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Original Article

Insights of Healthcare Workers and Community Members on Mental Health Perception and Practices in Meru County, Kenya

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ABSTRACT

Mental health is a neglected field in many low and middle-income countries, such as Kenya, where information on the prevalence of mental health conditions is scarce. This problem is aggravated by an uneven distribution of mental health service providers and widespread ignorance and stigma around mental illness in the general population. The study in Meru County, Kenya, aimed to assess the knowledge, attitudes, and practices of healthcare workers and community members regarding mental health. The study, a descriptive cross-sectional survey, involved 535 community members and 109 healthcare workers, employing both qualitative and quantitative methods. Data was collected through household surveys, key informant interviews, and focus group discussions and analysed using univariate frequencies, descriptive statistics, and thematic analysis. The study revealed that 39% of community members had a family member with a mental health condition, while 68% of HCWs had been diagnosed with such conditions. Mental illness was often attributed to supernatural causes, genetics, substance abuse, and socio-economic pressures. A significant gap was found in the availability of counselling services in health facilities, with only 29.4% of HCWs reporting their presence. The perception of the affordability and accessibility of mental health services varied greatly between HCWs and community members. Additionally, while HCWs reported the availability of free medication, community members experienced shortages. The study also noted differing attitudes towards patients with mental illness in terms of respect and dignity and highlighted the use of traditional healers and religious leaders for mental health issues. This study contributes valuable insights into the state of mental health in Kenya, highlighting the high burden of mental illness, limited availability of services, and prevalent myths and misconceptions. It underscores the need for improved healthcare worker training, public awareness, and stronger health systems to address mental health issues effectively in Kenya and similar rural environments.

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INTRODUCTION

Mental health, as defined by (Bebbington, 2001), is a state of well-being where individuals recognise and realise their abilities, cope with life's normal stresses, work productively and fruitfully, and contribute to their communities". Positive mental health includes emotion, cognition, social functioning and coherence (WHO, 2019a). One of the main factors influencing both general health and socioeconomic advancement is mental health. Improved quality of life, healthier lifestyles, greater productivity, better recovery from illness, higher education attainment, employment, and earnings, better physical health, increased social cohesion and engagement, fewer limitations in day-to-day living, and better relationships with adults and children are just a few of the outcomes it influences for individuals and communities (WHO, 2019b).

Mental health is a neglected area of priority in many low and middle-income countries (World Health Organization, 2011). Recently, there have been a number of international calls to scale up the provision of mental health services in these countries (Patel et al., 2008), supported by evidence for cost-effective interventions, including those applicable in African contexts. However, global efforts to alleviate poverty have often overlooked the impact of mental ill-health (Kiima & Jenkins, 2010). A major gap exists in community-based interventions for those with mental, neurological, and substance use disorders (MNS) living in poverty.

The interplay between mental health and poverty in low and middle-income countries (LMICs) is complex, involving social causation and social drift mechanisms. People in poverty face higher risks of mental health problems due to stress from deprivation, increased trauma and adverse life events, obstetric risks, social exclusion, and food insecurity (Tsai et al., 2012). In recognition of this, the 65th and 66th World Health Assemblies adopted resolutions urging comprehensive, coordinated national-level responses to mental health and the development of comprehensive action plans that align with the Global Comprehensive Mental Health Action Plan 2013-2020.

In Kenya, the Mental Health Policy 2015-2030, aligned with the Constitution of Kenya 2010, Kenya Vision 2030, and Kenya Health Policy (2014 -2030), provides a framework for mental health system reforms (MoH, 2015). Article 43 (1) (a) of the Constitution asserts the right to the highest attainable standard of health, including mental health (GOK, 2010). Despite this, there is a lack of information on the prevalence of MNS in Kenya. It is estimated that one in ten people suffer from a common mental health condition, increasing to one in four among outpatient service attendees. Depression, anxiety disorders, and substance use disorders are the most diagnosed mental illnesses (MOH, 2020).

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Meru County[1], in Kenya's upper Eastern part, faces significant challenges in mental health care provision. With only one mental health unit in the Meru Teaching and Referral Hospital (MTRH), the region is ill-equipped to serve its 1.5 million residents and those from neighbouring counties (Government, 2018). The diagnostic and treatment gaps are exacerbated by weak overall mental health systems. This survey aimed to gather essential insights on current knowledge, attitudes, practices, and services regarding mental health from healthcare workers and the public. The information obtained is crucial for identifying training needs among healthcare workers, opportunities for community education, and advocating for enhanced mental health support systems at various care levels.

METHODS

The survey adopted a cross-sectional design, utilising a mixed-method approach that was descriptive, analytical, and consultative to gather data from community members and healthcare workers (HCWs) in Meru County, Kenya. The objective of this methodology was to enhance the validity and reliability of the research findings by triangulating qualitative and quantitative data. For the study, 109 HCWs and 535 community members in total were surveyed. Simple random sampling was used to recruit all cadres of healthcare workers at the selected health facilities who willingly agreed to participate.

Data collection tools included questionnaires targeting various mental health aspects at the community level and interview schedules for HCWs to gather their opinions and perceptions about mental health. Socio-demographic information was gathered using a self-reporting instrument, which covered age, gender, education qualifications, year of training, employment status, and deployment location.

