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Knowledge, Attitude, Practice, and Associated Factors of Health Extension Professionals with Regard to Mental Illness in West Amhara, Ethiopia

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ABSTRACT

Objectives: Between 76% and 85% of people with severe mental disorders receive no treatment in low-income and middle-income countries; the corresponding range for high-income countries is high, ranging between 35% and 50%. Approximately 20%–30% of primary care attendees apply primarily due to emotional problems. The majority of these cases often remain unrecognized, misdiagnosed, and inappropriately managed. Currently, mental health is one of the health extension programs. So we aim to examine knowledge, attitude, practice, and associated factors of health extension professionals with regard to mental illness in West Amhara, Ethiopia.

Methods: This cross sectional study was conducted from March to December 2017 in West Amhara, Ethiopia, on health extension professionals. Data were analyzed using logistic regression, and the level of significance of association was determined as a p-value <0.05.

Results: A total of 650 Health Extension Workers were selected, and the response rate was 623 (96%). A total of 71.9% of health extension professionals had good knowledge with regard to mental illness, and 65.5% had a positive attitude toward mental illness, while 60% have never practiced mental health services. 64.8% of health extension professionals did not refer any case of mental illness in the past 3 months. A basic psychiatric training is significantly associated with good knowledge, positive attitude, and practice.

Conclusion: This study showed that the knowledge was satisfactory, that a significant number of health extension professionals had a favorable attitude, and that also only a low number of health extension professionals practiced mental health in their working area. Thus, a basic mental health training should be arranged for health extension professionals.

Keywords: Attitude of health personnel, Ethiopia, attitude to health, mental disorders

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INTRODUCTION

Mental health is an indispensable part of health, and it has been defined by the World Health Organization as "a state of wellbeing in which every individual realizes his or her own potential [and] can cope with the normal stresses of life".[1] Mental illness comprised 13% of the total global disease burden in 2000, a figure that is expected to rise to 15% by the year 2020. Depression is the third leading cause of disease burden worldwide. It represents 4.3% of total disability adjusted life years and is predicted to become the second leading cause of the global disease burden by the year 2020.[2]

Human resources devoted to health systems in sub-Saharan Africa are scarce. To bring health care to the population, strategic primary care structures have evolved, although

there is a widespread concern about their performance and capacity to deliver in resource-poor settings. Primary care of mental disorders is crucial in all parts of the world because of the sheer scale of psychiatric morbidity, especially in sub-Saharan Africa where specialist expertise is very scarce.[3]

In Ethiopia, mental illness is the leading non-communicable disorder in terms of burden. Indeed, in a predominantly rural area of Ethiopia, mental illness comprise 11% of the disease total burden, with schizophrenia and depression included in the top 10 most burdensome conditions, outranking HIV/AIDS.[4]

The package of the health extension program (health extension worker—HEW) provided health interventions based on an analysis of major disease burdens for most of the population. After an analysis of the socioeconomic, cultural, and environmental diversities of the Ethiopian population, three versions of the health extension programs have been designed and implemented: the agrarian health extension programs, which covers over 80% of the population; the pastoralist Health extension programs; and the urban Health extension programs. Basic principles underpin the design and implementation of each. Variations include gender differences of the HEW in the alignment with the populations being served: almost all health extension workers in agrarian areas are female, and in urban areas, the intervention package was modified to focus on chronic health problems, environmental issue.[5]

METHOD

Study Setting

The study was conducted in the Amhara regional state, which is one of the nine states of the Federal Democratic Republic of Ethiopia.

Study Design

A cross sectional study was conducted among the health extension professionals.

Data Collection

Data were collected using a structured, self-administered, Amharic version questionnaire. A modified version of the Knowledge, Attitude, and Practice Questionnaire for health workers, designed by National Institute of Mental Health and Neurosciences, Bangalore, Department of Psychiatry was used for data collection, and a multidisciplinary institute for patient care and academic pursuit in the frontier area of Mental Health and Neuron Sciences. Data were collected by 10 trained nurses, and data collectors were supervised by two trained health officers.

Data Processing and Analysis

Data were entered, cleaned, and stored by EPI info 2002. They were analyzed using the SPSS version 20. Frequency and percentage are used to describe the data. Crude and adjusted OR was analyzed using logistic regression, and the level of the significance of association was determined as p value <0.05.

