



Assessment of knowledge, attitude and practice of health extension professionals towards people with mental illness in Adama city, Oromia, Ethiopia

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Abstract

Introduction: Mental health disorders are highly prevalent in Ethiopia which is known to result in substantial disability. Improving the knowledge, attitude and practice of the primary health care workers is important to reduce this problem. Hence, this study was focused at assessing knowledge, attitude, and practice towards mental illness among health extension professionals of Adama city, oromia, Ethiopia.

Objective: To assess knowledge, attitude and practice of health extension professionals towards mental illness in Adama city, oromia, Ethiopia, 2019 E.C.

Methods: Cross sectional study was conducted based on structured self-administered knowledge attitude and practice questionnaires to assess knowledge, attitude and practice of 68 HEPs towards mental illness. The data was entered and analyzed using SPSS version 20. Descriptive statistics was performed to describe the study population. The variables association was expressed in odds ratio with 95% confidence interval.

Results: In this study 88 health extension professionals were participated with the mean age of 30.96. This study showed that 50.0% of health extension professionals in Adama city had good knowledge, 51.5% had unfavorable attitude and 41.2% had good practice towards mental illness.

Conclusion and Recommendation: About half of HEPs had good knowledge, half had unfavorable attitude and less than half of them had good practice. Presence of having poor knowledge by half of HEPs and unfavorable practice by a little bit more than half of them decreased the HEPs practice of mental health service provision. Hence, providing refresher training to HEPs and fully implementing the national mental health strategy as well as proper clinical supervision and support to improve behavioral changes are recommended for Adama town health office.

Keywords: attitude, knowledge, health extension professional, mental illness, practice

Introduction

Background

Mental health is considered as the vital asset to human health and wellbeing. However, this term is narrowly defined, and may be conceptualized as the absence of mental illness. The terms “mental health problems” and “mental illness” link with the range of cognitive, emotional and behavioral disorders. These issues interfere with the lives and productivity of people. They are the most commonly reported type of mental health complaint, and are commonly the result of a reaction to life stresses or negative life experiences^[1].

About 450 million people suffer from mental or behavioral disorders worldwide today, mental disorder are widely recognized as a major contributor (14%) to the global burden of disease worldwide^[2]. In India, prevalence rates of mental and behavioral disorders are ranging from 9.54 to 370 per 1000 population^[3]. 1 in 4 health services have at least one mental, neurological or behavioral disorder but most of these disorders are neither diagnosed nor treated. The majority of these were often remaining unrecognized, misdiagnosed, and

inappropriately managed^[4].

Today, mental health problems are recognized as a public health problem in developed and developing countries^[5]. How people think and how they perceive their environments are altered by mental problems and illness. This can affect levels of hope, trust, self-efficacy, and personal relationships, and results in significant impacts on community wellbeing. Mental illness puts at risk the construction of our identities at a time when we are trying to find our personalities in relation to ourselves, others, and the wider society^[6].

Low level of mental health literacy is one of the causes of high incidence^[7]. Based on conducted study by Jorm^[8] the term ‘mental health literacy’ has been defined as “knowledge and beliefs about mental disorder (MD) which help their recognition, management or prevention”. Careful evaluation of the norms, beliefs and tradition within the individual’s cultural environment also belong to the recognition of MD^[9]. In Ethiopia where poverty, war, famine, displacement, and homelessness are common, mental health is also becoming a major public health

problem^[10].

According to the World Health Organization the cost of not treating mental illness may be high both in personal and financial terms^[4, 11].

A further challenge that needs to be addressed worldwide is the massive gap between population needs for mental health and what is actually provided in mental health care. The treatment gap particularly pronounced in low and middle income countries (LAMICs), where commonly over 75% of people with mental disorders receive no treatment or care at all, and less than 2% of health budget is spent on mental health^[12].

In many African societies, psychiatric illness is believed to be either an outcome of a familial defect or the 'handiwork of evil machinations' (demons, evil spirits)^[13]. Another common societal belief is that psychiatric patients are responsible for their illness, especially when it is an alcohol and/or substance related problem. This stigmatization denies psychiatric patients the empathy and understanding traditionally bestowed on the sick in the African society^[13, 14]. Stigma signifies a mark indicating that someone is of a lesser value than others, and this attitude also abounds among health workers in most cultures^[15, 16]. Having knowledge of mental illness does not always reduce the stigmatizing attitudes of primary health care workers^[17]. Prejudice towards people with mental illness has been shown to correlate with societal ignorance that such persons are dangerous and unpredictable, less competent and unable to live productive lives. This in turn increases stigma towards persons with mental disorders despite increased knowledge in mental health recognition, diagnosis and management by health workers^[15].

