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Mental Health among Primary Health Care Providers in UNRWA Clinics of Gaza Governorates: Knowledge, Attitude, and Practice

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بسم الله الرحمن الرحيم

"وَإِذَا سَأَلَكَ عِبَادِي عَنِّي فَإِنِّي قَرِيبٌ ۖ أُجِيبُ دَعْوَةَ الدَّاعِ إِذَا دَعَانِ ۖ فَلْيَسْتَجِيبُوا لِي وَلْيُؤْمِنُوا بِي لَعَلَّهُمْ يَرْشُدُونَ"

(البقرة:186)

Dedication

I dedicate this work to all students who study mental health, and hope that they can buy it in their hearts.

To my autistic daughter Rinad , and my family who tolerate me while being so busy.

To the soul of my father who inspires me even after his death.

To those who trying their best to make their life more simple, in peace, and cheerful.

Hala Al Rahman Maghari

Declaration

I certify that this thesis submitted for the degree of master, is the result of my own research, except where otherwise acknowledged, and that this study (or any part of the same) has not been submitted for a higher degree to any other university or institution.

Signature: ***Hala Maghari*** 

Hala A/ Rahman Ahmad Maghari

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Researcher: Hala Maghari

Abstract

***Aim*:** This study aimed to evaluate the level of knowledge, attitude, and practice of primary health care providers toward mental health at UNRWA health clinics in the Gaza governorates.

***Method*:** The study sample included all primary health care providers of UNRWA health clinics, (594) participants with response rate of (74%). The researcher developed a self designed questionnaire based on previous similar studies. The questionnaire composed of four structured parts; socio-demographic, level of knowledge, level of attitude, and level of practics of mental health.

***Results*:** The results revealed that primary health care providers knowledge was (78.3%), where level of attitude was (75%), and level of practice was (74.4%). Where, (34.9%) said 'yes' there are patients with mental health illnesses attending the clinics and (59.5%) said 'yes' sometimes there are. The most common mental health illnesses were, depression, anxiety, physical pain, PTSD, mental retardation, and hysteria. Primary health care providers tend to advice patients with mental health illnesses to seek psychologist's help (91%), where the second advice was (81.2%) to seek traditional healers help. Eighty two and nine percent agreed that integrating mental health services into primary health care services is important. However, (70.1%) admitted that they have the ability to deal with those patients, (63.6%) their practice changes when realize that the patient has mental illness. In addition, (73%) addressed that cultural attitudes influencing their ways of dealing with patients with mental health illnesses, and (75.7%) said that they need more time to consult patients with mental health illness. The study showed that, there were positive significant correlation between knowledge and practices and attitudes and practices. Regarding socio-demographic data, there were significant difference of attitudes toward the concept of mental health in favor to females and significant difference of attitudes toward mental health illnesses in favor to males. There were significant differences of knowledge, attitudes subscales, and practices a according to the level of education in favor to postgraduate and university degrees than diploma degree.

Conclusion Primary health care providers reported high level of knowledge, attitude, and practice toward mental health which indicate that such group must be supervised and supported to continue their work and increase their knowledge of more specific mental health problems and ways of dealing with such problems in primary health care level. This, also, may encourage them of spending more time with clients who have mental healyh problems and advice them properly. Cultural awareness about mental health has to be emphasized by health educators every where they apply their work. Finally, accommodation of primary health care system to increase consultation time in order to provide better care.

Table of Contents

Chapter 2: Conceptual Framework & Literature Review

Chapter 3: Methodology

List of Tables

List of Abbreviations

ABC	Affect, Behavioral change, and Cognitive
CBT	Cognitive Behavioral Therapy
CMH	Community Mental Health
CMHM	Community Mental Health Methods
CNHNs	Community Mental Health Nurses
EMRO	Eastern Mediterranean Region Office
GP	General Practitioner
IFO	Israeli Occupied Forces
KAP	Knowledge, Attitudes, and Practice
MH	Mental Health
MHIs	Mental Health Illnesses
MOH	Ministry of Health
MUS	Medical Unexplained Symptoms
NGOs	Non Governmental Organizations
NHS	National Health Services
NPPHCN	National Progressive of Primary Health Care Network
NP	Nurse Practitioner
OPT	Occupied Palestinian Territory
PHC	Primary Health Care
PHCPs	Primary Health Care Providers
SMI	Sever Mental Illness
SPSS	Statistical Package for Social Sciences
UK	United Kingdom
UNRWA	United Nation Relief and Works Agency
UNICEF	United Nation International Childers' Fund
WB/ GS	West Bank / Gaza Strip
WHO	World Health Organization

List of Annexes

Page

Chapter (1)

Introduction

Chapter One

Introduction

1.1 Overview

In this introductory chapter general background will be presented about knowledge, attitude, and practice (KAP) of mental health among primary health care providers (PHCPs) in primary health care settings (PHC). In addition to, all the research introductory components (justification of the study, objectives, and research questions will be stated). Finally, the light will be shed on some general information about Gaza demographic characteristics, primary health care services, mental health services, and UNRWA primary health care services.

1.2 Background

Now days, mental health is being largely overlooked as part of strengthening primary care services. This is despite the fact that mental illnesses are found in all countries, in women and men, at all stages of life, among the rich, poor, rural and urban settings (Wonca, 2008) Mental health illnesses are common, affecting more than 25% of all people at some time during their lives. The point prevalence of mental illness in the adult population at any given time is about 10%. Similarly, around 20% of all patients seen by primary health care providers have one or more mental health illnesses (Kabir, and et al, 2004).

Rates of mental illnesses are increasing all over the world, in developed and developing countries as well and Palestine is no exception to this trend. People suffering from mental illnesses tend not to turn to mental health clinics but to primary health care setting. Furthermore, Palestinians are the most vulnerable and risky people to have not only mental illnesses, but also serious ones. The life they have been living since 1967 under the Israeli occupation plays a great reason in general, and the last two years of restricted closure and siege in specific (Patel, 2008) .

Mental health is an increasing concern as the severe restriction on movement and lack of access to education and health care are present in everyday life of the Gazans. WHO study in the developing countries showed that 52% of those surveyed had thought of ending their life, 92% felt no hope for the future, 100% reported feeling stressed, and 84%

expressed feelings of constant anger because of circumstances beyond their control. Feelings of insecurity have also increased in the areas directly affected by the Separation Barrier: 90% compared to 75% in other areas (WHO, 2005).

As well known primary health care clinics are the first line providing the services for people with mental illness in the form of physical diagnosis and treatment. In Gaza, people attend primary health care clinics for physical and mental health care because they are the most accessible and familiar health services at the primary level (UNRWA Annual Report, 2007).

Three main reasons why people seek mental health help in primary health care settings instead of seeking help in definite mental health settings:

Firstly, the community negative attitudes towards people with mental illnesses can be attributed to stigma. Furthermore, community attitude and beliefs play a role in determining help-seeking behavior and successful treatment of the mental illness people. Unarguably, ignorance and stigma prevent people with mental illnsses from seeking appropriate help.

Secondly, People hardly realize and believe that they are suffering from mental health illnesses and they attend the primary health care clinic complaining of somatic symptoms.

Thirdly, primary health care providers are insufficiently capable of diagnose or treat mental illness people properly. That is, may be due to poor knowledge, skills, and the negative attitudes toward mental illness (UNRWA Annual Report, 2007).

The national Mental Health Policy advocates the integration of mental health promotion, treatment and rehabilitation into primary health care services . However, this goal cannot be successfully achieved without an understanding of primary health care providers knowledge, attitudes, and practice towards mental health and its illnesses (Goldfrach, 2007).

I therefore set out to ascertain the knowledge, attitude, and practice of primary health care providers regarding the causes, manifestations and treatment options of mental illness. Most of the available studies show the knowledge, attitudes, and practices of the general practitioners, barriers, and difficulties faced by them in dealing with the mental illness client. In this study, it will focus on other primary health care providers; nurses and paramedical, as well as general practitioners.

1.3 Main statement

"A study of knowledge, attitude, and practice of mental health among primary health care providers in UNRWA clinics of the Gaza governorates"

1.4 Problem statement

Mental health is becoming the most vulnerable issue in the recent modern life. Because of the sophisticated world, our mental health is affected in every day over 24 hours (WHO, 2005). Many mental health illnesses have been detected than ever before. In occupied Palestinian territory (OPT), such as the Gaza Strip (GS), it is possible that mental health illnesses are high due to the political, psychosocial, and economical situations. Therefore, all health services should be ready to face this challenge in order to minimize the risk and the consequences. In this study the knowledge of primary health care providers of mental health and mental health illnesses, primary health care providers attitudes toward those who have mental illnesses, and how the primary health care providers practice mental health and manage mental health illnesses in their job places. The study will be allocated in the UNRWA health centers of the five Gaza governorates.

1.5 Justification of the study

Human beings are at the centre of concern, their physical and mental status, for sustainable development. They are entitled to a healthy life in harmony with nature. People in the GS deserve more work regarding mental health as well as physical health.

The WHO (World Health Report 2008) argues that a renewal and reinvigoration of primary care is important now, more than ever. Nevertheless, the vision of primary care for mental health has not yet been realized in most countries. Lack of political support, inadequate management, overburdened health services and, at times, resistance from policy-makers and health workers has hampered the development of services (Wonca, 2008). The neglect of mental health issues continues despite documentation of the high prevalence of mental health illnesses, the substantial burden these illnesses impose on individuals, families, communities and health systems when left untreated. The neglect also continues despite scores of studies that have shown effective treatments exist and can be successfully delivered in primary health care settings (WHO, 2005).

This study will show the level of services provided by primary health care providers regarding mental health in primary health care settings in the Gaza Strip. Also the study will clarify the emergence role of primary health care providers in managing primary mental illness; not only general practitioners, but also nurses and paramedical staff. Finally, the study will call for the importance of integrating primary mental health within primary health care system.

1.6 Objectives

1.6.1 General objective

The study objective is to evaluate the level of knowledge, attitudes, and practices of primary health care providers towards mental health at the UNRWA health clinics in the Gaza Strip. Thus, the overall goal is to generate the necessary information that will allow the policy makers in UNRWA to take appropriate decisions and to design appropriate intervention plans to improve knowledge, attitudes, and practices of its' health providers toward mental health and mental illness clients. Therefore, primary mental services will improve within the primary health care settings.

1. 6.2 Specific objectives

1) To assess the level of knowledge on causes, manifestations and treatment of mental illness among primary health care providers.
2) To determine attitudes to mental health and its illnesses among primary health care providers, and the influence of the knowledge on their attitudes.
3) To describe the level of practice provided by primary health care providers to people with mental health illnesses.
4) To identify the barriers and difficulties faced by primary health care providers in applying proper mental health services.
5) To examine the relationship between knowledge, attitudes, and practices and socio-demographic characteristics.
6) To come with suggestions and recommendations for the decision makers at UNRWA services regarding this issue.

1.7 Research questions

The study addresses the following questions:

1) What is the level of the knowledge of primary health care providers of mental health, mental illnesses, causes, manifestations, and treatment in primary health care settings?

2) What are the attitudes of primary health care providers toward mental health its illnesses, causes, and management?

3) What are the actual practices of primary health care providers toward the clients with mental health illnesses who attend primary health care clinics?

4) Is cultural attitude influencing primary health care providers' attitude toward mental health and mental health illnesses ?

5) Is there relationship between knowledge, attitude, and practice toward mental health?

6) Do socio-demographic variables of primary health care providers affect their knowledge, attitude, and practice toward mental health?

7) Is the level of education of primary health care providers affect their knowledge, attitude, and practice toward mental health?

8) Is the type of the job of primary health care providers affect their knowledge, attitude, and practice toward mental health?

9) What are the barriers and difficulties faced by the primary health care providers while dealing with the mental illness patients ?

1.8 Context of the study

In this section background information will be presented about the Palestinian population, geography, demography, socioeconomic, political situation, and health context.

The current study will be conducted in the UNRWA health clinics; so that UNRWA health services will has a great chance of presentation.

1.8.1 Demographic context

Palestine (historical Palestine) is a small country 26,323 Square Kilometers (Annex 1) about the size of Wales in the United Kingdom or New Jersey in the United States of America (Cattan, 1988).

Palestine consists of two separated parts, the West Bank (WB) at the north area and the GS at the south of Palestine (MOH, 2005). The total population was estimated in 2007 at 3,888,262 individuals; 2,444,487 in West Bank and 1,443,814 in the Gaza Strip (PCBS, 2007).

The Gaza Strip (Annex 2) is a narrow band of land located on the south of Palestine, constituting the coastal zone of the OPT along the Mediterranean Sea between Egypt and Israel. It is 45 Kilometers long and 8 kilometers wide with an area of 362 square kilometers (MOH, 1999). Currently, the Gaza Strip is composed of five provinces: North Gaza, Gaza City, Mid Zone, Khan Younis and Rafah (MOH, 2005). The strategic position of it is being at the cross road of Africa, Asia and Europe made it target for and conquerors over the centuries. There are five towns in Gaza Strip, eight refugee camps and fourteen villages (MOH, 2005). Reports indicated that the Gaza Strip is the second most densely populated area. 68% of its' population are refugees living in the camps and mainly served by UNRWA (UN Annual Report, 2007).

1.8.2 Socio-political context

In 2005, Israel officially withdrew from the Gaza Strip. But the withdrawal did not end Israel's effective control of the OPT in all vital regards, thus inflaming Palestinian resentment rather than diffusing it. In August 2005, the last Israeli settlers left Gaza, followed by the last Israeli soldiers in September, as Israel pulled out of the Palestinian territory it had occupied since 1967. The Israeli withdrawal from Gaza gave the general impression, at least in the Western press that Israel was effectively turning over Gaza to the Palestinian Authority. That was not, and still is not, the case (WHO, 2006).

Israel continues to control the joint Gaza Strip / West Bank population registry, which means Israel gets to decide who is a “Palestinian resident” and who is a “foreigner.” Palestinians must seek Israeli approval for every individual who wants to move from Gaza

Strip to West Bank. The Rafah border crossing between Gaza Strip and Egypt was supposedly turned over to the Palestinian Authority. Israel continues to maintain complete control of the movement of people and goods between the Gaza Strip and West Bank, which Israel considers a "closed military area" off limits to anyone without a permit. As far as trade is concerned, Israel controls the three crossing points in and out of Gaza (Karni, Sufa, and Kerem Shalom). Israel routinely closes the crossings to any exchange of goods, causing severe food and other shortages in Gaza (Wikipedia, 2009). All these situations reflect deteriorating of the mental health of the Palestinians in general and of the Gazans people in specific.

1.8.3 Socio-economic context

The virtually total closure imposed on the Gaza Strip since Hamas's takeover in June has almost destroyed the Palestinian economy and threatens to turn its 1.4 million residents into charity cases. Israel has completely shut down the Karni crossing between Israel and the Gaza Strip, which was the primary artery for the import and export of almost all commercial items including goods and raw materials. Since the closure, import of humanitarian goods has been allowed through the Kerem Shalom, Sufa and Erez crossings, but their capacities are highly limited, according to the report (World Bank, 2007).

Seventy five percent of Gaza's factories have shut down because of the closure. The rest are operating on borrowed time, until the stocks of raw materials are exhausted, 85% of the population is already dependent on food aid from international organizations and the number is growing. There is a severe shortage of raw materials including flour and sugar for domestic and industrial consumption. The price of flour has increased by 34 %, powdered milk by 30% and rice by 20% (Izenberg, 2007).

The Palestinian recession is among the worst in the modern history; average personal incomes have been declined by more than a third since 2000, and nearly a half of Palestinian now live below the poverty line, 43% still live below the poverty average (World Bank, 2004).

Poverty is one of the most important determinants of health physically and mentally and invariably leads to general daily life stresses, depression and other mental health illnesses.

1.8.4 Health care context

Palestine experience in health care system is rather unique and complicated. The several years of occupation and the following unilateral withdrawal of the Israeli government did strongly influence the health care system in Palestine. The consequences of closures and separation formed a great challenge for the ministry of health (MOH) and other health care services as it created obstacles regarding the accessibility to health care services and affects the unity of the health care system in all Palestinian governorates (MOH, 2004).

Notwithstanding the extraordinary efforts that were exerted to prevent breakdowns in service delivery and quality, there were indicators of the deterioration of the health and nutritional status of the population, especially the Gaza Strip, face a distinct humanitarian emergency in regards to acute moderate and severe malnutrition (WHO, 2006).
Moreover, today's children grow up knowing mostly oppression and violence. A study of 1, 266 children in the West Bank and Gaza Strip showed that 48% had personally experienced violence or witnessed an incident involving an immediate family member (WHO, 2006). If that the case of the Palestinian children, how it going to be for the rest who are facing the same circumstances every day and every hour of their life.

1.8.5 Primary health care

Primary health care system is a major component of Palestinian health care system; this system has provided health care for all Palestinian people especially for children and other venerable groups. Primary health care centers in Palestine provide primary and secondary health care services as well as tertiary services. In the last five years and after the uprising of second Intifada (Al Aqsa), Primary health care centers in Palestine had been developed in a dynamic way to face the instability of Palestinian situation were Israeli occupied Forces (IOF) tend to divide Palestinian localities into isolated geographical areas. Primary health care centers try to offer affordable health services for all Palestinians regardless the geographical locations (MOH, 2005).

1.8.5.1 Primary health care in MOH

Over the past years, the Palestinians' health care system has developed side by side along with the development of Palestinian society in general. The total number of Primary health care centers in Palestine was 619; the MOH are responsible for 63.2%. Average of persons per center was 6,038. The ratio of visits per person was 1.08. In addition, to 1,265,539 visits were reported to specialized clinics in 2003 (MOH, 2004).
In 2004, the total number of Primary health care centers in Palestine increased to 731 centers compared with 595 centers in 2000, which reveals a rise of 22.8% in the last five years. The Number of PHC centers per 10,000 persons was 2.01 in 2004 while it was 1.9 in 2000 (MOH, 2005)

In Gaza the total number of Primary health care centers is 125 centers in comparison with 100 centers in 2000, which indicates an increase of 25% in the last five years. Although the Primary health care system in Gaza is unique, well established and functioning well, the high population density and the overcrowdings of population were responsible for the high ratio of population per centre. The highest ratio was recorded in Khan/Younis of 12,982 persons per centre and the lowest ratio in Mid-Zone of 6,247. The number of Primary health care centers per 10,000 persons was 0.93 (MOH, 2004).

Primary Health care services in Gaza Strip are provided by three sectors:

- Ministry of health (MOH)
- Nongovernmental organizations (NGO)
- United Nation Relief and Works Agency for Palestine Refugees in the Near East (UNRWA)

1.8.5.2 Primary health care in UNRWA

The registered population in Gaza is 1,443,814 and UNRWA served 884,376 as stated in the Annual Report of the Department of Health (UNRWA, 2007), the number is expected to be increased due to the additional service to women married to non refugees and the bad socio-economic situation in the recent years. This population is distributed among the five governorates.

Today UNRWA is serving the refugees in 20 Primary health care clinics all over the strip as follows:

- Three clinics in the North area
- Four clinics in the Gaza area
- Five clinics in the middle area
- Three clinics in Khan-Younis area
- And five clinics in Rafah area.

These primary health care centers provide maternal and child health care services, communicable and non communicable diseases treatment, community and school health services. The UNRWA offers health services free of charge for all refugees and plays a noticeable role in the vaccination program in cooperation with the MOH, in addition to curative services, antenatal and postnatal care and other specialized services. Furthermore, all refugees in Gaza Strip and West Bank have the right of accessibility to the governmental health care services. In Gaza Strip there were 2,828,022 visits seen by physicians and 626,371 visits seen by nurses in 2004 (UNRWA, 2007).

1.8.5.3 Primary health care in NGOs and private sector

Non governmental organizations Clinics (Non profit), in 2004, the health sector in NGOs owns and operates 265 mini Primary health care centers in Palestine. It was distributed as 214 centers in West Bank and 51 centers in Gaza Strip. Some centers include medical laboratories to perform simple investigations, and many pharmacies that provide the attendants with low cost medications. In Gaza, 84,677 visits to general clinics were reported, and about 248,358 visits to specialized clinics were reported (MOH, 2005). The Private sector (profit), hundreds of private settings are operated by private individual medical specialists, physicians, dentists, pharmacists, lab technicians and X-ray technicians (MOH, 2005).

1.8.6 Mental health services

In Palestine, mental health services are provided by four sectors, the MOH, UNRWA, NGOs and private sector. The community mental health department in MOH provides preventive, curative and community-based rehabilitation programs. The MOH in cooperation with WHO, Italian and French cooperation are implementing a new project to improve mental health services and policy (MOH, 2004).

In Palestine, within the activities of community mental health, the total number of new cases of mental disorders reported in 2004 was 1,967 with an incidence rate of 54.1 per 100,000 compared with 956 cases in 2000 with an incidence rate of 30.3 per 100,000, with an annual average incidence of 41.3 per 100,000 in the last five years resulted mainly from the Israeli incidents of violation against Palestinians during Al Aqsa Intifada. The incidence rates of mental illness were more common in Gaza Strip than in West Bank (MOH, 2004).

Mental health services are provided for the Palestinian population by 15 community mental health clinics (5 in Gaza Strip, one specialized in child mental health, and 10 clinics in West Bank). These clinics are distributed through primary health care centers in the different governorates in Palestine since 1994. In addition to four Electro-encephalography (EEG) units.

In 2004, 58,355 visits were made to community mental health clinics (41,749 in West Bank vs. 16,606 in Gaza Strip). Compared with 53,554 visits in 2000, with an increase percentage of 9.3%.

In addition to community mental health clinics, there are two mental hospitals in Palestine (Bethlehem and Gaza psychiatric hospitals). The reported incidence rate of mental disorders in 2004 was higher than that reported in 2000. This is mainly due to psychological trauma and stress that affected Palestinian people as a result of the Israeli violence (MOH, 2005).

1.8.6.1 Mental health as described by UNRWA

The number of mental health patients receiving treatment at community health centers has increased by 38% since 2000 (WHO, 2005).

UNRWA had reported that prevention and treatment of post-traumatic stress and other psychological and behavioral disorders, that are a consequences of exposure to traumatic events , are an emerging health priority for Palestine refugees. The chronically harsh living conditions coupled with long term political instability, violence and uncertainty are starting to take their toll, particularly on children, adolescents and chronically ill. The escalation of violence since 2000 has led to destruction and demolition of homes, siege, closures, curfew conditions and spiraling poverty among the civilian population. That all cause decline of MH in particular among Palestinian youth (UNRWA, 2007).

1.9 Terminology

Keywords: knowledge/ attitude/ practice/ primary health care/ primary health care providers/ mental health.

1.9.1 Knowledge about mental health

Early tendencies were to define knowledge based on dualisms and abstractions. From mere dualisms emerges a more sophisticated dynamic of emergent knowledge, as built upon experience, observations and reasoning. Afterwards, those defining knowledge gradually made concessions to the practical world, while still maintaining a higher ideal knowledge (Flecher, 2002).

Knowledge of mental health is also defined as expertise, and skills acquired by a person through experience or education; the theoretical or practical understanding of a subject, what is known in a particular field; facts and information or awareness or familiarity gained by experience of a fact or situation. Philosophical debates in general start with Plato's formulation of knowledge as "justified true belief". There is however no single agreed definition of knowledge presently, or any prospect of one, and there remain numerous competing theories (Mullins, 1997).

1.9.2 Attitude toward mental health

Attitude is a hypothetical construct that represents an individual's like or dislike for an item. Attitudes are positive, negative or neutral views of an "attitude object": i.e. a person, behavior or event. People can also be "ambivalent" towards a target, meaning that they

simultaneously possess a positive and a negative bias towards the attitude in question (Jung, 1966).

1.9.3 Practice mental health

Frequently repeated or customary action; habitual performance; a succession of acts of a similar kind; usage; habit; custom; as, the practice of rising early; the practice of making regular entries of accounts; the practice of daily exercise (Sager, 1993).

1.9.4 Primary Health Care

The concept of primary health care adopted at the Conference of Alma Ata in 1978 is endorsed by the NPPHCN and forms the basis of the NPPHCN definition of PHC (National Progressive of Primary Health Care Network, 1987). Primary health care is defined as seeks to extend the first level of the health system from sick care to the development of health. It seeks to protect and promote the health of defined communities and to address individual and population health problems at an early stage. Primary health care services involve continuity of care, health promotion and education, integration of prevention with sick care, a concern for population as well as individual health, community involvement and the use of appropriate technology (Fry and Furler, 2000).

1.9.5 Primary Health Care Providers (PHCP)

Primary Health Care Providers are all categories of medical staff, nursing staff, and Para-medical staff that provide care in PHC settings.

1.9.6 Mental Health

Mental Health is a term used to describe either a level of cognitive or emotional wellbeing or an absence of a mental disorder. From perspectives of the discipline of positive psychology or holism mental health may include an individual's ability to enjoy life and procure a balance between life activities and efforts to achieve psychological resilience.

The WHO states that there is no one "official" definition of MH. Cultural differences, subjective assessments, and competing professional theories all affect how MH is defined (WHO, 2001).

