A RESEARCH REPORT SUBMITTED TO THE UGANDA NURSES AND MIDWIVES EXAMINATIONS BOARD IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF DIPLOMA IN NURSING SCIENCE

BY

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ABSTRACT

Mental disorders are widely recognized as a major contributor (14%) to the global burden of disease worldwide. In Uganda only ten mental health units are available at regional level to treat 11,500, 000 mentally ill persons out of a population of 33, 000,000 and are manned by unqualified staff and poorly stocked with required medicines rendering them as good as useless. To assess knowledge, attitude and practices about care of the mentally ill persons, a descriptive cross-sectional study design quantitative in nature was used. Purposive and simple random sampling methods were used to recruit 79 respondents for the study. Out of whom 79 questionnaires were returned completely filled giving a response rate of 100%. 68% of the respondents strongly agreed that limited knowledge about cause of mental illness affects care of mentally ill persons, 69.6% of the respondents strongly agreed that mentally ill persons should be secluded from others and 65% of the respondents strongly agreed that mentally ill persons could be treated by thrusting limbs in fire. The researcher concluded that there was limited knowledge about home based care of mental ill persons as it was influenced by knowledge of cause of mental illness hence treatment was sought from traditional healers and religious groups. Attitudes about care of mentally ill persons were equally not good as mentally ill persons were viewed as a disgrace, dangerous and infectious. Practices about care of mentally ill persons were equally not promising as mentally ill patients were always restrained by tying with ropes, thrusting feet in fire and mostly managed by herbalist.

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Signature…….....Date……

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Signature……Date…….

DEDICATION

This research work will be dedicated to my father for his great support and encouragement in my academic endeavors.

ACKNOWLEDGEMENT

I am very thankful to the Almighty God for his mercy, protection and guidance during the whole period of my study, many thanks to all those who helped with the completion of this dissertation. My heartfelt appreciation to Ms. Rose Bel for her valuable advice and guidance in the design and conduct of this study together with devotion of taking the pain of going through the manuscript several times before the final production. My special thanks to the administration of Bushenyi-Ishaka municipality who provided all the support I needed during the data collection period. Together with respondents who participated in this study, I must say that without them data for the study could not have been gathered. I would also like to extend my thanks to all academic staff of the School of School of nursing Sciences of Kampala International University for their valuable comments during the whole process of the dessertation development and production.

Finally, I am grateful to my wonderful family for their moral and financial support throughout the period of my diploma program.

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LIST OF ACRONYMS

KIU WC-SONS-Kampala International University Western Campus School of Nursing Sciences.

MoH-Ministry of Health**.**

SPSS-Statistical Package for Social Scientists**.**

UBoS-Uganda Bureau of Statistics**.**

UNMEB-Uganda Nurses and Midwives Examinations Board.

WHO-World Health organization**.**

YLD-Years Lost due to Disability**.**

OPERATIONAL DEFINITION OF TERMS

Anxiety-A feeling of worry or unease**.**

Epidemic-Wide spread occurrence of an infectious disease in the community**.**

Ostracism-Exclusion from society or group**.**

Psychosis- A severe mental process in which thought and emotions are so impaired that contact is lost with external reality.

Psychosocial-Interaction of social factors and Individual thought and behavior.

Pychiatric-Relating to mental illness and its treatment.

Stigma-A mark of disgrace.

Substance abuse-Over indulgence in or dependence on addictive substance**.**

CHAPTER ONE

INTRODUCTION

1.0 Introduction.

This chapter contains background, problem of the statement, purpose of the study, specific objectives, research questions and justification.

1.1 Background.

Mental illness refers to all of the diagnosable mental disorders, which are characterized by abnormalities in thinking, feelings or behaviours (MedicineNet, 2011).

Globally, 14% of the global burden of disease is attributed to mental illness with 75% of those affected being found in low income countries which includes a broad spectrum of diagnoses, from common mental illnesses such as anxiety and substance abuse, to severe illnesses like psychosis (Njenga, 2012). In 2012, mental disorders accounted for 5 per cent of the total burden of disease and 19% of all disability in Africa. The burden of depressionis particularly significant, accounting for 5% of all disability. Thus, mental illness is a major cause of morbidity and a burden to the patients, their families and society (Brickell and McLean, 2014).

The social environment in many African countries does not nurture good mental health mainly due to the myriad conflicts and post conflict situations. War and other major disasters have a large impact on the mental health and psychosocial wellbeing of people. The WHO estimates that 50% of refugees have mental health problems ranging from posttraumatic stress disorder to chronic mental illness WHO, (2011).In addition, other natural shocks, including death, chronic diseases, floods, droughts and disease epidemics, have adverse mental health effects (Freeman*et al*., 2009).

Unfortunately, the financial and human resources in theAfrican Region are insufficient to address adequately the burden ofmental health disorders. The Region has fewer mental

healthprofessionals than other WHO regions. For example, the mediannumber of psychiatrists per 100,000 people is only 0.04. A similartrend is seen in the availability of psychiatric beds, whose mediannumber per 10,000 people is 0.34. Also, only 56% ofAfrican countries have community based mental health facilitiesand only 37% of the countries have mental health programs for children and only 15% of the countries have mental health programs for the elderly WHO, (2012). The rise in the number of individuals with mental health problems places an even greater burden to already under resourced health care services in the region (Hanlon*et al.*, 2010).

Given that there is no reliable national level data for population based prevalence rates of mental illness in Uganda, the treatment gap has been estimated from a conservative perspective using the global rate of 13% prevalence. Based on global prevalence rates, it is estimated that about 2.2 million people in Uganda (13% of the 16.7 million adult population) have had a mental disorder in the previous year, and about 501,000 (3% ofthe adult population) have had a severe form (Kigozi, 2007).

It is important to note that Poverty and mental health conditions interact in a negative cycle. People living in poverty not only lack financial resources to maintain basic living standards, but may also have fewer educational and employment opportunities. People with mental health conditions sometimes are unable to work because of their symptoms. Due to discrimination, others are denied work opportunities or lose employment(Hanson, 2012).Thoughthe proportion of people living below the poverty line significantly declined from 52% in 1992 to 31% in 2005. poverty still remains a significant problem for Uganda. Uganda remains one of the poorest countries, ranking 145 on the global Human Development Index (UBoS, 2009).

1.2 Problem statement.

Mental disorders are widely recognized as a major contributor (14%) to the global burden ofdisease worldwide (Prince, 2007).Nearly 25% of individuals, in both developed and developing countries develop one or more mental or behavioural disorders at some stage in their life (WHO,2011).

Psychiatric disorders comprise 10% of the burden of disease in Africa. In all regions, psychiatric conditions are the most important causes of disability, accounting for around one third of Years Lost due to Disability (YLD) among adults aged 18 years and over(WHO, 2008).

In Uganda only ten mental health units are available at regional level to treat 11,500, 000 mentally ill persons out of a population of 33, 000,000 and are manned by unqualified staff and poorly stocked with required medicines rendering them as good as useless (MoH, 2014).

Similarly in Nyamitooma ward no study has been done regarding knowledge, attitude and care of mentally ill persons, coupled with paucity of mental health services despite rising numbers of persons with various mental problems. This compelled the researcher to assess knowledge,attitudes and practices about care of the mentally ill persons in Nyamitoma ward.

