



Exploring Public Stigma Towards Mental Illness in Windhoek, Namibia: Global Perspectives and Implications for Intervention

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Abstract

This study examines public stigma towards mental illness in Windhoek, Namibia, focusing on the level of stigma, attitudes towards people with mental illness (PWMI), and the demographic variables that may influence these attitudes. Using a mixed-methods approach, the study employed the Community Attitudes towards the Mentally Ill (CAMI) scale to survey 150 participants, analysing data with inferential statistics. Additionally, three focus group discussions were conducted with participants from different socio-economic backgrounds to explore views on mental illness. The study found an overall public stigma level of 41 per cent according to the CAMI scale. Key demographic factors such as age, gender, and education were associated with higher stigma levels, with older adults, men, and those with lower educational attainment displaying more negative attitudes. Furthermore, participants from lower socio-economic groups held more misconceptions and misinformation about mental illness than those from higher socio-economic backgrounds. The study highlights the need for targeted interventions to reduce stigma, with strategies such as contact, protest, and education being particularly relevant in the Namibian context. These findings underscore the importance of addressing public stigma in mental health care and the necessity for further research and development of mental health services in Namibia.

Introduction

Mental illness is defined as a clinically significant disturbance in cognition, emotion regulation, or behaviour, typically associated with distress or impairment in functioning, and reflecting a dysfunction in underlying psychological or biological processes (World Health Organisation, 2022). Globally the stigma associated with mental illness remains a significant barrier to mental health care access and social inclusion (Faletia & Akinlotan, 2024). In African contexts public stigma is deeply rooted in cultural beliefs, misconceptions, and systemic neglect of mental health services. For example, Sichimba et al. (2022) found that

cultural beliefs relating to bewitching, demon possession, and sexual relations with uncleansed widows are often used as the lens through which causes of mental illness are explained in Zambia. Egbe et al. (2014) found in a study in South Africa that misconceptions about mental illness are propagated by family members, friends, employers, community members, and health care providers alike, resulting in delays in appropriate help-seeking and consequent prolonging of suffering. Ghana, South Africa, Uganda, and Zambia are but a few countries in Africa admitting neglect in the provision of national mental health services (Bird et al. 2011). Namibia, like many countries in sub-Saharan Africa, continues to face challenges in addressing



public stigma regarding mental illness ([The Namibian, 2025](#)).

Public stigma is characterised by negative attitudes, stereotypes, and discriminatory behaviours directed towards individuals with mental health conditions ([Sanabria-Mazo et al. 2023](#)). These attitudes contribute to social exclusion ([Rössler 2016](#)), delayed help-seeking behaviour ([Amatya et al. 2018](#)), and poorer mental health outcomes ([Link & Phelan 2006](#)). Research has demonstrated that demographic factors such as age, gender, education level, and socio-economic status influence the degree of stigmatisation ([Girma et al. 2013](#)). However, empirical data on public attitudes towards mental illness in Namibia remain limited. While previous studies have explored mental health stigma among specific professional groups, such as health workers ([Mutiso et al. 2017](#)), the perspectives of the general urban public remain under-researched.

Given the increasing urbanisation of Namibian society ([Weber 2017](#)) and the rising awareness of mental health issues ([Mukokobi 2025](#)), it is essential to understand current public attitudes towards mental illness. This study aimed to evaluate public stigma towards mental illness among residents of Windhoek from different socio-economic groups through a mixed-methods approach utilising the Community Attitudes to Mental Illness (CAMI) scale and in-depth interviews. Findings from this research are intended to inform future public health strategies and anti-stigma initiatives in Namibia.

This study is grounded in two foundational frameworks: [Goffman's \(1963\)](#) theory of social identity and stigma, and [Link and Phelan's \(2001\)](#) conceptualisation of stigma components. Goffman views stigma as a social process wherein individuals are discredited based on attributes society deems undesirable, such as mental illness. This framework highlights public stigma as socially constructed through interaction, where perceived deviance is shaped by cultural norms and societal reactions ([Bos et al. 2013](#); [Pescosolido 2013](#)). [Link and Phelan \(2001\)](#) expand this view by delineating stigma into five interrelated components: labelling human differences, linking these to negative stereotypes, separating labelled individuals from the general population, leading to status loss, and culminating in discrimination. Their model underscores how stigma operates at both interpersonal and structural levels, contributing to exclusion from social and economic opportunities ([Hatzenbuehler et al. 2013](#); [Yang et al. 2017](#)). Together, these theories provide a robust lens for examining how public stigma towards mental illness manifests in urban Namibian contexts, particularly by illustrating how cultural and societal forces reinforce marginalisation. Recent scholarship continues to validate and refine these frameworks, especially within non-Western settings, highlighting stigma's persistence and its implications for mental health outcomes ([Ahad et al. 2023](#); [Ran et al. 2021](#)).