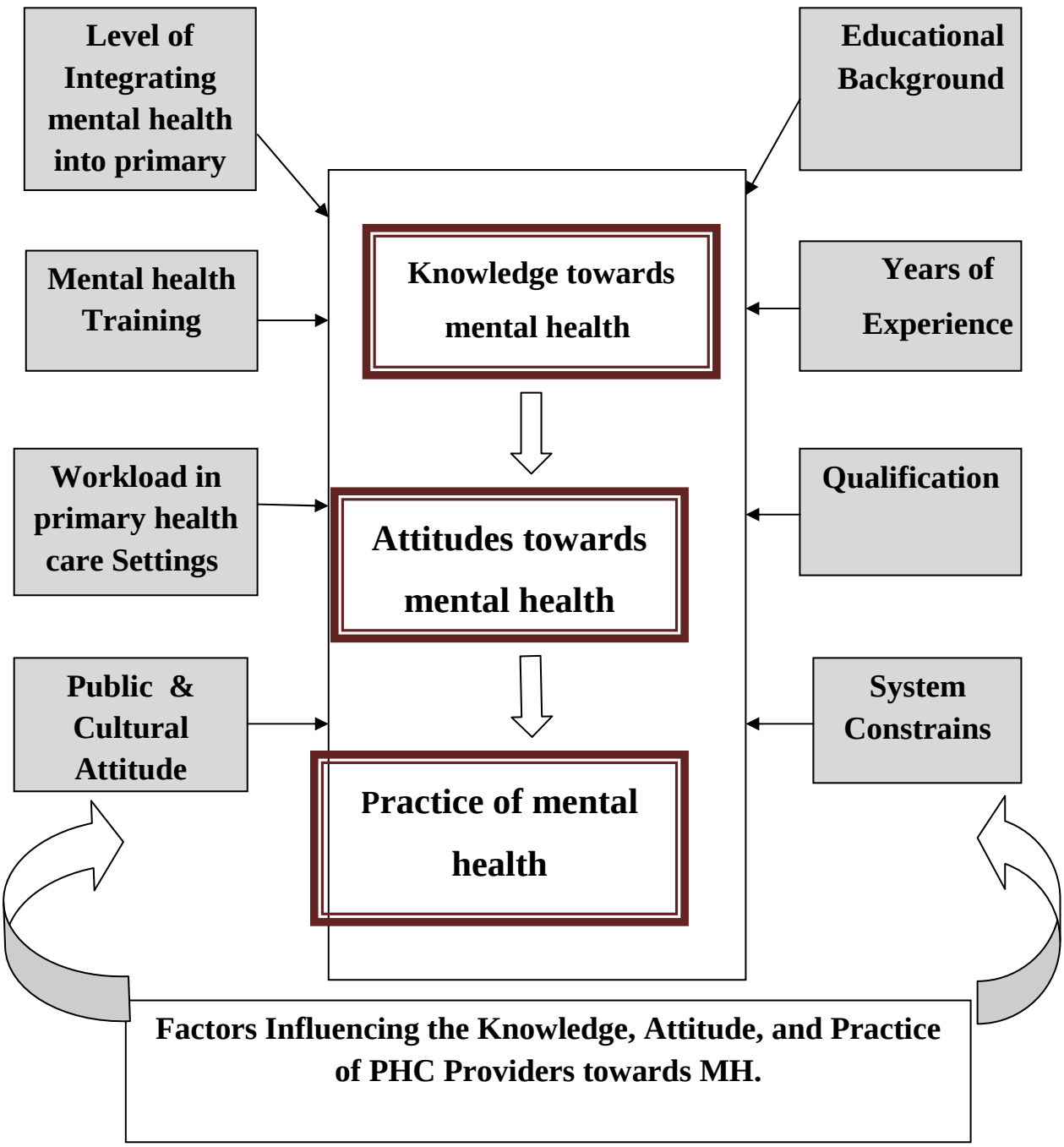
In this chapter the researcher sees the Gaza Strip is one of the most vulnerable area in the world which needs more physical and mental health care and support from the health care workers, mainly those who are working at primary level. In addition to, the researcher adopt the previous definitions of both primary health care and mental health. The study will goes through these definition to examiner the concepts of knowledge, attitude, and practice of primary health care providers toward mental health in primary health care setting.

Chapter (2)

Conceptual Framework & Literature Review

Chapter Two

Conceptual Framework of Mental Health among Primary Health Care Providers in UNRWA Clinics of Gaza Governorates: Knowledge, Attitudes, and Practice.



2. Conceptual Framework and Literature Review

In this chapter an overview of what have the literature wrote about mental health, primary health care, how mental health can be integrated into primary health care settings. Knowledge, attitude, and practice are going to be defined as the researcher will use their measurable definitions in the measurement tools. Also in this chapter the researcher will focus on the effect of knowledge, attitude, and practice on each other regarding mental health. Therefore a review of some of global and regional studies which were done to examine these variables.

2.1 Mental health

2.1.1 Mental health definition

It has always been easier to define mental disorders than to define mental health. In the United States the American Psychiatric Association has traditionally been the organization to define mental disorders (beginning as early as 1917 when it was known as The Association of Medical Superintendents of American Institutions of the Insane). More recently many have recognized that mental health is more than the absence of mental illness. Even though many of us don't suffer from a diagnosable mental illness, it is clear that some of us are mentally healthier than others (James, 1977).

Mental health is a term used to describe either a level of cognitive or emotional well-being or an absence of a mental disorder. From perspectives of the discipline of positive psychology or holism mental health may include an individual's ability to enjoy life and procure a balance between life activities and efforts to achieve psychological resilience (WHO, 2005).

Mental health can be conceptualized as stated by WHO as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2005). In this positive sense, mental health is the foundation for well-being and effective functioning for an individual and for a community. This core concept

of mental health is consistent with its wide and varied interpretation across cultures (WHO, 2001).

Mental health can be seen as a continuum, where an individual's mental health may have many different possible values (Keyes, 2002). Mental wellness is generally viewed as a positive attribute, such that a person can reach enhanced levels of mental health, even if they do not have any diagnosable mental health condition. This definition of mental health highlights emotional well-being, the capacity to live a full and creative life, and the flexibility to deal with life's inevitable challenges (Hattie and et al, 2004). Many therapeutic systems and self-help books offer methods and philosophies espousing strategies and techniques vaunted as effective for further improving the mental wellness of otherwise healthy people. Positive psychology is increasingly prominent in mental health (Witmer and Sweeny, 1992).

Here, the researcher sees the definition of WHO is the most applicable in the Palestinian culture, which can be adopted in this study.

2.1.2 History of mental health services

The history of mental health services in the United States has been chronicled by historian Gerald N. Grob in a series of landmark books from which this account is drawn (Atkinson and Hornby, 2002). The origins of the mental health services system coincide with the colonial settlement of the United States. Individuals with MI were cared for at home until urbanization induced state governments to confront a problem that had been relegated largely to families. The states' response was to build institutions, known first as asylums and later as mental hospitals. When the Pennsylvania Hospital opened in Philadelphia in the mid-18th century, it had provisions for individuals with mental illness housed in its basement (Koenig and et al,, 2001). Also in the mid-18th century, colonial Virginia was the first state to build an asylum for mental illness citizens, which it constructed in its capital at Williamsburg. If not cared for at home or in asylums, those with mental health were likely to be found in jails, almshouses, work houses, and other institutions. By the time of the Revolutionary War, the beginnings were in place for each of the four sectors of the de facto mental health system (Bennett, 2003).

The origins of treatment for mental illness in the general medical/primary care sector can be traced to the Pennsylvania Hospital. The origins of specialty mental health care can be traced to the Williamsburg asylum. Home care, the most common response to mental illness, probably became a part of the voluntary support network, whereas the human services sector was by far the most common organized or institutional response, by placing individuals in almshouses (homes for the poor) and work houses. The first form of treatment, known as “moral treatment” , was not given until the very end of the 18th century, after the Revolutionary War (Atkinson, 2002).

2.1.3 Mental health characteristic

The study of the characteristics that make up mental health has been called "positive psychology." Here are some of the ideas that have been put forward as characteristics of MH (Taylor and et al, 2002) :

2.1.3.1 The ability to enjoy life

The ability to enjoy life is essential to good mental health. James Taylor wrote that "The secret of life is enjoying the passing of time. The practice of mindfulness meditation is one way to cultivate the ability to enjoy the present. We, of course, need to plan for the future at times; and we also need to learn from the past. Too often we make ourselves miserable in the present by worrying about the future. Our life metaphors are important factors that allow us to enjoy life (Taylor and et al, 2002).

2.1.3.2 Resilience - The ability to bounce back from adversity

It has been referred to as "resilience." It has been long known that some people handle stress better than others. Why do some adults raised in alcoholic families do well, while others have repeated problems in life?. The characteristic of "resilience" is shared by those who cope well with stress (Taylor and et al, 2002) .

2.1.3.3 Balance - Balance in life seems to result in greater mental health

We all need to balance time spent socially with time spent alone. Extreme social isolation may even result in a split with reality. Those who ignore the need for some solitary times also risk such a split. Balancing these two needs seems to be the key – although we all balance these differently (Bonanno and et al, 2006).

2.1.3.4 Flexibility

We all know people who hold very rigid opinions. No amount of discussion can change their views. Such people often set themselves up for added stress by the rigid expectations that they hold. Working on making our expectations more flexible can improve our mental health. Emotional flexibility may be just as important as cognitive flexibility. Mental health people experience a range of emotions and allow themselves to express these feelings. Some people shut off certain feelings, finding them to be unacceptable. This emotional rigidity may result in other mental health problems (Taylor and et al, 2002).

2.1.3.5 Self-actualization

What have we made of the gifts that we have been given?. We all know people who have surpassed their potential and others who seem to have squandered their gifts. We first need to recognize our gifts, of course, and the process of recognition is part of the path toward self-actualization. Mental health persons are persons who are in the process of actualizing their potential. In order to do this we must first feel secure (Kajita, 2002).

These are just a few of the concepts that are important in attempting to describe mental health. The ability to form healthy relationships with others is also important. Adult and adolescent mental health also includes the concepts of self-esteem and healthy sexuality. How we deal with loss and death is also an important element of mental health (Bonanno and et al, 2006).

2.1.4 **Theories of mental health**

The researcher will present most of the theories which have been written in mental health. However, it is hard for the researcher to adopt a particular theory, because in primary mental health one can use one particular theory where the other can use another one or compination of more than one. The point here is to use the suitable approach in a particular situation for the seek of help for the client benefit.

Theories of human mental health (human development) are grounded in the developmental perspective. The developmental perspective takes into account the biological, social, and psychological environment; their interaction; and their combined effect upon the individual throughout the life span (Bennett, 2003). Develop mentalist L. Breger (1974) proposes that the developmental perspective incorporates three key precept. First, behavioral maturation proceeds from the simple to the complex. Second, future behaviors, whether temporally near or distant, are a product of their antecedents (prior responses to the developmental environment). Third, the human response to a particular event or experience often depends on the developmental stage at which the experience occurs (Fall and et al, 2003). Each of these precepts is thought to apply to neurobiological development, as well as behavioral/psychosocial development. Moreover, each has implications for whether an individual experiences either healthful or unhealthful development that may lead to a mental disorder. The three precepts are at the heart of each of the three major mainstream theories of developmental psychology that have guided research and increased our understanding of mental health across the life span (Hansen, 2006).

2.1.4.1 Piaget: Cognitive Developmental Theory

Jean Piaget formulated one of the most influential theories of cognitive development .Its focus was on cognitive (intellectual) development, that is, the processes by which children come to know and understand the world. Other aspects of human growth, both physical and emotional, are beyond the scope of his theory. Piaget posited that each step of cognitive development proceeds from the previous step in a fixed pattern, beginning at birth and ending in the teen years.

Piaget had a seminal influence on the discipline of cognitive psychology. Although empirical research has called into question some of the specifics of his theories, the broad outlines remain widely accepted (Garcia, 1995).

2.1.4.2 Erik Erikson: Psychoanalytic Developmental Theory

The psychoanalytic theory of development is best exemplified in the work of Erik Erikson, a psychoanalyst who expanded upon Freud's original theories of psychosexual development. One of Erikson's pioneering contributions was that development unfolded throughout the life span, a view that has become widely embraced (Bennett, 2003).

Freud postulated that development proceeded through a series of stages in which children seek pleasure or gratification from a particular body part (i.e., the oral, anal, and phallic stage). In contrast, Erikson's theories of child development focus on the interrelationship between a developing child's internal psychosexual development and his or her more external emotional development, emphasizing the interpersonal relationships that arise between the child and parents (Hansen, 2006).

Erikson conceived of the life course, from birth to old age, as a series of eight epigenetic stages that, as other developmental theories, proceed in a stepwise fashion, the next dependent upon how well the previous has been mastered: trust versus mistrust; autonomy versus shame and doubt; initiative versus guilt; industry versus inferiority; identity versus role diffusion; intimacy versus isolation; generativity versus stagnation; ego integrity versus despair (Garcia, 1995).

Erikson portrayed each stage as a crisis or conflict that needed resolution, either at the time or at a subsequent stage. Each successive stage presents its own challenges but, at the same time, offers the opportunity for correction of unresolved challenges of previous stages. At each stage the tension was between the psychosocial and psychosexual—the outward-looking versus inward-looking perspectives. Psychopathology, in the form of a mental disorder, would arise if a stage was ultimately not mastered successfully (Hansen, 2006) .

2.1.4.3 John Bowlby: Attachment Theory of Development

Fifty years ago, a new conceptualization of the psychoanalytic approach to development came into the lexicon of human development theory. John Bowlby's reinterpretation of Freudian development is grounded in both Darwinian evolutionary theory and animal ethology. The previous work of Konrad Lorenz and others, who explored the relationship between other animals and their caregivers, determined that the bonds of infant care and the attachment of young to their caregivers are seminal in the drive for survival. Similarly, Bowlby theorized that for humans, attachment to a caregiver had a biological basis in the need for survival .Moreover, he suggested that this attachment drive exists alongside the drive for nutrition and the sex drive, yet distinct and separate from them. Attachment is seen as the anchor that enables the developing child to explore the world (Fall and et al, 2003).

With the comfort and security of a stable and routine attachment to the mother or other primary caregiver, a child is able to organize other elements of development in a coherent way. In contrast, instability in the caregiving relationship whether physical distance, erratic patterns of parental behavior, or even physical or emotional abuse may interfere with the sense of trust and security, potentially giving rise to anxiety and psychological problems later in childhood or even decades later in life (Mercer, 2006)

2.1.5 Mental health promotion

Mental health promotion covers a variety of strategies, all aimed at having a positive impact on mental health. Like all health promotion, mental health promotion involves actions that create living conditions and environments to support mental health and allow people to adopt and maintain healthy lifestyles. This includes a range of actions that increase the chances of more people experiencing better mental health (WHO, 2007).

National mental health policies should not be solely concerned with mental health disorders, but also recognize and address the broader issues which promote mental health. These would include the socio-economic and environmental factors (HEA, 1997). This requires mainstreaming mental health promotion into policies and programmes in government and business sectors including education, labor, justice, transport, environment, housing, and welfare, as well as the health sector. Particularly important are

the decision-makers in governments at local and national levels, whose actions affect mental health in ways that they may not realize (Seedhouse, 2002). Cost-effective interventions exist to promote mental health, even in poor populations .Low cost, high impact evidence-based interventions to promote mental health include (HEA, 1997):

- Early childhood interventions (e.g. home visiting for pregnant women, pre-school psycho-social interventions, combined nutritional and psycho-social interventions in disadvantaged populations).
- Support to children (e.g. skills building programmes, child and youth development programmes)
- Socio-economic empowerment of women (e.g. improving access to education, microcredit schemes)
- Social support to old age populations (e.g. befriending initiatives, community and day centers for the aged);
- Programmes targeted at vulnerable groups, including minorities, indigenous people, migrants and people affected by conflicts and disasters (e.g. psycho-social interventions after disasters);
- Mental health promotion activities in schools (e.g. programems supporting ecological changes in schools, child-friendly schools)
- Mental health interventions at work (e.g. stress prevention programmes)
- Housing policies (e.g. housing improvement)
- Violence prevention programmes (e.g. community policing initiatives); and
- Community development programmes (e.g. 'Communities That Care' initiatives, integrated rural development)

Mental health and mental health disorders are determined by multiple and interacting social, psychological, and biological factors, just as health and illness in general. The clearest evidence is associated with indicators of poverty, including low levels of education, and in some studies with poor housing and poor income. Increasing and persisting socio-economic disadvantages for individuals and for communities are recognized risks to mental health (Seedhouse, 2002).

The greater vulnerability of disadvantaged people in each community to mental health disorders may be explained by such factors as the experience of insecurity and

hopelessness, rapid social change, and the risks of violence and physical ill-health (Norman, 2004).

A climate that respects and protects basic civil, political, socio-economic and cultural rights is also fundamental to mental health promotion. Without the security and freedom provided by these rights, it is very difficult to maintain a high level of mental health (MacDonald and O'Hara, 1998).

2.2 Primary health care

2.2.1 What is primary health care?

In this section the researcher adopts the Australian definition of primary health care and builds the study perspective on it. primary health care is defined as seeks to extend the first level of the health system from sick care to the development of health. It seeks to protect and promote the health of defined communities and to address individual and population health problems at an early stage. Primary health care services involve continuity of care, health promotion and education, integration of prevention with sick care, a concern for population as well as individual health, community involvement and the use of appropriate technology (Fry and Furler, 2000).

Primary Care is more clinically focused, and can be considered a sub-component of the broader primary health care system. Primary care is considered health care provided by a medical professional which is a client's first point of entry into the health system. Primary care is practiced widely in nursing and allied health, but predominately in general practice. (Keleber, 2001). WHO also describe primary health care as the essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (WHO, 1978). It is therefore understood as an approach to health care that promotes the attainment by all people of a level of health that will permit them to live socially and economically productive lives. Primary health care is health care that is essential, scientifically sound (evidence-based), ethical, accessible, equitable, affordable, and accountable to the community (Keleber, 2001). In addition it is not only primary medical

or curative care, nor is it a package of low-cost medical interventions for the poor and marginalized. On the contrary, it calls for the integration of health services into the process of community development, a process that requires political commitment, intersectoral collaboration, and multidisciplinary involvement for success (WHO, 1978).

2.2.2 History of primary health care

Thirty years ago, the Declaration of Alma-Ata articulated primary health care as a set of guiding values for health development, a set of principles for the organization of health services, and a range of approaches for addressing priority health needs and the fundamental determinants of health. The ambition, which launched the health for all movement, was bold. It assumed that enlightened policy could raise the level of health in deprived populations and thus drive overall development. The declaration broadened the medical model to include social and economic factors, and acknowledged that activities in many sectors, including civil society organizations, shaped the prospects for improved health. Fairness in access to care and efficiency in service delivery were overarching goal (Chan, 2008). With an emphasis on local ownership, primary health care honored the resilience and ingenuity of the human spirit and made space for solutions created by communities, owned by them, and sustained by them. Above all, primary health care offered a way to organize the full range of health care, from households to hospitals, with prevention equally important as cure, and with resources invested rationally in the different levels of care (WHO, 1978).

In 1994, a WHO review of world changes in health development since Alma-Ata bleakly concluded that the goal of health for all by 2000 would not be met. Today, primary health care is no longer so deeply misunderstood. In fact, several trends and events have clarified its relevance in ways that could not have been imagined 30 years ago. Primary health care increasingly looks like a smart way to get health development back on track (WHO, 2001).

The Millennium Declaration and its goals breathed new life into the values of equity and social justice, this time with a view towards ensuring that the benefits of globalization are more evenly distributed between countries. The Autoimmune deficiency syndrome epidemic showed the relevance of equity and universal access in a substantial way. With

the advent of antiretroviral therapy, an ability to access medicines and services became equivalent to an ability to survive for many millions of people (WHO, 2001).

In October 2008, WHO will issue its World Health Report on primary health care. Timed to commemorate the Alma-Ata anniversary, the report offers practical and technical guidance for reforms that can equip health systems to respond to health challenges of unprecedented complexity. Although the report does not aim to launch another social movement, it does ask political leaders to pay close attention to rising social expectations for health care; care that is fair as well as efficient, and incorporates many of the values so brilliantly articulated 30 years ago (Chan, 2008).

2.2.3 Principles of primary health care

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology universally made accessible to individuals and families in the community through their full participation and at a cost the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the country. The first level of individuals, family and the community with the national health system bringing health care as close as possible to where people live and work and constitute the first of the continuing health care process (Banerji, 2003). Primary health care, is made in the Director-General' s report to the 53rd meeting of the WHO Executive Board as early as in January 1975, proclaiming that `primary health care services at the community level is seen as the only way in which the health services can develop rapidly and effectively. He had enunciated principles for this purpose (Banerji, 2003): community participation, intersectoral collaboration, integration of health care programmes, equity, and self-reliance.

1. Community participation: is the whole mark of primary health care, without which it will not succeed. Community participation is a process by which individuals and family assume responsibility for their own health and those of the community and develop the capacity to contribute to their/and the community development. Participation can be in the area of identification of needs or during implementation. The community needs to participate at village, ward, district or local government level.

2. Intersectoral collaboration: this is the coordination of health activities with other sectors; such sectors include education, finance, agriculture, information etc. There should be a working relationship these bodies and the health ministry.

3. Integration of health services: this is defined as coordination of various primary health care components into a whole programme and made available at all times including referrals.

4. Equity: the health care resources available in a given community should not be in the handle of a few. And resources should be accessible and affordable to all.

5. Self reliance: this involves the use of technological methods and scientifically sounds and maintain by the community .It can be in terms of human resources, money or materials. Human resources as medical officer of health, community health officer, nurses midwives, community health extension work, community health Aid.

2.2.4 Components of primary health care

There are 8 components (elements)of primary health care discussed in two different reports for (Cueto, 2005) and (Litsios, 2002) as follow :

- Immunization- an increasing number of infectious diseases can be prevented by vaccinations example-measles, Meningitis, Pertusis, tuberculosis, yellow fever etc .
- Maternal and child care - pregnant women and women of child bearing age (15-49 years) are the target group for special care. Children under 5yrs of age are also vulnerable to childhood killer disease. Maternal and child health clinics are established in Nigeria to take care of these groups.
- Essential drugs- the most vital drugs should be available and affordable at all levels.
- Food and Nutrition- the family's food should be adequate, affordable and balanced in nutrients.
- Education - the community should be informed of health problem and methods of prevention and control.

- Illness and injury- adequate provision of curative services for common ailments and injuries should be made by the community.
- Water and sanitation - a safe water supply and the clean disposal of wastes are vital for health.
- Vector and reservoirs- endemic infection diseases can be regulated through the control or eradication of vectors and animal reservoir.

2.3 Integrating mental health into primary health care

A recent report by the World Health Organization (WHO) says that one person in four will be affected by mental illness at some stage in life. More than 400 million people worldwide are estimated to be suffering from some kind of mental and neurological disorder, including alcohol and substance abuse. Of the 10 to 20 million people who attempt suicide each year one million die - a rate as high as the death toll from malaria, according to WHO (WHO, 2001). For example, in Tanzania health experts say the number of mental health patients has trebled from 31,238 in 2001 to 97,570 last year.

They include mental retardation, epilepsy, stress, drug abuse, alcohol, and diseases such as HIV/AIDS, TB, cancer, diabetes and chronic malaria (Magola, 2008).

It is estimated that there are 2.5 million people with mental illnesses in the country but only a fifth of these get professional treatment**.** Alarming inequities in mental health care have been reported in Africa, Tanzania included. According to WHO there are a total of 1,200 psychiatrists and 12,000 psychiatric nurses serving a population of 620 million people in Africa. In contrast, in the European Region, which includes the countries of the former Soviet Union, there are 86,000 psychiatrists and 280,000 nurses serving a population of 870 million (Magola, 2008).

Although medicine has for many years extolled the virtues of treating the whole person, that concept will never be fully realized until mental health care and chemical dependency care are integrated into the primary care setting. Replicated research has shown that 50% to 70% of patients seen in primary care settings on a daily basis are coming in for psychosocial reasons and not for underlying organic medical problems. We are also aware that many common psychiatric problems, such as depressive and anxiety disorders, are

frequently undiagnosed in the primary care setting. The cost to patients' health and happiness, family members, and employers is very high as a result of these treatable but frequently untreated illnesses (Nimmer and et al, 1998).

World Mental Health Day 2008 highlights the present needs of people with mental health and the developments of present methodologies, treatment options and management of mental health. Advocacy is the key and this year's aim is to integrate the sense of advocacy to all people so that change could be feasible. This year's day also advocates that solving mental health issues could also be facilitated by feeding the right information to all kinds of people by providing reliable resources (WHO, 2001).

United Nation Secretary General Ban Ki-moon in his message on World Mental Health Day October 10, 2008, while emphasizing that mental disorders occur in all cultures and at all stages of life, said there can be no health without mental health. More broadly, all must do more to integrate mental health awareness into all aspects of health and social policy, health-system planning, and primary and secondary general health care. Health experts say knowing the symptoms and getting early treatment of mental illness could minimize its adversity. The symptoms include elevated mood, flight of ideas and depression Inability to think and reason or lack of knowledge or insight about illness are also pointers to the disease and the need for members of the public to be enlightened about the causes of mental impairment in order to minimize new occurrences(Ovuga and et al, 2007).

Mental health is of paramount importance for the personal well-being, family relationships and an individual`s ability to contribute to society. Physical illnesses should be treated immediately as some of them could lead to mental sickness. However any efforts to control the disease must be accompanied with remedy of inequities in mental health care. Emphasis has been placed on integrating mental health into primary health care. To achieve the objective analysts , there is a need to give priority to mental health courses for primary health care attendants from health facilities. Through public education the attendants can play a key role in eradicating stigma attached to mental illness which is the main reason why mental health is not a priority. The stigma attached to a mental illness does not just stay with the person affected by it, but it covers all of the individual`s family as well. This means that mentally ill people are often cast out from their families so that they can avoid the shame (Odejide and et al, 2002).

