

## Knowledge Of Mental Health And Mental Illnesses Among Community Members In Bungoma County, Kenya

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**Abstract:** Objective. The objective of the study was to determine the knowledge of mental health and mental illness by the community in Bungoma county Kenya. Design. The study was a descriptive cross-sectional study and Quantitative methods were adopted. Setting. The study was carried out in Bungoma County Sample. Five Sub-Counties in Bungoma County were purposively sampled to increase the representation. The household's heads were sampled by stratified sampling; the researcher divided the population into strata and drew a predetermined number using simple random sampling (n = 396) Analysis. Data was analyzed through descriptive statistics, chi-square test of independence and logistic regression. Main outcome measures. Knowledge of mental health and mental illness Results. 67.7% (268) disagreed that mental illness is an illness like any other. 60.6% (240) disagreed that one of the main causes of mental illness is lack of self-discipline and will power. Majority of the respondents 292 (73.7%) agreed that, if people become mentally ill, they would easily become ill again. Of the 396 respondents, 300 (75.8%) of respondents agreed that people with mental illness have a lower intelligent quotient. Chi square analysis showed that there was no statistically significant relationship between the knowledge of mental illness and gender  $X^2(1, N=369) = 0.22$ . Logistic regression was done and respondents who were single were 0.4 times more likely (OR=0.42, 95% C.I, 0.06-2.84) to belong to the 'poor knowledge' group than the 'good knowledge' group compared to the widowed Conclusion. That sensitization of the community/public on mental illnesses is important. Scaling up public awareness campaigns to reach more people by diversifying the approaches targeting specific group of family members having mentally ill persons.

**Keywords:** Mental health, Mental illness, Knowledge of mental illness, public knowledge, sensitization, stigma, myths about mental illness.

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### I. Background

The World Health Organization (WHO) recognized the importance of psychological wellbeing, defining health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" WHO-AIMS, (2005). For all individuals, mental, physical and social health are vital elements of life that are closely interwoven and deeply interdependent (WHO report, 2011). Today mental health problems are recognized as a public health problem in developed as well as developing countries Pinfold et al. (2008). A 2011, study in United States (U.S) found out that 5 to 6 million U.S workers aged 16 to 54 years "lost, failed to seek, or could not find employment" due to mental illness (Cohen & Struening, 2013). Reduced earnings and decreased employment potential put mentally ill individuals at an increased risk of poverty Pinfold et al. (2008). As Lund et al. (2013) explained, mental illness and poverty "interact in a negative cycle", in which poverty acts as a risk factor for mental illness, and mental illness increases the risk that individuals will drift into or remain in poverty". This negative cycle contributed to high rates of homelessness among individuals with mental illnesses Mas & Hatim (2009). The notion that mental health problems were less common in low-income countries than in developed countries was disputed by Morgan, (2010).

In a typical African context, mental health disorders and mental illness were normally associated with witchcraft and sorcery Issa et al. (2008), Gikonyo (2009) & Hugo (2011). Most families/communities perceived it as a punishment from "gods" for a wrong act committed by a family member, most especially the clan Reid et al. (2014). Usually the blame would be shifted to the mother of the person with mental illness, thereby initiating and causing family and marriage breakdown. A good sense of self-esteem was therefore required to cope effectively and promote good mental health for the family/community (Gikonyo, 2009). Evidence suggested that there was considerable variation in how families and community adapted to the demands of the affected individual and family (Kitchener & Jorm, 2013). Contextual factors such as socio-economic status, severity of

mental disorder and behavioral problems of the affected, social support and coping strategies were associated with psychological distress and depression (Muga & Jenkins, 2012).

