REVIEW ARTICLE

Stigma towards mental illness in Asian nations and low-and-middle-income countries, and comparison with high-income countries: A literature review and practice implications

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ABSTRACT

Background: Stigma related to mental illness (and its treatment) is prevalent worldwide. This stigma could be at the structural or organizational level, societal level (interpersonal stigma), and the individual level (internalized stigma). Vulnerable populations, for example, gender minorities, children, adolescents, and geriatric populations, are more prone to stigma. The magnitude of stigma and its negative influence is determined by socio-cultural factors and macro (mental health policies, programs) or micro-level factors (societal views, health sectors, or individuals' attitudes towards mentally ill persons). Mental health stigma is associated with more serious psychological problems among the victims, reduced access to mental health care, poor adherence to treatment, and unfavorable outcomes. Although various nationwide and well-established anti-stigma interventions/campaigns exist in high-income countries (HICs) with favorable outcomes, a comprehensive synthesis of literature from the Low- and Middle-Income Countries (LMICs), more so from the Asian continent is lacking. The lack of such literature impedes growth in stigma-related research, including developing anti-stigma interventions.

Aim: To synthesize the available mental health stigma literature from Asia and LMICs and compare them on the mental health stigma, anti-stigma interventions, and the effectiveness of such interventions from HICs.

Materials and Methods: PubMed and Google Scholar databases were screened using the following search terms: stigma, prejudice, discrimination, stereotype, perceived stigma, associate stigma (for Stigma), mental health, mental illness, mental disorder psychiatric* (for mental health), and low-and-middle-income countries, LMICs, High-income countries, and Asia, South Asian Association for Regional Cooperation/SAARC (for countries of interest). Bibliographic and grey literature were also performed to obtain the relevant records.

Results: The anti-stigma interventions in Asia nations and LMICs are generalized (vs. disorder specific), population-based (vs. specific groups, such as patients, caregivers, and health professionals), mostly educative (vs. contact-based or attitude and behavioral-based programs), and lacking in long-term effectiveness data. Government, international/national bodies, professional organizations, and mental health professionals can play a crucial in addressing mental health stigma.

Conclusion: There is a need for a multi-modal intervention and multi-sectoral coordination to mitigate the mental health stigma. Greater research (nationwide surveys, cultural determinants of stigma, culture-specific anti-stigma interventions) in this area is required.

Key words: Asia, comparison, low-and-middle income countries, mental disorders, mental health, review, SAARC nations, stigma

INTRODUCTION

Stigma is defined as "a set of negative and often unfair beliefs that a society or group of people have about something."[1] Other crucial terms related to stigma are *'stereotype,'* which refers to negative beliefs about a group, such as persons with mental Illness (PwMI) being stereotyped as dangerous or having weak character; *'prejudice,'* which entails the agreement of the individual/society with belief and the negative emotional reaction it invokes in them (e.g., PwMIs may be reacted to with a sense of anger, fear, or pity); and *'discrimination'* manifests as the behavioral response of individuals/societies to prejudice they harbor towards a group of individuals (e.g., PwMIs are often avoided and deprived of employment and housing opportunities).[2]

Stigma is broadly categorized into four types: *'Systemic/Structural/Institutional stigma'* refers to policies and practices of a nation or society, intentionally or unintentionally, that are at odds with the advantages/interests of the stigmatized

group; *'Public and interpersonal stigma'* represents knowledge and stereotypes, prejudice, and discrimination by members of society or community towards people with mental health conditions; *'Self or internalized stigma'* indicates persons with mental health conditions because of their awareness of the negative stereotypes of others either agree with them or turn those prevailing stigmas against themselves; and *'stigma by association'* refers to the attribution of negative stereotypes and discrimination directed against family member(s) of the index person(s) (e.g., parents, spouses, or siblings) or towards mental health professionals (e.g., psychiatrists or psychologists).[3]

Stigma towards mental illness (or associated morbidities) can adversely affect an individual's quality of life.[2] It prevents PwMIs from contacting or utilizing not only mental health (MH) services but health facilities for co-morbid physical illnesses as well, thereby negatively affecting the course and outcome of their health condition(s). Furthermore, stigma puts them in a disadvantaged position in the workplace, which can lead to serious adverse occupational and economic outcomes.[3]

Mental illness and associated stigma act as double jeopardy for the sufferer; PwMIs experience not only adverse consequences of the psychiatric illness (e.g., social, occupational, physical, and marital problems) but also those related to mental health/illness stigma (e.g., access to quality care, lack of occupational opportunities, loss of position in the society).[3,4]

Importantly, cultural factors also play a critical role in the stigma genesis, perpetuation, and adverse outcomes. Literature suggests that myths concerning mental illness vary across nations or societies. For instance, mental illness is considered as an outcome of spiritual incompetency or one's sin in Nepal and India, respectively; similarly, in Arab countries, it is often seen as an outcome of the adverse influence of Jinn or supernatural powers.[1] Likewise, the social support system (e.g., South Korea with better social capital for PwMI vis'-a-vis' China has lesser mental health stigma) and acceptable treatment options (e.g., countries like India, China, Nepal, and Kyrgyzstan have family members with greater reliance on the faith healing/religious coping have greater stigma Vs. The Western world, where the medical model of illness is more acceptable) has a significant bearing on the extent of stigma and outcome of mental disorders.[1-3]

Research demonstrates that certain socio-demographic and cultural factors are associated with higher mental health-related stigma: older age, male gender, low socio-economic status, and religious aspects (Confucianism in China, Buddhism in Nepal, beliefs on Jinn in Islamic nations, etc.) are positively related with the higher mental health-related stigma. It must be emphasized that the characteristics of stigma and its manifestations vary from nation to nation.[3,5,6] For instance, somatization is common in India, where such manifestations are acceptable forms of distress or sickness in society; in contrast, core features of depression or anxiety are common in High-Income Countries (HICs).

Likewise, a country's health system also determines its magnitude of stigma. Nations with higher institutionalization practices and the non-existence of national mental health policy or law to safeguard the rights of PwMIs invite higher stigma (e.g., many Low-and-middle income countries (LMICs)) as compared to the HICs with their well-established policies/legislations/programs to support community mental health services and participatory-care.

Fortunately, many LMICs, including South Asian Association for Regional Cooperation (SAARC) countries (e.g., India, Nepal), have developed and implemented national mental health policies/laws/programs, akin to HICs, which have been shown to reduce stigma; however, the implementation of these public-health measures, or their long-term implications are yet to be evaluated.

Similarly, several anti-stigma campaigns have been adopted by LMICs (Time to change-global (TC-GLOBAL) in Kenya, Nigeria; (SMART) in India; Reducing Stigma among Healthcare Providers (RESHAPE) in Nepal, etc.), akin to HICs, that are aimed at improving mental health literacy and social-contact-based interventions, their comparison with the well-established programs of developed nations (TTC, UK; Opening Minds, Canada; Beyond blues, Australia), or program still requires systematic research exploration.[7-9]

Despite the significance of the topic in the context of the Asian continent and LAMI countries, there is a lack of data comprehensively assessing the effectiveness of anti-stigma programs in these regions of the world. Additionally, there is a dearth of literature investigating characteristics of stigma reduction interventions in Asian countries and LMICs vis-à-vis Western or high-income countries. Moreover, research is scarce in providing insights into culturally relevant and sensitive interventions.

