

**FACTORS INFLUENCING QUALITY OF LIFE OF PATIENTS LIVING WITH
MENTAL ILLNESS: A CASE STUDY OF MATHARI NATIONAL TEACHING AND
REFERRAL HOSPITAL, KENYA**

By

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DECLARATION

I, Twahira Salim Masoud Abdalla, declare that this dissertation is my own original work and has not been presented for a degree at any other University.

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LIST OF ABBREVIATIONS

ANOVA:	Analysis of Variance
CDC:	Centre for Disease Control and Prevention
DSM:	Diagnostic Statistical Manual of Mental Disorders
KDHS:	Kenya Demographic and Health Survey
KNCHR:	Kenya National Commission on Human Rights
KNH-UON ERC:	Kenyatta National Hospital and University of Nairobi Ethics and Research Committee
S.D.:	Standard Deviation
S. I. R.:	Semi-Interquartile Range
SPSS:	Statistical Package for Social Sciences
WHO:	World Health Organization
WHOQOL:	World Health Organisation Quality of Life instrument
WHOQOL-BREF:	World Health Organisation Quality of Life instrument brief version

DEFINITION OF TERMS

Illness Characteristics:

These are characteristics of a disease such as its type, severity, duration etc

Mental Illness:

An illness or disorder that impairs a person's mental functioning. Its main characteristic is that the person thinks, feels, perceives, behaves or relates with others in an abnormal way (WHO, 2014)

Quality of Life:

A person's appraisal of his or her own life in terms of how good or bad it is, using both objective and subjective factors. This was determined by an instrument developed by the World Health Organisation to measure quality of life.

Socio-demographic Factors:

These are factors or characteristics that describe a person's position in society, and define a person according to age, sex, income level, culture, education, ethnicity and marital status

ABSTRACT

Quality of life is important to all human beings (Fallowfield, 1990) and is an essential element of health. Treatment should improve lives of people with mental illnesses, and a good way of evaluating the treatment being offered is looking at their quality of life.

The objectives of this study were to determine the quality of life and its associated factors among people living with mental illness attending the outpatient clinics at Mathari National Teaching and Referral Hospital, Nairobi County, Kenya.

The study is significant since the results will be discussed with a view of providing better care and understanding of the mentally ill.

This was a cross-sectional study conducted among 384 patients living with mental illness on follow-up at the outpatient clinics at Mathari National Teaching and Referral Hospital. Those who gave informed consent filled in the quality of life instrument, and a socio-demographic questionnaire.

The data collected from the instrument was entered the Statistical Package for Social Sciences, version 18 for analysis.

Descriptive statistics were used to describe the sample, and. inferential statistics, were also used to assess the relationships between the dependent and independent variables. The results are presented in the form of narratives and tables.

The mean quality of life score among the study participants was 327 out of a total possible score of 500. Marital status and income were found to be the only two factors that statistically significantly affected quality of life.

In conclusion, quality of life among people living with mental illness was found to be above the midpoint score, but in comparison, still below the norms for the general population.

It is recommended that in addition to medical treatment, more effort be made to integrate psychological treatment and support to help improve the subjective quality of life of patients with mental illness.

CHAPTER ONE: INTRODUCTION

1.1 Background Information

A mental illness or disorder is defined by the Diagnostic Statistical Manual of Mental Disorders as “a syndrome characterized by a clinically significant disturbance in an individual’s cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning” (DSM V, p. 20)

It also says that this usually leads to some disability or distress in normal activities such as social or occupational ones.

Mental illness is also defined as a disorder whose main characteristic is the poor regulation of thoughts, behaviour and moods (CDC, 2015)

It is believed that 450 million people around the world are affected by mental disorders. (www.mentalhealth.org.uk).

One in four people will experience mental health problems. (Davey, 2008). In Kenya, the estimated contribution of mental illness to the global burden of disease is 5.7%. Mental health professionals are few, with about 0.19 psychiatrists to 100,000 people, and 0.01 social workers for 100,000 people (World Health Organization, 2011). Quality of life is defined by the World Health Organisation as the ‘individual’s perceptions of their position in life in the context of culture and value systems in which they live and in relation to their goals, expectations, standards and concerns’ (WHOQOL, 1994a)

The concept of quality of life started gaining importance from the 1940s when the World Health Organisation declared that health should not be measured just by the absence of diseases but by overall quality of life (Trafford, 2013).

It has been recommended that not only subjective perceptions of the patient’s quality of life should be considered, but objective assessment as well, even by others, while treating a person

for mental illness. A person's functioning and the assets he/she has in his/her environment also needs to be considered (Katsching, 2006).

It is important to focus on quality of life in treating all types of illness because we are able to have an objective view on whether the treatment is effective, or whether it is harmful to the patient in other domains, including the social and psychological domain. Good treatment is one that does not harm the patient in any area and does not reduce their quality of life (Fallowfield, 1990).

Mental illness has gained more importance under the World Health Organisation's definition of health, which is 'physical, mental and social well-being and not merely the absence of disease and infirmity' (Fallowfield, 1990, p.19). This definition also encourages us to take a more holistic view of health, and not merely treat the illness but ensure social and psychological well-being. Therefore, quality of life has gained importance as a way of looking at treatment and health.

Mental disorders remain some of the leading causes of years lost to disability according to the World Health Organisation, which measures how many productive years an illness takes out of a person's life years. Depressive disorders are the leading cause of years lost to disability. Anxiety disorders are number five amongst the causes, and both bipolar disorder and schizophrenia rank among the top 20 causes of years lost to disability (2013).

Apart from the above-mentioned importance of putting our attention on mental illness, there are other motivations; mental illness affects poverty, social goals, education and health. This gives us an added incentive to improve our mental health care system (Kiima & Jenkins, 2003)

World Health Organisation (2015) determined that in most low and middle-income countries, budgetary spending on mental health is minimal, about 2 dollars per person or less. And the focus is usually on inpatients in mental hospitals. Also, there are few health professionals catering to those with mental disorders, sometimes less than 1 health worker per 100,000 people in low income countries, compared to 50 for every 100,000 people in high income countries. The global average is about 9 workers for every 100,000 people. The number of psychiatric beds per 100,000 people varies greatly around the world: in low income countries it is less than 5 beds per 100,000, in higher income countries it is around 50 beds per 100,000 people. In Africa, there are about 1.4 mental health workers for every 100,000 people. There are around 1.9 beds for every 100,000 people.

Quality of life is a measure that can be used to assess how satisfied people are with their lives. While entirely objective factors are used, subjective opinion is more important since people generally do know how satisfied they are with their lives (The Economist, 2005)

Quality of life is affected by many factors. One of those is health (The Economist, 2005). There is also the quality of health care, which may have an impact on a patient's well-being and quality of life (Alonazi and Thomas, 2014). Another very important factor is level of income, or material well-being, which has been shown to improve subjective ratings of quality of life (Kahneman and Deaton, 2010; The Economist, 2005). Hsiao et al (2012) found that age of onset of the disorder as well as employment status also affected quality of life, but duration of illness did not. Barnes et al (2012) found that certain types of mental illnesses (such as depression), as well as number of symptoms, affected the quality of life. Quality of life is positively affected by the presence of social support (Helgeson, 2003).

Another factor that affects quality of life in people living with mental illness is stigma. Stigma is described as a wish to avoid specific people or to expel or banish them (Burns 2006).It is

usually caused by people having a misconception about mental illness. In mental illness, stigma not only delays people seeking for help, but it becomes a barrier to them people seeking help, and also hinders their recovery. About 47% of people with mental illness have been harassed because of it. (Davey, 2008) Stigma has been shown to make mental disorders worse and to make people less likely to recover and lead a relatively normal life (Egbe et al, 2014). Other factors that can affect quality of life are security and political stability, as well as community and family life. (The Economist, 2005)

1.2 Problem Statement

While a diagnosis of mental illness is serious, one can live a stable, productive, happy and mostly normal life if there is adequate care. In Kenya, unfortunately, quality of care for people with mental illness is often limited, inadequate and poorly distributed mainly because of insufficient resource allocation for mental health, especially funding, equipment and staff. There are only a total of 1114 beds in the whole country to cater for people with mental illnesses, and mental health staff are too few to cater for the population (Kiima & Jenkins, 2010). There are only about 0.19 psychiatrists for every 10,000 people. On top of that, there are few facilities in the country catering to the mentally ill (KNHCR, 2011).

The inadequate treatment access for most Kenyans suffering from mental illnesses, financial constraints as well as the stigma they face, may increase risk of affected to low quality of life.

By studying the quality of life among the mentally ill, we can hopefully improve the care they get (Gallert, 1993), and this will lead to an improvement in mental health services.

There have been no studies done in Kenya on the quality of life of those suffering specifically from mental illnesses; the only ones that have been done have focused on other areas or other illnesses such as epilepsy. There are also very few studies that have been done in Africa and

the developing world on quality of life of people with mental illnesses (Aloba, 2013; Awadalla, 2005). Hopefully, this study will fill in this gap and bring information on quality of life of those with mental illness.

1.3 Justification of the Study

Quality of life is an important measure for assessing whether treatments work. . It also helps improve treatment being given to patients (Gallert, 1993). Thus, this study will bring to light the quality of life of those living with mental illness in Kenya, and what factors affect their quality of life. The study will generate new knowledge since we do not yet know the quality of life of mental health patients in Kenya. Hopefully it will generate information that can be used to help improve the quality of care for people living with mental illnesses.

The study is useful because it should be able to establish what the quality of life of Kenyan mental health patients is. This will assist in assessing whether or not it is satisfactory, and, if not, what areas need to improve. This will thus help us improve care of patients with mental illness.

1.4 Research Questions

1. What is the quality of life of patients living with mental illness on follow-up at the outpatient clinics at Mathari National Teaching and Referral Hospital?
2. What are the socio-demographic and illness-related factors that are associated with the quality of life of patients living with mental illness on follow-up at the outpatient clinics at Mathari National Teaching and Referral Hospital?