The national mental hospital has been transformed from an asylum of 1,000 beds to a smaller inpatient and outpatient unit as well as a national training centre for an advanced two year diploma in mental health for assistant medical officers. Mental health is being integrated into primary health care and WHO Primary Care Guidelines have been adapted (Wonca, 2008).

In October this year, the National Assembly enacted a new Mental Health Act 2008. Tabling the bill the minister for Health and Social Welfare, the new law has been drafted in observance of human rights requirements and gives the patients freedom of choice to seek medical treatment of their choice. The aim is to take full advantage of existing primary health care infrastructure by integrating mental health into the general health services of the country, including the grassroots level of the services in the village and the district. The overall objective is to create an infrastructure for mental health care provision which should meet the requirements of both adequate population coverage and quality of service and raise the community's awareness of mental health issues in order to enlist its support and participation(Ogundipe, 2009).

2.3.1 Rational for integrating mental health services into primary health care

Citing many benefits, a recent WHO publication titled "Integrating mental health into primary health care: a global perspective," suggested integration of mental health services with primary care.. There are some of the justifications supporting integration of mental health and primary care. The heavy burden of mental disorders, mental disorders aren't confined to a geographical territory; they are a challenge to populations around the world. Not only do they impair the affected individual, but also pose economical hardships on the family and the society (Stroul and Orlando, 2006).

Mental and physical health are interdependent, a number patients are afflicted with mental health problems as well as physical problems at the same time. Further, physical health issues can sometimes affect mental health too. Hence, integrated primary care services will enable treatment in a holistic manner, addressing physical disorders when they surface and at the same time prescribing central nervous system drugs for mental disorders, as and when needed .It will increase access to mental health care, there's a huge difference between the prevalence of mental disorders, and the number of people getting treatment for

these. This is true for all countries. Integration between mental and primary care will decrease this gap. This is so because people would be able to seek mental health services close to their homes, and this will also allow them to keep their families together without disturbing their daily activities (Ogundipe, 2009).

It will make mental healthcare affordable, this is so because primary care services for mental health are less costly than psychiatric hospitals. Also, patients will be able to curtail indirect costs that go along with finding specialist care in distant location. Good health outcomes ensue with primary care for mental health, a greater number of patients treated for mental disorders in primary healthcare lead to good outcomes, especially when the healthcare provided is linked to a network of services at secondary level and within the community. It will promote respect of human rights, primary healthcare mental health services can play a major role in diluting the stigma and discrimination linked to psychiatric illnesses. In addition it will even decrease the risk of human rights violations occurring in psychiatric healthcare facilities (Kim and Flaherty, 1997).

Many countries around the world already have "primary care for mental health" programs underway; some of these include Argentina, Australia, Belize, Brazil, Saudi Arabia, and the UK. With so many benefits of integration, mental healthcare services rendered by the medical industry should improve a lot with integration (WHO, 2005).

2.3.2 Challenges to overcome for successful integration

Integration of mental health services requires a lot of careful planning and there are likely to be several issues and challenges that will need to be addressed. Integration into primary health care, requires investment in the training of staff to detect and treat mental disorders. Within the context of training, primary health care workers may be uncomfortable in dealing with mental disorders and may also question their role in managing disorders. Therefore, in addition to imparting skills, training also needs to address the overall reluctance of primary health care workers to work with people with mental disorders. The issue of availability of time also needs to be addressed. In many countries primary health care staffs are overburdened with work as they are expected to deliver multiple health care programs. Governments can not ignore the need to increase the numbers of primary health care staff if they are to take on additional mental health work (Stroul and Orlando, 2006).

Adequate supervision of primary care staff is another key issue which needs to be addressed if integration is to succeed. Mental health professionals should be available regularly to primary care staff to give advice as well as guidance on management and treatment of people with mental health illnesses. Furthermore the absence of a good referral system between primary and secondary care can severely undermines the effectiveness of mental health care delivered at primary health care level.

Finally, governments must pay attention to key human resource management issues in primary health care adequate working conditions، payment, resources and support to carry out demanding work (Ogundipe, 2009)

2.4 Knowledge

2.4.1 What is knowledge?

Knowledge is defined as expertise, and skills acquired by a person through experience or education; the theoretical or practical understanding of a subject, what is known in a particular field; facts and information or awareness or familiarity gained by experience of a fact or situation. Philosophical debates in general start with Plato's formulation of knowledge as "justified true belief". There is however no single agreed definition of knowledge presently, or any prospect of one, and there remain numerous competing theories (Mullins, 1997).

Knowledge acquisition involves complex cognitive processes: perception, learning, communication, association and reasoning. The term knowledge is also used to mean the confident understanding of a subject with the ability to use it for a specific purpose if appropriate. The development of Scientific Method has made a significant contribution to our understanding of knowledge. To be termed scientific, a method of inquiry must be based on gathering observable, empirical and measurable evidence subject to specific principles of reasoning (Gerits, 2000).

2.4.2 Knowledge of mental health

Knowledge of mental health means extend the capacity of primary health care professionals and community support workers, to become more informed about the actual meaning of mental health toward themselves and toward their clients. Also they should be

involved in early recognition of mental health problems and mental health illnesses. Anxiety disorders, along with depression and substance abuse, comprise a group of disabling conditions whose presentation is often assumed normal. They frequently escape the notice of primary health professionals. Early recognition of these disorders will help facilitate early intervention. This reduces distress, disability and burden of illness, and has the potential to reduce the need for secondary mental health services (CCMHI, 2004).

The aim is to improve outcomes for people with a mental illness through more effective utilization of available resources, including increased knowledge of and access to current initiatives, improved linkages between service providers that encourage appropriate use of skills and knowledge, and appropriate inclusion of consumers and careers in service development. It also aims to provide support for overall system reform to address the quality of service provision across the sector (Brewis and Hurford, 2004).

2.5 Attitude

2.5.1 What is attitude?

Attitude is a hypothetical construct that represents an individual's like or dislike for an item. Attitudes are positive, negative or neutral views of an "attitude object": i.e. a person, behavior or event. People can also be "ambivalent" towards a target, meaning that they simultaneously possess a positive and a negative bias towards the attitude in question (Jung, 1966).

2.5.2 Components of attitude

Attitudes are composed from various forms of judgments. Attitudes develop on the ABC model (affect, behavioral change and cognition). The affective response is a physiological response that expresses an individual's preference for an entity. The behavioral intention is a verbal indication of the intention of an individual. The cognitive response is a cognitive evaluation of the entity to form an attitude. Most attitudes in individuals are a result of observational learning from their environment (Jung, 1966).

Unlike personality, attitudes are expected to change as a function of experience. Tesser (1993) has argued that hereditary variables may affect attitudes, but believes that they may do so indirectly (Mayers, 1980). The fact that there are these components makes the

notion of an attitude somewhat slippery, to say the least. Some beliefs certainly don't seem to involve attitudes. In that case, beliefs shape attitudes. It could work the other way round: a negative attitude towards, say, women could lead one readily to believe that most of them are bad drivers (Spoonces, 1992).

It is that interaction between beliefs and attitudes, as well as the interaction with whatever underlying values we may hold and opinions we may express that makes attitudes difficult to get a hold on. And, of course, we can't directly observe them - we can only ask people or infer their attitudes from what they do (Mayers, 1980)..

To measure attitude of the people, we can use {Fishbein method, Kelly's Personal Construct Theory, Likert Technique, and Osgood's Semantic Differential} from the Psychology of Communication: attitude (Jung, 1966).

2.5.3 Attitude to mental health

Cultural issues affect not only those who seek help but also those who provide services. Each group of providers embodies a culture of shared beliefs, norms, values, and patterns of communication. They may perceive mental health, social support, diagnosis, assessment, and intervention for disorders in ways that are both different from one another and different from the culture of the person seeking help.

In a survey sought to investigate the attitude of Palestinian primary health care professionals towards mental health and mental health illness in the Gaza Strip. A random ample of 166 general practitioners and nurses were surveyed using Likert-type scale (29 items). The study resulted in Factor analysis revealed three main attitude dimensions: western cognitive and community approach, emotional tolerance and reaction, and traditional attitude. Overall, older health professionals had significantly more traditional attitudes than the younger, whereas the younger showed a tendency toward more western attitudes. Older health professionals showed more emotional and tolerant attitudes towards mental illness than the younger. That is youngsters are usually the agents to introduce new concepts. Also, they are brought up with the frame of traditional values and conceptions that can easily cause emotional as well as intellectual turmoil (Afana and et al, 2002).

2.6 Practice

2.6.1 What is practice?

Sager had proposed a very realistic definition and description of practice, as practice is frequently repeated or customary action; habitual performance; a succession of acts of a similar kind; usage; habit; custom; as, the practice of rising early; the practice of making regular entries of accounts; the practice of daily exercise (Sager, 1993).

Practice is conceived of as activities or sets of activities. How these are demarcated, labeled and analyzed may vary. Activities have to be defined in a meaningful way, where the labels make sense for the people or the practice being analyzed. Activities are embedded in practice. Activities are built on knowledge, skills or competences of those performing the activities or of the community in which the activities are performed. Knowledge may be expressed in ways of communicating, in routines or procedures applied or in the patters through which the world is made sense of. practice involves humans. It is people performing activities, utilizing or using and creating knowledge. People are of highest importance ((Postill, 2002).

2.6.2 Practicing mental health

There are several ways helping in practicing mental health as primary health care providers, develop and initiate a training plan for primary health care staff to identify and manage those with mental or psychosocial disturbances through regular post graduate education intensive trainings, on-the-job case consultation and regular supervision of treatment, for incorporation of services into the primary health care setting (Dunivin, 1994). Then assist in the development of referral systems for mental health patients requiring specialized services and collaborate with the psychosocial adviser on the design and development of community based psychosocial programs for conflict-affected populations to ensure that clinical mental health and psychosocial activities are integrated (Zimmerman, 1991).

Also assist the psychosocial adviser in the integration of community based psychosocial activities in the primary school system, and ensure coordination in the design, development and implementation of mental health and psychosocial service and adequate linkages

between the primary health care setting, primary schools (education sector) and conflict affected communities. Coordinate project activities with relevant line Ministries; including the MOH and the Ministry of Education; UNICEF, WHO and other International and National Organizations involved in protection sector activities (Zimmerman, 1991).

Finally, establish a database and train primary health care providers to keep a comprehensive audit of all mental heath clinical work in order to provide comprehensive patient contact and management data. Coordinate project monitoring and evaluation activities, with attention to record of lessons learned through evidence-based practice for the purpose of project replication or expansion ((Dunivin, 1994).

2.7 Global Studies

Unfourtionatlly, most of the available studies on the primary health care providers attitude are only concerning the general practitioners attitude toward mental health and mental illnesses as consequence. In addition to, most of the available studies dealt with the health professionals' knowledge, attitudes, and practices through their knowledge and attitudes to mental health illnesses not to mental health as a separate concept. Therefore, the following presented studies are the most applicable ones to the recent research. The literature studies will be categorized to several subdivisions in order to cover the research theoretical framework.

2.7.1 Knowledge mental health among general practitioners

In study done to examine the general practitioners knowledge and attitudes toward the recognition and management of mental health. A sample of 63 general practitioners in Australia were interviewed, they showed that their attitude to mental health is affected by their level of knowledge to mental health (McCall and et al, 2002). Another study to explore the experience of providing and receiving primary care from the perspectives of primary health care providers and patients with serious mental health illnesses respectively, 39 general practitioners and eight practice nurses in Birmingham were interviewed. The study showed that most health professionals felt that the care of people with serious mental illness was too specialized for primary care. Primary care is of central importance to people with serious mental illnesses and the knowledge of the professional is highly

important (Lester, Tritter, and Sorohan, 2005). Also all general practitioners in the South Yvelines area in France (n = 492) were informed of the implementation of a local mental health program. General practitioners interested in taking part (n = 180) were invited to complete a satisfaction questionnaire on their practice in the field of mental health and to include prospectively all consultants over an 8-day period. It concluded that general practitioners need targeted collaboration with to support their management of mental health patients, whom they are willing to care for without systematic referral to specialists as the major therapeutic option and intervention program to increase their knowledge is needed (Younes and et al, 2005).

Another study assessed community physician needs and ability to identify mental health problems in children less than 6 years of age and to identify the learning needs among primary care physicians and their capacity to serve very young children. In Alberta, 192 general practitioners were participated. Most physicians reported that they did not have enough knowledge and support to detect and manage mental health problems in young children and that they received minimal undergraduate training. Community physicians require primary mental health care support to serve the mental health concerns of young children age 0-6 (Cawthorpe, 2005). To support the previous study, another study aimed to evaluate the prevention of mental disability in primary health care services in Maringá, Paraná, Brazil. The sample consisted of 90 male and female physicians from different fields, namely gynecology and obstetrics, pediatrics, general practice, and family health, as well as 66 male and female nurses. A multiple-choice questionnaire was filled out by the subjects themselves. The data showed that participants had an unsatisfactory perception of the relevance of mental disability within the overall population disease profile, and that they need more information on the respective genetic and environmental issues (Moraes and et al, 2006).

Also another study was to evaluate mental health care provided within primary health care setting. The study was conducted in a primary health care in the city of Sao Paulo, Brazil. Eleven pediatricians were interviewed for more in-depth analysis about mental health in children. The study analyzed 411 patient charts and held 206 interviews with the children's parents. Analysis of the resulting data shows that the pediatricians provided a diagnosis of mental health illnesses in 17.5% of the children examined. Only 25.3% of the children were diagnosed by the physician as having mental health problems. Interviews with

pediatricians identified difficulties in the definition and conceptualization of mental health problems, lack of organization in the referral system, and insufficient technical support (Tanaka and Lauridsen-Ribeiro, 2006).

Cross-sectional survey, in London, 163 family physicians identified to measure Practice patterns for managing depression, including screening, pharmacotherapy, and psychotherapy, shared care, and training needs. Family physicians reported spending a substantial portion of their time during patient visits (26% to 50%) addressing mental health issues, with depression being the most common issue (51% to 75% of patients with mental health issues). The study concluded that Satisfaction with shared care can be increased through better communication with mental health professionals. Physicians' management of adolescent patients can be improved by further medical training, consultation, and collaboration with mental health professionals. Training in evidence-based treatment of depression is particularly warranted given physicians' limited knowledge of CBT (Collins and et al, 2007). A study was also done in California; it examined implicit and explicit measures of bias toward mental health illnesses among people with different levels of mental health training, and investigated the influence of stigma on clinically-relevant decision-making. Participants (N = 1539) comprised of (1) MH professionals and clinical graduate students, (2) other health care/social services specialists, (3) undergraduate students, and (4) the general public self-reported their attitudes toward people with mental health illnesses, and completed implicit measures to assess mental health ilnesses evaluations that exist outside of awareness or control, compared with people without mental health training. Individuals with mental health training demonstrated more positive implicit and explicit evaluations of people with mental health illnesses. Further, explicit (but not implicit) biases predicted more negative patient prognoses, but implicit (and not explicit) biases predicted over-diagnosis, underscoring the value of using both implicit and explicit measures (Peris, Teachman, and Nosek, Oct.2008).

Little is known in our own as well as in other cultures about the knowledge and prejudices mental health professionals have about mental health illnesses and those affected. Therefore a unique study assessed mental health literacy and general attitudes towards people with mental health illnesses in a sample of Brazilian mental health professionals compared the outcomes among the different professional groups; and compared the data with a sample of Swiss mental health professionals. Both samples had equal scores for

social acceptance. Brazilian mental health professionals displayed a more positive attitude towards community psychiatry whereas the Swiss sample showed more stigmatization and social distance, and a more positive attitude towards psychopharmacology. There are some major differences in attitudes towards people with mental health illnesses between mental health professionals in Switzerland and Brazil. With respect to therapeutic interventions, the different health care systems as well as the cultural differences seem to have an impact (Des Courtis and et al, 2008).

Finally, a strategic sample of 19 general practitioners to gain insight into the management of children and adolescents with mental health problems in Norway. Their assessments were based on history taking, physical examination and acquired knowledge of development and prevalence of common health problems. Their interventions mostly consisted of parental counseling. Their assessments and interventions to a lesser extent relied on specific knowledge in child and adolescent psychiatry. The study concluded that the interested general practitioner is in a good position to provide services to these patients the others needs more educational programmes between GPs and child and adolescent psychiatry to explore the interface between the fields (Haftingand Garlov, 2009).

2.7.2 Knowledge of Mental Health among Nurses

Non psychiatric nurse practitioners must be able to recognize symptoms of common psychiatric disorders, know how to treat less complex mental illnesses, and know when to refer to psychiatric mental health nurse practitioners (Weber and Snow, 2006). This study described the course content, assignments, and teaching strategies used in a clinical core course in the nurse practitioner (NP) curriculum that is required for all nurse practitioners majors at the University of Texas at Arlington. Three hundred and eleven nurse practitioner were given 33 itemed questionnaires examining their knowledge to mental health and the effectiveness of mental health course. Since 1999, students from the eight different nurse practitioner programs have been required to take this course. Student, faculty, and graduate feedback about this course have been consistently positive. Many nurse practitioner students comment on feeling much more comfortable assessing for depression, suicide, and substance use (Weber and Snow, 2006). As well another study was to evaluate the degree to which a psychiatric clinical clerkship alters nursing students' attitudes toward individuals with mental health illnesses. The goal of the 4-week clerkship

is to provide students with the knowledge, skills, and professional attitudes that will enable them to care for individuals with mental health illnesses in different health care settings. Questionnaire was administered to 126 third-year students before and after the clerkship in Israel. After the clinical clerkship, students became more compassionate and less frightened by psychiatric patients, were more willing to care for individuals with mental illness, and expressed less need to segregate them from the community. In addition, in accord with professional attitudes, students became aware of their own attitudes (the responsibility attributed to patients) and their emotional responses, but these were no longer associated with reluctance to provide care (Romem and et al, 2008).

Finally, most research designed to explore undergraduate nursing students' attitudes towards mental health nursing tends to uphold clinical experience as the decisive factor, with much less attention paid to the theoretical component. In findings of a state-wide study conducted with undergraduate nursing students in Victoria, Australia. A pre- and post-test design (n = 160) was used to measure students' attitudes toward people with a mental health illnesses and toward mental health nursing and their sense of preparedness for mental health practice. A questionnaire was administered at two time points; the first time point was following completion of the mental health nursing theoretical component, and the second was following the completion of clinical experience. An additional scale was added at the second time point to evaluate students' opinions about their clinical placement. It showed that the students taking courses with a larger theoretical component tended to demonstrate higher scores (suggestive of more favorable attitudes) on all of the subscales, and that these differences were sustained following the completion of the clinical placement. These findings suggest that the amount of theory students receive in mental health nursing may be more influential than the relevant literature suggests (Happell, 2009).

2.7.3 Attitude to Mental Health among primary health care providers

The development of comprehensive health and mental health services depends on a number of factors. One overlooked factor, especially for the public sector, seems to be the attitudes of the health care providers. The attitudes of mental health trainees toward the poor, interdisciplinary interaction, and community mental health were assessed. While the

ethnic identity of the students had some influence, the major findings concerned the discipline of the students (Moffic and et al, 1983).

In a study done in the Spanish mental health services by Mira, Fernandez -Gilino, and Lorenzo(1997). The goal of the study was, firstly, to assess the opinions of primary care professionals about CMMH(community mental health model) and, secondly, to sample the opinions of the patients' relatives regarding mental health care, 884 primary caregivers (general practitioners, pediatricians, nurses and social workers) filled out a 14-item questionnaire with a five-point response scale. Several aspects of care were evaluated: accessibility, referral facilities, therapeutic support training or teaching activities, communication between primary health care and mental health professionals for their mutual collaboration, and appropriateness of resources. Most of the primary caregivers reported that the community psychiatric model improved accessibility, treatment and communication between the different levels. Nurses and pediatricians reported dissatisfaction with the CMMH (Mira and et al, 1997).

As well as, another study was done in Nigeria to assess the knowledge, practice and attitude of traditional mental health practitioners on mental health care; to organize training sessions aimed at improving their knowledge base, practice and; to evaluate such training after allowing for a period of practice. Two hundred and eighty six participants were assessed before and after trained in the concepts of normality and abnormality, types of mental health illness, treatment of mental health illness including follow up, after-care. The result gave the conclusion that the use of information, education and communication intervention techniques could lead to more positive and less hazardous forms of practice among health providers (Adelekan and et al, 2001).

Dentists are also part of the primary health care providers; they have their own opinion to mental health. In a study done in 2002 in USA assessed dental fear in a special needs dental clinic population. Using the Kleinknecht Dental Report assessment for 72 dentists, caregivers significantly overestimated fear levels when dealing with patients with disabilities (Martin and et al, 2002).

Another study done by Payne , Harvey , Jessopp , Plummer , Tylee , and Gournay (2002) in the United Kingdom's 24-hour nurse-led telephone advice service. The aim of the study was to measure confidence in dealing with mental health calls, knowledge of mental health

issues, and attitudes to mental health before and after training of how to deal with mental health illness patients. A postal questionnaire was sent to all nurse advisers working in 17 National Health Services direct sites in England before and after mental health training had been received. The study concluded that training in mental health can lead to increasing in confidence and a change in attitudes and would be beneficial for all nurses working in NHS Direct and in other primary care fields. It would also be beneficial to repeat the study with a larger number of nurses and after a longer period of time to assess the long-term effects of training (Payne and et al, 2002).

On the purpose of this, another study was to describe and analyze the content of mental health care from the practitioner's point of view. The specific aim was to outline the types of mental health care tools and the ways in which they are used by primary health care practitioners. The data were derived from interviews with doctors and nurses (n = 29) working in primary health care in six different health care centers of the Pirkanmaa region in Finland (Hyvonen and Nikkonen, 2004). The tools of mental health care used in primary health care were categorized as communicative, ideological, technical and collaborative tools. The study ended with the primary health care practitioner him/herself is an important tool in mental health care. On the one hand, the practitioner can be categorized as a meta-tool who has control over the other tools. On the other hand, the practitioner him/herself is a tool in the sense that s/he uses his/her personality in the professional context. The professional skills and attitudes of the practitioner have a significant influence on the type of caring the client receives.

Furthermore, Salmon and et al (2007) focuses on changing general practitioners' negative attitudes to patient with medically unexplained symptoms (MUS). The aim of the study was to identify how general practitioners' attitudes to patients with MUS might inhibit their participation with training to improve management. 33 general practitioners in United Kigdom (Liverpool PHC clinics) who had declined or accepted training in reattribution techniques in the context of a research trial. Salmon concluded to the need to understand whether some general practitioners are particularly challenged by psychological demands those patients with MUS, and whether this accounts for their devaluing psychological skills. In addition to, the need to understand the role of general practitioners' dualistic separation of physical and psychological care in their deprecation of psychological skills, and we need to explore how these putative effects of dualism can be overcome. Only if general

practitioners value their psychological role will they accept help to enhance it (Salmon and et al, 2007).

In a cross-sectional study examined the attitudes and barriers of primary care physicians in the southern region of Israel toward providing care for depression and anxiety in their practices. It questions 99 primary care physician, and it showes that 80.6% of the participants agreed with the statement that depression and anxiety are frequent problems in primary care and they should be treated in primary care clinics, but 37.3% reported to have little interest in treating mental disorders, 47.7% thought depression and anxiety should be treated in mental health clinics; 43.3% of the participants declared that they experienced a personal difficulty in taking care of patients with depression and anxiety, and 85% identified time constraint as a major barrier to care of depression and anxiety in primary care. This study suggested that in order to improve treatment of depression and anxiety in primary care, there is a need for a change of attitudes of the primary care providers (Goldfracht and et al, 2007).

Many other studies were done to enhance the importance of increasing knowledge for medical student about mental health illnesses, although that is not sufficient for attitude changes (Mas and Hatim, 2006) and (Tharyan and et al, April 2008).

In two parts series study, in Victoria, Happell, Robins, and Gough (Oct.2008) examined the negative attitude toward mental health illnesses and mental health nursing profession among undergraduate nursing student from considering this area as an attractive career option. Clinical experience has been identified as a potential strategy in enhancing more positive attitudes. However, research to date has not focused on the impact of clinical experience on specific factors such as attitudes to mental health nursing to people experiencing mental health illnesses and perceived preparedness for the mental health field. The study showed that the increased content of the theoretical component appeared to have a positive impact on their desire to join a career in mental health nursing. Also the study speculated the light on the perceived course of effectiveness was significantly and positively related to the students preparedness, attitude, and believes toward mental health illnesses. The other part of the study also emphasizes on the need for increased content of the theoretical component of mental health subjects (Happell and et al, Oct.2008).

2.7.4 Different Practices in Mental Health

General practitioners are important to the delivery of mental health care because they perform three important functions, as an identifier, as a referral agent and as a caregiver. In Israel a study investigated the importance of the attitudes general practitioners hold on their performance of two of these functions, screening and referring. Three major findings emerge from the results. First, the attitudinal dimensions uncovered are empirically distinct, suggesting that no single pro-to-anti psychiatry is present. Second, attitudes play a role in the screening of cases. A general practitioner is more likely to identify cases if he believes in the psychogenesis of physical disorders, and is not concerned that identification and referral will lead to negative consequences for the patient. Third and finally, attitudes do not play a strong role in the referral of cases once they have been identified as such. The findings are presented and interpreted by referring to the sensitive position general practitioners occupy between the public and the psychiatrist (Link and et al, 1982).

