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"EVALUATING THE EFFECTIVENESS OF PUBLIC HEALTH CAMPAIGNS IN REDUCING MENTAL HEALTH STIGMA". A CASE STUDY IN SOUTHEAST LIBERIA

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ABSTRACT

Mental Health stigma remains a significant barrier to accessing care and support in many low-resource settings, including Southeastern Liberia.

This study evaluates the effectiveness of public health campaigns in reducing stigma associated with mental health disorders in the region. Using a mixed-methods approach, the research assesses changes in public perceptions, attitudes, and behaviors before and after campaign interventions.

Data collection includes surveys, interviews, and focus group discussions with community members, healthcare workers, and local leaders.

Findings indicate that targeted awareness campaigns, particularly in schools and those incorporating community engagement and culturally relevant messaging, contribute to increased knowledge and improved attitudes toward mental health.

However, persistent challenges such as deep-rooted cultural beliefs and limited mental health services hinder sustained progress.

The study provides recommendations for enhancing future public health initiatives to further reduce stigma and improve mental health outcomes in Southeastern Liberia.

CHAPTER I

INTRODUCTION

Although stigma is still a major obstacle to effective intervention and care, mental health disorders are becoming a more widespread public health concern worldwide. Mental health problems are frequently misinterpreted in many African nations, including Liberia, which results in prejudice and marginalization of those who are impacted. Addressing stigma is particularly difficult in Southeastern Liberia because of the region's strong cultural views toward mental illness and lack of mental health resources. surveys combined with focus groups and qualitative interviews.

This allows for a comprehensive understanding of how public attitudes toward mental health have evolved in response to awareness campaigns. Additionally, the study examines the role of traditional beliefs, religious influences, and healthcare accessibility in shaping community perceptions and by evaluating the effectiveness of these campaigns, this study aims to provide evidence-based recommendations for improving future public health interventions.

Findings will contribute to broader efforts to integrate mental health into community health programs and policy initiatives in Liberia and similar settings.

This makes it possible to fully comprehend how awareness initiatives have affected public percept ions of mental health.

The study also looks at how community attitudes are shaped by traditional beliefs, religious influe nces, and healthcare accessibility.

This study intends to offer evidencebased suggestions for enhancing upcoming public health initia tives by assessing the success of these campaigns.

The results will support larger endeavors in Liberia and other comparable contexts to incorporate mental health into community health programs and policy initiatives.

1.1 Background

Mental health stigma is a global public health concern that significantly affects individuals' access to care, social integration, and overall well-being. In many African countries, including Liberia, stigma surrounding mental health remains deeply rooted in cultural beliefs, misconceptions, and inadequate health systems. Historically, mental illness has been associated with supernatural causes, such as witchcraft, spiritual possession, or divine punishment. As a result, individuals with mental health conditions often face discrimination, social isolation, and, in some cases, abuse and neglect. These factors create significant barriers to seeking professional mental health services, leading to poor mental health outcomes and an increased burden on families and communities.

Liberia, a country that has endured civil wars (1989–2003) and the devastating Ebola outbreak (2014–2016), has a high prevalence of mental health conditions, including post-traumatic stress disorder (PTSD), depression, and anxiety. Despite these challenges, mental health services remain limited, with only a few trained mental health professionals available to serve the population. The government of Liberia, in collaboration with international organizations such as the Carter Center, the World Health Organization (WHO), and local NGOs, has launched public health campaigns to address mental health stigma. These campaigns focus on community education, integration of mental health services into primary healthcare, and advocacy for mental health policies.

Southeastern Liberia, comprising counties such as Grand Gedeh, Sinoe, River Gee, and Maryland, presents unique challenges in mental health service delivery due to its remote location, high levels of poverty, and strong adherence to traditional beliefs. In these communities, mental illness is often attributed to supernatural forces, leading many individuals to seek help from traditional healers rather than healthcare professionals. Public health campaigns in the region have attempted to address these misconceptions by engaging community leaders, using radio programs, conducting school-based education, and training healthcare workers. However, the effectiveness of these campaigns in reducing mental health stigma and increasing access to care has not been thoroughly evaluated.

This study aims to assess the impact of public health campaigns on mental health stigma in Southeastern Liberia by examining changes in community attitudes, healthcare-seeking behaviors, and the effectiveness of communication strategies used in these interventions. The findings will provide valuable insights into the successes and limitations of current efforts and offer recommendations for improving mental health awareness and service accessibility in Liberia.

1.2 Problem Statement

Mental health is increasingly recognized as a fundamental pillar of public health and overall well-being globally. However, despite this growing awareness, mental health stigma persists as a pervasive and detrimental barrier, particularly in low-resource settings like Southeastern Liberia. Stigma, encompassing negative attitudes, beliefs, and discriminatory behaviors directed towards individuals with mental health conditions, manifests in various forms, including social rejection, exclusion, labeling, and prejudice. This deeply ingrained stigma has profound consequences, effectively isolating individuals experiencing mental health challenges and deterring them from seeking timely and appropriate mental health care.

In Southeastern Liberia, the impact of mental health stigma is particularly acute. A confluence of factors, including limited access to mental health services, deeply rooted cultural beliefs about mental illness (often attributing it to supernatural causes or moral failings), and a lack of widespread mental health literacy, contribute to a climate where stigma flourishes. Consequently, individuals

experiencing mental health conditions often face significant social ostracism, discrimination within their communities and even families, and a profound reluctance to disclose their struggles or seek help for fear of judgment and negative repercussions. This delay or avoidance of care not only exacerbates individual suffering but also places a significant burden on families and the community as a whole.

Recognizing the detrimental impact of mental health stigma, various public health campaigns have been implemented in Southeastern Liberia with the overarching goal of reducing this stigma by increasing public awareness about mental health, challenging negative attitudes and misconceptions, and promoting more positive and supportive behaviors towards individuals with mental health conditions. These campaigns often employ a range of strategies, including community outreach programs, educational workshops, media messaging through radio or local channels, and engagement with community leaders and traditional healers.

However, despite the good intentions and efforts behind these public health initiatives, a critical gap exists in our understanding of their actual effectiveness within the specific socio-cultural context of Southeastern Liberia. Fundamental questions remain unanswered: Are these campaigns truly successful in challenging deeply entrenched cultural beliefs surrounding mental illness? Do they effectively improve community acceptance and foster a more inclusive environment for individuals with mental health conditions?

Crucially, do these campaigns translate into tangible changes in help-seeking behaviors, encouraging individuals who need support to access available mental health services?

Furthermore, the effectiveness of these campaigns is likely influenced by a multitude of factors. The **reach** of the campaigns, determining how widely they penetrate communities across Southeastern Liberia, is paramount. The **messaging** employed, including its cultural appropriateness, clarity, and ability to resonate with diverse segments of the population, will significantly impact its persuasiveness. The **sustainability** of these campaigns, ensuring their long-term presence and consistent reinforcement of positive messages, is crucial for achieving lasting change. Logistical challenges, resource constraints, and the involvement of local stakeholders will all play a role in determining the sustainability and ultimate impact of these initiatives.

Without a rigorous and systematic evaluation of the effectiveness of existing public health campaigns in reducing mental health stigma in Southeastern Liberia, there is a significant risk that current efforts may be inadequate, misdirected, or fail to address the specific challenges and nuances of this unique cultural context. Resources may be inefficiently allocated, and opportunities to implement more impactful and culturally sensitive interventions may be missed. This study seeks to address this critical gap in knowledge by undertaking a comprehensive assessment of the impact of public health campaigns on mental health stigma in Southeastern Liberia. By employing a case study approach, this research will delve into the specific context of Southeastern Liberia, examining the changes in attitudes, knowledge, and behaviors related to mental health among key stakeholder

groups, including community members, healthcare workers (both formal and informal), and local leaders. The findings of this study are intended to provide evidence-based recommendations that can inform the design, implementation, and evaluation of future public health interventions aimed at effectively reducing mental health stigma and improving access to mental health care in Southeastern Liberia. Ultimately, this research aims to contribute to a more supportive and inclusive environment for individuals experiencing mental health challenges in this region.

1.3 Research Questions

1. To what extent have public Health campaigns influence community attitudes toward people with mental health disorders
2. How do cultural and traditional beliefs affect the perception of mental Health messages in southeastern Liberia
3. How can community engagement be strengthened to foster long-term attitudinal and behavioral changes toward mental health?

1.4 Research Objectives:

The key objectives of this study are as follow:

- Assess mental health stigma in Southeastern Liberia pre- and post-public health campaigns.
- Evaluate the impact of public health campaigns on public attitudes toward mental health.
- Identify key factors influencing the success or failure of mental health awareness initiatives.
- Examine the role of community engagement and cultural perceptions in mental health stigma.
- Recommend strategies for improving future public health campaigns aimed at reducing mental health stigma.

1.5 Study Variable

The Study variable in this study in this research are the exposure to public health campaigns (independent variable) and the level of mental health stigma (dependent variable) among people in southeastern Liberia.

1.6 Significance of the Study

This study on evaluating the effectiveness of public health campaigns in reducing mental health stigma in Southeastern Liberia holds significant value for multiple stakeholders, including policymakers, healthcare providers, community leaders, and individuals affected by mental health issues. The significance of the study is outlined as follows:

1. Addressing Mental Health Stigma in Liberia

Mental health stigma remains a major barrier to care in many parts of Liberia, particularly in Southeastern regions where cultural beliefs and limited awareness contribute to misconceptions. This study will provide insights into the extent of stigma and how public health campaigns influence attitudes and behaviors regarding mental health.

2. Assessing Public Health Campaign Impact

Public health campaigns aim to improve mental health awareness, but their effectiveness in Liberia has not been thoroughly studied. This research will evaluate whether existing campaigns have successfully changed perceptions, increased knowledge, and encouraged people to seek mental health services.

3. Informing Policy and Program Development

Findings from this study will help policymakers and public health officials design more effective mental health interventions tailored to the cultural and social context of Southeastern Liberia. It will also provide recommendations for improving current awareness strategies.

4. Enhancing Healthcare Access and Utilization

By identifying barriers to mental healthcare, such as stigma and misinformation, the study can support efforts to increase mental health service utilization. It will help healthcare providers understand community perceptions and adjust their outreach and treatment approaches accordingly.

5. Contributing to Public Health Research in Liberia

There is limited academic research on mental health stigma and public health interventions in Liberia. This study will contribute to the existing body of knowledge and serve as a reference for future research in mental health policy and advocacy.

6. Promoting Community Empowerment and Social Change

By highlighting effective stigma-reduction strategies, this research can empower communities to take an active role in mental health advocacy. Engaging community leaders, traditional healers, and healthcare workers in stigma-reduction efforts can lead to sustainable social change.

CHAPTER-II

REVIEW OF LITERATURE

The stigma associated with mental illness is still a significant obstacle that affects people's willingness to get treatment, seek assistance, and integrate into society. Self-stigma, or internalized shame, public stigma, or negative societal views, and structural stigma, or discriminating policies and practices, are some of its manifestations.

Public health campaigns are one of the many complete tactics needed to address this complicated issue, and they have the potential to be extremely important. In environments with few resources, such as Southeast Liberia, it is critical to assess the success of these initiatives to make sure resources are used effectively and the intended results are obtained.

Anti-stigma initiatives frequently use theories of attitude and behavior change as their conceptual foundation. Typically, campaigns use tactics that fall into three general categories: contact (facilitating relationship with people who have lived experience), education (proving myths with facts), and protest or advocacy (fighting discriminatory portrayals or laws). Each strategy targets a different aspect of stigma: protest targets overt discrimination and structural barriers, contact wants to promote empathy and lessen social distance, and education aims to increase understanding and debunk misconceptions. who have mental illness—are common evaluation metrics. These can be measured using tools like the Community Attitudes towards Mental Illness (CAMI) or Social Distance measures. It is frequently more challenging and resource-intensive to measure real behavioral change or decreases in discriminating.

Meta-analyses and systematic reviews of international anti-stigma initiatives show conflicting results in terms of their efficacy. Evidence for long-term attitudinal changes and their conversion into significant behavioral change is less consistent, even though many initiatives show good short-term effects on knowledge and attitudes, especially those that use social contact. The design, intensity, duration, target audience, and cultural context of the campaign all have a significant impact on its efficacy.

Because education-based interventions are relatively simple to administer, they are often used. They can successfully dispel certain beliefs and advance factual understanding of mental disease. But according to research, merely disseminating facts might not be enough to change deeply rooted prejudiced beliefs or discriminatory practices. The requirement for multi-component therapies is highlighted by the fact that changing one's knowledge does not always translate into changing one's attitude or behavior.

One of the more promising methods for enhancing attitudes and lowering social distance is social contact tactics, which involve direct or indirect connection (such as video testimonials) with people sharing their recovery stories. It is believed that the method entails developing empathy, humanizing the experience of mental illness, and dispelling preconceptions via interpersonal interaction.

Effective contact-based intervention implementation, however, necessitates thorough preparation,

ethical considerations, and assistance for those sharing their experiences.

One important component of a successful marketing is the target audience. Campaigns that target particular groups, such as healthcare practitioners, employers, youth, or community leaders, may have a very different approach and impact than those that target the broader population. To maximize impact and achieve significant decreases in stigmatizing behaviors within pertinent social spheres, messages and strategies must be tailored to the target group's unique beliefs, concerns, and influence levels.

Sustainability and long-term impact are important evaluative factors that are sometimes overlooked because of financing cycles and research limitations. Without reinforcement or incorporation into more comprehensive systemic changes, short-term gains in knowledge or attitudes may gradually disappear.

When possible, longitudinal designs are needed for effectiveness evaluation, monitoring changes after the campaign period to see how long-lasting effects are and what factors lead to long-lasting change.

Both the way stigma manifests and the possible efficacy of interventions are significantly influenced by contextual circumstances. Particular difficulties occur in low- and middle-income nations (LMICs). These include a lack of knowledge about mental health, a strong belief in traditional or supernatural causes of mental disease, a lack of mental health resources, a dependence on community health professionals, and the pressures of poverty, war, or epidemics on top of mental health issues. Cultural sensitivity and adaptation to local distress idioms and explaining models are essential for campaigns.

Resource constraints frequently impede the implementation of advanced research designs or proven assessment instruments when evaluating campaigns in LMICs. It could be necessary to create or modify stigma measures locally so that they align with the cultural perception of mental illness and social exclusion. Although they need to be carefully facilitated, participatory assessment techniques that involve community members in defining success and gathering data can improve relevance and ownership.

Liberia and other post-conflict environments offer more levels of complexity. Damaged health infrastructure, population dislocation, and maybe changed societal norms coexist with high prevalence rates of trauma-related mental health problems (such as depression and PTSD).

Interventions that are trauma-informed and cognizant of the legacy of conflict are necessary because stigma in these settings may overlap with experiences of violence, loss, and societal instability.

In particular, the terrible Ebola virus and protracted civil wars are two traumas that define the Liberian setting. The country's mental health situation and response capabilities have been profoundly affected by these occurrences. There are few mental health services available, especially outside of Monrovia, and they are primarily dependent on foreign non-governmental organizations and a small number of qualified specialists. These services are frequently incorporated into primary

care or assisted by community health volunteers.

Designing and assessing anti-stigma efforts in Southeast Liberia requires an understanding of local conceptualizations of mental illness.

Help-seeking behaviors (typically aimed first at traditional healers) and community reactions (ranging from support to exclusion or fear) are influenced by traditional beliefs that frequently attribute mental discomfort to spiritual causes, witchcraft, or curses. Campaigns must reduce harmful practices, advance biomedical understanding, and respectfully traverse these religious systems.

There is a remarkable lack of published research particularly assessing anti-stigma efforts in Liberia, much alone Southeast Liberia. Dedicated evaluations that concentrate solely on stigma reduction campaigns and their quantifiable impact are scarce, despite the existence of more general mental health needs assessments and intervention studies (often pertaining to post-conflict trauma or integrating mental health into primary care via frameworks like the mhGAP). There is a substantial knowledge gap here.

Because of this disparity, assessing a campaign in Southeast Liberia would probably need utilizing best practices that have been developed internationally and in other LMIC/post-conflict contexts, while also developing measurement and methodology unique to the local situati on. Using already existing community structures (such as community health workers, local leaders, and religious organizations), creating culturally relevant message and assessment instruments, and establishing reasonable evaluation objectives in light of resource limitations are important factors to take into account. Mixed- methods techniques could be used as part of southeast Liberia's evaluation tactics.

Targeting certain community segments, quantitative data may be gathered through the use of modi fied attitude/social distance scales that are given both before and after the campaign. In order to understand the campaign's reception, perceived impact, unintended consequences, and contextual nuances that quantitative data might overlook, qualitative data such as focus groups or interviews with community members, leaders, healthcare professionals, and people with lived experience would be essential.

In order to document the campaign's implementation fidelity and determine whether it was delivered as intended, process evaluation would also be essential. What obstacles and enablers did you face during the rollout? This data is crucial for analyzing campaign results and figuring out why a campaign worked (or didn't) in a certain situation. It also offers important insights for comparable campaigns in the future.

In Liberia, the function of volunteers or community health workers (CHWs) is especially important. They could play a crucial role in spreading anti-stigma messages because they are frequently the first point of contact for basic services and health information in rural areas like the Southeast. An essential component would be assessing the success of campaigns carried out by CHWs, taking into

account their own attitudes and confidence levels.

Although it is more difficult to quantify, structural stigma—which may be seen in municipal regulations, resource distribution, or exclusion from community events—should also be taken into account during evaluation. Indicators could be reports of prejudice, inclusion in decision-making, or changes in community behaviors; these could be recorded over a longer period of time using qualitative techniques or community monitoring systems.

The World Health Organization (WHO) defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (WHO, 2016)." The Department of Mental Health and Substance Dependence in WHO, Geneva, has the goal of reducing the burden associated with mental and neurological disorders and to promote mental health worldwide. (Amir Chapel Institute for Social Research, UNM, 2016)

Mental health awareness is crucial as it reduces stigma, promotes early intervention, and supports individuals seeking help.

By fostering understanding and acceptance, research shows that awareness encourages a supportive community, improves access to mental health services, and enhances overall well-being. Recognizing mental health's importance leads to better outcomes for individuals and society (Hrymoc, M; 2024). According to the Centers for Disease Control and Prevention, in the United States it is reported that more than one in five young people and adults experience a mental health condition. These individuals struggle with mental health issues in silence due to stigma and lack of understanding, and raising mental health awareness helps reduce this stigma, encouraging individuals to seek the help they need. Moreover, promoting awareness creates a more supportive community, leading to early intervention and better overall well-being for everyone. Every time a person with a mental health condition is unfortunate to receive treatment early, their symptoms may deteriorate and result in emergencies. Stigma which is the focus of what people with mental health issues is refers to the unfavorable attitudes, convictions, and behaviors that society holds towards certain groups or individuals based on perceived differences. It leads to discrimination, exclusion, and unfair treatment. Stigma can be particularly damaging with relation to mental health, as it can prevent people from seeking help, accessing services, and feeling supported by their community.

Globally, one of the most important factors influencing marketing effectiveness is targeting particular target audiences. Young people-focused interventions, frequently provided in schools, have potential, especially education-based strategies, however meta-analyses have shown that their impacts are typically modest and transient. Workplace interventions are also becoming more popular since they have the ability to increase employees' knowledge and helpful behaviors. Cultural sensitivity is essential for worldwide efficacy. It is rarely successful to translate campaigns directly

from one context to another. As evidenced by adaptation efforts in North India using the Ecological Validity Model, effective adaptation takes into account local languages, cultural perceptions about mental illness (e.g., attributions to spiritual causes vs. biogenetic factors), social norms, and preferred communication channels. Around the world, the media has two roles.

Although social media as well as campaigns in the media can swiftly spread information and reach large audiences, if they are not handled correctly, they run the risk of distributing false information or reinforcing prejudices.

Efforts to reduce stigma must include both responsible reporting and positive media representations. Online, short films with personal narratives have been successful. Social contact is generally regarded as a potent tactic, especially when it involves people sharing their own experiences. According to research, there is a negative correlation between stigmatizing sentiments and knowing someone who has a mental condition. Peer involvement is being incorporated into campaigns more and more, but research including the Global Mental Health Peer Network has shown that genuine and helpful involvement rather than tokenistic is essential for impact. Bridging the gap between tangible behavior change and greater knowledge or attitude alterations is a continuing challenge on a worldwide scale. Campaigns may raise awareness or cause respondents to report more positive sentiments on surveys, but this does not always result in less prejudice in social interactions, employment, or housing. Long-term behavioral consequences are still hard to measure.

