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Reducing the stigma of mental health disorders with a focus on low- and middle-income countries

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ABSTRACT

Mental health disorders are a burgeoning global public health challenge, and disproportionately affect the poor. Low- and middle-income countries (LMICs) bear 80 % of the mental health disease burden. Stigma associated with mental health results in delayed help seeking, reduced access to health services, suboptimal treatment, poor outcomes and an increased risk of individuals' human rights violations. Moreover, widespread co-occurrence of physical comorbidities such as noncommunicable diseases with mental health disorders makes the treatment of both conditions challenging and worsens prognosis. This paper explores various aspects of stigma towards mental health with a focus on LMICs and assesses measures to increase help-seeking and access to and uptake of mental health services. Stigma impacts persons living with mental illness, their families and caregivers and healthcare professionals (mental health professionals, non-psychiatric specialists and general practitioners) imparting mental health care. Cultural, socio-economic and religious factors determine various aspects of mental health in LMICs, ranging from perceptions of health and illness, health seeking behavior, attitudes of the individuals and health practitioners and mental health systems. Addressing stigma requires comprehensive and inclusive mental health policies and legislations; sustainable and culturally-adapted awareness programs; capacity building of mental health workforce through task-shifting and interprofessional approaches; and improved access to mental health services by integration with primary healthcare and utilizing existing pathways of care. Future strategies targeting stigma reduction must consider the enormous physical comorbidity burden associated with mental health, prioritize workplace interventions and importantly, address the deterioration of population mental health from the COVID-19 pandemic.

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1. Introduction

Globally, one in every three individuals suffer from a mental illness during their lifetimes disrupting the state of their mental health.(Vigo et al., 2016) Approximately, 970 million people had a mental health disorder (MHD) in 2017, accounting for 14.4 % of years lived with disability (YLDs) from all causes.(G.B.D. Disease Injury Incidence Prevalence Collaborators, 2018) The actual mental health burden is arguably far higher; assuming the overlap between psychiatric and neurological disorders, MHDs would account for 32.4 % of total YLDs. (Vigo et al., 2016) Depression, anxiety, bipolar disorder, schizophrenia and other psychoses, dementia, substance use disorders, attention deficit hyperactivity disorder and developmental disorders including autism are the leading contributors of MHDs.(G.B.D. Disease Injury Incidence Prevalence Collaborators, 2018) While MHDs affect people in all groups of society, the poor remain disproportionately affected. This is of particular concern in the 153 low- and middle-income countries (LMICs) where 85 % of the world's population resides and over 80 % of the MHDs occur.(Alloh et al., 2018; Rathod et al., 2017) By 2030, depression will be the third and second highest cause of disease burden in LMICs and middle-income countries, respectively.(Rathod et al., 2017) Moderators of the high mental health burden in many LMICs include poverty, low socio-economic status, unemployment, low education levels, rapid urbanization, internal migration, lifestyle changes, younger population demographics and discriminating practices towards certain population subgroups.(Alloh et al., 2018; Cia et al., 2018; Rathod et al., 2017)[6]

The economic costs of MHDs are contributed directly by healthcare expenditures and indirectly by reduced productivity of individuals and their caregivers at home and in the workplace. Lost wages combined with the health care costs can have catastrophic financial consequences for patients and their families. As populations increase and age over the next decades, the cost of MHDs will more than double from 2010 to 2030 (US$ 870 billion to US$ 2 trillion).(Bloom et al., 2011) The anticipated economic toll of MHDs in LMICs between 2011 and 2030 is estimated at US$ 7.3 trillion.(Bloom et al., 2011)

Physical and mental health disorders are associated via "bidirectional" links (Fig. 1).(Stein et al., 2019; Von Korff et al., 2009) Chronic conditions such as cardiovascular diseases, diabetes, cancer, and respiratory diseases collectively termed as non-communicable diseases (NCDs) often coexist with MHDs, attributed to the shared risk factors. (Stein et al., 2019) The World Health Organization (WHO) estimates that a quarter of all patients using a health service suffer from at least one mental, neurological or behavioral disorder, which are often undiagnosed or untreated.(Bloom et al., 2011) A World Psychiatric Association (WPA) study observed widespread physical comorbidities in patients with severe MHDs accompanied with poor healthcare provisions and access for the patients.(De Hert et al., 2011b) Stigmatization of persons with MHDs at healthcare systems level is a major barrier in the management of physical comorbidities and needs to be addressed to improve physical and mental health of people with severe mental illness. (De Hert et al., 2011a)

