

Attitude and Its' associated factors towards Mental Illness Among Residents of Mertule Mariam Town, Northern Ethiopia: Mixed Method

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Abstract

Background: Mental illness affects cognition, emotion, and behavior of an individual. It accounts for 13% of the global burden of diseases. About 76% and 85% of people in low and middle-income countries with severe mental illness did not receive treatment due to fear of expected discrimination and stigma to diagnosed people with mental illness. There are no published works on the attitude of the community in this study area. This study aimed to assess the attitude and its' predictors towards mental illness among residents of Mertule Mariam town, Ethiopia 2017.

Methods: Community-based cross-sectional study was conducted from May to June 2017. Data were collected from 964 participants using Community Attitude to Mental Illness Inventory (CAMI). Data were entered using epi-info version 7 and exported to SPSS version 20. Descriptive and binary logistic regression analyses were employed to identify the associated factors to attitude.

Result: The response rate was 98.2% with the sex distribution of 58.5% (554) males. The attitudes of the community were more authoritarian (52.8%), less benevolent (52.3%), more socially restrictive (38.8%) and positive to mental health service (59.2%). Age [AOR=2.50, CI 1.56-4.23, P-value= 0.001], educational level, occupational status, getting information about mental illness, and knowing someone who has mental illness have been significantly associated to authoritarianism. Age (18-24) [AOR=3.08(1.5-6.3) p-value=0.002], educational status, occupational status and getting information about mental illness were the significant variables for benevolence subscale. Age, marital status, getting information about mental illness [AOR=0.02, CI 0.05-0.75, P-value <0.05], sources of information were significant variables for social restrictiveness subscale. Marital status, occupational status, history of mental illness, relationship with mentally ill, and involved in caring for mentally ill [1.85(1.28-2.65)**] were significantly associated factors for community mental health ideology.

Conclusion and recommendation: The findings of this study showed that the attitude of residents of Mertule Mariam town was more authoritarian (undermining), less benevolent, less socially restrictive (less socially avoidant) and more positive for mental health service. The positive attitude of the participant was associated with getting information about mental illness. Using mass media and health institutions to disseminate information about mental health is essential to improve the attitude of the community.

1. Background

Mental illness is a condition that affects the cognition, emotion, and behavior of an individual. It also affects the individual's ability to realize his potential, cope with normal life stressors, act productively and contribute to his community (1, 2). It is one of the major contributors of disability-adjusted life of years(DALYs) and the global burden of disease (GBD) (3, 4).

In Ethiopia, mental illness is the leading contributor to disease burden out of non-communicable diseases (NCD) in which it comprised 11% exceeding HIV/AIDS (5). Even though mental illnesses are highly prevalent and incapacitating to the community of this world (6), no more help is requested from the

modern health facility. The community's attitude hinders the help-seeking intention of the community to mental illness (7).

Larger proportions of people with mental illness never receive treatment from mental health care staff globally. Similarly, more than three-fourths of people with mental illness in low and middle-income countries never receive treatment. This is because people with mental illness fear stigma and discrimination from the community (1, 8).

Nigerian community has widely held bad attitude believing that mentally ill patients are dangerous due to their violent behaviors including avoiding basic social contacts; the majority will be afraid to have a conversation with people with mental illness and only a few segments of the community will consider having marriage consideration with them(9).

Community-based studies illustrated that the community rejects marriage with people with mental illness, isolate and put in separate place under supervision. Most of the respondents afraid to be neighbors, feel ashamed to talk about someone who has a mental illness that lives in the home together with them and refused to maintain the friendship. The community associated mental illness with difficulty at work and lack of will power and discipline (10–13).

Most of the Ethiopian community believes that mental illnesses are to be caused by "punishing hands of God" for disobeying the principles, doctrines and social taboos (14). For instance, in the Borana semi-nomadic population, the majority of the community believes supernatural influences cause mental illness. Bewitchment, witchcraft, possession by evil spirits were the central causes not only for "madness" but also for property loss. People left someone who has mental illness alone if he/she did not respond with treatment, and based on patient condition, he/she may choose to live with the family getting his/her basic needs or wander around the street naked (15).