Campaigns must also address self-stigma, which is the internalization of unfavorable public perceptions by individuals with mental health conditions, which results in feelings of shame, low self-esteem, and a reluctance to ask for assistance. Interventions that use empowerment techniques and peer support can be very successful in overcoming self-stigma. Globally, sustainability and funding are significant challenges, particularly in LMICs. Project-based in nature, many campaigns lack the long-term funding necessary for long-term effects. Long-term transformation requires securing continuous funding, integrating initiatives into current health systems, and developing local capacity. Anti-stigma initiatives must be connected to observable advancements in easily available, high-quality mental health care. Increasing awareness without offering resources for assistance may backfire. Stronger mental health treatment systems and public awareness campaigns are frequently implemented in tandem as part of successful global programs. Unintended repercussions need to be taken into account. In other research, for instance, educational efforts that emphasize the biogenetic roots of mental illness unintentionally boosted pessimism about recovery and a desire for social distance while simultaneously lowering blame. Careful testing and framing are necessary for campaign messages. There are continuous worldwide issues in measurement and evaluation. Significant challenges still exist in creating culturally appropriate stigma measures, carrying out thorough longitudinal research to monitor long-term effects, separating the effects of campaigns

from other societal shifts, and obtaining funding for thorough evaluation, especially in LMICs. Systematic reviews draw attention to differences in study technique and quality.

A study in the US, discovered that every $1 spent on raising awareness of early intervention and addiction programs results in a $2–$10 reduction in medical expenses.

Another study conducted by Daniel Alexander Benjamin Walsh and Juliet Louise Hallman from the King College, UK titled "A Critical Review of Mental Health Related Anti-Stigma Campaigns" they affirmed that by using a knowledge-attitudes-behavior practice (KABP) paradigm, professionals have focused on educating the educating the public about biological causes of mental disease. Nowadays, it is typical for education-based campaigns to be customized for important groups and to incorporate social interaction of some kind, particularly in high-income nations. However, studies indicate that the public still faces mental health issues after more than two decades of well-known national programs (such as Time to Change in England and Beyond Blue in Australia).

In addition, assessments of anti-stigma initiatives reveal that they have little to no lasting impact, and there have been grave worries expressed about their potential unforeseen repercussions.

Additionally, they attempted to demonstrate that systematic problems with problem conceptualization have existed. Specifically, the various types of knowledge that are embodied in daily life—often outside of conscious awareness—are not addressed by the KABP paradigm. They also point out how public practices that create a division between "us" and "them" have been maintained by a singular focus on fixing the public's perceived deficiencies in professionalized forms of knowledge. They suggested in their conclusion that public health practitioners might thoroughly examine these identity-related social processes with the use of methodological tools. Additionally, they suggested that by thoroughly investigating these processes, individuals might create novel solutions that are based on how the general population understands mental health and illness.

"The stigma and associated discrimination toward persons suffering from mental and behavioral disorders is the single most important barrier to overcome in the community," according to a 2001 World Health Organization declaration. Since then, the majority of public health experts have stuck to a deficit model of health-related behaviors and believed that stigma is perpetuated by the public's ignorance or misinformation regarding mental illness. As a result, most interventions have been education-based, with half being stand-alone programs to increase mental health literacy (MHL) and a third including contact of some kind.

More than four out of five interventions have been carried out in high-income nations, which is consistent with a typical treatment gap in mental health. There is a severe lack of evidence for long-

term behavioral change, even if anti-stigma campaigns have been demonstrated to have modest to medium-term positive attitude change advantages at the population level, and it is hoped that these attitudinal impacts may be sustained.

Additionally, these initiatives' unexpected consequences have raised serious concerns, particularly for those that just aimed to inform the public about biological models of mental illness. It has been discovered that these models encourage the public to have categorical views of difference as well as distance-promoting feelings of dread and sympathy. The study also noted that these unintended consequences are consistent with a larger body of research on stigma and health, which indicates that the public's reaction to medical illnesses frequently follows a typical affective distancing-blame-stigma pattern. In particular, studies of the reasons why the public perpetuates health-related stigmas reveal that beliefs of difference are psychologically calming because they enable people who do not have a health condition to believe that they are both immune to the perceived threat and to uphold positive forms of social identity.

However, to our knowledge, no mental health-related public health campaigns have explicitly been designed to challenge these distancing-blame-stigma patterns. This evaluation deviates from the prevalent methodology used by other reviewers in order to comprehend these restricted and unexpected consequences.

We demonstrate the need for new interventions based on the public's understanding of mental health and illness by examining the conceptualization and operationalization of stigma related to mental health by public health professionals, as well as the inconsistent efficacy of these campaigns. The Knowledge-Attitude-Behavior Practice (KABP) paradigm has been used broadly in the conceptualization of anti-stigma campaigns. Furthermore, stigma associated with mental health has primarily been attributed to a lack of professional expertise, which reflects the agendas involved.

To enhance knowledge on the practice, public health practitioners are encouraged to consider three main ways to address mental health related stigma: ***education-based interventions; protest-based interventions; and contact-based interventions.***

In England, from 2009 to 2014, social media, mass media, and social interaction events were used in social marketing campaigns (SMCs) to lessen stigma around mental health; however, the effectiveness of these strategies has not yet been assessed. The target demographic consisted of middle-class individuals in their mid-twenties to mid-forties. An online market research panel was used to recruit people both before and after each advertising burst, with an average of 956.9 ± 170.2 unique participants per burst. An online survey was filled out by participants to assess their knowledge of the Mental Health Knowledge Schedule (MAKS), their attitudes about mental illness

(CAMI), and their behaviors (Reported and Intended Behaviors Scale, or RIBS). Additionally, sociodemographic information and awareness of the SMC were gathered. 10,526 persons in all were interviewed. Both the level of SMC awareness and the use of SMC-media channels were found to be rising. After adjusting for confounders, it was discovered that knowledge of the SMC was linked to higher scores on the MAKS, the "tolerance and support" CAMI subscale, and the RIBS. In conclusion, given these encouraging results, more social media-based population- based initiatives could be a useful tactic to combat stigma.

Another electronic way to help reduce stigma around mental health is to raise awareness online. "WhatMakesUs" was the organization that carried out the exercise. Reducing stigma around mental health in the Greater Omaha-Council Bluffs metropolitan area of the United States was the goal of the digital media campaign. By analyzing various facets of mental health stigma, such as social distance, attitudes, behaviors, and self-efficacy, among campaign-aware (CA) and non-campaign-aware (NCA) individuals, the study assessed the campaign's effectiveness at the conclusion of its second year. The campaign's viability and potential for adaptation to other US regions were also examined in the study.

A cross-sectional online poll was carried out in the area where the campaign was being implemented. A panel hiring firm used non-probabilistic techniques to find respondents. Google Analytics was used to gather and examine digital analytics from the campaign's website and social media accounts.

Compared to NCA respondents, the respondents showed greater positive actions and self-efficacy toward people with mental health disorders (MHCs), as well as decreased social distance and stigmatizing attitudes and beliefs. The percentage of campaign awareness respondents who said they lived with ($p = .001$), worked with ($p = .005$), and had close friendships with people who had MHCs was significantly greater.

Compared to NCA respondents, campaign awareness respondents found therapy and counseling to be effective treatments for MHCs ($p = .005$), felt more comfortable offering support to people with MHCs ($p < .001$), took action to improve their own mental health ($p = .032$), and thought their workplaces actively participated in their mental health ($p = .029$). Digital data showed that the campaign's target audience was successfully engaged. The results showed how effective digital campaigns are at combating the stigma associated with mental health issues and offered insightful information for initiatives in the future.

Mental health problems (MHD) are the primary cause of disability in sub-Saharan Africa. If people with MHD are to be permitted to live in dignity and be socially included, as opposed to being viewed as outcasts or witches, as is currently the case, health care professionals and the general public in Sub-Saharan Africa must be aware of the disease.

Three public health professionals, Susanne Spittel, André Maier, and Elke Kraus, mapped and summarized the degree to which awareness of mental health disorders and dementia in sub-Saharan Africa is valued in a

review published in a public health journal with the title "Awareness challenges of mental health disorder and dementia facing stigmatization and discrimination: a systematic literature review from Sub-Sahara Africa." Using electronic databases (PubMed, CINAHL, and PsycINFO), a systematic review was carried out. Selected studies were subjected to a content analysis. Results on stigmatization and awareness issues were found and grouped. After screening 230 publications in total, 25 were chosen for this review. The findings show that people's views of illnesses are influenced by strong superstitious beliefs.

These ideas encourage stigmatizing beliefs about those who suffer from dementia and mental illnesses. Higher educated individuals were less inclined to socially remove themselves from those with mental health issues and dementia (PwD), according to a correlation between education level and stigmatizing attitudes. Surprisingly, even those with health-related education (such as nurses and doctors) tended to have negative opinions of MHD and PwD and strong beliefs in supernatural causes of illness, such as witchcraft. Some evidence about the impact of traditional beliefs on mental health illnesses.

These strong beliefs, which permeate many facets of sub-Saharan African society, encourage stigmatization and superstitious views about illnesses.

According to the report, raising awareness and educating people about mental health issues is crucial to lowering stigma. Additionally, it showed that while chronic diseases like dementias are more common in older groups (60+ years), mental health issues are among the primary causes of disability and are more common in younger populations (0-59 years).

Furthermore, it found that approximately 10% of people suffer from mental health issues, despite the fact that mental health services are not adequately provided. 84% of people worldwide reside in low- and middle-income countries (LAMIC), with 14% residing in Sub-Saharan African nations (SSA), according to a 2016 World Bank report cited in the article. There are rarely laws or policies in place to provide basic mental health treatments in many LAMIC countries, especially in Africa. Data from Africa show very high scores in illiteracy and extremely low scores in expenditure on mental health, mental health resources, and low disability-adjusted life years by neuropsychiatric conditions. Sub-Sahara Africa counts a high prevalence of infectious diseases, which impacts the prevalence of probable common mental health disease (eg, HIV-related dementia).

Moreover, the number of people living with dementia is increasing – especially in LAMIC as numbers rise more prominently compared to the developed world.

It came to the conclusion that by 2050, the number of people with disorders in LAMIC will have more than tripled. This is due to infectious diseases like HIV and TB, as well as a growing middle class in Africa that has better access to sustainable livelihoods and can seek better medical care, w hich will likely increase life expectancy, morbidity, and mortality rates.

Unfortunately, the majority of these illnesses go untreated because they are not well diagnosed. Perceived stigma is more common in poorer nations and is closely lined to mental health concerns. Different traditional beliefs are held by people from different cultures around the world.

While these beliefs can be effective in curing people, they can also have negative impact on attitudes towards those who suffer from mental health disorders, even among those who have been educated in medicine.

There are supernatural perspectives on illness, particularly in cultures where customs are highly valued. People in the majority of African civilizations have a strong belief in supernatural abilities. People's actions, particularly if they are perceived as acting "strange," might be misunderstood and result in accusations and isolation as long as disorders (like dementia) are not recognized or given a "name."

Research indicates that health campaigns are noncommercial interventions that aim to improve health by enlightening, influencing, or inspiring action over a predetermined time frame. Health campaigns often seek to either create or reinforce healthy behaviors or modify behaviors that compromise health. Health campaigns, however, can also aim to educate or convince people about health-related issues or modify public policies that impact health (e.g., enhance knowledge or affect views, attitudes, norms, etc.).

In order to eliminate health disparities and achieve health equity which is commonly defined as "the state in which everyone has the opportunity to attain full health potential" with the added stipulation that "no one is disadvantaged from achieving this potential because of social position or any other socially defined circumstance" health campaigns must take into account vulnerable and underserved populations, even though they occasionally aim to reach large numbers of people. (National Academies of Sciences, Engineering, and Medicine, 2017).

Additionally, look into Populations that are deemed more susceptible to risk—that is, an adverse consequence or harm—are known as vulnerable populations. For instance, COVID-19 has raised concerns about health equity globally and had a disproportionate impact. Because of their social standing or other socially established factors, some groups are more protected from the pandemic's threats. Demographics and other factors that are pertinent to health equity can be used to define vulnerability.

This includes but is not limited to country or global region, urban versus rural location, age, gender, race/ethnicity, socioeconomic status (e.g., measured by education, income, occupational status, etc.), incarceration status, immigration status, health status (e.g., populations with chronic illnesses or who are immunocompromised, those who are pregnant) and health behavior (e.g., people who smoke).Concerns about vulnerability and vaccine fairness have come up in relation to the COVID-19 pandemic. Poorer nations are less able to safeguard their populations because they have fewer access to vaccines and vaccine technologies. In wealthier nations, where fewer immunized groups are at higher risk of hospitalization and mortality, unequal access and uptake of vaccines also raise issues about vaccine equality.

At the same time, persons in occupations where they must interact with large numbers of people in person, such as retail workers and servers, have increased potential to develop the disease.

Additionally, people with chronic illnesses are more vulnerable to the pandemic than people in good health. The COVID-19 pandemic serves as a reminder that vulnerability results from a combination of social, economic, environmental, and individual-level factors. In health campaigns, vulnerability is frequently defined in terms of the audiences the campaign seeks to directly or indirectly target, despite the fact that it depends on the circumstances. Intersectional populations, in which an individual concurrently belongs to several non-exclusive groups that influence positionality, risk, and resilience, are examples of such populations.

Related categories including special populations, key populations, disparity populations, priority populations, and at-risk groups may overlap with vulnerable populations. Although there are considerable differences, when a certain group matches more than one category, the names are occasionally used interchangeably. For instance, males who have sex with men make up a population for which several classifications may be applicable in an HIV health campaign intervention.

Vulnerable groups who experience structural disadvantage are more likely to get inadequate care and unequal access to resources that support them in reaching their optimal health. This covers socioeconomic variables that are linked to health status and health-related outcomes in addition to access to medical care.

People in underprivileged urban and rural areas, for instance, might have to drive farther to get to hospitals and specialized medical care. In contrast to their more affluent peers, they might not have access to or have poorer quality access to technology that support health communication, have less alternatives for nutritious food, and be more exposed to environmental contaminants. Reaching one's full potential in terms of health is influenced by more than just aspects related to material wealth and services.

Groups such as racial and ethnic minorities, religious minorities, and other social groups that are excluded from equal participation in society due to systemic racism or other group-based discrimination are considered marginalized. Communities that are experiencing high levels of conflict and violence, or that are experiencing economic hardship, are more likely to experience negative health effects due to stress and trauma, especially when there is a lack of social cohesion. Discrimination against social groups can lead to worse experiences and outcomes for those groups, even when overall policies are the same or resources are technically equally available.

Beyond affecting access and quality of access to resources, racism and discrimination can also worsen health by causing stress; chronic stress has in turn been linked to a number of health problems. In addition, historically rooted and ongoing traumas can lead to distrust of institutions. For example, medical mistrust can affect willingness to utilize potentially beneficial health services even when they are available.

There can be similarities among populations that are vulnerable, marginalized, and underserved, as both marginalized and underserved individuals often have limited resources and opportunities, especially in relation to health. The concept of intersectionality, introduced by Kimberlé Crenshaw,

adds complexity to this situation because individuals may belong to both higher and lower social status groups at the same time. For example, a highly educated, affluent White man in the United States who is a gay man living with HIV may experience his condition in a different way than a Black man with similar demographic traits or a Black woman. While it is possible to categorize groups as vulnerable, marginalized, or underserved, it is important to think of these

terms comparatively since they are inherently relative in the context of health campaigns (Cabral A. Bigman, University of Illinois at Urbana-Champaign, USA).

Research has shown that Link and Phelan (2001) observed significant differences in how stigma is defined within scientific studies. Often, authors use the term loosely to describe a sense of shame or disgrace, or they associate it with related ideas like stereotyping or exclusion. When provided a clear definition, Goffman's influential theory often comes into play, where stigma is described as a deeply discrediting trait that diminishes the individual's social worth. In contrast, Thornicroft (2006) presents three social psychological elements: knowledge, attitudes, and behavior, while Link and Phelan adopt a more expansive socio-structural approach. This broader lens shows that stigma arises from the interaction of various elements.

Initially, individuals need to identify and define a specific human difference, in this instance, mental illness, as important in society. This leads to cultural categories being created to sort people into various groups. Next, the identified differences must be associated with a range of negative traits, which establishes a harmful cultural stereotype that is broadly applied to all individuals within that group. Subsequently, those who are categorized and stereotyped are regarded as fundamentally different from the dominant population, resulting in an 'us versus them' separation. Moreover, groups facing stigma are considered socially less valuable and systematically encounter disadvantages concerning access to social and economic resources, such as income, education, and housing. This situation leads to poorer health and social consequences. Discrimination can occur in individual exchanges or may take a structural form, where the effects of established institutional practices lead to inequality. Ultimately, stigmatization is heavily dependent on access to social and economic power, because only those in power are able to disapprove of and marginalize others effectively. According to this framework, any approach aiming to reduce stigma must be diverse in strategies to tackle the various ways that lead to unequal outcomes and must operate on multiple levels to address stigma upheld at both personal and societal structures. Link and Phelan argue that initiatives focused on only one aspect, such as employment equality, will likely fail, as their success can be weakened by the broader social issues that remain unaddressed. They propose that efforts must either lead to significant shifts in the negative perceptions of powerful groups or alter the power dynamics that enable these groups to act based on those beliefs. When discussing stigma from a global public health standpoint, it is important to have a definition that underlines the significant social and structural elements that create inequalities for individuals with mental health issues. This perspective reflects the difficult reality for those residing in middle- and low-income nations, where

policies, healthcare systems, and financial resources often systematically exclude individuals with mental illnesses and their families.

Although Link and Phelan provide a thorough definition, many anti-stigma initiatives still equate

'stigma' with attitudes. Programs like Time to Change and Me Scotland reflect this issue. Advocates such as Everett and Sayce have criticized this viewpoint that sees stigma solely as an attitude, as it overlooks the reality that people with mental illnesses often have their rights as citizens and human beings violated.

They advocate for a model focused on rights or social justice that changes the focus from attitudes to the necessity of achieving social and economic fairness for individuals with disabilities in every aspect of life, such as healthcare, education, and employment. Stigma variations across cultures Apart from the evident structural disparities in mental health systems and access to services that primarily impact low and middle-income nations (The World Health Organization, 2003), few efforts have been made to explore cultural differences in public and personal stigma using standardized methods for data gathering and analysis. One significant study is by (Thornicroft et al. 2009), which highlighted personal stigma experiences reported by 732 individuals with schizophrenia from 27 both developed and developing nations. A remarkable 72% expressed a desire to hide their diagnosis, 64% feared they would face discrimination when seeking work training or educational opportunities, and 55% worried about discrimination in close relationships. The consequences of discrimination were apparent in various daily interactions, including with family, friends, and employers, across all studied countries. Follow-up analysis included qualitative information from 15 of the countries involved (Rose et al. 2007). Surprisingly, minor cross-cultural differences were discovered, confirming that personal stigma experiences are widespread and present a global public health concern. In 2015, the ASPEN study group (Anti-stigma Program European Network) investigated discrimination reported by 1082 individuals with depression across 34 countries sorted by their Human Development Index scores (Very High; High; Medium/Low) (Lasalvia et al. 2015). Participants from high-income nations (with elevated Human Development Index scores) were more likely to expect discrimination, but this group did not indicate a higher incidence of actual discrimination experiences. Possible explanations for the increased anticipation of discrimination in wealthier countries include the nature of jobs, the wider socio- economic context, understandings of mental disorders, and self-perception. For instance, nearly twice as many individuals in high-income nations anticipated discrimination related to employment. In lower-income countries, there may be a stronger focus on family and community connections along with greater community support for individuals with mental health issues.

Additionally, in lower-income nations, blame for mental disorders is less often placed on individuals or their families, as causes are frequently linked to external factors beyond personal control, such as divine will, Karma, or other supernatural forces.

The movement for service users in these countries is either underdeveloped or absent, leading individuals with mental disorders to be less informed about stigma and its impacts. As nations progress, expected stigma might rise. In 2015, (Stuart et al. 2015) investigated the perceptions of psychiatry and psychiatrists using a randomly selected sample of 1057 non-psychiatric clinical teaching faculty across 15 academic institutions, primarily located in lower and middle-income countries. Ninety percent of the participants believed that psychiatrists did not serve as effective role models for medical students. Also, 84 percent felt that psychiatric patients should not receive treatment outside dedicated facilities, while 73 percent viewed psychiatric patients as emotionally taxing. Significant differences in stigma scores, which were based on the number of endorsed items, appeared only in three nations: China, which had lower-than-average scores, and Ukraine and Russia, which had scores higher than average.

