

**THE DETERMINANTS OF MENTAL HEALTH LITERACY AMONG MEDIA
PRACTITIONERS KENYA**

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DECLARATION OF ORIGINALITY

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DEDICATION

I dedicate this work to the blessed and eternal memory of my late grand-mother Mrs Clementina Nyarotso Chitayi who enrolled me to nursery school at Ebubaka. She laid the solid foundation upon which I have built my academic career. She provided me with love, support and taught me the value of hard work. When the going gets savage, I have no better anchor than the memories of your teachings, grandma.

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LIST OF ABBREVIATIONS/ACRONYMS

AMIQ – Attitude to mental illness questionnaire

CAMIMH – The Canadian Alliance of Mental Illness and Mental Health.

DSM – Diagnostic and statistical manual of mental disorders

ICD 10 – International classification of diseases tenth edition

MAKS – Mental health knowledge schedule

MHL – Mental Health Literacy.

KDHS – Kenya demographic and health survey

KNCHR – Kenya National Commission on Human rights

KNBS – Kenya National Bureau of statistics

NAMI – The national mental health association

OCD – Obsessive compulsive disorder.

SPSS – Statistical Package for social science.

WHO – The World Health organization

DEFINITIONS

Attitude – In social or clinical psychology, a relatively stable and enduring predisposition to behave in a certain way towards persons, objects, institution or issues.

Mental Health – A state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life , can work productively and fruitfully, and is able to make a contribution to his or her community.

Mental Health Literacy (MHL): The knowledge, beliefs and abilities that enable the recognition, management or prevention of mental health problems.

Stigma – a mark of disgrace or discredit that sets a person apart from others. It involves negative stereotypes and prejudice about others and is often measured in terms of social distance (the degree to which people are willing to interact socially with others). Stigma can be enacted through social rejection and discrimination or felt as the fear of social rejection and discrimination.

ABSTRACT

Background: Several studies have shown that presentation of pessimistic and imprecise images of mental ill health in the media promotes stigma by perpetuating myths and misconceptions. However few studies exist on mental health literacy of media practitioners – who are the main source of information to the public.

Study Objective: To determine the mental health literacy of media practitioners in Kenya

Method : A total sample of 164 media practitioners working for five media houses in Nairobi were selected using systematic sampling and interviewed using a demographic questionnaire, the mental health knowledge schedule (MAKS) and the attitude to mental illness questionnaire (AMIQ). The collected variables were analyzed using Independent t-test, Pearson correlation, Analysis of variance (ANOVA) and descriptive statistics.

Results: 55% of the respondents were male and 45% were female. The mean knowledge score on MAKS was 44.7, suggesting adequate knowledge of mental illness. The mean attitude score on AMIQ was -5.27 suggesting a negative attitude. The knowledge of mental illness was associated with level of education ($p = 0.0298$). Media practitioners with a higher level of education of 1st degree (45.2 +/- 4.4) or 2nd degree (45.7 +/- 4.4) had a significantly higher knowledge of mental illness than those with a certificate/diploma (43.0 +/- 5.2). There were no significant differences in the level of comprehension of mental illness based on the marital status ($P = 0.2056$), age ($P = 0.9228$) or gender ($P = 0.0672$). There were no significant differences in the attitude towards mental illness based on marital status ($P = 0.8927$), age ($P = 0.9655$), gender ($P = 0.06200$) or educational level ($P = 0.1637$). There was no association between awareness of mental illness and attitude towards mental ill health (Pearson correlation = -0.100, $P = 0.203$).

Conclusion: The study showed that media practitioners in Kenya have adequate overall knowledge of mental sickness but a negative attitude towards mental ill health. A higher level of education is associated with better mental health literacy. The finding of a negative attitude towards mental illness provides a likely explanation for negative portrayal of mental illness in the media in the past and portends a risk to public mental health education in future.

CHAPTER ONE

INTRODUCTION

1.1 Background of the study

The media practitioners Act 2008 of Botswana stated that, a media practitioner is a person who writes, edits and transmits news or any other information to the public. This may include a journalist a broadcaster, an editor or publisher of a journal.(National assembly, 2008). The Kenya media council Act 2013 does not define a media practitioner but defines journalism as the gathering, writing, editing and presenting of news or news items in newspapers and magazines, radio and television programs, in the internet or any other manner as may be specified.(National assembly K. , 2013). It can hence be inferred that media practitioner and journalist are closely related terms with the definition of a media practitioner including a journalist.

Mass media is a principal resource of information for the public about mental ill health. Images and narratives in the media influence thinking and create social standards. While the link between negative media portrayal of mental illness and stigma has been demonstrated through extensive study, there are few studies on mental health literacy of media practitioners generally. To the researcher's knowledge, no study on mental health literacy among media practitioners has been conducted locally although anecdotal reports suggest that media practitioners have limited knowledge about the causes of mental illnesses, symptoms and management; making a study of mental health literacy among media practitioners a necessity.

1.2 Definition of Mental Health Literacy

Literacy in mental health is the understanding and beliefs about mental diseases which help their identification, management and prevention (Jorm et al., 1997a).

Mental health literacy includes the following domains; knowing how to obtain and sustain decent mental health; accepting mental illnesses and their treatment; diminishing stigma against mental disorders; and enhancing help seeking ability. (Kutcher, Bagnell, & Wei, 2015)

Studying the mental health literacy of media practitioners is a precursor to formulating appropriate interventions aimed at fighting stigma of mental illness.

1.3 Importance of Mental Health Literacy to media practitioners

1. Mental health literacy of media practitioners is an important factor in understanding of stigma because media practitioners are an important cradle of information about mental illness for the general public, persons living with mental illnesses and mental health workers.
2. In the course of reporting on mental illnesses, certain negative stereotypes have been observed over time. These stereotypes entrench stigma. Studies consistently show that both showbiz and news media provide excessively dramatic and twisted images of mental illness that accentuate impulsiveness, criminality and dangerousness. They also encourage negative responses to the mentally ill including scorn, fear and rejection. (Stuart, 2003).

3. Negative portrayal of persons with mental illness results in social, emotional and treatment challenges. Negative images weaken self-esteem, help-seeking behaviors, drug compliance and overall return to wellness. (Stuart., 2006)
4. There are no local studies on mental health literacy of media practitioners in Kenya. Anecdotal reports indicate a low level of mental health literacy among media practitioners in Kenya.

1.4 Consequences of poor mental health literacy to media practitioners and the society

McKeown and Clancy (1995) assert that the link between mass media representations of mental illness and the knowledge of the public is circular: negative images encourage negative attitudes and ensuing media coverage feeds off an already negative perception in the community. This indicates that accurate images of mental sickness would promote positive attitudes and the ensuing media coverage would feed off a positive public perception.

Persons with mental diseases face many challenges such as stigmatization culminating in abuse of basic rights both at community level and institutions (Ministry of health, Kenya, 2015)

According to Ganesh (2011), Stigma remains a dominant negative force in all social relations. It is considered a consolidation of three related problems: ignorance (illiteracy), negative attitudes (prejudgement) and marginalization (exclusion).

The role of the media in sustaining or reducing stigma is well documented. Media has the power to impact peoples' perceptions. Research findings has shown that media is one of the most significant sources of information for the community (Coveradale, Naim & Claasen, 2002). A positive impact in terms of more accurate portrayal of mental illness would be

expected of a media practitioner with a positive attitude towards mental illness. (Edney, 2004).

This study was founded on the hypothesis that a media practitioner who has good mental health literacy will have a positive attitude towards mental illness hence would portray mental illness more accurately while one who lacks mental health literacy will have a negative attitude towards mental illness therefore would portray mental illness negatively.

According to the Kenya Demographic and Health Survey (KDHS. 2014), 68% of Kenyan households own a radio while 35% own a television, reaffirming the primacy of media as a powerful source of information to the Kenyan public. (Ministry of Devolution and Planning, Kenya, 2014).

Kenyan media has faced criticism with regard to use of dramatic language that in many cases tend to spread myths and stereotypes on mental illness. This move promotes fear and improper assumptions in the community.

In 2013 a story of 40 patients absconding from Mathari hospital (Kenya's national teaching and referral psychiatric hospital), was reported. Many stereotypes were apparent in the reporting by media which erroneously used terminologies such as 'escape' instead of 'abscond' and went on to assert that the 'escape' was pre-planned and meticulously executed since, in the media practitioners opinion, people who are deranged cannot have the capacity to do that. The reporting portrayed the mentally ill as zombies, always sedated, incapable of independent thought, mentally challenged, or just outright stupid to the extent that any intelligible thing they do should be considered a sign of wellness or conspiracy (Atwoli, A., 2013).

According to MIND – a health charity in the United Kingdom, off-putting media reportage has a direct and detrimental blow on persons with mental illnesses lives. (Kismet, B., 2006)

In this study the researcher investigated mental health literacy of media practitioners. While the many studies in the world tend to focus on harmful portrayal of mental diseases in the media, few have paid attention to the knowledge and attitude of media practitioners and the determinants thereof.

1.5 Statement of Problem

The mass media has the power to influence perceptions. The KDHS 2014 reports that 38% of Kenyan homes own a television while 68% own a radio. Mental illnesses are associated with stigma. Stigma is reinforced by inaccurate information pre-eminently represented by negative portrayal of mental illness. Despite the evidence that stigma exists in Kenya against mental illness, no studies have been done on mental health literacy of media practitioners who are shapers of public opinion. Negative media coverage affects patients; by impeding recovery and triggering prejudice and discrimination. It also influences how mental health workers attend to the mentally ill. In society stigma resulting from negative media portrayal of mental illness reduces the chances of the mentally ill from attaining education and employment leading to poverty. This study established current knowledge levels of media practitioners in Kenya and their attitude towards mental illness. The determinants of mental health literacy were therefore established.

1.6 Study Objectives

1.6.1 Broad Objectives

To establish the knowledge of and attitude toward mental illness among media practitioners in Kenya

1.6.2 Specific Objectives

1. To establish the level of knowledge of mental illness among media practitioners in Kenya.
2. To establish the attitude toward mental illness among media practitioners in Kenya.
3. To determine the relationship between socio-demographic factors of media practitioners and their knowledge and attitude of mental illness
4. To establish the relationship between knowledge of mental illness and attitude toward mental illness among media practitioners in Kenya.

1.7 Research Questions

1. What level of awareness of mental illness is among media practitioners in Kenya?
2. What is the attitude toward mental illness among media practitioners in Kenya?
3. What is the association between the socio-demographic factors of media practitioners and their knowledge and attitude of mental illness?
4. What is the relationship between knowledge of mental illness and attitude toward mental illness among media practitioners in Kenya

1.8 Rationale of the Study

There are no local studies of mental health literacy of media practitioners. Anecdotal reports show negative depiction of mental illness in the media which may contribute to stigma. This study aims to establish the knowledge and attitudes of media practitioners towards mental illness. The data obtained will be used to give feedback to the various policy organs concerned with media regulation such as the communication authority of Kenya, the media council of Kenya and the various schools of journalism in the country. Feedback from the study will also be shared with the department of mental health at the ministry of health to establish the need for consistent communication campaigns on mental health awareness.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

Mental health literacy is the awareness and beliefs about intellectual disorders that benefit their identification, management, or prevention. It focuses on equipping of people to trounce structural obstacles to health and to tackle both discrimination and stigma (Johm, *et al.*, 1997a). The following are components of mental health literacy:

- The capacity to recognize specific mental wellbeing challenges.
- Awareness and beliefs about risk dynamics, self-management methods, and of the professional support available.
- Attitudes that expedite recognition and suitable help-seeking.
- Knowledge of how to look for mental health information.

(England, 2005)

2.2 Overview of Mental Disorders

Mental disorders encompass a wide spectrum of problems with varied symptoms. They are generally characterized by some amalgamation of anomalous thoughts, emotions, behavior, and relationships with others (WHO, 2016).

Table 2.1: Broad categories of mental and behavioral disorders according to ICD-10.

Category of disorder	Examples
Organic mental disorders	Alzheimer's dementia and delirium
Mental disorders due to use of psychoactive substance	Alcohol, cannabis, khat or opiod use disorders.
Schizophrenia, schizotypal and delusional disorders;	
Emotional or mood disorders	Depressive episode and bipolar disorder.
Stress-related, neurotic and somatoform disorders	obsessive compulsive disorder and generalized anxiety disorder
Behavioral disorders associated with physical and physiological disturbances	eating disorders and sleeping disorders
Disorders of adult behavior and personality	trans-sexualism and paranoid personality disorder.
Mental retardation	
Emotional and behavioural disorders with childhood	conduct disorder
Disorders of physiological development	autism and specific reading disorders
Unspecified mental disorders	

(WHO, 2003)

2.3 Global Burden of Mental Disorders.

In 2003, about 450 million people were estimated to suffer from mental disorders worldwide.

One in four persons met the criteria of having a mental illness at some point within the period of their life (WHO, 2003).

At any one time, 10% of adults and children will have a mental disorder. Mental disorders contribute 14% to the global burden of disease including death and disability. Mental, neurological and substance abuse contribute 31% in the global distribution of non-fatal disease burden.(WHO, WORLD BANK, 2016).

