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PERCEIVED STIGMA, ATTITUDINAL AND INSTRUMENTAL BARRIERS TO MENTAL HEALTH HELP-SEEKING BEHAVIOUR AMONG CAMEROONIAN REFUGEES IN TAKUM LGA, TARABA STATE, NIGERIA

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ABSTRACT: As of mid of year 2022, UNHCR had registered about 77,000 Cameroonian men, women, and children as refugees in the states of Akwa-Ibom, Anambra, Benue, Cross River, Enugu, and Taraba. There is a growing concern that a considerable number of Cameroonian refugees in Taraba State faces barriers with regards to seeking mental health support and care. It is in this stand that this study examined the perceived barriers to mental health help-seeking behaviour among Cameroonian refugees in Takum LGA, Taraba State, Nigeria. Using a quantitative design, a cross-sectional survey was employed and 312 (43.6% males and 56.4 females) Cameroonian refugees were sampled through a snowball sampling technique. The data were collected using the Barriers to Access to Care Evaluation (BACE v3), and three hypotheses were tested using the chi-square test (goodness of fit). The results revealed that Cameroonian refugees residing in Takum, Taraba State, Nigeria, had significantly greater levels of perceived stigma as a barrier to mental health help-seeking behaviour ($\chi^2 = 10.051$, $p < .05$). Similarly, the results indicated significantly greater levels of perceived attitudinal barriers to mental health help-seeking behaviour ($\chi^2 = 23.705$, $p < .05$). Finally, the results revealed significantly greater levels of instrumental barriers to mental health help-seeking behaviour ($\chi^2 = 6.782$, $p < .05$). The findings indicate that Cameroonian refugees in Takum, Taraba State, Nigeria, face significant perceived stigma, attitudinal, and instrumental barriers to seeking mental health help. The study recommended that mental health professionals, policymakers and stakeholders should prioritize the mental well-being of refugees during programming, policy making/decision, and implementation of services.

Keywords: Perceived Barriers, Mental Health, Help-Seeking Behaviour, Cameroonian Refugees.

INTRODUCTION

Recently, numerous communities have been experiencing a prolonged upheaval, leading to the widespread trauma of individuals in certain regions across the globe. According to the United Nations High Commissioner for Refugees (UNHCR), approximately 103 million people were forcibly displaced worldwide as of mid-2022 (UNHCR, 2022). This figure comprises refugees, asylum seekers, internally displaced persons, and others in dire need of international protection, including refugees not under UNHCR's jurisdiction. According to a study by Cénat et. al., (2022), approximately 4.2 million refugees had left Ukraine as of April 4, 2022. Additionally,

an estimated 17.6 million people in Ukraine needed humanitarian assistance in 2023 according to the 2023 report by the United Nations High Commissioner for Refugees (UNHCR, 2023).

The ongoing Anglophone crisis in Cameroon, marked by violent conflict between separatist groups and government forces, has led to widespread displacement, with thousands of Cameroonians seeking refuge in Nigeria. These refugees often experience significant psychological burdens due to traumatic experiences in their homeland and face additional stressors in their new environment (Akef et al., 2024; Sandhya, 2024).

As of the middle of 2022, UNHCR has registered about 77,000 Cameroonian men, women, and children as refugees in the states of Akwa-Ibom, Anambra, Benue, Cross River, Enugu, and Taraba (UNHCR, 2022). There is a growing concern that a considerable number of Cameroonian refugees in Taraba State may face barriers when it comes to seeking mental health support and care (UNHCR, 2022). Despite having known mental health issues, including PTSD, refugees are less likely than people of native birth to use mental health services (Lamkaddem et al., 2014).

Mental Health

Mental health refers to a person's well-being, encompassing their emotional, psychological, and social aspects (Graham et al, 2019). "Mental health help-seeking" refers to the act of actively pursuing or seeking support, assistance, or treatment for mental health concerns (Byrow, 2020). It involves an individual recognizing and acknowledging their mental health needs and taking proactive steps to access appropriate resources and professional help.