Several studies have found out that many members of the community lack knowledge about mental illness, especially with respect to beliefs and myths about causes of the disorders (Trainer, 2008). Some believed that psychiatric illness was not a disease, but a curse that was caused by witchcraft and evil spirits. (Watson & Corrigan, 2002; Sadok & Sadok, 2015) agreed that traditional communities believed that mental illnesses are caused by spirits and curses, with influences by the moon, or that it is a divine punishment. Trainer & Pierre (2014) reiterated 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 (Abbey et al., 2011). For example, in Malaysia beliefs by psychiatric patients in supernatural causes were associated with great use of traditional healers and poor compliance with modern medication (Jorm, 2010). Therefore, negative beliefs about causes and lack of adequate knowledge have been found to sustain deep seated negative attitudes about mental illness (Gureje et al., 2005). Conversely, better knowledge has often been reported to result in improved attitudes towards people with mental illness and a belief that mental illnesses were treatable, can encourage early help seeking and promote better outcomes (Ephraim-Oluwanuga & Kola., 2010). However, in practice professional help was often not sought at all or only sought after a delay (Barney et al., 2008). Early recognition and appropriate help seeking only occurred if mentally ill patients and their “supporters” (e.g. their family, teachers, employers 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).

The National Development plan report on statistics (GOK, 2002) further indicated that approximately 1.8 million people in Kenya aged between 0-19 have mental health disorders. The taskforce established that there were 998 persons enrolled in special schools and units in other major towns (KDHS, 2008). Out of these 225 had mental health disorders comprising of autism, mental retardation among other conditions (Livingstone & Boyd, 2010). As per the census report by Kenya National Bureau of Statistics (GOK, 2009), there are no statistics on the number of persons with mental illness since some have been hidden from the public and the number registered does not give the true picture of the target population (Becker & Klumman, 2013). Studies have shown that in the Western world, mental illnesses are generally thought to be caused by psychological factors, such as environmental stressors, or childhood events (Krifton et al., 2012). Biochemical and genetic influences, although recognized as causal factors, are not considered as important as environmental ones (Jorm, 2011). Some studies suggested 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 (Krifton et al., 2012). Over the last 50 years, philosophies of service delivery to people with mental health problems have changed considerably (Ephraim-Oluwanuga & Kola, 2007). More particularly, in the last few decades the focus has changed from medical and therapeutic needs only to an approach that included the needs of the whole family.

In the developed world, these changes have coincided with the de-institutionalization of people with mental illness and children with an intellectual disability, legislation mandating a range of advocacy, educational and intervention policies, and the increasing entry of these children into mainstream schools (Stuart, 2008). For example, in the 1970's in the United States, legislation was passed that mandated early intervention programs for families with a person with mental health problem, recognizing the important role of the family in maximizing the life outcomes especially for the children and people with mental health conditions (Trainer & Pierre, 2014). According to Modest (2008), causes of mental illness is not synonymous, but vary 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 (Mehta et al. 2010). Inarguably, ignorance and stigma prevent the mentally ill from seeking appropriate help (Kabir et al. 2009). Researchers have often assessed stigma, associated with mental illness, by surveying the community's attitudes and perceptions towards “mental patients”, or “persons with mental illness”, and in using these terms, evoking images of chronic psychopathology (Corrigan et al. 2011).

The researcher therefore, sought to fill exiting knowledge gaps in the study area. Past studies on causes of mental illnesses were done in different geographical regions and differently Krifton *et al.* (2012). This is the knowledge gap that the study attempted to address Modest (2008). This study also sought to understand the local contexts of perception in order to develop effective programs to change such attitudes in the community where the mentally affected lives Mehta et al (2010). Therefore, the researcher found it necessary to conduct this study. The objective of the study was to determine the knowledge of mental health and mental illness by the community in Bungoma County, Kenya.

## II. Methods

The study was conducted in Bungoma county and ethics approval was obtained from Masinde Muliro University of Science and Technology ethics board, National commission for science and technology. No further approval was needed since the project did not require access to patients or personal data.