A study done in Nigeria states that being male and literate are the factors associated with a positive attitude to mental illness. Literates have 7 times more positive attitudes to mental illness than their counters (9). Based on a study done in Ghana, females are more authoritarian than men are and social restrictiveness decreases with age. More educated people are less authoritarian and less socially restrictive than persons with only basic education are. They also expressed more benevolent than less educated (16). Females have a bad attitude on marital prospects with mentally ill and illiterates have a more negative attitude to live with people who have a mental illness than literates (17).

In southwest Ethiopia, a study showed higher educational status and exposure to mental illness information decreases stigma (14). Community-based cross-sectional study done in Worabe town showed that illiterates have a more socially restrictive and less humanistic attitude. Having mental health information is highly associated with less socially restrictive and a less authoritarian attitude towards people with mental illness (18).

Even though there are few studies in Ethiopia (12, 14, 15, 17–21) assessing the attitude of the community to mental illness but they are limited to the southern and western regions. As much as we know, there are no published data regarding the attitude of the community to mental illness in the northern part of Ethiopia. Therefore, this study has the importance of determining the attitude of the community to mental illness among residents of Mertule Mariam town, Northern Ethiopia, Ethiopia.

2. Methods

Study design and setting: Community-based cross-sectional study design using mixed (both qualitative and quantitative) methods were conducted in Mertule Mariam town, East Gojam Zone, Ethiopia from May to June 2017.

Study population

All residents of the town aged 18 years or more and those who reside 06 months and more were included. Those who were severely ill and unable to communicate verbally were excluded from the study.

Sampling Procedure and Technique

Multistage sampling technique was applied. The sampled households were distributed to the two kebelles proportionally. The households were selected with a systematic random sampling method considering that they are homogeneous. The first household, and when there was more than one adult in each selected household, was selected using a lottery method. Using double population proportion formula, we estimate sample size for associated factors and we got 964 with a 10% non-response rate.

Data collection tools: Data were collected using interviewer-administered semi-structured questionnaire by 6 clinical nurses. The tool consists of socio-demographic, illness perception, social support and Community Attitude to Mental Illness Inventory (CAMI) including information and exposure-related variables. CAMI has a total of 40 items with four sub-scales which are authoritarianism, benevolence, social restrictiveness, and community mental health ideology. It is five scales Likert (1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree). It has been used in different countries of Africa including Ethiopia (16, 22). It has been checked and validated in Ethiopia. The reliability Index using Cronbach alpha was found as [AU α = 0.61 BE, α = 0.60 SR, α = 0.70 CMHI, α = 0.82] with the overall reliability of CAMI scale α = 0.84 (18). Four focus group discussions were held that include religious leaders, health workers and community participants who were selected purposely.

Data Processing and Analysis: The collected data were entered using Epi info 7th version and exported to SPSS version 20 for analysis. Descriptive statistics and binary logistic regression were used. A P-value of less than 0.2 and a chi-square test was considered to identify factors associated with outcome variable on bivariate logistic regression. These variables were taken to multivariate logistic regression and a p-value less than 0.05 was taken as statistically significant presented by OR with 95% confidence interval. Qualitative data were collected by the principal investigator with Amharic language and later transcribed

to the English language. The transcribed data were organized into a theme and were presented being triangulated with quantitative data.

Ethical Consideration: Ethical clearance was obtained from the institutional review committee of the University of Gondar and Amanuel mental specialized hospital. Permission paper from the town administration was requested and distributed to the two kebele administrations. Data collectors were explaining about the aim of the study and were asking oral consent before they started data collection. The right to ask questions about the study and to terminate the interview whenever they want to stop was offered for the study participants. The information gathered from the participants were kept confidential.

