THE PERCEPTION OF THE LOCAL COMMUNITIES OF ISHAKA TOWN COUNCIL TOWARDS PSYCHIATRIC PATIENTS AND SERVICES AT KAMPALA INTERNATIONAL UNIVERSITIES TEACHING HOSPITAL

BY

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A RESEARCH REPORT SUBMITTED TO FACULTY OF CLINICAL MEDICINE AND DENTISTRY IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF BACHELOR OF MEDICINE AND BACHELOR OF SURGERY OF KAMPALA INTERNATIONAL UNIVERSITY

NOVEMBER, 2014

DECLARATIONS

I, hereby declare that this research report is my original work and has not been submitted to any university or institution of higher for any academic award.

Sign …… Date……

APPROVAL

This is to certify that this research report has been prepared under my supervision and has never been presented anywhere for other purpose and is now ready for submission to Faculty of clinical medicine and dentistry of Kampala International University

Sign..... Date …….....…

DEDICATION

This work dedicated to my friends and family

LIST OF ACRONYMS

C	*circa*, about
e.g.	*Exempli gratia*, for example
et al	*et alii*- and others
ibid.	*ididem*-in the same book
IOM:	Institute of Medicine
KIUTH	Kampala International University Teaching Hospital
MoH	Ministry of Health
n.d	No Date
n.edit	No Edition
n.n	No Name
n.p	No Publisher
op cit	*opere citao*- in the work already quoted
SO	Specific Objectives
WHO	World Health Organization

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Abstract

The prevailing view of health-related stigma is that it refers to perceived, enacted, or anticipated avoidance or social exclusion, and not to an individual blemish or mark (Weiss, Ramakrishna &Somma 2006; Goffman 1963). Embarrassment associated with accessing mental health services is one of the many barriers that cause people to hide their symptoms and to prevent them from getting necessary treatment for their mental illness symptoms (U.S. Department of Health and Human Services, 1999; 2001; Greene-Shortridge et al., 2007; Nadeem et al., 2007).

A community based survey was conducted within Ishaka town in Bweziryze ward involving 73 respondents and 7 key informants to determine the attitudes of the local community of ishaka towards psychiatric patients and services at Kampala International University Teaching Hospital.

The study showed that most of the respondents did not seek psychiatric services from KIUTH, 74(93.67%) and those who sought services from KIUTH was 5(7.33%) of the respondents, and that most respondents believed that mental illness can be cured 32(40.5%), and most of the KIs agreed that mental health problems are common in their society and yet the understanding about this problem is low. According to the group of respondents, the most common causes of the mental health in the community is drugs and substance abuse, traditional causes (mostly mentioned was bewitching and bad lack), and that they were not sure of the cause.

This study concluded that the utilization of psychiatric services from KIUTH is low and this is due to the divided opinions on the causes and outcomes of psychiatric illness among the communities in Ishaka town council in Bushenyi district.

The study recommended that; The hospital should conduct community based mental health education to improve community understanding on the cause and outcomes of mental health, the hospital should liras with local leaders to address the challenges of drug abuse that was consistently reported by the community as the common cause of mental health problem within

Ishaka town council and he university should carry out more studies with a wider scope to describe the pattern of utilisation of psychiatric services from alternative sources to improve on advocacy and education about mental health problems.

CHAPTER ONE: INTRODUCTION

1.0 General Introduction

This chapter will introduce the reader to the basic information about the subject under study, discuss the problems that have been taken as a subject of study as the problem statement and describes the justifications for the study objectives, justifications scopes, and describe briefly the concepts about the utilizations HIV preventive services among students. A conceptual framework is hereby presented at the end of the chapter.

1.1 Background

The prevailing view of health-related stigma is that it refers to perceived, enacted, or anticipated avoidance or social exclusion, and not to an individual blemish or mark (Weiss, Ramakrishna & Somma 2006; Goffman 1963)

Embarrassment associated with accessing mental health services is one of the many barriers that cause people to hide their symptoms and to prevent them from getting necessary treatment for their mental illness symptoms (U.S. Department of Health and Human Services, 1999; 2001; Greene-Shortridge et al., 2007; Nadeem et al., 2007)

People's attitudes and beliefs predict their behavior (Ajzen & Fishbein, 1980). People's beliefs and attitudes about mental illness might predict whether they disclose their symptoms and seek treatment and support.

Studies shows that, a larger percentage of people endorsed the benefits of treatment by a physician for people with major depression in 2006 (91%) than in 1996 (78%) (Pescosolido et al., 2010). However, improvements in neurobiological understanding of mental illness were unrelated to negative attitudes and, in some cases, increased the odds of negative attitudes (e.g., need for social distance, perceived dangerousness) (Pescosolido et al., 2010).

Stigma poses a barrier for public health primary prevention efforts designed to minimize the onset of mental illness, as well as with secondary prevention efforts aimed at promoting early treatment to prevent worsening of symptoms over time (Weiss, Ramakrishna, & Somma, 2006).

