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Community Perceptions on Mental Illness in Bungoma County, Kenya

Peter Nandikove[1]
[1]*School of Nursing, Midwifery and Paramedical Sciences; Masinde Muliro University of science and Technology.*

Thomas Ong'ondo Ng'ambwa[2]
Department of Reproductive Health, Midwifery and Child Health; Masinde Muliro University and Technology

Abstract
Objective. The objective of the study was to evaluate the perceptions towards mental illness and the mentally ill by the community in Bungoma County, Kenya. Design. The study was a descriptive cross-sectional study and Quantitative methods were adopted. Setting. The study was carried out in Bungoma County Sample. Five Sub-Counties in Bungoma County were purposively sampled to increase the representation. The household's heads were sampled by stratified sampling; the researcher divided the population into strata and drew a predetermined number using simple random sampling (n = 396) Analysis. Data wasanalyzed through descriptive statistics and regression. Main outcome measures. Attitude towards the mentally ill Results. From the results, 69.7% (276) of the respondents think the mentally ill are a burden to the society. Majority of the respondents 67.7 % (268) agreed that the best therapy for many of the mental patients is to be part of the normal community.The results showed that 69 % (272) disagreed that virtually anyone can become mentally ill. From the results 66.7% (264) agreed that it is frightening to think of people with mental problems living in a residential neighbourhood.Majority 260 (65.7%) agreed that the mentally ill should not be given any responsibilities.Regression model results indicated that the two predictors: a) attitude and b) knowledge of mental illness and mental health, explained 34.4% of the variance ($F\ [2, 369] = 24.713$, $p < 0.05$, $R^2 = .344$), equating to a medium effect size. Regression analyses found that predictor variables perception ($\beta = .19$, $p < 0.05$) significantly predicted increased likelihood that participants would stigmatize people with mental illness. Conclusion. The study findings established that there is negative perception by members of the community of Bungoma County towards the mentally ill persons. Recommendation. The study recommends that sensitization of the community/ public on mental illnesses is important in Bungoma County. Scaling up public awareness campaigns to reach more people by diversifying the approaches targeting specific group of family members having mentally ill persons.

Keywords: ***Bungoma, Kenya, Mental health, Mental illness, Attitude towards mental illness, public knowledge, sensitization, stigma, myths of mental illness.***

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I. Background

Better knowledge has often been reported to result in improved community perception and attitudes towards people with mental illness, whilst beliefs that mental illness are treatable, can encourage early treatment seeking and promote better outcomes (Taylor & Deer, 2011). It is a widely shared belief that an increase in the community's mental health literacy should result in an improvement of attitudes towards people with mental illness. More recently, community attitude in some countries have changed as a result of initiatives to improve the community`s mental health literacy, and in becoming more like those of professionals (Creswell *et al*., 2015). However, the prevailing attitudes towards seeking professional help for such problems and to what extent these beliefs actually influence service use for mental health problems are unknown. Thornicroft, (2008), Alonso (2015) also concluded that improved knowledge, attitudes and behavior show the strongest evidence for effective interventions at present, then direct social contact with people at the individual level (Collins *et al*., 2011).

Inadequate mental health literacy is said to be problematic because inadequate knowledge is associated with delays in treatment seeking, decreased levels of treatment seeking and utilization of non-optimal treatment (Rush *et al*.2011). Inadequate knowledge about mental illness was wide spread in the community (Krogstad*et al*.2014). Although, the mental health literacy definition, namely it being the knowledge and beliefs about mental disorders, was not questioned, negative stereotypes and stigmatizing attitude of mental health

professionals towards people with mental illness are controversial issues (Francis, 2008).This study sought to fill the mental literacy gap in the community by using triangulated methods to create awareness in the community and use psychotherapy as a form of treatment towards the mentally ill and the community at large in Bungoma County.

