NURSES' KNOWLEDGE, ATTITUDES AND PRACTICES TOWARDS MENTAL ILLNESS IN THE MAFETENG DISTRICT, LESOTHO

BY

BERNADETT 'MALEHLOHONOLO DAMANE

DISSERTATION

Submitted in accordance with the requirements for the degree

MASTERS IN SOCIAL SCIENCES IN NURSING

Faculty of Health Sciences

School of Nursing

University of the Free State

Supervisor: Dr Idalia Venter

February 2018

DECLARATION

I, Bernadett ‘Malehlohonolo Damane declare that the master’s research dissertation or interrelated, publishable manuscripts / published articles that I herewith submit at the University of the Free State, is my independent work and that I have not previously submitted it for a qualification at another institution of higher education.

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28 February 2018

DEDICATION

I would like to dedicate this dissertation to my late mother Martha M. ‘Moso who passed away when I was preparing this book and to my late sister Florence M. Sekotlo for inspiring me. I will always cherish your love.

ACKNOWLEDGEMENTS

My solemn gratitude to:

God Almighty for a healthy life and grace during the entire period of this study.

My Supervisor, Dr. Idalia Venter for being patient, my mentor, a counsellor and a mother throughout whole study.

The Ethics Committees of the University of the Free State (UFS) and Ministry of Health, Lesotho for granting me the permission to conduct this study.

Scott College Management for giving the opportunity to study and endlessly supporting me throughout the entire duration.

Scott Hospital Management for allowing me to carry out a pilot study in their institution.

Mafeteng Hospital Management, Manager Hospital Nursing Services, District Health Management Team and health centres' nursing staff for giving me the opportunity to utilize their time and facilities to conduct the study

All nursing staff who made this study a success by their participation.

Riona Delport for always offering help with a smile. Your support will always be appreciated.

My husband Pitso for inspiring me, my sons Lehlohonolo and Mosebi, my daughters Monica and Rethabile for the confidence they had in me even in difficult moments, the endless support and ensuring that I progressed.

My colleagues at Scott College of Nursing for their endless support and encouragement.

The rest of my family and friends, whom they are too many to mention, thank you for the encouragement and always being with me in this journey.

Many people who saw me through this journey for the endless motivation and support they provided, without you this book would never be complete.

ABSTRACT

Mental illness is a pervasive and disabling problem worldwide especially in low and middle income countries. In Lesotho, people with mental illness are first attended at primary health care settings by mostly non-psychiatric health personnel. Inadequate mental health knowledge has been shown to result in negative attitudes towards mental illness thereby affecting negatively the behaviour of health care providers towards people with mental illness,

The aim of the study was to describe nurses' knowledge, attitudes and practices (KAP) towards mental illness in the Mafeteng district, Lesotho. A quantitative cross-sectional descriptive design was adopted in this study with a convenience sample of 79 respondents. A four-part pilot tested structured questionnaire was utilised to collect data from the nursing staff placed at Mafeteng district government and Christian Health Association of Lesotho (CHAL) health facilities. Data was collected following approval by Health Sciences Research Ethics Committee (HSREC) of the University of the Free State (UFS) and Ministry of Health Research Ethics Committee, Lesotho.

Gaps in relation to the KAP of nurses towards mental illness have been identified. A significant number of the nursing staff believes that mental illness is not a serious problem and patients with mental illness do not deserve the same attention that other patients do. These beliefs signify insufficient knowledge and inappropriate attitudes that impact on how nurses react towards mental illness and patients with mental illness. Even though majority of respondents endorsed that psychotropic medications are effective in treating mental illness, they are not comfortable to be around these patients. Only 37% of the 79 respondents feel that they are adequately prepared to address mental illness

Recommendations made include initiation of mental health educational programmes for nurses to empower them to increase their knowledge in order to gain of confidence in issues of mental health and illness.

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ABBREVIATIONS

APA	American Psychiatric Association
CHAL	Christian Health Association of Lesotho
DHMT	District Health Management Team
DSM	Diagnostic and Statistical Manual of Mental Disorders
ICD	International Classification of Disease
KAP	Knowledge, attitudes and practices
LNC	Lesotho Nursing Council
MHNS	Manager Hospital Nursing Services
MOTU	Mental Observation and Treatment Unit
NA	Nursing Assistant
RN	Registered Nurse
RNM	Registered Nurse Midwife
RPN	Registered Psychiatric Nurse
UFS	University of the Free State
WA	Ward Attendant
WHO	World Health Organization

CHAPTER 1

INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

Lesotho, also known as the Mountain Kingdom, is one of the world's small developing countries. It has an estimated population of 2 203 821 (World Bank, 2016: Online). Its lowest point is 1 000m above sea level, and it is a landlocked country entirely surrounded by the Republic of South Africa. Lesotho is divided into two major areas, namely, the highlands and lowlands. The highlands are elevated mountainous regions located along the Drakensberg chain and the Maluti Mountains, while the lowlands are located at a lower elevation, along the banks of the Orange and Caledon Rivers.

The two major health service providers in Lesotho are the Lesotho government and a non-governmental organization, the Christian Health Association of Lesotho (CHAL). The network of health facilities within the country consists of 21 general hospitals and four specialised hospitals, namely, a mental hospital (Mohlomi), a leprosarium hospital (Bots'abelo), an HIV and AIDS centre (Senkatana), and an HIV and AIDS paediatric centre (Baylor Centre of United Nations Excellence) (WHO, 2011:21). In addition, there are four private hospitals and four filter clinics. Furthermore, there are 192 health centres sometimes called clinics that are administered by different bodies. To be specific, the government administers 12 hospitals and 85 health centres, while CHAL manages eight hospitals and 73 health centres, one general hospital is privately-owned, the Lesotho Red Cross Society has four health centres and the Maseru City Council owns two health centres. There are 33 privately-owned health centres. These healthcare facilities are distributed throughout the country (Lesotho Review, 2015: Online). About 90% of the private for profit health facilities are situated in the four large districts of Maseru, Berea, Mafeteng, and Leribe (Ministry of Health, 2014). However statistics regarding health facilities in Lesotho is presented or documented in varying numbers in different research papers and/or documents. Table 1.1 depicts the composition of the health facilities by levels and ownership.

Table 1.1: Distribution of health facilities by levels and ownership

PROPRIETOR	*GENERAL HOSPITALS*	*PRIVATE HOSPITALS*	*SPECIALISED HOSPTITALS*	*HEALTH CENTRES*	*FILTER CLINICS*	*TOTAL FACILITIES*
GOVERNMENT	12	0	4	85	4	**105**
CHAL	8	0	0	73	0	**81**
RED CROSS	0	0	0	4	0	**4**
MASERU CITY COUNCIL	0	0	0	0	2	**2**
PRIVATE	1	4	0	33	0	**38**
TOTAL	21	4	4	195	6	**230**

According to the Lesotho Health Sector Strategic Plan of 2012/13-2016/17 (2013: 8), the formal system of Lesotho health facilities is divided into the national (tertiary), district (secondary) and community (primary) levels. The national level comprises of referral and specialised hospitals inclusive of a Mental hospital. Specialised hospitals provide specialised services, such as psychiatric and leprosy care. District level is comprised of filter clinics and district hospitals. These facilities provide both inpatient and outpatient care services though they vary widely as the services are determined by or dependent on factors such as finances, equipment, and human resources. Generally, services include diagnostic and treatment services, minor and major operative services, ophthalmic care, counselling and care of rape victims, radiology, dental services, mental health services, and blood transfusions as well as preventive care. Some specialised care is also available for TB, HIV, and non-communicable diseases. Community level comprises health posts and health centres which are the first point of care within the formal health system. Managed by nurse clinicians (advanced nurse practitioners) with comprehensive skills in preventive and curative care and in the dispensing of medication, health centres offer curative and preventative services, including immunizations, family planning, antenatal and postnatal care. The nurse clinician is working with registered nurses (RNs), registered

nurse midwives RNMs and nursing assistants NAs. The mandate of the nurse clinician also extends to supervising the community public health efforts and training volunteer community health workers (CHWs). Health posts provide community outreach services and are typically managed by volunteers. Services in health posts are different from health centres in that they are not running on daily basis but on regular intervals.

Filter clinics are a first point of care intended to lighten the load of district hospitals and function as “mini-hospitals,” offering preventive and curative services and limited inpatient care. These clinics are especially important in Maseru district, where the national referral hospital serves as a district-level hospital as well. Unlike health centres, filter clinics are staffed by doctors and some even have pharmacy technicians. Additionally, selected laboratory and radiology services (administered through the hospitals) are also offered in these clinics.

Regarding people with mental health problems in Lesotho, the first step of care is consultation at primary government, CHAL or privately owned health facilities. If necessary, they are referred to the Mental Observation and Treatment Unit (MOTU) as the second step. For further management, referral is made to the mental hospital. MOTUs are located at each district government hospital except for Thaba- Tseka district as it does not have a government hospital. These units are under the supervision of the district general hospital while the Mental hospital provides supportive professional mental services to the units. The units offer similar services to the mental hospital inclusive of but not limited to counselling, observations, diagnostic, treatment and admissions though with brief stay. Ideally, MOTUs are staffed by at least five people: one being a registered psychiatric nurse (RPN), others can be RN/RNMs, NAs or ward attendants (WA). At CHAL hospitals, there are PNs (at least one per hospital) who are assigned as overseers of mental health services. Services are to some extend similar to those offered at the units. In Thaba-Tseka district, mental health services are offered at CHAL hospitals and health centres.

The study site is Mafeteng district. It is located in the lowlands, has a variety of health facilities of interest and also a satisfactory population density. The majority of its health

facilities are easy to reach compared to other districts in the lowlands, or the highlands, where population is sparse. Mafeteng is composed of one government hospital, eight primary health facilities that are government owned and nine CHAL-owned primary health facilities. The following is the map of Lesotho showing where Mafeteng is located.

Figure 1.1 Map of Lesotho *(adopted from WorldAtlas)*

Lesotho is classified as a least developed country, which is a country that exhibits the lowest indicators of socioeconomic development, with the lowest Human Development Index ratings (UN, 1971:52). Least developed countries have to work hard in order to graduate from this unfortunate position, and must strive to have a healthy population through prevention and treatment of, among other disorders, mental illness.

According to the World Health Organization (2011a:1-4), the following facts pertaining to Lesotho's mental health legislature have been identified:

- Dedicated mental health legislation exists and was initiated in 1964; however, an officially approved mental health policy does not exist, even though mental health is specifically mentioned in the country's general health policy. The mental health

policy has been drafted but not officially approved, and mental health legislation has been under revision since 2010.

- A mental health plan does not exist.
- Prescription regulations authorise primary health care doctors to prescribe psychotropic medicines.

The Ministry of Health authorises primary health care nurses to prescribe and/or to continue prescription of psychotropic medicine, though with restrictions. On the other hand, the official policy does not permit primary health care nurses to independently diagnose and treat mental disorders within the primary care system.

- Officially approved manuals on the management and treatment of mental disorders are not available in the majority of primary health care centres.

While mental illness is very common all over the world and Lesotho is no exception, mental health expenditure for the country accounts for only 1.8% of the total budget of the Ministry of Health. Of this allocation, the Mohlomi mental hospital consumes 82.11% of the budget (WHO, 2011: Online). Essentially, all nurses come into contact with people with mental illness. The country is operating mostly with contracted psychiatrists from other countries. Nonetheless, in recent years the country spends most of the time without psychiatrists as they do not stay long. During their service, they are stationed at the mental referral hospital, which is the only one in the whole country. In addition, the Psychiatric Mental Health Nursing Programme was discontinued at the National Health Training College in 2009, though the programme resumed in 2016 with four students and still running to date. Ideally, based on its total population, the country should be operating with 6 000 nursing personnel. This number of staff is not on the ground – there are less than 4 000 nurses (Lesotho Review, 2015: Online). According to Lesotho Nursing Council (LNC) records available during conduction of this study, of all nurses registered with LNC 108 were PNs though majority of them were reported to be serving outside psychiatry. According to Mental Health Atlas country profile report (2014), there was 181 reported mental health inpatient and outpatient staff in the country. These include different cadres delivering mental health services.

1.2 PROBLEM STATEMENT

Mental illness and mental retardation also called intellectual disability are among the most common types of disabilities found in the population of Lesotho (Nkhoma, 2013:Online). Psychiatric disorders are a major burden of disease worldwide, and people suffering from these disorders are often treated by non-psychiatric health workers in general health facilities (Ndetei, Khasakhala, Mutiso & Mbwayo: 2011:225). On World Mental Health Day, 2011, the World Health Organization's regional director stated that studies conducted in Africa, to date, indicate that at least one in six people who visit primary health care facilities suffer from some form of mental illness (WHO 2011b:Online). There are no indications that Lesotho is an exception.

Reed and Fitzgerald (2005:249) recognize that the need for care of people with mental problems in general hospitals has increased and nurses are the important resource not only in hospital care but in the delivery of mental health care as well. Their study revealed that one of the basic factors that are generally considered to contribute to the administration of total therapeutic nursing care is nurses' attitudes towards patients. It is explained in conclusion of their study that these attitudes are, to a great extent develop as the result of nurses' exposure to mental health environment and experiences in working and interacting with patients with mental illness. Conversely, it is of concern that research suggests that health professionals, including nurses, have negative attitudes towards people with mental illness (Chow, Kam & Leung 2007:357). Negative attitudes towards mental illness imply that people with any mental illness will be targets of unfair discrimination. Individuals and families will suffer stigmatization resulting in reluctance or delay in seeking medical help. This can lead to high rates of treatment defaulters thereby increasing rates of hospitalization and poor patient care. Moreover absenteeism from work, poor performance in activities or unemployment will also add to the challenges.

Due to these reasons it is important to explore knowledge, attitudes and practices of nurses towards mental illness and people with mental illness, as well as the factors that might influence their attitudes in Mafeteng, Lesotho since little research has been done in relation to this issue.

1.3 AIM OF THE STUDY

The study aimed to describe the knowledge, attitudes and practices of all registered nurses and nursing assistants towards mental illness and people with mental illness in the Mafeteng district, Lesotho.

1.4 OBJECTIVES

The objectives of the study are to:

- Describe the demographic profile of nurses in the Mafeteng district, Lesotho;
- Describe the knowledge of, attitudes towards and practices of nurses towards mental illness in the Mafeteng district, Lesotho; and
- Make recommendations, if necessary, to address any identified problems towards mental illness.

1.5 RESEARCH QUESTION

What are the knowledge, attitudes and practices of nurses towards mental illness in Mafeteng district, Lesotho?

1.6 CONCEPTUAL FRAMEWORK

The conceptual framework provided in Figure 1.1 will be utilised to guide the study.

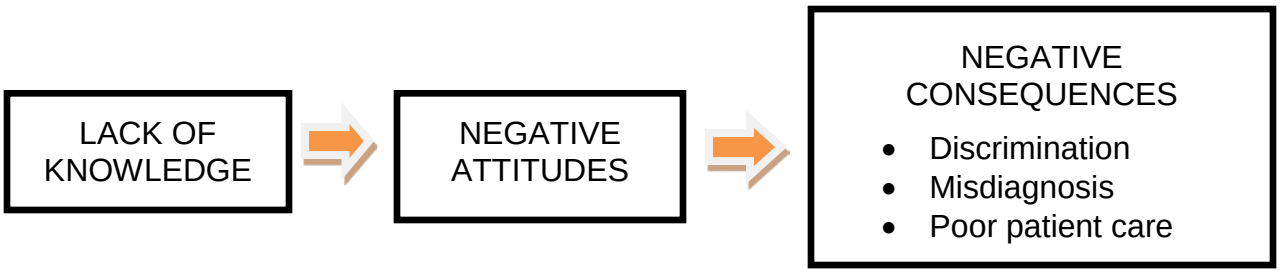

Figure 1.2: Conceptual framework of the study

As has been explained in the problem statement, nurses are the professional group that has the most contact with people who make use of the health facilities in Lesotho. People seeking out health services include people with mental health care needs. The fact that very few of the nurses are trained as mental health care nurses causes concern. The assumption is that nurses with better knowledge of mental health are likely to have a more positive attitude towards people with mental illnesses, which will enhance the central activity of the nurse-patient relationship, resulting in delivery quality care. Nonetheless, Ndetei *et al*. (2011:226) argue that having knowledge about mental illness does not always improve the attitudes of nurses, which could involve stigmatisation.

Morris, Scott, Cocoman, Chambers, Guise, Valimaki and Clinton (2011:460) point out that the harbouring of negative attitudes by healthcare professionals towards any patient can have implications for the patients' recovery; therefore, providing nurses with relevant information and education has the potential to improve attitudes towards people with mental illness by reducing fear and stigma among nurses. Research indicates that there is a significant positive relationship between nurses' attitudes and their practice (Jiang, He, Zhou, Shi, Yin & Kong, 2013: Online).

The study will, therefore, explore nurses' knowledge, attitudes and practices (KAP) towards mental illness and mentally ill people based on the above mentioned arguments.

1.7 DEFINITION OF TERMS

The following key concepts will be clarified: nurse, registered nurse, nursing assistant, knowledge, attitude, practice and mental illness.

1.7.1 Nurse

Lesotho Government Gazette No. 49 (1998:106) defines a nurse as any person certified as such by the LNC. For the purpose of the study, a nurse is referred to as a person who obtained a qualification for the nursing profession and who works at health facilities in Mafeteng district, Lesotho. A nurse in this context can be a RN, RPN, RNM or NA

1.7.1.1 Registered nurse

According to the Lesotho Government Gazette No. 49 (1998:2), an RN is an individual who has completed a programme of basic nursing education and training and has obtained a diploma qualification, and practices nursing in Lesotho.