Conducted between 4th and 11th December 2020, the survey targeted a diverse group of community members, including household heads, youth, religious leaders, herbalists, traditional healers, the *Njuri Ncheke*[2], police officers, chiefs, and sub-chiefs. Healthcare workers from selected health facilities, encompassing doctors, clinical officers, nurses, public health representatives, and Community Health Extension Workers (CHEWS), along with Community Health Volunteers (CHVs), also participated.

The community sample was drawn using systematic and simple random sampling proportionate to the population size of sub-counties. Sub-locations and villages were selected randomly, while households were chosen systematically. The first household in each sequence was selected purposively. Strict adherence to COVID-19 prevention protocols was maintained throughout the survey.

Research Assistants received training in COVID-19 prevention, informed consent processes, subject privacy protection, and data confidentiality. Data collection was conducted using the Open Data Kit (ODK) platform on electronic devices like phones and tablets. Interviews were scheduled at convenient times for informants, and anonymity was ensured by using codes for respondent identification. All data was stored on Amref's secure server for analysis. The authors had access to all the data collected, which did not have personally identifiable information.

Ethical approval was obtained from the Amref Ethical and Scientific Research Committee (ESRC P907/2020), and necessary permissions were secured from the Ministry of Health at national and county levels, as well as from facility

[1] Meru County is approximately 225 kilometres northern east of Nairobi bordering: Isiolo County to the north, Nyeri County to the southwest, Tharaka Nithi to the southwest and Laikipia to the west. The county is made up of nine constituencies: Igembe south, Igembe central, Igembe north, Tigania west, Tigania east, North Imenti, Buuri, Central Imenti, and South Imenti.

[2] *Njuri Ncheke* is the supreme governing council of elders for the Meru people of Kenya.

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in-charges in Meru County. Participants provided written informed consent after being thoroughly briefed about the study's purpose, voluntary participation, privacy, confidentiality, risks, and benefits. The study excluded minors, did not involve invasive procedures, and did not offer incentives for participation.

Data Analysis

Data analysis began on January 15, 2021, using the Statistical Package for Social Sciences (SPSS) software version 21. The data was cleaned to exclude irrelevant cases and identify improbable responses. Univariate frequencies and descriptive statistics were applied to reflect key mental health concepts, with results presented through graphs, tables, and pie charts. Qualitative data from Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) were transcribed, coded into themes, and analysed using NVivo 11 qualitative data analysis software.

RESULTS

Socio-Demographic and Other Characteristics of the Respondents

The survey included 535 household respondents, achieving a 100% response rate. The average age of these respondents was 44.27 years. Of these, a majority of 56.4% were female and 79.1% were married. An overwhelming 98.9% identified as Christians. Notably, 50.3% of the respondents lacked formal education. Regarding mental health awareness, 90.5% acknowledged its importance, and 35.1% reported having a family member with mental health needs. These demographic details are elaborated in Table 1. In the healthcare workers segment, the survey encompassed 109 professionals with an average age of 34.36 years. Females constituted 57.8% of this group, and 69.7% were married. All healthcare worker respondents were Christians. Educationally, 64.2% held a diploma, but only 32.1% had received specific training in mental health.

Table 1: Socio-demographic characteristics of the household respondents

Characteristic	Description	Per cent
Sub-county	Tigania East	33.5
	Imenti Central	32.7
	Igembe North	33.8
Gender	Male	43.2
	Female	56.4
Marital Status	Married	79.1
	Divorced	1.1
	Separated	7.9
	Single	12.0
Religion	Muslim	0.7
	Christian	98.9
	Hindu	0.2
	Others	0.2
Highest level of education	No formal education	50.3
	Primary education	27.3
	Secondary education	9.2
	Certificate	7.7
	Diploma	4.7
	Bachelor's degree	0.7
	Masters	0.2

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Knowledge Levels among HCWs and Community Members on Mental Health

Community's Knowledge of Mental Health Needs

The community's awareness of mental health needs and illness was assessed through the survey. According to the community members, mental illness is caused by, among other things, generational curses in some families; drug and substance abuse, especially marijuana; witchcraft; social economic, and financial, pressures, genetic factors where one inherits or is born with a mental illness; and injuries from accidents which leave some people with mental illness. Below are a few quotes on the causes of mental illness in the community;

> *Some people are born with the condition [mental illness], and they grow up with it. Others get mad as a result of drug and substance abuse, especially marijuana.* (IDI_Respondent)

> *Some can be inherited; others are due to the environment; for instance, if an accident happens and one is injured, maybe [in] his head to an extent that his brain is affected, it can lead to mental illness. Still, some diseases can lead to some people having those mental issues, among many other reasons* (IDI_Respondent)

> *People who have been bewitched, some people have taken drugs and other substances. Others are thieves who have been bewitched for stealing. Some are born like that in communities where they have mad people while others, in an effort to have quick money, end up stealing, and then the owner bewitches them* (IDI_Respondent)

In the survey, witchcraft was frequently mentioned as a perceived cause of mental illness, with 64.1% of respondents believing that mental illnesses are due to possession by evil spirits. A significant 82.4% understood that mental illnesses are not contagious, and 89.3% acknowledged that they are treatable. Furthermore, 91.4% recognised that mental illnesses are common and can affect individuals of all ages and backgrounds. However, there was a consensus that mental illness prevalence is notably higher among males, particularly in the youth demographic. While 76.4% believed that individuals with mental illness can lead fulfilling lives, 87.5% also perceived them as dangerous.