Therefore, to bridge the gap in the existing literature current review aims to highlight the characteristics of stigma in Asian countries, including SAARC nations, and other LMICs, types of ongoing anti-stigma interventions, and compare it with the existing anti-stigma programs of the developed nations. Additionally, we intend to emphasize crucial aspects of these programs, including their cultural nuances and the most effective components of these interventions, and provide future directions.

MATERIALS AND METHODS

PubMed and Google Scholar databases were screened using the following search terms: stigma, prejudice,

discrimination, stereotype, perceived stigma, associate stigma (for Stigma), mental health, mental illness, mental disorder psychiatric* (for mental health), and low-and-middle-income countries, LMICs, High-income countries, and Asia, South Asian Association for Regional Cooperation/SAARC (for countries of interest). Bibliographic and grey literature were also performed to obtain the relevant records. The present review focuses on mental health stigma and anti-stigma literature relevant to the SAARC or Asian countries. Additionally, key research papers or documents from the World Health Organization (WHO), commissions (research bodies, such as the Lancet Commission), and psychiatry bodies (e.g., World Psychiatry Association (WPA)) were also explored to extract pertinent information. The findings of the review are described and discussed narratively. The results have been described under the headings of 1) Characteristics of the stigma of the Asian nations and LMICs (Vs. HIC), 2) stigma experiences by the vulnerable population, such as gender minorities, children, adolescents geriatric population with mental health issues, 3) comparison of anti-stigma strategies in the Asian nations, including SAARC nations, and LMICs (Vs. HICs), 4) effectiveness of anti-stigma interventions in the Asian nations and LMICs, and 5) limitations of the existing anti-stigma interventions in these countries.

FINDINGS

The review found that there is limited data from the SAARC nations. Most of the literature is available as part of the Asian countries.[5,6] Cultural influences, the cultural idiom of distress, literacy in general, mental health literacy particularly, mental health resources (financial and human), the existence of mental health policy, legislation, and community mental health program are crucial determinants of the magnitude of the mental health stigma and success of the anti-stigma program. Significant findings have been enumerated below:

Characteristics of the stigma of the SAARC nations and other LMIC (Vs. HIC) [Table 1]

In SAARC nations and other LMICs, stigma related to mental illness is usually based on the roots of traditional cultural beliefs and myths of specific countries. Other factors to which mental illness and associated behaviors are attributed are paranormal activities and magic religious beliefs, leading to a decreased perceived need for medical treatment. Such attitudes and myths can also be present in well-educated sections of society, including medical students, due to unawareness or ignorance of the medical model of mental illnesses. Such unfamiliarity can further enhance stigma against those seeking treatment in mental health institutes. Seeking medical treatment and thus not following societal norms can also lead to perceived repercussions, for example, family dishonor, deprivation of property rights, or prohibitions like prohibition to marry, etc. Mental illnesses are also often attributed to the weakness of the personality/mind of the patients, their "karma," or their poor upbringing by their parents. They may lead to isolation of the person or family in society or the workplace. However, the studies related to stigma in mental illness are few among SAARC and other LMICs.[10,11]

A sense of paternalistic approach is more common among mental health professionals and authorities, which may sometimes be necessary/acceptable by people to provide medical health services. This can sometimes lead to more Involuntary hospitalization, following old treatment methods and restraints methods, particularly in the absence of a proper national policy for mental health services. Many countries usually lag in legislative reforms like a national mental health policy to protect the rights of people with mental illness and those who have recovered (e.g., Philippines, Lebanon).

Poorly financed mental health services inaccessible to most deprived sections of society, creating a vulnerable section for mental illness and stigma. Poor coverage by insurance and government institutes. Mental health services mainly rely on private NGOs and organizations. There is often a poor organization, distribution, and utilization of services/resources for delivering mental health services, for example, Lebanon, despite having three mental health professionals per 1 lakh, has poor access to people as most are concentrated in a few cities. Thus, a proper framework and policy to provide mental health services and make them more accessible to people are lacking in many SAARC and LMIC countries.

In comparison to HICs, there is more literature as compared to LMICs. The studies indicate that the stigma related to mental illness is more disorder specific than mental illness in different HICs. For example, several studies have shown that the Japanese tend to have more unfavorable opinions about persons with schizophrenia than those from other countries, including Australia, Taiwan, the United Kingdom, and Indonesia. Also, the desire for distance from a PWMI or PWLE is more prevalent. As a result, people often favor institutional care of patients. In HICs, the awareness about mental illness and the stigma related to it is better than LMICs, but still, the stigmatizing attitude may persist in the community or workplace. A more stigmatizing attitude is prevalent for more severe mental illness and disability in HICs.

Stigma experienced by sexual and gender minorities (SGM)

Non-heterogenous sexual orientation or gender minority or sexually diverse or LGBTQ+ community (hence, gender minority group) often face stigma and discrimination in society, which spans across the world, irrespective of their socio-economic advantages.[12] These individuals suffer

Table 1: Interventions against mental health/illness stigma in high income countries (HICs)