For the purpose of this study, an RN refers to an individual who has undergone training and has obtained a qualification as an RN/Midwife or hold other nursing qualifications higher than diploma level, has been licensed by the LNC and practices within government or CHAL health care facilities in Lesotho as a nurse.

1.7.1.2 Registered Psychiatric Nurse

Townsend (2015: 211) defines a Psychiatric Nurse as an RN with hospital diploma, associate degree or baccalaureate degree in psychiatry or has a national certification. The individual should provide assessment of client condition both mentally and physically as well as offering care in all aspects. In this study, a Psychiatric Nurse is a RN with a psychiatric nursing qualification and licensed by the LNC as a Registered Psychiatric Nurse (RPN) and practices in government or CHAL health facilities in Lesotho.

1.7.1.3 Nursing assistant

The Nurses and Midwives Act (Lesotho, 1998:107) refers to a person who has undergone training for the Certificate in Nursing Assistant programme, has qualified, is listed by the LNC, and who practices in Lesotho as a nursing assistant.

For the purpose of this study, an NA refers to a person who has undergone either a two year or 18 or 15 months training in Nursing Assistant Programme, has obtained the Certificate in Nursing Assistant, listed by the LNC and practices as an NA in any government or CHAL health facility in Lesotho.

1.7.2 Knowledge

The *Oxford Advanced Learner's Dictionary* (Hornby, Cowie & Lewis, 2010: 827) defines knowledge as facts, information and skills acquired through experience or education. Badran (1995:8) defines knowledge as a combination of understanding the acquired information from a given experience, which is retained and applied to form a certain skill.

For the purpose of this study, knowledge refers to a combination of facts and information acquired through experience and that can be translated into a skill that can be utilised when dealing with mental illness. This encompasses the understanding of mental illness, including causes, symptoms, and treatment.

1.7.3 Attitude

According to Badran (1995:8), attitude refers to the way an individual feels and organises opinions in order to react in a certain way to a given situation. Fishbein (in Spring, 2002: Online) concurs, and defines attitude as an accumulation of information about an object, person, situation or experience; a predisposition to act in a positive or negative way toward some object. It is further stipulated that attitude is basically the information that individuals acquire and develop an opinion about someone or something. James, Isa and Oud (2011: 130) emphasize that attitude is 'a predisposition toward any person, idea or object and contains cognitive, affective and behavioural components'.

For the purpose of the study, attitude refers to how individuals perceive and react towards mental illness and people with mental illness

1.7.4 Practice

Badran (1995:8) describes practice as the application of rules and knowledge, which results in an individual taking a certain action, while the *Oxford Advanced Learner's Dictionary* (Hornby *et al*., 2010:1148) defines practice as a way of doing something, either in a typical or unusual way, in a specific organisation or situation.

In this study, practice refers to the cognitive representation of readiness and the observable response of a nurse in a given situation, together with the actual ease or difficulty of dealing with this situation relating to mental illness.

1.7.5 Mental illness

Mental illness refers to a syndrome that has multiple causes and may represent several different disease states that have not yet been defined. The term is used interchangeably with mental disorder. Mental disorders are defined as clinically significant disturbances in cognition, emotion regulation, or behaviour that reflect a dysfunction in the psychological, biological or developmental processes underlying mental dysfunction. (Boyd 2015:13). The diagnosis of mental illness is made based on the criteria according to the Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5) and/or the International Classification of Diseases-10th version (ICD-10).

In this study, mental illness refers to the state in which an individual portrays persistent signs and symptoms of mental disturbance that affect his or her daily functioning negatively. Such an individual has been diagnosed with mental illness based on the criteria described above.

1.8 RESEARCH METHODOLOGY

Methodology refers to the theory or strategies that researchers follow in order to get answers to the research question (Botma, Greef, Mulaudzi & Wright, 2010:287).The

subsections of Section 1.8 describe how the researcher went about exploring the KAP of nurses towards mental illness and people with mental illnesses.

1.8.1 Research design

Polit and Beck (2012:58) and Grove, Burns and Gray (2013:195) define research design as the architectural backbone or blueprint of a study. The researcher will use a quantitative, cross-sectional survey design, since the study wishes to explore the characteristics of RNs and NAs in terms of their KAP towards mental illness. The design will further enable the researcher to compare knowledge, attitudes and behaviour of respondents towards people with mental illness.

1.8.2 Research technique

The researcher will use a questionnaire that is a combination of two relevant, tested questionnaires. The reason for combining the two questionnaires is that there is no single questionnaire that addresses all the variables that need to be evaluated. The first questionnaire was used in a study that was carried out in Zambia by Kapungwe, Cooper, Mayeya, Mwanza, Mwape, Sikwese, Lund and The Mental Health and Poverty Project Research Programme Consortium (2011: 292-295). The aim of this study was to explore health care providers' attitudes towards people with mental illness in Zambia. The second questionnaire was used in a study by Bennett (2012: 88-95) on the effects of a mental health training programme on health care workers' knowledge, attitudes and practice in Belize. The questionnaire that is compiled from these two above mentioned questionnaires is attached as Annexure A.

1.8.3 Population and sample

Burns and Grove (2009:42) define population as all elements that meet the inclusion criteria in a given situation. A sample is a subset of the accessible population that is selected for a particular study (Botma *et al.,* 2010:124).

In this study, the population of interest is all nurses in Lesotho; however, only one of 10 districts, Mafeteng, has been chosen for its convenience. All RNs and NAs who are placed

in the Mafeteng district government- and CHAL-owned health facilities will be invited to participate, irrespective of gender, nationality, religion or political affiliation. There were a total of 154 RNs and NAs practicing at CHAL- and government-owned health facilities in the health system of Mafeteng district during the time of proposal writing.

1.8.4 Pilot study

A pilot study is a smaller version of a proposed study (Burns & Grove 2009:44). The pilot study will be carried out at Scott Hospital, Morija. Scott Hospital is a CHAL institution located in the Maseru district. It offers health services similar to those rendered at Mafeteng and other government hospitals though in different scale. The hospital is easily accessible to the researcher. Two RNs and two NAs who work at this hospital will be invited to participate in a pilot study. This institution is not part of the study, and the results of the pilot study will not be included in the actual study findings.

The purpose of the pilot study is to determine if the questionnaire is easy to understand, and to ascertain the time that will be taken to complete it (De Vos, Strydom, Fouché & Delport 2014:73).

1.9 DATA COLLECTION

Data collection is defined as the precise and systematic gathering of information to accomplish the research aim (Botma *et al,* 2010:131; Burns & Grove, 2009:43). In this study, data will be collected by means of a self-administered questionnaire that will be delivered by the researcher to the respective areas of the study. Fieldworkers will not be utilised. The questionnaire is compiled in English as it is commonly used in nursing. The training is conducted in English and all written communication in the health care services is done in English. Consent from the prospective respondents to participate in the research will be obtained during a staff meeting. At the meeting, the purpose of the study will be explained and questionnaires distributed. The researcher will remain in the background and only avail herself to address concerns where necessary. The questionnaires will be collected immediately upon completion.

1.10 VALIDITY AND RELIABILITY

Influencing factors that could weaken the validity and reliability of the study need to be considered. Methods of enhancing validity and reliability in this study are explained in subsections below.

1.10.1 Validity

Validity is defined as the degree to which a measurement represents a true value (Botma *et al.,* 2010:174). Questionnaires based on two standardised questionnaires will be utilised. The mode of administration will be the same as in the pilot study in that it will be completed by the intended target group within the same allocated time.

1.10.2 Reliability

Reliability refers to the consistency of measures obtained in the use of a particular instrument and indicates the extent of random error in the measurement method (Burns & Grove 2009:377). To ensure reliability, all respondents will complete the same questionnaire.

1.11 ETHICAL CONCERNS

All research must adhere to the principles of beneficence, non-maleficence, justice and respect for people. Before commencement of the study, approval will be obtained from the Evaluation Committee of the School of Nursing, University of the Free State (UFS), and the Health Sciences Research Ethics Committee of the UFS. The researcher will then submit the approved proposal to Ethics Committee, Ministry of Health, Lesotho, for subsequent approval.

Data collection will commence following approval of the proposal and receiving consent from the relevant authorities. An open invitation for participation will be extended to all nurses placed at government and CHAL health facilities in Mafeteng district. The information sheet (Annexure B) covering the contents of the study will be distributed to prospective respondents for them to make an informed choice about participation.

Respondents will be guided through the information sheet by the researcher. No one will be coerced into participation, and respondents will be informed that withdrawal is permitted at any time, without any penalty.

The following ethical principles were observed (Botma *et al.,* 2010:17-21).

1.11.1 Justice

In order to observe justice, fair selection of respondents will be ensured. All RNs and NAs in Mafeteng will be invited to participate, as long as they meet the inclusion criteria. Any changes or interventions that might occur will be communicated to respondents. Data collected will be kept confidential.

1.11.2 Respect for people

Respect for people is attained when the researcher observes anonymity and confidentiality. In this study respect for people will be ensured by providing all possible and adequate information about the study in order for respondents to make a decision regarding participation. In addition, approval to carry out the study will be sought from the ethics committees of the UFS and Ministry of Health of Lesotho respectively as mentioned earlier, following which permission will be obtained from relevant authorities at the relevant health centres through district health management team (DHMT) at the Mafeteng district hospital.

1.11.3 Beneficence

There are no direct advantages for respondents to take part in the study; however, should the study reveal a problem in relation to the KAP of the nurses, and corrective measures implemented, they will benefit. At the same time, there are no anticipated risks in relation to participation**.**

1.11.4 Non-maleficence

This principle states that participants will not be harmed. The researcher is not anticipating any harm; however some of the answers in the questionnaire might contradict the nurses' professional code and could lead to disciplinary actions or adversely affect employment conditions. Nevertheless, this threat will be avoided as the questionnaire is anonymous and as a result there will be no link between the respondents and the collected data.

1.12 DATA ANALYSIS

Descriptive statistics, namely, frequencies and percentages for categorical data and means and statistical variations or medians and percentiles for continuous data, will be calculated. The analysis will be done by the Department of Biostatistics at the UFS.

1.13 SCHEDULE OF EVENTS

The researcher planned to carry out and complete the study within a period of 15 months. The time is scheduled in such a way that it accommodates the various activities comprising the study, starting from submission of the protocol to the UFS Ethics Committee and ending with submission of the dissertation.

1.14 BUDGET

The funds required to support the project are estimated.

1.15 VALUE OF THE STUDY

The significance of the study is that, following data analysis, findings and recommendations will be made to the relevant stakeholders. The expectation is that results will inform planning in relation to psychiatric mental health nursing training and nursing education. More research will further be pursued to enhance mental health services.

1.16 CONCLUSION

In this chapter, the problem statement, the aim and objectives of the study were introduced. The conceptual framework and research methodology have been discussed. Ethical principles to adhere to were also highlighted. The next chapter discusses the literature review.

The following represents the structure of the study in sequence:

Chapter 2: Literature review;

Chapter 3: Research methodology used;

Chapter 4: Data analysis and interpretation of the findings;

Chapter 5: Conclusions reached, limitations and recommendations made.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION AND OVERVIEW

The following chapter presents a review of literature in relation to the problem statement. Various data sources were consulted to obtain information about knowledge, attitudes towards and practices relating to mental illness.

Based on the postulation that mental illnesses, also known as psychiatric disorders, present a major disease burden worldwide (Ndetei *et al.*, 2011:225), and the assertion that the most frequent types of disabilities found in the population of Lesotho emanate from mental illness and intellectual disability (Nkhoma, 2013:Online), it can be argued that mental illness is a major burden of disease in Lesotho, specifically; one of which the treatment is often the responsibility of non-psychiatric health workers.

Like in some other countries of the world, Lesotho provides free mental health services. Due to a scarcity of qualified personnel in Lesotho, nurses play a major role in delivering these services. This involvement of nurses leads to several questions: Have the nurses acquired adequate knowledge about mental illness? What are nurses' attitudes towards mental illness and people with mental illnesses? How do nurses translate their feelings into behaviour towards people with mental illnesses, that is, what is the nature of practices by nurses in relation to mental illness? It is believed that nurses' KAP determine the outcome of the care they are rendering to people with mental illnesses. According to Foster, Usher, and Baker (2009: 72), attitudes have an impact on both professional and personal behaviour.

Research conducted in different areas of the world about the KAP of nurses towards mental illness has found that health care providers, including nurses, hold negative attitudes that influence the utilisation of mental health care services and the quality of care being rendered adversely. These attitudes can serve as barriers in seeking mental health services with the consequences such as treatment defaulters, high rates of relapse and trying out other non-scientific treatment modalities thereby increasing rates of mental

illness (Ndetei *et al*., 2011:225; Tei-Tominaga, Asakura & Asakura, 2014:317). The researcher, therefore, wanted to explore these three related factors in nursing personnel who render care at all levels to people with mental illnesses in Lesotho, because few studies about mental health and illnesses have been conducted in Lesotho.

In this chapter, the background of mental health and mental illnesses will be explained. Mental illnesses, its aetiology and the prevalence of illnesses will be explored. The burden of mental illness on individuals, families and communities, as well as a definition and the impact of stigma will be presented. Mental health care in Lesotho, knowledge, attitudes and practices of nurses in relation to mental illness and people with mental illnesses will be discussed.

2.2 MENTAL HEALTH AND MENTAL ILLNESS

An understanding of mental health and mental illness is important for this study. In this section a brief overview of mental health and mental illness is provided.

2.2.1 Mental health

While the study is about nurses' KAP towards mental illness, it is worth looking at mental health first, in order to understand what mental illness encompasses.

According to Boyd (2015:12), mental health is,

> *"The emotional and psychological well-being of an individual who has the capacity to interact with others, deals with ordinary stress, and perceives one's surroundings realistically".*

Certain indicators should be present for a person to be regarded as mentally healthy. These indicators are characteristics that confirm that an individual is mentally sound, and include a positive attitude toward self; growth, development, and the ability to achieve self-actualisation; integration; being independent; being able to perceive and interpret ones surroundings as they are, as well as mastering and controlling ones' environment. The indicators imply that mental health is, therefore, essential for various benefits including personal wellbeing, social interaction, as well as being a citizen who can

contribute to a community. World Health Organisation and other service providers claim that there is no health without mental health. However, indicators such as a positive attitude towards the self, or the ability to master one's environment, can be exhibited while someone possesses neither mental nor physical health (Boyd 2015:12; Sorsdahl, Stein and Lund 2012:168; Townsend, 2015:14-15).

2.2.2 Mental illness

Mental illness is a common phenomenon in all cultures and has existed since time immemorial; though different literature sources provide different descriptions of this concept. People have been utilising different treatment modalities, depending on their perception of the illness. Historically, mental illness was associated with witchcraft, or being possessed by the devil or evil spirits. While mental health explains the wellbeing of an individual, the topic of mental illness evokes feelings of fear, embarrassment or even disgust, thus, fostering negative attitudes towards mental illness and mentally ill people (Feldman, 2015: 507; Shyangwa, Singh & Khandelwal, 2003:27).

The concept of mental illness has various synonyms, including mental disorder, psychological disorder, abnormal behaviour, psychiatric disorder or illness, mental health problems and psychopathology. In this study, mental illness and mental disorder are used interchangeably. In Chapter One, section 1.7.5, mental illness has been described from different perspectives.

Mental illness has various definitions, and only few are described here. Frisch and Frisch (2002:4) describe mental illness as:

> *"State in which an individual shows deficits in functioning; cannot view self clearly or has distorted image of self, is unable to maintain personal relationships, and cannot adapt to the environment*".

Townsend (2015:907), on the other hand, views mental illness as:

> *"The maladaptive responses to stressors from the internal or external milieu, evidenced by thoughts, feelings and behaviours that are contrasting with the local*

and cultural norms, and interfere with the individual's social, occupational and or physical functioning".

The American Psychiatric Association (APA, 2013: 20) states that a mental disorder is a "*syndrome characterised by clinically significant disturbances in cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning".* The disturbances are usually associated with distress or impairment in different areas of life, including social and occupational functioning. WHO (2014: Online) states that mental disorders comprise a broad range of problems, with different symptoms. They are generally characterised by some combination of abnormal thoughts, emotions, behaviour and relationships with others. Based on the above descriptions, mental illness can be explained as a state in which an individual portrays a significant disturbance in mental processes that leads to distress and impairment of functioning.

2.3 CLASSIFICATION OF MENTAL ILLNESSES

Various classification systems for mental illnesses have been proposed. The two most important psychiatric classifications are the Diagnostic and Statistical Manual of Mental Disorders (DSM), which was developed by the APA, and the International Classification of Diseases (ICD), that was developed by the WHO. The first edition of the DSM (DSM-1) was published in 1952. Over time, the criteria underwent review several times, until 2013, when the current version, the DSM-5, was published. In this study, the disorders will be described in terms of DSM-5 diagnostic criteria. The DSM-5 is designed such that it is similar and corresponds to the 10th edition of ICD, to ensure standardised reporting of international health statistics. Furthermore, DSM and ICD are similar in that the criteria for mental illness are based on the given clinical picture that is associated with impairment in functioning (Bulbulia & Laher, 2013: 52; Sadock, Sadock & Ruiz, 2015:290-1). This study will refer to the DSM, as it is the classification system that is used in Lesotho.

