COMMUNITY PERCEPTIONS TOWARDS PEOPLE

WITH MENTAL ILLNESS IN LUSAKA URBAN

DISTRICT

BY

MUTINTA FH KASARO

UNZA   2012

THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF NURSING SCIENCES

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By

MUTINTA F.H. KASARO

REGISTERED NURSE-1991(NDOLA)

REGISTERED MIDWIFE-2001 (LUSAKA

A RESEARCH SUBMITTED IN PARTIAL FULFILMENT OF THE
REQUIREMENT FOR THE AWARD OF BACHELOR OF
SCIENCE DEGREE IN NURSING AT THE UNIVERSITY OF
ZAMBIA

UNZA   2012

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ABBREVIATIONS

AIDS:	Acquired Immune Deficiency Syndrome
HIV:	Human Immune Virus
MoH:	Ministry of Health
DALYS:	Disability Adjusted Life Years
WHO:	World Health Organisation
BC:	Before Christ
DHMT:	District Health Management Team
NGO:	Non-Governmental Organisation
SPSS:	Statistical Package
WFMH:	World Federation for Mental Health Africa Initiative

IDECLARATION

I, *Mutinta F.H. Kasaro*, hereby declare that work presented in this dissertation is my own, original work undertaken in partial fulfilment of Bachelor of science degree in nursing and has been presented either wholly or in part, for any other degree and is not being currently submitted for any other degree.

Signed... Date.....................................

(Candidate)...

Approved by... Date...31· 05·12.........................

(Supervisor)...

STATEMENT

I, *Mutinta F.H. Kasaro*, do hereby certify that this study is entirely the result of my own independent investigations. The various sources to which I am indebted are clearly indicated in the text and references.

Signed ....Date.................................

DEDICATION

To

My husband IPB Kasaro whose encouragement, patience and consideration sustained me through the years of my studies

To

My children Nchachi, Nchimunya, Lage and Isaac and my grandson Masowe for understanding

To

My relatives whose love and care motivated me during this endeavour.

ABSTRACT

Problem statement and Objective

In Zambia like in many other countries, the concept of mental illness is stigmatised in various ways. Poor community sensitisation about mental illness has resulted in negative community perceptions towards people with mental illness. The objective of the study was to explore community perceptions towards people with mental illness in Lusaka Urban District.

Method

A cross sectional study using semi-structured questionnaire was conducted. A total of 50 respondents aged 18 years and above were interviewed. Participants were selected using simple random sampling method. Data were analysed using the Statistical Package of Social Scientists (SPSS) version 16.0. Factors included in the study were socio-economic status, Knowledge, cultural beliefs and service related factors. Health Belief Model was to address the factors that determine individual perception and the need to take actions such as seeking health institutional treatment.

Results

Despite the often assumed negative perception leading to stigma, the results revealed that 70 percent of the respondents had positive perceptions towards people with mental illness. Ninety percent of the respondents had adequate knowledge about mental illness, and majority of the respondents stated that they had quality health services. However, most of the respondents stated that mentally ill people were only treated at the referral hospital.

Recommendations

Further research is recommended in order to facilitate evidence based policy formulation and policy implementation in Zambia. There is also need to sensitise community members on positive perceptions towards people with mental illness.

Conclusion

Positive community perception towards people with mental illness is important to improving and promoting the mental health of all Zambians.

CHARPTER ONE

1.0 INTRODUCTION

Negative perceptions towards people with mental illness are common world-wide. However, in Zambia mental illness has been neglected and this has resulted in negative perceptions towards people with mental illness. Furthermore, despite Zambia adopting the 1991 Health Reforms system where Primary Health Care is to be used as a vehicle for the delivery of health services as closer to the family as possible, mental illness is still not well integrated with Primary Health Care services (Mwape et al, 2010). Therefore, there is either limited or no community sensitsation about positive perceptions towards mentally ill people. It is important that health professional should provide information, education, and communication to the public about positive perceptions towards people with mental illness.

1.1 BACKGROUND INFORMATION

Mental illness has been recognised for a long time. In the early Christian era, it was believed that mental illness was due to possession of demons. Those who presented with mental disorders were treated inhumanly. In relation to this belief, treatment involved taking patients to priests for prayers. In some instances, magicians were consulted for interventions. Where treatment by the above measures was not successful, stronger measures such as punishment and or even killing was instituted (Nambi, 2006).

Around 460-377BC, Hypocrates (Greek physician) initiated the first understanding of mental disorders. However, this progress lasted for only a short period and was followed by the middle age where people with mental illness were either chained or put into prison while others were still being killed. In the late middle age period, better places of safety were built. This continued until in 1792 when Philippe, a French physician through his experiments revealed that the mentally ill could live a better life. This led to setting free all of those who were in chains and providing them with improved conditions of living.

By the early 1950s some drugs for treatment of mental illness had been introduced. Barbiturates (drugs with sedative, anticonvulsant, or anaesthetic effect) were discovered and used successfully. Chlorpromazine (a tranquilising drug) was also discovered. As a result of this discovery, psychiatric care became more established. The care in these institutions was designed to be delivered in four categories namely: outpatient, short term hospitalization, partial hospitalisation, and prevention of mental illness and promotion of positive mental health (Nambi, 2006). However, this was not the case in Zambia where historical records show that there was no formal mental health care in the then Northern Rhodesia. The Lunacy Ordinances was enacted in 1927 while the Mental Disorders Ordinances was enacted in 1951. This was followed by the opening of the only mental hospital (Chainama Hospital) in the country in 1962. The Hospital provided guidance on mental health policy issues. Human resource development and the training of Medical Assistants Psychiatry (Clinical Officers) started in 1964, while the training of Enrolled Psychiatric Nurses started in 1966. In 1974, the Ministry of Health took over management of Chainama hospital and the training schools.

In 1978, the National Mental Health coordinating Group in the Ministry of Health (MoH) outlined priorities for mental health services in Zambia. In order to improve the quality and accessibility of health services, the primary health care programme was introduced in 1981, and the structure of mental health services was established at the village, health centre, district, provincial and specialized levels. In line with this, in 1991, government introduced health reforms and decentralised health service delivery in an effort to meet its vision of delivering health care services as close as possible to the family. This led to the establishment of the Central Board of Health which assisted in providing technical input in the formulation of the mental health policy. Disability Adjusted Life Years (DALYS) was used to rank disease burden and mental illness ranked 17th (MoH, 2005).

Mwape et al (2010) observed that despite Zambia having embarked on health reforms in 1991, mental health is still neglected as it has been given a low priority. The Ministry of health mission statement is to provide quality and cost effective health care to all. However this does not take care of mental health considering that there is either absence of, or limited health services at primary health care level.

It also has been stated that mental health has always been given poor profile and low priority, although research has shown that some health workers were willing to have mental health services integrated with primary health care. This would facilitate early detection and treatment of mental illness (Mwape et al, 2010). The service would then be brought as close to the community as possible.

It is also known that mental disorders cause substantial human suffering in many societies. World Health Organisation (WHO, 2011) indicates that mental disorders account for 14 percent of the global disease burden. It is further noted that up to 30 percent of the global population has some form of mental disorders. In their work on the economic burdens of mental disorders in Africa, Zergaw et al (2006) noted that suffering in Africa is caused and exacerbated by many factors which include socio-economic and political factors. Ndetei et al (2006) further highlights that mental illness causes severe disability and suffering to patients, their relatives and the society. This is because social and leisure activities for the mentally ill and the whole family are restricted. Although mental illness or disorders are not fatal, they are a burden because of their high prevalence, chronicity and early onset in nature. They also have a devastating effect on the functioning and quality of life of an individual. This arises from family neglect of the individuals suffering from mental disorder as they are perceived as violent and unproductive. Zergaw et al (2006) also states that the leading causes of disability in today's world are mental health problems and that early onset of mental disorder has severe adverse effects on life course transition. They also state that although mental illness is perceived not to be serious, the cost of outpatient treatment for schizophrenia, and hour/days lost by the patient's relatives are more than those lost by diabetic patients and their relatives.

Although mental illness is increasingly recognised as a leading cause of disability worldwide, there are still weak mental health policies in many countries including Zambia. This has impacted negatively on the type and quality of mental health services offered in these countries. Mental illness is stigmatised and perceived as of low priority (Omar, 2010). This is evident by the inadequate services for patients with mental disorders in many health facilities and the state and quality of life the mentally ill lead.

Community perceptions towards people with mental illness are to a larger extent influenced by culture and beliefs. It is believed that mental illness occurs as a result of demon possession, witchcraft or due to a bite by a mentally ill person. People with mental illness are perceived as outcasts who are being punished for their wrong actions. They are also perceived as though they are subhuman and cannot think logically such that they are not involved in decision making processes. Mentally ill people are feared because they are perceived to be violent and dangerous. As such many people prefer that the mentally ill are nursed in mental health institutions only as they would disturb patients with other types of illness (Kapungwe et al, 2010).

1.2 STATEMENT PROBLEM

1.2.1 Global perspective

According to Zergaw et al (2006), although mental health problems directly cause little mortality, mental health problems are a major disease burden in communities. It is further stated that five of the ten leading problems causing disability are mental health disorders. Mental health affects progress towards attaining the Millennium Development Goals because they increase the risk of both communicable and non communicable diseases, and injuries (Prince et al, 2007). WHO (2011) indicates that mental disorders account for 14 percent of the global disease burden. However, the figure is likely to rise to 15 percent by the year 2020. Despite the measures put in place to integrate mental health services in primary health care, little has been achieved especially in the developing world.

Therefore the disease has continued to be a major threat to the health of individuals and families. The Academy of Medical Services report (2008) reveals that "450 million people worldwide suffer from mental health or behaviour disorders or psychosocial problem, and one in four will be affected by mental disorder at some stage." The report further reveals that by 2030 unpopular depressive disorder will be the second leading cause of health burden and that by 2040 about 81.1 million people will be living with dementia. Currently mental disorders account for 14 percent of the global disease burden. Out of the fourteen percent of global disease burden, 75 percent of the affected people are mainly from low and middle in-come countries (WHO, 2011).

1.2.2 Local perspective

Mental illnesses are a major disease burden within the community (MoH, 2005). It is therefore important to establish community perceptions of people with mental illness as perception may influence health seeking behaviour. Positive community perceptions of mental illness may influence the affected to seek medical treatment and consequently adhering to treatment. On the other hand negative perceptions of the mentally ill patient are likely to result in neglecting the patient. A Zergaw et al (2006) state that disease burden of nuero-psychiatric conditions in Africa is four percent. However there is disproportionate allocation of resources. About "eight percent of African countries spend less than one percent of their total health budget on mental health".

There is also shortage of trained health workers. This has caused the poor perceptions of the mental illness as no authority attaches high recognition for it despite its low ranking on the Daily life adjusted years.

In Zambia, acute psychotic, and schizophrenia at prevalence rate of 3.61 and 1.8 per 10,000 populations respectively (MoH, 2005). A study which was conducted in Zambia shows that cultural beliefs and practices have implications on perceptions towards people with mental illnesses. People with mental illnesses are perceived as being fearful and unproductive. They are scorned, humiliated and condemned. Sometimes stigmatisation is also transferred to the family and even the community such as institutions for the mentally ill, (MoH, 2005 and Kapungwe et al, 2010). Perception towards people with mental illness will determine how well the patient will be treated. According to MoH (2005), 70 to 80 percent of people with mental health problems in Zambia first seek assistance from traditional health practitioners before they seek help from conventional health practitioners. This is because they are perceived as being demon possessed or bewitched.

MoH (2005) Mental Health Policy also reveals that most of the severely disturbed mental patients are perceived to be violent. This type of perception results in these patients lodged in police custody before admission to the hospital.

1.3 FACTORS CONTRIBUTING AND /OR INFLUENCE PERCEPTIONS

1.3.1 Perception/Stigma

Stigma is a sentiment of condemnation with a gross negative connotation that people have about particular illnesses or way of behaviour. Stigma and discrimination comes in many forms and have an influence on an individual perception, acceptance of the illness, treatment and outcome Ndetei et al (2006).

Stigmatisation and discrimination of the mentally ill and their families by community members in Zambia is extensive and it occurs at three levels namely individual level, community level, and government level. At individual and community levels people with mental illnesses are feared, harassed and denied jobs. Some of those already in employment many be discharged on medical grounds as they are perceived as either a danger to themselves or to the society (Kapungwe et al, 2010; Katontoka, 2007). A report by Katontoka (2007) also revealed that people who suffer from mental illness are stigmatised in various forms. Some are perceived as having some misfortune or punishment from God while others are sidelined from developmental projects because their decision making ability is undermined.

At community level stigmatisation of mentally ill patients is also prevalent among family members who perceive people with mental illness as subhuman. In some instances, this is so severe that mentally ill patients are abandoned. Further, some healthcare providers perceive people with mental illness not able to make good decisions. As a result of stigmatization, people with mental illnesses are not involved in decision making even when they are admitted. Facilities like mosquito nets may be provided to patients with general conditions but may not be provided for the mentally patients because they are perceived as irresponsible and destructive (Kapungwe et al, 2010).

