KNOWLEDGE, ATTITUDES AND PRACTICES OF MENTAL HEALTH AMONGST THE SOMALI COMMUNITY: INTERVIEWS FROM GARISSA COUNTY

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DECLARATION

This research project is my original work and has not been presented for a degree in any other institution.

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This research project has been submitted for examination with our approval as the supervisors.

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DEDICATION

I dedicate this project to all the mentally ill patients in Garissa County. To every family that has a mentally ill patient and is burnt with worries and sadness, to all mental health service providers, and to every mental health teacher who strives to utilize their words to convey knowledge, empathy, experience, and values to save the patients from this bondage of pain and anguish.

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ABBREVIATIONS AND ACRONYMS

DSM	:	Diagnostic and Statistical Manual of Mental Disorders
FGD	:	Focus Group Discussion
GAD	:	Generalized Anxiety Disorder
GoK	:	Government of Kenya
HSP	:	Health Service Provider
KMPPDU	:	Kenya Medical Practitioners, Pharmacists and Dentists Union
MOH	:	Ministry of Health
NIMH	:	National Institute of Mental Health
NNAK	:	National Nurses Association of Kenya
PCG	:	Primary Caregivers
PTSD	:	Post Traumatic Stress Disorder
TH	:	Traditional Healer
UNHCR	:	United Nation High Commission for Refugees
UoN	:	University of Nairobi
UK	:	United Kingdom
USA	:	United States of America
WHO	:	World Health Organization

OPERATIONAL DEFINITION OF TERMS

Attitude: This is the feeling, behavior, regard or thinking towards mental health and patients suffering from mental illnesses.

Caregivers: Anybody who is involved in taking care of or treating the mentally ill patients at Garissa District Hospital.

Habatsawda: Traditional oil used for treating mental illness

Jinn: a Somali/Arabic word for demons and evil spirits)

Knowledge: This is the familiarity, awareness or understanding of mental health based on facts, information, descriptions, and treatments.

Musibian: A type of evil spirit

Practice: The common/natural actions carried out in treating mental illnesses.

Primary care givers: The main caregivers who were the immediate family members or relatives of the mentally ill patients at Garissa District Hospital who are always with the patients most of the time.

Sheikh: Islamic scholar

Shimar: Traditional herbs

Traditional healer: Somali Sheikhs and clan elders in Garissa who attend to mentally ill patients

Waali: Someone who is mentally ill

Zaatar: traditional herbs used for treating mental illness

TABLE OF CONTENTS

DECLARATION ii
DEDICATION iii
ACKNOWLEDGEMENTS iv
ABBREVIATIONS AND ACRONYMS v
OPERATIONAL DEFINITION OF TERMS vi
ABSTRACT x
CHAPTER ONE: INTRODUCTION 1
1.1 Background to the study 1
1.1.1 General types of mental disorders 1
1.1.2 State of mental health in the world 2
1.1.3 Specific context of Garissa 5
1.2 Problem statement 6
1.3 Chapter summary 8
CHAPTER TWO: LITERATURE REVIEW 9
2.0 Chapter Introduction 9
2.1 Knowledge surrounding mentally ill patients 9
2.2 Attitudes towards mentally ill patients 12
2.3 Practices surrounding mentally ill patients 15
2.4 Government policies concerning mental health in Kenya 17
2.4.1 Mental health service pattern 19
2.4.2 Primary care service in Kenya 20
2.5 Theoretical framework 21
2.6 Study justification 22
2.7 Specific study questions 24
2.8 Objectives of the study 24
2.8.1 Main objective 24
2.8.2 Specific objectives 24
2.9 Scope of the study 25

CHAPTER THREE: RESEARCH DESIGN AND METHODOLOGY 26
3.0 Introduction 26
3.1 Research design 26
3.2 Target population 26
3.2.1 Inclusion criteria 26
3.2.2 Exclusion criteria 27
3.3 Sample and sampling technique 27
3.3.1 Sampling procedures 28
3.4 Data collection tools and techniques 29
3.5 Reliability and validity of the study instruments 31
3.6 Data analysis methods and presentation 32
3.7 Ethical considerations 32
3.8 Limitations and delimitations of the study 33
3.9 Assumption of the study 33
3.10 Chapter summary 34
CHAPTER FOUR: RESULTS 35
4.1 Introduction 35
4.2 Demographic characteristics of the respondents 35
4.2.1 Age of the respondents 35
4.2.2 Gender of the respondents 35
4.2.3 Level of education 35
4.2.4 Duration of stay in Garissa 36
4.2.5 Duration with patient 36
4.3 Knowledge surrounding mental health disorders 36
4.3.1 Health service providers KIIs (Key Informant Interviews) 36
4.3.2 Key Informants Interviews with traditional healers 37
4.3.3 Primary care givers (PCGs) KIIs 39
4.3.4 Focused group discussion 41
4.4 Attitude of the community towards people suffering from mental illnesses 43
4.4.1 Health service providers (HSP) KIIs 43
4.4.2 Traditional healers KIIs 44

4.4.3 Primary care givers KIIs 44
4.4.4 FGD response..45
4.5 Practices Towards Mental Health Disorders..46
4.5.1 Health service providers KIIs 47
4.5.2 Traditional healers KIIs 48
4.5.3 Primary care givers KIIs 50
4.5.4 Focused group discussion 51
CHAPTER FIVE: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS53
5.1 Introduction...53
5.2 Discussion...53
5.3 Conclusion 56
5.4 Recommendations...57
REFERENCES...58
APPENDICES 68
Appendix 1: Study budget 68
Appendix 2: Study work plan 69
Appendix 3: Letter of introduction (For Garissa General Hospital)..............................70
Appendix 4: Informed consent [Primary caregivers, traditional healers & health service providers] 71
Appendix 5: Key informant interview for primary caregivers (English) 72
Appendix 6: Somali translation of the key informant interview (Primary Caregivers).....77
Appendix 7: Key informant interview - Health service providers....................................79
appendix 8: key informant interview for traditional healers..80
Appendix 9: Focus groups recruitment telephone call 81
Appendix 10: Focus group discussion topics...82
Appendix 11: Plagiarism report 83

ABSTRACT

Background: Mental disorders are a widely significant contributor to global burden of disease. Few studies have been done amongst the Somali community, leading to little empirical research that relates to knowledge, attitudes, and practices of mental illness amongst this conservative population.

Objectives: The study aimed to assess, the knowledge, attitudes and recovery-oriented practices towards people suffering from mental disorders among a group of Somali community members.

Methodology: This was a grounded theory study that employed only qualitative methods of data collection and analysis. A total sample of 24 respondents who included the primary caregivers, traditional healers (Somali Sheikhs and clan elders) and health service providers (psychiatric nurses, clinical officers, physician, nurses, social worker and surgeon) included in the study. The purposive sampling method was used to select purposively the key informants. Eight (8) Somali primary caregivers who were from the directory of Garissa General Hospital, eight (8) health service providers at the hospital and eight (8) traditional healers who use traditional remedies and practices in treating or managing mental disorders recruited from a nearby mosque at Garissa General Hospital. The populations then clustered to get the representative reach of each. The primary data collection instruments used upon consent of the respondents included both general interviews guided approach and focus group discussions between the periods of 10th April 2017 to 21st April 2017.

In the beginning, the respondents were interviewed individually as crucial informants and then later brought together in 3 separate focus group discussions, one for each group. The Nvivo software was used for data analysis and qualitative presentations in forms of direct quotations from the respondents used.

Results: The findings show that majority of the respondents believed that Jinn and evil eye as the primary causes of mental illnesses, and stated that Quran reading was an essential remedy for it. Respondents also emphasized the need for empathy and positive attitudes towards the patients.

Conclusion: Traditional beliefs regarding the causation of mental illness were widespread even among the respondents including the medical workers. These beliefs could be due to perhaps poor diagnosis and management of mental illnesses in the medical facilities that make the outcomes similar to that of patients managed by traditional healers thus reinforcing the beliefs in the latter.

Recommendation: The study recommends improvement of mental health services together with continuous psycho-education. This recommendation could change the attitudes and practices regarding mental illnesses. Further, the mental health department of the hospitals in Garissa should foster collaboration between themselves, traditional healers and the county government to improve mental health awareness in the community further. The findings also suggest that Garissa General Hospital mental health department should include voluntary counseling sessions and support groups for the primary caregivers and health service providers to build firm support, show goodwill and increase awareness among the caregivers.

Limitations: The study was limited to a small size sample of respondents at Garissa County, so the result may not be generalized to the rest of Somali community in Garissa County or at large.

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

The human traits have enthralled both the society and scientists throughout the existence of humankind. The belief concerning mental health in the past was that mental illness was the outcome of supernatural phenomena (Alexander, Franz, and Sheldon, 1966). DSM V defines mental illnesses as a condition that impacts a person's thinking, mood or behaviour and may affect their ability to relate to others and function on a daily basis. This illness covers a comprehensive range of illnesses, which differ vastly from one another concerning their signs, causes, results, and managements (American Psychiatric Association, 2013).

Mental illness also commonly known as a mental disorder can be experienced in the long-term or short-term with mild to profound intensities (WHO, 2010). The diagnosis and characteristics of mental disorders are subject to individual pre-dispositions (DSM V, 2000). Some of the major classifications of mental illnesses are depression, anxiety, schizophrenia, bipolar, mood disorder, personality disorders, autism, substance-related disorders and eating disorders. Around 20% of all patients visiting primary health centres are reported to have had one or more mental health disorders (WHO, 2001). El-Gabalawy, Katz, and Sareen (2010) opine that, although everybody experiences intense feelings of worry or unhappiness sometimes, mental disorder is present when these feelings become so overpowering that it affects the person's functionality on the day to day activities.

1.1.1 General types of mental disorders

Generalized Anxiety Disorder (GAD) is an illness characterized by fears, which are persistent, intense, and extreme (American Psychiatric Association, 2013). The disorder is quite familiar with high rates of co-morbidity. The cause of the illness is not entirely known but is considered to be caused by alterations in brain chemistry as well as heredities, worry and life experiences (Evans et al., 2008). Heredities, traumas from childhood, substance uses are some of the risk factors of GAD (Heimberg, Turk and Mennin 2004). The diagnosis of GAD mostly links to poor societal and occupational

functioning, sorrow as well as the compromised value of lifecycle (Roemer and Orsillo, 2007).

Another common mental disorder is Substance Use Disorders. These disorders occur when the continual use of drugs or alcohol leads to health and functional impairment of the person to the extent, he/she fails to meet day to day life responsibilities like work, school, or home (American Psychiatric Association, 2013). According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria (American Psychiatric Association, 2013).

Post-Traumatic Stress Disorder (PTSD) is severe and complicated mental disorder that occurs in response to overwhelming acute stress (American Psychiatric Association, 2013). Sometimes its normal to experience some forms of distress after highly traumatic events like a disaster, war or even assault, whereas the rest of people will not return to normal functioning without intervention. Individuals with PTSD develop long-term and incapacitating problems (Markowitz, Milrod, Bleiberg and Marshall, 2009).

Schizophrenia is a severe mental illness that affects how a person feels, thinks, and behaves (DSM IV-TR, 2000). Schizophrenic patients may seem to have lost touch with reality. Their ability to make sense of thoughts, feelings and the world around them is earnestly affected. A psychotic episode may involve delusions, such as false beliefs of persecution, guilt, or grandeur (Corrigan, Green, Lundin, Kubiak& Penn 2001). A subtype of schizophrenia is diagnosed depending on the predominance of the symptoms at the time of the evaluations (NINDS, 2011).

1.1.2 State of mental health in the world

Mental and behavioural dysfunctions can influence anyone from any nation or culture irrespective of gender, age, wage or societal position. The issue occurs with such regularity that it is affecting more than 25% of all people once in their lifetime (WHO, 2001). Besides, the commonness of mental illness among the grown-up populace at any given time is at about 10% (WHO, 2001). Most countries lack access to required primary mental health care and treatment, while in other countries the absence of community-

based mental health care means the only concern available is in psychiatric institutions which are associated with human rights violations (WHO, 2017). In the United States, studies show an expected 26.2 % of Americans aged 18 and older or one out of every four adults will experience the ill effects of a diagnosable mental health-related issue annually (Kessler, Chiu, Demler, & Walters, 2005). The United States categorises mental disorders as a number two disease after obesity (Insel, 2008).

A report was done in Turkey by Human Rights in Mental Health Initiative (RUSİHAK, 2013) revealed poor conditions in all of Turkey's mental disorder hospitals, where patients are forced to bathe altogether, remain isolated for days, tied to their beds and deprived of proper rehabilitation services. Additionally, a study conducted in Malaysia by Khan, Hassali, Tahir (2010) found out that, people associated mental illnesses to mystical agents, or possession by spirits. There exist two mythologies that, intellectually ill individuals are random and linked to threat and fierceness and psychiatric medication is probably likely to result in the damage to the brain as signaled by patient's abnormal expressions. This belief hampers help seeking of intellectually ill individuals (Khan et al., 2010). Thus, this denotes that they rarely seek medication.

