ASSESSMENT OF KNOWLEDGE AND ATTITUDES TOWARDS MENTAL ILLNESS AND THE CARE AMONG RESIDENTS OF CELL B ISHAKAMUNICIPALITY

BY

MWESIGE GERALD

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ABSTRACT

The literature on mental illness demonstrates poor knowledge of mental illness among the general population and also indicates that people often have stigmatizing attitudes towards mental illness.

A descriptive cross-sectional study and quantitative approaches were employed in data collection and 67 respondents were involved both males and females who were selected using simple random sampling method.

The results indicated that generally knowledge on mental illness was poor although majority of the respondents (67%) knew the meaning of mental illness. 58.2% didn't know examples of mental disorders, 38.8% attributed mental illness to witchcraft and 40.3% would seek treatment from a traditional healer. Attitudes towards mentally ill people were very poor as 55.2% agreed that they cannot associate with a mentally ill person and 49.2% expressed fear for mentally ill people. Results about the care for mentally ill indicated that 54% cannot take a mentally ill person to hospital but 48.4% of these would instead take a mentally ill person to a traditional healer.

The recommendation is that basic mental health awareness programs should be implemented for general public especially newly school going children and youth to improve the knowledge and understanding and attitudes to reduce fear and negative perceptions and attitudes in order to enhance positive patient experiences and improve the care for mentally ill people.

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APROVAL FORM

This research has been produced under supervision and submitted with my approval.

Supervisor: **MADAM MUSIMENTA PAMELA**

Signature……

Contact Address……

SR. KABANYORO ANNET

Dean School of nursing KIU- Western Campus:

Signature…….Date……

AUTHORIZATIONS

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Author: **MWESIGE GERALD**

Signature…….. Date…….

Address:mwesigethegerald@gmail.com

DEDICATION

I dedicate this research to my Auntie Namuli Eva, my father Kyaligonza Vicent, my mother Namazzi Gertrude and my entire family, for the unwavering support they have accorded me in my entire education.

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I wish to recognize and acknowledge all brethrens and friends in Ishaka, Mukono and Kampala for the ceaseless prayers ever since I started my course really the Lord has been merciful to me because of the combined effort of prayers wherever you are may his name be praised. Finally special thanks to Kampala international university for the good, well equipped and well organization Library it has been of great value to my research.

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LIST OF ACRONYM

AIDS	Acquired immune deficiency syndrome
CDC	Center for Disease Control
HIV	Human immune virus.
KIU-SONS	Kampala International University School of Nursing
KIU-TH	Kampala International University Teaching Hospital
MNS	Mental, Neurological and Substance use
NCCAH	National Collaboration Centre of Abnormal Health
SSA	Sub Saharan Africa
UK	United Kingdom
WHO	World health organization.

DIFINITION OF KEY TERMS

1. **Knowledge:** According to Oxford English dictionary, knowledge refers to information or awareness gained through experience or education or the total of what is known.
2. **Attitude** Attitude is a way of thinking or feeling about something.
3. **Health:** According to the world health organization (WHO) health refers to a state of complete physical, mental, social and economic wellbeing of an individual and not merely in the absence of a disease or infirmity.

4. Mental health literacy (Tibebe. A & Tesfay. K, 2015). , defined 'mental health literacy' as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention.

5. Mental illness Mental illness is any define disease or condition affecting the brain that influences the way a person thinks, feels, behaves and relates to others, and to his surroundings.

6. Care According to Oxford English dictionary, care means look after something or somebody

7. Mental health (WHO) defines mental health as a state of well-being in which every individual realizes his potential, can cope with normal stresses of life, can work productively and fruitfully and is able to make contributions to his or her community.

CHAPTER ONE

1.1Introduction

Globally, mental health problem is recognized as a public health problem in developed and developing countries (Tibebe & Tesfay, 2015). About 450 million people suffer from mental or behavioral disorders worldwide today, mental disorder are widely recognized as a major contributor (14%) to the global burden of disease worldwide (Mariam, *et al*., 2016) .World Health Organization (WHO) reported that in 2002, 154 million people suffered from depression, 25million suffered from schizophrenia, 91 million people suffered from alcohol disorders, and 15 million people suffered from drug use disorders. According to Manda, *et al*., (2017), nearly 25% of individuals in both developed and developing countries develop one or more mental and behavioral disorders at some stage in their life.

Despite the fact that mental illness and mental health care awareness programmers being extended extensively over the past few decades , mentally challenged patients are still being mocked, ostracized, labeled, ill-treated and misunderstood by the greater community, family and sometimes health care personnel (Ukpong & Abasiugbong, 2010). In addition, studies indicate that large populations have negative attitudes and beliefs towards mentally ill patients, usually stemming from the fact that lay people, generally have poor knowledge regarding mental illness (Sadik, *et al*, 2010). Due to lack of knowledge, insight, misperceptions, false beliefs and myths relating to mental

illness, some societies believe that mentally ill patients are often treated as outcasts or mad people (Bener & Ghuloum, 2011).

In developing countries like Nigeria, the general belief is that preternatural or supernatural forces, witches, evil spirits and even God cause mental illness. These beliefs have influenced attitudes of Nigerians towards mentally ill. Historically people with mental illness were burned, hanged, mutilated, abandoned and restrained with chains, all in the bid to save their souls, or bring redemption to their families and curb the inequities causing mental illness within the families (Okpalauwaekwe, *et al*, 2017). Some studies conducted in Africa have suggested that experience of stigma by people with mental illness maybe common, but there is no information on how widespread negative attitudes to mental illness maybe in the community (Tibebe & Tesfay, 2015). Crabb, *et al*, (2012) reported that there is poor understanding of mental health and mental illness in Africa, and research by other investigators indicates that mental illness is often not generally recognized.

In Sub Saharan African (SSA) countries few studies have been conducted in recent years on knowledge, attitudes and beliefs of community members and healthcare workers towards mentally ill patients (Chikaodiri, 2009). The aforementioned studies indicated that people with higher education tend to have more knowledge and positive attitudes towards mentally ill patients (Ndetei, *et al*, 2011). Some studies conducted also expose the various myths and misconceptions about mental illness were the participants in the study often expressed fear and attitudes towards people with mental

illness and often viewed the mentally ill patients as dirty, worthless, and dangerous. Sometimes people also associate people with mental illness with witchcraft and works of evil machines (Ewhoudjakpor, 2009). In Ethiopia, poverty, war, famine displacement and homelessness are common, mental health is also becoming a major public health problem. However, little is known about perception of the public regarding mental illness (Tibebe & Tesfay., 2015).

Taking a look at East Africa, for example Tanzanian, historically, mental health care has been provided by a traditional healing system based on the commonly believed association between mental illness and religious and spiritual factors. Furthermore, traditional healing is more accessible than Western medicine for many people seeking mental health care especially for those in rural areas due to a lack of available and accessible mental health care professionals, poor transportation and acceptance of spiritual and/or supernatural causes for health problems (Kutcher, *et al*, 2016).