At national level, government resource allocation towards mental health services is too low (less than one percent) even though it is clear that financial resources determine the type and quality of services provided and how well laws are implemented.

1.3.2 Socio-economic factors

In the present study, socio-economic factors included are social support and poverty.

Social support: Social support factors are the relationship between the respondents and the society. This also includes the type of support an individual receives from family members, and community members among others. According to MoH (2005), men and women are traditionally ascribed to social roles. Men are expected to provide security for the family while women are assigned to domestic roles. Women are also expected to be submissive to their husbands. Some of these roles and cultural beliefs may be stressful leading to mental illness such as anxiety and depression.

Poverty: Economic factors are issues related to the discipline of accessibility and use of services and resources in a given situation. In Zambia mental illnesses are on the increase mainly because of the socio-economic problems that exist in the country (Katontoka, 2007).

1.3.4 Knowledge

Knowledge about what mental illness, including the cause and how it can be prevented may influence community perceptions towards people with mental illness. Information, Education and Communication is an important tool used to impart knowledge to individuals, families and community. In Zambia mental health promotion strategies are inadequate. In schools mental health promotion is only done on pilot bases while no health promotion programmes are undertaken by hospitals. Similarly there are no health promotion programmes at work places (MoH, 2005). Lack of knowledge that mental illness is treatable may discourage people from seeking of mental health service.

According to MoH (2006), knowledge by the public about the human rights will change community perceptions towards people with mental illnesses. Some of the rights are access to health care, and information. People empowered with knowledge about mental health may develop positive perceptions towards mental illness

1.3.5 Cultural factors

Culture is a patterned life ways, values, beliefs, norms, symbols, and practices of individuals, groups or institutions that are learned, shared and usually transmitted from one generation to another (Tomey and Alligood, 2006). Cultural beliefs and practices may have implications on community perceptions on mental health and mental illness.

Cultural beliefs may contribute to the development of negative attitude towards mentally ill patients and their family.

Practices: Negative perceptions towards people with mental illness have been reported to have resulted in rejection and avoidance by families, friends and communities in many countries. In many countries that perceive mentally ill people as having been cursed, the mentally ill people are isolated and are feared. This isolation and fear create a barrier to caring for mentally ill people in the family and community (MoH, 2005).

Beliefs: In situations where mentally ill patients are cared for, many times they are taken to traditional healers before seeking conventional health intervention because they are perceived as having been cursed (MoH, 2005). According to Byaruhanga-Akiiki (2006), treatment for the cursed is beyond western medicine.

1.3.5 Service related factors

In this study, service related factors include staffing, and availability of health facilities. It is assumed that health facility and service provision may have an influence on community perception towards the mentally ill patients.

Staffing: According to Sikwese et al (2010), there are only forty-four mental health personnel per hundred thousand people. Critical shortage of health service providers has a negative implication on community perceptions towards people with mental illness. A study conducted by Mwape e al (2010), revealed that community perception is likely to change when they see mental patients being cared for and recovering rather than being locked in seclusions. Therefore negative staff attitude is likely to result in negative community perceptions of people with mental illness and shun western medical treatment.

Health Facility: The type of infrastructure where mental health services are provided may have an influence on community perceptions about mental illness because the standards of some health facilities are not conducive to stay in. According to MoH (2005), mental health services are mostly provided in provincial hospitals and at Chainama where the infrastructure is in deplorable condition making it not conducive for human habitation. In Zambia mental health is not well integrated at Primary Health Care level. This implies that mentally ill patients have to travel long distances to the provincial or district hospital where services are available (MoH, 2005). This is assumed to negatively influence community perceptions towards people with mental illnesses because there is no sensitization on how to care for the

mentally ill people. Further, families of low economic status may not be able to take their sick relatives to district hospitals which may be several kilometres from their communities.

1.4: FIGURE 1.1: PROBLEM ANALYSIS DIAGRAM
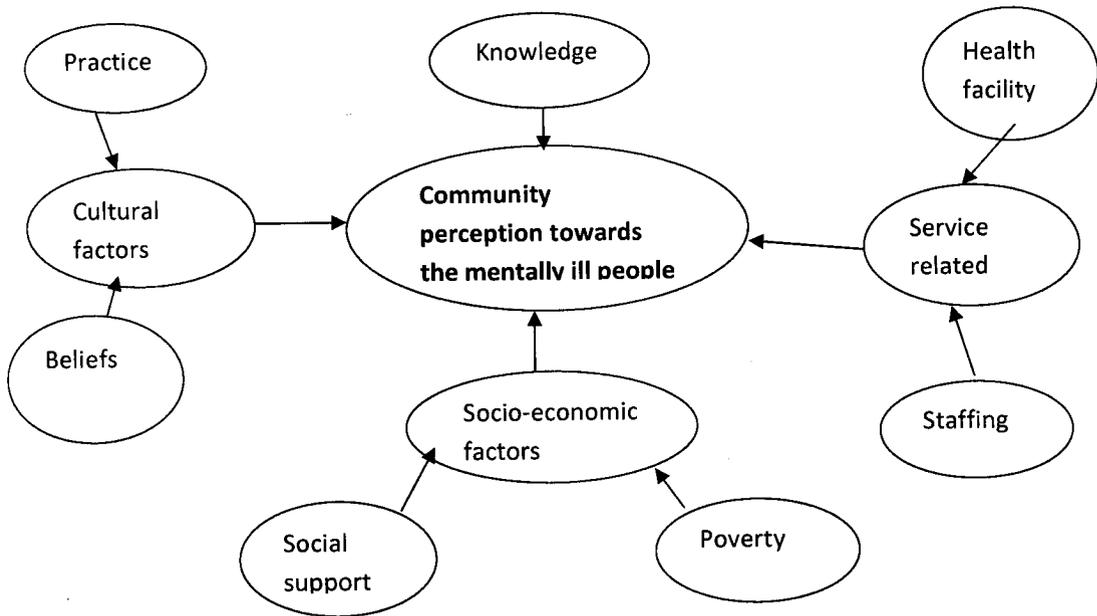
1.5 CONCEPTUAL FRAMEWORK

According to Basavanthappa (2006), a theoretical framework is a base rationale for making predictions about the relationship among variables in a research study. It is an outline of reference that is based on observations, definitions of research design, and research interpretation among others. This framework serves as a guide to methodically identifying logical and precise association among variables.

This study will be guided by Health Belief Model. According to Ngare et al (2006), the health belief model is one of the most influential, socio-psychological perspectives used to explain how preventive behaviours are acquired. To a large extent perception influences the behaviour undertaken by individuals in relation to health. The Health Belief Model has as its concepts perceived susceptibility, perceived severity, perceived benefits, perceived barrier, cue to action, and self efficacy.

These concepts accounts for people's action and their competence to actions taken.

a) **Perceived susceptibility:** This is where an individual perceives himself/herself as not being susceptible to a certain illness or disease. One is not likely to take positive action to prevent him/her from getting the condition.

b) **Perceived severity:** Involves belief about the seriousness of the disease and its consequences. In this case if mental illness is not perceived as a severe illness which needs medical attention, the mentally ill patient will not be taken to a health facility for treatment.

c) **Perceived benefits:** These are beliefs about effectiveness of taking action as compared to the seriousness of the problem. If community members will perceive mental illness as a preventable and curable disease, they will be willing to take care of the mentally ill patients.

d) **Perceived barrier:** These are imagined or real blocks and personal cost of undertaking a given behaviour. For example mental health services are not well integrated at primary health level, so people have to travel long distances to go to either district or provincial hospitals where such services are offered.

e) Cue to action: Cue to action is dependent on the influence of the modifiers and the consideration of the perceived benefits without perceived barrier of the perspective action.

f) Self efficacy: This is confidence in one's ability to take the action. Perception of the matter will to a large extent influence the action taken. For example positive community perception towards people with mental illness will lead to caring of such people.

Figure 1.2: Health Belief Model

Individual perceptions	Modifying factors
Perceived susceptibility to negative perception towards people with mental illness and perceived severity of these perceptions (e.g a person recognises risk factors and consequences of negative perception towards people with mental illness)	Knowledge factor about mental illness Socio-economic (those in lower social class are more affected) Disease related (e.g. stigma) Service related (e.g deliberated infrastructure) Cultural beliefs (e.g mental illness is due o witchcraft)

Positive perception towards people with mental illness

Likelihood of action Perceived benefits of preventive action (eg education about causes of mental illness) minus perceived barrier to preventive action (e.g. belief that mental illness is cursed by witchcraft and it is a curse

Cues to action

- Mass media information (e. g on social support to people with mental illness)
- Signs and symptoms of mental illness (e. g restlessness, insomnia , anorexia, self neglect)

Likely hood of taking recommended preventive health action (e.g. avoiding stressful situations).

Adapted from Becker. M. (1974) as in Basavanthappa 2007

1.6 JUSTIFICATION OF THE STUDY

Mental illness is one of the main health problems in Zambia. It is however important to note that mental health services have not been well integrated at primary health care level. The purpose of this study is to determine community perceptions towards people with mental illness in Lusaka Urban. The way mental illness is perceived in the community is likely to influence the type and design of interventions taken. Individuals with mental illnesses are vulnerable to negative perceptions by the community which may lead to infringement of their civil and human rights. Therefore, establishing community perceptions of people with mental illness may streamline and improve delivery of mental health services in Lusaka Urban.

The information obtained in this study is likely to show gaps in the way people with mental illness are perceived and intention to prevent mental illness in the country's express demographic and epidemiological transitions. These results are also intended be used to develop educational resources and behaviour transform strategies that will be used to strengthen positive perceptions of people with mental illnesses. Recommendations from this study will be forwarded to the District Health Management so that necessary action may be taken to improve community perceptions of people with mental illness.

1.7 RESEARCH OBJECTIVES

1.7.1 General objective

To explore community perceptions towards people with mental illness.

1.7.2 Specific objectives

1. To determine whether socio-economic factors are related to community perceptions towards people with mental illness.
2. To find out whether knowledge about mental illness influences community perceptions towards mentally ill people.
3. To determine whether cultural factors influence community perceptions towards mentally ill people.
4. To establish whether service related factors are associated with community perceptions towards mentally ill people.

1.8 RESEARCH HYPOTHESIS

According to Polit and Beck (2012), a hypothesis is a tentative guess, about the relationship between variables that suggest an answer to the research problem.

1. Community members with high socio-economic status have more positive perceptions of people with mental illness than those with low socio-economic status.
2. Community members with adequate knowledge about mental illness have better perceptions of people with mental illness than those with inadequate knowledge.
3. Community members with negative cultural beliefs are more likely to have negative perceptions towards people with mental illness
4. The more accessible mental health services are, the better the community perceptions towards people with mental illness.

1.9 CONCEPTUAL DEFINITION OF TERMS

Conceptual definition is the abstract or theoretical meaning of the concept being studied, (Polite and Beck, 2001).

Mental illness: Mental illness is "disturbance in thinking, emotion and behaviour" (Berkow et al, 1999)

Perception: The conscious recognition and interpretation of sensory stimuli that serve as a bases for understanding, learning, and knowing for motivating a particular action or reaction (Anderson et al, 1998).

1.9 VARIABLES AND CUT-OFF POINTS

According to Bassavanthappa (2007), a variable is a measurable or potentially measurable component of an object or event that may fluctuate in quantity or quality or that may be different in quantity or quality from one individual object or event to another individual object of event of the same general class.

Table 1.1: Variables and Cut-off points

Dependent variable	Cut off point	Indicator	Question number
Perception	Respondent able to score 4-7 marks on perception. Respondent able to score 0-3 marks on perception.	Positive Negative	7 -15 7-15
Independent Variables	**Cut off point**	**Indicator**	**Question number**
Socio-economic	Respondent able to have at least two to three meals per day. Respondent have only zero to one meal per day.	High Low	16 16
Knowledge	When respondent is able to score 4-5 correct responses on the knowledge about mental illness. When respondent is able to score 0-3 correct responses on knowledge about mental illness.	Adequate Inadequate	17-25 17-25
Culture	Respondent scores 0-1 Respondent scores 2-3	Negative cultural influence Positive cultural influence	26-29 26-29
Service related	Respondent scores 1-2 Respondent scores 3-4	Good services Poor services	30-31 30-31

1.9.1 Types of variables

The two types of variables are dependent and independent variables.

1.9. 1.1 Dependent Variables

Dependent variable is the variable that changes as the researcher manipulates the independent variable. It is also known as the out-come, effect, response, the criterion measure or behaviour that the researcher wishes to study, predict or explain a phenomenon (Basavanthappa, 2006). In the present study, perception is the dependent variable.

1.9.1.2 Independent variable

An independent variable is a variable that can be manipulated or changed by the investigator. Independent variable can be manipulated by the researcher in order to study the effect upon the dependent variable. Independent variable is also called the cause, stimulus, experimental variable or treatment (Basavanthappa, 2006). Therefore, socio-economic status, knowledge, cultural beliefs, and service related factor are independent variable in the present study.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

Literature review is a key step in every research process. It is first conducted to identify information on a study topic in order to develop a comprehensive understanding of the state of knowledge related to the topic. It is also done at the end of the study in form of a written summary of a research problem (Polit and Hungler, 2007). It involves a comprehensive, logical and critical review of scholarly publications, unpublished scholarly materials, audio visual materials, and personal communications (Basavathappa, 2007). Literature review for this study will focus on perception and stigma, economic status, knowledge, cultural beliefs, and service related factors, considering that these are assumed influencing factors to community perceptions.

