Stigma against mental health disorders in Nepal conceptualised with a ‘what matters most’ framework: a scoping review

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Introduction

Stigma is a complex and multifaceted phenomenon that can have multiple, detrimental effects on individuals, family members and society (Wahl and Harman, 1989; Corrigan et al., 2014). In the case of mental health, stigma has been identified as sometimes being more distressing and debilitating than the illness itself (Thornicroft, 2003). Various studies have reported on the nature of stigma, its types and effective interventions. However, most of the evidence on the topic comes from high-income countries (HICs). Reviews conducted of effective interventions to reduce mental health stigma showed very few studies conducted in low- and middle-income countries (LMICs) (Semrau et al., 2015). Although stigma and discrimination are considered...
universal phenomena, their manifestations may vary according to culture and contexts. Cultural context is known to influence many aspects of mental disorders (Alarcón et al., 2009). Developing a stigma intervention and measuring its effectiveness in a particular setting is a challenge if the context-specific understanding of stigma, its causes and manifestations are missed.

One way to understand this cultural context is evaluating ‘what matters most’, an approach that conceptualises structural stigma as a moral experience and explains how threats to personal and group identity, or what is most at stake, may lead to stigmatizing behaviours (Yang et al., 2014a). In healthcare settings, a provider’s role as a healer in society may be jeopardised when encountering a patient with mental disorders whom they are not equipped to care for – this should be considered along with threats to other societal norms and values that are shaped by the provider’s life experience, gender, caste, ethnicity and religion (Kleinman, 1999; Yang et al., 2007). By identifying stigma as a moral experience and addressing what matters most, anti-stigma interventions can be better tailored to local contexts.

There is a growing burden of mental disorders in Nepal, an LMIC in South Asia. However, fewer than 10% of people with mental disorders receive any form of treatment (Luitel et al., 2017). There are various supply-side challenges to this treatment gap, such as lack of mental health services in primary healthcare, and lack of regular supply of medicines (Luitel et al., 2017). However, on the demand side, stigma related to mental disorders has been identified as a dominant barrier to mental healthcare (Clement et al., 2015). Despite this, limited studies have been conducted to understand the local context and concepts of stigma in Nepal. Therefore, we conducted this scoping review to understand the stigma in the context of Nepal. The aim of this study was to synthesise the literature on mental health stigma in Nepal and understand stigma processes. Stigma processes include drivers, manifestations and consequences of stigma and the influence of ‘what matters most’ on these processes in the context of Nepal.

Methods

We employed a scoping review method (Arksey and O’Malley, 2005) with a focus on exploring the literature on mental health stigma in Nepal. Our guiding questions for the review were:

1. What are the causes or drivers of stigma related to mental disorders in Nepal?
2. How is stigma related to mental disorders manifested at different levels, what behaviours, where, by whom and why?
3. What approaches have been used to reduce stigma for mental health conditions, and what evidence supports these approaches?

Search and screening strategy

The databases searched included PsycINFO, Medline, Web of Science and NepJol (a Nepali database) for a 20-year period from 1 January 2000 to 24 June 2020. Box 1 includes search terms used in all databases. As this is a sub-review of a broader scoping review of stigma for all health conditions in Nepal, the initial strategy used for the review included all health conditions and was not just restricted to mental health. Due to the limited search strategy that could be used in NepJol, only ‘Stigma’ was used as a search term. As a modification from the protocol, the search was repeated in PsycINFO, Medline and Web of Science with added terms for structural stigma. This was because during the data extraction phase, we noticed that we may have missed some literature given the vagueness in how ‘structural stigma’ is defined in existing literature. The same inclusion criteria applied, with the specification for mental health-related structural stigma and discrimination. See Box 2 for the inclusion criteria used. The review was registered through the Open Science Framework (OSF) (osf.io/u8jhn).

The title and abstract screening were completed by three reviewers (LW, DG, AP and MN). The full-text screening was completed by one reviewer (LW) with 20% of the articles re-assessed for eligibility by two other reviewers (AP and DG). Any disagreements between reviewers were resolved through discussion and additional review by the supervisor (BK). The screening was guided by the Preferred Reporting Items for Systematic Review and Meta-analysis Extension for Scoping Reviews (PRISMA-ScR) (Tricco et al., 2018).

Data extraction and synthesis

Following the full-text screening, four authors (LW, DG, AP and MN) extracted information from the included articles using a framework developed by the authors (BK and SW). The framework covered key themes on stigma: (a) key stigma-related findings, (b) explanatory models, (c) characteristics of stigmatised groups, (d) myths, (e) ‘what matters most’, (f) locations and types of stigmatisation, (g) cultural norms and social interactions, (h) structural stigma, (i) impact of stigma and (j) recommended interventions. In addition, a separate sheet was created to extract information on any stigma-related interventions that were conducted or evaluated. The themes related to interventions included (a) intervention name, (b) type of intervention, (c) duration and (d) materials used.

After data extraction, DG collated the findings using narrative synthesis and shared them with the review team for inputs. Additionally, we conducted a quality review of 18 quantitative studies with stigma as primary outcome. We used the Systematic Assessment of Quality in Observational Research (SAQOR) tool with a modification for Cultural Psychiatric Epidemiology, SAQOR-CPE (Ross et al., 2011; Kohrt et al., 2014) to understand the scope and generalisability of the findings.

Results

Study selection

Figure 1 includes an overview of the search process. The search strategy for the international database resulted in 887 references, out of which 278 were duplicates. After removing duplicates,
and adding 145 articles identified from the Nepali database, a total of 754 articles were included for the title and abstract screening. We removed 574 after the title and abstract screening because they did not meet our inclusion criteria. For full-text review, we added 13 articles identified through cross-referencing. We completed a full-text review for 193 articles and excluded 136 that did not meet the inclusion criteria or were of conditions other than mental disorders. A total of 57 articles were included in the study for data extraction and synthesis.

Table 1 gives an overview of the publications that were included in this review. Out of 57 studies included, 19 were quantitative, 19 were qualitative, nine were mixed methods, five were review articles (including literature reviews and scoping reviews), two were ethnographies, and three were other types of publications (including reports, opinion articles and protocols). The quality assessment of 18 relevant quantitative observational studies showed that only three were of ‘moderate quality’, while the remaining 15 were of ‘low-quality’. The main reasons for ‘low-quality’ were inadequacy in measurement quality (no mention of tool adaptation and validation in the local context), and sampling method (biased group not generalisable beyond research study and recruitment methods not well described). No articles were excluded after quality review. Hence, although we summarise the findings from these quantitative studies below, results need to be interpreted with caution because of the quality limitations.