2.4 DSM-5 DIAGNOSTIC CRITERIA

The DSM was introduced to provide clear diagnostic criteria to enable clinicians to diagnose mental illnesses. Its main function is to assist in diagnosing and classifying abnormal behaviour, by providing a relatively precise definition of such behaviour (Feldman, 2015:510; Townsend, 2015:902). According to Sadock *et al.* (2015:291), the DSM-5 lists 22 major categories of mental disorders, comprising of more than 150 distinctive illnesses. The DSM also provides the associated features, such as age, culture, gender-related features, prevalence, incidence, risk, course, complications, predisposing factors, and differential diagnoses that form the basis of describing each disorder. The disorders are organised to follow the lifespan pattern, such that disorders that occur in childhood are listed first, followed by those appearing during adulthood.

Table 2.1 lists examples of mental disorders appearing in both childhood and adulthood. Some conditions that are common during childhood can persist until adulthood. Some conditions are easy to diagnose, since a patient will be portraying obvious abnormal behaviour, while others are often missed, because they mimic physical conditions, and does not exhibit any symptoms of abnormal behaviour. Some conditions are more common than others, for example, depression is so common that it is known as "*the common cold of psychiatry*" (Uys & Middleton, 2014:359).

Table 2.1: Classification of mental illnesses

CATEGORY	***MENTAL ILLNESS***
Neurodevelopmental disorders	Intellectual disability or intellectual developmental disorder, communication disorders, autism spectrum disorder, attention-deficit/hyperactivity disorder, specific learning disorders and motor disorders
Schizophrenia spectrum and other psychotic disorders	Schizophrenia, delusional disorder, brief psychotic disorder, schizoaffective disorder, substance/medication-induced psychotic disorder, psychotic disorder due to another medical condition and catatonia

Bipolar and related disorders	Bipolar I disorder, bipolar II disorder, cyclothymic disorder, bipolar disorder due to another medical condition and substance/medication-induced bipolar disorder
Depressive disorders	Major depressive disorder and persistent depressive disorder or dysthymia
Anxiety disorders	Panic disorder, agoraphobia, specific phobia and social anxiety disorder or social phobia
Obsessive compulsive and related disorders	Obsessive-compulsive disorder, body dysmorphic disorder, hoarding disorder, trichotillomania, excoriation or skin-picking disorder, obsessive-compulsive disorder due to another medical condition and other specified obsessive-compulsive and related disorders
Trauma- or stressor-related disorder	Reactive attachment disorder, disinhibited social engagement disorder, posttraumatic stress disorder, acute stress disorder, adjustment disorder and persistent complex bereavement disorder
Dissociative disorder	Dissociative amnesia, dissociative fugue, dissociative identity disorder and depersonalisation/derealisation disorder
Somatic symptom and related disorders	Somatic symptom disorder, illness anxiety disorder, functional neurological symptom disorder, psychological factors affecting other medical conditions, factitious disorder and other specified somatic and related disorders
Feeding and eating disorders	Anorexia nervosa, bulimia nervosa, binge-eating disorder, pica, rumination disorder and avoidant/restrictive food intake disorder
Elimination disorders	Enuresis and encopresis
Sleep wake disorders	Insomnia disorders, hypersomnolence disorder, parasomnias, narcolepsy, breathing-related sleep disorders, restless leg syndrome, substance/medication-induced sleep disorder and circadian rhythm sleep-wake disorders
Sexual dysfunction	Delayed ejaculation, erectile disorder, female orgasmic disorder, female sexual interest/arousal disorder, genitor-pelvic pain/penetration disorder

Gender dysphoria	Characterized by a persistent discomfort with one's biological sex and in some cases, the desire to have sex organs of the opposite gender
Disruptive, impulse-control, and conduct disorders	Oppositional defiant disorder, intermittent explosive disorder, conduct disorder, pyromania and kleptomania
Substance-related disorders	Substance-induced disorders, substance use disorders, gambling disorder, alcohol-induced disorders
Neurocognitive disorders	Delirium, mild and major neurocognitive disorders
Personality disorders	Paranoid personality disorder, histrionic personality disorder and dependent personality disorder
Paraphilic disorders and paraphilia	Paraphilia, exhibitionism, voyeurism, frotteurism, paedophilia and sexual masochism
Other mental disorders	Other specified mental disorders due to another medical condition, unspecified mental disorder due to another medical condition

(Sadock *et al.,* 2015:291-298)

Following this list of illnesses, it is imperative to describe the factors that are responsible for their occurrence. Section 2.5 presents a discussion of the aetiology of mental illness, namely, biological, psychological and environmental factors.

2.5 AETIOLOGY OF MENTAL ILLNESS

The exact cause of mental illness is not known, however, there are theories designed to explain the causes. Characteristically, mental illness results from a multifaceted interplay between biological, social and psychological factors. Biological factors include genetic factors, physical factors and changes in the brain structure. Psychological factors encompass individuals' personality traits and personality types, while social or environmental factors include but not limited to culture, religion, families, environmental events, abnormal life events, and economic disadvantage. In most cases, a complex

interaction between biological, psychological and social or environmental factors contributes to the emergence of mental health and neurological problems (Alhaidar, Online; Medicinet Health Direct: Online). Causes of mental illness are broadly explored from 2.5.1to 2.5.3 below.

2.5.1 Biological factors

According to Bhandari (2016: Online), some mental illnesses have been linked to abnormal functioning of nerve-cell circuits or pathways that connect particular brain regions. Nerve cells within these brain circuits communicate through chemicals called neurotransmitters, thereby linking the nervous system and behaviour (Feldman, 2015:64). When describing neurotransmitters, Feldman states that they are chemicals that carry messages across the synapse to the dendrite of a receiving neuron. Hence, a deficiency or an excess of a neurotransmitter can produce severe behaviour disorders. An example is the case of schizophrenia, which involves an excess of the neurotransmitter dopamine, which leads to distortion of reality, while in major depression, the dopamine activity is reduced, and in mania, increased. Defects in or injury to certain areas of the brain have also been linked to some mental illnesses. Neurotransmitters that are commonly involved in the occurrence of mental illness are serotonin, dopamine and noradrenalin (Feldman, 2015:524; Sadock *et al.,* 2015:350).

Another biological factor that may be involved in the development of mental illness is heredity, which suggests that some mental illnesses run in families – people who have a family member with a mental illness may be somewhat more likely to develop a mental illness (Feldman, 2015:527; Townsend, 2015:422). Susceptibility is passed on in families through genes. Research indicates that many mental illnesses are linked to abnormalities in several genes, rather than just one or a few. Not everybody who is susceptible will suffer mental illness, but the occurrence is dependent upon the interaction of inherited genes and the environment that an individual finds her/himself in (Bhandari, 2016 Online).

Other mental health problems that have purely biological basis are neurocognitive disorders. For example, dementia which is referred to as a major neurocognitive disorder in DSM-5. It can be caused by Alzheimer’s disease which is commonly diagnosed in people older than

65 years of age. Its prominent manifestations are emotional and behavioural changes, impairment in cognition, memory and orientation (Boyd, 2015:723; Townsend, 2015:334). Infections are also linked to brain damage and the development of mental illness or worsening of its symptoms. The occurrence of autism spectrum disorders is, for example, associated with disruption of early foetal brain development. Furthermore, long-term substance abuse and malnutrition adversely affect the functioning of the body on a biological level, resulting in conditions such as depression, anxiety and schizophrenia. Apart from the above-mentioned factors, structural abnormalities in the brain also play a role in the occurrence of some mental illnesses, including schizophrenia (Bhandari 2016: Online; Feldman, 2015:527; Sadock *et al.,* 2015:694).

2.5.2 Psychological factors

Psychological factors that may contribute to mental illness include severe psychological trauma suffered in childhood, such as emotional, physical or sexual abuse or neglect, an important early loss, such as the loss of a parent. The effect from these factors could be poor ability to relate to others among others (Medicinet Health Direct: Online).

2.5.3 Environmental factors

Mindwise (2015: Online) views environmental factors as "*Factors around us*", which encompass the life and living circumstances of an individual. Family and community support networks, employment status and work stressors can play a part in the development of mental illness. All these factors provoke negative consequences that put pressure on an individual's mental health. Low socioeconomic status, for instance, is linked to the occurrence of schizophrenia and other mental problems in a manner that firstly, low socioeconomic status brings about poverty; thus, triggering symptoms of some mental disorders or worsening already existing mental problems. Secondly, people with schizophrenia who are engaged in some employment may fail to keep their jobs and fall into poverty, thus impacting negatively on their health (Bhandari, 2016: Online; Townsend, 2015:425). Bhandari further states that certain stressors can trigger mental illness in a person who is susceptible, for example, due to loss of a loved one, either through death or divorce, which could lead to conditions such as elimination disorders and major

depressive disorders in children (Uys & Middleton, 2014:735). Lastly, while biological factors can play a role in causing eating disorders, social or cultural expectations or demands are also responsible for the development of eating disorders and other mental conditions (Feldman, 2015:324). From the above views, it is clear that no single factor is responsible for the causation of mental illness; instead, a combination of more than one factor is associated with the occurrence of the illness.

2.6. THE PREVALENCE OF MENTAL ILLNESS

Mental illness accounts for a significant and growing proportion of the global burden of disease, yet remains a low priority in many low- and middle-income countries, as indicated in Chapter One. This section explores the global prevalence of mental illness. According to the Mental Health Atlas country profile of 2014, Lesotho does not have clear reports on the prevalence of mental illness, however, it was found in 2008 that the most commonly diagnosed mental illnesses in Lesotho are depression and anxiety (Commonwealth health: 2011: Online)

The onset of majority of mental illnesses is around early adulthood stage, the crucial time when human beings are productive, pursuing careers and starting families among many milestones and as a result causes disability (Uys & Middleton, 2014:409). A study by Lund *et al.* (2008, cited by Samouilhan & Seabi, 2010:76) found a high prevalence of mental illness in South Africa, and the rate seemed to be increasing rapidly and it was estimated that 17% of the total population had psychological disorders in 2007. Studies carried out subsequent to that of Lund *et al*. confirmed this trend. According to global surveys of mental illnesses and studies carried out in South Africa, there is evidence that the prevalence of mental illness is increasing (Sorsdahl *et al*., 2012:168).

It is anticipated that, by 2030, mental health problems will constitute 15% of the global burden of disease. Regardless of the growing burden of mental illness and the resultant suffering of individuals and society, efforts that have been employed to address mental illness did not yield satisfactory results (Jack-Ide, Uys & Middleton, 2014:1; Shrestha, 2015:3). The WHO (2008) proposed a model for integrating mental health services into primary health care, with the expectation of reducing stigmatisation of patients and

addressing staff shortages. The aim of this model is to improve access to mental health care services nevertheless full integration is not yet attained in many countries. In 2013, it was estimated that there were at least 450 million people in the world suffering from some kind of mental illness, with 150 million affected by depression and 25 million by schizophrenia (WHO, 2008: Online).

2.7 THE BURDEN OF MENTAL ILLNESS ON INDIVIDUALS, FAMILIES AND COMMUNITIES

According to the WHO (2003: Online) mental illnesses are accompanied by direct and indirect burden. The burden of distressing symptoms is amplified by stigma and discrimination, which impair the individual's ability to participate in work and leisure activities. The WHO report also indicates that it is not only persons with mental illness who suffer the consequences, but their families and caregivers too are also burdened by stigma and discrimination due to their relationship with the ill person. Furthermore, an unquantifiable burden of suffering and lost opportunities is compounded by time and financial resources being expended. As a result, the ability of caregivers to provide physical and emotional support to those who are ill is affected.

The burden that the family bears due to mental illness is considerable, and exacerbated by stigma. Apart from being on the receiving end of stigma and discrimination, families serve as caregivers, supporters of other families in similar situations, as teachers and educators of the public, as well as advocates for better services, thus, increasing their already unbearable burden. In addition, it is clearly pointed that caregiving responsibilities involve being a treatment supporter and ensuring that relationships between the patient and other people are maintained. They also have to bear financial costs to ensure the survival of patients. These responsibilities result in caregivers being emotionally affected (Uys & Middleton 2014:88).

Research confirm that persons with mental illness are denied their rights, including the right to employment; thus, increasing the burden on individuals, families and communities at large. Unemployment is one of the major burdens of individuals with mental illness, as they cannot find or retain employment due to the mental illness, regardless of their

expertise. Unemployment negatively impacts government expenditure, as those with mental illness are not contributing to the economy of their country. This imposes a huge challenge, because, in many countries, mental health services are free. Lesotho is not an exception, and the expectation is that mental health services expenditure will be accommodated within a limited budget, as indicated in Chapter 1. People with mental illness who are employed, are compelled to take early retirement, due to stigma and prejudice in the workplace, as well as a decline in work performance owing to poor mental functioning (Karpansalo, Kauhanen & Lakka, 2005:71).

According to Uys & Middleton (2014:84), the diagnosis of mental illness is the most terrifying experience a person can tolerate because mental illness is viewed differently to other illnesses by society. People diagnosed with or labelled as having mental illness suffer the consequences of being discriminated and stigmatised. This is affirmed by several studies that show evidence of negative attitudes, among the general public and health care providers, towards undesirable conditions, including mental illness (Kapungwe *et al.,* 2011:290; Louis & Roberts, 2013:123). Due to negative consequences that are brought about by stigma in various spheres of life, the researcher finds it worth exploring the relationship between mental illness and stigma.

2.8. STIGMA

Stigma goes hand in hand with mental illness. There is evidence that one of the reasons why people with mental illnesses and their families are without jobs, housing and even friends is due to stigma (Uys & Middleton, 2014:85).

2.8.1 Defining stigma

The word stigma comes from the Greek word which means to tattoo or to brand. Broadly speaking, stigma is a negative evaluation of a person who is tainted or discredited on the basis of attributes, such as a mental disorder or illness, race, ethnicity, drug misuse or physical disability. It is a mark of shame, disgrace, or disapproval, which results in an individual being ignored by other people. It is also described as a collection of negative

attitudes, beliefs, thoughts, and behaviours that influence the individual, or the general public, to fear, reject, avoid, prejudice and discriminate against people with mental illness. Stigma signifies a mark indicating that someone is of a lesser value than others, and this attitude exists among both health workers and community members. (Boyd 2015: 14; Dictionary 2007: Online; Gary 2005:80; Ndetei *et al*. 2011:226; Shrestha, 2013:35).

2.8.2 Stigma and mental illness

Corrigan (2004: 615) explored the failure of patients with mental health problems to engage in their treatment. Based on the results of his study, the reason is *stigma*. Mental illness is among the phenomena that are characterised by intense stigma by the general public as well as health professionals, inclusive of mental health professionals (Sadock *et al*., 2015:1402). Sorsdahl *et al.* (2012:169) state that compared to other members of the society, those with mental illnesses are viewed as being more unpredictable, tense and dangerous, worthless, delicate, slow, weak, dirty, and foolish. Due to these labels, patients with mental illness are being discriminated against, to the extent that they are denied opportunities equal to that of other members of society. These characteristics are portrayed and confirmed by abusive treatment that people with mental illness have always endured. Historically, during the Middle Ages, treatment modalities were inhumane, and included driving out evil spirits by means of whipping, trephination, immersion in hot water, starvation and burning. Sometimes patients were even sent out to the sea to search for their lost rationality – this is the origin of the expression “ship of fools” (Townsend 2015:13; Uys & Middleton, 2014:4).

Historically, in Lesotho, like in many countries of the world, persons with mental illness did not receive proper treatment. They were housed in what was known as the Detention Centre situated at Mohale’s Hoek prison, where they were cared for by unskilled personnel. People from neighbouring villages used to visit the place to tease and watch patients when portraying abnormal behaviours. Some stigmatising behaviours are still observable, even today, as some patients are brought to health facilities viciously beaten and bound with materials that cause harm such as wires; the maltreatment is due to the belief that they are possessed by evil spirits or they are evil spirits themselves. Deribew and Tesfaye (2005) emphasise that, globally, many patients with mental illness are

victimised and have become the target of stigma and discrimination. A study carried out in Zambia by Kapungwe *et al*. (2011:291) explains explicitly that stigmatising patients with mental illness is a common phenomenon across all cultures. This matter is confirmed by a study carried out in Nigeria (James, Omoaregba & Okogbenin, 2012), where the first large-scale, community representative study of popular attitudes towards persons with mental illness found stigma to be widespread, with most people indicating that they would not tolerate even basic social interactions with someone with a mental illness. Bennett (2012:12) also carried out a study on the prevalence of stigma and its pervasiveness among the police, teachers and students, as well as health professionals. Bennett found that stigma is prevalent among all these groups. It was also found to be present among people working in the mental health field, including psychiatrists, who are credited with advanced knowledge and training, and who are supposed to assist persons with mental illness and protect their human rights (Thornicroft, Rose & Mehta, 2010:55).

The above-mentioned labels attached to mental illness affect individuals with mental illness and their families negatively. Section 2.8.3 addresses the effects of stigma on individuals with mental illness and relevant stakeholders.

2.8.3 Effects of stigma on persons with mental illness and mental health services

Literature indicates the existence of negative impacts by stigma on persons with mental illness as well as mental health services. The following bears reference to this issue. The WHO, World Health Report (2001:17) states that stigmatisation complicates access to those who need help, treatment and care, and that stigma is responsible for a huge hidden burden of mental problems. Stigma is a recognised barrier to the effective management of mental illnesses in several parts of the world. It affects health professionals' readiness to provide effective interventions for individuals with mental illness. Shrestha (2013:35) makes it clear that attitudes influence both professional and personal behaviour.