Country	Program	Aims and methods	Outcome/remark
Singapore	Beyond the label, 2016	• The first extensive, nationwide anti-stigma campaign in Singapore • A 5-year initiative that seeks to change public perceptions of mental illness through the following means: • Publications and videos for creating awareness regarding stigma faced by PWMI, supporting those in recovery and appreciating their achievements, facilitating more discussions on mental health in the society guiding how to connect and support PWMI in recovery, and promoting a positive role of media in spreading awareness.	• 3rdmedition of the Beyond the Label Campaign launched in 2020 amid greater mental health challenges posed by the COVID-19 pandemic • Multifaceted outreach by sufferers of SMDs organized public education sessions mental health film festivals and outreach talks in schools and community organizations.
	Ninth International Conference—Together Against Stigma—was held in Singapore in October 2019	• Singapore was the first Southeast Asian country to host the 'Together Against Stigma' (TAS) international conference to discuss stigma issues	• It gave an opportunity for the international community to talk and learn about topics associated with mental health stigma, such as the most recent advancements, research findings, and best practices.
Qatar	Wellness Ambassador/2019 (Qatar Foundation, 2019)	• A first of its kind of initiative to improve mental health disorders awareness in schools with a focus on the adolescent population. • Promoting peer-to-peer interaction and support for students. • Under this program selected school students were trained as "wellness ambassadors" under the guidance of licensed psychologists for different mental disorders and to dispel common myths prevalent among other students. • Wellness ambassadors were involved in engaging in daily talks with their peers, social media, facilitating academic activities and campaigns on mental health-related topics	• Active involvement of students in spreading awareness about mental health and students engaged in conversation about mental health with wellness ambassadors • Wellness ambassadors were active in referring or bringing the students in need of mental health interventions by professionals • A significant improvement in the knowledge about mental health was observed in the year-end survey. • After the successful implementation of the pilot program, the program is being implemented in more schools as well and the feasibility of implementing it in ministry schools is being assessed.
England	Time to Change, (2007-2021)	• A social campaign to fight stigma at different levels and in different settings • At workplaces and schools – advocating both attitudinal and structural changes through time to change pledges and providing support, training, or networking to bring about real change at ground level and encouraging the people with lived experience (time to change champions) to share their experience. Supporting schools and colleges to run anti-stigma activities. • At the community level – involving media, running various campaigns to spread awareness, involving private organizations (creating local time to change hub), encouraging volunteers to join the time to change programs	• Also been implemented in Ghana, Nigeria, Kenya, Uganda, and India • Since the baseline in 2016-17, significant people have reported better attitudes towards mental illness, more so since the program started. • People with lived experience reported decreased workplace and social discrimination. • About 2/3rd of People with lived experience who worked with time to change felt more empowered to combat stigma and prejudice related to mental health consequently each year.
Australia	Beyond Blue	• Targets the stigma experienced by people with depression and anxiety disorders promoting nondiscriminatory institutions, systems, communities, and policies. • Initiatives taken under Beyond Blue are National advertising campaigns and supporting resources, media coverage including social media, the beyond blue speaker's bureau (platform for sharing subjective experiences of people with depression/anxiety), Stigma Reduction Interventions: Digital Environments (STRIDE) project, etc.,	• Although Beyond Blue has been effective in its awareness-raising activities but has not been as effective in the reduction of stigma and discrimination due to mental illness. • However, there have been continuous efforts to improve the strategies.
	Batyr program	• Focus on the young population • Stigma reduction through sharing of lived experience • Prevention and early intervention through mental health education • Training and employment pathways for young people with lived experience of mental illness	• 65% of students reported greater intentions to seek treatment after participating in the program, compared to a national average of 22%.

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Table 1: Contd...

Country	Program	Aims and methods	Outcome/remark
	National Stigma and Discrimination reduction strategy	• A project by the national mental health commission, Australia • Aims to implement foundational actions across settings to address stigma and discrimination, reduce self-stigma, public stigma, and structural stigma	• Public feedback on the draft was taken from November 2022 to February 2023, thus giving all stakeholders an opportunity to express their views on the draft. • The draft has been released with specific actions, timeframe, the responsibility of implementing to the concerned authority, and expected outcomes to achieve the objectives
New zealand	Like Minds, Like Mine 1996	• One of the first comprehensive national initiatives to fight discrimination and stigma against PWMI. • Anti-stigma media campaign focused on addressing prejudice and discrimination associated with mental distress and promoting greater social inclusion by utilizing a "human rights-based approach to disabilities" • Promotes new inclusive attitudes, behavior, and structures and • Provides mental health support to individuals with mental distress	• Considered as one of the most successful programs against stigma and discrimination against PWMI • Significant improvement in attitudes towards PWMI among population esp. youngsters • The cost-benefit analysis reveals a benefit of about 13 dollars for every dollar spent in this program.
Japan	WPA led an international anti-stigma campaign called "Open the Doors" from 1996 onward involving over 20 countries, with Japan being the only Asian participant.	• Aims to increase awareness and knowledge of schizophrenia, its treatment • Decreasing stigma against people with lived experience concerning schizophrenia • Encouraging actions/initiatives to end discrimination against those with schizophrenia	• Literature on the outcome of this program is not available in these countries
	In 2002, the JSPN undertook its first nationwide anti-stigma intervention in Japan by changing the Japanese name for schizophrenia, "seishin-bunretsu-byo," which means "mind-split disease," to "togo-sitcho-syo," which means "integration disorder."	• First in the world taken to reduce stigma by renaming schizophrenia, a move that was subsequently followed by other countries (Desapriya and Nobutada, 2002	• Sato has reported that, over a period of 3 years, the renaming increased the percentage of cases in which patients were informed of the diagnosis increased from 36.7% to 69.7%. • 86% of psychiatrists found the new term to be more suitable to inform patients of the diagnosis and explain to them the modern concept of the disorder (Sato, 2006). • Articles that linked schizophrenia to danger were increasing in frequency before renaming schizophrenia but started to decrease after renaming (Aoki *et al*., 2016) • However, research also shows that between 1985 and 2013 articles on schizophrenia contained more negative words than depressive disorder and diabetes mellitus (31.5%, 16.0%, and 8.2%, respectively); hence, renaming schizophrenia might have a limited effect (Koike, Yamaguchi, Ojio, and Ando, 2018).
	Educational programs for local communities have also been arranged (Yamaguchi, Mino, and Uddin, 2011)		• Year-long video interventions, using filmed social contact, were more effective in reducing stigma than a self-instructional internet search (Koike *et al*., 2018).
Czech Republic	"On the Level" 2019	• An initiative using a targeted approach focusing on health care professionals, social care workers, public administrative workers, communities nearby mental health institutes, PWMI, and their caregivers via - • 1. Festival activities like "NA Hlavu" (means "On the Head" in English) - a multimedia festival includes activities like movie projection, discussions, lectures, quizzes, leaflets, etc. • 2. Health weeks (annual events comprising public lectures, concerts, discussion on mental health, displaying works of PWMI)	• Marginally more favorable attitudes towards PWMI, less stigmatizing attitudes • However, the desire for future contact with PWMI did not show any change.

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Country	Program	Aims and methods	Outcome/remark
	Mental health care reform, 2013	• Aims to improve the quality of life of people with mental health problems through 10 implementation programs consisting of the three community mental health programs , deinstitutionalization, multidisciplinary, new services, de-stigmatization, early detection, and early intervention, the project Strengthening Evidence-based Mental Health Care Development and the project Analytical Support for Mental Health Care Reform	• Increased awareness about PWMI among the population • Lesser stigmatizing attitude • However, no statistically significant improvement in intended behavior between 2013 and 2019
Spain	OBERTAMENT campaign	• Mass media campaign • Aims to educate public about stigma and discrimination faced by PWMI and their consequences on PWMI	• Improvement in attitudes and a slightly stronger desire for future contact
Sweden	Hjärnkoll campaign	• To encourage openness and awareness about mental health problems • Ambassadors people with experience of mental health problems share their stories in different settings	• Positive outcomes in terms of both attitudes and desire for future contact

Canada	Opening Minds (OM) - General and Working Minds	• Largest mental illness anti-stigma initiative in Canada by MHCC, 2009.
		• Aims to
		  • Improve Canadians' attitudes and behaviors towards those who experience mental illness so that they are treated fairly and have the same opportunity to participate in society as everyone else.
		  • To foster an atmosphere where people with mental illness feel at ease seeking support, care, and assistance on their path to wellness.
		• The programs target Health care professionals, the youth, the workforce, and the media
			• Pre- and post-surveys of media campaigns have failed to produce a meaningful change in people's attitudes to mental illness and PWMI.
			• Whereas contact-based education (sharing of their own experience by people with lived experience) has been found to be most effective in combating stigma.
			• TWM (The Working Mind: Workplace Mental Health and Wellness program) – developed by the OM initiative, it has been well received by the target population and found to have a positive, but short-lasting, impact.