3. Result

3.1 Socio-demographic characteristics

Among the 964 study participants, 947 responded to the interview completely which make 98.23% response rate. out of the respondents, 58.5% (554) were males while 393 (41.5%) were females (Table1). Amhara ethnicity (99.7%) and orthodox religion (98.7%) took a greater proportion of the respondents. Only 18.2% (178) of respondents have a degree and above educational level, while 12.2% of respondents cannot read and write (Table 1).

Table 1
socio-demographic distributions of participants among residents of Mertule Mariam town,
Northern Ethiopia, Ethiopia, 2017.

Variables	Category	Frequency	percent
Age	18–24	241	25.4
	25–34	463	48.9
	35–44	193	20.4
	> 44	50	5.3
Sex	male	554	58.5
	female	393	41.5
marital status	single	426	45.0
	married	417	44.0
	divorced	85	9.0
	widowed	19	2.0
Ethnicity	Amhara	944	99.7
	other	3	.3
Religion	orthodox	935	98.7
	other(Muslim and protestant)	12	1.3
Educational Status	unable to read and write	116	12.2
	elementary school	126	13.3
	secondary school	260	27.5
	college diploma	267	28.2
	degree and above	178	18.8
Occupational Status	government employee	387	40.9
	housewife	70	7.4
	farmer	59	6.2
	NGO employee	45	4.8
	merchant	168	17.7
	student	152	16.1
	other	66	7.0

Variables	Category	Frequency	percent
Estimated monthly family Income	under extreme poverty (< 750)	290	30.6
	Under poverty (751–1200)	113	11.9
	Above poverty level (> 1201)	544	57.4

3.2 Respondent social support

Among participants, only 17.2% have strong social support while 39.6% (375) have poor social support and the rest covers a moderate level of social support.

3.3 Mental health information

About 575 (60.72%) of 947 participants have ever got information about mental illness during the last one year and 39.7% (376) of participants got the information from people other than media or health institutions while 11.6% got the mental health information from health institutions. Mass media gives information to 6.5% of participants while 4.4% of participants got the information from magazines. About 37.8% of participants got information about mental illness from school and religious institutions.

3.4 Contacts with someone who has a mental illness

About 69.4% of participants know someone who has a mental illness and only 6.9% of them have relatives who have a mental illness. Around 70% of respondents had never involved in caring for someone who has a mental illness. Thirty-three percent of participants have been hurt and 72.5% of participants have witnessed hurt by people who have a mental illness.

3.5 Illness perception of mental illness

Around 58.1% of participants graded mental illness as very severe and 81.6% of participants believe that mental illness requires treatment. Most (71.5%) of believing different psychosocial factors as major causes for mental illness while 6.5% and 7.5% of participants believe evil spirit possession and God's punishment as a cause of mental illness respectively.

Table 2
 Perception of mental illness among residents of Mertule Mariam town, Northern Ethiopia, Ethiopia, 2017.

Variables	Category	frequency	percent
Perceived severity of mental illness	mild	24	2.5
	moderate	66	7.0
	sever	307	32.4
	very sever	550	58.1
Perceived cause of mental illness	psychosocial factor	677	71.5
	nerve damage	13	1.4
	poverty	22	2.3
	substance use	102	10.8
	evil spirit possession	59	6.2
	God's punishment	71	7.5
Perceived need of treatment for mental illness	yes	773	81.6
	no	174	18.4
Perceived good place for help	holywater	207	21.9
	holywater and hospital	101	10.7
	hospital	614	64.7
	sorcerer	24	2.5

3.6 Community attitude to mental illness

Respondents were more authoritarian (52.8%), less benevolent (52.3%), more socially restrictive (38.8%) and positive to mental health service (59.2%). Those aged greater than 44 years old show that they are more authoritarian and more socially restrictive than the other age groups (66%). Females are more authoritarian than males with a negative attitude to mental health service and care (55%, 44%). Married people are more authoritarian than singles and less authoritarian than widowed ones (58.5%). Peoples who had information about mental illness are less socially restrictive than their counters (63.9% Vs 51.7%).