Mental Health Help-seeking Behaviour

"Mental health help-seeking behaviour" refers to the actions and behaviours exhibited by individuals when they actively seek out support, treatment, or resources to address their mental health concerns. It encompasses a range of activities, such as reaching out to mental health professionals, counsellors, or therapists, attending support groups, utilizing self-help resources, and seeking information about mental health and well-being (Bila & Carbonatto, 2022).

Stigma and Mental Health Help-seeking Behaviour

The term "stigma" describes how someone can be devalued, discredited, and shamed due to traits or qualities they possess. Stigma typically results in unfavourable social experiences like discrimination, marginalization, rejection, and isolation. Stigma around a medical condition, such as mental illness, can have an impact on a person's sickness and course of treatment, including their ability to receive adequate and skilled medical care. (Muhammad et al., 2021).

In a study conducted in Rwanda by Muhorakeye & Biracyaza, (2021) participants reported experiencing both self-stigmatization and social stigma related to their mental disorders. They expressed concerns about attaching a mental disorder label to themselves, their family members, and community members, leading to a reluctance to seek mental health services and disclose their condition. The participants described negative attitudes and lack of empathy from the community, resulting in psychosocial issues such as frustration, shame, and social neglect.

Attitudinal Barriers and Mental Health Help-seeking Behaviour

An attitudinal barrier in the context of mental health refers to a set of negative or prejudiced beliefs, attitudes, or stereotypes that individuals or society may hold toward those experiencing mental health challenges or conditions. These attitudes can manifest as stigma, discrimination, or misconceptions about mental health issues. Attitudinal barriers can hinder individuals from seeking help, accessing appropriate care, or fully participating in society, thereby exacerbating the challenges associated with mental health (Rowan et al., 2023).

Attitudinal barriers also play a crucial role in the help-seeking behaviour of refugees. These barriers include personal beliefs and attitudes towards mental health services, such as scepticism about the effectiveness of treatments, mistrust of healthcare providers, and cultural beliefs that may attribute mental health problems to supernatural causes rather than medical conditions (Khatib et al., 2023; Stevens et al., 2022). Among Cameroonian refugees, traditional beliefs and reliance on informal support systems, such as family and community networks, can further discourage engagement with formal mental health services (Yohani et al., 2020).

Instrumental Barriers and Mental Health Help-seeking Behaviour

Instrumental barriers encompass practical obstacles that hinder access to mental health care. These include financial constraints, lack of transportation, language barriers, and limited availability of mental health services (Planey et al., 2019). For Cameroonian refugees in Nigeria, these barriers are often intensified by their precarious legal status, economic instability, and overall inadequacy of healthcare infrastructure in refugee settings (UNHCR, 2020). Addressing these barriers is essential for improving the mental health outcomes of refugees, and effective interventions must consider the unique cultural, social, and economic contexts of refugee populations.

Statement of the Problem

Humanitarian organizations providing psychiatric and nonpsychiatric mental health services to refugees in Taraba State reported that among 4,196 refugees registered under the UNHCR in Takum LGA, 2,859 adults accessed mental health services between 2020 and 2022 (JRS, 2022). However, there was a significant drop in follow-up visits, with 1,389 refugees defaulting by the end of 2022 (JRS, 2022). Despite these insights, there is a lack of research exploring the specific barriers faced by this population in accessing mental health services in Takum, Taraba State. The study aimed at (1) examining the relationship between stigma and mental health help-seeking behaviour, (2) understanding how the difference in attitudinal barriers affects mental health help-seeking behaviour and (3) determining how instrumental barriers significantly influenced mental health help-seeking behaviours among Cameroonian refugees in Takum, Taraba State, Nigeria.