Materials and Methods

A mixed-methods research strategy was used to explore public stigma towards mental illness ([Bryman 2006](#); [Haslam & McGarty 2018](#)). Quantitative data were gathered through a structured survey for

measuring community attitudes regarding mental illness. Qualitative data were collected via semi-structured interviews to explore participants' views regarding mental illness, experiences of stigma and discrimination, reasons for not seeking treatment, and perceptions of differences between mental and physical illnesses. Given the mixed-methods nature of the study, both deductive and inductive reasoning were applied ([Haslam & McGarty 2018](#)). The quantitative component followed a deductive approach by testing predefined dimensions of stigma through the structured survey. In contrast, the qualitative interviews employed an inductive approach, allowing themes to emerge from participants' responses. Applying both deductive and inductive approaches allowed for a meaningful integration of structured, numerical insights from survey data with the rich, lived experiences shared by participants during interviews. Furthermore, data were gathered at a specific moment in time and therefore the research design is cross-sectional ([Coolican 2024](#)). The study was guided by a critical realist ontology ([Scott 2010](#)), acknowledging that while stigma towards mental illness exists as a real phenomenon, people's understanding and experiences of it are shaped by their socio-cultural contexts. Epistemologically, the study followed a pragmatic stance ([Finley 2024](#)), allowing for the use of both quantitative and qualitative methods to explore and interpret the complexity of stigma in the Namibian context.

The population of this study consisted of people currently living in the Windhoek municipal area, constituting approximately 494 085 inhabitants ([ATUUAT Africa 2024](#)). Citizens younger than 18 years, people diagnosed with a mental illness, and people who were not English literate were excluded from the study. A total of 150 participants were included in the quantitative phase of the study, recruited using non-probability convenience sampling ([Coolican 2024](#)). Although the total population of Windhoek is estimated at approximately 494 085, this figure includes all age groups. As the study focused specifically on adults aged 18 years and older, the relevant population is substantially smaller. While a commonly recommended sample size for large populations is approximately 384 for a 95 per cent confidence level and a 5 per cent margin of error ([Daniel & Cross 2018](#)), this applies to studies aiming for general population representativeness. Given the exploratory nature of this study, its focus on attitudes within an adult urban population, and practical constraints, a sample of 150 participants was considered adequate. Moreover, the sampling strategy prioritised breadth across diverse demographic groups within Windhoek's adult population, aligning with similar public health and stigma research that have used comparable sample sizes ([Girma et al. 2013](#); [Sanabria-Mazo et al. 2023](#)). As such, the sample size, while modest, was sufficient for uncovering key trends and supporting meaningful inferences regarding public stigma towards mental illness in the target context. For the qualitative phase a self-selecting sampling method was used, where individuals voluntarily chose to participate ([Colman 2015](#)). Participants were recruited from three socio-economic areas in Windhoek, namely Ludwigsdorf (high), Pionierspark (middle), and Otjomuise (low), each representing distinct socio-economic strata within the city. Socio-economic status (SES) was considered a relevant

factor in the qualitative part of this study, as existing research indicates that attitudes towards mental illness and stigma can vary significantly across socio-economic groups (Girma et al. 2013). One focus group of eight participants was held in each area.

This study employed two instruments: the Community Attitudes towards Mental Illness (CAMI) scale for quantitative data collection, and a semi-structured interview guide for qualitative data. The CAMI scale (Taylor & Dear 1981) comprises 40 items rated on a 5-point Likert scale and includes four subscales: Authoritarianism, Benevolence, Social Restrictiveness, and Community Mental Health Ideology. Higher scores indicate more stigmatising attitudes. The scale has demonstrated acceptable reliability (Cronbach's α ranging from .68 to .88) and has been used in various African contexts, though not yet validated in Namibia. Demographic data (e.g., age, sex, education level) were collected from all quantitative participants. Qualitative data were gathered through focus group discussions guided by an interview schedule exploring community perceptions and stigma towards mental illness. Participants also provided demographic details, including their socio-economic area of residence.