2.2 PERCEPTION/STIGMA

Perception is conscious recognition and interpretation of sensory stimuli that serve as bases for understanding, learning, and knowing for motivating a particular action or reaction (Anderson et al, 1998). However, in the present study perception will mean community's conception about people with mental illness. Stigma is the sentiments of disapproval people have about particular ailment or way of behaving (Hornby, 2011). In the present study stigma is considered as the unrealistic, unproven thinking and reactions projected on people with mental illness. A study conducted in Uganda to assess stakeholders' perception of health-seeking behaviour among people with mental health illness revealed that in some communities help is mainly sought from traditional healers before considering seeking conventional treatment. The behaviour is mainly influenced by the belief about the causes of mental illnesses (Nsereko et al, 2011). Nsereko et al,'s (2011) study also concluded that positive perception towards mental illness may influence utilization of conventional medicine. The study further revealed that collaboration between traditional healers and practitioners of conventional medicine is necessary for the mentally ill people to receive absolute care.

A study conducted in Zambia to determine knowledge and attitude of a representative sample revealed that negative perceptions of mental illness were common across the country. Almost all respondents perceived people with mental illness as dangerous because of their violent behaviour. A large number of the respondents stated that they would not want to be in contact with the mentally ill. Almost all respondents were afraid to have a conversation with the mentally ill (Kapungwe et al, 2010).

A study conducted in Iraq revealed that mentally ill patients, mental health professionals, and the actual concepts of mental illness are all stigmatised (Sadik, 2011). Stigma towards mental illness results in low prioritization of mental health services which may subsequently lead to low financing, and poor information dissemination about mental illness. In South Africa, it was observed that stigmatization of people with mental illnesses may deter them from seeking mental health services while Omar et al (2010) revealed that stigma is a barrier to movement of mentally ill people. Adewuya (2007) states that there is some stigmatizing attitude towards mental illness which is associated with causal views. The study identified health education as an important tool for eradicating stigma which put the population at risk. The programme should include sensitizing people on the causes of mental illness. However the survey conducted in Iraq by Sadik et al (2011) indicated that the community understand the scientific causes of mental illness although they do not understand the nature of mental illness. Failure to understand the cause of mental illness and the nature of mental illness creates a negative attitude towards management of people with mental illness. According to Meikie (2011), although a study conducted in England revealed increase in positive view about people with mental illnesses only one in four would trust a woman with history of mental illness to babysit a child. Sadik et al (2011) stated that attitude towards mental illness and the people with mental illness can only be changed through coordinated public education.

2.3 SOCIO-ECONOMIC

Economic status of an individual has an effect on his/her mental health. According to Ssebunya et al (2009), there is an association between poverty and mental illness. Distress due to poverty aggravates mental illness, and poverty is known to be the major cause of mental illness. However, mental illness also leads to poverty for both the care givers and the patient. Memecan (2009), revealed that financial status of many minorities may hider them from accessing conventional mental health services, while Nsereko et al (2011) state that socio factors influence accessibility of mental health services.

2.4 KNOWLEDGE

Knowledge about mental illness and action taken on such matters are important for decision making. According to Omar et al (2010), the invisibility of mental illness and lack of tangible outcomes from interventions were cited as reasons for low awareness of mental illness among people. Inadequate knowledge about a subject entails low focus and interest to invest and address the problem arising from negative perceptions of people with mental illness. Kapungwe et al (2010) stated that misunderstandings of causes of mental illness are prevailing within families, communities, among general and mental health providers, and at government level. They suggested education campaigns, implementation of the policy, and legislation to improve knowledge about mental illness may result in positive perceptions towards people with mental illness. In another research, Omar et al (2010) stated that there is poor knowledge and understanding of mental illnesses among general public in Ghana, Uganda, South Africa and Zambia. Stake holders in the above stated countries also showed poor knowledge and understanding of mental illness. This was due to inadequate utilization of available information on mental health, and lack of routine information education and communication about mental health policy processes. The study emphasised the need to collaborate with various stakeholders in order to implement policy and increase awareness of mental health services starting from individual, family, and community level up to policy makers.

It is from the above back ground that it is imperative that efforts and commitment by policy makers and governments should make service delivery effective and accessible. Concerted effort and commitment may be the ground breaking for enhancement of positive community perceptions towards people with mental illness. Through this commitment, education information and communication may help raise the knowledge base in the communities and among health service providers, and help increase positive perceptions of mental illness. When communities and individuals are brought to a clear understanding of mental health, issues of stigmatisation and cultural misconceptions may be negated eventually and generally perceptions of mental illness will improve.

2.5 CULTURAL BELIEFS

The cultural beliefs of every community have an influence on how mental health is perceived and managed. In the present study the cultural beliefs considered are witchcraft and social practices regarding to care of the mentally ill. People with negative cultural beliefs are more likely to seek treatment from traditional healers than those with positive cultural beliefs. Community members who believe that mental illness is contagious are likely to neglect their patients. Memecan (2009) states that some cultural beliefs require an individual strake by mental illness go back to the community to seek treatment rather than seeking professional treatment. In Zambia practitioners of traditional or herbal medicine are still widely consulted before seeking help from conventional health practitioners (MoH, 2005). According to Kapungwe et al (2010), Zambia is a low in-come country which still pays little consideration to addressing the negative beliefs and practices about mental illness. Therefore culture still has great influence on mental illness.

2.6 SERVICE RELATED

Service related factors considered in the present in the present study are staffing and health facility status. Economic status of a country affects its ability to provide quality health services, and implementation of policies which may promote mental illness awareness. A study conducted by Omar et al (2010) in Ghana, South Africa, Uganda, and Zambia revealed that mental health policies were lacking or out dated in many countries. The out dated policies were not appropriate to effectively deal with matters of mental illness and perceptions towards people with mental illnesses. These policies were also poorly implemented and inadequately disseminated because of lack of resources. Omar et al (2010) further stated that mental health services were not integrated at primary health level.

Nsereko et al (2011) revealed that service related factors such as availability of health facilities are likely to influence community members on where one seeks treatment for mental illness. In a related mental health symposium it was stated that there is need to expand community level capacity to address mental health. This could be achieved through increased communication and collaboration among mental health NGOs, and government agencies. To improve knowledge and attitude of mental health and general workers towards people with mental illness, mental health services were to be directly integrated into HIV/AIDS programmes.

Dissemination of mental health information to impart knowledge to various levels of society was to be enhanced thorough collaboration (World Federation for Mental Health Africa Initiative, 2008).A comparative study conducted in Ghana, Uganda, South Africa, and Zambia revealed that financial and human resources for mental health use were inadequate. Ghana allocated six percent of the government budget to mental health, Uganda allocated one percent (although at the time of research it was four percent), South Africa allocated between one and eight percent, while Zambia allocated only zero point four percent.

In Zambia mental health system is concentrated in regional and district institutions (Omar et al, 2010).Due to long distances, community members are likely to seek treatment from traditional healers.

2.7 CONCLUSION

Literature review reveals several gaps in terms of perceptions about mental illness. It has shown that negative perceptions of mental illness were common across the country. In most cases, there is an association between economic status and mental illness. Another gap is created by cultural beliefs which still have great influence on mental illness. Literature review further revealed that the mental health system in Zambia is concentrated in regional and district institutions and that misunderstanding of causes of mental illness are prevailing within families, communities, among general and mental health providers, and at government level. There is scarcity of research on community perceptions of mental illness in Zambia which underscores the importance of conducting the present research.

CHAPTER THREE

3.0. RESEARCH METHODOLGY

This chapter explains the methodology that was used to collect relevant information to answer the research question. It also describes among others the research design, data collection, research setting, the study population, sample determination and sample selection. The chapter further looks at the pilot study, validity and reliability, ethical consideration, and dissemination of findings.

3.1. STUDY DESIGN

A research design is the entire plan, structure and strategy of investigations of answering the research question, including specifications for enhancing the study's reliability and validity. (Polit and Beck, 2012). It is an overall plan for the research. The study design depends on the type of problem, the knowledge already available about the problem and the resources available for the study. The basic purpose of the research design is to provide answers to research question (Basavanthappa, 2006). Therefore, this study employed a non-intervention cross-sectional and explorative design which involves a systematic collection and presentation of data to give a clear picture of the phenomenon under study (Polit and Hungler, 2007). On the other hand, cross sectional study design is aimed at quantifying the distribution of some variables in a study population at one point in time, while exploratory study designed is aimed to enhance knowledge of a field of study (Basavanthappa, 2007). Explorative studies provide the basis for confirmatory studies (Burns and Groove, 2009). The non-interventional cross sectional explorative design was suitable because no treatment or intervention was required during the study. Both quantitative and qualitative designs were used in this study because there was need to test relationship and examine cause and effect of interaction among variables. Qualitative design was used to get answers to variables that dealt with human behaviour. Quantitative research design is a formal, objective systematic process to describe, test relationships, and examine cause and effect of interaction among variables while qualitative research designs involve identification and exploration of a number of often mutually related variables that give insight to human behaviour (perception, motivations,

opinions, attitudes), in the nature and causes of certain problems and in the consequences of the problems for those affected (Basavanthappa, 2006).

The quantitative study design was used to establish relationship between variables that were quantifiable such as demographic data while qualitative design was used to gain detailed information on perception towards mentally ill patients and knowledge about mental illness.

3.2 RESEARCH SETTING

Research setting is the physical location and conditions in which data collection will take place in a study (Polit and Hungler, 2007). This study was conducted at Chawama, Chilenje, Chipata, and Kalingalinga health facilities in Lusaka urban. These centres were selected because they offer both preventive and curative services. The location selected provided access to a cross-section of community members with different social and economical background. The setting was convenient considering limited resources.

3.3. STUDY POPULATION

Study population is the total group of individual persons or things meeting the designated interest to the investigator (Basavanthappa, 2007). In this study, the study population consisted of all adults (18 years and above), both males and females who resided in the catchment area of Chawama, Chipata, Chilenge, and Kalingalinga health facilities.

3.3.1. Target population

According to Burns and Groove (2009), a target population is a group of people who meet the sampling criteria and to which the study results will be generalised. It is determined by sampling criteria. In this case the target population was adult males and females living with or without mentally ill patients in the catchment areas of the mentioned health facilities.

3.3.2 Accessible population

According to Burns and Groove (2009), "an accessible population is the portion of the target population to which the researcher has reasonable access." In this study the accessible population consisted of all adult males and females (18 years and above) who reside in the catchment area of Chawama, Kalingalinga, Chipata, and Chilenge health facilities.

3.4. SAMPLE SELECTION

Basavanthappa (2006) defines sampling as a procedure of selecting a subset of the population in order to get information regarding an event in a way that represents the entire population. Similarly, Polit and Beck (2006) define sample selection as the process of obtaining information about an entire population by examining only a part of it. With this background, this section explains how the health facilities were selected. It further explains how respondents were selected. Lusaka urban has twenty-eight clinics from which four were sampled using a non probability purposive sampling method. According to Burns and Groove (2009), purposive sampling is a judgemental or selective sampling method that involves conscious selection of certain subjects or elements to include in the study. Simple random sampling which is a probability method of sampling was used to select study respondents. This type of sampling involves using unplanned selection procedures to ensure that each respondent is chosen on the basis of chance. All participants of the study population will have an equal, or at least a known chance of being included in the sample (Basavathappa, 2007).

A list of all the clients escorting patient to the health facility per day was written and used as a sampling frame for that day. Each client on the list was given a number. On each day six respondents were interviewed. Twenty clients were selected as part of sampling frame. Then twenty papers were put in a box, after which the box was shaken vigorously to ensure randomization. A paper was picked from the box at a time and the number was noted and replaced in the box. This procedure was repeated until six participants were selected. If a number was selected twice, it was ignored but it was put back in the box.

3.4.1 Inclusion criteria

According to Burns and Groove (2009), inclusion criteria are those qualities that a subject or element must possess to qualify to be part of the target population. For one to be included in the present study, one had to be eighteen years and above as this is the legalised age for one to give consent. The inclusion of respondents was open to both those living or not living with a person with mental illness. The respondents were to be able to converse either in English or Zambian language (particularly Tonga, Lozi, Bemba or Nyanja) to enhance communication. The respondent was to volunteer and be willing sign consent to participate in the study.

3.4.2 Exclusion criteria

Burns and Groove (2009) defines exclusion criteria as those qualities which can cause one to be excluded from the target population. In this study all those who did not consent, people with mental illnesses, and those below eighteen years of age since they could not give consent were excluded. The present study also excluded patients to avoid stressing them. Clients who could not communication in English, Tonga, Bemba, Lozi or Nyanja were excluded to avoid communication breakdown. The other people excluded from the study are those who did not volunteer to participate.

