KNOWLEDGE AND ATTITUDES OF THE KINONDONI COMMUNITY TOWARDS MENTAL ILLNESS

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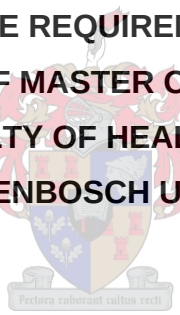

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DECLARATION

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the authorship owner thereof (unless to the extent explicit otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Signature..... **Date.....**

ABSTRACT

Mental health knowledge is defined as “the knowledge and beliefs about mental disorders which aid their recognition, management or prevention”. Although mental illness is a common condition in the community, only a few people with these disorders generally undergo treatment with about only 70% of individuals seeking help.

Contributing to the community’s lack of knowledge, it has also been found that the public cannot recognise different types of psychological distress and mental illness, resulting in people not seeking mental health care.

From the evidence perused in the literature, the researcher observed that communities with sound mental health knowledge and a positive attitude towards mental illness are motivated to seek professional help, whilst communities with a lack of mental health knowledge and a negative attitude towards mental illness are less motivated to seek professional help. The researcher therefore aimed at determining the knowledge and attitudes of the Kinondoni community members towards mental illness.

In determining the knowledge and attitudes of the Kinondoni community members towards mental illness, the research design was a descriptive, cross-sectional survey, with a quantitative approach. An adjusted, existing questionnaire, with, self-compiled, closed ended questions, was used to collect data. Reliability was supported by a pilot study to test the questionnaire beforehand. Face and content validity focused on readability, clarity and development of the questionnaire. The ethical principles were used to make sure the rights of participants were protected.

The ethical approval was obtained from Stellenbosch University institutional review board number IRB0005239 to conduct research. Furthermore the study permit was given by the Kinondoni Municipal Medical Officer of health with reference number TD/K/3/VOL/207.

The collected data was analysed by using the Statistical Package for Social Sciences (SPSS).

The results were presented in tables of means, in which each variable had its own table of analysis of variance. The results were as follows; knowledge about mental illness was very poor as most of the respondents in Kinondoni community n=182 (61%) responded that mentally ill people cannot perform regular jobs, had no friends, and were dangerous. Respondents n= 239 (79.6%) had negative attitudes towards people with mental illness as they stated that they have no right to find a job, have friends and be integrated into society.

The results conclude that the Kinondoni community members have less knowledge and negative attitude towards mental illness.

The researcher summarises the completed process of this research study and recommend policy makers to formulate guidelines to strengthen nursing practice and education, to create awareness to the community on mental illness and also recommend for further study.

OPSOMMING

Geestesgesondheidskennis word gedefinieer as die kennis van geestesongesteldhede wat bydra tot die herkenning, hantering en voorkoming van geestesongesteldhede. Alhoewel geestesongesteldhede ‘n algemene toestand is in die gemeenskap, is daar slegs ‘n klein aantal geestesongestelde individue wat behandeling ondergaan, met omtrent 70% van die genoemde individue wat hulp soek.

Bydraend tot die gebrek van die gemeenskap se kennis het dit ook aan die lig gekom dat die publiek ook nie die verskeie sielkundige stressors en geestesongesteldhede erken nie, wat veroorsaak dat mense nie geestesgesondheidsorg benader nie.

Uit die literatuurstudie het die navorser geobserveer dat die gemeenskappe met geestesgesondheidskennis en ‘n positiewe houding gemotiveerd is om hulp te soek en gemeenskappe met ‘n gebrek aan geestesgesondheidskennis minder gemotiveerd is om professionele hulp te soek. Die navorsing het hierbenewens ten doel gehad om die kennis en houding van die Kinondoni gemeenskapslede aangaande geestesongesteldhede te bepaal.

Om die kennis en houding van die Kinondoni gemeenskap te bepaal is ‘n kwantitatiewe deursnitopname gedoen. ‘n Bestaande vraelys met geslote vrae is aangepas om data in te samel. Betroubaarheid is deur die loodstudie ondersteun, terwyl sig- en inhoudsgeldigheid op die leesbaarheid, uitklaring en ontwikkeling van die vraelys gefokus het. Die etiese standaarde is gebruik om die regte van deelnemers te beskerm. Vervolgens is die gekollekteerde data met SPSS ontleed. Die bevindinge is deur middel van tabelle van gemiddeldes, waar elke verandelike sy eie variansie vertoon het, voorgestel.

Ten slotte is riglyne beskryf. Die resultate is as volg; kennis betrefffende geestesongesteldhede was baie swak onder die meerderheid repondente van Kinondoni se gemeenskap n=182 (61%) het vertoon dat geestesongestelde

persone nie gereelde werk kan verig nie, geen vriende kringe het nie en baie gevaarlik is. Respondente n=239 (79.6%) het n negatiewe houdng teenoor persone met n geestesgebrek en maak melding dat geestesgestremde persone geen reg op om te werk besit, vriende te het en om te integreer in die gemeenskap.

Die gevolgtrekking van die resultate toon dat die Kinondoni gemeenskaps lede baie min kennis en n negatiewe houding teenoor geestesgebreke het. Die navorser maak n volledige opsomming van die navorsings' studie en maak n aanbeveling aan beleid opstellers om riglyne te formuleer deur versterking van die verpleeg praktyk en onderwys, om bewustheid van gesondheidsgebreke aan die gemeenskap daar te stel en beveel ook verdere studies aan.

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DEDICATION

I dedicate this thesis to my lovely wife, Elizabeth Sebastian Kimaro, my son, Joel John Chikomo, my mother, Emilia Johnson Kilumbo, my cousin, Amani Millinga, my young sisters, Modesta Kilumbo and Upendo Chikomo, for their support, love and patience during my studies.

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CHAPTER ONE

Introduction of the study

1.1 Introduction

Mental health knowledge is defined by Jormfeldt (2006:3) as “the knowledge and beliefs about mental disorders which aid their recognition, management or prevention”. This includes the ability to recognise specific disorders, knowing how to seek mental health information, knowledge of risk factors and causes, and knowledge of self treatments and professional help (Francis, 2002:8; Griffiths, 2009:2). Recent studies have shown that mental health knowledge is not a single dimension, but rather represents knowledge and beliefs about mental disorders that emerge from a general pre-existing belief system (Griffiths, 2009:2; Lauber, 2005b:835). According to Angermeyer, Holzinger and Matscinger (2009:225), many studies are done on mental health knowledge, and to increase the community’s knowledge of mental disorders, therefore, many countries introduce study initiatives (Angermeyer & Dietrich, 2005:164; Griffiths, 2009:2). However, few studies on mental health have been done in the community setting (Griffiths, 2009:2).

In this research, it has been noted that mental illness is a common condition, with a life time prevalence of about 40 - 50% in the community. However, only a few people with mental disorders generally receive treatment (Dahlberg, Waern and Runeson 2008:2). Following this, Farrer, Leach, Griffiths, Christensen and Jorn (2008:1) conclude that about 70% of individuals, suffering from mental illness, do not seek help. Additionally, the World Health Organisation (WHO) estimated that 450 million people suffer from mental, or behavioural disorders, of which only a small proportion receives treatment (World Health Organisation report, 2001:23). Hugo, Boshoff, Traut and Stein (2003:715) also reiterate that although there has been increasing advances in psychiatry, the community often has poor mental health knowledge and many people with mental illness may be unaware that effective treatment is available in health facilities. Similarly, inadequate knowledge of mental health problems, even in the

wealthy, developed countries, causes problems because only few people in need of mental health care make use of mental health services (Aroma*a,* Tolvanen, Tuulari and Wahlbeck, 2009:1). Likewise, in developing countries inadequate knowledge of mental illnesses hinders community members to use mental health services (Muga & Jenkins, 2008:470).

In support of the previous authors' literature, studies have shown that better knowledge leads to more favourable attitudes. Angermeyer *et al*. (2009:225) report that there is growing evidence that health literacy has increased in Western countries in recent years. According to these authors, the knowledge of mental health by community members and families has influenced changes in behaviour towards mental illness (Dahlberg *et al*., 2008:2). This is evident in the community becoming more knowledgeable and able to recognise mental disorders (Angermeyer *et al*., 2009:225). In addition, Kabir, Iliyasu, Abubakar and Aliyu (2004:2) conclude from their studies that literacy is significantly associated with positive attitudes towards the mentally ill, whilst the knowledge of the public affects attitudes to mental illness and its treatment, hence facilitating adequate community support. Hocking (2003:47-48) likewise suggests that a better way of combating stigma in the community, is by improving mental health knowledge, by stopping the constant reinforcement of stigma in the media and by encouraging the media to report on mental illness responsibly.

Adding to the opinions of the previous authors, Dahlberg *et al*. (2008:2) assert that knowledge of mental illness has resulted in positive changes in behaviour towards mental illness and its treatment. Hugo *et al*. (2003:716) concur with the previous authors that knowledge of mental health and good attitudes towards people with mental illness, facilitate community support and involvement. Hugo *et al*., (2003:716) agree that community attitudes influence the help seeking behaviour of mental health sufferers, and that a lack of knowledge in diagnosis and management of mental illness, may prevent people with mental disorders from seeking professional help.

Inadequate knowledge thus hinders community members to use mental health services in both developing and developed countries (Muga & Jenkins, 2008:470).

From the above discussion, therefore, it was concluded that the community's knowledge affects attitudes, which in turn influence help seeking behaviour (Lauber, 2005b:835-836).

Contributing to the community's lack of knowledge, it has also been found that the public cannot recognise different types of psychological distress and mental illness, thus influencing treatment negatively (Kitchener & Jorm, 2002:1). This emphasises that a lack of knowledge in the community can lead to negative attitudes towards people suffering from mental illness (Dahlberg *et al*., 2008:2). It is further expected that communities are the essential components in giving primary care for people suffering from mental illness, but often they require knowledge (Pickett-Schenk, Cook, Steigman, Lippincott, Bennett and Grey, 2006:1043). As a result they do not understand many of their relatives' behaviours, such as hostility, apathy and social withdrawal (Pickett-Schenk *et al*., 2006:1043). Communities, in general, therefore provide care without having information about the causes and treatment of mental disorders and without any training concerning symptom management, or on how to approach mental challenges (Pickett-Schenk *et al*., 2006:1043).

Contrary, Kabir *et al*. (2004:2) explain that their studies have revealed that literacy is found to be significantly associated with a positive attitude towards the mentally ill. This positive attitude then improves knowledge and public attitude towards mental illness, as well as improves treatment that facilitates adequate community support, which in turn leads to a higher mental health seeking behaviour. Hocking (2003:47-48) further suggests that a better way of combating stigma in the community is by improving mental health knowledge, by stopping the constant reinforcement of stigma in the media and by encouraging the media to report on mental illness responsibly.

The above thus support the view that communities with sound mental health knowledge and a positive attitude towards mental illness, are motivated to seek professional help, whilst communities with a lack of mental health knowledge and a negative attitude towards mental illness, are less motivated to seek professional help. This research thus aimed at determining the knowledge and attitudes of the Kinondoni community members towards mental illness.

1.2 Statement of the problem

Linking to the previous discussions, the researcher's existing assumptions, as supported by previous research, were that a lack of knowledge in the community and a negative attitude towards mental illness negatively influence health seeking behaviour which leads to chronicity on mental illness. The researcher therefore planned to assess the knowledge and attitudes of the community in Kinondoni municipal area towards mental illness, in order to describe guidelines to assist nurses to improve the knowledge of the community regarding mental illness.

1.3 Significance of the study

No existing research outcomes were found on the community's knowledge and attitudes towards mental illness in Tanzania. It was therefore expected that this study would lead to policy makers to formulate guidelines that would assist in improving the knowledge and attitudes regarding mental illness of the Kinondoni community, which would in turn enhance the health seeking behaviour of this community.

In a similar study, conducted on the community's attitude towards and knowledge of mental illness in South Africa, Hugo *et al*., (2003:715), concurred that more work needed to be done to educate the public about the psychological underpinnings of psychiatric disorders and about the value of effective treatments.

1.4 Research question

What is the knowledge and attitudes of the Kinondoni community towards mental illness?

1.5 Research aim and objectives

1.5.1 Aim

This research aimed at assessing the knowledge and attitudes of the Kinondoni community members towards mental illness.

1.5.2 Objectives

The specific objectives of this research were to determine whether:

- Community members have general knowledge about mental illness
- Stigma of mental illness exist among community members
- There is rejection of people suffering from mental illness
- Community members are aware of existing mental health services in their area.

1.6 Definition of terms

In this section the key concepts are highlighted and discussed. Core concepts, which influenced the context of this research, are highlighted and explained in the broader context of knowledge regarding mental illness. The researcher also emphasises personal experiences in psychiatric nursing throughout these discussions.

1.6.1 Mental health knowledge

Mental health knowledge describes knowledge and beliefs about mental disorders, which aid in their recognition, management, or prevention (Francis,

Pirkins and Dunt, 2002:8). It also includes the ability to recognise specific disorders, knowing how to seek mental health information, having knowledge of risk factors and causes, having knowledge of self treatment and of professional help available, as well as attitudes that promote recognition and appropriate help seeking (Francis *et al*., 2002: 8).

1.6.2 Health

Health, as defined by the World Health Organization (2001:3), “is a state of complete physical, mental and social well-being and not merely absence of disease or infirmity”. Andrew and Henderson (2005:1) revised this definition by adding a spiritual aspect, hence it being a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity.

1.6.3 Mental illness

Mental illness is a clinically significant behavioural or psychological syndrome, associated with distress or impairment in one or more important areas of functioning (Baumann, 2007:720).

Mental illness is defined as a psychiatric illness or disease. Its manifestations are primarily characterised by behavioural or psychological impairment of functioning, measured in terms of a deviation from some normative concept. It is associated with distress or disease, not just an expected response to a particular event, or limited to relations between a person and society (Sadock & Sadock, 2007:279).

Mental illness is also defined as clinically significant conditions, characterised by alterations in thinking, mood (emotions), or behaviour, associated with personal distress and / or impaired functioning (World Health Organization, 2001:21).

Mental illness refers to a group of disorders causing severe disturbances in thinking, feeling, and relating, and resulting in a substantially diminished capacity for coping with the ordinary demands of life (Chapman, Perry and Strine, 2006: 2). It can influence the onset, progression, and outcome of other illnesses and often correlates with health risk behaviours, such as substance abuse, tobacco use, and physical inactivity (Chapman et al., 2006: 2).

1.7 Chapters of the thesis

Chapter 1 Introduction and overview of the research

Chapter 2 Literature review

Chapter 3 Research methodology

Chapter 4 Realisation of the research and interpretation of the research findings

Chapter 5 Conclusions and recommendations of the research

1.8 Summary

This chapter has given an overview of the proposed study. It has been shown that better knowledge should lead to more constructive attitudes and changes in behaviour towards mental illness (Angermeyer *et al*., 2009:225). Contrary, inadequate knowledge hinders community members to use mental health services in both developing and developed countries (Muga & Jenkins, 2008:470).

Many studies suggest that lay people generally have a poor knowledge of mental illness and tend to have views that differ from professionals about the ability to recognise specific disorders or different types of psychological distress, knowledge and beliefs of risk factors and causes, knowledge and attitudes about self-help interventions, knowledge and attitudes about professional help

available, attitudes that facilitate recognition and appropriate help seeking, and knowledge on how to seek mental health information.

This study was undertaken with the expectation that information from this study would significantly contribute towards the improved knowledge and positive attitudes of the Kinondoni community members regarding mental health care.

The following chapter will discuss the literature review undertaken during this study.

CHAPTER TWO

Literature review

2.1 Introduction

In this chapter the outcomes of the literature review regarding the knowledge and attitudes of communities, generally and in Tanzania, towards mental illness and the influence thereof on health seeking behaviour, are discussed. As per Burns and Grove (2007:135-138), a literature review provides knowledge about theories and scientific knowledge of a particular problem and ends up with what is known and what is not known. Knowledge of the community is therefore important, because this knowledge facilitates prevention, early recognition and intervention, and a reduction of stigmas, associated with mental illness, according to Bourget and Chenier (2007:7).

This literature review, regarding the gaining of knowledge on mental illness, was conducted by searching the computerised data-bases, websites, journal articles and books at the Medical Library at Stellenbosch University.

The literature review is discussed under the following headings: rationale for the literature review, health knowledge and mental health knowledge, prevalence of mental illness, the community's knowledge and attitude towards mental illness in Tanzania, process of facilitating mental health knowledge in the community, knowledge about causes of mental illness, attitudes towards mental illness, attitudes related to health seeking behaviour, the role of media, the role of community, knowledge and attitudes towards mental illness and behavioural change, influence of mental health knowledge on community support, community's knowledge and attitude towards the treatment of mental illness, and consequences of a lack of knowledge and negative attitudes.

2.2 Rationale for the literature review

A literature review should assist the researcher to refine the research topic, and identify gaps to enrich the planned research, by using outcomes from existing research to further develop the proposed study (De Vos, 2005:124). Therefore, a literature review should be executed before, after and during the study, to build on existing research, to confirm a scientific process and to weigh against the discussion of the findings of this research (De Vos, 2005:124).