The WHO defined stigma as "a mark of shame, disgrace or disapproval that results in an individual being rejected, discriminated against and excluded from participating in a number of different areas of society".(Thornicroft et al., 2007) Stigma towards people with MHDs can be conceptualized in terms of stereotype (negative belief about the self/-group), prejudice (agreement with belief and/or negative emotional reaction) and discrimination (behavioral response to prejudice, such as exclusion from social and economic opportunities).(WHO, 2002) The United Nations prioritized population mental health in the Sustainable Development Goal 3.4 (SDG 3.4).(UN, 2016) The UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care decry any discrimination on the grounds of mental illness and advocate for the right of every patient to be treated in their own community and receive the least restrictive and intrusive treatment (WHO, 2002). However, the implementation of these principles remains far from satisfactory.(WHO, 2002)

This paper aims to address various aspects of stigma towards mental health with a focus on LMICs and assess measures to increase rates of presentation for common MHDs.

2. Consequences of mental health stigma

Stigmatization of mental health manifests at the level of the individual (intrapersonal), society (interpersonal) and health systems (structural) (Fig. 2).(Corrigan and Watson, 2002; Henderson et al., 2014)

2.1. *Self-stigma and internalized stigma among people with MHDs*

Self-stigma involves emotionally/cognitively absorbing the negative beliefs about the self, largely based on shame, accepting mental illness

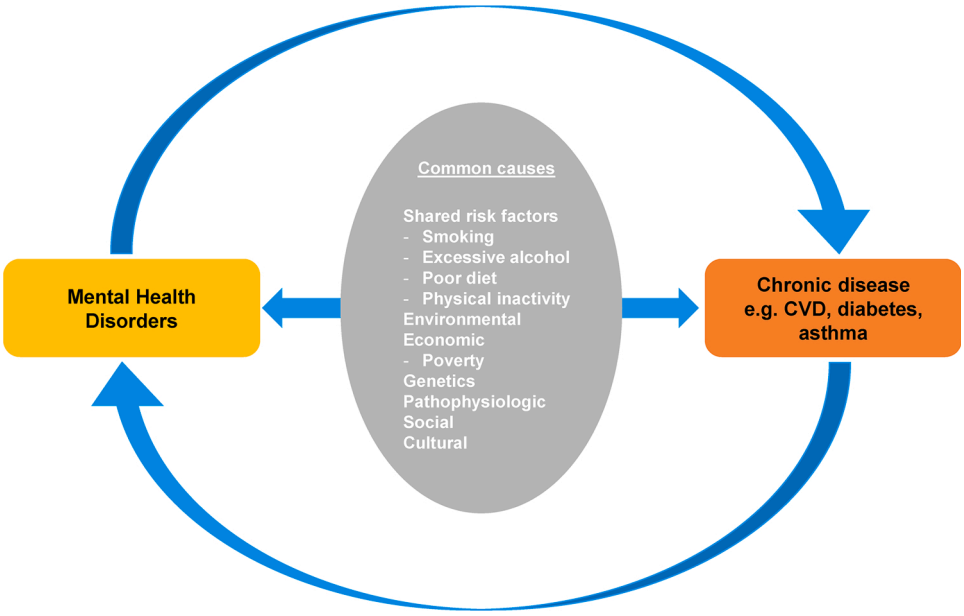

Fig. 1. Mental health and chronic disease comorbidity model. CVD, cardiovascular diseases.