Most of the qualitative studies with stigma as the major theme or domain focused on public stigma of either general community members or healthcare workers. Quantitative or mixed methods studies predominantly focused on self or internalised stigma of members or healthcare workers. Quantitative or mixed methods or domain focused on public stigma of either general community limitations.

The findings from the scoping review are collated into six broad themes related to stigma:

1. ‘What matters most’: cultural factors that influence mental health stigma.

Although most studies did not explicitly explore the concept of ‘what matters most’, the theme was identified from the description of cultural contexts that shape stigma related to mental disorders in Nepal. Various studies discussed what mattered most to PWLE, their family members, the general community and health workers. Identified topics included social acceptance, productivity and income generation, social prestige and honour (ijjat), privacy or anonymity, marriage and equality.

For PWLE in Nepal, social acceptance and anonymity were described to matter the most (Kaiser et al., 2020). This was reflected in their interest in engaging in productive activities, so they are looked upon as contributing members of society. Anonymity and privacy were primary concerns for PWLE and their families. Their concerns included privacy while visiting health facilities particularly because some PWLE were hiding their disorders from family and community members. Family members who could afford to take PWLE to India or big cities for treatment would do so due to fear of the community finding out about their disorders. This also resulted in PWLE not being willing to seek treatment or take medications because of potential discovery by family and community members. The greatest hesitation was related to seeking care in one’s community and local health facilities.

Similar to PWLE, what mattered most for family and community members were productivity and economic contribution (Angdembe et al., 2017; Pandey, 2019). The community members felt that the biggest support for PWLE was their involvement in income-generating activities (Angdembe et al., 2017). In one of the studies (Pandey, 2019), the family members described financial burdens for taking care of PWLE and negative financial impacts on their professional lives. Family members mentioned losing prestige (Nepali: ijjat) in the society as an important cultural reason for not disclosing the diagnosis or seeking care (Kohrt and Harper, 2008; Brenman et al., 2014). Another reason, especially for parents of PWLE, was not being able to marry off their children as a result of mental illness, particularly for daughters. Not being able to marry off one’s daughter was considered one of the biggest cultural burdens for parents in Nepal, which is further amplified by the myth that marriage would heal mental disorders (Brenman et al., 2014).

For the health workers, what mattered most were the structures required for delivering quality mental health care. Health workers reported physical threat (possibility of personal harm and experiencing violence while treating PWLE), loss of social prestige in the community for treating PWLE, and lack of professional knowledge and competence (how to treat illness) as the most important to them (Kohrt et al., 2020). Several publications reported public and health workers’ perceptions of PWLE as violent and aggressive people who can damage property and harm themselves or others. Thus, fear of harm or danger was a prominent driver of

Box 2. Inclusion criteria

Inclusion criteria for eligibility of searched texts:

1. Articles published in English or Nepali only
2. Articles published between 01/01/2000–06/24/2020
3. Articles focused on Nepal as a geographical location (excludes studies carried out among Nepali population outside geographical area of Nepal such as Bhutanese refugees)
4. Articles published in both Nepali and international peer-reviewed journals
5. Relates to articles focused on stigma and its definitions such as discrimination, prejudice or stereotype
6. Articles focused on stigma related to health conditions (excludes studies in other forms of stigma and discrimination such as gender and ethnicity and its effects on health outcomes)
7. Includes data regardless of its ‘quality’ and study design
8. Articles that include or mention at least one stigma-related outcome or domain

Inclusion criteria for eligibility of searched texts:

1. Articles that include or mention at least one stigma-related outcome or domain
2. Articles focused on mental disorders other than mental disorders. A total of 57 articles were included in this review. Out of 57 studies included, 19 were quantitative, 19 were qualitative, nine were mixed methods, five were review articles (including literature reviews and scoping reviews), two were ethnographies, and three were other types of publications (including reports, opinion articles and protocols). The quality assessment of 18 relevant quantitative observational studies showed that only three were of ‘moderate quality’, while the remaining 15 were of ‘low-quality’. The main reasons for ‘low-quality’ were inadequacy in measurement quality (no mention of tool adaptation and validation in the local context), and sampling method (biased group not generalisable beyond research study and recruitment methods not well described). No articles were excluded after quality review. Hence, although we summarise the findings from these quantitative studies below, results need to be interpreted with caution because of the quality limitations.

Most of the qualitative studies with stigma as the major theme or domain focused on public stigma of either general community members or healthcare workers. Quantitative or mixed methods studies predominantly focused on self or internalised stigma of people with lived experiences of mental disorders (PWLE) (Adhikari, 2015; Neupane et al., 2016; Amaty et al., 2018; Rathod et al., 2018; Maharjan and Panthee, 2019; Shrestha, 2019), public stigma (family and community members) (Neupane et al., 2016; Amaty et al., 2018; Koirala et al., 2019; Luettel et al., 2019; Pandey, 2019), health workers’ stigma (Gartoulla et al., 2015; Pathak and Montgomery, 2015; Kohrt et al., 2018b, 2020), medical and pharmacy students’ stigma (Panthee et al., 2010; Adhikari, 2018; Jalan, 2018; Shakya, 2018), and perceived stigma among PWLE and family members (Adhikari et al., 2008; Lamichhane, 2019). Four studies exclusively focused on courtesy stigma (Angermeyer et al., 2003). Twenty publications focused on PWLE’s experiences and their
mental disorders stigma among health workers in Nepal (Kohrt and Harper, 2008; Neupane et al., 2016; Mahato et al., 2018; Upadhaya et al., 2020).

For the handful of PWLE working as advocates in Nepal, what mattered most focused on equality in decision making regarding policies (Gurung et al., 2017; Koirala et al., 2019). They expressed a sense of frustration for not having equal rights or not being taken seriously in decision-making processes.

(2) Structural facilitators and barriers (structural stigma)

Although structural forms of stigma were not directly reported in any of the publications, many studies (13 of 57) reported structural barriers and facilitators that perpetuated mental disorders stigma or contributed to the treatment gap. Lack of mental health-related policies and strategies, adequate allocation of budget, and issues in supply of medicines were some of the frequently reported barriers.