Conversely, recent survey conducted in 2011, showed that 90% of the relatives questioned on mental disorders, believed that mental health was a significant clear understanding of mental illness (Mamo,2007).Several studies revealed inadequate knowledge about mental illness among the general population and stigmatizing attitude towards people with mental illness (Knox *et al*.2001).However, it has not been determined whether mental health professionals held fewer stigmatizing attitudes than the general population (Radford, 2010).Another consequence of poor mental health literacy is that the task of preventing and helping mental disorders was largely confined to professionals. However, the prevalence of mental disorders was so high that the medical workforce cannot help everyone affected and tends to focus on those with severe and chronic problems (Dunkley *et al*.,2008).Inadequate knowledge and negative attitudes have been seen as factors limiting help seeking and such negative attitude can involve self-stigmatization in which a person has internalized the negative attitude held by society and applied these to him or herself (Chikomo, 2012). This attitude reduces the likelihood of a person who is depressed to seek professional help (Jorm*et al*.2011; Dochetry,2009).There is growing evidence that mental health literacy has increased in Western countries in recent years. Studies from the United States of America, Australia and Germany have shown that the communities have become more able to recognize mental disorders and that better knowledge has led to more positive attitudes as demonstrated by a number of anti-stigma campaigns (Corrigan, 2011; Satorius, 2011).

However, this assumption has been challenged by findings from recently conducted population studies, observing that the community's knowledge about mental disorders maybe unrelated, or even inversely related (Angermeyer, 2009; Bryne, 2009; Alonso, 2015; Lauber*et al*., 2007). It is a widely shared belief that an increase in the community's mental literacy should result in an improvement of attitudes towards people with mental illness. Arguably, while surveys of community beliefs have been carried out in a number of countries, little is known about cross-culture differences in mental health literacy (Evans-Lacko*et al*., 2014). What the community beliefs about mental illness and the effectiveness of modern health services in managing mental illness would influence health seeking behaviors. The level of mental health literacy within a community underpins its inability to develop the structures to promote mental health, prevent mental illness, recognize and respond to mental health problems and related disorders (Mamo, 2007).

It has been concluded that Canadians are more inclined to recommend medical help for symptoms of mental disorders. However, they are still somewhat ambivalent about medical care, especially with regards to common mental health problems and with regards to psychiatric medications (Knox *et al*. 2001). In Nigeria, as elsewhere, one of the most commonly cited reasons for the underutilization of available psychiatric services by the lay community was the notion of stigmatization (Adebowale&Ogunlesi, 2010).Negative reactions towards those with mental illness are thought to contribute towards delays in help seeking, as well as placing many individuals who have received psychiatric treatment at a disadvantage with regards to community support and involvement (Adebowale&Ogunlesi,2010).

According to Wisner *et al*., (2014), the application of indigenous knowledge in the face of hazards and other threats is referred to as coping mechanism or coping strategy. In the range of disaster contexts, Morgan, Fischoff, Bastrom& Atman, (2001), categorized the coping mechanisms into four broad areas: economic diversification, where one had more than one source of income; technological, where infrastructure was well planned so that housing can be accessed by the low class including such families of affected persons; building scape areas underneath or on top of roofs:- in this study the chronic schizophrenic like living on tree tops pausing a risk of falls and fractures, a health hazard and social as well as cultural categories. In Bangladesh, several coping mechanisms have been practiced by communities and such include shelters and rafts for mobility (Patel, 2016).

Adebowale&Ogunlesi, (2010) were of the opinions that the stigma that goes along with mental illness acted as a serious barrier to individual seeking mental health treatment and lowers their self-esteem and might lead to home-run away. This situation caused much stigma to the family members and may finally become a contributing factor for the patient defaulting from taking medication and attending medical check-up. Viklud (2010), also argues that on the other hand, if the social agents are supportive, they help in promoting healthy social relationships of people with mental health disorders which may help them overcome the stigma.

Researchers have often assessed stigma associated with mental illness, by surveying the community's perception towards "mental patients", or "persons with mental illness", or "mentally ill" and in using these terms evoking images of chronic psychopathology (Corrigan, 2011). People's beliefs regarding mental illness should not only be known, but the purpose of their beliefs should be understood. Such attitudes and beliefs about mental illness can only be studied within a cultural context to be able to understand what they know concerning mental illness (Marquadt, 2002). To date, no research has been done on the community perceptions affecting the socio-economic well-being of the communities in Kenya, who have distinct cultural practices,

different customs and traditions. Mental health educational and awareness programs should be advocated for by the government to positively promote mental health/illness in the community (Muga, Kizito, Jenkins &Mbaya, (2012). The mental health literacy has been found to be still unsatisfactory and need to be improved, in order not to hinder community support to the mentally ill persons.

