Mental Health Stigma at Primary Health Care Centres in Lebanon: Qualitative Study

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Research Article

Keywords: mental health, mental disorders, healthcare, Primary health care (PHC), INDIGO, LMIC, Lebanon

Posted Date: October 19th, 2021

DOI: https://doi.org/10.21203/rs.3.rs-968670/v1

Mental health stigma at primary health care centres in Lebanon: qualitative study

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Abstract

Background

Mental health related stigma is a global public health concern and is considered a major barrier to seeking care. In this study, we explored the role of stigma as a barrier to scaling up mental health services in primary health care (PHC) centres in Lebanon. We focused on the experiences of PHC workers, while providing services to patients with mental disorders, and the perceptions of stigma or discrimination among individuals with mental illness and their families. This study was part of a larger multinational stigma reduction programme, called INDIGO-PRIMARY.

Method

Semi-structured qualitative interviews (n=46) were carried out, with policy makers (n=3), PHC management (n=4), PHC staff (n=24), service users and family members (n=15). The topic guides explored knowledge, implicit and explicit attitudes of staff, challenges of providing treatment, and patient outcomes including experiences of stigma. All interviews were coded using NVivo and analysed using a thematic coding framework.

Results

Results were analysed at five stigma-related layers: from structural stigma at the system level, down to provider-based stigma at PHC level, community level stigma, family stigma and self-stigma. Interestingly at the PHC level, stigma reporting differed among staff according to a power gradient. Service users described positive experiences in PHC. Nurses and social workers did not explicitly report incidents of stigma or discrimination but describing patients with mental health disorders as violent or uncooperative, underscored internalized negative views on mental health. GPs and directors were more outspoken than nurses regarding the challenges faced when dealing with mental health patients. Nevertheless, mental health professionals reported that things have been getting increasingly better over recent years.

Conclusions

This qualitative study revealed that stigma was still a major concern that affects patients with mental disorders and provided a deeper understanding on what should be done to decrease stigma at PHC centres; first addressing

structural stigma by revising laws, second shaping interpersonal stigma, third commitment of PHC management to deliver high quality mental health integrated services, and fourth addressing intrapersonal stigma by building public empathy.

Index Terms- Stigma, mental health, mental disorders, healthcare, Primary health care (PHC), INDIGO, LMIC, Lebanon

Background

Mental health related stigma is a global public health concern. It is considered a major barrier to seeking care and ongoing treatment participation because it may cause fear, discrimination, and reluctance to seek help in people suffering from mental health disorders [1] [2] [3].

Stigma is an indication of shame that typically creates unfavourable attitudes towards the receiver, leading to derogatory discrimination when it is related to a person with mental disorder [4]. It is a heterogeneous notion including a spectrum of perceptions and behaviours [5] so that it applies to issues of knowledge leading to ignorance, attitudes associated with prejudice and behaviour made manifest by discrimination [4]. Moreover, stigma is defined by two categories of variants: “Experiential variants” - including perceived, endorsed, anticipated, received and enacted stigma - and “action - oriented variants” – including courtesy, public, structural provider based and self-stigma [6]. Stigma and discrimination connected to mental illness have been portrayed as having worse effects and causing more suffering than the mental health problems themselves [7]. Addressing stigma has been highlighted as a significant objective of the World Health Organization (WHO) Action Plan 2013-2020 for mental health [8].

Within the service delivery context, stigma is understood to be functioning at three interlinked levels; structural stigma represented by policies and legislations, interpersonal stigma constituted by issues related to knowledge, attitudes and behaviour, and intrapersonal stigma connoted by negative beliefs about the self - including both self-stigma and internalized stigma [9]. Health professionals’ behaviour can affect self-stigma due to the effect of interpersonal interactions [9]; for example, when they commonly use words that are stigmatizing or use judgmental terms for mental illness instead of speaking of the person who has the illness [10].

In general medical settings, research has shown that healthcare providers may express negative attitudes of fear, guilt and aggression towards patients with mental disorders, which has a negative impact on patient care [11]. Some practitioners may hold stereotyped beliefs, so that they treat mental health patients negatively, and may label them and perceive them to be dangerous [12].

In low- and middle-income countries (LMICs), stigma and discrimination towards individuals with mental health illness led to prevalent human rights abuses [13]. In Arab countries, stigma remains largely

understudied [14] and similarly to other settings stigma has been found to represent a huge obstacle to mental healthcare provision in the Arab world [15]. Another important problem affecting structural stigma, especially in LMICs, is the scarcity of resources in terms of funding, community resources and human resources [16] [17]. Therefore, patients with mental health disorders may not receive appropriate or effective care for their mental or physical health due to poor staff training, inadequate supervision, and other structural factors [9].

Lebanon is a middle-income country with an overall treatment gap of more than ninety percent in mental health [18]. Lebanon is known for its political unrest. The health system was overstretched due to the increase of the population residing in Lebanon as a result of the Syrian crisis [19]. Mental health resources in Lebanon are constrained in spite of a huge necessity for mental health and psychosocial support services [20]. In 2014, the National Mental Health Programme (NMHP) was established with the aim of reforming the mental health framework and scaling up services. In reference to the first national strategy "Mental Health and Substance Use Prevention, Promotion, and Treatment Strategy for Lebanon 2015-2020", stigma remains a main challenge facing mental health [20]. Stigma is considered a cross-cutting encounter across all levels of care and is negatively impacting service development and delivery, as well as leading to discrimination [20].

The aim of this study was to explore stigma associated with mental illness at primary health care centres in Lebanon. It also aims to inform a deeper understanding regarding the integration of mental health into PHC which is a cornerstone of the mental health reform in Lebanon. It was therefore intended to understand the experiences of primary healthcare workers while providing services and when dealing with patients with mental health disorders. Further, the study aimed to understand the experiences of patients with mental health disorders and their families when attending primary health care centres and whether they perceived any stigma or discrimination, such as being treated differently because of their illness. This study was embedded within a larger programme, called INDIGO-PRIMARY, which seeks to develop an anti-stigma intervention resulting from cross-country findings and that will help support both staff and patients with mental health disorders in primary care in the future [21].

This paper presents results from the situational analysis investigating current processes at Primary Health Care Centres (PHC centres) in Lebanon [22]. These data are significant for understanding what should be done to decrease stigma and therefore to improve mental health treatment and provide support for patients with mental

disorders in primary healthcare settings in Lebanon, where the number of mental health professionals working in the public sector is relatively low.

Method

Design

Methods comprised the analysis of qualitative data arising from interviews with policy makers, PHC management, PHC staff, service users and family members (n=46). The ethics protocol was approved from Saint Joseph's University Beirut (CEHDF 1193). This study was nested within a multinational study (INDIGO -PRIMARY) investigating mental health stigma in primary care in 7 countries [22].