In some parts of Uganda, history over the past decade has been that of violence with civil strife and wars resulting in high prevalence of depression and post traumatic disorders and high alcohol consumption (Kigozi, *et al*, 2015).

1.2. Problem Statement

Neuropsychiatric disorders are estimated to constitute about 14% of the global burden of disease, with approximately 80% of people with mental illness living in low- and middle-income countries (LMIC) such as Uganda. Majority of these cases are handled

by non-psychiatric where majority of them go unrecognized leading financial loss. Misconceptions about psychiatric patients being under the control of evil spirits and therefore being dangerous (Kigozi, *et al*, 2015).

Cultural beliefs have a great impact on mental health care, treatment and mentally ill patients. Globally, more than 70% of people with mental illness receive no treatment from health care staff. This phenomenon is more prominent in African communities especially in Sub Saharan Africa (Manda, *et al*, 2017).

Despite the increased burden of mental disorders, still there is information gap showing the knowledge and attitude of residents towards mental illness. Therefore the results of this study will be used as base line data for planning to improve the knowledge and attitude of residents and for further studies on the subject area.

1.3 Purpose of the Study

The purpose of the study is to assess the knowledge and attitudes towards mental illness and care among residents of cell B Ishaka Municipality.

1.4 Objectives

The specific objectives are:

1.4.1 To assess the knowledge towards mental illness among residents of Cell B Ishaka Municipality.

1.4.2 To explore the attitudes towards mental illness among residents of Cell B Ishaka Municipality.

1.4.3 To assess the care towards mentally ill people among residents of Cell B Ishaka municipality.

1.5 Research Questions

The research questions are:

1.5.1 What is the knowledge of the residents of cell B Ishaka Municipality towards mental illness?

1.5.2 What are the attitudes of the residents of cell B Ishaka municipality towards mental illness?

1.5.3 What is the care towards mentally ill people among residents of Cell B Ishaka municipality?

1.6 Justification of the study

Various studies have indicated that negative attitudes, prejudice and discrimination towards persons with mental illness occur globally (Barke, *et al*, 2011). Studies have also shown that lack of knowledge regarding the manifestation of mental illness has a role to play in handling of mentally challenged patients. This indicates the need for the public regarding mental health literacy (Kutcher, *et al*, 2016). Therefore the study findings will be beneficial to;

Ministry of Health

It might enable policy makers to formulate training guidelines for community sensitization on management of mentally ill patients and how they can be changed.

Nursing practice

The results of the study could contribute to a body of knowledge on the public's attitudes towards mental illness which may contribute to the implementation and initiation of relevant study programs.

Community

The study will help in clearing superstitions and negative beliefs held by people towards mental illness thus promoting positive care for the mentally ill patients.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter deals with review of literature relevant to study that was obtained from various sources that include medical and nursing journals, text books and internet and is presented in relation to the study objectives.

2.2 Knowledge on mental illness

Research conducted in Qatar indicates that the level of mental health knowledge and mental health literacy amongst members of the public is very poor (Bener & Ghuloum, 2011). This could be attributed to the various myths about mental illnesses among various ethnic groups indicating why different communities would perceive mental illness differently.

Van der Ham, *et al*, (2011), in an explorative study conducted in Vietnam, found that the participants in the study were unable to identify and name the different mental illness. Some of the participants in the study conducted by Ganesh, (2011) amongst the general public in South India could mention a few mentally ill disorders. This is because knowledge, attitudes and perceptions can be influenced by factors such as ethnicity, religion, age, gender, working experience and culture (Chaudhury & Minas, 2011).

However, the knowledge pertaining to the causes of mental illness was poor and many of the participants alluded mental illness to punishment from God (Barke, *et al*.,

2010).Cultural beliefs often influence people's general knowledge of mental illness (NCCAH,2009).Research by Crabb, *et al*, (2012) revealed that most people in Sub-Saharan Africa associate mental illnesses to cultural beliefs. In contrast, a research conducted in America to determine knowledge, attitudes and perceptions of various groups of people towards mental illness and mentally ill patients, demonstrate that the general public attribute mental illness to stress, family related matters and biological factors such as trauma to the brain, illicit drug use, dysfunction of the brain and vulnerability to mental illness (Gateshill et al, 2010).

Despite the knowledge people have on mental illnesses, cultural beliefs often outweigh the mental health literacy as society tend to hold on to cultural beliefs more (Bener & Ghuloum, 2011).Historically in Tanzania, mental health care has been provided by a traditional healing system based on the commonly believed association between mental illness and religious and spiritual factors. Furthermore, traditional healing is more accessible than Western medicine for many people seeking mental health care especially for those in rural areas due to a lack of available and accessible mental health care professionals, poor transportation and acceptance of spiritual and/or supernatural causes for health problems (Kutcher, *et al*, 2016).

Studies that identified similar gaps recommended programs of enlightenment in which mental health literacy promotion and training should be established. (Kapungwe, et al., 2011). Pande, *et al*, (2012) support the view that higher literacy levels are associated with more positive attitudes towards mental illness.

2.3 Attitudes towards mental illness

Mental Health report of the (Centre of Disease Control, 2012) indicate that the attitude and beliefs about mental illness are shaped by an individual's knowledge about mental illness, interaction with mentally ill people, cultural stereotyping and various other factors.

Quinn, *et al*, (2009) revealed that older people had more favorable perceptions towards mental illness. Adewuya and Oguntade, (2007) investigating social distance found that the age groups of the participants were significantly associated with social distance, which implies that there is a relationship between the age of the participants and the variables that tested social distance. Yamawaki, *et al*, (2011) supported the fact that women generally have more favorable and less stigmatizing attitudes towards mentally ill patients.

Chikaodiri, (2009) states that in Nigeria, non-mental health care workers fear mental health users so much that they expressed fears about treating mentally ill patients in a general teaching hospital. Participants in this research study expressed fear and negative attitudes towards mentally ill patients and often viewed mental ill patients as dirty, worthless, dangerous etc. and from time to time they also associated mental illness with witchcraft and the works of evil machines (Ewhrudjakpor, 2009). Some Ghanaians expressed their unwillingness to marry people with mental illnesses (Barke,*et al*, 2011).A study conducted by Li, *et al*, (2014) supports the fact that Asian people have high levels of stigmatization towards mental illness.

A study conducted in Switzerland participants reflected and displayed social distance and more negative attitudes towards mentally ill patients, but they also displayed more positive attitudes towards psycho-pharmacology (Des Courtis, *et al*., 2008). Furthermore, mentally ill people often encounter discrimination and stigmatization when they seek employment and apply for work although the Bill of Rights and Patient's Rights Charter discourages discrimination towards disabilities, mental illnesses and AIDS (McDaid, 2011).