Misconceptions about psychiatric patients being under the control of evil spirits are the main motivations behind the inglorious, long and persistent use of physical restraints and endorsing of segregating attitudes by society towards them and Health workers are not completely free from these abovementioned unfavorable beliefs and attitudes towards psychiatric patients^[18].

Studies also demonstrate that health professionals have negative attitudes toward some aspects of mental illness and were less optimistic about prognosis and less positive about likely long-term outcomes when compared with the general public^[19]. Health care providers have been known to stigmatize patients who use psychiatric medications or services by offering discouraging advice, disparaging remarks, and rejecting behavior. This form of discrimination may have a negative impact on patients' self-esteem and the way they seek help or adhere to prescribed medical treatments in addition, negative attitudes that manifest as apprehension or discomfort during patient interactions may lead to ineffective counseling or the lack of essential medical services^[20].

In Ethiopia, mental illness is the leading non-communicable disorder in terms of burden. According to WHO Country Cooperation Strategy (CCS) 2012–2015, in Ethiopia there is an increasing trend of mental health problems. This is due to urbanization affects mental health through the influence of increased stressors and factors such as overcrowded and polluted environment, high levels of violence, and reduced social support. In order to overcome this, WHO and the Ethiopian Federal Ministry of Health (FMOH) are currently implementing the WHO Mental Health Hap Action Program (mhGAP) aimed at integrating mental health into PHC through a decentralization

process. Mental Health Gap Action Program (mhGAP) is WHO program aims at scaling up services for mental, neurological and substance use disorders for countries especially with low and middle income^[21]. The HEP professionals are female diploma graduate nurses trained on the Health Extension Program for 3 months.

This study therefore aimed to determine the knowledge, attitude and practice towards mental illness among health extension professionals at Adama city. This information would be useful in the formulation of policy for training, management and service delivery on mental health issues in Adama city and add to the global data on the same subject.

2. Objective of the study

2.1. General objective

To assess knowledge, attitude and practice of health extension professionals about mental illness in Adama city, Ethiopia

2.2. Specific Objective

- To describe knowledge of health extension professionals about mental illness in adama city, Ethiopia
- To describe attitude of health extension professionals about mental illness in adama city, Ethiopia
- To describe practice of health extension professionals about mental illness in adama city, Ethiopia

3. Methodology

3.1. Study Design

A Cross-sectional study design was conducted

3.2. Source Population

All health extension professionals in Adama city

3.3. Study Population

All health extension professionals from all kebeles in Adama city

3.4. Inclusion Criteria

All health extension professionals in the different health facilities and on duty during the study period were recruited into the study.

3.5. Exclusion Criteria

Those health extension professionals, who were on maternal leave, annual leave, seriously ill, on grief, generally not on daily activity were excluded.

3.6. Sample Size and Sampling Method

All health extension professionals (88) in Adama city

3.7. Sampling Procedures

The respondents of the study were identified in the following way. The Kebeles were identified in Adama city. All the identified kebeles were involved in the study. Then After identifying the eligible health extension professionals, Sampling-frame were constructed through complete enumeration of health extension professionals.

3.8. Data Collection Instruments

Self-administered knowledge, attitude and practice questionnaires to investigate knowledge, Attitude and practice of

health extension professionals towards mental illness were developed for the purpose of the study. The questionnaire contains socio demographic, knowledge, attitude and practice questions. Knowledge was assessed by 18 item knowledge questionnaire, attitude was assessed by 6 item attitude questionnaires and practice was assessed by 7 item practice questions. Data was distributed and collected by three data collectors and 1 health officer was recruited to as supervisor and was trained before data collection.

The questionnaire was pre tested by taking 5% of health extension professionals and based on the findings from the pretest, the questionnaire was revised.