Regarding community members' tendencies to seek mental health services, 78.7% of respondents indicated that people often turn to healthcare facilities for mental health support. The survey also found that, in addition to formal health facilities, many seek help from religious leaders and traditional healers, including the *Njuri Ncheke*, a council of elders. It was also noted that some families do not seek any assistance for their relatives with mental illness, with instances of them being confined at home. When inquired about their awareness of local health facilities offering mental health services, only 32% were aware of such facilities in their area.

Health Care Workers' Knowledge of Mental Health Needs

The survey explored HCWs' knowledge of mental health, and they highlighted that they are caused by, among other factors, disease, drug and substance abuse, genetics, and societal pressure. Reporting on the causes of mental illness, one of the HCWs stated;

> *Basically, there are a number of causes. One has to do with genetics. We have families that are known to have issues of mental illnesses. Two, some diseases do cause mental illnesses. There are others that are a result of the abuse of certain drugs and substances. Others are as a result of trauma. There are many different causes; however, in the community, people have different opinions on what could contribute to mental illnesses. People out there would think they have been bewitched. Others believe in certain superstitions (*KII_Respondent)

The majority of healthcare workers (93.6%) who participated in the survey believed that mental illnesses are not a result of witchcraft or evil

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spirits, though they recognised that this view is commonly held in the community. Regarding their understanding of mental health and illness, a significant 91.7% were aware that mental illnesses are not contagious. However, 54.1% perceived people with mental illness as potentially dangerous. A substantial 98.2% agreed that mental illnesses are widespread and can impact individuals of various ages and backgrounds. Additionally, 89% held the view that those with mental illness can lead fulfilling and meaningful lives and believed in the curability of mental illnesses. Further details on these findings are available in *Table 2*.

Table 2: Healthcare Workers knowledge of mental health needs

		Igembe North	Imenti Central	Tigania East	Total
Mental illnesses are contagious	True	16.7	8.3	0	8.3
	False	83.3	91.7	100	91.7
People with mental illness are dangerous	True	69.4	47.2	45.9	54.1
	False	30.6	52.8	54.1	45.9
Mental illnesses are caused by witchcraft, possessions, or evil spirits	True	8.3	0	10.8	6.4
	False	91.7	100	89.2	93.6
Mental illnesses are common and can affect people of all ages and backgrounds	True	97.2	100	97.3	98.2
	False	2.8	0	2.7	1.8
People with mental illness could feel better if they tried harder	True	33.3	69.4	73	58.7
	False	66.7	30.6	27	41.3
People with mental illness can have fulfilling, meaningful lives	True	72.2	94.4	100	89
	False	/27.8	5.6	0	11

The best way of promoting respect and dignity for individuals with mental health conditions according to 60.6% of respondents is to make sure consent to treatment is received from the caregiver and/or family. When the knowledge of depression among healthcare workers was evaluated, slightly more than half (56.0%) of the respondents were aware that low energy, difficulty sleeping, and disinterest in routine activities are some of the symptoms of depression. When asked about an effective combination treatment for depression, psychosocial treatments and antidepressants were mentioned by 79.8% of the respondents.

Slightly more than half (53.2%) of the respondents knew that there is a significant danger of stigma and prejudice for those who suffer from psychosis or bipolar disorder. There were differences between the sub-counties, with Imenti having the lowest knowledge level (33.3%) among healthcare workers.

As seen in *Figure 1*, slightly more than half (55%) demonstrated an acceptable understanding of managing a seizure when asked about what signs would necessitate immediate medical attention.

Around 23.9% of the surveyed respondents understood child developmental disorders, with nearly half (49.5%) recognising these disorders as impairments or delays in functions linked to the maturation of the central nervous system. The majority, 82.6%, identified psychosocial intervention as the primary treatment for these disorders in children and adolescents. When advising adolescents with mental or behavioural disorders, a significant 96.3% of respondents recommended avoiding drugs, alcohol, and nicotine. In the context of dementia, 69.7% of healthcare workers acknowledged memory and orientation issues as common symptoms. Knowledge levels varied across different sub-counties, with Imenti Central showing the highest level of knowledge among healthcare workers at 86.1%, in contrast to Tigania East, which had the lowest at 51.4%.

