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Breaking barriers: mental health literacy and stigma in Addis Ababa's schools – a qualitative study in Ethiopia

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ABSTRACT

Objectives To explore the mental health literacy of school communities and stigma against students with mental disorders in Ethiopia's specific context.

Design Qualitative study using in-depth and key informant interview guides.

Participants Nine teaching and psychosocial support staff participants (five men and four women; years of experience ranging between 2 and 35; three school counsellors, two clinical nurses, two special needs teachers, one counselling psychologist and one class principal teacher) were purposefully recruited on the basis of their proximity to the students' academic Journeys and health-related issues.

Setting Key Informant Interviews were conducted with nine participants working at four high schools (two private schools, one affiliated with a church and two public schools, one with a programme for special needs students) in Addis Ababa, Ethiopia.

Results This study revealed that there is a significant lack of awareness and misconceptions about mental health issues within the school community, and that students suffering from mental disorders often face discrimination and stigma. These factors contribute to delays in seeking care, which may result in poor coping strategies. School-based programmes aimed at promoting mental well-being and reducing the stigma observed at the study sites are inadequate for addressing these challenges effectively.

Conclusions In this study, we identified key challenges among school communities, as perceived and reported by school-based professionals, including a lack of awareness, misconceptions and notable stigma against schoolchildren with mental disorders. To establish a well-coordinated school mental health system, governance should focus on (1) establishing comprehensive mental health literacy and promotion, (2) reducing stigma and (3) implementing service delivery and/or referral programmes within schools in Addis Ababa. To ensure a holistic and inclusive mental health support in Ethiopian schools, future studies should engage students and their parents directly triangulating these professional observations.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ Strengths include the study design, as a qualitative study provides in-depth insight into school community perceptions of and stigma toward mental disorders.
⇒ This contextual understanding is key for developing mental health interventions tailored to this specific population.
⇒ A significant limitation is the exclusion of other important stakeholders such as students, parents and schoolchildren with lived experience.
⇒ Another limitation of our study is that it is only representative of the capital city context, which might differ from peripheral cities and rural areas.

INTRODUCTION

Mental disorders affect one in seven (14%) children aged 10–19 worldwide,[1] although they are frequently ignored and untreated. Children and adolescents with mental disorders are especially susceptible to stigma, discrimination, social exclusion, maladaptive coping behaviours, physical illness, human rights violations and educational challenges.[1]

For schoolchildren struggling with mental health challenges, being stigmatised and discriminated against by the community is among the major factors negatively affecting their well-being and help-seeking behaviour.[2] Cultural beliefs and stereotypes continue to shape public perceptions of mental disorders, often leading to discrimination and social exclusion.[2] In addition, they face difficulties in their day-to-day life and experience enormous distress as their emotional regulation, relationships and academic performance are often negatively impacted by their mental disorders.[3]

In Ethiopia, these perceptions are deeply rooted in cultural and religious beliefs, which can complicate the understanding and management of mental health issues.[4] Traditional views often associate mental disorders with moral failure or supernatural phenomena, fostering a reluctance to seek help and a tendency to rely on traditional healers.[5] Consequently, students struggling with mental health issues may

face heightened stigma from peers, educators and even family members.

Given this context, schools represent a vital platform for promoting mental and emotional well-being. They are essential for preventing mental health issues and for identifying students who may be struggling with mental disorders.[6] Research indicates that school-based mental health services, including counselling and mental health education, can significantly benefit students by enhancing their understanding of mental health and providing access to necessary resources.[7] Although some studies report inconsistent findings regarding the overall and particularly long-term impact of anti-stigma campaigns,[8 9] with a few suggesting that such campaigns might even exacerbate stigma, interventions targeting mental health stigma within educational settings have generally shown promise in reducing stigma among students.[10] A study indicated that many teachers in Ethiopia have a relatively poor level of awareness of mental health issues, making it difficult for them to detect and address whenever their students experience various psychosocial and mental health issues, which is also reflected in the general education system.[11]

Our study aimed to provide insight into the existing level of mental health literacy of the school community in Addis Ababa and shed light on the stigma experienced by schoolchildren with mental disorders. By analysing these insights, we hope to contribute to ensuring that schools are more inclusive and supportive of children who struggle with mental health issues.