stereotypes, alienating oneself from others (described as "social distancing" in the context of mental health, distinct from "physical distancing" in the context of COVID-19 pandemic), and feeling a sense of disempowerment.(Henderson et al., 2014; Wasserman et al., 2020) At the societal level, stigma stems from a lack of knowledge on causes, symptoms and treatment options of MHDs and a lack of personal contact with persons with MHDs.(Baumann, 2007) Negative attitudes and behaviors of healthcare professionals toward patients also reinforce self-stigma.(Knaak et al., 2017) The struggle with symptoms, disability, social distance and stigma associated with MHDs leads to poor quality of life in several domains of life: education, marriage, parenting, employment, housing and satisfactory health care.(Corrigan and Watson, 2002; Hocking, 2003; Romeo et al., 2017; Stuart, 2016; WHO, 2002)

Stigma is inversely associated with help seeking from formal healthcare services which worsens the prognosis and perpetuates the misperception of MHDs as incurable.(Clement et al., 2015; Stuart, 2016) In LMICs, over 75 % of people that require mental healthcare do not receive any kind of intervention, compared with a "treatment gap" of only 35 %–50 % in developed countries.(Mascayano et al., 2015) Patients with MHDs are at heightened risk for poor health behavior, healthcare access, noncompliance to prescribed medications, diminished immunity and unfavorable disease outcomes.

2.2. Stigma among families and caregivers

Involving patients and their families in their own care can be beneficial for short- and long-term improvements in the mental health, function and quality of life of those with MHDs.(Javed and Herrman, 2017) The burden of care faced by carers can be categorized into objective factors, including health impact, financial costs, and limitations imposed on daily activities and subjective factors explained by psychological responses, such as anxiety, feelings of loss and embarrassment.(Loza and Effat, 2017) A Sri Lankan study observed that carers often encountered stigma, discrimination, exclusion, economic burden and hardships in accessing adequate care.(Javed and Herrman, 2017) The valuable work contributed by the families often goes unrecognized and most countries do not provide financial support for the care services rendered by the families.(Javed and Herrman, 2017) The caregiver perspective on children with intellectual disabilities in Pakistan identified difficulties in dealing with aggression, schooling, socialization, inappropriate behaviors, sleep and feeding as the significant areas of concern.(Imran et al., 2015b) While setting policies, it is important to address not only the needs of the patients but also carers' need for knowledge about the illness, as well as emotional and financial support. (Loza and Effat, 2017; Romeo et al., 2017)

2.3. Stigma among healthcare professionals

The psychiatric profession shares a complex relationship with stigma, with its members simultaneously being stigmatizers, stigma recipients and strong agents of destigmatization.(Schulze, 2007) Healthcare professionals across the spectrum contribute to stigmatization through conscious or unconscious bias in several ways: exhibiting a disinterest in the person's mental health history, social distancing, psychiatric labelling, therapeutic pessimism, structural discrimination related to poor quality psychiatric treatment or rehabilitation measures