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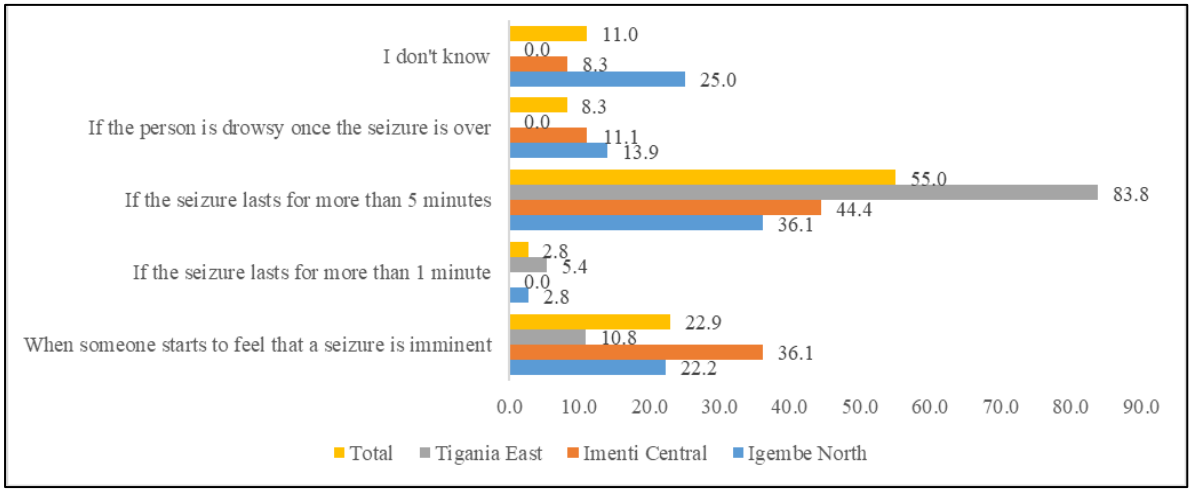
Figure 1: Knowledge among HCWs on emergency medical management of a seizure



Attitudes and Practices of HCWs and Community Members towards Mental Health and Illness

Attitudes of Community Members towards Mental Health and Illness in Meru County

The survey investigated community members' perceptions of mental illness. According to the study results, 43.9% of the respondents believed that mental health illnesses were caused by a curse. This was affirmed by one respondent who mentioned,

> *"The community members blame them without even caring to know how they got in the state they are in. I have heard some members referencing the illnesses to the families of the infected. They say it is the fault of their forefathers and other unfounded myths".* (IDI_Respondent)

More than half (53.3%) of the respondents disagreed or strongly disagreed with the statement that mental illnesses cannot be treated by conventional medicine. This view was also shared by one of the IDIs, a *Njuri Ncheke* member, who, despite being a Christian, noted that certain conditions need more than prayers, and he would personally transport the patient with mental illness to the hospital. He stated;

> *"I would take them to hospital. Although I am a Christian and go to church, I cannot take them to be prayed for. There are some things that need more than prayer".* (IDI_Respondent)

Regarding where the facilities offering mental health services are located, 66.3% of the respondents disagreed with the view that residents should not accept the location of mental health facilities in their villages or neighbourhoods to meet the needs of the local community, and 61.1% of the respondents disagreed even more with the idea that locating mental health services in residential neighbourhoods endangers the residents. One of the respondents also noted that;

> *"If such a chance would come and we get a place to take children with mental health conditions, it would be such a blessing to us and the community at large".* (IDI_Respondent)

Additionally, 66.3% of the respondents did not agree with the view that the best therapy for people with mental illness is to be separated from the rest of the community. Also, 61.1% of the respondents did not agree that community members should fear people coming into their neighbourhood to obtain mental health services. Details are highlighted in *Table 3*.

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Table 3: Community's Attitude towards Mental Illness

		Tigania East	Imenti Central	Igembe North	Total
Mental illnesses are as a result of a curse	SA	33.5	2.9	13.3	16.6
	A	16.8	29.7	35.4	27.3
	N	10.1	16.6	19.9	15.5
	D	22.9	32.0	24.3	26.4
	SD	16.8	18.9	7.2	14.2
Mental illness is untreatable with conventional medicine.	SA	8.4	2.9	8.8	6.7
	A	22.9	14.3	27.6	21.7
	N	31.3	8.6	14.9	18.3
	D	21.8	61.7	42.5	41.9
	SD	15.6	12.6	6.1	11.4
Residents should not accept the location of mental health facilities in their villages/neighbourhoods to serve the needs of the local community	SA	12.8	2.9	2.8	6.2
	A	30.2	6.9	18.8	18.7
	N	12.3	0.6	13.3	8.8
	D	26.8	65.7	51.9	48.0
	SD	17.9	24.0	13.3	18.3
The best therapy for many people with mental illness is not to be part of a normal community	SA	10.6	1.7	3.3	5.2
	A	26.8	12.6	13.8	17.8
	N	19.0	2.9	9.9	10.7
	D	29.1	68.6	59.7	52.3
	SD	14.5	14.3	13.3	14.0
As far as possible, mental health services should not be provided through community-based facilities	SA	6.7	1.7	3.9	4.1
	A	25.7	11.4	21.0	19.4
	N	22.9	2.9	9.9	12.0
	D	31.3	65.1	60.2	52.1
	SD	13.4	18.9	5.0	12.3
Locating mental health services in residential neighbourhoods endangers local residents	SA	14.0	0.0	3.3	5.8
	A	34.6	7.4	22.7	21.7
	N	20.1	4.6	9.4	11.4
	D	19.6	73.7	56.4	49.7
	SD	11.7	14.3	8.3	11.4
Residents have all to fear from people coming into their neighbourhood to obtain mental health services	SA	12.8	1.1	2.8	5.6
	A	37.4	7.4	21.0	22.1
	N	19.6	2.9	11.0	11.2
	D	19.6	72.6	56.9	49.5
	SD	10.6	16.0	8.3	11.6
Mental health facilities should be kept out of residential neighbourhoods	SA	14.0	0.6	4.4	6.4
	A	38.5	19.4	27.6	28.6
	N	14.5	4.0	10.5	9.7
	D	21.2	60.0	53.0	44.7
	SD	11.7	16.0	4.4	10.7
Local residents have good reason to resist the location of mental health services in their neighbourhood	SA	13.4	0.0	4.4	6.0
	A	36.3	7.4	15.5	19.8
	N	20.7	5.1	13.8	13.3
	D	19.6	66.9	58.6	48.2
	SD	10.1	20.6	7.7	12.7
Having mental patients living within residential neighbourhoods might not be a good therapy and risks the lives of residents	SA	20.7	2.3	5.5	9.5
	A	30.7	22.9	24.9	26.2
	N	20.1	9.1	9.4	12.9
	D	17.9	55.4	54.1	42.4
	SD	10.6	10.3	6.1	9.0
	SA	14.5	2.3	4.4	7.1