Stigma and discrimination associated with mental illness result in the underutilisation of mental health services. This seems to be the opposite of the ideal situation, in which mental health professionals should serve as advocates and role models in society; their

views towards people with mental illness should positively influence the behaviour of the society instead of holding stigmatising attitudes (James, *et al.* 2012:32). In their research, Sorsdahl *et al.* (2012:169) affirm that stigma is a barrier to scaling up services for persons with mental illness. In addition, the burden is increased, due to various beliefs among the general public about mental illness. These studies reveal the presence of varying degrees and patterns of stigma towards persons with mental illness, which influence the relationship between patients, family members, health professionals and the society at large. According to Boyd (2015:14), persons with mental illness have been humiliated, hanged and or even stoned to death because of stigma. Boyd further points out that stigma leads to community misunderstandings, prejudice and discrimination, and it is one of the major barriers to treatment facing individuals with mental health problems.

In summary, the literature is clear that stigma is a barrier to the full utilisation of mental health services; thus affecting the lifestyle functioning of the affected persons and resulting in increasing the burden of mental illness. This conclusion is confirmed by Ikeme (2012:5), who stipulates clearly that stigma and discrimination can disrupt the lives of individuals living with mental illness, preventing or slowing down their opportunities to become productive citizens. The question is has the world done something to reduce stigmatising behaviours? The following section explains efforts exercised to combat stigma.

2.8.4 Combating stigma

Combating stigma has never been an easy task. Various efforts have been applied to fight stigma, but little has been accomplished, since many studies show that stigma and discrimination in relation to mental illness are still issues that the world is grappling with.

According to the World Psychiatric Association (WPA, 2000), several programmes have been put in place to reduce the persistent stigma faced due to mental illness. The aim of these programmes was to challenge negative stereotypes and discriminatory responses that generate social disability around the world; nonetheless, these programmes are rarely evaluated. In addition to the programmes, studies that were carried out in different areas point out that there are three general approaches that can be followed in an effort

to combat stigma and these are education, contact and protest. It is argued that, although each of these stigma-reducing approaches has some degree of validity on the surface, they are not uniformly effective, however, short educational workshops are found to produce positive changes in attitudes towards people with mental health problems. While education is important, disclosure is vital in the process of reducing stigma (Corbiere, Samson, Villotti, & Pelletier 2012:1; Corrigan & Penn 1999; Online; Pinfold, Toulmin, Thornicroft, Huxley, Farmer & Graham 2003: Online). According to the WHO (2001), governments are encouraged to move away from large mental institutions, towards community health care, and rather to integrate mental health care in primary health care services and the general health care system. This advice represents an effort to avoid isolating patients, which would prevent people from engaging in negative labelling. Furthermore, a recommendation by the WHO (2001:4), at the 65th World Health Assembly, aimed to introduce human rights protection for people with mental health problems. Among the strategies proposed were developing policies and laws that protect and promote human rights, and establishing independent monitoring mechanisms. The purpose of these mechanisms is to improve conditions in health facilities, in line with international human rights standards, such as the United Nations Convention on the Rights of Persons with Disabilities. Another recommendation was to involve people with mental health problems in employment and income-generating programmes, to introduce supported employment programmes, and to provide social protection grants. The assumption is that the more supportive the environment, the less the probability of mental problems being exacerbated; and the more stigmatising attitudes will be reduced. In conclusion, reducing stigma requires a concerted effort from all relevant stakeholders in order to overpower it. Furthermore, existing health care systems must be strengthened. Section 2.9 below discusses health care systems in Lesotho.

2.9 MENTAL HEALTH CARE IN LESOTHO

In Lesotho, mental health services are the responsibility of the Ministry of Health and the services are free. Lesotho has one mental referral hospital that admits men and women of different ages, from 14 years upwards. In 2011 the hospital was renovated with the aim of increasing bed capacity from 60 to 115 in order to accommodate children and

adolescents (Mental Health Atlas, 2011: Online). During the time of the study the hospital had about 12 PNs, while the rest of the nursing staff comprised of RNs, RNMs, NAs and WAs. A Medical Officer available at the time assumed the duties of a psychiatrist, served at the hospital and supported all MOTUs.

The nursing staff is charged with the total care of patients within the health facilities. As mentioned in Chapter 1, the WHO's Mental Health Atlas (2011a: Online) states that, in Lesotho, primary health care nurses are authorised by the Ministry of Health to care for persons with mental illnesses even though there are restrictions in relation to prescription of psychotropic medication, since there are no guiding manuals in health facilities. Secondly, the official policy does not permit primary health care nurses to diagnose and treat mental disorders independently in the primary care system. Practically, the nursing staff is composed of a Nurse Clinicians RNs/RNMs, NAs and WAs.

As stated in Chapter 1, the basic nurses training include a mental health component in various programmes. RNs/RNMs and NAs who trained in Lesotho are only introduced to mental health nursing of the child, adolescent and adult – RNs had a semester course while some NAs had a 1 year course and others a semester course during their training. RNs/RNMs who are interested in mental health had to pursue a 1year programme to specialise in psychiatric mental health nursing to obtain a qualification in psychiatric nursing. RPNs are placed in MOTUs, where they have full responsibility of running the units independently and ensuring that all mental health activities in the unit are occurring together with those of primary health care facilities within their catchment areas. Ideally, they are paired with RNs, NAs and WAs and work together to accomplish all duties performed in the unit. The daily duties of RPNs include consultation of patients in the unit, hospital and or at health centres, counselling, outreach services (for which they sometimes travel long distances), school health services as well as mental health awareness campaigns. The Psychiatrist or Medical officer visit the units as per scheduled times. Based on the above information, it can be argued, therefore, that caring for people with mental illnesses is done mostly by nursing staff that have little or inadequate training in relation to issues of mental health and illness, since the majority received only a brief introduction to matters related to mental health.

The need to care for people with mental health problems in general hospitals has increased. While Uys and Middleton (2014:107) make it clear that a positive diagnosis of a mental-health-related illness in terms of accepted diagnostic criteria should be made by a mental health care practitioner authorised to make such a diagnosis, generalist nurses are the major providers of hospital care and have become an important resource in the delivery of mental health care (Reed & Fitzgerald, 2005:249). Lesotho is no exception, as nurses with no speciality in psychiatry play a fundamental part in the care of patients with mental illnesses, from primary to tertiary levels of care. In Lesotho, people with mental illness are, first, consulted at the primary health care facility, mostly by nurses, before they can be referred to any point of care for further management. Patients who warrant observation at the MOTU are admitted and observed up to a period of about 28 days before referring the patient to the hospital, if necessary.

According to literature, nurses' responsibilities in relation to mental health in Lesotho are similar to that of some parts of the world. Nurses face various challenges inclusive of changing expectations and behaviours patient as well as shortage of staff. These challenges may burden nurses and negatively affect the quality of nursing care based on the mentioned responsibilities. There are changes in mental health services that impact the role and practice of mental health nursing. While nurses attempt to provide a safe environment, they struggle to provide therapeutic care due to the fact that patients with mental illnesses are demanding, acute, and disturbed. Even though the nursing staff struggle to deliver quality care, it is fair to acknowledge the dynamic role played by these health workers in the diagnosis and management of patients with mental illness in the face of these massive challenges. Nonetheless, research made it clear that, even though they are playing an essential role in the absence of psychiatrists, mismanagement may occur if they miss the diagnoses of mental illnesses, due to lack of knowledge and time when evaluating patients presenting with psychiatric symptoms (Hamdan-Mansour & Wardam, 2009:705; Cleary, Walter & Hunt, 2005; Rey, Walter, and Giuffrida, 2004; O'Brien & Cole, 2003; Ndetei *et al*., 2011:225).

Uys & Middleton (2014: 45) indicate that comprehensive mental health care is essential in order to meet the needs of individuals and families affected by mental illness. They

further explain an effective approach to follow that includes primary, secondary and tertiary prevention strategies. Primary prevention strategies include health education that is carried out in an effort to impart information and knowledge that assist to prevent mental illness while secondary prevention aims to reduce the prevalence of the illness through early detection and effective treatment. Ongoing education is important at this stage. Tertiary prevention is about rehabilitation and enhancement of recovery. Ongoing treatment and care is of the utmost importance at this level. It is at this juncture where the multidisciplinary team work jointly for the betterment of the patient with mental illness. The team consists of psychiatrists, occupational therapists, all categories of nurses, clinical psychologists, social workers and pharmacists (Uys & Middleton, 2014: 39).

Clark, Parker and Gould (2005: 205) agree that nurses play an integral role in the delivery of health care services to persons suffering from mental illnesses, especially in rural and remote areas. Shortage of expertise in the mental health care field increases the burden of mental illness on communities as confirmed in a study carried out by Kakuma, Minas, Van Ginneken, Dal Poz, Desiraju, Morris, Saxena and Scheffler (2011:1665), who estimated that there was a shortage of 1.18 million specialist mental health personnel in low- and middle income countries of which Lesotho is included.

2.10 KNOWLEDGE, ATTITUDES AND PRACTICES OF NURSES TOWARDS MENTAL ILLNESS

Knowledge can influence positively the way people feel and behave in response to such feelings, though it is not always the case. It is believed that people who are well informed can act effectively and produce favourable results. However, it is emphasised that the possession of accurate information does not predict the ability of making wise judgments, nor is misinformation necessarily an antecedent of bad decisions. Literature indicates that knowledge has been consistently shown to be non-influential in predicting behaviour (Ajzen, Joyce, Sheik and Cote, 2011:101; Wallace, 2002: Online).

The relationship between knowledge, attitudes and practices of nurses in relation to mental illness will be discussed based mostly on the theory of Ajzen *et al*. (2011: 102). According to the theory of planned behaviour people's intention to perform a specific behaviour emanates from an informational foundation that closely links with the knowledge component of this study's intended KAP survey. However, the knowledge component will not necessarily reflect the degree of knowledge nurses show about mental illness, but rather their beliefs, which ultimately determine their behaviour or practice.

Three groups of beliefs are identified, namely, behavioural, normative and control beliefs. Behavioural beliefs depict the nurses' behaviour in respect to a specific mental illness and a consequence that leads from this behaviour. Normative beliefs reflect the nurses' behaviour towards and expectation of a specific mental illness due to the enacted behaviour. Flowing from normative beliefs are subjective norms. The subjective norm not only provides a link between the nurses' behaviour and mental illness, but also states that the expectation is linked to the expectations of other relevant nurses in this field, who are involved in the care of persons with mental illness. Control beliefs portray factors a nurse perceives, which could either assist or hamper the control over mental-illness-related issues. Lastly, nurses' perceived behavioural control reflect the link between a specific mental-illness-related behaviour and the nurses' perception of their ability to manage the specific behaviour.

In line with the KAP survey, specific attention is given to the attitudes of nurses, as an element playing a role in the actual mental-illness-related behaviour or practice. The nurses' attitudes towards mental-illness-related issues, as well as their subjective norms and perceived behavioural control of such issues, all strengthen or weaken their intention to perform specific mental-illness-related behaviour. The behaviour equals what the KAP survey refers to as *Practice*. Therefore, nurses' behaviour in relation to mental illness will depend on their intention to act out behaviour, as well as the actual behavioural control the nurse has over performing such behaviour in the long run. Several researchers validate this theory, as explained below.

In a study by Al-Rabeei, Dallak and Al-Awadi (2012: 222), the idea was that an important factor driving the spread of HIV and AIDS in developing countries is lack of knowledge about how the disease is spread and how it can be prevented. The argument is that the high prevalence rate of mental illness can be attributed to a similar shortcoming. Ajzen *et al*. (2011:102), however, make it clear that possession of the required knowledge is not enough; instead, people must also be motivated to perform the behaviours in question.

Another contributing factor that can influence the knowledge and attitudes of health care providers either positively or negatively has been found to be an adequacy of clinical experience during training. This is affirmed by a study by Cleary, Horsefall, O'Hara-Aarons, Mannix, Jackson and Hunt (2011:185), which found that adequate clinical exposure increases undergraduate nursing students' knowledge of and confidence in the field. In Lesotho, the majority of the nursing staff who care for patients with mental illness have limited exposure to mental health content and clinical practice during training. For instance, RNs undergo *one month* of clinical exposure while NAs have the exposure of *two weeks* during training.

It is clear, therefore, that several factors play a role in achieving a desired behaviour. While knowledge is one of important factors, it cannot suffice to bring about positive outcomes in relation to mental illness and people with mental illness. Attitudes and how people act under the influence of their feelings about mental illness also play a vital role in producing the desired outcomes.

Baron and Byrne (1987) state that attitudes are lasting, general evaluations of people, including oneself, objects or issues, that persist over time. Furthermore attitudes guide peoples' experiences and determine the effects of experience on one's behaviours. In addition, attitudes determine a person's personality; they influence the actions of an individual towards the world. Most importantly, attitudes affect one's social interactions. According to Foster *et al.* (2009: 72), attitudes influence both professional and personal behaviour. While positive attitudes are favoured, the consequences of possession of negative attitudes are unpleasant especially in mental illness. Negative attitudes toward mental illness as studied by Foster *et al*., (2009) appear to worsen the overall quality of life of individuals with mental illnesses as they result in stigma and discrimination. They declare that stigma and discrimination associated with mental illness, as explicated by mental health professionals and the general public, lead to a situation whereby mental health services are under-utilized. Nonetheless it is mentioned in their study that for the past 50 years, programmes aiming to reduce the stigma about mental illness have been introduced but the shortcoming is that these initiatives advocated for medical rather than psychological explanations for mental illness.

Morris *et al.* (2011:460) agree that if healthcare professionals harbour negative attitudes towards any patient, these attitudes can have implications for the patients' recovery. Venter (2014: Online) found that attitudinal problems regarding mental illness and a lack of skills are among the factors that lead to failure of health providers to detect mental illness. Therefore, providing nurses with relevant information and education has the potential to improve their attitudes and behaviour towards mental illness and people with mental illness, by reducing fear and stigma. Clark *et al*. (2005:205) state that nurses require knowledge, skills and networks in mental health that will enable them to provide effective mental health care. However, acquisition of knowledge about mental illness does not always reduce the stigmatising attitudes of primary health care workers. Prejudice towards people with mental illness has been shown to correlate with societal ignorance and beliefs that mentally ill persons are dangerous and unpredictable, less competent and unable to live productive lives.

Although many definitions of attitude have been proposed, most investigators would agree that a person's attitude represents his evaluation of the entity in question as stated earlier (Ajzen & Fishbein, 1977: 889). It is also recognised that knowledge may play a significant role in shaping attitudes which in turn could determine responses to particular situations or circumstances (Igbinomwanhia, James & Omoaregba, 2013: 196).

2.11 SUMMARY

It is clear that mental illness is common worldwide. In many African societies, mental illness is believed to be either an outcome of a familial defect or the handiwork of evil machinations. Another common societal belief is that patients are responsible for their illness, especially when it is a problem related to alcohol and/or substance abuse (Ndetei *et al*., 2011:226).

Even though mental illness is common, there are few studies on mental health issues, particularly about the attitudes of nursing staff – the major health care providers, especially in Lesotho – towards mental illness. Despite growing evidence of the importance of mental health for economic, social and human capital, people with mental health problems, mental health services and professionals, and even the very concept of mental health, receive negative publicity and are stigmatised in public perceptions (Vijayalakshmi, Reddy, Math & Thimmaiah, 2013:66). Literature indicates that people with mental illnesses are stigmatised. Stigma signifies a mark, which indicates that someone is of a lesser value than others. It is clear that a stigmatising attitude not only exists among the general public, but also thrives among health workers in most cultures.

In this chapter, a literature review of matters pertaining to knowledge, attitudes and practices of nurses in relation to mental illness was conducted. The methodology used for this study will be discussed in Chapter 3.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

Chapter 1 gave an overview of the study, starting with the problem statement and context of the problem**.** Chapter 2 provided the reader with a literature review of information pertaining to the KAP of nurses as it relates to mental illness worldwide. This chapter will give a description of the research design and the method applied in order to achieve the objectives of the study. Consideration will be given to the quantitative, descriptive, cross-sectional research design used. The research technique, namely the structured questionnaire used to collect data, will be explained, and considerations relating to the population and sampling, pilot study as well as validity and reliability, will also be described. Ethical concerns and the value of the study will be looked into.

3.2 RESEARCH DESIGN

Research design is defined as development of the framework of the study or the overall plan, strategy or structure that will assist the researcher to pursue and accomplish the objectives of a study through responses to the research question. Furthermore, the research design guides the researcher regarding the projections and the implementation of the study processes. The research technique to be used is determined by the research design followed, and guides the researcher in the selection of the population, sample and data collection method to utilise. The framework, therefore, serves as a plan of reference that ensures security against all unexpected factors that could hinder or interfere with the validity of the findings (Botma *et al*., 2010:39; Burns & Grove, 2009:218; De Vos *et al*., 2014:142; Grove *et al*., 2013:43; Polit and Beck 2012:58). A descriptive, cross-sectional, quantitative design was used in this study.

3.2.1 Descriptive research design

A descriptive design is a non-experimental design used to describe the variables without manipulating the situation. The main aim of the descriptive design is to observe, count and classify phenomena with the intention of, (i) identifying patterns in variables; (ii) describing and defining variables; and (iii) identifying initial relationships among variables. Descriptive research is generally preferred when there is limited knowledge about the event or the situation of interest. This design was found to be relevant for this study, as there was little or no evidence of studies having been done regarding the KAP of nursing staff in relation to mentally ill patients in Lesotho. However, a shortcoming of this design is that it cannot be used to infer causality; nonetheless, it is relatively less time consuming and, as a result, cost-effective (Botma *et al*., 2010:110; Grove *et al*., 2013:87; Polit & Beck 2012:226).