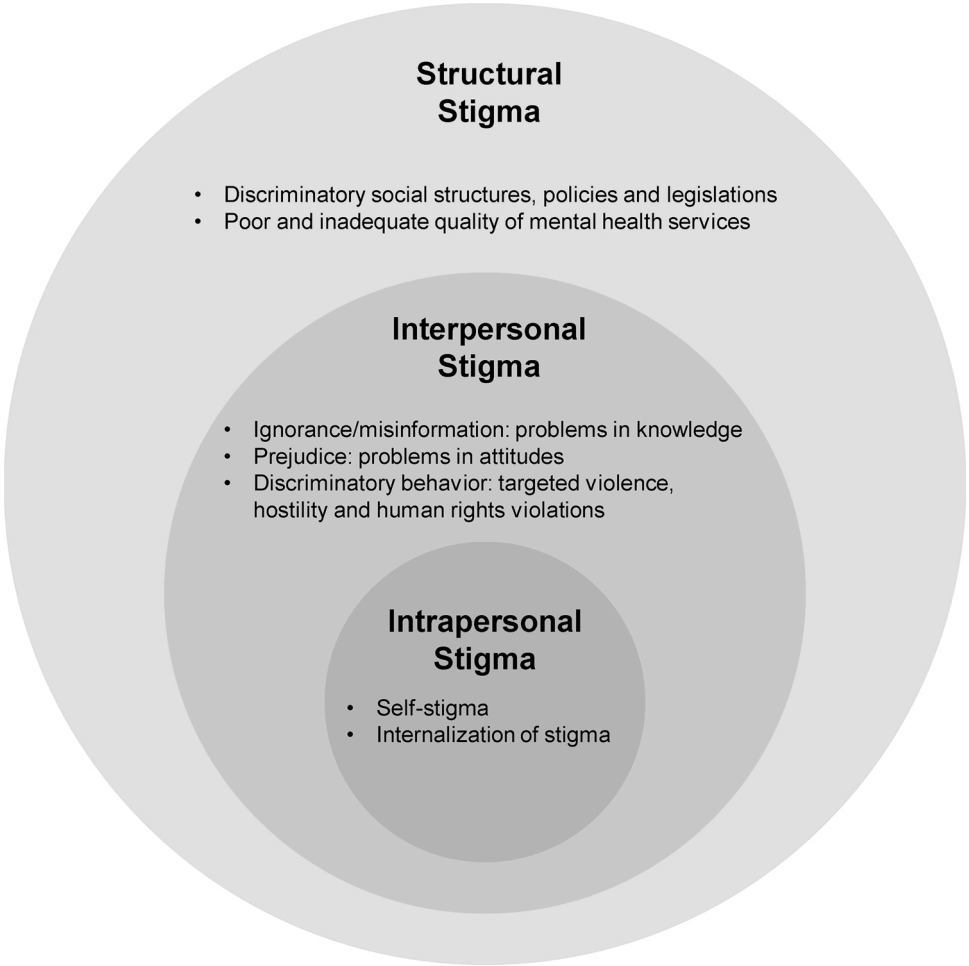

Fig. 2. Multiple levels of stigmatization of mental health.

and sharing insufficient information on diagnosis.(Heim et al., 2018; Henderson et al., 2014; Knaak et al., 2017; Schulze, 2007) Older age, higher education and longer duration of clinical experience among healthcare professionals were associated with more favorable attitudes toward persons with MHDs.(Henderson et al., 2014) Stigma may manifest within healthcare settings as violations of fundamental human rights, including the right to good emotional and physical health.(Knaak et al., 2017)

Psychiatrists and their discipline are also targets of stigma and discrimination perpetuated by unfavorable stereotypes, inequitable distribution of healthcare resources and unfavorable opinion among medical students.(Lai et al., 2001; Schulze, 2007) Stigmatization of MHDs has inward-facing impacts on healthcare professionals' and medical students' willingness to seek help for a mental health problem for fear of being perceived as less competent, less productive and unsafe to work with.(Knaak et al., 2017; Sartorius et al., 2015)

Delay in the diagnosis and treatment of physical illnesses in people with MHDs is another consequence of stigmatization as diagnostic and treatment overshadowing leads to misattribution of non-mental health symptoms to a patient's mental illness.(Henderson et al., 2014; Knaak et al., 2017; Stein et al., 2019) People with MHDs are less likely to be screened for cardiovascular diseases, diabetes, osteoporosis or receive medical visits owing to factors related to treatment, knowledge of comorbidities among psychiatrists, attitudes of medical doctors and unsatisfactory organization of health services.(Leucht et al., 2007) Conversely, the presence of comorbid MHDs are overlooked by physicians in the presence of significant physical disease (Sartorius et al., 2015). Various degrees of knowledge gaps in the assessment and management of MHDs were observed among non-psychiatric healthcare professionals and medical students in Latin America, Pakistan and Saudi Arabia.(Eissa et al., 2020; Hayat et al., 2019; Imran et al., 2011; Richly et al., 2014)

3. Cross-cultural factors in stigma

Cultural factors play a significant role in determining various aspects of mental health, ranging from perceptions of health and illness, help seeking behavior, attitudes of the individuals and practitioners and mental health systems. Five key elements make up the framework of cultural diversity and their mental health implications (Table 1). (Gopalkrishnan, 2018) Cultural factors such as perceived shame of an MHD diagnosis, desire to protect family reputation and personal dignity define treatment seeking behaviors. People with MHDs in LMICs such as India often present somatic symptoms compared with cognitive symptoms in western countries.(Gopalkrishnan, 2018) In LMICs where government support for MHDs is minimal, lack of family support due to perceptions of stigma can lead to total neglect of a person with MHDs. (Gopalkrishnan, 2018) Traditional healers and communal unity based on faith is preferred to resolve mental health crisis in many LMICs, e.g., the Philippines.(Pineda and Alonso-Balmonte, 2016; Tanaka et al., 2018; Tuliao, 2014) The Philippine society centers around hospitality and the familial unit, which delay help seeking for MHDs with people fostering the early symptoms until there is manifestation of heavy stressors in their environment.(Pineda and Alonso-Balmonte, 2016; Rivera and Carl Abelardo, 2017; Tanaka et al., 2018; Tuliao, 2014)