Untreated symptoms can have grave consequences for people living with mental illness and negatively impact families affected by these disorders. For example, most people with serious and persistent mental illness (mental disorders that interfere with some area of social functioning) are unemployed and live below the poverty line, and many face major barriers to obtaining decent, affordable housing (U.S. Department of Health and Human Services, 1999). These individuals may need a number of additional social supports (e.g., job training, peer-support networks) to live successfully in the community,

1.2 Statement of the Problem

Globally, only about 20% of adults with a diagnosable mental disorder (Wang et al., 2012) or with a self-reported mental health condition (Hennessy et al., 2013) saw a mental health provider in the previous year.

Knowledge and beliefs can aid in the recognition, management, or prevention of mental health disorders or mental health literacy (Jorm et al., 1997). Tracking attitudes toward mental illness can serve as an indicator of the public's mental health literacy. For example, in a 1996 study, 54% of the U.S. public attributed major depression to neurobiological causes, and this increased to 67% in 2006 (Pescosolido et al., 2010).

In recognition of the roles played by positive knowledge, governments around the world have embarked on mental health promotion by creating awareness and devolving local opinions and attitudes about mental health. In Uganda, the draft national mental health policy has highlighted the significance of community empowerment to improve understandings about mental Health just like it was in the HSSP I and II (MoH 2012). To date, a large number of Ugandans feel relax and unwilling to seek mental health care due to mental sickness besides all the interventions (Amone, 2012)

To date very limited information is available about the global literacy in rural Uganda communities; and it's important that this study compares the attitudes of local community of Ishaka Town council. Bushenyi municipality towards to assessing mental health care from KIUTH

1.3 Justification of Study

First of all the study report will be submitted to the faculty of clinical medicine and dentistry of Kampala International University as a requirement in partial fulfillment of the requirement for the award of bachelor of clinical medicine and bachelor of surgery of Kampala International Unievrsity, 2014. Besides, the study will provide additional resources and reference for future researchers in the same areas of interest, and finally, the study results will be subjected to further evaluations to improve understandings about the situations of perceptions towards the utilizations of psychiatric services among local communities in Uganda.

1.4 Research Objectives

1.4.1 Broad Objectives

To determine the perceptions of the local communities of Ishaka Town council towards the utilizations of psychiatric services from Kampala International University Teaching Hospital

1.4.2 Specific Objectives

1. To describe the proportions of respondents who have seeked KIUTH with those utilising alternative treatments
2. To determine the opinions towards the outcomes of psychiatric treatment from Kampala International University
3. To determine the perceptions of the local communities of Ishaka towards the cause of psychiatric illnesses

1.5 Research Questions

1. What is the proportion of people seeking psychiatric health care services from KIUTH compared to those seeking alternative treatments

2. What is the opinions of respondents towards the outcomes of psychiatric illness from KIUTH
3. What are the perceptions of the respondents towards the causes of psychiatric illness?

1.6 Scope of the Study

1.6.1 Time Scope

The study was conducted between the months of September 2014 to January 2014. Detailed working schedules during this time scope is illustrated in appendix I (work schedule)

1.6.2 Content Scope

The study concentrated in describing the proportion of respondents seeking mental health care services from KIUTH as compared to those seeking care from alternative sources, including the traditional healers and other sources of perceived cure

The study further described in a narrative form the opinions of the respondents towards the outcomes of psychiatric illnesses treated from a formal health care system at tertiarylevel using the KIUTH model.

And thirdly, the study described the opinions towards what the respondents describe as the correct causes of mental illness within Bushenyi district taking the case of Ishaka Town council.