Mental illness carried a huge stigma in the Somali community, where those with profound mental disorders are often isolated socially and discriminated against (WHO, 2010). These patients are considered less worthy, and in most cases, no respect is given to them. There is a Somali proverb that states ''the mind that is lost does not come back again easily' (Dhimir tagey dhagsi kumay imaadi) (Boynton, Bentley, Jackson, and Gibbs, 2010). Mentally ill patients are often made fun of by children who throw stones at them and apart from chaining and violence; additional human rights violations against mentally ill people include the prevention of access to their funds, properties, and inheritances (Kivalenge, 2015).

Numerous studies have indicated that attitudes surrounding causes of mental disorders may upset forms of looking for assistance, monitoring and reactions to illness management. Kabir1, Illyasu1, Abubakar1, and Aliyu (2004) found out that deficiency drives the adverse attitude concerning intellectually ill individuals in public awareness

concerning the particular type of disorder. Their findings further stated that the behavioural patterns of sick intellectually individuals seeking assistance are affected by general opinions and beliefs concerning mental illness. Policymakers list issues regarding psychological health frequently the least priority. Disease due to mental illness receives very little responsive from the government where mortality is still mostly the result of communicable diseases and malnourishment (Kabir1 et al., 2004).

Paralleled to other parts of health, mental health services in African countries are still a weakly financed area of social services (WHO, 2010). The African continent as a whole does not provide reliable, quantifiable numbers concerning the incidence of mental illness due to the absence of reliable medical records in office-based data framework (WHO, 2010). However, as indicated by Harder, Mutiso, Khasakhala, Burke, and Ndetei (2012), "All markers from the accessible epidemiological information propose that the examples and pervasiveness of mental health issues in Africa are like those found in High-Income Countries, yet that is similarly as the likenesses go."

Another study directed in Tanzania to focus learning and impression of a group about maladjustments uncovered that group information about mental sicknesses was inferior (Chikomo, 2011). There was a conviction that mentally sick individuals could not perform a consistent occupation, have companions and incorporates into the group. The religious confusion that maladjustments are brought about by sin, following a violation of God's edicts outcomes to behaviour that is destructive to person and others. Along these lines, antagonistic convictions about reasons and absence of sufficient learning have been discovered to be a key reason for adverse mentality individuals have about emotional instabilities (Chikomo, 2011). The awareness people have of mental illnesses affect the approach towards the mentally ill people. The negative stereotypes and stigmatising arrogances society have near mentally ill individuals, leads to behaviour that declines the attention of a sick individual.

Mental illness is widely misinterpreted and stigmatized in Kenya. Most relatives have slight or no information about mental illness and how to help those who are ill. The mentally ill patients are made fun of, accused and criticized for their disease (Kiima,

Njenga, Okonji & Kigamwa 2004). Kenyans, despite consisting of different cultures have the same belief that mental disorder is a curse and not an illness that is caused by witchcraft and evil spirits (USPKENYA, 2012). Access to healthcare remains hampered by poverty, political instability and corruption, and fast population growth (Ndetei, Ongecha, Mutiso, Kuria, Khasakhala & Kokonya, 2007). Prioritizing resource allocations also becomes a challenge in Kenya because of contending health primacies; infectious diseases, HIV/AIDS, malaria, malnutrition (Ndetei et al., 2007).

1.1.3 Specific context of Garissa

Garissa is one of the 47 Kenyan counties that lies in the northern part of the country and has an estimated population of 623,060; 95% of the population in Garissa is estimated to be of Somali descent, and Islam is the predominant religion (GOK, 2009). In Garissa County, just like in other parts of Kenya, health services provision is regulated by the Ministry of Health, and guided by the community health strategy (GOK, 2009), that provides for leveling of health provision. Garissa level five hospitals; a government facility sits at the top of healthcare institution in Garissa County and is naturally expected to provide the best available mental health care for the populace in that region. However, it is important to note that there is a mix of private, non-governmental or faith-based organizations that provide similar services. Data regarding the prevalence rate of mental illness in the county is not available; thus, it seems that this situation is rarely documented.

The container term for mental disorder in the Somali language is ‘waali’ translated as ‘madness’ or ‘insanity’ and used for anyone who displays violent behaviour irrespective of the basis. Key features of waali are ‘throwing stones,’ ‘screaming,’ ‘eating from dumpsters,’ ‘walking naked,’ ‘talking incessantly’ (or ‘not talking at all’) ‘crying,’ ‘losing control of yourself, loss of hygiene and aggression. There are limited comprehensive studies of the attitudes of mental and psychosocial health among the Somalis in Kenya (UNHCR, 2013). In 2010 during a survey by Handicap International among 291 people with mental disorders in the Daadab camp (Garissa, Kenya), 19% were chained at the moment of the research, and another 25% had been chained in the past (UNHCR, 2013).

1.2 Problem statement

The Somali community is an essential part of Kenyan cultures despite this, the mental health problems and pathways to proper health care for this community is still not well developed, yet it has some of the highest unreported numbers of mental illnesses in the country. This is attributed to the fact that a good number of them are post-conflict refugees who are highly vulnerable and the stigma on Kenyan Muslims especially the Somalis due to increasing terrorism and trafficking activities in the Country; The effect of war distress, social segregation, and alteration in social status make acculturation challenging. These have a significant influence on psychosocial modification. Equally important, there is a need for reconnection and addressing needs of vulnerable irrespective of their religion or beliefs (Boynton et al., 2010).

The Somali community residing in Garissa County has religious and cultural beliefs that are contrary to modern medicine (UNHCR, 2013). So it is the researcher's interest to find out how and why they prefer one treatment practice to the other, the knowledge of mental illness in Garissa among the Somali community and the stigma still surrounding this topic. This lack of mental health awareness manifests in how the communities handle those who have a mental illness, to the county government that has not factored in need to educate the public on mental health. In essence, there is a lack of awareness and sensitisation of mental health care in Garissa such that one is almost condemned when they diagnosed to having a mental disorder.

Somalis in other region believe demons, bad omen, curses or bad luck causes mental illness, and the mentally ill are ill-treated because they are seen as a shame to the family, burden or dangerous to themselves or the society. Most of them are therefore caged/chained to prevent their movement, (Kivalenge, 2015). Others are put through a Quran reading programme where the Quran is shouted into the ears severally to drive out the demons. This practice has dramatically affected such patients and most have died in the process due to this misconception (Boynton et al., 2010). Therefore, this study intended to assess how this perception has affected the treatment of these people even in the medical facilities and what can be done to improve the situation.

WHO (2014) defines health as a state of the whole physical, intellectual and social well-being and not merely the nonexistence of illness or sickness and further stating that mental health should be a societal concern rather than only for those who have a mental disorder. What are the knowledge, attitudes, and practices offered by the medical personnel at Garissa general hospital? How do this knowledge and attitudes differ from that of primary caregivers of mentally ill patients and traditional healers? Why are there few medical personnel dealing with mental health in the hospital, what are the levels of community awareness regarding mental health, and why hasn't there been affirmative action to ensure mental health patients are treated just like other patients since one does not choose to be mentally sick?

Studies by scholars such as Kiima, Njenga, Okonji and Kigamwa (2004), state that most communities in Kenya have the same belief that mental illness is not a disease but a curse that is caused by witchcraft and evil spirits. Equally, reports by USPKENYA (2012) state that mental health is an act of witchcraft, while unpublished findings by Chikomo (2011) opines that mental health is an act of nature, and the same therefore applies to Garissa.

In the Somali community, blame is placed on the mentally ill for bringing the illness upon themselves, whereas others may see mentally ill people as victims of fate, religious and moral transgressions or even witchcraft (WHO, 2011). This belief may lead to denial by both sufferers and their families with subsequent delays in seeking professional treatment. Many Somalis with mental illness are socially isolated and vulnerable (WHO, 2011). The pain of this isolation is felt intensely because Somali culture is traditionally communal and family oriented. Most often, the mentally ill are chained or imprisoned (WHO, 2001).

There are also limited comprehensive studies of perceptions of mental and psychosocial health among the Somalis in Kenya (UNHCR, 2013). Whether the community creates the ostracism or self-imposed due to anticipated negative responses, the social isolation creates a profound worsening of mental illness. This communal segregation can be very perplexing and can make the practice of recovery very problematic. In fact, even without past psychological health complications, isolation from community alone can contribute

to the development of depression. The researcher therefore, aimed to investigate; the knowledge, attitudes among Somali caregivers, health service providers and traditional healers regarding the etiology and practices of mental illness in Garissa County? Why does the community treat the sick inhumanly by even coining a name for them (waali)? There seems to be little or lack of data regarding the state of mental health in Garissa, how possible is it to treat a disease without data, why hasn't data been collected? What is happening in Garissa level five hospitals regarding mental health care? Empirically, there seems a disconnect regarding general healthcare in Garissa level five hospital, to mental healthcare thus the need to assess the knowledge, attitudes, and practices of mental health amongst the Somali community: Interviews from Garissa county.

1.3 Chapter summary

Chapter one of this study on the knowledge, attitudes, and practices of mental health amongst the Somali community: Interviews from Garissa county has presented the background of the study, statement of the problem and research objectives.

CHAPTER TWO

LITERATURE REVIEW

2.0 Chapter Introduction

This chapter presents the literature review, which explores studies that undertake the empowerment groups' realm, the theoretical framework, study justifications, study questions, objectives of the study, the limitations and the scope of the study. According to Mugenda and Mugenda (2003), literature review involves systematic identification, location, and analysis of documents containing information relating to the research problem investigated. Moreover, literature review helps determine new approaches and stimulates new ideas.

2.1 Knowledge surrounding mentally ill patients

Mental disorders are broadly recognized as a critical contributor (14%) to the global burden of disease worldwide (WHO, 2004). Poor mental health is linked to sudden social change, societal segregation, unhealthy lifestyle, stressful work conditions, physical ill health, and human rights violations (WHO, 2016). Although some nations have been prosperous in fighting stigma and increasing acceptance of the mentally ill, lack of awareness is very evident in developed and developing countries. Mentally ill people are labeled as "different" from other people and are viewed negatively by others (Wynaden et al., 2005; El-Gabalawy et al., 2010).

Knowledge about mental disorders set the stage for how one interacts with and support an individual with mental illness. People's beliefs and attitudes concerning mental disorders similarly frame how they understand and express their emotional problems and psychological distress and whether they disclose these symptoms and seek care. About one in four U.S. adults (26.2%) age 18 and older has a mental disorder (mood disorder, anxiety disorder, impulse control disorder, or substance abuse disorder) (Kessler, Chiu, Demler & Walters, 2005), implicating that mental disorders are common and can affect anybody.

Approximately 44 % of the Nigerian study participants had a severe level of self-stigma with the corresponding magnitudes amongst Ghanaian and Kenyan participants being 20.7 and 37.5 %. 33.3 % of the participants who stated low self-stigma reported supernatural attribution, 70 % of the respondents with the peak level of self-stigma described supernatural attribution within the three sites. While low scorers attributed supernatural causality, it was often with a religious emphasis (Makanjuola, Esan, Oladeji, Kola, Appiah-Poku, Harris & Othieno, 2016).

Whether stigma is experienced as societal barring or discrimination, it can be unbearable for people and creates a problem for public health prevention efforts. Diverse attitudes exist concerning the consequences of different labels related to describing mental illness (Sayce, 2000). The prevailing view of health-related stigma is that it refers to seeming or expected avoidance or social exclusion, and not to an individual imperfection or mark (Weiss, Ramakrishna & Somma, 2006).

Despite centuries of learning, mental disorder is still alleged as a symbol of weakness. Stigmatization has been well defined, and there are many individual explanations of psychiatric illness, where shame supersedes even the most extreme of symptoms (Weiss et al.,). The stigma of mental disorders, although more often related to a situation than to a person's appearance remains a powerful negative attribute in all social relations. Concerning social stigma, Crisp, Gelder and Rix Meltzer (2000) suggests that stigmatising attitudes towards people with mental illnesses are widespread.

In a survey of more than 1700 adults in the UK, Cirsp et al. (2000) found that the most generally held belief about mental health patients is that, they were very unsafe to be around, in particular, schizophrenia and alcohol/ drug related patients. Secondly, the survey also stated that people believed that some mental health disorders such as eating disorders and substance abuse were self-inflicted, and thirdly respondents believed that people with mental health problems were hard to engage within a conversation. People managed to hold these unconstructive beliefs irrespective of their age, nevertheless of what knowledge they had of mental health problems, and regardless of whether they knew somebody who had a mental health problem (Crisp et al., 2000). More current

findings of attitudes to persons with a diagnosis of schizophrenia or major depression convey similar results. In both cases, a substantial number of members of the community considered that individuals with mental disorders such as depression or schizophrenia were irregular, unsafe and they would be less likely to hire somebody with a mental health problem (Wang & Lai, 2008; Reavley & Jorm, 2011).

Stigma and discrimination linked to schizophrenia were found to have a significant impact on the lives of individuals from a study investigating patient's perceptions of stigma in India. 97% of the participants reported that stigma was caused by a shortage of knowledge about schizophrenia, whereas 73% of the participants believed stigma was by the nature of the illness itself (Shrivastava, Johnston, Thakar, Sarkhel & Sunita, 2011).