However, in this study, the purpose of the literature review was to give a clear understanding of the nature and meaning of the problem that had been identified, to provide sources for selecting or focusing on the topic, in order to reduce the chances of selecting an irrelevant topic, and to save time and avoid duplication and unnecessary repetition (De Vos, 2005:123). In addition, the literature review was done to identify deficiencies in previous research and to fill a proven need, and to demonstrate the underlying assumptions of the general research question (De Vos, 2005:124).

Most importantly, this literature review aimed at contributing towards the improvement of mental health knowledge and attitudes of members of the Kinondoni community in Tanzania.

2.3 Health knowledge and mental health knowledge

In this section, the core concepts which influenced the context of this research are clarified and explained, including the historical review of health knowledge and mental health knowledge.

Many studies have found a connection between health literacy and health knowledge (Mamo, 2007:399). Health literacy is the degree to which individuals have the capacity to obtain processes and understand basic health information and services needed to make appropriate health decisions (North Carolina Institute of Medicine, 2003:15). Originally, health literacy was defined as a

functional capacity, in terms of basic capacity skills and how these affect the ability of people to access and use health information.

Health literacy is recognised by the World Health Organization as an important aspect of health promotion and may be defined as the personal, cognitive and social skills, which determine the ability of individuals to gain access to understand and use information to promote and maintain good health (Francis *et al*., 2002:8).

The concept of health knowledge means more than being able to read and write. It also includes the broader skills needed to function in a health care environment (Francis *et al*., 2002:8).

Mental health knowledge describes knowledge and beliefs about mental disorders, which aid in their recognition, management, or prevention (Francis *et al*., 2002:8). This also includes the ability to recognise specific disorders, knowing how to seek mental health information, knowledge of risk factors and causes, knowledge of self treatment and of professional help available, and attitudes that promote recognition and appropriate health seeking (Francis *et al*., 2002:8). Mental health literacy encompasses an individual's knowledge and beliefs about mental illness whilst poor mental health literacy often represents a powerful barrier to treatment (Mamo, 2008:399).

2.4 Prevalence of mental illness

The prevalence of mental illness is discussed, highlighted and explained in this section, in order to emphasise the extent of the problem of mental illness. This section also focuses on the development of guidelines to assist nurses to help in improving the knowledge of the community regarding mental illness.

A study that was done in the United States in 2000 and 2003, indicated that nearly half of Americans (46.4%) reported meeting criteria at some point in their life for either DSM–IV anxiety disorder (28.8%), mood disorder (20.8%), impulse-control disorder (24.8%), or substance use disorders (14.6%) (Media

Wiki, 2007:10). Another study, done in 2004 across Europe, found that approximately one in four people reported meeting criteria at some point in their life for one of the mood disorders (13.9%), anxiety disorders (13.6%), or alcohol disorder (5.2%) (Media Wiki, 2007:11).

In Tanzania the exact prevalence of mental illness is unknown, but various researchers have scientifically estimated the prevalence. According to Modest (2008:2), mentally ill patients have tripled from 31,238 in 2001 to 97,570 in 2007, and it was estimated that there were 2.5 million people with mental illnesses in Tanzania in 2008. The same author is of the opinion that about 30 to 50% of adults would experience a mental illness, of which 50% of them would experience moderate to severe symptoms (Modest, 2008:2).

2.5 The community's knowledge and attitudes towards mental illness

The purpose of this research was to determine the community's knowledge and attitudes towards mental illness in Tanzania. In this section the researcher introduces and contextualizes the research.

According to a similar study done in Australia in 1995, it became clear that when there was an increase in awareness and knowledge about recognition of depression, specifically (Highet *et al*., 2005:54-57; Jorm *et al*., 2006:4), the community myths towards mental illness reduced and the health beliefs started matching those of health professionals (Jorm *et al*., 2006:4; Jorm *et al*., 2005:877).

Negative views, such as those implying that people with mental illness are irresponsible and therefore incapable of making their own decisions, are widespread, and negative beliefs often lead to discrimination (Gureje, Lasebikan, Ephraim-Oluwanuga, Olley and Kola, 2005:1). Although no information exists on how widespread negative attitudes towards mental illness in communities are (Kabir *et al*., 2004:2). These attitudes lead to discrimination in many areas, including the workplace and households. Family and friends can

also contribute towards discrimination, *via* anticipated and actual discrimination (Angemeyer, 2004:1), and therefore internalised stigmas can decrease life satisfaction and self-esteem of the mentally ill (Read, Haslam, Sayce and Davies., 2006:304).

Negative attitudes of the community about mental illness present problems for those who are suffering from psychological disorders (Lipczynska, 2005:1). Gureje *et al.* (2005:436), based on studies conducted in North America and Western Europe, suggest that stigmatisation is a major problem in the community. According to Mehta, Kassam, Leese, Butter and Thornicroft, (2009:278), prejudice and discrimination by the community against people with mental illness are common, are deeply socially damaging and are a part of more widespread stigmatisation.

Mehta *et al*. (2009:278) further state that stigmas against people with mental illness can contribute to negative outcomes, as well as perpetuating self-stigmatisation and contributing to a low self-esteem. Stigmas interfere with the right of people to participate fully in the community, because they are living in the difficult situation of rejection and exclusion (Gureje *et al.* (2005:436-437). Furthermore, in many circumstances people, suffering from mental illness, have no opportunities of having adequate housing, loans, health insurance and jobs (Gureje *et al.* (2005:437).

Studies on stigmatisation in the community have shown that people with mental illness have decided to stop taking treatment, isolated themselves from loved ones, or have given up on the things they wanted to do, because of discrimination. 40% of people with mental illness in South Africa have said that they didn't socialise, because negative stereotypes kept them isolated (Norman *et al*., 2008:852).

Another common misconception about people with mental illness is that they cannot live independently, let alone make significant contributions to the community (Norman *et al*., 2008:851). Throughout history, however, people with serious mental illness have contributed enormously to societies in terms of

politics, culture, academic life, athletics, business, art and science. People with mental illness have been leaders and visionaries, both enriching and expanding our knowledge and understanding in every arena (Read et al., 2006:304).

Recent studies on mental health literacy in Australia have shown that the public are not well informed about mental illness. It is thus important that the level of mental health literacy in the community be improved, in order for individuals to recognize mental illness and manage their own mental health more effectively (Francis *et al*., 2002:4).

2.6 Process of facilitating mental health knowledge in the community

In this section the process, which facilitates the community's ability to recognize mental illness, is explained.

Some community surveys in a number of countries have shown poor recognition of mental disorders and beliefs about treatment (Mamo, 2008:399). Although people distinguish abnormal from normal behaviour at a relatively satisfactory level, the recognition of a particular diagnosis is poor (Lauber *et al*., 2005:835). Surveys in several countries have found that members of the community do not correctly recognize disorders (Jorm *et al*., 2000:1). Also, an Australian survey on mental health literacy showed that many people could not give the correct psychiatric label to a disorder portrayed in a depression or schizophrenia vignette (Jorm *et al*., 2006:4; Jorm *et al*., 2005:878). In addition, a survey of the Australian population revealed that most people did not view mental disorders as health problems and when asked specifically to name mental health problems, depression was the most common response, followed by anxiety / stress (Highet *et al*., 2002:1).

Recognition of mental illness has improved somewhat in Australia following implementation of initiatives to improve mental health knowledge. However, researchers still believe that there is room for improvement (Jorm, Mackinnon,

Christensen and Griffiths, 2005:877; Jorm, Barney, Christensen, Highet, Kelly and Kitchener, 2006:143).

It is not clear what exactly influences recognition, but people who have had contact with people who have been depressed, are more likely to identify depression as an illness (Lauber, Nordt, Falcato and Rossler, 2003:3). Contrary, it is believed that age and gender may also play a role. The ability to correctly recognize and label depression in a vignette appeared to be higher in younger people and in women (Highet *et al*., 2002:1; Fisher & Goldney, 2003:34).

2.7 Community Knowledge about causes of mental illness

This section describes various beliefs in the community regarding causes of mental illness, based on studies being done in various countries.

Several studies have found that many members of communities lack knowledge about mental illness, especially with respect to beliefs about causes thereof (Jorm *et al*., 2006:143). Some believe that psychiatric illness is not a disease, but a curse that is caused by witchcraft and evil spirits (Stephen and Andreas, 2008:367-393). Elise (2006:1-2) agrees that traditional communities believe that the mentally ill are caused by spirits and curses, with influences by the moon, or that it is a divine punishment. Elise (2006:1-2) reiterates that beliefs of this nature keep the stigma and discrimination alive.

Studies have shown that beliefs about causes may alter patterns of help seeking and responses to treatment. For example, in Malaysia beliefs by psychiatric patients in supernatural causes were associated with greater use of traditional healers and poorer compliance with medication (Jorm, 2000:397). Therefore, negative beliefs about causes and lack of adequate knowledge have been found to sustain deep seated negative attitudes about mental illness (Gureje, Olley, Ephraim-Oluwanuga and Kola, 2006:107). Conversely, better knowledge has often been reported to result in improved attitudes towards

people with mental illness and a belief that mental illnesses are treatable, can encourage early treatment seeking, and promote better outcomes (Gureje *et al*., 2006:107).

According to Lauber (2003:5), misconception, from a religious perspective, about mental illness may include that it is caused by sin, since the deliberate breaking of God's commandments indeed results in such behaviour that is hurtful to self and to others.

Studies have shown that in the Western world, mental illnesses are generally thought to be caused by psychosocial factors, such as environmental stressors, or childhood events. Biochemical and genetic influences, although recognized as causal factors, are not considered as important as environmental ones (Jorm, 2000:397). Some studies suggest that serious mental illnesses, such as schizophrenia, are more likely to be linked to genetic causal factors, compared to common mental disorders, such as depression (Jorm, 2000:397).

According to Gill (2005:1), causes of mental illness is not synonymous, but varies widely, from inherited chemical imbalances responsible for the development of such illnesses as depression, bipolar disorder, and schizophrenia, to brain diseases, to causes that are more immediately under our control. Improved knowledge about causes may lead to improved overall knowledge about mental illness and promote supportive attitudes to the mentally ill (Gureje *et al*., 2006:105).

In a survey of 1,596 Japanese, it was found that the most frequently cited cause was problems in interpersonal relationships (Tanaka, Ogawa, Inadomi, Kikuchi and Ohta, 2005:96-101). Similarly, in a survey of South Africans (55% Afrikaans speaking), 83% stated that schizophrenia was caused by psychosocial stress (difficulties in work or family relationships, or stressful life events), whilst only 42.5% thought it was a medical disorder (brain disease, heredity, constitutional weakness) (Hugo *et al*., 2003:715-719).

Across cultures, knowledge about the causes of mental illness varies and has never been very favourable, worldwide (Issa, Parakoyi, Yussuf and Musa, 2008:43). This has been acknowledged by the World Health Organization that has called for greater education of the public and greater openness about mental illness (Issa *et al*., 2008:43).

2.8 Community attitudes towards mental illnesses

In this section the researcher explains how knowledge can influence attitudes towards mental illness in the community.

Studies have shown that poor knowledge about mental illness and negative attitudes towards people with mental illness are widespread in the general public (Nordt, Rossler and Lauber, 2006:709). Negative attitudes and discriminating behaviours towards people with mental illnesses are often referred to as stigmas. Stigmas involve negative stereotypes and prejudices and are often measured in terms of social distance (Watson *et al*., 2002:22-23; Lauber *et al*., 2004:266). The stigmatizing of mental illnesses remains pervasive and problematic and often results in active discrimination (Stuart, 2005:22). This is of concern for a number of reasons. People may as a result be reluctant to seek treatment for or disclose mental health problems, even common forms of anxiety and depression, for fear of social rejection and discrimination, or may discontinue treatment (Watson & Corrigan, 2002:22).

It has also been suggested that having a medical understanding of a mental disorder increases negative attitudes, because the disorder is then viewed as inherent and chronic (Lauber *et al*., 2004:266). Also, according to Lauber *et al*. (2004:266), having a medical understanding of mental illness, identifying the person in the vignette as being ill and having a positive attitude towards medical treatment, increase social distance.

2.9 Attitudes related to help seeking behaviour

According to Dahlberg *et al*. (2008:2), help seeking behaviour is complex; therefore the extent of contact treatment differs among mental disorders.

Among high prevalence disorders, panic and mood disorders have the highest rates of contact treatment, while alcohol related disorders have the lowest rates (Dahlberg *et al*., 2008:2). Numerous studies have shown that a minority of people with mental health problems seek professional help (Jorm, 2000:397; Watson & Corrigan, 2002:3). Even in the wealthy, developed countries, only a minority of people in need of mental health care will make use of mental health services (Aromaa *et al*., 2009:1). The prevalence of mental disorders means that most people will have close contact with someone with a mental health problem at some point, but many of them lack the knowledge and skills to provide helpful responses (Jorm *et al*., 2005:877-878; Jorm *et al*., 2007:5).

Research has shown that it is now well recognised that up to 70% of individuals with mental health disorders do not seek help (Farrer *et al*., 2008:1). Furthermore, it has been argued that help seeking should improve with better recognition and labelling of mental disorders, an increased understanding of the causes and treatments of mental health problems and a belief in the rationale for treatment approaches (Farrer *et al*., 2008:1). The advantages of early help seeking have been clearly articulated, with early help seeking providing the opportunity for early intervention and improved long-term outcomes for mental disorders (Farrer *et al*., 2008:1).

However, in practice, professional help is often not sought at all, or only sought after a delay. Early recognition and appropriate help seeking will only occur if mentally ill patients and their "supporters" (e.g. their family, teachers, and friends) know about the early changes produced by mental disorders, the best types of help available, and how to access this help (Dahlberg *et al*., 2008:3).

Studies have found that people with depression are reluctant to seek professional help, with estimates indicating that over half of people with major depression in the community do not consult a health professional (Barney, Griffiths, Jorm and Christensen, 2006:51). According to recent research, this reluctance is most evident with respect to help seeking from mental health professionals (Barney *et al*., 2006:51). Angermeyer and Matschinger (2001:220)

support and have come to a similar conclusion, following a study of attitudes towards help seeking among the German population.

Past studies on help seeking behaviour among the mentally ill have mainly focused on the examination of individual and structural determinants (Angemeyer, 2001:220). The impact of the socio-cultural context has been largely neglected. However, attitudes and belief systems, as transmitted by family, kinship and friendship networks, influence the manner in which an individual defines and acts upon symptoms and life crises (Angemeyer, 2001:220). Furthermore, community attitudes and beliefs play a role in determining help seeking behaviour and successful treatment of the mentally ill. Moreover, mental health literacy is an important determinant of help seeking behaviour (Lauber *et al*., 2005:2). Inarguably, ignorance and stigmas prevent the mentally ill from seeking appropriate help (Kabir, 2004:2).

2.10 The role of the media

In this section the researcher explains the role of the media and shows the relationship between the media and personal attitudes, because the media has been found to increase psychological distress and fear of stigmas among people with mental illnesses, which influence knowledge and health seeking behaviour (Stuart, 2005:22).

The media can play a significant role in any movement for change and in determining community attitudes towards mental illness (Hocking, 2003:2). On the other hand, the media can play a huge role in creating misconceptions about mental illness (Joshua, 2004:5). The way they are portrayed in magazines, newsletters, television and in movies, the mentally ill act as destructive, aggressive, and crazy and have nothing to contribute towards families, nor to the community (Joshua, 2004:5). Moreover, media has been seen as the major cause of distress to the mentally ill, and to families and friends of people with a mental illness. Trainor and Pierri (2008:2) state that movies and television often portray the individual, suffering from mental illness, as unpredictable and violent. Again, media scripts show people with mental

illness that they should be feared, because they have been seen as homicidal maniacs (Trainor & Pierri, 2008:2).

According to Hocking (2003:47), it has been specifically noted that information and broadcasting media, such as television, movies and newspapers, portray people, suffering from mental illness, in an unfavourable and incurable manner, because they don't have enough knowledge. In doing so, they prepare society's mind to be sensitive and to look at the mentally ill as dangerous, or out of control (Hocking, 2003:47). Popular movies about killers with mental health issues and some magazines show the coverage of tragedies and violence caused by people with mental health issues (Patrick & Amy, 2002:3). Patrick and Amy (2002:3) add that jokes about people with mental illnesses, distort the community's perception about mental illness. People with mental illnesses are often characterised as unpredictable, dangerous, or violent in films, television and the print media (Stuart, 2003:22).

According to the Centre for Addiction and Mental Health (2001:1), some people learn what they know about mental illness from the mass media. Communities are daily exposed to radio, television and newspapers that present people with mental illness as violent, criminal, dangerous, comical, incompetent and fundamentally different from other people in the respective area (Corrigan & Watson, 2002:18*).* These inaccurate images show unfavorable stereotypes, which can lead to the rejection and neglect of people with psychiatric disorders (Karine, 2000:1-2).

Commonly, misconceptions of people with mental illness include the following: People with mental illness are all potentially violent and dangerous, they are somehow responsible for their condition, and they have nothing positive to contribute (Mehta *et al*., 2009:278).

There are many negative stereotypes about mental illness, including those just mentioned (Byrne, 2000:66). These misconceptions have a direct impact on attitudes towards people with mental illness, in that they result in discriminatory behaviours and practices. These stereotypes lead to expectations that people

with mental illness will fail when looking for a job, living independently, or building long-term relationships (Karine, 2000:1-2).