### Research Design

The study designs adopted for this study was descriptive cross-sectional and evaluation because they employ quantitative approaches, where self-administered questionnaires were used for data collection. This particular designs were ideal since the research entailed collecting and comparing data from the phenomena at the same time of study (Basavanthappa, 2011). A descriptive research design determines and reports the way things are (Mugenda & Mugenda, 2008). Polit & Hungler (2010) observed that a descriptive research design was used when data was collected to describe persons, organizations, settings or phenomena. The purpose of the design was to gather data at a particular point in time with the intention of describing the nature of the existing conditions (Burns and Grove, 2011). Descriptive study design was also ideal as the study was carried out in a limited geographical scope and hence it was logistically easier and simpler to conduct considering the limitations of this study (Mugenda & Mugenda, 2008). It helped make judgments about values or worth of developing mental health campaigns and other rehabilitation programs like half-way home centers for the mentally ill (Wisner *et al.* 2014). Therefore, the descriptive survey was deemed the best strategy to fulfill the objectives of this study.

### Study setting

The study was carried out in Bungoma County, Kenya. Bungoma town is the Headquarter of Bungoma County and the third largest County in Western Kenya (Maphill, 2011). It was the Mount Elgon region in the former larger Western Province and it lies 102 kilometers North West from Kisumu City on an altitude of 4,400ft (1,340 m) (Kenya Mpya, 2013). According to the Government of Kenya Census (2012), it has a population of 1,375,063 (1.38m) and the County covers an area of 2,206.9 km<sup>2</sup> (852.1 sq mi). There are 67,358 households within the County (Kombo & Delmo, 2015).

### Participants

Mugenda and Mugenda (2008) defined population as all elements (individuals, objects and events) that meet the sample criteria for inclusion in a study. In this study the target population were people who resided in Bungoma County and met the criteria of interest to the researcher (Burns & Grove, 2011). The researcher then randomly sampled the units of the study from the accessible population (Polit & Hungler, 2010). The researcher focused on community households heads aged 18 years and above. The research used a sample size of 398.

Bungoma was purposively selected because of the post-election violence in 2008, 2009 and 2013 in Kenya, which caused closure of most factories and industries, thereby increasing violence related mental illnesses and exacerbating existing ones (Inyanji, 2014). It recorded the highest cases of depression and other mental health disorders (Kenya Red Cross, 2015). Like in the Mt Elgon region, there were a lot of animosity resulting in people torching houses and hacking one another to death (UNHCR, 2012). Five Sub-Counties in Bungoma County were purposively sampled to increase the representation (KDHS, 2008/9). The household's heads were sampled by stratified sampling; the researcher divided the population into strata and drew a predetermined number using simple random sampling. The sample size was determined using Cochran equation (1963):

$$n = \frac{z^2 p q}{d^2}$$

Where:

n = the desired sample size (when the target population is greater than 10,000)

z = standard normal deviation set at 1.96 which corresponds to 95% confidence interval

p = proportion of the target population estimated to have a characteristic that is being measured (at 50%) to maximize sample size.

q = 1 – p (1 – 0.5) = 0.5

d = degree of accuracy desired set at 0.05

Therefore,

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

In order to take care of any losses due to spoilage and lack of response, a 10% attrition was added to the sample size making it 422.

### **Questionnaire**

Questionnaires were selected as data collection instruments. A questionnaire is a printed self-report form designed to elicit information that can be obtained through the written responses of subjects. The information obtained through a questionnaire is similar to that obtained by an interview, but questions to have less depth (Denzin, 1970). The instrument comprised of the following sections: In section one, the information that was collected was the demographic characteristics and included age, gender, marital status, education level and religion. In section two, nine questions sought to determinental health knowledge levels (Bloom, 1998).this questions were modified from a validated tool used by (Ng & Chan 2004). The questions were ranked on a 2-point likert scale with the anchors being disagree=0 to agree=1. To increase the validity and reliability of the instruments, the questionnaire was evaluated by experts. Then based on the feedback the final questionnaire was prepared for pre-test. The pretest study was conducted in one Sub-County in Bungoma County. The reliability of the scale of the 9 items was found to be: Internal consistency = (Cronbach's  $\alpha = 0.79$ ).Deleting selected items would not increase the alpha.