Studies cited low political will to prioritise mental health services that resulted in the lack of supportive mental health policies and strategies (Luitel et al., 2017; Petersen et al., 2017). The situation was further aggravated by discriminatory policies such as those encouraging imprisonment and forcibly initiating treatment that violated the rights of PWLE (Drew et al., 2011). Another policy-level barrier was the vagueness of suicide policies that led to public misunderstanding of suicide as illegal in Nepal (Hagaman et al., 2016; Ramaiya et al., 2017). This led to under-reporting of suicides, which hampers accurate data collection and programme planning (Hagaman et al., 2016). Another policy-level challenge to reporting is the lack of mental disorder-related indicators in government-level health reporting. Under-reporting of mental disorders negatively influenced the government resource management during the 2015 earthquake in Nepal (KC et al., 2019). The disaster risk reduction and management plans did not include mental health care packages resulting in the massive rise of cases post-earthquake that were almost exclusively addressed through international/national non-government organisations’ effort (KC et al., 2019). A key barrier to developing and implementing inclusive mental health policies was poor involvement of PWLE in the policy-making process. The long-standing structural hierarchy and power dynamics between service providers and PWLE as noted by many advocates made it difficult for PWLE to actively participate in planning and decision-making process (Lempp et al., 2018). This was also cited as the main reason behind systematic marginalisation of PWLE within the policy-making and other health systems processes (Gurung et al., 2017).

In terms of programme planning, mental health was not as prioritised as other sectors (e.g. maternal health) where the most budget was allocated (Upadhaya, 2014). This led to inadequate mental health-related training and lack of supervision for primary healthcare providers. Another important structural challenge was an inadequate supply of psychiatric medications. Health workers also pointed out how there was a lack of referral mechanisms and private rooms for counselling that reduced health workers’ motivation to treat patients with mental disorders (Luitel et al., 2017; Upadhaya et al., 2018, 2020; Lamichhane, 2019). Health professionals were also concerned about being stigmatised for choosing ‘psychiatry’ or ‘mental health’ as a specialty which led to a lack of mental health specialists in Nepal (Hagaman et al., 2018). Even for those interested in specializing in mental health, the coursework had a strong focus on

Fig. 1. PRISMA-ScR search strategy.
| SN | Study article no., title, (citation) | Study population | Sample size | Study design | Type of stigma mentioned | Stigma-related measures used/tools validation | Quality assessment (for quantitative study only) |
|----|-----------------------------------|------------------|-------------|--------------|--------------------------|------------------------------------------------|-----------------------------------------------|
| 1. | Situational analysis to inform development of primary care and community-based mental health services for severe mental disorders in Nepal (Angdembe et al., 2017) | Policy makers, primary healthcare workers, service users and community members | FGD (n = 69); KII (n = 25) | Cross-sectional qualitative study | Public stigma | NA | NA |
| 2. | Maternal mental health in primary care in five low- and middle-income countries: a situational analysis (Baron et al., 2016) | Mothers with mental health problems | NA | Cross-sectional situation analysis using mixed methods | Public stigma and health worker stigma | NA | NA |
| 3. | Pathways and access to mental health care services by persons living with severe mental disorders and epilepsy in Uganda, Liberia and Nepal: a qualitative study (Kisa et al., 2016) | Key informants (policy makers, health care workers, community leaders, teachers, service users) | 26 KIs and 9 FGDs (of 6 participants each) | Cross-sectional qualitative study | Public stigma, health worker stigma | NA | NA |
| 4. | Prevalence of self-stigma and its association with self-esteem among psychiatric patients in a Nepalese teaching hospital: a cross-sectional study (Maharjan and Panthee, 2019) | Patients with mental illness attending psych outpatient department | 180 | Cross-sectional quantitative study | Self-stigma | Internalised Stigma of Mental Illness (ISMI); Rosenberg Self Esteem Scale (RSES) – translation and adaptation in Nepali | Moderate quality |
| 5. | Knowledge status on mental health among health professionals of Chitwan District, Nepal (Gartoulla et al., 2015) | Health professionals | 100 | Descriptive cross-sectional study | Health worker stigma | Semi-structured tool developed and used to measure knowledge, attitude and practice | Low quality |
| 6. | Mental health care in Nepal: current situation and challenges for development of a district mental health care plan (Luitel et al., 2015) | Publicly available information; government officers, psychiatrists, service providers | NA | Cross-sectional qualitative | Public stigma and structural barriers | NA | NA |
| 7. | Nepal’s silent epidemic of suicide (Cousins, 2016) | NA | NA | Report | Public stigma and structural barriers | NA | NA |
| 8. | Suicide surveillance and health systems in Nepal: a qualitative and social network analysis (Hagaman et al., 2016) | Health system workers, foreign aid agency workers, government workers, hospital workers, legal/law enforcement, NGO workers | 36 in-person interviews, 23 of 36 participated in social network analysis | Cross-sectional qualitative | Public stigma, health worker stigma | NA | NA |