A national survey conducted in France that explored knowledge, attitudes and perceptions towards schizophrenia, bipolar mood disorder and autism revealed prejudice as well as stigmatization; participants also viewed mentally ill people as dangerous and labeling of mentally ill patients was also prevalent in this study (Durand-Zaleski, *et al*, 2012). Adewuya and Oguntade, (2007) also proved, in their study that the participants in the study regarded mentally ill patients as dangerous, unpredictable, and aggressive; and that mentally ill patients have a poor prognosis

2.4 Care towards mentally ill people

Globally, more than 70% of people with mental illness receive no treatment from health care staff. According to the Centre of Disease Control (CDC, 2012), a person's perception and attitude towards mental illness influences how they treat, support and interact with mentally ill people. Cultural beliefs have a great impact on mental health care, treatment and mentally ill patients. This phenomenon is more prominent in African communities especially in Sub Saharan Africa (Manda, *et al*, 2017).

Mentally ill people are often blamed as victims of unfortunate fate, religious and moral transgression, or even witchcraft. This may lead to denial by both sufferers and their families, with subsequent delays in seeking professional treatment. The belief that a disturbed mental state is a result of an "evil eye" or black magic leads the majority of patients to seek traditional healers first and only present to a psychiatrist once the disturbance is severe or unmanageable at home, often quite late in the illness (Manda, *et al*, 2017).

Historically people with mental illness were burned, hanged, mutilated, abandoned and restrained with chains, all in the bid to save their souls, or bring redemption to their families and curb the inequities causing mental illness within the families (Okpalauwaekwe, *et al*, 2017). Despite the fact that mental illness and mental health care awareness programs being extended extensively over the past few decades, mentally challenged patients are still being mocked, ostracized, labeled, ill-treated and misunderstood by the greater community, family and sometimes health care personnel (Ukpong & Abasiugbong, 2010).

A national survey and systematic review in Australia different mental illnesses with regards to treatment, the participants indicated that they'll seek help from a general practitioner, psychologists, family and friends. Participants also viewed relaxation and physical activity as well as medication as treatment options. Despite this, non-medical personnel are still reluctant to help mentally ill patients who are in crises (Gates, *et al*, 2011).

In light of the above studies, we can conclude that despite the fact that a significant number of studies conducted in Africa indicated that some people firmly believe that sangoma's and traditional healers can heal mental illness, the results in the present study dismiss the assumption that sangoma's can heal mental illness (Chikaodiri, 2009).

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter presents the research methodology which includes the study design and rationale, study setting and rationale, study population, sample size determination, sampling procedure, inclusion criteria, definition of variables, research instruments, data collection procedure, data management, data analysis, ethical consideration, limitation of the study, dissemination of results. Quality control techniques and ethical considerations of the study are discussed in this chapter as well.

3.1 Study Design and rationale

The study was descriptive using both quantitative and qualitative approaches. Under quantitative, the findings were presented in numerical form such as percentages, using frequency tables, bar graphs and pie charts. Under qualitative approach, descriptive, narration and explanation of findings were done. To gather quantitative data, a questionnaire was designed and administered to the respondents. The researcher chose the above methods because they aided rapid collection of data at a single point in time.

3.2 Study setting

The study conducted in cell B town ward, Ishaka town council, Ishaka Division, Bushenyi district in western Uganda, 56 kilometers west of Mbarara along Mbarara-Kasese highway, a distance of around 1673 Metres from Bushenyi district Headquarters. Most of its population is dominated by youths, some of whom are Boda

Boda cyclists, some sell chapatti, others are students and others are traders dealing in businesses like selling agricultural produce, retail shops. It also has bars which open as early as before midday and close beyond midnight. The nearest health units around the area are KIU-TH and Ishaka Adventist Hospital from where people access treatment but its only KIU-TH with a mental health unit in the area.

3.3 Study Population

The study targeted males and females aged 18 years and above residing in cell B Ishaka Municipality, Bushenyi District.

3.4 Sample Size Determination

The sample size was determined using Fisher's (1990) method in which the sample size was given by the expression

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

n= Desired sample size

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

P=50% (constant) or o.5% since there is no measures estimated

Q= 1-p =1-0.5= 0.5 and,

d=degree of accuracy desired 0.12 or 0.12 probability level (at 95% confidence level)

Therefore by substitution in the formula,

$\frac{1.96^2 x 0.5 x 0.5}{0.12 x 0.12} = 67$

There the sample size will be 67 respondents

3.4.1 Sampling procedure

Simple random sampling method was used for quantitative data collection. To reduce the bias, the number of residents present at their homes was be elicited; equal number of ballot papers assigned “yes or no” were folded and mixed together in one box. Then each selected member was given chance to pick one. Those that picked yes were given questionnaires to fill. Any member that picked “no” was not a legible participant and when the sample size was not realized, this was replaced by another round of picking assigned “yes” or “no” by those who were not selected in the first round.

3.4.2 Inclusion criteria

The study included only males and females of cell B aged 18 years and above that willingly consented to participate in the study.

3.4.3 Exclusion criteria

All residents of cell B below 18 years and those who declined consenting to the study.

3.5. Definition of Variables

3.5.1 The independent variables for the study include:

Knowledge on mental illness.

Attitudes towards mental illness.

3.5.2 The dependent variables for the study include:

Care for the mentally ill patients.

3.6 Research Instruments

The researcher collected data from the respondents using questionnaires which were divided into four parts that is; first section collected data about social demographic profile, the second section assessed knowledge towards mental illness and the third section assessed attitudes towards mental illness and the fourth section assessed the care for the mentally ill patients. It had open-ended questions and was written in English.

3.7 Data Collection Procedure

Permission to conduct the study was obtained from KIU-SONS research committee.

After the completion of sampling process, the investigator interviewed the residents in their homes. The investigator introduced himself to the prospective participants and read to individual participants the consent form in details and purpose of the study as well as the rights of the participants. Whenever a participant agreed to be interviewed, he/she was asked to provide a written consent by signing or finger printing. After obtaining the written consent, the investigator entered the questionnaire serial number and date of interview and proceeded from first up to last question using the language understood by the participant. The investigator entered understood responses given by the participants by ticking the appropriate response and entered the same number into

the coding box. This was done to ensure data quality as the one entered in the coding box. The numbers that were not the same were considered invalid.

The researcher reviewed the questionnaire on daily basis to ensure they were being completed and any error corrected to avoid being repeated.

3.7.1 Data management

The filled questionnaires were checked for validity before leaving the data collection site. Data was coded manually and entered correctly in the computer. The questionnaires were kept properly under lock and key to avoid access by those not authorized.