### **Data Analysis**

Data analysis was done using the statistical program for social sciences (SPSS) version 23. Inferential and descriptive statistics were used to analyze data. Descriptive analysis of data was done using the mean, frequencies and percentages. In this study association between the study variables was assessed by a two-tailed probability value of  $p < 0.05$  for significance. Visual inspection of the data illustrated that missing data appeared to be missing at random. After visual inspection, in order to further examine the pattern of missing data, the researcher evaluated whether the data was missing completely at random (MCAR). The researcher utilized Little's MCAR test (Schlomer *et al.*, 2010) which employs a chi-square statistical analysis and assumes the null hypothesis, that missing data is missing completely due to randomness. In this case, failing to reject the null hypothesis indicates that the data was most likely not missing in a random way. For this study, Little's MCAR test results showed that Knowledge ( $\chi^2 [112] = 86.447, p = .965$ ) was not significant indicating that the variables were missing completely at random, the researcher proceeded to address the missing data. To avoid reducing the variances of the scores by replacing missing items using subscale means, the missing data items were instead imputed using the Expectation- Maximization (EM) algorithm within SPSS 23; EM is considered a superior method for conducting missing data imputation when one has MCAR data (Schlomer *et al.*, 2010). Their guidelines were considered when reviewing the missing data for the current research study. Each question was coded and entered in SPSS (Barohn *et al.*, 2012). The findings were entered in the variable view of the Statistical Package for Social Sciences (SPSS) version 20.0 screen, each questionnaire at a time, starting with first to last questionnaire (Cohen, 2011). The researcher conducted analyses of normality, for the outcome variable, prior to hypothesis testing by examining kurtosis and skewness of the data. In order to test and identify possible outliers in the data, graphical assessment visuals, including scatter and box plots were used. Elimination of observed outliers was based on a case by case basis, dependent on standard deviations, and on normality and homogeneity of variance assessments. Normality was assessed using examination of the histograms by seeing how they related or deviate against a normal bell curve distribution and observing the levels of kurtosis and skewness present.

Univariate analysis was used to describe the distribution of each of the variables in the study objective, appropriate descriptive analysis was used to generate frequency distributions, tables and other illustrations used to analyze community knowledge. Bivariate and multivariate analysis was used to investigate the strength of the association and check differences between the outcome variable and other independent variables. One-way analysis of variance (ANOVA) at 0.05 level of significance was used to determine if there is differences in Knowledge among levels of the demographic characteristics. The knowledge questions were to be indexed for each household head member and an index score was to be computed and was recorded on a new variable. Alpha level for all the computations was considered  $p < 0.05$ .