Differences among countries accounted for just 18 percent of the variation in the average score of the scale. These findings suggest that negative views held by professionals about mental health are widespread globally, showing more similarities than differences across various nations. Recently, Seeman and his team conducted a worldwide survey on the stigma related to mental illness using an innovative online platform, gathering responses from over half a million people in 229 countries. This survey did not implement a standardized measure for stigma and likely attracted respondents who were comfortable with technology, typically younger males with higher education. In the more advanced nations, such as Canada, the USA, and Australia, 7 to 8 percent of respondents thought individuals with mental health issues were more violent, whereas this view was held by 15 to 16 percent in developing nations like Algeria, Mexico, Morocco, and China. We can only guess why individuals in developing countries are more inclined to label someone with mental illness as violent. Seeman and his colleagues highlight that culture, traditions, and the availability of education and healthcare all influence how the public views mental health conditions. It remains unclear whether the differences in public attitudes or other elements related to the lower treatment gap in wealthy nations compared to poorer ones contribute to these disparities. For instance, in developing countries, the limited availability of treatment and hospital resources to manage potential violence may lead to increased encounters with severe mental illness and related violence within the community.

However, in many developing countries, people with more serious global mental health disorders are typically managed at home where they may be hidden away to avoid shame and embarrassment, or they may be segregated in large and far away mental hospitals. (Cambridge University Press)

Those in the community would then represent people with less severe disorders who are less likely to become violent. Despite day to-day experiences, the public stereotype still may be that the ‘mentally ill’ (defined as those that must be hidden away) are more disturbed and violent.

Whatever the explanation, these findings do suggest that the content of public stereotypes may differ

depending on country and development level.

More research is now needed to uncover the social and cultural conditions that may explain these findings. There is also evidence that the content of public stereotypes and stigmatizing attitudes differs depending on the disorder group considered. For example, in a random sample of Americans responding to the General Social Survey, vignettes of people with drug or alcohol dependence were more likely to be rated as likely to be a danger to others (over 60% agreed);

2.1 Search Methods

I utilized information gathered from systematic reviews about various anti-stigma programs that might demonstrate their immediate success in affluent countries. My literature search then focused on three areas that had not been previously examined: Mental Health Awareness: Breaking the Stigma, the effectiveness of anti-stigma programs in low- and middle-income nations, and primary studies on medium- to long-term impacts. I searched for potentially relevant abstracts published before this time using various search terms across electronic databases. Detailed information about the eligibility criteria for studies and the data analysis methods used is provided in the appendix. Due to significant methodological issues with the studies included in the systematic reviews, few meta-analyses were performed. The results indicated that interventions often lead to short- to medium-term increases in knowledge and, less frequently, improvements in attitudes. The differences in strength between treatments aimed at altering attitudes versus those aimed at enhancing knowledge could explain the variations in results, or it might reflect the use of diverse research methods. Four evaluations shared information on the overall trends of effect sizes, revealing that the interventions had moderate to mild impacts. There was a general consensus that programs involving social interactions or personal narratives were more effective than those that simply provided factual information about the prevalence of mental health issues. Researchers have also examined moderators of effects to identify the most successful contact types. For example, social interaction somewhat challenges existing stereotypes, yet more research in this area is necessary. Some interventions warrant careful examination as they might inadvertently increase stigma, like suggesting a biological or genetic cause for mental health disorders. Most reviews pointed out the methodological weaknesses of the included studies, stressing the necessity for stronger methods, randomized trials, the use of validated measures, and follow-up after the immediate post-intervention phase. Several reviewers pointed out the inadequacies of the interventions, which were often lacking in theoretical backing and developmental research or sometimes failed to offer training, manualization, or reliability evaluations. Major evidence gaps included a lack of studies from low- and middle-income countries, insufficient data on cost- effectiveness, effects of discrimination, as well as multi-exposure, multi-component, and long- term interventions. Approaches aimed at the general public to reduce stigma have been investigated through systematic reviews, controlled interventions, repeated cross-sectional surveys, and longitudinal studies. Until recently, these studies focused on changes in knowledge or attitudes but did not assess their impact on behavior.

A meta-analysis conducted by Corrigan and colleagues that examined 79 interventions aimed at tackling public stigma found that both education and social interaction were effective in reducing stigmatizing beliefs and planned behavior. Based on the research conducted by Corrigan and his team, it was determined that direct, real-life contact was more beneficial than contact via videos. Furthermore, for adults, personal contact proved to be more effective than just providing instructions. The research indicated that media campaigns in Norway and England yielded moderate improvements in both knowledge and attitudes. In England, a particular focus on depression was included. Although there was some change in public awareness due to a wider initiative by the Royal College of Psychiatrists called Every Family in the Land, people's attitudes did not shift significantly. In Australia, several important studies examined how mental health first aid offered to entire communities impacted attitudes. These studies showed a fairly consistent trend in positive attitude changes but provided weaker evidence for actual knowledge improvement. The Beyond Blue program, which targets depression awareness, led to better public understanding and feelings towards the issue. Different states and territories in Australia were assessed based on how widely the program was embraced, which included local educational events and media communications. The findings indicated that residents in areas with higher involvement in the Beyond Blue initiative were more likely to identify depression in themselves and those around them. A program known as Like Minds Like Mine aims to reduce stigma and discrimination while encouraging community participation. Research indicates that effective campaigns for mental health awareness should focus on enhancing understanding, diminishing stigma, and enabling early recognition and treatment. It has been suggested to tailor messages for particular groups, such as young adults or those struggling with substance abuse. This includes a summary that highlights the essential components to create an effective mental health awareness campaign. The evaluation of educational campaigns related to mental health and suicide is not very common and often lacks strong methodological approaches, which creates challenges in drawing definitive conclusions. Recent analyses have found that campaigns aimed at preventing suicide and enhancing "mental health literacy" can lead to short-term improvements in knowledge and attitudes related to mental health and suicide, such as better recognition of depression.

However, many studies indicate that there are limited impacts on actual behaviors when communications are the only strategy used. A review examining different stigma reduction campaigns since the 1990s highlights the evolution within this area of research, demonstrating various approaches taken. Some key messages conveyed include that (1) mental illness should be recognized as a condition like any other, (2) mental health is a vital part of our overall well-being, (3) mental illnesses are common and affect a significant portion of the population, and (4) promoting

social inclusion is effective.

A campaign that follows this approach portrays individuals with mental health issues as accountable, capable of recovery, and able to lead fulfilling lives. A strong theoretical foundation is crucial for creating the most effective mental health awareness campaign (Kelly et al., 2007).

The Theory of Planned Behavior Model was utilized in the Suicide Intervention Project, while the Compass Strategy relied on the Transtheoretical/Stages of Change Model, the Health Belief Model, and the Diffusion of Innovations Model, all guided by the evidence-based "Precede- Proceed" Model (Kelly et al., 2007, 2). Additional evaluations of mental health awareness initiatives indicate that well-known athletes or other influential figures have effectively increased awareness and enhanced public attitudes towards mental health.

There are three categories of stigmas linked to mental health conditions: societal stigma, personal stigma, and institutional stigma (Tanielian and Jaycox, 2008). Societal stigma involves common misunderstandings about those with mental health issues. Personal stigma arises when individuals adopt the negative views of society, while institutional stigma happens when mental health policies unjustly restrict an individual's chances (Tanielian and Jaycox, 2008). These stigmas collectively create obstacles to receiving treatment. Sociological theories view public stigma as a broad societal element that impacts both individuals and the community. By applying labelling theory, these sociological concepts stress that stigma emerges from social interactions, where labelling, stereotyping, separation, loss of status, and discrimination contribute to its existence (Thornicroft et al., 2015). The effects of stigma can worsen the challenges linked to the main symptoms of mental disorders, leading to negative impacts on various life areas, including relationships, education, and employment. Discrimination can create barriers, which may result in reduced income, job loss, and restricted access to housing or healthcare (Thornicroft et al., 2015). Many studies that have looked into the short-term effectiveness of interventions in wealthier nations showed considerable variation in their methods and clinical practices, making it difficult to perform meta- analysis. The findings indicate that interventions tend to lead to improvements in knowledge in the short to medium term and, though less frequently, in attitudes. The differences in outcomes may result from varying levels of intensity in knowledge-focused interventions versus those aimed at altering attitudes, or they could reflect different research methods used. Even though studies do not always align, there is a clear agreement that interventions involving social interaction or firsthand stories are generally more successful than alternative approaches like providing statistics about mental illness. Some interventions might even lead to negative effects, such as increasing

stigma, particularly when biological reasons are cited as the cause of the mental illness (Holzinger et al.,

2008).

Most evaluations of research regarding mental health awareness campaigns have criticized the quality of methodology, highlighting the necessity for more randomized trials and stronger approaches, the use of untested measures, and often no follow-up after the immediate post-intervention period in several studies (Thornicroft et al., 2015). A meta-analysis conducted on 79 intervention studies aimed at decreasing stigma in the general population by Corrigan et al. in 2012 demonstrated that both educational approaches and social interactions helped reduce stigmatizing beliefs and behaviors. The authors determined that live interactions were more beneficial than viewing recorded ones, revealing that for adults, personal contact proved to be more effective than educational methods. Evidence exists that interventions designed to lessen stigma for individuals with mental health issues are effective. Mittal et al. found that among 14 reviewed studies, eight yielded positive results in diminishing self-stigma, with effects that ranged from small to moderate. Many strategies to reduce self-stigma typically involve group-based psychoeducational sessions, which may incorporate elements of cognitive-behavioral therapy, as highlighted by Mittal et al. in 2012. Numerous countries have investigated anti-stigma programs targeting students in schools and colleges. Such programs mainly focused on providing mental health education or combining this education with direct interaction with individuals who have experienced mental health challenges, such as peer support workers. A comprehensive review of anti-stigma programs in educational settings indicated mixed methodological quality among the studies, with only two random trials available. This made it challenging for one reviewer to draw definitive conclusions, according to Schachter et al. in 2008. Corrigan et al. in 2012 also noted that while direct contact was most effective for adults, educational approaches seemed to be more advantageous for adolescents. Mental health professionals who work with these diverse populations can sometimes contribute to stigma and discrimination. They may be sources of stigma, experience stigma themselves, or act as agents for reducing stigma. However, interventions aimed at decreasing stigma among healthcare staff are rare, as mentioned by Thornicroft et al. in 2015. Despite extensive evaluations of mental health awareness initiatives, the intervention types most frequently regarded as effective include education or informational efforts, along with various forms of social interaction between those with and without mental health conditions, as pointed out by Corrigan et al. in 2012. The findings from systematic reviews indicated that social interaction emerged as the most effective intervention for adults in short-term studies, although it was inconsistent in producing results for longer follow-up periods.

At a broad community level, there tends to be a reliable pattern showing that a positive shift in attitudes brings short-term benefits, although evidence for improvements in knowledge is not as strong.

For individuals with mental health issues, some group anti-stigma initiatives appear promising. Specific groups like students often see temporary improvements in attitudes through interventions based on social contact, but knowledge gains happen less frequently. Therefore, there is a notable need for research with follow-ups over extended periods to evaluate if initial improvements are maintained or diminished, and to determine if ongoing or sporadic interventions are necessary to ensure continued progress (Thornicroft et al., 2015).

Based on earlier research, interventions that involve education seem to effectively reduce stigma among younger individuals, despite some educational initiatives showing inconsistent results or no impact. Four studies (Winkler et al., 2017) examined contact interventions; of these, two indicated positive outcomes (Winkler et al., 2017; Mulfinger et al., 2018) while the other two showed mixed results (Vila-Badia et al., 2016) or no impact (Pinto-Foltz et al., Myer 2011). This variability complicates the evaluation of the effectiveness of contact-only strategies in tackling stigma in this review.

Combining education with contact methods may lead to reductions in stigma, but these effects were not consistently significant or sustained in the long run (Staniland and Byrne, 2013). Successful intervention strategies included educational methods, such as lessons and curriculums that featured modules clarifying stigma-related topics, and activities like video games and guided discussions, which could combat stigma by correcting false information regarding mental health. Additionally, interacting with individuals who have mental health challenges could help in reducing stigma as well. In most cases, effective programs involved trained educators or psychologists leading these initiatives, which might have enhanced the effectiveness of the anti- stigma measures. Individuals with mental health challenges frequently face stigma and discrimination within their communities worldwide, including those suffering from common mental illnesses like anxiety and depression, as well as more severe conditions such as schizophrenia and substance use disorders. Goffman, a prominent researcher on stigma, defined it as a “deeply discrediting” label that diminishes an individual from being “a whole and usual person to a tainted, discounted one.” Since his observations, various stigma types have been recognized. For instance, public stigma consists of the stereotypes, negative perceptions, and discriminatory actions from community members, healthcare professionals, or even relatives who might stigmatize someone based on certain traits. This idea can be divided into three categories: knowledge-related issues (misinformation), attitude-related issues (prejudice), and behavior- related issues (discrimination).

The tangible experience of stigma, known as discrimination, refers to the individual's personal feelings of being discriminated against, excluded, or devalued due to specific characteristics. Self-stigma, or internalized stigma, develops when individuals accept the negative beliefs and biases directed at them, resulting in a loss of self-worth and leading to feelings of stress, shame, hopelessness, depression, as well as a sense of isolation and social withdrawal. Stigma and discrimination have extensive effects on individuals with mental health issues, and those affected often say these challenges can be more difficult than the illness itself. These effects can lead to many negative outcomes, including high levels of stress and anxiety, social isolation, reduced overall well-being, fewer job opportunities, financial hardship, challenges in personal relationships, and limited access to healthcare, along with decreased willingness to seek medical help. (Semrau et al. International Journal of Mental Health Systems)

The consequences can occur directly or indirectly; for instance, self-stigma may prevent someone from pursuing a job for fear of failure after accepting stigma, or a lack of social support may contribute. Although the experience of stigma appears to be quite similar across different environments, the ways it operates are intricate and can be influenced by cultural factors regarding what is prioritized in a specific community. This includes cultural views on mental health conditions, beliefs about their origins, and cultural values that can encourage changes in behavior, such as reducing discriminatory actions or promoting individuals seeking help. Engaging actively with someone who has firsthand experience with mental health challenges tends to be more helpful than just passive contact, although the way this engagement happens—whether in person or online—doesn't seem to significantly affect the outcome. Research has indicated that mental health service use increased after an awareness campaign in a resource-limited area of South-East Nigeria.

Between the years 2011 and 2013, Amaudo Itumbauzo, a civil society organization focused on mental health in South-East Nigeria, created and executed a program aimed at raising awareness about mental health issues. The initiative sought to alter the community's understanding and beliefs regarding individuals with mental health disorders while also promoting the use of their Community Mental Health Programme, which operates within three South-Eastern Nigerian states to incorporate mental health into local government health services. (Semrau et al. International Journal of Mental Health Systems) This initiative featured training sessions for volunteer Village Health Workers, enabling them to connect with crucial community figures such as traditional leaders, churches, and groups for women and youth. These workers communicated mental health information that countered prevalent myths and included a media and radio campaign to spread awareness.

This updated approach was made in collaboration with CBM, an international NGO. The program notably increased visits to primary care clinics associated with the Amaudo Community Mental Health Programmed. The Indigo-Local study mentioned here builds upon the Amaudo program and expands its reach to additional environments. This study is part of the larger Indigo Partnership initiative, which aims to develop and test various culturally-adapted, multi-level stigma reduction strategies related to mental health across a range of target groups in seven locations throughout five Low- and Middle-Income Countries (LMICs) in Africa and Asia.

Originating from the Indigo Network, the Indigo Partnership consists of an international group of researchers dedicated to enhancing mental health by minimizing stigma and discrimination associated with mental illness. As the previous Amaudo initiative did not include a targeted role for social contact interventions with individuals experiencing mental health challenges, the Indigo-Local study introduced an aspect that incorporated personal interactions into its awareness efforts through media and professional information sharing. Consequently, the Indigo-Local intervention retains elements from the Amaudo project while intentionally integrating user testimonies to foster social contact, as evidence has emerged indicating that this can successfully reduce stigma and discrimination among trained community health workers, the broader community, and service users, while also enhancing the uptake of mental health services. (Semrau et al. International Journal of Mental Health Systems)

Prior research reveals that Nigeria faces a multitude of health challenges requiring public health campaigns for effective resolution.

According to Muhammad, Abdulkareem, and Chowdhury, notable health concerns in Nigeria include infectious diseases, managing vector-borne diseases, maternal and infant mortality, inadequate sanitation and hygiene, disease surveillance, non-communicable diseases, and traffic-related injuries. The researchers contended that these various health challenges have resulted in minimal improvements in the health status of Nigerians, indicating a need for well-structured programs to effectively tackle these issues. Thus, public health communication serves as an essential tool for addressing some of these challenges and is being employed in various contexts. However, there is a pressing need to assess the nature and efficacy of public health communication practices in Nigeria to validate their effectiveness. According to Muhammad et al. Public Health communication focuses on enhancing the health and well-being of a community or group by means of communication. According to O'Sullivan, Yonkler, Morgan, and Meritt in 2003, it generally includes personal interactions (like discussions between peers, couples, or health professionals and clients), community-based methods (such as engagement with family, religious leaders, and local organizations), and widespread media platforms (for instance, television, radio, newspapers,

magazines, outdoor advertising, and the internet).

Ofurun and Tob in 2016 made an effort to examine various case studies regarding public health communication approaches in Nigeria to evaluate how effective these strategies are in promoting healthy living.

The examination analyzed several pertinent studies addressing health concerns, including Female Genital Mutilation (FGM) in Lagos (Isiaka and Yusuf, 2013), Polio Public Health Communication Strategies in Northern Nigeria (Nasiru, et al. , 2012), Family Planning in Rural Nigeria: The Ebelle Scenario (Omoera, 2010), The Effectiveness of Sources of HIV/AIDS Awareness in a Rural Community in Imo State, as well as Awareness and Uptake of Cervical Cancer Screening among Women in Onitsha (Kawonga, 2003). The review's results showed that the success of public health communication relies heavily on the chosen strategy. Although mass media plays a crucial role in public health campaigns. The Rise of Mental Health Concerns in Nigeria the rise of international mental health disorders in Nigeria has become a serious public health challenge, requiring urgent action. According to the World Health Organization (WHO), an estimated 20 to 30% of Nigerians are affected by mental health issues, leading to millions facing various levels of mental health struggles (WHO, 2022). Despite this alarming statistic, mental health remains largely unappreciated within the country's healthcare system. The 2022 National Mental Health Survey revealed that one in four Nigerians will experience a mental health condition at some point in their lives; however, only a small percentage seek or receive proper treatment due to stigma, lack of knowledge, and insufficient healthcare systems (Adebowale & Ogunleye, 2022). Disorders like depression, anxiety, and substance use frequently occur together, worsening individuals' challenges.

Depression is a major mental health challenge in Nigeria, representing a significant portion of the overall mental health burden. Research by Abayomi et al. (2021) indicated that roughly 15% of adults in Nigeria are affected by depression, making it one of the most common illnesses in the country. Anxiety disorders, including post-traumatic stress disorder (PTSD), panic disorders, and generalized anxiety, are also widespread. PTSD is especially common among those who have experienced violence, terrorism, or displacement, with Northern Nigeria being notably impacted due to the insurgence causing intense psychological distress (Ibrahim & Yahaya, 2023). Issues related to substance use disorders, driven by the growing misuse of substances like tramadol, codeine, and cannabis, have become significant, particularly among the younger population in Nigeria. (Okon et al. 2022) pointed out that drug addiction closely relates to the socio-economic struggles faced by young Nigerians, including unemployment and poverty.

Various socio-economic and cultural factors influence the mental health situation in Nigeria. Poverty

plays a crucial role, as it exacerbates stress, limits access to health services, and increases the risk of mental health disorders. The National Bureau of Statistics (2023) reports that over 40% of Nigerians live below the poverty line, creating a setting that fosters mental health problems.