RESULTS

Socio-Demographic Characteristics of Health Extension Workers

All of the respondents were women, and 349(56%) were certified nurses. The medium age of respondents was 27.03 (22–37 years). A total of 361 (57.9%) were between 25 and 30 years old. Majority of the respondents 520 (83.5%) were Orthodox, and 579(93%) were of Amhara ethnicity. A total of 319 (52.2%) of the respondents were married. The work experience ranged from 2 to 15 years, and majority of respondents had the work experience ranging from 6 to 10 years.

Knowledge, Attitude, and Practice of Health Extension Workers Toward Mental Illness

A total of 448(71.9%) of health extension professionals had good knowledge about mental illness, and 408(65.5%) had a favorable attitude toward mental illness. However, 374(60%) of health extension professionals did not practice mental health service (Table 1).

Factors Associated with Knowledge, Attitude, and Practice of Health Extension Professionals Toward Mental Illness

Psychiatry training showed a significant association with the knowledge of health extension professionals about mental illness; those health workers who underwent a mental health training were 1.64 times more likely to have good knowledge compared to health workers who never completed such training (OR=1.64; 95%CI, 1.15–2.33) (Table 2).

Table 1. Knowledge, attitude, and practice of health extension workers toward mental illness (n=623)

Variable	Category	N	%
Knowledge	Good knowledge	448	71.9
	Poor knowledge	175	28.1
Attitude	Favorable	408	65.5
	Unfavorable	215	34.5
Practice	Practiced	249	40.0
	Not practiced	374	60.0

The age group had a significant association with the attitude. The participants in the age group 25–30 years were 1.84 times more associated with favorable mental health than those from the age group <25 years (OR=1.69; 95%CI, 1.11–2.59) (Table 3).

The age group was significantly associated with practice. Participant in the age group >30 years were 0.56 times more associated with practicing mental health than the age group <25 years (OR=0.56, 95%CI; 0.34–0.93) (Table 4).

Table 2. Association between knowledge with training of Health Extension professionals with regards to mental illness (n=623)

Variable	Good knowledge N (%)	Poor knowledge N (%)	Odds ratio (Adjusted)	95% CI		p
				Lower	Upper	
Age						
≤24 years	92 (20.5%)	29 (16.6%)	1			
25–29 years	253 (56.5%)	108 (61.7%)	0.85	0.49	1.52	0.59
≥30 years	103 (23.0%)	38 (21.7%)	0.98	0.43	2.26	0.96
Working experience						
≤5 years	169 (37.7%)	57 (32.6%)	1			
6–10 years	220 (49.1%)	97 (55.4%)	0.72	0.49	1.07	0.11
>10 years	59 (13.2%)	21 (12.0%)	0.85	0.46	1.58	0.61
Marital status						
Single	200 (44.6%)	93 (53.1%)	1			
Married	238 (53.1%)	81 (46.3%)	1.32	0.92	1.88	0.13
Divorced	3 (0.7%)	0 (0.0%)	5.93	0.00		0.99
Widowed	7 (1.6%)	1 (0.6%)	3.95	0.48	32.85	0.20
Training						
Yes	279 (61.3%)	85 (48.6%)	1.64	1.15	2.33	0.006
No	176 (38.7%)	90 (51.4%)	1			

Table 3. Association between Attitude with Age of Health Extension professionals with regards to mental illness (n=623)

Variable	Favorable N (%)	Unfavorable N (%)	Odds ratio (Adjusted)	95% CI		p
				Lower	Upper	
Age						
≤24 years	69 (16.9%)	52 (24.2%)	1			
25–29 years	250 (61.3%)	111 (51.6%)	1.75	1.14	2.68	0.01
≥30 years	89 (21.8%)	52 (24.2%)	1.38	0.83	2.28	0.21
Working experience						
≤5 years	140 (34.3%)	86 (40.0%)	1			
6–10 years	217 (53.2%)	100 (46.5%)	1.14	0.72	1.81	0.58
>10 years	51 (12.5%)	29 (13.5%)	1.19	0.53	2.67	0.68
Marital status						
Single	184 (45.1%)	109 (50.7%)	1			
Married	216 (52.9%)	103 (47.9%)	1.18	0.83	1.67	0.36
Divorced	3 (0,8%)	0 (0.0%)	6.94	0.00	.	0.99
Widowed	5 (1.2%)	3 (1.4%)	1.17	0.26	5.23	0.83
Training						
Yes	244 (59.8%)	113 (52.6%)	1.38	0.98	1.93	0.06
No	164 (40.2%)	102 (47.4%)	1			