People with mental illness were often stigmatized due to lack of their knowledge about their illness (Lauber*et al*., 2007). The general community had been the main target of these endeavors, because it's mental health literacy that is on perception, attitude, beliefs and myths surrounding mental disorders and the awareness of different treatment options, has been repeatedly shown to be low (Lauber*et al*.,2010; Morgan *et al*., 2010; Wisner *et al.*, 2014).It has become evident that mental health knowledge encompasses an individual's perception, attitudes and beliefs about mental illness whilst poor mental health literacy often represents powerful barrier to treatment. The literature revealed that mental health knowledge influenced health seeking behavior of the mentally ill individuals and community willingness to support them. Contrary, inadequate and poor knowledge hindered the community members to use mental health services in both developing and developed counties towards people with mental health problems (Muga*et al*., 2012). Consistent with the literature, many studies suggested that the lay people generally have poor knowledge of mental illness and tend to have views that differ from professionals about the ability to recognize specific disorders or different types of psychological distress, knowledge and beliefs of risk factors and causes, knowledge and attitudes about self-help interventions, knowledge and attitudes about professional help available, attitudes that facilitate recognition and appropriate help seeking, and knowledge on how to seek mental health information.. The objective of the study was to evaluate the perceptions of the community on mental illness in Bungoma county.

II. Methods

The study was conducted in Bungoma county and ethics approval was obtained from Masinde Muliro University of Science and Technology ethics board, National commission for science and technology. No further approval was needed since the project did not require access to patients or personal data.

Research Design

The study designs adopted for this study was descriptive cross-sectional and evaluation because they employ quantitative approaches, where self-administered questionnaires were used for data collection. A descriptive research design determines and reports the way things are (Mugenda&Mugenda, 2008). Polit&Hungler (2010) observed that a descriptive research design was used when data was collected to describe persons, organizations, settings or phenomena. Descriptive study design was also ideal as the study was carried out in a limited geographical scope and hence it was logistically easier and simpler to conduct considering the limitations of this study (Mugenda&Mugenda, 2008). It helped make judgments about values or worth of developing mental health campaigns and other rehabilitation programs like half-way home centers for the mentally ill (Wisner *et al*. 2014). Therefore, the descriptive survey was deemed the best strategy to fulfill the objectives of this study.

Study setting

The study was carried out in Bungoma County, Kenya. Bungoma town is the Headquarter of Bungoma County and the third largest County in Western Kenya (Maphill, 2011). It was the Mount Elgon region in the former larger Western Province and it lies 102 kilometers North West from Kisumu City on an altitude of 4,400ft (1,340 m) (Kenya Mpya, 2013). According to the Government of Kenya Census (2012), it has a population of 1,375,063 (1.38m) and the County covers an area of 2,206.9 km ^{2} (852.1 sq mi). There are 67,358 households within the County (Kombo &Delmo, 2015).

Participants

Mugenda and Mugenda (2008) defined population as all elements (individuals, objects and events) that meet the sample criteria for inclusion in a study. In this study the target population were people who resided in Bungoma County and met the criteria of interest to the researcher (Burns & Grove, 2011). The researcher then randomly sampled the units of the study from the accessible population (Polit&Hungler, 2010). The researcher focused on community households heads aged 18 years and above. The research used a sample size of 398.

Bungoma was purposively selected because of the post-election violence in 2008, 2009 and 2013 in Kenya, which caused closure of most factories and industries, thereby increasing violence related mental illnesses and exacerbating existing ones (Inyanji, 2014). It recorded the highest cases of depression and other mental health disorders (Kenya Red Cross, 2015). Like in the Mt Elgon region, there were a lot of animosity resulting in people torching houses and hacking one another to death (UNHCR, 2012). Five Sub-Counties in Bungoma County were purposively sampled to increase the representation (KDHS, 2008/9). The household's heads were sampled by stratified sampling; the researcher divided the population into strata and drew a

predetermined number using simple random sampling. The sample size was determined using Cochran equation (1963), a 10% attrition was added to the sample size making it 422.