Additionally, the high unemployment rate—especially among the youth—aggravates these issues, where feelings of hopelessness and frustration contribute to an uptick in mental health disorders (Adesina et al., 2023). Gender has a significant effect on mental health because women often face additional obstacles due to gender-based violence, cultural customs, and limited autonomy. This situation leads to higher levels of depression and anxiety in females compared to males (Okoro et al., 2022). In Nigeria, cultural and religious beliefs play a major role in determining mental health outcomes. In certain communities, mental health problems are perceived as spiritual afflictions or consequences of moral failings, causing considerable stigma and reluctance to seek professional help. Often, traditional and spiritual healers are the first point of contact for individuals with mental health issues, which may delay proper diagnosis and treatment (Gureje et al., 2021). Furthermore, societal pressure to conform to cultural norms hinders open discussions about mental health, thus reinforcing the stigma around seeking help. Elements Leading to Mental Health Stigma in Nigeria, mental health stigma remains a common issue, deeply rooted in cultural, religious, and social structures. Cultural and religious beliefs greatly shape perceptions of mental health, often creating negative attitudes towards those experiencing mental health challenges. In various Nigerian traditions, mental illnesses are frequently linked to supernatural forces such as curses, witchcraft, or divine punishment (Atilola, 2015). Such beliefs are upheld by longstanding customs and religious views that see mental health challenges as spiritual issues requiring spiritual solutions rather than medical ones. As a result, individuals dealing with mental health issues often undergo rituals, exorcisms, or other traditional methods, usually instead of evidence-based medical treatments.

This approach not only delays accurate diagnosis and care but also continues to foster stigma, as those affected are often viewed as morally or spiritually inadequate. Misconceptions about mental health and mental disorders increase stigma in Nigeria. Many people mistakenly associate mental illness solely with severe psychiatric conditions like schizophrenia, neglecting the range of mental health issues that also includes depression, anxiety, and stress-related disorders (Gureje et al., 2015).

This narrow viewpoint fosters fear and loneliness, as people with mental health challenges are often seen as dangerous, unstable, or violent. Additionally, the lack of clear understanding regarding the causes of mental illness increases stigma. Many within Nigeria view mental health struggles as a result of personal weakness or as something people bring upon themselves, leading to blame and bias against those affected.

These misconceptions are reinforced by inadequate mental health education and the limited inclusion of mental health topics in mainstream educational systems, creating gaps in knowledge and understanding. Cultural attitudes and language play a large role in continuing mental health stigma. In Nigeria, terms like "madman," "lunatic," or "crazy" are often used to describe individuals with mental health issues, worsening their marginalization and reinforcing negative stereotypes (Adeosun, 2016). Such derogatory language fosters a sense of contempt and dehumanization, preventing people from seeking help for fear of mockery or judgment. The way society views mental health is also shaped heavily by media portrayals, which often depict those with mental illnesses as either comical figures or dangerous beings (Obindo et al., 2021). These representations reinforce existing biases and lead to the exclusion of individuals facing mental health challenges from social and economic opportunities. Furthermore, cultural expectations that value toughness and resilience make it difficult to have open discussions about mental health.

Recognizing mental health issues can be viewed as a sign of weakness, causing many to hide their feelings or avoid seeking help.

These factors create a cycle of stigma that obstructs efforts to improve mental health awareness and access to services in Nigeria. Tackling this issue requires a well-rounded approach that includes public education campaigns, culturally relevant solutions, and the involvement of traditional and religious figures to reshape the viewpoints surrounding mental health. To diminish stigma and improve mental health results in the nation, confronting these deeply-rooted ideas and beliefs is essential. The Impact of Awareness on Stigma Reduction Raising mental health awareness is crucial for fighting stigma and fostering a supportive environment for those facing mental health challenges. Mental health awareness involves sharing accurate information about mental disorders, their occurrence, and the importance of early intervention. It also means addressing misconceptions and biases that support stigma. Awareness initiatives aim to boost understanding, acceptance, and compassion, which are vital for reducing discrimination against people with mental health issues. In Nigeria, where cultural beliefs and false information significantly influence mental health perceptions, enhancing awareness has become an important method for tackling stigma and its harmful effects on individuals and communities.

Globally, various strategies have been employed to raise mental health awareness, providing valuable perspectives that could be adapted to the Nigerian context. Public health initiatives remain one of the most effective approaches. The annual mental health campaigns organized by the World Health Organization (WHO) have played a significant role in public education and advocating for improved mental health services worldwide (WHO, 2021).

These initiatives utilize various media channels to connect with different audiences and deliver messages tailored to specific cultural and economic contexts. Social media has emerged as a powerful tool for mental health advocacy, allowing individuals and organizations to share personal experiences, provide educational resources, and challenge stigma on a large scale.

Additionally, community-based approaches, such as workshops and mental health discussions, have proven effective in fostering conversation and normalizing mental health topics. In countries like Canada, grassroots initiatives such as Bell Let's Talk have shown how community efforts can raise awareness and reduce stigma (Knaak et al., 2019). When applying these worldwide strategies in Nigeria, it is essential to adapt them to the local cultural and socioeconomic realities.

In several communities, traditional and religious leaders hold significant influence and can play an essential role in advocating for mental health. By using their influence to share accurate information and clarify misconceptions about mental health, these leaders can help shift public perceptions.

Furthermore, incorporating mental health education into school programs is vital for creating a more aware generation that understands mental health challenges better. Schools significantly impact how young people think about mental health, providing them with the tools to care for their own and each other's well-being. Teaching and advocacy are essential in shifting perceptions regarding mental health. These educational initiatives aim to equip individuals with the knowledge needed to understand mental health conditions, recognize their signs, and seek help when necessary. They often target specific groups, such as health workers, to reduce stigma in the medical field. Studies show that healthcare workers often have negative attitudes towards those with mental health conditions, leading to poor treatment (Atilola et al., 2015). Workshops and training sessions can help reduce these biases and improve care quality. Advocacy complements education by promoting the voices of those who have faced mental health challenges. Stories shared through media or speaking engagements make mental health issues more relatable, decreasing fear and stigma. Advocacy efforts also include pushing for changes in policies and increasing funding for mental health services. The implementation of the National Mental Health Act in Nigeria in 2023 marked a significant step forward in fighting stigma and raising awareness about mental health (Onwukwe et al., 2023). Continued advocacy is crucial for ensuring this law is effectively put into practice and for creating an all-encompassing mental health care system. Awareness of mental health issues is critical in reducing stigma and nurturing a more accepting society. Both international and local strategies, such as public health campaigns and community-based projects, education, and advocacy, are essential in this effort. Nigeria stands to gain immensely from considering cultural contexts and integrating mental health education within schools.

Combining education, advocacy, and systemic changes can greatly assist in erasing the stigma surrounding mental health. Involvement of stakeholders is key in eliminating mental health stigma, fostering a supportive community for individuals facing these challenges. Health professionals and non-governmental organizations (NGOs) are particularly important in this effort. Healthcare workers are crucial for both mental health care and advocacy, as their expertise allows them to tackle misconceptions about mental illness by providing accurate information to patients and communities. Research suggests that employing person-centered approaches focused on empathy and comprehensive care can help professionals reduce stigma (Audu et al., 2021).

Therefore, training healthcare workers in culturally aware approaches to mental health care is essential. This preparation helps them address deep-rooted cultural attitudes that often contribute to stigma in Nigeria. By educating families, healthcare practitioners can create supportive environments for people with mental health issues, helping to lessen stigma within communities (Oladipo et al., 2019). NGOs play a vital role in supporting government efforts to fight mental health stigma. They often spearhead awareness initiatives and execute community outreach programs aimed at both urban and rural populations. Organizations like the Mentally Aware Nigeria Initiative (MANI) have been vital in organizing awareness campaigns, advocacy programs, and mental health first-aid training that have significantly reduced stigma (Akinola et al., 2022). Moreover, non-governmental organizations often address gaps in mental health services by offering free or reduced-cost care, particularly in disadvantaged areas. This availability helps to make seeking help for mental health concerns more acceptable and challenges the belief that discussing mental illness is forbidden. The media plays an important role in changing the conversation around mental health. As a powerful tool for communication, it can influence how the public views and understands these issues. Research shows that when mental health topics are portrayed positively in the media, stigma can decrease and understanding can improve (Gureje et al., 2020). Documentaries, news stories, and social media initiatives that present real-life experiences of those with mental health challenges help to humanize their situations and confront biases. In Nigeria, platforms like Instagram and Twitter have become spaces for open discussions about mental health, driven by influencers and advocates. Media outlets have a duty to avoid perpetuating harmful stereotypes or sensationalizing mental health issues. They should focus on accurate reporting and language that promotes dignity and respect. In many Nigerian communities, traditional and religious leaders hold essential positions, and their involvement in mental health awareness efforts is vital. These leaders are often consulted for health and social issues within the cultural and spiritual context of Nigeria, making their opinions highly valued. By combining mental health education with cultural and religious beliefs, they can play a

crucial role in reducing stigma.

Religious leaders can use sermons and community gatherings to educate their followers about the medical and psychological aspects of mental illnesses, disputing the idea that these conditions are solely of spiritual nature (Adebayo et al., 2021).

Similarly, traditional leaders can utilize their influence to advance community-based mental health initiatives and support programs. Collaboration among healthcare professionals, NGOs, the media, as well as traditional and religious leaders is critical. Their joint efforts create a comprehensive approach that tackles stigma from various angles, fostering an environment supportive of mental health awareness and assistance in Nigeria. Challenges in Promoting Mental Health Awareness There are numerous obstacles to increasing mental health awareness in Nigeria that significantly hinder efforts to address mental health issues and reduce stigma. One major challenge is the limited access to mental health care across the country. The number of mental health facilities is alarmingly low, with very few institutions available for a population of over 200 million people (Olawale et al., 2022). These facilities are primarily situated in urban areas, which means individuals in rural communities often have little to no access to professional mental health services. The lack of qualified mental health professionals exacerbates the problem. According to the World Health Organization (WHO), Nigeria has fewer than one psychiatrist for every 100,000 people, which is significantly below the recommended ratio (WHO, 2023). This shortage creates a significant gap in service delivery, as those in need of treatment often cannot access the necessary care.

A major challenge within the healthcare system is the stigma that exists. This stigma surrounding mental health is widespread and impacts not only the general public but also healthcare workers, who may hold negative opinions about those suffering from mental illnesses. Studies show that some healthcare providers in Nigeria view mental health issues as a personal flaw or a spiritual problem. This leads to biased behaviors and reluctance to offer proper care. As highlighted by Adewuya and Makanjuola in 2020, this stigma reduces the quality of care provided and discourages individuals from asking for help due to fears of being judged or mistreated.

Furthermore, a lack of appropriate training and knowledge among healthcare staff about mental health problems significantly contributes to this stigma. Addressing this systemic bias is crucial for improving the mental health system nationally. Socio-economic challenges also pose a significant barrier to mental health awareness and advocacy. A large portion of Nigeria's population lives in poverty, prioritizing basic needs over mental health services, as noted by Odeyemi et al. in 2021. The cost associated with mental health treatment, including consultations and medication, is often too high for many Nigerians, limiting their access to care. In addition, there's a noticeable lack of

consistent financial support for mental health education and advocacy programs.

These initiatives often receive insufficient funding compared to other health concerns, leading to fragmented efforts that fail to reach a broad audience. Cultural and religious beliefs further reinforce the socio-economic barriers to mental health understanding. In many Nigerian communities, mental illness is seen as a punishment or curse from supernatural forces, resulting in the isolation of those affected by mental health issues. Families often seek out traditional healers or spiritual solutions instead of professional treatment, which causes delays in care and perpetuates stigma, as discussed by Adeosun et al. in 2019. The combination of cultural and religious influences, along with financial limitations, makes it challenging to promote widespread acceptance and understanding of mental health issues. To tackle these challenges, a multifaceted approach is essential. There should be a focus on increasing funding for mental health services and training healthcare providers to offer non-stigmatizing care. Additionally, community- centered projects that involve cultural and religious leaders in awareness efforts can help break down socio-economic barriers. To reduce mental health stigma in Nigeria, a well-rounded approach is needed. This should involve community initiatives, sharing personal stories for advocacy, and integrating mental health education into schools and workplaces. These strategies, based on research and global best practices, can help challenge deep-seated beliefs, cultural prejudices, and structural obstacles that promote stigma. Community-based mental health programs are vital in Nigeria, where traditional beliefs significantly shape attitudes toward mental health. Engaging communities through interactive methods allows mental health professionals and advocates to align their efforts with local customs and values. Outreach programs can also involve traditional and religious leaders as supporters, leveraging their influence to raise awareness about mental health and reduce stigma, as mentioned by Abdulmalik et al. in 2019. Additionally, initiatives such as mobile health clinics and community rehabilitation programs can make sure that mental health services are available to rural and underprivileged areas. These programs not only provide support but also create spaces for discussions about mental health, encouraging people to seek help without fear of judgment (WHO, 2020). Community-focused projects promote dialogue and create safe places, which help to break down stigma and normalize discussions about mental wellness. Using personal stories for advocacy is a powerful way to challenge stigma associated with mental health. Stories of recovery and strength can address negative beliefs and foster understanding. Studies show that hearing personal accounts from those who have faced and managed mental health issues can significantly reduce biased views (Corrigan et al. , 2016). In Nigeria, those who have experienced mental health challenges can share their stories through public events, social media campaigns, or films to highlight mental health topics and correct

misunderstandings. Organizations like She Writes Woman and Mentally Aware Nigeria Initiative have effectively used this approach to amplify voices and create a sense of community among those affected by mental health issues (Ogunwale et al., 2021).

Narrating personal experiences can inspire hope, nurture empathy, and encourage others to seek help by showcasing paths to recovery. Integrating mental health education into schools and workplaces is crucial for creating an environment that prioritizes mental well-being.

Schools play a key role in shaping attitudes, making it important to implement mental health awareness programs within educational settings. Courses on mental health can teach students about its importance, help them recognize early warning signs, and reduce stigma from a young age (Kutcher et al., 2016). Similarly, mental health initiatives in the workplace can lessen the stigma faced by employees dealing with mental health conditions. Employers can provide training for managers, create support programs for workers, and develop policies that support mental health. Research shows that work practices that support mental health can decrease stigma and improve productivity and employee satisfaction (Doran et al., 2021).

By weaving mental health awareness into educational and work environments, we can create a cultural shift that places mental health on an equal footing with physical health. In conclusion, to reduce mental health stigma in Nigeria, ongoing efforts through community-based approaches, narrative advocacy, and the systematic inclusion of mental health education are essential. Mental health stigma is a pervasive global problem characterized by negative beliefs, attitudes, and discriminatory behavior towards individuals with mental health disorders (Corrigan et al., 2014). The complex, interpersonal, and structural impacts of this stigma lead to social isolation, feelings of loneliness, and a diminished quality of life (Goffman, 1963; Link & Phelan, 2001).

In nations with low to moderate incomes, mental health resources are often limited, and cultural elements may amplify negative perceptions, intensifying the impact of stigma related to mental health (Patel, 2007). Efforts to improve public health have emerged as a crucial strategy in tackling mental health stigma. These programs aim to increase awareness within the community, eliminate misconceptions, promote understanding, and inspire supportive actions (Crisp et al. , 2005). Various communication methods, including face-to-face interactions, community engagement, and media outreach, are employed to convey specific messages. Nonetheless, the effectiveness of these initiatives can be influenced by cultural practices, current levels of awareness, how campaigns are designed and executed, as well as the availability of mental health services (Schulze et al. , 2005). Southeast Liberia presents a unique and under-explored area for studying mental health stigma and the potential influence of public health efforts. The region has encountered serious challenges,

including the impacts of civil wars and the Ebola crisis, which likely influenced mental well-being and potentially worsened pre-existing stigmas (Bolay et al. , 2019; World Health Organization, 2016).

To develop interventions that are sensitive to local culture and suitable for the context, it is important to understand how effective public health campaigns are at reducing mental health stigma in this specific sociocultural environment. This literature review will facilitate a focused exploration in Southeast Liberia and will examine existing knowledge about mental health stigma, the theoretical backgrounds of anti-stigma efforts, evidence of their success across various settings (particularly in LMICs), and the distinct sociocultural dynamics of Liberia. Understanding Mental Health Stigma In social sciences, mental health stigma is a complex and multi-layered issue that has been extensively researched. It involves a distinction between self-stigma and public stigma (Corrigan, 2000). "Public stigma" refers to the negative views and beliefs that society holds about individuals with mental illness. When individuals with mental health conditions take these negative societal perceptions to heart, they experience self-stigma, leading to diminished self- worth, feelings of shame, and a hesitance to seek help. Link and Phelan (2001) expanded on this by characterizing stigma as including discrimination, labeling, stereotyping, segregation, and loss of status. Cultural factors significantly shape how stigma manifests and its intensity regarding mental health. In many LMICs, believing that mental health challenges stem from witchcraft, superstitions, or moral failings often results in social exclusion and a preference for traditional healing methods over formal mental health care (Jenkins et al. , 2010). Fears of social rejection and the stigma surrounding mental illness may prevent individuals and their families from discussing their issues openly or obtaining necessary assistance (Ngui et al. , 2010). Research by the WHO in Liberia supports these findings. The stigma associated with mental health has extensive consequences. As noted by Sirey et al. (2001), stigma serves as a major barrier to accessing mental health services, which delays both diagnosis and treatment and leads to poorer outcomes. Self-stigma can hinder recovery and reintegration into society, diminishing hope and self-efficacy (Livingston & Boyd, 2010). Additionally, people experiencing mental health issues may face limited options for housing, employment, and education due to structural stigma rooted in institutional practices and policies (Pescosolido et al., 2013). Thus, it is crucial to address mental health stigma to improve the lives of those affected by mental illness and to promote overall public health. Models for Anti-Stigma Initiatives Public health programs aimed at reducing stigma related to mental illness often integrate various theories of social and behavioral change.

The Social Contact Theory (Allport, 1954) suggests that fostering positive interactions among different social groups can reduce bias and negative stereotypes. Mental health campaigns can connect those with lived experiences of mental illness to the general public, helping to humanize heir stories and combat stigmatizing ideas (Corrigan et al. , 2001).

The Information Deficit Model asserts that stigma results from a lack of knowledge and understanding about mental illness. Campaigns based on this model aim to correct myths and misconceptions by informing the public about the biological, psychological, and social dimensions that lead to mental health disorders (Crisp et al. , 2005).

However, some research indicates that simply sharing information may not effectively change deeply held beliefs and behaviors (Pinfold et al. , 2003).

The Societal Standards Theory highlights how perceived societal standards can influence individual behavior. Anti-stigma initiatives can seek to shift perceptions by showcasing the commonality of mental health issues and promoting positive attitudes and supportive actions as the norm (Berkowitz, 2004). The Extended Parallel Process Model (EPPM) (Witte, 1992) offers a valuable understanding of how fear appeals work in health campaigns. While campaigns can spotlight the negative impacts of stigma, their success also depends on empowering individuals to take action while mitigating perceived threats. Effective anti-stigma programs often utilize aspects of several theoretical models, employing a multifaceted approach that encompasses social engagement, education, and efforts to modify social norms (Henderson et al., 2013).

The strategies and foundational theories should be tailored to the specific manifestations of stigma and cultural contexts of the targeted groups. Evidence Supporting Anti-Stigma Campaigns' Effectiveness An increasing volume of research has examined the effectiveness of public health efforts in reducing stigma around mental health across various environments. Systematic reviews and meta-analyses yield mixed results but generally indicate a positive trend. According to evaluations by the Swedish Public Health Agency, social interaction and educational approaches are among the effective strategies shown to reduce stigma.

The impact of national programs, such as England's "Time to Change" campaign that involved social marketing, media outreach, and community participation, has been analyzed in wealthier countries. Studies of "Time to Change" reveal that public stigma has notably diminished, and the perceptions of individuals with mental health challenges have improved (Evans-Lacko et al., 2013). While evidence from low- and middle-income countries (LMICs) is less extensive, it is increasing concerning the success

of anti-stigma initiatives. A systematic review by (Shidhaye et al. 2013) highlighted the importance of cultural awareness and local engagement when adapting and executing anti-stigma strategies in LMICs.

Research from nations including Ethiopia and India has indicated that community-driven interventions, like contact-based programs and peer-led educational efforts, can effectively reduce local stigma (Nadkarni et al., 2017; Fekadu et al., 2014). However, the available evidence remains limited, and in-depth studies are needed in these contexts, particularly for large-scale public health strategies. Factors influencing the effectiveness of these campaigns include the length and intensity of the intervention, the specific demographic being targeted, the cultural relevance of the messaging, as well as the accessibility and quality of mental health services that individuals can be referred to (Jorm, 2012). If campaigns do not tackle underlying cultural beliefs or connect individuals with appropriate support, they might produce little impact or even unintended backlash. When evaluating the effectiveness of anti-stigma efforts, it is crucial to consider the unique sociocultural landscape of Liberia, especially Southeast Liberia. This region is known for its strong community bonds and diverse cultural practices, where traditional healing methods often play an essential role in the identification and treatment of health issues (Cooper et al., 2017). The mental health of individuals in Southeast Liberia has likely been severely affected by the long civil conflict and the Ebola crisis, leading to increased psychological distress and trauma-related conditions (Bolay et al., 2019).