2.11 The role of the community

In this section the researcher explains the role of the community towards people with mental illness. It has been found during community surveys that community members have a potentially important role to play in supporting people with mental disorders and deficiencies in mental health literacy (Kabir *et al*., 2002:2). Furthermore, members of the community have a high probability of having contact with someone who has a mental disorder and they require knowledge and skills to provide support to these people (Jorm *et al*., 2006:143).

However, community surveys on mental health literacy in a variety of countries have found that many members of the community lack knowledge about mental disorders, they do not correctly recognize specific disorders, have negative attitudes about treatments, have basic beliefs about causes, and frequently hold stigmatizing attitudes (Lauber *et al*., 2004:266).

During a survey done in Sweden, it was found that the community has had difficulty in dealing with people with mental disorders, saying that they did not know how to behave, were afraid of making mistakes and did not have sufficient knowledge (Jorm *et al*., 2006:142).

This lack of mental health literacy and support skills could have an effect on help seeking and outcomes of people with mental disorders (Gureje *et al*., 2006:105). Family and friends are seen by the community as the most important sources of help for a person with a mental disorder (Jorm *et al*., 2005:15).

According to Jorm *et al*. (2006:142), good social support is known to be a predictor of better outcomes and may reduce risk of self-harm. During this study they found that the reason for the mentally ill patient for not seeking professional help for depression was a belief that others would have a negative reaction (Barney *et al*., 2006:51). Therefore, once professional help is sought,

relatives and friends can influence attitudes and adherence to treatment (Jorm *et al*., 2006:142).

2.12 Knowledge and attitudes towards mental illness and behavioural change

2.12.1 The effect of adequate knowledge

Better knowledge has often been reported to result in improved community attitudes towards people with mental illness, whilst beliefs that mental illness are treatable, can encourage early treatment seeking and promote better outcomes (Gureje *et al*., 2006:2). It is a widely shared belief that an increase in the community's mental health literacy should result in an improvement of attitudes towards people with mental illness. More recently, community attitudes in some countries have changed as a result of initiatives to improve the community's mental health literacy, and in becoming more like those of professionals.

However, the prevailing attitudes towards seeking professional help for such problems and to what extent these beliefs actually influence service use for mental health problems are unknown (Kabir *et al*., 2004:2). Studies that were performed in the USA and Canada found that prior experience with the mental health care system was associated with a more positive attitude towards help seeking (Alonso, 2005:2). Matthias, Angermeyer, and Matschinger, (2005:1) also conclude that improved knowledge, attitudes and behaviour show the strongest evidence for effective interventions at present, than is direct social contact with people with mental illness at the individual level, and social marketing at the population level (Thornicroft, Brohan, Kassam and Lewis-Holmes, 2008:1).

2.12.2 The effect of inadequate knowledge

Inadequate mental health literacy is said to be problematic, because inadequate knowledge is associated with delays in treatment seeking, decreased levels of

treatment seeking, and utilization of non-optimal treatments (Mamo, 2007:1). Inadequate knowledge about mental illness and negative attitudes towards people with mental illness are widespread in the general community (Nordt, 2006:709). Although the mental health literacy definition, namely it being the knowledge and beliefs about mental disorders, is not questioned, negative stereotypes and stigmatizing attitudes of mental health professionals towards people with mental illness are a controversial issue (Nordt, 2006:709).

Studies of mental health literacy in Australia have shown that these communities were not very well informed about mental illness. A survey conducted in 2001 showed that 90% of respondents believed that mental health was a significant issue in Australia, but overall, respondents did not have a clear understanding of mental illness (Francis *et al*., 2002:8-9). Several studies revealed inadequate knowledge about mental illness among the general population and stigmatizing attitudes towards people with mental illness (Nordt, 2006:709). However, it has not been determined whether mental health professionals held fewer stigmatizing attitudes than the general population (Nordt *et al*., 2006:709).

Another consequence of poor mental health literacy is that the task of preventing and helping mental disorders is largely confined to professionals. However, the prevalence of mental disorders is so high that the mental health workforce cannot help everyone affected and tends to focus on those with severe and chronic problems (Jorm, 2000:399). Inadequate knowledge and negative attitudes have been seen as factors limiting help seeking and such negative attitudes can involve self stigmatization, in which a person has internalized the negative attitudes held by society and applied these to him- / herself (Jorm *et al*., 2006:142). This attitude reduces the likelihood of a person who is depressed to seek professional help (Jorm *et al*., 2006:142; Barney *et al*., 2006:51).

2.13 Influence of mental health knowledge on community support

In this section the researcher explains the influence of mental health knowledge towards community support of people with mental illness.

There is growing evidence that mental health literacy has increased in Western countries in recent years. Studies from the USA, Australia and Germany have shown that the community has become more able to recognize mental disorders and that better knowledge has led to more favourable attitudes, as demonstrated by a number of anti-stigma campaigns (Crisp, Gelder, Rix, Meltzer and Rowlands, 2004:1; Sartorius, 2005:4). However, this assumption has been challenged by findings from recently conducted population studies, indicating that the community's knowledge about mental disorders and its attitudes towards people, suffering from these disorders, may be unrelated, or even inversely related (Lauber, 2004:266; Angermeyer *et al*., 2009:225). It is a widely shared belief that an increase in the community's mental health literacy (Jorm, 2000:396) should result in an improvement of attitudes towards people with mental illness. However, while surveys of community beliefs have been carried out in a number of countries, little is known about cross-cultural differences in mental health literacy (Jorm *et al*., 2005:15).

2.14 Community's knowledge and attitudes towards the treatment of mental illnesses

This section compares the attitudes of communities towards mental health treatment in countries being studied.

It has been concluded that Canadians are more inclined to recommend medical help for symptoms of mental disorders. However, they are still somewhat ambivalent about medical care, especially with regards to common mental health problems and with regards to psychiatric medications (Bourget and Chanier, 2007:5).

What the community believes about mental illness and the effectiveness of modern health services in managing mental illness, would influence health

seeking behaviour (Muga & Jenkins, 2008:470). The level of mental health literacy within a community underpins its ability to develop the structures to promote mental health, prevent mental illness, recognise and respond early to mental health problems and mental disorders (International Union for Health Promotion and Education, 1999: 2).

2.15 The consequences of a lack of knowledge and negative attitudes

In this section the researcher explains how a lack of knowledge and negative attitudes can influence behaviour towards mental illness in the community.

A lack of mental health literacy can limit the optimal use of treatment services (Jorm *et al*., 2005:1). Community knowledge of mental health problems has been found to be inadequate, whilst this lack of knowledge is a fertile soil for developing negative behaviour towards mental illness. Furthermore, although the community believes in self-help and support from family and friends and in psychotherapy, the community's attitudes towards medical treatment are suspicious (Aromaa *et al*., 2009:1-2).

Poor mental health literacy in the community leads to delays in recognition and help seeking, hinders community acceptance of evidence based mental health care, and causes people with mental disorders to be denied effective self-help and appropriate support from others in the community (Kitchener & Jorm, 2002:1).

The community's mental health literacy has been found to be still unsatisfactory and needs to be improved, in order not to hinder community support (Angermeyer *et al*., 2006:2). People with mental illnesses are often stigmatised, due to a lack of knowledge about their illness (Lauber *et al*., 2005:835). The general community has been the main target of these endeavours, because its mental health literacy, i.e. the knowledge and beliefs about mental disorders and the awareness of the different treatment options, has been repeatedly shown to be low (Lauber *et al*., 2005:835).

Inadequate knowledge about mental illness, its symptoms and possible treatment approaches are negatively associated with health care use (Lauber *et al*., 2005:835). However, it is unclear what level of mental health literacy can be expected from the general population (Lauber *et al*., 2005:835). Increasing the community's knowledge of mental health problems may remain insufficient, if negative stereotypical beliefs prevail in society (Aromaa *et al*., 2009:1-2).

In Egypt, as elsewhere, one of the most commonly cited reasons for the under utilization of available psychiatric services by the lay community was the notion of stigmatization (Hani & Tamer, 2009:3). Stigmatization is thus an important obstacle in the provision of mental health care for people with mental disorders (Norman *et al*., 2008:851).

Negative reactions towards those with mental illnesses are thought to contribute towards delays in help seeking, as well as placing many individuals, who have received psychiatric treatment, at a disadvantage with regards to community support and involvement (Norman, Sorrentino, Windell and Manchanda, 2008:851). The stigma that goes along with mental illness acts as a serious barrier to individuals seeking mental health treatment (Teachman, Wilson and Komarovskaya, 2006:1). Stigmatising attitudes towards mental illness are reinforced by a lack of knowledge, and it would seem logical to tackle this from the earliest possible age (Shaha, 2004:213).

Inarguably, ignorance and stigma prevent the mentally ill from seeking appropriate help (Kabir *et al*., 2004:2). Researchers have often assessed stigma, associated with mental illness, by surveying the community's attitudes towards "mental patients", or "persons with mental illness", and in using these terms, evoking images of chronic psychopathology (Corrigan *et al*., 2001:1).

People's beliefs regarding mental illness should not only be known, but the purpose of their beliefs should be understood. Such attitudes and beliefs about mental illness can only be studied within a cultural context (Adebowale & Ogunlesi, 1999:1). To date, there has been no research on community attitudes towards mental illness from Beni Suef Governorate, a culturally distinct part of

the country of Tanzania, having different customs and traditions. Mental health educational programs should be advocated to the community to promote positively mental health. (Hani & Tamer, 2009:3).

2.16 Summary

In this chapter it became evident that mental health knowledge encompasses an individual's knowledge and beliefs about mental illness whilst poor mental health literacy often represents a powerful barrier to treatment. It is found that mental health knowledge influences health seeking behaviour of the mentally ill individuals whilst poor knowledge hindered the community members to use mental health services in both developing and developed countries towards people with mental illnesses.

In addition, there is a need to initiate of educational programs focused on the community, on nursing education and on clinical practices, as well as on recommendations for further research that would be important for the nursing practice and the community as a whole. This chapter presented the literature review used in this research. In the following chapter the researcher discuses the methodology used in this study.

CHAPTER THREE

Research Methodology

3.1 Introduction

This chapter describes the research design and methodology that were used during this study; including population, sample, reliability and validity, data collection, data analysis, data collection instruments, pilot study and ethical considerations.

The purpose of this chapter was to explain the research design and the methodology that was applied to determine the knowledge and attitudes of the Kinondoni community members towards mental illness in this municipal area in Tanzania. This study included interrelated processes to achieve the objectives

During this phase, the researcher formulated the purpose and objectives of the study, as well as the research question that guided this research. The researcher also conducted a literature review and selected a research design and methodology. The context of this study was identified as four divisions in the Kinondoni municipal area in Tanzania.

After that, the researcher selected the sample, using inclusion criteria, and conducted a pilot study to test and refine the questionnaire and to ensure the validity and reliability of the questionnaire. The researcher upheld ethical considerations throughout the study.

Finally the researcher involved data analysis and interpretation, presentation of the findings and making recommendations for practice and further research, based on the findings.

3.2 Methodology

3.2.1 Research design

In this section the researcher describes the methodology that was used to undertake this research project. The research methodology focused on the research process and the kinds of tools and procedure to be used (Mouton, 2001:56).

The research design is the blueprint of a study and its purpose is to maximise control over factors that can interfere with the validity of the findings (Burns & Grove, 2007:237). It focuses on the end product, the point of departure and the logic of the research (Mouton, 2001:56). It also aids in making an informed choice, suited to the particular research goal and objectives (De Vos *et al*., 2008:132).

Therefore, for the purpose of this study, the research design was descriptive cross-sectional survey with a quantitative approach which enabled the researcher to determine the community's knowledge and attitudes towards mental illness.

3.2.2 Population, study area and sampling

3.2.2.1 Population

The population, for the purpose of this study, included all people aged 18 years and above at the Kinondoni municipal area in Tanzania.

3.2.2.2 Study area

The study area refers to the place where the research data is collected (Brink, 2006:64).

This study was conducted in the community of Kinondoni municipal area, which comprises of four (4) divisions namely, Magomeni, Kinondoni, Kibamba and Kawe. These divisions are further divided into twenty seven (27) wards, which are again sub-divided into villages in the rural areas and sub-wards in the urban areas.

The researcher obtained the necessary permission to conduct this study from the Kinondoni Municipal Director (annexure 1).

3.2.2.3 Sampling

The sample in a study is the set of persons who meet the sampling criteria (Burns & Grove, 2007:324). Sampling involves the process of selecting a group of people, events, behaviour, or other elements, which enables the researcher to conduct a study (Burns & Grove, 2007:324). In order to generalize from the sample to the population, the sample has to be representative of the population to ensure that representation of population from sub-groups is better, and that a stratified, random sampling procedure is used (Hopkins, 2000:4).

The sample was stratified according to the four (4) Kinondoni divisions namely, Magomeni, Kinondoni, Kibamba and Kawe. The researcher selected a random sample for each stratum (division), equivalent to the target population proportions of that stratum (Burns & Grove: 2007:333), whilst an equal number of participants were selected for each stratum, according to the wards. Table 3.1 below shows the stratification for the different divisions and wards within the Kinondoni community area.

Table 3.1: Divisions and wards in Kinondoni municipal area

DIVISION	NUMBER OF WARDS	POPULATION
Magomeni	8	369,651

Kibamba	4	125,444
Kawe	6	262,545
Kinondoni	9	331,227

The sample size for the quantitative aspect of this research was determined as per the statistician's advice. It had been noted that the coverage of a total population was seldom possible and that all members of the population could not possibly be reached, as the population may be too large to study, or due to a possible lack of resources and time to perform the study (De Vos, 2008:194-195).

Following this, only a portion of the study population was studied, i.e. a sample. During this research the population was divided into four strata, according to the four Kinondoni divisions, whereby the wards were selected randomly, according to the principles governing the table of random digits to get a sample size (De Vos, 2008:199). Following the above discussion participants were then selected using systematic random sampling whereby, the researcher had to select participants from every second household. In households where there were many people, one who volunteered to participate and meets the inclusion criteria was selected.

The statistician was thus consulted with regards to the number of participants to be selected for this research, in order to reach the sample size.

A total sample size of 204 respondents was required in order to estimate the proportion of the community having adequate knowledge of mental illness, within a precision of ± 5.5% (95% confidence interval). The statistician used a computerised formula to determine the sample size of 204 as drawn from the total population of 1,088,867. This sample was potentially inflated by a factor of 1.1 to allow for potentially non-responsive respondents, giving a total figure of 224 individuals. The researcher was advised by the statistician to increase the sample size to 300 individuals. Thereafter, the proportionality factorization was

used to determine the sample size per division having being inflated. For example; Magomeni division with the total population of 369,651 had to have sample size of 102, with this baseline, Kinondoni division proportionally gave 91 participants and hence Kibamba and Kawe gave 35 and 72 respectively. Based on the above calculations and advice, the sample size was divided as per table 3.2 below:

Table 3.2: Divisions, populations and sample sizes in Kinondoni municipal area

DIVISION	POPULATION	SAMPLE SIZE
Magomeni	369,651	102
Kibamba	125,444	35
Kawe	262,545	72
Kinondoni	331,227	91

In this study, the researcher used the separate variance formula of t-test to answer the question (De Vos, 2008:243). This was achieved by the number of participants from each division and the variances among them throughout the Kinondoni municipal area.

3.2.3 Inclusion criteria

Persons were included in the sample based of the following criteria:

- Community members were residing in the Kinondoni municipal area;

- Community members were randomly selected and agreed to participate; and
- All community members were aged from 18 years and above.

The participants at the division level selected by using simple random sampling, of which table of random numbers was used (Burns & Grove: 2007:332), The researcher places a pencil on table with eyes closed, that the number was the starting place. Then, by using a pencil up, down, right or left, numbers was identified in order until the desired sample size was obtained.

3.2.4 Pilot study

A pilot study is a small scale study, using a small sample of the population. The purpose of the pilot study is to provide a miniature trial run of the methodology being planned for the major project. It provides an opportunity to refine or adjust methods and instruments, to acquaint research assistants with the instruments, respondents and analysis of data, and to identify the action of intervening variables so that they can be eliminated (De Vos, 2008:206).

The pilot study was also conducted in the Kinondoni municipal area and participants in this pilot study would not again participate in the main study. Data collection was done with the support of four research assistants, who had been selected and trained by the researcher on how to collect data. These assistants also helped with the data collection during the main research. The sample size for the pilot study was 10% (30 participants) of the sample size of the main study. The participants for the pilot study selected as in main study.

During this study the researcher conducted a pilot study in order to:

- Evaluate the time needed for completion of the questionnaire;
- Determine whether the questions were correct, clear and understandable;
- Eliminate difficulties in the wording and phrasing of the questions; and
- Give the researcher and assistants experience in administering the questionnaire and in dealing with participants.

3.2.5 Instrumentation

A research instrument, according to Brink (2006:154), refers to the devices used to collect data, such as questionnaires, tests and checklists.

A questionnaire, as defined by the New Dictionary of Social Work (1995:51 as in De Vos *et al*., 2005:166) is “a set of questions on a form which is completed by the respondents in respect of a research project”. In addition, the objective of a questionnaire is to obtain facts and opinions about a phenomenon from people who are informed on the particular issue (De Vos *et al*., 2008:166).