1.5 Study Objectives

1.5.1 Broad Objective:

The broad objective was to determine the quality of life and associated factors of people living with mental illness at Mathari National Teaching and Referral Hospital, Nairobi, Kenya

1.5.2 Specific Objectives:

The specific objectives of the study are to:

1. Determine the quality of life level of people living with mental illness on follow-up at the outpatient clinics at Mathari Hospital
2. Determine socio-demographic factors associated with the quality of life among people living with mental illness on follow-up at the outpatient clinics at Mathari Hospital
3. Determine the illness-related factors associated with the quality of life among people living with mental illness on follow-up at the outpatient clinics at Mathari Hospital

1.6 Hypotheses

1. Quality of life among patients living with mental illness is lower than that found in the general population.
2. Quality of life is affected by socio-demographic characteristics and illness related factors.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

There has been increasing research in quality of life in recent years. The following chapter will try to summarize the main points from the studies that have been carried out

2.2 Quality of Life among People with Mental Illness

One way to find out if health care is effective is by measuring quality of life of patients. Quality of life is a subjective term but also implies all non-medical aspects of the disease, i.e. the subjective and human aspect of the effects of disease. It highlights and tries to measure or describe the psychosocial side of an illness (Katching, 2006). However, it is still an underutilized assessment in studies on the mentally ill. Although it relies heavily on subjective self-reports, as a measure it has been found to be generally quite reliable. (Awadalla et al, 2005) The majority of lucid patients with psychiatric disorders can reliably give an honest appraisal of their quality of life, and caregivers are able to supplement the information the patients give, as shown in a study among Sudanese psychiatric inpatients to measure quality of life using the WHOQOL-BREF, which also found that many patients with mental illnesses are dissatisfied with their quality of life (Awadalla et al, 2005).

A cross-sectional study among people living with epilepsy at Kenyatta National Hospital showed that quality of life of people living with epilepsy, a neurological condition, was much lower (49%) compared to healthy controls (77%) (Kinyanjui, 2007. Master's thesis)

2.3 Factors that Affect Quality of Life

Quality of life among the mentally ill is affected by many factors. First is the quality of health care, which may have an impact on a patient's well-being and quality of life, as found in a study by Alonazi and Thomas (2014). Another factor is level of income, which has been shown

to improve subjective ratings of quality of life (Kahneman and Deaton, 2010). Additionally, Hsiao et al (2012) found that the age of onset of the disorder as well as employment status also affected quality of life, but duration of illness did not. Barnes et al (2012) found that certain types of mental illnesses (such as depression), as well as number of symptoms, affected the quality of life. Quality of life is positively affected by the presence of social support, according to Helgeson (2003)

Hansson (2006) carried out an analysis of quality of life literature among people with severe psychiatric disorders, and found that, in severe mental illness, subjective life quality is more influenced by the disease itself, a person's self-esteem and by social support rather than by external conditions. Also, people with severe mental disorders seem more satisfied with their lives when they live in community settings.

The European Study of the Epidemiology of Mental Disorders (Alonso et al., 2004) carried out a study in six European countries on mental health state in mental and physical disorders, and their effect on days of work lost and quality of life. In the study, people with these disorders were interviewed to identify the effect on quality of life and days of work lost. Multivariate regression analysis was used to determine the association between the variables. The results showed that the higher the number of mental disorders and physical illnesses a person had, the lower their quality of life, and the more days lost to work. With quality of life, mental disorders tended to impact more on the mental quality of life, and physical disorders had more impact on the physical aspect of quality of life, although mental disorders were more likely to affect both areas. People with one or more mental disorders had a lower quality of life and lost more work days compared to those who did not. The authors concluded that mental illness affected work days lost and quality of life to a greater degree than physical illnesses.

In a meta-analysis of quality of life literature, it was found that, for people with mental illness, feeling ill or having symptoms were important in perception of quality of life. People with severe mental disorders were more likely to experience a poor quality of life. (Connell et al., 2012)

Another study focused on asking people living with mental illness what factors they considered affected their quality of life. It revealed that self-perception; feelings of having independence and choice, well-being, hope, relationships and belonging, activity and physical health were important factors affecting mental health patients' quality of life. (Connell et al., 2014)

Very few quality of life studies among people with mental illnesses have been carried out in the African continent.

Despite this recognised dearth of literature, a review of literature in Nigeria found that low quality of life was related to illness issues, especially presence of anxiety and depressive disorders or other medical problems, as well as taking of medication. Quality of life was also linked to factors such as support, employment, and marital status. (Aloba et al, 2013)

The presence of psychiatric symptoms has also been shown to affect the quality of life in other medical conditions.

Sherbourne et al (2000) reported that the presence of mood and anxiety syndromes tends to have a negative effect on the health-related quality of life among people living with HIV/AIDS in the USA. Additionally, they found that there was little known about quality of life in the mentally ill despite the knowledge that mental illness can at times be even more debilitating than physical illness as far as well-being and functioning are concerned.

Schizophrenia has been described as the most debilitating of psychiatric disorders and it is not surprising that it has been associated with low health-related quality of life (Ho et al 1998).

Depression has also been found to have a higher negative affect on quality of life. (Connell et al., 2014)

Kinyanjui (2007) found that the factors affecting quality of life of people living with epilepsy were: living in the rural areas, being unemployed, being an unskilled labourer, poor income level, and having a high seizure burden.

2.4 Improving Quality of Life among the Mentally Ill

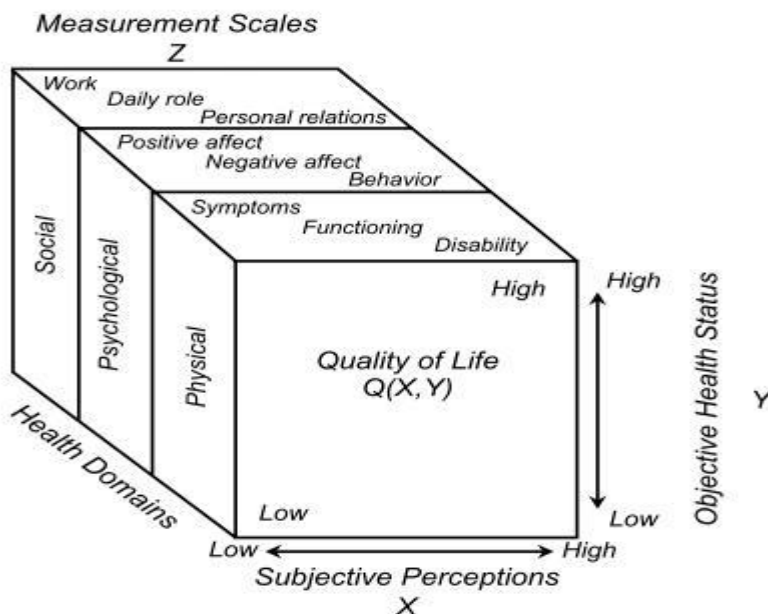
Feelings of mastery and economic independence are important factors in improving quality of life among the mentally ill and quality of life can be significantly improved by programs that provide some economic resources and empowered service delivery (Rosenfield, 1992).

Also, improving quality of health care does lead to an improvement in patient's quality of life. On top of that, improving social and economic factors such as family, support, housing and employment opportunities leads to an improvement in quality of life (WHO, 2003).

2.5 Theoretical Framework

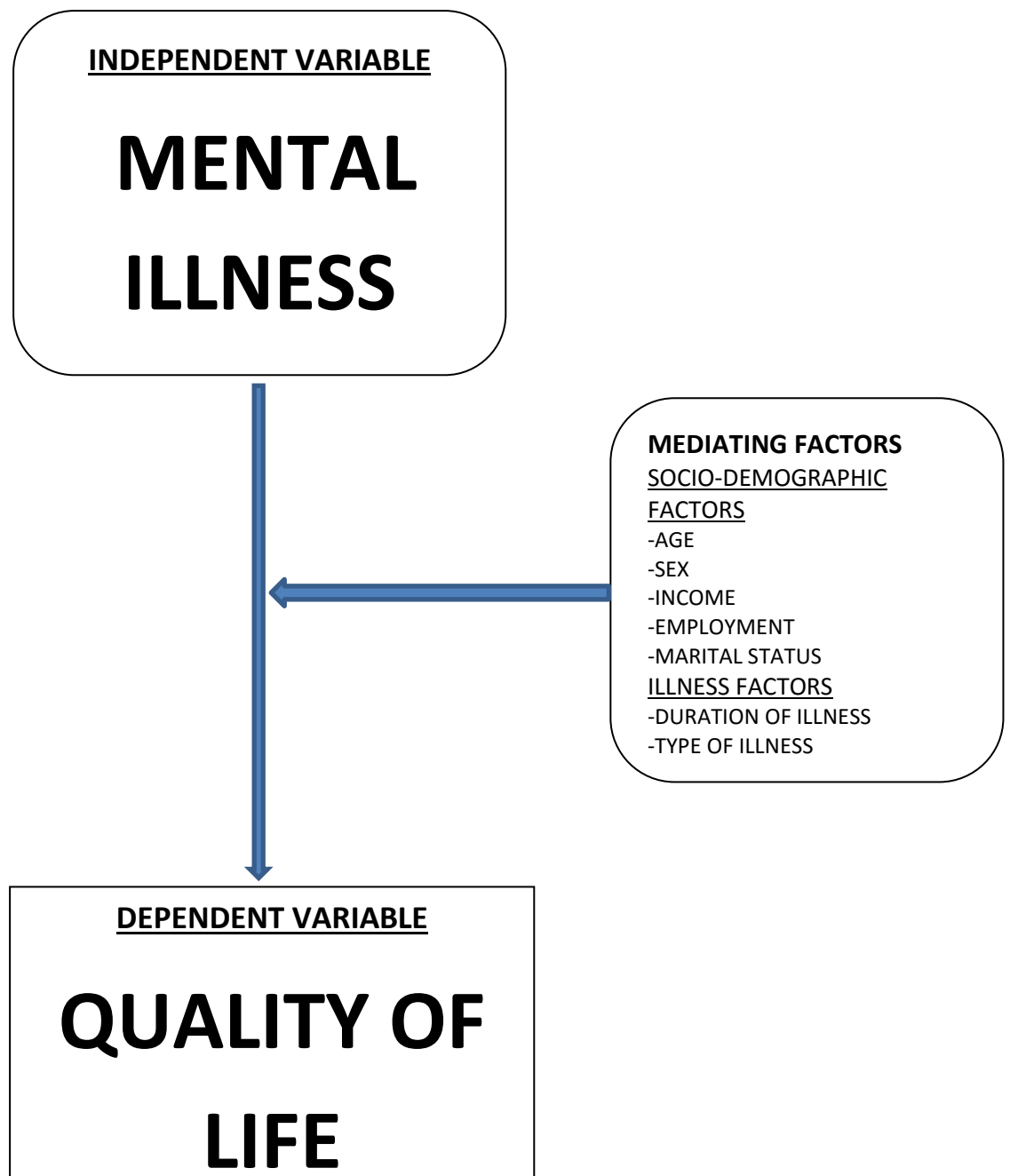
There are various theories around quality of life. According to Ventegodt, Merrick, and Andersen (2003) quality of life includes both subjective and objective elements. Important aspects for quality of life are well-being, life satisfaction, biological information system, happiness, life's meaning, fulfilling one's potential, fulfilling needs, and other factors that are more objective than subjective. Trafford (2013) states important aspects in health-related quality of life are physical, psychological and social areas of one's life.