As Falissard and Martin (2022) emphasised, 'the time has come' for the field to embrace qualitative methods, which are 'especially well-suited to exploring the inner experiences and subjective meanings that underpin mental health problems and care pathways among youth' (European Child and Adolescent Psychiatry). Our study is a timely response to this call.

The findings from this study contribute to the limited research on mental health and stigma in the school context in low- and middle-income countries (LMICs) such as Ethiopia, and provide valuable insights to inform the development of school-based mental health programmes and policies that address the unique challenges faced by students with mental disorders.

METHODOLOGY

Research team and reflexivity

The research team consisted of two male and three female multidisciplinary investigators with over 5 years of experience in clinical psychiatry and public health. Prior to the interview, the researchers and the participants had no existing relations. During the recruitment and consent process, the participants were informed of the researchers' affiliations, and the purpose of the study. The researchers maintained a reflexive stance and used semi-structured interview guides to ensure their clinical backgrounds did not overshadow the participants' authentic cultural and spiritual perspectives.

Participants and recruitment

An intensity purposive sampling technique was used to identify respondents for Key Informant Interviews (KII). Nine participants across four high schools (two private schools, one affiliated with a church and two public schools, one with a programme for special needs students) were interviewed between 14 February and 17 April 2023, with a 100% response rate. The participants included school community representatives who frequently engage with students regarding their health and academics, such as school counsellors, clinic nurses in school, class principal teachers and special needs teachers. The participants' selection also accounted for the school type, gender, role and years of service. By focusing on these key informants, the study captures the perspectives of professionals who are primary observers of the school environment. However, it is important that the study's findings reflect the school community's mental health literacy and stigma as perceived and reported by these professionals, rather than through direct assessment of students or parents.

The number of participants was determined after data saturation was reached during data collection, as new data points replicated existing patterns without adding significant new information.

Theoretical framework

The study employed a qualitative descriptive approach. This approach was chosen to clearly describe the participants' experiences and perceptions of mental health literacy and stigma within a school setting. The study approach was further guided by the 'Social Stigma Theory', which provides a framework for understanding how 'discredited attributes' lead to social exclusion and discrimination.[12] This theoretical lens, along with a cultural-constructivist approach,[13] was used to account for the unique spiritual and supernatural explanatory models prevalent in Ethiopia. These models informed our semi-structured interview guides and provided a deductive basis for our thematic analysis. Using these frameworks, we explored how cultural and spiritual explanations of mental disorders contribute to the social 'marking' of students in the Ethiopian context.

Data collection procedures

Face-to-face interviews were conducted by one of the authors (FA) within the respective school settings. To ensure confidentiality and open discussion, only the participants and the researchers were present during the interviews. Each participant engaged in a single interview session lasting 40–50 minutes. Data collection was guided by a semi-structured KII guide.

The KIIs focused on understanding the mental health literacy of the participants, stigma habits and discrimination against students with mental disorders, among school communities, especially within school-related contexts. The KII was guided by six main research questions:

1. What are the common manifestations of mental disorders among school students?

2. What factors contribute to the development of mental disorders among students?
3. What are the misconceptions about mental disorders held by students?
4. What stigmatising experiences do students with mental health issues face in schools?
5. How do students with mental disorders react when they face discrimination?
6. What actions have been taken to reduce the stigma surrounding mental disorders in schools?