Research Questions

This study was guided by the following questions:

1. Does stigma limit mental health help-seeking behaviour among Cameroonian refugees in Takum, Taraba State, Nigeria?

2. Do attitudinal barriers limit mental health help-seeking behaviour of Cameroonian refugees in Takum, Taraba State Nigeria?
3. Do instrumental barriers limit mental health help-seeking behaviour among Cameroonian refugees in Takum, Taraba State Nigeria?

The Health Belief Model (HBM)- Irwin M. Rosenstock, (1922-2019)

HBM is derived from behavioural and psychological theory. The Health Belief Model states that people's beliefs influence their health-related actions or behaviours. The model describes a person's health behaviour as an expression of health beliefs and is the most commonly used theory in health education and health promotion (Trifiletti, 2015). It also provides a way to understand and predict how people will behave in relation to their health and how they will comply with treatment regimens. Over the years, the HBM has been used in numerous public health contexts since it was developed. Three key areas can be distinguished based on the validation of the model's capacity to explain and predict a wide range of health-related behaviours in many domains and populations (Zewdie et al., 2022).

The approach has also been applied to the creation of numerous effective health related interventions. The HBM was therefore chosen as the theoretical framework for this study because it is the most appropriate for the research aim and objectives. The main constructs of the model are Perceived Susceptibility, Perceived Severity, Perceived Benefits and Perceived Barriers (Joseph et al., 2019). Each of these perceptions, individually or in combination, can be used to explain health behaviour. More recently, other constructs have been added to the HBM; thus, the model has been expanded to include Modifying Factors, Cues to Action and Self-Efficacy. Additionally, the HBM was applied in this study to query the behavioural patterns that arises when refugees are faced with mental health challenges and what cues of action they took towards help-seeking from professionals and facilities providing such care.

Hypotheses

The following hypotheses were tested in the study:

1. More Cameroonian refugees residing in Takum, Taraba State, Nigeria, will significantly demonstrate greater levels of perceived stigma as a barrier to mental health help-seeking behaviour.
2. More Cameroonian refugees residing in Takum, Taraba State, Nigeria, will significantly demonstrate greater levels of attitudinal barriers to mental health help-seeking behaviour.
3. More Cameroonian refugees residing in Takum, Taraba State, Nigeria, will significantly demonstrate greater levels of instrumental barriers to mental health help-seeking behaviour.

METHOD

Research Design

This study adopted a quantitative design method. A cross-sectional survey was used to collect data on the perceived barriers to mental health help-seeking behaviour among Cameroonian

refugees in Takum LGA Taraba state, Nigeria. This design allows the researcher to collect quantitative self-reported data from Cameroonian refugees via a questionnaire.

Participants

Overall, 312 Cameroonian refugees (men and women) residing in the Takum, Shibong, Kashimbila, and Sufa communities of the Takum LGA of Taraba state who were 18 years and older and who had accessed psychiatric and nonpsychiatric mental health services in 2022 but defaulted coming for follow-up who voluntarily consented and participated in the study. Exclusion criteria were refugees who are children under the age of 18 years and refugees who did not have access to mental health services.

Sample Size and Sampling Technique

Sampling Size

To calculate the sample size using the Krejcie & Morgan (1970) formula at 95% confidence level and a margin of error of 5%.

The formula is:

n = N / (1 + N x (e^2))

Where:

N = Population size (1394)

e = Margin of error (5% or 0.05)

Plugging in the values and calculation of the sample size:

n = 1394 / (1 + 1394 x (0.05^2))

n = 1394 / (1 + 1394 x 0.0025)

n = 1394 / (1 + 3.47)

n = 1394 / 4.47

n ≈ 311.85

Rounding up to the nearest whole number (since one cannot have a fraction of a participant in the sample), the recommended sample size for a population of 1394 with a 95% confidence level and a 5% margin of error would be approximately 312.