Additionally, these experiences may have shaped how the community perceives and addresses mental health concerns.

A WHO report emphasizes the repercussions of these events on Liberia's mental health landscape. In Southeast Liberia, traditional perspectives and behaviors towards mental illness may be widespread, which can influence the nature of stigma and how individuals seek or avoid care.

Crafting effective and culturally appropriate anti-stigma campaigns requires insight into the various cultural factors contributing to mental suffering. It may be beneficial to incorporate religious leaders, traditional healers, and community figures in the development and implementation of these initiatives to foster trust and promote acceptance. Research has underscored the importance of community engagement in mental health programs in LMICs. In Southeast Liberia, as is the case in many LMICs, there are likely to be limited mental health services available. The existence or absence of affordable, quality mental health care can greatly affect the success of anti-stigma efforts. If campaigns succeed in motivating individuals to seek help but fail to provide access to suitable resources, this can lead to disappointment and undermine their credibility (Corrigan, 2004). For any assessment of public health initiatives focused on decreasing mental health stigma in Southeast

Liberia, it is crucial to have a thorough understanding of the local social and cultural environment. This includes knowledge of traditional beliefs, the impact of historical traumas, existing community frameworks, and the accessibility of mental health services.

CHAPTER-III

RESEARCH METHODOLOGY

3.1 Research Design

A research design using mixed methods and case studies combines both quantitative methods, such as surveys, and qualitative methods, including interviews and focus groups. This approach aims to assess how effective public health campaigns are in lowering mental health stigma in Southeast Liberia.

3.2 Study Area & Study Population

The research took place in the southeastern region of Liberia, which includes five counties: Maryland, Grand Kru, Grand Gedeh, River Gee, and Sinoe. The total population in these counties is around 774,073 people. The specific populations are as follows: Maryland has 172,587 residents, Grand Kru has 109,342, Grand Gedeh has 216,342, River Gee holds 124,653, and Sinoe is home to 151,149. The group of people studied is made up of individuals who are between 15 and 60 years old or older.

3.3 Study Period

The research took place between January 2025 and May 2025.

During this period, data was gathered, the intervention was carried out, and analysis occurred. The timeline of the research aims to assess how well public health campaigns can decrease mental health stigma in Southeastern Liberia, which includes five counties: Maryland, Grand Kru, Grand Gedeh, River Gee, and Sinoe.

3.4 Selection Criteria

Criteria for This Study:

3.4.1 Inclusion Criteria

Participants in this study are residents of Southeastern Liberia aged 15 and older, inclusive of all genders. Adults who have consented are more likely to have been exposed to public health campaigns. Individuals residing in the area for a minimum of 6 months to 1 year will be included to obtain a well-rounded perspective among both men and women, ensuring sufficient exposure to local health initiatives.Both those familiar with the campaigns and those who are not will be considered.

3.4.2 Exclusion Criteria

Those who are younger than 15 years Temporary visitors or non-residents of Southeastern Liberia to ensure the case study region remains relevant, the following groups were excluded:

1. Individuals with cognitive limitations that may hinder their ability to give informed consent or accurately respond to survey or interview questions.
2. People who are either unwilling or unable to engage in the study. Sample Size The study will include residents from five counties in Southeast Liberia: Maryland, River Gee, Grand Kru, Grand Gedeh, and Sinoe.

3.5 Calculation of Sample Size

For this research, a sample size of 385 residents was chosen based on critical logical considerations regarding their responses to the questionnaires. As this is designed as a pre-test/post-test evaluation, we aim to assess how effective the public health campaigns are in lowering mental health stigma through a case study conducted in Southeast Liberia.

Gender Distribution: A balance of male and female participants was included, without specifically addressing potential gender differences but focusing on gathering insights into awareness and responses to prevention measures.

• **Age Distribution:** Participants aged 15 to 60 and older were included, with efforts made to represent various age ranges (for example, 12-14, 15-16, 17-18) sufficiently.

• **Socio-Economic Status:** Participants were categorized according to socio-economic backgrounds (**e. g.,** Self-Employed, Unemployed, Employed) ensuring relevant interventions across diverse social environments.

• **Level of Education:** Stratification according to educational achievements (**e. g.,** Primary, Secondary, Undergraduate, Graduate, and PhD) was also applied, supporting relevant interventions in varied educational settings.

• **County of Residence:** Participants were stratified based on their counties (Maryland, River Gee, Grand Kru, Grand Gedeh, and Sinoe) to ensure relevance in interventions across different educational environments.

The resultant sample size will facilitate meaningful comparisons regarding knowledge and awareness of mental health stigma, evaluated before and after the intervention, and will allow for the analysis of trends within subgroups, such as by gender, age, and socio-economic status.

Various equations may be applied to determine confidence intervals, depending on different factors including the standard deviation.

The formula utilized to find the sample size for this research is.

$$n = \frac{z^2 \times P\hat{}(1-p)}{\varepsilon^2}$$

$$n' = \frac{n}{1 + \frac{z^2 \times p(1-\rho\hat{})}{\varepsilon^2 N}}$$

Where:

Z is the z score

E is the margin of error

N is the population Size

P is the population proportion

3.5 Sampling Technique & Data Collection Tools

3.5.1 Sampling Technique

In this research, the technique used is stratified random sampling. This approach makes sure that various subgroups of residents in the southeast, such as gender, age, economic status, and education level, are well represented in the final sample. By using this method, selection bias is reduced, and the applicability of the results is enhanced.

3.5.1.1 **Stratification**:

The population of residents in each selected counties was based on stratified sampling method with the following factors:

3.5.1.1.1 Gender: Male and female residents.

3.5.1.1.2 Age: residents different age ranges (15-29, 30-44, 45-59, 60 & above).

3.5.1.1.3 **Socio-economic Status**: self employe, unemployed, and employed groups.

3.5.1.2 **Consent Process**:

After finding the participants who met the criteria, we collected informed consent from all residents as well as from parents or guardians of minors during data collection. The consent document outlines the study's purpose, the procedures to be followed, and the rights of participants regarding privacy and confidentiality..

3.5.2 Data Collection Tools

To gather comprehensive data for this mixed-methods study, several data collection tools was employed:

3.5.2.1 **Pre-Test and Post-Test Surveys**:

A structured **self-administered questionnaire** used to collect quantitative data at both the baseline (pre-test) and after the intervention (post-test). The surveys consist of the following components:

3.5.2.1.1 **Demographic Information**: Age, gender, socio-economic status, etc.

3.5.2.1.2 **Attitude and Perception**: Frequency of how people feel about mental health, attitudes toward mental health.

3.5.2.1.3 **Knowledge and Awareness**: Understanding about mental health.

3.5.2.1.4 **Program Feedback**: Participants' opinions on the intervention content and delivery.

3.5.2.1.5

The survey is designed using validated scales where applicable, and the data is analyzed using descriptive and inferential statistics (e.g., paired t-tests, chi-square tests).

1. **Open-Ended Survey Questions**:

In the pre-test and post-test surveys, participants answered open-ended questions, which gave them a chance to share their views on mental health, stigma, prevention, and intervention using their own language. This will offer additional qualitative information about the personal experiences of adolescents.

3.6. Pretesting of the Tools

Prior to using the tools in the main research, a pretest was carried out to evaluate how clear, relevant, and reliable the survey instruments and interview protocols were. By pretesting, researchers can discover any problems with the tools and make needed changes before starting the complete data collection process.

3.6 Ethical Considerations

Fundamental Ethical Guidelines & Particular Aspects of This Research

During this research, the ethical treatment of individuals was honored. Obtaining informed consent is crucial in any form of research, including case studies and surveys. The participants were informed about the objectives, techniques, potential risks and benefits, measures for confidentiality, and their right to withdraw from the study at any time without facing any charges.

Challenge in Context

Given the various backgrounds and the region's many languages, it was important to recognize potential differences in

literacy and language issues. Therefore, local dialects were used to help clarify our goals and objectives.

Additionally, understanding the study's concepts and being aware of mental health terms were

essential.

As a researcher collaborating with community leaders our primary focus was to ensure that participants felt no pressure. This was crucial for effectively assessing how well public health campaigns worked to lessen mental health stigma in the area during my survey. It was made clear that joining the study was entirely optional and would not affect access to other services.

Vulnerability

People who have mental health issues, or who are related to them, may be at risk. Vulnerability is created by stigma itself. people who live in areas of Liberia that are likely to be resource -constrained or post-conflict may be more vulnerable.

Additional precautions were put in place and make sure interviews were handle tactfully and in private for mitigation.

Evaluated participants risks (such as emotional distress or unwelcome disclosure) and established clear explicit procedures to hand those risks (such as support referral channels).

(Steer clear of study methods that might unintentionally hurt people or raise stigma.

CHAPTER-IV

DATA ANALYSIS AND INTERPRETATION

This section analyzes the information collected for the research titled "Assessing the Impact of Public Health Campaigns reducing Mental Health Stigma: A Case Study in Southeast Liberia. "

The findings are derived from the feedback of 200 participants, with 30% identifying as female and 70% as male. Among them, 49% were aged between 15 and 29, 40% were in the 30 to 44 age range, 44% belonged to the 45 to 59 group, and 21% were 60

years or older. Regarding socioeconomic status, out of the 200 responses, 54. 5% indicated they were unemployed, 24. 5% reported being self-employed, and 21% were in regular employment. The counties represented in the study include 64. 3% from Maryland,

15. 6% from Sinoe, 8. 5% from Grand Kru, 7. 6% from River Gee, and 4. 8% from Grand Gedeh.

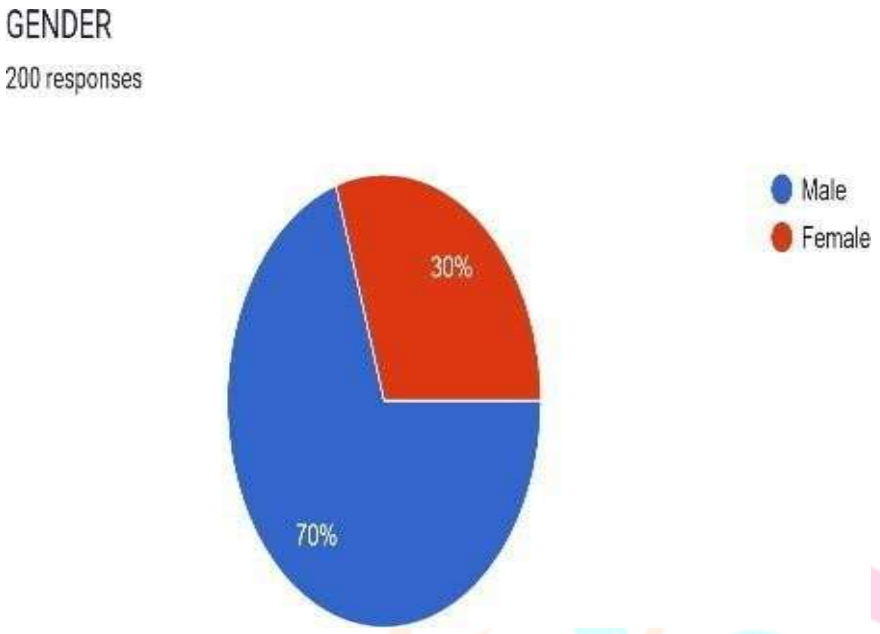


Figure: 1 based on 200 participants' responses, 30% of whom were female and 70% of whom were male.

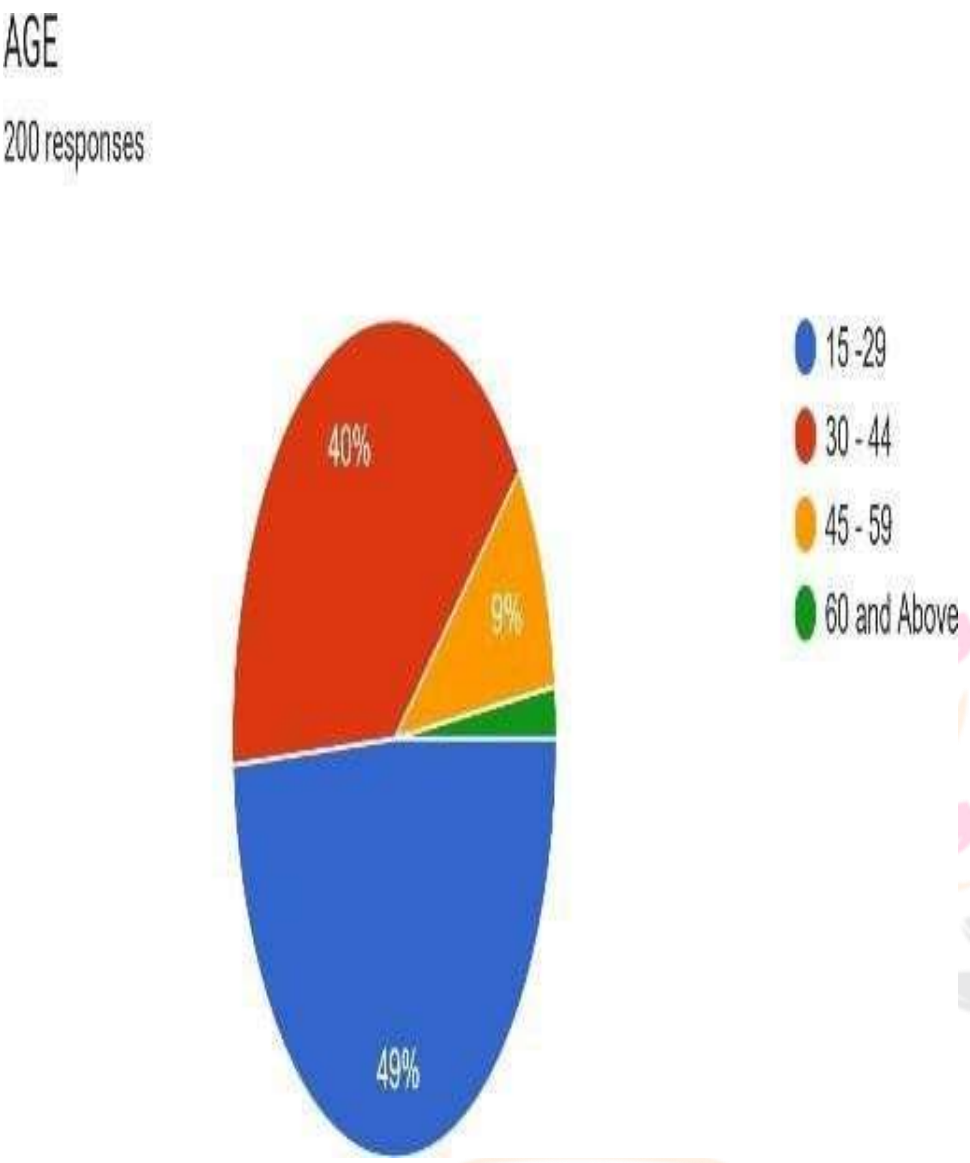
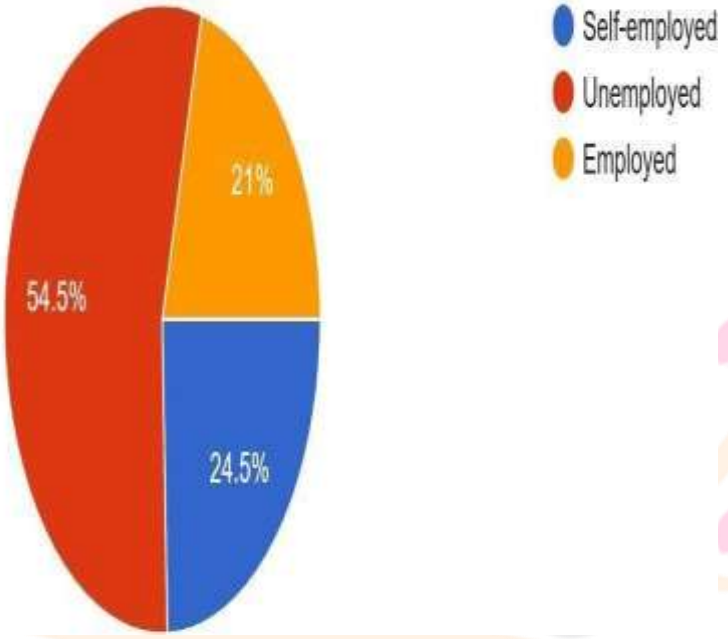


Figure: 49% of whom were 15-29 year of age, 40% were 30-44 years, 44% were 45-59 years and 21% of whom were 60 years and above