3.2.2 Cross-sectional design

A cross-sectional design involves a process of data collection from a specific sample at a single moment in time. Furthermore, it gives the researcher the opportunity to recognise problems and draw conclusions in relation to current practice (Botma *et al*., 2010:110; Brink, Van Rensburg & Van Der Walt, 2009: 10; Grove *et al*., 2013:43; Polit & Beck, 2012:184).

The advantages of this design are that it has been proven to be economical, as participants are captured in a specific setting at the same time. It is also quick and easy to conduct, as it is generally based on a questionnaire survey; furthermore, it is a once-off activity, since no follow-up meetings are required (Botma *et al*., 2010:113; Polit & Beck, 2012:186; Sedwick, 2014: Online). Due to these features, and the fact that some of the respondents were stationed in inaccessible locations, and limited funds were allocated to conduct the study a cross-sectional design was applicable for exploring the nurses' KAP.

3.2.3 Quantitative research

Polit and Beck (2012:739) define quantitative research as, “the investigation of phenomena that lend themselves to precise measurement and quantification often involving a rigorous and controlled design”. Control mechanisms are exercised to reduce bias and optimise validity. The data that is gathered is attached to numbers, which are statistically analysed and used to describe and deduce predictions about events or behaviours. The results that are obtained may be generalised, due to the objective nature in this approach. Quantitative research design enables description of the prevailing situation and formation of relationship between variables. It focuses its attention on measurable aspects of human behaviour and is only used if the data can be measured in numbers (Botma *et al*., 2010:109; Bryman, 2012:159; Polit & Beck, 2012:14).

A quantitative research design was found to be relevant for this study, as the intention was to explore and describe the behaviour of nursing staff towards mental illness. It is a quick approach, since it uses a questionnaire. It is not expensive to administer, as it permits data collection from the sample at a single event, without any subsequent meetings for further data collection being required. The technique used is explained below.

3.3 THE RESEARCH TECHNIQUE

3.3.1 Questionnaires

A research technique refers to methods or measurement strategies that are used to collect data. A questionnaire is a document containing printed questions and other types of items that require research subjects to provide answers or opinions. The aim of the questionnaire is gathering information suitable for analysis from the written responses given by the research subjects. There is evidence that, compared to interviews, there is no difference between information gathered through questionnaires and interviews, except that questionnaires sometimes give less detailed information (Burns & Grove, 2011:345; De Vos *et al*., 2014:186; Brink *et al.,* 2009:102; Grove *et al*., 2013:425,

Hassan, 2016: 42; Polit & Beck, 2012:305). In this study, a structured questionnaire was found suitable and was used to collect data.

Methods of administration of questionnaires vary. Questionnaires can be self-administered, or responses can be taken down by the researcher. The researcher can utilise either face-to-face or telephonic approaches to collect data. With face-to-face interviews, the interviewer meets with the respondents to ask questions in person. The face-to-face method is used when literacy levels of respondents are a problem (De Vos *et al*., 2014: 356). This is not applicable in this study as respondents are literate.

In administering a telephonic questionnaire, the interviewer asks questions over the telephone and records answers during the interview. The advantages of this method are that it is fairly cost-effective in relation to travelling and time, as the researcher works from one area. Information is collected in a short time and the level of literacy of the respondent is not a factor. Challenges of this approach include the difficulty of collecting sensitive data, and the possibility of the respondent ending the interview prematurely (De Vos *et al*., 2014:187; Marshall, 2016: Online; Polit & Beck, 2012:265).

Self-administered questionnaires can be sent out by mail, electronically, or handed out to respondents at a communal place. Advantages of self-administered questionnaires are that they are economical, and quick to complete only if they are within recommended length. Inadequate literacy of respondents poses a challenge, as the questionnaires are completed individually in a form of writing. Another disadvantage is a low response rate, however, if the questionnaires are handed out personally, a higher response rate is possible and respondents have the opportunity to ask questions (Bowling, 2005; Polit & Beck, 2012:310). Self-administered questionnaire method was intended to be used for this study though it was not successful. Different methods of distributing these questionnaires, as well as advantages and disadvantages of these methods are explained from sections 3.3.1.1 to 3.3.1.3 according to De Vos *et al*. (2014:186-190) and Polit & Beck (2012: 309 -312).

3.3.1.1 Mailing questionnaires

In this case, questionnaires are posted to the respondents, who complete them and send them back to the researcher. An advantage is that this method is cost-effective, as the researcher does not incur travelling expenses to meet with respondents. Some people may find being in contact with the researcher threatening and this influences their responses. With a mailed questionnaire, respondents feel liberated, as there is no face-to-face contact with the researcher and they complete the questionnaire in their own time. Limitations include a low response rate, an inability of the researcher to ensure that the person is the intended respondent, and a high degree of bias. Sometimes, it is difficult to track respondents' failure to follow instructions until it is too late, and they have submitted their questionnaires.

3.3.1.2 Distributing questionnaires electronically

This distribution method has four modes. An emailed survey involves the questionnaire being sent to the respondent, who completes it and returns it using e-mail. The second type uses a web-based survey, whereby the questionnaire is completed online. The third way involves using computerised interactive voice response (IVR), which relies on telephone calls, and the last type is through various ways of using computer, laptop or desktop. The aim of this approach is to work electronically, and to avoid using paper-based questionnaires. Advantages of electronic distribution include few mistakes, elimination of paper, and the ability to collect data from even remote areas. It is also easy to transfer data from the electronic devices to the central database for analysis. Disadvantages of this type of distribution are that illiterate persons struggle to operate electronic devices and are at risk of being excluded from participation.

3.3.1.3 Hand-delivering questionnaires

The questionnaire is delivered by hand and collected at a later stage, after being completed – if possible, not more than 48 hours after distribution. The advantages are that the response rate is high due to personal contact and since it does not take long to complete, feedback is received within a short period of time. Furthermore, clarity can

be sought from the researcher as there is personal contact between the researcher and the respondent. However, hand-delivering questionnaires have limitations, among which limited coverage, due to travelling costs, as well as problems relating to respondents' literacy.

The initial plan in this study was to utilise the self-administered questionnaire approach, owing to the fact that the health facilities are far apart and scattered throughout the district. I had to travel long distances along gravel roads, some of which in poor condition. Appointments were scheduled in such a way that health facilities located along the same route or direction would be scheduled during a trip of one or two days, to deliver questionnaires, have them completed and to collect them during the same visit. This plan did not work, as the nursing staff could not avail themselves due to various acceptable reasons while the researcher was at health facilities. The reasons include being away from the facility for outreach services delivery, workload pressure due to the number of patients/clients and limited staff, attending workshops or meetings or being off duty. Due to these reasons, the alternative was to deliver questionnaires to each facility by hand and to collect them on agreed dates. The distribution was done within a short space of time. The information leaflet was read to respondents upon distribution of the questionnaire. The mode of handing out the questionnaire was the same at all health facilities.

The questionnaire was to be completed anonymously. Anonymity encourages participation by and loyalty from respondents when giving feedback. This is in line with what Botma *et al*. (2010:135) indicate, namely, that anonymous questionnaires encourage respondents to give first-hand or honest information. In addition, this approach was cost-effective, as the researcher worked alone, without any assistance.

This method also faced limitations. The health facilities, as mentioned earlier, are far from each other, thus, increasing travelling costs. To address this challenge, appointments were made with gatekeepers prior to delivery and collection of questionnaires; they were also reminded telephonically. In spite of appointments and reminders, the researcher had to make more than one trip to health facilities to collect questionnaires, as some questionnaires were not available at the initial collection time.

Another challenge that was noticed during analysis of the completed questionnaires was that some respondents misinterpreted some items.

3.3.2 Development of the questionnaire

The development of a questionnaire requires skill and effort to produce a valid and reliable tool. Questionnaires can be extracted and adopted from existing literature, used as they are, or modified. Modification includes addition or exclusion of items in the existing questionnaire to address the needs of a specific study. Furthermore, researchers sometimes combine modifications by using more than one questionnaire depending on the needs of a study (Botma *et al.*, 2010:134; Grove *et al*., 2013:426). Features of a good questionnaire are explained below.

3.3.2.1 Features of good questionnaires

As stated in Chapter 1, a questionnaire is a document that contains printed questions. The way questions are arranged is important. Questions relating to the same theme should be grouped together, while the questions should start from a general perspective and move towards more specific aspects. It is advisable to start with simple and interesting questions that lead to more sensitive questions. Questions should be clear, with no ambiguities, so that the respondent does not have to wonder what is being asked. Items should be stated in a positive rather than a negative manner, and the researcher should avoid asking two questions in one item. Lengthy questions or statements will put respondents off; so long items need to be limited as far as possible (Botma *et al*., 2010:134).

The researcher did not develop a questionnaire for this study, but, instead, adapted existing questionnaires by selecting only information relevant to this study, to compile one questionnaire. A combination of two relevant questionnaires was used. The first questionnaire relates to a study that was carried out in Zambia by Kapungwe *et al.* (2011). The aim of the study was to explore health care providers' attitudes towards people with mental illness in Zambia. The second questionnaire was used by a study by Bennett (2012), on the effects of a mental health training programme on health care workers' KAP in Belize.

The questionnaire compiled for this study was only available in English, as this is the language used during training as well as in actual practice (at work) in Lesotho. Closed-ended and open-ended questions enabled the researcher to collect a variety of information. In this study, closed-ended questions are mostly used for the purpose of collecting ample information in a reasonable amount of time. The questions were presented in a Likert scale where five options were provided to choose from. Responses to closed-ended questions are easy to code. A data collecting instrument should comprise certain basic characteristics, including feasibility, reliability, validity, appropriateness and suitability (Babbie, 2004:245; Neuman 2007:181).

3.3.2.2 Structure of the questionnaire

The first section collected biographical data, including information on age, gender, marital status and qualifications. Section B focuses on assessing knowledge about mental illness and people with mental illness, while Section C examines attitudes, and Section D assesses practices relating to mental illness.

Section 3.3 described the research technique used; the following section describes the population, target population, accessible population and sampling.

3.4 POPULATION AND SAMPLING

Population refers to all cases that qualify to participate in a given research study, whether events, persons, behaviours or records; while the target population refers to the whole set of persons, behaviour, events or objects that can be chosen to represent the accessible population for a certain study. Accessible population is a set of persons, behaviour or events and objects that meet the sampling criteria and which are available to participate in a given study. The sample is a subset, or a smaller portion, of the accessible population that is selected for a particular study (Botma *et al*. 2010:124; Burns & Grove, 2009:42; De Vos *et al.,* 2014:223; Grove *et al.,* 2013:351; Polit & Beck, 2012: 273).

In this instance, the target population comprised all nursing staff (RNs and NAs) in the country. Some, health centres operate in the highlands as they are located across the

country, which means some centres are located in hard-to-reach areas. The mountainous terrain, together with scattered and isolated rural villages, represent a significant access barrier to both staff and patients, and the WHO estimates that around three quarters of this rural population live beyond of walking distance of a health facility (Lesotho Review, 2015:Online). The Review further mention that retaining health workers in the remote parts of the country is also problematic, though measures have been taken in motivating them to stay and work in the highlands.

Based on the above-mentioned facts, only one district, Mafeteng, was chosen as the study site. This decision was due to its location in the lowlands and the structure of its health facilities. Only government and CHAL institutions were considered for the study, as mentioned in Chapter 1 the government owns one hospital and eight primary health facilities while CHAL owns nine health centres.

All RNs and NAs who were working in the Mafeteng government hospital and all government and CHAL health centres were invited to participate. Ideally, each health centre should be run by five nursing staff, that is, nurse clinician (advanced nurse practitioner), at least two RNs and/or two NAs, though this is not the case in practice. Not all health facilities have the ideal personnel complement – some were found to be run by three staff members, and some by four staff members. Only one had seven staff members. Another observation is that the distribution of staff by qualifications is different across facilities. According to the statistics presented to the researcher by the Manager Hospital Nursing Services (MHNS) before commencement of data collection, there were 154 staff members for all health facilities identified for participation in the study.

3.5 PILOT STUDY

A pilot study is defined as a smaller version of a full-scale study, and specific pretesting of a particular research instrument. It is also known as the dress rehearsal of the main investigation. Pilot studies are not done as merely routine in research, but for various reasons, including refinement of methodology, to find out whether the study is feasible, and to ascertain the adequacy and ambiguity of the research instruments. It also helps to measure the time required to complete the questionnaire. A pilot enables the

researcher to establish whether the sampling frame and technique are effective, and to assess the likelihood of success of proposed recruitment approaches (De Vos *et al.,* 2015:73; Grove *et al.,* 2013:46; Van Teijlingen & Hundley, 2001:Online). Due to these benefits, a pilot study was carried out.

The pilot study was carried out at Scott Hospital after being granted permission by MHNS at the hospital as is the person in charge of the nursing staff. Employees of the hospital, two RNs and two NAs, were invited to participate in the pilot study. Pilot subjects were employees of Scott Hospital, which offers the similar services as Mafeteng Hospital and its primary health facilities. The information leaflet was read and discussed with pilot subjects. They agreed to participate and completed the questionnaires. The respondents were asked to assess the questionnaire for ambiguity and to measure the time spent completing the questionnaire. The minimum time taken to complete the questionnaire was 20 minutes, and the maximum 30 minutes. Measuring the time taken to complete the questionnaire enables the researcher to ascertain whether the tool is within reasonable length or not. If a questionnaire is too long, it discourages people to complete it, while, if it is too short, it fails to address the topic being explored in sufficient depth and as a result pose a threat to the instrument validity (De Vos *et al.,* 2011: 193; Grove *et al.,* 2013: 429). Pilot study respondents were not engaged in the actual study. The value of a pilot study for enhancing validity and reliability has been discussed. Validity and reliability are discussed in the following section.

3.6 VALIDITY

Validity refers to the degree to which a measurement represents a true value. Focus is put on the usability of the instrument chosen. Usability refers to the simplest method by which an instrument can be administered, interpreted by the respondent and scored or interpreted by the researcher. There is a range of validity types including content, predictive, criterion and construct validity (Biddix, n.d.: Online; Botma *et al*., 2010:174; Grove *et al*., 2013:393). The following section briefly explains types of validity relevant to the study undertaken.

3.6.1 External validity

External validity refers to the extent to which the results of the study can be generalised from a sample to a population (Grove *et al*., 2013:202). The external validity of the instrument used was established directly from the sampling, which represented the population accurately.

3.6.2 Content validity

Content validity focuses on the relevance of the content of an instrument (Van Teijlingen & Hundley, 2001: Online). Content validity was therefore used to establish whether the questions asked accurately assessed what the researcher wanted to know, that is, the KAP of nursing staff in relation to mental illness. For the purpose of this study, content validity was achieved by using a questionnaire compiled from two pre-existing questionnaires. The questionnaire was appraised by the evaluation committee of the School of Nursing of the UFS. The committee assessed the relevance and sequence of the content. Gaps were identified and recommendations were proposed for amendments. Furthermore the pilot study was conducted to enhance the validity.

3.7 RELIABILITY

Reliability refers to the consistency of measures obtained by the use of a particular instrument, and indicates the extent of random error in the measurement method (Botma *et al*., 2010:177; Burns & Grove, 2009:377; Grove *et al*., 2013:389; Uys & Basson 1991). Reliability assesses how consistently the measurement technique measures a concept (Grove *et al.,* 2013:45). Grove *et al*. further indicate that, even when certain attribute is observed on different occasions, records from different observers should be the same, as an indication of the reliability of the instrument used. Reliability assists researchers to select a measurement method relevant to a particular study.

Like validity, there are different types of reliability, namely, stability reliability, equivalence reliability and internal consistency (Grove *et al*., 2013:389). Stability

reliability refers to consistency of results when the same attribute is repeatedly tested over time using the same measuring instrument. To assess stability reliability in this study, pilot study participants were asked to complete the same questionnaire two weeks after they had initially completed the questionnaire. Their responses were mostly the same, which lead me to assume that the initial assessment was reliable.

3.8 DATA COLLECTION

Data collection is a process that includes subject selection and collection of data from these subjects. Data maybe collected using different approaches, depending on research design and measurement methods. The methods are observation, testing, measuring, questioning, recording or a combination of any of the methods (Grove *et al.,* 2013:523). As stated in section 3.3.1, in this study, data was collected using a questionnaire. The procedure followed will be described.

Upon approval of the research proposal by relevant ethics committees, the researcher reported to the office of MHNS, Mafeteng Hospital, to present the proposal. The office of DHMT at the hospital was informed about my initiative of conducting a study, since this office oversees operations of the health centres. The researcher had to make appointments with gatekeepers, that is, RNs in charge in each individual health centre, before travelling to any one of them, with the exception of the Hospital, where an arrangement was made with the MHNS. The study was focused on 18 government- and CHAL-owned health facilities.

As indicated in Chapter 1, the plan was to request an opportunity during monthly nurses meeting, so as to introduce self and provide information about the intention and processes of the study, administer questionnaires to those who agreed to participate, and then stay in the background while staff completed the questionnaires, and collect them upon completion. However this strategy was successful in one institution (hospital) only. With other facilities unanticipated circumstances required the change of plan. The alternative approach was to leave the questionnaires behind and collect them at a later stage. In the end of this process, 120 questionnaires were delivered, of which only 79 were completed. The same mode of administration of the questionnaires was done with

all selected respondents, on the set dates at all health facilities, in spite of some changes that were influenced by factors beyond the researcher's control.