3.9. Variables

3.9.1 Dependent Variable

- Knowledge, attitude, & practice

3.9.2. Independent Variable

Socio- demographic variables (age, sex, marital status, work experience, religion, family history of mental illness)

3.10. Operational Definition

Health Extension Professionals: HEP are female diploma graduate nurses trained on the Health Extension Program for 3 months.

Knowledge: Knowledge was assessed by 18 item knowledge questions. The response was graded as 2 for correct answers, 1 for incorrect answers and 3 for those who don't know. Those who scored above the total mean score of 18 item knowledge questionnaire were considered as having good knowledge and those who scored below the total mean score were considered as having poor knowledge.

Attitude: Attitude was assessed by 6 item attitude questions. The response was graded as; 1-disagree, 2-neutral and 3- agree. Those who scored above the total mean score of 6 item attitude questionnaire were considered as having favorable attitude and those who scored below the total mean score were considered as having unfavorable attitude.

Practice: Practice was assessed by 7 item practice questions. The response was graded as 1-yes, 2-no. Those who scored above the total mean score of 7 item practice questionnaire were considered as having good practice and those who scored below the total mean score were considered as having poor practice.

Mental Illness: mental illness is a behavioral or psychological syndrome or pattern associated with distress or with a significantly increased risk of suffering, death, pain, disability, or an important loss of freedom.

3.11 Data Collection Process

Four data collectors were selected for data collection, who had previous experience in data collection were collected the quantitative data by using self- administered knowledge, attitude

and practice questionnaires to assess knowledge, attitude and practice of HEPs in Adama town. Principal investigator and the supervisor were supervised the overall data collection activity.

3.12. Data Processing and Analysis

Data was entered into EPI Info version 7 and transferred to SPSS version 20 for analysis. Data entry, cleaning, processing, preliminary analysis was done by the researcher. Frequencies and other descriptive statistics were used to describe the data. Binary and multiple logistic regression analysis were used to assess the association between independent and dependent variables.

3.13. Data Quality Management.

The questionnaire was pre-tested on health extension professionals of different kebeles in Adama city who was participated in the main study. The aim of this pilot study was to ensure that these questionnaires could reliably use among the target sample recruited for the study.

3.14. Ethical Consideration

A written legal permission regarding the study was obtained from the Institutional Review board of the Adama Hospital Medical College after approval of research proposal. Informed consent was obtained from all health extension professionals who participated in the study with the right to withdraw at any point during the study. No invasive procedure was used and no incentives offered for participation. The participants received an explanation that the study results will be of benefit to the general practice of medicine.

3.15. Confidentiality

Confidentiality of results was assured by not indicating the names of the respondents on the questionnaires.

4. Result

4.1. Knowledge of HEPs towards mental illness in Adama town

About half (50%) of health extension professionals have good knowledge towards mental illness and another 50% of them have poor knowledge. Half (50%) of the respondents said that genetic exposure causes mental disorder. 72.1% of HEPs respond that use of psychoactive substance causes mental illness. Most (72.1%) of the respondents refused that mental illness is caused by God punishment, 76.5% and 83.8% of respondents said that conflict in marriage and divorce causes mental illness respectively. Majority 91.2%, 58.8% of respondents answered that financial constraints and evil sprite causes mental illness respectively, 76.5%, 55.9%, 47.1%, 70.6% and 61.8% of respondents said that evil eye, curse, witchcraft, will of god, and magic doesn't cause mental disorder respectively. 92.6% of the respondents preferred medical treatment, 66.2% of them didn't preferred traditional treatment, 66.2% preferred religious therapy and 63.2% preferred spiritual treatment. Most of the respondents 95.6% and 89.7% said that mental disorder is treatable and mental health treatment has good outcome respectively (Table 2).