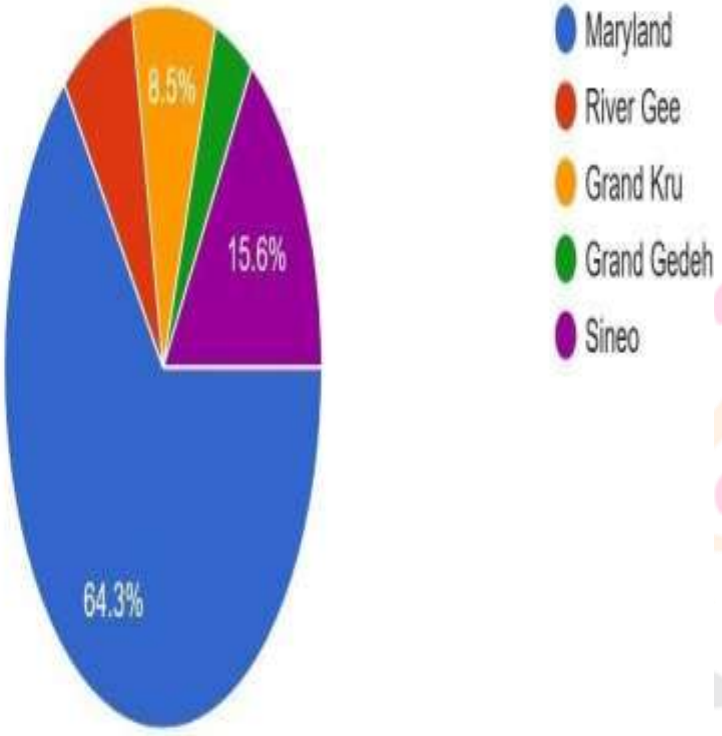
OCCUPATION

200 responses



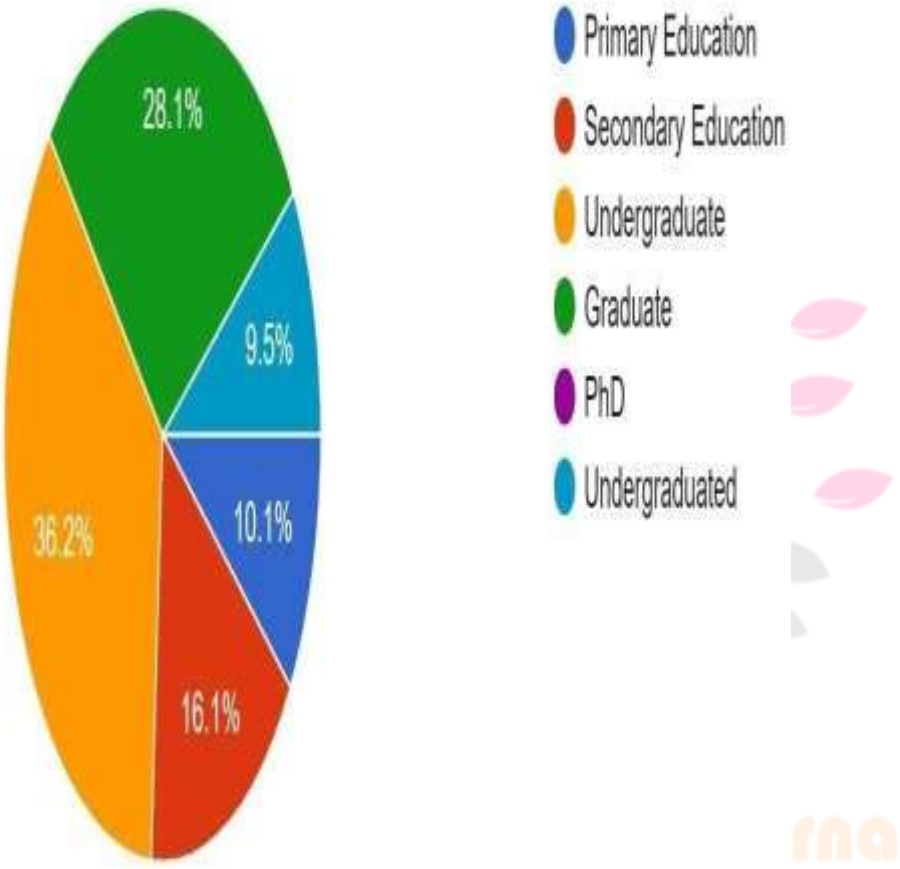
COUNTY OF RESIDENCE

199 responses



LEVEL OF EDUCATION

199 responses



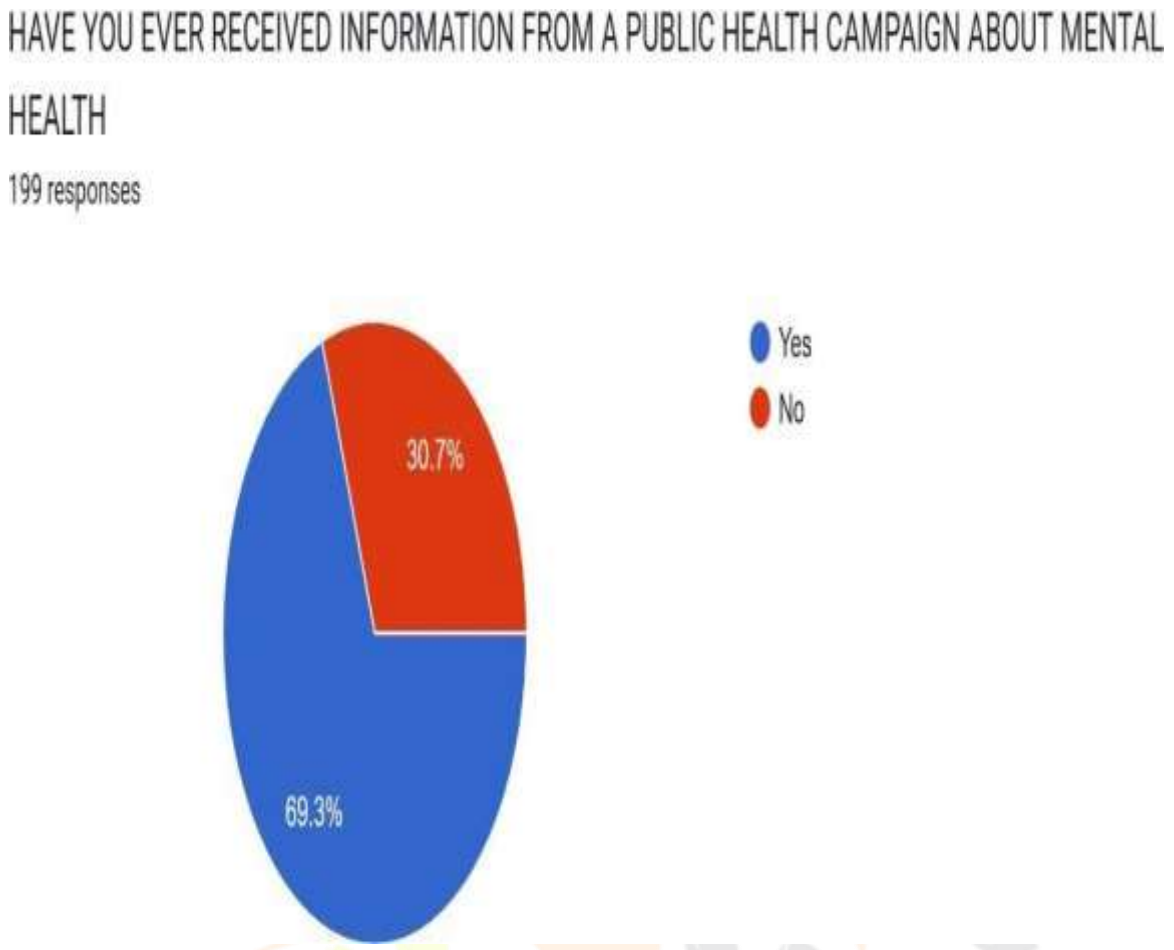


FIGURE: 6 Shows a significant majority (69.3%) report having received information from a public health campaign about mental health, while a notable minority (30.7%) have not.

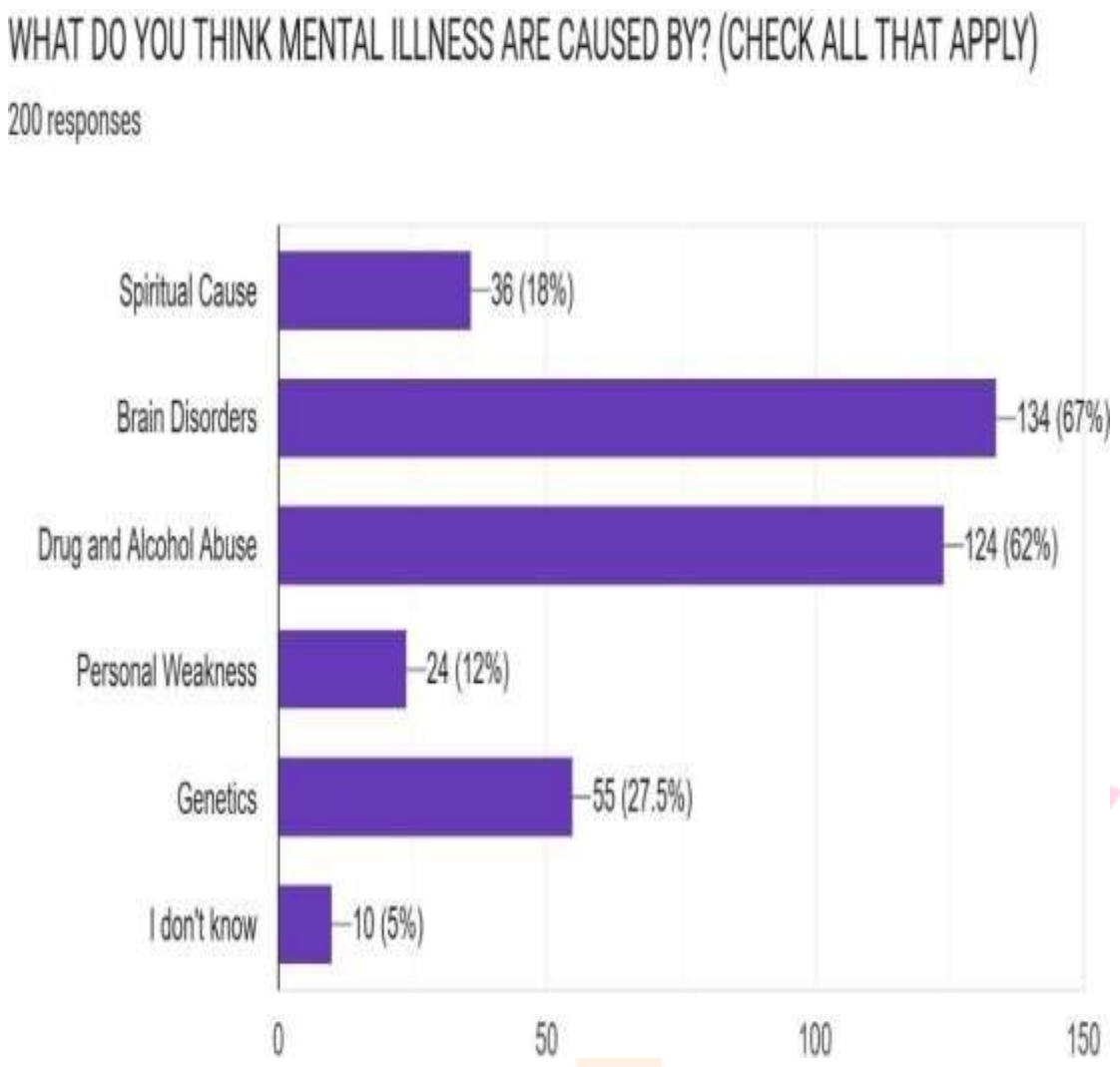


TABLE 1: According to the research, mental illness is thought to be primarily caused by brain disorder and drug and alcohol abuse, with spiritual causes and personal weakness being viewed as less important aspects.

Genetics and ignorance are ranked in the middle.

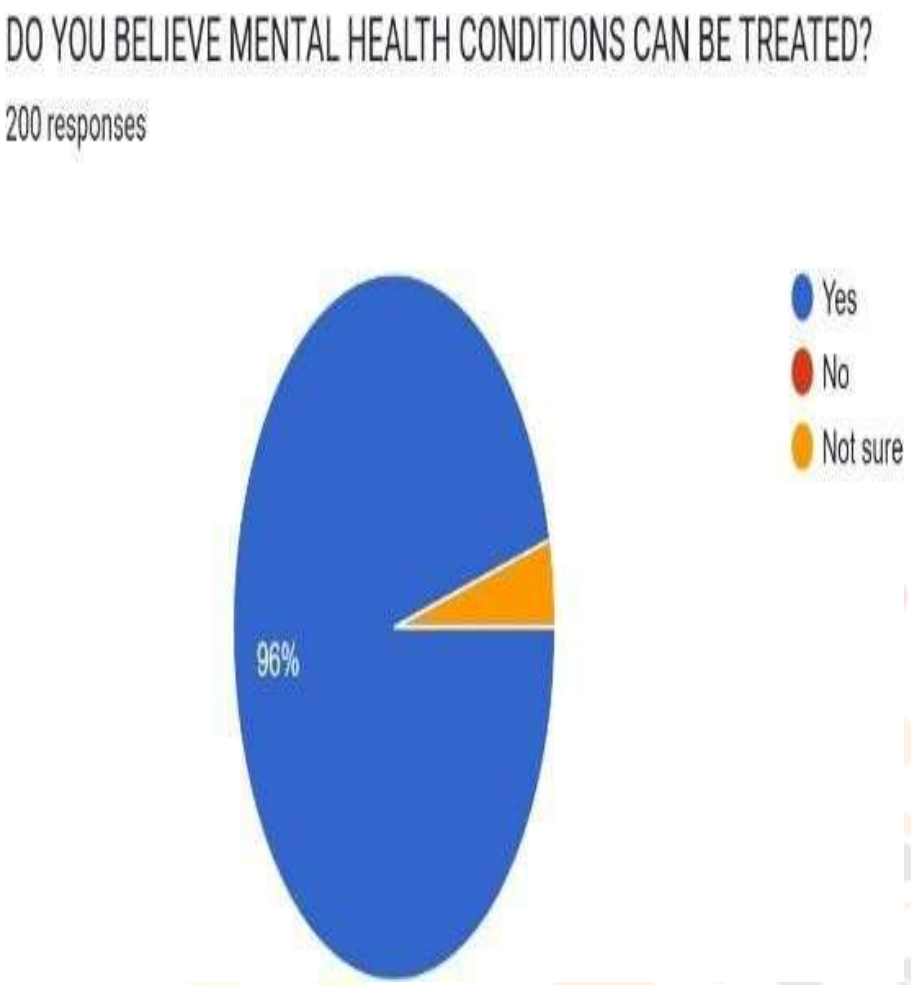


FIGURE 7: indicates that public health campaigns in Southeast Liberia have been highly effective in reducing mental health stigma, as an overwhelming 96% of respondents believe mental health conditions can be treated, with no one expressing doubt and only a small 4% remaining uncertain.

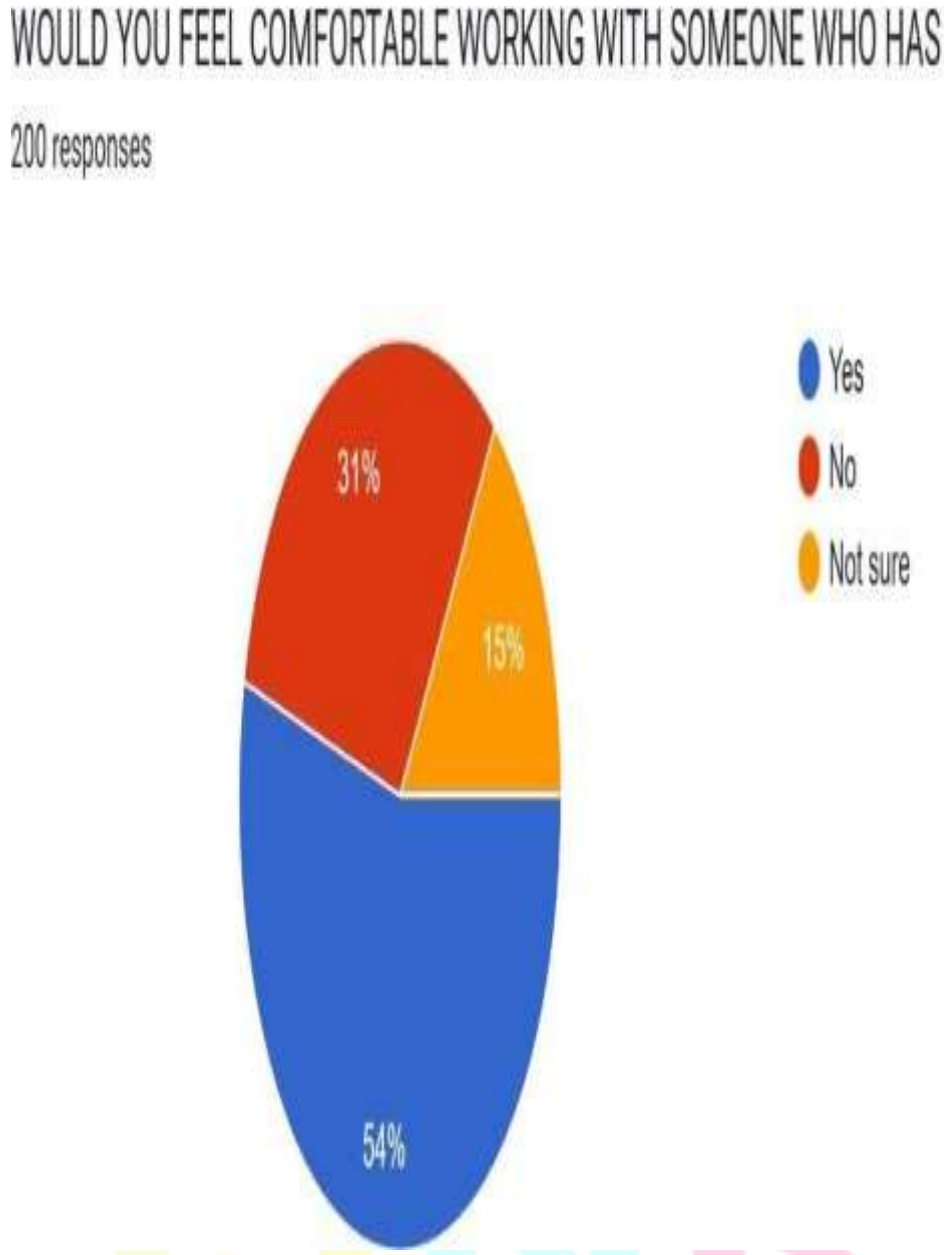


FIGURE 8: **reveals moderate success of public health campaigns in Southeast Liberia, as 54% of respondents feel comfortable working with someone who has a mental illness, though 31% remain uncomfortable and 15% uncertain, indicating room for further stigma reduction efforts.**

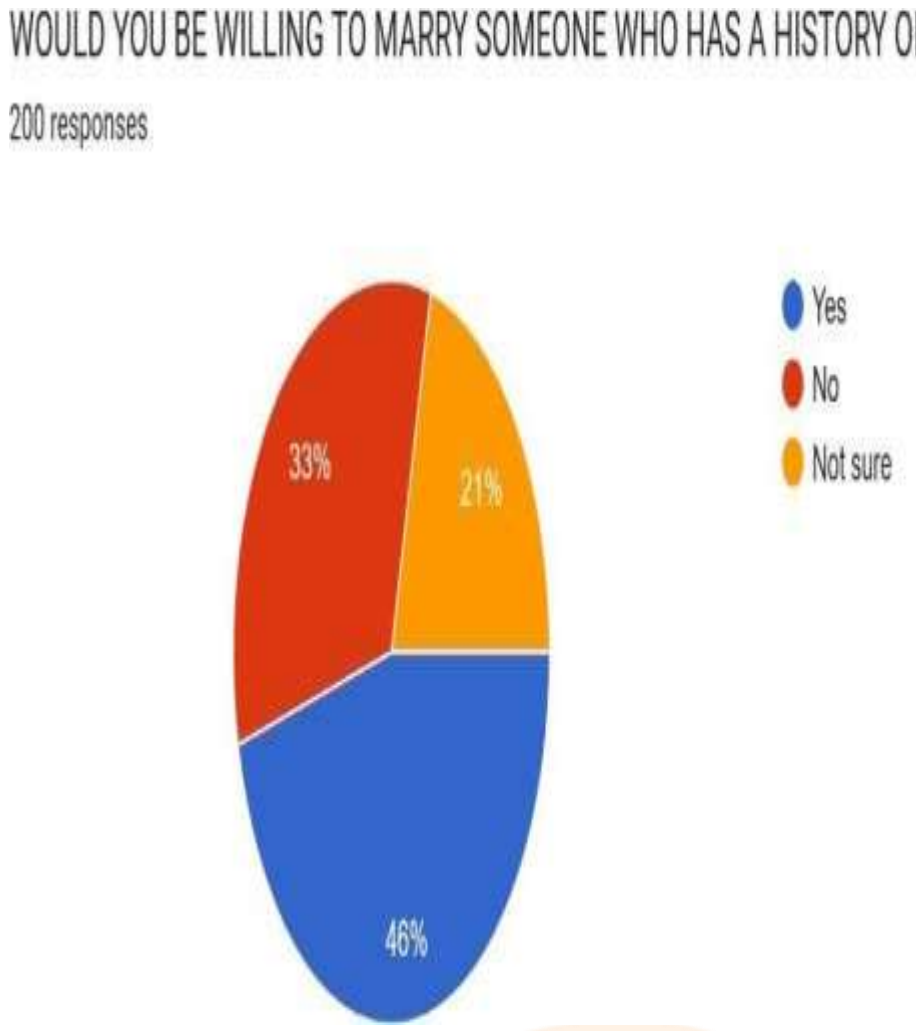


FIGURE 9: shows progress but ongoing challenges in reducing mental health stigma in Southeast Liberia, as 46% of respondents are willing to marry someone with a history of mental illness, while 33% are unwilling and 21% remain uncertain, highlighting mixed attitudes toward deeper social acceptance.