As it has been mentioned before, the landscape of the country interferes with some activities, such as travelling. Even though Mafeteng is located in the lowlands, it has health facilities that are located in remote, under developed areas. Two health centres were not accessible by motor vehicle owing to the fact that at the time of data collection, it was heavily raining and the roads were impassable. Another challenge was that some personnel, who met the inclusion criteria, were not interested in participating, due to various reasons, among which the need to be remunerated for participation. Furthermore, appointments were made, but when the researcher reached the health centres, the prospective respondents were not available due to various reasons as highlighted before.

3.9 ETHICAL CONSIDERATIONS

The Belmont Report (1979) identifies three principles that must be adhered to when research is conducted on human subjects, namely, respect for people, beneficence and justice. Respect is reflected by keeping the respondents' data confidential. The research does not always have a direct benefit for respondents, but no person should be harmed by a study. Justice is ensured by treating the respondents in a fair manner – that means adhering to the protocol at all times (Botma *et al*., 2010:17-20). Acquiring permission to conduct the study and the right to consent followed by the ethical principles are discussed below.

3.9.1 Acquiring permission

Upon acquiring permission from the Ethics Committees, the researcher was granted a letter of consent with an ethics research number and approval certificate from the UFS and Lesotho's Ministry of Health respectively. Both documents were then submitted to the MHNS, Mafeteng Hospital, who referred the researcher to the DHMT office, which

is the office working directly with all primary health care facilities in the district. The office informed the personnel in charge of the health facilities about the activity and authorised the researcher to commence with data collection process. Entry into the field was gained through “gatekeepers” and “key informants”, who were the RNs at the relevant health facilities (Polit & Beck, 2013:61).

3.9.2 The right to consent

Informed consent means that participants are fully informed about the imminent study (Grove *et al*., 2013:175; Polit & Beck 2012:15). An open invitation was extended by a brief presentation made to the nursing staff about the study and its processes. Emphasis was on the purpose and benefits of the study. The topic of the study was presented to the nursing staff, using the information leaflet (refer to Appendix A). The leaflet comprised the following:

- Invitation to participants;
- What the study involved;
- Risks of participating;
- Benefits of participating;
- The fact that participation was voluntary;
- Reimbursements;
- Confidentiality; and
- Contact details of the researcher and HSREC UFS

This information sheet was attached to the questionnaire as a reference, to assist respondents to make an informed choice. No consent forms were filled in, because completing the questionnaire indicated consent. No-one was coerced to participate nor punished for not participating. Neuman (2007:54) stipulates clearly that the fundamental principle of social research is that participation must be voluntary. It was also indicated

in the information leaflet that there would be no penalty for deciding to withdraw at any moment before the end of the study

3.9.3. Justice

According to Botma *et al*. (2010:19), the principle of justice requires that respondents are treated fairly. In order to observe the principle of justice, everyone who met the inclusion criteria was given an equal opportunity to participate. All RNs and NAs in Mafeteng district were invited to participate. All the conditions of the protocol were observed. The pilot study was done to determine the length of time spent completing the questionnaire. The information leaflet was also read and made accessible to respondents, to assist them to make informed decisions about participation. The leaflet also included the contact details of the researcher as well as the ethics committee, so that they could report relevant matters or lodge complaints, if necessary.

3.9.4. Confidentiality

Respect for people is proven when the researcher observes anonymity and confidentiality.

Anonymity is ensured by a secure means of protecting confidentiality and observing the right to privacy of the respondent (Grove *et al*., 2013:172; Polit & Beck, 2012:162). It is the duty of the researcher to safeguard the privacy and identity of the respondents. This can be achieved by not linking participants with data and, in this case, by using questionnaires lacking any identifying data that could be linked to the participant – instead of names, numbers were used. The researcher personally distributed questionnaires to all health facilities. Containers similar to ballot boxes and envelopes were left at facilities for submission of completed questionnaires. Some respondents submitted their questionnaires personally when the researcher arrived at facilities for collection of questionnaires. No-one except the researcher had access to information on the completed forms.

Confidentiality says information provided by participants to the researcher will not be publicised or shared with other people without the permission of the participant, who

has the right to choose whom to share information with. In any case, the participant is not compelled to disclose or to keep information (Grove *et al*., 2013:172; Moule & Goodman, 2007:64; Polit & Beck, 2012:162).

Data that was collected was kept confidential by locking it up. Names were not used on any documents or during reporting. No identifying information is kept on the computer used for the purpose of this study to avoid the risk of exposing participants. All materials used to collect data are kept under lock and key as a way of preventing information from being accessed by unauthorised people. The respondents were assured that the information would be treated as confidential as possible, and that measures would be instituted so that no individual's identity could be traced to a questionnaire or any information. An arrangement for information sharing was made. The agreement between the respondents and the researcher is that, upon completion of the study, findings will be shared by the researcher, orally and through written material.

3.9.5 Beneficence and non-maleficence

In this study participation had no direct benefits to the respondents. Nevertheless, the researcher had to ensure that participation did not bring any harm (Botma *et al.,* 2010:20; Polit & Beck 2012:152). The questionnaire was scrutinised by two ethics committees and deemed not to pose any risk to the respondents. The contact details of the researcher were available in the information leaflet for the convenience of the respondents. Possibility of losing one's job for participation and stating one's opinions about mental illness was guarded against as respondents are anonymous such that any information gathered is not linked to anybody. Therefore the researcher did not anticipate that any harm would befall respondents.

3.10 DATA ANALYSIS

Descriptive statistics, namely frequencies and percentages for categorical data and means and statistical variations or medians and percentiles for continuous data, were calculated. As stated earlier, 79 of 120 questionnaires were completed and analysed.

The analysis was done by the Department of Biostatistics at the UFS. The detailed analysis is presented in Chapter 4.

1.17 CONCLUSION

Research methodology was discussed in this chapter, as were research design and technique, validity and reliability, data collection methods and ethical concerns. Data analysis will be discussed in Chapter 4.

CHAPTER 4

DATA ANALYSIS AND DISCUSSION OF RESULTS

4.1. INTRODUCTION

The research methodology was discussed in the previous chapter. The aim of this chapter is to provide a description of the analysed data as obtained from the structured questionnaire. Descriptive statistics namely frequencies, and percentages for categorical data and medians and percentages for continuous data were calculated. The data was analysed and interpreted according to the sequence of the questionnaire and have the following order: Biographic information**,** information regarding knowledge about mental illness, information regarding attitudes towards mental illness and **i**nformation regarding practices towards mental illness and patients with mental illness. Data collection commenced on the 25 October 2016 and ended on the 07 February 2017. This duration was influenced by the factors stipulated in Chapter 3.

4.2. BIOGRAPHICAL DATA OF RESPONDENTS

The biographical information in this study entails aspects such as the nurses' gender, as both males and females provide services to patients in these institutions. It also includes the age group of nurses, the home language as well as the position of employment. Biographical information further includes the educational level of nursing staff, as the level of education and the specific training regarding mental illness could influence the knowledge, attitude and practice these personnel display.

4.2.1 Gender, age, marital status and language of respondents

The Lesotho gender ratio as estimated by World Data Atlas (2015: Online) was 94.18 males per 100 females, which means 48.5% for males to 51.5% females, a difference of 3%. However, in this study out of 79 respondents female nurses are almost three times more than males, that is 81.0% (n=64) as compared to 18.9% (n=15) refer to table 4.1. This can be attributed to the fact that nursing has historically been a female-dominated

profession**.** Ndetei *et al*. (2011:228) and Rappleye (2015: Online) assert that this ratio is in line with several studies which have established that female nurses are found to be dominating in several parts of the world. The age of respondents ranges between 22 to 66 years with the median age of 32 years. Most of respondents were married 59.5% (n-47) followed by those that are unmarried with 29.1% (n=23). A relativity small number were widowed 5.1% (n=4) or divorced 3.8% (n=3) and the smallest number living together 2.5% (n=2). The majority of people living in Lesotho speak Sesotho as is their mother tongue which most of the nursing staff speak. Citizens of Lesotho who speak other languages like Xhosa and Swati do understand and speak Sesotho well. Nurses who speak English are mostly from outside the country. 95% (n=75) of the nursing staff speak Sesotho, while English and other languages share the remaining five percent (English 2.5% and others 2.5%). See Table 4.1.

Table 4.1 Biographic data of respondents

DEMOGRAPHICS	FREQUENCY (n=79)	PERCENTAGE (%)
GENDER		
Male	15	18.99
Female	64	81.01
AGE		
21-30	30	37.97
31-40	26	32.91
41-50	12	15.18
51-60	9	11.39
61-70	2	2.53
MARITAL STATUS		
Married	47	59.49
Unmarried	23	29.11
Divorce/separation	3	3.80
Widow/widower	4	5.06
Living together	2	2.53
LANGUAGE		
Sesotho	75	94.94
English	2	2.53
Other	2	2.53

Figure 5.1 below is an illustration of respondents' age showing the minimum, median and maximum age

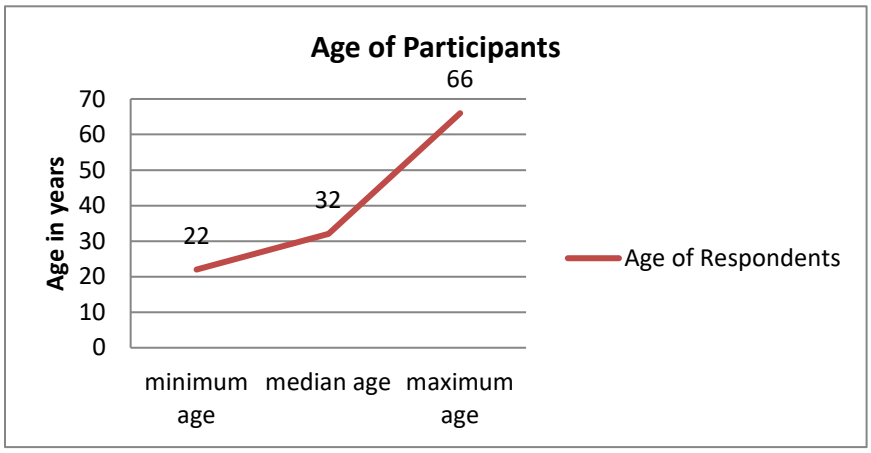

Figure 5.1 Age distribution of respondents

4.2.2. Qualifications of respondents

The population of Lesotho attaches great importance to education, for instance, the majority of the respondents 75% were RNs of which 29.1% (n=23) hold a Degree or Masters in Nursing comprising of 4 males and 19 females. This category is followed by those with Diploma in Midwifery by 40.5% (n=32) and occupies almost half of the population of the sample. Females are dominating in this category by almost 40%. Diploma in General Nursing has the least candidates, consisting of 3 females and 1 male. Respondents holding the Certificate in Nursing Assistant has 25.3% (n=20) with 3 males and 17 females. These make a total of 64 female and 15 male respondents. From this analysis, the majority of respondents are RNs possessing a single qualification of diploma in nursing to master's degree level as compared to NAs. This profile is in line with the distribution of nurses across Lesotho.

4.2.3. Health facility where respondents practice and duration of their experience

As mentioned in Chapter 1, the study was done in Mafeteng District concentrating on government and CHAL health facilities only. The government has one hospital and eight health centres while CHAL run nine health centres. The final overseer of all health care

lies with the district hospital, office of DHMT. Many respondents 75.95% (n=60) are based at the primary health facilities while 24.1% (n=19) are hospital based

The majority of respondents, 61.5% (n=48) have been practicing for more than five years while 25.6% (n=20) of the respondents' clinical experience ranges from one to five years. A total of 3.9% (n=3) represent respondents with clinical experience of between six months and a year. The remaining 8.97% (n=7) represent those who have been in the system for less than 6 months. One participant did not respond to this item hence (n=78). See table 4.2.

Table 4.2 Distribution of respondents by qualification, duration of practice and type of health facility

CHARACTERISTIC	***FREQUENCY (N=79)***	***PERCENTAGE (%)***
QUALIFICATION		
Degree/Master (in Nursing)	23	29.11
Diploma in Midwifery	32	40.51
Diploma in General Nursing	4	5.06
Certificate in Nursing Assistant	20	25.32
EXPERIENCE		
<6 months	7	8.97
>6 months	3	3.85
>12 months	20	25.64
>5 years	48	61.54
TYPE OF FACILITY		
Hospital	19	24.05
PHC (Health centre)	60	75.95

4.3. MENTAL HEALTH LECTURES AND REFRESHER COURSES

Mental health is a component of nurses' training curricula across all nursing programmes from nursing assistant to degree level in Lesotho. In this section, respondents were asked if they had received mental health lectures during their training. Majority of respondents 86.1% (n=68) indicated that mental health was among the courses in their curricula

therefore received lectures related to mental health during their training. In contrast 13.9% (n=11) of respondents stated that they did not receive any. This seems incongruous not unless there are other factors to this effect though the researcher is uncertain of such since it has already been stated that mental health is an element across all programmes. However the possible reason for this inconsistency is could be that respondents trained outside the country where the curricula did not incorporate the element of mental health. Regarding attendance of refresher courses and/or workshops, 59.5% (n=47) has never had any during their practice. Those who attended a refresher course once comprise 20.3% (n=16) of respondents, while 5.1% (n=4) had two, 2.5% (n=2) had three and 12.7% (n=10) had five or more within the past two years. See Table 4.3. In summary 59.5% of nurses has had no training or information on mental health nursing during the past 2 years.

Table 4.3 Lectures during training and refresher courses in practice

CHARACTERISTIC	FREQUENCY (N=79)	PERCENTAGE (%)
MENTAL HEALTH LECTURES		
Yes	68	86.08
No	11	13.92
REFRESHER COURSES/WORKSHOPS		
Nil	47	59.49
Once	16	20.25
Two times	4	5.06
Three times	2	2.53
More than three times	10	12.66

4.4 KNOWLEDGE ON MENTAL ILLNESS

In the context of this study, knowledge refers to the understanding of mental illness, including predisposing factors, causes, symptoms, and treatment. The following section describes the results obtained from the analysis of knowledge of respondents regarding mental illness.

The questions on knowledge were 14 in number, the responses of which were based on a 5-point Likert scale: Strongly agree; agree; undecided; disagree; and strongly disagree; which will be discussed according to data analysed and presented in Table 4.4. Numbering of items in the table tally with the sequence of items in annexure A. The items in the questionnaire that reflect sufficient knowledge of mental illness are allocated a score of one (1) while zero (0) are allotted responses reflecting insufficient knowledge. Respondents who are unsure were also classified as lacking sufficient knowledge.

Table 4.4 Distribution of frequency and percentage of respondents regarding knowledge of mental illness

ITEMS	**0 Insufficient knowledge**		**1 Sufficient Knowledge**	
	Frequency	**%**	**Frequency**	**(%)**
3. I believe that my training adequately prepares me to care for people with mental illness.	12	29.27	29	36.73
4. Medications are effective in treatment of mental illness.	8	10.23	68	89.47
5. People with mental illness need constant care.	3	3.95	73	96.05
6. "Psycho" and "maniac" are correct terms for mental illness	49	64.47	27	35.53
7. People with mental illness are hurt by "slang" names for their disorders.	17	22.37	59	77.63
8. Mental illness is not a serious illness.	70	92.11	6	7.89
9. Patients with mental illness are often treated unfairly.	27	35.53	49	64.47
10. Mental illness is often shown in negative ways on televisions and movies.	32	42.11	44	57.89
11. Psychological treatment for mentally ill patients is useful.	1	1.32	75	98.68
12. Mental Illness is often confused with effects of drug abuse.	15	19.74	61	80.26
13. Mental Illness is caused by something biological.	30	39.47	46	60.53

14. Mental Illness and mental retardation are the same.	20	26.32	56	73.68
15. A person with bipolar disorder acts overly energetic.	26	34.21	50	65.79
16. Most people with severe form of mental Illness do not get better even after treatment.	30	39.47	46	60.53
17 Schizophrenia involves multiple personalities.	62	81.58	14	18.42

Only 51.9% (n=41) of respondents attended item 3. One can assume that the rest 48% (n=38) did not answer this question because they have never been exposed to any training at all. Of the 41 respondents that had training 29 indicated that their training prepared them adequately to deal with mental illness. This constitutes 36.7% of 79 respondents meaning that less than half of this sample feels adequately trained to deal with mental illness. This rate is of great concern as literature describes that the amount of information acquired in any subject matter develop the knowledge base which in turn influences attitudes that are translated into the way individuals perform or behave (Ajzen, 2011).

The majority of respondents, 89.5% (n=68) are aware of the effectiveness of the medication in the treatment of mental illness while 10.2% (n=8) of the nursing staff are not certain about the medication effectiveness. Regarding the care of patients with mental illness, 96.1% (n=73) state that patients need constant care. This belief does not consider the fact that if medication is effective, patients can recover and lead productive lives.

Certain language can cause offence and may be inaccurate when used in news stories that involve someone with a mental health problem (Nunn, 2014: Online). Boyd (2015:15) points out that even jokes that portray people with mental illness as stupid, dangerous and incompetent strengthen the stigmatizing attitudes and reinforce negativity towards those with mental illness. Boyd further affirms that “Psycho” and “Maniac” are considered to be falling under the offensive language for addressing people with mental disorders as they reinforce negative associations. Only 35.5% (n=27) of the respondents indicated that

using terms like psycho and maniac is unacceptable while 64.5% (n=49) of respondents did not consider these terms to be incorrect.