2.4 Mental Disorders in Kenya.

According to the Kenya Ministry of Health, there is a scarcity of information on the frequency of mental and behavioral disorders in Kenya.(Ministry of Health, 2015). It is estimated that 25% of outpatients and 40% of inpatients suffer from mental health disorders(KNCHR, 2011). The likely prevalence of psychosis in Kenya is 1% (Kiima & Jenkins, 2010).

In the Kenyan general hospital settings, the most frequent diagnosis is stress-related and anxiety disorders, substance abuse and depression.(Ndetei et al., 2009).

This finding is supported by a community study of the prevalence of psychiatric morbidity in Western Kenya. Four hundred and twenty (420) adults were interviewed using the Mini International Neuropsychiatric interview version 7 of the DSM-5 and a researcher created a social demographic questionnaire. Forty five percent (45%) of the participants had a lifetime diagnosis of one mental disorder at the least.. Fifteen point seven percent (15.7%) had anxiety disorder, twelve point three percent (12.3%) major depressive disorder, eleven point seven percent (11.7%) substance use disorder; seven point six percent (7.6%) had experienced psychosis. (Kwobah, Epstein, Mwangi, Litzelman & Atwoli, 2017)

Notwithstanding the high frequency of mental disorders in Kenya, persons with mental disorders face stigma.(Ministry of Health, 2015). Stigma is known to be an outcome of ignorance, negative attitudes and discrimination (Ganesh, 2011).

2.5 The Role of Media in Mental Health Literacy

Kenya has a vibrant media industry. This comprises of mainstream and social media. The mainstream media includes; television, radio and newspapers.

One of the major roles of media is to educate the public thereby contributing to the literacy of the masses. It is a powerful tool in shaping perceptions. Media is the public’s most important source of information on mental health. (Coverdale et al., 2002).

According to the American National Mental Health Association, People gather mental Health illness information from the following media sources: (NMHA, 1997)

Table 2.2: Mental health information sources

TV/ Newsmagazine shows	70%
Newspapers	58%
TV news	51%
News magazine	34%
TV talk shows	31%
Radio news	26%
Other magazines	26%
Internet	25%
Non-fiction	25%
Talk shows on radio	18%
Women’s magazine	18%

(NMHA, 1997)

2.6 Media practices that reinforce stigma against mental illnesses

In the course of reporting about mental illnesses, certain negative stereotypes have been observed over time. These stereotypes entrench stigma. Studies reliably show that both news and entertainment media provide devastatingly dramatic and distorted images of mental illness that stress criminality, dangerousness and unpredictability. They also model negative and harmful reactions to the mentally ill including ridicule fear and discrimination..(Stuart, 2003). This study did not take into account the impact of social media on enhancing mental health literacy or propagating stigma.

2.7 Negative images and stereotypes of mental ill health in media.

A study of 300 newspaper paper articles in the United States of America was conducted covering six different newspapers for the year 1999. This research showed that positive images of people with mental illness were rare. Few stories depicted persons with mental illnesses as productive members of society (Edney, 2004). When the media portrays the mentally ill as unproductive, the general public presumes that persons with mental disorders are a burden to the society; unable to contribute meaningfully to their communities.(Wahl, 2001).

The mentally ill are often wrongly depicted as violent. Glasgow University, a study was conducted of 562 newspapers items containing depictions of mental health and illness; it revealed that sixty two percent (62%) of the information was on violence that related to mental disorder persons. Stories that earn most media attention appear to be those that link mental illness to crime and violence in USA yet only 3-5% of violence in the country is committed by a person with mental disorder (Monahan, 1992).

The depiction of the mentally ill as violent or criminals extends to entertainment media. The commonest depiction of mental illness in standard media has involved mentally ill people who are break the law and are violent.(Day & Page, 1986). Mental ill health is depicted as resisting clear explanation, and thus unstable, difficult to understand and impossible to predict.(Rose, 1998), asserts that media portrays people with psychiatric diagnoses as unsafe, dangerous and violent.

In one study, seventy two point one percent (72.1%) of adults portrayed as mentally unwell in television drama maimed or killed others. They are unlikely to find work outside home and if they do are likely to fail (Signorielli, 1989). Despite the association of mental illness and violence in TV drama, studies have shown that individuals with mental illness who do not have co-morbid substance use disorder end up committing a forceful crime than any other persons (Steadmen et al.,1998). Other negative stereotypes include the depiction of mentally ill persons as outcasts, simple minded and a drain on society. Psychiatrists and psychiatric facilities also suffer negative stereotyping (Guimon, 2010), reports that media presents erroneous and unappealing stereotypes of the psychiatric occupation that misleads the public and jeopardize the trustworthiness of mental health care professionals.

The media monitoring project in Australia 2000/01 and 2006/07 shows an improvement in the quantity and quality of coverage of mental illness.

The study showed that ten point six percent (10.6%) of the media items on mental illness stigmatize mental illness. Five point eight percent (5.8%) use language that is inappropriate. Sixteen point two percent (16.2%) labeled person by diagnosis. One third (33%) revealed that a particular person had a mental illness and identified them by name,. only nineteen

point eight percent (19.8%) of media items provided information on help services.(Pirkis & Francis, 2012)

Television programs hardly portray persons with mental illnesses as having the ability to get well or become productive members of community. The limited focus on dysfunctional behavior in the absence of personal recovery narratives also promotes pessimistic and cynical views of psychiatric treatment and contributes to a dearth of mental health resources and policy initiatives (Wahl , & Roth, 1982).

Media has a pivotal role to play in public mental health education. There are many stereotypes about mental illnesses in the media. These stereotypes need to be challenged. This study focused on the mental health literacy of media practitioners in Kenya. The outcome of this study forms a basis for further research and grounds for improving the training of media practitioners in Kenya with a view to improving their mental health literacy.

2.8 Consequences of negative depiction of mental illness in media.

There are profound results of negative media images for persons with mental illness that span emotional, behavioral and social realms. These images damage self-esteem, compliance to medication and overall recovery. (Stuart , 2006). The US surgeon general's report (1999) identified stigma as a key hindrance to improved mental healthcare. Lack of requisite knowledge, prejudice and discrimination combine to enable stigma towards people with mental disorders.(Health, 1999)

It has been reported that negative media coverage has a direct and injurious effect on the lives of mentally challenged persons as revealed by a survey from MIND, a UK Charity. 515

respondents suffering from a range of mental disorders about their stance on media coverage of mental illness were surveyed. Half of the respondents said that the media coverage had a negative consequence on their own mental health. Thirty four percent (34%) said that this resulted in an increase in their depression and anxiety symptoms. Twenty two percent (22%) of the participants said that as result of the media coverage, they felt more withdrawn while eight percent (8%) reported feeling suicidal as a result of the press coverage.(Baker &MacPherson, 2000).

The negative social impact of negative media stereotypes revealed in the study included increased hostility from neighbors among twenty five percent (25%) of respondents. The negative coverage also caused twenty percent (25%) of respondents to put off an application for a job or volunteer position.(Baker & MacPherson, 2000).

A German study on the correlation between media expenditure and desired social distance towards people with a mental illness recommended that stories of people living well with mental disorders should receive greater media coverage. These narratives have the potential for desirable effects on the readers attitudes towards persons living with mental disorders.(media, 2012).

Negative stereotypes against psychiatric treatments create suspicion. In spite of much research evidence representing effectiveness of psychiatric interventions, the treatments are often viewed with deep suspicion which makes them difficult to access and subjects them to more stringent monitoring.(Sartorius, 2004).

The main aim of this study was to find out the mental health literacy of the media in light of the pivotal role of mass media in informing the public about mental illness and the serious

consequences that can emerge when the media coverage falls into a pattern of negative stereotyping of mental illnesses and mental health services.

2.9 Studies of mental health literacy among media practitioners.

Mental health literacy of media practitioners determines the mental health literacy of the community. Mental health literacy of the media informs the public's perceptions. There are generally few studies focusing on the mental health literacy of the media despite numerous studies on the role of the media in fighting or promoting stigma in the community. This study focused on the mental health literacy of media practitioners in Kenya. Given that there are few studies focusing on mental health literacy in the media, this section discusses studies that have been done both in the media as well as in other groups including entire societies.

2.9.1 Local Studies.

There are no local studies on mental health literacy of media practitioners in Kenya. However, a 2015 study on the collision of communication campaigns on mental health behavior alteration among secondary school students in Nairobi County found that the levels of knowledge of mental health among public secondary school students were low, the messages communicated during communication campaigns on mental health were inadequate and the communication campaigns were ineffective. Among the 334 students interviewed, only 6 had knowledge that depression, bipolar mood disorder, schizophrenia is mental illnesses. This represents less than 2% of respondents. This study established that there was little coverage of mental illness in the media outside major days that focus on mental health such as the mental health day observed worldwide on 10th October.(Nyakundi, 2015)

2.9.2 Regional Studies

According to Oluwale & Obadeji (2014), their study revealed that supernatural factors are responsible for mental illness while genetic causes also cause mental illness. About ninety percent (90%) of the respondents who participated in the study had a negative attitude towards people with mental illness. A majority of the respondents would find marrying someone with a mental illness repulsive while over half would be ashamed if a member of their family had a mental illness.(Oluwale & Obadeji, 2014)

In November, 2016, a study of perceptions and attitudes of students of mass communication toward mental illness in a tertiary institution of Nigeria was published in the Indian journal of social psychiatry. The respondents in the study constituted of 180 final year mass communication students in a tertiary institution in Nigeria.

The study showed only one fifth of the respondents had come across an advert or a campaign about mental illness. Seventy four point one percent (74.1%) of respondents who had come into contact with mental health information used television and radio. More than half of the students rated environmental factors as leading among causes of mental illness. Eighty five point nine percent (85.9%) of the students would not marry a person if they knew the person had a mental disorder.

Three quarter $\frac{3}{4}$ of respondents in the study deemed persons with mental illness as posing risk to the public owing to violent demeanor. About eighty percent (80%) of respondents believed that persons with mental illness were incapable of holding a regular job.(Oluwale & Obadeji, 2016).

A South African study on community attitudes towards and knowledge of mental illness (n=667). The study found that the respondents saw mental illness as resulting from stress or lack of will power as opposed to having a medical basis. Respondents advocated talking over the problem but not seeking professional assistance. Psychotherapy was preferred option of treatment. The study concluded that stigma and misinformation regarding mental illness exist, influencing chosen treatment method and health seeking. More work therefore needed to be done to educate the society about the psychobiological caused of psychiatric disorders and about the value of effective management.(Hugo, Boshoff, Traut, Zungu-Dirway & Stein, 2003).

2.9.3 Global Studies

The original study under the terminology ‘mental health literacy’ was carried out in 1995 and published in the 1997 medical journal of Australia under the title “Mental health literacy”: a survey of the public’s ability to recognize mental disorders and their beliefs about the effectiveness of treatment. It was a cross-sectional study with a sample of 2031 individuals. The study used structured interviews using vignettes of a person with either depression or schizophrenia. While most participants recognized the presence of some mental disorder only 27% properly identified schizophrenia and 39%% correctly identified depression. The conventional psychiatric treatments such as admission, electroconvulsive therapy, antidepressants and antipsychotics were cited as more injurious than helpful. The study recommended that the level of mental health literacy needed to be raised if mental diseases are to be recognized early in the community and appropriate interventions instituted. (Jorm, et al., 1997a).

There is need for strong emphasis on public education to increase mental health literacy among general public. Regardless of a better knowledge of mental illness in subjects aged 18-30 years, there is still a poor attitude towards mental illness in all age brackets. This is attributed to the negative depiction of mental disorders in the media. It is suggested that any attempt to raise public consciousness regarding mental illness and associated stigma should involve the media using a cautiously planned methodology.(Ganesh, 2011).

A project to study mental health literacy project in Canada was conducted by the Canadian Alliance on Mental illness and mental health (CAMIMH). The project involved: a preliminary focus groups with Canadian youth and seniors; Literature review; National survey on mental health literacy and Follow-up focus groups with a diversity of Canadians. The report found reasonably good mental health literacy among Canadians. The prevalence of mental disorders was under-estimated by many of the participants.. In this study, the media was pointed out as bearing responsibility for the reported increase in public perceptions of fear and dangerousness related to mental disorders. The report indicated that the media was interested in reporting the dramatic aspects of mental illness. (CAMIMH, 2007).

2.10 The conceptual framework: Mental health literacy among media practitioners in Kenya.

The flowchart below gives a summary of the conceptual framework in this study.