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		Tigania East	Imenti Central	Igembe North	Total
It is frightening to think of people with mental problems living in residential neighbourhoods	A	38.5	24.6	28.2	30.4
	N	20.7	4.6	8.8	11.4
	D	16.2	59.4	55.2	43.6
	SD	10.1	9.1	3.3	7.5
Locating mental health facilities in a residential area downgrades the neighbourhood	SA	8.9	0.0	3.9	4.3
	A	25.1	4.0	19.3	16.1
	N	22.9	4.0	9.9	12.3
	D	26.3	57.1	56.9	46.8
	SD	16.8	34.9	9.9	20.5

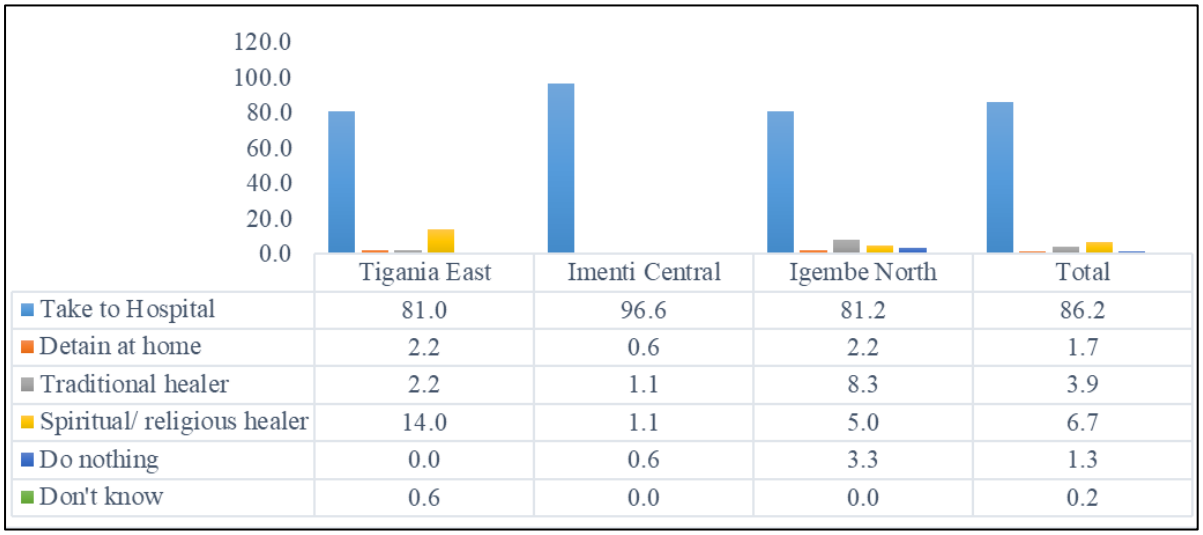
Key: Sa = Strongly agree; A = Agree; N = Neutral, D = Disagree; SD = Strongly disagree

Community Practices towards Mental Health Needs

To understand community practices regarding mental illness, community members were surveyed about their actions if a family member were to have a mental illness. Notably, 86.2% stated they would seek hospital treatment for them. Other responses included taking them to a spiritual or religious healer (6.7%), a traditional healer (3.9%), keeping them at home (1.7%), taking no action (1.3%), and a small fraction (0.2%) admitted uncertainty about what they would do. These findings are detailed in Figure 2 and corroborated by insights from in-depth interviews;

> *"Some go to Meru or Isiolo Hospital, while others come to us as herbalists. There is a medication that we offer for such cases and consistent headaches. There are also those who go to be prayed for, but as an individual, I do not believe in that".* (IDI_Respondent)

Figure 2: What would you do if you had a family member with a mental health condition



	Tigania East	Imenti Central	Igembe North	Total
Take to Hospital	81.0	96.6	81.2	86.2
Detain at home	2.2	0.6	2.2	1.7
Traditional healer	2.2	1.1	8.3	3.9
Spiritual/ religious healer	14.0	1.1	5.0	6.7
Do nothing	0.0	0.6	3.3	1.3
Don't know	0.6	0.0	0.0	0.2

When asked if they had ever known someone in their family who suffered from a mental illness, 39.1% of them said yes. As shown in Fig 3, 80.9% of the respondents said that they sought help from a hospital. Other responses included going to pray (9.6%), doing nothing (6.2%), being detained at home (0.5%). Others (2.9%) were unaware of the treatment received by family members who had mental health needs.