Juczyński (2006) mentioned among the objective factors that define quality of life are one's education level, income, health status, personal relationships as well as environmental factors such the economic state of the country. On the other hand, quality of life is also a personal subjective evaluation of a person's situation using beliefs and states of one's emotions.



From Trafford (2013). University of British Columbia (2013) [Illustration on Health-Related Quality of Life] Measuring Health Related Quality of Life. Retrieved from <http://patientreportedoutcomes.ca/2013/03/26/measuring-health-related-quality-of-life/>

2.6 Conceptual Framework



Mental illness tends to affect quality of life of patients suffering from it (Barnes et al, 2012). An illness characteristic such as type of mental illness affects one's quality of life (Sherbourne et al, 2000). Quality of life also seems to be affected by socio-demographic factors such as employment and marital status (Aloba et al, 2013).

CHAPTER THREE: STUDY METHODOLOGY

This chapter outlines how the study was carried out, and the main methods that were used to answer the research questions. It describes the methods used and these include the study site, study design, study population, study variables, sample size determination, data collection and handling, data analysis and presentation, and ethical consideration.

3.1 Study Site

The study was conducted at Mathari National Teaching and Referral Hospital, the main psychiatric hospital in the country. This hospital is located at the outskirts of Nairobi, about 5 km from the Nairobi city centre. It has 750 beds, so at any one time around 750 patients are admitted into its wards (Kiima and Jenkins, 2010). It was set up in the colonial era around 1910 as an isolation ward, and then in 1924 it became an asylum. It is one of the four referral hospitals in the country, and is the principal psychiatric teaching hospital in Kenya. Apart from treating psychiatric patients, it also serves as an outpatient hospital for other general conditions. It has a maternal and child clinic, a family planning clinic, and a dental clinic as well as other general wards so it serves the community as a hospital (Mount Kenya University, 2015). Most patients are from Nairobi and its surroundings, because, even though Mathari hospital is a national referral hospital, most provincial hospitals around the country have psychiatric units staffed with psychiatrists who are able to take care of most of the presenting cases (Ndetei et al, 2007). It has 14 psychiatric wards, 4 of which are forensic, catering to inmates. 10 are civic: these are 5 male and 5 female wards. It also has a drug rehabilitation ward¹. Patients discharged from wards are followed up through outpatient clinics on specific days of the week. The outpatient

¹Personal communication from Mr Mwove, Nursing Officer in Charge at Mathari Hospital.

department also manages other patients. Most of the treatment given is in the form of medication and psychosocial help.

The rationale for choosing Mathari Hospital was that, being a referral hospital, it has the greatest number of patients from all over the country with a diverse range of mental disorders.

3.2 Study Design

This was a descriptive cross-sectional study that used quantitative methods to answer the research questions regarding the quality of life of people with mental illness.

A data collection instrument was used to measure quality of life among those suffering from mental illnesses.

3.3 Study Population

The study population was comprised of patients living with mental illness who were on follow-up at the outpatient clinics in Mathari National Teaching and Referral Hospital.

3.4 Inclusion and Exclusion Criteria

3.4.1 Inclusion Criteria

The subjects included in the study were:

1. People living with mental illnesses
2. Those attending the psychiatric outpatient clinics in Mathari Hospital for follow-up
3. Those who provided written informed consent

3.4.2 Exclusion criteria

The subjects excluded from the study were those:

1. whose disorder was so severe that they were not able to answer the questions on the instrument
2. who were aged less than 18 years or greater than 65 years of age because after 65 dementia can set in and confound the results
3. who had no insight or had severe intellectual disabilities and who could therefore not give informed consent
4. who declined to participate in the study

3.5 Study Variables

3.5.1 Independent Variables

The independent variable was presence of mental illness. Mediating factors were age, sex, marital status, employment, household income, education level, illness type and duration

3.5.2 Dependent Variable

The dependent variable was the quality of life of the study participants.

3.6 Sampling and Sample Size Determination

3.6.1 Sample Size Determination:

The following formula for prevalence studies was applied for sample size determination:

(Hulley et al, 2013)

$$\text{Sample size} = N = 4Z_{\alpha}^2 S^2 / W^2 = 157$$

Standard normal deviate for $\alpha = Z_{\alpha} = 1.96$

Where:

n = is the required sample size

S = is the estimated standard deviation of scores of quality of life among those with mental illness. Since this value is unknown in Kenya, a value of 16 was used (Hawthorne et al, 2006)

W= degree of precision or a tolerance error margin set at $\pm 5\%$.

Substituting in the above formula

$$N = 4(1.96)^2(16)^2 / (0.05)^2 = 157$$

The sample size is 157.

However, the sample in the study slightly exceeded as 384 people was interviewed for the study.

3.6.2 Sampling Procedure

Patients were selected at random on clinic days and anyone who agreed to take part in the study was taken through the study process. They were informed about the study, its objectives and procedures, as well as any risks or benefit in taking part. They were told that their participation was voluntary and everything would be kept confidential. They were then asked to fill and sign a consent form. Thereafter, those who gave consent filled the socio-demographic questionnaire and the quality of life instrument. This study process was repeated on subsequent clinic days, systematically going through all the wards, until the sample size was attained. This was done at the individual wards because that is where the outpatient clinics are held, each patient goes back to the ward they had been admitted into.

3.7 Data Collection

The quality of life instrument (WHOQOL-BREF) was used to assess quality of life. It is a shorter version of the WHO Quality of Life questionnaire (WHOQOL-100) which has 100 questions. This was developed to come up with a measure of quality of life that could be used among many different cultures. The WHOQOL-BREF has 26 questions, 24 of which are grouped into 4 domains (physical health, psychological, social relationships, and environment). The total scores from each domain are arrived at through adding the values of each response since the WHOQOL answers are on a Likert scale of one to five. So the total scores are arrived at adding up the total scores from each domain and the first 2 questions are multiplied by 4 to make the scores comparable to the WHOQOL-100 and to give the total score (a higher score indicates a better life quality) (World Health Organization, 2015b).

A simple socio-demographic questionnaire was used to gather socio-demographic data (i.e. age, sex, marital status, income and employment status) from the respondents. Additional questions in the socio-demographic questionnaire captured duration of mental illness and clinical diagnosis. Both instruments were filled by the respondent with the assistance of the investigator or the assistant researchers. It took an average of 20 minutes to fill both.

The data collection instruments were pretested among 5 mentally ill inpatients who had been discharged or were awaiting discharge from one of the ward within the Mathari National Hospital.

Six research assistants were recruited and trained on how to carry out the data collection. Most of them had a background in psychology, clinical psychology or medicine. Thereafter, they proceeded with data collection. Filled data collection tools were stored in an envelope and stored safely and securely in a cupboard away from people.

All filled questionnaires were kept in storage until the study was over in case anything needs to be confirmed.

3.8 Data Quality Assurance, Analysis and Presentation

Every individual filled questionnaire was checked for errors after each data collection day. The collected data was entered into Microsoft Excel to be cleaned and subsequently transferred into a statistical package (SPSS v 18.0) for analysis. Means, medians, standard deviations, semi-interquartile ranges and proportions were also determined at initial data analysis. Thereafter, analysis of variance (ANOVA) was used to assess relationships between the variables, more specifically between quality of life and socio-economic factors (such as education, age, sex) and illness factors (years of illness, type of illness).

Narratives and tables were used to present the results.

3.9 Assumption

All patients knew what illness they were suffering from and how long they had had it.

3.10 Minimization of Errors and Biases

1. A structured questionnaire was used to collect data from study participants.
2. The study subjects were randomly selected for the study. This ensured representativeness of the subjects
3. The data collection tool was pretested out at a specific ward in the hospital that was not used thereafter to collect data for the study in order to ensure the results obtained were valid.
4. Filled questionnaires were reviewed for completeness before data entry and analysis.
5. Confidentiality of the data collected was emphasized to the study participants.

3.11 Ethical Considerations

All the data collected in the study were kept in a safe place. Approval to undertake the study was obtained from the School of Public Health, the KNH–University of Nairobi Ethics and Research Committee as well as from the Mathari National Teaching and Referral Hospital Continuing Medical Education Department. The study participants were fully informed about the study and were required to give consent before they could take part in the study. Those who agreed were then given a consent form to sign, and left with a copy.

Since the study was being carried out amongst the mentally ill, a vulnerable group, the guardian or caregiver was also allowed to give consent for the study on a separate assenting form. On the other hand, most mentally ill patients were able to give consent as long as they had insight and understood the content of study. To ensure that they had insight and understood the study, the investigator gauged each respondent before administering the questionnaire from the response to being informed about the study whether they have understood and whether they could thus give informed consent.

The participants were informed that their participation in the study was purely voluntary and that they could withdraw from participating at any time. Participants were not required to write their name or give any personal identification in the questionnaire. The participants suffered no physical harm from taking part in the study. On the other hand, there was no direct benefit to the study participants. However, a hand out on tips to improve quality of life was handed out to everyone who participated. On top of that the study will indirectly benefit the participants by possibly shedding light on what the quality of life is among people living with mental illness in Kenya. It is anticipated that the study will generate information that can help improve the quality of life of those suffering from mental illness.

3.12 Limitations

The research was carried out in a hospital setting so it may be difficult to generalise the findings to the general population, particularly to people with mental illness who are not on treatment or follow-up.

The study may be prone to recall bias, since data was collected using questionnaires, with no review of existing medical records or direct observation. Data was checked for inconsistencies or blanks to reduce errors.

3.13 Dissemination of Results

The results from the study are to be discussed at a forum at the University of Nairobi during the defence of the dissertation. The results will be bound into a book that will be deposited at the University of Nairobi library. A summary report of the results will be provided to Mathari National Teaching and Referral Hospital. The results will be published in a peer-reviewed journal.

CHAPTER FOUR: STUDY RESULTS AND FINDINGS

4.1 Introduction

This chapter presents results on the socio-demographic characteristics of the study participants, the illness-related characteristics of the participants, as well as their quality of life. The relationships between quality of life and socio-demographic and illness-related factors are also presented.