The interview guide was prepared by conducting literature reviews to address the study's objectives. It was translated from English into Amharic, pilot tested with two individuals who met the inclusion criteria. Based on their feedback, minor adjustments were made to the phrasing of some questions to ensure they were clearly understood. All the interviews were audio recorded, transcribed into Amharic and then translated into English. Field notes were recorded during and after each session to capture non-verbal cues and the environmental context. Transcripts and findings were not returned to the participants for comment or correction due to time constraints

Data analysis

SWM and FA independently coded the transcripts using Open Code software, V.4.03. Intercoder agreement was assessed by comparing a sample of coded transcripts. Any inconsistencies were resolved by a reconciliation process, ensuring both coders reached the same understanding of each code. A codebook was developed from concepts and themes derived from the interview questions and the interview guides (inductive and deductive codes). Following this, the data were analysed thematically using the codes in the codebook, where related concepts from themes were grouped into an organising theme, which summarised the concepts into a structured format. As a result, the description was completed according to the thematic areas. The credibility of the results was maintained by peer debriefing and prolonged participation. To ensure reliability, peer review was conducted in terms of dependability, and consistency was checked in the findings. A detailed description of place, context and culture in the research process improved the transferability of the study.

Rigor

To evaluate the rigour of the qualitative study, we employed dependability, conformability and transferability. The interviews were audio-recorded to ensure credibility and to capture the participants' responses accurately. Additionally, an audit trail was created, encompassing the interview guide, audio recordings, transcripts and data analysis process. Dependability and conformability were established by involving three other researchers in decision-making related to the study. Transferability was further ensured through purposive sampling. See online supplemental table S1 for the complete Consolidated criteria for Reporting Qualitative research (COREQ) report.

Table 1 Background characteristics of the study participants, Addis Ababa, Ethiopia, 2023

No.	Participant code	Generalised affiliation	Generalised role
1	KII1	Public school	Psychosocial staff
2	KII2	Public school	Health staff
3	KII3	Public school	Teaching staff
4	KII4	Public school	Psychosocial staff
5	KII5	Public school	Teaching staff
6	KII6	Private school	Teaching staff
7	KII7	Private school	Psychosocial staff
8	KII8	Private school	Health staff
9	KII9	Private school	Psychosocial staff

KII, Key Informant Interviews.

Patient and public involvement

Patients or the public were not involved in the design, conduct, reporting, or dissemination plans of our research.

RESULTS

The study involved nine participants, including counsellors, a school clinic nurse, special needs teachers and class principal teachers. For a detailed breakdown of the participants' roles and involvement in the study, refer to table 1.

The results are reported in four major thematic areas: (1) perception of mental health and mental disorders, (2) stigmatising experiences, (3) stigma reduction and (4) recommendations.

Perception of mental health and mental disorders

This section describes the common manifestations, attributed causes and misconceptions about mental disorders, reported by the participants.

Manifestation of mental distress and mental disorders

According to the participants, recognising mental distress and mental disorders among students in the school environment is challenging for teachers, counsellors, school nurses, administrators and even their parents. Initial evaluations may not always reveal underlying mental health concerns, which often become noticeable only after students begin attending classes.

They also noted that distinguishing between behavioural problems and mental disorders can be challenging; even trained professionals within the school may find it difficult to identify and manage these situations effectively.

Even the parents may not be aware of their child's problem until it becomes so obvious in a school setting. For example, difficulties in reading and writing can be indicators of underlying mental health challenges such as intellectual disability. There are still students who are identified with mental illness after they have already started their education. KII3

A participant from private schools noted that students with mental disorders often show a decline in their academic performance, exhibit fatigue or drowsiness and struggle to maintain focus and concentration on their studies. These symptoms also included behaviours such as students crying, leaving the classroom during lessons, showing signs of depression, such as being emotionally overwhelmed or feeling down, and engaging in disruptive actions. The other participants also recognised the considerable effect of students' mental health challenges on their academic success.

There was one specific incident we encountered in the past. We had a student who faced ridicule and discrimination due to her mental illness. This unfortunate situation led to a decline in her participation in class and became more isolated, which negatively affected her academic performance and overall well-being. KII6

The participants noted that mental disorders, such as depression, appeared to impact female students more, whereas male students seemed to be more affected by substance use problems, such as smoking cigarettes.