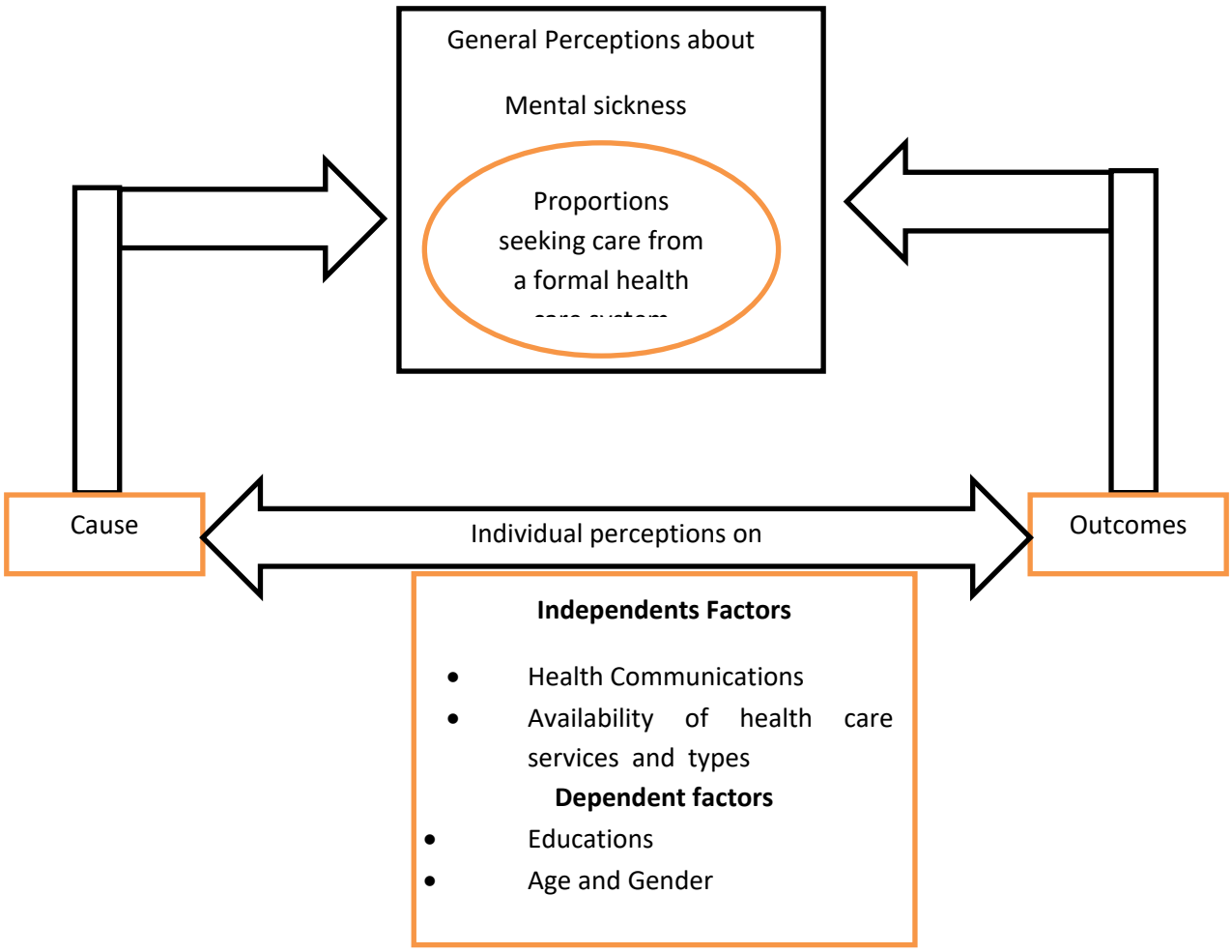
1.6.3 Geographical Scope

The study was conducted in Ishaka Town Council, Bushenyi district, western Uganda, and the respondents included all respondents who have stayed in Ishaka Town Council for at least six months, this was intended to exclude visitors who may not understand the cultural and moral values and acclimationstowards seeking psychiatric services within the study area

1.7 Conceptual Framework

1.7.1 Diagrammatic Conceptual Framework

Figure 1: Conceptual Diagram



1.7.2 Description of the Conceptual Framework

This conceptual diagram above shows that most of the factors influencing individual and community perceptions about mental health in Uganda falls broadly into the two categories of dependent and independent variables. The dependent variables are social and demographic characteristics majorly; such as age, gender and education levels, while the major independent variables are the health communication and availability of care.

CHAPTER TWO: LITERATURE REVIEW

2.0 General Introductions

In this chapter, the researcher has presented the findings, views, opinions and conclusions of institutions and individuals who had worked previously on similar objectives for which the work is now being presented here. The findings are globally reviewed and comprise major ideas and findings from a variety of scholars.

2.1 Previous Literature

About one in four U.S. adults (26.2%) age 18 and older, in any given year, has a mental disorder (e.g., mood disorder, anxiety disorder, impulse control disorder, or substance abuse disorder) (Kessler, Chiu,Demler, & Walters, 2005), meaning that mental disorders are common and can affect anyone.

Many adults with common chronic conditions such as arthritis, cancer, diabetes, heart disease, and epilepsy experience concurrent depression and anxiety—further complicating self-management of these disorders and adversely affecting quality of life (Chapman et al., 2005; El-Gabalawy et al., 2010; IOM, 2012)

Stigma and discrimination against people with mental disorders, indeed, are common throughout world (World Health Organization, 2001).

Personal belief about mental illness is thought to shape one's openness to service use (Karasz, 2005). Minority elders in particular are known to be subject to cultural misconceptions and stigma related to mental illness (Lin & Cheung, 1999; US Department of Health and Human Services, 2001).

People's beliefs and attitudes toward mental illness set the stage for how they interact with, provide opportunities for, and help support a person with mental illness. People's beliefs and attitudes toward mental illness also frame how they experience and express their own emotional problems and psychological distress and whether they disclose these symptoms and seek care (Rosemari, 2012)

Attitudes and beliefs about mental illness are shaped by personal knowledge about mental illness, knowing and interacting with someone living with mental illness, cultural stereotypes about mental illness, media stories, and familiarity with institutional practices and past restrictions (e.g., health insurance restrictions, employment restrictions; adoption restrictions) (Corrigan et al., 2004; Wahl, 2003).