Denmark	One of us 2011	• Aims to reduce stigma related to mental illness in Denmark • A national initiative with local and regional components to mitigate stigma • Social contact with PWLE of mental illness and target groups • Encouraging dialogues through social media • Making PWLE of mental illness as ambassadors and serve as a key to various programs and activities • The first ten years worked as a collaboration between public and private mental health organizations. • In 2021, it merged with The Danish Health Authority	• Survey in between 2010 and 2014 demonstrates a positive change regarding the knowledge about recovery from depression and schizophrenia • Surveys in 2011, 201,2 and 2014 show increased awareness among the population regarding about campaign in subsequent years • Evaluation in 2014 also showed that being an ambassador has a strong empowering impact on the ambassadors' personal life
Lithuania	Lithuanian Mental Health Strategy, 2007	• Policies for effective mental health services in primary care, schools, and social services • Focus on community-based mental health services	• Significant mental health care services have moved into the deinstitutionalized setting, but the stigma associated with mental illness persists
	Mental health ambassador	• Involving PWLE (patients and caregivers) as ambassadors in dispelling myths related to mental illness and treatment.	• It's crucial that such ambassadors are trained, including enhancing their knowledge, attitudes, and skills, in expressing themselves and helping others.
	Measures taken by the government	• Public information campaign to increase mental health awareness • Working group to review the profession and activities from which the PWMI are barred from • First nationally representative survey on attitudes related to mental health and stigma in 2019 • Provisions of publicly funded mental health care services	• Lithuania's suicide rate has decreased significantly over the past decade, and diagnosis gaps between urban and rural areas have shrunken • However, significant stigma around mental illness persists
Thailand	National Education Act (1999) Persons with Disabilities Empowerment Act B.E. 2550 (2007)	• Mentally disabled people have the right to study without any fee for 12 years. • Promoted employment in government services for persons with physical and mental disabilities.	• Specific Mental health anti-stigma program/ strategy is lacking. • Literature assessing the outcome of the existing public health measures on stigma reduction is lacking

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Country	Program	Aims and methods	Outcome/remark
	One-day psycho-educational program for the caregivers of persons with schizophrenia (didactic session, group discussion, and communication skill building) (Worakul P *et al*.)	• A significant change in the knowledge and attitude of the participants towards schizophrenia. • The program was rated as interesting and very useful	• Limitations: pre-post single-arm design. • Change in knowledge and/or attitude may not translate into behavior change.
Hong-kong (Chan 2015)	New Chinese name of psychosis (si-jue-shi-tiao-thought and perceptual dysregulation) in place of jing-shen-fen-lie (mental split-mind disorder).	• Resulted in increased use of 'si-jue-shi-tiao' was found equally across themes. • jing-shen-fen-lie' was decreasingly used in positive/ neutral themes over time	• Less stigmatizing names can have a positive impact in reducing mental health public stigma. • Long-term impact of such policy measures needs to be evaluated and in different cultures.

JSPN=Japanese Society of Psychiatry and Neurology. World Bank Country Classifications by Income Level (https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups)

from various mental health issues (often at a higher rate than the general population), such as depression, anxiety, psychological distress, suicidality, substance use disorders, etc.[12,13] (King and Boonchooduang, *et al*.).[13,14] Cultural norms and practices greatly influence the onset and progression of these psychological problems among the gender minority group. Unfortunately, societies that have greater acceptance and promote nature in terms of same-sex or sexually diverse practices, Hinduism, Buddhism, Confucianism, and Shinto, have now kept a negative view towards individuals from gender minority groups.[12] Moreover, the attitude of the societies or nations also varies within the same region; for instance, countries like Singapore in Asia have less permissible attitudes towards non-heterosexual practices.

Minority-stress hypotheses have posited that because of greater perceived or societal stigma (including structural stigma) towards gender minority groups, the latter are prone to develop several mental health conditions.[15] Moreover, these individuals have limited access to mental health care or psychological support due to barriers to seek mental health care.[16,17] Furthermore, healthcare providers' poor knowledge and attitude or cultural competence towards gender minority groups negatively influence treatment outcomes. Literature suggests that gender-affirmative approaches during the treatment or therapy result in greater treatment adherence and better short- and long-term effects.[16] Therefore, health professionals in general, and mental health professionals in particular, need to be trained in cultural competence and gender affirmative approach to care for persons from the gender minority group. It is crucial to note that sexually minority youth experience higher mental health concerns (vs. heterosexual youth) and stigma related to their sexuality in schools/ colleges, including bullies from fellow students, colleagues, and teachers; therefore, school mental health providers and pediatricians need to be cognizant of these issues among the LGBTQ+ youth and provide timely support and intervention.[14]

HICs have come up with policies, curricula, strategies, or programs that are non-discriminatory and promote greater social inclusion of gender minorities one-two decade ago: British Psychological Associations' Action Plan to improve lives of the LGBTQ people in the UK (2020), National health Services' initiative to train staff in cultural competency and inclusive organizational culture, American psychiatry association's guidelines on working with people from gender minority (2012, updated in 2020).[18,19] Tardively, many countries, both low-and middle-income countries, have followed the policies/action plans of the HICs; Countries like India's effort to ban conversion therapy for the LGBTQ community and the Indian Psychiatry Society's position statement on the LGBTQ community are steps in the right direction[20,21] or China's effort to decriminalize homosexuality or LGBTQ advocacy movements.[22]

Mental health stigma faced by children and adolescents

Not only do adults with mental health issues suffer from stigma and internalized and social stigma, but children and adolescents with mental health conditions and their caregivers and treating mental health professionals (affiliate stigma) experience stigma.[23,24] For instance, a study from Taiwan by Chang *et al*. (2020) shows that the caregivers of children and adolescents with ADHD suffer a great deal from the affiliated/courtesy stigma, which is shaped by the public stigma towards mental illnesses of the children and internalized stigma.[23] Latter, not only has a poor psychological influence on them but also adversely affects their attitude and behavior towards the mental health conditions of their children: low belief in the biological nature of ADHD of children, poor help-seeking, less reliance on the pharmacological or behavioral interventions, and poor adherence to treatment. The authors highlight the necessity to undertake an ecologically sensitive treatment approach, policies that could mitigate the negative image in media towards children with ADHD, and greater communication between the education system and caregivers. Moreover, it emphasizes the need for MHPs to take up outreach activities

to identify and psychoeducate caregivers of children suffering from such neurodevelopmental disorders.[20] Research also shows that interventions addressing the society-wide prejudices and stereotypes involving various stakeholders, such as media, schools, and government, are more beneficial in reducing stigma related to children and adolescents with mental health problems.[24]