Qualitative interviews consisted of semi-structured interviews using five different topic guides according to interviewee, provided by the INDIGO-PRIMARY steering group [22]. The topic guides explored knowledge, implicit and explicit attitudes of staff, burnout, provider clinical competence and quality of care comprising primary care staff training level and training needs, experiences, and challenges of providing treatment, patient outcomes including experiences of treatment, experiences of stigma and discrimination and other barriers to optimal care as well as sociocultural factors *(Table 1)*. The topic guides provided a list of topics, broad questions, and probes to be explored, whereby the phrasing of questions was locally adapted to Lebanon and took into account cultural and contextual factors. All questionnaires were translated to Arabic and adapted by the NMHP team.

A member of the local research team explained the study to participants verbally and gave them an accompanying participant information sheet to read. All participants were asked to complete and sign an informed consent form at the beginning of the study except when the interview was conducted over the phone. The outreach process of participants was done through PHC centre focal point staff who were tasked with describing the study and taking the verbal consent of participants. The interviewer would reiterate the explanation of the study and the consent form to the participant when the phone call was scheduled. The interviewer made sure the participant had ample to ask questions ahead of the start of the interview. Phone interviews were mainly done for service users who preferred so, and in these cases, consent was taken verbally.

The participant information sheet and consent form stated that the participation in the study is voluntary, it explained the aims and nature of the study in lay terms, as well as what was expected from participants if they decided to take part and that participants could withdraw from the study at any time.

Participants

Selection of 4 PHC centres was done in collaboration with the PHC department at MOPH and the NMHP team. PHC centres trained on mhGAP were selected in Beirut governorate and Mount Lebanon governorate. The NMHP team coordinated with the focal persons in each PHC centre (director of centres or management coordinators) who ensured the first contact with key informants and service users, who were chosen according to availability and below requirements of key stakeholder groups; no other specific sampling method was applied. In accordance with the cross-country INDIGO PRIMARY study, five categories of stakeholders were included in the sample:

The first category were the Primary care workers (at least 3 participants per PHC centre) where this group included both clinical and administrative staff. In this category, two levels of providers and staff were interviewed. The first-level providers were those who work within the primary care centres and who had received general rather than specialist mental health training (i.e. mhGAP training). Cadres included were professionals, including general practitioners, family doctors, nurses, and other general paraprofessionals. The second-level providers were the administrative and support staff working in the centres, who had direct or indirect contact with service users.

The second category were service users and family members (at least 3 participants per PHC centre). Eligible participants were persons with a diagnosis of a mental disorder attending one of the participating primary care services and seeking care for themselves. They had to be able to provide consent for taking part in the study, aged 18 years or older, any gender, and any nationality. Also, eligible were their family caregivers, i.e. family members who spent a significant amount of time with the service user and were involved in their care. Participants whose current state of functioning inhibited their capacity to comprehend the study, provide consent and perform the research activities (as assessed by their primary care doctor or health worker), e.g., service users in psychiatric emergencies were excluded from participation.

The third category were primary care centre managers or lead primary care clinicians (at least 1 per PHC centre), i.e., the local lead for managing staff and services provided at the primary care facility.

The fourth category were associated mental health professionals (at least 1 per PHC centre): Mental health professionals who collaborate with the primary care facility, e.g., psychiatrists or psychotherapists providing services at the PHC centre.

The fifth category were programme managers and policymakers (at least 1): Local or national representatives of health authorities, institutions involved in policymaking or funding bodies relevant to mental healthcare in primary care.

Data collection

Data were collected through qualitative interviews (n = 46); Programme managers and Policy makers (n=3), Service Users (n = 14), Nurses (n=6), GPs (n= 5); mental health professionals (n=6), Frontliners (n=4), PHC Management (n=4), Family members (n=1), other staff (n=3) (*Table 2*).

The data collection phase was done in two stages. At first, the NMHP team conducted 12 qualitative interviews between August and December 2018 in two primary care centres. Then the team tried, unsuccessfully, to interview service users from these two PHC centres. This was in fact a main challenge in the first round of interviews, where SUs either were not available since the psychotherapist stopped working in one of the PHC centres or SUs refused to be interviewed or failed to show up to a scheduled meeting with the interviewer. Reasons for participants refusal were not disclosed to the research team by the PHC centre focal point staff.

The second stage expanded on the work done in the phase 1 to gather more data from PHC centres in order to reach some saturation and to do more interviews, therefore and since the recruitment of SUs in the first round was challenging, we gave them the option to be interviewed over the phone for privacy and ease reasons. These additional interviews were launched in September 2019 in one of the previous PHC centres but with other staff than the previous round, as well as in two new PHC centres in Beirut and Mount Lebanon area. In this phase 31 individual interviews were conducted (for staff, SUs and family members) in the PHC centres as well as 3 other interviews with policy makers and programme managers. All interviews were conducted in Arabic and were held for an average of approximately 30 minutes each. Findings for the phase 1 of these

interviews were included in the cross-country analysis [22], whereas this paper goes beyond this initial sample to cover the perspectives of a larger number of interviewees (n=46).

Data Analysis

Interviews were recorded, transcribed then translated to English by the NMHP team then verified again in comparison to the recordings. All interviews were coded using NVivo and analysed using a thematic coding framework [23] [24] that was created jointly with the research teams in all sites in accordance with the cross-country study. A code book had already been developed in Tunisia which included the main topics in the interview guide and was later updated to reflect minor changes in the Lebanon site. Consensus coding was used to reach inter-rater reliability. Each coder independently coded each interview, then the two coders met to compare and agree on final codes. All codes were reviewed extensively by the project team to ensure correct coding and that no unnecessary dual coding existed.

Results

Primary Health Care Level

Stigma as expressed by service users

Across all centres, service users described positive experiences while accessing mental health services in primary health care. Experiences of stigma and discrimination inside the selected primary health care centres were never mentioned in 14 interviews with SUs from four PHC centres. SUs conveyed feeling accepted, respected and well treated by the PHC centres Healthcare Workers (HCWs). The overall perception of staff behaviour from all PHC centres was positive in the way they treat and respond to patients with mental health disorders. Only one service user reported stigma in a previous PHC centre accessed before. Nevertheless, self-stigmatizing behaviours and attitudes were voiced clearly in the aforementioned interviews. One SU refused to acknowledge that he was receiving a mental health service as this might suggest that he is insane. Other SUs described hiding their mental health conditions, their treatment with mental health professionals, or their dispositions from other health workers and centres' attendees. SUs belonging to vulnerable groups, such as members of LGBTQI community and Syrian refugees, reported being respected and heard in the PHC centres

with no incidents of discrimination mentioned. SUs made the point to contrast their positive experiences at the PHC centres with difficult and marked experiences of stigma and discrimination in Lebanon overall.