Positive attitudes and beliefs can result in supportive and inclusive behaviors (e.g., willingness to date a person with mental illness or to hire a person with mental illness). Negative attitudes and beliefs may result in avoidance, exclusion from daily activities, and, in the worst case, exploitation and discrimination. Stigma has been described as ―a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses (President's New Freedom Commission on Mental Health, p. 4, 2003).

Stigma leads to social exclusion or discrimination which results in unequal access to resources that all people need to function well: educational opportunities, employment, a supportive community, including friends and family, and access to quality health care (Link & Phelan, 2001; Corrigan et al., 2004).

These disadvantages can cause a person to experience more negative outcomes. Being unemployed, living at or below the poverty line, being socially isolated, and living with other social disadvantages can further deflate self-esteem, compounding mental illness symptoms, and add to the burden of stigma (Sartorius, 2005).

Stigma can also interfere with self-management of mental disorders (tertiary prevention) (Sirey et al., 2001), but such supports may not be available. Other individuals with depression and anxiety might avoid disclosing their symptoms and instead adopt unhealthy behaviors to help

them cope with their distress (e.g., smoking, excessive alcohol use, binge-eating). These behaviors can increase their risk for developing chronic diseases, worsening their overall health over time. Recent studies have found an increased risk of death at younger ages for people with mental illness (Colton & Manderscheid, 2006).

Different opinions exist regarding the implications of different labels associated with describing mental illness (e.g., brain disease) and felt or experienced stigma (Sayce, 1998; Corrigan & Watson 2004; Corrigan, Markowitz, & Watson, 2004; Pescosolido et al., 2010).

The prevailing view of health-related stigma is that it refers to perceived, enacted, or anticipated avoidance or social exclusion, and not to an individual blemish or mark (Weiss, Ramakrishna, & Somma, 2006; Goffman, 1963). Different methods exist for measuring health-related stigma, and challenges and limitations associated with distinguishing between felt versus experienced stigma in attitudinal research have been described (Link et al., 2004; Green, 1995).

Gender, education and prior contact with mental health professionals are significant predictors of attitudes toward mental health services only in the younger adult sample. Parallel findings show that for nonminority as well as minority populations. Women, for example, are generally more willing to talk about their emotions and seek outside help (Tata & Leong, 1994); similarly, education is positively associated with professional help seeking (Yi & Tidwell, 2005). Also, studies have reported that prior experiences with mental health professionals facilitate future use of the services (Tijhuis et al., 1990).

In another study, for older adults, depressive symptoms were a significant predictor of attitudes toward mental health services, with more symptoms associated with a more negative attitude. Overall the findings suggest a concerning gap between mental health service needs and attitudes toward services. Older adults were likely to believe that depression is a sign of personal weakness and that having a mentally ill family member brings shame to the whole family, whereas younger adults were likely to accept the medical conceptualization of depression (Rosemaria, 2012)

Several classic studies in social psychiatry have illuminated the important role thatcultural beliefs play in shaping societalresponses to people with mental illnesses (Hollingshead and Redlich', 1995)

A study to compare the Australian public's attitudes towards people who have been treated for a mental disorder with the attitudes of general practitioners found that health professionals rate long-term outcomes more negatively and discrimination as more likely. This study concluded that It is possible that these more negative attitudes are realistic, being based on greater knowledge of mental disorders. However, professional attitudes may be biased by greater contact with patients who have chronic or recurrent disorders. Either way, health professionals need to be aware of the effects that their negative attitudes might have on patients and the public (Anthony F, 2000)

In another study of U.S. adults, only about one fourth agreed that people are caring and sympathetic to people with mental illness (Kobau, DiIorio, Chapman, & Delvecchio, 2010). When asked about how much it would be worth to avoid mental illness compared to general medical illnesses, the public was less willing to pay to avoid mental health treatment than they were to pay to avoid physical health treatment (Smith et al., 2012). These studies provide important snapshots of attitudes toward mental illness across the country; however, studies that examine attitudes in depth such as distinguishing between attitudes relative to perceived or experienced stigma, studies that link attitudes to actual behavior, or studies that track attitudes toward mental illness at the state level do not occur routinely.

Consistent with Star's observation that mental illness is something that "people want to keep as far from themselves as possible," we found a strong desire for social distance across several domains of social interaction. One possible reason for this is that the symptoms themselves represent undesirable personal attributes that people want toavoid.

But our results concerning the unrealistically elevated fear of violence associated with the vignettes lead us to question this idea as a full explanation. It is not just that the symptoms are

undesirable but that they induce fear (i.e., fear that the person will do something violent). And, as our results also show, there is an appreciable correlation between this fear and willingness to interact. This suggests that at least some part of people's reluctance to engage in interaction is an exaggerated fear that symptoms lead to violence. The ideas of "danger" and "fear" that Star emphasized nearly 50 years ago are still with us and play a large role in public perceptions of people with mental illnesses.

CHAPTER THREE: STUDY METHODOLOGY

3.1 Study Area

The study was conducted in Ishaka Town Council, Bushenyi Municipality, Bushenyi district, western Uganda.