3.7 Factors associated with community attitude toward mental illness

Factors that have a p-value less than 0.2 on bivariate regression were taken into multivariate logistic regression and those that have a p-value less than 0.05 were taken as statistically significant.

Authoritarianism

The odds of being more authoritarian among those aged between 35–44 years old is 2.5 times more as compared to the age group 18–24 years old [CI = 1.56–4.23, p-value = 0.001]. The odds of being authoritarian among those who have elementary education was decreased by 60% as compared to illiterates [0.4 (0.19–0.77) p-value = 0.007]. The odds of being authoritarian decreased by 67% among degree holders as compared to illiterates.

Benevolence

The odds of being more benevolent among peoples aged ≥ 44 years old is 3 times more as compared to the reference age (18–24) [AOR = 3.08(1.5–6.3) p-value = 0.002]. The probability of being benevolent decreased by 83% among Peoples who perceive mental illness mild as compared with those who perceive very sever [AOR = 0.17 (0.06–0.5) p-value = 0.001].

Social restrictiveness

People aged between 35–44 years old are 2.7 times more likely to stigmatize people who have mental illness as compared to those aged between 18–24 years old [CI (1.7–4.33), p-value = 0.001]. Widowed peoples are prone to stigmatize mentally ill people 4 times as compared to single ones [CI (1.17–13.7), p-value]. Poor Knowledge of mental illness exposes to social restrictiveness by 1.75[CI (1.31–2.34), p-value = 0.001] times as compared to having good knowledge.

Community mental health ideology

The odds of having a favourable attitude to mental health service integration among married people is 1.65 [(1.16–2.36), p-value = 0.005] times more as compared to single people while widowed were [6.2(1.56–24.8), p-value = 0.01 times] more favorable than singles. The odds of having favorable attitude among peoples who perceive mental illness need treatment were 2.17((1.47–3.2)p-value < 0.001) times more as compared to their counters.

Table 3

Binary logistic regression analysis of respondent' selected Socio-demographic characteristics and other factors associated with attitude towards mental illness among residents of Mertule Mariam town, Northern Ethiopia, Ethiopia, 2017.

Variables	Category	Authoritarianism		Benevolence	
		C O R	AOR	C O R	AOR
Age	18–24	ref	Ref	Ref	Ref
	25–34	1.82(1.32–2.49)	1.70 (1.2–2.5)**	1.08(0.79–1.48)	1.10(0.80–1.52)
	35–44	3.06(2.06–4.54)	2.5 (1.56–4.2)**	1.39 (0.95–2.04)	1.38(0.93–2.05)
	> 44	3.10(1.63–586)	2.6 (1.16–5.70)*	2.26 (1.2–4.25)	2.09(1.08–4.06)*
Educational status	Illiterate	Ref	Ref	Ref	Ref
	elementary school	1.82(1.12–2.94)	0.4(0.2–0.7)**	0.71(0.43–1.18)	0.39(0.20–0.76)**
	secondary school	0.72(0.45–1.13)	0.88(0.54–1.44)	0.75(0.48–1.16)	0.93(0.58–1.47)
	Diploma	1.09(0.75–1.60)	0.4(0.21–0.86)*	0.551(0.35–0.85)	0.46(0.23–0.91)*
	degree and above	1.05(0.7–1.54)	0.3(0.15–0.7)**	0.95(0.59–1.52)	0.36(0.17–0.75)**
Getting information	yes	0.82(0.63–1.07)	4.18(1.1–16.2)*	0.83 (0.63–1.07)	0.22(0.06–0.81)*
	no	Ref	Ref	Ref	Ref
Knowing mentally ill	yes	1.37(1.04–1.81)	0.64 (0.45–0.9)*	0.89 (0.67–1.18)	0.95(0.71–1.28)
	no	Ref	Ref	Ref	Ref
hurt by mentally ill	yes	1.39 (1.06–1.82)	0.67(0.48–0.93)*	1.26 (0.96–1.66)	0.71(0.5–0.9)*
	no	Ref	Ref	Ref	Ref
Perceived severity of mental illness	Mild	1.69(0.71–4.01)	0.2(0.06–0.57)**	4.46(1.64–12.1)	0.17(0.06–0.50)**
	Moderate	0.42(0.24–0.72)	0.4(0.17–1.15)	0.71(0.42–1.21)	0.37(0.15–1.01)
	Sever	0.97(0.73–1.28)	0.4(0.50–1.04)	1.19(0.90–1.58)	0.41(0.16–1.03)