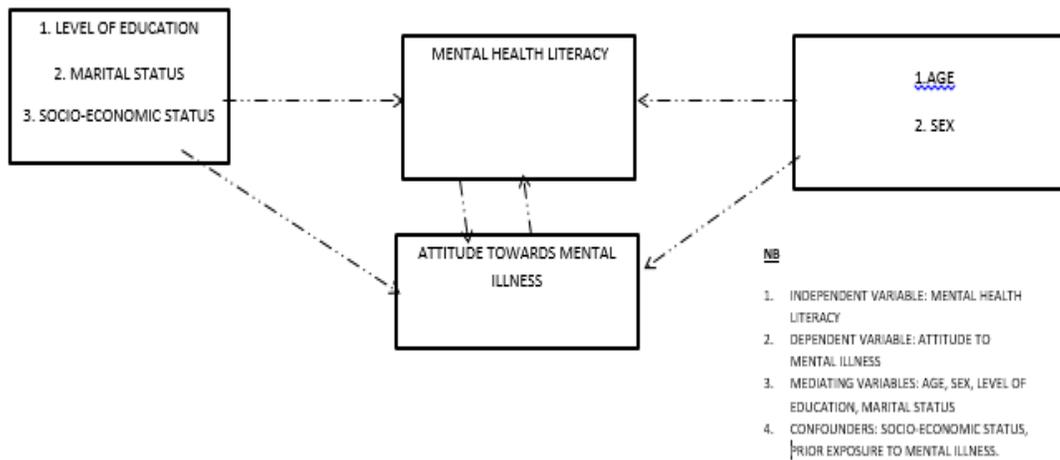


Figure 2.1: Conceptual framework

CHAPTER THREE

3.0 STUDY DESIGN AND METHODOLOGY

3.1 Introduction

In this chapter, the methods that were used to collect data for the study are explained. Research design, the target population and data collection methods are also explained. Data analysis has also been discussed explaining the statistical tools that were used to analyze, present and interpret the data.

3.2 Research Design

This is a cross-sectional descriptive study.

3.3 Study site

This study was conducted in five media stations in Kenya namely: The Standard Group, Nation Media Group, MediaMax Group, The Royal Media Services and The Kenya Broadcasting Corporation. These media houses are located in Nairobi County.

The Nation media group is a private media company founded in 1960 by His highness the Aga Khan and has businesses in television networks, film and TV entertainment. The media house has the 300 media practitioners accredited by the media council of Kenya. It is located at the nation centre building within the central business district in Nairobi. Their largest media outlet is the Nation TV (NTV) and the Daily Nation newspaper.

The Standard group owns the Kenya Television Network (KTN), The Standard newspaper, Radio Maisha and County weekly magazine. The Standard group is headquartered at along Mombasa road in Nairobi County. Standard group has a total of 323 media practitioners (Media Council of Kenya Website).

The Mediamax network owns the K24 television, Milele FM radio station and Kameme FM radio station and the People Daily newspaper (distributed for free). It is located along Kijabe Street at the DSM place. Mediamax has a total of 248 media practitioners accredited by the media council of Kenya.

The royal media services own the Citizen television, Citizen Radio and several radio stations broadcasting in various vernacular languages. It is located along Maalim Juma Road off Dennis Pritt Road in Nairobi. The royal media services have a total of 123 media practitioners on the media council of Kenya website.

The KBC is the state owned media organization in Kenya that broadcasts in both English and Swahili on television, radio and vernacular FM stations. It's located a long Harry Thuku road in Nairobi. On the media council of Kenya website, KBC has 10 approved media practitioners.

3.4 Study population

The study targets the journalists registered with the media council of Kenya and currently employed in any of the 5 media houses chosen for the study: Nation media group, standard group, royal media services, Kenya Broadcasting Corporation and K24.

The five media stations employ a total of 1005 journalists with standard media group employing the highest at 323 journalists and KBC having the lowest at 10 although KBC gets assistance from the Kenya news agency (KNA) which also employs journalists. The NMG has a total of 300 journalists; MediaMax network has 248 while the royal media services has 123 journalists (Media council of Kenya (2017). Accreditation. www.mediacouncil.or.ke/en/mck/index)

A journalist in Kenya may hold a certificate, diploma or degree from a college or university. The length of training varies with the institution and the qualification being pursued.

Once a journalist has completed their study, they are accredited by the media council of Kenya before being able to legally practice journalism in Kenya. The accreditation also applies to students in the final year of study who are on attachment as well as foreign journalists working in Kenya. The media council of Kenya was established through the media act 2013. Its functions include: promotion and protection of the freedom and independence of media; the prescription of standards of journalists, media practitioners and media enterprises and accredit journalists and foreign journalists by certifying their authority, integrity and competence against official standards based on the quality and training of journalists in Kenya. (National assembly K. , 2013). The study employed inclusion and exclusion criteria as follows:

INCLUSION CRITERIA

The study employed the following inclusion criteria:

- Media practitioner registered with the media council of Kenya.
- Media practitioner working for any of the 5 media houses
- Media practitioner who gave informed consent

EXCLUSION CRITERIA

The study employed the following exclusion criteria:

- Media practitioner who was not a Kenyan citizen.
- Media practitioner who had not completed their basic course in journalism.

3.5 Sampling procedure

3.5.1 Sampling Frame

The sample frame for this study was journalists registered with the media council and currently employed in any of the 5 mainstream Kenyan media houses.

3.5.2 Sampling Technique

Journalists working for the five media stations (KBC, Media Max, Standard Media Group, Nation Media Group and Royal Media Services) and met the inclusion criteria were selected using systematic sampling.

3.5.3 Sample Size determination

Using Cochran's (1977) sampling formula;

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

n – estimated sample size

d – The level of precision

p – proportion of those with condition of interest

Z – confidence level

Using a confidence interval of 95% , expected prevalence of 50% and a level of significance of 5% (0.05),

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

$$n = 384$$

$$n' = \frac{n}{1 + (n-1)/N}$$

$n' =$ adjusted sample size

$n =$ sample size

$N =$ population size.

The population size is 1004, being the total number of media practitioners accredited by the media council of Kenya. There have been no mental health literacy studies in Kenya, therefore 50% of the population size will be used to determine N .

50% of 1004 = 502

$N = 502$

Therefore $n' = 384 / 1 + (384 - 1) / 502$

Numerator = 384

Denominator = 1.76

$n' = 384 / 1.76$

$n' = 219$ Respondents.

The respondents will be allocated to each of the media houses in accordance to the number of their registered media practitioners on media council of Kenya website as follows.

0. Standard group (323 media practitioners)

No. of participants from standard group = $\frac{323 \times 218}{1004}$

No. of participants from standard group = 71.

1. Nation media group (300 media practitioners)

No. of participants from nation media group = $\frac{300 \times 143}{1004}$

No. of participants from nation media group = 66

2. Mediamax network (248 media practitioners)

$$\text{No. of participants from Mediamax network} = \frac{248 \times 143}{1004}$$

$$\text{No. of participants from Mediamax} = 54$$

3. Royal media services (123 media practitioners)

$$\text{No. of participants from royal media services} = \frac{123 \times 143}{1004}$$

$$\text{No. of participants from royal media services} = 27$$

4. Kenya broadcasting corporation – KBC (10 media practitioners)

$$\text{No. of participants from KBC} = \frac{10 \times 143}{1004}$$

$$\text{No. of participants from KBC} = 3.$$

3.4 Data Collection instruments

Questionnaires with three sections were used to collect primary data: a researcher designed socio-demographic questionnaire, a mental health knowledge schedule (MAKS) and an attitude to mental illness questionnaire (AMIQ). The questionnaires were issued by drop and pick method to ensure high response rate.

3.4.1 Attitude to Mental Illness Questionnaire (AMIQ)

This is a tool that measures a person's approach towards psychological conditions. The AMIQ was validated by Luty and colleagues (Luty, 2006). It has good psychometric properties; test-retest reliability, alternative reliability, good stability, face, construct and criterion validity. Participants respond to each item on a 5-point Likert scale response system. The range of score is from a minimum of -2 to a maximum of +2. The maximum possible score is +10 while the minimum possible score is -10 per respondent. Three questions 1, 4 and 5 are reverse scored to indicate the direction of the correct answer. The higher the score, the more positive the respondents' attitudes and vice-versa. Participants utilize the instrument by reading a fictional vignette or watch a video describing a person with a substance use disorder or other mental disorder.

In the current study the Attitude to mental illness questionnaire was designed in the original version whereby the respondents read a vignette describing someone with a mental illness. They then responded to five questions on a likert scale. The name of the subject on the vignette was changed to correspond with a common name in Kenya.

3.4.2 Mental Health Knowledge Schedule (MAKS)

The MAKS comprises of two sections. The first part has six items that tests mental health knowledge in areas of recognition, treatment and support, help-seeking, recovery and employment. The second part of the scale consists of 6 items that inquire about ability to identify mental conditions. The degree to which a respondent agrees with a statement on the scale is chosen on a scale of -2 to +2. (Evans-Lacko, Little & Meltzer, 2010).

MAKS scores are analyzed using an ordinal scale (1 to 5). When a respondent strongly agrees with a correct statement or strongly disagrees with the wrong statement they earn 5 points. When a respondent strongly disagreed with a correct statement or strongly agrees with a wrong statement they earn one point. The intermediate points follow this order. The total score for each participant is calculated by adding together the response values for each item. Don't know is coded as neutral (score of 3). Items 6, 8 and 12 are reverse coded to reflect the direction of the correct response. The total maximum score is 60 while the minimum possible score is 12. It has good psychometric properties; test-retest reliability, internal reliability and validity.

In this study it was used together with the attitude to mental illness questionnaire (AMIQ) and the scores obtained used to determine the relationship between knowledge of mental illness and attitude towards mental illness.

It is a short and practical tool for assessing stigma related mental health knowledge. Social desirability can however influence participant's responses.

3.4.3 Demographic data form

Enrolled participants were subjected to researcher designed socio-demographic questionnaire to collect data about their gender, age, level of education, marital status, income and residence.

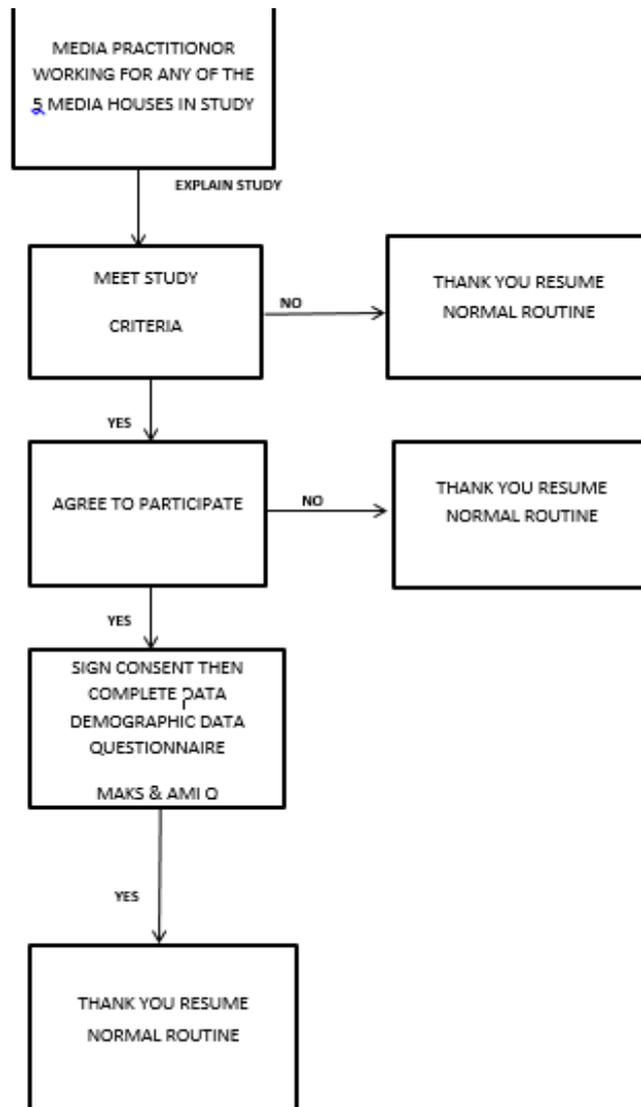
3.5 Pretesting of questionnaires.

Questionnaires were pre-tested before the final distribution. The pilot was done on a portion of the respondents from the study population who were then excluded from the final study to eliminate biasness. The media house selected for pretesting of the questionnaire was Ebru Africa television. Ten respondents participated in the pilot study. No changes were made to the original questionnaires.

3.6 Data collection procedures

Participants enrolled in the study that met the inclusion criteria and were willing to participate in the study were invited to sign an informed consent after informed consent explanation. They then proceeded to complete the socio-demographic questionnaire, AMIQ and MAKS.

Figure 3.1 Recruitment and data collection flowchart



3.7 Data Analysis Methods

Coding of questionnaires was done before feeding the data into excel spreadsheet, statistical package for social sciences SPSS version 20 was used to analyze data.

The data was then analyzed based on descriptive analysis to describe participant characteristics, knowledge and attitude for the entire sample. Independent t-tests and analysis of variance (ANOVA) were performed to test for any association between the media practitioners' socio-demographic factors and the knowledge of mental illness and

attitude towards mental illness. The spearman correlation was performed to determine the relationship between knowledge of mental illness and attitude towards mental illness among the media practitioners. Tables and graphs were used to display the data.

3.8 Ethical considerations

1. Study approval was sought and granted by the KNH/UON Ethical and Research Committee (study reference no. P421/07/2017). Consent was requested from participants who met inclusion criteria and a consent declaration form was signed. The signing was only done after ascertaining participant's understanding of the consent information using a checklist.
2. Participant's confidentiality and privacy of information was protected using coding of the questionnaires. The researcher assigned a study identification number to each subject in the order in which the subjects were enrolled in the study. The names of respondents were not used.
3. The data was entered into SPSS software version 20 using only the numeric identification code to identify participants. The administered questionnaires, having been analyzed are kept safely for a period of two years after which a paper shredder will be employed to destroy them.
4. A write up summary of the research with recommendations will be given to the five media houses where the study was carried out, school of journalism, the ministry in charge of communication, ministry of health and the KNH/UON ethical and research committee.