Questionnaire

Questionnaires were selected as data collection instruments. The instrument comprised of the following sections: In section one, the information that was collected was the demographic characteristics and included age, gender , marital status, education level and religion. In section two, questions sought to determineperceptions towards mental illness by the community (Bloom, 1998).this questions were modified from a validated tool used by (Ng & Chan 2004). The questions were ranked on a 2-point likert scale with the anchors being disagree=0 to agree=1. To increase the validity and reliability of the instruments, the questionnaire was evaluated by experts. Then based on the feedback the final questionnaire was prepared for pre-test. The pretest study was conducted in one sub-county hospital.The reliability of the scale of the items was found to be: Internal consistency = (Cronbach's $\alpha = 0.87$).

Data Analysis

Data analysis was done using the statistical program for social sciences (SPSS) version 23. Inferential and descriptive statistics were used to analyze data. Descriptive analysis of data was done using the mean, frequencies and percentages. In this study association between the study variables was assessed by a two-tailed probability value of $p<0.05$ for significance. Visual inspection of the data illustrated that missing data appeared to be missing at random. After visual inspection, in order to further examine the pattern of missing data, the researcher evaluated whether the data was missing completely at random (MCAR). Standards guidelines were considered when reviewing the missing data for the current research study. Each question was coded and entered in SPSS (Barohn et al, 2012). The findings were entered in the variable view of the Statistical Package for Social Sciences (SPSS) version 20.0 screen, each questionnaire at a time, starting with first to last questionnaire (Cohen, 2011). The researcher conducted analyses of normality, for the outcome variable, prior to hypothesis testing by examining kurtosis and skewness of the data. In order to test and identify possible outliers in the data, graphical assessment visuals, including scatter and box plots were used. Elimination of observed outliers was based on a case by case basis, dependent on standard deviations, and on normality and homogeneity of variance assessments.

III. Results

Out of the 422 questionnaires distributed, 396 were correctly filled and returned which represented a response rate of 87 percent. According to Mugenda and Mugenda (2003) a response rate of 50 percent is adequate, a response rate of 60 percent is good, and a response rate of 70 percent is very good. Therefore, the 87 percent response rate reported for this study formed an acceptable basis for drawing conclusions. While we should not expect full response in studies where responding is voluntary, scholars utilizing questionnaires should aim for a high response rate (Baruch &Holtom, 2008). Firstly,the study asked the respondents to indicate their background characteristics based on the gender, religion, marital status; age-bracket and education level. The summary of their responses is given in Table 1.

Table 1: Background characteristics of respondents

Demographics		Frequency	Percent
Gender	Male	172	43.4%
	Female	224	56.6%
	Total	**396**	**100.0**
Religion	Christian	220	55.6%
	Muslim	164	41.4%
	Hindu	8	3%
	Total	**396**	**100.0**
Marital Status	Single	148	37.4%
	Married	216	54.5%
	Separated	12	3%
	Divorced	8	2%
	Widowed	12	3%
	Total	**396**	**100.0**
Education level	No education	4	1.0%
	Primary education	220	55.6%
	Secondary education	120	30.3%
	College	28	7.1%
	University	24	6.1%
	Total	**396**	**100.0**

Age Bracket	18-24 years	200	1.0%
	25-34 years	128	55.6%
	35-45 years	48	30.3%
	Over 45 years	16	7.1%
	Total	**396**	**100.0**

The study sought to find the perceptions of the community with regards to mental illness. From the results, 69.7% (276) of the respondents think the mentally ill are a burden to the society, while29.5% (117) of the respondents disagreed. Majority of the respondents 67.7 % (268) agreed that the best therapy for many of the mental patients is to be part of the normal community. Only 32.3 % (128) disagreed.The results showed that 69 % (272) disagreed that virtually anyone can become mentally ill. While 31.3 % (124) agreed that virtually anyone can become mentally ill.From the results 66.7% (264) agreed that it is frightening to think of people with mental problems living in a residential neighborhood, while 33.3% (132) disagreed that it is frightening to think of people with mental problems living in a residential neighborhood.Majority 260 (65.7%) agreed that the mentally ill should not be given any responsibilities, while 34.3% (136) disagreed and they were for the idea that mentally ill people should have responsibilities assigned to them. The majority of people268(67.7%) in the community disagreed that they have the responsibility to provide the best possible care for the mentally ill, while only 128(32.3%) agreed.The results showed that 344(87%) of the respondents felt that the mentally ill could do regular jobs, while 52(13.1%) felt that people with mental illness could not do regular jobs.Majority344(86.9%) said that that people with mental illness do not have unpredictable behavior, while 52(13.1%) said that people with mental illness have unpredictable behavior.From the results 300(75.8%) of the respondents agreed that it was rare for people who are successful at work to have mental illness, while 96 (24.2%) disagreed that it was rare for people who are successful at work to have mental illness. Summary of findings is in table 2 below.