There are also behaviors that they show. They may even shiver in the classroom. In addition, the teachers may send them to us. When we ask them politely, they tell us that they are taking drugs. KII2

The participants indicated that students with mental disorders face challenges in understanding academic subjects, which is evident in their difficulties with tasks such as maths and sentence construction, suggesting underlying issues in comprehension and expression. Negative experiences in lessons, including poor performance and frustration, result in a lack of motivation, aversion to certain subjects and an overall lack of interest in education.

The inability to maintain focus and engagement was reported to frequently lead to conflicts between students and their teachers. These negative experiences, combined with the students' mental health issues, contribute to their reluctance to advance in their grades. As a result, many of these students opt to return to a lower grade level after reaching a certain point.

Teachers often question why students are not listening, paying attention, or completing their homework. Sometimes, they may resort to insults or punishments, such as expelling the students from the class, which can lead to conflicts. As school counselors, we try to guide them differently. We tell them, 'When you feel sick and unable to understand your lessons, come here, and we will explain it to you.' We reassure them that when they feel overwhelmed or bored, they can come to us and calmly work through it together. KII4

Explanatory models of mental disorders

Almost all the participants highlighted the bidirectional relationship between addiction and mental disorders among students. Addiction among students was identified as a major contributing factor to mental disorders and behavioural challenges. The use of substances such as hashish/marijuana and excessive consumption of tramadol pills were reported to worsen their existing mental health issues.

The participants mentioned that financial and academic stress are some of the factors contributing to students' mental health challenges. When experiencing overwhelming stress, students may tend to use unhealthy coping strategies such as substance use. In addition, although the school community has attempted to initiate discussions and counselling regarding substance use and associated risks, the students do not take this matter seriously.

The primary issue at hand is addiction. While the specific substances they consume remain undisclosed, it is evident that they use drugs such as hashish and tramadol, and other painkiller pills. The reasons behind their drug use vary, such as the loss of a caregiver, poverty, etc. KII3

The students generally lack awareness about mental disorders. Despite efforts to inform them about the potential harm caused by certain substances and the risk of mental illness, students often exhibit disbelief and a lack of concern. KII5

They reported that most students dealing with mental health issues came from difficult backgrounds, such as from single-parent households, orphans or not living with their parents. Coming from economically disadvantaged families, living in poverty, hunger and malnutrition, particularly among disabled children, were also identified as significant factors affecting their overall well-being.

The participants also noted that peer pressure and age influence mental disorders. According to the respondents, high school students, typically around the ages of 15 and 16, are more vulnerable to peer pressure and are therefore more likely to engage in risky behaviours. However, these issues tend to decrease as students advance to higher grades.

Misconceptions about mental disorders

The participants reported that students tend to link mental disorders with individuals who behave inappropriately, show disrespect or fail to dress suitably, viewing it as a condition of 'abnormal thinking' or 'madness'. However, the participants also noted that schoolchildren often have a simplistic understanding of mental health

issues. They typically do not recognise conditions such as anxiety and depression as mental disorders. Furthermore, they may avoid discussing mental health matters out of fear of being associated with more severe mental disorders.

> Depression and anxiety are often not recognized as mental disorders by the students; students casually use these terms to describe their emotional states, expressing feelings of being overwhelmed or down. KII1

Certain misconceptions within the school community and among parents, such as mental disorders are contagious, contribute to stigma, create fear among families, who worry that their children could develop mental health issues through interactions with affected students.

> Families perceive those mental disorders as contagious. They ask why their child has been with such children because… KII3

Those respondents from schools with religious affiliations often attributed mental disorders to spiritual causes, such as evil spirits. This strong religious influence led to a preference for spiritual explanations over considering mental disorders as products of biological, psychological and social factors, or issues related to an individual's mental state.

> Students often perceive mental illness as a curse from God or an evil spirit or attribute it to family-related factors, rather than a legitimate condition. KII8

Stigmatising experiences

This section presents the reactions of the school community to students with mental disorders and the responses of students with mental disorders when they are discriminated against, as observed by the participants.