(Continued)
| SN | Study article no., title, (citation) | Study population | Sample size | Study design | Type of stigma mentioned | Stigma-related measures used/tools validation | Quality assessment (for quantitative study only) |
|----|-----------------------------------|------------------|-------------|-------------|--------------------------|---------------------------------------------|-----------------------------------------------|
| 9  | Caregivers’ attitude towards people with mental illness and perceived stigma: a cross-sectional study in a tertiary hospital in Nepal (Neupane et al., 2016) | Caregivers of patients | 170 | Cross-sectional quantitative study | Public stigma, internalised stigma | Internalised Stigma of Mental Illness (ISMI) Community Attitude towards Mental Illness (CAMI) tool | Low quality |
| 10 | Mental health needs and resources in Nepal (Hall et al., 2016) | Mental health professionals | 35 | Cross-sectional qualitative study | Public stigma and self-stigma | NA | NA |
| 11 | Needs assessment of mental health training for auxiliary nurse midwives: a cross-sectional survey (Simkhada et al., 2016) | Auxiliary nurse midwives | 76 | Cross-sectional quantitative study | Public stigma, health worker stigma | NA (no stigma outcome measure used) | NA |
| 12 | Service user and care giver involvement in mental health system strengthening in Nepal: a qualitative study on barriers and facilitating factors (Gurung et al., 2017) | Mental health service users and caregivers | 24 | Cross-sectional qualitative study | Public stigma, structural barriers, health provider stigma | NA | NA |
| 13 | Persistent complex bereavement disorder and culture: early and prolonged grief in Nepali widows (Kim et al., 2017) | Widows, key informants (individuals who’ve worked professionally with widows) | 37 interviews and 3 focus groups consisting of 20 widows | Cross-sectional qualitative study | Public stigma | NA | NA |
| 14 | Treatment gap and barriers for mental health care: a cross-sectional community survey in Nepal (Luitel et al., 2017) | Adults | 1983 | Cross-sectional survey | Self-stigma, public stigma | NA (no stigma outcome measure used) | Moderate quality |
| 15 | Strengthening mental health system governance in six low-and middle-income countries in Africa and South Asia: challenges, needs and potential strategies (Petersen et al., 2017) | Policy makers, health care planners | 141 (28 in Nepal) | Cross-sectional qualitative study | Public stigma, structural barriers, health provider stigma | NA | NA |
| 16 | Current situations and future directions for mental health system governance in Nepal: findings from a qualitative study (Upadhaya et al., 2017) | National-level policy makers, district-level planners | 17 policy makers, 11 planners | Cross-sectional qualitative study | Public stigma, structural barriers, health provider stigma | NA | NA |
|   | Health risks and challenges in earthquake responders in Nepal: a qualitative research (KC et al., 2019) | Experts in the field of disaster management | 11 experts in the field of disaster management | Cross-sectional qualitative study | Public stigma | NA | NA
|---|---|---|---|---|---|---|---
| 18 | Change in treatment coverage and barriers to mental health care among adults with depression and alcohol use disorder: a repeat cross-sectional community survey in Nepal (Luitel et al., 2019) | General public | The baseline (N = 1983) and the follow-up (N = 1499) | Repeat cross-sectional survey | Public stigma | Barriers to Access to Care Evaluation (BACE) – translation and adaptation reported | Moderate quality
| 19 | Internalised stigma, coping and social support with mental illness in Manipal Teaching Hospital, Pokhara, Nepal (Shrestha, 2019) | Psychiatric patients | 136 patients with mentally ill people | Cross-sectional quantitative study | Self-stigma | Internalised Stigma of Mental Illness (ISMI) Scale – reliability and validity tested and reported | Low quality
| 20 | A study to assess the knowledge regarding human right of mentally ill patient among community people in Kaski, Pokhara, Nepal (Koirala et al., 2019) | Community members | 40 community people residing in Ward no 27 of Pokhara Municipality of Kaski District, Nepal. | Cross-sectional quantitative study | Knowledge on human rights of PWLE | Self-developed semi-structured questionnaire | Low quality
| 21 | Stigma perceived by family members of psychiatric patients attending outpatient department of a teaching hospital (Lamichhane, 2019) | Family members of psychiatric patients | 180 family members accompanying the patients in outpatient department | Cross-sectional quantitative study | Perceived-stigma | Standardised tool for Self-stigma of Mental Illness Scale (SSMIS) – not validated in Nepal | Low quality
| 22 | Perception of stigma among caregivers of mentally ill people (Pandey, 2019) | Family members of patients with mental illness | 50 family members of patients with mental illness | Cross-sectional quantitative study | Public stigma (caregiver stigma) | Self-stigma of Mental Illness Scale (SSMIS) – not validated or adapted | Low quality
| 23 | Eliciting recovery narratives in global mental health: benefits and potential harms in service user participation (Kaiser et al., 2020) | Service users | Qualitative | Public stigma | NA | NA | NA
| 24 | Reducing mental illness stigma in healthcare settings: proof of concept for a social contact intervention to address what matters most for primary care providers (Kohrt et al., 2020) | Primary health care providers | Forty-one primary care workers (19 non-prescribers and 22 prescribers; 4 FGDs and 25 KIIs) | Mixed-methods proof-of-concept intervention study | Public stigma, health worker stigma | Social Distance Scale (SDS) and mhGAP attitudes assessment – previously used in Nepal | NA
| 25 | Mental health and psychosocial support services in primary health care in Nepal: perceived facilitating factors, barriers and strategies for improvement (Upadhaya et al., 2020) | Primary health care workers and female community health volunteers | 55 primary care health workers and female community health volunteers | Cross-sectional qualitative | Public stigma, perceived stigma | NA | NA
|   | (Continued) |
| SN | Study article no., title, (citation) | Study population | Sample size | Study design | Type of stigma mentioned | Stigma-related measures used/tools validation | Quality assessment (for quantitative study only) |
|----|------------------------------------|------------------|-------------|--------------|-------------------------|---------------------------------------------|-----------------------------------------------|
| 26 | Reducing stigma among healthcare providers to improve mental health services (RESHAPE): protocol for a pilot cluster randomised controlled trial of a stigma reduction intervention for training primary healthcare workers (Kohrt et al., 2018a) | Health workers | NA | Intervention protocol | Provider stigma | NA | NA |
| 27 | Medical students’ attitude towards psychiatry and mental disorders (Adhikari, 2018) | Medical students at their first, third and fourth year of medicine | 270 | Cross-sectional quantitative study | Provider stigma | Stigma tools not mentioned or described | Low quality |
| 28 | How competent are non-specialists trained to integrate mental health services in primary care? Global health perspectives from Uganda, Liberia and Nepal (Kohrt et al., 2018b) | Primary healthcare workers | 44 | Interventional longitudinal study | Provider stigma | mhGAP attitude, MICA, Social Distance Scale – translated but not validated in Nepal | NA |
| 29 | Service user and caregiver involvement in mental health system strengthening in low- and middle-income countries: a cross-country qualitative study (Lempp et al., 2018) | Service user advocates/representatives from user led organisations, family members/caregivers, service users from community | 24 | Cross-country qualitative study | Self-stigma, public stigma, structural barriers | NA | NA |
| 30 | Qualitative evaluation of mental health training of auxiliary nurse midwives in rural Nepal (Mahato et al., 2018) | Auxiliary nurse midwives (ANMs) | 15 ANMs | Qualitative study | Public stigma | NA | NA |
| 31 | A service user co-facilitated intervention to reduce mental illness stigma among primary healthcare workers: utilizing perspectives of family members and caregivers (Rai et al., 2018) | Caregivers and service users | 17 service users and caregivers | Qualitative study | Public stigma, self-stigma | NA | NA |
| 32 | Prevalence and correlates of alcohol use in a central Nepal district: secondary analysis of a population-based cross-sectional study (Rathod et al., 2018) | Community people | 1983 (first round); 1499 (second round) | Community-based survey | Internalised stigma | ISMI – tool not validated for Nepal | Low quality |
| No. | Study Title                                                                 | Participants/Design                                                                 | Study Type       | Stigma Type         | Status          | Quality   |
|-----|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------|---------------------|-----------------|-----------|
| 33  | Psychotropic drugs in Nepal: perceptions on use and supply chain management (Upadhaya et al., 2018) | Drugs producers/promoters/distributers; policy makers/government actors; service providers; service users | Qualitative study | Public stigma       | NA              | NA        |
| 34  | Culture and mental health in Nepal: an interdisciplinary scoping review (Chase et al., 2018) | NA                                                                                   | 38 publications  | Scoping review      | Public stigma   | NA        |
| 35  | Stigma causing delay in help-seeking behaviour in patients with mental illness (Amatya et al., 2018) | Patients from outpatient clinic in Manipal teaching hospital, Pokhara – Dept of Psychiatry | Cross-sectional quantitative study | Self-stigma, public stigma | Self-reported public stigma scale Internalised Stigma of Mental Illness-10 (ISMI10) No mention of the tool being translated or adapted for Nepal | Low quality |
| 36  | Attitudes of undergraduate medical students towards the persons with mental illness in a medical college of western region of Nepal (Jalan, 2018) | MBBS students                                                                        | 68               | Longitudinal prospective survey | Medical student’s stigma | Attitude Scale for Mental Illness (ASMI)-not translated, adapted for Nepali population | Low quality |
| 37  | How intern doctors view ‘psychiatry and mental health’? (Shakya, 2018)       | Intern doctors in psychiatry department                                                | 50               | Cross-sectional semi-qualitative survey | Medical student’s stigma | Self-prepared semi-qualitative questionnaire | Low quality |
| 38  | Nepal mental health country profile (Regmi et al., 2004)                     | NA                                                                                   | NA               | Literature review    | Public stigma   | NA        |
| 39  | Cultural challenges to psychosocial counselling in Nepal (Tol et al., 2005)  | NA                                                                                   | NA               | Literature review    | NA              | NA        |
| 40  | Experiencing stigma: Nepalese perspectives (Adhikari et al., 2008)           | Inpatients in psych ward                                                              | 65 recruited     | Retrospective cross-sectional quantitative study | Perceived stigma | Questionnaire with items derived from numerous stigma measures | Low quality |
| 41  | Navigating diagnoses: understanding mind–body relations, mental health and stigma in Nepal (Kohrt and Harper, 2008) | Published literature, traditional healers, general population                         | NG               | Mixed methods – review and ethnographic study | Public stigma   | NA        |
| 42  | Nepali concepts of psychological trauma: the role of idioms of distress, ethnopsychology and ethnophysiology in alleviating suffering and preventing stigma (Kohrt and Hruschka, 2010) | Persons with psychological trauma, counsellors, health professionals | Ethnography      | Public stigma        | NA              | NA        |
Table 1. (Continued.)