Following ethical clearance from the University of Namibia, participants for the quantitative phase were recruited in Windhoek's city centre. Informed consent was obtained through a consent section at the beginning of the questionnaire, where participants were asked to read a short explanation of the study and indicate their voluntary agreement to participate by ticking a consent box before proceeding. A total of 150 adults completed the CAMI questionnaire, which took approximately five to ten minutes. For the qualitative phase, focus group participants were recruited via community contacts from three socio-economic areas. Prior to each session participants were provided with a detailed participant information sheet explaining the purpose of the study, confidentiality measures, and their rights. Written informed consent was obtained from each participant before the start of the discussion. One focus group was held per area, each lasting approximately 60 minutes. Sessions took place in a neutral private office at the Auas Hills Centre. Participants were debriefed at the end of each session. Transport was arranged for individuals with mobility challenges, and refreshments were provided to ensure a welcoming and respectful environment. Discussions were audio-recorded with participants' permission and supplemented with field notes to ensure comprehensive data collection.

Descriptive statistics were used to summarise demographic information and CAMI scale responses. Inferential statistics, including Spearman correlations, t-tests, and ANOVAs, were conducted to examine differences in attitudes based on demographic variables. Statistical analyses were performed using SPSS Version 29.0. A significance level of $p < 0.05$ was used for all tests. Qualitative data were manually coded and thematically analysed following Braun and Clarke's (2008) approach.

Ethical approval for the study was obtained from the Research Ethics Committee of the University of Namibia. Participation was voluntary, and confidentiality and anonymity were maintained throughout the research process.

Results

The following quantitative findings were obtained from this study:

Some 150 adult participants from Windhoek completed the CAMI questionnaire. The sample was nearly gender-balanced (51% male, 49% female). Age distribution was as follows: 19% were aged 18–24, 33% aged 25–34, 25% aged 35–44, 13% aged 45–54, 6% aged 55–64, and 4% were 65 years or older. Educational attainment ranged from no formal schooling (7%) to postgraduate qualifications (4%), with the largest proportion (36%) having some high school education without a diploma.

The CAMI questionnaire responses were scored on a five-point Likert scale, with higher scores reflecting stronger stigmatising attitudes. Negative items were reverse-coded, and total scores were converted into ordinal data. Analysis of responses from 150 participants revealed an average public stigma score of 41%, indicating a moderate level of stigma towards people with mental illness among adults in the Windhoek region. A Spearman's correlation analysis revealed a statistically significant moderate positive relationship between age and public stigma towards mental illness, $r_s = .443$, $p < .001$. This indicates that older individuals in the sample tended to report higher levels of stigma. Age-group analysis further showed that participants aged 65 and older expressed the highest levels of stigma, while those aged 25 to 34 reported the lowest. Spearman's correlation analysis indicated a statistically significant moderate positive relationship between sex and public stigma, $r_s = .433$, $p < .001$. This suggests that male participants reported higher levels of stigma towards people with mental illness compared to female participants. A Spearman's correlation analysis revealed a statistically significant strong negative relationship between participants' level of education and their level of public stigma, $r_s = -.608$, $p < .001$. This finding indicates that individuals with higher levels of education tended to report lower levels of stigma towards people with mental illness. To determine which demographic variable had the strongest influence on public stigma, a multiple regression analysis was conducted using age, sex, and level of education as predictors. While both age ($\beta = .243$, $p < .001$) and sex ($\beta = .245$, $p < .001$) showed moderate positive effects on public stigma, level of education emerged as the strongest predictor with a significant negative effect ($\beta = -.487$, $p < .001$). The model explained 48.7% of the variance in public stigma scores ($R^2 = .487$, adjusted $R^2 = .477$), indicating a large effect size (Cohen et al. 2003). All assumptions for regression analysis were met, including linearity, independence of residuals (Durbin-Watson = 1.968), homoscedasticity, absence of multicollinearity, and normality of residuals.

The following qualitative findings were obtained from this study:

Three focus groups were conducted, each representing a different socio-economic area in Windhoek. The low socio-economic status (LSES) group included five men and three women; the middle socio-economic status (MSES) group had six women and two men; and the high socio-economic status (HSES) group included five women and three men. Age ranges across groups reflected a broad adult spectrum, with participants aged between 18 and over 65 years, distributed similarly to the quantitative sample. Participants were probed

regarding their understanding of the concept of mental illness, their understanding of mental illness stigma and discrimination, their understanding about why people with mental illness do not readily seek treatment, and their perceptions about the difference between mental and physical illness.