4.2 Socio-Demographic Characteristics of Study Participants

Three hundred and eighty four study participants were recruited into the study. Table 1 presents the socio-demographic characteristics of the study participants. A total of 258 (67.2%) were male, while 156 (32.8%) were female. The age of the respondents ranged from 18 years to 65 years, with a mean age of 34.5 years, a standard deviation of 10.59 years. The median age was 34 years and the semi-interquartile range was 7.5 years. When disaggregated by gender, the female respondents in the study were slightly older than the male respondents, 38 and 33 years old, respectively.

About two-thirds (63.8%) of the study participants were single, 28.9% were married, 5.2% were separated, 0.8% were divorced and 1% were widowed Eighty (20.8%) study participants were employed, 114 (29.7%) were self-employed, 58 (14.8%) were casual workers, 104 (27.1%) were unemployed and 23 (5.9%) were students.

One hundred and twenty three (32%) of the respondents completed primary school level, 136 (35.4%) had attained secondary level education and 104 (27.1%) had studied up reached tertiary level. Four (4) of the respondents (1%) had no formal education, while 3 (0.7%) had attended special schools.

Asked about household income, the participants reported a monthly household income that ranged from Kshs 0 to above Kshs 100,000 with a median income of 5,000 shillings and a semi-interquartile range of 12,500 Kenya shillings. Two thirds (66%) of the participants had a household monthly income of less than 10,000 shillings.

Table 1: Socio-demographic Characteristics of the Study Participants

Characteristic	Frequency	Percentage
Age (years)		
15-19	11	2.9
20-24	57	15.0
25-29	73	19.0
30-34	76	20.0
35-39	49	13.0
40-44	52	14.0
45-49	22	5.7
50-54	23	6.0
55-59	13	3.4
60 and above	7	3.8
Total	384	100.0
Mean \pm S.D. :	34.5 \pm 10.59 years	
Sex		
Male	258	67.2
Female	126	32.8
Total	384	100.0
Level of Education		
None	4	1.0
Special	3	0.8
Primary	123	32.0
Secondary	136	35.4
Tertiary	108	28.1
Total	384	100.0
Marital Status		
Single	245	64.0
Married	111	29.0
Separated	20	5.1
Divorced	3	0.9
Widowed	4	1.0
Total	383*	100.0
Employment Status		
Employed	80	21.1
Self-employed	114	30.1
Casual Labourer	58	15.3
Unemployed	104	27.4
Student	23	6.1
Total	379*	100.0
Income (Kshs)		
Up to 10,000	254	72.4
10,001-50,000	72	20.5
50,001-100,000	16	4.5
Above 100,000	9	2.6
Total	351*	100.0
*No response for some participants		

4.3 Illness-Related Characteristics of Study Participants

The self-reported illness-related characteristics considered in this study were the type of illness and the duration the participants had suffered from the mental problem.

Duration of Illness

The duration of illness among the study participants ranged from a few days since the diagnosis to 54 years, with a mean duration of 7.1 years, a median of 3 years and a semi-interquartile range of 4.5 years.

Sixty five (16.9%) of the participants reported that they had had mental illness for a period of less than one year while a majority - 319 (83.1%) reported they had been mentally ill for more than one year. The majority of the respondents, 244, (63%) had had the illness for a period of between 1 and 7 years.

Type of Illness

The self-reported mental illnesses the study participants were as follows: 72 (18.8%) depression, 63 (16.7%) schizophrenia, 38 (9.9%) bipolar disorder and 37 (9.6%) drug/alcohol-induced psychosis. Other illnesses included: psychosis, cerebral malaria, epilepsy, anxiety, and meningitis. The less common types of illnesses among the study participants were Alzheimer's disease, Parkinson's disease, brain injury, obsessive-compulsive disorder and post-traumatic stress disorder. One hundred and thirty (33.1%) participants could not explain what they were suffering from. Table 2 summarises the illness-related factors of the study participants.

Table 2: Illness-Related Characteristics among the participants

Characteristic	Frequency	Percentage
Duration of Illness (years)		
Under 1 year	59	15.6
1 – 2	100	26.5
3 – 4	41	10.8
5 - 6	44	11.6
7 – 8	13	3.4
9 – 10	29	7.7
> 10	92	24.3
Total	378*	100.0
Type of Illness		
Depression	72	28.3
Schizophrenia	63	24.8
Bipolar	38	15.0
Drug/Alcohol-induced	37	14.6
Psychosis	14	5.5
Cerebral malaria	12	4.7
Epilepsy	5	2.0
Brain Injury	4	1.6
Parkinson's	2	0.8
Anxiety	2	0.8
Meningitis	1	0.4
Alzheimer's	1	0.4
Brain Illness	1	0.4
Obsessive-Compulsive	1	0.4
Post-trauma Stress	1	0.4
Total	254*	100.0
*No response for some participants		

4.4 Quality of Life of Study Participants

The WHOQOL-BREF, a quality of life instrument, was used to assess the quality of life of the study participants. The instrument itself has four main domains into which the questions are grouped (Physical, psychological, social and environmental): so it has an overall total score and four domain scores. The physical domain deals with the functioning of the body and areas such as energy and fatigue. The psychological domain deals with feelings, esteem, thinking and concentration. The social domain deals with personal relationships and social support. The environmental domain deals with issues such as the environment, whether one feels safe, access to health care, work satisfaction and transport. The total possible score is 500 for the whole tool. Each domain has a total possible score of 100. The WHOQOL-BREF has 26 questions, 24 of which are grouped into the 4 domains (physical health, psychological, social relationships, and environment). The total scores from each domain and the first 2 questions are multiplied by 4 to make the scores comparable to the WHOQOL-100 and to give the total score (a higher score indicates a better life quality) (World Health Organization, 2015b).

The mean score for quality of life among the study participants was 327 (63.4%) with a standard deviation of 78.4. The median score and semi-interquartile range were 330 and 50.1, respectively.

One hundred and ninety respondents (53%) scored between 300-400 points out of a total of 500. Only 73 participants (19.5%) scored below the mean of 250, and 301 (80.5%) of the participants scored above average. Only 31 respondents (8.4%) scored up to 200 points.

Table 3 presents the quality of life scores for study participants.

Table 3: Quality of Life Scores for the Study Participants

Quality of Life Score	Number of participants	Percentage
Less than 100	5	1.4
101-200	26	7.0
201-300	99	26.5
301-400	198	52.9
401-500	46	12.3
Total	374*	100.0

*Incomplete responses for some participants

The mean score for the different age groups differed slightly. The highest score was a mean score of 350.8 for those between 50 and 54 years, while the lowest score was a mean score of 293.6 for those between 55 and 59 years. No trend in the scores was noted.

Females had a mean score of 313.0 as compared to the mean score of males at 318.7.

When categorised according to marital status, those who were married had the highest quality of life mean score at 324.0. The lowest mean score was among those who were widowed, with a quality of life score of 243.9.

Those with the lowest mean quality of life score had a mean household income of Kshs 10,000 and below: their mean score was at 312.3. Those with a higher income - above Kshs 100,000 - had the best quality of life score at 394.5. There was a noticeable trend with an increase in the quality of life scores as the income increased.

Those unemployed had the lower mean quality of life score at 324.1, while those employed had a higher mean quality of life at 331.5.

The lowest mean quality of life score was seen among those who had not attended school at 283.5, and the highest mean score was with those who had a primary level education at 324.2.

No trend was noted in the mean scores of the study participants.

Table 4: Mean Scores per Category (Socio-demographic Variables)

VARIABLE	MEAN ± S.D.
Age group (Years)	
15-19	339.3 ± 97.5
20-24	312.7 ± 71.7
25-29	321.7 ± 77.0
30-34	305.9 ± 74.7
35-39	326.9 ± 81.1
40-44	311.3 ± 85.1
45-49	302.1 ± 84.8
50-54	350.8 ± 70.6
55-59	293.6 ± 91.9
≥60	327.0 ± 43.3
Gender	
Females	313.0 ± 81.9
Males	318.7 ± 76.7
Marital Status	
Single	319.6 ± 76.9
Married	324.0 ± 77.4
Widowed	243.8 ± 108.4
Divorced	256.4 ± 121.1
Separated	272.6 ± 72.5
Household Income	
≤ 9,999	312.3 ± 75.7
10,000-49,999	321.3 ± 78.7
50,000-99,999	335.1 ± 114.9
≥100,000	394.5 ± 45.9
Employment Status	
Employed	331.5 ± 81.8
Self-employed	319.2 ± 82.7
Casual worker	327.2 ± 71.3
Unemployed/ Student	304.4 ± 78.7
Level of Education	
Primary	324.5 ± 65.7
Secondary	308.6 ± 73.6
Tertiary	321.5 ± 93.8
Special	310.0 ± 18.5
None	283.8 ± 109.8

When categorised according to duration of illness, the lowest mean score (298.7) was for those who had had the illness for 3 to 4 years. Those who had had the illness from 9 to 10 years had the highest quality of life score at 328. No trend was noted

When categorised according to illness, those who had the lowest mean score (182.7) had obsessive compulsive disorder. The highest score was with those with brain illness at 366.3. No trend in the scores was noted.

A higher score of life presents a better quality of life according to the WHOQOL tool.

Table 4 and 5 show the mean scores per category.

Table 5: Mean Scores per Category (Illness Variables)

VARIABLE	MEAN ± S.D.
Duration of Illness (Years)	
< 1	328.2 ±67.5
1 – 2	318.0 ±85.2
3 – 4	298.7 ± 79.8
5 - 6	309.0 ± 76.5
7 – 8	330.9. ± 89.9
9 – 10	333.6 ± 62.0
> 10	312.3 ± 80.6
Type of Illness	
Depression	307.1 ±84.4
Schizophrenia	325.1 ±98.6
Bipolar	317.9 ±84.8
Drug/Alcohol-Psychosis	306.3 ±74.1
Psychosis	343.6 ±72.9
Cerebral Malaria	313.5 ±77.1
Epilepsy	255.2 ±87.1
Brain Injury	298.6 ±42.1
Anxiety	343.0 ±30.7
Parkinson's	326.3 ±24.6
Alzheimer's	363.5 ±78.5
Brain Illness	366.2 ±78.6
Obsessive-Compulsive	182.7 ±78.2
Meningitis	263.2 ±78.4
Post trauma	274.6 ±78.5
Unknown	321.3 ±64.5

The mean score for the physical domain was 56.2, for the psychological domain it was 66.1, for the social domain it was 66.3, and for the environmental domain it was 60.9. The median quality of life score was highest for the psychological domain and lowest for the environmental domain. Table 6 presents summary statistics of quality of life scores for the different domains.