Reactions toward students with mental disorders

The responses revealed that there is variation in the reactions observed within the school community. In schools where the number of students with mental disorders is very low, there is a pattern of fear, discrimination and misconceptions among students towards their peers with mental disorders. These students tend to avoid approaching them due to a fear of potential attacks. Instances of running away and perceiving them as dangerous, mocking their actions, giving them derogatory nicknames, blaming them for disruptive incidents and engaging in gossip and discrimination were reported.

> When our students encounter peers with mental health problems, there is a sense of hesitation in approaching them owing to the fear of potential harm or being attacked. The students experience conditions of discrimination against these peers while also trying to protect themselves. KII9

In contrast, students in more inclusive educational settings exhibit less discriminatory behaviours, as they do not tend to treat peers with mental disorders differently unless overt actions are present.

> In our experience, unless the students with mental disorders exhibit overt manifestations, we have not observed any discrimination from the students toward them. There is sometimes a fear among students in regard to interacting with individuals with mental health conditions, as they may believe that the person might act unpredictably. KII5

The participants also noted that, as the children advanced through high school, they became more mature and better equipped to support their peers. Students focus on understanding and helping one another, creating strong relationships among those with mental disorders. Close friends often act as intermediaries, communicating the challenges faced by these students to teachers and staff.

> Students with mental disorders frequently choose to confide in their close friends instead of directly approaching teachers or staff, as they believe their peers have a greater understanding of their conditions and be more supportive. Rather than engaging in discriminatory behavior, which is often the case, they show that if a student is depressed and sleeping in class, their classmate may cover them by saying they are sick. KII7

Response when discriminated against

The participants expressed that students with mental disorders are aware of how their peers perceive and treat them, which significantly impacts their experiences within the school community. They often feel feared and stigmatised, with older students being particularly conscious of the discrimination they encounter. These students closely observe the social dynamics in the school, noting who offers support and who displays negative behaviours, including derogatory remarks, which shape their understanding of their environment. Additionally, the fear of being labelled 'crazy' leads many to hesitate in discussing or acknowledging their mental health issues openly.

They also noted that when faced with discrimination or aggression from peers, students with mental health issues exhibit a range of reactions. Some may respond with aggression, whereas others become fearful and may cry. Signs of distress, such as crying and reluctance to return to school, are also common.

> When they are aggressively mocked and bullied, the immediate reactions of students can vary. Some may respond aggressively or engage in physical fights, while others may breakdown and cry, even more, may become unwilling to return to school… KII1

> There are students with mental disorders who refuse to attend school. Despite the efforts of the parents

and teachers to offer love and guidance, their motivation to go to school remains elusive owing to the fear of negative labeling. KII6

Some opt to conceal their condition, fear stigma and isolation or confide in teachers and report instances of mistreatment, whereas others tend to self-stigmatise, affecting their self-esteem and overall well-being. Moreover, those with a higher level of understanding of their condition may choose to ignore the mistreatment inflicted by others.

> …based on my experiences, students with mental disorders often perceive that all other students hate them and constantly observe their actions. I recall a student who left last year and would openly share his feelings, saying, 'I feel like all students are watching me. The reason I'm not in line-ups is because I believe everyone is observing me, and I think they all dislike me. That is why I frequently argue with students and teachers. I do not have any friends'. KII7

Stigma reduction

This section focuses on actions taken by the schools and school community to reduce stigma.

The participants reported that the schools they work for employ diverse strategies, initiatives and interventions to address the stigma surrounding mental disorders within their respective settings. The continuous provision of support in their school contributed to positive behavioural changes among the students. They acknowledged the crucial role of the school community and parental support in facilitating positive transformations among students struggling with addiction and self-harm, who often feel trapped. Moreover, they shared their involvement in a broader project called the 'Stigma Project', which aims to enhance understanding and combat the stigma associated with mental disorders. The project involves diagnosing students with mental disorders and linking them to professional support. Additionally, they create awareness through collaboration with school mini-media and other educational materials.