| SN | Study article no., title, (citation) | Study population | Sample size | Study design | Type of stigma mentioned | Stigma-related measures used/tools validation | Quality assessment (for quantitative study only) |
|----|------------------------------------|------------------|-------------|-------------|--------------------------|---------------------------------------------|-----------------------------------------------|
| 43 | Nepalese pharmacy students’ perceptions regarding mental disorders and pharmacy education (Panthee et al., 2010) | Undergrad pharmacy students in year 1 and 3 from different universities: KU, TU, PU | 200 | Cross-sectional survey | Public stigma | Self-developed with items derived from Mental Illness Performance Scale | Low quality |
| 44 | Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis (Drew et al., 2011) | People with mental and psychosocial disabilities | 9 | Mixed methods – review, expert consultation/ interview | Public stigma | NA | NA |
| 45 | Mental health first aid programme in Nepal (Jha et al., 2012) | NA | NA | Literature review | Public stigma | NA | NA |
| 46 | Illness causation and interpretation in a Newar Town (Subedi, 2011) | Local elderly people | NA | Ethnography | Public stigma | NA | NA |
| 47 | Mental health, mass media and stigma reduction (Upadhyaya, 2014) | NA | NA | Opinion article | Self, public stigma and structural barriers | NA | NA |
| 48 | Stigma in mental illness: relative’s perspective (Adhikari, 2015) | Relatives or care givers of patients | 67 | Cross-sectional retrospective study | Self, public stigma | Self-stigma of Mental Illness Scale (SSMIS) – adapted for Nepal | Low quality |
| 49 | Setting priorities for mental health care in Nepal: a formative study (Jordans et al., 2013) | Psychiatrists, psychologists and psychiatric nurse, primary health care staff, policy makers or health managers, representatives of mental health organisations, and 1 representative of a mental health user group, community members | 26 (priority setting exercise) 27 (TOC workshop); 33 (KII interviews); 9 FGDS (n = 84) | Mixed methods (ToC, KIs, FGDS, priority setting) | Public stigma, health worker stigma | NA | NA |
| 50 | Conflict and mental health: a cross-sectional epidemiological study in Nepal (Luitel et al., 2013) | Adult population | 720 | Cross-sectional mixed-methods study | Public stigma | NA | NA |
| ID  | Title                                                                 | Participants                                                                 | Methods/ Data Sources                                                                 | Stigmas                                                                 | Data Quality |
|-----|----------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------|
| 51  | Demand and access to mental health services: a qualitative formative study in Nepal (Brenman et al., 2014) | Those working at health organisation level, working at the health facility level, and member of the community | KII 33, FGD 83                                                                          | Health worker/provider stigma, Public stigma, Family/relative stigma, Self-stigma | NA           |
| 52  | Breaking through barriers and building disaster mental resilience: a case study in the aftermath of the 2015 Nepal earthquakes (KC et al., 2019) | Individuals representing institutions working in post-earthquake setting | Interview with 12 institutions                                                           | Public stigma, structural barriers                                        | NA           |
| 53  | Stigma in mental illness: perspective from eight Asian nations (Kudva et al., 2020) | NA                                                                            | NA                                                                                      | Public stigma, health worker stigma                                        | NA           |
| 54  | Development and pilot testing of a mental healthcare plan in Nepal (Jordans et al., 2016) | Routine monitoring and evaluation data                                        | 135 patients                                                                           | Structural barriers                                                       | NA           |
| 55  | Suicide in Nepal: qualitative findings from a modified case series psychological autopsy investigation of suicide deaths (Hagaman et al., 2018) | Family members of the person who had committed suicide                        | 39 cases                                                                               | Structural barriers, public stigma                                         | NA           |
| 56  | A cultural adaptation of dialectical behaviour therapy in Nepal (Ramaiya et al., 2017) | Professional/para-professional mental healthcare providers, psychosocial providers, and women scoring 1 or above in item 9 of BDI | 12 professional/para-professionals, 15 psychosocial providers, 10                      | Public stigma, structural barriers                                        | NA           |
| 57  | General practitioners' knowledge, practices and obstacles in the diagnosis and management of dementia (Pathak and Montgomery, 2015) | General practitioners from hospitals in Nepal                                  | 380 GPs from 12 public hospitals                                                        | Self-reported KAP questionnaire– tool adapted to Nepali language from US instruments on knowledge tests related to Alzheimer disease | Low quality  |
biomedical treatment and use of drugs, with a lack of alternative treatment such as psychotherapies and counselling (Subedi, 2011).