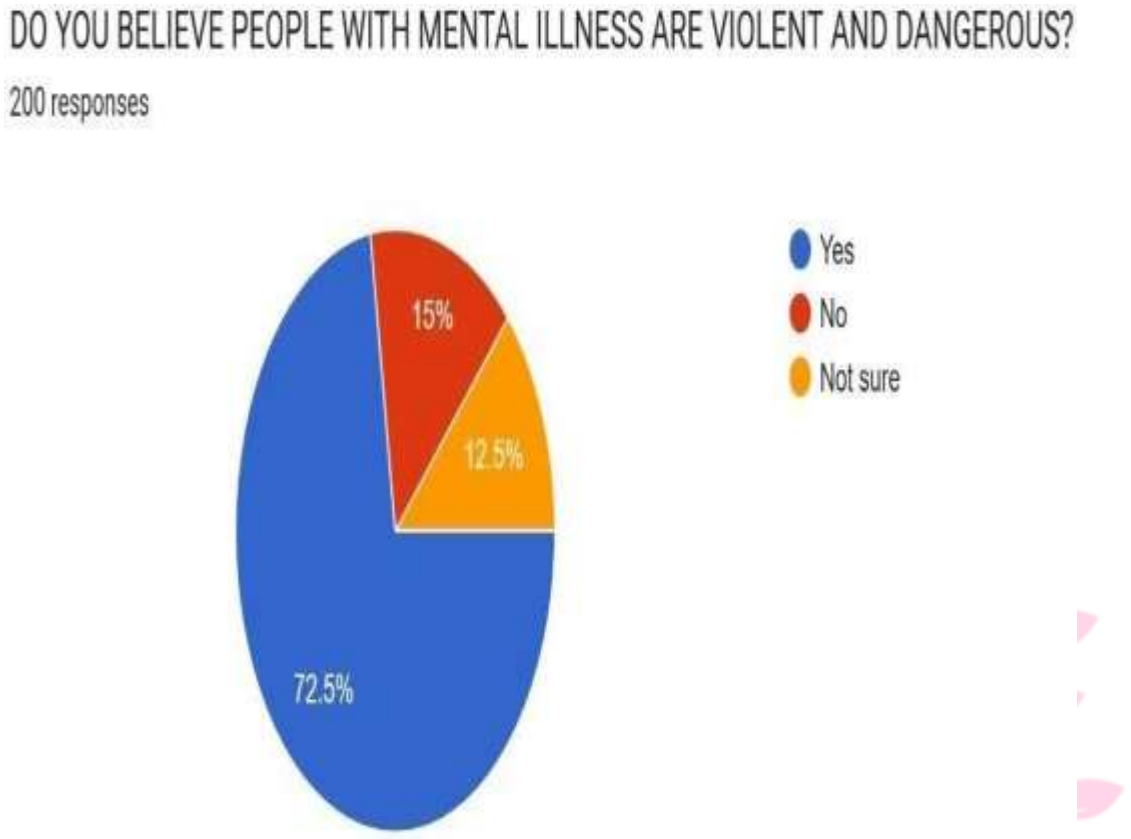


FIGURE 10: The data suggests significant challenges remain in combating mental health stigma in Southeast Liberia, as 72.5% of respondents perceive people with mental illnesses as violent and dangerous, while only 15% disagree and 12.5% are uncertain, highlighting deeply rooted misconceptions

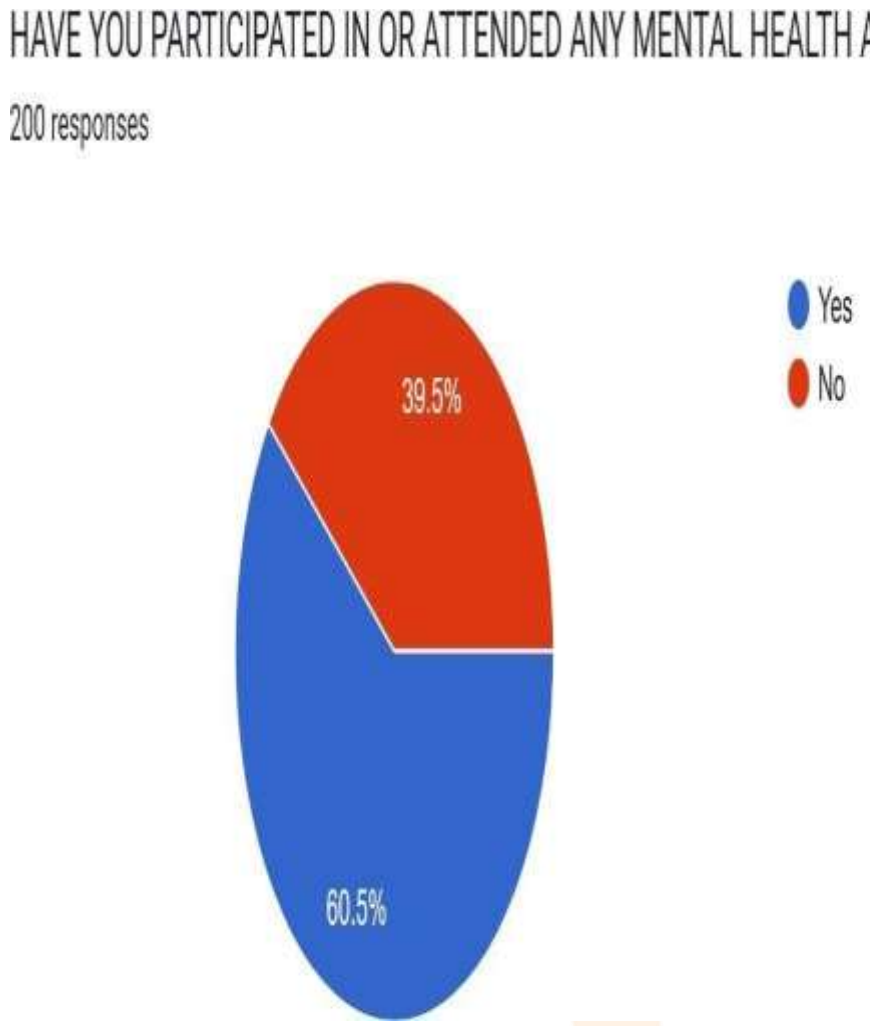


FIGURE 11: indicates promising engagement with mental health awareness efforts in Southeast Liberia, as 60.5% of respondents have participated in or attended such programs, though the remaining 39.5% highlights opportunities for broader outreach and inclusion.

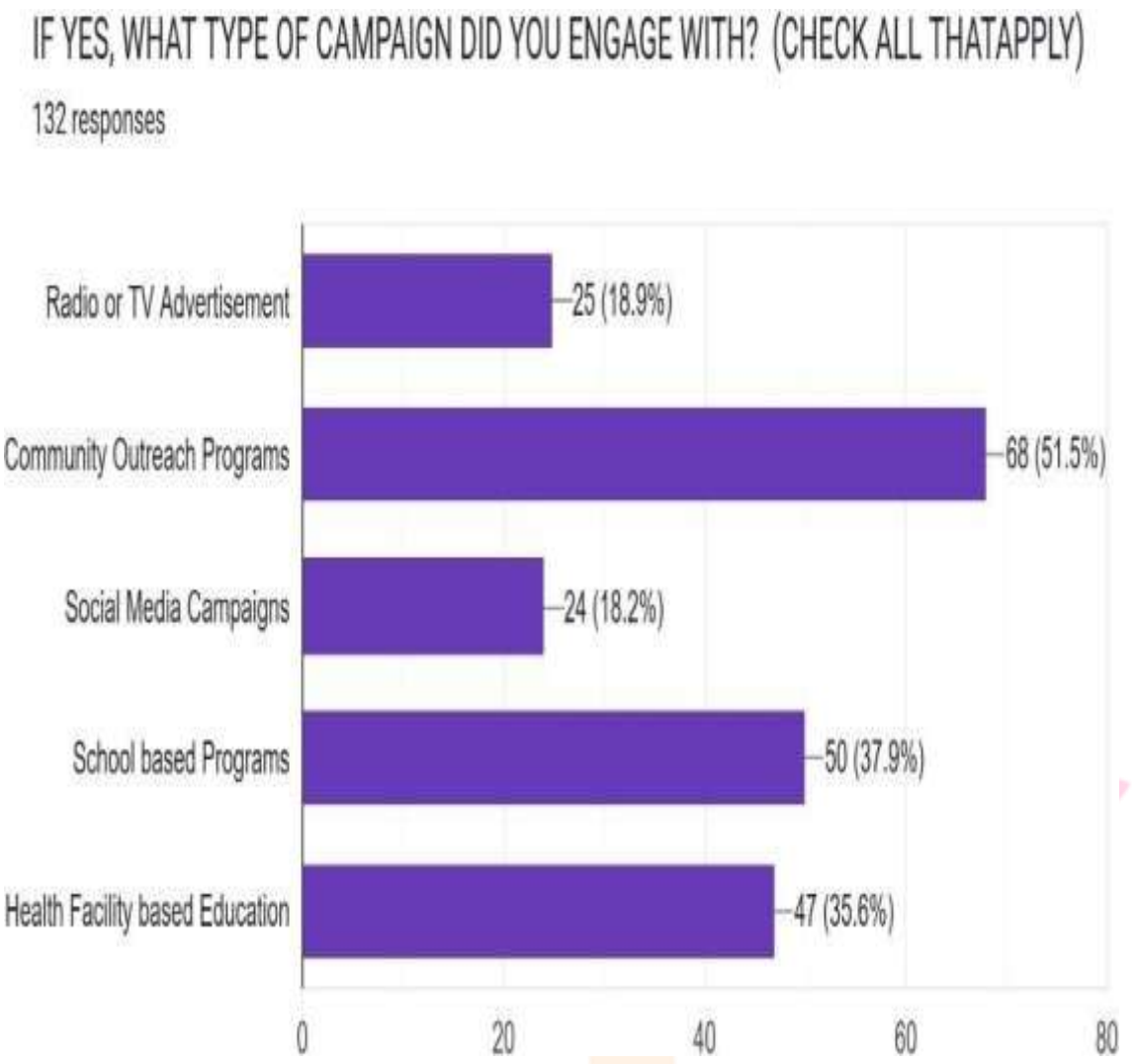


TABLE 2: Based on the engagement rates in Southeast Liberia, community outreach programs and school-based programs appear to be the most impactful channels for reaching the public with campaigns designed to reduce mental health stigma.

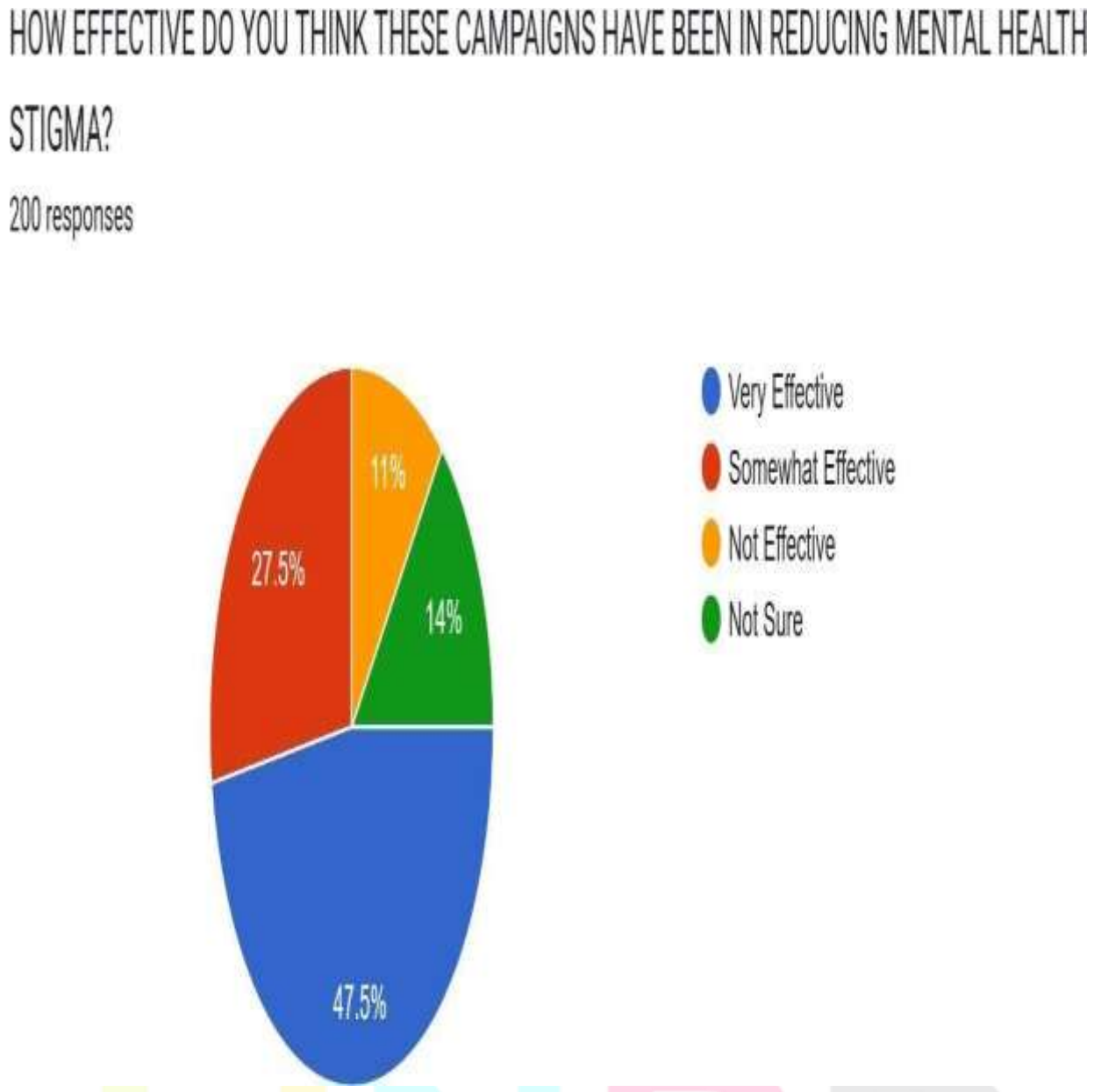


FIGURE 12: Based on respondent perception, the public health campaigns have had a significant positive impact, as three-quarters (75%) believed they were either very or somewhat effective in reducing mental health stigma.

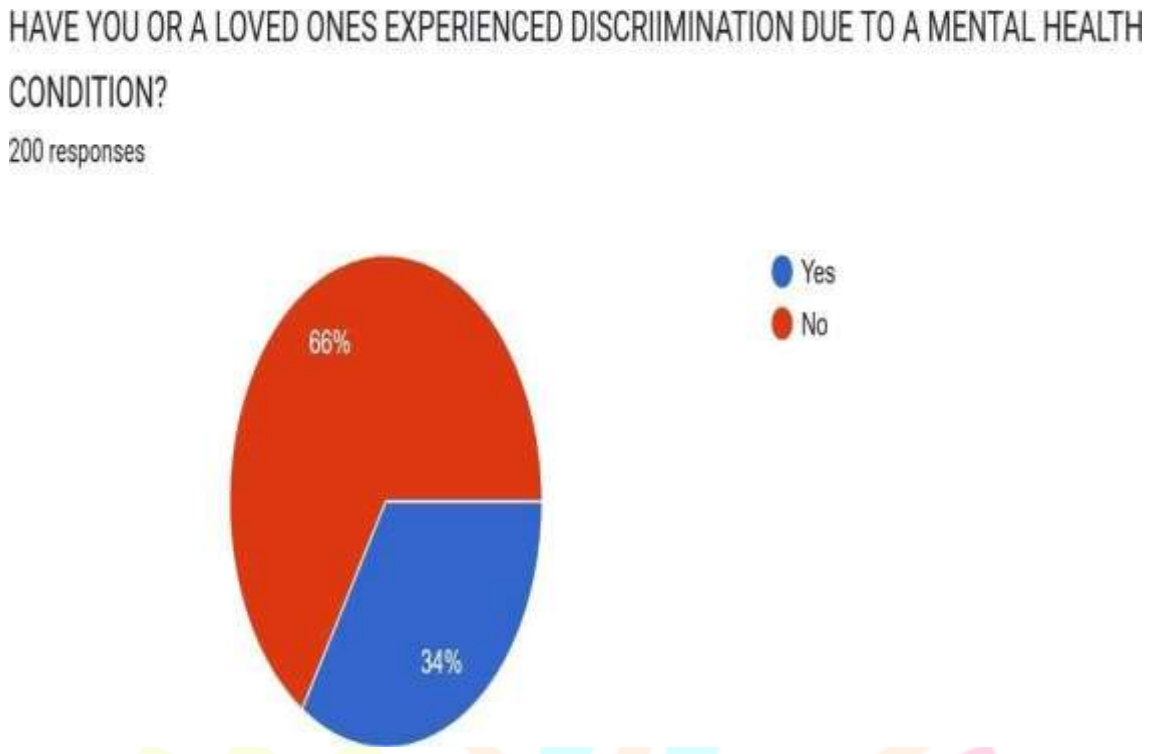


FIGURE 13: The data suggests that while 66% of respondents report no experiences of discrimination due to mental health conditions, the 34% who have indicated that stigma and discriminatory behaviors persist, necessitating continued advocacy and education efforts.

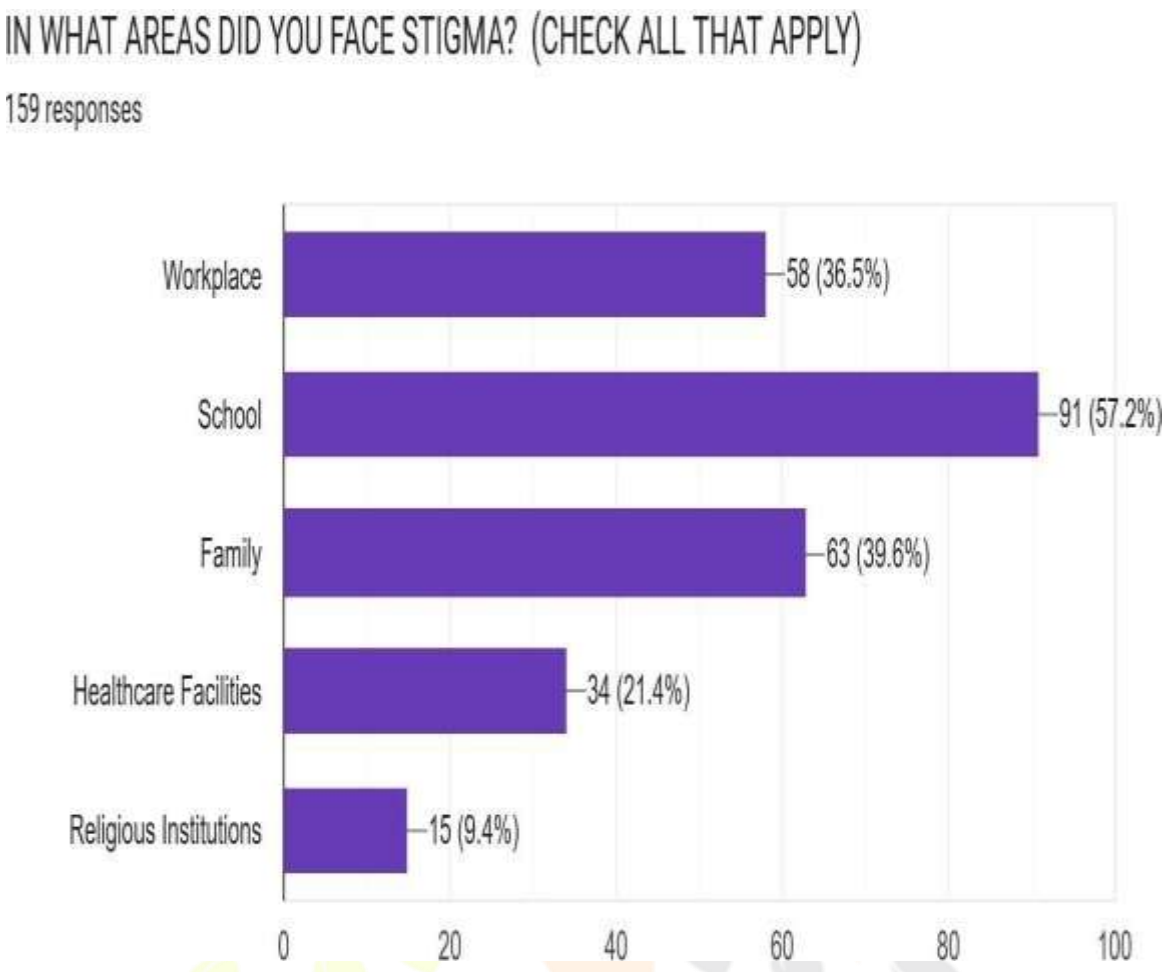


TABLE 3: School: The highest percentage, 57.2%, indicates that ztigma is particularly prevalent in educational environments.