3.2 Study Population

The target population were the residents of Ishaka Town council in Bushenyi district, who have ever attended or utilized psychiatric services from Kampala International University Teaching Hospital within the last one year.

3.3 Study Design

The study design was a cross sectional in nature, in which data was collected mainly from residents within Ishaka. Other opinion leaders and community leaders who are responsible for guiding the communities towards the utilizations of psychiatricillness within the community were included as key informants

3.4 Inclusion and Exclusion Criteria.

3.4.1. Inclusion Criteria

Residents who have at least had one patient in their families or neighboring family in the last 12 months.

3.4.2 Exclusion Criteria

Residents who have taken less than a year within Ishaka

Residents who decline to consent to participate in the study.

3.5 Sample Size

Samples size was determined using a statistical formula adapted from fishers formula of 1962, given by

$$n = \frac{z^2 p(1-p)}{d^2}$$

Where: n- Is the sample size. p- Study proportion. d- Is the level of precision (5%).

So by substitution,

$$n = \frac{1.96^2\ 0.5\ (1-0.5)}{0.11^2}, \quad n = 79$$

3.6 Data Analysis

Data wasanalyzed electronically using SPSS (V16). The major independent variables to be analyses be were age, gender, tribe, against dependent variables; numbers of times they have sought for psychiatric services in the last one year, the outcomes of the illness and relative cause of the illness, other preventive services utilized and the referral links utilized. Chi square test will be used to test thestudy hypothesis.

3.7 Ethical Considerations

The reportwas submitted to the supervisor for approval of its scientific and ethical validity. The researcher was then formally introduced to the research area through a letter from the training Institution, and will be guided for ethical clearance from the local council 1 leader to seek the permission for the study to be conducted in their wards.

This study involveed access to personal information and thus written informed consent was sought from the individual participants where possible before they are involved in the study.

Confidentially matters was observed by use of codes and no names were placed in the questionnaire, and responses kept under lock and key and only to be used for the research purpose

3.8 Anticipated Challenges

The following challenges were facedduring the study, low levels of corporations from the local residents; the researcher mitigated this through personal dialogue with individuals to raise awareness and promoted cooperation during the study.

CHAPTER FOUR: STUDY FINDINGS

Figure 2: Age Distribution of Respondents

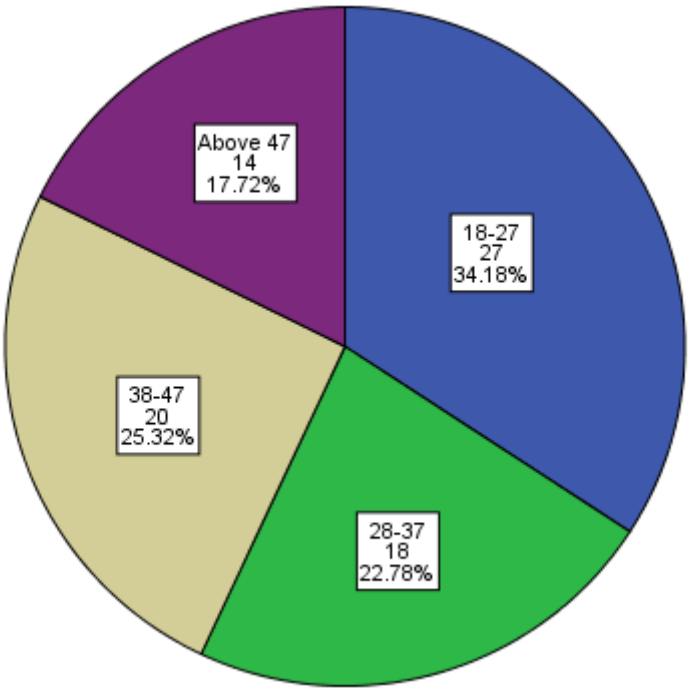


Figure 2 above shows that 34.18% of the respondents were 18-27 years old, followed by those who were 38-47 years old groups 25.32%, and 22.78%, 28-37 years old and the least number of respondents were above 47 17.72%.

Table 1: Gender distribution of Respondents

		Frequency	Percent
Valid	Male	26	32.9
	Female	53	67.1
	Total	79	100.0

The table above shows that majority of the respondents in this study were female, 67.1% (53) and 32.9%(26) were males