Table 2: Summary of Attitude items

Attitude Items	**Agree**	**Disagree**
The mentally ill are the burden to the society.	279 (69.7%)	117 (29.5%)
The best therapy for many of the mental patients is to be part of the normal community.	128 (32.3%)	268 (67.7%)
Virtually anyone can become mentally ill.	124(31%)	272(69%)
It is frightening to think of people with mental health problems living in a residential neighborhood.	132 (33.3%)	264 (66.7%)
Mentally ill should not be given any responsibility.	260 (65.7%)	136 (34.3%)
We have the responsibility to provide the best possible care for the mentally ill.	128 (32.3%)	268(67.7%)
Do you think people with mental illness can do regular jobs	344 (87%)	52 (13%)
People with mental illness have unpredictable behavior	52 (13.1%)	344 (86.9%)
It is rare for people who are successful at work to have mental illness	300 (75.8%)	96 (24.2%)

Multivariate analysis of the relationship between perception, knowledge and stigma

The researcher evaluated if the community's perception (attitude) and knowledge predicted stigma. Multiple regression analyses were conducted, utilizing the enter method, in order to test if the variables significantly predicted stigma. Regression model results indicated that the two predictors: a) attitude and b) knowledge of mental illness and mental health, explained 34.4% of the variance ($F [2, 369] = 24.713$, $p < 0.05$, $R^2 = .344$), equating to a medium effect size. Regression analyses found that predictor variables perception ($\beta = .19$, $p < 0.05$) significantly predicted increased likelihood that participants would stigmatize people with mental illness. However, knowledge ($\beta = .027$, $p = 0.304$was not a significant predictor of stigma. Results from Pearson's correlation showed that there was a significant positive relationship between attitude (396) = .33, $p < .05$ and stigma and there was also a significant positive relationship between knowledge r (396) = .14, $p < .05$ and stigma. Specifically, the higher the attitude scores the respondent had, the more likely they are to stigmatize a person with mental illness. Given that variables a) attitude and b) knowledge of mental illness, offer almost similar information, the researcher decided to test for any multi-collinearity that may be present within the regression model. Running a bivariate correlation matrix resulted in a Pearson correlation score of r (396) = .27, $p < .05$, between the variables a) knowledge and b) attitude in the community. Additionally, collinearity statistical tests indicated that multi-collinearity was not a concern (Attitude, Tolerance = .934, VIF = 1.071; Knowledge, Tolerance = .934, VIF = 1.071).Multicollinearity becomes more prevalent and problematic when tolerance levels are below .40 and when VIFs are over 2.5 (Marquardt, 1970).Both tests suggested that it was safe to assume that the two variables are not significantly inter-correlated and act as independent predictor variables within the regression model Table 3

Table 3: Regression table for attitude and knowledge as predictors of stigma

	Unstandardized Coefficients		Standardized Coefficients			Collinearity Statistics	
	B	Std. Error	Beta	*t*	*Sig.*	Tolerance	VIF
(Constant)	1.762	.454		3.881	.000		
Attitude score	.190	.029	.327	6.454	.000	.934	1.071
Knowledge score	.027	.026	.052	1.030	.304	.934	1.071

IV. Discussion

The objective of the study was to find out the perceptions towards mental illness by the community in Bungoma County. From the results, 69.7% (276) of the respondents think the mentally ill are a burden to the society. Possible explanation could be due to the negative perception by the community which has a trickledown effect on the mentally ill patients. The mentally ill perceive themselves as useless and helpless increasing burden to their relatives. According to Kabir*et al*., (2009) Poverty, unemployment, internal conflict, displacement and HIV add to the mental health burden. Majority of the respondents 67.7 % (268) agreed that the best therapy for many of the mental patients is to be part of the normal community. The findings show that respondents don't think mentally ill patients should be part of a normal community. In a study by Benedicto et al. (2016)the majority of the respondents (86.2%) mentioned the best model of treatment as the hospital. This concurs with what was found in a study by Kabir*et al*., (2009) in North Nigeria in which respondents felt that mentally ill patients should be locked away in hospitals. However, this finding is in disagreement with what was found in a study by Gureje*et al*., (2005) in Nigeria in which traditional healing was the most preferred treatment. Stigma can be deeply hurtful and isolating and be one of the most significant encounters by people with mental problems Mehta *et al*., (2009).