Early recognition allows for adequate treatment that might speed up recovery, this fact was studied in Netherland to explore the general practitioners' ability to recognize mental health illnesses, the communication style that is supposed to support this ability, the subsequent treatment of mental health illnesses, and the patient's recovery. Two databases were used. First, an observation study, involving 351 videotaped consultations held by 15 general practitioners, yielded information on communication style and recognition abilities in this study were selected randomly. The second database obtained treatment data and measures of patient recovery from a 1-year follow-up study dealing with the treatment and course of mental health illnesses. Patients in this study were selected because their general practitioners considered their problems. The study concluded that relationships between the general practitioners' recognition ability and various measures of patients' recovery did not prove univocal. Both positive, negative and absent relationships were found (Van der Pasch and Verhaak, 1998).

However, study was to describe and analyze the content of mental health care from the practitioner's point of view. The specific aim was to outline the types of mental health care tools and the ways in which they are used by primary health care practitioners. The data were derived from interviews with doctors and nurses (n = 29) working in primary health care in six different health care centers of the Pirkanmaa region in Finland . The tools of mental health care used in primary health care were categorized as communicative,

ideological, technical and collaborative tools. The study ended with the primary health care practitioner him/herself is an important tool in mental health care. On the one hand, the practitioner can be categorized as a meta-tool who has control over the other tools. On the other hand, the practitioner him/herself is a tool in the sense that s/he uses his/her personality in the professional context. The professional skills and attitudes of the practitioner have a significant influence on the type of caring the client receives .(Hyvonen and Nikkonen, 2004).

On the other extreme, a comparison study between treatments received from primary care physicians and from psychiatrists in USA. 539 primary care participants with at least one anxiety disorder, almost half (47.3%) were untreated. Nearly 21% were receiving medication only for psychiatric problems, 7.2% were receiving psychotherapy alone, and 24.5% were receiving both medication and psychotherapy. Unfortunately the results showed poor primary health care providers practice, nearly half the primary care patients with anxiety disorders were not treated. However, when they were treated, the care received from primary care physicians and psychiatrists was relatively similar (Weisberg and et al, 2007).

2.7.5 Effect of training on knowledge, attitudes, and practices of primary health care providers toward mental health

This section presents the importance of training in improving primary health care providers' knowledge, attitudes, and practices toward mental health in their work and toward their clients. The previous studies all agree on the positive effect of training regarding the statement of this study.

In Nigeria, structured questionnaire was used on 207 primary health care providers were assessed on the concept, attitude to, detection and treatment of mental disorders. primary health care providers without previous exposure to mental health training, many of them (72%) expressed a generally negative attitude towards patients with mental health illnesses Suggestions are made on the short and long term training requirements of the primary health care providers in order to ensure the successful integration of mental health care into the primary health care (Abiodun, 1991). On the same year, another study was similarly conducted in the university of Kansas (USA) , mental health preparedness training to public health and allied health professionals and assessed the impact of the training on

perceived mental health preparedness knowledge. One hundred and fifty seven participants attended one of 10 training presentations on mental health emergency preparedness. The study ended with data about gaps in practitioner knowledge regarding mental health preparedness. While the self-report nature of responses is a limitation, these findings serve as the first step toward producing and implementing effective mental health preparedness information and training on a wide scale (.Hawley and et al, 1991).

Later on, a study aimed to explore whether community MH nurses (CMHNs), community nurses (CNs) and practice nurses (PNs) have different perspectives on early diagnosis of dementia and to consider the possible effects of any variation. Data are drawn from questionnaires completed by CMHNs (79), community nurses (153) and practice nurses (36) who attended workshops offered on 24 occasions in 21 settings across the UK. The results concluded that While CMHNs may have a key role in responding effectively to the newly identified needs of people with early dementia, other nurses working in the community are likely to encounter people with early dementia, and PNs are unable to identify early dementia. Their confidence in doing so should be enhanced by continued professional development (Manthorpe and et al, 2003).

In opinion of most of the physicians the mental health illnesses are related with, at least, 1 of each 5 consultations. A high proportion considers that the teams of primary health care cannot be taken charge of the existent demand, mainly when it is high the assistance pressure. Most says that more specific training should exist in mental health and more coordination with the specialized services. That was the outcome of a study done in Castilla-La Mancha region on 301 general practitioners were selected by random stratified sampling to fulfill a self-complimented questionnaire on the opinion of the primary health care physicians on the assistance demand in mental health, their training necessities and their attitudes about this mental health illnesses. About attitudes, 43.7% (95% CI; 37.7-49.8) said that the primary health care physicians cannot be taken charge of the existent demand. This opinion as significantly more frequents in physicians with more patient assigned, more assistance pressure, without postgraduate assistance formation, with less perceived demand, without training in mental health and worse knowledge of the specialized resources (Latorre and et al, 2005).

Another training program underwent an extensive evaluation to determine its impact on the mental health knowledge, confidence in performing medical and psychiatric procedures,

skills and attitudes of its trainees. One hundred and four Cambodian primary care practitioners were trained in a primary care setting over a 2-year period. There was a significant improvement in primary health care providers' confidence in all clusters of medical and psychiatric procedures counseling, medical evaluation, prescribing medications, psychiatric diagnosis, assessing risk for violence, traditional treatments, and treating trauma victims (Henderson and et al, 2005).

A four – day training program was administered for 49 community nurse regarding therapeutic attitudes measured by the co-morbidity problems perceptions questionnaire and knowledge of alcohol, drugs and co-morbidity measured by a structured questionnaire. The results concluded that the training programme was effective in improving the therapeutic attitudes of participants to working with clients who have co-existing mental health and substance use problems, both immediately after the training was delivered, and at six-month follow-up. It was also effective in improving participants' overall knowledge of alcohol, drugs and co- morbidity (Munro and et al, 2007).

Here the researcher ends this section by presenting a study done this year in Tanzania to ascertain the current status of the knowledge, attitude and practice pertaining to depression among primary health care workers. All the primary health care workers (N = 14) in four primary health care centers were assessed the health worker's knowledge and attitude towards the causes, consequences and treatment of depression. The majority of respondents felt that becoming depressed is a way that people with poor stamina deal with life difficulties. The findings suggest a need to strengthen the training of primary health care workers in Tanzania about the detection of depression, pharmacological and psychological treatments, and psychosocial interventions (Mbatia and et al, 2009).

2.7.6 Barriers faced by primary health care providers when practicing mental health

Recognition that mental and general healths are intertwined suggests the need to find ways to link these sectors of care. Several difficulties in providing accessible and adequate mental health services make it particularly important to discover ways to integrate general health with mental health services. These difficulties include shortages of knowledge and trained health care professionals, system constrains and gap in referral for specialized

services, community stigma attached to mental health illnesses and services, and long consultation time in a work load primary health care setting (Van Hook and Ford, 1998).

2.7.6.1 Shortages of knowledge and trained health care professionals

In a study aimed to investigate communication between general practitioner and psychiatric teams about a representative group of patients with serious mental illnesses 100 patients and their general practitioners were interviewed. Its' result showed general practitioner' knowledge about the care their patients received was limited. Most general practitioner perceived their role as providing physical care and prescribing. Few patients consulted by general practitioners for mental health care. General practitioner perceived themselves as less involved in the care of Black Caribbean or Black African patients. Considerable discontinuities of care between secondary and primary care were identified. General practitioner involvement in the care of patients with serious mental illnesses appears limited. Better communication is necessary if care is to be shared (Bindman and et al, 1998).

Beside to , another study done in Australia aimed to investigate the effects of prior general practice training in mental health and practice location on general practitioner attitudes toward depression, self-confidence in assessing and treating depressed patients, identification of doctor, patient and practice barriers to the effective care of depressed patients in general medical practice and general practitioner -reported current clinical practice. Four hundred and twenty out of 608 general practitioners were returning the questionnaire which focused on current clinical practice, perceived barriers to care of depressed patients and doctors' self-efficacy for assessing and treating depressed patients. The result did show that those with prior mental health training ($p=0.00$) were more confident in the use of non-pharmacological treatments. Female GPs without mental health training were the least confident in the use of these methods ($p=0.01$). Overall, general practitioners with mental health training were more positive in their attitudes toward depression and their treatment of these patients ($p=0.00$). Female general practitioners appeared more positive in their attitudes toward depression than male general practitioners ($p=0.01$), although the results were not entirely consistent. The study concluded the participation in mental health training by general practitioner appears to be related to their attitudes toward depressed patients and to their confidence and abilities to

diagnose and manage the common mental health illnesses effectively (Richards and et al, 2004).

In UK a questionnaire-based study sought to compare the expectations of two distinct groups of nurses, one from a mental heath and the other from a non- mental heath background prior to becoming prescribers. Non- mental heath nurses were of the opinion that being able to prescribe would increase efficiency and maximize resources, while mental heath nurses saw prescribing primarily in terms of the benefits to clients--increased choice, improved access to care, better information about treatments and better quality of care (Nolan and Bradley, 2007).

Nevertheless, pharmacists have lack of training in mental health issues was the most important barrier reported. Cooperation with general practitioners in depression care was desired, but the current level of cooperation was rather low. For pharmacists to effectively take up depression care, perceived barriers need to be addressed through specific training programs and increased cooperation with general practitioners. This is the situation in the study which done in Belgium to survey 200 community pharmacists about the care of patients with depression in comparison with patients with other, physical conditions.. However, depression care is a relatively new role for pharmacists, and little is known of their attitudes, current practices, and barriers toward it (Scheerder and et al, 2008).

2.7.6.2 Barriers within the primary health care system

Sometimes the primary health care system doesn't offer sufficient protocols regarding mental health and mental health illnesses in order to ease and smoothen the process of practicing mental health by primary health care providers. For example, 247 general practitioners, 146 community nurses, 36 practice nurses, 79 community mental health nurses and others working in a range of hospital, residential and community settings attended 24 one-day workshops in 21 cities and towns in the UK. A nominal group approach was used relating to the early diagnosis of dementia in the community. All health professionals were situate dementia in a family context but do not yet use a disablement model of dementia which might reduce tensions about early diagnosis and the disclosure of the diagnosis. The term diagnosis could usefully be replaced by recognition, to aid this shift in model. Service gaps may emerge or widen if earlier diagnosis of dementia is pursued as a policy objective (Iliffeand et al, 2003).

Community Mental Health Services in Australia tried to explore the views of community care and mental health workers on barriers to the management of mental health illnesses and how these could be addressed. 100% of relevant mental health workers, 86% of community health professionals and representatives from a wide range of community organizations were interviewed (n = 38). The study revealed a number of barriers that are being addressed through a memorandum of understanding between services. Initiatives to foster collaboration between mental health services and general practitioners have not included other providers of primary health care. The study identified a number of barriers to collaboration between mental health and community-based services, including poor communication, difficulties with referral and cultural differences between services. Of all these themes, the most significant was the lack of communication at individual, case management and organizational levels (Sweeney and Kisely, 2003).

In other two studies , the researcher asked for system support while dealing with chronic pain optimal treatment (Dobscha and et al, 2008) and the other while dealing with depression care interventions. Beside to, another six barriers emerged from the second study, difficulty diagnosing depression, patient resistance, fragmented mental health system, insurance coverage, lack of expertise, and competing demands and other responsibilities as a primary care provider (Henke and et al, 2008).

2.7.6.3 Workload in primary health care settings

In this study the general practitioners claimed that the extra workload induced by patients with mental health illnesses may sometimes cause general practitioners to be reluctant to become involved in mental health care (Zantinge and et al, 2006). A cross sectional study conducted in the Netherlands in 2000–2002,a nationally representative selection of 195 general practitioners from 104 general practices participated in this National Survey. Data from: 1) a general practitioner questionnaire; 2) a detailed log of the general practitioners' time use during a week and; 3) an electronic medical registration system, including all patients' contacts during a year, were used. Multiple regression analyses were conducted with the general practitioners' workload as an outcome measure, and the general practitioners' attention for mental health illnesses as a predictor. general practitioner, patient, and practice characteristics were included in analyses as potential confounders. The study resulted to that the general practitioners' inattention for a patient's mental health

illnesses is not related to their workload. The general practitioners' extra workload when dealing in a consultation with patients' mental health illnesses is not automatically translated into a higher overall workload. This study does not confirm general practitioners' complaints that mental health care is one of the components of their job that consumes a lot of their time and energy (Zantinge and et al, 2006).

On the other hand, There is evidence that longer consultations in general practice are associated with improved quality of care; but this needs to be balanced against the fact that doctor time is a limited resource and longer consultations may lead to reduced access to health care. In a study done in Australia, questionnaires were distributed on midline, pubmed, and google line to determine whether management of psychological problems in general practice is associated with an increased consultation length and to explore whether longer consultations are associated with better health outcomes for patients with psychological problems. Consultations with a recorded diagnosis of a psychological problem were reported to be longer than those with no recorded psychological diagnosis. General practitioners reported that time pressure is a major barrier to treating psychological problems and increased consultation length is associated with more accurate diagnosis (Hutton, Gunn, 2007). This result goes side by side with a paper written regarding the workload of community mental health nurses. The data show that the workload of community mental health nurses is increased by the greater complexity of needs of community mental health clients. Service change has also resulted in poor integration between inpatient and community services and tension between generic case management and specialist roles resulting in nurses undertaking tasks for other case managers. These issues, along with difficulties in recruiting and retaining staff, have led to the intensification of community mental health work and a crisis response to care with less time for targeted interventions (Henderson and et al, 2008).

2.7.6.4 General public opinion to mental health and mental health providers

Research has yielded consistent evidence of high levels of psychiatric morbidity and psychosocial problems among primary care patients and recent studies have focused on improving physician recognition. These studies are based on the unexamined assumption that patients want their physicians to treat psychosocial disorders; thus, under recognition is examined by analyzing characteristics of physicians and medical settings. Patient characteristics, particularly attitudes about the appropriateness of seeking help for

psychosocial problems in primary care, have not been examined in relationship to under recognition. Therefore, the following studies examine general public and patients' opinions toward mental health as a concept, mental health services, and mental health providers (Good and et al, 1987).

The attitude of the care receivers certainly affects the care providers' attitude and work performance. The following study focused on the patient attitudes about appropriateness of requesting care for psychosocial difficulties, the extent to which patients discuss difficulties with their physicians, and the degree to which physician recognition is explained by these patient characteristics. The study sample of 883 adult patients was drawn from 23 primary care practices. Over 70 % of patients find it appropriate to turn to their primary care physicians for help with emotional distress, family problems, life stress, behavioral problems, and sexual dysfunction. However, only 1/5 to 1/3 of patients who have experienced difficulties have discussed these problems with their primary care providers. Attitudes about appropriateness are significantly related to physician recognition of psychiatric symptoms and family difficulties but account for limited variance in levels of recognition (Good and et al, 1987).

Another two studies have been designed to describe the acceptability of the CMHM (community mental health model) to assess the opinions of primary care professionals about CMHM and to sample the opinions of the patients' relatives regarding mental health care. In the first survey, 884 primary caregivers general practitioners, pediatricians, nurses and social workers. Most of the primary caregivers reported that the community psychiatric model improved accessibility, treatment and communication between the different levels. Nurses and pediatricians reported dissatisfaction with the CMHM. In the second survey,(n= 780) the satisfaction of patients' relatives with the services provided by the therapists was assessed, 31.13% of relatives were satisfied with therapists' competence but dissatisfied with their communication skills (.Mira and et al, 1997).

From the same prospective, in Michigan, 1,358 adults participated in a telephone survey to explore their knowledge of mental health benefits and preferences for providers. Large proportion of the respondents was uninformed about their mental health benefits. 1/4 of the sample was unsure if their health plan even included mental health services. Forty three percent they believed that mental health benefits were equal to benefits provided for general medical services. Therefore, the study concluded that general public lacks

information about important mental health benefits, and this lack of information may represent a barrier in their seeking care when needed. Given the overriding preference for primary health care providers to treat mental health illnesses, particularly among older adults, mental health issues should be given more attention at all levels of primary care education (Mickus and et al, 2000). Again the negative attitude of general population toward psychological help-seeking is presented in the study from the University of Memphis. 103 medical students, 22 faculty, 31 primary care providers, and 395 people from the general population responded to the mail-out survey. Attitudes toward help-seeking were more negative among the general population group than among students and providers. For these students, faculty, and providers, attitudes toward seeking help were more positive if they reported having received mental health services in the past (Smith and et al, 2002).

The media is the primary source of public information. Therefore, accurate and positive portrayal of mental illness on both electronic and printing media may be necessary to sensitize the public so as to improve the negative cultural environment surrounding persons with mental health illnesses (Abasiubong and et al, 2007). However, a study was done to assess the attitude of the Journalists to mental health illnesses and compare the journalists' attitudes with that of the nurses. Two hundred and fifty journalists in Uyo and 180 nurses were randomly assessed for attitudes to mental health, 210 (84.0%) journalists and 154 (85.6%) nurses were analyzed. Negative opinions were prevalent among the respondents in the region of over 70% among journalist and 60% in Nurses in most cases. There is a widespread negative attitude to mental health illnesses among journalists and this is a reflection of the general population. The media is the primary source of public information. Therefore, accurate and positive portrayal of mental health illnesses on both electronic and printing media may be necessary to sensitize the public so as to improve the negative cultural environment surrounding persons with mental illness (Abasiubong and et al, 2007).

Finally, the degree to which the mental health services are utilized depends partly on the public's views about mental illness and the public's perceptions about the roles of the providers of the services. This idea is proved in a study done in Kenya; the aim of the study was to explore the conceptual model underlying the views of the Kenyan public about mental health illnesses and relate it to the national mental health policy of 1994. The public did not expect bio-psychosocial care from the health services, but rather only the

biological/pharmacological component, relying on other care providers for psychosocial management (Muga and Jenkins, 2008).

2.7.7 Integrating mental health into primary health care system

The health care system is moving in the direction of primary care and organizational practice. New forms of mental health delivery are needed to maximize the potential of these new health care programs for mental health services. The new integrated programs which bring mental health providers into the primary health care programs for direct services as well as consultation. Issues discussed include mutual roles, changes in services, the referral process, and provider relationships. The advantages of such integrated programs include decreased stigma, increased prevention through earlier detection and referral, increased family orientation, greater coordination of care, and less duplication (Morrill, 1978).

A collaborative treatment by both primary care physicians (PCPs) and mental health providers (MHPs) have better outcomes than patients who receive usual care. A study describes the perceptions of primary care physicians of the frequency of concurrent treatment in community settings, the degree of collaboration between co-treating providers, and factors associated with greater interaction and collaboration. A survey was distributed to a stratified random sample of 276 eligible family physicians in Michigan. Primary analyses were descriptive statistics of primary care physician practice patterns. Secondary analyses explored predictors of collaboration with multivariable regression. A total of 162 eligible primary care physicians (59%) returned the survey. Primary care physicians reported that they co-treated approximately 30% of their depressed patients with mental health providers. The study concluded concurrent treatment of patients is common in the community, but these treatments are less interactive and collaborative than the treatment models proven effective in randomized controlled trails. If concurrent treatments are to become more collaborative-with regular contact and effective communication-co-location of practices appears: Family physicians, counselors, and psychiatrists expressed great satisfaction with a shared mental health care program based in primary care.mportant (Valenstein and et al, 1999).

Family physicians, counselors, and psychiatrists expressed great satisfaction with a shared mental health care program based in primary care. A High levels of satisfaction with the model were recorded in a study was done in Ontario to determine whether health care providers are satisfied with an integrated program of mental health care. 138 family physicians, psychiatrists, and mental health counselors providing mental health care in primary health care settings. Family physicians increased their skills, felt more comfortable with handling mental health illnesses, and were satisfied with the benefit to their patients. Psychiatrists and counselors were gratified that they were accepted by other members of the primary care team. Areas for improvement included finding space in primary care settings and better scheduling to allow for optimal communication (Farrar and et al, 2001).

To explore the impact of placing Community Mental Health Nurses (CMHNs) at two primary care practices in South Staffordshire. Data were collected by means of a questionnaire which was sent to primary care personnel at these practices, to ascertain their opinions with respect to the contribution of practice-based CMHNs. Overall, primary care personnel were satisfied with the quality of the service received from the CMHNs, especially in terms of improved communication. They felt that the new arrangements enabled a quicker and more efficient access to the services of the CMHN. The results are discussed in terms of the value of having CMHNs within the primary health care setting, and in terms of service planning and future recommendations for mental health services within primary care (Crawford and et al, 2001).

In another study aimed to compare family physicians' reports of their experiences managing patients with psychiatric disorders in setting with and without access to collaborative mental health services. One hundred and one family physicians from Canada were asked about their knowledge, skills, and degree of comfort in managing the psychiatric disorders derived from the primary health care version of the 10th edition of the International Classification of Diseases (37 with access to collaborative care and 64 without access). They concluded that family physicians with access to collaborative care reported greater knowledge, better skills, and more comfort in managing psychiatric disorders and greater satisfaction with mental health services. Further work is needed to establish why this is so and to determine any effect on patient outcomes, such as symptoms, quality of life, and psychosocial functioning (Kisely and et al, 2006) .

Lots of studies were done to investigate the importance of collaborated mental health programs into primary health care in order to enhance primary health care providers' practices to mental health and mental health illnesses. One of these studies was done to assess primary health care providers' attitudes and self-reported behavior with regard to identifying and managing depression in adult patients before and after a chronic disease/collaborative care intervention. A self-administered cross-sectional survey was conducted in 6 targeted practices among 39 family practice physicians, family nurse practitioners, and residents before and after implementation of a depression in primary care project. The result completely agreed to what has mentioned, after a chronic disease/collaborative care approach to depression treatment in primary care was implemented, primary health care attitudes and behaviors about depression treatment were significantly modified. More guideline-concordant care, and increased collaboration with mental health services, was reported. Implications for future primary care depression intervention activities and research are discussed (Upshur and Weinreb, 2007).

Finally, shared mental health care between Psychiatry and PHC has been developed to improve the care of common mental health illnesses but has not hitherto been adequately evaluated. This study evaluated a consultation-liaison intervention, explore long-term general practitioners' opinions relating to impact on their management and on patient medical outcome, and to determine the referral rate, after a sufficient time lapse following the intervention to reflect a "real-world" primary care setting. One hundred and thirty nine collaborating general practitioners (response rate: 84.9%) were invited two years after the intervention to complete a retrospective telephone survey for each patient. The study concluded that the intervention supported general practitioners were better in their management of patients with common mental health problems (Younès and et al, 2008).

2.8 Regional and Arabic studies

I will start this section by presenting a brief overview of the existing mental health condition in the Eastern Mediterranean Region (EMR) of the World Health Organization (WHO) and WHO/EMRO's collaborative activities with the Member States of the Region. The EMR is composed of 23 countries extending from Morocco in the west to Pakistan in the east. About 450,000,000 people live in the Region. The countries of the Region have diverse historical and cultural backgrounds and climatic, environmental, and economic

conditions (Mohit1, 2001). Arabic is spoken by about 50% of the people living in 80% of the countries of the Region. During the past 2 decades, WHO has been active in many areas of mental health with the aim of integrating services within the general and primary health care systems. Such activities have included, among others, collaboration with the countries in areas of planning, training, research and development of integrated services (Mohit1, 2001).

Egypt is the site of one of WHO's demonstration projects of the Nations for Mental Health Programme, which aims to integrate mental health within primary health care through training of general practitioners and nurses (WHO, 2001).

In Saudi Arabia several training courses for general practitioners have been held and a practical training manual has been published. The academic community and the Ministry of Health now endorse the policy of continuous training of general practitioners. There have been other training activities in relation to industry and in oil-producing areas (WHO, 2001).

Studies in the Arabic region are in a limited extend and scattered between here and there. In a study done in El- Manama (Bahrain), medical students' attitude toward psychiatry has been examined. It concluded that attitude to psychiatry was moderately positive with 15.7% of the sample size students selected psychiatry as one of the top three career choices (Al-Ansari and Alsadadi, 2002).

Another study done by Afana, Dalgard, Bjertness, and Grunfeld (2002) in the Gaza Strip. It investigated the detection rate by general practitioners of mental health illnesses in the primary health care setting. The study showed that general practitioners (n= 32) detected only11.6% of the patients with mental health illnesses. The study recommended the importance of mental health training for the general practitioners in the primary health care clinics (Afana and et al, 2002) .

In Palestine mental health illnesses constitute one of the largest – and least acknowledged – health problems in the occupied Palestinian territory (OPT). Around a third of Palestinians are in need of mental health interventions, yet mental health services are among the most under-resourced areas of health provision. Palestine included, mental health illnesses are often a source of fear. In some cases, this leads to rejection of the mentally ill. Because

illness carries a stigma, patients tend to present emotional or psychological distress in the form of physical symptoms such as headaches, colic and back pain. This suggests that the extent of mental illness is being significantly under-reported. Health workers have only recently begun to acknowledge the political and environmental factors involved in mental ill-health (Afana and et al,E.2004).

In the same manner Qureshi, Van der Molen, Schmidt, Al-Habeeb and Magzoub, (2004) had executed study at Buraidah Mental Health Hospital to assess the pre-and post-psychiatric training knowledge and attitudes of general practitioners, and to explore certain factors, which predict gain in knowledge and change in attitude. The study resulted to that Psychiatric training courses significantly enhance general practitioners' knowledge together with significant changes in certain attitudes that have vast psychiatric implications including destigmatization, early diagnosis and better treatment of primary care patients with mental disorders (Qureshi and et al, 2004).

By looking at some Arabic studies on the attitude, diagnosing, and treating the most common mental health illnesses detected in the primary health care setting. We will find that depression is one of the most common causes of morbidity in developing countries (Nasir and Al-Qutob, 2005). In Jordan, continuing medical education for providers about depression, provision of counseling services and antidepressant medications at the primary care level, and efforts to destigmatize depression may result in increased rates of recognition and treatment of depression in this population (Nasir and Al-Qutob, 2005).