Study instrument

The BACE (Barriers to Access to Care Evaluation) scale, developed by Clement et al. (2011), was used to collect quantitative data on the perceived barriers to mental health care among refugees. This 30-item scale measures three types of potential barriers—stigma (12 items), attitude (10 items), and instrumentality (8 items)—using a 4-point Likert scale ranging from 0 (strongly disagree) to 3 (strongly agree). Participants self-completed the measure, and the instrument demonstrated good psychometric properties, including validity, reliability, and acceptance. James et al. (2019) revealed an overall BACE scale reliability of 0.80, with the 12-item stigma subscale achieving a reliability of 0.87. In this study, the reliability was 0.76.

Procedure

In conducting the research, the researcher obtained a letter of introduction to the authorities of the study area as well as approval from the National Commission for Refugees, Migrants, Internally Displaced Persons (NCFRMI), and Jesuit Refugee Service (JRS). Ethical approval was also obtained from the relevant authorities. The data were collected using a questionnaire instrument.

Ethical considerations were meticulously observed. Consent and cooperation were sought and willingly obtained. Participants were informed of their right to withdraw at any time without repercussions since participation was voluntary and no incentives were attached. However, they were assured of the anonymity and confidentiality of their information. Participants who consented to participate were administered the questionnaire, and after completion, they were debriefed about the benefits of the study.

Data Analysis

To test the study hypotheses, the chi-square test (goodness of fit) was employed. The chi-square test (goodness of fit) is appropriate because it assesses whether there is a significant difference between two or more categorical levels (high and low). For instance, the chi-square (goodness of fit) test helped determine whether there were significant differences in the frequency of perceived stigma, attitudinal barriers, and instrumental barriers among the refugees. Since the data involve counts and frequencies, the chi-square test (goodness of fit) is suitable for testing these hypotheses.

RESULTS

Descriptive statistics

Table 1: Demographic Characteristics of the Study Participants (N = 312)

	Frequency	Percentage %
Age Group (Years)		
18-25	83	26.6
26-35	112	35.9
36-45	64	20.5
46-55	35	11.2
56 & above	18	5.8
Gender		
Male	136	43.6
Female	176	56.4
Marital Status		
Divorced	18	5.8
Married	90	28.8
Single	167	53.5
Widowed	37	11.9
Religion		
Christianity	258	82.7
Islam	54	17.3
Educational Level		
Collage	28	9.0
Illiterate	69	22.1
Primary	78	25.0
Secondary	133	42.6
University	4	1.3
Ethnic Group		
Takum	312	100

Table 1 presents the demographic characteristics of the study participants, totalling 312 individuals. Regarding age distribution, the largest proportion falls within the 26-35 age group, comprising 35.9% of the sample, followed by those aged 18-25 (26.6%) and 36-45 (20.5%). Participants aged 56 and above represent the smallest percentage at 5.8%. Gender-wise, females constitute a higher percentage (56.4%) compared to males (43.6%). Concerning marital status, the majority are single (53.5%), followed by married individuals (28.8%). Divorced and widowed participants each represent smaller percentages at 5.8% and 11.9%, respectively. In terms of religion, Christianity is predominant, with 82.7% of participants identifying as Christian, while 17.3% adhere to Islam. Regarding educational level, the highest percentage is observed among those with a secondary education (42.6%), followed by primary (25.0%), illiterate (22.1%), and college-educated (9.0%) individuals. Only a small fraction (1.3%) has attained a university education. Finally, (100%) of all participants are seeking refuge in Takum LGA communities.

The means and standard deviations of the three variables measured are presented in Table 2.

Table 2: Means and Standard Deviations of the Variables

	Mean	Std. Deviation
Perceived Stigma	16.32	6.64
Attitudinal Barrier	14.96	4.44
Instrumental Barrier	11.82	4.75

Table 2 above provides insights into the average scores and variability of perceived stigma, attitudinal barriers, instrumental barriers, and overall barriers to mental health-seeking behaviour among the study participants. The mean score for perceived stigma was 16.32, with a standard deviation of 6.64. This indicates that, on average, participants reported moderate levels of perceived stigma, with some variability in individual responses. A higher mean suggests a greater perception of stigma as a hindrance to seeking mental health support. The mean score for attitudinal barriers is 14.96, with a standard deviation of 4.44, signifying a moderate level of negative attitudes towards mental health assistance. A higher mean indicates stronger negative attitudes. For instrumental barriers, the mean score is 11.82, with a standard deviation of 4.75, suggesting a moderate level of practical obstacles in accessing mental health services.