According to Rose, Pinfold, Thornicroft & Kassam (2007: Online) slang names used against people with mental illness perpetrates the stigma which is always attached to people with mental illness. Stigma poses a major barrier to help-seeking people and particularly young people with mental health problems, A substantial number of participants 77.6% (n= 59) were in agreement with the statement that people with mental illness are hurt by slang names, while the remaining 22.4% (n= 17) felt that there is nothing wrong in using slang names for patients. This is worrying because almost a fifth of the sample does not understand how derogatory names can hurt their patients. When one considers that over 64% of all respondents stated in question 6, that psycho and maniac are correct terms for people with mental illness but in this question 77.6% felt that one should not use derogatory terms towards patients, it may be an indication that they truly think that these terms are scientifically correct.

Sandy Lewis, Head of Psychological Services at Akeso Psychiatric Clinics, attributes the Life Esidimeni saga and tragic death of over 100 patients in South Africa with mental illness to health professionals who do not take mental illness as a serious problem (Health and wellness, 2017: Online). The majority of the respondents, 92.1% (n=70) do not consider mental illness to be a serious problem, while only 7.9% (n=6) state that mental illness is a serious problem. When one considers the burden of disease as explained in Chapter 2 these respondents are not aware of the severe nature of the problem of mental illness.

About 64.5% (n=49) of respondents supported the statement that patients with mental illness are often treated unfairly, while just above a third of respondents 35.5% (n=27) feel that patients with mental illness receive a fair treatment. Research suggests that most media portrayals of mental illness are stereotypical and negative (Boyd, 2015:15). Boyd gave a few examples whereby psychiatric hospitals are portrayed as dangerous and inhospitable institutions in which the care was harsh and delivered by cold-hearted workers. This picture is observed in the film of *The Snake Pit* (1948) and *A Beautiful Mind*

(2001). Around 57.9% (n=44) of the respondents are of the opinion that mental illness is often shown in negative ways on television and movies, while also quite a notable number of them, 42.1% (n=32) do not find anything wrong concerning this matter. This is of great concern as over half of respondents could not identify problems from media regarding how mental illness is perceived or defined. Regarding the importance of psychotherapy, almost all but one participant 98.7% (n=75) are aware of the importance of psychological treatment for patients with mental illness. Majority of respondents 80.3% (n=61) are on the affirmative that mental illness is often confused with the effects of alcohol. However, the minority 19.7% (n=15) have the opposite perception. This is a challenge that almost 20% will not be able to distinguish between the two conditions. This can lead to diagnosing people with alcohol effects as mentally ill and as a result maltreat such people.

As mentioned in Chapter 2, mental illness has a biological cause (Boyd, 2015:340-1). More than two thirds 60.5% (n=46) of respondents are of the opinion that mental illness is caused by something biological, however, 39.5% (n=30) do not believe so. One can only speculate what these nurses think of what they consider to be the cause of mental illness. This is half of the sample and a cause for concern since appropriate treatment goes together with knowledge of the root cause of the problem. However, one possible reason could be that mental illness is not caused by a single factor so this item could be somehow complicated or interpreted differently.

During the manic phase of a bipolar condition, a person may become highly energetic, have a million ideas, become very talkative and stay up all night (Sadock *et al.* 2015:360; Townsend, 2015: 499). The greater number of respondents, (n=50) 65.8% indicated that a person with bipolar disorder acts overly energetic, whereas (n=26) 34.2% did not associate this to be one of bipolar disorder symptoms. As this is a very clear sign of mania it is of concern that more than a third of nurses do not know this and will miss this important symptom.

Mental retardation, also known as intellectual disability refers to a condition where the individual has a lower intelligence quotient (IQ) and has difficulty in coping with the realities of day to day life (Feldman, 2017:262). While on the other hand, mental illness

as described in Chapter 2 refers to psychological condition that affects the thoughts, behaviour and emotions of an individual. About 73.7% (=56) of respondents did not consider mental illness and mental retardation to be the same, whereas 26.3% (n=20) mistook the statement to be correct. More than a quarter of nurses do not understand the difference between mental illness and mental retardation. Again this is serious as it indicates a fundamental lack of knowledge where people with intellectual disability could receive inappropriate treatment.

Research carried out at the National Empowerment Center by Fisher (2017: Online) has shown that people can fully recover from even the most severe forms of mental illness. The larger part of the respondents constituting 60.5% (n=46) are of the opinion that most people with a mental illness can get better. This confirms the idea that with medication and psychotherapy, mental illness can be controlled and people lead a normal life. However 39.5% (n=30) did not believe that people with mental illness can get better after treatment. A common misconception is that people with schizophrenia possess multiple personalities and among these respondents this misconception is prevalent. Only 18.4% (n=14) of the participants indicated that schizophrenia does not involve multiple personalities. While over three quarters 81.6% (n=62) are of the opinion that people with schizophrenia possess numerous personalities.

In conclusion, the study results indicate that only about 38% of the nursing staff claim that they have adequate training to work with patients with mental illness. This is supported by the evident insufficient knowledge as indicated in study findings.

According to Boyd (2015:338) schizophrenia is a serious mental disorder that affects about 1% of the worldwide population. Boyd further explains that the symptoms of schizophrenia are so severe that without early treatment, the life of the patient is totally disrupted. It is therefore cause for alarm that nurses have such a fundamental flaw in their understanding of this prevalent illness. It would seem that respondents are less informed about schizophrenia, and this is supported by having only 18.4% (n=14) who are of the opinion that it does not involve multiple personalities, while the vast majority of respondents 81.6% (n=62) endorsed this notion.

Regardless of the above stated shortcoming, almost all respondents recognise the importance of psychological therapy as well as the effectiveness of psychotropic medications, but at the same time about 40% felt that mental illness is not treatable. The fact is with effective treatment, the prognosis is positive. This is again cause for concern as the nurses might feel that to treat these patients is basically a waste of resources including time.

The high percentage of nurses who do not consider terms like psycho and maniac to be hurtful are of great concern and one can argue it to be an indication of nurses discriminating against people with mental illness as has been indicated in the literature. However as indicated earlier, they might be truly thinking that these terms are appropriate as compared to the use of slang names. It is also a cause for concern to notice that over a quarter of respondents are comfortable with use of slang names towards patients. This can be linked to the fact that some respondents though with small portion (8%) regard mental illness not serious. More than a quarter of nurses seem not to be informed about the difference between mental illness and mental retardation. Again this is serious as it indicates a fundamental lack of knowledge.

The above section focused on the results about knowledge of respondents towards mental illness. Results about attitudes towards mental illness will be discussed in section 4.5 below.

4.5. ATTITUDES TOWARDS MENTAL ILLNESS

Attitude encompasses feelings and misconceptions the respondents may have towards mental illness and persons with mental illness. Nurses' Attitudes were tested on a set of 12 items as reflected in Table 4.5.

In a similar manner, the rule that was applied in Section 4.4 above in terms of scoring items for knowledge will be applied in this section as well. While knowledge was explained as sufficient or insufficient, attitudes are either appropriate or inappropriate. Appropriate attitudes are given a score of one (1) and inappropriate attitudes are scored as zero (0).

Table 4.5 Distribution of frequencies and percentages of respondents' attitudes towards mental illness (n=79)

ITEMS	0 Inappropriate attitude		1 Appropriate attitude	
	Frequency	%	Frequency	(%)
18. I Find it hard to talk to someone with mental health problems	27	34.18	52	65.82
19. Even after the treatment, I would be doubtful to be around people who have been treated for mental illness.	17	21.52	62	78.48
20. Mentally ill patients are entitled to the same attention in the health centre as are general patients.	5	18.99	64	81.01
21. People with mental illness should not be allowed to work	11	13.92	68	86.08
22. Political and individual rights of mentally ill persons should be suspended while on treatment to help them.	22	27.85	57	72.15
23. Those with mental illness should not be allowed to have children.	16	20.25	63	79.75
24. Mental hospital/s is/are the only place/s for people with mental illness to be treated.	19	24.05	60	75.95
25. I would ask for exemption to treat those with mental illness.	36	45.57	43	54.43
26. People with mental illness are usually dangerous.	37	46.84	42	53.16
27. People with mental illness are usually violent.	40	50.63	39	49.37
28. People with mental illness are usually unpredictable	67	85.90	11	14.10
29. People with mental illness can lead a normal life	16	20.25	63	79.75

There is increasing evidence that disparities in healthcare provision contribute to poor physical health of people with mental illness, which are attributed to among other things,

the separation of mental health services, healthcare provider issues including the pervasive stigma associated with mental illness (Lawrence & Kisely, 2010: Online). This is confirmed as stated earlier that personnel distribution is not balanced and some health centres in Lesotho especially those in rural areas are managed by few people.

More than 65.8% (n=52) of respondents indicate that they can interact and communicate comfortably with patients with mental illness while 34% find it difficult to talk to these patients. Regarding interaction with patients after treatment, 21.5% of respondents showed they cannot be comfortable to be around people with mental illness. Nevertheless majority of respondents, 81.0% (n=64) demonstrated appropriate attitude by believing that patients with mental illness are entitled to the same attention in the health centre as are all other patients, whereas almost a fifth, 19.0% (n=15) of all nurses feel that people with mental illness do not deserve the same treatment as other patients. It seems that these nurses do not think that people with mental illness are entitled to equal treatment as the rest of the population.

People with mental illness can lead a normal life: Almost 79.7% (n=63) respondents were in agreement that people with mental illness can lead a normal life, while the minority of 20.3% did not endorse this view. This item supports the impression that even the worst cases of mental illness can be treated as explained in section 4.4 and as a result persons with mental illness can recover and lead a normal life. It differs from the fact that 93% feel they need constant care. Possibly a misunderstanding of the question can explain the apparent anomaly.

Regarding the patients' rights, there is an indication of appropriate attitude though the limitation is observed in a portion of respondents. The majority of respondents 86.1% (n=68) stated that people with mental illness should be allowed to work while 13.9% felt the opposite. The same goes with the suggestion that political and individual rights of mentally ill persons should be suspended while on treatment to help them, was rejected by the majority of respondents 72.2% (n=57) while only 27.8% supported the statement. Furthermore the majority of 79.7% (n=63) discarded the idea that those with mental illness should not be allowed to have children. When responding to the item that the hospital is

the only place for those with mental illness, 75.9% (n=60) claim that hospital is appropriate for treatment while 24.0% is of the different opinion

Regarding the issue of nurses asking for exemption to treat those with mental illness, almost half of the participants 45.6% indicated that they would prefer to be exempted from treating people with mental illness while only 54.4% were prepared to manage these patients. This might link to the question of people with mental illness being dangerous and violent where 46.8% of respondents considered people with mental illness to be dangerous and 50.6% believe that they are violent. These responses correspond with knowledge section about negative media portrayals regarding mental illness in which 42.1% of respondents perceive mental hospitals as dangerous and patients being dangerous and violent. The fact is people with mental illness are no more likely to be violent than anyone else. Most people with mental illness are not violent and only 3 - 5% of violent acts can be attributed to individuals living with a serious mental illness (Myths and facts, 2017: Online). Despite the above mentioned research findings, only 49.4% (n=39) of respondents rejected this idea. Therefore it is evident from the study that nurses still maintain the idea that people with mental illness are dangerous and violent. The common misconception about people with mental illness is rampant among these nurses. The same goes with the notion that people with mental illness are usually unpredictable: people with severe mental illnesses are over 10 times more likely to be victims of violent crime than the general population (Myths and facts: 2017:Online). The minority of participants about 14.0% (n=11) defied the statement, while the majority 86.0% (n=67) supported the statement. It can be concluded that nurses maintain that persons with mental illness are unpredictable.

Even though a portion of respondents demonstrated appropriate attitude in majority of items, far too many nurses exhibit attitudes that are harmful towards people with mental illness. More than 50% of respondents showed appropriate attitude towards patients with mental illness but 34% felt that it is difficult to communicate or socialise with patients with mental illness. Some respondents even indicated that even after the treatment, they doubt that they can easily interact with these patients. It is a cause for concern and may signify an inappropriate attitude and discrimination towards this patients or lack of

confidence. As indicated in Chapter 2, this might be one of the factors that lead to poor utilisation of mental health services as patients fear stigma and discrimination. With regard to the idea that hospitals are the only appropriate places for people with mental illness, 75.9% of respondents asserted to this idea while 24.1% rejected this idea.

It is argued that those with a mental disability should be given equal opportunities like any other person. If they want to work and are capable, qualified and fit for the job, then let them work. According to the findings, there are nurses who felt that patients should be denied some of their rights. Much as mental illness is considered a serious illness, it is treatable with a positive prognosis resulting in individuals leading a normal life.

4.6. PRACTICES TOWARDS MENTAL ILLNESS

According to Bennett (2012:49), practice refers to actions based on knowledge and attitude. Nurses and other professionals are required to assess, manage and provide some form of intervention to persons with mental illness in their communities. In this section, the assessment on nurses' practice towards mental illness and people with mental illness was based on five questions which are structured as shown in Table 4.6. The first two questions are based on a, 5-point Likert scale, strongly disagreed, disagree, undecided, agree and strongly agree. The last three are based on a "yes" or "no" response the former indicating good practice. Practice is stated as effective or ineffective where effective practice is given a score of one (1) while ineffective practice is scored zero (0).

Table 4.6 Distribution of frequency and percentages of respondents' attitudes towards mental illness (n=79)

ITEMS	**0** **Ineffective practice**		**1** **Effective practice**	
	Frequency	**%**	**Frequency**	**(%)**
30. It is hard to talk to someone with mental health problems	26	32.9	53	67.1

31. I am comfortable with attending to people with mental illness.	38	48.1	41	51.9
32. Have ever referred anyone with a mental illness?	40	50.6	39	49.4
33. Did you receive feedback on the patients you have referred?	49	62.03	30	37.97
35. Do you think the health facility where you work can accommodate the care of persons with mental illness?	23	29.11	56	70.79

Almost a third of respondents 32.9% (n=26) find it hard to talk to a person with mental illness which corresponds almost exactly with the answers given in question 18. While 67.1% of respondents feel comfortable talking to people with mental illness, this is not enough since effective communication with patients is part of therapy. Furthermore, there were about half of the respondents, 51.9% who assert that they are comfortable in attending people with mental illness. There seems to be a disparity in findings between feeling comfortable talking with the patient and being comfortable attending to the patient as only 67% of respondents are comfortable talking to patients. The challenge is that caring and communication occur simultaneously so this might adversely affect the quality of care towards patients. Almost half 48.1% (n=38) indicated that they are uncomfortable to do so.

Regarding the question of whether the participants have ever referred a patient with mental illness, 49.2% (n=39) indicated that they had referred a patient while 50.6% (n=40) had never referred a patient. It is accepted that in people attending a PHC facility, almost 20% have a certain mental illness (Ogunsemi, Oluwole, Abasiubong, Erinfolami, Amoran, Ariba, & Alebiosu, 2010:46). Based on this fact, it is of great concern that less than half of the respondents have never referred a patient. With respect to an opinion whether participants think the health facility where they work can accommodate the care of persons with mental illness, 70.9% (n=56) accepted that their health facilities can accommodate the care of patient with mental illness, and the remaining 29.1% were against the idea. One of the reasons mentioned is lack of expertise regarding mental health and illness. This is line with the discussion in Chapter 2. It therefore implies that

even though the infrastructure can allow admission of patients, the challenge in relation to the skill regarding care of persons with mental illness still remains. It is important to mention that the structures of health centres in Lesotho are similar even though they might differ in size.

4.7 SUMMARY OF FINDINGS

Knowledge was tested on a set of 14 items, therefore, could obtain a score from 0 to 14, with higher scores signifying better knowledge. Most importantly, the median score was 10 that is about 71.4% which showed high knowledge with the lower quartile score of almost 64.3% mark, that is 9 (out of 14).

With respect to attitude, nurses were tested on a set of 12 items, in a similar manner, higher scores signified positive attitude. Respondents displayed moderately positive attitudes with the median of 8, while the lower quartile score stood at 50% that is 6 (out of 12), and the upper quartile was about 83.3%. This shows that there is still a possibility of improvement in their attitude. Practice scores were calculated based on 5 items Likert scale. Nurses could obtain scores from 0 to 5 with higher scores indicating better practice. They showed fair practice scores with the median score of 60% that is 3 (out of 5), despite the discouraging lower quartile score which is below 50%.

In combination of knowledge, attitudes and practice (KAP), the discussion is based on the median figures reflected on the KAP Summary Statistics. With the median for knowledge of 71.4%, which falls within the high region implies that relatively, the nursing staff in Mafeteng district health facilities has basic knowledge regarding mental health issues, despite the discrepancies shown in the analysis. Regarding attitude, the median of 66.6%, it therefore means that some work needs to be done to change their attitudes. With respect to practice, the median within the average score range of 60%, a lot of work is to be done to influence practice.

This chapter looked at data analysis and findings. Chapter 5 will address limitations, recommendations and conclusions.

CHAPTER 5

RECOMMENDATIONS, LIMITATIONS AND CONCLUSION

The research findings were presented and discussed in Chapter 4. Limitations, recommendations and conclusion are addressed below.

5.1. LIMITATIONS OF THE STUDY

The limitations identified involved the sample, completion of the questionnaire and the questionnaire itself.

Due to logistical factors, the study was conducted in only one health district, Mafeteng which is more similar to Maseru in terms of the topography and type of facilities so the results should be more comparable to that district. However the districts in the highlands are very different in that health facilities are hard to reach and are run by few personnel, whether these results are representative of them is not so clear. The sample size was small since one district was used due to limited funds and time. The question remains as to whether the same study results would be yielded in other parts of the country?