The results showed that 69 % (272) disagreed that virtually anyone can become mentally ill. The findings showed that the perceptions of the community towards the mentally ill were negative and this could be attributed to the limited knowledge about causes of mentally illness. According to Modest (2008), mentally ill patients have tripled from 31, 538 to 97,570 in 2007, and it was estimated that there were 2.5 million people with mental illness in Kenya in 2008 Mas &Hatim (2009). From the results 66.7% (264) agreed that it is frightening to think of people with mental problems living in a residential neighborhood. This is consistent with findings by Mehta *et al*., (2009) who observed that people with mental health problems were frequently the object of ridicule or derision and were depicted within the media as being violent, impulsive and incompetent.

Majority 260 (65.7%) agreed that the mentally ill should not be given any responsibilities. The findings are consistent with findings from a study done in Delta State in Nigeria by Kamla (2009), factors which facilitated this negative attitude towards mental illness included stigma, violence behavior of mentally ill patients, impaired cognitive functioning and lack of knowledge towards mental illness among community members. The findings in this study are also supported by the study done in Kinondoni Tanzania by Chikomo (2012). The majority of people268(67.7%) in the community disagreed that they have the responsibility to provide the best possible care for the mentally ill. This indicates that perceptions of the study population towards people with mental health problems is generally poor. In a study done by Sangeeta & Mathew, (2017) in India, nearly half of the patients and general public believed full or good recovery could be attained if treated. Relatives appeared to be more optimistic than the other groups as almost 70% held such belief. On the other hand, most respondents in all groups (relatives and community) expected the illness to remain unchanged if left untreated

The results showed that 344(87%) of the respondents felt that the mentally ill could do regular jobs. This could be due to the information seen in the media which was extremely negative, and it painted a damaging and often false pictures of those with mental illness Francis *et al*. 2002). In a study by Benedicto *et al*.(2016)50.5%), of the participants reported that a mentally ill patient cannot do a regular job when asked if a mentally ill person could do a regular job (figure 5); while n=69 (35.6%) reported that they cannot have a regular job because they will be making mistakes and ruin the job.Majority344(86.9%) said that that people with mental illness do not have unpredictable behavior.This findings are inconsistent with previous studies which noted that the public felt that people with mental illness had unpredictable behavior Benedicto *et al*.(2016); Sangeeta & Mathew, (2017). Trainer & Pierre (2014) stated that movies and television often portray the individual suffering from mental illness as unpredictable and violent. Again, media scripts showed that people with mental illness should be feared, because they have been seen as homicidal maniacs Trainor &Pierri, (2014).

From the results 300(75.8%) of the respondents agreed that it was rare for people who are successful at work to have mental illness. Possible explanation could be due to the limited knowledge of mental illness. In a study done by Sangeeta & Mathew, (2017)more respondents in the general public considered pregnancy-related issue, substance abuse, poverty, and problems during childhood as the causes of mental illness. This negative perception is consistent with a previous study in Ethiopia that noted significant number of the respondents from Gimbi community had poor perception of mental illnessBenti, Ebrahim, Awoke, Yohannis, & Bedaso (2016).

This study is in line with the study conducted in India where 39.4% of the respondents were found to have poor perception about mental illness Salve, Goswami, Sagar, Nongkynrih&Sreeni- Vas (2013).

V. Conclusion& Recommendation

The study findings established that there is negative perception by members of the community of Bungoma County towards the mentally ill persons. This had led to stigma and stereotype effect on the mentally ill. Still majority of the members of the community thought that the mentally ill should be isolated from the community.Regression results showed that there was a relationship between attitude and stigma; and attitude was a good predictor of stigma in the society. However, there was minimal relationship between knowledge and stigma, but knowledge was not a significant predictor of stigma. The impact of the socio-cultural context had been largely neglected. Perception and beliefs play a role in determining help seeking behavior and successful treatment of the mentally ill. Moreover, mental health literacy was an important determinant of help seeking behavior. The study recommends that sensitization of the community/ public on mental illnesses is important in Bungoma County. Scaling up public awareness campaigns to reach more people by diversifying the approaches targeting specific group of family members having mentally ill persons.