Another critical area is stigma related to children and adolescents with mental health concerns encountering the criminal justice system. Stigma towards this vulnerable population creates a divisive narrative, thereby marginalizing them, limiting access to care, and posing barriers to the family members in seeking help, which in turn makes these children more vulnerable to coming in contact with the justice system. Therefore, it is vital that those with adverse childhood experiences need to be identified first, and properly supported, including providing them with a safe environment and providing with adequate professional health care.[25]

Similarly, children and adolescents with higher stigma, a proxy indicator of the occasional bullying victimization, were associated with higher informal (vs. formal) mental help-seeking and non-preference to be labeled as mentally ill.[26]

There are various anti-stigma interventions targeted toward youth with mental health problems, particularly in HICs, Asia, or other regions, that have positive results in terms of decreasing the prevalence of depression, improving mental health literacy, having a positive attitude towards mental health help-seeking and ensuring a stigma-free environment in the school/college campus.[27-29] For instance, bring change to the mind and college toolbox project, an institutionally-supported and students-led project at Indiana University in the US (involving active and passive engagement of the youth in anti-stigma activities),[28] Little Prince is depressed in Hong Kong (audio-visual materials; having both professional and teachers-led interventions) Lai *et al*.,[29] and depression literacy program (lectures of depression, video-documentary on depression, and awareness activities) in Malaysia[27] have brought about positive change in the lives of the individuals suffering from the mental illnesses as well as among youth.

However, these interventions are only limited to select, too high-income Asian countries, and their long-term effectiveness and behavioral change need to be systematically investigated.

Mental health stigma experienced by the geriatric population

Like other age groups, the geriatric population with mental disorders suffers from a great deal of perceived or public stigma towards geriatric mental health conditions, such as depression, suicide, and dementia Herrmann *et al*.[30] Elderlies face double jeopardy in the sense that public or societal stigma is not only restricted to their mental health conditions but also discrimination related to their aging (ageism).[31]

Research shows that geriatric mental health stigma prevails among all the stakeholders: the general population, health care professionals, caregivers of geriatric mentally ill individuals, and persons suffering from mental illnesses.[32]

The prevailing stigma, whether internalized or public, not only delays the identification of mental health problems among the elderly but also acts as a barrier to access care and poor treatment adherence. Moreover, the pessimistic attitude of healthcare professionals towards the course and outcomes of dementia or other old-age mental health conditions (depression, suicide, substance use), on top of the perceived stigma of the elderly, compounds the problem.[33]

Research shows that discrimination and social support indirectly moderate the relationship between stress and depression among the geriatric population.[34] Therefore, it's crucial that policymakers, community leaders, patient-caregiver groups, and healthcare professionals, particularly geriatric psychiatrists, work in collaboration to improve the social support of elderly individuals with mental health conditions and mitigate aging-related discrimination.[32]

Some data indicates that interventions aimed at improving the knowledge and skills of the community/hospice nursing professionals working with the geriatric population in identifying signs and symptoms of depression and ways to communicate with the individuals suffering from mental disorders and referral physicians can substantially reduce stigma related to depression and suicidality among the older.[35] Likewise, a collaborative care model where mental health assessment and treatment is integrated with primary healthcare services for the elderly improves the identification of depression, reduces perceived stigma related to mental health conditions; and that such models are sustainable, effective for both short-term and long-term outcomes, and cost-effective.[36]

However, the available research on the stigma related to geriatric psychiatry is limited to HICs (US, Germany, UK, etc.). Among the Asian countries, the data is primarily restricted to South Korea and China; therefore, greater research on this topic is required from other Asian countries (Indian sub-continent), particularly those investigating the cultural determinants of the stigma in the geriatric population and the positive role community, and the national legislations/programs/policies can play in ameliorating this stigma and facilitate mental health care access and effective treatment.

Characteristics of commonly used anti-stigma interventions in the Asian nations or LMICs (Vs. HIC) [Table 2]

As compared to the HICs or global north, anti-stigma interventions are limited in Asian/SAARC countries or LMICs; moreover, these interventions are restricted in terms of the region and targeted population (e.g., entire population vs. specific population, mental illness vs. disorder-specific interventions). Below we have enumerated the characteristics of the available interventions in the LMICs or Asian nations:

1. Educational strategies – Creating awareness about mental illness and related stigma is one of the major strategies to combat stigma in SAARC and other LMICs. The various components of education involve busting the myths prevalent in society, explaining the medical concept of mental illness, letting them know that mental illnesses are treatable and manageable, and how to identify various mental health conditions and seeking medical help early. Also, how to cope with caregiving-related burdens. Various means are being used for spreading awareness, for example film festivals and movie clubs, marathon runs, involving famous personalities to educate or share their own stories, using simpler methods of mental health education dissemination like videos, movies, etc., a sensitive and appropriate portrayal of mental illness in media, a social media campaign to target prevalent myths, providing a platform to the PWLE to share their experience.[37-39] Various NGOs are also involved in creating awareness.[10,40] Changing the names of the psychosis/schizophrenia to less stigmatizing term in some Asian countries have shown a reduction in public stigma or negative stereotypes in print/social media. The feasibility and effectiveness of such nomenclature change can be explored by other nations/societies.[41,42]
2. **Legislations –** legislation plays a vital role in protecting the rights of PWMI, ensuring mental health services are easily accessible and free of discrimination, and the right to study/work and prohibiting discriminatory structural and behavioral discrimination, involuntary admissions, inhuman treatment, unnecessary restraints in homes or hospitals, deprivation of societal, workplace and marriage rights. Many Asian countries (India, China, Philippines), including LMICs (Bangladesh, Sri Lanka, etc.), have developed national mental health legislation to ensure right-based care for PWMI.[43-46] However, the specific anti-stigma program is still lacking in many Asian/SAARC nations.
3. **Services-oriented strategies –** Access to healthcare for mental illnesses remains a significant challenge in Asians and many other LMICs. The constraints include poor connectivity, fear of isolation from society, and financial burden due to hospitalization and medications. Hence, strategies like community-based treatment to minimize the isolation of the patients and family, provision of free medicines, and hospitalization also remove the financial constraints as a barrier to seek treatment. The District Mental Health Program of India, the 686" program of China, the RESHAPE program of Nepal, and skills training in mental health care for nurses, teachers, and police are notable programs/strategies in this direction.[47-49]
4. **Special programs** – There is overall a few special programs against stigma in Asian and SAARC countries. Some of the available anti-stigma programs in this region are Open the Doors for Schizophrenia in Japan, RESHAPE Nepal, SMART mental health India, and TIME TO CHANGE GLOBAL (India and African countries).[39,49-51] However, these programs are restricted to an individual disease or a local area.