1.3 Purpose of the study.

To assess knowledge, attitude and practices about care of the mentally ill persons..

1.4 Study objectives.

i)To assess knowledge of community members about home based care of the mentally ill persons in Nyamitooma ward, Ishaka municipality Bushenyi district.

ii)To assess attitudes of community members about home based care of the mentally ill persons in Nyamitooma ward, Ishaka municipality Bushenyi district.

iii)To assess practices of community members about home based care of the mentally ill persons in Nyamitooma ward, Ishaka municipality Bushenyi district.

1.5 Research questions.

i)What is the level of knowledge of community members about home based care of the mentally ill persons in Nyamitooma ward?

ii)What are the attitudes of community members about home based care of the mentally ill persons in Nyamitooma ward?

iii)What are the practices community members about home based care of the mentally ill persons in Nyamitooma ward?

1.6 Justification.

Although the idea of health without mental health sounds absurd, mental health is perhaps the most neglected aspect of health in developed and developing nations. Addressing mental disorders often appears to be an after thought in health and social policy development, added to existing 'more important health issues' rather than a part of an individual and population overall health and wellbeing. Therefore results obtained in this study will be beneficial to;

i) Nursing research.

The study findings will be used as a reference for other researchers with similar interest in assessing knowledge, attitude and practices about care of the mentally ill persons.

ii) Nursing education.

The study findings will be used by other students as a reference in their future assignments.

iii) Nursing practice.

The study findings will be used to plan health education activities so as to reduce stigma among about mental illness and therefore improve care of the mentally ill persons.

iv) The community.

The community members will learn to embrace mentally ill persons as part of the community and that any one can suffer from mental illness and wouldn't like to be stigmatized.

1.7 Scope of the study.

1.7.1 Geographical scope.

The study was conducted from Nyamitoma ward Ishaka municipality Bushenyi district. Nyamitooma ward is 383 km south west of Kampala, Uganda's largest city and capital and 15Km west of Bushenyi town. Nyamitoma is hilly and has mosty savannah vegetation with a few artificial forests consisting of mostly eucalyptus trees.

1.7.2 Contextual scope.

The study was carried out to assess knowledge, attitude and practices about care of the mentally ill persons and make appropriate recommendations so as to improve care of the mentally ill persons.

1.7.3 Time scope.

The study was carried out from 1st Jully to 30th august 2016.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction.

This chapter deals with review of relevant literature in relation to the study objectives which include; To establish level of knowledge of community members in the care of mentally ill persons inNyamitooma ward Ishaka municipality, to assess the attitude of community members about care of mentally ill persons in Nyamitooma Ishaka municipality and to assess the practices of community members about care of patients with mental illness in Nyamitooma ward Ishaka municipality.

2.1 Knowledgeof community members about care of the mentally ill persons.

Limited knowledge about mental illnesses remains a concern in various countries of the world especially in developing countries. This Lack of knowledge about mental illnesses has been found by various studies as a key cause of devastating beliefs people have about causes of mental illnesses such as that mental illnesses are not diseases but equated to possession of evil spirit, witchcraft or curse (Polkinghorne, 2015).

WHO has acknowledged that, knowledge about the cause of mental illness varies across cultures and has never been favorable worldwide, thus calling need for public education and greater openness about mental illness. As a result, improved knowledge about causes of mental illness may lead to improved help seeking behavior and promote supportive attitudes to the mentally ill. Furthermore, adequate public knowledge about mental illness is one way to deal with negative perceptions people have towards mentally ill people (WHO, 2011).

In a cross-sectional survey involving 380 persons made up of government workers and the general public in Accra, Ghana, it was found that almost all the people interviewed could

accurately describe what mental illness is. Un interestingly, however, nearly half (45.3%) of the respondents did not know possible associated causes of mental illness (Jallon, 2007).

In the studies carried out in Nigeria by Ojinnaka,(2009) heredity was identified as a cause of mental disorders by 19.9 %, followed by brain injury (19.2%), possession by evil spirits (16.3%) and brain infection (11.7%). Overall 26% of the respondents had good knowledge of mental illness whereas 31% and 43% had fair and poor knowledge of mental illness respectively.

A study of the knowledge about mental illness among rural inhabitants of Tanzania showed that nearly 70% indicated that they did not know the cause of mental illness. Further, 33.3% identified heredity, witchcraft, infection of the spinal cord, hernia, insects in the stomach and casting of evil spirits on the individuals as possible causes of mental illness (Ozer,2011). Majority of respondents (47.0%) opted for spiritual healing. This was followed by orthodox medical care (34.0%) and the use of traditional herbal medicines (19.0%) (German, 2007).

Studies carried out inZambia on knowledge of mental illness showed thatmajority of the respondents (39.0%) mentioned that mental illness is manifested by convulsions. Other manifestations of the mental illness described by the respondents included falling down (36.0%), rolling of eyes (11.3%) and foaming of mouth (10.3%). Up to 25.2% of respondents did not know the cause of mental illness (Kobau and Price, 2012).

In a related study in Uganda on knowledge about mental illness showed that most of the respondents (82.6%) wrongly agreed with the statement that mental illness is an infectious condition, while 13.3% believed mental illness not to be infectious (Rwiza *et al.*, 2013).

These results are related to findings of Santos,(2008) in Kenya where as many as 78% wrongly believed it to be infectious, with just 20% correctly saying that it is not an infectious disease.

2.2 Attitudes of community members about care of the mentally ill.

In a study in United Emirates by Baker *et al.*,(2009) a small percentage (7%) objected to allowing their children to play with children with mental illness, but up to 68% objected to their children marrying a person suffering from a mental disorder.

The same response pattern as above was found in a study from Iran.The attitude towards daughters marrying a person suffering from any form of mental illness was negative (75%). However, Iranians had a positive attitude about employing people suffering from mild mental disorders and their association with healthy people (Masoudnia, 2009).

Mental health is a socially constructed and defined concept, implying that different societies, groups, cultures, institutions and professions have diverse ways of conceptualising its nature and causes, determining what is mentally healthy and unhealthy, and deciding what interventions, if any, are appropriateGordon, (2013).

Mental illness is a taboo subject that attracts stigma in much of Africa. A study conducted in Uganda revealed that the term ‘depression’ is not culturally acceptable amongst the population, while another study conducted in Nigeria found that peopleresponded with fear, avoidance and anger to those who wereobserved to have a mental illness (Arboleda, 2012).

It is worth noting that social stigma has meant that in much of Africa mental illness is a hidden issue equated to a silent epidemic as many households with mentally ill persons

hide them for fear of discrimination and ostracism from their communities. Girls from homes known to have mental illness are disadvantaged due to the fact that a history of mental illness severely reduces their marriage prospects (Brickell, and McLean, 2011).

Stigma remains a powerful negative attribute in all social relations. The social rejection resulting from this may handicap mentally ill people even further(Stuart and Arboleda, 2011).

People suffering from mental illness have been discriminated against in several ways (Kale,2007). In numerous countries, families try to hide the disorder to allow the person with a mental disorder and other family members to marry. People with mental disorders find it difficult to obtain jobs. Procuring a driver's license is often problematic (German,2007).