Behavioural symptoms linked with schizophrenia were also believed to cause stigma, whereas drug-related problems were seen as playing a less powerful part in stigma. Sixty-nine percent of patients feel that stigma comes from attitudes from the general community, 46% from co-workers and 42% from family members (Shrivastava et al., 2011). Rural areas are affected more by the requirement for mental health care because of limited mental health resources (Auditor General Victoria, 2002). This has caused rural general hospitals having higher rates of admittances of people with mental disorders (Australian Institute of Health and Welfare, 2014).

Research conducted in urban areas has found that many nurses responsible for care feel unprepared to support mental health needs, and have negative attitudes to caring for people with mental health problems (Brinn, 2000). The necessity to investigate how attitudes affect nursing care has been identified from results that negative attitudes lead to social isolation that decreases the ability to provide adequate care (Corrigan et al., 2001). King, Judd, and Grigg (2001) found that general health professionals report poor knowledge and absence of support, and the necessity for continuing support and education to provide adequate care.

2.2 Attitudes towards mentally ill patients

Personal knowledge about mental illness shapes the attitudes and beliefs. When such attitudes and beliefs are conveyed positively, they can lead to empathetic behaviours (e.g., employing a person with mental illness). When such views and opinions are expressed negatively, they may result in prevention, segregation from everyday doings, and, in the worst-case mistreatment and discrimination (Corrigan et al., 2004).

Stigma has been described as a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses. Stigma leads to social exclusion or discrimination. Moreover, stigma results in unequal access to resources that all people need to function well educational opportunities, employment, a supportive community, including friends and family, and access to quality health care (Kessler et al., 2005). These types of disparities in education, employment, and access to care can have cumulative long-term negative consequences.

Stigma remains a dominant negative feature in all social relations. It is considered a union of 3 linked glitches: absence of knowledge, negative attitudes, and elimination or evasion behaviours. Persons who are branded as mentally ill associate themselves with society's negative notions of mental illness and that society's contrary responses contribute to the frequency of mental disorder (Corrigan et al., 2004).

A study in Australia has investigated the attitudes of psychiatric hospital staff toward hospitalization and treatment of patients with a borderline personality disorder (Bodner, Cohen, Mashiah, Segal, Grinshpoon, Fischel & Iancu 2015). Apparently, according to Bodner et al. (2015), nurses and psychiatrists described meeting a more significant number of borderline personality disorder patients through the previous month and displayed more undesirable feelings and less compassion to these patients compared to psychologists and social workers. The whole sample evaluated the decision to hospitalize a patient with a borderline personality disorder as less necessary than the choice to hospitalize a patient with Major Depressive Disorder. Nurses were willing to study short-term methods for treating patients with BPD, and a minor fraction of psychiatrists

expressed a relevance in enhancing their professional practices in managing these patients (Bodner et al., 2015).

Although numerous Western countries have practiced the deinstitutionalization movement, some major psychiatric institutions still exist in countries like Taiwan (Chang, Heller, Pickett, & Chen, 2013). The responsibilities for the care of mentally ill patients fall unto the staffs working in these psychiatric institutes. Therefore, the attitudes of these hospital staff members toward people with mental illness significantly impact the lives of these residents.

Now, recovery-oriented services are the universal trend in the field of mental health, and supportive attitudes of service providers are necessary for recovery-oriented services to be successful (Chang, Heller, Pickett, & Chen, 2013; Mead & Copeland, 2000; Smith, 2000). The study further stated that the attitudes of mental health professionals toward people with mental illness are essential for recovery, but they indicated that this is a neglected topic. People who are older or have lower educational levels tend to demonstrate more negative attitudes (Smith, 2000).

Some studies have reported that people who have received mental health training or have sufficient knowledge about mental illness tend to have relatively positive attitudes (Mann & Himelein, 2004). Nevertheless, other studies have also found that health professionals who have received related training did not exhibit better attitudes than other non-professional employees (Aydin, Yigit, Inandi, & Kirpinar, 2003; Nordt, Rossler, & Lauber, 2006).

Contact experience is viewed as a decisive factor. People having the previous contact with people with mental illness tend to have positive attitudes (Corrigan et al., 2001). Furthermore, previous studies have also found that the condition of people with mental illness significantly influences people's beliefs (Ojanen, 1992). Namely, if people with mental illness manage their symptoms appropriately and maintain their daily functions, they will be more likely to experience more friendly attitudes and receive more support. However, these factors may differ with each other and have different effects in different cultures or populations.

A U.S study stated out that only about one fourth agreed that individuals are kind and compassionate to persons with mental illness (Kobau, DiIorio, Chapman & Delvecchio, 2010). In another study, when people were asked about how much it would cost to avoid mental illness compared to common medical diseases, the public was less prepared to pay to avoid mental health treatment than they were to pay to prevent physical health treatment (Smith et al., 2012). These studies provide valuable snapshots of attitudes toward mental illness across the country; however, studies that examine attitudes in depth such as distinguishing between attitudes relative to perceived or experienced stigma, studies that link attitudes to actual behaviour, or findings that track attitudes concerning mental illness at the state level do not happen regularly. These short, cross-sectional reports tell us little about how perspectives change with historical events.

Factors that are linked with social space in the overall populace towards adults with mental illness are gender (Phelan & Basow, 2007) and perceiver (a person who desires social distance) (Hinkelman & Haag, 2003; Marie & Miles, 2008; Phelan & Basow, 2007). Scholars Marie & Miles 2008; Phelan & Basow (2007) have found that women incline to be more agreeable than men to involve in a relationship with somebody diagnosed with depression.

Marie and Miles (2008) examined understanding of the perceiver with numerous mental illnesses. A significant primary outcome was found for gender, with women perceivers rating the characters in vignettes as more dangerous than male participants (Marie and Miles, 2008). Phelan and Basow (2007) found that gender of the target character was a substantial judge of social distance, with female targets being more socially accepted than male targets. This may be because participants perceive male characters in vignettes as more dangerous than female characters. Hinkelman and Haag (2003) also have assessed how gender and adherence to strict gender roles impact attitudes toward mental illness.

Persons with rigid gender roles were less prone to have positive attitudes. Thus, gender only did not justify for differences in beliefs; instead, it was gender roles that related to attitudes towards mental illness. Researchers have suggested that stigma also exists among mental health professionals (Lauber, Anthony, Ajdacic-Gross, & Rossler, 2004;

Nordt, Rossler, & Lauber, 2006). Lauber et al. (2004) established no significant disparities amongst psychiatrists and the overall population on their favoured social distance from persons with a mental illness. Both psychiatrists and the total population specified that the closer the psychological proximity (e.g., allowing the person with mental illness to marry into their family compared to working with someone with a mental illness), the more social distance they desired (Nordt et al., 2006).

The procedure of reconnecting with the earth is a critical part of the time spent on mental recuperation. This is because individuals determined to have mental illness frequently feel desolate and need help from others. To recoup from emotional sicknesses, they need to augment a progression of reconnections with others when looking for support and social backing. Janzan, Nelson, Hausfather and Ochocka (2007) stressed the procedure of reconnecting with nature in a winding model of mental recuperation, and contend that people in recovery need to reconnect and arrange their place inside of the earth to encourage their recuperation. Equally necessary, other steps in overcoming mental health stigmas include the patients' seeking treatment, not allowing stigma to create self-doubt and shame to the patients', speaking out against the stigma, educating people about mental illnesses, learning about mental illnesses, creating support groups and joining them to name but a few.

2.3 Practices surrounding mentally ill patients

Humiliation linked with accessing mental health services is one of the many fences that cause people to hide their symptoms and to stop them from attaining required management for their symptoms (U.S. Department of Health and Human Service 1999; 2001; Greene-Shortridge et al., 2007; Nadeem et al., 2007). Stigma poses a barrier for public health primary prevention efforts designed to minimise the onset of mental illness, as well as with secondary prevention efforts aimed at promoting early treatment to prevent worsening of symptoms over time (Weiss, Ramakrishna and Somma, 2006).

Stigma can also interfere with self-management of mental disorders (tertiary prevention) (Sirey et al., 2001). Untreated symptoms can have grave consequences for people living with mental illness and negatively impact families affected by these disorders. For

example, most people with severe and persistent mental illness are unemployed and live below the poverty line, and many face significant barriers to obtaining decent, affordable housing (U.S. Department of Health and Human Services, 1999).

Stigma about mental illness can lead people to fear to disclose that they have mental health problems, which may prevent treatment and recovery. Stigma can also result in limited life opportunities. Stigma poses barriers to public health prevention efforts designed to the onset of the mental disorder and the prevention or deteriorating of symptoms over time (Sirey et al., 2001). Stigma can lead to lower prioritisation for public resources allocated to mental health services and more inferior quality of care delivered to people with mental illness (Greene-Shortridge et al., 2007).

Attitudes toward mental illness can also influence how policymakers allocate public resources to mental health services, pose challenges for staff retention in mental health settings, result in poorer quality of medical care administered to people with mental illness, and create fundraising challenges for organizations who serve people with mental illness and their families (Kadri and Sartorius, 2005; Pescosolido et al., 2010; Stuart, 2005). People's attitudes and beliefs predict their behaviour thus their beliefs and attitudes about mental illness might predict whether they disclose their symptoms and seek treatment and support (Ajzen & Fishbein, 1980).

Knowledge and ideas that can aid in the recognition, management, or prevention of mental health disorders are defined as mental health literacy (Jorm et al., 1997). Tracking attitudes toward mental illness can serve as an indicator of the public's mental health literacy. For example, in a 1996 study, 54% of the U.S. public attributed significant depression to neurobiological causes, and this increased to 67% in 2006 (Pescosolido et al., 2010). Similarly, a more significant percentage of people endorsed the benefits of treatment by a physician for people with major depression in 2006 (91%) than in 1996 (78%) (Pescosolido et al., 2010). However, improvements in neurobiological understanding of mental illness were unrelated to negative attitudes and in some cases increased the odds of adverse beliefs (e.g., need for social distance, perceived dangerousness).

There is lack of psychological health care and management in most countries (WHO, 2008). In others, the lack of community based mental health care means the only concern available is in psychiatric institutions that are associated with inhuman and degrading treatment and living conditions. Mentally ill patients are excluded from community life and denied fundamental rights such as housing, employment, education and shelter due to their mental disability (WHO, 2008). Many are deprived of the right to vote, marry and have children. As a consequence, numerous people with mental disorders are living in extreme poverty that in turn, disturbs their capacity to benefit access to proper care, mix into society and recuperate from their illness (UN, 2008).

In one study done in India, it stated that the duration of untreated disease from first psychotic illness to neuroleptic treatment in schizophrenia was 796 weeks (Tirupati, Rangaswamy & Raman, 2004). Numerous people who might benefit from these services do not obtain them or do not fully adhere to treatment routines once they have begun. Treatment adherence plays a vital role in psychiatric rehabilitation, however poor adherence to medication and psychosocial treatment is frequent among individuals with schizophrenia, which upturns their likelihood of relapse and re-hospitalisation (McCann, Boardman, Clark & Lu, 2008).

Equally important, a study done in Kenya by Jenkins, Othieno, Okeyo, and Aruwa (2013) found out that health workers reported the primary caregivers of mentally ill patients, take the patients to the church than to the hospital, since the mental illness was attributed to demons. Health workers further stated that stigma was a significant problem, and mental illness was more stigmatized than HIV/AIDS (Jenkins et al., 2013).

2.4 Government policies concerning mental health in Kenya

A Mental Health Policy provides a framework for interventions for securing mental health in Kenya. Mental health is a significant determinant of the general health and societal well-being. The realism of mental illness across the nation and the predicament of individuals who have mental illness cannot get ignored. The rule was established as an outcome of an amplified need for mental health services and evidence-based interventions (GOK, 2011). The government recognises that the health of the individuals

is a national priority and that it has the accountability of warranting that psychological health forms part of the federal and local agenda. The policy seeks to reform mental health system in Kenya to address the systemic challenges, developing trends and mitigate the weight of mental disorders.

The policy also pursues to service the Mental Health Act, Cap 248, which is the primary legal framework for mental health, (GOK, 2011). This policy is anchored on other related policy and legal reforms that have set the national direction in the health sector. Fundamental among them is the Constitution of Kenya, the Kenya Vision 2030 and the Kenya Health Policy (2012-2030). Also, the policy borrows from international evidence-based best practices. The Mental Health Policy is a federal obligation to pursuing policy channels and plans to attain ideal health status and capacity of each.

This policy recognizes that the goal of realizing mental health is the responsibility of every person and every sector whether public or private. The system acknowledges that the government has the responsibility to take care of persons with mental illness and promote mental health in the country. No person with a mental illness or disorder in Kenya should live without care and support (Ndetei et al., 2011).

A comprehensive and multi-dimensional approach to mental health interventions is fundamental (Ndetei et al., 2011). People with mental disorders have the capability of living productively within their communities. Whereas psychological health policy interventions are broad and cutting across a diverse sector, the mental health policy is primarily a health policy. Consequently, the focus and emphasis are on health policy interventions (GOK, 2011).