Reference

[1]. Adebowale,T.O. &Ogunlesi, A.O. (2010). Beliefs and knowledge about etiology of mental illness among Nigeria Psychiatric Patients and their relatives. Afr J M SG, 28, 34-41.

[2]. Alonso, S, &Kapral, R. (2015). Effective Medium theory for reaction and diffusion co-efficient of heterogeneous systems. doi:10.1103/phs Rev Lett 102: 238302.

[3]. Angermeyer, M, Holzinger, A; &Matscchinger, H. (2009). Mental health literacy and attitudes towards people with mental illness, a trend analysis based on population surveys in the eastern part of German.doi:1016/j. eorpsy. 2015.07.0010.

[4]. Baruch, Y., & Holton, B. C. (2008). Survey response rate levels and trends in organizational research. Human Relations, 61(8), 1139-1160.

[5]. Benedicto, M., Mndeme, E., Mwakagile, D. S. M., &Tumbwene, E. (2016). Community Knowledge , Attitudes and Perception towards Mental Illness in Dodoma Municipality , Tanzania, 1(3), 10–18.

[6]. Benti, M., Ebrahim, J., Awoke, T., Yohannis, Z., &Bedaso, A. (2016). Community Perception towards Mental Illness among Residents of GimbiTown, Western Ethiopia, 2016.

[7]. Bryne, P. (2009). Stigma of Mental Illness and ways of diminishing it. 6:65-72.

[8]. Chikomo, J.G. (2011). Knowledge and Attitude of the Kinondoni Community towards Mental Illness. Dissertation presented to the University of Stellenbosch in South Africa. URL: http://hdl. Handle.net/10019.1/6562'

[9]. Creswell, J.W. (2015). Designing and Conducting Mixed Methods Research. London: Sage Publications Ltd, 2007

[10]. Cohen, J, &Struenning, E.L. (2012). Opinions about mental illness in the personnelof two large mental hospitals. J Abnormsocpsychol, 64:349-60.

[11]. Corrigan, P.W, & Watson, A.C, (2011). Understanding the impact of stigma on people with mental illness. World Psychiatry, 1(1): 16-20.

[12]. Corrigan. P.W. (20004). Best practices: strategic change: five principles for socialmarketing campaigns to reduce stigma, psychiatr serve, 62:824-6.

[13]. Dunckley, W., Hugnes, S., &Hagginson, R. (2008). Measuring mental illnessstigma, Schizophr Bull, 30:511-41.

[14]. Evans-Lacko, London, J., Little, K., Henderson, C.Thornicroft, G. (2014). Evaluation of a brief Anti-stigma campaign in Cambridge: do short-term campaigns work?BMC Public Health, 10:339.

[15]. Francis, C. (2008). Improving mental Health Literacy: areview of the literature. Centre for Health Program Evaluation.

[16]. Gureje O., Lasebikan V. O., Ephraim-Oluwanuga O., Olley B. O. & Kola L. (2005) Community Study of Knowledge of and Attitude to Mental Illness in Nigeria. British Journal of Psychiatry 186, 436-441. http://bjp.rcpsych.org/content/186/5/436.long.

[17]. Inyanji, J. (2014, October, 28). Kakamega opens rehabilitation Centre. Standard newspaper, P, 12.

[18]. Jorm, A.F., Mackinnon, A., Christenson, H., & Griffiths, K.M. (2011). Structure of beliefs about helpfulness of interventions for depression and schizophrenia: results from a national survey of the Australian public. Soc psychiatry Psychiatrepidermiol, 40:877-883, doi: 10.1007/s00127–005-0991-x.

[19]. Kabir, M., Iliyasu, Z., Abubakar, I.S., &Aliyu, M.H. (2014). Perception and beliefs about mental illness among adults in Karfi Village, Northern Nigeria. BMCInternational Health and Human Rights, 4:3, doi:10.1186 /1472-698x-4-3. Knox,

[20]. Kamla, R. (2009). Knowledge, Beliefs and Attitudes of Health Care Providers towards the Mentally Ill in Delta State, Nigeria. Annals of General Psychiatry, (8),19. doi: 10.1186/1744-859X-8-19.