Inferential statistics

Three hypotheses were tested with the chi-square test (goodness of fit), as shown in Table 3

Table 3. Chi-square (goodness of fit) test for levels of perceived stigma barrier

Stigma barrier	Observed N	Expected N	Chi-Square χ^2	*p* – Value
Low	128	156.0	10.051	.002
High	184	156.0		
Total	312			

Hypotheses 1 (Table 3) revealed that Cameroonian refugees residing in Takum, Taraba State, Nigeria, had significantly greater levels of perceived stigma as a barrier to mental health help-seeking behaviour ($\chi^2 = 10.051$, $p < 0.05$). This means that more Cameroonian refugees residing in Takum perceived stigma as a barrier to mental health help-seeking behaviour. Hypotheses one is therefore supported.

Table 4: Chi-square (goodness of fit) test for levels of attitudinal barrier

Attitudinal barrier	Observed N	Expected N	Chi-Square χ^2	*p* – Value
Low	113	156.0	23.705	<.001
High	199	156.0		
Total	312			

The results of hypothesis 2 (Table 4) indicate that more Cameroonian refugees residing in Takum, Taraba State, Nigeria, significantly revealed greater levels of perceived attitudinal barriers to mental health help-seeking behaviour ($\chi^2 = 23.705$, $p < 0.05$). This implies that the majority of Cameroonian refugees residing in Takum had perceived attitudinal barriers as barriers to mental health help-seeking behaviour. Hypothesis two is also statistically supported.

Table 5: Chi-square (goodness of fit) test for instrumental barriers

Instrumental barrier	**Observed**	**Expected**	**Chi-Square**	***p* – Value**
	N	**N**	**χ^2**	
Low	133	156.0	6.782	.009
High	179	156.0		
Total	312			

The results of hypothesis 3 in (Table 5) indicate that more Cameroonian refugees residing in Takum, Taraba State, Nigeria, will significantly experience greater instrumental barriers to mental health help-seeking behaviour ($\chi^2 = 6.782$, $p < 0.05$). This shows that the majority of Cameroonian refugees residing in Takum had perceived instrumental barriers as a factor hindering mental health help-seeking behaviour. Again, Hypothesis three is supported.

DISCUSSION AND CONCLUSION

This study examined the perceived barriers to mental health help-seeking behaviour among Cameroonian refugees in Takum LGA, Taraba State, Nigeria. All three hypotheses indicated statistically significant differences among refugees, specifically showing greater levels of perceived stigma and attitudinal and instrumental barriers to mental health help-seeking behaviour.

The results of hypotheses one revealed that Cameroonian refugees residing in Takum, Taraba State, Nigeria, significantly demonstrated greater perceived stigma as a barrier to mental health help-seeking behaviour. The finding that Cameroonian refugees in Takum, Taraba State, Nigeria, exhibit significantly greater levels of perceived stigma as a barrier to seeking mental health help can be attributed to several interrelated factors. First, the cultural context of both Cameroonian and Nigerian societies often stigmatizes mental health issues. Mental illness is frequently associated with weakness, spiritual failure, or moral shortcomings, leading individuals to avoid seeking help for fear of social ostracism. This stigma can be particularly pronounced among refugee populations who may already be vulnerable and face additional layers of discrimination and marginalization (Place et al., 2021).

The findings of hypothesis one is in agreement with the study of Murithi (2022), which found that a significant proportion of individuals who had never sought help for mental health concerns attributed their reluctance to the fear of experiencing societal stigma. Additionally, feelings of shame and embarrassment associated with mental illness symptoms have been identified as barriers to help-seeking in various populations (Byrow et al., 2019). Furthermore, studies have shown that self-stigmatization and social stigma are related to mental disorders,

leading to a reluctance to seek mental health services and disclose their condition (Muhorakeye & Biracyaza, 2021; Graham et al., 2016).