Mirroring several international and regional treaties that Kenya has ratified, Article 43(1)(a) of the Kenyan Constitution protects the right to the maximum possible standard of health. Definite in line with the global law, this incorporates both physical and mental health. The right to health is a comprehensive right that includes the liberty to regulate one's health and body, as well as rights; to amenities, goods, services and conditions favorable to the awareness of the uppermost achievable standard of health. These liberties and rights place similar duties on the Government to respect, defend and accomplish the

right to health, as reflected in Article 21(1) of the Constitution (Ministry of health, 2016). Director of mental health Kenya noted that mental health is a crucial determinant of overall health and socioeconomic development and since psychological health interventions cut across other sectors, a multidisciplinary and inter-sectoral approach is vital (Ministry of health, 2017).

The United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care elaborate on such entitlements in the context of mental health and include the rights: to the best available care; to be treated with humanity and respect; to protection from exploitation, abuse and degrading treatment; to the same level of care as for physical illness; to community integration; to periodic review of treatment; to liberty; and to access information.

2.4.1 Mental health service pattern

The health service is broadly designed into six categories: "the national referral hospitals also commonly known as level 6, provincial general hospitals (level 5), district public hospitals (level 4), health centers (level 3), dispensaries (level 2) and volunteer community health workers (level 1)" (Jenkins, Kiima, Okonji, Njenga, Kingoro & Lock, 2010). The Ministry of Health was divided into two ministries in 2008, that is the Ministry of Medical Services which is accountable for health delivery at national, provincial and district level, and the department of public health and sanitation which is responsible for health delivery in health centers, dispensaries and the community.

Budgets were now decentralized to local district councils from MOH as part of treasury reorganizations. Parting the MOH with its essential purposes of program forming, law preparation, values and rules for service conveyance, directive, routine supervising and assessment, funds sourcing and mobilisation (Jenkins et al., 2010). However enormous inadequate resources for mental health still remain, and planned support is essential for sufficient prioritizing of mental health in every region and jurisdiction It is important to note that there had been no mental health epidemiological studies at household level in Kenya.

Evaluation of the status of mental health services in the country by the Ministry of Health reconfirmed that the country's health care system operates under extremely resource-restricted conditions, regarding infrastructure, workforce and finances. Mental health specialist care is primarily delivered at the district level by psychiatric nurses running outpatient clinics, by psychiatric nurses at provincial levels running inpatient units and outpatient clinics, and by the national referral hospitals at Mathari, GilGil hospital and Moi University (Jenkins et al., 2010).

The University of Nairobi in Kenya provides training programs for Psychiatrists, thus producing around six new psychiatrists annually, and the statistics have extended from 16 psychiatrists in the public service in 2001 to 46 in 2009. Also, 24 psychiatrists are working in private practice (Ministry of Health, 2016). Accordingly, majority of the psychiatrists are in Nairobi and that the operating psychiatrist-population ratio outside Nairobi is one psychiatrist per province of 3-5 million people. North Eastern Province currently has no psychiatrist or psychologists. This shortage of human resource and the continued inadequate funding of mental health services both harshly restrain access to professional care, and this state will quickly get poorer lest urgent action is taken to train additional psychiatric nurses (Jenkins et al., 2010).

2.4.2 Primary care service in Kenya

Level 2 and Level 3 are staffed with general nurses and clinical officers who have minimal training about mental health but have not until now received detailed training in diagnosing and treating mental disorders (Jenkins et al., 2010). These staffs identify and provide treatments for psychotic patients that are comparatively noticeable even to untrained people. These staff may also refer very complicated cases of psychosis to the district level if transportation and amenities are accessible. Disorders such as depression or anxiety are misdiagnosed, or proper management is provided despite their commonness, due to lack of appropriate knowledge and understanding on its symptoms by the primary caregivers (Jenkins et al., 2010).

During the situational appraisal in 2012 in the country, the amount of critical psychotropic drugs did not meet requisite requirement. Due to this scarcity of medicines in health care facilities, patients and their families had no choice but to either buy their own medicine or go without them. KEMSA has supplied the dispensaries and health centers with drug kits but the psychotropic drugs delivered have not been enough. In 2007, level 4 and five hospitals were the only hospitals provided with antidepressants while other levels were supplied with chlorpromazine, diazepam and phenobarbitone (Jenkins et al., 2010). Even though the new policy set in 2008 made antidepressants accessible at fundamental care level, past lack of antidepressants at health center level has resulted in the widespread but inaccurate prescription of diazepam, which is not useful for psychological complications and is incredibly addictive (Jenkins et al., 2010).

2.5 Theoretical framework

Scientific research of attitude has determined the overall connection between mentality and behaviour. Though attitude is not observable and hence, demanding to be defined, it is essential to study and understand attitudes because 1) Attitudes guide our thoughts, 2) Attitudes influence our feelings, and 3) Attitudes affect behaviour (Myers, 1990, p.90 cited by J.E., Bullock, 2002). The structural model of attitude that will be used in this research is the Theory of Reasoned Action (TRA). A theory developed by Fishbein (1980), which is based on the idea that the proximal cause of behaviour is the intention to behave, which is caused by attitude and subjective norms.

Fishbein further states that attitude targets the person’s opinion about whether the behaviour is positive or negative, and a subjective norm targets the person’s perception of social pressures from significant others to perform the actions they ought to do. Beliefs determine attitudes and subjective criteria about the consequences of the work and feelings about the opinions of specific importance to others.

The TRA model shapes on a past of attitude research that transpired in three phases: 1) issues of measurement and relation to behaviours; dynamics of specific attitude alteration; and 3) understanding the organization and purpose of attitudes (Hogg & Terry, 2000).

Other scholars have backed to the growth of the TRA model by adding the principle that behaviour can result from less intentional processes such as previous behaviour, habit, and perceived behaviour control (Bentler & Specart, 1981). However, Fishbein (1980) and Bentler & Specart (1981) have demonstrated numerous times that the two critical components in determining behaviour are attitudes and subjective norms. According to Trafinow and Fishbein (1994), in the TRA model, most actions can be categorized under attitudinal control (AC) and to a degree of normative power for most people. Trafinow and Fishbein go on to state that attitudes are global judgments about behaviour (positive or negative), and subjective norms are the target person's judgments about what others who are essential think he or she should do. Bagozzi, Baumgartner, & Yi (1989) conducted a study demonstrating that action-oriented people have higher tendencies toward attitudinal control.

2.6 Study justification

The study specifically focused on the Somali community in Garissa County and not any other community in the area because of the prevalence of mental health problems among the Somali population, which are not recognized. Anecdotal reports from media, families, religious institutions and civil society suggest the prevalence of mental health problems, but there is lack of adequate data on mental health problems, level of knowledge, attitudes and practices among the Somali community in Garissa through empirical research to allow for comprehensive intervention to mitigate the issues.

Equally important, the community has been profoundly affected by the Alshabaab tag (being framed as an Alshabaab just because of being a Somali) in the recent years, which then complicates the way they interact with other communities, and adds onto their vulnerability to mental disorders such as anxiety disorders and depression.

Furthermore, there is undocumented high level of illiteracy and lack of awareness concerning mental health issues among the Somali Community (World Bank, 2014) in which they prefer traditional medication as opposed to the hospital when treating mental disorders. This has led to the loss of many lives of the patients, escalation of the symptoms while others are taken to the hospital when it is already too late, being left to

loiter in the world without anyone to take care of them or being chained in their homes to prevent harm and attacks.

Another factor that makes these patients suffer most is because most of the members of the community believe that these are conditions caused by demons and in some instances subjects the patients to very hostile situations such as being caged or being caged together with a hyena that is believed to bite the patients and take the demons out.

Despite the high prevalence of mental health patients in Garissa County, and in the whole of North Eastern Province, there is no psychiatrist or Psychologist present in the general hospital, thus posing an extremely challenging environment for the mentally ill patients. This study aims to establish the magnitude of mental health problems, level of knowledge, attitudes and practices regarding mental health care among the Somali community in Garissa County.

This study also intended to help the healthcare professionals in the County take a keen interest on mental health patients, as these are conditions that can be managed if diagnosed on time and the right treatment regime adopted. Further, the study aims to highlight the need for policy change regarding mental health care in Garissa County, the importance of an increased level of knowledge, attitudes and practices amongst caregivers, traditional healers and health service providers on mental health. The study further highlights the need for the hospital to provide both physical and social infrastructure regarding mental health.

Finally, this study will aid the policymakers to formulate better responsive policies that will enable adequate budget allocation, proper staffing and procurement of medical equipment, medical supplies, and community sensitisation in Garissa County. For the academicians, this study highlights on the mental health epidemic among the conservative Somali community, emphasizing on the data (knowledge, attitudes and practices for caregivers, traditional healers and health service providers) for further studies in this area.

2.7 Specific study questions

The following specific questions guided this exploratory qualitative study

i. What is the level of mental health knowledge, attitudes and caring practices of Somali primary caregivers of Somali people with mental illness?

ii. What level of mental health knowledge and professional attitudes and practices are demonstrated by health service providers towards Somali patients who have mental illness in Garissa hospital?

iii. How does this knowledge, professional attitudes and practices differ from those demonstrated by traditional healers towards mental illness in Garissa?

2.8 Objectives of the study

2.8.1 Main objective

The study aimed to describe the mental health knowledge, attitudes and practices adopted by primary caregivers, health service providers and traditional healers in the Somali community in Garissa County.

2.8.2 Specific objectives

The specific objectives were:

i. To explore the knowledge of mental health by traditional healers, health service providers and primary caregivers in Garissa County.

ii. To establish the attitudes of the traditional healers, health service providers, and primary caregivers towards people suffering from mental illnesses in Garissa County.

iii. To investigate the beliefs of the community towards people suffering from mental illnesses at Garissa County

iv. To determine the practices of the traditional healers, health service providers and primary caregivers towards mental health disorders in Garissa County.

v. To compare the knowledge, attitudes and practices of traditional healers with that of health service providers and primary caregivers.

2.9 Scope of the study

The study assessing mental health care among the Somali community in Garissa County focused on determining the levels of knowledge, attitudes and practices of persons who get into contact with mental health patients at family or medical facilities. This study was conducted in Garissa level five hospitals during 10th April 2017 to 21st April 2017and reached only the personnel at the facility within that period. The study further put into consideration the applicable government policies and ascertained the implementation levels at Garissa hospital.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.0 Introduction

This chapter presents the research methodology used in conducting the study describing the research design, location of the study, target population, sampling procedures, sample size, data collection instruments, the procedures employed for data collection and analysis. This study covered a period of one year from February 2017 to February 2018.

3.1 Research design

This was a grounded theory study that employed only qualitative methods of data collection and analysis.

3.2 Target population

There were three types of population in this study;

i. The Somali primary caregivers who were the immediate family members of mentally ill patients treated at Garissa District Hospital
ii. The health service providers who were the medically trained personnel at Garissa District Hospital
iii. The traditional Somali healers who were the custodians of traditions and respected by the community due to their role in dealing with matters affecting the communities including mental health problems.

3.2.1 Inclusion criteria

Population one: Primary care givers

These were the brothers, parents, sisters, cousins or guardians of Somali patients who have a mental illness.

Population two: Health service providers

Psychiatric nurses, medical officers, nurses, surgeons in Garissa District Hospital.

Population three: Traditional healers

Somali Sheikhs in Garissa who attend to mentally ill patients.

3.2.2 Exclusion criteria

Population one: Primary care givers

Those primary caregivers of persons suffering from mental illnesses and are not of the Somali Community.

Population two: Health service providers

Medical personnel not employed at Garissa General Hospital.

Population three: Traditional healers

Those sheikhs who are not of Somali descent and do not treat patients with mental illnesses, and that don't reside in Garissa County.

3.3 Sample and sampling technique

Purposive sampling that is suitable for a qualitative experiential study was sought. The study sampled the respondents according to the target population size for each population. The first sample was drawn from population one of the primary caregivers and estimated at eight respondents from the hospital directory. The second was drawn from the health service providers and estimated at eight respondents at Garissa General hospital departments. This consisted of the nurses, medical officers, psychiatric nurses, gynecologists, and surgeon. Then the third study population included eight respondents (Sheiks and clan elders) from the mosque. These respondents were chosen because the Sheiks and clan elders have a deep understanding of the history of the Somali Community and all the happenings including trends in the treatment and management of mentally ill patients. Therefore, the total sample was 24 distributed as shown in table 3.1.

Table 3.1: Sample size distribution

Population type	Size
Primary Care Givers	8
Health Service Providers	8
Traditional Healers (Sheikhs/ Clan elders)	8
Total	**24**

3.3.1 Sampling procedures

Under primary caregivers, purposive sampling was used to choose Somali families with patients who have mental illness found from the hospital directory. For health service providers, stratified purposive sampling was also used to determine the general staff at the hospital, and then picked from the staffing records from the records office at Garissa General Hospital.