CHAPTER FOUR

4.0 RESULTS AND FINDINGS

Chapter four presents the results of the statistical analysis of the study on the determinants of mental health literacy among media practitioners in Kenya. The results are presented according to the research questions. The chapter discusses the demographic profiles of the respondents, The mental health knowledge and the attitude of the media practitioners towards mental illness. The significance level was set at $P < 0.05$.

General Information

Table 4.1: Response Rate

Questionnaires	Occurrence	% (percent)
Filled and collected	164	75
Unfilled	55	25
Total	219	100

Out of the 219 questionnaires distributed, 164 questionnaires were fully completed. This represented a response rate of 75 percent. The response rate is adequate when compared to studies in similar settings.

Table 4.2: Response Rate

4.2 Demographic profile of respondents

The demographic statistics presented are gender, age, marital status and level of education of respondents working in media industry. The socio-economic status cannot be analyzed because the respondents did not complete the question on level of income.

Table 4.2: Summary of Demographic Profile of Respondents

Variable	Categories	Frequency (N=164)	Percentage (%)
Gender	Male	83	55.0
	Female	68	45.0
	<i>Not Indicated</i>	13	
Age	Below 20 years	2	1.3
	21 to 30 years	91	57.2
	31 to 40 years	54	34.0
	41 to 50 years	10	6.3
	Above 50 years	2	1.3
	<i>Not Indicated</i>	5	
Education Level	Certificate	4	2.5
	Diploma	34	21.3
	1st University degree	97	60.6
	2nd University degree	25	15.6
	<i>Not Indicated</i>	4	
Marital Status	Married	67	43.2
	Divorced/separated	2	1.3
	Single	82	52.9
	Widowed	1	0.6
	Others	3	1.9
	<i>Not Indicated</i>	9	

The study shows that the highest gender representation was male (55%), the highest age bracket was represented by 21 to 30 years of age (57.2%), and on marital status, the highest were single people representing 52.9% of respondents. On level of education, the study shows that most respondents 60.6% had first university degree. Categories that had extremely low numbers of respondents are shown in red. These were combined into other groups for the statistical analysis.

Table 4.3: Summary of Demographic Profile of Respondents

Variable	Categories	Frequency (N=164)	Percentage (%)
Gender	Male	83	55.0
	Female	68	45.0
	<i>Not Indicated</i>	13	
Age	30 Years and Below	93	58.5
	31-40 Years	54	34.0
	Above40 Years	12	7.5
	<i>Not Indicated</i>	5	
Education Level	Certificate/Diploma	38	23.8
	1st Degree	97	60.6
	2nd Degree	25	15.6
	<i>Not Indicated</i>	4	
Marital Status	Married	67	43.2
	Single	82	52.9
	Others†	6	3.9
	<i>Not Indicated</i>	9	

Note: †-Divorced/Separated/Widowed/Others

4.2.1 Gender of Respondents

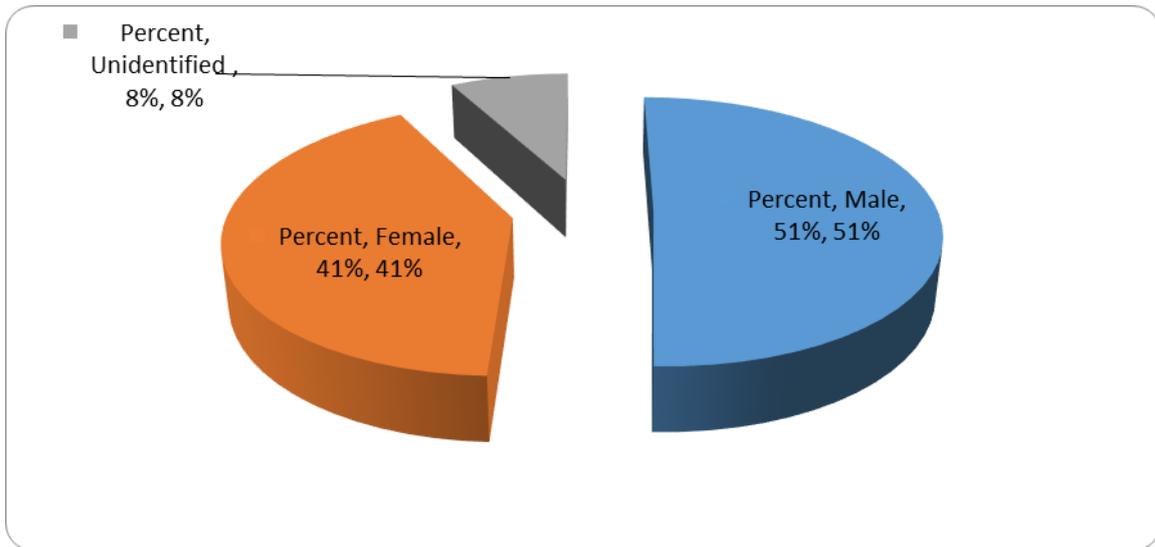


Figure 4.1: Gender of Respondents

Gender of respondents is illustrated in figure 4.1

This includes those who did not indicate their gender. When considering only those who indicated their gender, the males were fifty five percent (55%) and females were forty five percent (45%).

4.2.2 Age of Respondents

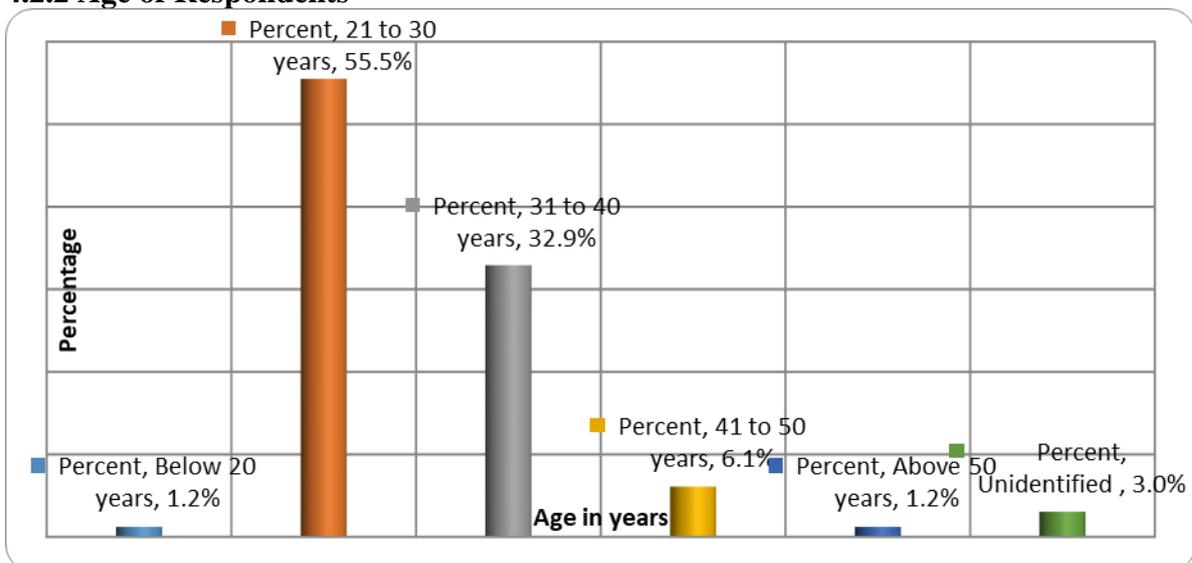


Figure 4.2: Age of respondents

The majority of respondents were in the age bracket 21-30 years at fifty five point five percent (55.5%). The ages below 20 years and above 50 years had the lowest numbers of respondents at 1.2% each.

4.2.3 Marital Status of Respondents

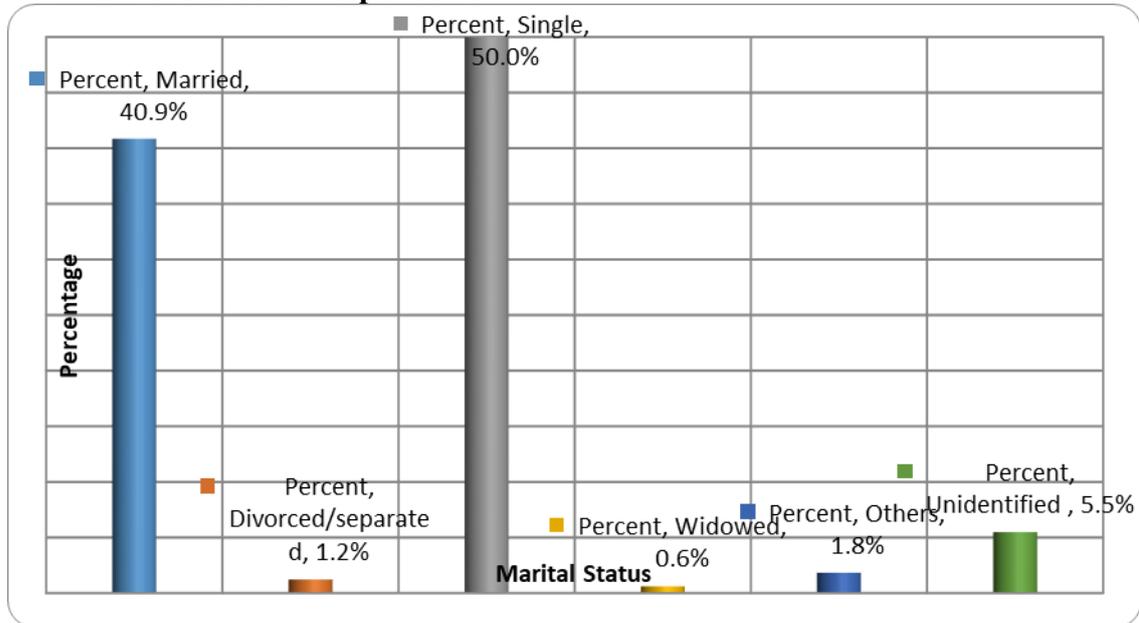


Figure 4.3: Marital Status of Respondents

The study shows that majority of respondents are single at 50% and the least number of respondents were the widowed at 0.6%.

4.2.3 Level of education

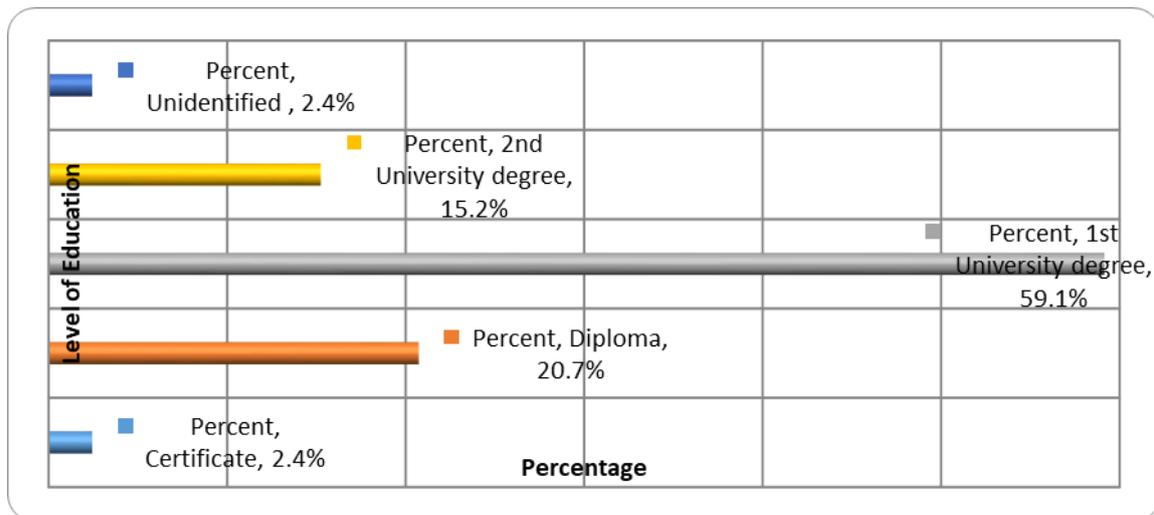


Figure 4.4: Level of Education of Respondents

More than half of the respondents had a university degree representing 59.1% of the respondents, while holders of a certificate were the least at 2.4%.

Level of Knowledge of Mental Illness among Media Practitioners

The first research question was; ‘What is the level of knowledge of mental illness among media practitioners in Kenya?’ This section presents the results and findings in descriptive statistics.

Descriptive Analysis of Level of Knowledge of Mental Illness

Table 4.4: Descriptive statistics for Level of Knowledge of Mental Illness

Level of knowledge of mental illness among media practitioners in Kenya		
N	Valid	164
	Missing	0
Mean		44.74
Median		45.00
Mode		46
Std. Deviation		4.737
Minimum		26
Maximum		55
Range		29

The findings of the study in table 4.3 above reveals the mean score for the level of knowledge of mental illness among media practitioners in Kenya is 44.74, the median score is 45, the mode score is 46 and the standard deviation is 4.737. The study also shows that the minimum score of the level of knowledge was 26 and the maximum score was 55. This gives a range of 29.