Without adequate information, misconceptions about mental illness prevail, making it harder for individuals to recognize symptoms and seek appropriate care. Another possible contributing factor is the lack of prioritization of mental health by community leaders, healthcare providers, and policymakers, which results in a dearth of advocacy and resources that could otherwise mitigate stigma.

The results of hypothesis two indicated that Cameroonian refugees residing in Takum, Taraba State, Nigeria, demonstrated significantly greater levels of attitudinal barriers to mental health help-seeking behaviour. The finding of hypothesis two could be attributed to the fact that many refugees might harbour scepticism about the effectiveness of mental health interventions due to a lack of exposure to or understanding of these services (Bauer et al., 2021). Past negative experiences with healthcare providers or the healthcare system in general can also contribute to these attitudes, fostering distrust and reluctance to seek help. Additionally, traditional beliefs and cultural practices might prioritize community or familial support over formal medical treatment for mental health issues. This preference can lead to the perception that professional mental health services are unnecessary or even inappropriate, further discouraging individuals from seeking help and perpetuating reliance on informal support systems that may not adequately address their needs.

These findings are in line with those of Gee et al. (2020), who revealed that low perceived need emerges as a primary barrier, particularly prevalent among individuals with mild to moderate cases. Additionally, greater nonculturally specific attitudinal and structural barriers to help-seeking behaviour in mental healthcare were found, and Wang et al. (2020) revealed a range of knowledge, attitudinal, and practical barriers impeding help-seeking for mental health issues among Asian– and Latinx–American adolescents within school contexts.

The results of hypothesis three also indicate that Cameroonian refugees residing in Takum, Taraba State, Nigeria, significantly demonstrated greater barriers to mental health help-seeking behaviour. In explicating the outcome of hypotheses three, it can be argued that the significant identification of instrumental barriers highlights the practical challenges that refugees face in accessing mental health services. Financial constraints are a major factor, as many refugees live in precarious economic conditions and may not afford the cost of mental health care (Jack-Ide & Uys, 2013). Access to healthcare facilities is constrained by the limited availability of transportation and long distances (Ssebunnya et al., 2019; Nakku et al., 2016). Language barriers and the lack of culturally sensitive mental health professionals also pose significant obstacles (Al-Soleiti et al., 2021).

The findings align with the study of Dumitrache et al. (2022), which found that cultural, linguistic, structural, and financial barriers were perceived as the most significant obstacles to accessing healthcare services. Likewise, Nguyen et al. (2021) reported that individuals facing financial strain were less likely to seek professional help for their mental health concerns. This aligns with the belief that mental health help-seeking behaviour reflects an individual's recognition, acknowledgement, and ability to afford the cost of improving their emotional and psychological well-being (Bila & Carbonatto, 2022).

The aforementioned practical difficulties are compounded by the broader socioeconomic struggles of refugees, making it difficult for them to prioritize mental health over immediate needs such as food, shelter, and physical health care (Ryu & Fan, 2023). Addressing these instrumental barriers requires systemic changes and support structures that can alleviate the logistical and financial burdens on refugees, enabling them to seek and receive appropriate mental health care (Luitel et al., 2017).

Overall, the HBM provides a useful framework for understanding the perceived stigma and attitudinal and instrumental barriers to mental health help-seeking behaviour among Cameroonian refugees in Takum LGA, Taraba State, Nigeria. In the context of Cameroonian refugees, perceived stigma significantly affects their mental health help-seeking behaviour by increasing the perceived social and cultural costs associated with being identified as having a mental health issue. Attitudinal barriers, shaped by cultural beliefs and personal attitudes towards mental health, affect the perceived benefits and self-efficacy related to seeking help. Instrumental barriers, such as limited access to mental health services, financial constraints, and language barriers, further exacerbate the perceived difficulties in obtaining necessary care. Thus, the HBM aids in identifying and addressing these multifaceted barriers to improve mental health outcomes for this vulnerable population.