Table 1: knowledge of HEPs in Adama town, Ethiopia 2011 E.C

Variable	Number	Percent (%)
Genetic exposure causes mental disorder		
No	25	36.8
Yes	34	50
I don't know	9	13.2
Use of psychoactive substance causes mental illness		
No	19	27.9
Yes	49	72.1
Mental illness is caused by god punishment		
No	49	72.1
Yes	12	17.6
I don't know	7	10.3
Conflict in marriage causes mental disorder		
No	9	13.2
Yes	52	76.5
I don't know	7	10.3
Divorce causes mental disorder		
No	7	10.3
Yes	57	83.8
I don't know	4	5.9
Religious therapy is preferred for mental illness		
No	15	22.1
Yes	45	66.2
I don't know	8	11.8
Medical treatment is preferred for mental illness		
Yes	63	92.6
I don't know	5	7.4
Financial constraints cause mental illness		
No	6	8.8
Yes	62	91.2
Evil eye causes mental illness		
Yes	9	13.2
No	52	76.5
I don't know	7	10.3
Evil sprite causes mental illness		
Yes	40	58.8
No	20	29.4
I don't know	8	11.8
Curse causes mental illness		
Yes	14	20.6
No	38	55.9
I don't know	16	23.5
Traditional treatment is preferred		
Yes	9	10.3
No	45	66.2
I don't know	16	23.5
Witchcraft causes mental disorder		
Yes	10	14.7
No	32	47.1
I don't know	26	38.2
Will of god causes mental illness		
Yes	7	10.3
No	48	70.6
I don't know	13	19.1
Magic causes mental illness		
Yes	15	22.1
No	42	61.8
I don't know	11	16.2
Spiritual treatment is preferred		
Yes	43	63.2
No	15	22.1
I don't know	10	14.7

Mental disorder is treatable		
No	3	4.4
Yes	65	95.6
Mental health treatment has good outcome		
No	6	8.8
Yes	61	89.7
I don't know	1	1.5

4.2. Attitude of HEPs towards mental illness in Adama city

About half (51.5%) of health extension workers have unfavorable attitude towards mental illness and 48.5% of them have favorable attitude. Majority 72.1%, 72.1% of the respondents disagree that the person with mental disturbance can be treated in the same health center with the general patient and traditional healers are better in effectiveness than medical care in treating mental disorder respectively. Most 55.9%, 51.5%, 76.5% of the

respondents agree that, the person with mental disorder can marry and may bring children, the person with mental disturbance can be employed and able to work effectively and the person with mental disorder can leave with others in society respectively. 63.2% of HEPs respond that they relate themselves to mentally ill patient friendly and 26.5% of them relate with caution (Table 3).

Table 2: Attitude of HEPs in Adama town, Ethiopia 2011 E.C

Variable	Number	Percent (%)
The person with mental disturbance can be treated in the same health-center with the general patient		
Disagree	49	72.1
Neutral	13	19.1
Agree	6	8.8
Traditional healers are better in effectiveness than medical care in treating mental disorder		
Disagree	49	72.1
Neutral	9	13.2
Agree	10	14.7
The person with mental d/o can marry and may bring children		
Disagree	22	32.4
Neutral	8	11.8
Agree	38	55.9
The person with mental disturbance can be employed and able to work effectively		
Disagree	22	32.4
Neutral	11	16.2
Agree	35	51.5
The person with mental d/o can leave with others in society		
Disagree	14	20.6
Neutral	2	2.9
Agree	52	76.5
How do you relate yourself to mentally ill patient?		
Friendly	43	63.2
With caution	18	26.5
Keep social distance b/c they are dangerous	7	10.3

4.3. Practice of HEPs towards mental illness in Adama city

About 41.2% of health extension workers have good practice towards mental illness and 58.8% of them have poor practice. Majority 94.1%, 88.2%, 70.8%, 97.1% and 97.1% of respondents performed provision of awareness creation, provision of counseling to mentally ill patient, ever diagnosed mental illness,

referred patients with mental illness and follows patients they referred respectively. Most 51.5% of HEWs didn't afraid of talking to mentally ill and 48.5% of them afraid of talking to mentally ill. Around 56.7% of respondents didn't work with mentally ill person

Table 3: Practice of HEPs in Adama town, Ethiopia 2011 E.C

Variable	Number	Percent (%)
Provision of awareness creation		
Yes	64	94.1
No	4	5.9
Ever diagnose mental illness		
Yes	48	70.6
No	20	29.4
Refer patients with mental illness		
Yes	66	97.1

No	2	2.9
Provision of counseling to mentally ill patient		
Yes	60	88.2
No	8	11.8
Following up on patients you referred		
Yes	66	97.1
No	2	2.9
Afraid of talking to mentally ill		
Yes	33	48.5
No	35	51.5
Did you work with mentally ill?		
Yes	29	42.6
No	39	57.4

4.4. Factors associated with knowledge, attitude and practice of HEPs towards mental illness.

After bivariate logistic regression analysis; age, religion, educational status, marital status, take psychiatric course in under graduate and work experience were not candidate variables for multivariate logistic regression analysis with P-value > 0.25, indicating that there is no any association between knowledge and socio-demographic variables.