### **III. Results**

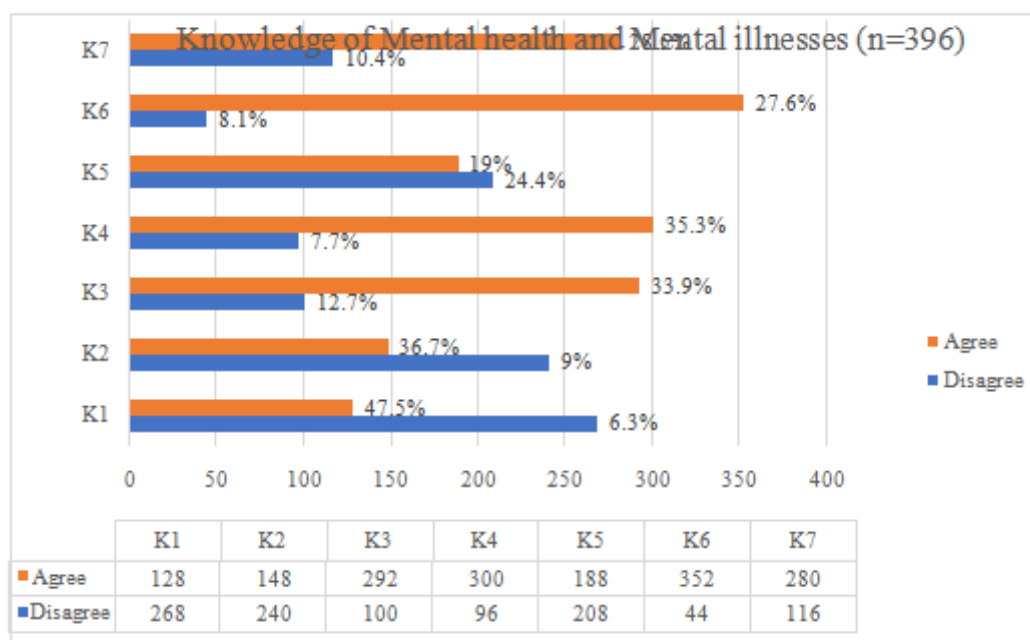
Out of the 422 questionnaires distributed, 396 were correctly filled and returned which represented a response rate of 87 percent. According to Mugenda and Mugenda (2003) a response rate of 50 percent is adequate, a response rate of 60 percent is good, and a response rate of 70 percent is very good. Therefore, the 87 percent response rate reported for this study formed an acceptable basis for drawing conclusions. While we should not expect full response in studies where responding is voluntary, scholars utilizing questionnaires should aim for a high response rate (Baruch & Holtom, 2008). Firstly, the study asked the respondents to indicate their background characteristics based on the gender, religion, marital status; age-bracket and education level. The summary of their responses is given in Table 1.

**Table 1. Background characteristics of respondents**

Demographics		Frequency	Percent
Gender	Male	172	43.4%
	Female	224	56.6%
	<b>Total</b>	<b>396</b>	<b>100.0</b>
Religion	Christian	220	55.6%
	Muslim	164	41.4%
	Hindu	8	3%
	<b>Total</b>	<b>396</b>	<b>100.0</b>
Marital Status	Single	148	37.4%
	Married	216	54.5%
	Separated	12	3%
	Divorced	8	2%
	Widowed	12	3%
	<b>Total</b>	<b>396</b>	<b>100.0</b>
Education level	No education	4	1.0%
	Primary education	220	55.6%
	Secondary education	120	30.3%
	College	28	7.1%
	University	24	6.1%
	<b>Total</b>	<b>396</b>	<b>100.0</b>
Age Bracket	18-24 years	200	50.5%
	25-34 years	128	32.3%
	35-45 years	48	12.1%
	Over 45 years	16	4%
	<b>Total</b>	<b>396</b>	<b>100.0</b>

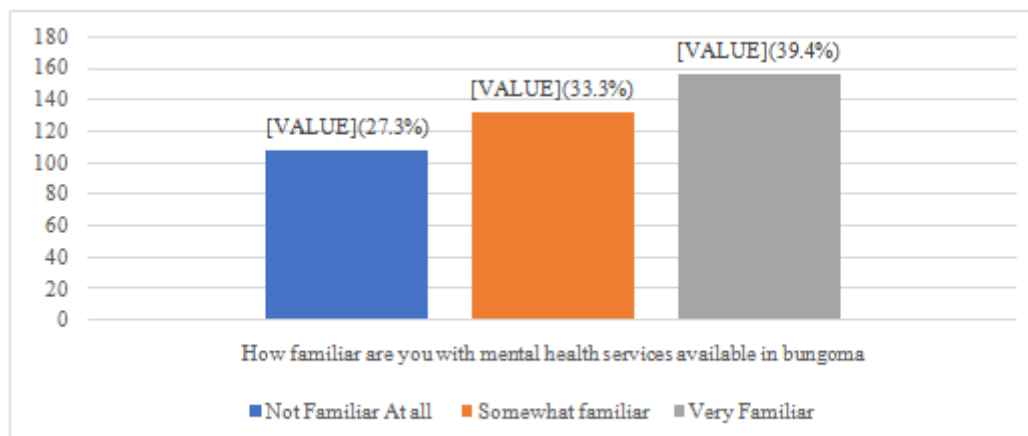
Findings in Table 1 revealed that, most 224 (56.6 %) were females while 172 (43.4%) were males. Distribution of age bracket showed that 200 (50.5%) were aged between 18-24 years, 128 (32.3%) were 25-34 years, 48 (12.1%) were 35-45 years, and 16 (4%) were over 45 years. Results on their level of education revealed that 220 (55.6%) had primary school education, 120 (30.3%) had secondary school education, 28 (7.1%) had college education and 4 (1%) had a no education at all. Findings in Table 1 revealed that, 268 (67.7%) disagreed that mental illness is an illness like any other. Results showed that 240 (60.6%) disagreed that one of the main causes of mental illness is lack of self-discipline and will power. Majority of the respondents 292 (73.7%) agreed that, if people become mentally ill, they would easily become ill again. Of the 396 respondents, 300 (75.8%) of respondents agreed that people with mental illness have a lower intelligent quotient. Majority of the respondents 352 (88.9%) agreed that mental illness and mental retardation are the same thing. Figure 1 below summarizes the responses on the knowledge items.