Very sever

Ref

Ref

Ref

Ref

*p < 0.05 **p < 0.01 ref = reference. *other = on street, other people's home, **other people = informed by somewhere, ***other = jobless, retired and daily laborer

Table 4

Binary logistic regression analysis of respondent' selected Socio-demographic characteristics and other factors associated with attitude towards mental illness among residents of Mertule Mariam town, Northern Ethiopia, Ethiopia, 2017.

variables	Category	social restrictiveness		community mental health ideology	
		Crude Odd Ratio	Adjusted OR	Crude Odd Ratio	Adjusted OR
Age	18–24	Ref	Ref	Ref	Ref
	25–34	0.77 (0.56–1.07)	1.7(1.2–2.42)**	0.77(0.56–1.05)	0.74(0.51–1.08)
	35–44	0.92 (0.63–1.36)	2.7(1.7–4.33)**	0.89 (0.6–1.31)	0.91(0.55–1.48)
	> 44	2.83 (1.49–5.36)	2.3(1.1–4.76)*	1.72 (0.87–3.42)	0.95(0.42–2.17)
marital status	Single	Ref	Ref	Ref	Ref
	Married	1.38 (1.05–1.83)	1.28(0.92–1.77)	1.53 (1.15–2.01)	1.65(1.16–2.36)**
	Divorced	0.87 (0.53–1.44)	0.81(0.47–1.41)	0.53 (0.33–0.85)	0.69(0.40–1.19)
	Widowed	7.04 (2.29–21.6)	3.75(1.1–12.67)*	4.25 (1.22–14.8)	6.2(1.56–24.8)*
Occupational status	Gov't employee	Ref	Ref	Ref	Ref
	Housewife	1.45(0.86–2.4)	1.45(0.82–2.56)	0.41 (0.24–0.69)	0.45(0.21–0.95)*
	Farmer	1.5(0.88–2.67)	1.12(0.61–2.07)	0.45(0.25–0.78)	0.30(0.13–0.71)**
	NGO employee	1.1 (0.58–2.1)	0.92(0.46–1.83)	0.48(0.26–0.90)	0.31(0.15–0.67)**
	Merchant	1.37 (0.94–1.98)	1.34(0.90–2.01)	0.53 (0.37–0.77)	0.41(0.25–0.69)**
	Student	0.94 (0.64–1.40)	0.91(0.58–1.43)	0.52(0.35–0.76)	0.46(0.26–0.83)*
	Other***	1.61 (0.95–2.73)	1.16(0.63–2.14)	0.81 (0.47–1.40)	0.62(0.33–1.17)
Getting information	yes	0.75(0.57–0.98)	0.02(0.05–0.75)*	0.58 (0.44–0.76)	0.47(0.14–1.61)
	no	Ref	Ref	Ref	Ref
Source of	mass media	Ref	Ref	Ref	Ref