For traditional healers, stratified and purposive sampling technique was also used to choose Sheikhs from the mosques where the first mosque was the baseline, and then the researcher bypassed the next three mosques and selected on the fourth and the same process used until eight (8) Sheiks were chosen to take part in the study. The Sheikhs were used in this study because they use traditional remedies or practices in treating or managing mental disorders.

First three (3) clan elders were picked through snowball sample technique where the researcher used members of the community who are well conversant with the orientation, geographical and trends on happenings in the area. The members' chosen assisted the researcher to select the remaining five (5) clan elders who can give more reliable information based on the purpose of the study.

3.4 Data collection tools and techniques

The study used qualitative data collection tools, which are general interview guided approach and focus group discussions on getting data from the respondents (Somali Primary caregivers, Health Service providers and traditional healers (Sheiks and Clan elders). Before the interview, an outline of issues to be explored was listed. The study was conducted by making numerous visits to Garissa General Hospital and the Mosques thus consulting widely on the respondent's role and the need to take part in the study. After the formal introduction was done and a rapport was established, the researcher scheduled various dates with the identified respondents under this category to collect the data by interviewing them.

The interview schedules were used to get data from the primary caregivers and health service providers. The schedules were conducted in the Garissa hospital during working hours on weekdays and preceded by introductory sessions where the purpose of the study was explained to the respondents, their consent to take part in the study sought and dates for interviews fixed. After that, the interview was conducted as agreed and the recording of the data from the key informants and interviews involved both writing and recording. After that, the researcher went to different mosques consulting widely about Somali sheikhs and Somali clan elders who provided treatments to mentally ill patients in the community.

Once the potential participants were established, their availability confirmed, an appointment was then provided depending on their availability. The interview took place at the mosque, and most preferably during morning hours because of the weather in Garissa. Recording of the data from the sheikhs/clan elders involved both tape recording and writing. 24 key informants consisting of primary caregivers (also translated in the Somali language for language barrier purposes), Health Service providers and traditional healers were interviewed. Interviews were done individually. All interviews varied in length from 30 mins-45 minutes respectively.

Finally, the researcher conducted three (3) separate Focus group discussions, where unstructured questionnaires depending on the theme derived from the key informants' interviews were used to obtain data from the three respondents (Primary caregivers, health service providers, and traditional healers) of the study. The three separate Focus group discussion were divided as such, one for primary caregivers, the 2nd for health service providers and lastly the traditional healers where they discussed their knowledge of mental illnesses, attitudes towards people suffering from mental illnesses and their practice-oriented methods in seeking or treating these mental disorders. The respondents used in the focus group discussions were the same respondents the researcher used in the interviews. The reasons being, this helped in deepening the understanding of the phenomena and clarifies the issues that might have come up during the in-depth interviews with the same people, and with diverse contributions on the matter. The same respondents approach also ensured a less intimidating approach since they were already familiar with the study being discussed and the researcher, hence maintaining the momentum of the study.

Once the potential participants were established after the key informant interview, time and locations of the focus group discussion were provided, and a verbal confirmation was secured. The researcher gave them a call two (2) days before the focus group discussion date confirming their availability and interest again. In this study, a room was secured at Garissa general hospital for three (3) different dates for the three (3) separate focus group discussions. After their consent to take part in the study established, they were asked the questions as per the themes derived from the key informant interviews and their responses recorded by the researcher.

Equally crucial for the general interview guided approach and focus group discussions for both traditional healers and primary caregivers, the interviews were conducted in either English or Somali language. The choice of this language in the interview was based on the literacy level of the population. For population two, Health service providers, the study was conducted in English language. This is informed by the fact that they are literate and for more in-depth analysis towards the research. All the interviews were recorded and fully transcribed.

The researcher provided compensation of Ksh five hundred (500) to each participant during the focus group discussion, reason being, these participants (traditional healers, primary caregivers, and health service providers) were taking time from their schedule to come and participate in the FGD. This compensation also served as transport reimbursement for that day. However, the researcher did not provide compensation during the in-depth interview. No payment was made because the researcher approached the primary caregivers and the health service providers at the hospital during clinic hours, and the traditional healers at the mosque; water and soft drinks were however provided for both interviews as it can get hot and having a drink during a lengthy discussion made participants comfortable.

In the event of psychological distress, the researcher would be seeking the assistance of the department of mental health/psychiatry at the Garissa hospital for any further referral; this was not experienced. As a clinical psychologist in training, the researcher also after each Focus group discussion or individual interview asked the participants for their feedback and enquired if there were any distressing thoughts or feelings and tried to address these and provide a referral to Mental Health services on the ground. During this time, the researcher kept her supervisors abreast of all such developments and took guidance from them.

3.5 Reliability and validity of the study instruments

The researcher first conducted a pilot study in one of the communities within the county, which is Medina Hospital in Garissa County where the primary research did not take place. The hospital is reputable in Garissa and is also reported to treat psychiatric patients. Majority of the patients are of the Somali community, and this was to ascertain the content validity of the tools and their ability to test the desired variables. Three (3) to eight (8) participants were necessary to carry out the pilot study. The purpose of the pilot study was to test the validity and reliability of the research instruments.

The first step in ensuring high validity in this research is by contacting the right subject experts who happen to be my supervisors (a psychiatrist, psychiatric social worker and clinical psychologist by training). Their involvement in the study design and interview

guide has been extensively sought, and the researcher is in regular communication with them. The strategy of triangulation of interview data was also to promote validity hence the research done from multiple perspectives along with the help of the supervisors who read the interview transcripts individually to validate the themes and data analysis.

The researcher first carried out a pilot interview and then shared the findings with the supervisors for their feedback. The pilot interview fleshed out the ability of the questions to map the desired domains. The researcher carried out two pilot interviews to ascertain the validity of our questions and come up with best strategies to make our participants comfortable in addressing the interview questions.

The researcher also ensured the right participants were contacted and recruited to participate in the study. Guaranteeing the participants provide data relevant to the research question and to avoid inaccurate or insufficient data that is critical but part of developing a process approach in qualitative research. The researcher also persisted with data sampling until saturation has reached.

3.6 Data analysis methods and presentation

The data collection methods of choice for this research are the guided interview, unstructured questionnaires and key informant interviews that generated qualitative data. The qualitative data were analyzed employing Nvivo software. This process uses inductive reasoning, by which themes and categories emerge from the data through the researcher's careful examination and constant comparison (Patton, 2002). Phenomenological approaches were used to analyze qualitative data to bring out the experiences of the respondents. Finally, there were qualitative presentations of the study findings inform of direct quotation/verbatim from the respondents.

3.7 Ethical considerations

This study involved human subjects; thus, ethical consideration was highly considered. Since there are many different and opposing schools of thought concerning mental illnesses, the researcher assured the respondents of their privacy and making sure that they remain anonymous throughout the process and only seeking their voluntary consent to participate in the study. At the same time, the researcher was careful not to put the

participants in an awkward position by making them feel that they should advocate for a specific approach to treatment.

Further, the researcher's probing of questions/responses to the participants' answers were given carefully; ensuring that the participants do not feel evaluated or judged or biased. The researcher also took care not to place the participants in an exam-like situation in which they could think that their knowledge is being tested. Thus, from the onset, the researcher informed the participants of all the facts and explained that there are no wrong or right answers. No prior preparation would be necessary before the interview, and this also allowed the participants to maintain their professional identity.

Respondents' informed consent included; expected duration of research, and right of participants to decline or withdraw during the process. Concerning issues of confidentiality, participants might not want their opinions made public. Thus, an agreed upon alias was used during transcription. At the same time, issues of confidentiality were more thoroughly addressed in the 'procedure' section and participants will obtain a signed copy of the consent form ensuring the confidentiality of the material. The recorded and transcribed data was kept in a secure location, with only the researcher and the supervisors having access and not bear any information disclosing the personal identity of the respondents.

3.8 Limitations and delimitations of the study

The study was conducted in 10th April 2017 to 21st April 2017. The following limitations were expected:

1) All the primary caregivers were drawn from the hospital.
2) Human subject: The study sought adequate permissions in this respect and was keen on ethical considerations to protect the respondents – this is for ethical considerations.

3.9 Assumption of the study

This study assumed that all the response gathered was genuine and is the actual position of the situation.

3.10 Chapter summary

This chapter has discussed the methodology that used in the study, and it has critically analyzed the research design, target population, the sample design, data collection techniques, validly and reliability test and the application package for data analysis.

CHAPTER FOUR
RESULTS

4.1 Introduction

This chapter presents the data found in knowledge, attitudes, and practices of mental health amongst the Somali Community: Interviews from Garissa County. The research was conducted on a sample of 8 respondents on each group to which interviews were administered. The chapter introduces with analysis of residents' personal information and then looks into the study of themes: level of mental health knowledge, attitudes and caring practices of Somali primary caregivers, traditional Somali healers and health service providers at Garissa General Hospital respectively. Findings from open-ended questions were presented in prose.

4.2 Demographic characteristics of the respondents

The respondents' personal information included gender, age, level of education, duration with the patient, duration of stay in Garissa, relationship with the patient, among others. The findings are presented in subsequent headings:

4.2.1 Age of the respondents

The study participants were requested to indicate their Age. Four (4) respondents were between the age of 18-40 years, while (13) thirteen respondents were between the age 41-63 years, while seven respondents were between age 64-86 respectively. This depicts that majority of the respondents were middle-aged.

4.2.2 Gender of the respondents

There were six female and two males; while the health service providers comprised of both male (5) and female (3), whilst the traditional healers were predominantly male (8) only.

4.2.3 Level of education

The study participants were requested to indicate their level of education in which four (4) primary caregivers and eight (8) traditional healers had no formal training. Only three (3) primary caregivers had completed high school education and one (1) primary caregiver who had double majors in Sociology and Political Science. The health service

providers had formal education up to the tertiary level. This shows a disparity in education level among the respondents' hence bringing a forth-different understanding of knowledge about mental health in the community and at large.

4.2.4 Duration of stay in Garissa

The respondents were requested to indicate the duration they have stayed in Garissa. From the findings, 50% of the respondents had remained in Garissa for forty years and above. The remaining indicated that they were in Garissa for more than eight years – where they moved from nearby towns like Wajir, Habaswein and Mandera. This could be taken to mean that all the respondents were conversant with the culture and social know-how, including being familiar with practices surrounding mental disorder in the Kenyan Somali community.

4.2.5 Duration with patient

The primary caregivers were asked to indicate the duration they had been together with the patient. majority of the principal caregivers had stayed with the patient for the period of six (6) and above, while the rest indicated leaving with the patient from one year to six years since they were diagnosed with mental illness. This shows that majority of the study participants had stayed with the patient for one year and above, hence they were able to understand the majority of the symptoms of the patient and what practices seemed to have worked for them during the period and knowledge entailed.

4.3 Knowledge surrounding mental health disorders

The first objective aimed at investigating the knowledge surrounding mental health disorders. The respondents were requested to describe their understanding of mental illness. The findings are presented in subsequent sections.

4.3.1 Health service providers KIIs (Key Informant Interviews)

Awareness of mental illness

Majority of the health service providers had a broad understanding and definition of mental illnesses. However, when it came to the different types of the disorders, some health service providers had the diseases mixed up and could not differentiate which was which; few of the HSP also had difficulties in naming at least three types of disorders.

They described the mentally ill patient as someone who is mentally handicapped or challenged mentally.

One health service provider indicated that mental illnesses are diseases mainly due to mood imbalance and abnormal behavior. He further went to explain, *"Normal mental functioning will not be happening, so the patient will not be active as per required" (KII, Interviewee 1, male, 39 years).*

Causes of mental illness

The HSPs described mental disorders to be caused by several things including substance use, environmental issues, evil spirits, Jinn, family genetics and the evil eye.

One health service provider shared *"Genes cause mental illness, it goes through family lineage, but most of the ones we have in our community of late are through psychosis" (KII, Interviewee 4, Male, 45 years).*

Another HSP recounted *"as a Muslim person, I do believe Jinn causes some mental illnesses. The existence of Jinn is described in the Quran, and we have seen several cases as such. The Jinn destroys the person"* (KII, Interviewee 6, Male, 32 years).

Despite his medical knowledge on the causes of mental illnesses, he also integrates it with his religious beliefs on the origins of mental illnesses.

While another one indicated *"Drug-induced psychosis are there too; Currently, we live in a developing community, and we have a lot of families that have drug-induced psychosis" (KII, Interviewee 1, Male, 39 years.*

4.3.2 Key Informants Interviews with traditional healers

Awareness of mental illness

The traditional healers through KIIs indicated that some of the symptoms of mental illness they encountered typically included fainting or withdrawal symptoms.

One particular healer said, *"When a patient has visible symptoms, for instance, fainting, the patient already knows about the condition, and everyone is aware. Reading the*

Quran to the patient suspected to be mentally ill would confirm the case as the patient fights when Quran is recited on them" (KII, Interviewee 1, Male, Age 63years).

This means to say the traditional healers can distinguish the symptoms of mental illness to that of other diseases; once Quran is recited on the patient, the symptoms diminish which acts as a confirmation of what the patient is suffering from as opposed to other illnesses.