According to Brink (2006:153), as a data collection instrument, questionnaires have important advantages, which include:

- Time saving and the collection of a lot of information;
- Provide personal information that can be easier to analyze;
- They ensure anonymity during data collection, since the findings cannot be linked to respondents; and
- The format of a questionnaire is standardized and does not depend on the mood of the researcher.

For the purpose of this study, an existing questionnaire which was posted in the internet was free to use and therefore it was adjusted and employed to collect data. The questionnaire was also used for the purpose of assessing the knowledge and attitudes of participants towards mental illness and was employed as a guide for the development of a questionnaire that would be applicable to this study and its context. Hence, it was adjusted to suit the needs of assessing the knowledge and attitudes towards mental illness of Kinondoni community members. Fifty (50) questions were adjusted from the office of institutional research and planning, University of South Florida, spring 1999 and Ng and Chan, (2000) a modified version of the questionnaire, opinions about mental illness in the Chinese Community.

This questionnaire consisted of three sections with close-ended questions. Section A collected the socio-demographic information. Section B tested the knowledge of community members in respect of the disease itself and its causes. Section C determined the attitudes of community members towards mental illness.

The adjusted questionnaire consisted of closed ended questions that were translated by Kiswahili experts into the local Kiswahili language as a final instrument which was used. Mental health experts were consulted with regards to the content and feasibility of the instrument.

Scoring of the questionnaire depended on the direction of the questions, based on the number of variables and the groups being studied. The scoring comprised of scales 1 - 2 where questions had two options, scales 1 - 3 where questions had three options, scales 1 - 4 where questions had four options and scales 1 - 5 where questions had five options.

The questionnaire was interpreted, based on the variables and groups that were used to make up the three sections of the questionnaire.

3.2.6 Data collection, management and analysis

According to Burns and Grove (2007:421), data collection is defined as “a systematic way of gathering information relevant to the research purpose or questions”.

Data was collected by the researcher and trained research assistants, using a structured questionnaire with close-ended questions. The participant took about 15-30 minutes to fill in the questionnaire.

Data analysis is conducted to reduce, organise, and give meaning to the data (Burns & Grove, 2007:41) and involves breaking up the data into manageable themes, patterns, trends and relationships (Mouton, 2001:108). Hand tabulation of the aggregated data should be undertaken to ascertain whether the

responses reflect sufficient variation to test the study's hypothesis, or to reflect the validity of the findings (De Vos *et al*., 2008:214).

The data analysis was performed by using the Statistical Package for Social Sciences (SPSS) version 13. This package was used to seek for the separation of means, with the observance of analysis of variance. The results were presented into tables of means, in which each variable had its own table of analysis of variance. Results were also represented by bar charts and graphs, which were used for the interpretations and discussions in chapter four.

3.2.7 Validity and reliability

Validity refers to the extent to which an empirical measure accurately reflects the concepts it is intended to measure (Babbie, 2004:143 as in De Vos *et al*., 2008:160). Burns and Grove (2007:376) reiterate that validity looks at truths, strengths and values, with the ability to obtain the needed data, whilst it tells the researcher whether the tool measures what it is supposed to measure. During this study the researcher considered the face validity and content validity.

Face validity, according to De Vos *et al*. (2008:161), is defined as the simplest and the least scientific definition of validity. Face validity in this study helped the researcher to reach the complement of readability and clarity of the instrument. This was confirmed during the pilot study, because the participants were able to read the questionnaire and understood it.

Content validity is defined as "an assessment of how well the instrument represents all the different components of the variable to be measured" (Brink, 2000:168). In addition, content validity assesses whether the instrument adequately measures the domain of interest (Brink 2006:215). Therefore, the content validity in this case was achieved via the testing of the instrument during the pilot study, where its content was seen to have measured what the researcher was intending to measure. Furthermore, the experts in mental health nursing approved the questionnaire.

Reliability refers to the precision and the accuracy of the instrument and it is concerned with the consistency of the measurement techniques (Burns & Grove 2007:364). Therefore, in this research the reliability was supported by a pilot study, during which a pre-testing of the Kiswahili version questionnaire was performed to identify any ambiguities and inaccuracies. Pilot study also gave an estimate of the time to interview each individual. The participants in the pilot study were similar to those in the main study and were done in the similar settings, but they were not included in the final study.

3.2.8 Ethical considerations

During the progress of this research project, the ethical principles, as described by Burns and Grove (2007:212-219), were used to ensure that the rights of participants were protected at all times. According to Brink (2006:39-40), the principles of respect for persons, beneficence and justice form the basis of the protection of human rights. The ethical approval was obtained from Stellenbosch University institutional review board number IRB0005239 to conduct research. Furthermore the study permit was given by the Kinondoni Municipal Medical Officer of health with reference number TD/K/3/VOL/207 to introduce the researcher to the ward executive officers and grant permission to conduct the research in their respective wards (annexure one). Also the voluntary informed consent was obtained from the participants through oral and written informed consent. (annexure one).

3.2.9 Principle of respect for persons

The principle of respect for persons indicates that participants are autonomous, meaning that they have the right to self-determination (Brink, 2000:39). For this reason, participants with diminished autonomy were given protection during this study. At the beginning of this study, the selected participants were explained and informed that participation was voluntary, and that they could withdraw from the study at any time, without the risk of penalty.

3.2.10 Principle of justice

Regarding the principle of justice, the researcher considered the participants' rights to fair selection, treatment and privacy. The selected population for this study was treated fairly and any agreements made by participants were also being respected. Furthermore, the researcher respected participants' rights to privacy, whereby private information of participants was withheld from others, or was not shared against participants' will. This was done throughout the procedure of anonymity and confidentiality (Brink, 2000:41).

3.2.11 Principle of beneficence

The principle of beneficence was applied to make sure that every effort was made to protect participants from discomfort and harm (Brink, 2000:40). Psychological treatment was given to those participants who felt psychological discomfort during this study. The researcher informed the participants to report any emotional discomfort they might experience during the study.

For the benefit of the Kinondoni community also, the report, with outcomes of this study, would be shared and disseminated to all stake holders, including the District Medical Officer and the Municipal Director.

3.2.12 Principles of confidentiality and anonymity

Confidentiality denotes the handling of information in a confidential manner. It also refers to agreements between persons to limit access by others to private information (De Vos, 2008:61). During this research the researcher refrained from sharing information, without the prior authorisation by the participant.

For the purpose of this research, confidentiality was based on the following: participants only shared information they wished and they were entitled to have secrets, participants chose with whom to share personal information and the researcher had the duty of maintaining confidentiality that exceeded loyalty (Burns & Grove, 2007:212).

Anonymity during this study was assured to participants, since no name appeared on the interview schedule and no information, related to participants, was available to anyone beyond the research team. In addition, since information was given anonymously, it ensured the privacy of information. During this research participants had the right to anonymity and the right to assume that the collected data was kept confidential. For this reason, the participants' identities were not linked at all, not even by the researcher, to his / her individual responses.

3.2.13 Implications of the research and practise

An increase in mental health knowledge by the community is expected to change their behaviour towards mental illness (Angermeyer *et al*., 2009:225). This has been evident in communities that have become more knowledgeable and able to recognise mental disorders (Angermeyer *et al*., 2009:225).

Similarly, studies by Kabir *et al*. (2004:2) showed that literacy was found to be significantly associated with positive attitudes towards the mentally ill, as well as the improved knowledge and positive attitudes of the Kinondoni community members regarding mental health care. Therefore, community members should be more prepared to seek mental health care when their knowledge of mental health increases, which should alleviate the burden of mental illness in the community.

3.2.14 Summary

In this chapter the researcher described the research design and methodology of this study. The research process was discussed and applied to this study in various steps, including data collection, the hypotheses, sampling, instrumentation, data collection, validity and reliability, and ethical considerations. In the following chapter the researcher discusses the data analysis, interpretation and discussion.

CHAPTER FOUR

Data analysis, Interpretation and Discussion

4.1 Introduction

This chapter presents the analysis and interpretation of the data collected during this research study.

The objectives of this study were to determine the knowledge and attitudes of the Kinondoni community members towards mental illness, and the outcomes would improve this community's knowledge regarding mental illness.

This chapter relates to the main aim, namely to assess the knowledge and attitudes of the Kinondoni community members towards mental illness, based on the outcomes of the completed questionnaires by respondents.

The researcher collected the research data from the respondents by using a structured questionnaire, consisting of three sections:

- Section A: Socio-demographic information.
- Section B: Knowledge of community members in respect of the disease itself and its causes.
- Section C: Attitudes of community members towards mental illness.

A sample of three hundred (300) community members from the Kinondoni municipal area participated in this study during April 2010.

After consultation with the statistician, the total recommended sample size was 204 respondents. This sample was potentially inflated by a factor of 1.1 to allow for potentially non-responsive respondents, giving a final figure of 224 individuals, after which 300 were decided upon.

A statistician analysed the data, using the Statistical Package for Social Sciences, version 13 for Windows. Frequency distributions, cross-tabulation

and chi-square tests were calculated at a 5% (p = 0.05) level of statistical significance. Descriptive and inferential statistics, such as frequencies, tables and percentages were used during the data analysis and the preparation of data summaries.

As stated in chapter three a total of 300 respondents were interviewed, using a structured questionnaire. For those items were not all of the participants responded, the frequency and percentage were calculated according to the number of responses, as in table 4.1, for example.

During the pilot study that had been conducted prior to the main study, 30 questionnaires were used. Based on the preliminary results being obtained from the pilot study, it was concluded that the questionnaire was user friendly and without errors, and no adjustments were made.

4.2 SECTION A: Descriptive results

4.2.1 Socio-demographic information

The socio-demographic information which was collected included gender, age, academic qualifications, occupation, marital status and religion. Results are presented in table 4.1 below.

Table 4.1: Socio-demographic information (n=300)

VARIABLES	DESCRIPTON	FREQUENCY	PERCENTAGE
1	**GENDER (n=300)**		
	Male	n=128	42.7
	Female	n=172	57.3
	Total (N)	**300**	**100**
	Missing respondents	0	0
2	**RELIGION (n=300)**		
	Christian	n=166	55.3
	Muslim	n=124	41.3

	Hindu	n=5	1.7
	Total (N)	**295**	**98.3**
	Missing respondents	n=5	1.7
3	**AGE (n=300)**		
	18-28	n=152	50.6
	29-39	n=88	29.3
	40-50	n=38	12.7
	51 and above	n=13	4.4
	Total (N)	**291**	**97**
	Missing respondents	9	3
4	**MARITAL STATUS (n=300)**		
	Single	n=114	38.1
	Married	n=157	52.5
	Separated	n=10	3.3
	Divorced	n=9	3.0
	Widowed	n=9	3.0
	Total (N)	**299**	**99.9**
	Missing respondents	n=1	0.1
5	**EMPLOYMENT STATUS (n=300)**		
	Employed	n=79	26.3
	Unemployed	n=218	72.7
	Total (N)	**297**	**99**
	Missing respondents	n=3	1
6	**EDUCATIONAL LEVEL (n=300)**		
	No education	n=5	1.7
	Primary education	n=164	54.6
	Secondary education	n=97	32.3
	College	n=20	6.7
	University	n=14	4.7
	Total (N)	**300**	**100**
	Missing respondents	n=0	0

Variable 1: Gender

Table 4.1 shows gender of respondents who participated in the study. With reference to gender, (Q1) n=128 (42.7%) of the participants were male and n=172 (57.3%) were female.

Variable 2: Religion

The religion categories of respondents were;(Q2) Christian n= 166 (56.3%), Muslim n=124 (42%), and Hindu n=5 (1.7%). While n= 5 (1.7%) were missing respondents because they didn't return the questionnaire. The majority of the participants were Christian in this regard.

Variable 3: Age group

Table 4.3 shows the age categories of the respondents participated in this study. In this regard,(Q3) n=152 (52.2%) were aged between 8 and 28; n=88 (30.2%) were aged between 29 and 39; n=38 (13.1%) were aged between 40 – 50 and n=13 (4.4%) were age 51 and above. While n= 9 (3%) were missing respondents because they didn't answer the question.

Variable 4: Marital status

All respondents (n=300) answered this item. Table 4.1 indicates that (Q4) n=157 (52.5%) of respondents were married, n=114 (38.1%) were single, n=10 (3.3%) of the respondents separated, n=9 (3.0%) were divorced, and n=9 (3.0%) were widowed. While n= 1 (0.1%) were missing respondents because they didn't answer the question.

Variable 5: Employment status

All respondents (300) answer this item,(Q5) n=218 (73.4%) were non-employed where as n=79 (26.6%) were employed. While n= 3 (1%) were missing respondents because they didn't answer the question.

Variable 6: Educational level

A total of 300 answered this item, Table 4.6 indicates that, (Q6) n=164 (54.7%) of the respondents were primary education, n=97 (32.3%) were secondary education, n=20 (6.7%) were college education, n=14 (4.7%) were University education and n=5 (1.7%) were not gone to school.

4.3. SECTION B: Community Knowledge about mental illnesses

The outcomes of participants' responses to questions about their knowledge of mental illness are represented in this section as follows:-

Table 4.2: How familiar are you with mental health services available in Kinondoni municipality?

Variable		very familiar	somewhat familiar	not familiar	Total (N)
7 How familiar are you with mental health services available in Kinondoni municipality?	**Frequency**	n= 82	n=98	n=120	300
	Percentage	27.3	32.7	40	100

Variable 7: familiarity with mental health services available

Table 4.2 show that the majority, n=120 (40%) of the respondents were not familiar with the mental health services available in their area, n= 98 (32.7%) were somewhat familiar and n=82 (27.3%) were very familiar with the existing mental health services available.

Table 4.3: How much do you know about mental illness?

Variable		A good deal	A little	None	Total (N)	Missing respondents
8 How much do you know about mental illness?	**Frequency**	n= 66	n=143	n=86	295	n=5
	Percentage	22.4	48.5	29.2	98.3	1.7

Variable 8: How much do you know about mental illness?

As shown in table 4.3 the majority, n=143 (48.5%), of the respondents expressed the view that they had little knowledge of mental illness, while n=86 (29.2%) of respondents knew nothing about mental illness.

Table 4.4: Assessment of community knowledge on mental illness

Variables	Responses Total (N)	Yes		No	
		Freq	%	Freq	%
9 Do you think people who are suffering from mental illness have many friends?	N= 300	n=42	11.9%	n=258	88.1%
10 Do you think people with mental illness can do a regular job?	N= 300	n=93	31%	n=207	69%
11 People with mental illness are dangerous, because of violent behaviour?	N= 300	n=217	72.3%	n=83	27.7%

Variable 9: Do you think people who are suffering from mental illness have many friends?

In table 4.4 above, participants asked whether people who suffer from mental illness have many friends. The majority n=258 (88.1%) answered ‘no’ meaning that there was no possibility mentally ill people to have many friends. The rest of

participants n= 42 (11.9%) answered ‘yes’ that there is a possibility mentally ill people to have many friends.

Variable 10: Do you think people with mental illness can do a regular job?

Table 4.4 above shows that the majority, n=207 (69%), of participants answered ‘no’ with the statement that people with mental illness can do a regular job. While n= 93 (31%) of the participants answered ‘yes’ that people with mental illness can do a regular job.

Variable 11: People with mental illness are dangerous, because of violent behaviour?

Table 4.4 above shows that most of the participants, n=217 (72.3%), answered ‘yes’ with the statement that people with mental illness are dangerous because of violent behaviour, while n= 83 (27.7%) answered ‘no’.

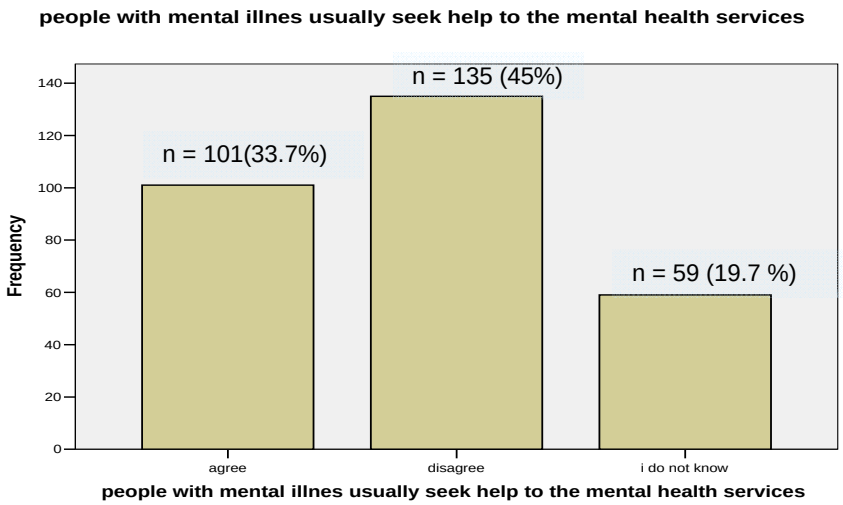


Figure 4.1: Variable 12. People with mental illness usually seek help at the mental health services.

Variable 12: People with mental illness usually seek help at the mental health services.

Figure 4.1 above, shows that majority, n=135 (45.8%), disagreed with the statement that people with mental illness usually seek help at the mental health services, n= 101 (33.7%) of the participants agreed and n= 59 (19.7%) does not know whether people with mental illness usually seek help at the mental health services or not.