**Figure 1: Knowledge of Mental Health and Mental illnesses**



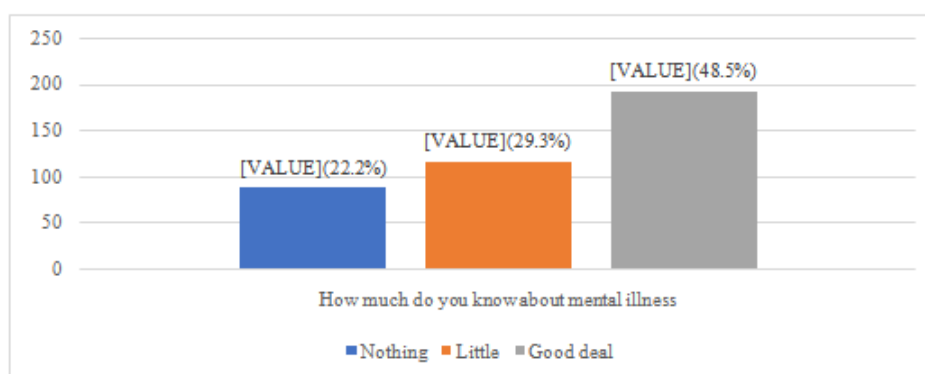
**Key**

- K1**-Mental illness is an illness like any other
- K2**-One of the main causes of mental illness is to lack self-discipline and will power
- K3**- If people become mentally ill, they will easily become ill again
- K4**-People with mental illness have a low intelligence quotient
- K5**-The best therapy for mental patients is to be part of a normal community
- K6**-Mentall illness and mental retardation are the same thing
- K7**-Virtually anyone can become mentally ill



**Figure 2.** Familiarity with mental health services available in Bungoma County.

With regard to mental health services in the County, only 156 (39.4%) said that they were very familiar with mental health services available in Bungoma County, 132 (33.3%) said they were somewhat familiar with the mental health services offered in the county. However, 108 (27.3%) said they were not at all familiar with the mental health services available in the County



**Figure 3.** How much respondents know about mental illness.

Almost half 192 (48.5%) of the respondents reported to have a good deal of knowledge about mental illness, 116 (29.3%) reported to have little knowledge about mental illness, while 88 (22.2%) said they had no knowledge about mental illness.

Respondents answered a total of seven closed ended questions. Scale scores were computed by adding responses to the seven questions. The score varied from 7 - 21 points and was classified into 2 levels according to the Blooms' (1956) cut off point as follows:

- High Knowledge (above 60%) 13 or more score.
- Poor Knowledge (below 60%) 12 or less score.