Staff members at the centre are able to feel my pain. They understand my unhappiness. (Service User1, PHC4, Female).

I keep my condition private. I do not want anyone to know that I am seeing a psychiatrist. (Service User5, PHC3, Female).

Stigma as expressed by the Healthcare Providers

Healthcare workers including nurses, receptionists and social workers did not explicitly report incidents of stigma or discrimination against patients with mental health disorders but describing the latter as violent, uncooperative or difficult, underscored internalized negative views on mental health and revealed implicit stigma.

GPs and directors were more outspoken than nurses regarding the challenges faced when dealing with patients with mental disorders. For them, they considered these patients to be a burden that PHC centres didn't want to take on, they continuously mentioned several accidents caused by patients with mental disorders, pointed out their violent behaviour, and discussed crisis incidents that happened at the centre. In addition, prioritization of reaching patient target numbers to meet the increased needs seemed to be significant to PHC centres directors; so that doctors often overlooked mental health causes of patients' symptoms. The general attitude expressed by doctors and managers towards patients with mental disorders seemed to be overwhelmingly negative. One GP even reported that patients with mental disorders need to be institutionalized, isolated from their community, and kept under the supervision of the NMHP or the Ministry of Public Health (MoPH), and not the PHC centre. A management coordinator reported that, in the past, security officers were often called in to manage and watch over patients with mental disorders, but later the way they treat patients has improved a lot, and currently the trained nurse on mhGAP is the focal person who convinces patients with mental disorders to accept the support from the centre.

Although the lack of SU experiences of stigma and discrimination in the PHC centres is encouraging, interviews with mental health professionals underscore some negative attitudes by health workers towards patients with mental disorders. One mental health professional explains that although HCWs' attitudes may not translate into actual behaviours towards patients with mental disorders, their curiosity to learn more about their disorders, share personal identifiers and talk about experiences with patients breaks patient confidentiality. However, mental health professionals mentioned that things have been getting increasingly better over the past years, especially when the PHC centre was involved in advocacy campaigns conducted by the NMHP at the MoPH in their respective areas, as well as in other mental health projects, but a long way for a full integration of mental health services at PHC centres is yet ahead.

"It is possible that a patient comes in and he is very irritated. He might shout at the staff and say obscene things, we immediately know that he is suffering from MH problems… Usually they are nervous, they might instigate a fight with anyone. You can't say no to them." (Data entry officer, PHCC1, Female).

"A patient once had an anger fit and started to break items at the centre. I lost two laptops along with their data; so I had to buy two new laptops. The patient did not wish to wait to see the doctor, so he broke the laptops. There was another incident, which involved another patient with mental disorders who came to collect insulin for his mother. The patient had requested more. This led to an argument. The pharmacist resigned as a result. The pharmacist had to request the support of the security officer for safety reasons. I lost the pharmacist and I lost two laptops." (Director, PHCC4, Male).

Stigma outside primary health care

Stigma as expressed by service users in the community

Service users were referred to mental health professionals by clinicians at the centres or decided to refer themselves. SUs reported they were hiding their mental health condition from their partners, children and families for fear of being left, fear of stigmatization or threat of discontinuing the treatment. A brother of a female SU threw her antidepressants in the garbage when he learned that she was seeking help for her mental

health disorder. Another SU expressed that her husband doesn't know about her mental health disorder because she was afraid that he might leave her for this. It was obvious that the social context surrounding SUs is often unsupportive. Service users were either neglected or held responsible for their mental health problems. In an attempt to underline the reasons behind the unsupportive familial and communal environment, mental health professionals reported that religion, or at least some aspects and religious practices and their intimate influence on people's lives, often acted as a barrier for help seeking or acceptance of diagnosis by the patients and their families. One nurse also reported that the surrounding environment of her PHC centre believed that lack of religious practice leads to mental health disorders. For these reasons HCWs and PHC centres suggested that working with religious figures was a way to help bring the patient to the centre for treatment.

"6 months ago, my eldest daughter would say to me, "mom, we are not insane, we do not need to see a psychologist, please do not make me go." With time, my children started to accept the psychologist." (Caregiver, PHCC3, Female).

"*My neighbours do not understand why my children are so loud and that my children suffer from mental health problems." (Service User, PHCC4, Female).*

"My husband tells me I am mentally ill and makes fun of me." (Service User, PHCC4, Female).

"Some people assume that the patient is going through difficulties (or has depression) because the patient does not pray. Some religious people think that a person who has faith would not be affected by life's trials and tribulations. They think that instead of seeing a psychiatrist the patient should pray". (Nurse1, PHCC3, Female).

Structural Stigma

According to the interviews with policy makers, PHC directors and healthcare providers, the factors influencing stigma at structural level were training, understaffing, lack of resources and lack of staff care that are mainly affected by funding. Policy makers find themselves facing two difficult truths: a top-down approach, starting with advocating for and revising existing mental health laws and securing a budget for the

NMHP, which is often thrown to the side in a country in economic and political turmoil with far higher presumed priorities. On the other hand, a bottom-up approach is faced with the fact that PHC centres run with very limited resources and therefore the addition of mental health service provision is perceived as a heavy burden to carry. Policy makers advocated for a system level approach, hinting that the entire care system needs to be revolutionized.

GPs and directors particularly focussed on structural barriers. They stated that the time invested with mental health patients, be it for the initial assessment and diagnosis or the frequently needed follow ups, is time that could have been allocated to a number of other patients. An underlying issue on the PHC centre's requirement for a certain number of patients per GP, a factor in increasing profit is therefore pointed out. Many healthcare providers didn't see their role in providing mental healthcare or in engaging with beneficiaries having mental health conditions, besides GPs were clearly stating that working with mental health patients was not part of their job description. While nurses were ambitious and enthusiastic to provide mental health services at the PHC centres, the latter was added to their existing tasks and increased their workload, yet this was a managerial decision that could not be refused. Several nurses reported experiencing burnout from their work with little done at the PHC centres to assist them. While some PHC centres agreed to grant one day off for staff care, other PHC centres were pushing them to use their days of leave if they needed to rest.

Mental health professionals emphasized the need for further trainings accompanied with a thorough training on principles and guidelines when dealing with mental health patients. However, other structural barriers go beyond the discontinuity of mental health trainings, which certainly affected the knowledge of healthcare providers and their skills to deal with mental health beneficiaries, to also include the interrupted supervision provided to HCWs by mental health professionals. One GP mentioned that with lack of supervision and no incentives for the additional tasks, doctors will not be motivated and confident to provide mental healthcare. For instance, once one PHC Centre lost their attending psychologist, who was also in charge of supervising all mental health patients, the HCWs, unsupervised, completely wrote off any symptom of mental health disorder in a very vulnerable population.