Table 6: Quality of Life Scores by Domain

<u>Domains</u>	Mean	±	S. D.	Median	S.I.R.
Physical	56.2	±	10.64	68	10.71
Psychological	66.1	±	18.09	71	12.5
Social	66.3	±	18.98	67	12.5
Environmental	60.9	±	23.20	59	12.5

4.5 Comparisons of Quality of Life Scores for Different Variables

One-way analysis of variance (ANOVA) was used to determine significant differences between the mean scores of quality of life of respondents for different levels of independent variables. A p-value of less than 0.05 at 95% confidence interval was considered significant for all analyses. Table 7 presents these results.

Different characteristics yielded different results, a majority of which were not statistically significant. The mean quality of life scores were found to be statistically significantly different for the marital status and household income levels of the study participants ($p < 0.05$). The mean quality of life scores were found not to be statistically significantly different for age, sex, level of education, type of employment, type of illness and duration of illness.

Table 7: Results of ANOVA of Socio-demographic Variables and Quality of Life

VARIABLE	MEAN ± S.D.	Fisher's (F) statistic	Significance (p-value)
Age group (Years)			
15-19	339.3 ± 97.5	1.273	.121
20-24	312.7 ± 71.7		
25-29	321.7 ± 77.0		
30-34	305.9 ± 74.7		
35-39	326.9 ± 81.1		
40-44	311.3 ± 85.1		
45-49	302.1 ± 84.8		
50-54	350.8 ± 70.6		
55-59	293.6 ± 91.9		
≥60	327.0 ± 43.3		
Gender			
Females	313.0 ±81.9	.437	.509
Males	318.7 ±76.7		
Marital Status			
Single	319.6 ±76.9	3.191	.014*
Married	324.0 ±77.4		
Widowed	243.8 ±108.4		
Divorced	256.4 ±121.1		
Separated	272.6 ±72.5		
Household Income			
≤ 9,999	312.3 ±75.7	3.341	.011*
10,000-49,999	321.3 ± 78.7		
50,000-99,999	335.1 ± 114.9		
≥100,000	394.5 ± 45.9		
Employment Status			
Employed	331.5 ±81.8	2.033	.089
Self-employed	319.2 ±82.7		
Casual worker	327.2 ±71.3		
Unemployed/ Student	304.4 ±78.7		
Level of Education			

Primary	324.5 ±65.7	.939	.441
Secondary	308.6 ±73.6		
Tertiary	321.5 ±93.8		
Special	310.0 ±18.5		
None	283.8 ±109.8		

Table 8: Results of ANOVA on Illness Variables and Quality of Life

VARIABLE	MEAN ± S.D.	Fisher's (F) statistic	Significance (P-value)
Duration of Illness (Years)			
< 1	328.2 ±67.5	.826	.797
1 – 2	318.0 ±85.2		
3 – 4	298.7 ± 79.8		
5 - 6	309.0 ± 76.5		
7 – 8	330.9. ± 89.9		
9 – 10	333.6 ± 62.0		
> 10	312.3 ± 80.6		
Type of Illness			
Depression	307.1 ±84.4	1.645	.999
Schizophrenia	325.1 ±98.6		
Bipolar	317.9 ±84.8		
Drug/Alcohol-Psychosis	306.3 ±74.1		
Psychosis	343.6 ±72.9		
Cerebral Malaria	313.5 ±77.1		
Epilepsy	255.2 ±87.1		
Brain Injury	298.6 ±42.1		
Anxiety	343.0 ±30.7		
Parkinson's	326.3 ±24.6		
Alzheimer's	363.5 ±78.5		
Brain Illness	366.2 ±78.6		
Obsessive-Compulsive	182.7 ±78.2		
Meningitis	263.2 ±78.4		
Post trauma	274.6 ±78.5		
Unknown	321.3 ±64.5		

A multiple regression analysis was run to find out how positively or negatively the variables affected the quality of life. Table 9 below shows the results of this analysis. The results of the regression showed that quality of life is probably negatively affected by poor marital status, negative illness characteristics and low level of education. It is probably positively affected by age, gender, employment status and income.

Table 9: Results of Multiple Regression Analysis on Socio-economic and Illness Variables and Quality of Life

Coefficients ^a								
Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95.0% Confidence Interval for B	
		B	Std. Error	Beta			Lower Bound	Upper Bound
1	(Constant)	300.442	22.170		13.552	.000	256.838	344.047
	Age	.263	.462	.036	.570	.569	-.645	1.171
	Gender	1.561	9.143	.009	.171	.865	-16.422	19.544
	Marital Status	-10.624	3.583	-.163	-2.966	.003	-17.670	-3.578
	Illness	-.446	.526	-.050	-.848	.397	-1.480	.589
	Job Status	7.714	3.397	.124	2.271	.024	1.033	14.396
	Average Income	.000	.000	.111	2.016	.045	.000	.001
	Education	-2.341	4.932	-.026	-.475	.635	-12.041	7.360

a. Dependent Variable: Quality of Life

CHAPTER FIVE: DISCUSSION OF FINDINGS

This chapter discusses the findings of the study.

5.1 Socio-demographic Characteristics

5.1.1 Gender

A majority (67.2%) of the study participants were male. This is different from the normal Kenyan population, where females are slightly more at 51% (KDHS, 2015). However, this is in keeping with previous studies that have shown that number of males in Mathari Hospital is slightly higher (63%) compared to the number of females (Ndetei et al, 2008). This can be explained by the fact that men are more likely to be admitted into mental hospitals by the authorities (Mukherjee, and Scutt, 2015). This ratio of male to females may have also been affected by the number of wards that were available for study: respondents were approached whilst coming for clinic at the five major psychiatric wards, out of which 3 were male wards, while 2 were female.

A related study by Kinyanjui (2007) assessing the quality of life of patients with epilepsy attending an outpatient clinic in Nairobi, Kenya, also showed slightly higher number of males than females among the study subjects.

Gender did not statistically significantly affect the quality of life. This could be because there is no big difference between men and women and how they are cared for when they have a mental illness: most of them, whether male or female, are dependent on their families for help, and continue to live with their families. So their quality of life is relatively similar. These findings are similar to a study by Mercier, Péladeau, and Tempier (1998) that did not find any statistically significant difference in the quality of life when it compared the quality of life scores of men and women living with mental illness in Canada.

5.1.2 Age

Most of the respondents were aged between 30 and 34 years. This finding is similar to those of previous studies which showed that majority of the patients at Mathari Hospital are aged between 26 years and 40 years of age (Ndetei et al, 2008). Studies also show that most patients start falling ill in early adulthood (National Health Services, 2014) Also, the Kenya Demographic and Health Survey (KDHS, 2015) puts the highest adult population group around the ages of 25 to 30 years, which is similar to the population at Mathari. (Ndetei et al, 2008)

Age of the respondents was found not to be statistically significantly associated with the quality of life of the participants. This is unlike the findings of a study by Mercier, Péladeau, and Tempier (1998) carried out in Canada, on people in different age groups living with mental illness which found that age affected quality of life: the older the study respondents were, the better the quality of their lives, as they tended to come into a state of acceptance of themselves and their lives. It is possible that this was because this study was done in a developed country where there is high quality care for older people.

Whereas in Kenya, both young and old people with mental illness still have the same challenge, as mostly they live at home with their families, so the situation does not change with age, thus that may be the reason quality of life was not affected by age.

5.1.3 Marital Status

About two thirds (64%) of the respondents were single. Similar studies at Mathari hospital have shown that majority of the patients with mental illness are single (Ndetei et al, 2008). A study on people living with epilepsy in Nairobi also showed that a high proportion of people with mental illness are single (Kinyanjui, 2007). This is probably because having a mental illness

impacts the ability to form and maintain social relationships, and the stigma that comes with it may push away potential partners (Aloba et al, 2013).

Marital status was found to be statistically significantly associated with one's quality of life. This has also been shown in other studies where marital status was significant, such as the meta-analysis of quality of life research done in Nigeria by Aloba et al in 2013. Family life is also significant in its effect on quality of life (The Economist, 2005). This could be because those married can depend on two incomes in the household, thus improving their economic quality of life. Also, those who are married tend to get moral support from their spouses.

5.1.4 Employment Status

Quite a low proportion of the respondents were either self-employed (29%) or unemployed (27.1%). This is in keeping with the Kenya statistics of about 20% unemployment (KDHS, 2015). Similar studies have shown an even higher incidence of unemployment in patients exposed to mental illness (Kinyanjui, 2007). This is because having a mental illness may make it harder to get employment (Aloba et al, 2013) because of stigma, which affects people with mental disorders (Davey, 2008) and the nature of the illness.

Employment status was found not to be statistically significantly associated with quality of life. This is in contrast with a study conducted by Hsiao et al on quality of life of people living with schizophrenia in the community (2012) in which employment status was significant in its effect on quality of life.

A possible reason for this difference could be that, in the Kenyan context, most mentally ill patients live with their families, so they depend on their family members to take care of them. Therefore, whether they are employed or not, they still have someone they can depend on, and therefore the employment status may not affect the quality of their lives as much.

5.1.5 Education

The level of education was well-distributed with about a third having studied and finished at primary school, a third that stopped studying at secondary, and a third at tertiary level. A previous study by Ndetei, at Mathari Hospital showed that about 40% had completed primary school and up to 40% had gone up to secondary school, and less than 10% had had tertiary education.(Ndetei et al, 2008). Another study by Kinyanjui (2007) came up with similar findings. This means that a third of people with mental illness find it hard to study beyond primary school, possibly because of the nature of the illness.(Aloba et al, 2013) In the KDHS (2015), about 40% of people do not get to secondary school.

Only 1% of the study participants had not gone to school. This is in keeping with the general statistics in the country where number of people who have never gone to school is low and keeps decreasing (KDHS, 2015). Also, the number of people in Kenya with secondary education has increased to 37%, which is similar to the population at Mathari. (KDHS, 2015)

The level of education was found not to be statistically significantly associated with quality of life among the study participants. This is similar to a meta-analysis study by Ross and Van Willigen (1997) that sought to find out the effect of education on quality life. They found out that quality of life was not statistically significantly associated with the level of education. This could be because education, while making people more knowledgeable, does not necessarily provide them with coping mechanisms to better deal with their illness.