Cultural impacts on the therapeutic relationship also need consideration given the diverse cultures in LMICs. In the Arab culture, families and communities share the burden of individuals with MHDs;(Rathod et al., 2017) however, risk of abandonment of the patient by families and communities in some instances due to the associated stigma and practical burden remains a caveat in these settings.(Javed and Herrman, 2017) In Pakistan, children with developmental disorders reported high levels of self-stigmatization, arising from taboo of mental health and fear of rejection in the joint family system.(Khalil et al., 2020) Egyptian patients with MHDs had higher interpersonal stigma than self-stigma and affirmed their need for additional help besides psychiatric intervention.(Sidhom et al., 2014) Therapeutic models for treating addiction disorders in Mexico highlighted the importance of gender as the social parameters and stigma differ for addicts who are women, men or persons with gender identity issues.(Mora-Rios et al., 2017) Mexican women were nearly twice as likely to recognize the presence of MHDs and considered psychiatric interventions as the most adequate treatment of symptoms compared with men who often considered non-psychiatric interventions.(Robles-Garcia et al., 2013) Attributing MHDs to religious elements is also recognized as coping mechanism in the Mexican society. (Mora-Rios et al., 2016)

Table 1
The key elements in the framework linking cultural factors and mental health.

Element	Description
Emotional expression	• Perception that lack of emotional balance leads to MHDs which may get aggravated by talking about the issues • Reluctance in utilizing talk therapies • E.g., African and Southeast Asian cultures
Shame	• Significant role of family in the life of the individuals and belief that diagnosis of MHDs may impact family • Slow access to professional therapists • E.g., Asian cultures
Power distance	• Large differences in power between therapists and patients • Determines the extent of the therapeutic alliance • E.g., Asian cultures
Collectivism	• A supportive factor to resilience and coping with MHDs • A risk factor in mental health • E.g., Asian cultures
Spirituality & religion	• Dual role in terms of attribution to the etiology of disease and coping mechanism for MHDs • E.g., Middle-eastern cultures

MHDs, mental health disorders.

4. Addressing mental health stigma in the LMICs

There is limited data on the effectiveness of anti-stigma interventions in LMICs; none are longitudinal, or address behavior change around discrimination. The need of the hour is to study the effectiveness and feasibility of stigma-reducing interventions and identify the key target groups and cultural adaptations for these interventions.(Heim et al., 2018) Some recommendations for addressing stigma in LMICs from literature and expert opinions from the authors are outlined in Table 2. Further evaluation of these measures is warranted.

4.1. Legislation

The WHO recommends member countries to develop comprehensive policies for improving population mental health, utilizing existing resources to achieve the greatest possible benefits and assisting the reintegration of persons with MHDs into all aspects of society.(WHO, 2008) In 2010, Argentina enacted the National Law on Mental Health with the intention to allow individual freedom in deciding admission to psychiatric facilities and subsequently close down psychiatric hospitals. (Stagnaro, 2018) However, improper planning, inadequate resources and limited jurisdiction has created greater gap between demand and supply of health services, particularly for poorer populations.

Many LMICs prioritized the implementation of national anti-stigma interventions focused on improving mental health knowledge and attitudes toward individuals with MHDs.(Mascayano et al., 2015) However, most LMICs spend <1% of their health budget on mental health, which is dismal considering that neuropsychiatric disorders account for 12.3 % of total disease burden.(Bloom et al., 2011; WHO, 2002) An increase in mental health budget allocations and implementation of mental health acts need to be prioritized in LMICs.(Imran et al., 2018)

4.2. Health literacy, education and awareness

Anti-stigma awareness programs are often based on two key

Table 2
Expert recommendations for addressing mental health stigma in low- and middle-income countries.