3.7.2 Data analysis and presentation

The study data was first analyzed manually, by use of paper and pens and tallying, then presented in form of tables, bar graphs and pie charts using Microsoft Excel 2010.

3.8Ethical Considerations

A letter of introduction was obtained from the school administrator, KIU-SONS, introducing the researcher to the Local Council administration of cell B Ishaka Municipality and seeking permission to carry out the study. After permission was granted, the local council chairperson introduced the researcher to the respondents. The study only commenced after the objectives of the study had been clearly well explained to participants to make them understand and had them voluntarily consent to participate in the study. Respondents were assured of maximum confidentiality of all the information given and numbers were used instead of respondents' names.

3.9 Limitations of the study

Rainy weather: The rains would interfere with the scheduled dates and time of interaction with the respondents. This was over came by use of an umbrella, rain coat and gumboots.

Language barrier: Due to the fact that the study area was in Ankole region, researcher faced a problem of language barrier. A translator however would help to interpret whenever necessary.

Limited funds: The researcher sought assistance from the parent, and friends to provide him with money for research.

3.10 Dissemination of results

A copy of the results was forwarded to the local council administration of cell B Ishaka Municipality for appropriate interventions, a copy to Kampala International University western campus library, another copy to Uganda Nurses and Midwives Examinations Board as one of the requirements for the award of a diploma in nursing sciences and the researcher also retained one copy for future reference.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.0 Introduction

This chapter deals with analysis and presentation of data collected inform of charts and frequency tables. Out of 67 respondents interviewed, 67 returned completely filled questioners giving a response rate of 100%.

4.1 Bio demographic profile

Table 1 Shows bio demographic profile of the respondents (n=67)

Socio-demographic characteristics		**Freq (n)**	**Perc (%)**
Age(years)	8-28	20	29.9
	29-39	32	47.8
	40-50	10	14.9
	51 and above	05	7.4
	Total	**67**	**100**
Sex	Male	25	27.3
	Female	42	62.7
	Total	**67**	**100**
Marital status	Single	29	43.3
	Married	35	52.2
	Separated	03	4.5
	Cohabiting	00	00
	Total	**67**	**100**

Level of education	None	16	23.9
	Primary	27	40.3
	Secondary	19	28.3
	Tertiary	05	7.5
	Total	**67**	**100**
Religion	Christian	37	55.2
	Muslim	19	28.4
	Others	11	16.4
	Total	**67**	**100**
Occupation	Employed	11	29.9
	Self-employed	19	14.9
	Un employed	37	55.2
	Total	**67**	**100**

Table 1 show that almost half of the respondents (47.8%) were of age range 29-39 years while only 7.4% were 51 and above years. Majority of the respondents (62.7%) were females while only 37.3% were males. A big percentage 52.2% were married, 43.3% were single and only 4.5% had separated. Most of the respondents (40.3%) attained primary level of education while only 7.5% attained tertiary level. Most of the respondents (55.2%) were Christians, 28.4% were Muslim and 16.4% had other beliefs. Most respondents (55.2%) were unemployed, 29.9% were employed and only 14.9% were self-employed.

4.2 Knowledge of residents towards mental illness

Figure 1: Shows knowledge on the meaning of mental illness (n=67)

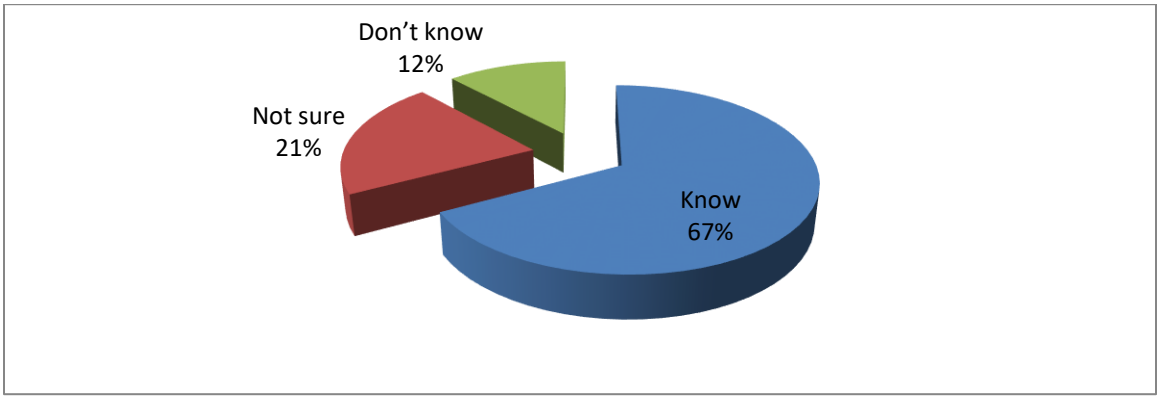


Figure 1 show that most of the respondents (67%) knew the meaning of mental illness and only 12% didn't know the meaning of mental illness.

Table 2: Shows knowledge on examples of mental disorders (n=67)

Response	**Frequency(n)**	**Percentage (%)**
Mentioned at least five	10	14.9
Mentioned less than five	18	26.9
Did not mention any	39	58.2
Total	**67**	**100**

Table 2 shows that more than half of the respondents (58.2%) didn't mention any mental disorder while only 14.9% were able to mention at least five mental disorders.

Table 3: Shows knowledge on the causes of mental illness (n=67)

Response	**Frequency(n)**	**Percentage (%)**
Witchcraft	26	38.8
Stress	15	22.4
Substance abuse	18	26.9
Punishment from God	08	11.9
Others	00	00
Total	**67**	**100**

Table 3 shows that most respondents (38.8%) attributed mental illness to witchcraft, 26.9% attributed it to substance abuse, 22.4% attribute it to stress and only 11.9% mentioned punishment from God.

Table 4: Shows knowledge on treatment for mental illness (n=67)

Response	**Frequency(n)**	**Percentage (%)**
Medication	22	32.8
Traditional healer	27	40.3
Good support	18	26.9
Others	00	00
Total	**67**	**100**

Most of the respondents (40.3%) mentioned that mental illness is treated by a traditional healer and 26.9% of the respondents mentioned good support.

4.3 Attitudes towards mentally ill people.

Table 5: Shows response on whether mentally ill people can still have a job and work (n=67)

Response	**Frequency(n)**	**Percentage (%)**
Agree	32	47.8
Strongly agree	11	16.4
Neither agree nor disagree	13	19.4
Disagree	9	13.4
Strongly disagree	2	3
Total	**67**	**100**

Nearly half of the respondents (47.8%) agreed that mentally ill people can still have a job and work normally while only 3% strongly disagree with it.

Table 6: Shows response on whether they would associate with mentally ill people (n=67)

Response	**Frequency(n)**	**Percentage (%)**
Agree	9	13.4
Strongly agree	4	6
Neither agree nor disagree	6	9
Disagree	37	55.2
Strongly disagree	11	16.4
Total	**67**	**100**

More than half of the respondents (55.2%) disagreed with whether would associate with mentally ill people while 13.4% agreed with the statement. 16.4% strongly disagree with it.