Table 4. Association between Practice with Age of Health Extension professionals with regards to mental illness (n=623)

Variable	Practiced N (%)	Not practiced N (%)	Odds ratio (Adjusted)	95% CI		p
				Lower	Upper	
Age						
≤24 years	53 (21.3%)	68 (18.2%)	1			
25–29 years	153 (61.4%)	208 (55.6%)	0.91	0.59	1.39	0.66
≥30 years	43 (17.3%)	98 (26.2%)	0.56	0.33	0.95	0.03
Working experience						
≤5 years	99 (39.8%)	127 (34.0%)	1			
6–10 years	122 (49.0%)	195 (52.1%)	0.90	0.58	1.41	0.65
>10 years	28 (11.2%)	52 (13.9%)	1.43	0.62	3.31	0.40
Marital status						
Single	108 (43.4%)	185 (49.5%)	1			
Married	137 (55.0%)	182 (48.6%)	1.38	0.98	1.94	0.07
Divorced	3 (1.2%)	0 (0.0%)	2.21	0.00		0.99
Widowed	1 (0.4%)	7 (1.9%)	0.42	0.05	3.59	0.43
Training						
Yes	162 (65.1%)	195 (52.1%)	1.53	1.09	2.15	0.01
No	87 (34.9%)	179 (47.9%)	1			

Psychiatry training showed a significant association with the practice of health extension professionals when it comes to mental illness; those health workers who took mental health training were 1.5 times more associated with practicing than the health workers who never had such a training (OR=1.71; 95%CI, 1.23–2.38) (Table 4).

DISCUSSION

Our results are in compliance with the results of a previous study examining the knowledge and attitude of primary health care personnel concerning mental health in Nigeria. It showed that the lack of basic health care training was associated with failure to recognize mental health problems, restricted knowledge concerning psychotropic drug therapy, and inability to visualize practical forms of mental health that could be introduced at the primary care level.[6]

In addition, 69.8% of the respondents strongly supported the integration of mental health in primary health care. Both studies conducted in Addis Ababa and Zambia also showed similar findings, that is, that there was a strong support for integrating mental health into primary health care from care providers as a way to facilitate early detection and intervention for mental health problems. Participants believed that this would contribute to the reduction of stigma and the promotion of human rights for people with mental health problems. However, health providers felt they required a basic training to enhance their knowledge and skills when it comes to providing health care to people with mental health problems.[6,7]

A total of 62.1% of health extension professionals had no experience in the identification of mental illness in the past 3 months, and 64.8% said that they had not seen any cases of mental disorder 3 months prior to this study. However, some of them were because of lack of adequate knowledge 111 (17.8%) and not available of psychotropic medications 49%. One hundred (17.3%) of the respondents considered that mentally ill patients should be managed only at a psychiatric hospital, and 14.3% considered that mentally ill patients should be managed only by a mental health professional. According to a study done in Addis Ababa, 61.8% had no experience when it comes to diagnosing and treating mentally ill patients because of the lack of adequate knowledge (56.6%) and medications shortage 24.6%.[6] A similar study was done in Kenya with similar results, claiming that general health workers, even if they were capable of handling psychiatric problems, preferred such patients managed at mental health institutions than having them managed in general wards. They also tended to equate mental illness with psychosis. In addition, 72.4% of primary health care providers had not practiced mental health services prior to this study.[8]

CONCLUSION

The study findings identified that there was good knowledge, and a significant number of HEW had a favorable at-

titude; however, only a small number of health extension professionals practiced mental health at their work.

On the other hand, the mental health training significantly associated knowledge and practice of urban health extension professionals. Thus, a basic mental health training should be arranged for health extension professionals.

Study Limitations

The study design was cross sectional, and thus, is difficult to know the causal relationship between the explanatory variables and the outcome variables.

Disclosures

Peer-review: Externally peer-reviewed.

Conflict of Interest: None declared.

Ethics Committee Approval: The study was approved by the Local Ethics Committee.

Authorship Contributions: Concept – T.Z.T.; Design – T.Z.T.; Supervision – T.Z.T., D.E.A.; Materials – D.E.A.; Data collection &/or processing – T.Z.T., D.E.A.; Analysis and/or interpretation – T.Z.T., D.E.A.; Literature search – T.Z.T., D.E.A.; Writing – T.Z.T., D.E.A.; Critical review – T.Z.T.

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