In Abu Dhabi McCall and Saeed, (2006) explored the current general practitioner knowledge and attitude towards anxiety and depression in primary care in a quantitative cross-sectional descriptive study. 90 general practitioners working in primary care were questionnaired. The result of the study showed that general practitioners in Abu Dhabi lack adequate knowledge about anxiety and depression (McCall and Saeed, 2006) .

All the previously mentioned studies come to the conclusion that most of the primary health care providers in both global and regional research have almost the same poor attitude to mental health and mental health illnesses and insufficient knowledge in dealing with mental ill patients.

Chapter (3)

Methodology

Chapter Three

3. Methodology

This chapter addresses issues related to methodology used to answer the study questions. It includes the study design, population, period and place of the study, sample size, sampling method, and method of conducting the study. Beside to, the construction of the self designed questionnaire which composed of four parts, piloting, and its validity and reliability. Then, it presents data entry, the ethical consideration, inclusion and exclusion criteria, and finally limitation of the study.

3.1 Study design

This is a descriptive analytical study, which tries to answer the study questions about assessing the KAP among the primary care center workers at UNRWA in the Gaza strip. It has been selected because this method would be useful for descriptive analysis of study variables. This type of study measures the levels and the correlation of the variables of the phenomenon, which applied on a sample of the population in particular time and period. Also, this type of study is easily applicable, economical and cost effective.

3.2 Population and sample

3.2.1 Study population

The study population consisted of Palestinian primary health care providers who are working at UNRWA primary health care clinics among the whole Gaza Strip regions. (North, Gaza, Middle, Khan- Younis, and Rafah zone). The study population is composed of three main categories medical health care providers, nursing health care providers, and paramedical health care providers.

3.2.2 Study sample

3.2.2.1 Main sample

The whole study population included in the study in order to obtain the highest level of representativeness. In addition , taking in consideration exclusion criteria.

Four hundred and ten of the study population were responded to answer the questionnaire in addition to 29 participants in the pilot study, therefore the response rate was 74%.

A convenient sample of medical, nursing, and paramedical workers at the UNRWA's primary health care centers; in Gaza Strip as shown in table (3.1).

Table 3.1: Categories of primary health care providers and their numbers in UNRWA primary health care providers clinics.

Health providers' categories	No.
Medical health providers (specialists, general practitioners, dentists)	178
Nursing staff health providers (staff nurses, practical nurses, midwives)	294
Para-medical health providers (pharmacy assistant, laboratory technicians, physiotherapists, x-ray technicians	122
total	594

In addition to, the respondent of primary health care providers according to clinics in table (3.2).

Table 3.2: Distribution of the sample according to the clinics

Name of clinic	No.	%
Al-Rimal clinic	61	14.9
Jabalia clinic	48	11.7
Rafah central clinic	47	11.5
Al-Nuseirat clinic	40	9.8
KhanYounis central clinic	29	7.1
Maa'n clinic	25	6.1
Dier El Balah clinic	25	6.1
Rafah - Tal Al sulta clinic	22	5.4

Al zytoun- Sabra clinic	22	5.4
Gaza Town clinic	19	4.6
Biet Hanon clinic	14	3.4
Maghazy clinic	14	3.4
Beach clinic	12	2.9
KhanYounis - Japanese	10	2.4
Al-Naser clinic	9	2.2
Al-Buraij clinic	8	2.0
Rafah – Alshouka clinic	5	1.2
Total	410	100

3.2.2.2 Pilot sample

The researcher applied the questionnaires of this study on a 29 pilot sample from Al-Burij and Al-Nusierat two primary health care centers of the original population of the study sample; 13 males and 16 females, (mean of age= 43.96 years, SD= 9.81). They were excluded from the studied sample, where this technique used to estimate and discuss the clarifying of the instruments and to estimate validity and reliability of the questionnaires prepared by the researcher that used in this study.

3.3 Place of the research

The study conducted on the twentieth UNRWA primary health care clinics. So that, it represented all areas of the Gaza Strip regions. (North, Gaza, Middle, Khan- younis, and Rafah zone). The questionnaire was filled by the primary health care provider each in his/her clinic.

3.4 Period of the study

The study was performed from September 2008 to November 2009 about fourteen months. This period included proposal preparation till designing the instrumental tool, collecting data was on August 2009, coming out with results and recommendations on November 2009.

3.5 Instruments of the study

The researcher prepared socio-demographic questionnaire, level of knowledge about mental health questionnaire, level of attitudes toward mental health questionnaire, and level of practices of mental health questionnaire, that described in detail in the following sections. First form of the questionnaire was seen and modified by panel of expertise in mental health. The expertise added some variables in the socio-demographic questionnaire as years of qualification and monthly income. Also they omitted some parts of the knowledge questionnaire which were similar to those in the attitude questionnaire. In addition to their modifications on practice questionnaire statements in order to make them in a sound of actions and behaviors. Then the second form of questionnaire was modified after entry of the pilot sample; items which were misunderstood were corrected, and others which have no reliability were omitted. Finally, the third and last form was used after confirmation of the study supervisor.

3.5.1 Socio-Demographic Questionnaire

Socio-demographic questionnaire developed by the researcher includes; age, sex, place of residency, qualification, years of experience in primary heath care settings, monthly income, and if he or she had any course of mental health . All these independent variables will be managed with other dependant variables in order to come out with a descriptive meaning and answers for the questions of this study (annex 5).

3.5.2 Knowledge about Mental Health Questionnaire

This scale developed by the researcher by referring to similar questionnaires from the literature (Isawi, 2003) and (Shoqier, 2005). This questionnaire contains 23 item were distributed into four subscales. Items of the scale that checked by four choices:

Strongly agree = 4 scores

Agree = 3 scores

Opposite = 2 scores

Strongly opposite = 1 score

While the items (8 – 10 - 21) with reversal coded scores.

The scoring of the scale ranged between (23 – 92 score), the high scores means good knowledge about mental health, while the low scores means poor knowledge about mental health.

3.5.2.1 Validity and reliability of the knowledge questionnaire

To compute the internal consistency of the knowledge questionnaire; the researcher calculates the correlation coefficients of every item of the scale with the total scores of its subscale, as shown in table (3.3). As shown in the following table, all of the items were significant correlated in internal consistency validity with its subscale, were the correlation coefficients for the items ranged R=(0.387- 0.792).

Table (3.3) Internal consistency of knowledge questionnaire items with its subscale.

Subscales	Item No	Corr. Value	Sig. Level	Item No	Corr. Value	Sig. Level
Concepts of Mental health	1	0.461	0.012	4	0.696	0.001
	2	0.621	0.001	5	0.725	0.001
	3	0.668	0.001	6	0.579	0.001
Mental health illnesses	7	0.510	0.005	9	0.622	0.001
	8	0.579	0.001	10	0.765	0.001
Causes of Mental health illnesses	11	0.476	0.009	16	0.640	0.001
	12	0.672	0.001	17	0.670	0.001
	13	0.765	0.001	18	0.646	0.001
	14	0.792	0.001	19	0.699	0.001
	15	0.510	0.005			
Treatment of Mental health illnesses	20	0.481	0.008	22	0.680	0.001
	21	0.606	0.001	23	0.387	0.038

In addition, the researcher calculates the correlation coefficients of every subscale with the total scores of the scale, as shown in table (3.4).

Table (3.4) Internal consistency of the subscale of knowledge questionnaire with total scores of the scale

Subscales	Correlation value	Sig. Level
Concepts of Mental health	0.759	0.001
Mental health illnesses	0.603	0.001
Causes of Mental health illnesses	0.686	0.001
Treatment of Mental health illnesses	0.515	0.004

As shown in previous table, all of subscales were significant correlated in internal consistency validity with the total scores of the scale, were the correlation coefficients for the subscales ranged R=(0.515- 0.759).

3.5.2.2 Cronbach's alpha reliability

The researcher estimated the reliability of the knowledge questionnaire by using the equation of Cronbach's alpha (No. of items = 23); where the value of alpha = (0.724). Then the knowledge about mental health questionnaire measurement device is valid and reliable for data collection from the study sample in Gaza Strip.

3.5.3 Attitudes Toward Mental Health Questionnaire

This scale developed by the researcher with the help of an Indian experience of training primary health care providers in mental health care (Nimhans, 1990) and contains 34 items, distributed into three subscales. Items of the scale that checked by four choices:

Strongly agree = 4 scores

Agree = 3 scores

Opposite = 2 scores

Strongly opposite = 1 score

While the items (11 – 13 – 14 – 16 – 17 – 18 – 21 – 22 – 23 – 24 – 25 – 26 – 27 – 28 – 29 – 30 - 33) with reversal coded scores.

The scoring of this scale ranged between (34 – 136 score), the high scores mean positive attitude toward mental health, while the low scores mean negative attitude toward mental health.

3.5.3.1 Validity and reliability of the attitudes questionnaire:

To compute the internal consistency of the attitudes questionnaire; the researcher estimate the correlation coefficients of every item of the scale with the total scores of its subscale, as shown in table (3.5).

Table (3. 5) Internal consistency of attitudes questionnaire items with its subscale

Subscales	Item No	Corr. Value	Sig. Level	Item No	Corr. Value	Sig. Level
Attitudes about the concepts of mental health	1	0.522	0.004	6	0.756	0.001
	2	0.830	0.001	7	0.424	0.022
	3	0.462	0.012	8	0.501	0.006
	4	0.486	0.008	9	0.611	0.001
	5	0.407	0.029	10	0.668	0.001
Attitudes about mental health illnesses and its causes	11	0.453	0.014	18	0.452	0.014
	12	0.492	0.007	19	0.670	0.001
	13	0.710	0.001	20	0.102	0.597
	14	0.676	0.001	21	0.866	0.001
	15	0.081	0.675	22	0.724	0.001
	16	0.642	0.001	23	0.626	0.001
	17	0.698	0.001			
Feelings about coping with people with mental health illnesses	24	0.571	0.001	30	0.486	0.008
	25	0.577	0.001	31	0.473	0.009
	26	0.779	0.001	32	0.406	0.030
	27	0.671	0.001	33	0.660	0.001
	28	0.847	0.001	34	0.594	0.001
	29	0.664	0.001			

As shown in previous table, most of the items (32 item) were significant correlated in internal consistency validity with its subscale, were the correlation coefficients for the items ranged R=(0.406- 0.866). While there were two items (15 and 20) not significant with its subscale, then the researcher rejected this items, and the total number of items will remains (32 item instead 34 item).

Then the total score of the scale will range between (32 – 128 score). In addition the researcher calculates the correlation coefficients of every subscale of with the total scores of the scale, as shown in table (3.6).

Table (3. 6) Internal consistency of the subscale of attitudes questionnaire with total scores of the scale

Subscales	Correlation value	Sig. Level
Attitudes about the concepts of mental health	0.463	0.011
Attitudes about mental health illnesses and its causes	0.760	0.001
Feelings about coping with people with mental health illnesses	0.827	0.004

As shown in previous table, all of subscales were significant correlated in internal consistency validity with the total scores of the scale, were the correlation coefficients for the subscales ranged R=(0.463- 0.827).

3.5.3.2 Cronbach's alpha reliability

In addition; the researcher estimated the reliability of the attitudes questionnaire by using the equation of Cronbach's alpha (No. of items = 32); where the value of alpha = (0.858). Then the attitudes toward mental health questionnaire measurement device are valid and reliable for data collection from the study sample in Gaza Strip.

3.5.4 Practices at Mental Health Questionnaire

This scale developed by the researcher and obtained from her twenty years experience in PHC clinics and by the help of the Indians' training questionnaire (Nimhan, 1990) . this

questionnaire contains 21 items measuring the practices of mental health skills among primary health care providers. Items of the scale that checked by four choices:

Strongly agree = 4 scores

Agree = 3 scores

Opposite = 2 scores

Strongly opposite = 1 score

Not applicable = 0 score

The fifth choice is not related to the field of my work always coded 0.

While the items (3 – 4 – 11 – 15 – 16 – 17 – 18 – 19 – 20 – 21) with reversal coded scores.

The scoring of this scale ranged between (0 – 84 score), the high scores means good practices at the field mental health, while the low scores means poor practices at the field mental health. In addition; this questionnaire contain two exploring questions, the first question is about the number of weekly mental health patients comes to the primary care center, the second is about the type of mental health disease of them.

3.5.4.1 Validity and reliability of the practices questionnaire

To compute the internal consistency of the practices questionnaire; the researcher estimate the correlation coefficients of every item with the total scores of the scale, as shown in table (3.7).

Table (3.7) Internal consistency of practices questionnaire items with its subscale

Scale	Item No	Corr. Value	Sig. Level	Item No	Corr. Value	Sig. Level
Practices of mental health	1	0.448	0.015	12	0.442	0.016
	2	0.612	0.001	13	0.811	0.001
	3	0.659	0.001	14	0.606	0.001
	4	0.697	0.001	15	0.410	0.027

	5	0.494	0.006	16	0.009	0.964
	6	0.617	0.001	17	0.008	0.968
	7	0.544	0.002	18	0.807	0.001
	8	0.043	0.826	19	0.609	0.001
	9	0.540	0.002	20	0.826	0.001
	10	0.679	0.001	21	0.593	0.001
	11	0.028	0.887			

As shown in previous table, most of the items (17 item) were significant correlated in internal consistency validity with the total scores of the scale, were the correlation coefficients for the items ranged R=(0.410- 0.826). while there were four items (8 – 11 – 16 - 17) not significant with the total scores of the scale, then the researcher rejected this items, and the total number of items will remains (17 item instead 21 item).

Then the total score of the scale will ranged between (0 – 68 score).

3.5.4.2 Cronbach's alpha reliability

In addition; the researcher estimated the reliability of the practices questionnaire by using the equation of Cronbach's alpha (No. of items = 17); where the value of alpha = (0.895). Then the practices at the field of mental health questionnaire measurement device are valid and reliable for data collection from the study sample in Gaza Strip.

3.6 Data entry and analysis

After data collection from the sample the researcher used SPSS computer program Version-11 for data entry, cleaning and analysis that used in the pilot study which determined the validity and reliability of the instruments using correlation coefficient to estimate internal consistency validity, and Cronbach's alpha equation to estimate reliability.

While the researcher used other statistical analysis that clarifying the results such as frequencies, t- independent test, comparing means of two independent groups and one way ANOVA to investigate the differences between means of more than two groups on the dependent variables.

3.7 Ethical Considerations

Before starting with the data collection the researcher guaranteed how protecting the informants rights considered, insure confidentiality, mention the right to withdraw, and to consider the consequences of the information, and to make sure not to harm the informants. Therefore an official letter will obtain from Helsinki committee in the Ministry of Health to allow the researcher to carry out his study (Annex 3). In addition to, another agreement was obtained from the administration offices of the health program at UNRWA headquarter in Gaza Strip to facilitate data collection procedures (Annex 4).

3.8 Inclusion and exclusion criteria

The researcher sees that there are no inclusion or exclusion criteria because the study took all of the study population as a whole as its' sample population without any inclosing or excusing of the study population members.

3.9 Limitation of the study

There are a number of limitations are predicted to apply the study

1) Some of the health professionals were in leave, sick leave, or maternity leave. Others are considered in the health posts but not actually in the duty due to retirement procedures.

2) People are hardly able to explain their attitudes.
3) Cultural factors may have affected the validity of the instruments.
4) Recent political and economical instability impose a major stress on the participant which may affect their logical opinion toward mental health.

Chapter (4)

Results

Chapter Four

4. Results

In this chapter the researcher will view the results in four models; the first is the socio-demographic characteristics of the study sample. The second is about the levels of knowledge, attitudes, and practices of mental heath. The third were about the relation between knowledge, attitudes, and practices of mental heath. Where the fourth model is about the differences in knowledge, attitudes, and practices of mental heath according to socio-demographic data of study sample; using descriptive statistics; frequencies, percentages, means and standard deviation and ratio scale and person correlation coefficient. In addition to differentiate between knowledge, attitudes, and practices of mental heath according to the socio-demographic variables the researcher will using t-independent test, and one-way ANOVA test (F-test), as the following:

4.1 Socio-demographic results of the study sample

The total number of sample selected for the current study was a 410 of medical, nursing, and paramedical workers at the UNRWA's primary care center; in Gaza Strip. The highest number of them was 61 person from Al-Rimal clinic (14.9%), followed by 48 person from Jabalia camp clinic (11.7%), 47 person from Rafah central clinic (11.5%).

The demographic characteristics are presents in table (4.1). It describes the study sample according to sex; 177 were males of the study sample (43.2%), 233 females (56.8%). Age of the study sample 51 with range of age 30 years and less (12.4%), 142 aged 31 – 40 years (34.6%), 140 were aged 41 – 50 years (34.1%), and 77 were aged 51 years and above (18.8%). The minimum age was 20 years and the maximum age was 60 years, (Mean = 41.84 years, SD= 9.19). Also the table shows residence of the study sample 154 were living in camp (37.6%), 32 were living in village (7.8%) and 224 were living in city (54.6%). In addition to marital status; 367 of the study sample were married (89.5%), 25 were single (6.1%), 10 were widowed (2.4%), and 8 of the sample were divorced (2.0%). Beside to, 271 of the study sample with nuclear family (66.1%), 139 with extended family (33.9%). 77 of the study sample were have family size 4 persons and less than (18.8%), 174 were 5–7 persons (42.4%) and 159 of sample were have 8 and above of family size (38.8%).

In case of education 191 of the study sample were educated to diploma level (46.6%), 172 of sample were educated to the university level (42.0%), 46 of sample were educated to the master degree (11.2%), and only one of them were educated to the doctoral degree (0.2%), in other words 47 of the sample educated to the postgraduate studies (11.4%) as shown in the same table.

Table 4.1: Demographic characteristics of the study sample (N=410)

Variable	No.	%
Sex		
Male	177	43.2
Female	233	56.8
Total	410	100.0
Age		
30 years and less	51	12.4
31 – 40 years	142	34.6
41 – 50 years	140	34.1
51 years and above	77	18.8
Total	410	100.0
Residence		
Camp	145	37.6
Village	32	7.8
City	224	54.6
Total	410	100.0
Marital status		
Married	367	89.5
Married	367	89.5
Single	25	6.1
Widowed	10	2.4
Divorced	8	2.0
Total	410	100.0
Type of family		
Nuclear	271	66.1
Extended	139	33.9
Total	410	100.0
Size of family		
4 and less than	77	18.8
5 - 7 persons	174	42.4
8 and above	159	38.8
Total	410	100.0
Level of education		
Diploma	191	46.6
University	172	42.0
M.A	46	11.2
PH.D	1	0.2

This lead us to the types of jobs of the study sample. In table (4.2) showed the job characteristics; there were 110 of the sample work as a medical stuff (26.8%), 193 of the sample work as a nursing stuff (47.1%), and 107 of the sample work as a paramedical stuff (26.1%). Unfortunately, 44 of the study sample work in field of mental health (10.7%), 366 works only in the field of physical health (89.3%). Finally, the table shows that; 170 of the study sample work 10 years and less than in primary care centers (41.5%), 157 work for 11 - 20 years (38.3%), and 83 of them work more than 20 years in primary care centers (20.2%). According to the salary (monthly) there were 255 of study sample had monthly income 1000 $ and less than (62.2%), 142 with monthly income from 1001-2000 $ (34.6%), 13 of sample were had more than 2000 $ monthly income (3.2%).

Table 4.2 Job characteristics of the study sample

Variable	**No.**	**%**
Type of Job		
Medical	110	26.8
Nursing	193	47.1
Paramedical	107	26.1
Total	410	100.0
Years of working in primary health care		
10 years and less than	170	41.5
11 - 20 years	157	38.3
more than 20 years	83	20.2
Total	410	100.0
Working in the field of mental health		
Yes	44	10.7
No	366	89.3
Total	410	100.0
Monthly income		
1000 and less than $	255	62.2
1001 – 2000 $	142	34.6
More than 2000 $	13	3.2
Total	410	100.0

4.2 levels of knowledge, attitudes, and practices of mental health among the study sample

4.2.1 Level of knowledge about mental health illnesses among the study sample

The following table (4.3) shows that the total scores of the knowledge about mental health among the study sample at the level of 78.3% (mean72.07), where the ratio scales plays the role in this step. Where the highest weight of knowledge subscales is knowledge about causes of mental heath illnesses 80.2% (mean 28.87), followed by knowledge about treatment of mental heath illnesses 77.9% (mean 12.47), and knowledge about mental heath illnesses 77.7% (mean 18.29). While the lowest knowledge subscale is the Knowledge about concepts of mental health 76.2% (mean 18.29).

Table 4.3: Level of knowledge about mental heath in the study sample (N= 410)

No	Variable	No of items	Mean	St. Dev.	Ratio scale %	Ranks
1	Knowledge about concepts of mental health	6	18.29	2.230	76.2	4
2	Knowledge about mental heath illnesses	4	12.43	1.686	77.7	3
3	Knowledge about causes of mental heath illnesses	9	28.87	3.588	80.2	1
4	Knowledge about treatment of mental heath illnesses	4	12.47	1.758	77.9	2
Total scores of knowledge about mental health		23	72.07	5.709	78.3	

4.2.2 Level of attitudes toward mental health among the study sample

The following table (4.4) shows that the total scores of the attitudes toward mental health among the study sample at the level of 75.0% (mean 96.02), where the ratio scales plays the role in this step. The highest weight of attitude subscales is attitudes about the concepts of mental health 80.8% (mean 32.30) , followed by attitudes about mental heath illnesses

and its causes 76.9% (mean 33.82), where the lowest attitude subscale is the feelings about coping with mental health patients 68.0% (mean 29.90).

Table 4.4: Level of attitudes toward mental health in the study sample

No	Variable	No of items	Mean	St. Dev.	Ratio scale %	*Ranks*
1	Attitudes about the concepts of mental health	10	32.30	3.366	80.8	1
2	Attitudes about mental heath illnesses and its causes	11	33.82	3.397	76.9	2
3	Feelings about coping with patients with mental heath illnesses	11	29.90	4.687	68.0	3
Total scores of attitudes toward mental health		32	96.02	7.676	75.0	

4.2.3 Level of practices of mental health among the study sample

The following table (4.5) shows that; 143 answer that say 'yes' always there were patients with mental health complains coming to the clinic 34.9%, 244 sometimes 59.5% of the study sample, that means most of the study sample 387 (94.4%) revealed that yes there were patients with mental health illnesses coming to the clinic.

Table 4.5: Percentage of primary health care providers that say 'yes' there are patients with mental heath illnesses attending the clinics

Variable	No.	%
Yes always	143	34.9
Yes sometimes	244	59.5
Not present	5	1.2
Absolutely Not present	0	0.0
Not my work	18	4.4
Total	410	100.0

The following table (4.6) shows that; 265 says that 1- 5 pts with mental heath problems were coming weekly to the clinic 34.9%, 50 says that 6- 10 pts with mental heath problems were coming weekly 12.2%, and 67 says that more than 10 pts with mental heath

problems were coming weekly 16.3% of the study sample.

Table 4.6: Number of patients complaining of mental heath illnesses seen by primary health care provider/ week

Variable	No.	%
1- 5 persons	265	64.6
6- 10 persons	50	12.2
More than 10 persons	67	16.3
Total	382	100.0

In the following table (4.7) 'accumulated measurement' 196 of pts with mental heath illnesses were coming to the clinic suffering from depression 51.3%, 176 suffering from tension and anxiety 46.1% of them, 173 suffering from physical pains 45.3% of them, 89 suffering from spastics and epilepsy 23.3% of them, were every one of the study sample may answer more than one choice.

Table 4.7: Prevalence of mental heath illnesses among patients coming to the clinic

Variable	No.	%
Depression	196	51.3
Tension and anxiety	176	46.1
Physical pains	173	45.3
spastics and epilepsy	89	23.3
PTSD	34	8.9
Mentally retarded	29	7.6
Mentally diseases	22	5.8
Hysteria	14	3.7
Total	382	100.0

4.2.3.1 Types of practices of mental health among the study sample

In the following table (4.8), the level of practices of mental health, using ratio scales in this step. Where the highest practice was 91% of the advice given to seek psychologists, followed by 85.4% of understanding the pts' complain to provide better service, and 82.9% of integrating mental health services into primary health care settings. While the lowest item was the 55.4% of if there any protocol that guiding primary health care providers in dealing with patients with mental health complains .

Table 4.8 : Types of practices of mental health among the study sample

No	Practices	Mean	St. Dev.	Ratio scale %	*Ranks*
1	Are there any patients come to the clinic complaining of mental health illnesses ?	3.20	0.846	80.1	5
2	Do you have enough capability to deal with these cases?	2.84	0.790	71.0	13
3	Do your practices change if the patient has any mental health complain?	2.54	0.838	63.6	16
4	Do the public attitudes (cultural attitudes) affect your practices toward patients with mental health illnesses ?	2.92	0.737	73.0	11
5	I understand the patients' mental condition in order to provide a better service.	3.41	0.841	85.4	2
6	Do you notice that the physical complains related to the psychological complains for those clients?	3.06	0.743	76.6	7
7	Is there any protocol in your clinic guiding you in dealing with patients with mental health illnesses ?	2.21	1.068	55.4	17
8	I listen carefully to the patients' mental health complains.	2.88	1.004	71.9	12
9	I need more time to listen to the patients' MH complains.	3.03	1.220	75.7	8

10	I depend on counseling while dealing with patients with mental health illnesses.	2.96	1.149	74.0	9
11	Integrating mental health services into primary health care services will ease my practice as primary health care provider.	3.32	0.926	82.9	3
12	I advice patients with mental health illnesses to refer to psychologist.	3.64	1.136	91.0	1
13	I advice patients with mental health illnesses to refer to psychiatric hospital immediately.	2.58	0.884	64.5	15
14	I advice patients with mental health illnesses to refer to traditional healers.	3.25	1.056	81.2	4
15	I advice patients with mental health illnesses to depend on psychiatric medication only.	2.93	1.067	73.3	10
16	I advice patients with mental health illnesses to depend on herbal treatments only.	3.07	1.083	76.7	6
17	I don't give any advice.	2.73	1.142	68.2	14

The following table (4.9) shows that the total scores of the practices of mental health among the study sample at the level of 74.4% (mean 50.57).