3) Explanatory models of mental disorders

The terminology used for mental disorders and the explanatory models invoked by community members and health workers perpetuated stigma against PWLE. Regarding explanatory models, the most perceived causes included supernatural forces, curses, sinful behaviour, improper rituals or cultural practices and witchcraft. Bad karma (negative effects of past misdeeds including prior lives) or bhagy (fate) that prompted stigma towards PWLE (Kohrt and Harper, 2008; Subedi, 2011; Kisa et al., 2016; Angdembe et al., 2017). This led to the labelling of PWLE as abhagi (unlucky or ill-fated) or paapi (sinful persons). The general public also perceived mental disorders to be hereditary, which extended the use of these terms when describing the entire family such that anyone in the family of PWLE would be labelled with derogatory terminology (Subedi, 2011). Similarly, common symptoms of mental disorders as reported in several studies were exhibiting violent behaviour, being dishevelled, roaming around the road aimlessly, not taking care of personal hygiene, laughing spontaneously and not being able to do given tasks; these beliefs amplified the negative perceptions towards PWLE and increased stigma (Kohrt and Harper, 2008; Kohrt et al., 2020; Upadhaya et al., 2020).

Another belief was that mental disorders were incurable. Health workers reported that mental disorders were life-long conditions that had no effective treatment. The general public stated that mental disorders could not be cured by Western biomedicine but only through traditional healing (Kisa et al., 2016; Simkhada et al., 2016; Koirala et al., 2019; Lamicchhane, 2019; Kaiser et al., 2020). This was also reflected in conceptions about the use of psychotropic medications for mental health conditions; most people described that once a person starts taking medications, she/he must take it for life (Upadhaya et al., 2018). Some studies reported public views that mental disorders are contagious and can be spread through touch. Similarly, an ethnographic study (Kohrt and Harper, 2008) described how Nepali community differentiated mental disorders as dysfunctions of ‘brain-mind’ (dimaa) while psychosocial distress as that of ‘heart-mind’ (man) and how the mental disorders and dysfunction of ‘brain-mind’ were more stigmatised as it was associated with lack of behavioural control, inability to abide by social norms and more likely to be permanent compared to transient distress associated with problems in the ‘heart-mind’.

Community members, sometimes even health workers, labelled PWLEs with stigmatizing terms such as paagai/baulaaahaa (mad/crazy), taaar khusheko (loose wire), dimaa naghaiyeko (no brain-mind), bokshi laageko (afflicted by witchcraft), paapi/paap ko bhog (sinful), khusket (someone whose mind has become lose), dimaa crack bhaiyeko (one whose brain-mind has cracked) (Kohrt and Harper, 2008; Kisa et al., 2016; Angdembe et al., 2017; Lempp et al., 2018; Upadhaya et al., 2020). Such stigmatizing terms were mostly used towards people with low socio-economic conditions such as Dalits (low caste groups, historically referred to as untouchables), women, widows and other minorities (Mahato et al., 2018); this highlights the intersectionality of the perception of mental disorders with female gender, marginalised ethnicities and persons of low socio-economic status. The public perceived that PWLE, especially women, showed symptoms such as talking incessantly, and should be isolated from society (Mahato et al., 2018). A study carried out among caregivers and relatives of PWLE reported higher correlates of negative attitudes toward mental disorders if PWLE had low education status and were females (Neupane et al., 2016).

4) Manifestations of stigma and locations of discrimination

The review identified a number of manifestations of mental disorders. Studies reported the prevalence of self-stigma ranging from 34 to 54% of patients in psychiatric Outpatient Department (OPD) of national hospitals, and 80% of persons screening positive for alcohol use disorder in the community reported internalised stigma (Amatya et al., 2018; Maharjan and Panthee, 2019; Shrestha, 2019). The patients scored high on components such as stereotype endorsement, discrimination experience and social withdrawal. Similarly, family members reported high perceived stigma (52.2%) including the perception that PWLE were violent and burdensome financially (Pandey, 2019), and needed the same kind of discipline and control as a young child (Neupane et al., 2016). PWLE reported feeling rejected by family members (Jordans et al., 2013). More than 50% slightly or strongly agreed to being avoided by others, asked to resign from work and neglected by health professionals (Adhikari et al., 2008). Several studies also reported how PWLE are isolated in the communities, often avoided and considered ineligible to take part in social activities and festivities (Kisa et al., 2016; Lamicchhane, 2019). PWLE are also considered ineligible for work or marriage and even if they do get married, mental disorders are considered acceptable grounds for divorce (Drew et al., 2011; Hagaman et al., 2018). High levels of perceived stigma were reported among patients in the context of marriage, such as having their opinions taken less seriously, feeling of being looked down upon and feeling of being treated as less intelligent or as a failure.

Advocates for PWLE reported explicit discrimination from stakeholders in policy-making or decision-making processes via exclusion or tokenistic involvement (Gurung et al., 2017; Lempp et al., 2018). Human rights abuses were mentioned in some publications where the PWLEs were subjected to violence by the community members and chained/locked up by the family members. Hence, the locations of stigma mostly reported by the studies were home, community or social setting, and healthcare settings (Angdembe et al., 2017).

5) Consequences and impacts of stigma

The studies reported consequences and impacts of mental disorders stigma, which included low help-seeking behaviour, treatment non-adherence, concealment of disorders, poor resource allocation and poor engagement of PWLE (Regmi et al., 2004; Jordans et al., 2013; Upadhaya, 2014; Adhikari, 2015).

Studies overall reported poor help-seeking behaviour among PWLE and their families. Even among those seeking treatment, studies reported low medication adherence among PWLE (Adhikari, 2015; Upadhaya et al., 2018, 2020). The belief that mental disorders are incurable was linked to non-adherence (Jordans et al., 2013) and the use of alternative treatments such as traditional healing (Luitel et al., 2015; Kisa et al., 2016; Angdembe et al., 2017; Upadhaya et al., 2017; Lamicchhane, 2019). Studies reported that idioms of distress in Nepal focused mainly on physical symptoms such as gyastrik (a Nepali idiom
encompassing both gastritis and psychological distress) which made it difficult to identify mental disorders (Kohrt and Hruschka, 2010). Similarly, families often registered PWLE under false names in health facilities, which later created problems in continuity of care and follow-up (Kaiser et al., 2020). Low help-seeking behaviour also contributed to reduced demand for mental health services in health facilities which then impacted resource allocation and supply in procurement and policies (Upadhyaya et al., 2018). A major consequence of concealment of illness by PWLE and families was disruption in the involvement of PWLE and family members in stigma reduction activities, advocacy and health systems strengthening processes because such engagement typically relies on disclosure of mental disorders to the community (Tol et al., 2005; Gurung et al., 2017; Rai et al., 2018).