3.5 SAMPLE SIZE

Sample size is number selected in such a way that the individuals in the section represent as near as possible the characteristics of the population (Polit and Hungler, 2007). A sample size of fifty (50) community male and female participants was chosen. The minimum sample size was used because of inadequate time, human and financial resources. The results were a representation of Lusaka urban since the study was a cross sectional one. However the results were not generalised to represent the whole country because the study was only conducted in Lusaka.

3.6 Operational definition

Operational definition is the researcher's definition of a term that provides a description of the method for studying the concept by citing the necessary operations (manipulation and observations) to be used (Basavanthappa, 20007).

Knowledge: One should be able to define what mental illness is and explain how it can be prevented.

Perception: This is community's conception about people with mental illness.

Cultural Belief: This is the traditional understanding of mental illness in a given society.

Stigma: This is unrealistic and unproven thinking and reactions projected on people with mental illness

Service related factors: this the way how health services are designed and provided to people with mental illness.

Economic status: Good economic status will refer to anybody able to have at least two to three meals per day, while poor economic status will refer to anybody only managing to have one meal per day.

3.7 DATA COLLECTION TOOL

A data collection tool refers to an instrument used to collect information. It may be in form of a questionnaire, an interview schedule, or a projective device among others (Burns and Groove, 2009). Data for the present study was collected using both open and close ended questions. Closed ended questions offer respondents a set of specific response opinion, while open ended questions do not restrict the respondent's answers or opinion (Polit and Beck, 2012). Semi-structured interview was conducted to both the literate and illiterate people. For the illiterate participants, questions were interpreted into the language they understood. Non-verbal behaviour and mannerisms were observed, unclear questions were clarified.

The advantage of using this interview schedule was that participants were able to give information freely. They were not limited by options provided. However some participants may not have been free to express themselves in front of the interviewer. Information collected included: demographic data, perception and stigma, knowledge about mental health, economic status, cultural beliefs, and utilization of mental health services.

3.7.1 Validity

Validity is the extent to which an instrument reflects what it is intended to examine (Polit and Hungler 2007). Validity constitutes both external and internal validity. Internal validity concerns the extent to which conclusions can be drawn about the effects of one variable on another. It seeks to determine whether the observed effect on the dependent variable was due to the action of the independent variable and not something else (Polit and Hungler 2007).

Internal validity was upheld by avoiding selection bias of respondents. Probability method of selection was used to ensure randomization. Questions were simple, specific, and clearly constructed to avoid uncertainty. This above measures also prevented respondents from being bored which could have affected their responses. A limited number of respondents was interviewed every day in order to provide for sufficient time to respondents and not to administer questionnaires to tired and fatigued respondents. Same questions were asked to each respondent in the same sequence.

External validity is concerned with the extent to which research findings can be generalized to a larger population or to a different social, economical and political setting (Polit and Hungler 2007). It is important in research as it determines the significance of the study result. In this study, external validity was upheld by employing strategies that dealt with threats to validity such as appropriate selection of study design, study participants, and use of pilot study to pre-test the research instruments. Objectivity was exercised during data collection and analysis so that the study findings would be a true reflection of what the respondents revealed.

3.7.2 Reliability

Reliability is the stability of measures obtained in the use of a particular instrument and indicates the degree of random error in the measurement method (Burns and Grove, 2009). Reliability takes into consideration how well an instrument will produce the same information each time it is used. For ensuring accuracy, relevance, completeness, consistency and uniformity of the data collected, regular cross checking, inspection andscrutinizing of information on the research data collecting instrument was done.

3.8. DATA COLLECTION TECHNIQUES

Data collection techniques is the process of gathering needed information to address a research problem (Polit and Hungler, 2007). It involves methodically collection of information from respondents in relation to the objectives of the study.

Therefore, face-to-face interview was used to collect data from respondents by using semi-structured interview schedule.Togather the needed information from respondents, privacy was practiced by conducting the interview in an isolated room where no one was interfering and/or seeing respondents. Each interview lasted between 15-20 minutes and a maximum of five clients were interviewed per day.The interviewer started by self introduction, and it was explained to the respondents that participation in the study was voluntary. All respondents were assured that their participation in the study would be treated and held with high confidentiality. The respondents were informed of the benefits of the study. Following all the explanation, a consent form from the respondent was obtained. This was followed by interviewing the respondent using the semi- structured interview schedule while probing where answers were not very clear. At the end of the whole interview, each respondent was thanked for participating in the study. Completeness ofthe responses was checked to ensure

that they were all well written. Data from closed and open ended questions were sorted out by categories and coded before entering it on a Statistical Package for Social Science (SPSS) program.

3.9 PILOT STUDY

According to Polit and Beck (2012), a pilot study is a small-scale version or trial, conducted in rehearsal for the actual study.A pilot study is a small preliminary investigation of the same general character as a major study which is designed to acquaint and establish problems that could be corrected in preparation for the large research project. It used to detect errors and flaws in the selected tools. The subjects who participate in the pilot study are not involved the actual study. The pilot study helps determine how feasible the study would be, and how valid and reliable the data collection tools are, and how possible it would be to analyze the data collected. Pilot study for the present study was conducted at Kalingalinga health facility in Lusaka urban District. Kalingalinga catchment has comparable area with the areas where the main study was conducted as it has the presentation of high, medium, and low class people. Five randomly selected respondents from the list of the clients were selected on the day of data collection for the pilot study. The five respondents selected represented ten percent of the total sample for the study.

The findings of the pilot study were used to make changes to the methodology. Some questions were modifiedin the questionnaire in order to collect detailed information.

This helped to test validity, reliability and practicability of the data collection tools and techniques that were used in the actual study.

3.10 ETHICAL CONSIDERATION

According to Polit and Beck (2012), Ethics is a system of moral values that is concerned with the extent to which study procedure stick to professional, legal and social obligations to the study respondents. It is required that the development and implementation of research should be ethically and culturally acceptable. Before conducting the study, permission was requested from the supervisor to get ethical clearance while permission was sought from District Director of Health (Lusaka district) to conduct a study in the district, and from the Health Centre In-charges for the study setting. During data collection, permission was sought from all participants. The purpose of the study was explained to the participants, confidentiality was assured, and codes were used instead of names. A consent form was obtained from each

respondent and then interviewed individually in room to promote privacy. Completed interview schedules were kept under strict security to avoid unauthorized access to the information gathered.

CHAPTER FOUR

4.0 DATA ANALYSIS AND PRESENTATION OF FINDINGS

Data analysis refers to systemic organization and synthesis of research data, and testing of research hypothesis using the data collected (Polit and Beck, 2012). The major purpose of data analysis is to develop meaning and explanation from the research findings. In the present study, data was collected using semi structured interview schedule. The interview schedules were counted, checked for completeness, and entered on Statistical Package of Social Scientists (SPSS) version 16.0.

4.1 DATA ANALYSIS

Data analysis is the systematic organization and synthesis of research data, and the testing of research hypotheses using those data (Polit and Beck, 2012). The responses were verified, coded and plotted down on Statistical Packaging for Social Sciences for easier analysis. This was to assist in full understanding of the data collected and familiarize with a method that could be used anywhere. Frequency tables and numerical descriptions were prepared. Cross tabulation tables were prepared to show the relationship of variables. Responses for open ended questions were transcribed and themes made for further analysis. The impressions were then be systematically classified into themes. All the similar ideas and concepts were written down according to themes. Then these were coded and plotted on the data matrix tables and graphs.

4.2 PRESENTATION OF FINDINGS

According to Polit and Beck (2006), presentation of data involves exhibition of results of the data collected. Data have been categorised into sections to facilitate a clear interpretation. The findings of the study are presented using bar graphs, frequency tables, pie charts and cross tabulations. Frequency table give precise results of the study therefore ensuring thoughtful interpretation by the reader. To help explain the relationship between variables, cross tabulations were used while pie charts are used to show total scores for variables. The findings of the study are presented according to study variables involved which are demographic data, perception and stigma, knowledge about mental illness, culture beliefs and service related factors.

4.2.1 SECTION A: DEMOGRAPHIC DATA

In this section the variables presented include age, sex, marital status, denomination, level of education and type of employment. These were chosen because they because were assumed to have an influence on perception towards people with mental illness. Therefore, sections have three bar graphs and one frequency table showing the social demographic characteristics of the respondents.

Table 4.1: Age (n=50)
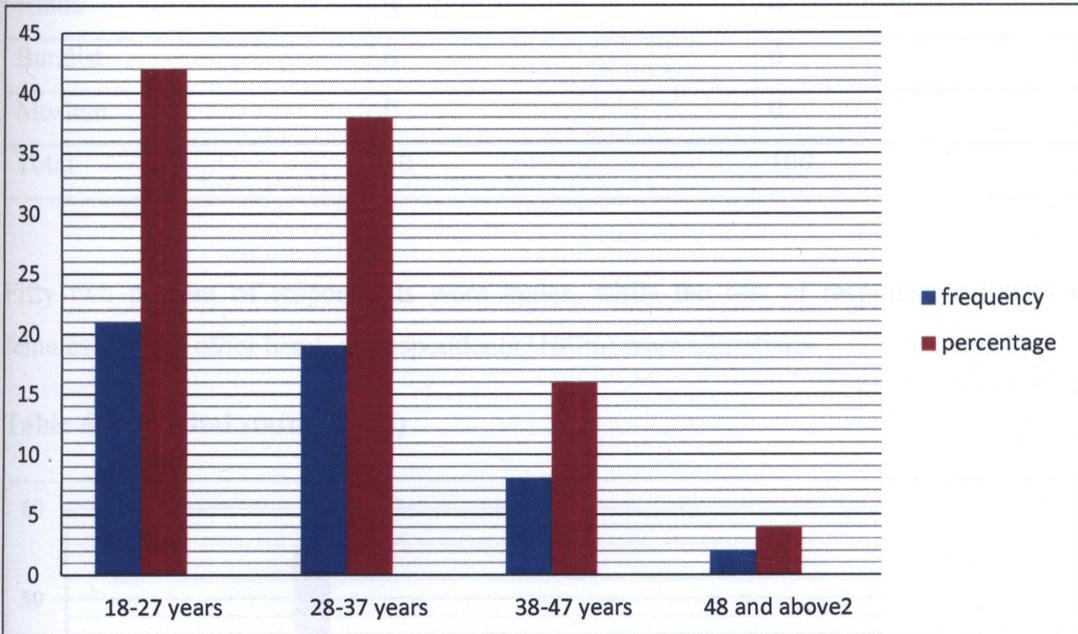
The age of participants ranged between 18 and 52 years. The mean age was 30 years seven months (SD 8) showing a skew to the left.

Table 4.2: Sex and Religion (no=50)

Sex	Frequency	Percentage
Male	26	52
Female	24	48
Total	50	100
Religion		
Christians	50	100
Hindu	0	0
Bundist	0	0
Moslem	0	0
Total	50	100

Fifty two percent of respondents were males, while the rest of respondents (48%) were females. On the other hand, all respondents (100%) were Christians.

Table 4.3: Marital status (n=50)
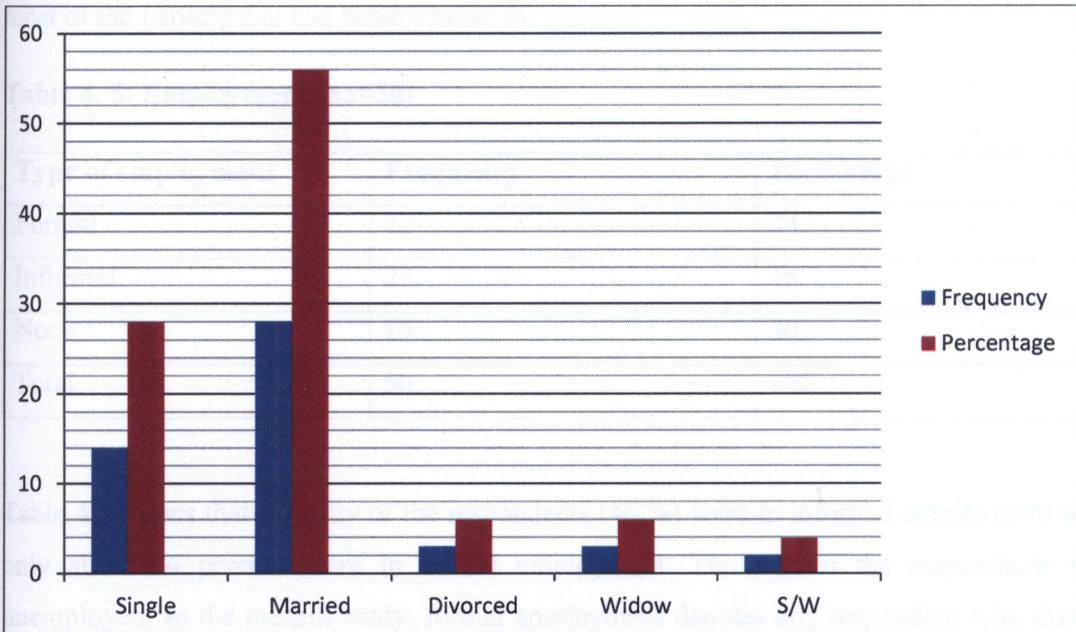
Table 4. 3 indicates that 56 percent of participants were married. On the hand, two percent of participants were on separation (S) while the other two percent of participants had lost their husbands (W: Widowers).