**Table 2. Knowledge of mental illness**

Sources	Frequency
Poor Knowledge	199
Good Knowledge	197
<b>Total</b>	<b>396</b>

With regards to Knowledge of mental illness 50.3% of the respondents scored less than 60 percent in the knowledge items and were categorized as having poor knowledge in mental illness (Bloom, 1998). However, 49.7% had over 60 percent score in the knowledge items and hence were categorized as having good knowledge

**Bivariate analysis of the relationship between Client characteristics and Knowledge of mental illness**

Results from table 3 show that the knowledge of mental illness among females was higher 52.7% compared to males 48.8% however chi square analysis showed that there was no statistically significant relationship between the knowledge of mental illness and gender  $X^2(1, N=369) = 0.22, p > 0.05$ . Respondents in the age bracket 35-45 years had the highest knowledge (72.7%) of mental illness, while those in the age bracket 34-45 years had the poorest knowledge of mental illness (38.7%). Results from the chi square showed that there was a statistically significant relationship between knowledge of mental illness and age  $X^2(3, N=369) = 32.722, p < 0.05$ .

Multinomial logistic regression was done, and the results showed people in the age group 18-24 were 1.7 times more likely (OR=1.17, 95% C.I, 0.4-3.8) to belong to the ‘poor knowledge’ group than the ‘good knowledge’ group compared to respondents over 45 years. With regards to marital status, respondents who were separated from their spouses had the highest knowledge (66.7%) of mental illness, while majority of the single people had poor knowledge of mental illness (55.6). Results from chi square test showed that there was a statistically significant relationship between marital status and knowledge of mental illness  $X^2(4, N=369) = 39.109, p < 0.05$ .

Logistic regression was done and respondents who were single were 0.4 times more likely (OR=0.42, 95% C.I, 0.06-2.84) to belong to the ‘poor knowledge’ group than the ‘good knowledge’ group compared to the widowed. Table 3 is a bivariate analysis of client characteristics and knowledge of mental illness.

**Table 3: Bivariate analysis of Client characteristics and Knowledge of mental illness**

	Poor Knowledge (60%>)	Good Knowledge (60%<)	O.R(95% C.I)	$\chi^2(p\text{ value})$
<b>Gender</b>				<b>0.882</b>
Male	84 (51.2%)	80 (48.8%)	-	
Female	104 (47.3%)	116 (52.7%)	-	
<b>Age Bracket</b>				<b>0.001</b>
18-24years	92 (46.9%)	104 (53.1%)	1.171 (0.359-3.825)	
25-34 years	76 (61.3%)	48 (38.7%)	2.098 (0.636-6.920)	
35-45 years	12 (27.3%)	32 (72.7%)	0.110 (0.022-0.544)	
Over 45	8 (50%)	8 (50%)	*	
<b>Religion</b>				<b>0.983</b>
Catholic	104 (49.1%)	108 (50.9)		
Muslims	80 (50%)	80 (50%)		
Hindu	4 (50%)	4 (50%)		
<b>Marital Status</b>				<b>0.05</b>
Single	80 (55.6%)	64 (44.4%)	0.419 (0.062-2.835)	
Married	92 (43.4%)	120 (56.6%)	0.209 (0.33-1.344)	
Separated	4 (33.3%)	8 (66.7%)	0.500 (0.05-4.957)	
Divorced	8 (100%)	0 (0.0%)		
Widowed	4 (50%)	4 (50%)	*	
<b>Educational Level</b>				<b>0.069</b>
Primary Education	116 (54.7%)	96 (45.3%)		
Secondary Education	48 (40%)	72 (60%)		
College	12 (42.9%)	12 (50%)		
University	12 (50%)	12 (50%)		
*Reference category				

**IV. Discussion**

The objective of the study was to find out knowledge of mental illness by the community in Bungoma county. The study revealed that the respondents were fairly educated though they did not have any other training skills on how to manage and cope with to identify signs of mental illness. This finding concur with Tierney *et al.* (2011) who pointed out that education level influences general view on matters of mental health. The findings also showed that 268 (67.7%) disagreed that mental illness is an illness like any other. The possible explanation could be due to the myths associated with mental illness (Mehta *et al.* 2010). Studies in the

developed world also show that, there has been de-institutionalization of people with mental illnesses and children with intellectual disability. Legislation has mandated a range of advocacy, educational and intervention policies and the increased entry of these children into mainstream schools (Stuart, 2011).