Figure 3: Proportion of respondents who have sought psychiatric services

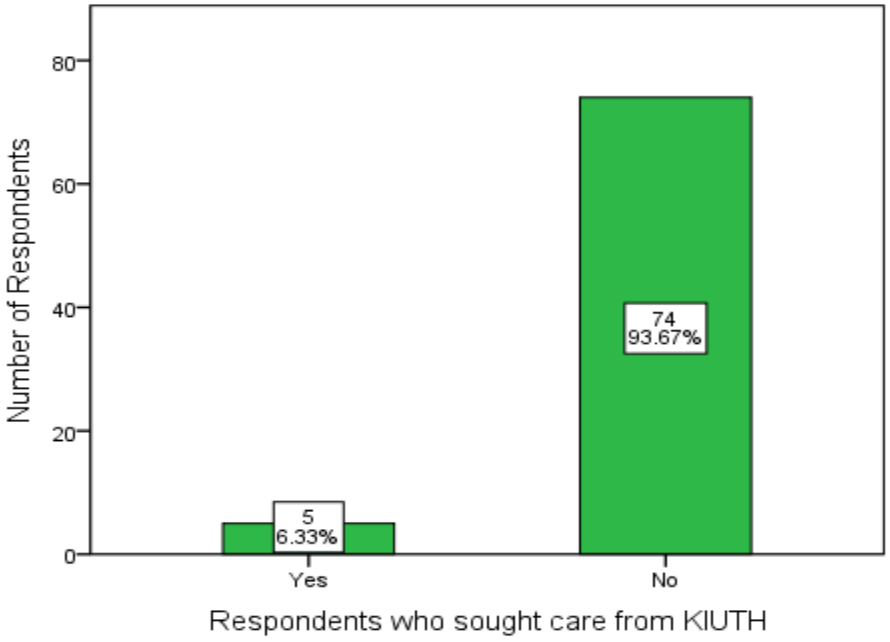


Figure 3 above showed that most of the respondents did not seek psychiatric services from KIUTH, 74(93.67%) and those who sought services from KIUTH was 5(7.33%) of the respondents.

Table 2: Proportion of Respondents seeking alternative care

		Have you ever suffered mental illness yourself?		Total
		Yes	No	
sought care from KIUTH	Yes	4	0	4
	No	1	74	75
Total		5	74	79

Table 2 above showed that 4 of the 5 respondents who reported suffering mental sicknesses had sought care from KIUTH and 1 did not seek care from KIUTH.

	Frequency	Percent
Can be cured	32	40.5
Improves	12	15.2
Cannot be cured	18	22.8
Sometimes chronic	4	5.1
Total	79	100.0

Table 3: opinions on the outcomes on psychiatric illness

Table 3 above showed that most of the respondents believed that mental illness can be cured 32(40.5%), followed by 18(22.8%) who believed mental illness cannot be cured and 12(15.2%) believed mental health sickness can improve with treatment and 4 (5.1%) believed that mental illness sometimes becomes chronic even with treatment

Key informants interview was conducted among 7 KIs within Ishaka town ward on their perceptions about the cause of mental ill health, most of the KIs agreed that mental health problems are common in their society and yet the understanding about this problem is low. According to the group of respondents, the most common causes of the mental health in the community is drugs and substance abuse, traditional causes (mostly mentioned was bewitching and bad lack), and that they were not sure of the cause.

CHAPTER FIVE

DISCUSSION, CONCLUSIONS AND RECOMMENDATION

5.1 Discussions

This study showed that most of the respondents did not seek psychiatric services from KIUTH, 74(93.67%) and those who sought services from KIUTH was 5(7.33%) of the respondents.

This showed that thenumber of respondents assessing psychiatric services were high though a large number of respondents did not seek care from the health point. Earlier, 20% of the respondents were shown not to be assessing services for mental health problems. This study showed that a relatively large number of respondents were assessing services compared to the previous statistics. Amone in 2012 showed that up to 12 % of the respondents do not seek mental health care.

One reason for this finding could also be due to the fact that the study was conducted within the vicinity of teaching hospital with regular programs on mental health problems within the surrounding communities

The researcher believed that most of the respondents who were not reached by this survey could not be assessing psychiatric services from KIUTH as there is still wide spread health related stigma which might be perceived, anticipated as shown previously by Weis et al. another factor could be that most of the respondents who did not seek mental health care services had embarrassment associated with assessing mental health services. Several studies have documented that embarrassment associated with assessing mental health services prevent sick people from assessing mental health services.

This study also showed that though the utilization of psychiatric services is good among the communities of Ishaka town council, a large number of people are still suffering from mental health problems.

Most of the respondents believed that mental illness can be cured 32(40.5%), followed by 18(22.8%) who believedmental illness cannot be cured and 12(15.2%) believed mental health sickness can improve with treatment and 4 (5.1%) believed that mental illness sometimes becomes chronic even with treatment

This showed that there is a mixed opinion on the cure of mental health problems within Ishaka town council.

Prvious studies by Anthony Lorm had shown that there was misappropriate information among health practitioners and the public. In his study, health professionals rate long-term outcomes more negatively and discrimination as more likely.

This study could have possibly been that more negative attitudes are realistic, being based on greater knowledge of mental disorders. However, professional attitudes were also biased by greater contact with patients who have chronic or recurrent disorders. Lormrealsied that, health professionals need to be aware of the effects that their negative attitudes might have on patients and the public.

This study however did not look at the perception of the local health workers serving the communities in Ishaka but realized that negative attitudes exist on the outcomes of mental health within the communities.

This implies that most of the people would not be seeking mental health services as there are a mixed attitudes about the outcomes of psychiatric illness among the people in Ishaka. One study conducted by Makaere university college of public health had shown that it was common in Uganda for most of the respondents not to attend mental health clinics due to their perceived opinions that mental health problems were not curable.