The minimum score on the mental health schedule (MAKS) is 12 while the maximum possible score on MAKS is 60. All the respondents had a mean score of 44.74 which represent 74.57% level of knowledge of mental illness among media practitioners in Kenya.

The table below breaks down the responses to the specific questions on the MAKS. Questions 6 , 8 and 12 are reverse scored in accordance with the direction of the correct response. The ideal response to this statement should be to strongly disagree while for the rest of the questions should be to strongly agree. On the MAKS questionnaire, the respondents were asked to indicate the extent to which they agree with each of the following statements on a likert scale.

Kindly choose a response that best shows your level of agreement or disagreement with each of the following statements

	Strongly Disagree	Slightly Disagree	Neither Disagree Nor Agree	Slightly Agree	Strongly Agree	Don't Know	Unanticipated
Most people with mental health problems want to have employment	10.0%	10.0%	18.7%	20.7%	30.7%	6.7%	3.3%
If a friend had a mental health problem, I know what advice to give them to get professional help	1.3%	4.7%	6.0%	32.0%	45.3%	10.0%	0.7%
Medicine can be a successful treatment for people with mental illnesses	2.0%	4.7%	10.0%	22.7%	60.0%	0.7%	0.0%
Psychotherapy (for example talking therapy or counseling) can be an effective treatment for people with mental health problems	1.3%	2.7%	6.0%	26.0%	62.0%	1.3%	0.7%
People with severe mental health problems can fully recover	3.3%	11.3%	18.0%	27.4%	36.7%	3.3%	0.0%
People with mental illnesses go to a healthcare professional for assistance	30.7%	25.3%	20.0%	10.0%	10.7%	3.3%	0.0%
Kindly indicate the degree to which you agree disagree that each of the following conditions is a mental illness							
Depression	10.0%	6.7%	4.7%	26.7%	51.3%	0.0%	0.7%
Stress	14.7%	12.7%	12.7%	30.0%	28.7%	0.0%	1.3%
Schizophrenia	0.7%	7.3%	8.0%	15.3%	52.0%	8.7%	8.0%
Bipolar mood disorder (manic depression)	1.3%	3.3%	18.0%	16.7%	56.7%	2.0%	2.0%
Drug addiction	15.3%	14.7%	8.0%	14.0%	46.7%	1.3%	0.0%
Grief	26.0%	20.7%	12.7%	15.3%	22.0%	3.3%	0.0%

Table 4.5 Level of Knowledge of Mental Illness per question from MAKS

From table 4.4 above: The highest number of respondents gave a correct response with regard to treatment. On whether psychotherapy was an effective mode of treatment, 86% of respondents agreed with the statement (slightly and strongly). On whether medication is an effective form of treatment 82.7% agreed with the statement (slightly and strongly). 58.7% (strongly and slightly) agree that stress is a mental illness. 30% of respondents do not know that drug addiction is a mental illness. 16.7% of respondents disagreed that depression is a mental illness. 58.7% of the respondents wrongly belief that stress is a mental illness while 37.2% wrongly belief that grief is a mental illness. 20% of the respondents disagreed that most individuals with mental illnesses want to have some form of employment while for the same question, 26.4% of the respondents were neutral. This translates to 46.4% of the respondents who failed to answer favorably with regard to employment of people living with mental disorders.

4.4 The attitude towards mental illness among media practitioners.

The second research question was; ‘What is the attitude toward mental illness among media practitioners in Kenya?’ The descriptive results for the variable of attitude toward mental illness among media practitioners were provided in terms of the percentage, mean, median, mode, maximum score, minimum score, range and standard deviation.

Descriptive Analysis of Attitude towards Mental Illness

Information on the attitude of media practitioners was gathered using the Attitude to mental illness questionnaire (AMIQ).

Table 4.5 shows the statistical analysis obtained for the attitude towards mental illness among media practitioners in Kenya.

Table 4.6: Descriptive statistics for attitude towards Mental Illness from AMIQ

Attitude towards mental illness among media practitioners in Kenya		
N	Valid	164
	Missing	0
Mean		-5.27
Median		-5.00
Mode		-8
Std. Deviation		3.046
Minimum		-10
Maximum		6
Range		16

On the AMIQ scale, the minimum possible score is -10 and the highest score is +10. Higher scores indicate a positive attitude while lower scores indicate a negative attitude. The highest score obtained was +6 while the lowest score was -10 giving a range of 16.

The mean score is -5.27 which indicates an overall negative attitude towards mental illness.

Table 4.6 below gives an analysis into the responses to each of the five items on the AMIQ questionnaire. The vignette given was: ‘Mr. Juma has been injecting heroine for the past one year’ indicate the extent to which you agree with the following statements;

Questions 1, 4 and 5 are reverse scored according to the direction of the correct response.

Table 4.7: The Attitude toward Mental Illness among Media Practitioners per question from AMIQ

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know	Unspecified
Do you think that this would damage Mr. Juma's career?	0.0%	0.7%	4.7%	19.3%	71.3%	0.0%	4.0%
I would be comfortable if Mr. Juma was my colleague at work.	27.3%	28.0%	25.3%	10.7%	3.3%	0.7%	4.7%
I would be comfortable inviting Mr. Juma to a dinner	25.3%	20.0%	28.7%	14.0%	4.0%	4.0%	4.0%
	Very Unlikely	Unlikely	Neutral	Quite Likely	Very Likely	Don't Know	Unspecified
How likely do you think it would be for Juma's wife to leave him?	2.0%	6.7%	18.7%	28.7%	38.0%	2.0%	4.0%
How likely do you think it would be for Mr. Juma to get into trouble with the law?	1.3%	0.7%	6.7%	15.3%	71.3%	0.0%	4.7%

From table 4.6 above, 14% of the respondents agreed (strongly or slightly) that they would be comfortable with Mr. Juma as a colleague at work. 55.3% of the respondents would not wish to have Mr. Juma as a colleague at work. 18% would invite Mr. Juma for dinner while 45.3% would not invite him for dinner at their house. 63.7% of the respondents also expect that Mr. Juma's wife would leave him while 86.3% expect that it would be likely (very and quite) for Mr. Juma to get into trouble with the law.

Question one and five had the highest number of respondents give the incorrect response.

In question one ; 90.6% of respondents agreed (slightly and strongly) that the habit would

damage Mr. Juma’s career. While in question five, 86.3% of respondents thought it likely that Mr. Juma would get into trouble with the law.

4.5 The Association between Socio-Demographic Factors, Level of Knowledge and Attitude towards Mental Illness

The third research question was: ‘What is the association between socio-demographic factors of media practitioners and their knowledge and attitude of mental illness?’ This section presents a summary of the correlations.

Table 4.8: Association between Socio-demographic factors and MAKS Scores

Variable	Category	N	Mean(SD)	Group Differences
Gender	Male	83	44.2±4.5	$t_{(149)}=-1.84$; $P=0.0672$
	Female	68	45.6±5.1	
Age	30 Years and Below	93	44.8±5.1	$F_{(2, 158)}=0.08$; $P=0.9228$
	31-40 Years	54	44.7±4.3	
	Above40 Years	12	44.3±4.2	
Marital status	Married	67	44.5±4.9	$F_{(2, 154)}=1.60$; $P=0.2056$
	Single	82	45.3±4.4	
	Others	6	42.0±6.9	
Education Level	Certificate/Diploma	38	43.0±5.2	$F_{(2, 159)}=3.59$; $P=0.0298$
	1st Degree	97	45.2±4.4	
	2nd Degree	25	45.7±4.9	

In Table 4.7, independent t-test was performed to test for differences in the knowledge of mental illness on the basis of gender. The difference in the knowledge was not significant. There was no association between gender and knowledge of mental illness. ($P = 0.0672$).

Analysis of variance (ANOVA) was performed to test for the differences in the mental health knowledge based on the variables of age , marital status and level of education. Certificate/diploma holders had significantly lower level of knowledge of mental illness (43.0 +/- 4.2) compared to first degree holders (45.2 +/- 4.4) and second degree holders (45.7 +/- 4.9). P-value = 0.0298. The differences in the level of mental health knowledge was not significant for age (P = 0.9228). The difference in the level of mental health knowledge was not significant with regard to marital status. (P = 0.2056).

The following are graphical displays of the relationship obtained between knowledge of mental illness and the four socio-demographic variables of gender, age , level of education and marital status.

Association between gender and level of knowledge of mental illness

The mental health knowledge among the females was a higher (45.6 +/- 5.1) than the males at (44.2 +/- 4.5) but the difference in not statistically significant.

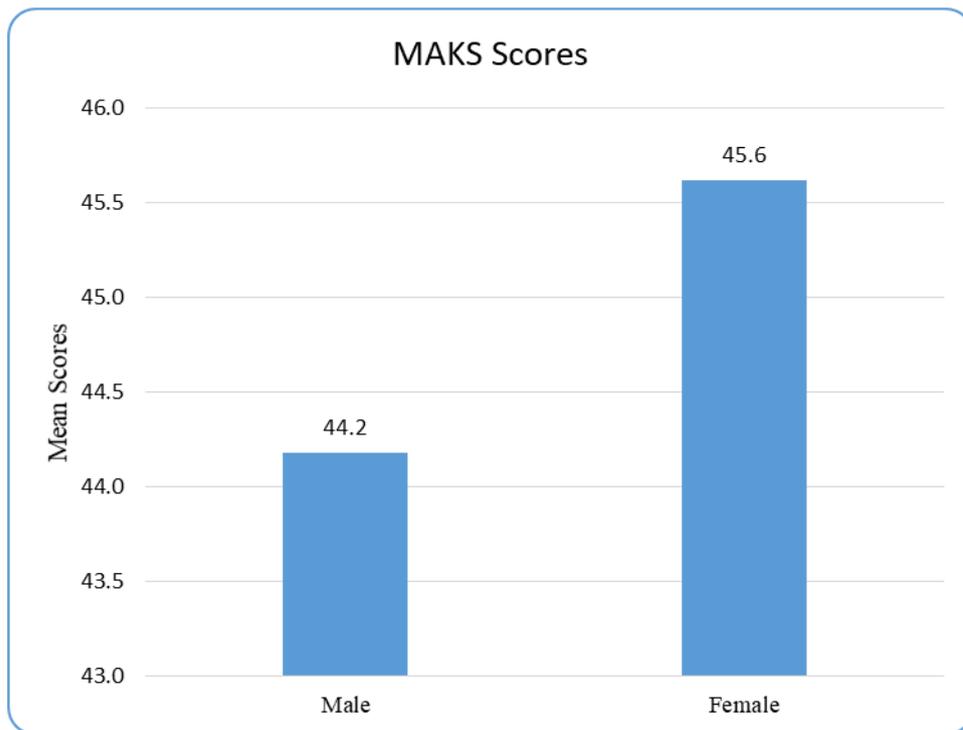


Figure 4.5: Gender and Level of Knowledge of Mental Illness

Association between age and level of knowledge of mental illness

The pie-chart from figure 4.6 below shows how age relates to the level of knowledge of mental illness among media practitioners in Kenya. Respondents aged 30 years and below had the highest MAKS score of 44.8 while those above 40 years had the lowest MAKS scores at 44.3. The difference in the means for the level of knowledge among the different age categories is not statistically significant.

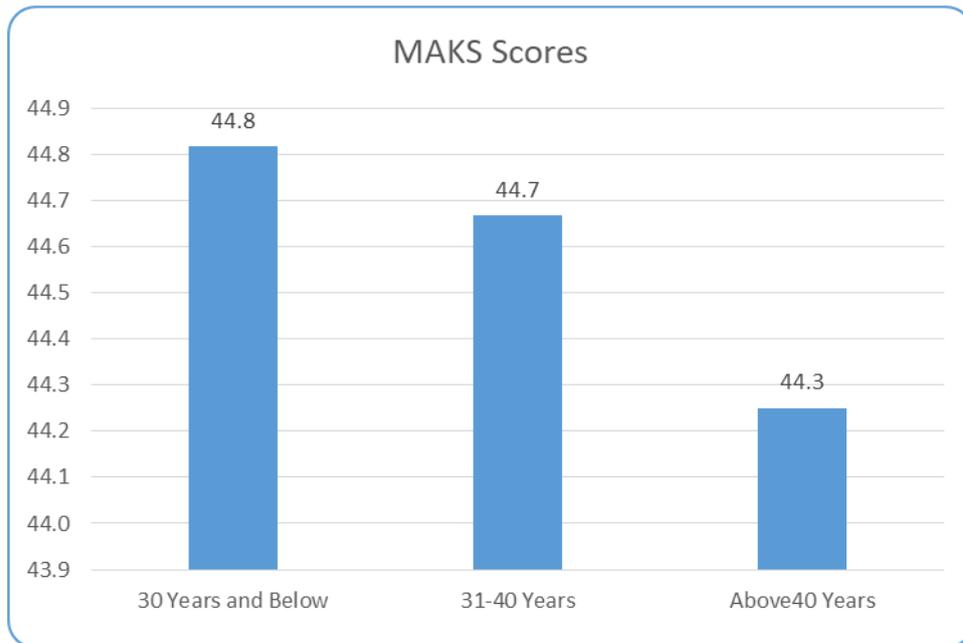


Figure 4.6: Age and Level of Knowledge of Mental Illness

Marital status and level of knowledge of mental illness

The histogram in figure 4.7 below shows the relationship between marital status and level of knowledge of mental illness among media practitioners in Kenya. The single respondents had a higher level of knowledge of mental illness (45.3) than the married (44.5). However this difference in the level of knowledge was not statistically significant.