Table 7: Shows response on whether they fear mentally ill people (n=67)

Response	**Frequency(n)**	**Percentage (%)**
Agree	33	49.2
Strongly agree	13	19.4
Neither agree nor disagree	00	00
Disagree	17	25.4
Strongly disagree	4	6
Total	**67**	**100**

Nearly half of the respondents (49.2%) agreed that they fear mentally ill people while only 6% strongly disagreed.

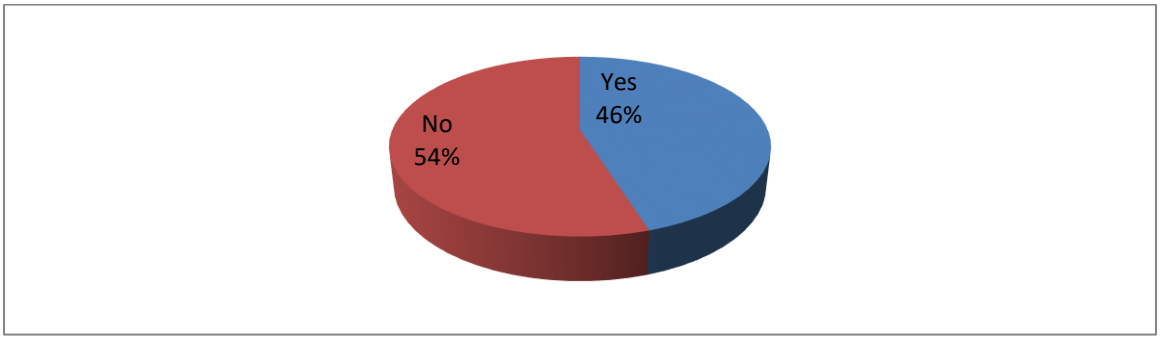
Table 8: Shows response on whether they would feel ashamed if they had a mentally ill person in their family n=67

Response	**Frequency(n)**	**Percentage (%)**
Agree	19	28.4
Strongly agree	10	14.9
Neither agree nor disagree	00	00
Disagree	22	32.8
Strongly disagree	16	23.9
Total	**67**	**100**

Most of the respondents (32.8%) disagreed on whether they would feel ashamed if they had a mentally ill person in their family and 23.9 % strongly disagreed with it while nearly the same number of respondents (28.4%) agreed.

4.4 Care towards mentally ill people

Figure 2: Shows response on whether they would take a mentally ill person to hospital for special attention (n=67)



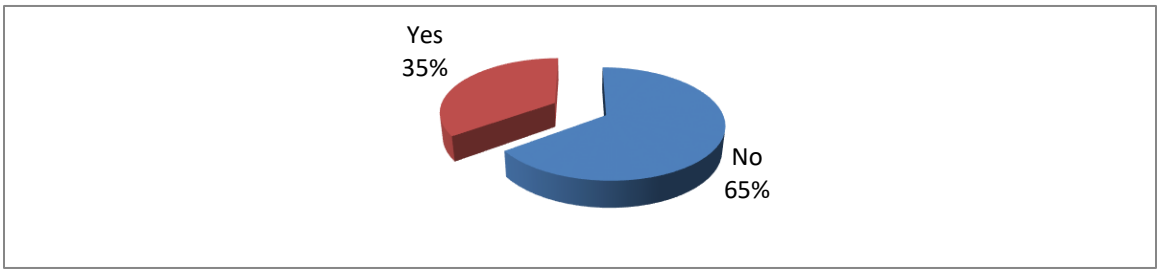
More than half of the respondents (54%) stated they would not take a mentally ill person to hospital while 46% of the respondents were positive about the statement.

Table 9: Shows response to others alternatives to hospital for special attention of mentally ill patients (n=31)

Response	**Frequency(n)**	**Percentage (%)**
To church/ mosque	3	9.7
Traditional healer	15	48.4
Others	13	41.9
Total	**31**	**100**

Nearly half of the respondents (48.4%) mentioned that they would take mentally ill patients to a traditional healer instead of hospital while only 9.7% mentioned church/mosque.

Figure 3: Shows response to whether they have ever looked after a mentally ill person (n=67)



Most of the respondents (65%) have never looked after a mentally ill person while only 35% have ever.

Table10: Shows response on ways of looking after mentally ill people (n=44)

Response	**Frequency(n)**	**Percentage (%)**
Occupying his or her mind with different activities	22	50
Helping him/her to bathe and wash his or her clothes	8	18.2
Giving him or her food	14	31.8
Others	00	00
Total	**44**	**100**

Half of the respondents (50%) would occupy the patients mind with different activities while only 18.2% would help mentally ill people to bathe and wash their clothes while 31.8% would give them food.

CHAPTER FIVE

DISCUSSION, CONCLUSION, RECOMMENDATION

5.0 Introduction

This chapter deals with interpretation and discussion of findings objectively in relation to the study background, problem statement and literature review to answer research questions, conclude and make recommendations about knowledge and attitudes of residents of cell B towards mental illness and the care. Out of the 67 participants recruited in the study, 67 questionnaires were returned completely filled thus a response rate of 100%.

5.1 Discussion of study findings.

5.1.1 Demographic characteristics

Most of the respondents (47.8%) were of the age range 29-39 years while only 7.4% were 51 and above years. Although this study did not correlate between age and care for mentally ill patients, it is important to note that knowledge of mental health improves with time basing on the previous experience. Therefore as one grows he/she acquires knowledge on the different aspects of mental illness. A mixed method study conducted by Quinn *et al*, (2009) in the United Kingdom suggests that older people have a more positive perspective towards mental illness. Majority of the respondents (62.7%) were females while only 37.3% were males. This could probably have been because most females were married and would remain home to do house work.

A big percentage of the respondents (52.2%) were married 43.3% were single and only 4.5% had separated. Although this study did not correlate between marital status and mental illness, it is worth noting that married couples always share the responsibility of passing cultural issues to their offspring which in turn determines their attitudes and how they treat mentally ill people.

Most of the respondents (40.3%) attained primary level of education while only 7.5% attained tertiary level. Majority attained primary level education probably due to government influence of Universal Primary Education (UPE).The aforementioned studies indicated that people with higher education tend to have more knowledge and positive attitudes towards mentally ill patients (Ndetei, *et al*, 2011).

Most of the respondents (55.2%) were Christians, 28.4% were Muslims and 16.4% belonged to other beliefs. This probably implies that most people are exposed to religious teachings which discourage traditional practices related to mental illness. Respondents who receive the information from religious places receive more sympathetic preaching about people with mental illness and thus adopt good attitudes towards mentally ill.