[21]. Knox, H., Carta, M.G., Grabe, H.J., Schwan, C. (2001). Being a Psychiatric patient in the community. Scandinavian journal of Publich health (29, December 2011): 248-255

[22]. Krogstad, U., Hosfoss, D., Hyjordtdal. P. (2014). Continuity of hospital care:beyond the question of personal contracts. British Medical Journal, 324:36-38.

[23]. Lauber, C., Nordt, C., Falcato, L., &Rossler W. (2007). Do people recognize mental illness? Factors influencing mental health literacy. European Archievesof Psychiatry and Clinical Neuroscience, 253: 248–251.

[24]. Lauber, C., Nordt, C., Rossler, W. (2010a). Recommendations of mental health professionals and the general population on how to treat mental disorders. SocPsychiatryEpidemial, 40:835–843.

[25]. Mamo D.C.(2007). Addressing patient needs: the role of mental health literacy. doi: 10.1176/appl.ajp.2007.07091513r.

[26]. Marquadt, D. (2002). Generalized inverses, Ridge Regression, Biased Linear Estimation and Nonlinear Estimation, Technometrics, 12, 591-612.

[27]. Mas, A. &Hatim. (2009). "stigma in mental illness: attitudes of medical students towards mental illness". Med J Malaysia. 57(4): 433-44.

[28]. Mehta, N., Kassam, A., Leese, M., Butler, G., &Thornicroft, G. (2010). Public attitudes towards people with mental illness in England and Scotland:1994-2003. British Journal of Psychiatry. 194:278-284, doi:10.1192/bjp,bp. 052654.

[29]. Modest,J.M. (2008). Mental health issues in African countries**, [**www.wavuti.com] Date of access 10 June 2016

[30]. Morgan, M.G, Fischoff, B, Bastrom, A, Atman, C.J, (2010. Risk communication; a mental models approach. Cambridge University Press.
[31]. Muga, R., Kizito, & Jenkins, Mbaya. (2010). (Unpublished). Overview of the healthSystem in Kenya.
[32]. Mugenda, O. M., &Mugenda, A. G. (2005). Research Methodology. Quantitative and Qualitative Research Methods: Kenya
[33]. Ng & Chan. (2004). A modified version of the questionnaire: opinions about mental illnessin the Chinese community, OMICC
[34]. Patel, M. (2016).Urban disaster mitigation and preparedness.The 1999 Kocaeli earthquake, Urban and Regional Planning, University of Califonia, Los Angeles, C.A.
[35]. Radford, T. (2010 February 6). The Guardian.
[36]. Rush, N., Evans-Laccko, S.E., Henderson, C., Fiach, C., Thornicroft, G. (2011). Knowledge and attitudes as predictors of intentions to seek help for and disclose mental health illness.Psychiatrserv, 62:675-8.
[37]. Salve, H., Goswami, K., Sagar, R., Nongkynrih, B., &Sreeni- vas, V.(2013. Perception and attitude towardsmental illness in an urban community in SouthDelhi—a community-based study. Indian Journal of Psychological Medicine, (35), 2,154–158.
[38]. Sangeeta, S. J., & Mathew, K. J. (2017). Community Perceptions of Mental Illness in Jharkhand , India, 97–105.
[39]. Sartorius, N., & Schulze, H. (2011).Reducing stigma of mental illness, bjp.Rcpsych.org/cgi/190/3/192.
[40]. Taylor, S.M., & Dear, M.J. (2009). Global pattern of experienced and anticipated discrimination against people with schizophrenia: across-sectional survey. Lancet, 373:408-15.
[41]. Trainer, G., &Pierri, P.H. (2014). Effects of an educational program on public attitudes towards mental illness, Psychiatry and clinical neurosciences (2003), 57:595-602.
[42]. Thornicroft, G., Brohan, E., Kassam, A. & Lewis-Holmes, E. (2008). Reducing stigma and discrimination: candidate interventions. 2:3, doi: 10.1186/1752-4458-2-3
[43]. Viklud, A.(2009). Global forum for community mental health.Display[http: [www.gfcmh.com/? page id = 85].Date of access: 7 June 2015.
[44]. Wisner, B., Blaikie, P., Cannon, T. Davis, I. (2014). (2nd edition). At Risk; Natural Hazards, people's vulnerability and disasters. London: Routledge

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