information	magazine	1.5 (0.67–3.34)	1.43(0.18–11.55)	1.4 (0.61–3.23)	1.43(0.17–11.55)
	health institution	0.5 (0.25–1.01)	0.44(0.20–0.90)*	0.36 (0.19–0.68)	1.94(0.23–16.36)
	other people**	1.20(0.69–2.11)	1.72(0.23–13.11)	0.84 (0.48–1.46)	0.75(0.09–5.88)
	Religious place and school	1.34 (0.77–2.36)	1.59(0.15–16.98)	1.28 (0.73–2.23)	1.72(0.23–13.10)
Mental illness history	yes	1.03 (0.66–1.61)	0.99(0.62–1.62)	0.62 (0.38–0.98)	1.78(1.05–3.0)*
	no	Ref	Ref	Ref	Ref
Relationship with PWMI	relatives	1.09(0.64–1.85)	1.12(0.61–2.04)	1.12 (0.67–1.88)	0.91(0.62–1.35)
	neighbour	1.19 (0.81–1.75)	1.11(0.73–1.67)	1.84 (1.23–2.74)	1.54(0.92–2.58)
	friend	1.56 (1.08–2.26)	1.54(1.04–2.28)*	2.37 (1.58–3.55)	2.75(1.70–4.45)**
	Other*	Ref	Ref	Ref	Ref
Caring mentally ill	yes	1.68 (1.27–2.23)	1.71(1.25–2.3)**	0.45 (0.34–0.62)	1.85(1.28–2.65)**
	no	Ref		Ref	Ref

PWMI- people with mental illness, *p < 0.05 **p < 0.01 ref = reference. *other = on street, other people's home, **other people = informed by somewhere, ***other = jobless, retired and daily laborer

4. Discussion

This study assessed the community attitude to mental illness through four subscales. The four subscales of attitude measurement were authoritarianism, benevolence, social restrictiveness, and community mental health ideology.

The community held an avoidant attitude; they cannot go back to work, they are dangerous and should be treated far from the community residential area. This is supported by a community study done in Nigeria and Malaysia. The community believes that mentally ill people are mentally retarded, public nuisance and dangerous (9, 23). Many participants of the focus group discussion also support this; *'mentally ill peoples cannot control themselves and choose what is good for them rather act in contradiction. They shout, wander around the street, and bite people. Another participant said that mentally ill peoples act as 'brainless more than animals'.* These ideas collectively describe how mentally ill people are stigmatized and discriminated by their community. The community called *'mentally ill'* only

those who are aggressive, violent and those who wander on the street. Due to the name given to the violent, all mentally ill patients are thought to be also violent and aggressive.

Age was significantly associated factor for authoritarianism, benevolence and social restrictiveness but not for mental health ideology. It has a positive association that showed older people are more authoritarian, benevolent and socially restrictive as compared to the youngsters. This is supported by a study finding in Malawi so that older peoples are more authoritarian and socially restrictive (24). Age was not associated with attitude on a study done in worabe town, silte zone, Ethiopia (18), a study done in Hawassa town (21) and community study done in Nigeria (9). The difference may be due to model difference, instrument and method difference. Elders were more authoritarian who force others to accept their ideas and consider patients inferior, more benevolent who strives to help mentally ill people and more socially restrictive affecting the social relationship of the patient. These authoritarian and socially restrictors are affecting people who have mental illness negatively because they do not allow them to take their choice, and to interact socially.

When people's educational status upgrades from elementary school to diploma and degree, their attitude of authoritarianism and benevolence decreases. This might be due to the fragmented information they could get from schooling and they are going to be less controlling and more negligent for the care of the mentally ill. Findings in Ghana show; when the educational status of the participant increases, their authoritarianism and social restrictiveness decrease (16). This study shows that when people learn more, their attitude to mental illness got more positive. This difference might be due to the population difference (all urban and mentally ill patients) and the way of using the tool (CAMI). The Ghanaian researcher used the tool as yes /no questionnaire and assessed the community attitude.