Table 4.4: Level of education
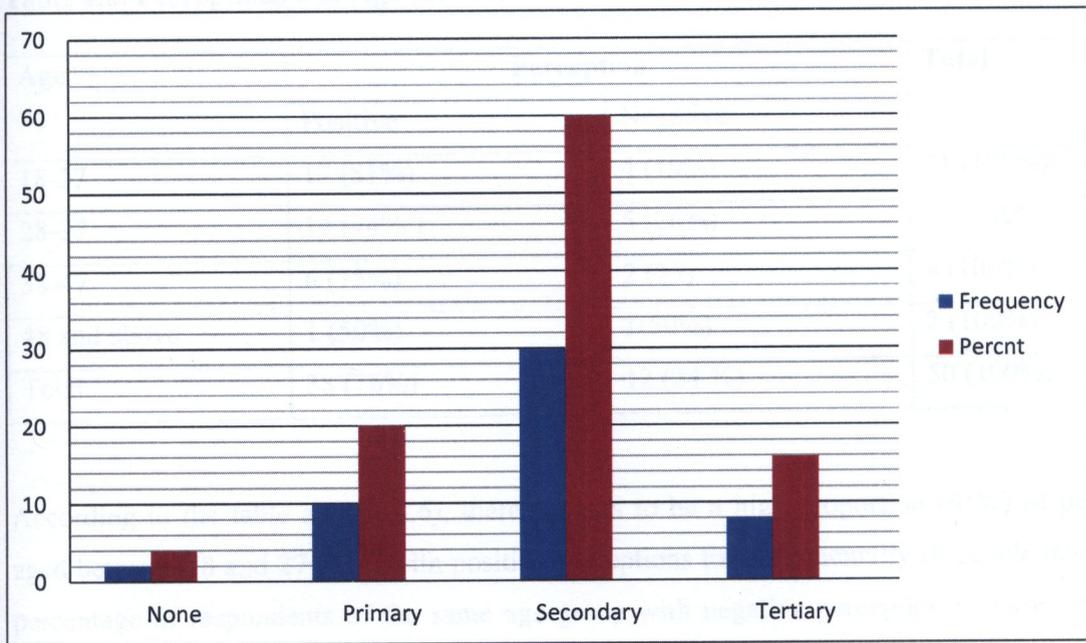
Majority of participants (60%) attained secondary education, while 20 percent attained primary school education only. On the other 16 percent attained tertiary education. Therefore, most of the participants had basic education.

Table 4. 5: Employment (no=50)

Type of employment	Frequency	Percentage
Formal	12	24
Informal	23	46
None	15	30
Total	50	100

Table 4.5 shows that majority of the respondents (46 %) were in informal employment while only about 24 percent were in formal employment. The rest of the respondents were unemployed. In the present study, formal employment denotes any respondent who draws a salary at the end of the month.

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Table 4.6: Perceptions and Age (no=50)

Age	Perception		Total
	Positive	Negative	
18-27	17 (81%)	4 (19%)	21 (100%)
28-37	14 (74%)	5 (26%)	19 (100%)
38-47	6 (75%)	2 (25)	8 (100%)
48 and above	1 (50%)	1(50%)	2 (100%)
Total	38 (76%)	12 (24 %)	50 (100%)

According to the table above (4.6), there appears to be a high proportion (81%) of people aged between 18 and 27 years with positive perceptions towards mentally ill people than the percentage of respondents of the same age group with negative perception towards people with mental illness (19%). The analysis revealed that there is no association between perceptions towards people with mental illness and age.

Table 4.7: Perceptions and Level of education (no=50)

Level of education	Perception		Total
	Positive	Negative	
None	1(50%)	1(50%)	2 (100%)
Primary	8 (80%)	2 (20%)	10 (100%)
Secondary	25(83%)	5 (17%)	30 (100%)
Tertiary	4 (50%)	4 (50%)	8 (100%)
Total	38 (76%)	12 (24%)	50 (100%)

Out of 100 percent of participants with secondary level of education (83%) indicated to have positive perceptions toward people with mental illness, while only 17 percent indicated to have negative perceptions towards people with mental illness. This entail that people with some educations perceive mentally ill people in a positive way.

4.2.2: SECTION B: PERCEPTION /STIGMA TOWARDS PEOPLE WITH MENTAL ILLNESS

This section explains community perceptions/ stigma towards people with mental illness. Perceptions /stigma towards people with mental illness were categorized into two categories namely positive and negative perception and stigma. Scores for positive perceptions/ stigma ranged from four to seven while scores for negative perceptions ranged from zero to three. Two questions were not graded but helped clarifying issues about other questions.

Table 4.8: Treatment of mentally ill people in the community (no=50)

Does your culture encourage caring for mentally people with mental illness?	Frequency	Percentage
Yes	48	96
No	2	4
Total	50	100
Treatment of mentally ill people		
Neglected	22	44
Physically abused	3	6
Denied opportunities to go to school or to be employed	5	10
Treated like any other person	20	40
Total	50	100
Community perceptions towards mentally ill people		
Normal	19	38
Not normal	21	62
Total	50	100

The study revealed that a substantial proportion (96%) of respondents reported that their culture encouraged taking care of the mentally ill people. Only four percent of respondents stated that culture did not encourage caring for the mentally ill people. This shows that generally mentally ill patients are cared for.

Table 4.8 further shows that 44 percent of participants stated that mentally ill people were neglected, while 40 percent revealed that mentally ill people were treated just like any other person in the community. Furthermore, most of the participants (62%) stated that people with mental illness were treated as though they were not normal.

However, the remaining 38 percent of the participants responded stated that people with mental illness were perceived as normal as any other person in the community.

Table 4.9: Effect of mental illness on relationships (no=50)

Does mental illness affect relationships	Frequency	Percentage
Yes	30	60
No	20	40
Total	50	100
How is the relationship affected by mental illness (n=30)		
Cannot cooperate	15	50
Feared	6	20
Discriminated	9	30
Total	30	100

Table 4.9 shows that 60 percent of respondents believed that mental illness affected the mentally ill person's relationship with the family and the community. However, it is interesting to note that 40 percent of participants responded that the relationship was not affected at all.

Out of 30 participants who stated that the relationship was affected, 50 percent revealed that mental illness affected the mentally ill person's relationship with the family and community because of lack of cooperation on the part of the mentally ill person. On the other hand 20 percent of respondents stated that the relationship would be affected because family and community members were afraid of people with mental illness.

Table 4.10: Whether mental illness is contagious (no=50)

Is mental illness contagious	Frequency	Percentage
Yes	6	12
No	44	88
Total	50	100
Who provide support to the mentally ill people?		
Community members	49	98
None	1	2
Total	50	100

Table 4.10 above reveals that most of the participant (88%) responded that mental illness was not contagious. However the remaining 12 percent believed that mental illness could be passed from one person to another and therefore was contagious. The table further indicates that 98 percent of participants stated that community members provided support to the mentally ill.

Table 4.11: Decision making (no=50)

Do you involve people with history of mental illness in decision making?	Frequency	Percentage
Yes	33	66
No	17	34
State reasons why you do not involve people with history of mental illness in decision making		
Cannot contribute constructively	15	88
They are violent	2	12
Total	17	100

Table 4.11 shows that majority (66%) of respondents stated they would involve people with history of mental illness in decision making. The remaining 34 percent of participants would not involve people with history of mental illness in decision making. In addition, 88 percent of participants who would not involve people with history of mental illness in decision making believed that such people could not contribute constructively.

The remaining 12 percent responded that they would not involve people with history of mental illness in decision making because they were violent.

Figure 4.1: Perception/Stigma
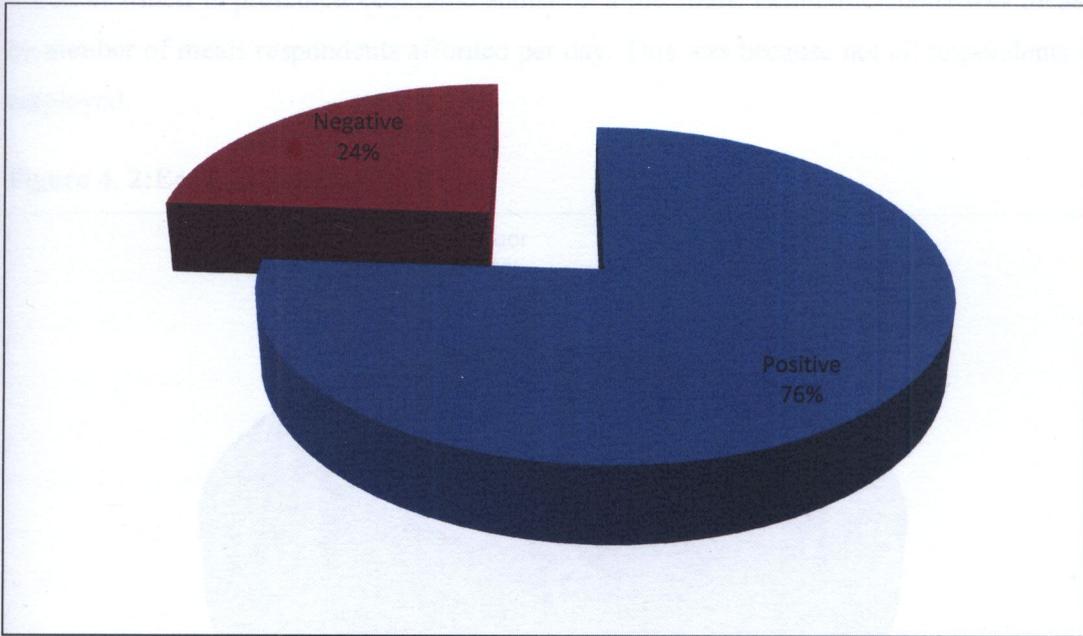
The majority of respondents (78%) had positive perceptions and attitude towards people with mental illness while 24 percent had negative perception towards people with mental illness.

4.23: SECTION C: SOCIO-ECCONOMIC STATUS

This section explores the socio-economic status of respondents because it was assumed that socio-economic status of a person had an influence on people's coping. The section had one question which is presented economic status on a pie chart. Economic status was measured by number of meals respondents afforded per day. This was because not all respondents were employed.

Figure 4. 2:Economic status
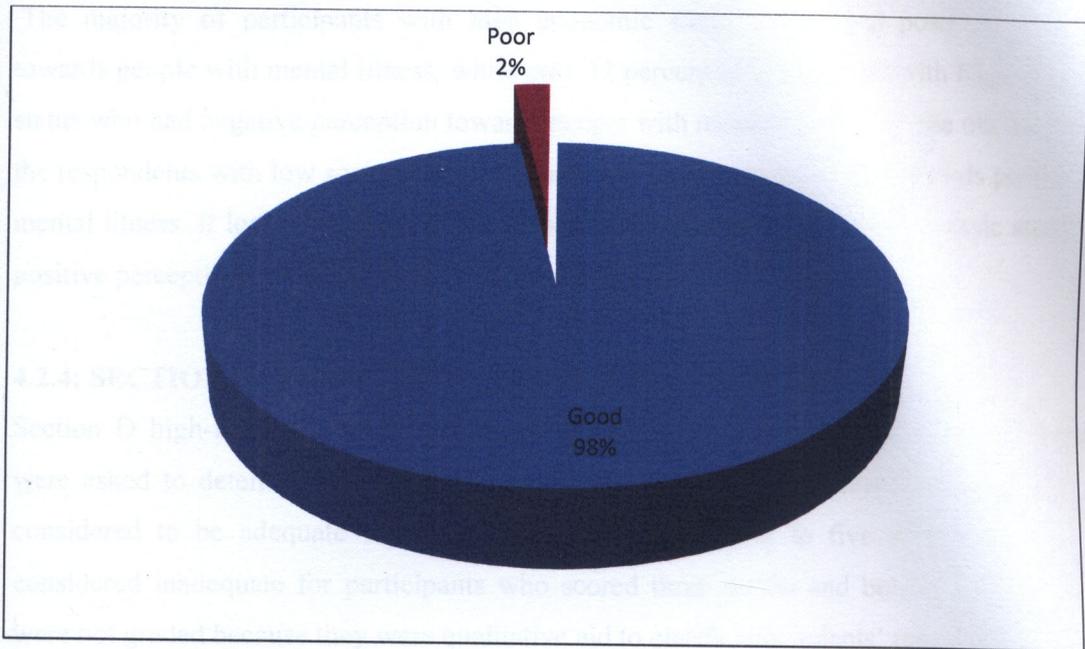
Figure 4.2 above serves as summery of findings of this section. Economic status for majority of respondents (98%) was good, while only two percent of participants reported poor economic status.

Table 4.12: Perceptions and Economic status (no=50)

Economic status	Perception		Total
	Positive	Negative	
High	37 (75%)	12 (25%)	49 (100%)
0-1 (Low)	1(100%)	0	1 (100%)
Total	29 (58%)	21 (42%)	50 (100%)

The majority of participants with high economic status (75%) had positive perception towards people with mental illness, while only 12 percent of participants with high economic status who had negative perception towards people with mental illness. On the other hand, all the respondents with low socio-economic status had positive perceptions towards people with mental illness. It looks like most of the respondents regardless of socio-economic status had positive perceptions towards people with mental illness.