Most of the respondents (55.2%) were unemployed, 29.9% were employed and only 14.9% were self-employed. Socio-economic status of the individual can probably affect him/her psychologically and hence may resort to substance abuse to relieve stress.

5.1.2 Knowledge towards mental illness

Majority of the respondents (67%) knew the meaning of mental illness and only 12% didn't know the meaning of mental illness. This could have been because they might have had someone in their family or community who is mentally ill. This assumption is based on the findings of the CDC, (2011) that suggest that familiarity with mental illness and mental health services as well as exposure to mentally ill patients increases the knowledge pertaining to mental illness. For those who didn't know what the term means (12%), it could have been due to the focus on mental illness as a general term other than on specific mental disorder which might have created a bias to respondents in individual studies.

More than half of the respondents (58.2%) didn't mention any mental disorder while only 14.9% were able to mention at least five mental disorders. The results are in line with the report by Ganesh, (2011) which suggested that the knowledge on mental illness amongst the general public in South India was poor. Some of the participants in the study conducted by Ganesh could mention a few mentally ill disorders.

However, Van der Ham, *et al*, (2011), in an explorative study conducted in Vietnam, found that the participants in the study were unable to identify and name the different mental illness. This is because knowledge can be influenced by factors such as ethnicity, religion, age, gender, working experience and culture (Chaudhury & Minas, 2011).

Most respondents (38.8%) attributed mental illness to witchcraft, 26.9% attributed it to substance abuse, 22.4% attribute it to stress and only 11.9% mentioned punishment from God. The findings in the aforementioned studies indicate that the knowledge of the public regarding the etiology of mental illness is poor Bener & Ghuloum, (2011). A study which involved African American woman postulates that the participants attribute the causes of mental illness to stress, family and work related matters (Ward & Heidrich, 2009). However, the results of the study are in line with the research by Crabb, *et al*, (2012) which revealed that most people in Sub-Saharan Africa associate mental illnesses to cultural beliefs. Sometimes people with mental illness are associated with witchcraft and works of evil machines Culturally, Nigerians regardless of education seem to adhere in varying degrees to a belief in supernatural causation for any illness or outcome (Ewhoudjakpor, 2009).However, the results might be due to the fact that the majority of the sample was deeply rooted in cultural/ethnic beliefs as found amongst Africans.

Most of the respondents (40.3%) mentioned that mental illness is treated by a traditional healer and 26.9% of the respondents mentioned good support. A supernatural view of the cause of mental illness will imply choice for traditional means of treatment and the orthodox means. Hence, spiritualists and traditional healers are then patronized. Historically in Tanzania, mental health care has been provided by a traditional healing system based on the commonly believed association between mental illness and religious and spiritual factors. Furthermore, traditional healing is more

accessible than Western medicine for many people seeking mental health care especially for those in rural areas due to a lack of available and accessible mental health care professionals, poor transportation and acceptance of spiritual and/or supernatural causes for health problems (Kutcher, *et al*, 2016).

5.1.3 Attitudes towards mentally ill people.

Studies investigating and exploring the attitudes of the general public globally revealed that the attitudes towards mentally ill patients are mostly negative (Des Courtis *et al*, 2008). Studies indicate that large populations have negative attitudes and beliefs towards mentally ill patients, usually stemming from the fact that lay people, generally have poor knowledge regarding mental illness (Sadik, *et al*, 2010). Despite the fact that mental illness and mental health care awareness programs being extended extensively over the past few decades, mentally challenged patients are still being mocked, ostracized, labeled, ill-treated and misunderstood by the greater community, family and sometimes health care personnel (Ukpong & Abasiugbong, 2010).

Most of the respondents (51%) disagreed with the statement that mentally ill people can still have a job and work normally while 20% agreed with the statement. Henderson *et al*, (2013) contradict with the study findings in a study conducted in England on mental health problems in the workplace suggested that depending on a person's diagnosis, mentally ill people can have work and still function optimally. However the study findings are in line with Sorsdahl, Stein & Myers, (2012) who suggested that a person who has recovered from a mental illness will not be able to return to work.

More than half of the respondents (55.2%) disagreed with whether mentally ill people should be associated with while 13.4% agreed with the statement. 16.4% strongly disagreed with it. This could have been because they regard mentally ill people as dangerous and unpredictable. The findings are in line with the study on attitude towards mental illness among Nigerians which indicated that the most prevalent attitude expressed was social distance and avoidance expressed in 52% (13/25) of the participants (Chikaodiri, 2009). A study conducted in Switzerland participants reflected and displayed more negative attitudes, stigmatization and social distance towards mentally ill patients (Des Courtis, *et al*, 2008).

Nearly half of the respondents (49.2%) agreed that they fear mentally ill people while only 6% strongly disagreed. Chikaodiri, (2009) states that in Nigeria, non-mental health care workers feared mental health users so much that they expressed fears about treating mentally ill patients in a general teaching hospital. A national survey conducted in France which involved adults that explored knowledge, attitudes and perceptions towards schizophrenia, bipolar mood disorder and autism revealed that participants also viewed mentally ill people as dangerous and labeling of mentally ill patients was also prevalent in this study (Durand-Zaleski, *et al*, 2012).

Most of the respondents (32.8%) disagreed on whether they would feel ashamed if they had a mentally ill person in their family and 23.9 % strongly disagreed with it while nearly the same number of respondents (28.4%) agreed. This could have been because some societies believe that mentally ill patients are outcasts or mad people (Bener &

Ghuloum, 2011). Historically people with mental illness were burned, hanged, mutilated, abandoned and restrained with chains, all in the bid to save their souls, or bring redemption to their families and curb the inequities causing mental illness within the families (Okpalauwaekwe. U, *et al*, 2017).

5.1.4 Care for the mentally ill patients

All these objectionable views and beliefs on causes of mental illness further complicate the preference for type of care.

More than half of the respondents (54%) stated they would not take a mentally ill person to hospital while 46% of the respondents were positive about the statement. Nearly half of the respondents (48.4%) mentioned that they would take mentally ill patients to a traditional healer instead of hospital while only 9.7% mentioned church/mosque. Although results from our scoping review showed that a few studies reported preference for a combination of both treatment options, it is likely that the element of cultural misconception, which has been shown in the Nigerian society to affect their health seeking behavior, may still make them choose the traditional means of treatment over the western approach. The issue is that a lot of Nigerians, who have lost hope in the health-care system, will resort to spiritual answers by going to prayer houses, traditional healers and spiritualists (Chikaodiri, 2009).

Most of the respondents (65%) have never looked after a mentally ill person while only 35% have ever. This may be explained by a comparative study between mental health and non-mental health personnel conducted in Lincolnshire- UK by Gateshill *et al*

(2011) who reported that non mental health care workers regard mentally ill patients as being dangerous and unpredictable.

