study Design: This study employed a community-based, cross-sectional design utilising a concurrent mixed-methods approach**.** This design was selected to comprehensively quantify mental health knowledge and attitudes while capturing rich, contextual narratives to explain the quantitative findings. The qualitative component was guided by a phenomenological orientation to deeply understand the lived experiences of adolescents.

Study Location: The research was conducted in Sakubva**,** a high-density suburb of Mutare, Zimbabwe**.** This location was purposively selected due to its high levels of socioeconomic adversity, limited health infrastructure, and the documented prevalence of psychosocial stressors, making it a critical site for investigating adolescent mental health in a resource-constrained urban setting.

Study Duration: Data collection was carried out over a concentrated period of eight weeks from October to November, 2025. This timeframe included community entry and sensitisation, recruitment, and the administration of all surveys and focus group discussions.

Sample size: 77 adolescent participants.

Sample size calculation: The sample size for the survey component was calculated using the standard formula for cross-sectional studies ($N = Z^2 * [p (1-p)] / d^2$, where:

- $Z = 1.96$ (95% confidence level)
- $p = 0.50$ (expected prevalence of low mental health literacy, set for maximum variability)
- $d = 0.09$ (desired precision/margin of error) with a 95% confidence level and a 5% margin of error.

Subjects & selection method: A two-stage sampling approach was implemented. First, key informants—including healthcare providers, community childcare workers, and school authorities—were identified through purposive sampling based on their expertise. Second, adolescent participants were selected via simple random sampling. Households in Sakubva with eligible adolescents were listed and randomly selected using a lottery method until the target sample was reached.

Inclusion criteria:

1. Adolescent Participants:

Aged 14–19 years.
Current resident of Sakubva suburb, Mutare.
Able to provide **assent**, with a parent or guardian providing **informed consent**.

Fluent in Shona or English to ensure comprehension of questions and ability to express themselves fully.

2. Community Member Participants (e.g., Parents, Guardians, Teachers):
A parent/guardian of an adolescent in the target age range (14-19) residing in Sakubva, or a teacher/school official employed at a secondary school within Sakubva.
Have direct and regular interaction with adolescents in their care or classroom.
Able to provide informed consent.
Fluent in Shona or English.

3. Key Informants / Professional Stakeholders:
Individuals in a professional or leadership role directly influencing adolescent health or community welfare in Sakubva (e.g., healthcare workers, community-based organization staff, social workers, relevant local government officers).
Minimum of one year of service in their current role within the community.
Able to provide informed consent.
Fluent in Shona or English.

Exclusion Criteria (Applied to All Groups):
1. Individuals who, in the researcher's judgment, are unable to participate meaningfully due to acute psychological distress, severe cognitive impairment, or other conditions that would compromise the validity of consent or the ability to engage coherently in an interview or survey.
2. For adolescents: those with a known, severe psychiatric or cognitive diagnosis that significantly impairs comprehension or communication, as reported by a parent or guardian.

Data Collection Procedure

This study employed a concurrent mixed-methods strategy, collecting data over an eight-week period following ethical approval. Quantitative data were gathered through a structured, self-administered survey translated into Shona and back-translated to ensure conceptual validity; it measured mental health knowledge, stigma, help-seeking behaviour, and demographics among adolescent participants. Qualitative data were obtained through semi-structured interviews with key professional informants and focus group discussions with segmented adolescent groups, designed to explore systemic perspectives and community-specific norms. All instruments were pilot-tested for clarity and cultural appropriateness and reviewed by expert practitioners. Data collection sessions, held in familiar community venues, proceeded after securing informed consent; surveys were administered in groups with researcher support, while interviews and discussions were audio-recorded for transcription and thematic analysis.

Data analysis

Data analysis followed a concurrent mixed-methods procedure. Quantitative data from the structured surveys were cleaned, coded, and analysed using SPSS (Version 28). Descriptive statistics, including frequencies and percentages, summarised participant demographics and key variables, while inferential statistics such as chi-square tests examined associations between variables. For the qualitative component, audio recordings from interviews and focus groups were transcribed and analysed using reflexive thematic analysis. This process involved familiarisation with the data, systematic coding, and the development and refinement of themes to capture nuanced participant perspectives and lived experiences. Throughout the analysis, identifiers were removed and pseudonyms applied to ensure confidentiality. The findings from both strands were integrated during interpretation; quantitative results provided broad measures of prevalence, while qualitative themes offered explanatory depth and context, with the combined results presented through narrative exposition supported by direct quotes and summary tables.

III. Results

Demographic Characteristics of Participants

The study sample comprised 77 adolescents (35 females, 42 males) aged 14–19 from Sakubva. Most participants (80.5%) had attained Ordinary Level education, with smaller proportions at Advanced Level (15.6%) or tertiary level (3.9%). Age distribution was relatively even across the range (14–19 years), supporting representative insights into this adolescent cohort.

Prevalence and Perceptions of Mental Health Problems

Quantitative and qualitative data indicated a high burden of mental distress. Nearly all adolescents (94.8%) acknowledged persistent sadness among peers, and key informants identified depression as a leading,

often unrecognised, issue. Drug and substance abuse was unanimously recognised (100% agreement) as a severe and visible problem, described by participants and informants as a primary driver of mental health crises, including psychosis and sleep disorders.