Table 4.9: Level of practices of mental health in the study sample

Variable	No. of items	Mean	St. Dev.	Ratio scale %
Practices of mental health	17	50.57	7.842	74.4

4.3 The relation between knowledge, attitudes, and practices of Mental Health among the study sample:

As shown in the following table (4.10), there were positive significant correlation between knowledge and attitudes toward mental health among the study sample (Person's correlation "R"= 0.299, P= 0.001). Also, there were positive significant correlation between knowledge and practices in the field of mental health among the study sample (Person's correlation "R"= 0.138, P= 0.01).

In addition, there were positive significant correlation between attitudes toward mental health and practices among the study sample (Person's correlation "R"= 0.280, P= 0.001).

That means the high incidence of any variable of KAP of mental health among the study sample will combine with high incidence of the other two variables among the study sample.

Table 4.10: Correlation between knowledge, attitudes, and practices of mental health among the study sample

Variable	Knowledge	Attitudes
Attitudes	0.299	
Practices	0.138	0.280

p< 0. 01 p< 0.001

4.4 Knowledge, attitudes, and practices of mental health according to socio-demographic variables among the study sample

4.4.1 Knowledge, attitudes, and practices of mental health according to sex

T-independent test demonstrated to investigate the differences between male versus female in knowledge, attitudes, and practices of mental health among the study sample.

As shown in following table (4.11); the result found that there were no significant differences in knowledge about mental health and its subscales according to sex. In addition, there were no significant differences in attitudes toward mental health according to sex. There were no significant differences in practices in mental health according to sex.

While there were a significant differences in subscale of attitudes about the concepts of mental health according to sex T- value = 2.94 , in favor to female.

There were significant differences in subscales of attitudes about mental health illnesses and its causes, and feelings about coping with mental health patients according to sex T-value = 2.018 and 2.025, in favor to male.

Table 4.11: Independent t-test comparing means of knowledge, attitudes, and practices of mental health according to sex

Variable	Male N = 177		Female N = 233		T- value Df= 408	Sig. Level
	Mean	SD	Mean	SD		
Knowledge about concepts of mental health	18.1412	2.17092	18.4077	2.27265	1.199	0.231
Knowledge about mental health illnesses	12.5141	1.77453	12.3777	1.61721	0.811	0.418
Knowledge about causes of about mental health illnesses	28.9435	3.82384	28.8197	3.40539	0.346	0.730
Knowledge about treatment of about mental health illnesses	12.5367	2.11866	12.4249	1.42777	0.637	0.524
Total scores of knowledge about mental health illnesses	72.1356	5.90490	72.0300	5.56807	0.185	0.853
Attitudes about the concepts of mental health	31.7458	3.26618	32.7253	3.38634	2.946	0.003
Attitudes about mental health illnesses and their causes	34.2090	3.54457	33.5279	3.25899	2.018	0.044
Feelings about coping with patients with about mental health illnesses	30.4407	4.63290	29.4979	4.69696	2.025	0.043
Total scores of attitudes toward mental health	96.3955	7.79726	95.7511	7.58787	0.842	0.400
Practices of mental health	50.5537	7.66105	50.5880	7.99419	0.044	0.965

$p < 0.05$ $p < 0.01$ $p < 0.001$

4.4.2 1 Knowledge, attitudes, and practices of mental health according to age

In order to investigate the difference in knowledge, attitudes, and practices of mental health according to age of the study sample, the researcher demonstrates one-way ANOVA analysis.

The following table (4.12) that shows: there were no significant differences in most of dimensions of knowledge, attitudes, and practices and its total scores of mental health according to the age of the study sample.

However, there were significant differences in subscales of knowledge about causes of mental health illnesses F- value = 3.41 / P = 0.018, and attitudes about the concepts of mental health F- value = 3.86 / P= 0.01 according to age.

Table 4.12: One-way ANOVA comparing knowledge, attitudes, and practices of mental health according to age

Variable	Source of variance	Sum of Squares	DF	Mean Square	F-value	Sig. Level
Knowledge about Concepts of mental health	Between Groups	2.140	3	.713	0.142	0.934
	Within Groups	2032.738	406	5.007		
	Total	2034.878	409			
Knowledge about mental health illnesses	Between Groups	1.819	3	.606	0.212	0.888
	Within Groups	1161.032	406	2.860		
	Total	1162.851	409			
Knowledge about Causes of mental health illnesses	Between Groups	129.552	3	43.184	3.414	0.018
	Within Groups	5135.853	406	12.650		
	Total	5265.405	409			
Knowledge about Treatment of mental health illnesses	Between Groups	2.423	3	.808	0.260	0.854
	Within Groups	1261.782	406	3.108		
	Total	1264.205	409			

Total scores of knowledge about mental health illnesses	Between Groups	130.320	3	43.440	1.336	0.262
	Within Groups	13200.336	406	32.513		
	Total	13330.656	409			
Attitudes about the concepts of mental health	Between Groups	128.683	3	42.894	3.865	0.010
	Within Groups	4505.815	406	11.098		
	Total	4634.498	409			
Attitudes about diseases of mental health illnesses	Between Groups	38.671	3	12.890	1.117	0.342
	Within Groups	4683.331	406	11.535		
	Total	4722.002	409			
Feelings about coping with patients with mental health illnesses	Between Groups	25.683	3	8.561	0.388	0.762
	Within Groups	8959.608	406	22.068		
	Total	8985.290	409			
Total scores of attitudes toward mental health	Between Groups	289.515	3	96.505	1.646	0.178
	Within Groups	23810.134	406	58.646		
	Total	24099.649	409			
Practices of mental health	Between Groups	241.217	3	80.406	1.310	0.271
	Within Groups	24915.088	406	61.367		
	Total	25156.305	409			

$p< 0.05$ $p< 0.01$ $p< 0.001$

Post –hoc analysis using Scheffee statistical test was done and indicated the means of knowledge and attitudes subscales of mental health according to age of the study sample, as shown in the following table (4.13):

The group of 30 years age of study sample were significantly higher in knowledge about causes of mental health illnesses (mean 29.82 / SD 4.04) and attitudes about the concepts of mental health (mean 33.41 / SD 3.07) than who 51 years of age and above of the study sample.

Table 4.13: Means of knowledge and attitudes subscales of mental health according to age

Variable		No.	Mean	S.D
Knowledge about Causes of mental health illnesses	30 years and less	51	29.82	4.043
	31 - 40 years	142	29.21	3.571
	41 - 50 years	140	28.66	3.342
	51 years and above	77	27.98	3.567
Attitudes about the concepts of mental health	30 years and less	51	33.41	3.073
	31 - 40 years	142	32.56	3.438
	41 - 50 years	140	32.07	3.202
	51 years and above	77	31.50	3.519

4.4.3 Knowledge, attitudes, and practices of mental health according to place of residence of the study sample

In order to investigate the difference in knowledge, attitudes, and practices of mental health according to place of residence of the study sample (camp, village, or city) the researcher demonstrates one-way ANOVA analysis.

The following table (4.14) shows that: there were no significant differences in most of dimensions of knowledge, attitudes, and practices and its total scores of mental health according to the place of residence of the study sample. Where, there was a significant difference in subscale of knowledge about mental health illnesses (F- value = 3.29 / P = 0.038) according to place of residence .

Table 4.14: One-way ANOVA comparing knowledge, attitudes, and practices of mental health according to place of residence

Variable	Source of variance	Sum of Squares	Df	Mean Square	F-value	Sig. Level
Knowledge about Concepts of mental health	Between Groups	9.732	2	4.866	0.978	0.377
	Within Groups	2025.146	407	4.976		
	Total	2034.878	409			
Knowledge about mental health illnesses	Between Groups	18.536	2	9.268	3.296	0.038
	Within Groups	1144.315	407	2.812		
	Total	1162.851	409			
Knowledge about Causes of mental health illnesses	Between Groups	2.241	2	1.121	0.087	0.917
	Within Groups	5263.164	407	12.932		
	Total	5265.405	409			
Knowledge about Treatment of mental health illnesses	Between Groups	4.229	2	2.114	0.683	0.506
	Within Groups	1259.976	407	3.096		
	Total	1264.205	409			
Total scores of knowledge about mental health illnesses	Between Groups	68.461	2	34.231	1.050	0.351
	Within Groups	13262.195	407	32.585		
	Total	13330.656	409			

Attitudes about the concepts of mental health	Between Groups	3.244	2	1.622	0.143	0.867
	Within Groups	4631.253	407	11.379		
	Total	4634.498	409			
Attitudes about diseases of mental health illnesses	Between Groups	15.788	2	7.894	0.683	0.506
	Within Groups	4706.214	407	11.563		
	Total	4722.002	409			
Feelings about coping with patients with mental health illnesses	Between Groups	72.395	2	36.197	1.653	0.193
	Within Groups	8912.896	407	21.899		
	Total	8985.290	409			
Total scores of attitudes toward mental health	Between Groups	159.224	2	79.612	1.353	0.260
	Within Groups	23940.425	407	58.822		
	Total	24099.649	409			
Practices of mental health	Between Groups	19.230	2	9.615	0.156	0.856
	Within Groups	25137.075	407	61.762		
	Total	25156.305	409			

$p< 0.05$ $p< 0.01$ $p< 0.001$

Post –hoc analysis using Scheffee statistical test was done and indicated; the means of knowledge about mental health illnesses according to place of residence of the study sample, as shown in the following table (4.25) . The groups of persons who live in village of the study sample were significantly higher in knowledge about mental health illnesses (mean 13.15 / SD 1.68) than who live in city of the study sample.

Table 4.15: Means of attitudes about mental health illnesses and their causes according to place of residence

Variable		N0.	Mean	S.D
Knowledge about mental health illnesses	Camp	154	12.42	1.710
	Village	32	13.15	1.686
	City	224	12.34	1.651

4.4.4 Knowledge, attitudes, and practices of mental health according to marital status of the study sample:

In order to investigate the difference in knowledge, attitudes, and practices of mental health according to marital status of the study sample (married, single, widowed, or divorced) the researcher demonstrates one-way ANOVA analysis.

In the table (4.16) shows that; there were no significant differences in most of dimensions of knowledge, attitudes, and practices and its total scores of mental health according to the marital status of the study sample.

However, there were a significant difference in subscales of attitudes about mental health illnesses and their causes (F- value = 3.72 / P = 0.011) according to marital status.

Table 4.16: One-way ANOVA comparing knowledge, attitudes, and practices of mental health according to marital status

Variable	Source of variance	Sum of Squares	Df	Mean Square	F-value	Sig. Level
Knowledge about Concepts of mental health	Between Groups	27.725	3	9.242	1.869	0.134
	Within Groups	2007.153	406	4.944		
	Total	2034.878	409			
Knowledge about mental	Between Groups	9.341	3	3.114	1.096	0.351
	Within Groups	1153.510	406	2.841		

health illnesses	Total	1162.851	409			
Knowledge about Causes of mental health illnesses	Between Groups	8.450	3	2.817	0.218	0.884
	Within Groups	5256.955	406	12.948		
	Total	5265.405	409			
Knowledge about Treatment of mental health illnesses	Between Groups	14.701	3	4.900	1.592	0.191
	Within Groups	1249.504	406	3.078		
	Total	1264.205	409			
Total scores of knowledge about mental health illnesses	Between Groups	18.733	3	6.244	0.190	0.903
	Within Groups	13311.923	406	32.788		
	Total	13330.656	409			
Attitudes about the concepts of mental health	Between Groups	51.689	3	17.230	1.526	0.207
	Within Groups	4582.809	406	11.288		
	Total	4634.498	409			
Attitudes about diseases of mental health illnesses	Between Groups	126.567	3	42.189	3.727	0.011
	Within Groups	4595.435	406	11.319		
	Total	4722.002	409			
Feelings about coping with patients with mental health illnesses	Between Groups	165.318	3	55.106	2.537	0.066
	Within Groups	8819.972	406	21.724		
	Total	8985.290	409			
Total scores of attitudes toward mental health	Between Groups	276.874	3	92.291	1.573	0.195
	Within Groups	23822.775	406	58.677		
	Total	24099.649	409			
Practices of mental health	Between Groups	333.795	3	111.265	1.820	0.143
	Within Groups	24822.510	406	61.139		
	Total	25156.305	409			

$p < 0.05$ $p < 0.01$ $p < 0.001$

Post –hoc analysis using Scheffee statistical test was done and indicated; the means of attitudes about mental health illnesses and its causes according to marital status of the study sample, as shown in the following table (4.17):

The group of married persons of the study sample was significantly higher in attitudes about mental health illnesses and their causes (mean 33.99 / SD 3.35) than single of the study sample.

Table 4.17: Means of attitudes about mental health illnesses and their causes according to marital status

Variable		**N0.**	**Mean**	**S.D**
Attitudes about mental health illnesses and their causes	Married	367	33.99	3.357
	Single	25	31.76	3.394
	Widowed	10	33.60	2.875
	Divorced	8	32.75	4.131

4.4.5 Knowledge, attitudes, and practices of mental health according to type of family

T-independent test is demonstrated to investigate the differences between nuclear versus extended family in knowledge, attitudes, and practices of mental health among the study sample.

As shown in following table (4.18); the result found that there were no significant differences in knowledge, attitudes, and practices of mental health and its subscales according to type of family.

While, there were a significant differences in subscale of attitudes about the concepts of mental health (T- value 2.59 / P = 0.01) and total scores of attitudes toward mental health according to type of family (T – value = 2.25 / P= 0.025) , in favor to nuclear family.

Table 4.18: Independent t-test comparing means of knowledge, attitudes, and practices of mental health according to type of family

Variable	Nuclear family N = 271		Extended family N = 139		T- value Df= 408	Sig. Level
	Mean	*SD*	*Mean*	*SD*		
Knowledge about concepts of mental health	18.32	2.266	18.23	2.165	0.359	0.720
Knowledge about mental health illnesses	12.40	1.688	12.48	1.686	0.452	0.651
Knowledge about causes mental health illnesses	28.95	3.429	28.71	3.886	0.621	0.535
Knowledge about treatment of mental health illnesses	12.46	1.522	12.48	2.151	0.073	0.942
Total scores of knowledge about mental health illnesses	72.15	5.509	71.92	6.097	0.374	0.708
Attitudes about the concepts of mental health	32.60	3.323	31.70	3.380	2.592	0.010
Attitudes about mental health illnesses and their causes	34.01	3.418	33.45	3.338	1.576	0.116
Feelings about coping with patients with mental health illnesses	30.01	4.736	29.68	4.598	0.685	0.494
Total scores of attitudes toward mental health	96.63	7.686	94.84	7.543	2.255	0.025
Practices of mental health	50.58	8.040	50.55	7.469	0.035	0.972

$p < 0.05$ $p < 0.01$ $p < 0.001$

4.4.6 Knowledge, attitudes, and practices of mental health according to size of family

In order to investigate the difference in Knowledge, attitudes, and practices of mental health according to size of family of the study sample, the researcher demonstrates one-way ANOVA analysis.

The following table shows (4.19) that: there were no significant differences in all of dimensions of Knowledge, attitudes, and practices and its total scores of mental health according to the size of family of the study sample.

Table 4.19: One-way ANOVA comparing Knowledge, attitudes, and practices of mental health according to size of family

Variable	Source of variance	Sum of Squares	Df	Mean Square	F- value	Sig. Level
Knowledge about Concepts of mental health	Between Groups	8.111	2	4.055	0.814	0.444
	Within Groups	2026.767	407	4.980		
	Total	2034.878	409			
Knowledge about mental health illnesses	Between Groups	8.093	2	4.047	1.426	0.241
	Within Groups	1154.758	407	2.837		
	Total	1162.851	409			
Knowledge about Causes of mental health illnesses	Between Groups	50.144	2	25.072	1.957	0.143
	Within Groups	5215.261	407	12.814		
	Total	5265.405	409			
Knowledge about Treatment of mental health illnesses	Between Groups	4.964	2	2.482	0.802	0.449
	Within Groups	1259.241	407	3.094		
	Total	1264.205	409			
Total scores of knowledge about mental health illnesses	Between Groups	20.939	2	10.469	0.320	0.726
	Within Groups	13309.718	407	32.702		
	Total	13330.656	409			

Attitudes about the concepts of mental health	Between Groups	12.593	2	6.296	0.554	0.575
	Within Groups	4621.905	407	11.356		
	Total	4634.498	409			
Attitudes about diseases of mental health illnesses	Between Groups	16.835	2	8.418	0.728	0.483
	Within Groups	4705.167	407	11.561		
	Total	4722.002	409			
Feelings about coping with patients with mental health illnesses	Between Groups	57.838	2	28.919	1.318	0.269
	Within Groups	8927.452	407	21.935		
	Total	8985.290	409			
Total scores of attitudes toward mental health	Between Groups	51.633	2	25.816	0.437	0.646
	Within Groups	24048.016	407	59.086		
	Total	24099.649	409			
Practices of mental health	Between Groups	247.321	2	123.660	2.021	0.134
	Within Groups	24908.984	407	61.201		
	Total	25156.305	409			

$p< 0.05$ $p< 0.01$ $p< 0.001$

4.4.7 Knowledge, attitudes, and practices of mental health according to level of education

In order to investigate the difference in Knowledge, attitudes, and practices of mental health according to level of education of the study sample, the researcher demonstrates one-way ANOVA analysis.

The following table (4. 20) shows that: there were a significant difference in knowledge about mental health illnesses, and knowledge about treatment of mental health illnesses two subscales of knowledge according to the level of education of the study sample (F – value = 3.13 / P= 0.04) and (F- value = 4.77 P= 0.009) .

Also the table shows that: there were a significant difference in attitudes about mental health illnesses and their causes, feelings about coping with patients with mental health

illnesses, and total scores of attitudes toward mental health according to the level of education of the study sample (F- value= 5.53 / P= 0.004), (F- value = 3049 / P = 0.03) and (F – value = 6073 / P = 0.001).

The table (4.20) shows that there was a significant difference in practices of MH according to the level of education of the study sample (F – value = 4.87 / P = 0.008).

While there were no significant differences in the other subscales according to the level of education of the study sample.

Table 4.20: One-way ANOVA comparing knowledge, attitudes, and practices of mental health according to level of education

Variable	Source of variance	Sum of Squares	Df	Mean Square	F- value	Sig. Level
Knowledge about Concepts of mental health	Between Groups	1.355	2	0.677	0.13	0.873
	Within Groups	2033.524	407	4.996		
	Total	2034.878	409			
Knowledge about mental health illnesses	Between Groups	17.639	2	8.820	3.13	0.045
	Within Groups	1145.212	407	2.814		
	Total	1162.851	409			
Knowledge about Causes of mental health illnesses	Between Groups	47.036	2	23.518	1.83	0.161
	Within Groups	5218.369	407	12.822		
	Total	5265.405	409			
Knowledge about Treatment of mental health illnesses	Between Groups	28.981	2	14.491	4.77	0.009
	Within Groups	1235.224	407	3.035		
	Total	1264.205	409			
Total scores of knowledge about mental health illnesses	Between Groups	119.545	2	59.772	1.84	0.160
	Within Groups	13211.111	407	32.460		
	Total	13330.656	409			

Attitudes about the concepts of mental health	Between Groups	22.538	2	11.269	0.99	0.371
	Within Groups	4611.960	407	11.332		
	Total	4634.498	409			
Attitudes about diseases of mental health illnesses	Between Groups	124.953	2	62.476	5.53	0.004
	Within Groups	4597.050	407	11.295		
	Total	4722.002	409			
Feelings about coping with patients with mental health illnesses	Between Groups	151.850	2	75.925	3.49	0.031
	Within Groups	8833.441	407	21.704		
	Total	8985.290	409			
Total scores of attitudes toward mental health	Between Groups	772.497	2	386.249	6.73	0.001
	Within Groups	23327.152	407	57.315		
	Total	24099.649	409			
Practices of mental health	Between Groups	589.014	2	294.507	4.87	0.008
	Within Groups	24567.290	407	60.362		
	Total	25156.305	409			

$p< 0.05$ $p< 0.01$ $p< 0.001$

Post –hoc analysis using Scheffee statistical test was done and indicated the means knowledge, attitudes, and practices of mental health subscales according to level of education of the study sample, as shown in the following table (4.21).

The group of university and postgraduate studies of study sample was significantly higher in knowledge attitudes and practices of mental health subscales than the group of diploma educational level of the study sample. This result revealed that there were positive correlation between educational level and knowledge, attitudes and practices of mental health among the study sample.

Table 4.21: Means of knowledge, attitudes, and practices of subscales of according to level of education

Variable		N0.	Mean	S.D
Knowledge about diseases of mental health	Diploma	191	12.21	1.680
	University	172	12.59	1.649
	Postgraduate	47	12.74	1.762
Knowledge about Treatment of mental health illnesses	Diploma	191	12.18	1.467
	University	172	12.72	2.027
	Postgraduate	47	12.72	1.637
Attitudes about mental health illnesses and their causes	Diploma	191	33.24	3.261
	University	172	34.40	3.480
	Postgraduate	47	34.06	3.312
Feelings about coping with patients with mental health illnesses	Diploma	191	29.26	4.527
	University	172	30.37	4.816
	Postgraduate	47	30.78	4.596
Total scores of attitudes toward mental health	Diploma	191	94.56	7.302
	University	172	97.27	7.917
	Postgraduate	47	97.42	7.338
Practices of mental health	Diploma	191	49.48	7.766
	University	172	51.06	8.027
	Postgraduate	47	53.19	6.739

4.4.8 knowledge, attitudes, and practices of mental health according to type of job

In order to investigate the difference in knowledge, attitudes, and practices of mental health according to type of job of the study sample (medical, nursing, or paramedical), the researcher demonstrates one-way ANOVA analysis.

The following table (4.22) shows that: there were no significant differences in most of subscales of knowledge, attitudes, and practices of mental health and its total scores according to the type of job of the study sample.

However, there were significant differences in subscales of feelings about coping with patients with mental health illnesses (F- value= 4.18 / P= 0.016), and practices of MH (F-value= 16.47 /P = 0.001) according to type of job.

Table 4.22: One-way ANOVA comparing knowledge, attitudes, and practices of mental health according to type of job

Variable	Source of variance	Sum of Squares	Df	Mean Square	F-value	Sig. Level
Knowledge about Concepts of mental health	Between Groups	17.576	2	8.788	1.77	0.171
	Within Groups	2017.302	407	4.957		
	Total	2034.878	409			
Knowledge about mental health illnesses	Between Groups	5.555	2	2.778	0.97	0.377
	Within Groups	1157.296	407	2.843		
	Total	1162.851	409			
Knowledge about Causes of mental health illnesses	Between Groups	34.625	2	17.312	1.34	0.261
	Within Groups	5230.780	407	12.852		
	Total	5265.405	409			
Knowledge about Treatment of mental health illnesses	Between Groups	2.520	2	1.260	0.40	0.666
	Within Groups	1261.684	407	3.100		
	Total	1264.205	409			

Total scores of knowledge about mental health illnesses	Between Groups	33.199	2	16.599	0.50	0.602
	Within Groups	13297.457	407	32.672		
	Total	13330.656	409			
Attitudes about the concepts of mental health	Between Groups	28.581	2	14.290	1.26	0.284
	Within Groups	4605.917	407	11.317		
	Total	4634.498	409			
Attitudes about diseases of mental health illnesses	Between Groups	8.164	2	4.082	0.35	0.703
	Within Groups	4713.838	407	11.582		
	Total	4722.002	409			
Feelings about coping with patients with mental health illnesses	Between Groups	181.141	2	90.571	4.18	0.016
	Within Groups	8804.149	407	21.632		
	Total	8985.290	409			
Total scores of attitudes toward mental health	Between Groups	123.205	2	61.602	1.04	0.352
	Within Groups	23976.444	407	58.910		
	Total	24099.649	409			
Practices of mental health	Between Groups	1884.276	2	942.138	16.47	0.001
	Within Groups	23272.029	407	57.179		
	Total	25156.305	409			

$p < 0.05$ $p < 0.01$ $p < 0.001$

Post –hoc analysis using Scheffee statistical test was done and indicated the means of feelings about coping with mental health patients and practices of mental health according to type of job of the study sample, as shown in the following table (4.23). The results found that; the group of medical type of job of study sample was significantly higher in feelings about coping with mental health patient's subscale (mean 30.57 / SD 4.57) than the group of paramedical type of job of the study sample.

The results found that; the group of medical and nursing type of job of study sample was significantly higher in practices of mental health subscales (mean 52.84 / SD 5.72) than the group of paramedical type of job of the study sample.

Table 4.23: Means of feelings about coping with mental health patients, and practices of mental health according to type of job

Variable		No.	Mean	S.D
Feelings about coping with people with mental health illnesses	Medical	110	30.57	4.570
	Nursing	193	30.11	4.505
	Paramedical	107	28.83	4.980
Practices of mental health	Medical	110	52.84	5.720
	Nursing	193	51.17	7.018
	Paramedical	107	47.15	9.832

4.4.9 Knowledge, attitudes, and practices of mental health according to years of work in PHC centers

In order to investigate the difference in knowledge, attitudes, and practices of mental health according to years of work in primary care centers of the study sample (10 years and less than, 11-20 years, more than 20 year), the researcher demonstrates one-way ANOVA analysis.