In the table below the responses 'strongly disagree' and 'disagree' are collapsed into one response 'disagree' and also the responses 'strongly agree' and 'agree' are collapsed together into one response 'agree' to simplify the report in this regard.

Table 4.5: Assessment of knowledge level towards health services

Variables	Total respondents	Disagree	Neutral	Agree	Missed respondents
13 There are sufficient existing services for the mentally ill?	**Frequency N= 298**	n=157	n=61	n=80	n=2
	Percentage	52.6	20.5	26.8	0.7
14 Mental hospitals are an outdated means of treating the mentally ill?	**Frequency N= 297**	n=165	n=51	n=81	n=3
	Percentage	55.6	17.2	27.2	0.1
15 Community members have good reason to resist seeking mental health services available in their neighbourhood?	**Frequency N= 296**	n=172	n=45	n=79	n=4
	Percentage	58.1	15.2	26.7	1.3

16 Community members have nothing to fear from people coming into their neighbourhood to obtain mental health services?	**Frequency N= 298**	n=180	n=31	n=87	n=2
	Percentage	60.4	10.4	29.2	0.7

Variable 13: There are sufficient existing services for the mentally ill?

As shown table 4.5 the majority, n=157 (52.6%), of the respondents disagreed with the statement that there are sufficient existing services for the mentally ill, n= 80 (26.8%) agreed. Other respondents n= 61 (20.5%) does not know whether there is sufficient existing services for the mentally ill or not, while n= 2 (0.7%) were missing respondents because they did not return the questionnaire.

Variable 14: Mental hospitals are an outdated means of treating the mentally ill?

A total of 297 answered this item, Table 4.5 indicates that, n= 165 (55.6%) of the respondents disagreed with the statement that mental hospitals are an outdated means of treating the mentally ill, n= 81 (27.2%) of the participants agreed. Other participants n=51(17.2%) have nothing to say about this statement while n= 3 (0.1%) were missing respondents because they did not respond to the answer.

Variable 15: Community members have good reason to resist seeking mental health services available in their neighbourhood?

Table 4.5 show that, n=172 (58.1%) of participants disagreed with the statement that community members have good reason to resist to seek mental health services available in their neighbourhood while n= 79 (26.7%) of the participants agreed. Other participants n= 45 (15.2%) do not know if community

members have good reason to resist seeking mental health services available in their neighbourhood or not and the rest n= 4 (1.3%) of the participants did not respond...

Variable 16: Community members have nothing to fear from people coming into their neighbourhood to obtain mental health services?

Table 4.5 shows that the majority, n=180 (60.4%) of participants disagreed with the statement that community members have nothing to fear from people coming to their neighbourhood to obtain mental health services, n= 87 (29.2%) of the respondents agreed, n= 31 (10.4%) did not know and the rest of the participants n= 2 (0.7%) did not respond..

4.4 SECTION C: Community attitudes towards mental illness

In the table below the responses 'totally disagree' and 'almost totally disagree' are collapsed into one response 'disagree' and also the responses 'sometimes agree', 'almost totally agree' and 'totally agree' are collapsed together into one response 'agree' to simplify the report in this regard.

Table 4.6 Behaviours and mental health services

Variables	Responses Total	Agree	Disagree	Missed responses
17 People with mental illness have unpredictable behaviour	**Frequency N=300**	n=261	n=38	n=1
	Percentage	87	12.7	0.3
18 If people become mentally ill once, they will easily become ill again	**Frequency N=300**	n=224	n=75	n=1
	Percentage	74.7	25	0.3
19 If a mental health facility is set up in my street or community, I will move	**Frequency**	n=64	n=235	n=1

out of the community.	**N=300**			
	Percentage	21.3	78.3	0.3
20 Even after a person with mental illness has been treated, I would still be afraid to be around them.	**Frequency N=300**	n=106	n=192	n=2
	Percentage	35.3	64	0.7
21 Mental patients and other patients should not be treated in the same hospital.	**Frequency N=300**	n=167	n=132	n=1
	Percentage	55.7	44	0.3
22 When a spouse is mentally ill, the law should allow for the other spouse to file for divorce.	**Frequency N=300**	n=86	n=212	n=2
	Percentage	28.7	70.7	0,7

Variable 17: People with mental illness have unpredictable behaviour

Table 4.6 above shows that the majority, namely n=261 (87%), of the participants have agreed that people with mental illness have unpredictable behaviour. The results further show that n= 38 (12.7%) of the participants disagreed that people with mental illness have unpredictable behaviour while n=1 (0.3%) did not respond.

Variable 18: If people become mentally ill once, they will easily become ill again

Table 4.6 above shows that the majority, namely n=224 (74.7%), of the participants agreed that if people become mentally ill once they will easily become ill again, at the same time n=75 (25%) of the participants disagreed. On the other hand, n= 1 (0.3%) of the participants did not respond.

Variable 19: If a mental health facility is set up in my street or community, I will move out of the community

Table 4.6 above shows that the majority, n=235 (78.3%) disagreed that If a mental health facility is set up in their street or community, they will move out of

the community, n=64 (21.3%) of participants agreed that they will move out of the community and others n=1(0.3%) of the participants did not respond.

Variable 20: Even after a person with mental illness has been treated, I would still be afraid to be around them.

Table 4.6 above shows that the majority,n=192 (64%) disagreed that they will not be afraid after a mentally ill person has been treated, while n= 106 (35.3%) agreed and n=2 (0.7%) of the participants did not respond.

Variable 21: Mental patients and other patients should not be treated in the same hospital.

Table 4.6 above shows that the majority, n= 167 (55.7%) of the participants agreed with the statement that mental patients and other patients should not be treated in the same hospital, while n= 132 (44%) of the participants agreed with the statement and n=1 (0.3%) of the participants did not respond.

Variable 22: When a spouse is mentally ill, the law should allow for the other spouse to file for divorce

Table 4.6 above shows that the majority, n=212 (70.7%) disagreed with the statement that the law should not allow the spouse to file for divorce when a spouse is mentally ill, while n= 86 (28.7%) of the participants agreed and n=2 (0.7%) of the participants did not respond.

Table 4.7: People with mental illness tend to be violent

Variable	**Response**	**Frequency**	**Percentage**
23 People with mental illness tend to be violent	Agree	213	71
	Disagree	82	27.3
	Missed respondents	5	1.7
	Total (N)	**300**	**100**

Variable 23: People with mental illness tend to be violent

The majority n=213 (71%), of the respondents agreed with the statement that people with mental illness tend to be violent, while n= 82 (27.3%) disagreed with the statement (Table 4.7).

Table 4.8: People with mental illness are dangerous

Variable	Response	Frequency	Percentage
24 People with mental illness are dangerous	Agree	240	80
	Disagree	57	19
	Missed respondents	3	1.0
	Total (N)	**300**	**100**

Variable 24: People with mental illness are dangerous

Variable 24 (table 4.8), n= 240 (80%), of the participants agreed with the statement that people with mental illness are dangerous, while n=57 (19%) of the participants disagreed with the statement.

In the table below the responses ‘totally disagree’ and ‘almost totally disagree’ are collapsed into one response ‘disagree’ and also the responses ‘sometimes agree’, ‘almost totally agree’ and ‘totally agree’ are collapsed together into one response ‘agree’ to simplify the report in this regard.

Table 4.9 Rejection towards people suffering from mental illness

Variables	Responses	Agree	Disagree	Total (N)	Missed respondents
25 People with mental illness should be feared.	**Frequency**	203	93	296	4
	Percentage	67.7	31	98.7	1.3
26 It is easy to identify with	**Frequency**	245	52	297	3

those who have a mental illness.	**Percentage**	81.7	17.3	99	1
27 You can easily tell who has a mental illness, by the characteristics of their behaviour	**Frequency**	213	85	298	2
	Percentage	71	28.3	99.3	0.7
28 People with mental illness have a lower Intelligent Quotient.	**Frequency**	232	68	300	
	Percentage	77.3	22.7	100	
29 All people with mental illness have some strange behaviour.	**Frequency**	241	59	300	
	Percentage	80.3	19.7	100	
30 It is inappropriate for a person with mental illness to get married.	**Frequency**	190	110	300	
	Percentage	63.3	36.7	100	
31 Those who have a mental illness cannot fully recover.	**Frequency**	130	166	296	4
	Percentage	43.3	55.3	98.6	1.4
32 Those that are mentally ill should not have children.	**Frequency**	113	185	298	2
	Percentage	37.7	61.7	99.4	0.6
33 There is no future for people with mental illness.	**Frequency**	118	182	300	
	Percentage	39.3	60.7	100	

Variable 25: People with mental illness should be feared.

Table 4.9 show responses of questions 25 to 33. In question 25 most of the participants agreed on the questions asked, that is n=203 (67.7%) people with mental illness should be feared, while n=93 (31%) of the participants disagreed and n=4 (1.7%) of the participant didn't return the questionnaire.

Variable 26: It is easy to identify with those who have a mental illness.

Table 4.9 above shows that the majority, namely (Q 26) n=245 (81.7%) of the participants agreed with the statement that, it is easy to identify with those who

have a mental illness, while n= 52(17.3%) disagreed with this statement and n= 3 (1%) of the participant didn't return the questionnaire.

Variable 27: You can easily tell who has a mental illness, by the characteristics of their behaviour

Table 4.9 above shows that the majority, namely (Q 27) n=213 (71%) of the participants agreed with the statement that, you can easily tell who has a mental illness, by the characteristics of their behaviour, while n=85 (28.3%) disagreed and n=2 (0.7%) of the participant didn't return the questionnaire.

Variable 28: People with mental illness have a lower Intelligent Quotient

Table 4.9 above shows that the majority, namely (Q 28) n=232 (77.3%) of the participants agreed with the statement that people with mental illness have a lower Intelligent Quotient, while other participants n=28 (22.7%) disagree with this statement..

Variable 29: All people with mental illness have some strange behaviour.

Table 4.9 above shows that the majority, namely (Q 29) n=241 (80.3%) of the participants agreed with the statement that all people with mental illness have some strange behaviour and n= 59 (19.7%) disagree.

Variable 30: It is inappropriate for a person with mental illness to get married.

Table 4.9 above shows that the majority, namely (Q 30) n=190 (63.3%) of the participants agreed with the statement that, it is inappropriate for a person with mental illness to get married, and n= 110 (36.7%) disagree with this statement.

Variable 31: Those who have a mental illness cannot fully recover.

Table 4.9 above shows that the majority, namely (Q 31) n=166 (55.3%) of the participants disagreed with the statement that, people with mental illness cannot

fully recover while others n=130 (43.3%) disagreed on the questions asked and n= 4 (1.4%) of the participant didn't return the questionnaire.

Variable 32: Those that are mentally ill should not have children.

Table 4.9 above shows that the majority, namely (Q 32) n=185 (61.7%)of the participants disagreed with the statement that mentally ill people should not have children, while others n=113 (37.7%) agreed and n=2 (0.6%) of the participant didn't return the questionnaire.

Variable 33: There is no future for people with mental illness.

Table 4.9 above shows that the majority, namely (Q 33) n=182 (60.7%) of the participants disagreed with the statement that, people with mental illness have no future while n=118 (39.3%) agreed on the question asked.

Table 4.10: People with mental illness can hold a job

Variable	Response	Frequency	Percentage
34 People with mental illness can hold a job	Agree	183	61
	Disagree	117	39
	Total (N)	**300**	**100**

Variable 34: People with mental illness can hold a job

In question 34 (table 4.10), n=183 (61%), of the respondents agreed that people with mental illness can hold a job and others n= 117 (39%) disagreed.

The following table below the responses 'totally disagree' and 'almost totally disagree' are collapsed into one response 'disagree' and also the responses

'sometimes agree', 'almost totally agree' and 'totally agree' are collapsed together into one response 'agree' to simplify the report in this regard.

Table 4.11 Attitudes towards community support and rehabilitation

Variables		Responses	Agree	Disagree	Total (N)	Missed respondents
35	The care and support of family and friends can help people with mental illness to get rehabilitated.	**Frequency**	260	38	298	2
		Percentage	86.7	12.7	99.4	0.6
36	Corporations and the community (including the government) should offer jobs to people with mental illness.	**Frequency**	274	24	298	2
		Percentage	91.3	8	99.3	0,7
37	After a person is treated for mental illness, they can return to their former job position.	**Frequency**	255	43	298	2
		Percentage	85	14.3	99.3	0.7
38	The best way to help those with a mental illness to recover is to let them stay in the community and live a normal life.	**Frequency**	138	160	298	2
		Percentage	46	53.3	99.3	0.7
39	After people with mental illness are treated and rehabilitated, we still should not make friends	**Frequency**	95	203	298	2
		Percentage	31.7	67.7	99.4	0.6

	with them.					
40	After people with mental illness are treated, they are still more dangerous than normal people.	**Frequency**	116	182	298	2
		Percentage	38.7	60.7	99.4	0,6
41	It is possible for everyone to have a mental illness.	**Frequency**	215	85	300	
		Percentage	71.7	28.3	100	
42	We should not laugh at the mentally ill, even though they act strangely.	**Frequency**	266	32	298	2
		Percentage	88.7	10.7	99.4	0.6
43	It is harder for those who have a mental illness to receive the same pay for the same job.	**Frequency**	151	146	297	3
		Percentage	50.3	48.7	99	1.0
44	After treatment, it will be difficult for the mentally ill to return to the community.	**Frequency**	109	191	300	
		Percentage	36.3	63.7	100	
45	People are prejudiced towards those with mental illness.	**Frequency**	200	99	299	1
		Percentage	66.7	33	99.7	0.3

Variable 35: The care and support of family and friends can help people with mental illness to get rehabilitated.

Table 4.11 show responses of questions 35 to 45. Most of the participants agreed on the questions asked, in question 35 n=260 (86.7%) of the participants agreed on the statement that, care and support of family and friends can help people with mental illness to get rehabilitated, n=38 (12.7%) of

the participants disagreed with this statement and n= 2 (0.6) of the participant didn't return the questionnaire.

Variable 36: Corporations and the community (including the government) should offer jobs to people with mental illness.

Table 4.11 above shows that the majority, namely (Q 36) n=274 (91.3%) of the participants agreed with the statement that, corporations and the community to offer jobs to people with mental illness, n=24 (8%) of the participants disagreed and n=2 (0.7%) of the participant didn't return the questionnaire.

Variable 37: After a person is treated for mental illness, they can return to their former job position

Table 4.11 above shows that the majority, namely (Q 37) n=255 (85%) of the participants agreed with the statement that, a person with mental illness can return to their former job position after treatment, while n=43 (14.3%) of the participants disagreed with this statement and n=2 (0.7%) of the participant didn't return the questionnaire.

Variable 38: The best way to help those with a mental illness to recover is to let them stay in the community and live a normal life.

Table 4.11 above shows that the majority, namely (Q 38) n=160 (53.3%) of the participants disagreed with the statement that, the best way to help those with a mental illness to recover is to let them stay in the community and live a normal life, while others n= 138 (46%) agreed with this statement and n= 2 (0.7%) of the participant didn't return the questionnaire.

Variable 39: After people with mental illness are treated and rehabilitated, we still should not make friends with them.

Table 4.11 above shows that the majority, namely (Q 39) n=203 (67.7%) of the participants disagreed with the statement that, after people with mental illness are treated and rehabilitated, we still should not make friends with them, while others n= 95 (31.7%) agreed with this statement and n=2 (0.6%) of the participant didn't return the questionnaire.

Variable 40: After people with mental illness are treated, they are still more dangerous than normal people.

Table 4.11 above shows that the majority, namely (Q 40) n=182 (60.7%) of the participants disagreed with the statement that, after people with mental illness are treated, they are still more dangerous than normal people and n=116 (38.7%) they agreed. Others n=2 (0.6%) of the participant didn't return the questionnaire.

Variable 41: It is possible for everyone to have a mental illness.

Table 4.11 above shows that the majority, namely (Q 41) n=215 (71.7%) of the participants agreed with the statement that, it is possible for everyone to have a mental illness and n= 85 (28.3%) of the participants disagreed with this statement.

Variable 42: We should not laugh at the mentally ill, even though they act strangely.

Table 4.11 above shows that the majority, namely (Q 42) n=266 (88.7%) of the participants agreed with the statement that, we should not laugh at the mentally ill, even though they act strangely, while n= 32 (10.7%) of the participants disagreed with this statement. Other participants n= 2 (0.6%) of the participant didn't return the questionnaire.

Variable 43: It is harder for those who have a mental illness to receive the same pay for the same job.

Table 4.11 above shows that the majority, namely (Q 43) n=151 (50.3%) of the participants agreed with the statement that, It is harder for those who have a mental illness to receive the same pay for the same job and n= 146 (48.7%) of the participants disagreed with this statement. Other participants n= 3 (1%) of the participant didn't return the questionnaire.

Variable 44: After treatment, it will be difficult for the mentally ill to return to the community.

Table 4.11 above shows that the majority, namely (Q 44) n=191 (63.7%) of the participants disagreed with the statement that, after treatment, it will be difficult for the mentally ill to return to the community and n=109 (36.3%) of the participants agreed with this statement.

Variable 45: People are prejudiced towards those with mental illness.