> The key actions taken to reduce stigma surrounding mental disorders at our school include identifying students exhibiting signs of mental disorders, forwarding the findings to relevant bodies, and using the mini-media to educate and empower them in creating awareness. KII3

The establishment of a counselling team, a 'Special Needs' club, and the celebration of 'International Disability Day' through activities such as drama, music and sports helped create a positive and inclusive environment. Training programmes, such as those that teach sign language, promote inclusivity and encourage interaction among students from diverse backgrounds. Additionally, a meal programme for students lacking proper nutrition enhances their overall well-being, especially for those students from socioeconomically disadvantaged backgrounds.

> The introduction of the meal program has greatly benefited the children. Previously, their faces appeared pale, and some even arrived without a lunch box or with an empty box to pretend that they had a meal. We witnessed numerous hardships before the implementation of this program. KII5

Another school employs a strategy of immediate isolation, intervention and warnings for students with difficult behaviours. The school's screening process, which includes interviews and examinations, prevents the admissions of new students and prompts the termination of existing students with addiction-related issues. A measure taken to maintain a safe and conducive learning environment for the rest of the students.

> Aiming to protect the rest of the students and minimize the number of admissions of new students with mental health issues related to addiction, the school applies a rigorous evaluation process, including requesting evidence of their behavior and academic records from previous schools. The existing students receive continuous awareness and support to prevent relapses or new incidents. KII7

The participants from the religiously affiliated school reported that they harness their religious foundation to combat stigma and encourage a supportive environment by teaching strong ethical values to students. This school encourages students to seek solace and support in their faith and turn to God during challenging times. They reported that offering religious lessons, including subjects such as ethics and prayers, helps students establish a connection between their religious beliefs and their mental well-being.

> In regard to mental illness and psychology, there is an ongoing discussion about the role of religion. In times of stress, turning to God or one's religion can provide a framework for finding solutions. Therefore, our school offers religious lessons to help students establish a connection between their faith and their well-being. KII9

While most participants focused on cultural and spiritual explanations, the analysis revealed minor themes about the physical school environment. Specifically, some participants noted that the absence of designated, private counselling space acted as a systemic barrier, hindering the ability to maintain confidentiality.

Recommendations

This section presents recommendations forwarded by the participants to better address mental health concerns in schools.

The participants emphasised the necessity of establishing school clinics and guidance services to address mental health issues by raising awareness and offering

support to students in need. They reported that opening these clinics and providing training for teachers and school administrators would enhance mental health promotion and ensure access to comprehensive services within the school system. Additionally, they suggested expanding mental health programmes to all educational levels, including elementary schools.

> A good academic performance alone is not adequate, and behavior plays a vital role in shaping a productive society. There is a need to improve awareness and find ways to bring about behavioral change. KII3

The participants also called for better access to quality mental health services. While they acknowledged the current guidance and counselling services, they expressed concerns about their effectiveness due to high workloads. A dedicated centre with mental health specialists could help address issues early and mitigate negative outcomes for students.

> Mental health is often neglected and overshadowed by other priorities in educational settings; therefore, it is important to address mental health issues, which are tailored on the basis of age and according to our country's context. KII3

They also highlighted the need for collaboration among stakeholders and shared responsibilities in addressing mental health concerns. They stressed the need for a comprehensive approach that starts at higher levels and extends to schools and local communities.

> We recommend involving the government in promoting mental health awareness through media programs and social media platforms to prioritize mental health and integrate it into the school curriculum. KII9

DISCUSSION

Our qualitative study explored school community mental health literacy and stigma against mental disorders in LMICs, specifically in Addis Ababa, Ethiopia. We found that there is a significant awareness gap and pervasive misconception toward mental health conditions among the school community, and according to the judgement of the interviewed teaching and psychosocial school staff, children with mental disorders experience severe stigma and discrimination. Both poor mental health literacy and stigma were identified as major barriers to timely care-seeking, often resulting in students resorting to maladaptive coping strategies, such as substance use, instead of talking to friends and teachers or seeking professional assistance. Students' academic performance, social interaction, self-care and overall well-being suffer as a result. Additionally, we discovered that despite schools' efforts to raise awareness of mental health concerns, promote inclusivity and reduce stigma and discrimination, substantial work remains to be done to close this gap.