"In the past, supervisors from the MoPH used to offer service providers at PHCs with a lot of support. Supervisors were providing essential support. We completed the trainings offered by the MoPH a long time

ago. Service providers are applying what they know. No trainings are being given at PHCs at the moment. Service providers might have forgotten the content of the trainings that they received. They have not received trainings in over 2 years. Supervision is very important". (Program Coordinator, Male)

"When we asked PHC staff members to provide mental health services, most staff members objected because they did not consider offering mental health support to be part of their job description". (Program Coordinator, Female)

"To be able to provide mental health at the level of primary care you need to have a system level approach, so this means that it goes way beyond just training and supervision". (Policy Maker, Male)

Based on these findings, our main insights are interpreted in the following illustration (Figure 1). As a summary, results lead to differentiating between five layers influencing stigma and affecting people with mental health disorders starting with structural stigma at system level, down to provider-based stigma - implicit and explicit stigma - at PHC level, community stigma as well as family stigma and self-stigma. Interestingly at PHC level, summary of findings and stigma reporting differed from one position to another which might be linked to the power gradient and to the risk of disclosure.

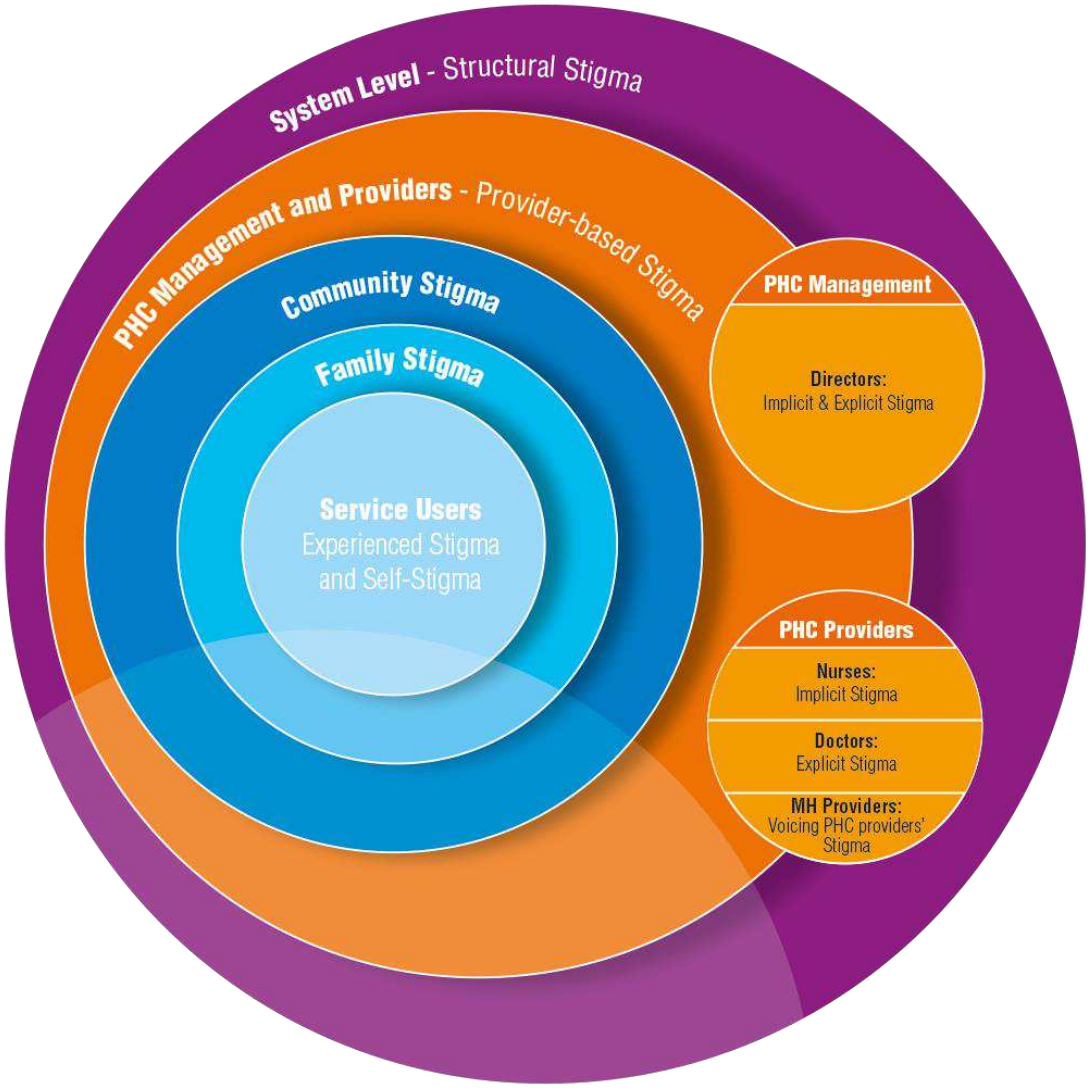

Figure 1: Results illustration divided into 5 layers of embedded stigma from the structural down to the self-level (Reference to the multilevel system layers of embedded stigma [25] [6])

Discussion

Community Level

SUs did not report any stigmatising attitudes at PHC level, however this could be subject to further investigation, since understanding the socioeconomic backgrounds and the dire needs of all service users interviewed can explain the overwhelmingly positive feedback we got from them. The fear of losing a free or semi-free support with all their medical related concerns could have influenced their answers. Furthermore, social desirability could have also influenced the results and answers.

The low level of stigma reported by SUs inside healthcare centres is also in line with a very recent study in Lebanon by Karam et al. [26] studying a representative household adults' sample and investigating barriers of care. In this study, stigma was not found to represent a large barrier to care (<6% mentioned that stigma is a barrier to treatment), the great barrier to treatment is the low perceived need for it in 73.8% of the cases.