5.1.6 Income

The level of household income was found to be low, with a median monthly income of Kshs 5,000. Similar findings were also found in a study by Kinyanjui (2007), where majority of the

patients had little or no income. This could be because majority of mentally ill patients cannot hold a job because of the illness (Aloba et al, 2013)

Income was found to be statistically significantly associated with quality of life. This finding is similar to another study by Kahneman and Deaton (2010) that found that income affected quality of life. Their study evaluated responses to a poll in the U.S. and analysed their data. Their study analysed opinion polls to check if there was any effect of income on quality of life, and they found that income was statistically significantly affected with quality of life. Income is significant because one who earns more can take better care of themselves, and thus feel better about themselves and their life.

5.2 Illness Characteristics

5.2.1 Duration of Illness

Most of the respondents (83%) had had the illness for more than 1 year, the mean being 7 years. This is probably because they were on follow-up at the clinics so many have had the illness for at least a few years. The average number of years for the duration of illness though is low probably because those who have had the illness for many more years do not come for clinic much because they are probably more stable and have discovered a routine and medication that works for them, thus they need less medical advice. This is similar to findings from other studies that show that those who have had mental illness for long, specifically longer than 10 years, do not come for clinic as often as those who have had the illness for a shorter period of time. (Aloba et al, 2013)

Duration of illness was found not to be statistically significant in determining quality of life. This finding is similar to those of a study by Ho et al (2012) on 50 people with first episode schizophrenia, where they found that duration of illness did not affect quality of life. Reasons

for duration of illness not affecting quality of life could be because many mental illnesses are chronic illnesses so it tends to affect people throughout their lifetime.

5.2.2 Self-reported Type of Illness

Depression and schizophrenia were the most common illnesses. This had been shown in other studies at Mathari too (Ndeti et al, 2008). These two are some of the most common mental illnesses. (National Health Service (2014); Mental Health America (2016)

A third of the study participants did not know their diagnosis. Many claimed they had never been told, a few said they were not sick. This may signal that the patients' literacy on mental illness is low, or they had no insight into their illness.

The type of illness was not statistically significantly associated with quality of life. This finding is different from other studies that have found type of illness to be significant, such as by Hansson (2006) and Barnes et al (2012), on people living with schizophrenia. It found the type of illness (schizophrenia) significantly affected quality of life.

As mentioned earlier this study depended on patients' knowledge to determine diagnosis, so this may have biased the study. However, type of illness was possibly not significant because, in the Kenyan setting, all illnesses are labelled as madness as everyone with a mental illness consider themselves mad or that they are not mentally okay, so the type of illness does not affect how one is treated by the society, thus it may not affect quality of life.

5.3 Quality of Life and Factors Influencing Quality of Life

5.3.1 Quality of Life

The higher the score the better the quality of life based on the WHOQL scale (Gholami, 2013). The quality of life score in this study population was above the mid-point (250) at (326.84) which is 63.7% of the total score of 500. Kinyanjui (2007) also found that the mean total quality of life score for the general population was 77.0% of the total possible score. The mean total score in this study was thus lower than the mean scores for the general population.

The mean quality of life scores was found to be lower than the norms in Kenya, and is probably because having of a mental illness might lead to lower quality of life. (Alonso et al, 2004) This could be because of the inadequate care for the mentally ill available in the country as shown by Kiima and Jenkins (2010).

5.3.2 Factors Influencing Quality of Life

In conclusion, the study showed that, marital status and household income significantly affected quality of life of patients with mental illness. This has been shown in other studies as well (Ho et al, 1998; Aloba et al, 2013). Kinyanjui (2007) also found that income was statistically significantly associated with the quality of life.

CHAPTER SIX: STUDY CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

The study comes up with the following conclusions:

1. The quality of life for a majority of the study participants was above average..
2. The most significant socio-demographic factors affecting quality of life of patients with mental illness were found to be marital status and household income of the respondents.

6.2 Recommendations

The study comes up with the following recommendations:

1. In addition to medical treatment, mentally ill patients should receive further psychological treatment to help improve their subjective quality of life
2. The government should offer economic support and income generating activities for persons living with mental illness so as to help improve their income
3. Efforts should be made during treatment of mentally ill patients to integrate families and offer marital therapy in order to stabilise the marital status of patients with mental illness
4. Other studies on quality of life are needed in order to get norms for the general population.

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APPENDICES

APPENDIX 1:

CONSENTING/ASSENTING INFORMATION:

TITLE OF THE STUDY: QUALITY OF LIFE AMONG PEOPLE LIVING WITH MENTAL ILLNESS: A CASE STUDY OF MATHARI NATIONAL TEACHING AND REFERRAL HOSPITAL

Introduction to the Study

I am Twahira Abdalla, a student of Masters in Public Health, University of Nairobi. I am conducting a study on quality of life among people with mental illness. The research will be carried out at the outpatient clinics at Mathari National Teaching and Referral Hospital. The purpose of this study is to find out what factors affect the quality of life of people living with a mental illness.

You/your ward (dependant) has been selected because you/your ward are above 18 years, and will provide important information for the study. You/your ward are being invited to take part in filling a questionnaire on quality of life, and a questionnaire on socio-demographic data.

Benefits/Risks

There will be no direct benefit to you as a participant. You will not receive any payment for taking part in the study. However, the information gathered from the study .will be used to improve the lives of people living with mental illness. Any results that would benefit you/your ward will be communicated to you. You will receive a hand out on mental health.

There are minimal risks in your participation in this study. Some of the questions asked may make you uncomfortable, you have the right to refuse to answer them. You will not pay anything to take part in the study.

Procedures

You will be asked to fill a socio-demographic questionnaire and a quality of life instrument. Filling in the questionnaire and instrument may take between 30-40 minutes.

Voluntary Participation and Withdrawal

Your participation in this study is purely voluntary. You can decline to participate with no penalty or denial of services to you/your ward. You have the right to drop out anytime, and you can skip questions or decline to give information and you will face no negative consequences.

Confidentiality

You will not be required to write your name or give any personal identification in the questionnaire. You will be given a consent form to sign, and you will be left with a copy. All the questionnaires shall be kept under lock and key and destroyed once the study is over. There shall be no way to identify individual participants.

APPENDIX 2

CONSENTING FORM

STUDY NUMBER: _____

I _____ hereby agree to participate in the study being carried out by Twahira Abdalla on the quality of life of people living with mental illness at Mathari National Teaching and Referral Hospital. I agree to fill in the questionnaire and the instrument measuring life quality. I understand there is little risk in the study on top of the answering of questions, and I will not pay anything to take part in the study. I also realise that there is no direct benefit to me or monetary compensation, but the study will hopefully lead to improvement in the lives of people living with mental illness. On top of that, any results that would help in the management of my condition will be communicated to me. I also understand that the study is purely voluntary and that I may withdraw from the study at any time and my withdrawal will not in any way deny me any health benefits to which I am entitled to.

Participant's Name _____ Telephone no _____

Participant's signature _____ / Left thumb print _____ Date _____

Witness's Name _____

Witness's signature _____ Date _____

Signature of principal investigator (or authorized representative) _____

Contact information

If you have questions now or in the future regarding your rights or this study or research related injury, please contact the Investigator, Twahira Abdalla on 0725777275, The Internal Supervisor, Mr Lambert Nyabola, on 0711382815 or The Chairperson, Kenyatta National Hospital- University of Nairobi Ethics and Research Committee through P O Box 20723-00200 Nairobi. Tel 020-272527 extension 44102

APPENDIX 3

ASSENTING FORM

STUDY NUMBER: _____

I _____ hereby agree for my ward (dependant) _____ to participate in the study being carried out by Twahira Abdalla on the quality of life of people living with mental illness at Mathari National Teaching and Referral Hospital. I agree for him/her to fill in the questionnaire and an instrument measuring life quality. I understand that my ward will not suffer any extra discomfort over and above answering questions in the instrument, and I will not pay anything to take part in the study. Also, I realise that there is no direct benefit to me or my ward or any monetary compensation, but the study will hopefully lead to improvement in the lives of people living with mental illness. On top of that any results that would benefit my ward will be communicated to me. I also understand that the study is purely voluntary and I may withdraw my ward from the study at any time and my withdrawal will not in any way deny my ward any health benefits to which he/she is entitled to.

Participant's Name _____ Telephone no _____

Participant's signature _____ / Left thumb print _____ Date _____

Witness's Name _____

Witness's signature _____ Date _____

Signature of principal investigator (or authorized representative) _____

Contact information

If you have questions now or in the future regarding your rights or this study or research related injury, please contact the Investigator, Twahira Abdalla on 0725777275 or The Internal Supervisor, Mr Lambert Nyabola, on 0711382815 or The Chairperson, Kenyatta National Hospital- University of Nairobi Ethics and Research Committee through P O Box 20723-00200 Nairobi. Tel 020-272527 extension 44102

APPENDIX 4

SWAHILI CONSENTING/ASSENTING INFORMATION

MAELEZO YA IDHINI

KICHWA CHA UTAFITI: UBORA WA KIMAISHA KATIKA WATU WANAOSHI NA SHIDA ZA KIAKILI: KESI YA UTAFITI KATIKA HOSPITALI YA KITAIFA YA UALIMU NA RUFAA YA MATHARI

Maelezo ya utafiti

Jina langu ni Twahira Abdalla, mwanafunzi anayesomea Masters in Public Health (Afya ya Kijamii), katika Chuo Kikuu cha Nairobi. Ninafanya utafiti kuhusu ubora wa kimaisha katika watu wanaoishi na shida za kiakili. Utafiti huu utafanywa katika Hospitali ya Kitaifa ya Ualimu na Rufaa ya Mathari. Lengo la utafiti hii ni kugundua nimambo gani yanayoathiri ubora wa maisha katika watu wanaoishi na shida za kiakili.

Wewe/mtegemezi wako mumechaguliwa sababu, umetimia miaka 18, na unaweza kutusaidia katika utafiti huu. Utaombwa ima kujaza dodoso kuhusu hali ya kimaisha na kifaa cha kupima ubora wa kimaisha.

Faida/Hatari

Hakutakuwa na faida yoyote kwa kuhusika katikia utafiti huu, lakini, utafiti huu utatusaidia kuchunguza ubora wa maisha shida za kisaikiyatria kwa undani zaidi ili tuweze kuyafahamu vizuri zaidi na kutuwezesha kuwahudumia wenye shida hizi kwa hali ya juu zaidi. Hakutakuwa na malipo yoyote kwa kuhusika katika utafiti huu. Utaarifiwa kuhusu majibu yoyote ambayo yataweza kukusaidia au kumsaidia mtegemzi wako. Utapewa hati kuhusa afya ya kiakili

Hakuna hatari katika kuhusika katika utafiti huu. Maswali utakayoulizwa yanaweza kukufanya uhisi taabu kuyajibu. Uko huru kutoyajibu. Hatalipa chochote kushiriki katika utafiti huu.