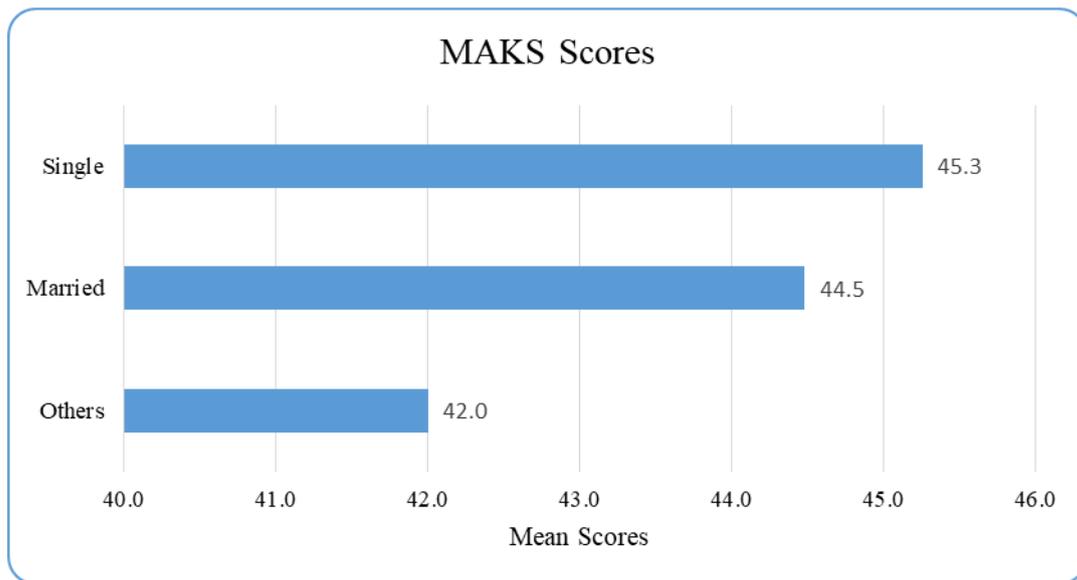


Figure 4.7: Marital Status and Level of Knowledge of Mental Illness

Level of education and level of knowledge of mental illness

Figure 4.8 shows the relationship between respondents' level of education and level of knowledge of mental illness among media practitioners in Kenya. From the graph, the MAKS score for respondents with certificate was 44.25, for respondents with diploma level of education was 42.85, for respondents with first university degree was 45.16 and the MAKS score for respondents with second university degree was 45.72. The difference in the level of knowledge with regard to level of education is statistically significant (P value = 0.0298).

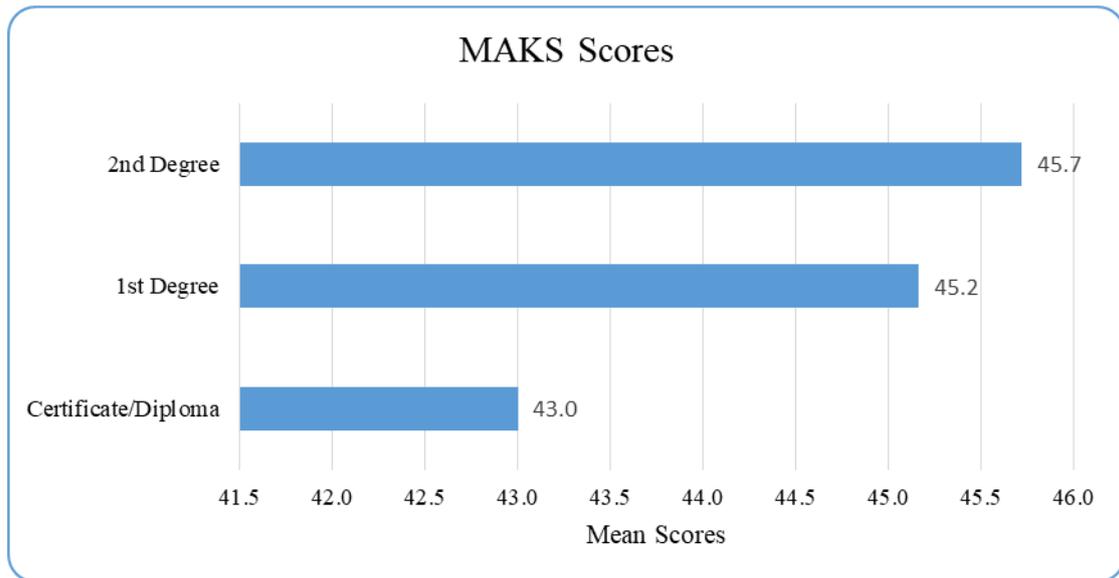


Figure 4.8: Level of Education and Level of Knowledge of Mental Illness

Association between socio-demographic factors and attitude towards mental illness

Variable	Category	N	Mean(SD)	Group Differences
Gender	Male	83	-5.2±3.0	$t_{(149)}=0.50$; $P=0.6200$
	Female	68	-5.4±3.0	
Age	30 Years and Below	93	-5.2±3.0	$F(2, 158)=0.04$; $P=0.9655$
	31-40 Years	54	-5.4±2.9	
	Above40 Years	12	-5.2±4.3	
Marital status	Married	67	-5.4±3.4	$F(2, 154)=0.11$; $P=0.8927$
	Single	82	-5.2±2.8	
	Others	6	-5.2±3.5	
Education Level	Certificate/Diploma	38	-4.5±3.5	$F(2, 159)=1.83$; $P=0.1637$
	1st Degree	97	-5.6±2.9	
	2nd Degree	25	-5.1±3.0	

Table 4.9 Relationship between socio-demographic variables and attitudes towards mental illness based on AMIQ

In Table 4.8 an independent t-test was performed on the difference in attitude between males and females. There was no significant difference between the attitude of males and females ($P = 0.6200$). Analysis of variance (ANOVA) was performed to test the differences in the attitude with regard to age, marital status and level of education.

There was no considerable difference in attitude with regard to age ($P = 0.9655$), No significant difference with regard to marital status ($P = 0.8927$) and no significant difference in attitude with regard to level of education ($P = 0.1637$).

The following is a graphical display giving further detail into the relationship between the socio-demographic factors and attitude towards mental illness among media practitioners based on the AMIQ scores.

Gender and attitude towards mental illness

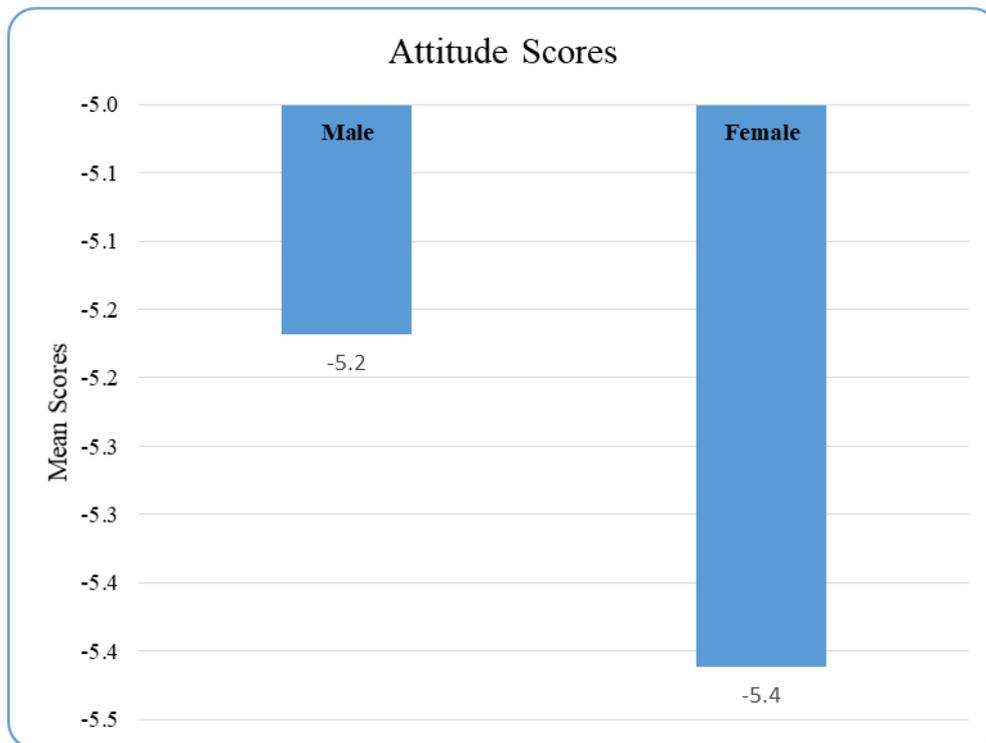


Figure 4.9: Gender and Attitude towards Mental Illness

Males showed a better attitude (-5.2) than females (-5.4) towards mental illness but it is not statistically significant.

Age and attitude towards mental illness

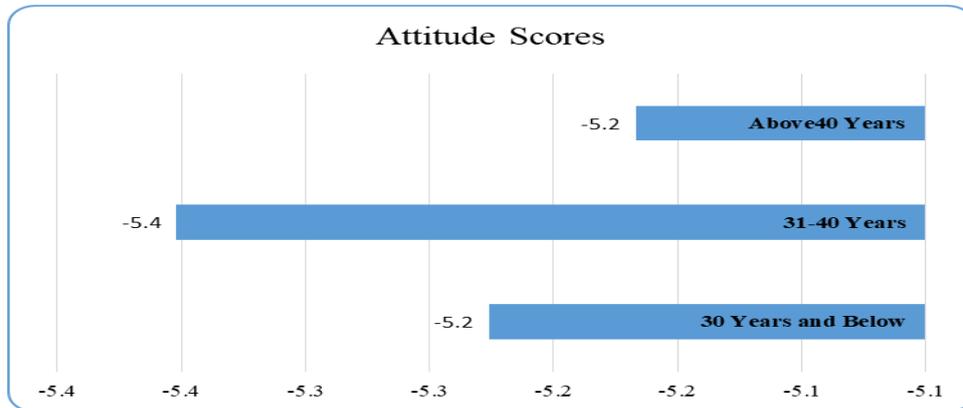


Figure 4.10: Age and Attitude towards Mental Illness

The most negative attitude against mental illness was observed in the age group 31-40 years (-5.4) while the age group below 30 years and above 40 years had a near identical attitude of -5.2. The differences in attitude were not statistically significant.

Marital status and attitude towards mental illness

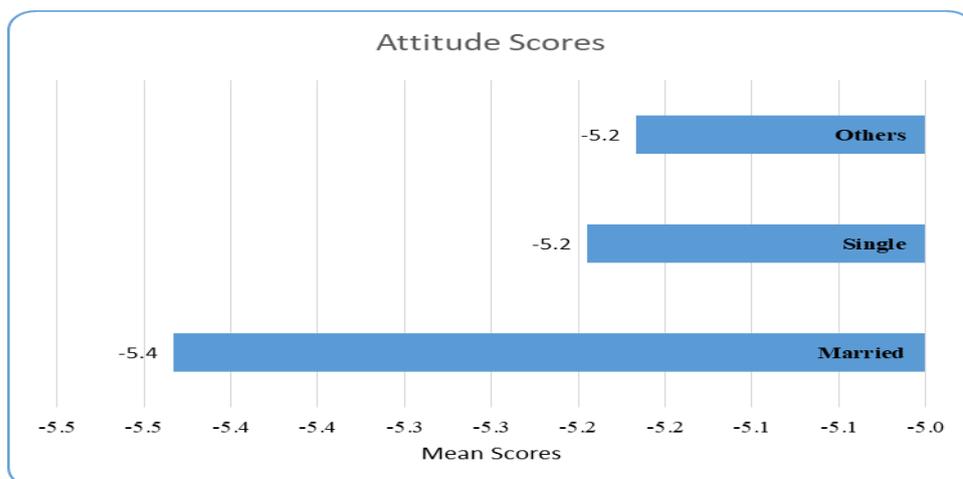


Figure 4.11: Marital Status and Attitude towards Mental Illness

The most negative attitude was observed in the married respondents (-5.4) and the most positive attitude was observed in the others (divorced and widowed) at -5.2). The difference in the attitude was not statistically significant.