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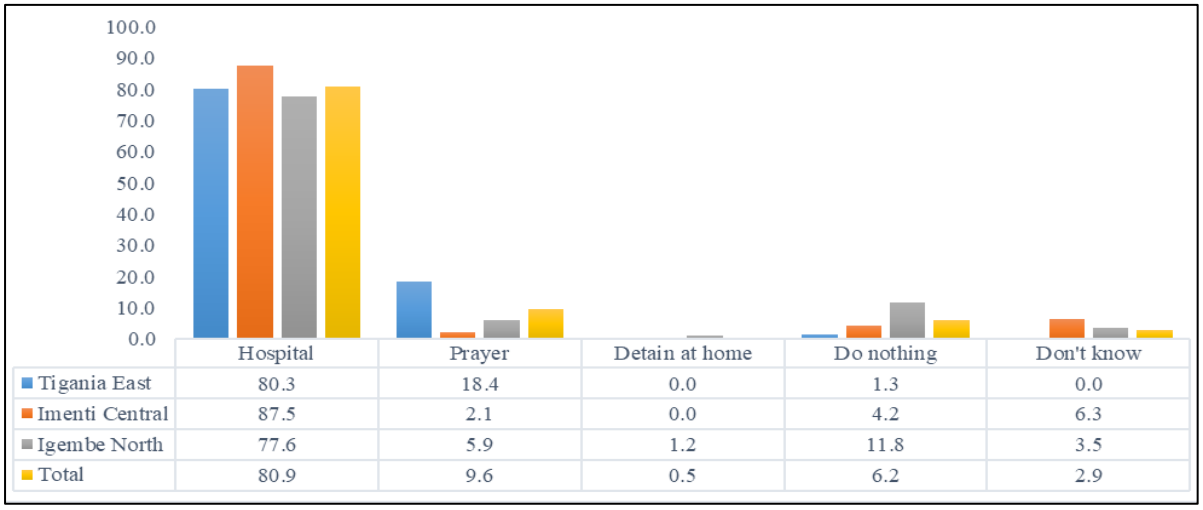
Figure 3: Where help was sought from



	Hospital	Prayer	Detain at home	Do nothing	Don't know
Tigania East	80.3	18.4	0.0	1.3	0.0
Imenti Central	87.5	2.1	0.0	4.2	6.3
Igembe North	77.6	5.9	1.2	11.8	3.5
Total	80.9	9.6	0.5	6.2	2.9

Health Care Workers Practices towards Mental Health

It was reported that most HCWs opted to refer patients rather than treat and manage mental health conditions because they lacked the necessary skills. According to one of the HCWs;

> *"They [the HCWS] are not very competent or very conversant with the treatment and management of mental illnesses, but they are able to suspect a case of mental illness after which they refer to higher levels for management"* (KII_Respondent)

According to the HCWs, they treat individuals with mental illness in the same manner as other patients. On the other hand, those who arrive with serious cases are seen as emergencies and given prompt attention. In response to this, a HCW said;

> *In the facility, we treat them just like other normal patients, although sometimes they come with their own issues. Some come when they are very rowdy and want to beat up everyone, but generally, all our patients are treated equally. We have a nurse who is at the Outpatient Department (OPD) who does the triage, especially those cases considered emergency. The person who comes up with a mental problem but is not of a high degree that person is treated with other patients. Somebody rowdy and maybe tied with rope carried by two or three relatives, that one we treat as an absolute emergency and we give it first priority. When they come, they are served very fast, and their referrals are done very fast and referred to level 5* (KII_Respondent)

With regards to the availability of services for patients with mental illnesses, the HCWs reported Meru Teaching and Referral Hospital as their main point of referral for persons with mental health conditions as the facility offered comprehensive and specialised mental health services, is well equipped with consultant psychiatrist, as was reported by one of the HCWs,

> *"The mental clinic in the General Hospital has been well equipped in terms of drugs and medical personnel. Generally basic management is done at Teaching and Referral Hospital Clinic*" (KII_Respondent)

Counselling and referrals are the primary services offered to individuals with mental health conditions at lower level facilities. One of the HCWs reported on the counselling and community awareness campaign, saying the following;

> *"I would say one is issues to do with counselling, as much as it is not necessarily targeting mental illnesses. We have conditions that are there, and if not well managed and proper counselling done, they would result in severe mental illnesses. We also have extension services being done by health care workers; for instance, officers go to schools addressing issues to do with drug*

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> *and substance abuse. These extension services work towards preventing occurrences of mental health later in life"* (KII_Respondent)

When asked if they had ever given a diagnosis of a mental disorder to a patient, 68% of respondents said yes in the study, and the majority (93.3%) said they had sent the patient to a mental health facility. Only 29.4% of the respondents mentioned that mental health patients receive counseling sessions at health facilities. Additionally, the survey revealed that just 33% of respondents ran community-based mental health awareness campaigns.