Utaratibu

Utaombwa kujaza dodoso kuhusu hali ya kimaisha, pamoja na kifaa cha kupima ubora wa kimaisha. Hii itakuchukua dakika 30-40.

Kushiriki na Kutoshiriki kwa Hiari

Kushiriki kwako katika utafiti huu ni kwa kujitolea, Unaweza kuamua kutoshiriki na wewe au mtegemezi wako hamtonyimwa huduma ambazo mngepata kwa kawaida wala adhabu yoyote. Una haki ya kujitoa katika utafiti huu wakati wowote, na unaweza kutojibu maswali au kukataa kutoa habari yoyote na hakutakuwa na adhabu yoyote.

Hakikisho ya siri ya utambulisho wa mshiriki

Hutohitajiwa kutoa jina lako au kujitambulisha katika kifaa, dodoso, mahojiano au majadiliano ya kikundi. Utapewa fomu ya idhini utie sahihi, na wewe utabaki na fomu ya idhini moja. Vifaa vyote na dodoso zote zitawekwa mahali panapofungwa kwa kufuli, na utafiti ukimalizika zitatupwa. Kutakuwa hakuna njia ya kuwatambua washiriki.

APPENDIX 5

SWAHILI CONSENT FORM

FOMU YA IDHINI

STUDY NUMBER: _____

Mimi _____ nakubali kushiriki katika utafiti unaofanywa na Twahira Abdalla kuhusu ubora wa kimaisha katika watu wanaoishi na shida za kiakili katika Hospitali ya Kitaifa ya Ualimu na Rufaa ya Mathari. Nakubali kujaza dodosa na kifaa cha kupima ubora wa kimaisha. Naelewa kuwa sitopata taabu yoyote zaidi ya kujibu maswali, na sitolipa chochote kushiriki katika utafiti huu. Naelewa kuwa sitapata malipo yoyote kwa ushiriki katika utafiti huu, lakini huenda utafiti huu ukaboresha maisha ya wenye shida za kisaikayatria. Nitaelezwa majibu yoyote yanayoweza kuboresha matibabu yangu. Pia naelewa kuwa naweza kuzitisha ushiriki wangu kwenye utafiti huu wakati wowote bila hofu ya adhabu yoyote, na bila kujikosesha huduma yoyote.

Jina la mshiriki _____ Nambari ya simu _____

Sahihi ya mshiriki _____ Tarehe _____

Jina la shahidi _____

Sahihi ya shahidi _____ Tarehe _____

Sahihi ya mtafiti mkuu (Ama mwakilishi wake) _____

Mawasiliano

Ukiwa na swali lolote wakati huu ama baadaye kuhusu haki zako kama mshiriki, kuhusu utafiti huu ama madhara yoyote yatakayotokea tafadhali wasiliana na mtafiti, Twahira Abdalla, nambari ya simu 07225777275 ama Msimamizi Lambert Nyabola, 0711382815, ama, Mwenyekiti, Kamati ya Maadili ya Utafiti ya Hospitali Kuu ya Kenyatta/ Chuo Kikuu cha Nairobi kupitia S.L.P 20723-00200 Nairobi ama piga simu 020-726300 mkondo 44102.

APPENDIX 6

SWAHILI ASSENTING FORM

FOMU YA IDHINI YA MLINZI

STUDY NUMBER: _____

Mimi _____ nakubali mtegemezi wangu _____ kushiriki katika utafiti unaofanywa na Twahira Abdalla kuhusu ubora wa kimaisha katika watu wanaoishi na shida za kiakili katika Hospitali ya Kitaifa ya Ualimu na Rufaa ya Mathari. Nakubali mtegemezi wangu ajaze dodosa na kifaa cha kupima ubora wa kimaisha. Naelewa mtegemezi wangu hatapata taabu yoyote zaidi ya kujibu maswali, na hatutolipa chochote kushiriki katika utafiti huu. Naelewa kuwa hatutapata malipo yoyote kwaushiriki katika utafiti huu, lakini huenda utafiti huu ukaboresha maisha ya wenye shida za kisaikayatria. Nitaelezwa majibu yoyote yanayoweza kuboresha matibabu ya mtegemezi wangu. Pia naelewa kuwa tunaweza kuzitisha ushiriki wa mtegemezi wangu kwenye utafiti huu wakati wowote bila hofu ya adhabu yoyote, na bila kumkosesha mtegemezi wangu huduma yoyote.

Jina la mshiriki _____ Nambari ya simu _____

Sahihi ya mshiriki _____ Tarehe _____

Jina la shahidi _____

Sahihi ya shahidi _____ Tarehe _____

Sahihi ya mtafiti mkuu (Ama mwakilishi wake) _____

Mawasiliano

Ukiwa na swali lolote wakati huu ama baadaye kuhusu haki zako kama mshiriki, kuhusu utafiti huu ama madhara yoyote yatakayotokea tafadhali wasiliana na Mtafiti mkuu, Twahira Abdalla, nambari ya simu 0725777275, ama Msimamizi Lambert Nyabola, 0711382815, ama ama Mwenyekiti, Kamati ya Maadili ya Utafiti ya Hospitali kuu ya Kenyatta/ Chuo kikuu cha Nairobi kupitia S.L.P 20723-00200 Nairobi ama piga simu 020-726300 mkondo 44102.

APPENDIX 7

SOCIO-DEMOGRAPHIC QUESTIONNAIRE

STUDY NUMBER _____

Age (*Miaka*) _____

Sex (*Jinsiya*) _____

Marital Status (*Hali ya ndoa*) _____

Diagnosis (*Ugonjwa*) _____

Treatment

(*Matibabu*) _____

What is your employment status? (Circle most appropriate) / *Je, kazi yako ni ya aina gani?*

(*Chora duara kwenye jibu linalofaa*)

- a. Employed (*Nimeajiriwa*)
- b. Self-employed (*Nina biashara yangu*)
- c. Casual worker (*Ninafanya kibarua*)
- d. Unemployed (*Sina kazi*)

What is your total combined household income per month? (Circle most appropriate)/ *Je, kila mwezi, watu wote wanaoishi myumbani wanapata pesa kiasi gani kutoka kazi zao ukizijumuisha zote? (Chora duara kwenye jibu linalofaa)*

- a.* Kshs 0-10,000
- b.* Kshs 10,000-50,000
- c.* Kshs 50,000-100,000
- d.* Above Kshs 100,000 (Zaidi ya shilingi 100,000)

APPENDIX 8

QUALITY OF LIFE INSTRUMENT

WHOQOL-BREF (Edited)

About You

Before you begin we would like to ask you to answer a few general questions about yourself: by circling the correct answer or by filling in the space provided.

What is your gender? Male / Female

How old are you? (age in years)

What is the highest education you received? None at all / Primary / Secondary / Tertiary

What is your marital status? Single / Married/ Living as married / Separated / Divorced / Widowed

How is your health? Very Poor / Poor / Neither Poor nor Good / Good / Very Good

Do you consider yourself currently ill? Yes / No

If there is something wrong with you, what do you think it is?

Please respond to the following questions if they are applicable to you:

What is your diagnosis?

In what year did you first test get this diagnosis?

In what year do you think you fell sick?

How do you believe you fell sick? (circle one only):

Instructions

This assessment asks how you feel about your quality of life, health, or other areas of your life. Please answer all the questions. If you are unsure about which response to give to a question, please choose the one that appears most appropriate. This can often be your first response. Please keep in mind your standards, hopes, pleasures and concerns.

We ask that you think about your life in the last two weeks. For example, thinking about the last two weeks, a question might ask:

1=Not at all 2=A little 3=A moderate amount 4=Very much 5=Extremely

11 (F5.3) How well are you able to concentrate? 1 2 3 4 5

You should circle the number that best fits how well you are able to concentrate over the last two weeks. So you would circle the number 4 if you were able to concentrate very much. You would circle number 1 if you were not able to concentrate at all in the last two weeks.

Please read each question, assess your feelings, and circle the number on the scale for each question that gives the best answer

for you.

1= Very poor 2=Poor 3=Neither poor nor good 4=Good 5=Very good

1(G1) How would you rate your quality of life? 1 2 3 4 5

1=Very Dissatisfied 2=Dissatisfied 3=Neither satisfied nor dissatisfied 4=Satisfied 5=Very satisfied

2 (G4) How satisfied are you with your health? 1 2 3 4 5

The following questions ask about how much you have experienced certain things in the last two weeks.

1=Not at all 2=A little 3=A moderate amount 4=Very much 5=An extreme amount

3 (F1.4) To what extent do you feel that physical pain prevents you from doing what you need to

do?

1 2 3 4 5

4 (F50.1) How much are you bothered by any physical problems related to your mental illness?

1 2 3 4 5

5 (F11.3) How much do you need any medical treatment to function in your daily life?

1 2 3 4 5

6 (F4.1) How much do you enjoy life? 1 2 3 4 5

7 (F24.2) To what extent do you feel your life to be meaningful?

1 2 3 4 5

8 (F52.2) To what extent are you bothered by people blaming you for your mental illness

1 2 3 4 5

9 (F53.4) How much do you fear the future? 1 2 3 4 5

10 (F54.1) How much do you worry about becoming worse? 1 2 3 4 5

1=Not at all 2=A little 3=A moderate amount 4=Very much 5=Extremely

11 (F5.3) How well are you able to concentrate? 1 2 3 4 5

12 (F16.1) How safe do you feel in your daily life? 1 2 3 4 5

13 (F22.1) How healthy is your physical environment? 1 2 3 4 5

The following questions ask about how completely you experience or were able to do certain things in the last two weeks.

1=Not at all 2=A little 3=Moderately 4=Mostly 5=Completely

14 (F2.1) Do you have enough energy for everyday life?

1 2 3 4 5

15 (F7.1) Are you able to accept your bodily appearance?

1 2 3 4 5

16 (F18.1) Have you enough money to meet your needs? 1 2 3 4 5

17 (F51.1) To what extent do you feel accepted by the people you know?

1 2 3 4 5

18 (F20.1) How available to you is the information that you need in your day-to-day life?

1 2 3 4 5

19 (F21.1) To what extent do you have the opportunity for leisure activities?

1 2 3 4 5

1=Very poor 2=Poor 3= Neither poor nor good 4=Good 5=Very good

20 (F9.1) How well are you able to get around? 1 2 3 4 5

The following questions ask you how good or satisfied you have felt about various aspects of your life over the last two weeks.