Another traditional healer also said, "*When others are withdrawn and neither talking nor engaging with others, Quran is recited on them, and then it becomes visible they have a mental illness. We hear voices other than that of the patient talking, and resisting the Quran reading. We use herbs on them at that moment and later prescribe for them to use it at home" (KKI, Interviewee 2, Male, 32 years).*

Causes of mental illness

It was apparent through the KIIs that the traditional healers believed evil spirits caused mental illness. One traditional healer said when questioned, *"Evil spirits cause mental illnesses. There are different types, to name a few; the most common we deal with is the Insi (the evil eye) and the Jinn (evil spirits). Their symptoms also vary, one is like the one I was telling you which is fainting, another the person is completely insane where he throws his clothes and can even harm others, other symptoms are those which the person converses out loud with himself/herself. They are very many I can't name it all" (KII, Interviewee 5, Male, 74 years).*

Another traditional healer was quite convinced that evil spirits were the only cause of mental illnesses when he said, *"Actually Jinn causes all mental illnesses. A nerve from the brain skips from its position, and then the person gets seizures. At first, it starts small, and then this condition becomes big; it's jinn. Another cause of mental illness is the evil eye, the person faints, and you will think the person is dead (KII, Interviewee 7, Male, 83 years).*

A third traditional healer added, *"There are those who have cold feet. It starts from the feet going up once it reaches the heart, the person faints; evil spirits also cause that"* He continued to state that *"The evil spirit causes one to lose their mind, they ran away, and once brought here they get cured."* He also continued to say *"For instance, all the girls brought here who are your age, there is a voice inside (Jinn) them which speaks. The voice says he has fallen in love with this girl, and he argues he won't leave, but after we offer our treatment, of course, it leaves" (KII, Interviewee 8, Male, 74 years).*

Evil spirits or the Jinn possession comes in different form and symptoms.

4.3.3 Primary care givers (PCGs) KIIs

Awareness of Mental Illness

The primary caregivers were asked to describe how they noticed that their patient was unwell and interview feedback suggests that their answers varied a little bit. Some indicated that they became aware of their patient being sick when they first noticed withdrawal symptoms, the patient complaining of a constant headache, seizures, and things attacking them or hearing voices instructing them to do things.

One PCG said, *"I noticed something was wrong with my daughter when I saw how she was excluding herself from everyone and everything, at times she will talk to herself and even beat people. She complained of a headache, feeling scared and dizziness, followed by insomnia, and her heart beating so fast. She was just not her normal self most of the time." (KII, Interviewee 3, female, 74 years).*

Another PCG through the KIIs stated *"I also noticed the patient symptoms start when he is broke. Aggression, especially towards the mother, follows this, he also says he gets a headache and hallucinations; a time he can't even explain himself" (KII, Interviewee 4, Male, 37 years)*

Another respondent who had been taking care of his cousin said, *"He has been unwell. He will stare at his hands for no reason. His back also hurts and his head. He will talk to himself and stand-alone for long. He will not converse with anyone. He prays, and he is also not violent. He is calm" (KII, Interviewee 8, Male, 32 years).*

Causes of mental illness

The primary caregivers believed that mental illness was as a result of evil spirits, family issues, environmental stressors, genetics or drugs. One mother who is taking care of her 43-year-old daughter said, *"The evil eye caused her sickness. She used to be a breadwinner of the family, with houses and businesses booming, over a sudden she became unwell".* She further insisted, *"mental illnesses, are caused by the evil spirits and the evil eye. You know the mouth of a human being is bad, they talk about you and look at you with envy, and as a result, you suffer the consequences". (KII, Interviewee 2, female, 84 years).*

Additionally, another primary caregiver who believed that environmental stressors such as family issues caused mental illness said that, *"The patient comes from a family history of mental illness. She started with depression and psychological distresses. I think what prompted her sickness is because her husband married another woman. Her husband treated her bad, and to my understanding, I think that is what prompted her illness. She must have been overthinking about her husband getting married to another wife, and this might have stressed her a lot." (KII, Interviewee 5, female, 44 years).*

Another caregiver taking care of his cousin said, *"it's a family issue. The boy acts as a breadwinner. His father (ancient man) is from Yemen and came to Garissa and married his mum (small girl) who is Somali – maybe the father had the same sickness, but the bride's family did not know. The father of the patient used to go back to Yemen (stay one year) and come back to Kenya for a month. They were five children, two of the five children have the same disease, so they must have got it from the father. He also continued to state that, "I also believe these extreme heats in Garissa plays a role; for instance, when a boy smokes bhang, with this extreme heat, what do you expect to happen? Some wires in his brain burn out, and as a result, mental illness happens." (KII, interviewee 8, male, 32 years).*

A lady taking care of her brother said *"He came from South Africa recently, and I was suspecting maybe some women gave him drugs. Even though he does not have such behaviors of engaging adultery and drugs, we wanted to request for a drug test and*

confirm whether he was using drugs or not" (KII, Interviewee 1, Female, 51 years).

The respondents were asked if anyone was immune to mental illnesses, and they all responded No. They further stated that mental illness could occur to anyone from any race, age, or economic status. All caregivers echoed the fact that mental illness does not discriminate.

4.3.4 Focused group discussion

Awareness of mental illness

There were several overlaps and interconnections between KII participant themes and FGD themes. Here is a vignette to review some of the crosscutting themes:

When the interviewer asked the participants about their exposure and understanding of mental illness, the following responses were offered.

Health service providers

Q. What is your exposure and understanding of mental illness?

R1. Mental illnesses are diseases mainly due to environmental problems, genetics, evil spirits, family problems, and drugs related issues (FGD, Male, 39 years)

R4. A mentally ill patient is someone who is mentally handicapped or challenged (FGD, Male, 45 years)

R6. Mental illness is when a person is withdrawn and not talking nor engaging others and behaving weirdly (FGD, male, 32 years.

Causes of mental illness

Q. What are the causes of mental illness?

R8. *Drugs caused mental illness (FGD, female, 43 years)*

R3. Jinn and evil eye cause some mental illnesses (FGD, Female, 53 years)

R4. Family issues and lack of job opportunities for the youth can also be a significant cause of mental illnesses. That is just so much stress for a person to handle and it leads them to break down and just act insane (FGD, male, 44 years).

Primary caregivers

Q. What is your exposure and understanding of mental illness?

R3. Evil spirits and the evil eye cause mental illnesses (FGD, Female, 44 years)

R2. People with mental illness were born like that, Allah (s.w.t) created them like that (FGD, Female, 83 years).

R4. Someone who has a mental illness is someone who is insane and cannot do anything for themselves. They require help with the majority of things. They live in a different world than ours and see things differently (FGD, Male, 37 years).

Causes of mental illness

Q. What are the causes of mental illness?

R2. *Mental illness is Allah's doing, he causes diseases, and He brings treatments for every disease, we can't argue with Allah's decree (FGD, Female, 84 years)*

R3. Jinn, evil eye, evil spirits cause mental illnesses (FGD, Female, 74 years)

R4. Family intermarriage between cousins creates genetic disposition hence a time to generate mental illnesses (FGD, Male, 37 years).

R8: Drug use causes mental Illness. We Somalis are very well known for chewing miraa, and nowadays people add tablets (pills like panadol, or unknown medicine) chewing these miraas. (FGD, male, 32 years.

Traditional healers

Q. What is your exposure and understanding of mental illness?

R2. *The mentally ill person faints, he talks to himself, others beat people up. All these doings are not them though, and it's the work of the Satan (FGD, Male, 32 years)*

R7. evil spirits, Jinn and Insan cause mental illnesses (FGD, Male, 83 years)

R8. They are weak and can barely do anything for themselves until they are treated (FGD, Male, 74 years).

Causes of mental illness

Q. What are the causes of mental illness?

R3. *Mental illness is caused by Jinn and evil spirits (FGD, Male, 44 years)*

R6. Witchcraft causes them. People get jealous of someone's wealth or wellbeing and as a result bewitch the person, leading the person to become insane (FGD, Male, 46 years).

4.4 Attitude of the community towards people suffering from mental illnesses

Regarding addressing the second objective of the study, which aimed at understanding, attitudes of the community towards people suffering from mental illnesses the following findings are presented.

4.4.1 Health service providers (HSP) KIIs

An attitude supportive of people with mental illness

According to the health service providers, they indicated that they supported the mentally ill and advised their caretakers to do the same and not to stigmatize them. One HSP said, *"The patients have their clinics, and that is where they get the support from the social workers" (KII, Interviewee 4, Male, 37 years).* The HSP advise the family members to support the patient and avoid stigmatizing them, seek assistance from health professions, and take care of that patient to the best of their ability.

One HSP said, *"If the patient sees a supportive family, the condition might at one point disappear. Concerning the community, stigmatization has decreased a little bit where instances of throwing stones have phased out. The medical personnel do not also discriminate. At occupational therapy where there are children with cerebral palsy, they educate the parents and the relatives on the condition (KII, Interviewee 1, Female, 51 years).* The HSP further agreed that they could have failed in some areas, as they did not have psychiatrists in their clinics.

Attitude

When asked whether they will be willing to marry someone who has a mental disorder, the majority of the HSP refused. They said they couldn't be married to someone who is mentally unstable, some of the reasons given were, how would they be able to converse with the person, perception of others towards them for marrying someone who is "insane". They even went ahead and stated that they were willing to divorce if their spouse had a mental illness during their marriage. Nevertheless, one HSP answered, *"He is willing to stay with his spouse if she is suffering from a minor mental disorder like depression. However, if the illness is like that of psychotic or loss of sanity, then that is a NO for him" (KII, Interviewee 8, male, 32 years).*

4.4.2 Traditional healers KIIs

Attitude

Majority of the traditional healers presented positive attitudes when it comes to being friendly and empathetic towards the patients. They considered the patients as ordinary human beings and their only difference being their illness. They further went ahead and answered that they were willing to engage with them at surroundings. When the traditional healers were asked if they were ready to get married to someone who is mentally ill, they were quick to answer NO; however, they advised their patients to seek marriage, as that could also become a form of cure for the illness like withdrawal and fainting as they described.

4.4.3 Primary care givers KIIs

Empathy and understanding needs of people with mental illness

Some of the caregivers indicated they could be friends with mentally ill though everyone said they wouldn't get married to them while they were in such condition. To this effect, one female caregiver said, *"I can be a friend with someone who has a mental disorder. There was this girl (may she rest in peace) who was my friend. She used to come and visit me, and she would borrow money from me. She was very sick - she even had stuff coming from her mouth, and everyone used to feel disgusted by her, but for me, I loved her until her death (KII, Interviewee 7, Female, 83 years).*

Another caregiver said, *"I will not be willing to marry someone with a mental disorder, but I can be friends with him or her. I can only marry one if circumstances cause, for instance, if the patient can get cured me marrying them (laughs). Why should I deny them that? (KII, Interviewee 5, Female, 44 years).*

Rejection of patients without familial support

The respondents indicated the presence of rejection in cases where the patient does not have a family as compared to that who has a family. The patient who does not have family members were left to loiter in the streets without being attended to by anybody, whereas the one who has gets treatment.

One PCG said, *"Community perception of mental illness is not good. People will think you might have done something bad in the past, or they label you as the family with the mentally ill person. That is not good at all" (KII, Interviewee 4, male, 37 years).*

The respondents further indicated that topics such as mental illness were/are never publicly discussed in the community. The patient's family in almost hush tones request for prayers from congregations thus saying their child has been bewitched but never admitting to having a mental illness.

4.4.4 FGD response

a) Health service providers (HSP)

Q. What are the forms of community awareness regarding mental health in Garissa County?

R1. *Community perception of mental illness is not good. As long as you are not directly affected by mental illness, they don't care much for it, or even bring awareness to mental health awareness (FGD, male, 39 years)*

R2. People are more concerned with issues of drought, water and maybe Malaria. I might be wrong, but I have never heard or seen any mental health awareness campaign being carried out in Garissa, Never" (FGD, Male, 47 years).

b) Primary caregivers (PCGs)

Q. What are the forms of community awareness regarding mental health in Garissa County?

R1. *The community does not fully accept someone with mental illness. They think the person has done something wrong in his past or he has been bewitched, but they barely acknowledge the presence of mental illness and it been an illness just like any other (FGD, Male, 41 years).*

R2. There is no much effort done when it comes to mental illness in the community. The sick will be taken to a sheikh who recites Quran on him/ her; if she gets well then good if not, the patient is abandoned (especially if he/she is not staying with his biological parents) (FGD, Male, 51 years).

R3. No information regarding mental health is present. Psychological health is barely talked or discussed in our community. It is like a bad omen to have mental illness (FGD, Female, 74 years).

c) Traditional healers

Q. What are the forms of community awareness regarding mental health in Garissa County?

R2. There is none. Politics is all that is discussed or Polio outbreak or census. (FGD, Male, 32 years)

R5. We the traditional healers advertise our expertise and treatments through local radio stations and word of mouth. We try to reach out to as many people as we can to provide a cure. But other than us, I have not seen anyone else do it (FGD, Male, 74 years).