Limitations of the Study

This study is not without limitations. First, the focus on Cameroonian refugees in a specific region of Nigeria may limit the generalizability of the findings to other refugee populations or regions with different sociocultural contexts. Second, reliance on self-report measures introduces potential self-report bias, as participants may provide socially desirable responses or inaccurately recall their perceptions of mental health barriers. Additionally, language and cultural barriers may have influenced participant responses, and the study's limited scope of variables excludes other potential influences on help-seeking behaviour. Addressing these limitations in future research will enhance the understanding of mental health help-seeking behaviour among refugee populations and inform more effective interventions.

Implications of the Study

The results of the study have significant implications. The higher levels of perceived stigma, attitudinal barriers, and instrumental barriers underscore the urgent need for targeted interventions to improve mental health support within the refugee community. Efforts should focus on reducing stigma, addressing negative attitudes towards mental health care, and overcoming practical obstacles to accessing services.

Additionally, the absence of significant age and gender differences in perceived barriers suggests that interventions should be inclusive and tailored to the diverse needs of all refugees, regardless of age or gender. This underscores the importance of implementing culturally sensitive and gender-inclusive approaches to mental health care provision. Overall, the study highlights the complex challenges faced by Cameroonian refugees seeking mental health assistance and emphasizes the necessity of comprehensive strategies to address these barriers and improve mental health outcomes within the refugee population in Takum, Taraba State, Nigeria.

Conclusion

This study on perceived barriers to mental health help-seeking behaviour among Cameroonian refugees in Takum LGA, Taraba state of Nigeria, revealed several noteworthy findings. The findings showed that the majority of the Cameroonian refugees in Takum, Taraba State, showed significantly high levels of perceived stigma, attitudinal barriers, and instrumental barriers to mental healthcare seeking behaviour. Based on this conclusion, the study emphasizes the urgency of addressing stigma and attitudinal and instrumental barriers to enhancing mental health help-seeking behaviours among Cameroonian refugees in Takum, Taraba State, Nigeria. Interventions should focus on raising awareness, providing culturally sensitive mental health services, and addressing practical challenges to ensure equitable access to mental health care and support for all individuals within the refugee community.

Recommendations

Based on the findings of the study, the following recommendations were made:

1. To address the significant levels of perceived stigma among Cameroonian refugees in Takum, Taraba State, educational campaigns should be initiated within the community by the the National Commission for Refugees, Migrants, and Internally Displaced Persons (NCFRMI), Taraba State Ministry of Humanitarian Affairs, Ministry of Education, INGO/NGOs, and other key stakeholders. Campaigns should aim to debunk myths and misconceptions surrounding mental health and promote understanding and acceptance. Additionally, community leaders and influencers should advocate for mental health awareness and reduce stigma through public discussions and awareness-raising activities.
2. Given the significant presence of perceived attitudinal barriers, it is crucial for policymakers and critical key actors to develop culturally sensitive mental health interventions tailored to the needs and beliefs of Cameroonian refugees. These interventions should address negative attitudes towards mental health care and promote the importance of seeking help when needed. Collaboration with community leaders, religious figures, and traditional healers can help ensure that interventions are culturally appropriate and well received within the community.
3. To mitigate instrumental barriers to seeking mental health help, the National Commission for Refugees, Migrants, and Internally Displaced Persons (NCFRMI), Taraba State Ministry of Humanitarian Affairs, INGO/NGOs, and key stakeholders should promote and improve the accessibility and affordability of mental health services. This could involve establishing mobile clinics or community-based mental health centres within refugee settlements, providing transportation support, and offering financial assistance or subsidies for mental health treatment. Additionally, information about available services should be disseminated in relevant languages to increase awareness and facilitate access.

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