On the other hand, experiences of stigma in the community were prominent and voiced by service users. Service users felt unsupported by their community, families and partners as well as being discriminated, labelled, and connoted by negative beliefs about the self. These findings are in line with a recent study in Lebanon exploring cultural misconceptions about mental illness among Lebanese university students [27] which found that 70% of the students believed that mental health issues are taboo in the Lebanese culture and should be hidden from family members. Several studies revealed discrimination against patients with mental disorders by family members, relatives, neighbours and the community, which is widespread in the Arab countries, MENA region, Asia and worldwide (e.g., [28], [29], [30]). Only very few families in Arab countries would seek treatment from mental health professionals and it may take years before seeking care [31], [32]. Other types of discriminatory behaviours linked to nationality, ethnicity and sexual orientation, are intimately linked to mental health disorders. In fact, since the start of the conflict in Syria, the PHC centres that are often present in underdeveloped and marginalized areas, became the hub of support for Syrian refugee families. With little and often ineffective work done on social cohesion between already underprivileged host-communities and the Syrian refugee communities [33] [34], the existing stigmatization based on nationality, culture and traditions exacerbated the mental health conditions of these communities. Mental health problems were often reported to be directly linked to social determinants such as living conditions and poverty [35] as well as overt aggression from host communities (e.g., neighbours or employers) towards Syrian men, women, children and other ostracized communities (LGBTQI).

PHC Level

At PHC level, many providers stated that recently stigma in society had diminished significantly due to increased knowledge and awareness, this could be a result of increased activities on different fronts and from different MH actors to increase awareness and tackle stigma including the work of the NMHP. However, it is important to continuously address further interpersonal stigma by increasing the level of awareness about

mental health in the general public in Lebanon. Analogously, awareness messages should also be disseminated at PHC centre level in specific using evidence-based interventions.

On the other hand, contrasting reports from staff with those from mental health professionals indicated that, although on the bend in the past couple of years, stigma related to mental health issues and negative attitudes from staff members towards patients suffering from mental health problems are still barriers to care. A comparison between the interviews with nurses on the one hand and GPs on the other hand revealed that nurses did not openly describe events of discrimination against patients with mental health disorders, while doctors were more outspoken regarding this issue. They clearly expressed that patients with mental health disorders were a burden on the centre, and that their treatment should be handled by specialists or in institutionalised settings. The latter statement is in line with a study in Oman [36], where both medical students and the public preferred that psychiatric care facilities should be located away from the community. Interestingly, the difference between nurses and GPs outcome regarding stigma where GPs were more outspoken regarding challenges so that they clearly expressed negative attitudes towards patients with mental health disorders, this could be linked to the balance of power and authority among physicians and nurses; therefore, it is correlated to the power gradient in the medical field [37]. In most Arab countries, literature shows that the medical profession dominates the nursing profession misleadingly forming a weak image of nurses in Lebanon and the region [38]. Another aspect could be linked to risk of disclosing negative attitudes that could affect nurses' career where they may fear losing their job.

Primary care providers discussing challenges of treatment underlines implicit negative attitudes towards patients with mental health disorders. In addition, some providers and managers shared some negative beliefs such as believing that patients with mental health disorders are violent and not trying to change and thus implying an attitude of blame. In literature, this perspective has been seen to be a conceivable reaction to the misperception that mental health could be a personality weakness or that individuals are blamed for their disorder, which has been found in previous studies amongst the overall population [39] [40]. Hence, the mentioned attitude can be considered as an indication that service providers have misconceptions without voicing them explicitly, an assumption that should be further investigated. Consistent with findings by Ross and Goldner [11] predominant nurses' attitude was that physical healthcare must be prioritized over mental

healthcare, as it is seen as an additional burden to their job or was 'not their job'. This is aggravated by the fact that financial incentives were absent.

System Level

In the literature, stigma can be implicitly found in nurses' behaviour, yet in some areas it is also explicit in policies [11]. An additional study by Reed & Fitzgerald's [41] revealed that "mental healthcare may often be left till last, only carried out if there is still time, and only by those who feel able". This also confirms that discriminatory policies, and structural procedures prevent the treatment seeking or prevent funding of adequate treatment therefore heavily influencing structural stigma [30] [39] [42] [43]. According to the interviews, training and supervision were highly emphasized in order to improve knowledge of the primary care providers and therefore to reduce stigma. This is coherent with the review of van Boekel et al. [44] who underscored that yet another aspect; training, supervision and policies will improve structural factors and will have advantageous influence on the attitudes of healthcare providers. To intervene at a structural level, several factors are tremendously important: PHC directors are invited to revise work procedures, PHC policies and staff job descriptions, along with installing incentives. Furthermore, it is important to ensure adequate infrastructure: such as private rooms for consultation and secure patient files for confidentiality. Moreover, it is important to address the wellbeing of staff and provide self-care, since high stress levels can lead to burnout of HCWs [45].

Although many structural changes on the health system level have occurred in recent years in Lebanon [19], the total expenditure on mental health from the overall MoPH's budget is very minimal and it is mainly allocated for long stay inpatient costs in mental hospitals [46] [18]. The establishment of the NMHP in 2014 and the launching of the first national strategy for mental health in 2015 [47] to reform the mental health system and scale up services have significantly expedited the provision of mental healthcare in PHC; however with the country facing economic collapse and political turmoil, funding challenges negatively affected training programmes, resources as well as interrupted the support and supervision component provided by mental health professionals to the healthcare providers.

Strengths and limitations of the paper

This study included several aspects which remained understudied previously. To our knowledge this is the first qualitative study in a PHC setting in Lebanon where Sus, along with a wide range of other stakeholders (n=46), were interviewed about mental health related stigma. Whereas in previous research the contribution of service users had been ignored [4], in this study there was a relatively significant number of service users (n=14) which constituted around 30% of the total interviews. In addition, having variety and heterogeneity within the service user sample interviewed, enriched the study content and informed about perception of stigma and barriers related to the Lebanese context since it included males and females, participants from the Lebanese community and Syrian displaced people as well as other nationalities (Iraqi, etc.), in addition to other vulnerable groups such as LGBTQI, and carers of minors with mental disorders. On the other hand, the present study also addressed structural stigma, which may have been taken into account in stigma research among primary care staff. An additional strength is that the qualitative approach employed, permitted to comprehend the specific context and cultural indications of stigma which have not been anticipated previously. In reference to Evans-Lacko et al. [48], 11% only of previous studies on stigma selected a qualitative methodology, of which a majority lack a concise definition of stigma.

The study is not without its limitations. First of all, it was conducted among four PHC centres in Beirut and Mount Lebanon governorate, whereas other more underprivileged areas (such as North, South Lebanon, Bekaa and rural areas) should be further explored in the future and may reflect other important outcomes. Furthermore, most of our findings rely on self-reports from PHC centre staff. Contact with most staff members (front liners, social workers, nurses & GPs) were exclusively established through their supervisors. Service users were also reached by contacting PHC centres focal points who then referred SUs to the research team to conduct the interviews. This outreaching technique might have affected the results. Although every effort was made to ensure confidentiality and assure SUs that their statements would not affect their treatment, the fear of losing services might still have affected some participants' responses. A more direct sampling technique without going through the PHC centres may have reduced the risk of this bias occurring. Another aspect that would impact results especially in regard to a sensitive subject such as stigma, is that the

interviews are subject to social desirability bias, where truthful responses may shade interviewees themselves in an unfavourable light. Furthermore, previous collaborations between the NMHP and PHC service providers may have reinforced the effect of social desirability.