4.5 Practices towards mental health disorders

The third objective aimed at determining the practices of the Somali community towards mental health disorders in Garissa County. The health service providers, traditional healers, primary caregivers and the focused group discussion present the findings in subsequent sections as responded.

4.5.1 Health service providers KIIs

Religion

The health service providers interviewed firmly believed in the practice of Quran recitation. One Health service provider said, *"I support treatment of mental illness by the sheikhs through religious practices like Quran recitation on the patient. We as Muslims believe Quran is essential and can treat such conditions (KII, Interviewee 1, Male, 39 years).*

Another HSP said *"The community mostly believes the traditional healing and Quran reading is more important when it comes to issues of mental illnesses, which I have no objection when it comes to Quran reading, it's imperative (KII, Interviewee 8, female, 43 years).*

"The tradition of Quran reading I encourage and some of the practices of the Prophet (p.b.u.h) however some practices of the traditional healers I do not accept. As a Muslim person, I only encourage the practices mentioned in the Quran and the teachings of the prophet (p.b.u.h)" indicated another HSP (KII Interviewee 3, Female, 53 years).

Hospital medication

The service providers also believed that the medical treatment played a significant role towards the healing. One HSP said, *"Hospital set up is good, but Quran reading is equally important to treat such conditions. We support both and tell them to take the drugs and have trust in the religious scriptures like reading Quran on them (KII interviewee 1, Male, 39 years).*

One HSP who was against the use of traditional medicine said *"For the medications, we use at the hospital, they have been tested, and there is certainty that there are going to work, however for traditional healers what assurance do they have? (KII, Interviewee 4, Male, 37 years).*

Traditional medicine

The health service providers however only in part supported the use of traditional medicine. One respondent said, *"For me, I support some parts of traditional healers. Things like the traditional herbs were practiced centuries ago, however, an extreme form of treatment like hitting the patient in the pretense of treating the patient, that is morally wrong, unacceptable" (KII, Interviewee 6, Male, 32 years).*

Another who reluctantly objected to using traditional medicine said *"But the community mostly believes the traditional healing is more important when it comes to issues of mental illnesses. I don't think traditional healers are doing a good job. After these patients go to these sheikhs (traditional healers) they still end up here, so I will not advocate for anyone to go to traditional healers" (KII, Interviewee 4, Male, 45 years).*

Another one who indicated, *"I do not advocate for those traditional healers who use herbs and suffocate the patients, it's hazardous and mostly leads to death. If one is covered with fumes of herbs s/he can suffocate and die" (KII, Interviewee 8, Female, 43 years).*

4.5.2 Traditional healers KIIs

Traditional medicine

The traditional healers were seen to be unaccepting when it comes to treating or managing mental illnesses through the hospital set up. Most of them did advise their patients not to seek medical attention, as they believed the issue was as a result of evil spirits and the hospital could not deal with such matters.

One traditional healer categorically stated, *"We don't advise our patients to go to the hospital. Even if the patient is using medication from the hospital, we ask him/her to stop the medication before we start our treatment on them". (KII, Interviewee 1, Male, 63 years).*

The traditional healers also believed that their treatments were far much better compared to the services offered in hospitals. One traditional healer stated, "Our treatments are better than the hospital set up. I say this because the hospital does not have the treatment

method to treat mental illnesses. These are illnesses caused by Jinn, evil spirits, and the evil eye. For instance, the jinn called Musibian. If a woman who has Musibian goes to the hospital, she is told they need to abort the baby because of complications here and there. However, when the same patient comes to us, we treat that condition and the woman carries her full pregnancy term and then gives birth to a healthy baby (KII, Interviewee 8, Male, 74 years).

The traditional healers believed that their medicine cured the mentally ill. One TH narrated how he healed a mentally ill patient by use of herbs. *"The patient used to faint; we also gave him some herbs, which he will use to steam bath with every time he faints. We also put liquid herbs on his nose to induces vomit for 21 days" (KII, Interviewee 2, Male, 32 years).*

Another traditional healer narrated how he cured a patient that was invaded by evil spirits *"One patient I remember most is one that had epilepsy. He is now well; I can even show him to you. He used to have seizures for five years. We provided his treatment here. We poured curative oil through his nose, and then he woke up; after that, we burn some herbs and cover him so that he can inhale that smoke of the herbs. You know these things are jinns (evil spirits), then we gave him medicine through the mouth, we also provide an oil that he needs to apply for 21 days" (KII, Interviewee 1, Male, 63 years).*

Another traditional healer went ahead to list the type of medications she used such as *"Zaatar"* which was good for kidneys, *"Shimar"* good for gas and *"habatsawda"* used to treat all kind of ailments" (KII, Interviewee 7, Male, 83 years).

Religion

The traditional healers firmly believed in the recitation of Quran on the mentally ill patient. One respondent said you *"God has all treatments. We read Quran on him/her; at times we say the call of prayers in his ears. After 21 days my patient got better" (KII, Interviewee 1, Male, 63 years)*

Another supported him when he indicated that, *"When a person suffers from the evil eye, the patient becomes different, after Quran reading and treatment; a voice communicates which says, "I am going out" and that voice is the Jinn (KII, Interviewee 7, Male, 83 years).*

4.5.3 Primary care givers KIIs

Hospital Medication

The respondents felt that the hospital medication played a role in healing the mentally ill though they integrated it with other methods like traditional healing. One particular respondent viewed hospital medication as an alternative as she said *"After nothing changed, we then brought her to the hospital, she is now on medication, and we bring her to the hospital for a refill of her medication. So far so good if the patient takes her medication she feels better however if she stops taking the medication, she starts becoming unwell." (KII, Interviewee 2, female, 84 years)*

She continued to say, *"she has been to the hospital six times, and she is taking medication right now, and so far, so good."* Another one said, *"I brought him to the hospital, for his blood tested and once I explained his symptoms, they sent us to the mental health department where he is receiving medication, and we have seen a huge improvement."* Majority of the primary caregivers seek medical assistance when traditional medicine fails.

Religion

From the response given by the primary caregivers, it was clear that they trusted and insisted on the use of Quran recitation on the mentally ill patient. One respondent indicated that they took their patient to the sheikh who recited the Quran on her. Another respondent said, *"God is the only one who can prevent the illness" (KII, Interviewee 3, Female, 74 years).*

Traditional medicine

The participants also suggested the use of traditional medicine on the mentally ill. One respondent who had been to the hospital several times said, *"We took her to traditional healers who read Quran on her and provided some herbs to treat her illness" (KII, Interviewee 5, Female, 51 years).*

Another one said, *"Sometimes religious leaders suggest the herbal treatment to cast away the evil spirits and the black magic, and it does work" (KII, Interviewee 4, Male, 37 years).*

4.5.4 Focused group discussion

The information from the focus group discussion agrees with the findings from the interview guide.

a) ***Health service providers***

Q. What are the barriers to seeking medical care for mentally ill patients in the Somali community?

R1. *Fear of the community labeling you as having a child who is mentally ill (FGD, Male, 32 years)*

R2. Socioeconomic status – some families think, they can't afford to come to the hospital or buying medication and the whole process is money consuming (FGD, Male, 39 years).

R3. Lack of knowledge or awareness (FGD, female, 43 years).

b) Primary caregivers

Q. What are the barriers to seeking medical care for mentally ill patients in the Somali community?

R1. *Fear of the community labeling you as having a child who is mentally ill (FGD, male, 37 years)*

R2. Illiteracy and lack of awareness of mental health. We don't understand these symptoms are treated in the hospital, and the only cures we know for these kinds of

illnesses are traditional healers (FGD, Female, 83 years).

c) Traditional healers

Q. What are the barriers to seeking medical care for mentally ill patients in the Somali community?

R1. *They do go to the hospital, it just that the hospital are not as equipped as we are when it comes to treating mental illnesses (FGD, male, 83 years)*

CHAPTER FIVE

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents summary, conclusion and recommendations on the knowledge, attitudes and practices of mental health amongst the Somali community: interviews from Garissa County.

5.2 Discussion

The study is the first study on knowledge, attitudes, and practices of mental health amongst the Somali community in Garissa. This study was significant for its conduction given the scarcity of information about mental health among the Somali population in the region. The respondents agreed to participate once approached for the interview. Though it was noted that some of the health service providers especially the ones' in the mental health department were slightly hesitant at first to participate in the study but later on agreed to participate in the study. The traditional healers were very enthusiastic about participating in the study compared to the other study participants.

The respondents had a broad knowledge of what mental health is. However, all respondents reported evil spirits, evil eye, bad omen and Jinn to be the cause of mental illness. This finding is similar to that observed in Sub Saharan African cultures (Makanjuola et al., 2016) that the general belief of the cause of psychosis is supernatural. The participants of the study acknowledged the different types of mental disorders, and they were also able to distinguish them by symptoms. Even though all the respondents agreed to evil spirits, evil eyes and the Jinn were the root cause; they added that genetic factors and environmental factors such as substance use to also be among the causes of mental illnesses.

It is encouraging to note that there are positive attitudes towards supporting patients suffering from mental illnesses compared to the past. Majority of the respondents stated that they were willing to help and seek treatment instead of abandoning the mentally ill patient; however, also reported was that the same sentiments were not extended to

patients who did not have a family as they were left to loiter in the streets. The society they explained rejects people with mental illnesses. People are scared of persons with mental illness if they are not blood-related; thus, keeping him/her at a distant and curse the devil. Some respondents also indicated that there was a general bad perception by the community towards the mentally ill. Handicap International reported similar findings in their survey, where among 291 people with mental disorders in the Daadab camp (Garissa, Kenya), 19% were chained at the moment of the research, and another 25% had been chained in the past (UNHCR, 2013).

Mental health should be a societal concern rather than only for those who suffer from a mental health disorder. This situation affects families, communities, societies as well as governments and thus having implications for budgets, planning, and development. It is imperative therefore that mental health is viewed as any other health concern for a developing nation like Kenya. The idea of mental illness not getting acknowledged or getting whispered among the people in the society can also be damaging; thus preventing patients from being referred for appropriate mental health care in the community. The study also established that individuals ask other people to pray for their child because they have been bewitched and will barely admit to them having a mental illness because of the stigma mental illness carries. Though, few respondents stated that stigmatization had decreased a little bit in the community where instances of throwing stones have phased out.

Regarding medical personnel, they do not stigmatize, and both primary caregivers and traditional healers held positive attitudes when it came to dealing with mentally ill patients, and all respondents expressed empathy and compassion towards them. Similar results were indicated in a study done by Kiima et al., (2009), where the majority of the community health workers felt comfortable dealing with depressed patients, and also thought that they could be a useful person to support depressed patients. When such attitudes and beliefs are expressed positively, they can result in supportive and inclusive behaviors.

Blame is often placed on the mentally ill person. He/she blamed for bringing the illness upon themselves, whereas others may see them as victims of fate, religious and moral transgressions or even witchcraft. This may lead to denial by both sufferers and their families with subsequent delays in seeking professional treatment in the medical set up. The conviction that a troubled mental state is an outcome of an Jinn or black magic leads many patients and patient's family to seek the assistance of traditional healers who then resort to various therapeutic options including Qur'an readings. The study established that the Somali community most often presents mental health problems to the hospital set up when the disturbance is severe or unmanageable at home, usually quite late in the illness. This is supported by a similar study finding in Kenya by Jenkins et al., (2013) who found out that health workers reported the primary caregivers of mentally ill patients take the patients to the church than to the hospital. Reason being mental illness was attributed to demons, thus mirroring the failure of primary care services to detect and treat these disorders effectively at the hospital set up and as a result reflecting negatively on the prognosis and response to treatment.

The study further established that even though the majority of the respondents were not against traditional healing, they were against the extreme measures sorted by some of the traditional healers, like suffocating the patient with fumes or beating the evil spirits out of the patient – a common practice practiced by traditional Somali healers (UNHCR, 2013). Some primary caregivers and health service providers pointed out that the traditional healing exercise has become a moneymaking business nowadays, where the majority of the traditional healers have become money oriented.

The study also established that bringing awareness to mental illness and integrating modern treatment with that of acceptable traditional healing would be useful. There is the need for traditional healers to be engaged in constructive dialogue with hospital management and the county government for integration of hospital and traditional treatment of mental illness. Thus, by empowering the traditional healers on how to recognize the different types of mental illnesses, or showing them simple translated tests, they will, therefore, be able to screen at their level, and in the process increase referrals and improve on the mental health information system ((Ndetei, Mbwayo, Mutiso,

Khasakhala & Chege 2013). Equally important, it was also reported in another study that, most experts recognized that there were gaps in illness management, hospital referrals, and teaching mental disorders. Consequently, teamwork with traditional healers might advance patient care (Musyimi, Mutiso, Ndetei, Unanue, Desai & Patel 2017).

Garissa level five hospital lacks adequate personnel required for an ideal/ almost ideal mental health institution; there are no psychiatrists or psychologists in the facilities who are the critical contact for the patient. For adequate care of people with a mental health condition, it is necessary that such facilities provide for out and inpatients. Through structures that take into cognizance, the movements of the mental health patients and their interactions with other patients in the hospital, Garissa level five hospital does not have these facilities and the mental health patients who a times are at a manic state are put together with the other patients.