Compared to SAARC or LMICs, the interventions in HICs are nationwide, incorporating several mental illnesses and targeting specific populations. With mental health policy and legislation already in place, most anti-stigma activities are program based. For example, the "Wellness Ambassador" program in Qatar targets adolescent mental health and students in schools and colleges. The "Time to Change" program in the UK and the "Opening Minds" program in Canada involves specific interventions for different setting and age groups like workplace, schools, and community levels. Similarly, the "Beyond Blue" program in Australia deals with stigma related to depressive and anxiety disorders in the Australian population. The "Like Minds Like Mine" program in New Zealand focuses on strategies for the inclusion of PWMI or PWLE into the community. One of the strategies to reduce stigma against schizophrenia in Japan and Hong Kong was to rename the disorders and have evidence of decreased stigma. Moreover, literature is also available regarding the above program's effectiveness in improving the population's knowledge, attitude, and behavior toward mental illness or PWMI.

Effectiveness of anti-stigma interventions in Asian countries/SAARC nations and LMICs

The awareness campaign in SAARC nations has been mostly successful in increasing the target population's knowledge, but how much of it is translated into a change in their behavior is still under-research.[52] On a positive note, the legislation has successfully brought down involuntary hospitalization.[53] However, the literature regarding the effectiveness of various strategies and the outcome study of the above legislation in mental health stigma reduction is still lacking.

Limitations of the anti-stigma interventions in the Asian countries/SAARC nations and LMICs

Overall, there is a dearth of studies in Asian countries/SAARC nations and LMICs on stigma related to mental illness and the effectiveness of various strategies being implemented at present. Given the lack of resources, the common limitations

Table 2: Interventions against stigma towards mental health/illness in low- and middle-income countries (LMICs) and Asian countries[$]

Country	Program	Aims and methods	Outcome/remark
Argentina	National Law on Mental Health/2010	• Aims to allow individual freedom in deciding admission to psychiatric facilities and subsequently close psychiatric hospitals	• Although the Law is aimed to reduce stigma attached to mental illness, a specific anti-stigma strategy is non-existing.
Brazil	Psicofobia, 2011	• A campaign of the Brazilian Association of Psychiatry. • Aims to fight stigma and discrimination against people who have mental conditions. • Creating Psychophobia[#] awareness by using social media provides a platform for PWMI to share their lived experiences.	• The campaign has received support from famous personalities and participation from society. • Gives PWMI a stage to voice their issues and guide them on how to fight stigma. • Additionally, the country passed a law considering Psychophobia as a crime.
Mexico	Arteyestigma/2020	• Publish the history of artists that have publicly shared their experience with mental illness in the official journal of the Mexican Psychiatric Association • Make the concept of mental illness and psychiatric treatment less threatening for individuals	• The outcome study of the campaign is awaited
	New Model of Care for Mental Health, 2002	• To eliminate human rights violations caused by old models such as inhumane care, and involuntary psychiatric treatment	• No relevant English literature found on the outcome of the model
China[$#]	Mental health reform program ("686" program) in 2004 two National Mental Health Working Plans • China National Mental Health Working Plan [2008–2015] • China National Mental Health Working Plan [2015–2020]	• Increase the availability of community-based mental health services and facilitate recovery. • Registration of patients with SMD, providing them free medications and hospitalization and training health professionals in the management of SMDs • Government officials and health professionals have disseminated mental health-related information through books, flyers, articles, videos, and films	• No specific anti-stigma strategy/program • Implementation research and the long-term impact of these interventions are awaited.
	Mental Health Law in 2013	• Protect the rights of the mentally ill persons. • Encourages the voluntary admission of patients, protects their rights to study, work, marry, and receive treatment, and fights against prejudice in the workplace, schools, healthcare, and public settings	• No decrease in involuntary hospitalization over the years, instead there was small, but significant, increase in involuntary hospitalization • Physical restraints are still common.
	Guangzhou mental health program (one-day course for community mental health staff)	• Reduce self-stigma and self-discrimination; • Improve knowledge, attitudes, and behavior; • Address structural stigma	• Long-term outcome not assessed • In the absence of a control group, the key factor behind these changes cannot be ascertained.
Indonesia			• Indonesia
	A film festival on mental health	• First of its kind initiative, films were made with a local psychiatrist cast, and this was done for the primary purpose of educating the public on mental health. • Films were distributed to different regions, training institutions, local communities, and selected cinema theatres.	• The measures are the beginning, and a concerted effort from the government and private sector is needed
	Marathon runs	• Aimed at raising awareness about depression, and celebrities have attended these events as well	
	Famous local celebrities, directors, and producers of theatre play	• Tackling sensitive stories on depression and suicide and actively partnering with psychiatrists to debrief and educate the audience after a play.	
	Philippine Mental Health Act, 2018	• To enhance the delivery of mental health services • Protect the rights of PWMI	• Emphasis on integrating mental health into general health framework. • Struggles to obtain stability both in terms of mental health promotion and economic stability which affect each other in a vicious cycle.

Contd...

Table 2: Contd...

Country	Program	Aims and methods	Outcome/remark
India [$]	District Mental Health Program 1996	• Reaches out to people in the community and attempts to reduce stigma via lectures, training programs, and social contact interventions (including both direct and filmed) • Community-based health workers play a key role to communicate, model and shape positive attitudes (M Koschorke *et al*.)	• Still there is a lack of national mental health anti-stigma strategy. • The impact of this programme in terms of quantitative reduction in stigma has not been systematically evaluated. • Outcome data is lacking. • Implementation in ground level needs to be assessed.
	Movie club approach	• A psychiatry movie club approach has also been used to spread awareness, reduce stigma, and train mental health professionals (Kalra, 2012)	• Doesn't have a control arm. • A priori confounders were not accounted for.
	Non govermental organisations (NGOs)	• A film festival organized by the Schizophrenia Research Foundation titled "The Frame of Mind" features several short films on mental illness and convenes an international competition for short films on mental health and stigma. • Regular newsletters and run websites to enable the community to learn more about their work	
	Indian Psychiatry Society in collaboration with the Live Love Laugh Foundation launched a national mental health anti-stigma campaign	• The famous celebrity of the country dispel myths concerning mental health. • Sensitization of the public about depression and mental illness- Together Against Depression	
	SMART Mental Health (Education, social contact, celebrities, drama, animation videos; focused on help-seeking and recovery)	• Improve knowledge, attitudes, and behaviors related to mental health and • reduce stigma perceptions related to help-seeking	
Kenya, Nigeria, Ghana, Uganda, and India	Time to Change Global	• Reduce self-stigma and self-discrimination; improve skills; improve knowledge, attitude, and behaviour. • Marketing campaigns in capital cities via traditional (e.g., billboards) and social media platforms to disseminate information and dispel myths associated with mental health conditions; training of 111 champions to run events	• A significant positive change in stigma-related outcomes in both Ghana and Kenya
Lebanon	National Mental Health Program (H Kerbage)	• Aims to raise awareness about psychiatry and to offer training for professionals in primary healthcare centers • Part of a 5-year (2015-2020) strategy to reform mental health care in the country	• Some of the planned goals of this program have yet to be met because of a lack of governmental funding, leaving it to financial support by civil society.
Nepal [$]	Reducing Stigma among Healthcare Providers (RESHAPE)	• Reduce mental health stigma among primary care providers (PCP) and improve the quality of care through the active involvement of PWLE and caregivers • Social contact through PhotoVoice recovery narratives, dispel myths, and interaction with an aspirational figure	• PCP reported a better subjective understanding of the patient's experiences, more confidence in the ability to identify and treat PWMI, more willingness to initiate psychological services • Quantitative measurement showed significant reduction in social distance scale and more accurate diagnosis of patients
Liberia	Carter Centre Mental Health Programe	• Reduce stigma among key Stakeholders (e.g., health workers, police officers, journalists, pharmacists, religious leaders, and teachers); promote the involvement of PWLE in advocacy organizations and policy-making	• Social contact through engagement with PWLE; develop positive messaging in media; skills training in mental health care for nurses, teachers, police, etc. • Outcome data is lacking.
Turkey	National Mental Health Policy (Ministry of Health of Türkiye [MHT], 2006	• Acknowledging the necessity to tackle stigmatization	• However, since then neither the congruously adopted action plan from 2011 has proven efficacious, nor have there been efforts to develop a concise legal framework • Efforts of NGOs have been sidelined and failed.