Results showed that 240 (60.6%) disagreed that one of the main causes of mental illness is lack of self-discipline. Lack of knowledge on causes of mental illness in the public has been documented in other studies elsewhere. Some believed that psychiatric illness was not a disease, but a curse that was caused by witchcraft and evil spirits (Watson & Corrigan, 2002). Sadok&Sadok, (2015) agreed that traditional communities believed that mental illnesses are caused by spirits and curses, with influences by the moon, or that it is a divine punishment. Trainer & Pierre (2014) reiterated that beliefs of this nature keep the stigma and discrimination alive. In addition, 108 (27.3%) said they were not at all familiar with the mental health services available in the County. This explains findings from other studies that reported only a small percentage of people with mental disorders generally received treatment (Viklud, 2010). The incidence is likely to be higher due to inadequacy of health services, specialized medical personnel and facilities (Regier et al., 2012). Similar studies carried out in Asia revealed that about 70% of individuals that suffered from mental illness did not seek help (Mati, 2012).

From the findings half 192 (48.5%) of the respondents reported to have a good deal of knowledge about mental illness. The findings are interesting because they are inconsistent with findings from literature, where majority of the respondents had low perceived knowledge of mental illness (Trainer, 2008, Watson & Corrigan, 2002 and Sadok&Sadok, 2015). Majority of the respondents 292 (73.7%) agreed that, if people become mentally ill, they would easily become ill again. The reason behind could be due to the limited knowledge on mental illness and its causes. Studies have reported that the community views mental illness as a strange occurrence and is associated with curses and bad omen (Sadok&Sadok, 2015). 75.8% of respondents agreed that people with mental illness have a lower intelligent quotient. This implies that the study population was unaware of other possible causes of mental illness and couldn't differentiate the various mental health problems a similar observation was reported by a study done by (Sangeeta & Mathew, 2017). 88.9% of the respondents agreed that mental illness and mental retardation are the same thing. The findings show that the community was able to detect a case of mental retardation which may be beneficial for an early intervention. A study done in Ethiopia found that, the community would be able to recognize a person in remission or less severe phases of mental illness and majority of the community (60%) reported that abnormal behavior was a sign of mental illness (Deribew&Tamirat 2005).

#### **Limitations**

Findings from this study are also based on a small, geographical sample and thus, may not represent other populations. Last, due to the nonrandomization of the sample, response bias may also be a limitation. Moreover, there may be selectivity bias such that only those nurses who were interested in the topic of antenatal physical activity agreed to participate in the study.

#### **V. Conclusion& Recommendation**

The study established that residents of Bungoma County had little to no knowledge about mental illness hence more should be done to increase awareness of mental health problems in the community through informal education, public awareness campaigns, and formal school intervention. The following recommendations were made based on the findings of the conclusions of the study.

- i. The study recommends that sensitization of the community/ public on mental illnesses is important in Bungoma County. Scaling up public awareness campaigns to reach more people by diversifying the approaches targeting specific group of family members having mentally ill persons.
- ii. Stimulate further research regarding mental health knowledge and perceptions in order to improve knowledge and a change in attitude and perceptions of the Bungoma Community as well as the health seeking behavior of mentally ill individuals. With increased awareness of mental illness, stigma will be reduced as well as stereotype mentality that negatively affect the mentally ill in the community.
- iii. By training more of community health workers towards positive perceptions for mental illness, in order to change the behavior and perceptions of the community as well as health seeking behavior of mentally ill. This will empower the Bungoma County community members regarding knowledge of mental illness and as a result increase community members' interaction with the mentally ill in the community.

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