DISCUSSION

The Sustainable Development Goals (SDGs), adopted globally in 2016, include a commitment to enhance mental health and address substance use disorders (United Nations, n.d.). Knowledge about mental health is crucial in improving awareness, reducing stigma, enhancing early diagnosis, and ultimately promoting overall mental well-being (Wei et al., 2015). However, this study revealed gaps in mental health knowledge among both community members and healthcare workers in Kenya. It's important to recognise that understanding mental health conditions plays a role in driving stigma, discrimination, and neglect towards individuals with mental health issues, often due to negative stereotypes (Mohamed, 2018). In low and middle-income countries (LMICs) like Kenya, approximately 80% of people with a mental health condition do not receive treatment despite its availability, often due to stigma, misdiagnosis, or lack of specialised practitioners (WHO, mhGAP-IG). The study uncovered that community members often hold misconceptions about mental illness, leading to judgment and criticism of those affected. This lack of understanding is mirrored across the African continent and highlights the need for governments and researchers to prioritise mental health, focusing on preventative and promotive services.

There were clear disparities and insights in the awareness of mental illness between community members and healthcare professionals in this study. This was discussed in relation to the causes of mental diseases, the availability of mental health care, the services provided, and the cost of those services. For instance, only 32% of community members were aware of a health facility offering mental health services.

Asked whether or not members of the community seek mental health services from health facilities, 78.7% of the respondents said they do so, while only 32% said they are aware of a health facility in the community that handles mental health and illness needs. Similar to findings from a study on access to mental health services in primary healthcare facilities in Kenya, religious leaders, and traditional healers are other places where community members seek mental health services (Marangu et al., 2021).

Some families were said to be detaining their family members who had mental health illnesses while others did not seek mental health services. Most Kenyans turn to traditional healers because they lack information on how to help those affected as they believe that mental illness is a result of a curse, witchcraft, or evil spirits (Mohamed, 2018). The majority of community members in most African countries lack sufficient understanding of mental health and sickness, indicating that mental health is still not given enough emphasis. This was depicted by the low percentage of respondents with sufficient understanding of child development disorders, symptoms of substance dependence, and emergency medical management of seizures.

Attitudes towards mental health services were mixed, with 66.3% opposing the idea that mental health facilities should not be located in residential areas and 61.1% disagreeing that such facilities pose a danger to local residents. These attitudes are crucial for developing community-based mental health interventions. The results of this study provide new perspectives on the existing discrepancies relating to mental health perceptions at the community level that have a

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direct bearing on access and utilisation of mental health care and treatment services. 66.3% of the respondents disagreed with the idea that isolating oneself from the general public is the ideal form of therapy for many individuals suffering from mental health issues.

These views are particularly relevant since mental health is becoming more and more important in Kenya and on the global agenda, which is why mental health in Africa needs to be given priority. To address social determinants of access and utilisation of mental health services, these attitudes can be leveraged in formulating community-based mental health interventions. Regarding how the community handles mental health and illness, 86.2% of respondents said they would take a family member to the hospital if they needed mental health care. Others reported that they would take them to a traditional healer, a spiritual or religious healer, do nothing or detain them at home, while others had no idea what they would do.

According to the WHO's 2017 Mental Health Atlas survey, 24% of countries worldwide had not established dedicated mental health policies, a figure that increased to 46% in Africa (WHO 2017, n.d.). The survey highlighted challenges in accessing mental health services, with 62.3% of respondents indicating they had convenient access to health facilities. However, these facilities primarily provided counselling and referral services, and more specialised treatment and management of mental health were mainly available at the Meru Teaching and Referral Hospital. This hospital's remote location led to higher transportation costs for many seeking its services.

In Sub-Saharan Africa, the availability and perception of mental health services significantly influence access. This situation was exacerbated by increased transport costs and travel restrictions due to the COVID-19 pandemic. Concerning service affordability, only 44.4% of respondents found the costs of mental health services manageable, and many reported having to purchase medication during stock-outs.

The survey also shed light on the dynamics between mental health service providers and patients. Just over half of the respondents (54.9%) felt that healthcare providers displayed positive attitudes towards patients with mental illnesses, and a slightly larger group (62.5%) believed that patients were treated with respect. These insights align with findings from recent research using the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS), which identified a lack of administrative structures as a key factor in the low prioritisation of mental health services access and utilisation (Mutiso et al., 2020).

The survey additionally established that one of the barriers to the access and utilisation of mental health services was the lack of awareness of the presence of mental health services in facilities. It was also determined that the COVID-19 pandemic was a barrier to the access and utilisation of mental health services. The fear of contracting COVID-19 was reported to have prevented people from going to seek mental health services in health facilities.

In their understanding of mental health, healthcare workers (HCWs) identified factors such as genetics, diseases, drug and substance abuse, and societal pressures as causes of mental illness. A significant majority (93.6%) did not attribute mental illnesses to witchcraft, possessions, or evil spirits. Furthermore, 91.7% of the HCWs acknowledged that mental illnesses are not contagious, and 98.2% understood that these conditions are common and can affect individuals of any age or background. Additionally, 89% believed that people with mental illness can lead fulfilling and meaningful lives, and 89.9% considered mental illnesses manageable.

However, the survey revealed a gap in HCWs' understanding of patient involvement in the treatment process. While 60.6% emphasised the importance of obtaining treatment consent from caregivers or family members, this underscores a need for greater focus on obtaining consent directly from patients, aligning with the WHO's Quality Rights initiative. This aspect highlights a

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discrepancy in integrating patient autonomy within the treatment framework.