Half of the respondents (50%) would occupy the patients mind with different activities while only 18.2% would help mentally ill people to bathe and wash their clothes while 31.8% would give them food. In Nigeria, it is evident that non-mental health care workers fear mental health users. This fear has caused unwillingness among them to treat mentally ill patients in a general teaching hospital (Chikaodiri, 2009).

5.2 Conclusion

According to the researcher, this study revealed that the residents in Cell B still have poor knowledge on mental illnesses based on the fact that most of them still attribute mental illness to supernatural causes. This reveals choice for traditional means of treatment to western medicine which delays referral to hospitals for proper management by a psychiatrist hence worsening the patient's condition. Very few could also identify different mental conditions that need to be treated with medication by either medical doctors or psychiatric nurses and most of them regard treatment by witch doctors named 'sangoma's' as an appropriate way of treating mental illness. Participants in this study believed that mentally ill patients should not be integrated in the communities and were also of the opinion that mentally ill patients should not take up employment at various establishments and companies. Mentally ill patients are also seen as violent, rude and dangerous. More undermining and avoidant attitudes towards people with mental illness were found. A higher education level was associated with

fewer stigmatizing attitudes against people with mental illness. Interventions for fighting stigma against people with mental illness should be targeted more on rural communities. Exposure to mental illness information and a higher education level led to a greater reduction in poor attitudes and improved knowledge on mental illness. Any form of explanation for the cause of mental illness, whether supernatural or psychosocial and biological, reduces poor attitudes and improves care towards people with mental illness. Interventions also should target people with higher income but a lower level of education. Community mental health information, education, and communication interventions generally are helpful to improve knowledge and care towards people with mental illness.

5.3 Recommendations

There is an urgent necessity, to improve the health care system by developing strategies that would improve mental health literacy, and change stigmatizing attitude at both institutional and community levels. This will in the long run improve the quality of the societal attitude towards mental illness and the socio-economy of the mentally ill. One practical yet feasible way to improve literacy in mental health is by instituting age-appropriate school-based educational programs.

The researcher also recommends that guidelines with basic information on mental illness should be established and distributed to general public to inform and educate them regarding basic mental health literacy. This will possibly enhance mental health

literacy and to possibly reduce negative perceptions and attitudes towards mentally ill patients.

In addition, it is necessary to encourage health workers (nurses, psychologists, psychiatrists and other health care professionals) to show positive attitude towards mentally ill persons as this play an important role in influencing their response to treatment.

In order to determine whether all people share the same views, the researcher recommends that a study should be conducted in both rural and urban areas to investigate the general public's knowledge about basic mental illness.

Future research should, among other areas, include evaluation of the implementation of the entire mental health care plan, including the benefits of integrated service delivery to provide evidence, particularly for policy makers, to enable them to make informed decisions on resource allocation.

5.4 Implications for nursing practice

Morbidity due to mental illness is on increase in among people both in young and old people due to poor knowledge and attitudes about mental illness which in the end affects the care. Therefore as members of the nursing fraternity, it is our responsibility to diligently carry out sensitization tailored to improve knowledge and care of mental illness in communities while executing our duties.

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APPENDIX I: CONSENT FORM

Serialno……

Dear respondents, I am **Mwesige Gerald** a student undertaking diploma in Nursing at Kampala international University School of Nursing Sciences. I am conducting a study on **Knowledge and attitudes towards mental illness and the care among residents of cell B Ishaka** M**unicipality**. Please you are kindly requested to participate in this study. All the information provided will be treated with maximum confidentiality and there is no need for writing your name on the questionnaire provided, only respond to the questions asked. Participation in the study is purely voluntary and you are free to withdraw from the study if at any point you feel uncomfortable to continue with the study, no penalty will be given to you.

There are no individual benefits for the study participants. The wider community and health sector stand to benefit from this study if the findings are adapted.

Respondent:

I have read the information stated and understood the significance of the study and ready to participate.

Respondents' signature.....Date.....

Researcher:

I have explained the topic and its objectives to the participants and they have understood the topic and its objectives and voluntarily consented to participate in the study.

Researchers' signature.....Date.....

APPENDIX II: QUESTIONNAIRE

1. Kindly respond to all questions by ticking the appropriate response in a box against the objectives given or fill in the blank spaces provided where applicable.
2. Do not indicate your name anywhere on the questionnaire provided only write your responses

Section A: Bio - Demographic Characteristics (Tick appropriately)

1. Age of participant

(a) 18-28 ☐ (b) 29 - 39 ☐

(b) 40 -50 ☐ (d) 51 and above ☐

2. Sex of the participant

(a) (a) Male ☐ (b) Female ☐

3. Marital status of the participant

(a) Single ☐ b) Married ☐

(c)Separated ☐ d) Cohabiting ☐

4. Level of education.

a) None ☐ b) Primary ☐

c) Secondary ☐ d) Tertiary ☐

5. Religion of the Participant

a) Christian ☐ b) Moslem ☐

f) Others (specify)……

6. Occupation of the participant

a) Employed ☐ b) Self employed ☐

c) Unemployed ☐

SECTION B: KNOWLEDGE PERTAINING TO MENTAL ILLNESS AND CARE

7. What do you know about mental health?

(a) Is inappropriate feelings about oneself and others, and failure to handle stresses and strange behavior from the community point of view. ☐

(b) Not sure ☐

(c) I don't know ☐

8. Mention some examples of mental health disorders. ……

9. What causes mental illness?

(a) Evil spirits ☐ (b) Stress ☐ ☐

(c) Substance abuse

d) Punishment from God ☐

(e) Others, specify……..

10. Mental illness can be cured by:

(a) Medication ☐ (b) Traditional healer ☐

(c) Good support ☐

(d) Others specify……

SECTION C: ATTITUDES TOWARDS MENTAL ILLNESS AND THE CARE.