Further noting, despite the unreported numbers of mental health patients in Garissa, the hospital budget allocation ratio for mental health care is far lower than its allocation for other health conditions. Its interaction with the public health care is more moderate such that the community health workers who are lowest in the health strategy do not have adequate referral lines for mental health patients.

5.3 Conclusion

The study is limited to a small sample of respondents at Garissa general hospital and few traditional healers, so the result may not be generalized to the rest of Somali community in Garissa County or at large.

The study concluded that there is little biological knowledge of mental illnesses in the community and mental health awareness is very much needed in Garissa County. Traditional beliefs regarding the causation of mental illness were widespread even among the medical workers. Perhaps poor diagnosis and management of mental illnesses in the medical facilities make the outcomes similar to that of patients managed by traditional healers thus reinforcing the beliefs in the latter. Possibly improvement of mental health services together with continuous psycho-education could change the attitudes and practices regarding mental illnesses.

5.4 Recommendations

The study findings make the following recommendations:

i. The mental health department of the hospitals in Garissa should foster collaboration between themselves and the county government to improve knowledge on mental illnesses further.

ii. The mental health department to include support groups to show goodwill and increase awareness among the mental health caregivers to build firm support.

iii. Garissa County government and the departments of mental health to come up with protocols that will design and aid the implementation of favorable mental practices and mental health awareness in the county.

iv. Allocation of at least one or two Psychiatrists and psychologist, or psychiatric social workers in the general hospital of Garissa.

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APPENDICES

Appendix 1: Study budget

Budget line	Particulars	Amount (Ksh)	Remarks
1	Printing and photocopy of Proposal	1500 x 3 = 4,500.00	Amount to be used to print final proposal for presentation to UON
2	Printing and Photocopy of tools	200 x 50 = 10,000.00	Amount to be used to print tools for study
4	Pretest of tools	100 x 30 = 3,000.00	Amount to be used to print consent forms during the pre-test
5	Transport to and from Garissa	20,000.00	Amount to be used to and from Garissa
6	Accommodation in Garissa	20,000	Accommodation, food and transport within town.
8	Printing and Photocopy of report	2000 x 3 = 6,000.00	Amount to be used to print final proposal for presentation to SML
9	Cost of permission from NACOSTI	2000 x 1 = 2,000.00	Amount to be used to Pay GOK to conduct study
10	Cost of permission from KNH	2000 x 1 = 2,000.00	Amount to be used to Pay KNH/UON Ethics and Research Committee for approval to conduct research on Human Subjects.
	Total	Ksh.67,500.00	

Appendix 2: Study work plan

Details	Sept 2016	Oct 2016	Nov-Jan 2016/17	Feb 2017	March 2017	April 2017	May-Jan 2017/18	Feb 2017
Proposal development								
Proposal defense								
Ethical approval								
Tools pre-test								
Data Collection								
Data Analysis								
Report writing								
Presentation of study findings								

Appendix 3: Letter of introduction (For Garissa General Hospital)

Dear Sir/Madam,

Re: Request for Research Data Collection

My name is Mohamed Umulkheir of student number H56/67089/2013, an MSc in Clinical Psychology student at University of Nairobi. I am conducting a study on Knowledge, Attitudes and Practices of mental health amongst the Somali Community: Interviews from Garissa County**.** For the purpose of facilitating this research work, I wish to collect data through the use of interviews and focus group discussions. The information is purely for the purpose of my academic research work and therefore it will be treated with strict confidentiality. I will be very grateful if you would kindly extend in allowing the study to take place by accepting to this request.

Thank you in advance, I look forward to your assistance.

Yours Faithfully,

MOHAMED, UMULKHEIR

Appendix 4: Informed consent [Primary caregivers, traditional healers & health service providers]

Hello, my name is Umulkheir Mohamed, a student from University of Nairobi, studying MSc Clinical Psychology. You have been chosen at random to be in a study about Knowledge, Attitudes, and Practices of mental health amongst the Somali Community: Interviews from Garissa County. This study involves research whose purpose is to understand the mental health knowledge, attitudes and practices adopted by various stakeholders in the Somali community in Garissa County. This will take 45 minutes of your time. If you choose to be in the study, I will Interview you, in the form of asking questions and you will be expected to answer the questions bearing in mind, there are no right or wrong answers.

There are no foreseeable risks or benefits to you for participating in this study. There is no cost or payment to you. If you have questions while taking part, please stop me and ask. We will do our best to keep your information confidential. This means that your interview responses will only be shared with my supervisors and we will ensure that any information I include in my report does not identify you as the respondent.

If you have questions about this research study you may contact me, Umulkheir Mohamed at 0722 518 349 in the event of a research related injury. If you feel as if you were not treated well during this study, or have questions concerning your rights as a research participant call The Secretary/Chairperson KNH-UoN ERC on Tel. No. 2726300 Ext 44102.

Your participation in this research is voluntary, and you will not be penalized or lose benefits if you refuse to participate or decide to stop. May I continue?

I certify that I have consented the participant (code no.)______________________

Researcher’s name: ____

Signature: ____

Date: ____

Appendix 5: Key informant interview for primary caregivers (English)

1. Sex?

   ………………………………………………………………………………………

2. Age?

   ………………………………………………………………………………………

3. Level of education?

   ………………………………………………………………………………………

4. Duration of stay in Garissa?

   ………………………………………………………………………………………

5. Duration of being with the patient?

   ………………………………………………………………………………………

6. Relationship with the patient?

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   ………………………………………………………………………………………

7. How did you notice that X was unwell?

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   ………………………………………………………………………………………

8. What did you do then?

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9. How did the illness come about? What might have triggered the illness?

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10. Have you gathered some understanding of the illness or treatment?

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11. Give a small history about his/her treatment regime since X was got sick

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12. Has he/she been to the hospital and how is the outcome so far?

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13. In your own understanding, do you think the illness could be prevented? If so, how?

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14. Is anyone immune to mental illness? If yes, who and why?

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15. Once someone gets mental illness can they ever get better again? If yes, how? If No, what are the reasons for this response?

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16. Would you be willing to be friends with someone who has a mental disorder? Would you be willing to be married to them? Why so?

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17. Should mental illness be considered like any other illness? Explain your answer in your own thoughts

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18. What are the forms of community awareness regarding mental health in Garissa County?

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19. What are the barriers of seeking medical care for mental ill patients in the Somali community?

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20. During community gatherings, do you discuss mental health issues? If so, at which gatherings are these issues discussed?

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21. What prompts the discussion? What sort of topics do you discuss? What are the main reactions of the people present? At which types of gatherings would you not discuss these topics?

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22. How involved are religious leaders in mental health issues? What role do they play?

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Thank You for Cooperation

Appendix 6: Somali translation of the key informant interview (Primary Caregivers)

1. Galmada?
2. Sanadka dhameqa?
3. heerka waxbarashada?
4. Mekasana jogta Garissa?
5. Mekasana lajogtey qofka bukan?
6. **6.** Xiriirka ay la leeyihiin bukaanka
7. Erayga caafimaadka maskaxda ama cudur maskax eed macnaheedu waxay noqonkartaa waxbadan oodadka kaladuwan. Marka aadmaqashaan cudurada dhimirka, maxa maskahdhadha kusodacaya?
8. Waamaxay nooca ugubadan eex anuunada dhimirka? Maxa adkataqa anaa kusaabsan cudurkan? Majiraa qof ooaad taqaanid xanuun kaxayo? yawey? (Waa ok hadii aadana qoonnoocka mid ah cudurada).
9. Mahax sababa cudurka dhimirka?
10. Waalaga hortagikaraa cudurada dhimirka?Haddii ay sidaastahay, sidee?
11. Ma jiraaq of difaaca u ah cudurka dhimirka? Haddii ay haatahay, waaqofkee?
12. Markaqo fuucudurka dhimirka helo, miye kaboksinikaran? Haddii ay haatahay, sidee?Haddiimaya, maxasabab ah?

13. Adiga kuugaarah, nooca daawayn taeekula tahayugu fiicanee kashaqeeya? Daryeelka Hosbital ama daryeelka dhaqanka? mahax? Fadlan sharax sababta?Sideeloo daaweeyaa cudurada kuwanu?

14. Dadka jiradha maskaxdhaqaban, miyeubahanyixiin jacayl?

15. Waxaa habboonin cudurka dhimirka la tixgeliyaa sidax anuunkastaookale?Sharax kabixi jawaabtaada fikirkaaga u gaar ah

16. Maxay yihiin caqabada haeedoonaya daryeelka caafimaad eebukaanka jiran maskaxda eebulshada Soomaaliyeed?

17. Maxayyihiin noocyada owacyi gabulshada eekusaabsan caafimaadka maskaxda ee Gobolka Gaarisa?

18. Intala gujiro kulannadabulshada, Mawaxaadu wadahad laanarrimaha caafimaadka maskaxda? Haddii ay sidaastahay,

19. Waxan oocyadai suyihiinarri mahankalahadlay?Maxaajirtey dooda?

20. Maxaa sort mowduucyoa yaadkalahadli? Maxayyihiin dhibaatoo yinkauguwaa weynee dadka la joogo? Atoono ocya dakaladu waneisusooaadan wadahadlila haamawduucy adan?

21. Sideeku lug yihiin hoggaamiya yaashadiintaeear rimahaca afimaadka maskaxda? Doorkee ay u ciyaaraan?

22. Sheikhe dhasitheu cawiyandhatka masqahadha kajiran

23. Ma gursanikarta kofjiratha masqahadhaqabo

Waadkumahadsantahayiskaashigaaad

Appendix 7: Key informant interview - Health service providers

1. How long have you been providing health care?
2. What is your exposure and understanding of mental illness?
3. What are the most common types of mental disorders in Garissa County?
4. What are your experiences in treating these cases? Could you give an example of a specific case?
5. What kind of support structures you have before you when you deal with someone with Mental illness?
6. How is the county government implementing the mental health policy Garissa County?
7. How does the hospital personnel fight stigmatization of Mental Illness?
8. Would you be willing to be friends with someone who has mental disorder? Would you consider being married to one?
9. What if you find out that a rehab center for patients with mental illness is being planned in your neighborhood, would you object to the plan?
10. What is the best treatment for mental illness in your opinion? Are traditional healers important in treating mental illness? Explain more?
11. How do you advise patients with mental illness and their primary care givers?
12. What questions would you expect primary caregiver to ask about mental health? How do you respond to these questions?
13. In what way do you deal with your religious faith and cultural beliefs when engaging with mentally ill patient?

appendix 8: key informant interview for traditional healers

1. How long have you been providing health care in Garissa County?
2. What qualification does one need in order to become a traditional healer?
3. Give me an example of one of the psychiatric cases you treated and how you treated it
4. In your own understanding, what causes mental illnesses?
5. Do the illnesses you treat differ? Kindly answer this by giving an example
6. How do you explain mental illness to your patients and their primary caregivers?
7. Kindly give me examples of the kind of interventions you use to treat mental illness?
8. How are these interventions performed? Is there one that is more effective than the other? Please answer this by giving an example
9. How are these interventions different from the hospital setup?
10. Would you advise any of your psychiatric patients to go to the hospital, kindly explain your answer by giving an example
11. During your experience as a traditional healer, have you made any friends who were mentally unwell?
12. Marriage is an important part of the Somali community; how do you address this with your patients?
13. In what way is the topic of mental illness discussed in the community today? Are people more accepting about these issues?
14. Do you think people should be addressing the issues of mental health and is there importance of mental health awareness?

Appendix 9: Focus groups recruitment telephone call

Name of person ______________________Phone number ____________________

Time called _________________________Better time to call __________________

Hi, this is Umulkheir Mohamed and I'm a student at University of Nairobi, conducting a study [Knowledge, Attitude and Practices of Mental Health amongst the Somali community: Interviews from Garissa County]. You have previously taken part in an interview of the same study at Garissa General Hospital and verbally confirmed your interest in taking part of the focus group discussion.

You're a **respondent** (traditional healer, primary caregiver (parent/guardian/family member of mental ill patient), and health service provider) right?

We're getting together a small group of **respondents'** (primary caregivers, traditional healers, and health service providers separately) to give us input on the knowledge, attitude and practices of mental illness among the Somali community in Garissa. We plan to get about eight respondents (traditional healers (one group), health service providers (one group) and primary caregivers (one group)) together. It will be: **Date, day Time (1 hour) Place.**

We will have a few refreshments and we will have 500 Ksh for you as a thank you for giving us your time and ideas.

Would you be able to join us?

No ________ Okay, Thanks for your time.

Yes _________ Great. Will send you a text message with address of the location, date and time.

Thank you once again.

Thank you for giving us your time and ideas. We look forward to seeing you at the discussion.

Appendix 10: Focus group discussion topics

Introduction

- Purpose of the meeting
- Introduction of the members
- Discuss the importance of confidentiality
- Emphasize on the importance of sincerity and dialogue

- The theme of questions asked during the focus group discussions, were derived from the general interview of the study respondents.

Thank you for imparting with us your time and input.

Appendix 11: Plagiarism report