(6) Measures and interventions

Our review identified only nine standard stigma measures used in quantitative and mixed-methods studies. The tools assessed self and internalised stigma with the Internalised Stigma of Mental Illness (ISMI) and Self-stigma of Mental Illness (SSMIS); public stigma with the Community Attitude towards Mental Illness (CAMI), public stigma scale (PSS), and Social Distance Scale (SDS); clinician’s attitudes with the Mental Illness Clinician’s Attitudes (MICA), mhGAP attitude scale and Attitude Scale for Mental Illness (ASMI); and stigma-related barriers to care with the Barriers to Access to Care (BACE). Five of the studies reported development of their own tool, either by generating new items, or consolidating items from multiple tools (Adhikari et al., 2008; Gartoulla et al., 2015; Pathak and Montgomery, 2015; Shakya, 2018; Koirala et al., 2019). Although ISMI was the most popular tool (n = 4 studies) to measure internalised stigma in Nepal, only one study reported a translation and adaptation process and reported tool reliability (Cronbach’s α = 0.87) (Shrestha, 2019). Studies using the SSMIS reported varying item numbers. The translation and adaptation process were reported for other measures except ASMI, CAMI and PSS. However, the studies did not report reliability or validity scores.

Only four of the reviewed publications mentioned implementation and evaluation of interventions to reduce mental disorder-related stigma in Nepal (Kohrt et al., 2018a, 2020; Rai et al., 2018; Kaiser et al., 2020). All four publications addressed the same intervention: REducing Stigma among HealthcAre ProvidErs (RESHAPE), which was explicitly designed using a ‘what matters most’ framework (Kohrt et al., 2020). The intervention embedded anti-stigma components such as myth-busting, PWLE recovery narrative through a PhotoVoice technique, and aspirational figures within the mhGAP training of primary healthcare workers in Chitwan District to reduce their stigma attitudes and improve competencies.

Discussion

Our scoping review identified a modest number of publications on stigma and discrimination related to mental disorders in Nepal (n = 57) from 2000 through 2020. The studies focused on a range of stigma types (internalised, perceived, public, courtesy, practitioner and medical students' stigma) and used diverse methods (quantitative, qualitative, mixed methods, ethnography) to understand stigma. However, few studies had mental health stigma as their primary outcome or domain. Additionally, most quantitative studies were conducted in specific populations and were of poor methodological quality and used measures that were not culturally adapted to the population under study. The stigma-related information and findings from these studies were extracted and collated under the themes of: (1) what matters most; (2) structural facilitators and barriers; (3) drivers and markers of stigma; (4) manifestations and locations; (5) consequences and impacts; and (6) measures and interventions. These themes are summarised and mapped into a conceptual framework (Fig. 2). This framework helps to understand the stigma processes in Nepal and also to identify the gaps in literature and the areas/domains where further interventions can be planned to help reduce mental health-related stigma in Nepal. The key findings, recommendations and contribution to the field are summarised in Table 2.

Structural barriers identified in our review included lack of mental health policies, low budgeting for mental healthcare, lack of trained human resources in primary healthcare settings and lack of medications. As shown in the conceptual framework, these structural barriers, and ‘what matters most’ for people in Nepali culture, interact with each other to influence the stigma processes such as stigma drivers, its manifestations and impacts. This influence of what matters most to cultures and structural barriers on stigma has also been highlighted by Yang et al. (2014a, 2014b). An example of this interaction is how what matters most to health workers can be influenced by availability of resources. For instance, if there is a scarcity of medications for the treatment of mental disorders, then health workers would prioritise conditions where resources are easily available. Similarly, if what matters most to the public is productivity then these attitudes will be reflected in policies, where less productive people experience structural discrimination.

The explanatory models of mental disorders including causal beliefs and symptoms and markers of stigma in Nepal are similarly influenced by these domains of what matters most and structural barriers and facilitators. Conflicts between the explanatory models of mental disorders such as perceived causes and symptoms, and what matters most to Nepali culture, exacerbated by the structural barriers may lead to marking of PWLE as being violent, sinful or not being able to make an independent living. This in turn manifests into various human rights abuses such as being chained or locked-up, discrimination in health facilities, refusals in marriage proposals and exclusion of PWLE in community or religious activities. These stigma manifestations related to mental disorders appear to be heightened when it intersects with other forms of drivers and markers such as gender, ethnicity and socioeconomic conditions in Nepal. Women, widows, Dalits and people living in poverty were identified to face more stigma in Nepal.

Another example of the interactions between the domains can be seen in how suicide is perceived by the culture (sin) and is reflected in policies (an illegal act), which has then shaped how people who attempt suicide are perceived as sinful or criminal (drivers and markers) (Hagaman et al., 2016, 2018). This is reported to manifest as internalised stigma and public stigma where such people perceive themselves as weak-minded with reduced potential for marriage. This leads to them not seeking or adhering to treatments (Jordans et al., 2013).

The conceptual framework describes how the domains interact with each other to shape and reshape stigma processes. It also helps suggest pathways to design interventions that may reduce mental health-related stigma by breaking these processes. As causal beliefs of mental disorders, lack of awareness, fear of harm or burden are some of the key drivers, interventions could target
these drivers through myth-busting exercises, awareness campaigns and education-based interventions. Interventions such as RESHAPE (Kohrt et al., 2018a, 2020) address what matters most to PWLE and the drivers of stigma among health workers through contact, myth-busting and recovery narratives (Rai et al., 2018). Other interventions may focus on the intersectionality that exacerbates stigma or tackle what matters most to the public by focusing on productivity or livelihoods. Studies have shown benefits of stigma interventions targeting multiple stakeholders and multiple domains (Richman and Hatzenbuehler, 2014; Rao et al., 2019). Currently, only one stigma intervention (RESHAPE) was identified through the review which points to a glaring gap in the mental health-related stigma field in Nepal. Since the time of the review, there have been more recent studies of stigma interventions in Nepal. A recent publication on the RESHAPE intervention demonstrated that stigma reduction not only contributed to improved attitudes over 16-month period, it was also associated with improved accuracy of clinical diagnoses (Kohrt et al., 2021). Another recent study, which used video-based recovery testimonials from PWLE, showed that stigma attitudes reduced with testimonials about depression but stigma increased with video testimonials about psychosis (Tergesen et al., 2021).