Contd...

Table 2: Contd...

Country	Program	Aims and methods	Outcome/remark
Bangladesh[$]	Mental Health Act, 2018 National Mental Health Policy, 2019 National Mental Health Strategic Plan 2020-2030	• Mental health has been included as part of the social and economic development of Bangladesh • Aims to protect persons suffering from mental illness's property rights and provides measures for mental health services	• The new mental health act, a strategic health plan to address mental health in the country, is a welcome step. • Lack of nation-wide anti-stigma campaign. • The act however neglects the low mental health funding which is necessary for building mental health resources • Early career psychiatrists are speaking in social media against mental health stigma.
Pakistan [$]	BasicNeeds Pakistan, 2011	• It is a nonprofit organization that offers mental health training to community volunteers, raises awareness of mental diseases and common symptoms, and dispels stereotypes or stigma	• Established the Centre for Women's Enterprise and Development in 2016 for creating career opportunities for women suffering from mental diseases. • Nation-wide anti-stigma program is lacking.
	the Pakistan Mental Health Ordinance, 2001	• It is related to the treatment of PWMI and management of their property and other matters	• It replaced the lunacy act of 1912 • Derogatory terms related to PWMI, and related terms removed, criminal and civil liability, human rights, decreasing the days of forced detention. • However, is not directly targeted toward the stigma of mental illness
Armenia	Outpatient project in Gegharkunik Marz by Médecins Sans Frontières (MSF)	• PWMI is treated by a multidisciplinary team • All services, including medication free of cost and right of PWMI given due importance. • Confidentiality respected • Educating the general population to encourage people to look for treatment and correct misconceptions • Advertisements on television, outreach campaigns, banners, and a schedule of special activities, including a run for kids on World Mental Health Day, to encourage them to talk about mental health issues.	• Surveys showed more involvement of respondents and an increase in awareness of services available. • MSF psychosocial program has been handed over to NGO "Mission Armenia" and the Ministry of Health (MOH)
China, Ethiopia, India, Nepal, Tunisia	International Study of Discrimination and Stigma Outcomes (INDIGO) partnership, 2018	• A 5 year research programe funded by the UK Medical research council • To further the research on the mechanism of stigma and reduce stigma in PWMI in LMICs and to establish a strong, sustainable collaborative research consortium	• Contributes to the field of stigma research in relation to mental health through the development of cross-cultural packages of assessment tools for stigma research, the provision of strategies for multi-level stigma reduction, and culturally and contextually appropriate anti-stigma interventions.
Sri Lanka[$]	Social media outlets- Sri Lanka Society of Psychiatry Community-Based Mental Health Care Package*for Children in Areas of Armed Conflict	• Improved case detection improved mental health care accessibility	• Need for integration of treatment for severe mental disorders, stronger involvement of families, and strengthening of primary prevention approaches

[#]'Psychophobia' term coined to define prejudice against persons with MHDs; [$]represents Asian countries; *mental health promotion activities in the communities, community sensitization and psychoeducation to increase awareness of the mental health needs of children, targeted subgroups of children with elevated psychosocial distress, providing individual counseling to reduce symptoms and improve functioning. NGO=non-government organization, SMD=Severe mental disorders, PCP=Primary care providers. [#]China is now classified as upper-middle-income country. World Bank Country Classifications by Income Level (https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups)

may include a lack of proper funding for mental health services in resource-poor countries; most countries still do not have updated legislation and proper guidelines for the treatment of mental illness and for protecting the rights of PWMI. Another critical factor is improper organization and distribution of mental health services which may lead to a difficult-to-reach population devoid of services.

WAY FORWARD

Greater research is required from Asian and SAARC countries, particularly Afghanistan, Bangladesh, Bhutan, Maldives, and SriLanka. Targeted, at different levels (structural, societal, and self-stigma), anti-stigma interventions that are evidence-based as well as innovative need to be utilized and

developed to address mental health stigma in the Asia and LAMI nations. Some of the critical issues around this are enumerated below:

Structural stigma: To counter structural or organizational stigma, countries need to adapt WHO-package guidelines on Mental health Policy, Legislation, and national programs.[54] A rights-based approach to mental health care, treatment, and rehabilitation is to be followed. Recently, countries like India (Mental Healthcare Act, 2017) and China (National Mental Health Law, 2012) have developed their national mental health policies, action plans, and laws; other countries must develop and implement similar public health measures. Although developing and implementing such policies/laws can prevent mental health stigma to a greater extent, their ground-level implementation and effectiveness in reducing all forms of stigma (structural, social, and individual) need to be assessed, including access to quality care.

Although several nationwide anti-stigma campaigns have been undertaken in many LMICs, including SAARC nations, however, effect-size of such interventions is low.[3,55] This could be attributed to their non-specific nature (one-size-fit-all approach to all the mental disorders and for all the target groups), heavily based on educative/cognitive component, lesser involvement of PWLE, not having a multi-model approach (involving PWLE, health professionals, media, social activist, NGOs, etc.).[3,9,56] Hence, more tailored- target group-specific and disease-specific- interventions, which bring about an attitudinal and behavior change among the public and PWMI or their caregivers, are to be designed and implemented. Involving PMLE at all stages of the intervention is vital in this context.

As stigma and its manifestations are determined by several socio-cultural factors, targeting them is the cornerstone of any anti-stigma program.[4,7] In this regard, anti-stigma measures need to involve religious leaders, faith healers, and community leaders while developing and implementing such interventions for the former to be culturally sensitive and relevant.

Anti-stigma interventions must follow a Bottom-up approach (from community to policy level) rather than a top-down approach (from policy and program to impractical implementation in the community). This will ensure that such programs will have such components. One such successful example is the Open Minds program of Canada.[9]

Integration of mental health care into general/primary health care is paramount.[3,4] This would not only reduce stigma related to mental illness and improve access to care but also ensure comprehensive care to co-morbid physical illnesses among PwMI and better treatment outcomes.[4] In this context, community health workers (medical officers, nurses, and allied staff) must be trained to assess and manage mental illnesses (including referral to the specialist).