Focus area	Recommendations
Legislations	• Develop sustainable, comprehensive and inclusive mental health polices • Implement and monitor the impact of policies • Allocate sufficient budget to mental health care
Health literacy, education and awareness	• Long-term mental health awareness program based on *normalization* and *medicalization* paradigm • Discontinue use of discriminatory and stigmatizing terms for people with MHDs • Collaborate with institutions - schools, universities and workplaces - to foster better mental health • Engage media and public personalities to reinforce a positive mental health agenda • Involve patients and their families in the delivery and monitoring of mental health care
Health system capacity building	• Task shifting to community health workers • Task sharing for providing psychosocial support • Mental health educational interventions targeted at healthcare professionals and frontline workers • Increased emphasis on mental health at undergraduate and post graduate medical curricula • Interprofessional approaches for addressing child and adolescent mental health issues
Access to care	• Integrate mental health services into primary health care • Assimilate non-medical practitioners such as traditional and faith healers in the pathway of care through educational interventions and collaborative relationships • Cultural adoption of mental health interventions • Implement early mental health interventions in children and youth

MHDs, mental health disorders.

messages, *normalization paradigm* (people with MHDs are similar to other people) and *medicalization* (MHDs are treatable).(Lauber and Sartorius, 2007) The WPA's 10-year 'Global Programme against Stigma and Discrimination because of Schizophrenia' was the largest initiative to reduce discrimination and increase legal protection for people with MHDs through education, outreach programs and updating public policies and laws.(Lauber and Sartorius, 2007; Sartorius, 2006) Other stigma reduction efforts include replacing stigmatizing terms with more acceptable terms in Latin America, developing campaigns on child mental health in LMICs and publishing motivational stories from people suffering from MHDs in Singapore.(Hoven et al., 2008; NUS, 2020; Sere et al., 2016) Anti-stigma programs for healthcare professionals improved their knowledge, social distance and attitude scores.(Lien et al., 2019; Mascayano et al., 2020)

Generalizing all mental illnesses promotes stigma; therefore, focus must be on destigmatizing labels associated with individual diagnosis, e.g., association of schizophrenia with violence and aggression, and of depression and anxiety disorder with weakness and lack of spirituality. Negative stereotypes of people with MHDs is frequently reinforced by the media, which can be overcome by sharing lived experience of public personalities with MHDs.(Hocking, 2003; Lai et al., 2001) Aligned with the WHO's call for more active involvement and support of patients and their families in the reorganization, delivery, evaluation and monitoring of services, the WPA helped developed a set of best practices for engaging with people with MHDs and their carers.(Javed and Herrman, 2017)

4.3. Health system capacity building

With limited mental health workforce in LMICs, community health workers can be trained on limited tasks including case detection, referrals and providing psychosocial support – a process termed as *task shifting*.(Heim et al., 2018; Rathod et al., 2017) Educational interventions targeting general practitioners, non-psychiatric specialists, nurses and non-mental health professionals (like teachers) are an effective strategy to improve knowledge, skills and confidence for treating people with MHDs.(Henderson et al., 2014) Incorporating increased mental health awareness and contact-based educational interventions in undergraduate/postgraduate medical curricula is associated with reduced stigmatizing attitudes and behaviors.(Papish et al., 2013)

MHDs are common among children and adolescents in the Middle East; however, there remains a lack of proportionate investment in child and adolescent mental health workforce in LMICs.(Clausen et al., 2018, 2020) Efforts to build the capacity of child mental health professionals in Pakistan encompassed fellowships in child and adolescent psychiatry, new autism program and dedicated psychiatry programs in several hospitals.(Azeem et al., 2015)

4.4. Access to care

Integrating mental health services into primary health care is an efficient way of closing the mental health treatment gap in LMICs, particularly in the rural communities.(Stein et al., 2019) Integration of mental health teams into primary care in LMICs across Africa, Middle East and Asia demonstrated improved attitudes of healthcare workers toward MHDs and the utility of connecting healthcare workers with mental health service users.(Mascayano et al., 2015) Non-medical practitioners such as traditional healers form an important step in the pathways of care in LMICs due to their accessibility and affordability and confidence in the service.(Assad et al., 2015; Hussein et al., 2012)