1=Very dissatisfied 2=Dissatisfied 3=Neither satisfied nor dissatisfied 4=Satisfied 5=Very satisfied

21 (F3.3) How satisfied are you with your sleep? 1 2 3 4 5

22 (F10.3) How satisfied are you with your ability to perform your daily living activities?

1 2 3 4 5

23 (F12.4) How satisfied are you with your capacity for work?

1 2 3 4 5

24 (F6.3) How satisfied are you with yourself? 1 2 3 4 5

25 (F13.3) How satisfied are you with your personal relationships?

1 2 3 4 5

26 (F15.3) How satisfied are you with your sex life? 1 2 3 4 5

27 (F14.4) How satisfied are you with the support you get from your family and friends?

1 2 3 4 5

28 (F17.3) How satisfied are you with the conditions of your living place?

1 2 3 4 5

29 (F19.3) How satisfied are you with your access to health services?

1 2 3 4 5

30 (F23.3) How satisfied are you with your transport? 1 2 3 4 5

The following question refers to how often you have felt or experienced certain things in the last two weeks.

1=Never 2=Seldom 3=Quite often 4=Very often 5=Always

31 (F8.1) How often do you have negative feelings such as blue mood, despair, anxiety, depression? 1 2 3 4 5

Did someone help you to fill out this form?

How long did it take to fill this form out?

Do you have any comments about the assessment?

THANK YOU FOR YOUR HELP

APPENDIX 9

QUALITY OF LIFE INSTRUMENT – SWAHILI VERSION

DODOSO KUHUSU UBORA WA KIMAISHA

WHOQOL-Bref

Kukuhusu

Kabla ya kuanza, tungependa kukuomba ujibu maswali kadhaa kukuhusu. Chora duara kwenye jibu sahihi au jaza nafasi ilioachwa.

Jinsiya yako? Mwanamume / Mwanamke

Una miaka mingapi? (Umri wako kwa miaka kamili)

Umesoma mpaka kiwango gani? Sijasoma / Shule ya msingi / Shule ya upili / Elimu ya juu

Hali ya ndoa? Sijafunga ndoa / Niko katika ndoa/ Tunaishi pamoja / Tumewachana/ Nimepata talaka/ Nimefiwa na mke au mume wangu

Afya yako iko vipi? Mbaya Sana / Mbaya / Si Nzuri wala Mbaya / Nzuri / Nzuri Sana

Je wewe unajihisi kama u mgonjwa? Ndio / La

Kama hujihisi uko sawa, unaona shida inaweza kuwa nini?

Tafadhali jibu maswali yafwatayo kama yanakuhusu:

Umeambiwa una ugonjwa gani na daktari?

Uliambiwa una ugonjwa huu mwaka gani kwa mara ya kwanza?

Unaona ulianza kuwa mgonjwa mwaka upi?

Unaamini uligonjekaje? (chora duara kwenye jibu moja tu):

Maelezo

Hili dodoso linakuuliza vile unahisi kuhusu ubora wa maisha, afya, na sehemu nyingine za maisha yako. Tafadhali jibu maswali yote. Kama huna hakika uchague jibu gani, tafadhali chagua jibu unaloona ni sahihi zaidi. Aghlabu hili litakuwa jambo la kwanza ambalo utalifikiria. Tafadhali tafakari viwangongezi vyako, matumaini yako, vinavyokufurahisha, na vinavyokutia wasiwasi.

Tunaomba ufikirie juu ya miasha yako hizi wiki mbili zilizopita. Kwa mfano, kuzifikiria wiki mbili zilizopita, swali linaweza kuuliza:

1=Hata si kidogo 2=Kidogo 3=Kiwango cha kati 4= Sana 5=Zaidi kabisa

11 (F5.3) Unaweza kuzingatia na kufanya kazi kwa makini? 1 2 3 4 5

Chora duara kwenye nambari inayolingana vile umekuwa ukiweza kuzingatia na kufanya kazi kwa makini katika kipindi cha wiki mbili zilizopita. Kwa hivyo, utachora duara kwenye nambari 4 kama ulikuwa unaweza kuzingatia na kufanya kazi kwa makini sana. Utachora duara kwenye nambari 1 kama hukuweza kuzingatia na kufanya kazi yeyote kwa makini.

Tafadhali soma kila swali, zingatia hisia zako, na chora duara kwenye mfwatano wa nambari wa kila swali ambali linakupa jibu linalofaa kwako.

1= Mbaya sana 2=Mbaya 3=Si nzuri wala mbaya 4=Nzuri 5=Nzuri sana

1(G1) Ubora wako wa maisha unaweza kuupa kiwango gani? 1 2 3 4 5

1=Sijatosheka kabisa 2=Sijatosheka 3=Sijisikii kama nimetosheka wala sijotosheka
4=Nimetosheka 5=Nimetosheka kabisa

2 (G4) Umetosheka vipi na afya yako? 1 2 3 4 5

Maswali yanayofwata yanauliza ni mara ngapi umehisi vitu fulani katika muda wa wiki mbili zilizopita.

1=Hata si kidogo 2=Kidogo 3=Kiwango cha katikati 4=Sana 5=Sana kabisa

3 (F1.4) Kwa kiwango gani unahisi kuwa maumivu ya kimwili yanakukatiza kufanya unayohitaji kufanya?

1 2 3 4 5

4 (F50.1) Unasumbuliwa kiasi gani na shida za kimwili yanayohusiana na shida yako ya kiakili?

1 2 3 4 5

5 (F11.3) Unahitaji kiasi gani cha matibabu kuweza kuendelea na maisha yako ya kawaida?

1 2 3 4 5

6 (F4.1) Unafurahishwa kiasi gani na maisha? 1 2 3 4 5

7 (F24.2) Unahisi kwa kiasi gani kuwa maisha yako yana maana?

1 2 3 4 5

8 (F52.2) Unasumbuliwa kwa kiasi gani na watu wanaokulaumu kwa ugonjwa wako wa kiakili?

1 2 3 4 5

9 (F53.4) Unaogopa kwa kiasi gani wakati unaokuja? 1 2 3 4 5

10 (F54.1) Unahisi wasiwasi kiasi gani kuwa hali yako itakuwa mbaya zaidi? 1 2 3 4 5

1=Hata si kidogo 2=Kidogo 3=Kiasi 4=Sana 5=Sana kabisa

11 (F5.3) Unaweza kuzingatia na kufanya kazi kwa makini kwa kiwango gani? 1 2 3 4 5

12 (F16.1) Unajihisi una usalama wa kiwango gani katika maisha yako ya kawaida? 1 2 3 4 5

13 (F22.1) Mazingira yako ya kimwili yana uzima kiwango gani? 1 2 3 4 5

Maswali yanayofuata yanauliza vile ulikuwa unahisi mambo kwa ukamilifu au ulikuwa ukiweza kufanya mambo kwa ukamilifu katika muda wa wiki mbili zilizopita

1=Hata si kidogo 2=Kidogo 3=Kiasi 4=Mara nyingi 5=Mara zote

14 (F2.1) Una nguvu za kutosha kwa maisha ya kawaida?

1 2 3 4 5

15 (F7.1) Unaweza kukubali vile mwili wako unaonekana?

1 2 3 4 5

16 (F18.1) Unazo pesa za kutosha za kutimiza mahitaji yako? 1 2 3 4 5

17 (F51.1) Kwa kiwango gani unahisi wanokujua wanakukubali vile ulivyo?

1 2 3 4 5

18 (F20.1) Unapata maelezo unayohitajia kwa maisha yako ya kawaida kwa urahisi?

1 2 3 4 5

19 (F21.1) Una fursa ya kujihusisha katika shughuli za kujiburudisha?

1 2 3 4 5

1= Mbaya sana 2=Mbaya 3=Si nzuri wala mbaya 4=Nzuri 5=Nzuri sana

20 (F9.1) Unaweza kuzunguka kila mahali kwa urahisi kwa kiwango gani? 1 2 3 4 5

Maswali yanayofuata yanakuuliza kama hisia zako kuhusu mambo kadhaa ya maisha yako zimekuwa nzuri kwa kiwango gani, au umejihisi umetosheka kwa kiwango gani na mambo haya katika kipindi cha wiki mbili zilizopita

1=Sijatosheka kabisa 2=Sijatosheka 3=Sijisikii kama nimetosheka wala sijotosheka

4=Nimetosheka 5=Nimetosheka kabisa

21 (F3.3) Umetoshekaje na usingizi wako? 1 2 3 4 5

22 (F10.3) Umetoshekaje na uwezo wako wa kufanya shughuli zako za kawaida za kimaisha?

1 2 3 4 5

23 (F12.4) Umetoshekaje na uwezo wako wa kufanya kazi?

1 2 3 4 5

24 (F6.3) Umetosheka na wewe binafsi kwa kiwango gani? 1 2 3 4 5

25 (F13.3) Umetoshekaje na uhusiano wako na wengine?

1 2 3 4 5

26 (F15.3) Umetoshekaje na uhusiano wako wa kujamiiana? 1 2 3 4 5

27 (F14.4) Umetoshekaje na usaidizi unaopata kutoka kwa familia na marafiki zako?

1 2 3 4 5

28 (F17.3) Umetoshekaje na hali ya mahali pako pa kuishi?

1 2 3 4 5

29 (F19.3) Umetoshekaje na upatikanaji wako na huduma za afya?

1 2 3 4 5

30 (F23.3) Umetoshekanaje na usafiri wako? 1 2 3 4 5

Swali linalofuata ni juu ya mara ngapi umehisi au kuona mamabo fulani katika wiki mbili zilizopita.

1=Hata kamwe 2=Mara kidogo 3=Mara kadhaa 4=Mara nyingi 5=Kila mara

31 (F8.1) Umehisi hisia mbaya kama kusunoneka sana, kukata tamaa, wasiwasi, au huzuni kupita kiasi? 1 2 3 4 5

Je, mtu amekusaidia kujaza fomu hii?

Imekuchukua muda gani kujaza hii fomu?

Una maoni yoyote kuhusu dodoso hili?

ASANTE SANA KWA USAIDIZI WAKO

HANDOUT ON QUALITY OF LIFE

HOW TO IMPROVE YOUR QUALITY OF LIFE

1. Try to improve yourself everyday
2. Find out what is blocking you from being happy
3. Get enough sleep by going to bed early
4. Do some physical activity you like
5. Focus on the present moment
6. Set goals you can achieve
7. Look at situations positively
8. Be grateful for what you have
9. Let go of things you can't control
10. Write down your goals and intentions

Adapted from <http://psychcentral.com/lib/therapists-spill-10-things-you-can-do-today-to-improve-your-life/>