2.3 Practices of community members about care of patients suffering from mental illness.

In Nigeria among the Bini people mental illness is treated by thrusting the patient's limbs into a fire, rubbing pepper into their eyes and face, and making an unconscious person drink cow's urine, a treatment that can lead to aspiration pneumonia (Singh and Arora, 2007)

A simillar study in Nigeria showed that when mental illness is recognized, patients were often sent to seek treatment via priests and herbalists based on evident symptoms. These alternatives were also sought by those already using conventional treatment in the hospital with no improvement(Collings, 2009).

In Ethiopean study by Shibre *et al.,* (2008) the following actions were done during an episode of mental breakdown; removal of dangerous objects (8%), taking the patient to the

hospital (6%), tying with ropes (84%), isolation (50.6%)and forcing food through the mouth(56%).

During role play exercise about mental illness in India, 52% of the students correctly responded by calling a doctor as soon as the warning signs appear in the person, while around 74% did so after the person became destructive (Koul *et al.*,2008). As a preventive measure, only 21% of students removed the harmful objects as person with mental illness could hurt himself or others (Senanayake, 2007).

Otsyula, (2013) observed that many patients in Kenya used both contemporary western-style medical services as well as traditional healers. The patients visited hospitals to seek the cure for illness while traditional doctors were visited for both the cure and the cause of illness. Several studies have suggested that many cultures have names for various mental health disorders, implying that they saw and recognized them in their practices

CHAPTER THREE

METHODOLOGY

3.1 Introduction.

This chapter includes; study design, study setting, study population, selection criteria, sample size determination, sampling technique, study variables, data collection techniques,

research instruments, data management, data analysis, quality control techniques and ethical considerations of the study.

3.2 Study Design and rationale.

This study was conducted through a descriptive cross-sectional study design quantitative in nature. The study design was selected because it aids in rapid data collection and allows a snap short interaction with a small group of respondents at a certain point in time thus allowing conclusions about phenomena across a wide population to be drawn. The study design was used to examine the residents of Nyamitoma ward in Ishaka municipality by assessing the knowledge, attitude and practices about care of the mentally ill persons.

3.3 Study setting.

The study was conducted from Nyamitoma ward Ishaka municipality Bushenyi district. Nyamitooma ward is 383 km south west of Kampala, Uganda's largest city and capital and 15Km west of Bushenyi town. Nyamitoma ward comprises of 3 cells namely Nyamimtooma A, Band C. Despite being located near Kampala International University Teaching Hospital with a good psychiatric unit, mentally ill persons in Nyamitoma ward have been neglected, stigmatized or even physically and sexually abused and being a peri urban setting it has one of the highest number of mentally ill persons who are not only neglected by family members but also physically and sexually abused by unscrupulous individuals in town.

3.4 Study Population.

The study population consisted of residents aged 18years and above in Nyamitoma ward.

3.4.1 Sample size determination.

Sample size was determined using Kish lisle (1965) method in which the sample size is given by the expression:

$$n = \frac{Z^2pq}{d^2}$$

n = desired sample size

Z = Standard normal deviation usually set at 1.96 for maximum sample at 95% confidence level.

P= 50% (constant) or 0.5 since there were no measures estimated.

Therefore P=1-O.5

=0.5

q = 1-p = 1-0.5 = 0.5 and,

d = Degree of accuracy desired 0.05

By Substitution we get:

$$n = \frac{1.96^2 \text{x } 0.5 \text{ x } 0.5}{0.05^2} = 384$$

n=384

Since target population is less than 10,000

nf= $\frac{n}{}$ N=Target population (100)

$$nf = \frac{384}{1+(n/N)} = \frac{384}{1+(384/100)} = 79$$ Therefore the sample size was79

3.4.2 Sampling procedure.

The researcher purposively selected two cells in Nyamitoma ward with the highest number of mentally ill persons basing on Bushenyi district health records and then randomly sampled seventy nine respondents out of the two cells for administration of the questionnaire.

3.4.3 Selection criteria.

Inclusion criteria.

The study included all residents aged 18 years and above who were present at the time of the interview and willing to consent for the study.

Exclusion criteria.

Respondents who were very sick, mentally ill, the deaf and those who did not consent were excluded from the study.

3.5 Definition of variables.

3.5.1 Dependent variable.

Factors affecting care of the mentally ill persons.

3.5.2 Independent variable.

Knowledge of community members about home based care of the mentally ill persons in Nyamitooma ward Ishaka municipality.

Attitudes of community members about home based care of the mentally ill persons in Nyamitooma ward Ishaka municipality.

Practices of community members about care of the mentally ill persons in Nyamitooma ward Ishaka municipality.

3.6 Research Instruments

A structured questionnaire was used as a tool for gathering information. The structured questionnaire was preferred in this study because a lot of information can be collected over a short period of time. The structured questionnaire was divided into four sections;

The first section was used to collect data about socio-demographic profile, the second sectionassessed knowledge about care of the mentally ill persons, the third section was used to assess attitude towards care of the mentally ill persons and the fourth section was used to assess practices of youth about care of the mentally ill persons.

3.7 Data collection procedure.

After the sampling process was completed, the researcher interviewed the respondents. The researcher introduced him self to the prospective participants and read to the individual participant the consent form that detailed the title and purpose of the study as well as the

rights of the participant. Whenever a participant agreed to be interviewed he/she was asked to provide written consent by signing or fingerprinting. If they refused to participate the interview would not proceed.

After obtaining the written consent, the researcher entered the questionnaire serial number and date of interview and proceeded from the first up to the last question using a language understood by the participant. The researcher entered responses given by the participant by ticking the appropriate response and entering the same number in to the coding box. This was done to ensure data quality as the response number ticked was supposed to be the same as the one entered in the coding box. If the numbers were different it would not be a valid response. The researcher reviewed the questionnaires on a daily basis to ensure they were being completed correctly and any errors corrected to avoid being repeated. The process of data collection continued until every effort to contact every study participant in the sample was exhausted. All completed questionnaires were kept safe by the researcher.

3.7.1 Data management.

Quantitative data was collected using a structured questionnaire. Completed questionnaires were checked for accuracy, for any missing data and completeness on a daily basis after data collection at the end of the day. This was followed by coding and entry of the data using Epi info 3.4.1 software for Windows and double entry into Statistical Package for Social Scientists (SPSS) version 16.0 software for analysis.

3.7.2 Data analysis and presentation.

Data was analysed by descriptive statistics using SPSS version 16.0 software and presented in frequency tables, piecharts and bargraphs.

3.8 Quality control techniques.

For reliability and validity,the questionnaires was pretested with a tenth of the sample size outside study area. The questionnaire was then revised and content adjustments made accordingly. After data collection, questionnaires were checked daily, for completeness, clarity, consistency and uniformity by the researcher.

3.9 Ethical consideration.

A letter of introduction was obtained from Kampala International University Western Campus School of Nursing Sciences (KIU WC-SONS) to permit the researcher to carry out the research.

Permission was obtained from chairman LCII Nyamitooma ward.