In case of attitude, in a bivariate analysis; age and religion were candidate variables for multivariate logistic regression analysis with P-value < 0.25. Among the variables analyzed for multivariate regression, those HEPs with age group of 25-30 years have 4.57 times favorable attitude than those with age group of >30 years and orthodox Christians have 3.46 times favorable attitude than Muslims and protestants (Table 5).

Table 4: Association of attitude score level with age and religion of respondents

Variable	Attitude level(favorable, unfavorable)	P-Value	Cor (Lower, upper)	Aor (lower, upper)
Age				
25-30	25,17	0.010	3.309(1.174,9.324)	4.489(1.439,13.998)
>30	8,18			
Religion				
Orthodox	19,16	0.045	2.227(.752,6.593)	3.462(1.029,11.649)
Muslim	6,4		2.812(.610,12.972)	
Protestant	8,15	0.050		1.832(1.001,3.356)

In case of practice, in a bivariate analysis; educational status and work experience were candidate variables for multivariate logistic regression analysis with (P-value < 0.25). Among the variables analyzed for multivariate regression, educational status didn't show significant association with practice. Those with work experience >7 years have 0.18 times good practice than those with work experience <4years and 4-7 years (Table 6).

5. Discussion

5.1 Knowledge of Hew Towards Mental Illness in Adama Town

This study focused on assessing knowledge, attitude, and practice of health extension professionals towards mental illness in Adama city Ethiopia with a view to suggest an appropriate knowledge, attitude and practice to the concerned body.

According to this study, 50.0% of the study participants had good knowledge, when compared to different studies conducted on similar study participants, the result of this study was similar with a study conducted in Addis Ababa, 50%^[39] but higher than other study conducted in Addis Ababa, 44.0%,^[41].

In this study 72.1% of study participants refused that mental illness is caused by god punishment, 66.2% preferred orthodox treatment and 95.6 % agreed that mental illness is treatable which is better when compared with studies done on Non-Mental Health Workers' Attitudes and Perceptions Towards People with Mental Illness in a Tertiary Health Facility in Damaturu, North East Nigeria in 2018, in which 56.4% disagreed that mental illness is

caused by God's punishment, 94.7% agreed orthodox treatment is preferred to other forms of treatment and 72.1% agreed that mentally ill patients can recover respectively^[37]. In study done on Knowledge, attitude, and practice towards mental illness service provision and associated factors among health extension professionals in Addis Ababa, Ethiopia, only 79.1% responded mental illness as curable^[41].

In this study 72.1% of study participants said that psychoactive substance causes mental disorder, 91.2% said financial constraints cause mental illness, 76.5% said that conflict in marriage causes mental disorder, 50% said that genetic exposure causes mental illness and 61.8% refused that magic causes mental illness which is better when compared to research done on Community Knowledge, Perceived Beliefs and Associated Factors of Mental Distress: A Case Study from Northern Ethiopia in which, only 54.2% expressed the view that substance abuse or misuse could cause MD, 41.9% financial distress or poverty cause mental disorder, Family conflict /marital disharmony was about 30.8%, Heredity (14.6%) and magic 25.4% causes of MD [40]. In study done on Knowledge, attitude, and practice towards mental illness service provision and associated factors among health extension professionals in Addis Ababa, Ethiopia, only 29.5% said drug/substance or abuse causes mental illness^[41].

The possible explanation for this result might be in-service training on mental health is often provided to HEWs working in the community due to the key recommendation of mhGap in Ethiopia is to provide training for non-mental health

professionals to deliver care for people suffering from mental illness^[45]. Again, the Ethiopian mental health strategy, to ensure integration of mental health service into primary health care needs and scaling up the service provision basic and in-service training of health professionals at all levels is very important^[46].

5.2 Attitude of Heps towards Mental Illness in Adama Town

According to this study, 51.5% of the study participants had unfavorable attitude, when compared to a study done on Knowledge, attitude, and practice towards mental illness service provision and associated factors among health extension professionals in Addis Ababa, Ethiopia, More than three-fourth of the UHEPs, 78.5%, did not have a favorable attitude towards mental illness^[41]. The possible reason for this gap may be due to educational status in which 89.7% of these study participants are degree holders which is higher than that in which 74.5% was diploma holders.