11. A person who had mental illness can still have a job and work normally.

a) Agree ☐ b) Strongly agree ☐

c) Neither agrees nor disagrees d) Disagree ☐

e) Strongly disagree ☐

12. Would you associate with a mentally ill person?

a) Agree ☐ b) Strongly agree ☐

c) Neither agrees nor disagrees ☐ d) Disagree ☐

☐

e) Strongly disagree

13. Do you fear mentally ill people?

a) Agree ☐ b) Strongly agree ☐

c) Neither agrees nor disagrees ☐ d) Disagree ☐

e) Strongly disagree ☐

14. Would you feel ashamed if you have a mentally ill person in your family?

a) Agree ☐ b) Strongly agree ☐

c) Neither agrees nor disagrees ☐ d) Disagree ☐

e) Strongly disagree ☐

SECTION D: CARE TOWARDS THE MENTALLY ILL PEOPLE

15. Would you take mentally ill patient to hospital for special attention?

a) Yes ☐ b) No ☐

16. If no to 15 (a) above where else would you take him or her?

a) To church/mosque ☐

b) To a traditional healer ☐

c) Others specify……

17. Have you ever looked after a mentally ill person?

a) Yes ☐ b) No ☐

18. If Yes in 17a) above, what were you doing for him or her?

a) Occupying his/her mind with different activities ☐

b) Helping him/her bathe and wash clothes ☐

c) Giving him/her food ☐

d) Others specify……

Thanks for your participation

APPENDIX III: WORK PLAN FROM MAY-SEPT 2017

SCHEDULED	**MONTHS &BY.**	May	June	July	Aug	Sep
Topic identification	Researcher/ supervisor					
Approval of topic	Research board					
Proposal writing and approval	Researcher, supervisor					
Data collection	Researcher					
Data analysis	Researcher/ supervisor					
Report writing	Researcher/ supervisor					
Submission of report	Researcher					

APPENDIX IV: BUDGET

Item	**Unit Price**	**Overall price**
Transport	5,000/=	10,000/=
Data collection	5,000/=	15,000/=
Air time/internet services	15,000/=	15,000/=
Photocopying	10,000/=	15,000/=
Typing and typesetting	30,000/=	35,000/=
Printing and binding	30,000/=	40,000/=
Stationary	20,000/=	20,000/=
Flash disk	20,000/=	20,000/=
Research fee	50,000/=	50,000/=
Miscellaneous	30,000/=	30,000/=
	Ground total	**250,000/=**

APPENDIX V: THE INTRODUCTORY LETTER

KAMPALA INTERNATIONAL UNIVERSITY
WESTERN CAMPUS
EXPLORING THE HEIGHTS

School of Nursing Sciences,
P.O.BOX 71 Bushenyi, Ishaka
Tel: +256 (0) 701 975572
E-mail: akabanyoro@gmail.com
Website: http://www.kiu.ac.ug

Office of the Dean - School of Nursing Sciences

CHAIRPERSON LC.I
CELL B TOWN WARD
17 AUG 2017
ISHAKA DIVISION
BUSHENYI-ISHAKA MUNICIPAL COUNCIL

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

RE: MWESIGE GERALD - DNS/0004/143/DU

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

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

His topic is **ASSESSMENT OF KNOWLEDGE AND ATTITUDES TOWARDS MENTAL ILLNESS AND CARE AMONG THE RESIDENTS OF WARD B ISHAKA MUNICIPALITY**

Any assistance rendered to him will be highly appreciated.

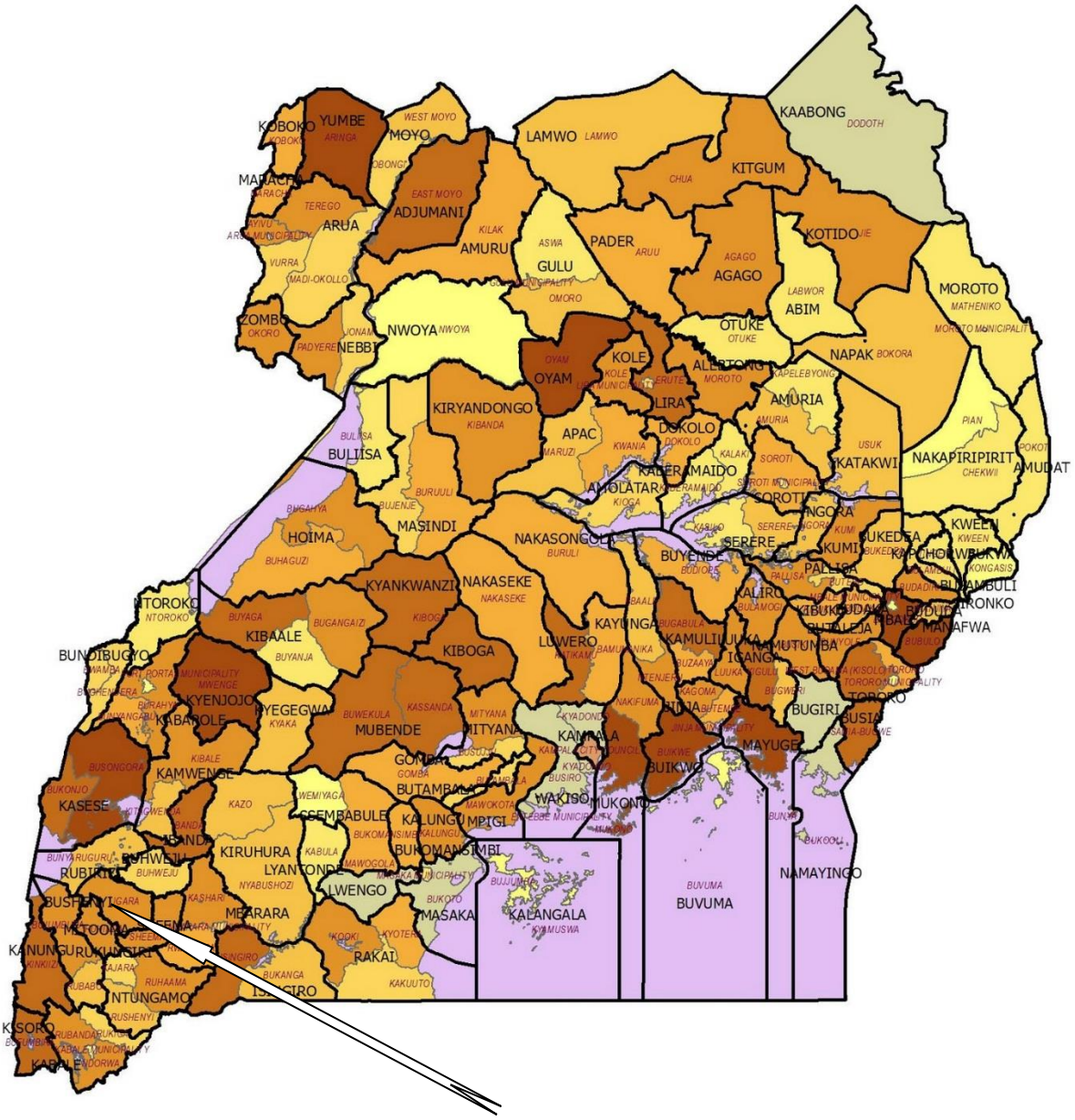
Thank you in advance for the positive response.

17 AUG 2017

Nabaliisa Sarah
RESEARCH COORDINATOR

"Exploring the Heights"

UGANDA SHOWING LOCATION OF BUSHENYI DISTRICT WHERE cell B IS LOCATED.



LOCATION OF BUSHENYI DISTRICT

APENDIX VII: MAP OF BUSHENYI DISTRICT WHERE CELL B IS LOCATED.

LOCATION OF CELL B.