Implications of the findings

This study may inform future interventions at the primary care level and will inform mental health training programmes, as well as supporting the framework for bridging the mental health treatment gap at PHC centres, and accordingly improving the integration of mental health services into primary care. Future activities and further analysis of the interviews can also be used to explore facilitators and barriers for integrating mental health into primary care and interventions that can support the integration, with the aim of informing mental health practice. In future research, ethnographic and observational data can complement interview findings and allow direct observation at primary care. Furthermore, combining qualitative with quantitative methods may be useful for better understanding stigma and reaching a larger sample which could be compared to other settings in the MENA region and worldwide. In addition, more detailed information about the interaction between different types of stigma and in various levels of health systems may allow more in-depth understanding. Future studies should examine the cultural and contextual factors bearing on stigma in primary care with larger study samples and in different areas to develop specific guidelines for cultural adaptations [49]. These findings can be used to inform adaptations of strategies to reduce mental illness stigma among PHC workers [5].

Conclusion

Our qualitative study shows that stigma is a major concern affecting patients with mental disorders despite the latter not explicitly experiencing overt stigmatising behaviours in a PHC setting. Therefore, and in order to improve the quality of mental health treatment in these settings and decrease stigma, our findings suggest new recommendations to tackle all layers of embedded stigma. First, structural stigma should be addressed by revising mental health laws, ensuring proper funding, increasing human resources, and changing policies to integrate MH at primary care settings. Second, interpersonal stigma should be tackled by providing

continual support and supervision as well as regularly building the capacity of healthcare staff. Third, management at PHC centres are invited to commit to deliver high quality mental health integrated services, and to give greater emphasis to staff care and performance-based incentives. Fourth, initiatives to address intrapersonal stigma are requested by building public empathy and enhancing capacity on both individual and community level with specific emphasis towards PHC beneficiaries. Finally, and building on the findings of this study, new interventions at each discussed level are urged to be implemented [50] [7] [51] to reduce stigma, and to bridge the mental health treatment gap.

Declarations

Ethics approval and consent to participate

The ethics protocol was approved from Saint Joseph's University Beirut (CEHDF 1193). The outreach process of participants was done through PHC centre focal point staff who were tasked with describing the study and taking the verbal consent of participants. All participants were asked to complete and sign an informed consent form at the beginning of the study except when the interview was conducted over the phone. Phone interviews were mainly done for service users who preferred so, and in these cases, consent was taken verbally.

Consent for publication

Not applicable

Availability of data and materials

All data generated or analysed during this study are included in this published article and its supplementary information files.

Mirja Koschorke, Nathalie Oexle, Uta Ouali, Anish V Cherian, Vayankarappadam Deepika, Gurucharan Bhaskar Mendon, Dristy Gurung, Lucie Kondratova, Matyas Muller, Mariangela Lanfredi, Antonio Lasalvia, Andrea Bodrogi Anna Nyulászi, Mario Tomasini, Rabih El Chammay, Racha Abi Hana, Yosra Zgueb, Fethi Nacef, Eva Heim, Anaïs Aeschlimann, Sally Souraya, Maria Milenova, Nadja van Ginneken, Graham Thornicroft, Brandon A. Kohrt, Perspectives of healthcare providers, service users, and their family members about mental illness stigma in primary care settings: A multi-site qualitative study of seven countries in Africa, Asia, and Europe, PLOS One, 2021 (Submitted and accepted).

Competing interests

The authors declare that they have no competing interests.

Funding

Funding was provided from Médecins du Monde to support one research assistant in Lebanon. BAK have received funding from the US National Institute of Mental Health (R01MH120649). GT is supported by the National Institute for Health Research (NIHR) Applied Research Collaboration South London at King's College London NHS Foundation Trust, and by the NIHR Asset Global Health Unit award. GT also receives support from the National Institute of Mental Health of the National Institutes of Health under award number R01MH100470 (Cobalt study). GT is supported by the UK Medical Research Council in relation the Emilia (MR/S001255/1) and Indigo Partnership (MR/R023697/1) awards. No funding agency was involved in the design, analysis, or decision to publish.

Authors' contributions

All authors contributed to the overall study. The initial INDIGO study is co-ordinated by Mirja Koschorke and Graham Thornicroft at the Centre for Global Mental Health, Institute of Psychiatry, Psychology and Neuroscience at King's College London and by Brandon Kohrt at Global Mental Health Division, George Washington University. In Lebanon, RC and EH co-led the research team. The desk review was done by EH, AA and MA. Questionnaires, guides, consents and other related forms were translated to Arabic and adapted locally to Lebanon by RAH. Selection of PHC centres was done in collaboration with the PHC department headed by RH with the NMHP team by RAH headed by RC. Initial contact regarding the study and invitation for PHC centres participation was established by RAH.

Interviews were conducted in Arabic by RAH and MA. Transcription of the interviews was done by MA with the support of the NMHP team. Coding was done by MA and AA with the support of a part time researcher. Review of codes was done by RAH. The first draft of manuscript was written by RAH. PC and MS provided revisions to scientific content of the manuscript, and they were regularly reviewing and commenting the manuscript. The views expressed are those of the author(s). All authors read and approved the final manuscript.

Acknowledgements

In the Lebanon site, we would like to acknowledge the PHC department at the MoPH and PHC coordinators, particularly Imad Haddad, Rima Chayya and Lara Mhanna. We would like to thank the directors of the primary care centres and focal persons who facilitated the process at their centres, the primary care providers, service users and family members that supported the study with their time and efforts. We would also like to thank MDM for funding this research project and the staff at MDM who were supporting this study, notably Marie Dermayan and Ahmad Metwalli. In addition, we would like to thank the NMHP team who were involved in implementing this study throughout all its phases; especially Perrine Posbic, Nour Kik, Jiana Tabbara, Sandra Maradian, Jinane Abi Ramia, Amjad Malaeb and Samyah Awada. Finally, we would like to acknowledge Joy Saade for her input in coding the second round of interviews. It is to be noted that the content of this article only reflects the authors' interpretations.

References

[1] “Schomerus, G., & Angermeyer, M. C. (2008). Stigma and its impact on help-seeking for mental disorders: What do we know? Epidemiologia E Psichiatria Sociale, 17(1), 31-37.”.

[2] “Corrigan, P. (2004). How stigma interferes with mental health care. American Psychologist, 59(7), 614-625.”.