Media and mental health

In terms of mental health stigma, media can act as a double-edged sword. There is ample literature that suggests that media can lead to the worsening of stigma through propelling misinformation, myths, and stereotyping of mental health conditions, including suicide. Hence, there is a dire need for responsible media coverage of mental health issues. Although several countries have developed media guidelines for reporting mental health conditions, they are rarely followed in their letter and spirit; moreover, many Asian and LAMI countries and LMICs do not have such specific guidelines. However, the media has the potential to dispel myths and stigma related to mental health conditions. They can have a significant role in anti-stigma campaigns that can promote mental health promotion, educate the public about mental health, and provide a valuable platform to the PWLE, thereby facilitating contact-based anti-stigma interventions.[39,55]

Sustainability of anti-stigma programs: for anti-stigma interventions to be sustainable, they need to be integrated with a larger government priority, such as the government's response during the COVID-19 pandemic, which also involves anti-stigma measures against mental health and frontline HCWs.[3]

Interpersonal stigma

Furthermore, anti-stigma interventions should involve community-health workers and employ social-contact-based interventions involving communication between PWLE and health workers; this would be more effective than traditional education-based and patient-caregiver-limited anti-stigma measures.[3,49,51]

Importantly, medical curricula and social sciences must incorporate the topic of stigma (including intersectionality: conditions commonly associated with stigma HIV/AIDS, Leprosy, marginalized individuals) so that young professionals get sensitized about the mental health stigma and its social construct, put effort to prevent or manage it.[57]

One of the common places where mental health stigma is prevalent and associated with significant adverse outcomes is the workplace. Literature, including one from Japan, suggests that workplace-based anti-stigma interventions can substantially reduce stigma and improve the work performance of PwMI.[58,59] The positive impact of such workplace-based interventions has also been reported by Guangzhou mental health program in China; however, workplace-based anti-stigma interventions are largely elusive in other Asian and LAMInations. Therefore, SAARC

nations must come up with workplace-based anti-stigma initiatives. Such programs should involve components of social contact and take on board the key personnel from the workplace (supervisors, managers, etc.).

Likewise, School-based interventions can reduce mental health stigma significantly.[60] Notably, mental health first aid (MHFA) delivered through the gatekeepers and activities involving arts, stories, videos, and role-plays are key strategies concerning this.[3] SAARC nations need to come up with more school-based anti-stigma interventions that suit the cultural and population characteristics of these countries.

Community participation while planning and delivering anti-stigma interventions is crucial. Anti-stigma programs must target key members/groups of society, such as community leaders, police, and religious leaders, for them to be effective.[61]

Family education and the involvement of caregivers in planning and delivering interventions aimed at reducing stigma are essential to decrease interpersonal and affiliate stigma. This will also empower caregivers and patients to tackle mental health-related stigma and contribute to their recovery.

Champions or aspirations individuals who have overcome their mental health problems and are successful in their respective fields- need to be involved or instead lead various interventions targeted towards stigma in SAARC nations; this has shown positive effects in the developed countries. This will reduce interpersonal stigma and ameliorate individual or perceived stigma. Media can play a vital role by providing a platform to such champions.

Individual stigma

Literature suggests that removing derogatory terminologies related to mental disorders can markedly reduce mental health stigma. Asian Countries like Japan and Hong Kong have replaced stigmatizing terms related to schizophrenia (mind splitting) with more informative or neutral terms such as integration disorders and incoordination between thoughts and perception.[6,7] Similarly, SAARC countries need to come up with non-stigmatizing terms for various mental disorders. The task force of the World Psychiatry Association (WPA) against stigma sub-committee and various psychiatric societies of the member countries, in collaboration with the World Health Organization or national agencies, can contribute to this.

Balanced psychoeducation about mental illness to PWMI can help reduce personal stigma significantly. It must be highlighted that a pure biological model of mental illness can instead worsen the stigma among PwMI;[49,55] therefore, psychoeducation should be contextual and balanced, incorporating components of biological, psychological, and social determinants of mental illnesses. Asian countries and LAMInations should come up with a guideline for psychoeducation of various mental disorders that are socially acceptable and culturally appropriate. Agencies like WPA and national psychiatry associations/societies can work towards this.

As highlighted previously, in many SAARC nations (India, China, Nepal, etc.), mental illnesses have been linked to a character flaw, religious/spiritual deviance of an individual, and the outcome of paranormal or supernatural influences; this attitude gives rise to stigma right from inception of mental health conditions and at the grass-root level.[4,6,7] The latter not only promotes stigma but also limits access to care for PwMI. Hence, it is essential that mental problems should be normalized and medicalized in these nations, which have shown positive results in reducing stigma, and mental health professionals and health workers must play a key role in this Avari *et al*.[62]

Fostering an approach of participatory mental health care (involving patients and their caregivers and MHPs) can reduce individual stigma substantially.[63] Fortunately, India and China have emphasized participatory-based mental health care in their mental health policy; their implementation and outcomes need to be investigated through robust research design.

CONCLUSIONS

Mental health stigma is prevalent worldwide; however, its determinants and manifestations can vary from country to country. Socio-cultural factors play a critical role in the onset of stigma, its perpetuation, and the success of anti-stigma measures. Literature suggests that forms and extent of stigma in Asian countries, more so in SAARC nations, are different from the Western world. However, there is limited data from the Asian and LMICs concerning stigma, including anti-stigma measures. Although countries like China and India have developed national mental health policies and laws to safeguard the rights of the PWME and curtail stigma, other SAARC nations have yet to join the league. Furthermore, the impact of such policies/legislation in tackling the stigma is yet to be researched. Few innovative and social-contact-based programs (SMART in India, RESHAPE in Nepal, and TTC- global) have been undertaken in SAARC nations; their long-term effectiveness required to be investigated; other SAARC nations must all research the effectiveness of such initiatives in their social context or come up with the relevant anti-stigma campaigns.

Stigma against vulnerable populations, such as gender minorities, children and adolescents with mental health conditions, and geriatric groups with psychiatric conditions, must be systematically investigated, and specific anti-stigma

interventions should be developed considering the cultural nuances of the Asian countries and their available resources.

Mutual knowledge sharing between the HICs and LMICs and among the LMICs should be promoted; collaboration with international (WHO, WPA) and national agencies (national psychiatric associations, NGOs) is paramount in countering stigma in SAARC nations. Involvement of PWMI in all stages of the anti-stigma programs, community and stakeholders' participation, sensitization of health professionals, particularly medical undergraduates, concerning stigma, and collaboration with media are vital strategies in reducing stigma. Greater research is required in the SAARC countries concerning the cultural determinants or nuances of the stigma, stigma registry to gauge the magnitude of stigma, and culturally sensitive and relevant anti-stigma programs.

Note

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