These results offer a specialised 'expert-proxy' perspective on the school environment. Because the participants interact daily with a diverse range of students and families, their insights offer a comprehensive view of the barriers and stigma present in Addis Ababa's schools. Nevertheless, these results remain the professionals' interpretation of the community's literacy levels.

While few studies in Ethiopia have examined mental health literacy, stigma and discrimination toward individuals with mental disorders, very few have focused on the educational context. Considering that the majority of mental disorders are reported to first present symptoms in late childhood and adolescence,[14] mental health interventions targeting schools and the school community will be crucial for the prevention, early detection and effective treatment of mental health conditions.

Our findings revealed that the school community lacks clarity about the common presentations of mental disorders, making it difficult to determine whether a student is experiencing a mental health issue. The participants often showed a tendency to believe that mental disorders manifest in only specific ways. Some also reported that depression and anxiety are not even regarded as mental disorders. This general lack of awareness about mental health conditions was corroborated by community studies conducted in Ethiopia and other LMICs.[15–17]

Symptoms such as fatigue, academic decline, emotional withdrawal and classroom disruptions were some of the additional common indicators of underlying mental health issues. The findings underscore how mental health issues directly impact students' academic engagement and performance.

Our participants, particularly those from religious schools, reported that religious and supernatural explanations are more widely accepted and that mental disorders are believed to be the results of human actions, sins, curses and evil spirits and that solutions only emanate from religious practices. In community studies conducted in Ethiopia, socioeconomic status and supernatural agents are commonly reported as causes of mental disorders.[16 18] This discourages help-seeking, in fear of being judged or discriminated against by others, leading to a delay in the diagnosis and treatment of mental disorders.[19]

Despite these challenges, our participants also demonstrated sensitivity in describing risk factors, behavioural signs of distress and dysfunctional coping mechanisms, and in identifying those most in need of support. Accordingly, adolescents who are orphans, live with a single parent, are economically disadvantaged or have addiction are perceived to struggle with mental health issues more. While socioeconomic factors are known to play a key role in the development of mental disorders globally,[20] in Ethiopia, where poverty remains a pervasive challenge, the impact of these factors on mental health cannot be overstated. The relationship between having a problematic substance use pattern and a mental disorder was highlighted by the study participants. Substance use can be both a cause and a consequence of mental health

issues, perpetuating a challenging cycle.[21] This double burden, along with the difficulty in accessing mental health services, highlights the need to focus on health promotion, prevention and the urgent need to integrate mental health and substance use within school health programmes.

According to the participants, most students with mental disorders are aware of the stigma and discrimination they face and respond in different ways. Some of the responses include ignoring abuse, crying, reacting violently, engaging in physical fights, withdrawing and even refusing to attend school. Students who manifested symptoms of severe mental disorders, more so than those with addiction problems or milder conditions, were prone to being stigmatised and discriminated against. These often manifested as derogatory nicknames, blame for disruptive events, rumours or even physical abuse. Facing stigma and discrimination makes openly discussing mental health issues very challenging. Stigma remains a significant barrier to individuals suffering from mental disorders.[22] Similar trends have also been reported in other studies, leading to decreased interest in using the scarcely accessible mental health services that exist in LMICs.[23 24]

We found that there are encouraging initiatives taken by schools aimed at creating a better awareness of mental health issues and lessening stigma against children with mental disorders. Some of the schools have formed counselling teams that make diagnoses, recommend interventions or provide referrals to centres providing mental health services. They also use mini-media, educational materials and sign language instructions, and engage in celebrations such as 'International Disability Day' through various events such as sports, music and drama. These activities ensure inclusivity, help students express themselves more freely and build their self-confidence, which in turn improves their mental health. The Ethiopian Federal Ministry of Health recently integrated mental health services into the health extension package,[25] but there is still an enormous gap in its implementation, particularly in school settings. The participants acknowledged that although individual schools in Addis Ababa have made efforts to reduce stigma, there remains a lack of an overarching governmental strategy and a structured system to connect the education sector with the mental healthcare system for referrals and collaboration.