[3] “Thornicroft, G. (2008). Stigma and discrimination limit access to mental health care. Epidemiologia E Psichiatria Sociale, 17(1), 14-19.”.

[4] “Thornicroft, G., Rose, D., Kassam, A., & Sartorius, N. (2007). Stigma: Ignorance, prejudice or discrimination? British Journal of Psychiatry, 190(3), 192-193.”.

[5] “Kohrt, B. A., Turner, E. L.,. . . Jordans, M. J. (2020). Reducing mental illness stigma in healthcare settings: Proof of concept for a social contact intervention to address what matters most for primary care providers.Social Science & Medicine,250,112852”.

[6] “Pescosolido, B. A., & Martin, J. K. (2015). The stigma COMPLEX. Annual Review of Sociology, 41(1), 87-116.”.

[7] “Thornicroft, G., Mehta, N., Clement, S., Evans-Lacko, S., Doherty, M., Rose, D., . . . Henderson, C. (2016). Evidence for effective interventions to reduce mental-health-related stigma and discrimination. The Lancet, 387(10023), 1123-1132.”.

[8] “World Health Organization (2013). Mental Health Action Plan 2013-2020.”.

[9] “Henderson, C., Noblett, J., Parke, H., Clement, S., Caffrey, A., Gale-Grant, O., . . . Thornicroft, G. (2014). Mental health-related stigma in health care and mental health-care settings. The Lancet Psychiatry, 1(6), 467-482.”.

[10] “Sartorius, N. (2007). Stigma and mental health. The Lancet, 370(9590), 810-811.”.

[11] “ROSS, C. A., & GOLDNER, E. M. (2009). Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: A review of the literature. Journal of Psychiatric and Mental Health Nursing, 16(6), 558-567.”.

[12] “Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. Annual Review of Sociology, 27(1), 363-385.”.

[13] “Drew, N., Funk, M., Tang, S., Lamichhane, J., Chávez, E., Katontoka, S., . . . Saraceno, B. (2011). Human rights violations of people with mental and psychosocial disabilities: An unresolved global crisis. The Lancet, 378(9803), 1664-1675.”.

[14] “Ouali, U., Jomli, R., Nefzi, R., Ouertani, H., & Nacef, F. (2017). Social stigma in severe mental illness in tunisia: Clinical and Socio-demographic correlates. European Psychiatry, 41(S1).”.

[15] “Gearing, R. E.,,. . . Al-Krenawi, A. (2012). Adaptation and translation of mental health interventions in Middle Eastern ARAB countries: A systematic review of barriers.. International Journal of Social Psychiatry, 59(7), 671-681”.

[16] “Thornicroft, G., Chatterji, S., Evans-Lacko, S., Gruber, M., Sampson, N., Aguilar-Gaxiola, S., . . . Kessler, R. C. (2017). Undertreatment of people with major depressive disorder in 21 countries. British Journal of Psychiatry, 210(2), 119-124.”.

[17] “Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007). Resources for mental health: Scarcity, inequity, and inefficiency. The Lancet, 370(9590), 878-889.”.

[18] “World Health Organization (2015). WHO-AIMS Report on Mental Health System in Lebanon. 2015.”.

[19] “Chammay, R., Karam, E., & Ammar, W. (2016b). Mental health reform in Lebanon and the Syrian crisis. The Lancet Psychiatry, 3(3), 202-203.”.

[20] Ministry of Public Health. 2015. Mental Health and Substance Use- Prevention, Promotion, and Treatment- Situation Analysis and Strategy for Lebanon 2015-2020 Version 1.1. Beirut: Lebanon..

[21] “Thornicroft, G., Bakolis, I., Evans-Lacko, S., Gronholm, P., Henderson, C., Kohrt, B. A., . . . Sartorius, N. (2019). Key lessons learned from the indigo global network on mental health related stigma and discrimination. World Psychiatry, 18(2), 229-230.”.

[22] Mirja Koschorke, Nathalie Oexle, Uta Ouali, Anish V Cherian,....Graham Thornicroft, Brandon A. Kohrt, “Perspectives of healthcare providers, service users, and their family members about mental illness stigma in primary care settings: A multi-site qualitative study of seven countries in Africa, Asia, and Europe,” *PLOS One,* 2021.

[23] “Green, J. (2004). Book review: Qualitative methods and health policy research. Sociological Research Online, 9(4), 108-109.”.

[24] “Srivastava, P., & Hopwood, N. (2009). A practical iterative framework for qualitative data analysis. International Journal of Qualitative Methods, 8(1), 76-84.”.

[25] “Cook, J. E., Purdie-Vaughns, V., Meyer, I. H., & Busch, J. T. (2014). Intervening within and across levels: A multilevel approach to stigma and public health. Social Science & Medicine, 103, 101-109.”.

[26] “Karam, E. G., Karam, G. E., Farhat, C.,. . . Thornicroft, G. (2018). Determinants of treatment of mental disorders In Lebanon: Barriers to treatment and changing patterns of service use. Epidemiology and Psychiatric Sciences, 28(6), 655-661”.

[27] “Rayan, A., & Fawaz, M. (2017). Cultural misconceptions and public stigma against mental illness among lebanese university students. Perspectives in Psychiatric Care, 54(2), 258-265.”.

[28] “Lauber, C., & Rössler, W. (2007). Stigma towards people with mental illness in developing countries in Asia. International Review of Psychiatry, 19(2), 157-178.”.

[29] “Sewilam, A. M., Watson, A. M., Kassem, A. M., Clifton, S., McDonald, M. C., Lipski, R., . . . Nimgaonkar, V. L. (2014). Suggested avenues to reduce the stigma of mental illness in the Middle East. International Journal of Social Psychiatry, 61(2), 111-120”.

[30] “Stier, A., & Hinshaw, S. P. (2007). Explicit and implicit stigma against individuals with mental illness. Australian Psychologist, 42(2), 106-117.”.

[31] “Eapen, V., & Ghubash, R. (2004). Help-Seeking for mental health problems of Children: Preferences and attitudes in the United Arab Emirates. Psychological Reports, 94(2), 663-667.”.

[32] “Dardas, L. A., & Simmons, L. A. (2015). The stigma of mental illness in Arab Families: A concept analysis. Journal of Psychiatric and Mental Health Nursing, 22(9), 668-679.”.

[33] “Mourad, L., & Piron, L. (2016). Municipal Service Delivery, Stability, Social Cohesion and Legitimacy in Lebanon. An Analytical Literature Review.”.

[34] “World Vision International. (2015). Social cohesion between Syrian Refugees and Urban Host Communities in Lebanon and Jordan. doi: https://www.wvi.org/disaster-management/publication/social-cohesion-between-syrian-refugees-and-urban-host-communities”.