Farmers had negative mental health ideology as compared to government employees. This idea is similar to one focus group discussion participant's idea that states as follows: (F-9 is 26 years old, married merchant and knows mentally ill on the street) *'I don't have any information about mental illness but I know they are called mad (ebid). It is not helpful to take them anywhere because it is caused by God's punishment and evil spirit possession. Mostly they are left on the street.'*

People who had information about mental illness were 4.18(1.07–16.26) times more authoritarian and their attitude of benevolent decreased by 78% as compared to those who do not. When people got more information, they are going to be more undermining and more un-humanistic to people who have mental illness. These types of people are more likely to keep mentally ill peoples behind a locked door.

Getting information from health institutions has a significant association with social restrictiveness [0.44 CI (0.2–0.4) p-value = 0.03] so that people were more supportive to people who have mental illness as compared to those who get information from mass media. This is supported by a study done in Hawasa town, Ethiopia: People who were informed by health workers were more comfortable giving a job and responsibility to people who have a mental illness (21).

Peoples who have ever been hurt by the mentally ill were less benevolent than those who are not [AOR = 0.71(0.52–0.95) p-value = 0.02]. This is typical of focus group discussion participant's ideas and other researches that are done in Nigeria (9). People who have mental illness are thought to be more violent, nuisance and dangerous which directly affects the negative attitude positively. *Female (F-1): I have been bitten by one mad man and after that I always afraid of them. They shall be left on the street because of their dangerous behavior. They are less likely to show improvement with treatment so that investing in people with mental illness is just wasting money.* They are left on the street and their basic needs will not be met (15). This could expose mentally ill people to be prone to another medical problem because they are forced to live without human basic needs.

People who have friends with mental illness and people who have ever involved in caring for people with mental illness were more likely to accept mental health services and allow the establishment of mental health facilities to the local area of residency. This is about twice as likely as their counters and these ideas are interrelated to each other. Someone whose friend has mental illness is more likely to involve in caring for the victims and in turn, is more likely to demand mental health facilities around their residency area. They are also less likely to fear to think about establishing mental health facility in their area. These variables did not show association in a study done in worabe town, Ethiopia (18).

5. Conclusion And Recommendation

The findings of this study indicated that more than half of the community was more authoritarian, less benevolent, less socially restrictive and have a positive attitude to mental health-care service. People with mental illness were viewed as inferior and seen as who need supervision as Children. The community denied them emphatic and humanistic care. They were also denied to have a job and responsibility at all in the community. Getting information from health institutions had brought a positive attitude towards someone who has a mental illness. Public mental health awareness creating programs, rehabilitation centers for people with mental illness and public groups, like school clubs, which help people with mental illness, are major areas of tackling the bad attitude of the community. Using health institutions as a means of delivering mental health information is also important.

Limitation of the study

The limitation of this study might be the name mental illness is broad and lacks specificity.

Acronyms And Abbreviations

AMSH: Amanuel Mental Specialized Hospital AU: authoritarianism BE: benevolence CAMI: Community Attitude to Mental Illness Inventory CMHI: community mental health ideology Epi info: Epidemiological Information GHSQ: General Help-Seeking Questionnaire MOH: Ministry of Health SPSS: Statistical Package for Social Science SR: social restrictiveness UOG: university of Gondar WHO: World Health Organization

Declarations

Ethical approval and consent to participate

Ethical clearance was obtained from the joint review committee of the University of Gondar and Amanuel mental specialized hospital. Data collectors had explained the aim of the study and had asked oral consent before they started data collection. The right to ask a question about the study and to terminate the interview whenever they want to stop was offered for the study participants. Permission paper from the town administration was requested and distributed to the two kebele administrations.

Consent for publication

Not applicable

Availability of data and material

The data sets used and/or analyzed during the current study are available from the corresponding authors on reasonable request.

Authors' contributions

BY, ZY, SS involved in designing and conducting the study. BY, ZY and AB involved in data collection, analysis, and interpretation of data. BY, ZY, SS, DA, and AB contributed to the designing and write up of the manuscript. All authors read and approved the final manuscript.

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Competing interest

The authors declare that they have no competing interests.

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