Level of education and attitude towards mental illness

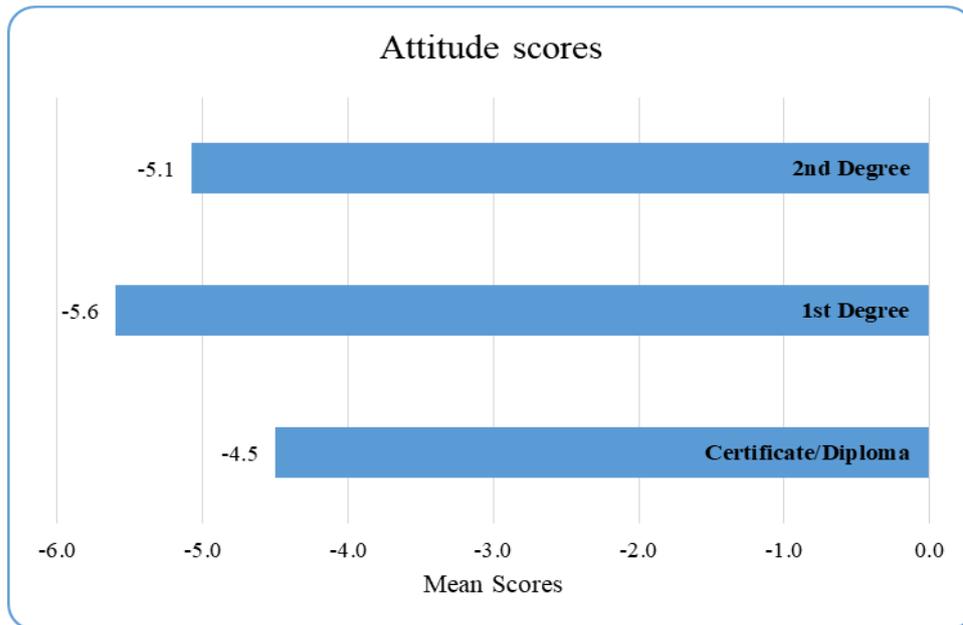


Figure 4.12: Level of Education and Attitude towards Mental Illness

From fig. 4.12, Respondents with a first degree had the lowest attitude towards mental illness (-5.6) while the respondents with certificate/diploma had the most positive attitude towards mental illness. The differences in the means of the attitude were not statistically significant.

4.6: Association between knowledge of mental illness and attitude towards mental illness

The fourth research question was; ‘What is the relationship between knowledge of mental illness and attitude towards mental illness among media practitioners in Kenya?’ To

establish the relationship between the two variables, a scatter graph of the attitude towards mental illness from the AMIQ scores was plotted against the knowledge of mental illness from the MAKS scores.

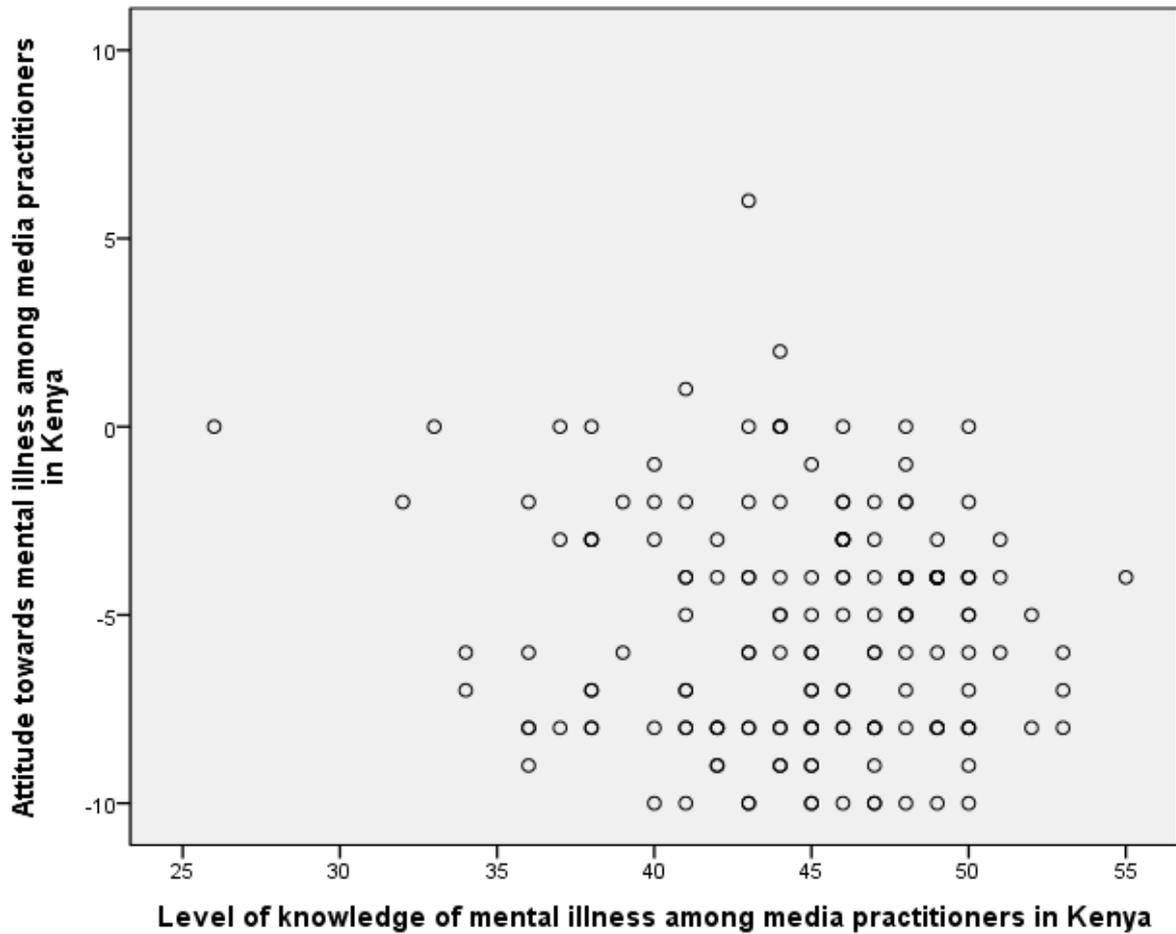


Figure 4.13 Scatter plot of attitude towards mental illness against knowledge of mental illness.

From figure 4.13 above, attitude towards mental illness is the dependent variable while knowledge of mental illness is the independent variable. The scatter graph shows no relationship between attitude towards mental illness and knowledge of mental illness. There is no linear, quadratic, exponential or polynomial relationship between the two variables.

These results were confirmed by the Pearson correlation whose results are shown on table 4.9.

Table 4.10: Relationship between Level of Knowledge of mental illness and Attitude towards Mental Illness

		Level of knowledge of mental illness among media practitioners in Kenya	approach towards mental sickness among media practitioners in Kenya
Level of knowledge of mental illness among media practitioners in Kenya	Pearson Correlation	1	-.100
	Sig. (2-tailed)		.203
	N	164	164
Attitude towards mental illness among media practitioners in Kenya	Pearson Correlation	-.100	1
	Sig. (2-tailed)	.203	
	N	164	164

In table 4.9, the Pearson coefficient obtained is -0.1 which is close to zero, indicating a lack of correlation between the two variables.

There is no important relationship between acquaintance of mental illness and attitude towards mental illness among media practitioners in Kenya.

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents a detailed discussion of the research results and what the results mean with regard to previous studies and the objectives of the current study. The study limitations, conclusions, implications for mental health in Kenya, and recommendations for future research are also presented.

5.2 Discussion

The study had 164 participants. 55% of the respondents were male while 45% were female. The findings vary slightly from those of a national survey of demographics of Kenyan journalists which found that 66% of respondents were male and 34% were female. (Ireru, 2015).

Kenyan media practitioners on this study had a mean score of 44.7 out of 60 on the mental health knowledge schedule (MAKS) scale. This mean score compares with the results of attitudes to mental illness 2013 research report of adults in England who had a mean score of 45.3 on the MAKS scale. (England, 2014). This shows a high overall knowledge of mental illness among Kenyan media practitioners. However the specific analysis showed that the respondents on this study had lower scores for the questions that required them to identify mental illnesses from a list that contained six conditions: depression, stress, schizophrenia, bipolar mood disorder, drug addiction and grief. 30% of respondents disagreed (slightly or strongly) that drug addiction is a mental illness. 16.7% also disagreed (slightly or strongly) that depression is a mental illness while at the same time 58.7% of the respondents agreed (strongly or slightly) that stress is a mental illness yet it is not. The failure to identify drug addiction and depression as mental

illnesses by high numbers of respondents could carry grave consequences especially given the high prevalence of substance abuse and depression in Kenya which stands at 11.7% and 12.3% respectively. (Kwobah et al., 2017)

The average score on the Attitude to mental illness questionnaire (AMIQ) was -5.27 among the respondents. This negative attitude among media practitioners in Kenya compares with a study of knowledge and attitude towards mental illness among media practitioners in South-West Nigeria which found expression of negative attitudes towards the mentally ill by media professionals. (Oluwole & Obadeji, 2014).

The overall negative score on the AMIQ is a likely manifestation of deeply entrenched stigma against mental illness in the Kenyan society as was established by the 2011 Kenya National Commission on Human Rights report , ‘Silenced minds: the systemic neglect of the mental health system in Kenya. (KNCHR, 2011).

The subject in the vignette is a person who abuses heroine and this is a possible explanation for the low attitude scores. In the mental health schedule (MAKS) questionnaire, 30% of the respondents disagreed that drug addiction is a mental disorder. This finding fits into a common societal belief that substance abuse is a result of personal failure rather than a disease. Similarly in a study of knowledge and attitude towards mental illness among university students at the university of West Indies, (N = 673), it was observed that of the different vignettes describing various mental illnesses, the one describing heroine addiction attracted the lowest (most negative scores). (Farid & Raechow, 2014)

The association between knowledge and attitude towards mental illness and each of the socio-demographic factors of gender, age, marital status and level of education was tested.

The study found no significant difference in level of knowledge of mental illness between males and females. Although females registered higher scores than males on the mental health knowledge schedule, the difference was not statistically significant. The results were different from those obtained from the study, 'Knowledge and attitude of mental illness among the general public in Southern India' which showed that males had significantly higher knowledge of mental illness than females. (Ganesh, 2011) . There was similarly no association observed between level of knowledge of mental illness and marital status and age.

There was however an association between level of knowledge of mental illness and level of education. Those with certificate and diploma had significantly lower levels of knowledge than respondents with either first degree or second degree. Higher education is associated with greater mental health literacy in studies of the general population as revealed by a study of mental health literacy among a population sample in rural China. (Yu et al, 2015). This observation is likely due to the exposure by educated persons to a wide range of educative resources on mental health. There was no significant relationship between knowledge of mental illness and age or marital status.

There was no association between attitude to mental illness and gender. Some studies have however shown a poorer attitude towards mental illness among women compared with men. ((Bener A, Ghoulum S, 2011)

There was no significant association between attitude to mental illness and age or respondents. There was a significantly higher expression of negative attitude towards mental illness among older media practitioners compared to their younger colleagues in the study on knowledge attitude of mental illness among media practitioners in south west Nigeria. (Oluwole, LO., Obadeji, A., 2014).

There was also no significant association between marital status and attitude to mental illness. There was also no significant relationship between level of education and attitude towards mental illness.

The study found no association between knowledge of mental illness and attitude towards mental illness. Other studies have similarly shown enduring negative attitudes towards mental illness despite reasonable knowledge. (Crisp , Gelder, Rix , Meltzer & Rowlands 2000). The results in this study however differ from those obtained in a ‘study of knowledge, attitude and practice (KAP) of mental illness among staff in general medical facilities in Kenya : practice and policy implications’ which showed a positive correlation between increasing knowledge of mental illness and a positive attitude towards mental illness. (Ndetei, Khasakala, Mutiso and Mbwayo, 2011). This study was however done among medical professionals. It also showed that knowledge of mental illness increases with the age of a medical professional.

The negative attitude towards mental illness observed in this study despite reasonable knowledge of mental illness could be as a result of entrenched stigma against mental illness in the Kenyan society that was reported by the Kenya national commission on human rights. (KNCHR, 2011)

Conclusions

The study showed that media practitioners in Kenya have adequate overall knowledge of mental illness but a negative attitude towards mental illness. A higher level of education is associated with better mental health literacy. The finding of a negative attitude towards mental illness provides a likely explanation for negative portrayal of mental illness in the media in the past and portends a risk to public mental health education in future.

Recommendations

1. Measures that target the improvement of mental health literacy among media practitioners should aim to reduce stigma by incorporating both education and contact with people living with mental illnesses.
2. Media houses in conjunction with the ministry of health should set up standard operating procedures on how mental health issues should be covered within news items to mitigate against the negative attitude towards mental illness among media practitioners and thereby combat the negative portrayal of mental illness in the media.
3. Further longitudinal studies should be conducted to establish the effect of structured mental health education on attitude of media practitioners. Mental health professionals should be used as controls in these studies.
4. Educational programmes in mental health among media practitioners should give preference to certificate and diploma holders whose level of knowledge is lower than the first or second degree holders.

5.3 Limitations

1. There was no data on level of income. Subsequent studies could use range of income instead of asking for actual income to improve responses to the question.
2. Social desirability bias could have led to some respondents providing inaccurate responses to the questions.
3. The study did not measure stigma directly hence the relationship between a low attitude towards mental illness and stigma towards mental illness cannot be fully established from the study.

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Appendix I: Consent Information Document (English version)

Title:

Mental Health Literacy Among Media Practitioners in Kenya.