All participating respondents were selected on the basis of informed consent**.**

The study was on voluntary basis and information was kept private and confidential. Participants' anonymity was kept. The study was conducted while upholding the professional cord of conduct in a manner that did not compromise the scientific inclinations of the research.

3.10 Study limitations.

It was hard to obtain audience from the respondents as they were having other duties to perform at home, this was however overcome by creating rapport and administering a questionnaire as quickly as possible.

Being a rainy season, it interfered with the process of data collection, this was however overcome by use of gumboots and a rain coat.

3.11 Dissemination of results.

Copies of results were disseminated to the Uganda Nurses and Midwives Examinations Board (UNMEB) for marking**,** Bushenyidistrict health office for appropriate interventions and School of nursing science at Kampala International University Western Campus.

CHAPTER FOUR

DATA ANALYSIS, INTERPRETATION AND PRESENTATION

4.0 Introduction.

This chapter is concerned with analysis, interpretation and presentation of data collected. Out of 79 respondents interviewed, 79 returned completely filled questionnaires thus giving a response rate of 100%.

4.1 Biodemographic data

Table 1.1: Shows bio demographic data of the respondents (n=96)

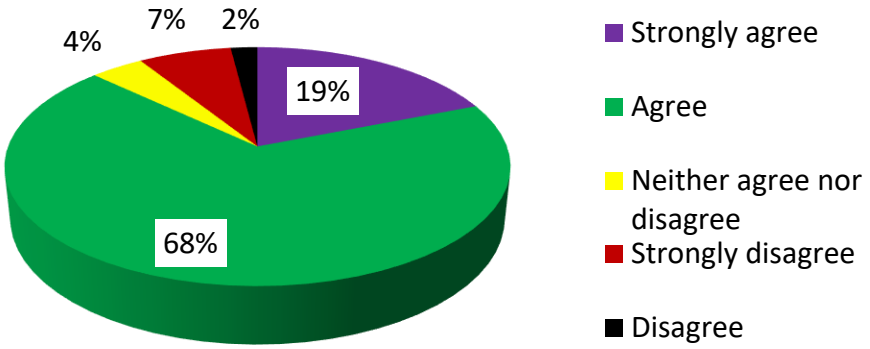
Bio demographic parameter		**Frequency(n)**	**Percentage (%)**
Age(Years)	18-23	11	13.9
	24-29	39	49.4
	30-35	24	30.4
	36-41	5	6.3
	42-47	-	-
	>48		
	Total	**79**	**100**
Sex	Male	34	43
	Female	45	57
	Total	**79**	**100**
Tribe	Munyankole	56	70.9
	Mukiga	23	29.1
	Others	-	-
	Total	**79**	**100**
Religion	Christian	66	83.5
	Moslem	13	16.5
	Others	-	-
	Total	**79**	**100**
Marital status	Married	78	98.7
	Single	-	-
	Divorced	-	-
	Widowed	1	1.3
	concubined	-	-
	Total	**79**	**100**
Employment status	Employed	3	3.8
	Un employed	67	84.8
	Self employed	9	11.4
	Total	**79**	**100**
Education	None	10	12.7
	Primary	50	63.3
	Secondary	17	21.5
	Tertiary	2	2.5

	Total	**79**	**100**

Nearly half of the respondents (49.4%) were of the age range between 24-29years while only 6.3% were between 36-41 years. More than half of the respondents 57% were female while only 43% were male. Majority of the respondents 70.9% were Banyankole while only 29.1% were Bakiga. Majority of the respondents (83.5%) were Christians while only 16.5% were Moslems. Majority of the respondents (98.7%) were married while only 1.3% were widowed. Majority of the respondents (84.8%) were un employed while only 3.8 % were employed. Most of the respondents (63.3%) attained primary level of education while only 2.5% attained tertiary level of education.

4.2 Knowledge about care of the mentally ill persons.

Figure 2.1: Shows response on whether limited knowledge about cause of mental illness affects care of mentally ill persons (n=79).



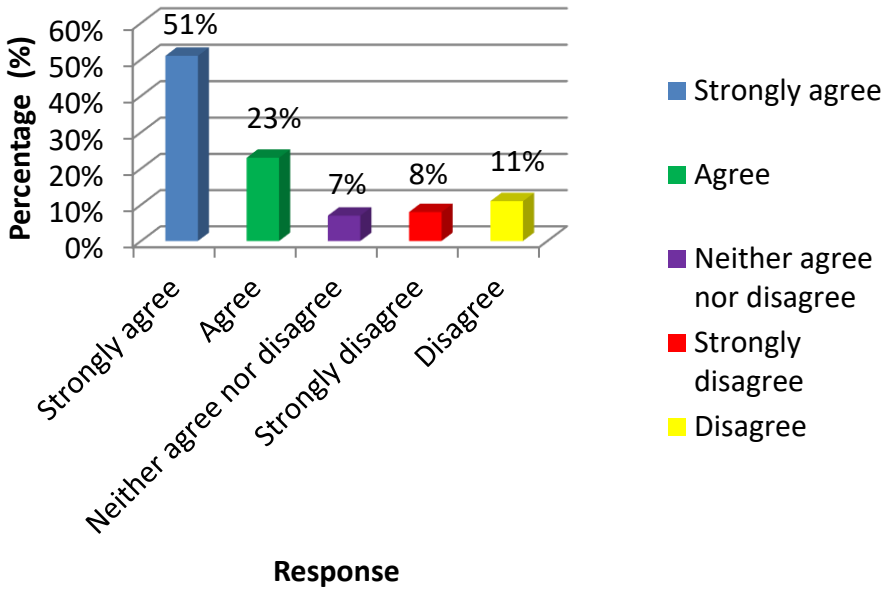
Most of the respondents (68%) strongly agreed that limited knowledge about cause of mental illness affects care of mentally ill persons while only 2% agreed.

Table 2.1: Shows response on whether mental illness was caused by evil spirits (n=79).

Response	**Frequency(n)**	**Percentage(%)**
Strongly agree	59	74.7
Agree	16	20.3
Neither agree nor disagree	-	-
Strongly disagree	-	-
Disagree	4	3.8
Total	**79**	**100**

Most of the respondents (74.7%) strongly agreed that mental illness was caused by evil spirits while only 3.8% disagreed.

Figure 2.2: Shows response on whether mentally ill persons should be treated outside the hospital setting (n=79).



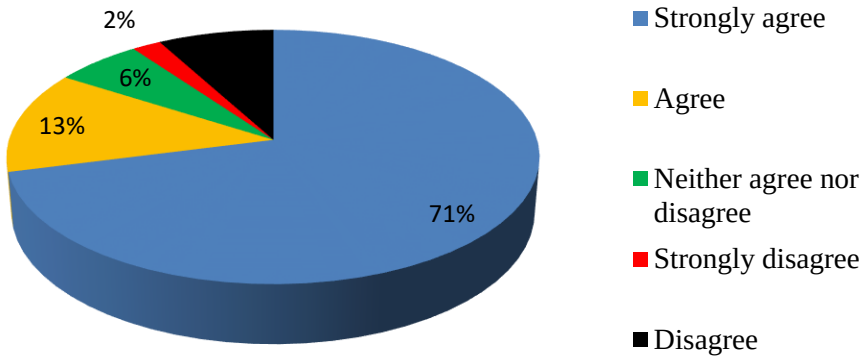
More than half of the respondents (51%) strongly agreed that mentally ill persons should be treated outside the hospital setting while only 7% neither agreed nor disagreed.