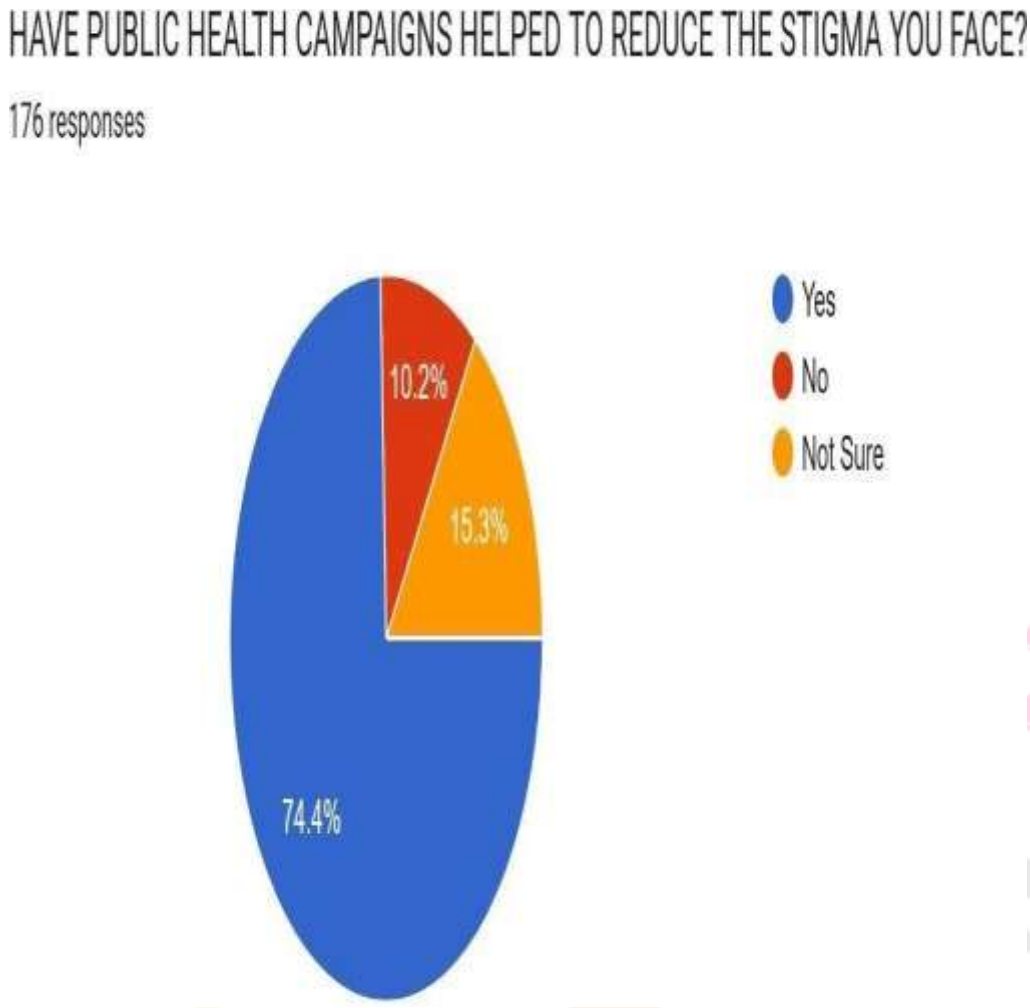


FIGURE 14: Public health campaigns appear to have had a significant positive impact, with 74.4% of respondents reporting reduced stigma, though 15.3% still feel unaffected, and 10.2% remain uncertain about their effect.

CHAPTER-V

FINDINGS, CONCLUSION, AND RECOMMENDATIONS

5.1 Summary of the Findings

Two hundred (200) individuals from various demographic backgrounds took part in a study aimed at assessing the impact of public health campaigns on reducing mental health stigma.

This specific research was conducted in Southeast Liberia. Of the participants, 30% were female, while 70% were male.

Looking at the age breakdown, 49% of those involved were aged between 15 and 29, 40% were between 30 and 44, and smaller groups included 4% who were aged 45 to 59 and 21% who were 60 years or older.

In terms of employment status, 21% were in jobs, 24. 5% were self-employed, and 54. 5% did not have employment. Most of the responses, 64. 3%, came from Maryland County, followed by Sinoe with 15. 6%, Grand Kru at 8. 5%, River Gee at 7. 6%, and Grand Geddeh at 4. 8%.

The data indicated that 69. 3% of participants had received information related to mental health from these campaigns, in contrast to 30. 7% who had not, showcasing the extensive reach of these initiatives.

The primary reasons perceived for mental illness included brain disorders and substance abuse, with spiritual beliefs and personal weaknesses viewed as less influential.

A mix of social and scientific perspectives was evident, positioning ignorance and genetic factors at the forefront of causal beliefs.

An impressive 96% of people agreed that mental health issues can be treated, while only 4% were unsure, highlighting the strong impact of the campaigns. Despite these positive outcomes, the effectiveness of the initiatives in reducing stigma was found to be only somewhat successful.

For instance, 54% of participants reported they felt at ease interacting with people experiencing mental health issues, while 31% still felt uncomfortable and 15% were uncertain.

Similarly, 46% expressed willingness to marry someone with a history of mental illness, contrasting with 33% who would not and 21% who were undecided, indicating that social acceptance continues to pose a challenge.

These varied views underscore the need for targeted communication and engagement to address both societal and personal barriers. The existence of widespread misconceptions is another critical concern; 72. 5% of participants believed that those with mental illnesses could be violent and a danger, while only 15% disagreed and 12. 5% were uncertain.

However, it was positive to note that 60. 5% of respondents engaged in mental health awareness activities. The 39. 5% who did not take part highlighted gaps in outreach efforts. Moreover, 57. 2% mentioned that stigma is frequently seen within educational environments, signifying that schools are key areas for addressing stigma.

In summary, improved perceptions of treatment possibilities and participation in awareness programs indicate that public health endeavors in Southeast Liberia are making significant progress in fostering understanding and decreasing stigma related to mental health.
Nonetheless, persistent myths and biases remain entrenched in society, particularly concerning issues of violence, social acceptance, and educational contexts.
The findings emphasize the importance of ongoing advocacy and tailored approaches, with an eye on school-based projects and community involvement as vital pathways for achieving sustainable outcomes.

5.2 Discussion of the Major Findings

Critical observations regarding the assessment of public health campaigns aimed at lessening mental health stigma. A Case Study in Southeast Liberia. were revealed through the detailed examination of participant demographics and their responses.

The research involved 200 individuals, with a majority being male (70%) and the remaining 30% female. It included a diverse age range, where smaller proportions represented older age groups, while most participants were aged between 15 and 29 (49%) and 30 to 44 (40%). In terms of economic standing, a significant number of individuals were without jobs (54. 5%), followed by those who were self-employed (24. 5%) and those who were employed (21%).

Moreover, the data indicated that the county of Maryland accounted for the highest number of responses (64. 3%), with lesser contributions from counties like Sinoe, Grand Kru, River Gee, and Grand Gedeh. These varied backgrounds allowed for a deeper understanding of the impact and reach of public health efforts.

A key discovery was the extensive sharing of mental health information via public health campaigns, with 69. 3% of the participants stating they received this information. However, the 30. 7% who were not reached highlights the necessity for broader outreach efforts.

Participants recognized brain disorders and substance abuse as the main perceived causes of mental illness, signaling a move towards a more scientific understanding. Spiritual factors and personal weaknesses were considered less important, while ignorance and genetics were seen as moderate influences.

These views suggest a mix of scientific knowledge and societal beliefs, indicating partial progress in changing misunderstandings.

Only 4% of those surveyed expressed comfort in working alongside individuals with mental health issues, while 31% admitted to still feeling uneasy, and 15% were uncertain. Similarly, 33% opposed the idea of marrying someone with a past of mental illness, 21% were unsure, and 46% were in favor.

These responses illustrate that, despite efforts to reduce stigma, personal and social barriers remain prevalent.

The findings underscore the necessity for targeted campaigns that encourage societal acceptance and alleviate stigma-related hesitance.

Another significant concern was the misconceptions surrounding mental illness, particularly the belief that individuals suffering from it are dangerous and violent. An alarming 72. 5% agreed with this notion, compared to just 15% who disagreed and 12. 5% who were uncertain. This situation emphasizes the existence of deep-seated biases that persist despite public health efforts.

Nevertheless, a growing participation and interest in awareness campaigns was evident, as indicated by the positive engagement rate of 60. 5%.

In contrast, the 39. 5% who had not taken part in these initiatives point to the necessity for more inclusive strategies and address gaps in participation. A substantial 57. 2% of the respondents indicated that schools are the settings where stigma is most prevalent, marking educational environments as critical areas for stigma.

In conclusion, the findings reveal that public health campaigns have made significant strides in reducing mental health stigma in Southeast Liberia. Enhanced perceptions of treatability and increased engagement in awareness programs signify important success. However, challenges remain, such as erroneous beliefs regarding violence and hesitation to pursue social acceptance.

Community outreach and educational environments must be prioritized for further intervention. Sustained advocacy, tailored messaging, and engagement efforts focusing on specific barriers are essential for achieving lasting stigma reduction and fostering a more accepting society.

5.3 Conclusion

The study concludes that public health campaigns in Southeast Liberia have achieved substantial progress in raising awareness and addressing mental health stigma. With 69.3% of participants reporting exposure to campaign information and 96% agreeing that mental health conditions are treatable, these efforts have undeniably contributed to promoting understanding and reducing misinformation about mental health. The identification of brain disorders and substance abuse as primary causes of mental illness further underscores the campaigns' success in shifting perceptions toward scientific explanations.

However, the findings also point to gaps in reach and understanding, indicating the need for continued education and outreach.

Despite the progress, the campaigns' impact on stigma reduction has been moderate, reflecting the complexities of changing societal attitudes. While more than half of respondents (54%) expressed comfort working with individuals with mental illness, significant proportions of participants remained uncomfortable (31%) or uncertain (15%).

Similarly, openness to deeper social acceptance, such as marrying someone with a history of mental illness, showed mixed results, with 46% expressing willingness but 33% unwilling and 21% unsure. These findings highlight the persistence of individual and societal barriers, requiring targeted interventions to foster a more inclusive mindset.

The survey found that the prevalence of misconceptions regarding people with mental problems is one of the main issues. Remarkably, 72.5% of respondents linked mental illness to danger and violence, demonstrating ingrained prejudices that are resistant to change.

This research highlights how crucial it is to create efforts that specifically target and destroy these damaging preconceptions.

Even though 60.5% of people participated in mental health awareness programs, the 39.5% who had never gone show how important it is to increase the reach and scope of these campaigns. Schools provide a particularly critical setting for targeted treatments because they have been identified as stigma hotspots (57.2%).

With some age groups, employment statuses, and counties underrepresented in the study, the results also show differences in demographic and geographic engagement.

The significant proportion of participants who were unemployed (54.5%) is one example of how socioeconomic variables may affect how people view and interact with mental health promotions.

In order to provide fair access to information and assistance, customized strategies that take these demographic and regional differences into account will be essential. Furthermore, the focus on school-based and community-based initiatives as successful outreach avenues emphasizes the necessity of a grassroots, cooperative strategy.

In conclusion, there is still more to be done even while Southeast Liberia's public health initiatives have achieved admirable progress in increasing awareness and lowering the stigma associated with mental illness. Significant obstacles that call for persistent campaigning and creativity include misconceptions, societal prejudices, and outreach gaps. Future campaigns might build on the current progress and promote a more educated and inclusive society by addressing the impediments that have been identified and increasing customized interventions. Achieving long- term effect and changing perceptions of mental health will require ongoing dedication and cooperation from all parties involved.

5.4 Implication

Numerous significant outcomes for future initiatives stem from research into the effectiveness of public health campaigns aimed at reducing stigma related to mental health in Southeast Liberia. Most importantly, the findings underscore the need for continuous, long-lasting public health efforts to challenge deep-seated myths regarding mental illness, particularly the widely held notion that it leads to danger and violence.

By countering these harmful beliefs with targeted messaging, it may be possible to eliminate societal biases and foster a better understanding. Moreover, the research points out the necessity of customizing campaigns for specific demographic and socioeconomic segments. With notable differences in engagement among various age groups, job statuses, and regions, strategies should be crafted to guarantee fair access to mental health information and services.

For example, directing resources to less represented counties and offering assistance to those without jobs could help close current gaps and improve the reach and effectiveness of campaigns. Since schools often serve as environments where stigma persists, they were identified as key intervention points.

The implication is clear: to address stigma early and cultivate more accepting attitudes in future generations, educational institutions should be prioritized for awareness campaigns that integrate mental health education into their curricula. School-based initiatives hold the potential to serve as transformative methods for reducing stigma at its core.

The research also stresses the importance of enhancing community engagement initiatives, particularly in disadvantaged and rural regions. The success of these efforts could be strengthened by collaborating with grassroots organizations, health professionals, and community leaders to raise mental health awareness.

Achieving enduring change will require active community participation and confronting cultural factors that fuel stigma.

Ultimately, the findings highlight the ongoing need for collaborative efforts across public health, education, local governmental bodies, and non-profit organizations. Such partnerships could enhance resource distribution, improve program accessibility, and ensure comprehensive approaches to mental health advocacy.

By applying the insights from this study, future endeavors focused on advancing awareness, acceptance, and support for mental health in Southeast Liberia can become more targeted, inclusive, and effective.

5.5 Recommendations

Motivate Volunteers for Community Involvement: Strengthen the connection between campaigns and local communities by informing and motivating volunteers to engage actively in programs aimed at raising mental health awareness.

Create Peer Support Groups: Inspire those who have faced mental health difficulties to publicly share their experiences; real-life stories can make mental health challenges feel more relatable and encourage understanding and compassion.

Involve Local Leaders and Influencers: Partner with faith leaders, traditional healers, local elders, and well-known personalities like celebrities to facilitate open conversations about mental health, using their influence to combat stigma.

Tailored Messaging for Cultural Relevance: Craft campaign materials that connect with the local audience by fusing traditional beliefs with contemporary mental health approaches, guaranteeing that the messages are relevant and powerful.

Prioritize Youth-Focused Programs: Launch mental health initiatives in educational settings, concentrating on the early identification of mental health issues and training teachers to effectively assist their students.

Enhance Mental Health Awareness and Access: To equip families and communities with the tools needed to understand and tackle mental health matters, provide visual aids, engage local members through radio shows with catchy jingles and advertisements, and create easily reachable care facilities.

REFERENCES

1. Hrymoc, M; has expertise in the psychopharmacology related to addiction and various mental health disorders, holding certifications in General Psychiatry, Addiction Psychiatry, and Addiction Medicine. 1 2024

2. National Academies of Sciences, Engineering, and Medicine, 2017.

3. CABRAL A. BIGMAN, associated with the University of Illinois at Urbana-Champaign, USA.

4. Goldney et al., 2008, which includes work by Robert D. Goldney, features the important publication Suicide Prevention, released by Oxford University Press in 2008.

5. Research by Kelly et al., 2007, and Boysen and Vogel, 2008 looked into the effects of educational programs on the stigma surrounding mental health issues.

6. Tanielian and Jaycox, 2008: Invisible Wounds of War discusses psychological and cognitive harm, their effects, and the support services available for recovery.

7. Thornicroft et al., 2015: Invisible Wounds of War further addresses psychological and cognitive injuries, their effects, and recovery assistance services.

8. Corrigan et al., 2012, studied self-stigma related to mental health, examining how it affects people's self-esteem, self-efficacy, and empowerment. They created the Self-Stigma of Mental Illness model.

9. Mittal et al., 2012, researched the presence of rickettsial infections in Delhi through serological evidence.

10. Schachter et al., 2008, published findings in PLoS Neglected Tropical Diseases which stated that objective evidence makes reports on the prevalence of clinical conditions more persuasive.

11. Winkler, Janoušková, Kožený, Pasz, Mladá, Weissová, Tušková, and Evans-Lacko, 2017.

12. Mulfinger et al., Mulfinger, Müller, Böge, Sakar, Corrigan, Evans-Lacko, Nehf, Djamali, Samarelli, Kempter, Ruckes, Libal, Oexle, Noterdaeme, and Rüsch, 2018.

13. Vila-Badia, Martínez-Zambrano, Arenas, Casas-Anguera, García-Morales, Villellas, Martín, Pérez-Franco, Valduciel, Casellas, García-Franco, Miguel, Balsera, Pascual, Julia, and Ochoa, 2016.

14. Pinto-Foltz et al. have added to the understanding of mental health, especially concerning stigma and its effects.

15. Pinto-Foltz, Logsdon, and Myer, 2011,

16. Staniland and Byrne, 2013, researched anti-stigma initiatives focused on higher-functioning autism. Their exploration was published in the Journal of Autism and Developmental Disorders and

assessed a six-session program targeted at adolescent boys.

17. Yonkler, Morgan, and Meritt (2003), wrote A Field Guide to Designing a Health Communication Strategy, published by the Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs.

18. Isiaka and Yusuf in 2013 studied "Perception of Women on Female Genital Mutilations and Implications for Health Communications in Lagos State, Nigeria. " This research appeared in the American Academic & Scholarly Research Journal.

19. In 2008, Williams Ezinwa Nwagwu investigated the challenges faced by the Triple Helix model of innovation systems in Nigerian universities. His findings were published in Technology Analysis and Strategic Management.

20. Erving Goffman's 1963 work Stigma: Notes on the Management of Spoiled Identity is considered a foundational text in the field of sociology.

21. Link and Phelan (2001) wrote an influential paper called Conceptualizing Stigma, published in the Annual Review of Sociology.

22. Patel (2007) produced an important paper titled Mental Health of Young People: A Global Public-Health Challenge, which appeared in The Lancet.

23. Crisp et al. (2005) contributed to social work education through their development of assessment frameworks.

24. Bolay et al. (2019) studied sustainable development and urban planning.

25. The World Health Organization (WHO) published the World Health Statistics 2016 report.

26. Jenkins et al. (2010) carried out a meta-analysis of isolation by distance (IBD) within landscape genetics, appearing in Ecography.

27. A study called Mental Disorders, Health Inequalities, and Ethics: A Global Perspective was written by Ngui and others in 2010, appearing in the International Review of Psychiatry.

28. In 2013, Pescosolido and colleagues referenced a paper by Ngui and other authors from 2010 called Mental Disorders, Health Inequalities, and Ethics: A Global Perspective, which was published in the International Review of Psychiatry.

29. The book The Nature of Prejudice by Gordon Allport, published in 1954, is a key text in the field of social psychology.

30. Berkowitz made important contributions to understanding social norms and their effects on behavior in 2004.

31. In her 1992 article titled Putting the Fear Back into Fear Appeals, Witte presented the Extended Parallel Process Model (EPPM), as noted by Henderson and colleagues.

32. Evans-Lacko and others in 2013 examined the impacts of economic downturns on mental health and was published in PLOS ONE.

33. Shidhaye and colleagues published a systematic review in the International Review of Psychiatry in 2013. The review focused on the link between somatoform disorders, anxiety, and depression among women in low- and middle-income countries.

34. A 2017 study by Nadkarni and co-authors explored the effectiveness of the Counselling for Alcohol Problems (CAP) program, which was featured in PLOS Medicine.

35. Nadkarni and others also had a research publication in 2014 addressing the effectiveness of the

Counselling for Alcohol Problems (CAP) intervention in PLOS Medicine.

36. In 2012, Jorm wrote a paper titled Mental Health Literacy: Empowering the Community to Take Action for Better Mental Health, which was published in the American Psychologist.

37. Cooper and colleagues published a study in the European Journal of Social Psychology in 2017 discussing Social Identity, Self-Esteem, and Mental Health in Autism.

38. Research on sustainable urban development was carried out by Bolay and others in 2019, focusing on Chau Doc city in Vietnam's Mekong Delta region.

39. Corrigan published a paper in the American Psychologist in 2004 titled How Stigma Interferes with Mental Health Care.

APPENDICES

Questionnaires

Section 1: Demographic Information Age:

15 - 29

30 - 44

45-59

60 and above

Gender Male Female

Work Status Self-employed Unemployed Employed

Education Level: Primary education Secondary education Under graduate Graduate
PhD

County where you live:

Maryland River Gee Grand Kru Grand Gedeh Sinoe

Have you received any information regarding mental health from a public health campaign?

Yes No

Section 2: Understanding and Awareness

1. Which sources have taught you about mental health? (Select all that apply)

Radio Television
Community gatherings social media
Healthcare professionals Educational institutions Religious organizations

2. What do you believe causes mental illnesses? (Select all that apply)

Spiritual reasons Brain issues Substance abusers Personal flaws Inherited traits
I Don't Know

3. Do you think mental health issues can be treated?

Yes No
Not certain

Section 3: Views and Opinions

4. Would you be at ease working alongside someone with a mental illness?

[ ] Yes

[ ] No

[ ] Not certain

5. Would you consider marrying someone who has had mental health challenges?

[ ] Yes

[ ] No

[ ] Not certain

6. Do you think individuals with mental illnesses are violent and threatening?

[ ] Yes

[ ] No

[ ] Not certain

Section 4: Influence of Public Health Campaigns

7. Have you taken part in or gone to any programs focused on mental health awareness?

[ ] Yes

[ ] No

8. If so, what kind of campaign did you take part in? (Select all applicable)

[ ] Radio or TV commercials

[ ] Community outreach activities [ ] Social media initiatives

[ ] School programs

[ ] Educational sessions in health facilities

9. How do you rate the effectiveness of these campaigns in decreasing mental health stigma?

[ ] Very effective

[ ] Somewhat effective [ ] Not effective

[ ] Not certain

Section 5: Experiences of Stigma

10. Have you or someone close to you dealt with discrimination because of a mental health issue?

[ ] Yes

[ ] No

11. In which areas did you experience stigma? (Select all that apply)

[ ]

Workplac e [ ]

School

[ ] Family

[ ] Healthcare settings

[ ] Religious organizations

12. Have public health campaigns aid in lessening the stigma you encounter?

[ ] Yes

[ ] No

[ ] Not certain

13. What changes would you recommend for upcoming mental health campaigns?

14. What extra assistance do you think is necessary to lessen mental health stigma in your community?