4.2.4: SECTION D: KNOWLEDGE ABOUT MENTAL ILLNES

Section D high-lights knowledge of the respondents about mental illness. Nine questions were asked to determine the level of knowledge of respondents. Level of knowledge was considered to be adequate for participants who scored four to five points while it was considered inadequate for participants who scored three points and below. Four questions were not graded because they were qualitative aid to clarify respondents' responses.

The section has four frequency tables to present the findings and one pie chart to summarise the findings of the section.

Table 4.13 Information about mental illness (no=50)

Have you heard about mental illness?	Frequency	Percentage
Yes	50	100
No	0	0
Total	50	100
Where did you get information about mental illness?		
Health centre	10	20
Community	40	80
Total	50	100
What is mental illness?		
Madness	4	8
Disorders of the brain	46	92
Total	50	100

It is interesting to note that all respondents (100%) had heard about mental illness.

Table 4.13 above shows that majority of participants (80%) accessed information about mental illness from the community. Only twenty percent of respondents heard about mental illness from the health centre.

On the other hand, 92 percent of respondents regarded mental illness as a disorder of the brain, while a negligible percentage (8%) of respondents regarded mental illness as madness.

Table 4.14: Causes of mental illness (no=50)

Do you know the causes of mental illness?	Frequency	percentage
Yes	25	50
No	25	50
Total	50	100
Causes of mental illness (n=25)		
Substance abuse	16	64
Stress and depression	4	16
Witchcraft	5	20
Do not know	25	50
Total	25	100

Table 4.14 indicates that 50 percent of the participants reported that they knew the causes of mental illness, the remaining 50 percent expressed ignorance about causes of mental illness. Table 4.14 further indicates that 64 percent of participants who responded that they knew causes of mental illness believed that substance abuse was the cause for mental illness. Furthermore 16 percent believed that stress and depression caused mental illness while 20 percent of respondents believed that mental illness was caused by witchcraft.

Table 4.15 Signs of mental illness (no=50)

Signs of mental illness	Frequency	Percent
True	50	100
False	00	00
Total	50	100
Is mental illness curable?		
Yes	44	88
No	6	12
Total	50	100

Table 4.15 shows that all respondents knew the signs for mental illness. On the other hand, majority of participants (88%) responded that mental illness was curable, while only 12 percent of respondents stated that mental illness was not curable.

Table 4.16: Treatment for mental illness (no=50)

What is the treatment for mental illness?	Frequency	Percentage
Health facility treatment	39	78
Herbal	1	2
I don't know	1	2
Prayers	3	6
No treatment	6	12
Total	50	100
Does taking of psychotic drugs prevent mental illness relapses?		
Yes	46	92
No	4	8
Total	50	100

According to the table (4.16) above, 78 percent of respondents stated that treatment for mental illness is sought from health facilities while, 12 percent stated that there was no treatment for mental illness. It is interesting to note that even if only two percent of respondents stated that treatment for mental illness is sought from traditional healers, a total of 18 percent of respondents stated that they would consult traditional healers as well.

Most of participants (92%) were aware that taking psychotic drugs would prevent relapses, while only eight percent of respondents stated that taking psychotic drugs would not help prevent relapses.

Figure 4.3: Knowledge about mental illness
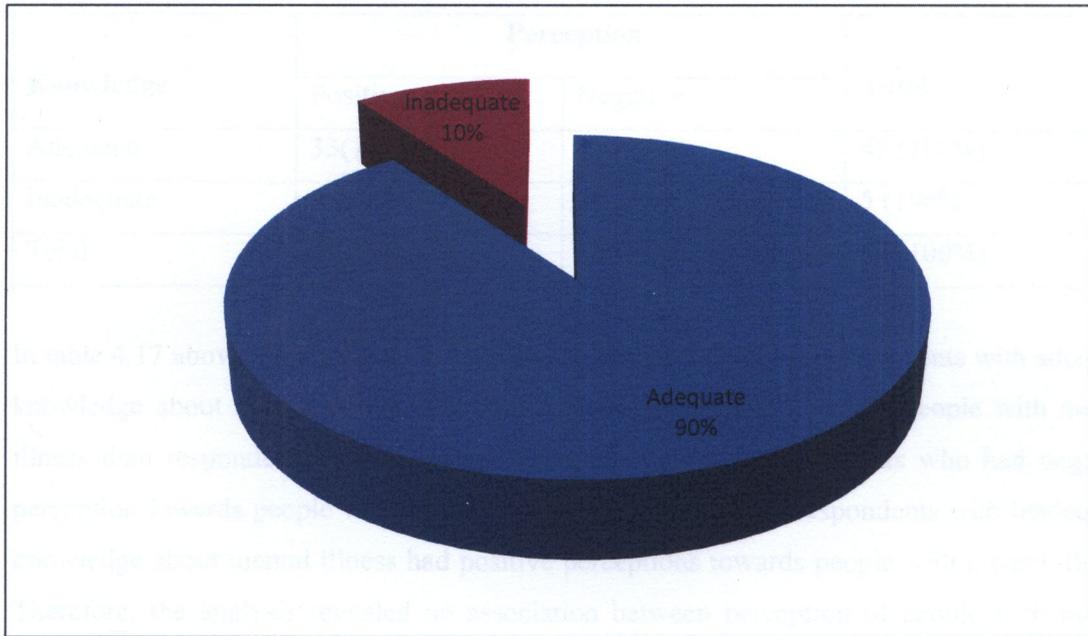
Figure three above shows that 90 percent of respondents had adequate knowledge about mental illness.

Table 4.17: Perceptions and Knowledge (no=50)

Knowledge	Perception		Total
	Positive	Negative	
Adequate	33(73%)	12 (27%)	45 (100%)
Inadequate	5 (100%)	0	5 (100%)
Total	38 (76%)	12 (24%)	50 (100%)

In table 4.17 above there appears to be a high proportion (73%) of respondents with adequate knowledge about mental illness who had positive perceptions towards people with mental illness than respondents with adequate knowledge about mental illness who had negative perception towards people with mental illness. Furthermore, all respondents with inadequate knowledge about mental illness had positive perceptions towards people with mental illness. Therefore, the analysis revealed no association between perception of people with mental illness and knowledge about mental illness.

4.2.5: SECTION E: CULTURAL BELIEFS

Section E explores how cultural beliefs influence perceptions towards people with mental illness. Four questions were considered in this section. There is one frequency table to present the answers and one pie chart to summarise the findings for cultural beliefs. Scores zero to one represent negative cultural beliefs while scores two to three denotes positive cultural beliefs.

Table 4.18: Caring for mentally ill persons (no=50)

Where do people prefer seek treatment for mental illness?	Frequency	Percentage
Health institution	41	82
Traditional healers	9	18
Total	50	100
Can you take care for mentally ill persons?		
Yes	44	88
No	6	12
Total	50	100
Would you provide basic needs for mentally ill person?		
Yes	44	88
No	6	12
Total	50	100
What type of care does your culture encourage for mentally ill people?		
Provide basic needs	40	80
Embrace them	6	12
I don't know	4	8
Total	50	100

Majority of respondents (82%) cited health institutions as a preferred place to seek treatment. Table 4.18 shows that nearly all respondents (88%) would take care of mentally ill people by providing basic needs for them while 12 percent of the respondents stated that they would not take care of mentally ill persons. Furthermore, majority of participants (80%) stated that their culture encouraged community members to provide basic needs to mentally ill people. Conversely, eight percent of respondents revealed that they were not aware of any type of care for the mentally ill that their culture recommended.

Figure 4.4: Cultural beliefs
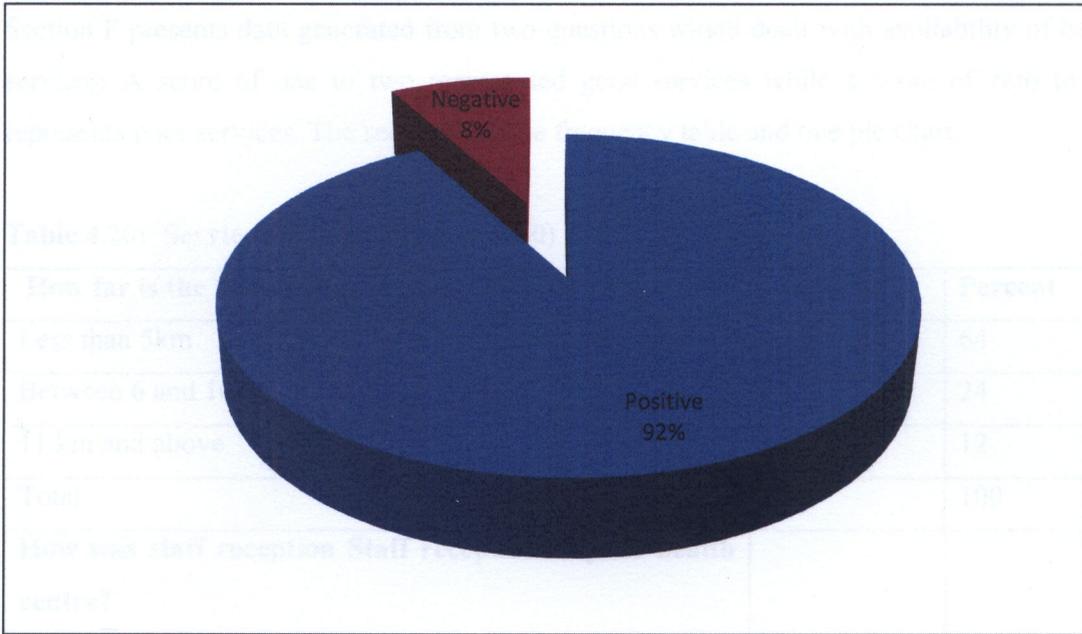
Nearly all respondents (92%) had positive cultural beliefs regarding mental illness although eight percent of the respondents still had negative cultural beliefs.

Table 4.19: Perception and cultural beliefs (no=50)

Cultural beliefs	Perception		
	Positive	Negative	Total
Negative	1 (25%)	3 (75 %)	4 (100%)
Positive	37 (80%)	9 (20%)	46 (100%)
Total	38 (76%)	12 (24%)	50 (100%)

The table above (4.19) shows a high proportion (75%) of participants with negative cultural beliefs had negative perceptions towards mentally ill people, while 80 percent of respondents who had positive cultural beliefs had positive perceptions towards people with mental illness. The analysis revealed there to be significant relationship between perception of mental illness and cultural beliefs, considering that the negative the cultural beliefs the negative perception of people with mental illness.

4.4.6: SECTION E: SERVICE RELATED FACTORS

Section F presents data generated from two questions which dealt with availability of health services. A score of one to two represented good services while a score of zero to one represents poor services. The section has one frequency table and one pie chart.

Table 4.20: Service related factors (no=50)

How far is the nearest health centre from your home?	Frequency	Percent
Less than 5km	32	64
Between 6 and 10 km	12	24
11 km and above	6	12
Total	50	100
How was staff reception Staff reception at your health centre?		
Negative	11	22
Positive	39	78
Total	50	100

The table (4.20) above showed that the majority of participants (64%) stayed within the radius of five kilometres from the nearest health facility. Only 12 percent of respondents stayed as far as eleven kilometres and beyond. On the other hand, more than three quarters (78%) of the respondents stated that health centre staff had positive attitude towards patients. The rest of participants (2%) stated that health centre staff had negative attitude towards patients.

Figure 4.5: Service related factors
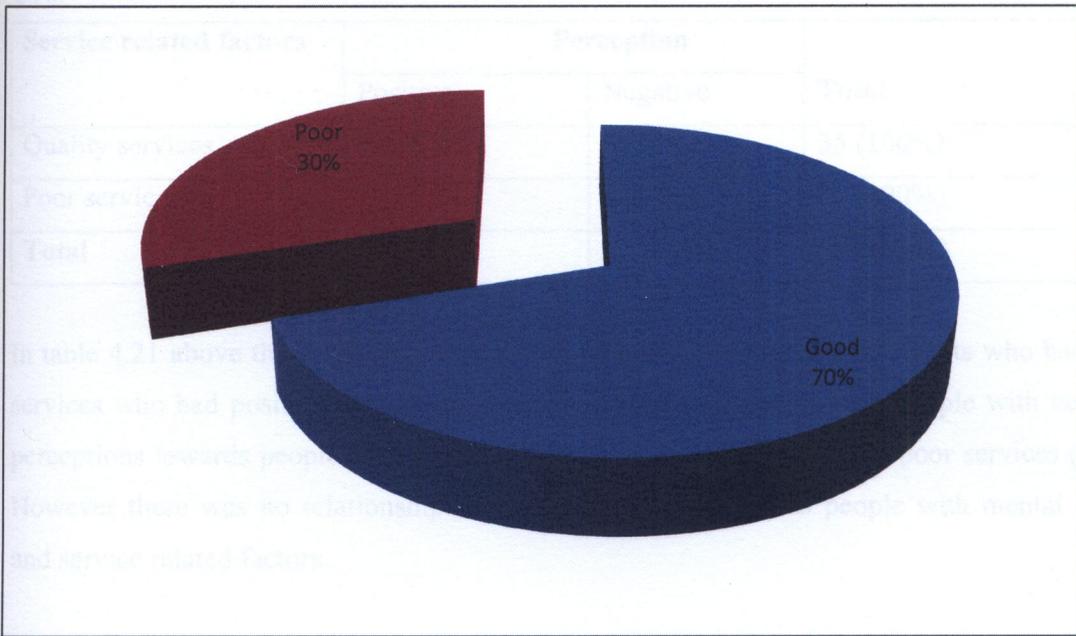
According to figure 4.5 above, seventy percent of respondents stated that service provision at the health facilities was good. This was measure by distance to the health facility and staff attitude as these may influence one's health seeking behaviour.