The following table (4.24) shows that; there were no significant differences in most of subscales of knowledge, attitudes of mental health and its total scores according to the years of work in primary care centers of the study sample. However, there were significant differences in subscales of knowledge about causes of mental health illnesses (F-value = 4.34 / P= 0.014) and practices of mental health (F- value= 4.22 / P= 0.015) according to years of work in PHC centers.

Table 4.24: One-way ANOVA comparing knowledge, attitudes, and practices of mental health according to years of work in primary care centers

Variable	Source of variance	Sum of Squares	Df	Mean Square	F- value	Sig. Level
Knowledge about Concepts of mental health	Between Groups	4.735	2	2.367	0.47	0.622
	Within Groups	2030.143	407	4.988		
	Total	2034.878	409			
Knowledge about mental health illnesses	Between Groups	7.018	2	3.509	1.23	0.292
	Within Groups	1155.833	407	2.840		
	Total	1162.851	409			
Knowledge about Causes of mental health illnesses	Between Groups	110.119	2	55.059	* 4.34	0.014
	Within Groups	5155.286	407	12.667		
	Total	5265.405	409			
Knowledge about Treatment of mental health illnesses	Between Groups	5.250	2	2.625	0.84	0.429
	Within Groups	1258.954	407	3.093		
	Total	1264.205	409			
Total scores of knowledge about mental health illnesses	Between Groups	118.801	2	59.400	1.83	0.162
	Within Groups	13211.856	407	32.462		
	Total	13330.656	409			
Attitudes about the concepts of mental health	Between Groups	44.626	2	22.313	1.97	0.140
	Within Groups	4589.872	407	11.277		
	Total	4634.498	409			
Attitudes about diseases of mental health illnesses	Between Groups	44.191	2	22.096	1.92	0.148
	Within Groups	4677.811	407	11.493		
	Total	4722.002	409			
Feelings about coping with	Between Groups	5.323	2	2.661	0.12	0.886
	Within Groups	8979.967	407	22.064		

patients with mental health illnesses	Total	8985.290	409			
Total scores of attitudes toward mental health	Between Groups	222.221	2	111.110	1.89	0.152
	Within Groups	23877.428	407	58.667		
	Total	24099.649	409			
Practices of mental health	Between Groups	511.373	2	255.687	4.22	0.015
	Within Groups	24644.932	407	60.553		
	Total	25156.305	409			

p< 0.05 p< 0.01 p< 0.001

Post –hoc analysis using Scheffee statistical test was done and indicated the means of knowledge about causes of mental health illnesses and practices of mental health according to years of work in primary health care centers of the study sample, as shown in the following table (4.25). The results found that; the group of 10 years and less than of work in primary health care centers were significantly higher in knowledge about causes of mental health illnesses subscale (mean 29.36 / SD 3.68) than the group of more than 20 year of the study sample.

Where; the group of 10 years and less than of work in primary health care centers were significantly higher in practices of mental health illnesses (mean 51.72 / SD 7.41) than the group of 11- 20 year of the study sample.

Table 4.25: Means of knowledge about causes of mental health illnesses and practices of mental health according to years of work in primary health care centers

Variable		No.	Mean	S.D
knowledge about causes of mental health illnesses	10 years and less than	170	29.36	3.680
	11 - 20 years	157	28.82	3.410
	more than 20 years	83	27.96	3.579

practices of mental health	10 years and less than	170	51.72	7.416
	11 - 20 years	157	49.22	9.019
	more than 20 years	83	50.75	5.694

4.4.10 Knowledge, attitudes, and practices of mental health according to monthly income

In order to investigate the difference in knowledge, attitudes, and practices of mental health according to monthly income of the study sample (1000 $ and less than, 1001 – 2000$, more than 2000$), the researcher demonstrates one-way ANOVA analysis.

The following table (4.26) shows that; there were no significant differences in most of subscales of knowledge, attitudes, and practices of mental health and its total scores according to the monthly income of the study sample.

While, there were a significant differences in subscales of knowledge about mental health illnesses (F-value= 3.12 / P 0.045), knowledge about causes of mental health illnesses (F-value= 3.95 / P 0.02), and total scores of knowledge about mental health illnesses (F-value = 5.46 / P 0.005) according to monthly income.

Table 4.26: One-way ANOVA comparing knowledge, attitudes, and practices of mental health according to monthly income

Variable	Source of variance	Sum of Squares	Df	Mean Square	F- value	Sig. Level
Knowledge about Concepts of mental health	Between Groups	7.930	2	3.965	0.796	0.452
	Within Groups	2026.948	407	4.980		
	Total	2034.878	409			
Knowledge about mental health illnesses	Between Groups	17.588	2	8.794	3.125	0.045
	Within Groups	1145.263	407	2.814		
	Total	1162.851	409			

Knowledge about Causes of mental health illnesses	Between Groups	100.362	2	50.181	3.954	0.020
	Within Groups	5165.043	407	12.691		
	Total	5265.405	409			
Knowledge about Treatment of mental health illnesses	Between Groups	16.291	2	8.146	2.657	0.071
	Within Groups	1247.914	407	3.066		
	Total	1264.205	409			
Total scores of knowledge about mental health illnesses	Between Groups	348.607	2	174.303	5.465	0.005
	Within Groups	12982.049	407	31.897		
	Total	13330.656	409			
Attitudes about the concepts of mental health	Between Groups	3.030	2	1.515	0.133	0.875
	Within Groups	4631.467	407	11.380		
	Total	4634.498	409			
Attitudes about diseases of mental health illnesses	Between Groups	1.652	2	.826	0.071	0.931
	Within Groups	4720.351	407	11.598		
	Total	4722.002	409			
Feelings about coping with patients with mental health illnesses	Between Groups	46.441	2	23.221	1.057	0.348
	Within Groups	8938.849	407	21.963		
	Total	8985.290	409			
Total scores of attitudes toward mental health	Between Groups	63.495	2	31.747	0.538	.585
	Within Groups	24036.154	407	59.057		
	Total	24099.649	409			
Practices of mental health	Between Groups	210.735	2	105.368	1.719	0.181
	Within Groups	24945.570	407	61.291		
	Total	25156.305	409			

p< 0.05 p< 0.01 p< 0.001

Post –hoc analysis using Scheffee statistical test was done and indicated the means of knowledge about mental health illnesses, knowledge about causes of mental health illnesses, and total scores of knowledge about mental health illnesses according to monthly income of the study sample, as shown in the following table (4.27).

The results found that; the 2000$ and less than monthly income were significantly higher in knowledge about mental health illnesses (mean 12.64 / SD 1.68), knowledge about causes of mental health illnesses (mean 29.19 / SD 3.52), and total scores of knowledge about mental health illnesses (mean 72.79 / SD 5.75) than the group of more than 2000$ monthly income of the study sample.

Table 4.27: Means of knowledge about mental health illnesses, knowledge about causes of mental health illnesses, and total scores of knowledge about mental health illnesses according to monthly income

Variable		N	Mean	S.D
knowledge about diseases of mental health	1000 $ and less	255	12.36	1.664
	1001 - 2000 $	142	12.64	1.685
	more than 2000 $	13	11.53	1.853
knowledge about causes of mental health illnesses	1000 $ and less	255	28.82	3.577
	1001 - 2000 $	142	29.19	3.528
	more than 2000 $	13	26.30	3.637
Total scores of knowledge about mental health illnesses	1000 $ and less	255	71.90	5.641
	1001 - 2000 $	142	72.79	5.753
	more than 2000 $	13	67.53	4.389

Chapter (5)

Discussion and Recommendations

Chapter Five

5. Discussion and recommendations

5.1 Introduction

This chapter introduces the main results that drawn out from the data interpretations. The researcher here will discuss the results in points in relation to what has been written in the literature review and previous studies in order to support the studies' findings and answer its questions as well. Principally, the researcher will also high light some recommendations regarding knowledge, attitudes, and practices of mental health among primary health care providers that might be taken inconsideration by the decision makers in the field of mental health services. Beside to other recommendations that require further investigations.

5.2 Main results discussion

In this study, the questionnaire was distributed among all primary health care providers in UNRWAs' clinics in the entire Gaza Strip. Response of the participants was 74.4% considerably fair that's enable the researcher to discuss the results with high transparency and confidence.

5.2.1 Knowledge of mental health

The total scale of knowledge about mental health was 78.3%, mainly primary health care providers best knowledge was about the causes of mental health illnesses 80.2%, followed by the knowledge about treatment of mental health illnesses 77.9%, then knowledge about mental health illnesses themselves 77.7%, and the lowest score of knowledge was about mental health as a concept 76.2%.

The lowest score was the knowledge of primary health care providers about mental health concept and the rest had higher scores. That indicates that while teaching mental health in the medical, nursing, and para-medical colleges; the concept didn't understand by their hearts and consciousness where there is no inspiration of what mental health is. Students in all categories remembered what had related to mental health; its causes, illnesses, and treatments rather than digesting its meaning. This interpretation agrees with previous studies that said that it is important to promot the level of knowledge about mental health by intervention programmes (Younes and et al, 2005); (Lester and et al, 2005);

(Cawthorpe, 2005); (McCall and Saeed, 2006) for general practitioners. Also, studies for the same category of primary health care providers stated that unsatisfactory perception of the relevance of mental health due to low level of knowledge (Moraes and et al, 2006). Similarly, the need for more educational programmes for general practitioners (Hafting, and Garlov, 2009). Previous studies focused on the knowledge about mental health for nurses as well as other primary health care providers (Weber and Snow, 2006); (Happell, 2009).

5.2.2 Attitudes toward mental health

On the other hand, the level of attitude toward mental health among primary health care providers in UNRWA clinics was less than the level of knowledge with total scale 75%. The level degreed from 80.8% for attitudes toward the concept of mental health. Followed by 76.9% for attitudes to mental health illnesses and their causes. Then, the lowest score of 68% for feelings about coping with people with mental health illnesses.

These scales reflect the fact that primary health care providers as a part of the Gaza Strip society, have a relatively positive attitudes toward mental health may be due to religious believes "fear of GOD". Then the attitudes decline regarding mental health illnesses that do need more knowledge. In term of coping and behaving, it becomes more difficult where the attitudes here are the lowest. These results reveal incongruent between the attitudes toward mental health and coping with people with mental health illnesses.

Attitudes results go along with what shown in previous studies of (Ansari and Sadadi, 2002); (Martin and et al, 2002) of dentists who showed overestimated fear when dealing with people with mental health illnesses. Also studies for (Salmon, and et al, 2007); (Goldfracht and et al, 2007); (Happell and et al, 2008).

5.2.3 Practicing mental health

Coming to the most difficult and important part, practice to mental health. Ratio scale was 74.4%. The researcher here rather to go through and discuss each item of this part due to its importance. Ninety four and four percent of primary health care providers addressed that ' yes' there are patients with mental health illnesses coming to primary health care clinics. Absolutely right, in the literature (Ogundipe, 2009); (Magola, 2008); (Ovuga and et al, 2007); (Odejide and et al, 2002), (WHO, 2001); (Nimmer and et al, 1988) address the

increasing number of mental health illnesses in all cultures and their high attendance to primary health care settings.

- By looking at the number of patients with mental health illnesses seen by primary health care providers per week in UNRWA clinics as primary health care which provide mainly physical service only, we find 163% of primary health care providers see more than 10 cases / week, 122% see from 5-10 patients with mental health illnesses, and 646% see from 1-5 patients with mental health illnesses. How come, if the service open the door and make the system ready to deal with and treat patients with mental health illnesses properly. The number that seen every week needs more magnified wise look. Precisely, the same literature (Ogundipe, 2009); (Magola, 2008); (Ovuga and et al, 2007); (Odejide and et al, 2002); (WHO, 2001); (Nimmer and et al, 1988) emphasis on the number of people with MHIs that increasing every year. However, detection rate of mental health illnesses in primary health care settings is relatively low, as shown in a Palestinian study, was 1.6% (Afana and et al, 2002).

- The results revealed that 51.3% of primary health care providers see patients with depression**,** 46.1% of them see anxiety cases, 45.3% see cases with psychosomatic complains, 23.3% see epileptic cases, and 8.9% see PTSD cases. These are common mental health illnesses which should be seen and treated in primary health care settings as stated in the previous studies (Nasir and Qutob, 2005); (Collins and et al, 2007); (Paris and et al, Oct.2008); (Tanaka and Lauridsen-Ribeiro, 2006).

- Different practices and behaviors of primary health care providers to patients with mental health illnesses have obtained from this study's results as advising and referring ways. The highest positive practice was 91% of advising patients with mental health illnesses to refer to psychologists. In contrast, 81.2% of primary health care providers were advising the patients to seek traditional healers. 76.7% were advising to depend on herbal treatment only. Also, 73.3% of primary health care providers were advising to depend on psychiatric medication only. Sadly that, 68.2% were give no advise. Finally, 64.5% were advising and referring to psychiatric hospital.

These different advices that given by primary health care providers reflects the poor and unorganized system regarding mental health services. In addition to, the need for more training, practicing, and modification of primary health care providers behavior especially when there was 81.2% ratio scale of advising to seek traditional healers, or even when

there was 68.2 % of giving no advise. Beside to, only 10.7% of the primary health care providers have working experience in the field of mental health. Similarly to previous studies that enhanced more training programmes for primary health care providers (Paris and et al, Oct.2008); (Romem and et al, 2008); (Happell, 2009); (Adelekan and et al, 2001); (Payne and et al, 2002); (Weisberg and et al, 2007).

- The results found that 71% ratio scale think that they have the ability to deal with mental health illnesses cases, while the rest have no ability. Reflecting to the previous point, still there is a need for more training. Similarly to the previous studies that showed the positive effect of training programmes for primary health care providers in order to increase their abilities in dealing with mental health illnesses (Hawley and et al, 1991); (Manthorpe and et al, 2003); (Latorre and et al, 2005); (Henderson and et al, 2005), (Munro and et al, 2007); (Mbatia and et al, 2009).

- Regarding the influence of social and cultural attitude on primary health care providers performance, the study showed 73% ratio scale primary health care providers were influenced by the cultural attitudes, and 63.6% of primary health care providers change their way of practice when realizing that the Patient has mental health illnesses. These results are similar to (Good and et al, 1987); (Mira and et al, 1997); (Smith and et al, 2002); (Muga and Jenkins, 2008); (DesCourtis and et al, 2008). In addition to, there is a widespread negative attitude to mental health illnesses among journalists and this is a reflection of the general population (Abasiubong and et al, 2007).

- In relation to consultation time, using counseling, and workload, the results found that 85.4% ratio scale of primary health care providers admit that they have to understand the patients' condition in order to provide better help and 74% ratio scale use counseling while dealing with patients with mental health illnesses. However, 71.9% of them listen carefully to patients with mental health illnesses and 75.7% need more time to listen. That means that primary health care providers are willing to listen carefully to their patients but do need more time and increase the ratio of using counseling. These results are incongruent with another study discussing the general practitioners claimed that extra workload by pts with mental health illnesses cause general practitioners reluctant to become involved in mental health care (Zanting and et al), however, the study does not confirm general practitioners' complaints that mental health care is one of the components of their job that consumes a lot of their time and energy**.** In contrast to the previous study

(Hutton and Gunn, 2007); (Henderson and et al, 2008) stated that there is evidence that longer consultations in general practice are associated with improved quality of care; but this needs to be balanced against the fact that doctor time is a limited resource and longer consultations may lead to reduced access to health care.

- The study's results show that 55.4% of primary health care providers applied that there is sort of system for dealing with patients with mental health illnesses through the programmes of psychosocial services that applied by UNRWA. However, there is no a definite protocol for this purpose. In fact most of the previous studies illustrated that the system can be a media of constrain that hinder the smoothness and the easiness of work especially in the field of mental health. So that the findings are congruent with (Iliffe and et al, 2003); (Sweeney and Kisely, 2003); (Henke and et al, 2008).

- The final point in this practices is 82.9% of primary health care providers agree to the idea of integrating mental health services into primary health care clinics in order to ease their work and provide better service for patients with mental health illnesses, that agree with the Palestinian study of (Afana and et al, 2004). Recently, referring to the literature WHO suggested integration of mental health services with primary health care is a global perspective (Stroul and Orlando, 2006). It is worthy to mention that mental and physical health are independent, a number of patients are afflicted with mental health illnesses as well as physical illnesses at the same time, and both are affected by each other (Ogundipe, 2009); (Kim and Flaherty, 1997). The importance of integrating both services is becoming an emergent enquiry of today's life; the result here is completely agree with the other previous ones (Morrill, 1978); (Valenstein and et al, 1999); (Farrar and et al, 2001); (Kisely, Duerden, Shaddick, and Jayabarathan, 2006); (Upshur and Weinreb 2007); (Younes and et al, 2008). Arabic countries also join WHO/EMRO's collaborative activities in the issue of integration (Mohit, 2001). Egypt is the site of one of WHO's demonstration projects of the National for mental health Programme, that aims to integrate mental health services into primary health care services (WHO, 2001).

As a researcher, I see that integration at the primary mental health level can be easier than any integration in the secondary or tertiary levels. Primary health care and primary mental health level are the first line in dealing with the client in our community, where the referral to more complicated and advanced health care levels is originated. Primary health care providers can provide basic mental health care, such as counseling (good lessening) and

appropriate referral in case of more complicated mental ill cases. So that integration at this level can be successfully occurs.

5.2.4 Relationship between knowledge, attitudes, and practices of mental health

The relationship between knowledge, attitudes, and practices is parallel in both; this study findings and literature review with the previous studies. It is found that there were positive significant correlation between knowledge and attitudes toward mental health among primary health care providers ("R"= 0.299, "P"=0.001). Also, there were positive significant correlation between knowledge and practices in the field of mental health among primary health care providers ("R"= 0.138, "P"=0.01), and the same, there were positive significant correlation between attitudes and practices ("R"=0.28 "P"=0.001). Therefore, high incidence of any variable will lead to high incidence of the other two variables. In another words, modification and enhancing of knowledge at the first step can lead to more positive attitudes and better practices as a consequence. Moreover, the study's findings regarding the relationship between knowledge, attitudes, and practices are going on what other studies that done before for the same purpose i.e. (McCall and et al, 2002); (Weber and Snow, 2006); (Hafting and Garlov, 2009). Other studies presented the positive effect of training in improving attitudes and practices at the same time as Saudi Arabia training programmes for general practitioners on mental health (WHO, 2001), and in western countries (Romem and et al, 2008); (Happell, 2009). In addition to, (Adelekan and et al, 2001) gave the conclusion that the use of information, education, and communication intervention could lead to more positive attitudes and less hazardous forms of practices toward mental health among primary health care providers.

5.2.5 Knowledge, attitudes, and practices of primary health care providers according to socio-demographic characteristics

In this section, the researcher will discuss knowledge, attitudes, and practices of primary health care providers according to socio-demographic variables:

- Gender issue is been raised, the results show that there were no significant differences in knowledge or practices according to sex. However, there were significant differences in attitudes; T-value was 2.95 (P=0.003) in the subscale of attitudes about the concept of mental health in favor to female. There were significant differences in the subscale of attitudes about mental health illnesses and their causes T-value was 2.018 (P=0.044) in

favor to male, and also the subscale of attitudes toward the feeling while coping with people with mental health illnesses T-value was 2.025 (P=0.043) in favor to male. The last piece of result is congruent with one in the previous studies that stated that female general practitioners without mental health training were the least confident in the use of these methods ((Richards and et al, 2004).

The researcher see these results could be due to the natural differences between male and female, where male tends to more practical .

- There were no significant differences in the most of dimensions of knowledge, attitudes, and practices according to age of the study sample. However, there were significant differences in the subscale of knowledge about causes of mental health illnesses F-value was 3.41 (P=0.018), and attitudes toward the concept of mental health F-value was 3.87 (P=0.01) in favor to the age group of 30 years and less (mean 28.82/ SD 4.04 and mean 33.41 / SD 3.07). The researcher sees that this group of age still has a fresh knowledge as they are newly graduates in one hand. In the other hand, the older groups start to loss the un experienced knowledge that don't have any refreshing courses or in-service training in the field of mental health and its diseases through their working years.

- The study's findings found that, there were no significant differences in most of dimensions of knowledge, attitudes, and practices according to the place of residence of the study sample. However, there was a significant difference in subscale of knowledge about mental health illnesses (F-value= 3.296 P=0.038) in to primary health care providers village residency. It is well known that people who live in villages have more simple and easy going life than those who live in camps or cities. In addition to, in villages the population is small, people know each others and know others' problems. mental health illnesses are more common in villages due to high percentage of close relative marriages. These could be a reasonable points why people live in villages have more knowledge about mental health illnesses.

- Also, there were no significant differences in knowledge, attitudes, and practices variables according to marital status. However, there was a significant difference in subscale of attitudes about mental health illnesses and their causes (F=3.727 and P=0.011) in favor to the married group. The researcher has no theoretical back ground to explain this result, but it could be a question for other future studies.

- There were no significant differences of knowledge, attitudes, and practices variables according to types of the family. However there was a significant difference in subscale of attitudes about the concept of mental health (T-value= 2.592 / P= 0.010) and total scores of attitudes toward mental health (T-value= 2.025 / P= 0.025) in favor to nuclear family.

- there were no significant differences in most of dimensions knowledge, attitudes, and practices variables and their total scores according to the size of the family of primary health care providers.

- Regarding level of education, there were significant differences in many areas of the study. knowledge, attitudes, and practices toward mental health among primary health care providers were obviously varied according to their level of education. Knowledge about mental health illnesses was (F- value = 3.134 and P= 0.045), knowledge about treatment of mental health illnesses was (F- value = 4.77 and P = 0.009). These results were in favor to postgraduate degrees and university degrees. These results agree with the definition of knowledge in general (Mullins, 1997) that stated that " knowledge is an expertise, and skills acquired by a person through experience or education; the theoretical or practical understanding of a subject". Also, the development of scientific method as courses of mental health in university degree or postgraduate has made a significant contribution to primary health care providers understanding and knowledge (Gerits, 2000). In previous studies (Lester and et al, 2005) showed that knowledge of primary health care professional is highly important.

In the same area attitudes about mental health illnesses and their causes was (F- value = 5053 and P = 0.004), in favor to postgraduate degree and university degree. Feelings about coping with people with mental health illnesses was (F- value = 3049 and P = 0.031), in favor to the same groups of postgraduate and university degrees. Total scores of attitudes to mental health was (F- value = 6.73 and P= 0.001), in favor to postgraduate and university degrees. It is important to mention here that, knowledge and attitudes toward mental health are in positive correlation with each others as mentioned before and previous studies congruent to the results obtained by this study in relation to high level of knowledge correlated with high level of attitudes (Adelekan and et al, 2001); (Payne and et al, 2002); (Hyvonen and Nikkonen, 2004).

Finally, practices of mental health was (F- value = 4.87 and P = 0.008) in favor to postgraduate degree and university degree. Again, as a consequence, primary health care

providers with high level of educational degree have high level of practices to mental health, for example general practitioners and registered nurses. This result agree with (Hyvnon and Nikkonen, 2004), they approved that the professional skills and attitudes of the practitioner have a significant influence on the type of caring the client receives.

- There were no significant differences in most of subscales of knowledge, attitudes, and practices of mental health and its total scores according to the type of job of the study sample. However, there were significant differences in subscales of feelings about coping with patients with mental health illnesses (F- value= 4.18 / P= 0.016), and practices of mental health (F- value= 16.47 /P = 0.001) according to type of job in favor to medical type of job among the study sample. The results found that; the group of medical and nursing type of jobs of study sample was significantly higher in practices of mental health subscales than the group of paramedical type of job of the study sample. This result is congruent with the study which done by (Lesterand et al, 2005) that stated that the knowledge of the health professional; GPs and Nurses; is highly important. Also it raised the fact that other paramedical staff as pharmacists have limited knowledge and therefore minimum practices of mental health as showed in (Scheerderand et al, 2008) study.

- There were no significant differences in most of subscales of knowledge, attitudes of mental health and its total scores according to the years of work in primary care centers of the study sample. However, there were significant differences in subscales of knowledge about causes of mental health illnesses (F-value = 4.34 / P= 0.014) and practices of mental health (F- value= 4.22 / P= 0.015) according to years of work in primary health care centers in favor to the group of 10 years and less than of work in primary health care centers. The researcher attributes these findings to the similar findings of the age groups where the age of 30 years and less has higher significance of attitudes and practices toward mental health and its illnesses than the other older age group. Exactly, this age group is the same group who worked 10 years and less in primary health care providers clinics.

- In relation to monthly income, there were no significant differences in most of subscales of knowledge, attitudes, and practices of mental health and its total scores according to the monthly income of the study sample. While, there were a significant differences in subscales of knowledge about mental health illnesses (F-value= 3.12 / P 0.045), knowledge about causes of mental health illnesses (F-value= 3.95 / P 0.02), and total scores of knowledge about mental health illnesses (F-value = 5.46 / P 0.005) according to monthly

income in favor to the 2000$ and less than of the study sample. General practitioner is the group who fall in this category of the monthly income. Therefore, primary health care providers whom has higher education in medical has higher knowledge of mental health, mental health illnesses and their causes.