Conversely, our findings revealed that some schools implement screening, isolation, warning and even immediate termination when dealing with students who have addiction and mental health conditions related to it, in an attempt to protect the rest of the students. This approach contradicts the WHO recommendations which emphasise that schools should be safe and inclusive areas where there is a compassionate approach, early treatment and access to care for children facing mental health challenges. In addition to violating students' basic right to education and health, these disciplinary approaches often worsen the outcomes for students with substance use disorders by increasing stigma, discouraging help-seeking behaviour and worsening psychological distress. Shifting from punitive school discipline toward health-affirming interventions is also recommended.[26] Therefore, schools should replace disciplinary frameworks with evidence-based interventions rooted in support, education and empathy.

The participants consistently acknowledged the critical role of the school community and family support in helping students who are battling addiction and self-harm, emphasising that offering continuous assistance would result in beneficial changes in their behaviour. They recommended the establishment of school clinics, guidance and access to comprehensive mental health services, sustainable training, ongoing mental health awareness campaigns and anti-stigma programmes within the school community and a collaborative effort of stakeholders to address mental health concerns within the school setting.

The evidence suggests that school-based mental health programmes can significantly improve students' mental health outcomes and reduce stigma.[27 28] The implementation of comprehensive mental health education and awareness campaigns promotes a culture of acceptance and support and reduces stigma and discrimination. Training school teachers about mental health issues also improves early identification and treatment for schoolchildren in need.[29 30]

This study included schools with unique features and included key individuals who had close engagement with the students. However, a significant limitation is that the study examined mental health literacy and stigma from the perspective of school-based professionals. Although these professionals are in close proximity to students, a direct exploration of students and their parents was not conducted. Future research should include these stakeholders to corroborate the professionals' observations and provide a more comprehensive view of the community's needs. Another limitation of our study is that it is only representative of the capital city context, which might differ from peripheral cities and rural areas. Nevertheless, the results provide important insight for the implementation of programmes in this specific local setting.

CONCLUSIONS

Our study highlighted a significant gap in the understanding of mental health issues among school community members, as well as a notable stigma and discrimination against schoolchildren struggling with mental disorders. These findings indicate how urgent interventions and strategies aimed at schools need to be developed. These efforts should strengthen existing school counselling services, mental health awareness programmes and community support initiatives, and train the school community to recognise and address mental health issues. These findings

provide a strong foundation for future quantitative and interventional studies. To build on these findings, future studies should include the perspectives of students, parents and other stakeholders. This will allow for the triangulation of observations by school professionals and ultimately foster a more inclusive and effective mental health support systems in Ethiopian schools.

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Contributors SWM, AJ, SD, EG and FAW conceptualised and designed the overall study. FAW and SWM were responsible for the data collection and analysis. AJ, SD and EG provided supervision during the data collection process. SWM drafted the manuscript with contributions from AJ, SD, EG and FAW. All authors read and approved the final manuscript. SWM is the guarantor. I used Grammarly and QuillBot to check for spelling and grammar and paraphrase some statements.

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Competing interests SWM, SD and AJ are affiliated with CIHLMU at the Hospital of Ludwig-Maximilians-University, Munich, the funder for this work. All other authors have no competing interests to declare

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Patient consent for publication Not applicable.

Ethics approval This study involves human participants and was approved by the School of Public Health at Addis Ababa University's Research Ethics Committee (Prev: 9-2022) and the Ethical Review Board at CIHLMU in Munich (Project Nr. 25-0796). After obtaining ethical approval, permission was obtained from the Addis Ababa Education Bureau, subcities and the participating schools. Written informed consent was obtained from all participants prior to data collection.

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