Most of the KIs agreed that mental health problems are common in their society and yet the understanding about this problem is low. According to the group of respondents, the most common causes of the mental health in the community is drugs and substance abuse, traditional causes (mostly mentioned was bewitching and bad lack), and that they were not sure of the cause.

This findings showed that the understanding on the cause of mental health are a big public health challenges.in previous studies, this did affect the utilization and openness to accept mental sickness and seek care within the time.

In one study , this was shown to vary according to the type of mental sickness that one suffers from. Rosemarie 2012 showed that adults with depressive symptoms were most likely to accept mental health problems while younger respondents with other symptoms were most likely to reject the fact that there is a chance of mental health sickness in their households. This according to Rosemarie is due to the fact that most adults mental health problems come with age while, its difficult for young people to become mentally sick.

The implication of the above finding here in Ishaka is that most of the patients would be delayed at home as they tend to think that these conditions might not be cured. This study did not look into details the challenges that such attitudes might have posed to the utilization of mental health services in the past few years as this was quite beyond the scope of this study.

5.2 Conclusion

This study concluded that the utilization of psychiatric services from KIUTH is low and this is due to the divided opinions on the causes and outcomes of psychiatric illness among the communities in Ishaka town council in Bushenyi district.

5.3 Recommendation

The study recommended that

1. The hospital should conduct community based mental health education to improve community understanding on the cause and outcomes of mental health
2. The hospital should liras with local leaders to address the challenges of drug abuse that was consistently reported by the community as the common cause of mental health problem within Ishaka town council and
3. The university should carry out more studies with a wider scope to describe the pattern of utilisation of psychiatric services from alternative sources to improve on advocacy and education about mental health problems.

Appendices

Appendix I: Work Schedule

S/NO.	ACTIVITIES	A			S			O	N	D	J	F	PER.RESPNONSIBLE
		W1	W2	W3	W1	W2	W3						
1	Topic formulation	X											Student/Simon
2	Approval of topic	X	X										Research committee
3	Synopsis writing		X	X									Student/ Simon
4	Draft proposal writing				X	X							Student/ Simon
5	Approval of proposal						X	X					Supervisor/Prof Kyamuka
6	Data collection						X	X	X	X			Student/ Simon
7	Data analysis and limitation.							X	X	X			Student/ Simon
8	1st draft report								X	X			Student/ Simon
9	Correction of 1st draft										X		Supervisor/Prof Kyamuka
10	Pdn. Of final report.										X		Student/ Simon
11	Approval											X	Supervisor/Prof Kyamuka

Appendices II: Budget

S/NO.	ITEMS	QUANTITY	RATES EACH	TOTAL AMOUNT(UG.SHS)
1	**Stationary**			
	-Pen	6	200=	1,200=
	-Ream of paper	2	8,000=	16,000=
	-Note book	3	2,000=	6,000=
	-Clip board	1	5,000=	5,000=
2	**Secretarial services**			
	Typing and printing	60 pages	1,000=	60,000=
3	Flash disk	1	40,000=	40,000=
4	Binding the final work	3 copies	2,000=	6,000=
5	**Refreshment**			
	Food/water	-	10,000=	10,000=
	TOTAL			**129,800/=**

Appendix III: Data Collection Tool

THE PERCEPTION OF THE LOCAL COMMUNITIES OF ISHAKA TOWN COUNCIL TOWARDS PSYCHIATRIC PATIENTS AND SERVICES AT KAMPALA INTERNATIONAL UNIVERSITIES TEACHING HOSPITAL

SELF ADMNISTERED QUESTIONAIRE

Date:…… Place of Interview……

Introduction

Name of Researcher: Simon

Purpose of the questionnaire: This questionnaire is developed as a data collection tool to be filed in by selected respondents. The data obtained from which shall be used only for research purposes only.

This data will be treated with the utmost confidentiality it deserves and will not be released to anyone/organization except for an academic purpose.

Section A: Bio data

1. Age
   a) 18-27 ☐
   b) 28-37 ☐
   c) 38-47 ☐
   d) 47 and above ☐

2. Gender

   a) Male ☐
   b) Female ☐

3. Tribe

a) Munyankole ☐
b) Rukiga ☐
c) Baganda ☐
d) Others ☐

4. Education Levels

a) None ☐
b) Primary ☐
c) Secondary ☐
d) Tertiary/University ☐

5. Have you ever suffered mental illness yourself?

a) Yes ☐
b) No ☐

6. Have you ever suffered from any of the following symptoms?

Anxiety	1. Yes 2. No
Depression	1. Yes 2. No
Extreme fear	1. Yes 2. No
Prolonged worries	1. Yes 2. No

7. Has any of your familymembersever suffered from any of the following symptoms?

Anxiety	3. Yes 4. No
Depression	3. Yes 4. No
Extreme fear	3. Yes 4. No
Prolonged worries	3. Yes 4. No