Table 2.2: Shows response on whether mental illness manifests with convulsions (n=79).

Response	**Frequency(n)**	**Percentage (%)**
Strongly agree	50	63.3
Agree	15	19
Neither agree nor disagree	-	-
Strongly disagree	11	13.9
Disagree	3	3.8
Total	**79**	**100**

Most of the respondents (63.3%) strongly agreed that mental illness manifests with convulsions while only 3.8% disagreed.

Figure 2.3: Shows response on whether mentally ill persons were infectious (n=79).



Most of the respondents (71%) Strongly agreed that mentally ill persons were infectious while only 2% strongly disagreed.

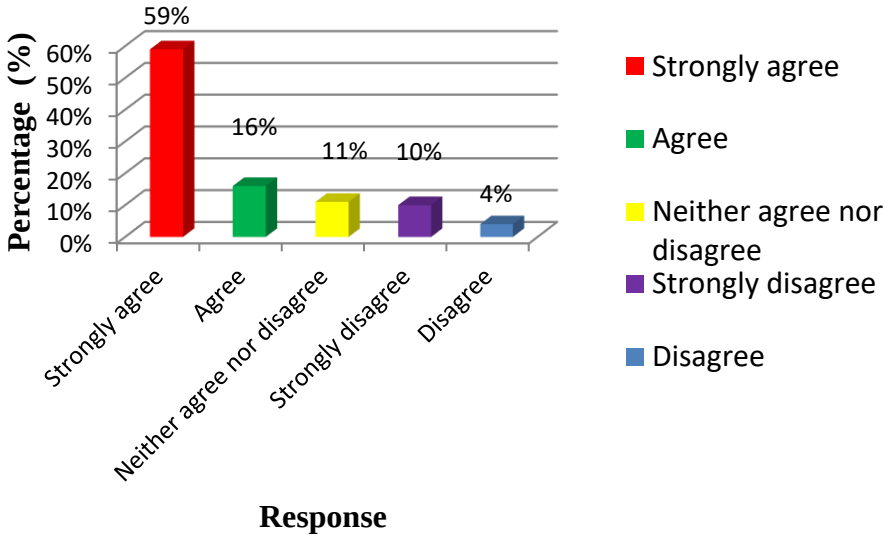
4.3 Attitudes about care of mentally ill persons.

Table 3.1: Shows response on whether mentally ill persons were a disgrace in the community (n=79).

Response	**Frequency (n)**	**Percentage (%)**
Strongly agree	59	74.6
Agree	10	12.7
Neither agree nor disagree	-	-
Disagree	7	8.9
Strongly disagree	3	3.8
Total	**79**	**100**

Most of the respondents (74.6%) strongly agreed that mentally ill persons were a disgrace in the community while only 3.8% strongly disagreed.

Figure 3.1: Shows response on whether mentally ill persons were dangerous and should be restrained (n=79).



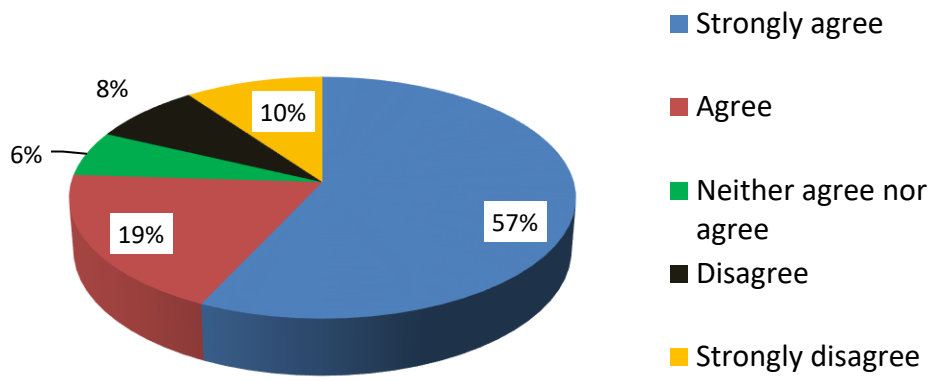
More than half of the respondents (59%) strongly agreed that mentally ill persons were dangerous and should be restrained while only 4% disagreed.

Table 3.2: Shows response on whether mentally ill persons should be secluded from others (n=79).

Response	**Frequency(n)**	**Percentage (%)**
Strongly agree	55	69.6
Agree	9	11.4
Neither agree nor disagree	-	-
Strongly disagree	10	12.7
Disagree	5	6.3
Total	**79**	**100**

Most of the respondents (69.6%) strongly agreed that mentally ill persons should be secluded from others while only 6.3% disagreed.

Figure 3.2: Shows response on whether mentally ill persons should not be employed (n=79).



More than half of the respondents (57%) strongly agreed that mentally ill persons should not be employed while only 6% neither agreed nor disagreed.

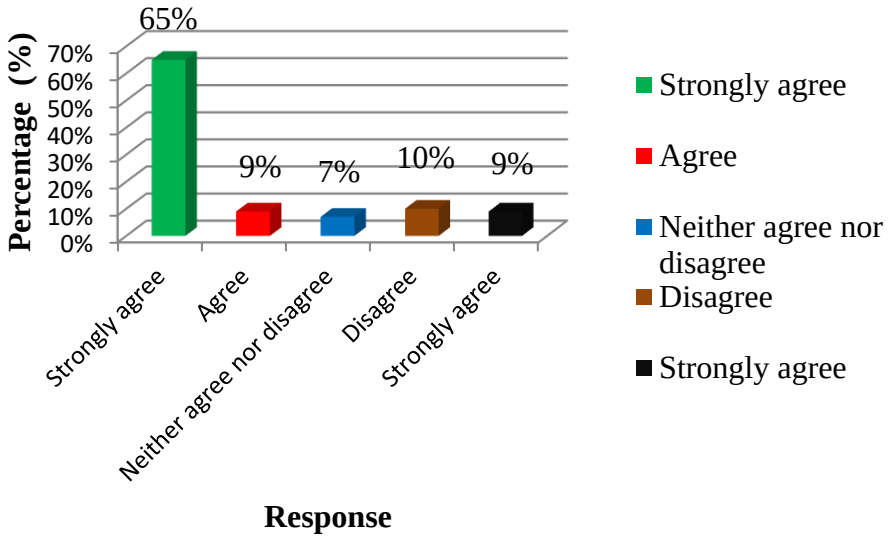
Table 3.3: Shows response on whether mentally ill persons should not be allowed to marry (n=79).

Response	**Frequency(n)**	**Percentage (%)**
Strongly agree	15	19
Agree	54	68.4
Neither agree nor disagree	-	-
Strongly disagree	8	10.1
Disagree	2	2.5
Total	**96**	**100**

Most of the respondents (68.4%) agreed that mentally ill persons should not be allowed to marry while only 2.5% disagreed.