Understanding of Mental Illness

In the low socio-economic status (LSES) group, mental illness was most commonly associated with abnormal behaviour (38%), but spiritual and supernatural explanations were also prominent. One participant remarked, 'Have something sent from God' [P3], while another stated, 'It is something caused through witchcraft' [P2]. Others viewed mental illness as an illness like any other, requiring help and support: 'It's someone who is sick and needs help, like any other disease' [P6].

The middle socio-economic status (MSES) group also emphasised abnormal behaviour (50%) and disturbances in thinking (38%). Participants often linked mental illness to cognitive dysfunction, stating, 'There is a disturbance in their brain that is affecting their thinking' [P7]. A smaller portion acknowledged emotional instability or general illness.

In the high socio-economic status (HSES) group, the dominant theme was emotional volatility (38%), followed by abnormal behaviour and disturbances in thinking. Some participants linked mental illness to stress-related conditions or biological causes, such as a chemical imbalance or genetic factors: 'It's a chemical imbalance, often with some genetic influence' [P17].

Understanding of Mental Illness Stigma and Discrimination

In the low socio-economic status (LSES) group awareness was limited. Several participants admitted not knowing what stigma meant, and one denied its existence altogether. However, others described stigma as manifesting through negative treatment, such as neglect, mockery, or social exclusion. One participant explained that stigma was the belief that people with mental illness could "never be normal" again.

The middle socio-economic status (MSES) group reflected similar uncertainty, with some participants also unable to define the concept. Others described stigma as being linked to societal rejection and diminished legitimacy of mental illness compared to physical conditions. The belief that those with mental illness are irreparably 'not normal' also featured in their responses.

Participants in the high socio-economic status (HSES) group showed greater awareness of stigma as a social construct grounded in misunderstanding and stereotyping. One participant noted, 'You think of *One Flew over the Cuckoo's Nest* when you think of mental illness, you always go to worst case scenario' [P13], highlighting how media portrayals influence public perceptions. Another participant shared a personal insight: 'Mental illness was just a word, until my father was diagnosed with it' [P18], reflecting a deeper empathy developed through lived experience. Others emphasised that stigma persists due to the tendency to trivialise symptoms or dismiss mental illness as less legitimate.

Beliefs About Why People with Mental Illness Do Not Seek Treatment

In the low socio-economic status (LSES) group the most prominent reasons cited for not seeking treatment were a lack of awareness, limited access to resources, and fear of stigma. Several participants explained that individuals might not recognise they were unwell or might be unable to afford treatment. One participant stated, 'They are not able to get help. They need help from someone or there is a lack of resources, like no medications and no money' [P2]. Cultural beliefs also influenced responses, as another participant expressed, 'It came from witchcraft, so hospitals can't treat it' [P1].

The middle socio-economic status (MSES) group voiced similar concerns, particularly financial constraints, fear of stigma, and insufficient family support. One participant remarked, 'They're afraid to be judged and rejected and that their families won't show them love and they'll be abandoned' [P9]. Others highlighted feelings of hopelessness, such as the belief that 'they will never be ok again' [P8].

Participants from the high socio-economic status (HSES) group emphasised stigma, misconceptions about treatment, and self-stigma. As one participant noted, 'Mental illnesses are not given the same legitimacy as physical illnesses, so you're just supposed to "just get over it"' [P14]. Another participant highlighted the internal conflict PWMI may face: 'Seeking treatment means that there is an admission that something is broken or wrong, and most people don't know about it ... so there is this fear of being ostracised' [P17].

Perceptions of Differences Between Mental and Physical Illness

A significant number of participants in the low (LSES), middle (MSES), and high (HSES) socio-economic status groups believed there was no essential difference between the two. As one participant put it, 'It's the same thing, there is no difference' [P1], while another added, 'They both have to do with some type of illness' [P12].

However, nuanced differences were still observed. In the LSES group, some described mental illness as internal and invisible, compared to physical illness which presents with clear symptoms: 'Mental illness is internal, physical illness can be seen externally' [P2]. Others in this group offered spiritual explanations, stating that mental illness is 'sent from God' [P5] or caused by 'a spirit entering a person' [P3].