Researcher:

Dr. Boniface Chitayi.

Supervisors:

Prof. Caleb Othieno

Prof. Anne Obondo

Introduction

My name is Dr. Boniface Chitayi, a postgraduate student at the University of Nairobi. I wish to conduct a study on the mental health literacy among media practitioners in Kenya. This study will be carried out at the Standard group, Nation media group, KBC, Media max network and the royal media group.

I would like to invite you to participate in the study.

Description of the study and study objectives.

This is a cross-sectional descriptive study among registered media practitioners working for the Standard group, The Nation media group, The royal media services, The Nation Media group, mediamax network and the KBC. The objective of the study is to determine the level of mental health literacy and attitude towards mental illness among media practitioners in Kenya. It will have 237 respondents and will take approximately one month to collect research data.

Requirements

For one to participate in the study you need to:

1. Be aged 18 years and above
2. Be a registered media practitioner in Kenya
3. Sign an informed consent form.

Procedure

If you agree to participate in the study you will be:

1. Be asked to sign a consent form expressing your voluntary participation.
2. Be asked questions that relate to your socio-demographic information.
3. Be asked questions on your mental health literacy and attitude towards mental illness.

Benefits:

There are no direct benefits for participating in this study.

However, results from the study will help identify knowledge gaps in mental health literacy. This information can be used by the management to identify training needs. The results from the study will also be used to orient mental health awareness campaigns by relevant stakeholders. This will help in fighting stigma against mental illnesses.

Risks

We do not anticipate that you will expose yourself to any risk by participating in this study.

Voluntary Participation

Your participation in this research is entirely voluntary. You are free to withdraw at any time. You may also choose not to answer specific questions. Your choice not to participate or choice to withdraw will not be used in any way against you.

Confidentiality

Your identity will be kept confidential. In addition your name or any other personal identifier will not be used in any reports or publications arising from this study. Instead you will be assigned a number to protect your identity. The questionnaires that you will complete will be stored safely with nobody having access to them apart from the researcher and the supervisors. The data collected from this study will be entered in computers and kept away from public access.

Compensation

You will not be paid to participate in this study.

Additional information

If you have questions about the study that are not answered in the consent information, please ask them. In addition, if you have questions in the future you may contact the following:

Researcher:

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NAIROBI

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Supervisor

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Telegram: varsity.

Appendix II: Informed Consent Form (English version).

I.....(name of participant) have read/heard and understood the explanation given to me about this study entitled ‘Mental Health Literacy Among Media Practitioners in Kenya.’

I have had the opportunity to ask questions that have been clarified to my satisfaction by (Name of person taking consent/researcher) in the language I understand.

I understand that my participation in this study is entirely voluntary and I can withdraw my participation at any time I want to withdraw without giving an explanation for doing so. I understand that if I withdraw my participation, it will not affect my employment in any way.

I understand that all information I give, including private information will be kept confidential. I accept to give information that will help in this study and also that whatever information received will be reported and published confidentially.

I agree to participate in this study.

Name of participant.....

Signature of participant.....Date.....

Signature of witness.....Date.....

Name of person taking consent.....

Signature.....Date.....

You will receive a copy of the consent form to take away with you.

If you have questions or would like to seek further clarification about this study, please contact:

1. Researcher

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P.O. BOX

NAIROBI

Tel. (254) 720819445

2. Supervisor

Prof. Anne Obondo

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Telegram: varsity.

Appendix III: Consent Information form (Swahili version).

HATI YA RIDHAA

Andiko:

Ujuzi na mtizamo wa afya ya kiakili miongoni mwa waandishi wa habari nchini Kenya.

Mpelelezi

Dr. Boniface Chitayi

Wasimamizi

Prof. Anne Obondo

Prof. C.J Othieno

Utangulizi

Mimi Dkt. Boniface Chitayi ni mwanafunzi wa uzamili katika chuo kikuu cha Nairobi.

Ninafanya utafiti kuhusu ujuzi na mtizamo wa afya ya kiakili miongoni mwa waandishi wa habari nchini Kenya. Utafiti huu utafanyika katika vyumba vya habari vya Nation media group na the Standard Group jijini Nairobi. Ninakualika ushiriki kwenye utafiti huu.

Maelezo kuhusu utafiti na lengo la utafiti

Huu ni utafiti wa maelezo miongoni mwa waandishi wa habari waliosajiliwa na wanaohudumu kwenye vyombo vya habari vya Nation media group na the Standard group. Lengo la utafiti huu ni kubaini viwango vya ujuzi na mtizamo kuhusu afya ya kiakili miongoni mwa waandishi wa habari nchini Kenya. Jumla ya wanahabari 237 watahiriki kwenye utafiti huu. Utafiti wenyewe utafanyika kwa muda wa mwezi mmoja.

Mahitaji ya kushiriki

Ili kushiriki kwenye utafiti huu , unahitajika:

1. Uwe na miaka kumi na minane au zaidi
2. Uwe umesajiliwa kama mwandishi wa habari nchini Kenya.
3. Kutia sahihi fomu ya ridhaa.

Utaratibu.

Ukikubali kushiriki katika utafiti huu:

1. Utaulizwa kutia sahihi fomu ya kuridhia kushiriki kwa hiari yako.
2. Utajibu maswali ya kibanafsi kuhusu jamii yako, maisha yako na mapato.
3. Utajibu maswali kuhusu ujuzi na mtizamo wako kuhusu afya ya kiakili.

Faida

Hakuna faida ya moja kwa moja itakopatikana baada ya kushiriki utafiti huu.

Hata hivyo uvumbuzi utakaopatikana baada ya utafiti huu utatumika kuangazia upungufu wa ujuzi kuhusu afya ya kiakili miongoni mwa wanahabari. Habari hii itaweza kutumiwa na waimamizi wa vyombo vya habari kuwapa wanahabari mafunzo ya afya ya kiakili.

Matokeo haya pia yatawazaidia washika dau wanaopigania maswala ya afya ya kiakili ili wapate kuendeleza kazi yao vyema katika hali ya kupigana dhidi ya unyanyapaa umaowalenga wenye maradhi ya kiakili.

Hatari ya usumbufu

Hakuna hatari yoyote itakayokukabili unaposhiriki kwenye utafiti huu.

Kushiriki kwa hiari

Kushiriki kwako katika utafiti huu ni kwa hiari yako na ukiamua kushiriki una uhuru wa kuondoka wakati wowote. Unaweza pia kuamua kutojibu baadhi ya maswali. Uamuzi wako wa kutoshiriki hautatumiwa kwa vyovyote dhidi yako.

Faragha

Utambulisho wako utawekwa kwa faragha. Jina lako wala namna yoyote ya kukutambulisha. Hazitatumika kwa ripoti yoyote ya utafiti huu. Badala yake utapewa nambari ya kulinda utambulisho.

Dodoso (fomu ya maswali ya utafiti huu itahifadhiwa kwa usalama hakuna mtu ataweza kuifikia isipokuwa mimi au wasimamizi wangu. Takwimu zitakazokusanywa katika utafiti huu zitahifadhiwa kwa kompyuta na kuzuiliwa kwa watu wengine. Kompyuta zitakazohifadhi takwimu zitalindwa na nywila au au namba za kisiri ili kulinda takwimu kutokana na matumizi yasiyoidhinisha , kupotea ama marekebisho.

Fidia

Hakuna fidia yoyote kwa kushiriki katika utafiti huu.

Maelezo Zaidi

Iwapo unahitaji ufafanuzi Zaidi au maswali yoyote kuhusu utafiti huu unaweza kuwasiliana na:

1. Mpelelezi kupitia anwani ifuatayo

a) Dr. Boniface Chitayi

P.O. Box 40663 – 00100

Nairobi

Tel. (254) 720 819 445

2. Msimamizi wa upelelezi kupitia anwani ifuatayo

a) Prof. Anne Obondo

P.O Box 19676-00202

Nairobi

Tel. (254) 721 849686

3. Kamati ya maadili ya utafiti ya pamoja ya chuo kikuu cha Nairobi na hospitali kuu
ya Kenyatta

Kenyatta National Hospital

P.O. BOX 20723-00202

Nairobi

Tel. (254) 020726300 extension: 44102, 44355

Email: uonknh_erc@uonbi.ac.ke

4. University of Nairobi, College of Health Sciences

P.O. BOX 19676-00202

Tel. (254) 020 2726300 extension: 44355.

Telegram: varsity

Appendix IV: Informed consent form (Swahili version).

FOMU YA RIDHAA

Mimi

.....

..(jina la mshiriki)

Nimesoma/nimeskiza na kuelewa yaliyotolewa kuhusu utafiti huu: **“Ujuzi na mtizamo wa afya ya kiakili miongoni mwa waandishi wa habari nchini Kenya.”**

Nilikuwa na nafasi ya kuuliza

.....(jina la

anayechukua ridhaa); maswali katika lugha ninayoelewa na sasa ni wazi nimeridhika.

Naelewa kwamba kushiriki kwangu katika utafiti huu ni kwa hiari yangu kabisa na naweza kujiondoa wakati wowote nitakapo bila ya kutoa maelezo kwa kufanya hivyo.

Mimi naelewa kuwa kuondoa kushiriki kwangu hakutniadhiri kwa vyovyote.

Naelewa kwamba taarifa zote nitakazotoa pamoja na taarifa za kibanafsi itakuwa siri.

Mimi nakubali kushiriki katika utafiti huu.

Jina la mshiriki

.....

Sahihi ya mshiriki.....tarehe.....

Sahihi ya shahidi.....tarehe.....

Jina la anayechukua ridhaa

Sahihi.....tarehe.....

Utapokea nakala ya fomu hii.

Iwapo unahitaji ufafanuzi Zaidi au maswali yoyote kuhusu utafiti huu unaweza kuwasiliana na:

5. Mpelelezi kupitia anwani ifuatayo

b) Dr. Boniface Chitayi

P.O. Box 40663 – 00100

Nairobi

Tel. (254) 720 819 445

6. Msimamizi wa upelelezi kupitia anwani ifuatayo

b) Prof. Anne Obondo

P.O Box 19676-00202

Nairobi

Tel. (254) 721 849686

7. Kamati ya maadili ya utafiti ya pamoja ya chuo kikuu cha Nairobi na hospitali kuu ya Kenyatta

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Appendix V: THE DEMOGRAPHIC DATA FORM

Please respond to these questions by writing a response in the space provided or ticking in the appropriated space where choices are provided.

VARIABLE	DATA
GENDER	a) MALE b) FEMALE
AGE	a) Below 20years..... b) 21-30 years c) 31-40..... d) 41-50years..... e) Above 51 years.....
RESIDENCE	
AVERAGE MONTHLY INCOME (in KES)	
MARITAL STATUS	a) Married..... b) Divorced/separated..... c) Single..... d) Widowed..... e) Other.....
LEVEL OF EDUCATION	a) CERTIFICATE b) DIPLOMA..... c) 1 ST UNIVERSITY DEGREE..... d) 2 ND UNIVERSITY DEGREE.....

Appendix VI: MENTAL HEALTH KNOWLEDGE SCHEDULE (MAKS)

A) Kindly choose a response that best shows your level of agreement or disagreement with each of the following statements.

STATEMENT	STRONGLY AGREE +2	SLIGHTLY AGREE +1	NEITHER AGREE OR DISAGREE 0	DISAGREE SLIGHTLY -1	DISAGREE STRONGLY -2	DON'T KNOW 0
1. Most people with mental health problems want to have employment.						
2. If a friend had a mental health problem, I know what advice to give them to get professional help						
3. Medication can be an effective treatment for people with mental health problems						
4. Psychotherapy (for example talking therapy or counseling) can be an effective treatment for people with mental health problems						
5. People with severe mental health problems can fully recover						
6. Most people with mental problems go to a healthcare professional to get help						

B) Kindly choose the level to which you agree or disagree that each of the following conditions is a mental illness.

CONDITION	STRONGLY AGREE +2	SLIGHTLY AGREE +1	NEITHER AGREE OR DISAGREE 0	DISAGREE SLIGHTLY -1	DISAGREE STRONGLY -2	DON'T KNOW 0
Depression						
Stress						
Schizophrenia						
Bipolar mood disorder (manic depression)						
Drug addiction						
Grief						

Appendix VII: ATTITUDE TO MENTAL ILLNESS QUESTIONNAIRE.(AMIQ).

Kindly read the following passage to be able to respond to the 5 questions/statements that follow.

Mr. Juma has been injecting heroine for the past one year.

Choose the response that best describes your opinion.

QUESTION/STATEMENT	STRONGLY AGREE +2	AGREE +1	NEUTRAL 0	DISAGREE -1	STRONGLY DISAGREE -2	DON'T KNOW 0
1. Do you think that this would damage Mr. Juma's career?						
2. I would be comfortable if Mr. Juma was my colleague at work.						
3. I would be comfortable inviting Mr. Juma to a dinner						
	VERY LIKELY +2	QUITE LIKELY +1	NEUTRAL 0	UNLIKELY -1	VERY UNLIKELY -2	DON'T KNOW 0
4. How likely do you think it would be for Juma's wife to leave him?						
5. How likely do you think it would be for Mr. Juma to get into trouble with the law?						