4.4 Practices about care of the mentally ill persons.

Figure 4.1: Shows response on whether mentally ill persons could be treated by thrusting limbs in fire (n=79).



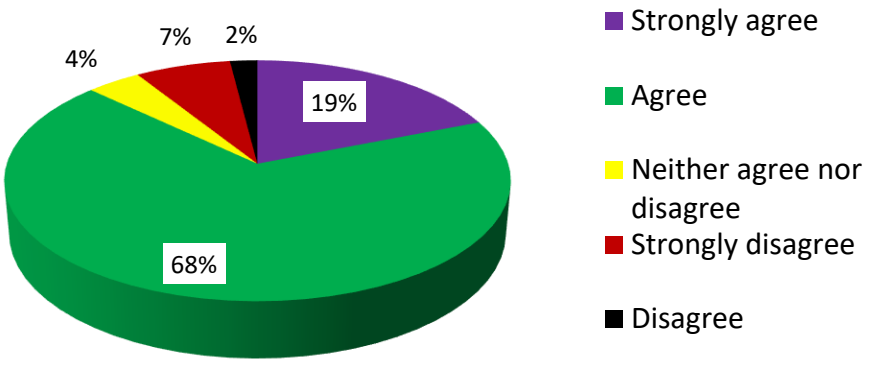
Most of the respondents (65%) strongly agreed that mentally ill persons could be treated by thrusting limbs in fire while only 7% neither agreed nor disagreed.

Table 4.1: Shows response on whether mentally ill persons should be managed by herbalists (n=79).

Response	Frequency (n)	Percentage (%)
Strongly agree	46	58.2
Agree	13	16.5
Neither agree nor disagree	-	-
Disagree	9	11.4
Strongly disagree	11	13.9
Total	**79**	**100**

More than half of the respondents (58.2%) strongly agreed that mentally ill persons should be managed by herbalists while only 11.4% disagreed.

Figure 4.2: Shows response on whether mentally ill person should be restrained by tying with ropes (n=79).



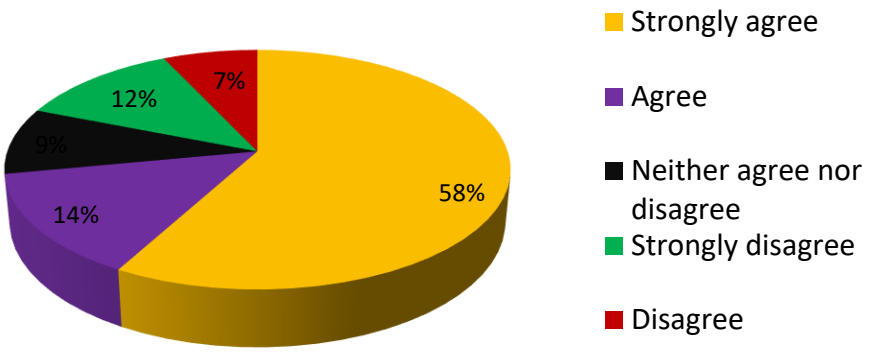
Most of the respondents (68%) agreed that mentally ill person should be restrained by tying with ropes while only 2% disagreed.

Table 4.2: Shows response whether mentally ill person should only be taken to the hospital after becoming destructive (n=79).

Response	**Frequency (n)**	**Percentage (%)**
Strongly agree	58	73.4
Agree	13	16.5
Neither agree nor disagree	-	-
Disagree	5	6.3
Strongly disagree	3	3.8
Total	**79**	**100**

Most of the respondents (73.4%) strongly agreed that mentally ill persons should only be taken to the hospital after becoming destructive while only 3.8% strongly disagreed.

Figure 4.3: Shows response on whether mentally ill persons should be treated with both traditional and modern medicine (n=79).



More than half of the respondents (58%) strongly agreed that mentally ill persons should be treated with both traditional and modern medicine while only 7% disagreed.

CHAPTER FIVE

DISCUSSION OF STUDY FINDINGS,CONCLUSION,RECOMMENDATIONS AND IMPLICATIONS TO THE NURSING PRACTICE.

5.1 Introduction.

This chapter deals with interpretation and discussion of the findings objectively in relation to the study background, problem statement and literature review to answer research questions, conclude and make recommendations about knowledge, attitude and practices about home based care of mentally ill persons. Out 79 respondents recruited in the study, 79 questionnaires were returned completely filled thus a response rate of 100%.

5.2 Discussion of findings.

5.2.1 Bio demographic data.

Nearly half of the respondents (49.4%) were of the age range between 24-29years while only 6.3% were between 36-41 years. Although this study did not correlate between age of the respondent and the care of mentally ill persons, it worth noting that experience incare of mentally ill increases with the amount time of time one has had contact with the mentally ill. Therefore elderly individuals are expected to be compassionate about the livelihoods of the mentally although it may not always be the case with every one.

More than half of the respondents 57% were female while only 43% were male. Females formed largest number of respondents in this study because, they were commonly found at home taking care of their families while the males were away trying to make the “ends” meet.

Majority of the respondents (70.9%) were Banyankole while only 29.1% were Bakiga.The tribe of the respondent influences their cultural orientation which has a bearing in the care of the mentally ill persons such as cultural beliefs that mental illness is a curse from god and should be treated by either priests of witch doctors.

Majority of the respondents (83.5%) were Christians while only 16.5% were Moslems. Religious beliefs can equally influence care of mentally ill especially when it is perceived that mental illness is caused by demons, Christians would prefer praying before seeking for medical interventions

Majority of the respondents (98.7%) were married while only 1.3% were widowed. Married individuals share collectively responsibility in the care of a family member or sibling who is mentally ill and therefore enhancing prognosis.

Majority of the respondents (84.8%) were un employed while only 3.8 % were employed. Poverty and mental illness are interlinked, mental ill is common among un employed individuals and it influences care of the mentally ill persons as well. This study findings are in line with the findings of Hanson, (2012) who stated that it is important to note that Poverty and mental health conditions interact in a negative cycle and that people living in poverty not only lack financial resources to maintain basic living standards, but may also have fewer educational and employment opportunities.

Most of the respondents (63.3%) attained primary level of education while only 2.5% attained tertiary level of education.Educational level of the respondent can influence their reasoning capacity in that peoples better education tend to have better health seeking

behaviours and reason better about the cause of mental illness although of them may some times side with religion or culture.

5.2.2 Knowledge about care of the mentally ill persons.

Most of the respondents (68%) strongly agreed that limited knowledge about cause of mental illness affects care of mentally ill persons while only 2% agreed. It is true that level of knowledge about mental illness influences the type of interventions one seeks for. Individuals with limited knowledge about cause of mental illness will always seek for intervention from witch doctors and tend to blame their neighbors to be source of the problem. This study findings are in line with the findings of Polkinghorne, (2015) who stated that limited knowledge about mental illnesses remains a concern in various countries of the world especially in developing countries and this Lack of knowledge about mental illnesses has been found by various studies as a key cause of devastating beliefs people have about causes of mental illnesses such as that mental illnesses are not diseases but equated to possession of evil spirit, witchcraft or curse. The study findings also agree with the findings of WHO, (2011) that acknowledged that, knowledge about the cause of mental illness varies across cultures and has never been favorable worldwide, thus calling a need for public education and greater openness about mental illness.