[35] “World Health Organization and Calouste Gulbenkian Foundation. (2014). Social determinants of mental health. Geneva, World Health Organization, 2014.”.

[36] “Al-Adawi, S., Dorvlo, A. S., Al-Ismaily, S. S., Al-Ghafry, D. A., Al-Noobi, B. Z., Al-Salmi, A., . . . Chand, S. P. (2002). Perception of and attitude towards mental illness in Oman. International Journal of Social Psychiatry, 48(4), 305-317”.

[37] “El-Jardali F, Longuenesse E, Jamal D, Kronfol NM (2014): The public health workforce and human distributions for health. In Public Health in the Arab World. 1st edi. Edited by Jabbour S, Giacaman R, Khawaja M. New York: Cambridge University Press; 2012:3”.

[38] “El-Jardali et al. (2012). The public health workforce and human distributions for health. Cambridge university press, 385-396.”.

[39] “Corrigan, P. (2005). On the stigma of mental illness: Practical strategies for research and social change. American Psychologist, 59(7), 614-625.”.

[40] “Rüsch, N., Todd, A. R., Bodenhausen, G. V., & Corrigan, P. W. (2010). Biogenetic models OF psychopathology, IMPLICIT guilt, and mental illness stigma. Psychiatry Research, 179(3), 328-332.”.

[41] “Reed, F., & Fitzgerald, L. (2005). The mixed attitudes of nurse's to caring for people with mental illness in a rural general hospital. International Journal of Mental Health Nursing, 14(4), 249-257.”.

[42] “Hinshaw, S. (2006). The mark of shame: Stigma of mental illness and an agenda for change. New York: Oxford University Press.”.

[43] “Holmes, E. P., Corrigan, P. W., Williams, P., Canar, J., & Kubiak, M. A. (1999). Changing attitudes about schizophrenia. Schizophrenia Bulletin, 25(3), 447-456.”.

[44] “Van Boekel, L. C.,...Garretsen, H. F. (2013). Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. Drug and Alcohol Dependence, 131(1-2), 23-35”.

[45] “Selamu, M., Thornicroft, G., Fekadu, A., & Hanlon, C. (2017). Conceptualisation of Job-related WELLBEING, stress and BURNOUT Among healthcare workers in rural ETHIOPIA: A qualitative study. BMC Health Services Research, 17(1).”.

[46] “Hijazi, Z., I. Weissbecker, and R. Chammay(2011), The integration of mental health into primary health care in Lebanon. Intervention, 2011. 9(3): p. 265-278.”.

[47] “Chammay, R. (2016a). Reforming mental health in Lebanon amid refugee crises. Bulletin of the World Health Organization, 94(8), 564-565.”.

[48] “Evans-Lacko, S., Courtin, E., Fiorillo, A.,. . . Thornicroft, G. (2014). The state of the art in European research on reducing social exclusion and stigma related to mental Health: A systematic mapping of the literature.European Psychiatry, 29(6), 381-389”.

[49] “Heim, E., Kohrt, B. A., Koschorke, M., Milenova, M., & Thornicroft, G. (2018). Reducing mental health-related stigma in primary health care settings in low- and middle-income countries: A systematic review. Epidemiology and Psychiatric Sciences, 29.”.

[50] “Gronholm, P. C., Henderson, C., Deb, T., & Thornicroft, G. (2017). Interventions to reduce discrimination and stigma: The state of the art. Social Psychiatry and Psychiatric Epidemiology, 52(3), 249-258.”.

[51] “Rao, D., Elshafei, A., Nguyen, M., Hatzenbuehler, M. L., Frey, S., & Go, V. F. (2019). A systematic review of multi-level stigma interventions: State of the science and future directions. BMC Medicine, 17(1).”.

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Abbreviation

MoPH: Ministry of Public Health, NMHP: National Mental Health Programme, PHC: Primary Health Care; mhGAP: Mental Health Gap Action Programme; LMIC: Low and middle income countries; SU: Service Users; GP: General Practitioner; HCW: Healthcare workers

Appendix

Table 1: Areas included in the topic guides

Programme managers and policy makers ● Health system structural and organisational factors
Lead primary care clinician or manager ● *Provision of mental health care at the PHC* ● *Training and supervision for primary care workers (includes questions on PHC worker knowledge)* ● *Potential barriers to optimal practice (includes questions on staff burnout, attitudes and clinical competence/quality of care)* ● *Socio-cultural factors (includes questions on attitudes)*
Primary care staff (clinical, administrative and support staff) in selected PHCs ● *Description of the role and commonly reported mental health problems* ● *Training and supervision for primary care workers (includes questions on PHC worker knowledge)* ● *Potential barriers to optimal practice (includes questions on staff burnout, attitudes and clinical competence/quality of care)* ● *Socio-cultural factors (includes questions on knowledge and attitudes)*
Associated mental health professionals ● *Description of the role* ● *Role in training and supervision of PHC staff and accepting referrals*

- *Experiences of supporting primary care providers and challenges*
- *Staff knowledge attitudes behaviour*
- *Role in any anti-stigma training or anti-stigma efforts*
- *Priority areas for interventions to address knowledge, attitudes and behaviours*

Service users (SU) and their family members

- *Description (age, socioeconomic, demographics)*
- *Type of mental health problems, explanatory models, help-seeking and possible reasons for delays in helpseeking*
- *Experiences with treatment*
- *Experiences of stigma and discrimination*
- *Resources and anti-stigma interventions*

Table 2: Qualitative Sample Participant Demographics

Stakeholder Group	**Number**	***Mental health Professionals***		***Lead primary care clinicians/managers***	
		Men	1	Men	2
Primary Care Providers		Women	6	Women	2
Men	4	Age 19 to 39	**4**	Age 19 to 39	**0**
Women	13	Age 40 or above	**1**	Age 40 or above	**4**
Doctor	5	Age not known	2	**Total**	**4**
Nurse	6	**Total**	**7**	***Caregivers/ Family members***	
Social Worker	2	***Service Users***		Men	0
Receptionist/Secretary/Admin Staff	4	Men	2	Women	1
Age 19 to 39	**7**	Women	12	Age 19 to 39	1
Age 40 or above	**4**	Common mental disorder	14	Age 40 or above	0
Age not known	6	Severe mental disorder	0	**Total**	**1**
No prior mental health training or experience	3	Diagnosis not known	0	***Policy Makers***	
Any prior mental health training or experience	14	Age 19 to 39	7	Men	2
Not known	0	Age 40 or above	7	Women	1
Total	**17**	**Total**	**14**	**Total**	**3**
Grand Total					**46**