A vast majority of KAP foreign studies towards mental illness have been produced but there is no evidence that there has been any of the same scale in Lesotho. Additionally, the researcher relied mostly on literature from other parts of the world. The researcher does not know if it was applicable to Lesotho as there have not been other studies to this effect in Lesotho – so the instrument may not be applicable. Another observation is that some literature available about Lesotho is documented differently yet addressing the same theme thus posing a challenge in selection of the most valid information.

According to the plan of events, data collection was to take a maximum duration of 6 weeks since health facilities are located in areas far apart from each other. As explained in Chapter 3, the original plan was for respondents to complete the questionnaires at the same time per health facility; while the researcher was available to answer questions, but the plan did not work instead it took almost three months to collect data. This could have

led to contamination in that the respondents could have discussed the questionnaire among themselves. Additionally, some challenges with the tool were identified during analysis. For instance, one item was about causes of mental illness and only mentioning one cause. Majority of respondents do not agree with this item. One would think that the respondents know a combination of factors so to them only one might seem inappropriate.

5.2. RECOMMENDATIONS

The government of Lesotho through the Ministry of Health is reinstating the Diploma in Psychiatric Mental Health Nursing Programme following its discontinuation for some years. This is a positive turn of events as the country is depleted of psychiatric nurses and furthermore it will help redress the lack of knowledge among nurses regarding mental illness, found in this study. Generally, the study findings indicate good KAP of nurses in Mafeteng however a lot needs to be done in relation to mental health in the country as a whole and to catch up on those nurses that have missed out. The following are therefore recommended:

5.2.1 Knowledge

Exposure to knowledge and the psychiatric practice does impact on attitudes in a good way even though its mechanism of action still needs research (Holmes, Corrigan, Williams, Conor & Kubiak, 1999). To close the gap identified in knowledge base, the authorities should consider increasing the focus on mental health in the basic training courses. That might convey to nurses the importance of mental health. Nurses who have already been trained need regular refresher courses and or workshops. It has been indicated that an amount of information acquired affects attitudes which in turn impacts on the way people act. Training in psychiatry can influence peoples' opinions about mental illness. In a study done on students views on mental illness it was found that upon completion of their training they viewed mental illness differently without the discriminatory beliefs they possess prior training (Madianos, Priami, Alevisopoulos, Koukia & Rogakou, 2005: Online).

Distribution of knowledge can also be done in the form of written materials. Advantage of information and technology should be taken where electronic equipment like cell phones could be used to spread the information about mental health and illness. Events like mental health day celebrations should be held throughout the country and utilized as opportune moments of spreading information to nurses and the public as well. Learning and sharing forums should also be used regularly as another platform for spreading the message.

The curricula of all levels of nurses at training institutions should be reviewed, ensuring the balance between classroom teaching and clinical practice to produce competent and confident nurses in terms of mental health issues. This can improve the nurses' KAP. However knowledge alone is not enough to influence people's behaviour towards mental illness, people should be motivated in relation to issues of mental health (Ajzen, 2011).

5.2.2 Attitude

Several research studies have examined the effects of education on attitudes about severe mental illness. Cross sectional studies have shown that members of the general public who have more knowledge about mental illness are less likely to endorse stigmatizing attitudes (Roman & Floyd 1981; Link & Cullen 1986; Link, Cullen, Frank & Wozniak, 1987; Brockington, Hall, Levings & Murphy. 1993). These studies suggest that education programs that increase factual knowledge about mental illness may improve attitudes about severe mental illnesses such as schizophrenia. Researchers who study the social cognitive underpinnings of stigma and stereotype believe that education challenges the misconceptions that support these stereotypes (Pruegger & Rogers, 1994:372). Persons are less likely to endorse these knowledge structures in the face of contrary information.

Several research studies have examined the effects of education on attitudes about severe mental illness. It is apparent that the education provided on mental health is beneficial though the amount and quality of information matters as has been mentioned in previous sections. This is confirmed by Wynaden, Orb, McGowan & Downie, (2000) in their study that those who undergone training reported greater understanding,

confidence, and control as well as changed perception towards mental illness. Reed and Fitzgerald (2005: 254) state that 50% of the respondents in their study pointed out that lack of education is among reasons that generate negative attitudes towards mental illness. With education regarding mental illness, attitudes can be influenced thus leading to more appropriate practices.

To change attitudes of nurses the same recommendations made for knowledge are needed. However the nurses must be exposed to persons who have a mental illness and who are successful and leading a normal life.

If knowledge and attitudes are addressed the practice should be influenced. However days like mental health celebrations mentioned before can be an opportune moment for nurses to meet people with mental illness that are doing well. That way the nurses can meet them as healthy individuals and not patients with mental illness.

Nurses in Lesotho need continuing development points to renew their registration annually. The LNC should consider making a part of mental health compulsory in the Continuing Professional Development programme to enhance learning of nurses on mental health issues.

Mental Health Act and policies exist but are not implemented as they should. Nurses are to a certain degree limited by the policy in terms of their roles when delivering mental health services as indicated in Chapter 1. All these should be reviewed to clarify individual's roles so as to improve nurses' confidence.

The example of the Government of Lesotho that is being set by allocating so few resources to mental health sends a clear message to health care workers that mental health is not important (refer to Chapter 1). Resources are limited but the impact of mental health on the effect of other health treatments should be explored so that the Government can understand how making mental illness a priority can lead to better usage of these resources. For instance, when one is suffering from depression that particular individual is prone to not relapse only but frequent hospitalisation and even death since compliance to treatment is a struggle. Patients who are working are at risk of losing their jobs due to

a decline in performance or inability to perform as a result of the illness. When these occur, the government expenditure on mental health is increasing or else the quality of services deteriorates since mental health services are free yet this loss of resources could be prevented through enhancement of nurses KAP.

Authorities should ensure smooth integration of mental health into PHC as this could improve interaction between patients and staff. A guide or manual should be distributed in all health facilities, by so doing, frustration among staff will be reduced as competence will develop through the use of the manual.

5.2.3 Research

Further research is necessary to identify the needs of nurses to shape the training, the impact of this training on their attitudes; what activities or events will have the most impact on the KAP of nurses.

5.3. CONCLUSION

The purpose of the study was to explore the KAP of nursing staff at Mafeteng, Lesotho. According to literature, mental illness is found to be contributing towards the burden of disease in Lesotho and is being treated mostly by non-psychiatric personnel (see Chapter 2). Furthermore, several studies carried out in different countries indicated that health professionals especially the nursing personnel have negative stigmatizing attitudes towards mental illness and people with mental illness.

Data were analysed and the results indicate that the KAP of nursing staff towards mental illness is not satisfactory as knowledge is rated around 70%, attitude at 67% and practice at 60%. It is clear that being well informed does not necessarily determine the behaviour, but there is a belief that somehow it causes an impact in the way a person perceives and acts upon a situation or event. On the other hand no knowledge is damaging. Recommendations have been done to address the identified shortcomings in order to achieve confident nursing personnel with appropriate attitude and practice towards mental illness.

“THERE IS NO HEALTH WITHOUT MENTAL HEALTH”.

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ANNEXURE A

QUESTIONNAIRE

INSTRUCTION S

Mark the appropriate block with an X or write your answer on the space provided.

For Office Use Only

A. BIOGRAPHIC DATA

1. Date questionnaire is completed (dd/mm/yy) ...../...../.....

						1-6
d	d	m	m	y	y	

2. What is your gender?

Male (1)	Female(2)	
		7

3. How old are you?

..... year

		8-9

4. What is you marital status?

Married/traditional marriage	1	
Unmarried	2	
Divorce/separation	3	
Widow/widower	4	
Living together	5	10

5. What is your home language?

Sotho	1	
English	2	11
Other..... (specify)	3	

6. What is the highest qualification you have acquired?

Degree/Masters (in nursing)	1	
Diploma in Midwifery	2	
Diploma in General Nursing	3	
Certificate in Nursing Assistant	4	12

7. In what type of health facility do you currently practice?

Hospital (1)	Health center (2)

13

8. How long have you been practicing?

< 6months	1
> 6 months	2
> 12 months	3
> 5 years	4

14

B. Items to assess knowledge about mental illness and people with mental illness

1. Have you ever received lectures on mental health?

Yes	1
No	2

15

2. Approximately how many lectures have you received over the past three years?

Nil	1
one time	2
two times	3
three times	4
more than three times	5

16

Items	***Strongly disagree***	***Disagree***	***Undecided***	***Agree***	***Strongly disagree***	
3. I believe that the lectures adequately prepare me to care for people with mental illness.	1	2	3	4	5	17
4. Medications are effective in treatment of mental illness.	1	2	3	4	5	18
5. People with mental illness need constant care.	1	2	3	4	5	19
6. "Psycho" and "maniac" are correct terms for mental illness.	1	2	3	4	5	20
7. People with mental illness are hurt by slang names for their disorders.	1	2	3	4	5	21
8. Mental illness is not a very serious problem.	1	2	3	4	5	22

9. Patients with mental illness are often treated unfairly	1	2	3	4	5		23
10. Mental illness is often shown in a negative way on television and movies.	1	2	3	4	5		24
11. Psychological treatment (such as talking to a psychologist or counsellor) is useful.	1	2	3	4	5		25
12. Mental illness is often confused with effects of drug abuse.	1	2	3	4	5		26
13. Mental illness is caused by something biological.	1	2	3	4	5		27
14. Mental illness and mental retardation are the same.	1	2	3	4	5		28
15. A person with bipolar disorder acts overly energetic.	1	2	3	4	5		29
16. Most people with severe forms of mental illness don't get better even after treatment.	1	2	3	4	5		30
17. Schizophrenia involves multiple personalities.	1	2	3	4	5		31

C. Items assessing Attitude

Items	***Strongly disagree***	***Disagree***	***Undecided***	***Agree***	***Strongly agree***		
18. Find it hard to talk to someone with mental health problems.	1	2	3	4	5		32
19. Even after the treatment, I would be uncomfortable to be around people who have been treated for mental illness.	1	2	3	4	5		33
20. Mentally ill patients are entitled to the same attention in the health center as are general patients.	1	2	3	4	5		34
21. People with mental illness should not be allowed to work.	1	2	3	4	5		35
22. Political and individual rights of mentally ill persons should be suspended while on treatment to help them.	1	2	3	4	5		36
23. Those with mental illness should not be allowed to have children.	1	2	3	4	5		37
24. Mental hospital is the only place for people with mental illness.	1	2	3	4	5		38

25. I would ask for exemption to treat those with mental illness.	1	2	3	4	5		39
26. People with mental illness are usually dangerous.	1	2	3	4	5		40
27. People with mental illness are usually violent.	1	2	3	4	5		41
28. People with mental illness are usually unpredictable.	1	2	3	4	5		42
29. People with mental illness can lead a normal life.	1	2	3	4	5		43

D. Items assessing Practice

Items	***Strongly disagree***	***Disagree***	***Undecided***	***Agree***	***Strongly agree***		
30. It is hard to talk to someone with mental problems.	1	2	3	4	5		44
31. I am comfortable with attending to people with mental illness.	1	2	3	4	5		45

32. Have you ever referred anyone with mental illness?

Yes	1
No	2

☐ 46

33. Did you receive feedback on the patients you have referred?

Yes	1
No	2
Do not know	3

☐ 47

34. If not, why not? ..... ☐ 48

35. Do you think the health facility where you work can accommodate the care of persons with mental illness?

Yes	1
No	2
Do not know	3

☐ 49

36. If not, why not?.....	☐ 50
THANK YOU FOR YOUR PARTICIPATION	

ANNEXURE B

INFORMATION LEAFLET

INFORMATION DOCUMENT

STUDY TITLE: "**NURSES KNOWLEDGE, ATTITUDES AND PRACTICES TOWARDS MENTAL ILLNESS IN MAFETENG: LESOTHO".**

Introduction:
I, Bernadett 'Malehlohonolo Damane, is doing research on the Knowledge, Attitudes and Practices (KAP) of Nurses towards mental illness.
Mental illness is very common in our country and in most cases affecting people at their prime time of their lives. Nurses have to care for people with mental illness and I want to explore the knowledge, attitudes and practices of nurses towards mental illness.

Please note that completing this questionnaire is an indication of understanding as well as giving consent. Upon completion of the study, you will get feedback through meetings and written materials. Permission to carry out this study has been granted by the UFS and Ministry of Health, Lesotho.

Invitation to participate: I am inviting you to participate in a research study.

What is involved in the study?
All you have to do is to complete a questionnaire. This should take at least 20-25 minutes.

Risks: There are no anticipated risks

Benefits: You may not benefit directly from this study but this information may help in informing planning and training towards mental health issues that will subsequently improve and strengthen mental health services in our country.

Participation is voluntary**,** and refusal to participate involves no penalty. You may discontinue participation at any time without any punishment.

Reimbursements: You will not be remunerated for completing this questionnaire.

Confidentiality No identifying information is asked on the questionnaire so your participation is completely anonymous**.**

Contact details of researcher(s) – for further information/reporting of study-related adverse events: Cell number +266 58482925/ 62482925; Work +266 52500110; E-mail address bmmoso@yahoo.com

Contact details of Secretariat: Health Sciences Research Ethics Committee of University of the Free State (HSREC-UFS) for reporting of complaints and or problems: Telephone number +27(0) 51 401 7795

ANNEXURE C

APPROVAL DOCUMENTS FROM RESEARCH ETHICS COMMITTEES:

UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE VRYSTAAT
YUNIVESITHI YA FREISTATA

UFS·UV
HEALTH SCIENCES
GESONDHEIDSWETENSKAPPE

IRB nr 00006240
REC Reference nr 230408-011
IORG0005187
FWA00012784

01 August 2016

MRS BM DAMANE
C/O DR I VENTER
SCHOOL OF NURSING
FACULTY OF HEALTH SCIENCES
UFS

Dear Mrs BM Damane

HSREC NR 42/2016
PROJECT TITLE NURSES KNOWLEDGE, ATTITUDES AND PRACTICES TOWARDS MENTAL ILLNESS IN MAFETENG DISTRICT, LESOTHO

1. You are hereby kindly informed that, at the meeting held on 26 July 2016, the Health Sciences Research Ethics Committee (HSREC) approved the above project after all conditions were met.

   ** Dr Venter was not involved in the approval of this project.*

2. The Committee must be informed of any serious adverse event and/or termination of the study.

3. Any amendment, extension or other modifications to the protocol must be submitted to the HSREC for approval.

4. A progress report should be submitted within one year of approval and annually for long term studies.

5. A final report should be submitted at the completion of the study.

6. Kindly use the **HSREC NR** as reference in correspondence to the HSREC Secretariat.

7. The HSREC functions in compliance with, but not limited to, the following documents and guidelines: The SA National Health Act. No. 61 of 2003; Ethics in Health Research: Principles, Structures and Processes (2015); SA GCP(2006); Declaration of Helsinki; The Belmont Report; The US Office of Human Research Protections 45 CFR 461 (for non-exempt research with human participants conducted or supported by the US Department of Health and Human Services- (HHS), 21 CFR 50, 21 CFR 56; CIOMS; ICH-GCP E6 Sections 1-4; The International Conference on Harmonization and Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH Tripartite), Guidelines of the SA Medicines Control Council as well as Laws and Regulations with regard to the Control of Medicines, Constitution of the HSREC of the Faculty of Health Sciences.

Yours faithfully

PROF WJ STEINBERG
VICE CHAIR: HEALTH SCIENCES RESEARCH ETHICS COMMITTEE

Health Sciences Research Ethics Committee
Office of the Dean: Health Sciences
T: +27 (0)51 401 7795/7794 | F: +27 (0)51 444 4359 | E: ethicsfhs@ufs.ac.za
Block D, Dean's Division, Room D104 | P.O. Box/Posbus 339 (Internal Post Box G40) | Bloemfontein 9300 | South Africa
www.ufs.ac.za

LESOTHO

Ministry of Health
PO Box 514
Maseru 100

REF: ID74-2016

Date: May 24, 2017

Category of Review:
[ ] Initial Review
[x] Continuing Annual Review
[ ] Amendment/Modification
[ ] Reactivation
[ ] Serious Adverse Event
[ ] Other _____

To:
Bernadett M. Damane
Candicate for Masters of Social Science in Nursing
University of Free State

Dear Ms. Bernadett,

RE: Nurses knowledge, attitudes and practices towards mental health illness in the Mafoteng district; Lesotho (ID74-2016)-Renewal

This is to inform you that on 23 May, 2017 the Ministry of Health Research and Ethics Committee reviewed and **APPROVED** the renewal of approval for the above study and hereby authorizes you to conduct the study according to the activities and population specified in the protocol. Departure from the approved protocol will constitute a breach of this permission.

This approval includes review of the following attachments:
[ ] Protocol dated 2016
[ ] English consent forms
[ ] Sesotho consent forms
[ ] Data collection forms
[ ] Participant materials
[ ] Other materials: Letter of request datec May 19, 2017 & a copy of approval letter dated June 14, 2016

This approval is **VALID** until June 13, 2018.

Please note that an annual report and request for renewal, if applicable, must be submitted at least 6 weeks before the expiry date.

All serious adverse events associated with this study must be reported promptly to the MOH Research and Ethics Committee. Any modifications to the approved protocol or consent forms must be submitted to the committee prior to implementation of any changes.

We look forward to receiving your progress reports and a final report at the end of the study. If you have any questions, please contact the Research and Ethics Committee at rcumoh@gmail.com (or) 22226317.

Sincerely,

Dr. Nyane Letsie
Director General Health Services (a.i)

Dr. M. M. Moteetee
Chairperson NH-REC