Culture shapes stigma differently in different social groups and cultural adoption of interventions following the concept of "what matters most" may help people in LMICs achieve the capacities essential to being viewed as a "full person" within their contexts.(Mascayano et al., 2015, 2020) Somatization of psychological symptoms as physical complaints in many cultural groups can be detected and diagnosed through appropriate trainings at primary and secondary care levels.(Rathod et al., 2017) Similarly, understanding adolescents' perception of their psychiatric difficulties may inform culturally sensitive interventions.(Imran et al., 2015a) Treatment gap in MHDs exists even in high-income countries in people with comorbid physical disorders and with high education and employment levels.(Subramaniam et al., 2019b) Thus, regulations recognizing psychosocial hazards of occupational risk and targeted interventions in educational and workplace settings are needed.

5. Anti-stigma initiatives in other countries

There are several long-running mental health anti-stigma campaigns such as 'Time to Change' in the UK, 'Opening Minds' in Canada and 'Beyond Blue' in Australia that have demonstrated significant positive change.(Time-to-change, 2020) Similar to the developed countries, there are interventions targeting mental health stigma adopted in other countries and may inform related programs across other LMICs (Table 3).(Gonzalez and Alvarez, 2016; Martinez et al., 2020; Medina-Mora et al., 2007; NCSS, 2020; Open Minds Foundation, 2016; Subramaniam et al., 2017, 2019a)

6. Future directions

The enormous burden of comorbid physical disorders and MHDs is a serious public health concern globally, but especially in LMICs due to limited resources. Thus, efforts must be made to reduce stigma towards mental health to increase rates of presentation for commonly occurring MHDs. Due to a complex multicausal mechanism linking MHDs with chronic conditions, integrated and multipronged person-centered and systems-based approaches are needed.(Sartorius et al., 2015) As a heavily stigmatized condition, best practices in managing

Table 3
Select mental health anti-stigma programs as best practice for low- and middle-income countries.

Program name (Country, year)	Background	Interventions	Outcomes
Beyond the Label (Singapore, 2016) (NCSS, 2020)	• 1 in 7 adult Singaporeans experienced ≥1 mood, anxiety or alcohol use disorder in 2016 (Subramaniam et al., 2019a) • Significant stigma towards mental illness present (Subramaniam et al., 2017)	• Stigma awareness towards persons with MHDs through resources, videos & publications • Promote campaign ambassadors to celebrate contributions of persons in recovery • Equip the public with tips & knowledge to interact with & support persons in recovery • Engagement tools to facilitate more conversations on mental health • Advocate for balanced portrayal of persons with MHDs in media	• 3rd edition of the Beyond the Label campaign launched in 2020 amid greater mental health challenges posed by the COVID-19 pandemic
Psicofobia (Brazil, 2011) (Psicofobia, 2020)	• Latin America is ranked 3rd worldwide in the number of people diagnosed with MHDs • In Brazil, 50 million people have MHDs	• 'Psychophobia' term coined to define prejudice against persons with MHDs • Social media campaign to raise awareness against Psychophobia • Share lived experiences of persons with MHDs including leading Brazilian personalities	• Brazil passed a law which considered Psychophobia as a crime
Arteyestigma (Mexico, 2020)	• About 26 % of Mexicans experienced ≥1 psychiatric disorder in their lifetime in 2005 (Medina-Mora et al., 2007) • Deaths due to mental and behavioral disorders increased by 33 % between 2008 and 2014 (Gonzalez and Alvarez, 2016)	• Publish the history of artists that have publicly shared their experience with mental illness in the official journal of Mexican Psychiatric Association • Make the concept of mental illness and psychiatric treatment less threatening for individuals	• The results of the campaign will be measured qualitatively by focus groups
Open Minds Foundation Advocacy (Philippines, 2002) (Open Minds Foundation, 2016)	• Around 6 million Filipinos are estimated to live with depression and/or anxiety (Martinez et al., 2020) • The Philippines has the 3rd highest rate of mental health problems in the Western Pacific Region (Martinez et al., 2020)	• Monthly support groups at a hospital to educate patients & caregivers on specific mental illnesses through psychiatrists • Host regular radio program to expand the reach of the program • Set up call center to provide information from a directory of psychiatrists • Develop models of healthcare financing for mental illness	• Create public awareness that mental illness is curable and manageable • Help relatives & friends of mentally ill patients understanding and coping with mental illnesses better
Wellness Ambassador (Qatar, 2019) (Qatar Foundation, 2019)	• In a 2009 survey in Qatar, 50 % of the adults believed that the depression & anxiety medication could cause addiction • 90 % said they would never marry someone with a mental illness	• 2-day workshop for high school students ('ambassadors') to equip them with tactics to effectively engage with their peers on issues related to mental wellbeing • Ambassadors may refer students to a school psychologist • Set up wellness meetings ('Majlis') for students to openly talk about mental health issues • Hold talks with guests (physicians, religious scholars, and other professionals) on dealing with mental health concerns and well-being	• At a year-end conference, ambassadors will put together a framework of initiatives based on experience and suggestions for implementation the following year