In this study about 72.1% of participants disagreed that the person with mental disturbance can be treated in the same health center with the general patient and 63.2% of study participants relate themselves with mentally ill patients friendly, when compared to study done on Non-Mental Health Workers' Attitudes and Perceptions Towards People with Mental Illness in a Tertiary Health Facility in Damaturu, North East Nigeria in 2018, has equivalent finding in which 74.5% disagree that the person with mental disturbance can be treated in the same hospital but 77.0% reported they would keep a social distance because such patients are dangerous^[37].

Also in research done on Attitudes of primary health care providers towards people with mental illness: evidence from two districts in Zambia 2010, 67.5% of study participants agreed that mentally ill patients should not be treated in the same hospital.

In this study 51.5% and 55.9% of participants agree that the person with mental disturbance can be employed and able to work effectively and can marry and may bring children respectively, when compared to a study done on Attitudes of primary health care providers towards people with mental illness: evidence from two districts in Zambia 2010, 61.2% of respondents agreed and 74.7% of respondents strongly agreed that mentally ill people should not be allowed to work or to have children respectively^[42].

In this study most 76.5% of study participants agree that the person with mental disorder can leave with others in society, compared to study done on Knowledge, attitude, and practice towards mental illness service provision and associated factors among health extension professionals in Addis Ababa, Ethiopia, (16.7%) of them strongly agreed and 41.1% agreed that mentally ill people can lead a normal life. The possible explanation for this result might be even though half of them relatively good knowledge about the subject matter, but have low exposure to mental illness service provision and cultural difference.

5.3 Practice of Heps towards Mental Illness in Adama City

According to this study, only 41.2% of the study participants had good practice towards mental illness, which is low when compared to research done on Knowledge, attitude, and practice towards mental illness service provision and associated factors among health extension professionals in Addis Ababa, Ethiopia in which only 75.2% had good practice towards mental illness.

In this study majority 94.1%, 70.6%, 97.1%, 97.1% and 88.2% of study participants responds provision of awareness creation, ever diagnosed mentally ill patient, referred mentally ill patient, Followed up on patients they referred and Provision of counseling to mentally ill patient respectively. When compared with research done on Knowledge, attitude, and practice towards mental illness service provision and associated factors among health extension professionals in Addis Ababa, Ethiopia, 98% of the study participants were providing awareness creation of mental illness to families, individuals, and groups, 10.8% of them were diagnosing mental illness, 90.8% were referring using referral form clients to further treatment to health centers, general hospitals and hospital that are providing only mental health service, 86.2% were following up on patients they have referred, whereas 85.3% of the study participants were providing counseling to mentally ill patients^[41].

In this study, around half 48.5% of study participants afraid of talking to mentally ill patients comparing to research done on Non-Mental Health Workers' Attitudes and Perceptions Towards People with Mental Illness in a Tertiary Health Facility in Damaturu, North East Nigeria in 2018, 64.2% of study participants afraid of talking mentally ill patients. The possible explanation for this finding is probably low knowledge and attitude leading to low practice compared to other studies even though the scoring systems were different.

6. Limitations

The limitation of this study is the possibility of recall bias that might have been introduced due to some knowledge related questions were difficult to remember because of time. The other limitation of this study is difficulty of collecting data because, most of HEPs go to field and repeatedly visiting most of the kebeles was mandatory.

7. Conclusion

The study found out that half health extension professionals' knowledge towards mental illness, appear to be good. It is evidence that most of them had the opportunity to be exposed to refresher courses related to mental health/illness. In addition to this, a significant proportion of HEPs in this study had unfavorable attitude towards mental illness. Despite their poor attitude, they happen to had good practice in providing mental health service around awareness creation, referral, follow up and counseling of mentally ill people in the community.

8. Recommendation

I recommend Adama town health office that intensive training supported with good practice on real patient should be given for all HEPs in Adama town to improve their knowledge, attitude and practice about mental illness. My recommendation also goes to AHMC, OROMIA Health office, Adama town health office and experts to do and encourage researchs done on related issues so as to improve KAP of HEPs about mental illness and so far to improve the health of the society.

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