Most of the respondents (74.7%) strongly agreed that mental illness was caused by evil spirits while only 3.8% disagreed. There are many misconceptions about causes of mental illness and it is not uncommon for individuals to delineate causation with spiritual world especially individuals with too much cultural inclinations. This study findings are in line with the findings of Jallon, (2007) who found out in a cross-sectional survey involving 380 persons made up of government workers and the general public in Accra, Ghana, that

almost all the people interviewed could accurately describe what mental illness is. Un interestingly, however, nearly half (45.3%) of the respondents did not know possible associated causes of mental illness. The study findings also agree with the findings of Ojinnaka,(2009) who carried out a study in Nigeria that possession by evil spirits was one of the causes of mental illness mentioned by respondents.

More than half of the respondents (51%) strongly agreed that mentally ill persons should be treated outside the hospital setting while only 7% neither agreed nor disagreed. The form of treatment sought depends on knowledge about cause of mental illness this means that if the cause is thought to be due to curses or evil spirits, treatment may be sought from church or traditional healers. This study findings are in line with the findings ofGerman, (2007) who found out in his study in Tanzania that majority of respondents (47.0%) opted for spiritual healing followed by orthodox medical care (34.0%) and the use of traditional herbal medicines (19.0%).

Most of the respondents (63.3%) strongly agreed that mental illness manifests with convulsions while only 3.8% disagreed. Only mental illnesses associated with neurological deficits or disturbance in the brains electrical activity manifest with convulsions. This therefore means that not every incidence of convulsion must be considered mental illness as some febrile illnesses and space occupying lesions can cause convulsions. This study findings are in line with the findings of Kobau and Price, (2012) who conducted a study in Zambia on knowledge of mental illnessand found thatmajority of the respondents (39.0%) mentioned that mental illnessmanifests with convulsions while other manifestations of the mental illness described by the respondents included falling down (36.0%), rolling of eyes (11.3%) and foaming of mouth (10.3%).

Most of the respondents (71%) Strongly agreed that mentally ill persons were infectious while only 2% strongly disagreed. Mental illness per se is not infectious unless associated with an infectious cause but that is usually short lived as it wanes off with convalescence from the infectious cause. This study findings are in line with the findings of (Rwiza *et al.*, (2013) who found out in a study in Uganda on knowledge about mental illness that most of the respondents (82.6%) wrongly agreed with the statement that mental illness is an infectious condition. These results were also related to findings of Santos,(2008) in Kenya where as many as 78% wrongly believed it to be infectious, with just 20% correctly saying that it was not an infectious disease.

5.2.3Attitudes about care of mentally ill persons.

Most of the respondents (74.6%) strongly agreed that mentally ill persons were a disgrace in the community while only 3.8% strongly disagreed. Mentally ill persons are facing a lot of stigma in our communities right from the families where they are born as they are viewed as a source shame to the family and are usually less cared for.This study findings are in line with the findings of Baker *et al.*,(2009) who found out in a study in United Emirates some respondents objected to allowing their children to play with children with mental illness and up to 68% objected to their children marrying a person suffering from a mental disorder. The study findings also agree with the findings of Masoudnia, (2009) who found the same response pattern as above in a study from Iran where the attitude towards daughters marrying a person suffering from any form of mental illness was negative (75%).

More than half of the respondents (59%) strongly agreed that mentally ill persons were dangerous and should be restrained while only 4% disagreed. Mentally ill persons are

perceived differently in different communities. Though some mentally ill persons may be dangerous especially in acute episodes, the truth is that they are human beings with emotions like any other individual although they may have abnormal emotional responses when provoked therefore no need to restrain every mentally ill person. This study findings are in line with the findings ofGordon, (2013) who stated that mental health is a socially constructed and defined concept, implying that different societies, groups, cultures, institutions and professions have diverse ways of conceptualising its nature and causes, determining what is mentally healthy and unhealthy, and deciding what interventions, if any, are appropriate.

Most of the respondents (69.6%) strongly agreed that mentally ill persons should be secluded from others while only 6.3% disagreed. Mentally ill persons need social skill training to improve on their livelihoods and well being therefore secluding them from others may impair social skill development and worsen the prognosis. This study findings are in line with the findings of Arboleda,(2012) who stated that mental illness is a taboo subject that attracts stigma in much of Africa and that in Nigeria, peopleresponded with fear, avoidance and anger to those who were observed to have a mental illness.

More than half of the respondents (57%) strongly agreed that mentally ill persons should not be employed while only 6% neither agreed nor disagreed. Most of the respondents (68.4%) agreed that mentally ill persons should not be allowed to marry while only 2.5% disagreed. Mentally ill persons are discriminated against in many forms including employment and marriage. Although there are some occupations where by employing a mentally unstable person may pose further risk to their health for example in industries where they are more prone to accidents, they can be employed in jobs requiring less skill

such as agricultural activities, brick making among others. This study findings are in line with the findings of Brickell, and McLean, (2011) who stated that social stigma has meant that in much of Africa mental illness is a hidden issue equated to a silent epidemic as many households with mentally ill persons hide them for fear of discrimination and ostracism from their communities and that girls from homes known to have mental illness are disadvantaged due to the fact that a history of mental illness severely reduces their marriage prospects. The study findings also agree with the findings of Stuart and Arboleda, (2011) who stated that Stigma remains a powerful negative attribute in all social relations.

5.2.4 Practices about care of the mentally ill persons.

Most of the respondents (65%) strongly agreed that mentally ill persons could be treated by thrusting limbs in fire while only 7% neither agreed nor disagreed. Many mentally ill persons are being managed in communities in many unconventional ways with some of them even suffering mortalities due to poor management.This study findings are in line with the findings of Singh and Arora, (2007) who sound out that in Nigeria among the Bini people mental illness is treated by thrusting the patient's limbs into a fire, rubbing pepper into their eyes and face, and making an unconscious person drink cow's urine, a treatment that can lead to aspiration pneumonia.

More than half of the respondents (58.2%) strongly agreed that mentally ill persons should be managed by herbalists while only 11.4% disagreed. It is common in many traditional settings for people to seek for treatment from traditional healers and yet traditional healers do not have scientifically proven facts about their interventions and in most cases they tend to delay patients in their shrines and worsen patients' condition. This study findings are in line with the findings of Collings, (2009) who found out that in

Nigeria when mental illness is recognized, patients were often sent to seek treatment via priests and herbalists based on evident symptoms.

Most of the respondents (68%) agreed that mentally ill person should be restrained by tying with ropes while only 2% disagreed. Unless destructive or aggressive, there is no need to restrain a mentally ill person by tying as restrain may result in other forms of injury to the patient. This study findings are in line with the findings ofShibre *et al.*, (2008) in Ethiopean study who found out that majority of patients were being restrained by tying with ropes (84%) followed by isolation (50.6%).