Another gap in the literature identified in the review is a sparse understanding of the mechanisms of how mental illness stigma intersects with other socio-demographic and economic factors. Also, there is limited knowledge on the impact of stigma related to mental disorders on PWLE, family members and the larger public outside the health system. The structural barriers and stigma have an overarching influence on other domains of stigma processes. Therefore, structural barriers, indicators to measure the structural barrier and discrimination and interventions to reduce structural barriers need to be explored further.

Similarly, the review revealed a focus mainly on internalised and public stigma. More studies need to be conducted to explore the anticipated and experienced stigma by PWLE and caregivers, especially in contexts such as the workplace, educational institutions, health facilities and other religious or community organisations. For example, a recent multi-country study conducted after the review period found that in many LMICs, PWLE had low expectations of how they would be treated by health workers and therefore they did not consider the experiences discriminatory, e.g. ‘this is how we expect to be treated’ (Koschorke et al., 2021). No publications were identified that focused on the mental health stigma and discrimination among children and adolescents, although a number of studies have explored the role of other forms of stigma (e.g. gender and caste discrimination, discrimination against former child soldiers) on poor mental health outcomes (Kohrt and Maharjan, 2009; Kohrt et al., 2010; Morley and Kohrt, 2013; Kohrt and Bourey, 2016) and social attitudes influencing what is labelled as mental illness among children (Burkey et al., 2016; Langer et al., 2019).

Another area where the review revealed paucity in information was measures of mental disorder-related stigma. Only nine stigma tools were reported across studies and most did not provide details on adaptation and measures of reliability/validity. Studies need to identify indicators that are most relevant to Nepali context and what matters most in Nepal to capture the stigma processes and evaluate the effectiveness of stigma interventions. Along with the measures, evaluation methods need to be diversified with intervention and longitudinal studies.

Finally, as the studies report on stigma and discrimination of PWLE, the researchers must be mindful of PWLE’s dynamics and influences in the discourse. PWLE led movements have highlighted the need for their involvement in all aspects of intellectual...
impacts.

Key learnings from the Nepal review

- Few studies include stigma as a primary outcome
- Only one anti-stigma intervention has been evaluated
- Large systemic and structural barriers are shaped by what matters most for the general public, people with lived experiences and health workers, and their explanatory models of mental disorders
- The labelling of people living with mental illness as violent, sinful and not able to make an independent living stems from interactions among explanatory models of mental disorders, what matters most to Nepali culture, and structural barriers
- Intersection of mental illness stigma with other socio-demographic and economic factors has received limited research attention
- Studies predominantly focus on internalised and public stigma, and few studies focus on experienced stigma
- Studies with mental illness stigma have not been conducted among children and adolescents
- Few tools have been locally adapted for stigma research

Key contribution in the field

- The conceptual framework for mental disorder-related stigma in Nepal provides visual representation on the complexity of stigma processes with domains that interlink with and influence each other. Although there are conceptual models for stigma processes, most do not describe the structural and cultural factors, using a what matters most perspective, that has impact on the drivers, manifestations and consequences of stigma

Key recommendations

- Future studies and interventions should target the complex process and multiple domains while addressing mental health-related stigma
- Mental health-related stigma studies should focus on intersectionality of stigma with other socio-demographic and economic factors as well as drivers and consequences of stigma on children and adolescents
- Procedures are needed for systematic cultural adaptation of stigma assessment tools
- Research should be conducted to understand the forms and drivers of structural stigma and expand intervention research to evaluate strategies for structural stigma reduction

and decision-making processes including research with slogans such as ‘Nothing about us without us’ (Charlton, 1998). Only a few of the articles in the review reported involving PWLE and caregivers in the research and publication process, while most of the studies limited the roles of PWLE to research participants. This in itself reflects the systemic marginalisation and discrimination of PWLE within the research and academic field. Hence, future mental health research, especially in the area of stigma and discrimination, should focus on the roles and process of effective involvement of PWLE to help enhance the findings and make it more relevant. Another issue to consider is who is leading mental health research in Nepal. A recent review of mental health research publications found that only 23% were led by Nepali women, and only 15% were led by researchers from Nepali ethnic minorities or low caste groups (Gurung et al., 2021). This is a notable under-representation of persons from stigmatised groups in Nepal leading research on stigma. A change in who conducts research about stigma is likely to impact what is learned about stigma and how to effectively reduce its detrimental impacts.

Limitations

We acknowledge a number of limitations of this scoping review. The qualitative coding process is inherently subjective. We have however tried to reduce some of the subjectivity through the involvement of multiple reviewers and discussion with senior researchers, including discussion of results with a co-author who is PWLE. We were also limited to conducting quality assessments of only quantitative studies and no studies were excluded due to low methodological quality. This decision was made as the major objective of this review was to explore existing stigma-related knowledge and information, rather than quality assessment. However, some quantitative studies had serious methodological flaws that we wanted to point out for the generalisability of the findings and for future studies. Similarly, despite our comprehensive search strategy, we acknowledge that the search terms may not have been exhaustive. Another limitation was that the study did not include approximately the past 12 months of publications. As with any review, there might have been new publications that may have come out after the review process and have not been included in this review. We have tried to address this in the discussion by including notable recent publications related to stigma. A final limitation is that our presentation of results and discussion did not account for change over time. From a popular media perspective, health professional education curricula, mental health training initiatives in primary care and community settings and major events impacting mental health, such as the 2015 earthquakes and recent COVID-19 pandemic, there are several factors that have likely influenced changes in attitudes over time. Because our review predominantly summarised content qualitatively, we are unable to conclude whether there have been significant changes over the past 20 years.

Conclusion

In this study, we highlight what matters most to key stakeholders regarding stigma related to mental disorders. Additionally, we summarised how mental disorders were explained, discussed and recognised in the community as documented in peer-reviewed journal publications in the past 20 years. We also highlighted several structural barriers that further aggravated mental health stigma in Nepal. As stigma processes are complex and interlinked, more studies are required to understand this complexity and establish effective interventions targeting multiple domains. Future stigma research should clarify what conceptual models can inform study design and interpretation. There is a need to develop procedures for systematic cultural adaptation of stigma assessment tools. Research should be conducted to understand the forms and drivers of structural stigma and expand intervention research to evaluate strategies for stigma reduction. Finally, greater opportunities for researchers with lived experience of mental illness and researchers from stigmatised groups are needed to guide the science of tackling stigma in Nepal.

Data

Additional data and materials related to the scoping review are available from the corresponding author dristy.1.gurung@kcl.ac.uk.

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