These findings of positive perceptions are consistent with the African community care ethos which is characterized by Noor et al. that families and communities commit to support their vulnerable members until proper care and treatment are available despite fragmented healthcare system in Africa (Noor et al., 2006). Despite challenges in the healthcare system, African families and communities are often committed to supporting their vulnerable members until appropriate care and treatment are accessible. This community-based approach to mental health care reflects a deep-rooted cultural value of collective responsibility and support for those in need.

The survey evaluated HCWs' knowledge of various MNS disorders, including acute manic episodes, depression, psychosis or bipolar disorders, dementia, and child and adolescent developmental disorders. It found that while most HCWs had a basic understanding of these disorders, there was a significant lack of skilled training in their treatment and management. HCWs could identify potential mental health conditions and refer patients to psychiatrists at the Meru Teaching and Referral Hospital. When asked about diagnosing mental illness, 68% had done so, with 93.3% referring these patients to mental health facilities. The study did not delve into the clinical practice and treatment choices of HCWs, but the findings suggest that patients with MNS disorders might not receive accurate diagnosis and treatment in primary healthcare settings in rural Kenya. Only 29.4% reported the availability of counselling services in health facilities, and a mere 33% conducted mental health awareness programs in the community, echoing the findings of a systematic review focusing on the mhGAP in low and middle-income countries (Keynejad et al., 2018). These results underscore the need for enhanced training for HCWs in Kenya to optimise mental health service provision, as highlighted in a study on capacity-building conditions (Marangu et al., 2014).

Regarding community access to and utilisation of mental health services, the majority (90.8%) found it convenient to access healthcare facilities for mental health needs. However, the remote location of the Meru Teaching and Referral Hospital, which serves as the primary referral centre for mental health and illness, posed a significant accessibility challenge.

CONCLUSION

This study contributes significantly to the understanding of mental health from the perspectives of healthcare workers and community members in an African and developing country context. It highlights a substantial burden of mental illness in the county, with a notable lack of comprehensive mental health services such as counselling, psychotherapy, psychiatric services, and the provision of psychotropic medications. The study also sheds light on prevalent myths and misconceptions about the causes of mental illness, which need addressing. Additionally, there are clear disparities in how healthcare workers and community members perceive mental health services – despite availability, these services are often unaffordable, leading communities to turn to traditional healers and religious leaders or to neglect mental health issues altogether.

The study findings indicate that there exists a noteworthy prospect for augmenting the competencies of community members and healthcare workers through evidence-based interventions. These interventions are aimed at boosting knowledge about preventive and promotive mental health strategies for the population, as well as developing effective intervention models for those suffering from mental illness. The insights gained from this study are essential for establishing mental health services that are rooted in community-based promotion and prevention, ensuring accessibility, affordability, and efficiency in primary health care, and facilitating seamless referrals to specialised mental health services. Such advancements could significantly reduce the 80%

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treatment gap and improve overall mental health outcomes in communities.

In the medium term, integrating mental health services into primary healthcare is crucial for enhancing service efficacy. This integration could be achieved through task shifting, where non-specialised healthcare workers receive targeted mental health education through Continuous Medical Education (CMEs), implementation of the WHO mhGAP-IG, and structured, cautious support supervision. These efforts should be communicated widely to individuals, families, communities, and society at large to maximise the benefits of increased mental health knowledge.

In conclusion, considering the insights of healthcare workers and community members on knowledge, attitudes, and practices identified, several key interventions are necessary to bridge these gaps. These include providing mental health information to community health workers, strengthening mental health support systems from the national to the household level, and launching concerted awareness campaigns to address mental health issues and stigma at the community level.

ABBREVIATIONS

AIMs Assessment Instrument for Mental Health Systems

CECM County Executive Committee Member

CHEWs Community Health Extension Workers

CHVs Community Health Volunteers

CMEs Continuous Medical Education

ESRC Ethical and Scientific Research Committee

FGD Focused Group Discussion

GOK Government of Kenya

HCWs Health Care workers

IDI In-depth Interview

KAP Knowledge Attitude and Practice

KII Key Informant Interview

LMIC Low Middle-income Countries

MH Mental Health

mhGAP Mental Health Gap Action program

mhGAP-IG Mental Health Gap Action Program -Intervention Guide

MNS Mental, Neurological and Substance

MoH Ministry of Health

MTRH Meru Teaching and Referral Hospital

OCS Officer Commanding Station

ODK Open Data Kit

OPD OutPatient Department

PSU Primary Sampling Unit

SPSS Statistical Package for Social Sciences

SSA Sub-Saharan Africa

WHA World Health Assembly

WHO World Health Organization

Consent For Publication

The authors unanimously consent for the information in this manuscript to be considered by your journal for publication and confirm that the results in this manuscript have not been published elsewhere, nor are they under consideration by another publisher.

Availability of Data and Materials

All data generated and analysed during this survey is included in this manuscript and has been attached as a supplementary file. The dataset is also available from the corresponding author on request.

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Authors' Contributions

CK, JM, CM, and DM conceptualised, designed, and performed statistical analysis, and they participated in the initial draft of the study. CK, JM, CK and DM participated in the design of the study and contributed to the finalisation of the manuscript. The manuscript was reviewed by PM,

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SW, YO and GK with commentaries. All authors read and approved the final manuscript.

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