In the MSES group participants suggested that mental illness may stem from the brain or from internal dysfunctions: 'Mental illness has to do with the brain' [P7]. Others saw it as lifelong and behaviourally evident, stating, 'The way they act, you can see something is wrong' [P9], and, 'A mental illness is a lifelong thing, but physical illnesses can be cured' [P11].

In the HSES group, three participants believed that while both types of illness may have similar origins (e.g., genetic or lifestyle factors), the real difference lies in societal acceptance: 'We just accept physical illnesses more easily' [P13]. Participants also highlighted that medical professionals often treat mental illness differently from physical

illness, contributing to social stigma and health inequities.

Discussion

The findings of this study reveal a complex picture of public stigma towards mental illness among residents of Windhoek. Although a moderate level of stigma towards people with mental illness among adults in the Windhoek region was indicated, this result suggests that while overtly negative attitudes may not dominate, significant misconceptions and social distancing tendencies persist within the community. This more subtle tone of stigma towards mental illness was also observed by [Pescosolido et al. \(2021\)](#), who found with trends in public stigma of mental illness in the United States of America from 1996 to 2018 a decrease in stigma towards depression, but that stigma associated with other mental illnesses, such as schizophrenia, remained persistent. These authors emphasised that while some progress has been made, significant misconceptions and desires for social distance continue to exist within communities. [Jorm and Oh \(2009\)](#) emphasise that social distance – the desire to avoid contact with individuals with mental illness – is a core component of stigma. According to [Jorm and Oh \(2009\)](#) individuals often prefer to maintain a distance from those with mental illnesses owing to misconceptions and fears, reinforcing the notion that moderate stigma levels can still result in substantial social distancing behaviours.

The positive relationship between age and public stigma towards mental illness that was found in the current study suggests that public stigma may decrease among younger adults, potentially reflecting generational shifts in mental health awareness and attitudes. Older generations, such as Generation X and Baby Boomers, often perceive mental illness as a taboo subject, leading to higher levels of stigma. This stigma is frequently rooted in misconceptions and a reluctance to acknowledge mental health issues, resulting in avoidance of treatment and prolonged suffering ([Baral et al. 2022](#)). In contrast, younger generations, including Millennials and Generation Z, tend to exhibit more open attitudes towards mental health. This shift is attributed to increased mental health education, greater exposure to mental health discourse through social media, and proactive anti-stigma campaigns ([Pescosolido et al. 2021](#)). These findings suggest that public stigma towards mental illness decreases among younger adults, reflecting generational shifts in mental health awareness and attitudes.

The findings that male participants reported higher levels of stigma towards people with mental illness compared to female participants align with previous findings that gender differences may influence mental health attitudes, with women often demonstrating greater empathy and lower stigmatising beliefs. In agreement with this finding, a systematic review by [Angermeyer and Dietrich \(2006\)](#) found that women generally hold more positive attitudes towards people with mental illness and are more supportive of seeking professional help. Similarly, a study by [Vogel et al. \(2007\)](#) reported that men are more likely to endorse stigmatising beliefs and less likely to seek psychological help due to concerns about appearing weak or

vulnerable. These findings suggest that societal expectations around masculinity may contribute to higher stigma levels among men. In the context of Windhoek, these gender differences in stigma may reflect broader cultural norms and beliefs about gender roles and mental health. Addressing these disparities may require targeted interventions that challenge traditional masculinity norms and promote greater awareness and understanding of mental health issues among men.

The finding that individuals with higher levels of education tended to report lower levels of stigma towards people with mental illness supports existing literature suggesting that increased educational attainment is associated with greater mental health literacy and more accepting attitudes. For example, [Fleary et al. \(2022\)](#) demonstrates that adults with higher health literacy show lower levels of mental health stigma and are more willing to interact with individuals with mental illnesses. Educational initiatives that are aimed at improving mental health literacy will increase understanding and awareness of mental illness which can lead to more supportive attitudes towards individuals with mental health conditions.

The results of this study furthermore indicate that amongst sex, education level, and age, education level has the largest impact on public stigma towards mental illness. The lower the education level, the higher the probability of stigmatising people who struggle with mental illness. This finding highlights that higher educational attainment is the most influential factor in reducing public stigma towards mental illness in the sampled population, underscoring the potential value of educational interventions in stigma reduction ([Fleary et al. 2022](#)).