Table 4.11 above shows that the majority, namely (Q 45) n=200 (66.7%) of the participants agreed with the statement that, people are prejudiced towards those with mental illness, while n=99 (33%) of the participants disagree. Other participants n=1 (0.3%) of the participant didn't return the questionnaire.

Table 4.12: It is hard to have good friends if you have mental illness

Variable	Response	Frequency	Percentage
46 It is hard to have good friends if you have mental illness	Agree	203	67.7
	Disagree	96	32.0
	Total (N)	299	99.7
	Missed respondents	1	0.3

Variable 46: It is hard to have good friends if you have mental illness

As shown by question 46 (table 4.12), n= 203 (67.7%), of the participants agreed that it is hard to have good friend if you have mental illness, while n= 96 (32%) disagreed with this statement and n=1 (0.3%) of the participant didn't return the questionnaire.

Table 4.13 It is rare for people who are successful at work to have mental illness

Variable	Response	Frequency	Percentage
47 It is rare for people who are successful at work to have mental illness	Agree	66	22
	Disagree	234	78
	Total (N)	300	100

Variable 47: It is rare for people who are successful at work to have mental illness

Question 47 in table 4.12 shows that majority of the participants, n=234 (78%) has disagreed that it is rare for people who are successful at work to have mental illness and n=66 (22%) of the participants agreed.

The following table below the responses 'totally disagree' and 'almost totally disagree' are collapsed into one response 'disagree' and also the responses 'sometimes agree', 'almost totally agree' and 'totally agree' are collapsed together into one response 'agree' to simplify the report in this regard.

Table 4.14 Stigmatizing attitude

Variables	Responses	Agree	Disagree	Total (N)	Missed respondents
48 It is shameful to have a	**Frequency**	51	249	300	

mental illness.	**Percentage**	17	83	100	
49 Mental illness is a punishment for doing some bad things.	**Frequency**	112	188	300	
	Percentage	37.3	62.7	100	
50 I suggest that those who have a mental illness should not tell anyone about their illness.	**Frequency**	95	203	298	2
	Percentage	31.7	67.7	99.4	0.6

Variable 48: It is shameful to have a mental illness

In table 4.14 shows responses on questions 48 to 50. In question 48, most of the participants, n=249 (83%) disagreed with the statement that, is It is shameful to have a mental illness and n=51 (17%) of the participants agreed.

Variable 49: Mental illness is a punishment for doing some bad things.

Table 4.14 above shows that the majority, namely (Q 49) n=188 (62.7%) of the participants disagreed with the statement that Mental illness is a punishment for doing some bad things, and n=112 (37.3%) agreed with this statement.

Variable 50: I suggest that those who have a mental illness should not tell anyone about their illness.

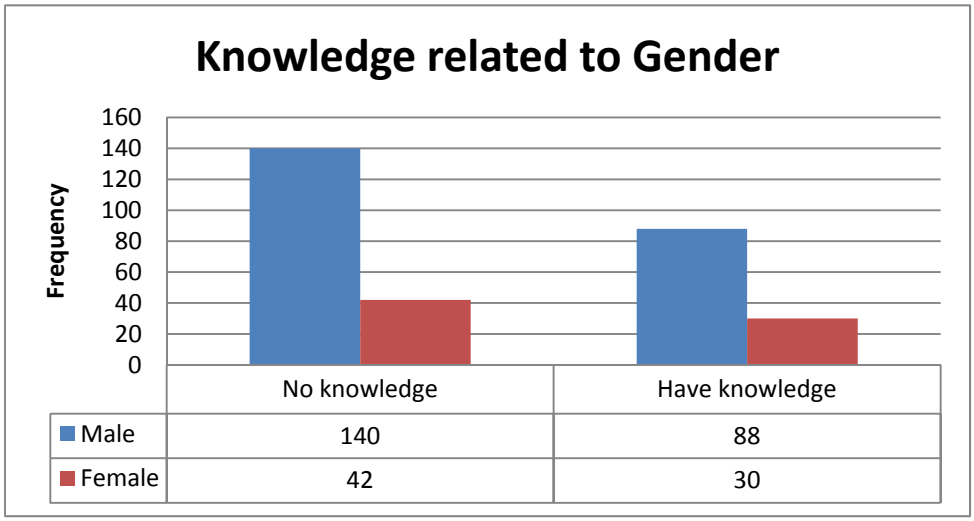
Table 4.14 above shows that the majority, namely (Q 50) n=203 (67.7%) of the participants disagreed with the statement that, those with mental illness should not tell anyone about their illness, and n=95 (31.7%) of the participants agreed with this statement. Others n=2 (0.6%) of the participant didn't return the questionnaire.

4.5. The relationships of variables; gender, age, marital status, employment status and educational level of the participants in relation to the knowledge and attitudes.

Descriptive analysis of the demographic data was performed. The chi-square test was used to compare the quality of characteristics among the different groups. In order to study the effect of the demographic characteristics on the participants' knowledge and attitudes towards mental illness, the chi-square with stratification was used. A binary logistic regression analysis was conducted.

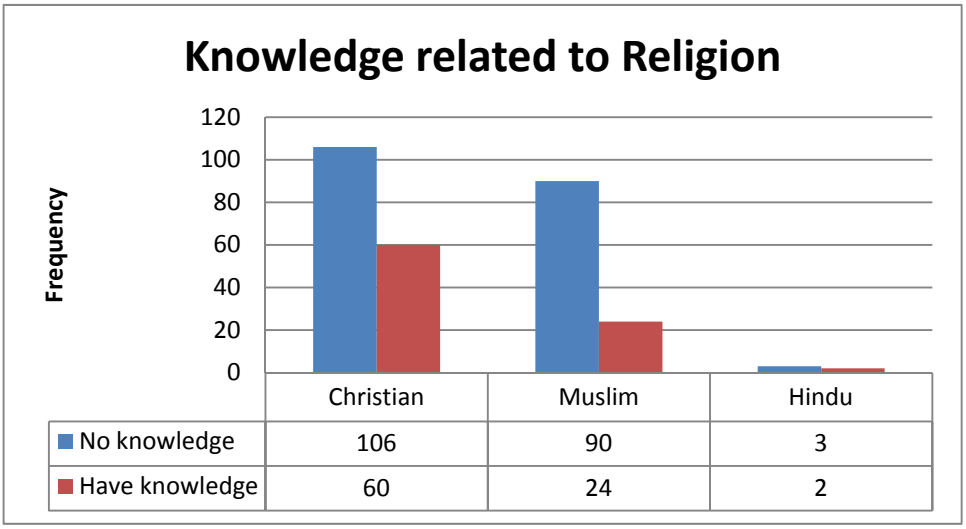
4.2.4 The analysis of Knowledge related to gender, religion, age, marital status, employment status and educational level

Figure 4.2 Participants' knowledge related to gender.



In figure 4.2 male and female participants, n=140 (61.4%) and n=42 (58.3%), respectively, seemed to have no knowledge of mental illness. This showed that gender in this community is not a differentiating factor, the relationship between male and female in relation to the knowledge is almost the same. A statistical insignificant association has been identified between gender and knowledge at the Pearson Chi-Square test p >0.642 level.

Figure 4.3: Participants' knowledge related to religion



In figure 4.3 Christian, Muslim and Hindu participants, n=106 (35.3%), n=90 (30%) and n=3 (1%), respectively, seemed to have no knowledge of mental illness. This showed that religion status in the community is not a differentiating factor; the relationship between Christian, Muslim and Hindu in relation to the knowledge is almost the same. These results were statistically insignificant at the Pearson Chi-Square test p >0.626 level.

Figure 4.4: Participants' knowledge related to age.

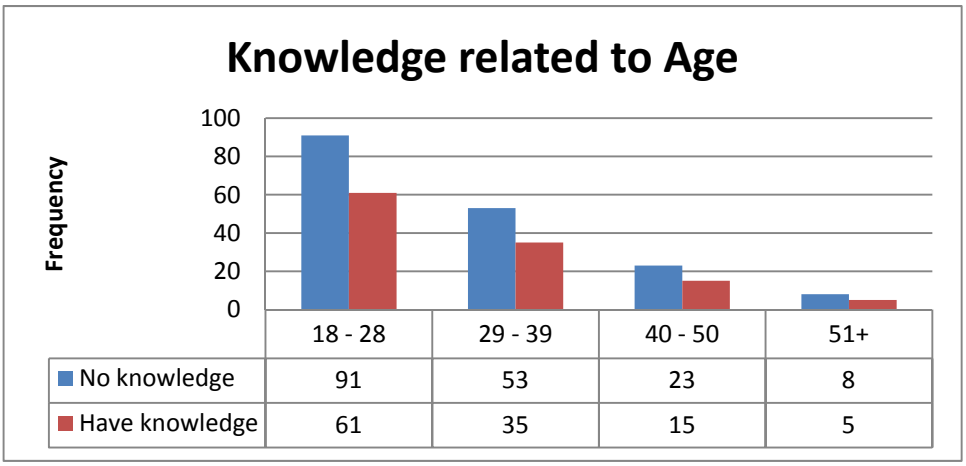


Figure 4.4 shows that across all the age categories ranges from 29-39 n= 91 (59%), 40-50 n=53 (60%) and 51 and above n= 8 (61%) showed that participants did not have knowledge about mental illness. The results also show

that age group have no relationship with knowledge. These results were statistically insignificant at the Pearson Chi-Square test p >0.99 level.

Figure 4.5: Participants' knowledge related to marital status.

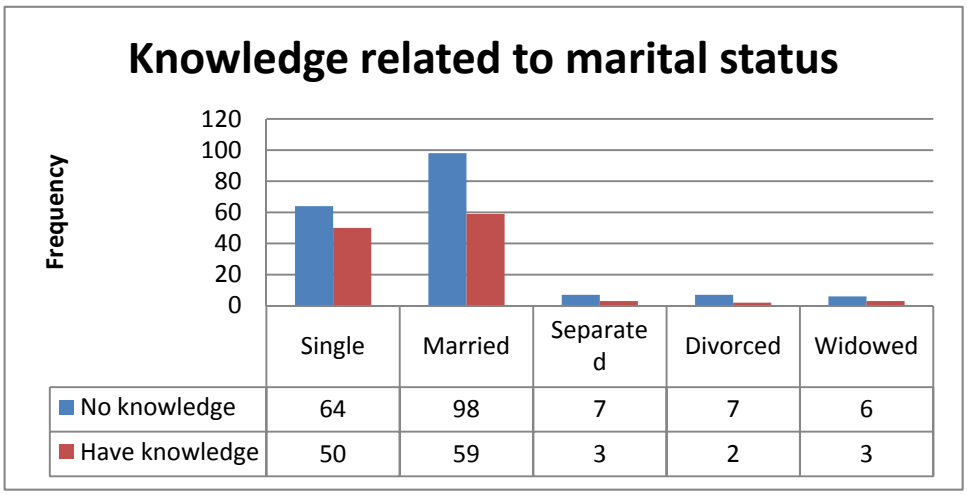


Figure 4.5 demonstrates that different marital statuses, single n=64 (21.3%), married n=98(32.6%), separated n=7 (2.3%), divorced n=7 (2.3%) and widowed n=6 (2%), had no impact on knowledge about mental illnesses. A statistical insignificant association has been identified between marital status and knowledge at the Pearson Chi-Square test >0.594 level.

Figure 4.6: Participants' knowledge related to employment status.

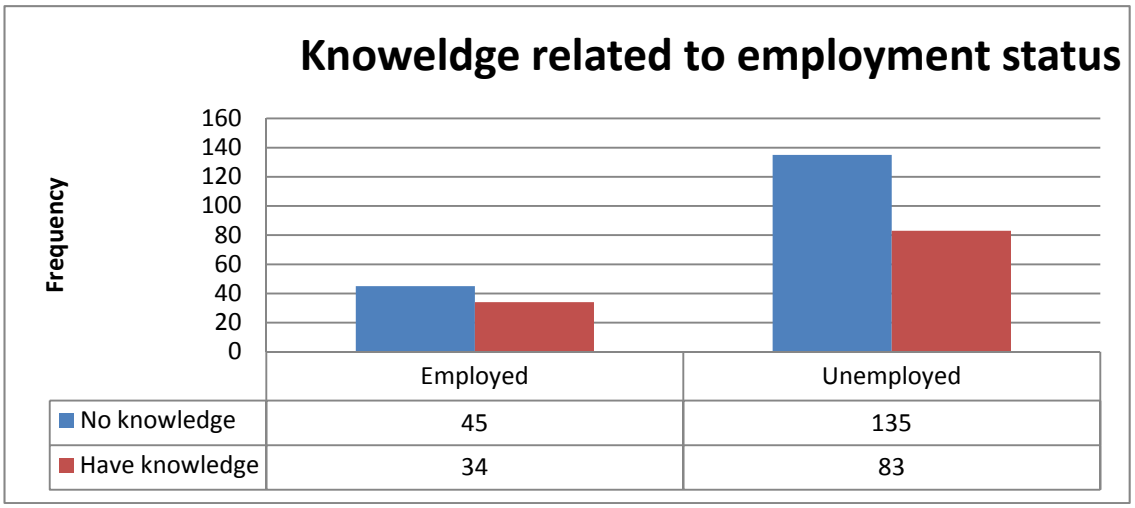


Figure 4.6 show that the employment status of participants did not affect their knowledge of mental illness. In this study, both employed and unemployed participants showed no knowledge about mental illness. These results were statistically insignificant at the Pearson Chi-Square test p >0.439 level.

Figure 4.7: Participants' knowledge related to educational level.

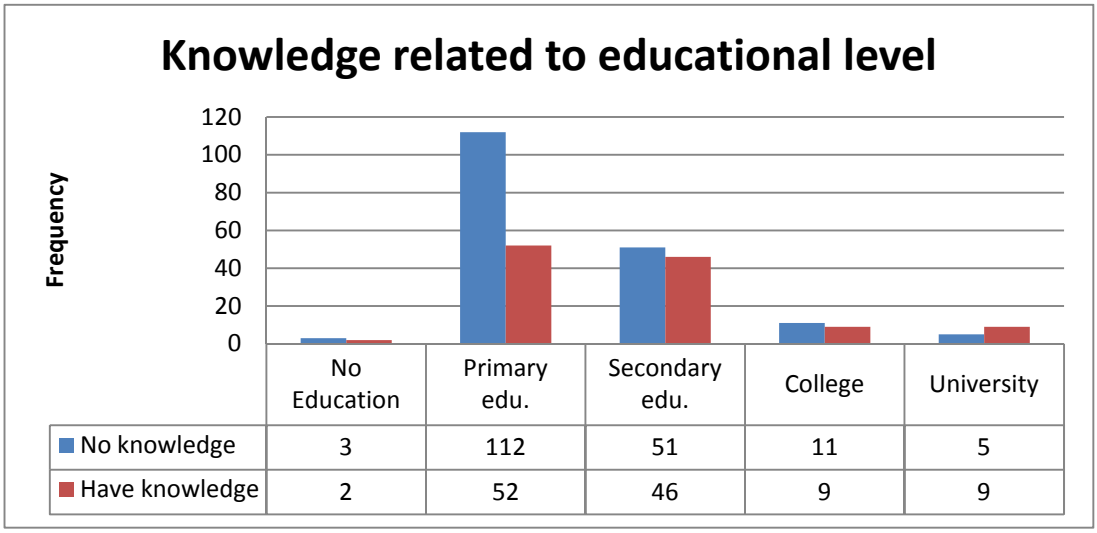


Figure 4.7 illustrates that participants who were higher educated, had more knowledge about mental illness, compared to those who had lower levels of education. This, however, did not rule out the previous results, which indicated that participants had no knowledge about mental illness. These results were statistically significant at the Pearson Chi-Square test p <0.032 level.

4.2.6 The analysis of Attitude related to gender, religion, age, marital status, employment status and educational level

Figure 4.8 Participants' attitude related to gender.