MHDs, mental health disorders.

multimorbidity in HIV/AIDS may be applicable to mental health. (Sartorius et al., 2015) As comorbid chronic diseases are mainly managed in outpatient settings, self-care skills and community-based care are indispensable in the context of an aging population. Though trained healthcare workers remain central in this model, involving civil society, traditional healers and other groups can effectively address the issues of knowledge and stigma, ensuring better management and therefore better outcomes for people with comorbid conditions.(Sartorius et al., 2015)

Stigma negatively impacts the utilization of mental health services at workplaces as most individuals believe it affects their career opportunities. Workplace anti-stigma interventions are effective in changing employees' knowledge, attitudes, and behavior towards people with mental health problems.(Hanisch et al., 2016) Compared with public efforts, tailored anti-stigma workplace interventions may be more promising as they could be longer-term, more intensive and made mandatory.

The COVID-19 pandemic presented a three-fold challenge to global public mental health: increased risk of MHDs and reduced mental well-being, increased vulnerability of people with MHDs to COVID-19, and

mental health interventions for health professionals and carers. (Campion et al., 2020) Inadequate availability of mental health interventions in the pre−COVID era compounded the challenge to mental health services during and post-pandemic. Public health interventions are needed to support individuals, carers and health professionals during the pandemic which may include improved trainings for healthcare professionals and public, use of digital technology, reduced social isolation, and group approaches implemented in schools and workplaces during lockdown or quarantine.(Campion et al., 2020) Furthermore, several COVID-19 frontline healthcare workers and recovered patients face stigma and discrimination at the workplace and surroundings, which in turn puts them at a higher risk of psychological problems. Dissemination of accurate information may counteract COVID-19 stigma in people, protect mental wellbeing and controlling this public health crisis effectively.(Singh and Subedi, 2020) The COVID-19 pandemic has provided an opportunity to normalize people's attitude towards mental health assessment without feeling embarrassed -or fearing stigma.

7. Conclusions

Mental health, like other aspects of health, can be affected by a range of socioeconomic factors that need to be addressed through comprehensive strategies for promotion, prevention, treatment and recovery using a "health-in-all policies" approach. Stigma, embodied in discriminatory social structures, policy and legislation, and personal and interpersonal interactions produces a disparity between services geared to physical and mental health, with lower availability, accessibility, and quality of services for MHDs.(Vigo et al., 2016) A worrisome trend emerging with the comorbidity of mental and physical disorders is the increasing fragmentation of the practice of medicine into super-specialties and corresponding knowledge gap of general practitioners across the many disciplines.(Sartorius et al., 2015) Integration of care for NCDs and MHDs and the collaboration of primary care providers with mental health professionals are potential strategies to improve access to care and reduce mental health stigma. In developing countries, there is a particular concern in reducing cultural, social, financial, or gender-related barriers to service delivery. This is reflected in the implementation of family and community-based interventions to manage serious MHDs, using destigmatizing strategies such as therapeutic optimism, extension of support networks and connection with formal and informal social services.

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