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Table 4.21: Perception and service related factors (no=50)

Service related factors	Perception		Total
	Positive	Negative	
Quality services	27 (77%)	8 (23%)	35 (100%)
Poor services	11 (73%)	4 (27%)	15 (100%)
Total	**38 (76%)**	**12 (24%)**	**50 (100%)**

In table 4.21 above there appears to be a high proportion (73%) of participants who had poor services who had positive perceptions towards mentally ill people than people with negative perceptions towards people with mental illness who stated that they had poor services (27%). However there was no relationship between perceptions towards people with mental illness and service related factors.

4.2.8: SECTION G: RESPONDENTS' SUGGESTIONS

This section presents the suggestions that were proposed by respondents on the methods of improving community perceptions towards people with mental illness.

Table 4.22: Respondents' suggestions (no=50)

Suggestion	Frequency	Percentage
Information, Education and communication to the public	43	86
No suggestion	7	14
Total	50	100

It is interesting to note that a substantial proportion (86%) of respondents suggested that education to the public about positive perception towards people with mental illness should be on going. However, the remaining 14 percent stated that they had no suggestions as to how community perceptions towards people with mental would be improved

CHAPTER FIVE

5.0 DISCUSSION

5.1 INTRODUCTION

There is scarcity of research conducted on perceptions towards people with mental illness in Zambia. The present study was conducted to explore community perceptions towards people with mental illness. In the study, participants were males and females aged between 18 years and above. A semi-structured questionnaire was used to collect the data. The data was analysed using Statistical Package of Social Scientists (SPSS) version 16.0.

5.2 DISCUSSION OF VARIABLES

5.2.1 Characteristics of the Sample

The sample consisted of 50 respondents form Lusaka Urban District. The mean age was 30.7 years (SD 8). The Majority of respondents were aged between 18 and 27 years. The age of the respondents is similar to that of the study conducted by He et al (2009) which revealed that the respondents were less than 35 years of age. Most of the respondents were married. The present study findings do not support He et al (2009) study findings which revealed that only few participants were married. Furthermore, the results of the present study revealed that all respondents were Christians. The present study results support CSO's (2007) study results which revealed that most of people in Zambia were Christians. Most of the participants had attained secondary school education. However, majority of women's level of education was low. The findings are similar to the demographic health survey results which indicated that most women only attained grade seven (CSO, 2007). On the other hand, only 22 percent of respondents were in formal employment. The study findings concur with the recent study results by Mundi (2012) and Chella (2009) which revealed that there are high rates of unemployment in Zambia.

5.2.1 Community Perception and Age

The study revealed no association between perceptions towards mental illness and age. This could be because both old and the young people are affected by mental illness occurrence at the same time. The younger and the older respondents perceived that everyone was susceptible to mental illness. As a result of this perception most of the respondents were able to take mentally ill people to health institutions to seek treatment.

The findings are similar to recent study findings by Jorm and Wright's (2008) and the Scotish Government (2009) which revealed that both young people and old people had positive perceptions towards people with mental illness. On the contrary, a study conducted by the Health Promotion Agency (2006) revealed that both younger and older respondents had negative attitude towards people with mental illness. On the hand, Chong et al (2007) found that older respondents had negative perceptions towards people with mental illness. Negative perceptions towards people with mental illness may lead to poor perception of the severity of the mental illness and consequently poor health seeking behaviour.

The present study results may differ from the above results because of the difference in the age of the respondents, study setting, and the small sample size used. The present study was conducted in one city only while the others were conducted country wide. Therefore, future research on more varied populations may improve the present understanding of the relationship between perceptions towards people with mental illness and age. Research should focus on explaining lack of difference in perceptions towards people with mental illness age as found by the present study. Public awareness and anti-stigma campaigns should also focus on those commonly held misconceptions and target specific populations.

5.2.2 Community Perception and Level of education

There was a relationship between perceptions towards people with mental illness and level of education. Positive perceptions of mental illness may influence actions such as caring for the mentally ill or seeking help from the health institutions, while negative perceptions towards people with mental illness may result in negligence of the mentally ill people. The result is consistent with results from a study by the Scottish Government (2009) which revealed that perceptions were closely related with educational achievement. The study revealed that people with no education had negative perceptions towards people with mental illness, while people with higher education would not want anyone to know if they had mental illness.

The findings also support Golberstein et al's (2008) study which revealed that students with high education had negative perceptions towards people with mental illness. In addition, Chong et al (2007) asserts that negative perceptions towards people with mental illness correlated with low education. However, even if the present study findings are similar to other research, future research with more representative populations needs to be conducted.

This may give different understanding of the relationship between perceptions and level of education.

5.2.3 Community Perception and Socio-economic status

The present study findings showed no relationship between socio-economic status and community perception towards people with mental illness. High economic status may facilitate accessing conventional medicine and subsequently resulting in positive perceptions towards mental illness. The findings also support Katontoka's (2007) study which revealed that low socio-economic status was perceived to precipitate metal illness and subsequent negative perceptions. Similarly, Ssebunya et al (2009) revealed that low socio-economic status was associated with negative perceptions towards mental illness. Additionally, Deribew and Yonas (2005) found that low socio-economic status was associated with negative community perceptions towards mental illness. The current study findings are contrary to WHO (2010) report which stated that socio-economic status was associated with community perceptions towards people to mental illness. The present study findings may be different from the above study findings because of the small sample size and the methodology used. Therefore, a qualitative study should be conducted. This may be more conclusive as it will be representative of all socio-economic classes.

5.2.4 Community Perception and Knowledge

The present study results revealed no association between community perceptions towards people with mental illness and knowledge. Adequate knowledge about mental illness may lead to confidence in community's ability to take actions such as seeking treatment from health facilities and caring for people with mental illness. Similarly WHO (2010) stated that lack of knowledge about mental illness resulted in negative perceptions towards people with mental illness. In addition, the results are also contrary to Angermeyer et al (2009), who found that adequate knowledge about mental illness leads to positive perceptions towards people with mental illness. The findings differ from a comparative study conducted by Omar et al (2010) which revealed that inadequate knowledge about mental illness influenced perceptions of mental illness in a negative way.

The differences in the mentioned studies may be attributed to sample size, study setting and the methodology used. The present study was conducted in one city only using a semi-structured interview schedule while the other studies were conducted in different countries using different methodologies such as purposive selection of respondents.

Further study should be conducted. There is also need to continue with community sensitisation programmes so that all people are aware of mental health problems and perceive them positively.

5.2.5 Community Perception and Cultural beliefs

Cultural beliefs were found to influence community perceptions towards mental illness considering that 75 percent of participants with negative cultural beliefs had negative perceptions towards people with mental illness. Negative cultural beliefs may result in negative community perceptions towards people with mental illness. The present findings support Deribew and Yonas (2005) who found that community members still believed that mental illness was caused by mystical powers. The belief that mental illness is caused by mystical powers results in negative community perceptions towards people with mental illness. Similarly, Gureje et al (2006) revealed that religious-magical views of causation were associated with negative perceptions towards people with mental illness, while Bird et al (2010) revealed that the general public perceived mental illness as a disease caused by moral misconduct. Therefore, further research using qualitative methodology should be conducted to broaden the understanding of the present results. There is also need to educate the general public about the negative impact that negative cultural beliefs have towards perceptions of people with mental illness.

5.2.6 Community Perception and Service related factors

The present study results revealed no relationship between services related factors and community perceptions towards people with mental illness. The Mental Health and Poverty Project (2011) revealed that implementation of mental health policies may lead to positive community perceptions towards people with mental illness. On the other hand, the present study findings are contrary to Gordon's (2012) study findings which revealed that presence of negative perceptions towards mental health issues attributed to lack of community awareness and sensitization on positive attitude towards mental illness. Therefore, community sensitization using a cross cultural approach in mental health matters may help the public to develop positive perceptions towards people with mental illness. Further research should also be conducted in various settings of the country using a qualitative method.

5.3. IMPLICATIONS TO HEALTH CARE SYSTEM

The study has shown that negative perceptions towards people with mental illness still exist among the general public. However, most of the participants had positive perception towards people with mental illness. The implications of the study have been discussed under four main subheadings through which different strategies may be implemented to improve community perceptions towards people with mental illness. These are nursing practice, nursing education, nursing administration, and nursing research.

5.3.1 Nursing Practice

Increasing awareness of mental health services may contribute to positive community perceptions towards people with mental illness. Sensitization on positive community perceptions towards people with mental illness should be conducted at all health care levels by nurses through Information Education and Communication.

5.3.2 Nursing Research

Research helps to provide evidence based practice. In this case, it is important that further research on community perceptions towards people with mental illness should be conducted using different methodologies. Qualitative studies may yield different insight into community perceptions towards people with mental illness. It is also important that study findings are published to contribute to provision of evidence based health service provision.

5.3.3 Nursing Administration

Health professionals trained in psychiatry should be employed so that patients with mental illness may be positively perceived and therefore treated positively. Administrators should provide more mental health service providers. They should also put in place measures on how to supervise health service providers to make sure that adequate information about positive community perceptions towards mentally ill people is given. Administrators should ensure that appropriate psychotropic drugs are always adequately stocked at all times to prevent negative perceptions towards people with mental illness. Finally, administrators must ensure good data management by all health care providers so that policy maker will be able to plan mental health services appropriately. Proper data management will also be used by researchers.

5.3.4 Nursing Education

Strategies to educate both health professionals and the public on positive perceptions towards people with mental illness must be implemented at all levels of health service provision. Ministry of Health in collaboration with Non Governmental Organisations (NGO) should plan to be holding seminars to sensitise community members on importance of positive perceptions towards people with mental illness. Community members need to be educated about positive perceptions towards people with mental illness through different media such radio, and television. In addition, at community level community based health workers should be trained so that they will be educating community members on positive perceptions towards people with mental illness. Ministry of education needs to include mental health in their curricular for all grades. Furthermore, administrators should plan and conduct workshops and seminars to sensitize members of staff on the need to have positive perceptions towards people with mental illness.

5.4 CONCLUSION

The study sought to explore community perceptions towards people with mental illness in Lusaka Urban District. Negative community perceptions towards people with mental illness may lead to poor care of people with mental illness, poor health care seeking behaviour and consequently poor recovery. It was evident that culture had an influence on perceptions towards mental illness. On the other hand, it was evident that there is still inadequate knowledge about mental illness as evidenced by beliefs that people with mental illness should just be prayed for or taken to traditional healers. This is mostly attributed to lack of community capacity building on mental illness.

To the author's knowledge, this is one of the few studies to explore community perceptions towards people with mental illness in Zambia. It is well recognized that there is no health without mental health (Prince et al, 2007). The Ministry of Health should ensure that both health workers and the general public are sensitised about positive perceptions towards people with mental illness. To achieve this, different health care systems should be involved.

5.5 RECOMMENDATIONS

Basing on the present research findings, interventions to change negative perceptions towards people with mental illness need to be instituted. The recommendations are therefore made for policy makers and implementers as follows:

5.5.1 Government

The government through Ministry of Health needs to ensure that mental health services are integrated into Primary Health Care. In addition, policy makers should to be sensitised on positive perceptions of mental illness and the importance of prioritising mental health services. The government through the ministry of health should also ensure that purposeful programs are implemented in the community involving community based health volunteers at all health facilities throughout Zambia. This may facilitate public awareness and anti-stigma campaigns focused on commonly held misconceptions about mental illness. Furthermore, the government should sponsor future research on more varied populations which may improve the present understanding of the relationship between perceptions towards people with mental illness and age where research should focus on explaining for lack of influence by age found by the present study.

5.5.2: Lusaka Health District Office

Lusaka District Health Management team should step up awareness programmes on community perceptions towards people with mental illness. The campaign should also address issues of promotion of mental health and prevention of mental illness. There should also be modification in presentation of information such as translating messages from English to Nyanja for easy reading by most of community members. Awareness programmes should be conducted throughout the year using various media such as televisions, radios, and posters among others.

There is need to engage mental health professionals and appoint focal persons at health institution level who will coordinate mental health activities. Furthermore, Lusaka District office should conduct workshops to orient health professional on positive perceptions towards the mentally ill people.

5.5.3: Health Care Providers

Health care providers should embark on giving Information Education and Communication to community members on positive perceptions towards people with mental illness. The community members should also be sensitized on causes of mental illness so that they have adequate knowledge about mental health which may result in positive perception towards mental illness, When giving health education on community perceptions towards people with mental illness, the audience's beliefs should be considered so that appropriate issues are discussed using the language best understood by most of the participants.