Mental Health Knowledge and Literacy

While most adolescents (89.6%) reported familiarity with the term "mental health," a significant knowledge gap was evident. Many (67.5%) conflated mental health with mental illness, and most (71.5%) could not identify symptoms of mental health problems. Predominantly, mental distress was attributed to supernatural causes (96.1%) and substance abuse, rather than being understood within a psychosocial or biomedical framework.

Attitudes, Stigma, and Help-Seeking Behaviour

Attitudes were characterised by pervasive stigma and negative self-perception. The vast majority of adolescents reported they would feel ashamed (96.1%), like a failure (98.7%), or weak (90.9%) if they had a mental disorder. This self-stigma correlated with strong avoidant tendencies: most would hide a problem (93.5%), not seek help (89.6%), and would avoid socialising (97.4%). Stigma extended to others, with most adolescents unwilling to associate with (85.7%), sit next to (96.1%), or have a person with a mental disorder visit their home (98.7%).

Coping Strategies and Endorsed Interventions

Coping mechanisms were largely avoidant, with all adolescents reporting they ignore problems hoping they will disappear. Knowledge of positive mental health practices was limited; many were unsure of the benefits of sleep, healthy eating, or talking about feelings for mental well-being. Participants unanimously supported community-based interventions, including early education (with 89.6% advocating for starting in primary school), family dialogues, community awareness campaigns, and the creation of a dedicated national mental health policy for adolescents.

Integrated Data Presentation

Table 1: Participant Demographics

Age	Female	Male	Ordinary Level	Advanced Level	Tertiary Level
14	3	8	11	0	0
15	8	6	14	0	0
16	7	7	14	0	0
17	8	9	17	0	0
18	4	5	3	6	0
19	5	7	3	6	3

Table 2: Prevalence of Selected Mental Health Issues

Issue	Agree/Strongly Agree	Key Qualitative Insight
Depression	94.8%	"So many of these youngsters have depression... They face so many challenges and it is sad that they don't realise that they have it."
Drug/Substance Abuse	100%	"Drug and substance abuse is now a problem here... It is very sad to see one of my age mates being an addict."

This integrated presentation quantitatively summarises key demographics and prevalence rates while anchoring the findings in the participants' own voices, providing a robust foundation for discussing intervention needs.

IV. Discussion

This study reveals a critical disconnect between the high burden of mental distress among adolescents in Sakubva and a systemic lack of accessible, culturally competent support, characterized by low mental health literacy and pervasive stigma.

A High Burden of Undiagnosed and Stigmatised Distress

Findings indicate a significant prevalence of mental health issues, with nearly all adolescents (94.8%) recognizing persistent sadness among peers, and unanimous agreement (100%) on the crisis of drug and substance abuse as a primary driver. This aligns with regional data on adolescent mental health burdens (WHO, 2021; UNICEF, 2020). However, this distress is heavily medicalised and stigmatized. A majority of adolescents attribute mental health problems to supernatural causes (96.1%) or personal moral failure, reinforcing a cultural narrative that pathologises suffering and isolates affected individuals.

Gaps in Mental Health Literacy

While most adolescents (89.6%) are familiar with the term "mental health," substantive literacy is low. Critical gaps exist in differentiating mental health from mental illness (67.5% conflated the two), recognising symptoms (71.5% were unable), and understanding biopsychosocial causes. This literacy gap, consistent with findings from other low-resource settings (Aluh et al., 2018), creates a fundamental barrier to early identification and help-seeking, leaving adolescents ill-equipped to understand their own experiences or support peers.

Pervasive Stigma and an Avoidant Coping Culture

The data paint a stark picture of an avoidant and stigmatising environment. Strong internalised stigma is evident, with most adolescents reporting they would feel ashamed (96.1%), like a failure (98.7%), or weak (90.9%) if they had a mental disorder. This translates into behavioural avoidance: most would hide a problem (93.5%), not seek help (89.6%), and actively isolate themselves (97.4%). This stigma is also projected outwardly, with most unwilling to associate with peers perceived to have mental disorders. This culture of silence and shame negates potential social support and creates a significant barrier to any formal intervention.

The Imperative for an Ecological, Community-Based Intervention

The findings consistently argue against isolated, individual-focused solutions, with adolescents and key informants unanimously calling for a multi-level, ecological approach. This entails coordinated action across systemic levels. At the broadest policy and resource level (macro/exo-system**)**, enacting a dedicated adolescent mental health policy and securing funding are essential to improve service access. Within the key institutional and relational contexts of the meso-system**,** mental health literacy must be integrated into primary school curricula while concurrently strengthening school- and family-based support through targeted education for parents and teachers. Finally, at the immediate community and interpersonal level (micro-system**)**, establishing youth-friendly safe spaces for activities and peer support, alongside launching de-stigmatisation campaigns, is critical to shift harmful cultural narratives. This integrated model aligns with Bronfenbrenner's theory by addressing the interdependent layers of influence on adolescent well-being, moving beyond treating symptoms to actively build a more knowledgeable, supportive, and resilient community environment that promotes mental health and facilitates early help-seeking.

V. Conclusion

The mental health crisis among adolescents in Sakubva is a societal issue sustained by low literacy, entrenched stigma, and fragmented support systems, necessitating a paradigm shift from individual pathology to a holistic, community-competence model. While this study offers a replicable, ecological framework for fostering sustainable change through multi-level intervention, its findings are tempered by potential social desirability bias inherent in stigmatised topics. Future research should, therefore, quantitatively assess the mental health literacy of key mesosystem actors—parents and teachers—and employ longitudinal designs to evaluate the impact of the proposed multi-level interventions.

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