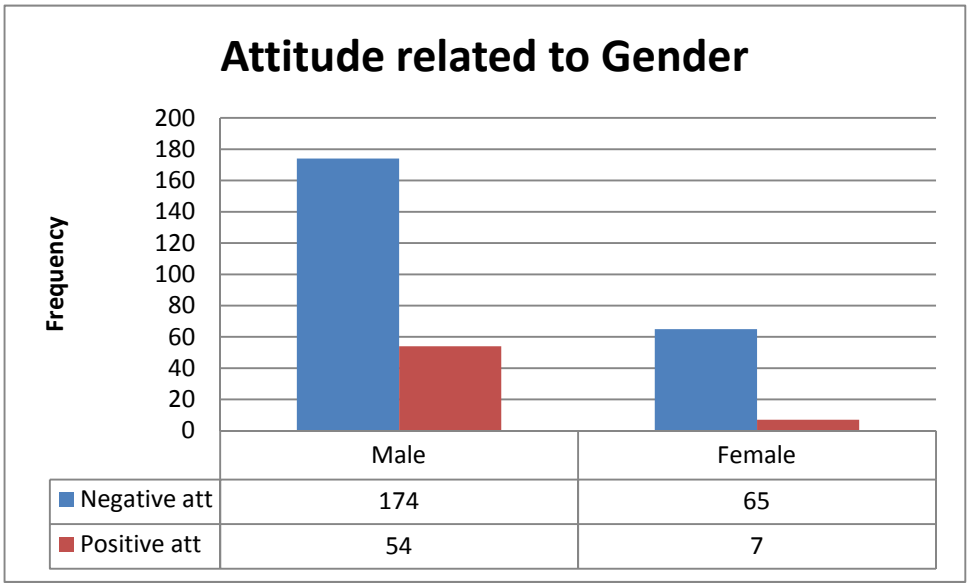


Figure 4.8 show that males generally have more negative attitudes towards people suffering from mental illness than females. These results were statistically significant at the Pearson Chi-Square test p <0.010 level

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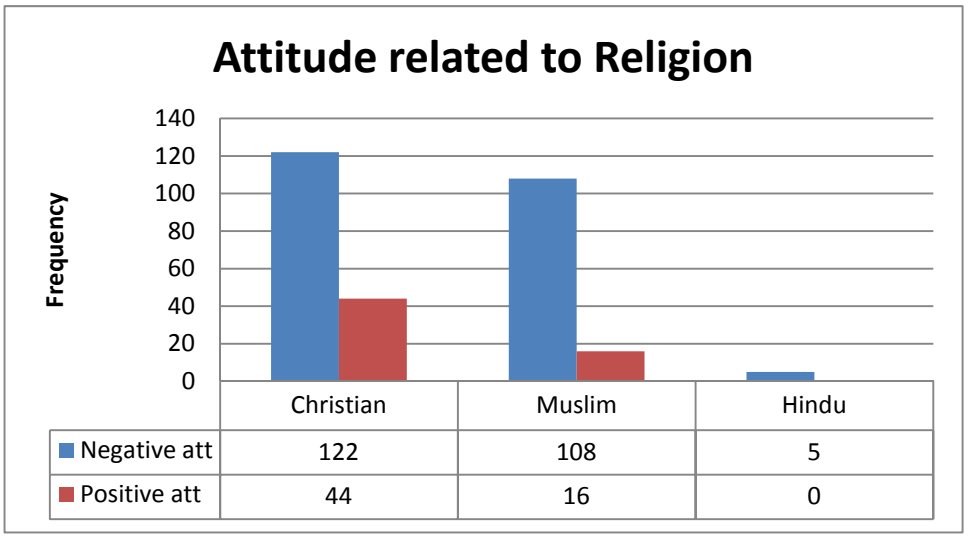
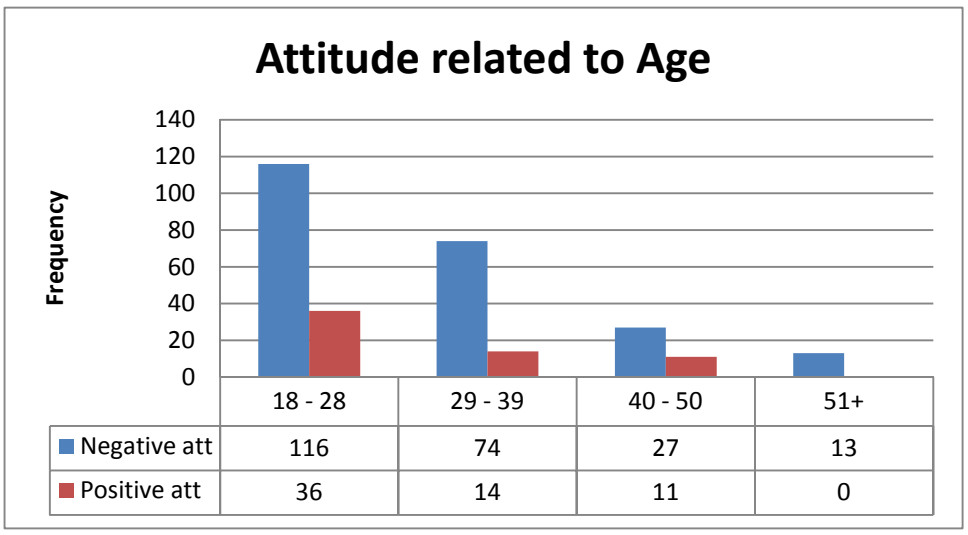
Figure 4.9 Participants' attitude related to religion.



In figure 4.9 Christian, Muslim and Hindu participants, n=122 (40.6%), n=108(36%) and n=5 (1.6%), respectively, seemed to have negative behaviour towards mental illness. This showed that religion status in the community is not a differentiating factor; the relationship between Christian, Muslim and Hindu in relation to the attitude is almost the same. These results were statistically insignificant at the Pearson Chi-Square test p >0.642 level.

Figure 4.10 Participants' attitude related to age.



In figure 4.10, almost all respondents at all age categories showed negative behaviour towards people with mental illness. Here, younger respondents (18 - 28 years as in figure 4.10 above) admitted to having negative attitudes towards mental illness. The results were statistically insignificant at the p >0.074 level.

Figure 4.11 Participants' attitude related to marital status.

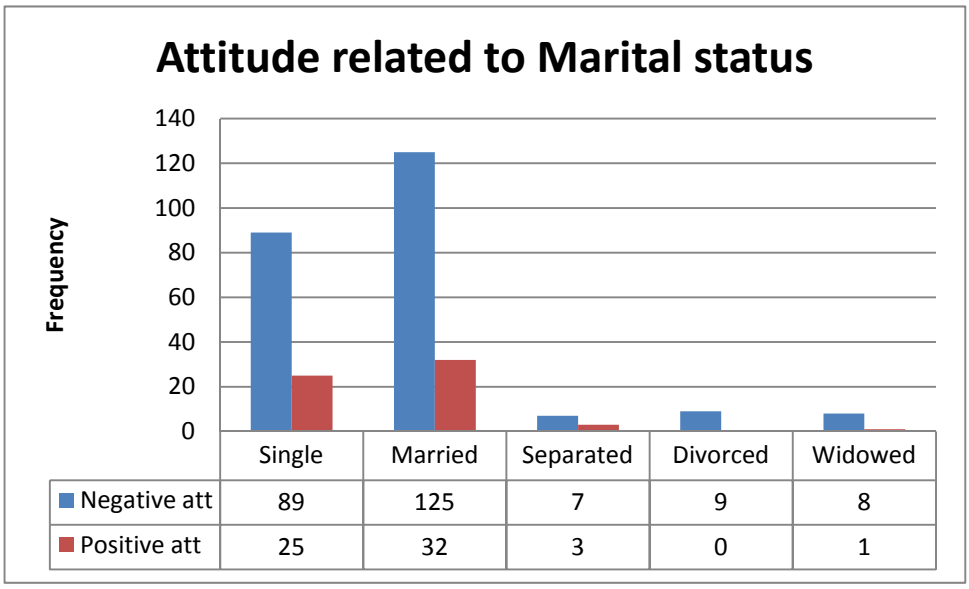


Figure 4.11, the results showed that, irrespective of marital status, all participants generally had negative perspectives towards mental illness. These results were statistically insignificant at the p >0.475 level.

Figure 4.12 Participants' attitude related to employment status.

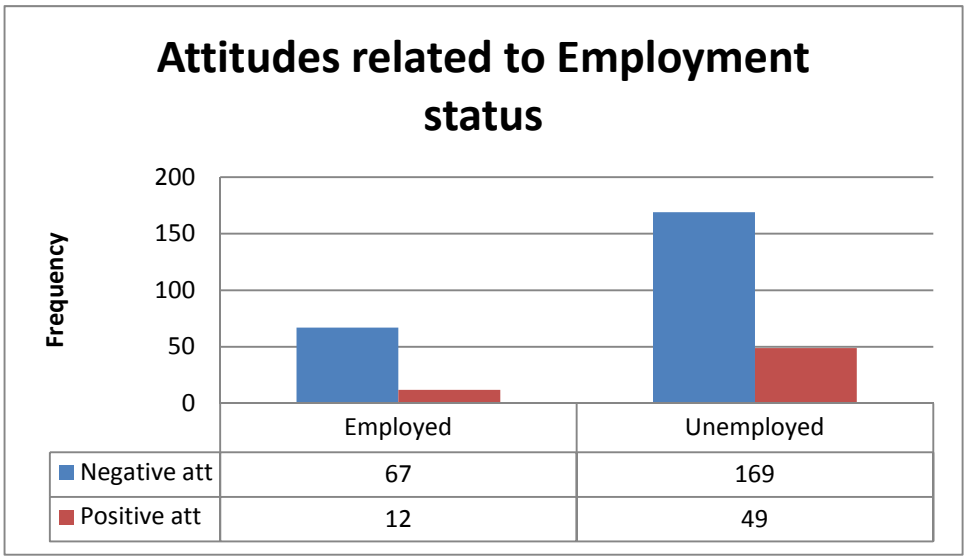


Figure 4.12 showed that, both the employed participants and unemployed participants had negative attitudes towards mental illness. These results were statistically insignificant at the p >0.170 level.

Figure 4.13 Participants' attitude related to educational level.

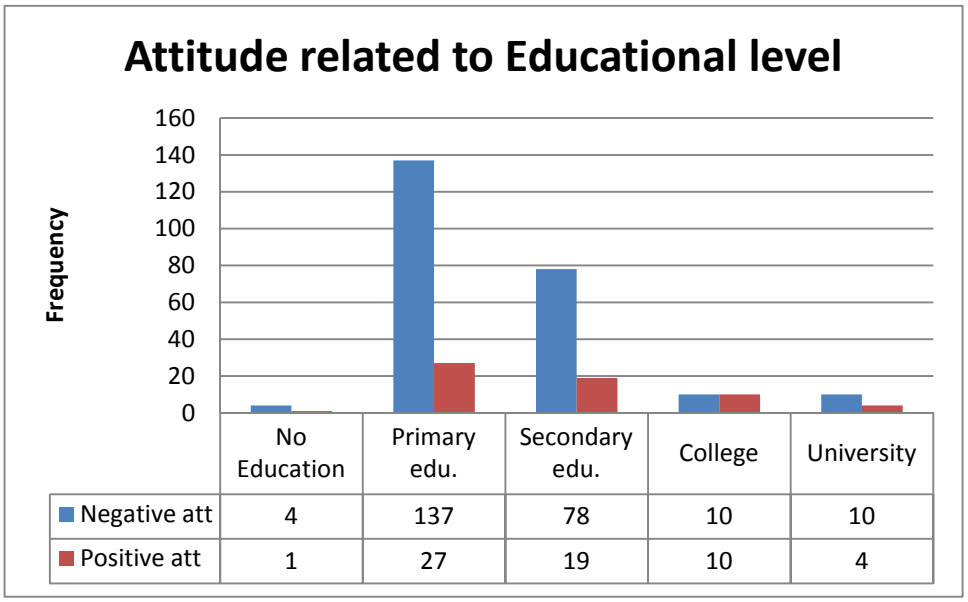


Figure 4.13 showed that, the most unfavourable attitudes were held by participants with primary education, followed by those with secondary education

and lastly by those with college and university education. Statistical association was shown between level of education and attitude, therefore the results were statistically significant at the p <0.011 level.

4.6 Discussion

To the researcher's knowledge, this was the first study that had been performed on the knowledge and attitudes of communities in Tanzania towards mental illness. In the literature study, it was shown that knowledge and attitudes were associated with health seeking behaviour.

The outcomes of this study as in objective one which stated that, to determine the general knowledge about mental illness suggested that knowledge about mental illness was very poor in the Kinondoni community n=182 (61%). Most of the respondents thought that mentally ill people could not perform regular jobs, had no friends, whilst most respondents also thought that people with mental illness were dangerous, because of violent behaviour. Also n=143 (48.5%) of the respondents reported that they know a little about mental illness. These negative views were equally expressed by all groups during this study, whilst gender, age, marital status and employment status showed no correlation with knowledge, or no knowledge about the mentally ill. This is also supported by recent study on mental health knowledge in Australia which shows that the public are not well informed about mental illness. It is thus important that the level of mental health knowledge in the community be improved, in order for individuals to recognize mental illness and manage their own mental health more effectively (Francis *et al*., 2002:4).

The negative attitudes of participants n= 239 (79.6%) towards people with mental illness was implied by their responses, which stated that mentally ill patients should not have the right to find a job, have friends and be integrated into society, like other “normal” people. It is also revealed that n=135 (45.8%) disagreed that people with mental illness usually seek help to the mental health services; this means that the Kinondoni community members do not seek help when they experience mental illness. These responses suggest that community members have stigmatizing attitude towards people with mental illness, following this, the second and fourth objective was answered.

The majority of participants also stated that they would not be friends with mentally ill people, but instead they felt the need to hide a friend’s illness from others. These findings answers the third objective and had been supported by Nordt *et al*. (2006: 709), who concluded that negative attitudes towards people with mental illness were widespread in the general public. For that reason, negative attitudes and discriminating behaviours towards people with mental illnesses are often referred to as stigmatisation. This was in accordance with other studies, which have also concluded that people may be reluctant to seek treatment for or disclose mental health problems, even common forms of anxiety and depression, for fear of social rejection and discrimination, leading to treatment discontinuation (Watson & Corrigan, 2002:22).

It was interesting to learn from the research outcomes that the higher the education levels of the participants the higher the percentage of positive responses. As acknowledged by World Health Organisation (Issa et al., 2008:43) that greater education leads to greater openness about mental illness.

From the results of this study, it was evident that males n=140 (46.6%) of all ages showed more negative attitudes towards the mentally ill, than females of all ages. Furthermore, the findings clearly showed that majority of the respondents having negative behaviour towards people with mental illness. Here, younger respondents (18 - 28 years) expressed negative attitudes, whilst respondents older than 51 expressed even more negative attitudes towards mental illness than others. This is supported by Highet et al., (2002:1) that

gender, and age may also play a role of having stigmatising attitude towards mental illness.

This study showed that marital status and employment status n=169 (56.3%) did not influence attitudes towards the mentally ill. This is contrary to Karine (2000:1-2; Gureje et al., 2005: 437; Norman et al., 2008:852) who states that mentally ill people fails to have employment and long term relationships with their beloved ones.

4.4 Conclusion

It is a widely shared belief that an increase in the community's mental health literacy should result in an improvement of attitudes towards people with mental illnesses (Gureje et al., 2006: 2). More recently, community attitudes in some countries have changed as a result of improving the community's mental health literacy to become more like those of professionals (Jorm et al., 2005: 1). Several studies have shown that knowledge of the community's attitude towards mental illness and its treatment is a vitally important prerequisite to the realisation of successful community based programs (Kabir *et al*., 2004:2).

The specific objectives set for this study were achieved namely to determine whether:

- Community members have general knowledge about mental illness
- Stigma of mental illness exist among community members
- There is rejection of people suffering from mental illness
- Community members are aware of existing mental health services in their area.

In the following chapter, the researcher briefly summarises this research study and give recommendations on how to improve the knowledge and attitude of the Kinondoni community members.

CHAPTER FIVE

SUMMARY, RECOMMENDATION AND CONCLUSION

5.1 Summary of chapters

In chapter one the researcher introduced, defined and contextualised the research. It has shown that better knowledge should lead to more constructive attitudes and changes in behaviour towards mental illness (Angermeyer *et al*., 2009:225). Contrary, it has shown that inadequate knowledge hindered the community members to use mental health services in both developing and developed countries (Muga & Jenkins, 2008:470).

Subsequently, in chapter two the researcher focused on a literature review concerning knowledge and attitudes regarding mental illness.

Chapter three described the research design and methodology of this study. The research process was discussed and applied to this study in various steps, including data collection, sampling, instrumentation, data collection, validity and reliability, and ethical considerations.

In chapter four the results were presented and interpreted. In conclusion, based on the research outcomes, the research question was answered that is the Kinondoni community members had less knowledge and held negative attitudes towards mental illness.

In the remainder of this chapter, the researcher described the proposed recommendations to help improve the knowledge and attitudes of the Kinondoni community members towards mental illness. The researcher further summarises the completed process of this research study and discusses the recommendations, based on the research outcomes.

5.2 Recommendations to improve the Kinondoni community's knowledge regarding mental illness

These recommendations focused on the community, nursing education and clinical practices, as well as on recommendations for further research that would be important for the nursing practice and the community as a whole. On the basis of the research results, the following are recommendations:

- Capacitate health workers to empower the Kinondoni community members regarding knowledge of mental illness, in order to change the attitudes of the community, as well as the health seeking behaviour of mentally ill individuals.

- To inform the nursing educators and developers of the mental health curriculum, in an effort to help improve the knowledge of mental health nursing students in order to assist the community and facilitate mental health education effectively.

- Stimulate further research regarding mental health knowledge and attitudes, in order to improve knowledge and a change in the attitudes of the Kinondoni community, as well as the health seeking behaviour of mentally ill individuals.

These recommendations are elaborated as follows:

5.2.1 Community level

The community should know and be empowered for the following:

- The ability to recognise specific disorders or different types of psychological distress;
- Knowledge and attitudes about risk factors and causes;
- Knowledge and attitudes about self-help interventions;
- Knowledge and attitudes about professional help available in the community; and
- Attitudes, which facilitate recognition and appropriate help-seeking, and knowledge on how to seek mental health information.