8. Are you now taking medicine or receiving treatment from a doctor or other health professional for any type of mental health condition or emotional problem?

a) yes, ☐
b) No, ☐
c) don't know, ☐

9. Is any of your family member taking medicine or receiving treatment from a doctor or other health professional for any type of mental health condition or emotional problem?

a) yes, ☐
b) No, ☐
c) don't know, ☐

	Strongly Agree	Agree	No opinion	Disagree	Strongly disagree
Do you agree that medical treatment can help people with mental illness lead normal lives?					
Do you agree that People are generally caring and sympathetic to people with mental illness					
Do you agree that people are usually assessing mental health care services from traditional healers					
Do you agree that traditional medicines are equally effective like hospital medicines					

Appendix IV: Map of Uganda showing Ishaka Bushenyi

REFRENCES

1. Ajzen, I., & Fishbein, M. (1980). *Understanding attitudes and predicting social behavior*. Englewood Cliffs, New Jersey. Prentice Hall.

2. Centers for Disease Control and Prevention. (2010). Attitudes toward Mental Illness—35 States, District of

3. Centers for Disease Control and Prevention. (2012). *Behavioral Risk Factor Surveillance System*. Atlanta, GA: Author. Available from http://www.cdc.gov/BRFSS (accessed July 9, 2014).

4. Centers for Disease Control and Prevention. (2008). *2007 Behavioral Risk Factor Surveillance System summary data quality report*. Atlanta, GA: Author. Available from ftp://ftp.cdc.gov/pub/data/brfss/2007SummaryDataQualityReport.pdf (accessed July 9, 2014).

5. Centers for Disease Control and Prevention. (2011). *2009 Behavioral Risk Factor Surveillance System Summary Data Quality Report*. Atlanta, GA: Author. Retrieved February 28, 2012 Available from ftp://ftp.cdc.gov/pub/data/brfss/2009_Summary_Data_Quality_Report.pdf (accessed July 9, 2014).

6. Chapman, D.P., Perry, G.S., & Strine, T.W. (2005). The vital link between chronic disease and depressive disorders. *Preventing Chronic Disease, 2*(1). Available from http://www.cdc.gov/pcd/issues/2005/jan/04_0066.htm (accessed September 9, 2014).

7. Colton, C.W., & Manderscheid, R.W. (2006). Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Preventing Chronic Disease, 3*(2). Available from http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm (accessed September 9, 2014).

8. Corrigan, P.W. (2012). Where is the evidence supporting public service announcements to eliminate mental illness stigma? *Psychiatric Services, 63*(1), 79–82.

9. Corrigan, P.W., Markowitz, F.E., & Watson, A.C. (2004). Structural levels of mental illness: Stigma and discrimination. *Schizophrenia Bulletin*, *20*(3), 481–491.

10. El-Gabalawy, R., Cox, B., Clara, I., & Mackenzie, C. (2010). Assessing the validity of social anxiety disorder subtypes using a nationally representative sample. *Journal of Anxiety Disorders*, *24*(2), 244-249.

11. Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. New York: Simon & Schuster, Inc.

12. Green, G. (1995). Attitudes toward people with HIV: Are they as stigmatizing as people with HIV perceive them to be? *Social Science & Medicine*, *41*(4), 557–568.

13. Greene-Shortridge, T.M., Britt, T.W., & Castro, C.A. (2007). The stigma of mental health problems in the military. *Military Medicine*, *172*(2), 157–161.

14. Hennessy, K.D., Green-Hennessy, S., Marshall, C. (2012). Datapoints: Receipt of reported mental health specialty care in the 2010 HealthStyles Survey. *Psychiatric Services, 63(*4*),* 306.

15. Institute of Medicine (IOM). (2012). Living well with chronic illness: A call for public health action. Washington, DC: The National Academies Press.

16. Jorm, A.F., Korten, A.E., Jacomb, P.A., Christensen, H., Rodgers, B., & Pollitt, P. (1997). ―Mental health literacy‖: A survey of the public's ability to recognize mental disorders and their beliefs about the effectiveness of treatment. *Medical Journal of Australia*, *166*(4), 182–186.

17. Kessler, R.C., Barker, P.R., Colpe, L.J., Epstein, J.F., Gfroerer, J.C., Hiripi, E., Howes, M.J., Norman, S.T., Manderscheid, R.W., Walters, E.E., &Zaslavsky, A.M. (2003). Screening for serious mental illness in the general population. *Archives of General Psychiatry*, *60*(2), 184–189.

18. Kessler, R.C., Chiu, W.T., Demler, O., & Walters, E.E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, *62*(6), 617–627.

19. Kobau, R., DiIorio, C., Chapman, D., &Delvecchio, P. (2010). Substance Abuse and Mental Health Services Administration/CDC Mental Illness Stigma Panel Members. Attitudes about mental illness and its treatment: validation of a generic scale for public health surveillance of mental illness associated stigma. *Community Mental Health Journal*, *46*(2), 164–176.

20. Link, B.G. & Phelan, J.C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, *27*, 363–385.