Participants from all the different socio-economic statuses with whom interviews were conducted indicated that mental illness can manifest in behavioural and cognitive symptoms. However, lower socio-economic participants specifically attributed spiritual and supernatural causes to mental illness whilst HSES participants leaned towards psychological and biomedical explanations. This pattern aligns with the deprivation-compensation theory, which posits that individuals in deprived socioeconomic conditions are more likely to believe in supernatural forces intervening in daily life. At the same time, the demythologised beliefs theory suggests that HSES individuals, with greater access to education and resources, are more exposed to scientifically based explanations for health and illness ([Pan et al., 2020](#)).

The concepts of mental illness stigma and discrimination against people suffering from mental illness were most often understood as negative treatment based on behaviour, while participants from higher socio-economic backgrounds more commonly trivialised the condition or misunderstood its severity. In contrast, participants from lower socio-economic backgrounds demonstrated greater uncertainty or outright denial of the phenomenon. Research indicates that stigma and discrimination against people with mental illness can vary significantly across different socioeconomic contexts, affecting public health outcomes and contributing to inequalities. These disparities underscore the importance of tailoring anti-stigma interventions to address the specific needs and perceptions of various socioeconomic groups ([Potts & Henderson 2020](#)).

Across all groups, fear of stigma and discrimination emerged as a consistent barrier to seeking treatment by people with mental illness, with LSES and MSES participants also frequently citing resource limitations and lack of support. HSES participants were more likely to mention internalised stigma and misunderstandings about mental illness and treatment. The finding that fear of stigma and discrimination consistently deters individuals from seeking mental health treatment across all socioeconomic groups is well-supported by existing literature. Stigma significantly impedes psychiatric care, leading to delayed treatment and suboptimal health outcomes (Ahad et al. 2023). In lower and middle socioeconomic status (LSES and MSES) groups, additional barriers such as resource limitations and lack of support further hinder access to mental health services. These challenges are exacerbated by systemic issues, including inadequate funding and infrastructure for mental health care in low and middle income countries, which contribute to reduced access to health services and increased risk of human rights violations (Javed et al. 2021). Conversely, individuals from higher socioeconomic status (HSES) groups are more likely to experience internalised stigma and misunderstandings about mental illness and its treatment. Internalised stigma – where individuals accept and internalise negative societal beliefs about mental illness – has been associated with poorer treatment outcomes, increased disability, and higher economic burden. This form of stigma can lead to avoidance of seeking help due to feelings of shame or fear of being ostracised (Sori et al. 2022).

Regarding the perceptions of differences between mental and physical illness, some participants across all groups view mental and physical illnesses as fundamentally alike, whilst other participants still differentiate between them based on visibility, perceived curability, spiritual beliefs, or societal treatment, especially among lower socio-economic participants. This aligns with research indicating that in many cultures, especially within low income communities, mental health issues are often interpreted through spiritual or religious lenses (Mboweni et al. 2023).

In conclusion, it is the belief of the authors that this study provides valuable insights into the multifaceted nature of public stigma towards mental illness among adults in Windhoek. While overtly negative attitudes were not prevalent, moderate levels of stigma persist, particularly in the form of social distancing, misconceptions, and cultural beliefs. Factors such as age, gender, educational attainment, and socio-economic status were found to influence stigmatising attitudes, with higher education emerging as the most significant protective factor. Importantly, stigma remains a critical barrier to help-seeking behaviour across all socio-economic groups, highlighting the urgency for targeted interventions to promote mental health literacy, reduce prejudice, and encourage timely treatment.

Some targeted anti-stigma interventions can be developed in response to the findings of this study. Community-based education campaigns should be implemented in low-education communities to challenge misinformation and improve mental health literacy. Contact-based interventions, where individuals with lived experience of mental illness share their recovery stories in schools, workplaces, and community

spaces, may reduce social distance and foster empathy. These initiatives can be supported by gender-sensitive programmes that address stigma among men, who in this study were found to hold more negative attitudes. Integrating mental health education into school curricula can promote early understanding and help shape positive attitudes from a young age. Furthermore, organising outreach activities in low socio-economic status (LSES) areas – such as mobile clinics, drama performances, or radio discussions in indigenous languages – can make mental health services more visible and accessible. It is also essential to train healthcare workers and community leaders in stigma reduction to improve service delivery. Finally, interventions should address internalised stigma, particularly among individuals from higher socio-economic backgrounds, by promoting acceptance and encouraging help-seeking.

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