Most of the respondents (73.4%) strongly agreed that mentally ill persons should only be taken to the hospital after becoming destructive while only 3.8% strongly disagreed. Once mental illness is detected then it is prudent to seek medical interventions early enough as this may lead to better prognosis other than waiting for the patient to first become destructive. This study findings are in line with the findings of Koul *et al.*, (2008) who found out during role play exercise about mental illness in India that 52% of the students correctly responded by calling a doctor as soon as the warning signs appear in the person, while around 74% did so after the person became destructive.

More than half of the respondents (58%) strongly agreed that mentally ill persons should be treated with both traditional and modern medicine while only 7% disagreed. Traditional medicines contain unproven ingredients and formulations in that the doses are measured in terms of cups or atraditional calabash and it's not easy to establish overdose or under dose therefore is better always to seek treatment from the hospital where patients are handled by skilled and trained personal. This study findings are in line with the findings of Otsyula, (2013) who observed that many patients in Kenya used both contemporary western-style

medical services as well as traditional healers and that the patients visited hospitals to seek the cure for illness while traditional doctors were visited for both the cure and the cause of illness.

5.3 Conclusion.

i) There was limited knowledge about home based care of mental ill persons as it was influenced by knowledge of cause of mental illness hence treatment was sought from traditional healers and religious groups.

ii) Atittudes about care of mentally ill persons were equally not good as mentally ill persons were viewed as a disgrace, dangerous and infectious.

iii**)**Practices about care of mentally ill persons were equally not promising as mentally ill patients were always restrained by tying with ropes, thrusting feet in fire and mostly managed by herbalist.

5.4 Recommendations.

i)Community health education programs about home based care of the mentally ill persons will help improve community knowledge about mental illness and care of the mentally ill persons.

ii)Training more mental health staff so as to increase health worker to patient ratio with anterior aims of improving outreach programs thus improving contact with the community and discouraging poor attitudes towards mentally ill persons.

iii)Strict laws by government against practices detrimental to mentally ill persons in the community will help discourage such practices.

5.5 Implications to the nursing practice.

Mental illness is ubiquitous in our communities and mentally ill persons are being mismanaged in shrines due to limited knowledge about the cause of mental illness. This study findings will therefore help nurses to plan their health education and out reach programs to improve community knowledge about home based care of the mentally ill persons and discourage poor practices and atittudes while reinforcing on positives so as to improvehome based care of the mentally ill persons.

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APPENDIX I: INFORMED CONSENT

Good morning/afternoon/evening?

My name is **Tukwasibwe Joshua** from Kampala International UniversityWestern Campus School of Nursing Sciences. I am here to conduct research **on Knowledge,attitude and practices about home based care of mentally ill persons in Nyamitooma ward Ishaka municipality Bushenyi district** as a partial fulfillments of the requirements for the award of diploma in nursing science.You have been selected at random (by chance) to participate in this study. The information gathered here will remain confidential and I will not write down your name or any information that can identify where you live or who you are. Your participation in the study is voluntary and you will not be affected in any way if you decide not to participate. You do not have to answer any questions that you do not want to. You can stop the interview at any time. The relevancy of this study will depend so much on your honest response to the questions asked. If you agree to participate, the interview will take about an hour. Do you agree to participate in the study? Do you have any questions or clarification you need before we begin?

Signature of the respondent …….

Date: _____/_____/_____

APPENDIX II: QUESTIONNAIRE ON KNOWLEDGE, ATITTUDE AND PRACTICES ABOUT CARE OF THE MENTALLY ILL PERSONS IN NYAMITOMA WARD ISHAKA MUNICIPALITY

Instructions; Dear respondent please tick appropriate response.

SECTIOA: BIODEMOGRAPHIC DATA

BIODEMOGRAPHIC PARAMETER		**RESPONSE (TICK)**
Age (years)	18-23	
	24-29	
	30-35	
	36-41	
	42-47	
	>48	
Sex	Male	
	Female	
Tribe	Munyankole	
	Mukiga	
	Others(Specify)	
Religion	Christian	
	Moslem	
	Others(Specify)	
Employment status	Un employed	
	Self employed	
	Employed	
Marital status	Married	
	Single	
	Separated	
	Widowed	
	Cohabiting	

SECTION B: KNOWLEDGE ABOUT CARE OF THE MENTALLY ILL PERSONS.

In this section tick appropriate response against statement provided either agree, agree, neither agree nor disagree or strongly disagree

Knowledge about home based care of mentally ill persons	Strongly agree	Agree	Neither agree nor disagree	Strongly disagree	Disagree
Limited knowledge about cause of mental illness affects care of mentally ill persons					
Mental illness is caused by evil spirits					
Mentally ill persons should be treated outside the hospital setting					
Mental illness manifests with convulsions					
Mentally ill persons are infectious					

SECTION C: ATITTUDES ABOUT CARE OF MENTALLY ILL PERSONS

Aittudes about home based care of mentally ill persons	Strongly agree	Agree	Neither agree nor disagree	Strongly disagree	Disagree
Mentally ill persons are a disgrace in the community					
Mentally ill persons are dangerous and should be restrained					
Mentally ill persons should be secluded from others					
Mentally ill persons should not be employed					
Mentally ill persons should not be allowed to marry					

SECTION D: PRACTICES ABOUT CARE OF THE MENTALLY ILL PERSONS

Practices about homebased care of mentally ill persons	Strongly agree	Agree	Neither agree nor disagree	Strongly disagree	Disagree
Mentally ill persons are can be treated by thrusting limbs in fire					
Mentally ill persons should be managed by herbalists					
Mentally ill person should be restrained by tying with ropes					
Mentally ill persons should only be taken to the hospital after becoming destructive					
Mentally ill persons should be treated by both traditional and modern medicine					

APPENDIX…….INTRODUCTORY LETTER

KAMPALA INTERNATIONAL UNIVERSITY
WESTERN CAMPUS

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P.O.BOX 71 Bushenyi, Ishaka
Tel: +256 (0) 704113921
E-mail: **elibethy2002@ gmail.com**
Website:**http://www.kiu.ac.ug**

OFFICE OF THE DEAN SCHOOL OF NURSING SCIENCES

TO WHOM IT MAY CONCERN

Dear Sir /Madam

Re: TUKWASIBE JOUSHUA DNS/E/0034/152/DU

The above mentioned is a student of Kampala International University undertaking Diploma in Nursing Sciences Extension program and he is in his final academic year.

He is recommended to carry out data collection as a partial fulfillment for the award of the Diploma in Nursing.

His topic is; **KNOWLEDGE, ATTITUDE AND PRACTICES ABOUT HOME BASED CARE OF MENTALLY ILL PERSONS IN NYAMITOOMA WARD ISHAKA MUNICIPALITY, BUSHENYI DISTICT. SOUTH WESTERN UGANDA**
Any assistance rendered to him will be highly appreciated

Thank you in advance for the positive response

12 JUL 2016

Apondi Winfred
Administrator school of Nursing Sciences

Recommended but with strict discipline

28 JUL 2016

APPENDIX V: MAP OF UGANDA SHOWING LOCATION OF BUSHENYI DISTRICT.

BUSHENYI DISTRICT.

APPENDIX VI: MAP OF BUSHENYI DISTRICT SHOWING LOCATION OF NYAMITOMA WARD IN ISHAKA MUNICIPALITY

NYAMITOMA WARD.