The guidelines for improving mental health literacy in the community usually comprise of education and communication approaches. These activities may be classified in a number of different ways, and can be considered in terms of **Scope** (universal preventive measures, for example, targeting the whole population or population groups), **Mode of delivery** for example, mass media, brochures, oral presentations by experts, religious leaders and community leaders, and **Scale**, small, local or large (Francis *et al*., 2002:8).

To facilitate the above, educational programs should be planned and conducted using various methods such as community sensitization, through campaigns and workshops in churches, schools, Non Governmental Organisations and all sectors to raise community awareness and to modify the attitudes of the

community towards people suffering from mental illnesses. Furthermore in the community there should be educational programs conducted by mental health practitioners for rehabilitation of mentally ill people and families with mentally ill patients. This is also supported by Francis *et al*. (2002:8).

5.2.2 Nursing education and clinical practice

Nursing educators and developers of the mental health curriculum should be informed, in order to include mental health education programs in the nursing curriculum. For that reason the community should receive direct education from nurses in primary care and clinical settings, in order to improve the knowledge of mental health nursing students to assist the community and facilitate mental health education effectively.

Nurses should know what and how they are going to teach, to assist the community regarding knowledge and appropriate attitudes towards mental illness. As has been noted, the range of attitudes among mental health professionals in relation to stigmatization is similar to that of the general public and stigmatizing behaviour from professionals is not uncommon (Hugo *et al*., 2003:716).

5.2.3 Recommendations for further research

A primary goal of psychiatric and mental health nursing is the promotion of mental health and the prevention of mental disorders. Even more importantly, all nurse-client interactions are potentially teaching / learning situations. The nurse attempts to understand the life experience of the client and uses this understanding to support and promote learning related to health and personal development. The nurse provides mental health promotion information to

individuals, families, groups, populations and communities (Buchanan *et al*., 1998:10).

A recommendation for further research that may be important to communities could be the development of guidelines that would help enhance the knowledge and attitudes of community members towards mental illness. Studies have shown that various change strategies have been applied to enhance the mental health literacy of health professionals and of the community, but with deferring degrees of success. Most of them have focused on raising awareness and changing attitudes, with the assumption that behavioural change would follow (Bourget Management Consulting for the Canadian Alliance on Mental Illness and Mental Health, 2004:17). However, Jorm (2005:877) states that there is some evidence that people who have information about mental illness may be less stigmatizing and more supportive of others who have mental health problems. For example, recognition of mental illness has improved somewhat in Australia, following the implementation of initiatives to improve mental health knowledge. However, researchers still believe that there is room for improvement (Jorm *et al*., 2006a:143). Apart from people having information about mental illness there is also a need to motivate people to have positive attitude towards mentally ill people so that they can be supported, and hence reduce the burden of being rejected by the families as well as the community.

5.3 Conclusion

Lack of knowledge and negative attitudes towards mental illness still bind the Kinondoni community. This fact was compounded by a lack of community mental health educational programs. There is thus a need for community mental health education in order to improve the knowledge and attitudes of the public towards mental illness. This may encourage early health seeking behaviour, as well as better treatment outcomes.

This research project provided an acceptable baseline to support progress in capacitating health workers to empower the Kinondoni community members

regarding knowledge of mental illness, in order to change the attitudes of the community, as well as the health seeking behaviour of mentally ill individuals. Also to inform the nursing educators and developers of the mental health curriculum, in an effort to help improve the knowledge of mental health nursing students in order to assist the community, provide care and facilitate mental health education effectively. And finally to stimulate further research regarding mental health knowledge and attitudes, in order to improve knowledge and a change in the attitudes of the Kinondoni community, as well as the health seeking behaviour of mentally ill individuals.

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ANNEXURE ONE

Written Consent Letter

KINONDONI MUNICIPAL COUNCIL

ALL CORRESPONDENCES SHOULD BE DIRECTED TO THE MUNICIPAL DIRECTOR

Tel: 2171022

In reply please quote:

Ref. No. FD/K/3/VIII/207

MUNICIPAL MEDICAL OFFICER OF HEALTH,
KINONDONI MUNICIPAL COUNCIL
P.O. BOX 61665,
DAR ES SALAAM

Date: 04th January, 2010

WARD EXECUTIVE OFFICERS,
KIBAMBA, KAWE, KINONDONI & MAGOMENI WARDS,
KINONDONI MUNICIPAL.

RE: RESEARCH PERMIT

Mr. John Chikomo

The above-mentioned candidate is a student at the **University of Stellenbosch, South Africa**, pursuing his **Masters degree in Nursing studies** with specialization in Research methodology focusing on Mental Health. He has been given a permit to conduct his research starting from 04/01/2010 to 28/02/2010 on "**assessment on knowledge and attitude of Kinondoni community members towards Mental illness**" in our Municipality.

Please provide him with all the necessary assistance so as he fulfills this task comfortably.

Best wishes,

Dr. Hafidh K.H. Ameir
For: Municipal Medical Officer of Health
Kinondoni Municipal Council

Copy: To above mentioned candidate.

CONSENT FORM

CERTIFICATE OF CONSENT

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Print Name of Participant_____

Signature of Participant _____

Date _____

Day/month/year

If illiterate [1]

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness_____ **Thumb print of par**

Signature of witness _____

Date _____

Day/month/year

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done:

1.
2.
3.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly

[1] **A literate witness must sign (if possible, this person should be selected by the participant and should have no connection to the research team). Participants who are illiterate should include their thumb print as well.**

and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this ICF has been provided to the participant.

Print Name of Researcher/person taking the consent_____

Signature of Researcher /person taking the consent_____

Date _____

Day/month/year

ETHICAL APROVAL REPORT

11 February 2010 **MAILED**

Mr J Chikomo
Department of Nursing
2nd Floor, Teaching building
Stellenbosch University
Tygerberg campus
7505

Dear Mr Chikomo

"Guidelines to improve the Kinondoni community's knowledge regarding mental illness."

ETHICS REFERENCE NO: N09/11/315

RE : APPROVAL

It is a pleasure to inform you that a review panel of the Health Research Ethics Committee has approved the above-mentioned project on 5 February 2010, including the ethical aspects involved, for a period of one year from this date.

Please note that the reviewer suggests that you use our special concise "Colleagues and student" participant informed consent form (PICF), accompanied by a short explanatory letter; see www.sun.ac.za/rds (click on application package).

This project is therefore now registered and you can proceed with the work. Please quote the above-mentioned project number in ALL future correspondence. You may start with the project, but this approval will however be submitted at the next meeting of the Health Research Ethics Committee for ratification. Notwithstanding this approval, the Committee can request that work on this project be halted temporarily in anticipation of more information that they might deem necessary to make their final decision.

Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly and subjected to an external audit.

Translations of the consent document in the languages applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Please note that for research at primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907)

and Dr Hélène Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

Approval Date: 5 February 2010

Expiry Date: 5 February 2011

Yours faithfully

MR FRANKLIN WEBER
RESEARCH DEVELOPMENT AND SUPPORT
Tel: +27 (0)21 938-9657 / E-mail: fweb@sun.ac.za
Fax: +27 (0)21 931-3352

DECLARATION BY THE LANGUAGE EDITOR

I, **Julia Handford**, herewith declare that I language edited and technically cared for the thesis of **John G. Chikomo** that is entitled: "**KNOWLEDGE AND ATTITUDES ASSESSMENT OF THE KINONDONI COMMUNITY TOWARDS MENTAL ILLNESS**".

Yours truly,

JULIA HANDFORD

_____

Signature and credentials of language editor
Julia S Handford [MBA, BCom (Acc), BSc (Hons), HTD]

Date: **9 August 2010**

ANNEXURE TWO

Research Questionnaire

KNOWLEDGE AND ATTITUDE QUESTIONNAIRE

Adjusted from:

1. Office of Institutional Research and Planning SVC 5022. 1999. University of South Florida, Spring, 1999.
2. Ng and Chan. 2000. A modified version of the questionnaire: opinions about mental illness in the Chinese community, OMICC.

A: SOCIO-DEMOGRAPHIC INFORMATION

(Select by ticking the appropriate answer)

1. Gender

a. Male

b. Female

2. Religion

a. Christian

b. Muslim

c. Hindu

d. Others (specify) _____

3. Age

a. 18-24

b. 25-34

c. 35 and above (specify) _____

4. Marital status

a. Single

b. Married

c. Separated

d. Divorced

e. Widowed

5. Employment

a. Employed

b. Unemployed

6. Educational level

a. No education

b. Primary education

c. Secondary education

d. College

e. University

B: KNOWLEDGE ABOUT MENTAL ILLNESS

(Select by ticking the appropriate answer)

7. How familiar are you with mental health services available in Kinondoni municipality?

a. Very familiar

b. Somewhat familiar

8. How much do you know about mental illness?

a. A good deal

b. A little

c. None

9. **Do you think people who suffer from mental illness have many friends?**
    a. Yes
    b. No

10. **Do you think people with mental illness can do a regular job?**
    a. Yes
    b. No

11. **People with mental illness are dangerous because of violent behaviour.**
    a. Yes
    b. No

12. **People with mental illness usually seek help at the mental health services.**
    a. Agree
    b. Disagree
    c. I don’t know

13. **There are sufficient existing services for the mentally ill.**
    a. Strongly disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly agree

14. **Mental hospitals are an outdated means of treating the mentally ill.**
    a. Strongly disagree
    b. Disagree

c. Neutral

d. Agree

e. Strongly agree

15. Community members have good reason to resist seeking mental health services available in their neighbourhood.

a. Strongly disagree
b. Disagree
c. Neutral
d. Agree
e. Strongly agree

16. Community members have nothing to fear from people coming into their neighbourhood to obtain mental health services.

a. Strongly disagree
b. Disagree
c. Neutral
d. Agree
e. Strongly agree

C: ATTITUDES TOWARDS MENTAL ILLNESS

(Select by ticking the appropriate answer)

17. People with mental illness have unpredictable behaviour.

a. Totally disagree
b. Almost totally disagree
c. Sometimes agree
d. Almost totally agree
e. Totally agree

18. If people become mentally ill once, they will easily become ill again.

a. Totally disagree
b. Almost totally disagree
c. Sometimes agree
d. Almost totally agree

e. Totally agree

19. **If a mental health facility is set up in my street or community, I will move out of the community.**
    a. Totally disagree
    b. Almost totally disagree
    c. Sometimes agree
    d. Almost totally agree
    e. Totally agree

20. **Even after a person with mental illness has been treated, I would still be afraid to be around them.**
    a. Totally disagree
    b. Almost totally disagree
    c. Sometimes agree
    d. Almost totally agree
    e. Totally agree

21. **Mental patients and other patients should not be treated in the same hospital.**
    a. Totally disagree
    b. Almost totally disagree
    c. Sometimes agree
    d. Almost totally agree
    e. Totally agree

22. **When a spouse is mentally ill, the law should allow for the other spouse to file for divorce.**
    a. Totally disagree
    b. Almost totally disagree
    c. Sometimes agree
    d. Almost totally agree

e. Totally agree

23. People with mental illness tend to be violent.

a. Totally disagree
b. Almost totally disagree
c. Sometimes agree
d. Almost totally agree
e. Totally agree

24. People with mental illness are dangerous.

a. Totally disagree
b. Almost totally disagree
c. Sometimes agree
d. Almost totally agree
e. Totally agree

25. People with mental illness should be feared.

a. Totally disagree
b. Almost totally disagree
c. Sometimes agree
d. Almost totally agree
e. Totally agree

26. It is easy to identify with those who have a mental illness.

a. Totally disagree
b. Almost totally disagree
c. Sometimes agree
d. Almost totally agree
e. Totally agree

27. You can easily tell who has a mental illness, by the characteristics of their behaviour.

a. Totally disagree
b. Almost totally disagree
c. Sometimes agree
d. Almost totally agree
e. Totally agree

28. People with mental illness have a lower Intelligent Quotient.

a. Totally disagree
b. Almost totally disagree
c. Sometimes agree
d. Almost totally agree
e. Totally agree

29. All people with mental illness have some strange behaviour.

a. Totally disagree
b. Almost totally disagree
c. Sometimes agree
d. Almost totally agree
e. Totally agree

30. It is inappropriate for a person with mental illness to get married.

a. Totally disagree
b. Almost totally disagree
c. Sometimes agree
d. Almost totally agree
e. Totally agree

31. Those who have a mental illness cannot fully recover.

a. Totally disagree
b. Almost totally disagree
c. Sometimes agree
d. Almost totally agree
e. Totally agree

32. Those that are mentally ill should not have children.

a. Totally disagree
b. Almost totally disagree
c. Sometimes agree
d. Almost totally agree
e. Totally agree

33. There is no future for people with mental illness.

a. Totally disagree
b. Almost totally disagree
c. Sometimes agree
d. Almost totally agree
e. Totally agree

34. People with mental illness can hold a job.

a. Totally disagree
b. Almost totally disagree
c. Sometimes agree
d. Almost totally agree
e. Totally agree

35. **The care and support of family and friends can help people with mental illness to get rehabilitated.**
    a. Totally disagree
    b. Almost totally disagree
    c. Sometimes agree
    d. Almost totally agree
    e. Totally agree

36. **Corporations and the community (including the government) should offer jobs to people with mental illness.**
    a. Totally disagree
    b. Almost totally disagree
    c. Sometimes agree
    d. Almost totally agree
    e. Totally agree

37. **After a person is treated for mental illness, they can return to their former job position.**
    a. Totally disagree
    b. Almost totally disagree
    c. Sometimes agree
    d. Almost totally agree
    e. Totally agree

38. **The best way to help those with a mental illness to recover, is to let them stay in the community and live a normal life.**
    a. Totally disagree
    b. Almost totally disagree
    c. Sometimes agree
    d. Almost totally agree

e. Totally agree

39. After people with mental illness are treated and rehabilitated, we still should not make friends with them.

a. Totally disagree
b. Almost totally disagree
c. Sometimes agree
d. Almost totally agree
e. Totally agree

40. After people with mental illness are treated, they are still more dangerous than normal people.

a. Totally disagree
b. Almost totally disagree
c. Sometimes agree
d. Almost totally agree
e. Totally agree

41. It is possible for everyone to have a mental illness.

a. Totally disagree
b. Almost totally disagree
c. Sometimes agree
d. Almost totally agree
e. Totally agree

42. We should not laugh at the mentally ill, even though they act strangely.

a. Totally disagree
b. Almost totally disagree
c. Sometimes agree
d. Almost totally agree
e. Totally agree

43. It is harder for those who have a mental illness to receive the same pay for the same job.

a. Totally disagree
b. Almost totally disagree
c. Sometimes agree
d. Almost totally agree
e. Totally agree

44. After treatment, it will be difficult for the mentally ill to return to the community.

a. Totally disagree
b. Almost totally disagree
c. Sometimes agree
d. Almost totally agree
e. Totally agree

45. People are prejudiced towards those with mental illness.

a. Totally disagree
b. Almost totally disagree
c. Sometimes agree
d. Almost totally agree
e. Totally agree

46. It is hard to have good friends if you have a mental illness.

a. Totally disagree
b. Almost totally disagree
c. Sometimes agree
d. Almost totally agree
e. Totally agree

47. It is rare for people who are successful at work to have a mental illness.

a. Totally disagree
b. Almost totally disagree
c. Sometimes agree
d. Almost totally agree
e. Totally agree

48. It is shameful to have a mental illness.

a. Totally disagree
b. Almost totally disagree
c. Sometimes agree
d. Almost totally agree
e. Totally agree

49. Mental illness is a punishment for doing some bad things.

a. Totally disagree
b. Almost totally disagree
c. Sometimes agree
d. Almost totally agree
e. Totally agree

50. I suggest that those who have a mental illness should not tell anyone about their illness.

a. Totally disagree
b. Almost totally disagree
c. Sometimes agree
d. Almost totally agree
e. Totally agree

ANNEXURE THREE

Declaration by Participant

By signing below, I _____ agree to take part in a research study entitled *(*Guidelines to improve the Kinondoni community's knowledge regarding mental illness*)*.

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) _____ on (*date*) _____ 2010

_____ _____

Signature of participant **Signature of witness**

DECLARATION BY PARTICIPANT IN KISWAHILI

Makubaliano na Mshiriki

Kwa kutia sahihi hapo chini, Mimi _____

Nakubali kushiriki (kuwa mshiriki) katika utafiti huu wenye kichwa kiitwacho (Guidelines to improve the Kinondoni Community's Knowledge regarding Mental illness) = Mwongozo wa kuboresha uelewa wa ugonjwa wa akili kwa wananchi wa Kinondoni.

Nakubali kwamba:

- Nimesoma maelezo kwenye fomu ya makubaliano yameandikwa.
- Nilipewa nafasi ya kuuliza maswali na maswali yangu yalijibiwa vizuri.
- Na nimeelewa kushiriki katika utafiti huu ni hiyari na sijalazimishwa na mtu kushiriki.
- Ninayo hiyari ya kuacha kushiriki wakati wowote na bila kuchukuliwa sheria wala kunyanyaswa kwa namna yoyote.
- Ninaweza kuacha kuendelea kushiriki hata kama utafiti unaendelea kama daktari wa utafiti huu, au mtafiti ataona itakuwa ni faida kwangu, au kama sitafuatisha mipango iliyopangwa.

Mahali _____ tarehe _____ 2010

_____ _____

Sahihi ya mshiriki **Sahihi ya shahidi**