In addition, health care providers should teach community members the importance of recognising signs and symptoms of mental illness and what actions to take when they have a mentally ill patient in the community. They utilise all gatherings they attend to give health education on community perceptions towards people with mental illness.

5.6 DISSEMINATION OF FINDINGS

Dissemination of research findings is the transmission or communication of research findings by presentation or publication to a variety of audiences, such as nurses, other health professionals, policy makers and consumers (Burns and Grove, 2005). It involves the measures that would be undertaken to make known to the appropriate authorities and the study participants what the study had found. Dissemination of findings for the current study will be printed and bound into reports which will be submitted to the University of Zambia, Department of Nursing Sciences, and to Lusaka District Health Office.

5.7 LIMITATION OF THE STUDY

The current study was hampered by the inclusion criteria of only people aged 18 years and above. This meant exclusion of those aged below 18 years who might have had negative perceptions as a result of their age. Therefore, their inclusion may have provided wider and different views on community perceptions towards people with mental illness.

Furthermore, while semi-structured interviews were conducted, participants' responses may have been affected by the presence of the researcher as some participants may not have expressed themselves freely.

Time during which the study was conducted was limited. As a result, the study did not use other data collection methods such as focus group discussions and observation to supplement on the data collected from semi-structured interview schedules.

The sample size of the study was small. As a result of this small sample size, the results of the study cannot be generalized to the rest of the population.

The study was further hampered by budget constraints which resulted in the selection of only 50 respondents. This also contributed to the limited techniques used in gathering the information.

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THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF NURSING SCIENCES

<u>TOPIC</u>

A STUDY TO DETERMINE COMMUNITY PERCEPTIONS TOWARDS PEOPLE WITH MENTAL ILLNESS PEOPLE IN LUSAKA URBAN

Semi-structured questionnaire

Serial number ....

Date of interview.............................

Place of interview...................................

INSTRUCTIONS TO THE INTERVIEWER

1. Introduce yourself to the respondents
2. Explain the purpose of the interview
3. Assure respondents of confidentiality and anonymity
4. Do not write the name of the respondent on the questionnaire.
5. Get written consent from the respondents before the interview
6. Tick (..) against correct responses or state responses in space provided.
7. Thank the respondent at the end of the interview.

SECTION A: DEMOGRAPHIC DATA

For official use

1. Gender of participant

    a)   Male   ( )

    b) Female   ( )

2. How old were you on your last birthday?.............years

3. What is your current marital status?

    a) Single   ( )

    b) Married   ( )

    c)   Separated   ( )

    d) Divorced   ( )

    e) Widowed   ( )

    f)   Widower   ( )

4. What is your Religion?

    a) Christian   ( )

    b) Islam   ( )

    c) Moslem   ( )

    d) Bundist   ( )

5. What is your highest level of education?

    a) Never been to school   ( )

    b)   Primary education   ( )

    c) Secondary education   ( )

    d) Tertiary education   ( )

6. What type of employment are you in?

    a)   Formal   ( )

    b) Informal   ( )

    c) unemployed   ( )

SECTION B: PERCEPTION AND STIGMATOWARDS MENTAL ILLNESS

7. Does your culture encourage caring for mentally ill people?

   a) Yes   ( )

   b) No   ( )

8. How are people with mental illnesses treated in your community?

   a) Neglected   ( )

   b) Physically abused   ( )

   c) Denied opportunities to go to school or cannot be employed   ( )

   d) Treated like any other person   ( )

9. How does the community perceive a person with mental illness?

....

....

10. Does mental illness affect one's relationship with the family or Community?

   a) Yes   ( )

   b) No   ( )

11. If the answer to question ten is yes explain

....

....

12. Is mental illness contagious?

   a) Yes   ( )

   b) No   ( )

13. Who gives support to the mentally ill people?

   a) Community members   ( )

   b) None   ( )

14. Does your community involve people with history of mental illness in decision making?

    a) Yes   ( )

    b) No   ( )

15. If your answer to question thirty two is no, give reasons

....

SECTION C: ECONOMIC STATUS

16. How many meals do you afford to take in day?

    a) Zero to One   ( )

    b) Two to Three   ( )

SECTION D: KNOWLEDGE ABOUT MENTAL ILLNESS

17. Have you ever heard about mental illness?

    a) Yes   ( )

    b) No   ( )

18. If the answer to question 15 is yes, where did you get the information

about mental illness?

    a) Health centre   ( )

    b) Community   ( )

19. What is mental illness in your own words?................

    ....

20. Do you know the causes for mental illness?

    a) Yes   ( )

    b) No   ( )

21. If the answer for question eighteen is yes, mention one cause

for mental illness...

....

22. Self neglect, Violent behaviour and wandering are some of the

signs and symptoms of mental illness.

    a) True   ( )

    b) False   ( )

23. Is mental illness curable?

    a) Yes   ( )

    b) No   ( )

24. If the answer to question twenty one is yes, explain the type

   of treatment for the mentally ill people...................................

....

25. Can consistent taking of psychotic drugs prevent the relapses

   of mental illnesses

    a) Yes   ( )

    b) No   ( )

SECTION E: CULTURAL BELIEFS

26. Where do people in your area prefer to seek treatment for a mentally

ill person?

    a) Health institutions   ( )

    b) Traditional healers   ( )

27. Would you take care of mentally ill persons?

    a) Yes   ( )

    b) No   ( )

28. If the answer to question twenty five (25) is yes, would you provide

them with all basic needs ?

    a) Yes   ( )

    b) No   ( )

29. What type of care does your culture promote for mentally ill

people?...

....

SECTION F: SERVICE RELATED FACTORS

30. How far is your home from the health centre?

    a) Less than 5Km   ( )

    b) Between 6 and 10 km   ( )

    c) 11 Km and above   ( )

31. How is staff reception at health centre?

    a) Positive   ( )

    b) Negative   ( )

END OF QUESTIONMAIRE
THANK YOU.

INFORMED CONSENT FORM

Dear participant,

My name is Mutinta FH Kasaro. I am a student at the University of Zambia, (School of Medicine) pursuing a Bachelor of Science in Nursing Programme in the Department of Nursing Sciences.

In partial fulfilment of the degree of Bachelor of Science in Nursing, I am required to undertake a research project. My study topic is on **Community perceptions towards people with Mental illness.**

You have been randomly selected to participate in this study and I want to inform you that participation in this study is purely voluntary and that you are free to withdraw at any stage of the study if you so wish. You will be asked some questions about mental illness. Information you will provide will be kept confidential and no name will be written on the questionnaire. Information you will provide will help develop better perception of people with mental illness.

I .... hereby called the participant understands the guidelines of this study and I am willing to participate in the study.

Date...

Signature/thumb print of respondent...

Signature of interviewer...

The University of Zambia,
School of Medicine,
Department of Nursing Sciences,
P.O. Box 50110,
Lusaka.

The District Director of Health,
Lusaka District Health Management Team,
P.O. Box 50827,
Lusaka.

U.F.S: The Head
Department of Nursing Sciences,
University of Zambia,
School of Medicine,
P.O. Box 50110.
Lusaka

Dear Sir/Madam,

RE: PERMISSION TO CARRY OUT A RESEARCH STUDY

I am a fourth year student pursuing a Bachelor of Science (BSc) degree in Nursing at the University of Zambia, School of Medicine, and Department of Nursing Sciences.

In partial fulfilment of the BSc Nursing Degree programme, I am required to conduct a research study. The title of my study is **"Community Perceptions towards People with Mental Illness"**. I am therefore asking for permission to carry out this study at Chawama, Chipata, Chilenje and Kalingalinga clinic. I intend to conduct this study between 7th NOvember and 28th November 2011.

Attached are my interview schedule and consent form. If you need any further clarification, please contact the Head of Department, Department of Nursing.

Your consideration will be greatly appreciated.

Thanking you in anticipation.

Yours faithfully,

REPUBLIC OF ZAMBIA

MINISTRY OF HEALTH

3 November 2011

LUSAKA DISTRICT HEALTH MANAGEMENT TEA
P. O. Box 508;
LUSAK

Mutinta F. H. Kasaro
University of Zambia
School of Medicine
Department of Nursing Sciences
P O Box 50110
LUSAKA

Dear Ms. Kasaro

RE: COMMUNITY PERCEPTIONS TOWARDS PEOPLE WITH MENTAL ILLNESS

We are in receipt of your letter over the above subject.

Please be informed that Lusaka DHMT has no objection for you to carry out a research within some DHMT Health Centres on "**Community Percerptions towards people with mental illness**", as partial fulfillment of programme requirements.

By copy of this letter the respective Health Centre In-charges are herewith informed.

Please ensure that a copy of the summary of findings is also provided to LDHMT at the end of the research study.

Yours faithfully,

DR. C. MBWILI-MULEYA
PRINCIPAL CLINICAL CARE OFFICER

CC: The Head – Department of Nursing Sciences
CC: In-charge – Chawama, Chipata, Chilenje and Kalingalinga and health centres

Appendix IV: Work Plan

ACTITVITY	TIME FRAME DATES	DURATION	RESPONSIBLE PERSON
Research Proposal development	6/06/11-18/08/11	69 days	Researcher
Finalize Research Proposal	22/08/11- 11/09/11	21 days	Researcher
Formulation of data collection tools	01/10/11- 05/10/11	5 days	Researcher
Clearance From Authority	06/10/11-3/11/11	28 days	Researcher
Pilot study	4/11/11	1 day	Researcher
Collection Tool Amendments	7/5/11	1 day	Researcher
Data Collection	8/11/11-28/11/11	20 days	Researcher
Data Analysis	14/12/11- 29/12/11	15 days	Researcher
Report Writing	3/01/12-24/01/12	21 days	Researcher
Submission of Draft Report to Supervisor	31/01/12	1 day	Researcher
Finalize Report	14/02/12-24/02/12	10 days	Researcher
Submit two bound copies for marking	25/02/12	1 day	Researcher
Submitting final copies	25 /03/12	1 day	Researcher

Appendix: V Gantt chart

ACTIVITY	RESP PERSON	MONTHS										
		Jun 2012	Jul 2011	Aug 2011	Sep 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	A... 2
Research Proposal Review	Researcher	█	█	█	█							
Finalize Research Proposal	Researcher					█						
Formulation of data collection tools	Researcher					█						
Pilot Study	Researcher					█						
Clearance From Authority	Researcher					█						
Data collection Tool Amendments	Researcher					█						
Data Collection	Researcher					█	█					
Data Analysis	Researcher							█				
Report Writing	Researcher								█			
Submission of Draft	Researcher								█			
Work on the final report	Researcher									█		
Submit corrected copy	Researcher										█	
Publican of results	Researcher											█

Appendix VI: Research Budget

DESCRIPTION	QUANTITY	UNIT COST (ZMK)	TOTAL (ZMK)
• Bond paper	3	35,000	105,000
• Stapler	1	25,000	25,000
• Staples	1 pkt	15,000	15,000
• Rubber	2	1000	2,000
• Notebooks	2	2,000	4,000
• Scientific calculator	1	85,000	85,000
• Pens	2	1000	2,000
• Pencils	3	800	2,400
• Perforator	1	25,000	25,000
• Flip chart	1	45,000	45,000
• Markers	4	3,500	14,500
• Manila files	10	1,500	15,000
• Filing clips	1 pkt	15,000	15,000
• Ring binders	4	10,000	40,000
• Folder	3	3,000	9,000
• Rulers	2	1,000	2,000
Sub Total			**300,400**
• Researcher	1 x 14 days	50,000	700,000
• Research bag	1	200,000	200,000
Sub Total			**900,000**
• Photocopying	300	200	60,000
• Typing Services	300 pages	2,500	750,000
• Binding	4	50,000	200,000
Sub Total			**1,010,000**

Budget summary

NO.	DETAILS	TOTAL AMOUNT
1	Stationery	300,400
2	Personnel costs (Allowances)	900,000
3	Secretarial services	1,010,000
4	Transport costs	500,000
5	Sub grand Total	3,420,400
6	**Grand total**	**3,062,400**

BUDGET JUSTIFICATION

In order to conduct this study effectively and professionally, a number of costs will be incurred as administrative and technical costs. The above budget is intended to facilitate a smooth conducting of the study. The budget has been divided into four parts namely; stationary, personnel costs, secretarial services and transport costs.

STATIONERY

Stationary is needed in this project for research proposal writing, preparation of questionnaires, data processing and analysis which will be done manually. Stationary will also be required the final research report.

PERSONNEL COSTS

The research project will also deserve some personnel related costs such as payment of lunch/meal allowances to the researcher and the one research assistant as they will be required to work outside normal working hours especially during data collection and data analysis.

TRANSPORT AND SECRETARIAL SERVICES

To facilitate researcher movement and secretarial services such as typing, photocopying, editing and printing, a cost to the research project will added.

PERSONNEL

The investigator will need money for Lunch for lunch and any other unforeseen circumstances during the study.

CONTIGENCY

Contingency fund will be required in case of any un foreseen circumstances like inflation and unstable currency. The contingency fund will be 10% of the total budget