5.3 Recommendations

5.3.1 Recommendations concerning primary health care providers

- Adequate promotion and support to primary care workers is required. Pre-service and /or in-service training of primary care workers on mental health issues is an essential . However, health workers also must practice skills and receive specialist supervision over time.
- Collaborative or shared care models, in which joint consultations and interventions are held between primary care workers and mental health specialists, are an especially promising way of providing ongoing training and support.
- Primary care tasks must be limited and doable. Typically, primary care workers function best when their mental health tasks are limited and doable. Decisions about specific areas of responsibility must be taken after consultation with different stakeholders in the community

5.3.2 Recommendations concerning policy makers

- Assessment of available human and financial resources, and careful consideration of the strengths and weaknesses of the current health system for addressing mental health. Functions of primary care workers may be expanded as practitioners gain skills and confidence.
- Protocols and polices should be available. Even where a policy exists, integration takes time and typically involves a series of developments. Meetings with a range of concerned parties are essential and in some cases, considerable skepticism or resistance must be overcome.
- Financial and human resources are needed. Although primary care for mental health is cost effective, financial resources are required to establish and maintain a service. Training costs need to be covered, and additional primary and community health workers

might be needed. Mental health specialists who provide support and supervision must also be employed.

- Collaboration with other government non-health sectors, nongovernmental organizations, village and community health workers, and volunteers is required.

5.3.3 Recommendations for further studies

- Further studies are needed to reduced Stigma for people with mental disorders and their families. Because primary health care services are not associated with any specific health conditions, stigma is reduced when seeking mental health making this level of care far more acceptable - and therefore accessible - for most users and families.
- Plan for a full spiral continuous programmes for community awareness in order to enhance negative cultural attitudes toward mental health and its issues.
- Studies needed to evaluate pre-service training in medical school curriculum related to behavioral health care; involve in-service training with providers already practicing. However, pre-service training for physicians should incorporate training related to behavioral health, engaging families and children in discussions about behavioral health, screening, communicating with other professionals especially nurses and paramedical students.
- Further studies are needed to evaluate in depth the primary health care providers practices after implementing promoting and support programmes. Also other studies should be done to assess the mental health readiness of primary health care providers themselves.

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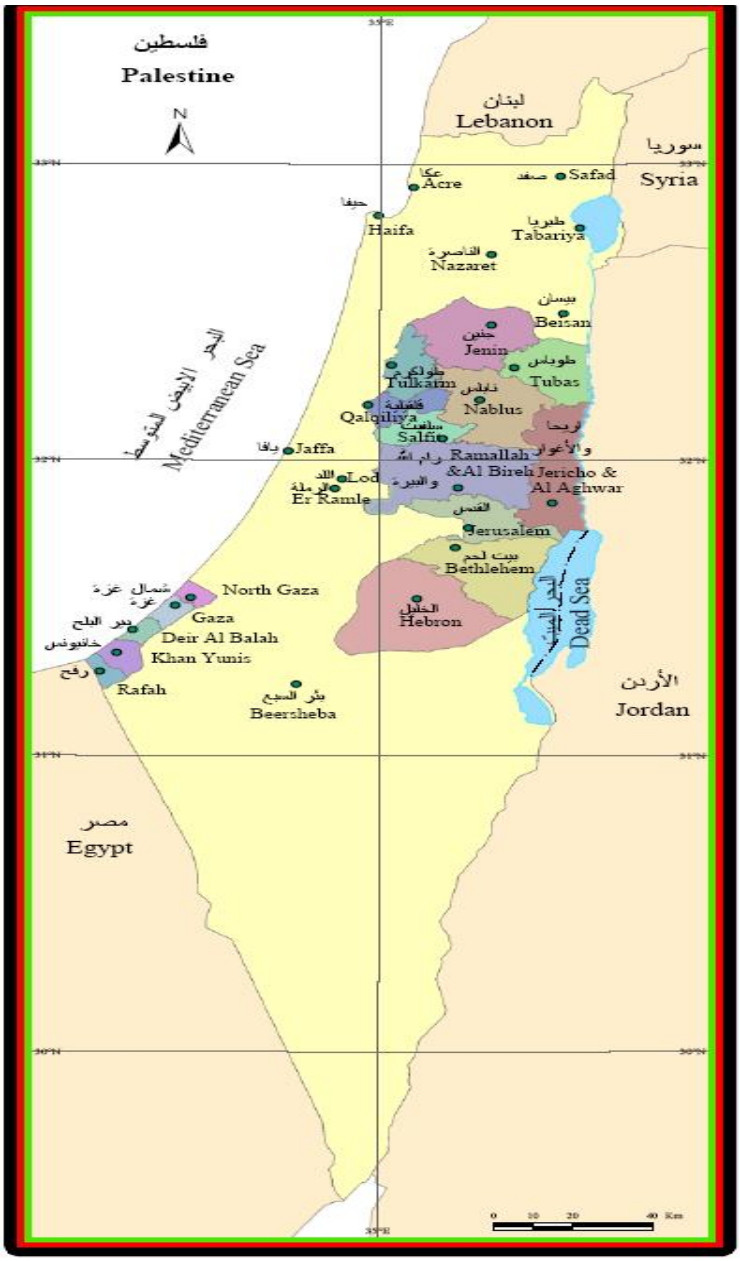
Annexes

Annex (1)

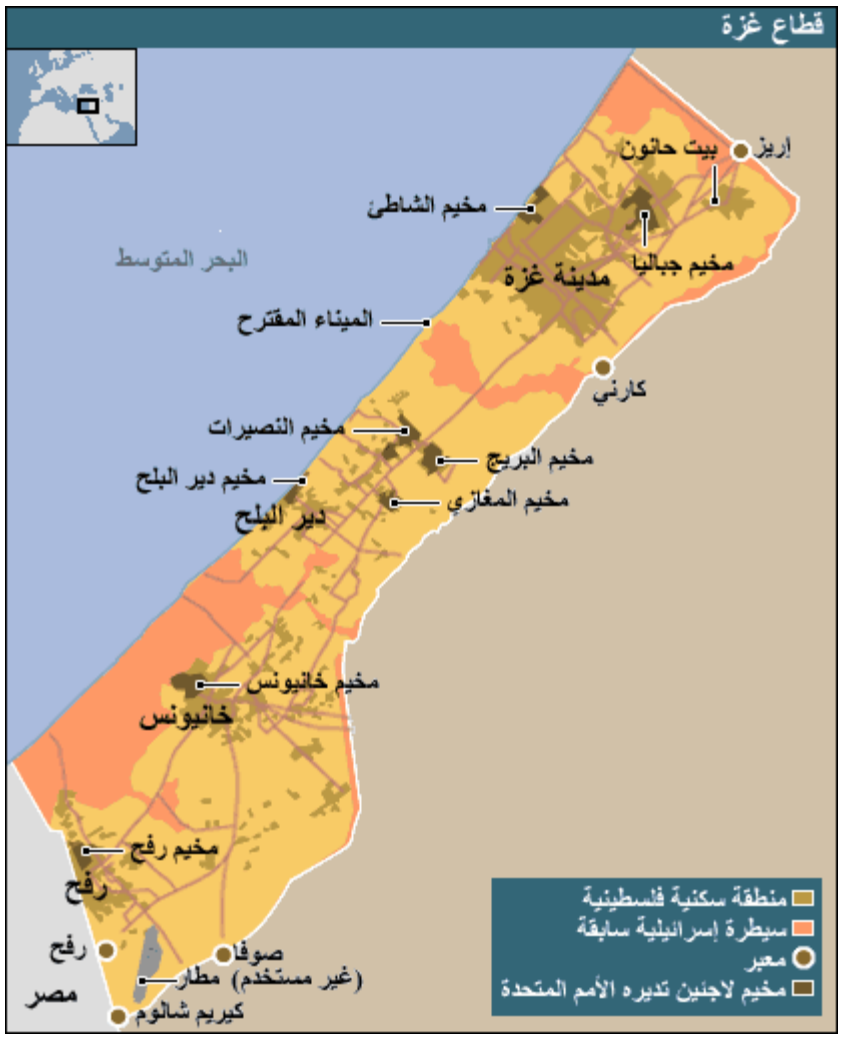
Map of Palestine



Source: MOH 2000

Annex (2)

Map of Gaza Strip



Source: BBC Arabic

Annex (3)

Annex (3)

Palestinian National Authority
Ministry of Health
Helsinki Committee

السلطة الوطنية الفلسطينية
وزارة الصحة
لجنة هلسنكي

التاريخ2009/6/3

Name:

الاسم: **هالة عبد الرحمن المغاري**

I would like to inform you that the committee has discussed your application about:

نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:-

Mental Health among Primary HealthCare Providers in UNRWA Clinics of Gaza Governorates :Knowledge ,Attitudes, and Practices.

In its meeting on June 2009

و ذلك في جلستها المنعقدة لشهر 6 2009

and decided the Following:-

و قد قررت ما يلي:-

To approve the above mention research study.

الموافقة على البحث المذكور عاليه.

Signature
توقيع

Member	Member	Chairperson
عضو	عضو	

Ministry of Health Helsinki Committee

Conditions:-

- Valid for 2 years from the date of approval to start.
- It is necessary to notify the committee in any change in the admitted study protocol.
- The committee appreciate receiving one copy of your final research when it is completed.

Annex (4)

Annex(4)

Al-Quds University

Jerusalem

School of Public Health

جامعة القدس

القدس

كلية الصحة العامة

2009/8/8

0 9 NOV 2009

الأخ/د. محمد المقادمة المحترم

مدير دائرة الصحة–وكالة الغوث

تحية طيبة وبعد،،،

Approved
to prepare
a letter

الموضوع: مساعدة الطالبة هالة المغاري

تقوم الطالبة المذكورة بأعلاه بإجراء بحث بعنوان :

"Mental Health among Primary Health Care Providers in UNRWA Clinics of Gaza Governorates: Knowledge, Attitudes, and practices "

كمتطلب للحصول على درجة الماجستير في الصحة النفسية المجتمعية و عليه نرجو التكرم للإيعاز لمن ترونه مناسب لتسهيل مهمة الطالبة في جمع البيانات اللازمة من عيادات الرعاية الأولية التابعة لإدارتكم الموقرة حيث سيتم الحصول على البيانات من قبل أطقم الأطباء والتمريض ومساعديهم العاملين الصحيين .

علماً بأن المعلومات ستكون متوفرة لدى الباحثة و الجامعة فقط.

و اقبلوا فائق التحية و الاحترام،،،

د. عبد العزيز ثابت

منسق برنامج ماجستير الصحة النفسية المجتمعية

نسخة:الملف

Jerusalem Branch/Telefax 02-24799234
Gaza Branch/telefax 08-2884422-2884411
Sphealth@admin.alquds.edu
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60
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10 أغسطس 2009

من / رئيس برنامج الصحة
بوكالة الغوث الدولية – غزة

إلى / جميع مدراء عيادات وكالة الغوث بقطاع غزة

الموضوع: مساعدة الطالبة هالة المغاري

أرجو التكرم بالسماح للطالبة هالة المغاري بجمع البيانات اللازمة من عيادات الرعاية الأولية التابعة لعياداتكم الموقرة حيث سيتم جمع البيانات من قبل أطقم الأطباء والتمريض ومساعديهم العاملين الصحيين.

علما بأن الطالبة المذكورة أعلاه تقوم بأجراء بحث بعنوان:

"Mental Health among Primary Health Care Providers in UNRWA Clinics of Gaza Governorates: Knowledge, Attitudes, and Practices"

وتقبلوا بقبول فائق الاحترام ،

د. محمد المقادمة
رئيس برنامج الصحة
وكالة الغوث الدولية – غزة

وكالة الأمم المتحدة لإغاثة
[illegible]

Annex (5)

بسم الله الرحمن الرحيم

دعـــــــوة

أخي المشارك / أختي المشاركة :

أنا الطالبة/ هالة عبد الرحمن المغارى _ أدرس بكلية الصحة العامة جامعة القدس–أبو ديس، أقوم بإعداد بحث بعنوان "**المعرفة والتوجهات والممارسات المتعلقة بالصحة النفسية لـــدى العـــاملين الصحيين في مراكز الرعاية الأولية بوكالة الغوث الدولية في كل محافظات قطاع غزة**"

باعتباره متطلب للتخرج والحصول على درجة الماجستير وتم اختيارك لأهمية الدور الذي تقوم / تقومي به في مجال الرعاية الأولية في عيادات وكالة الغوث.

تهدف هذه الدراسة: على التعرف على المعرفة والتوجهات والممارسات لـــدى مقـــدمي الخدمـــة الصحية تجاه الصحة النفسية لأفراد المجتمع الفلسطيني وكذلك الخروج بتوصيات تـــساعد فـــي تخفيف العبء النفسي الذي يعاني منه شعبنا في هذه المنطقة.

وشكرا لك علي مشاركتك في هذه الدراسة بالإجابة عن هذه الأسئلة

مشاركتك تطوعية يمكنك رفض الإجابة على أي سؤال وأرغب أن أؤكد لك أن المعلومـــات التـــي تذكرها/ يها ستكون مصدر ثقة وسرية وستستخدم فقط لغرض البحث العلمي وبدون ذكر الأسماء ولذا أرجو أن تكون الإجابات دقيقة.

وشكراً لك/ى على حسن تعاونك

استبيان للتعرف إلى مدى المعرفة والاتجاهات والممارسات المتعلقة بالصحة النفسية لدى العاملين الصحيين في مراكز الرعاية الأولية بوكالة الغوث الدولية في محافظات قطاع غزة

تاريخ تعبئة الاستبيان:_____ *** رقم الإستبيان**_____

اسم المركز الصحي:_____

أولاً: البيانات الأولية:

العمر: _____

الجنس: ☐ ذكر ☐ أنثى

مكان السكن: ☐ داخل المخيم ☐ خارج المخيم

الحالة الاجتماعية: ☐ متزوج/ة ☐ أعزب/اء ☐ أرمل/ة ☐ مطلق/ة

نوع الأسرة: ☐ نووية ☐ ممتدة

عدد جميع أفراد الأسرة: _____

عدد سنوات التعليم الجامعي: _____

مستوى التعليم: ☐ دبلوم ☐ بكالوريوس ☐ ماجستير ☐ دكتوراه

مكان التخرج: _____

هل ان المنهاج يحتوي علي مساق في الصحة النفسية: ☐ نعم ☐ لا

المهنة: ☐ طبيب عام ☐ طبيب أخصائي ☐ طبيب أسنان

☐ ممرض حكيم ☐ ممرض ☐ قابلة قانونية

☐ صيدلي ☐ مساعد صيدلي ☐ فني مختبر

☐ فني أشعة ☐ مرشد صحي ☐ مرشد نفسي

☐ أخصائي علاج طبيعي

مكان العمل: ☐ داخل قطاع غزة ☐ خارج قطاع غزة

عدد سنوات الخبرة في مجال الصحة: _____ سنة

سنوات العمل في مراكز الرعاية الأولية: _____ سنة

مكان العمل في الرعاية الأولية : ☐ داخل قطاع غزة ☐ خارج قطاع غزة

هل عملت في مجال الصحة النفسية ☐ نعم ☐ لا

إذا كانت الإجابة نعم فما هي الفترة _____ سنة.

الدخل الشهري للعائلة: _____ دولار أمريكي

ثانياً: مقياس المعرفة حول الصحة النفسية:

الرقم	السؤال	أوافق بشده	أوافقً	أعارض	أعارض بشده
أ-	**مفاهيم الصحة النفسية**				
1-	لديك معرفة كافية عن مفهوم الصحة النفسية.				
2-	الصحة النفسية تتصف بالقدرة علي التمتع بالحياة				
3-	الصحة النفسية هي مقدار الصلاده لدي الشخص				
4-	مفهوم الصحة النفسية يرتبط بقدرة الشخص علي التوازن في الحياه				
5-	مفهوم الصحة النفسية يرتبط بالمرونه في التعاطي مع صعوبات الحياه				
6-	الصحة النفسية هي الوصول إلي الكمال				
ب-	**أمراض الصحة النفسية**				
7-	تعتبر أن لديك معرفة كافية عن أمراض الصحة النفسية				
8-	المرض النفسي مرض معدي				
9-	هنالك فروق بين المرض النفسى و التخلف العقلي				
10-	المرض النفسي مرض وراثي ينتقل من الأباء إلي الأبناء.				
ج-	**أسباب الأمراض النفسية**				
11-	من أسباب الأمراض النفسية ضعف العامل الديني				
12-	من أسباب الأمراض النفسية ضعف العامل الأخلاقي				
13-	من أسباب الأمراض النفسية موت شخص عزيز				
14-	من أسباب الأمراض النفسية المشاكل المادية				
15-	من أسباب الأمراض النفسية القلق الدائم				

16-	من أسباب الأمراض النفسية البطالة				
17-	من أسباب الأمراض النفسية الفقر				
18-	من أسباب الأمراض النفسية المشاكل الأسرية				
19-	من أسباب الأمراض النفسية الحروب				
د-	**علاج الأمراض النفسية**				
20-	الأمراض النفسية يمكن شفاؤها.				
21-	المكان الوحيد لعلاج المرضي النفسيين هو مستـــشفي الأمـــراض النفسية				
22-	ممكن علاج الامراض النفسية في مراكز الرعاية الأولية				
23-	الحب و الدعم جزء لا يتجزء من غلاج الأمراض النفسية				

ثالثاً: مقياس المعتقدات عن الصحة النفسية

الرقم	السؤال	أوافق بشدة	أوافق	أعارض	أعارض بشدة
أ-	**معتقدات حول مفهوم الصحة النفسية**				
1-	أعتقد أن الصحة النفسية مهمة لكل فرد				
2-	أعتقد أن الصحة النفسية هي القدرة على التكيف في الحياة.				
3-	أعتقد أن الانسان يجب أن يكون قادر على حل مشاكله بنفسه.				
4-	اعتقد أن الصحة النفسية هي تقبل الحياة كما هي.				
5-	اعتقد أن الصحة النفسية تبني بالايمان بالله .				
6-	أعتقد أن الصحة النفسية هي تفهم مميزاتي وعيوبي.				
7-	أعتقد أن الصحة النفسية هي تفهم مميزات وعيوب الأخرين.				
8-	اعتقد أنه من المهم احترام رأي الأخرين مهما كان مخالف لرأي.				
9-	أعتقد أن العائلة عامل مهم لتحقيق الصحة النفسية				
10-	أعتقد أن الأصدقاء يلعبون دوراً مهماً في تحقيق الصحة النفسية				

ب-	**معتقدات حول الأمراض النفسية و أسبابها**				
11-	اعتقد أن الشخص المريض نفسيا غير قادر على تغيير حياته				
12-	اعتقد ان كل فرد يمكن أن يضطرب نفسياً.				
13-	اعتقد أن كل شخص يتعرض لضغط نفسي سوف يمرض نفسيا.				
14-	أعتقد أن المرض النفسي هو فشل في الحياة.				
15-	أعتقد أن المرض النفسي هو غباء وعدم فهم الحياة.				
16-	أعتقد أن أي تصرف غير طبيعي لأي شخص يعتبر أنه مريض نفسي.				
17-	أعتقد أن المريض النفسي مثل الميت بالحياة.				
18-	أعتقد أن المريض النفسي شخص متقلب المزاج والسلوك.				
19-	أعتقد أن المرض النفسي هو غضب من الله على الشخص المريض.				
20-	أعتقد أن المرض النفسي مس من الجن والشياطين.				
21-	أعتقد أن المريض النفسي يسيء لسمعة أهله.				
ج-	**مشاعر حول التعايش مع مرضي نفسيين**				
22-	أعتقد أن إذا عاش شخص سوي مع شخص مريض نفسيا سوف يصبح مريض نفسياً.				
23-	أ شعر بالخوف عند التعامل مع أي مريض نفسي.				
24-	أ شعر بالتعب عند التعامل مع أي مريض نفسي.				
25-	أ شعر بالضيق إذا كان جاري مريض نفسي.				
26-	لا أحب زيارة المرضى النفسيين في منازلهم.				
27-	أرفض استضافة أي مريض نفسي في بيتي.				
28-	أشعر بالحرج إذا كان قريبي مريض نفسي.				
29-	أشعر بالرضي بصداقتي مع مريض نفسي.				
30-	ممكن أن أزوج قريبي/قريبتي من شخص عنده مرض نفسي.				
31-	أرفض التعامل مع أي مريض نفسي حتى لو شفي.				
32-	أفضل التخصص في مجال الصحة النفسية				

رابعاً: مقياس التطبيق والخبرة لدى العاملين الصحيين في الرعاية الأولية:

1- هل يتردد علي العيادة أشخاص يشكون من مشاكل نفسية؟

☐ نعم دائماً ☐ نعم أحياناً ☐ لا يحضر

☐ لا يحضر مطلقاً ☐ لا ينطبق في مجال عملي

1-1 إذا كان الجواب ايجابياً، فكم عدد المرضى النفسيين الذين تواجههم في الأسبوع ؟

☐ 1 إلي 5 أشخاص ☐ 6 إلي 10 أشخاص ☐ أكثر من 10 أشخاص

1-2 ما هو نوع المرض النفسي الأكثر تردد بين هؤلاء؟

☐ شكوى جسدية متكررة ☐ اكتئاب ☐ أمراض ذهانية

☐ صرع (تشنجات) ☐ أعراض هستيريه ☐ تخلف عقلي

☐ قلق و توتر ☐ اضطرابات ما بعد الصدمة

☐ أعراض نفسيه أخرى، حدد_____

الرقم	السؤال	دائماً	أحياناً	لا	لا مطلقاً	لا ينطبق مع عملي
2	هل لديك قدره كافيه للتعامل مع هؤلاء المرضى؟					
3	هل تتأثر معاملتك مع المريض إذا كان لديه شكوى نفسية؟					
4-	هل تؤثر وجهة نظر المجتمع علي معاملتك مع المرضي النفسيين؟					
5-	أ تفهم الوضع النفسي للمريض لكي أتمكن من تقديم خدمة أفضل.					
6-	هل تلاحظ أن الشكوى الجسدية مرتبطة بالحالة النفسية لدي المريض؟					
7-	هل هنالك نظام أو بروتوكول متبع في العيادة لكيفية التعامل مع المرضي النفسيين؟					
8-	أستمع جيدا لمشاكل المرضى النفسيين.					

الرقم	السؤال	دائماً	أحياناً	لا	لا مطلقاً	لا ينطبق مع عملي
9-	أحتاج إلي وقت أكثر للاستماع إلي المريض النفسي					
10-	أعتمد علي الإرشاد النفسي في التعامل مع المرضى ذوي المشاكل النفسية.					
11-	دمج الصحة النفسية كبرنامج متكامل في مراكز الرعاية الصحية الأولية يسهل من عملي كمقدم خدمة صحية.					
12-	أنصح الشخص الذي يعاني من مشاكل نفسية بالتوجه إلي أخصائي أمراض نفسية.					
13-	أنصح الشخص الذي يعاني من مشاكل نفسية بالتوجه إلي مستشفى الأمراض النفسية مباشرة .					
14-	أنصح الشخص الذي يعاني من مشاكل نفسية بالتوجه إلي المعالجين الشعبين.					
15-	أنصح الشخص الذي يعاني من مشاكل نفسية بالاعتماد على أدوية الأمراض النفسية فقط.					
16-	أنصح الشخص الذي يعاني من مشاكل نفسية بالاعتماد على التداولي بالأعشاب فقط.					
17-	لا أقدم أي نصح في مجال الصحة النفسية.					

شكراً لحسن تعاونكم

الباحثة: هاله المغاري

Annex (6)

Invitation

Dear participants;

I'm Hala A/ Rahman Maghari , studying community mental health in Al Quds university (Jerusalem / Abu Dies). Currently, I'm preparing my theses on " **Mental Health among Primary Health Care Providers in UNRWA Clinics of Gaza Governorates: Knowledge, Attitudes, and Practice".**

The theses is one of the study's requirements for the master degree. Therefore, you have been chosen to participate in this work due to the important role you are applying in the field of primary health care at UNRWAs' health centers.

Aim of the study: to evaluate the level of knowledge, attitudes, and practices of primary health care providers toward mental health at UNRWA clinics in Gaza governorates. Also, to come out with suitable recommendations in order to release the tensions that our Palestinian suffer from.

Thank you for participation in answering the study's questionnaire.

You are free to accept or to refuse answering any question. I guarantee that your answers are under extreme confidentiality and top secret for the seek of scientific research without mentioning any names.

Thank you four your cooperation

Researcher: Hala Maghari

Questionnaire to evaluate the level of knowledge, attitudes, and practices toward mental health among primary health care providers toward mental health in UNRWA clinics of Gaza governorates.

Date:---------- questionnaire No.:----------

Health center: ----------

I. Socio-demographic data:

Age:----------

Sex: Male □ Female □

Place of residency: Camp □ Village □ City □

Marital status: Married □ Single □ Divorces □ Widow □

Family type: Nuclear □ Extended □

Family size:----------

Years of education:----------

Educational degree: Diploma □ Bachelor □ Master □ PHD □

Place of graduation:----------

The curriculum included course of mental health: Yes □ No □

Qualification: General practitioner □ Specialist □ Dentist □

Senior staff nurse □ Practical nurse □ Midwife □

Pharmacist □ pharmacy assistant □ X-ray technician □

physiotherapist □ E. Health worker □ psychosocial H. worker □

years of working experiences: ----------

years of primary health care work experiences: ----------

place of work : in side Gaza □ out side Gaza □

work in mental health field: Yes □ No □ If yes, how many years:----------

Monthly Income:----------$.

II. Level of knowledge of mental health

Se. No.	Statement	Strongly agree	agree	disagree	Strongly disagree
A.	**Mental health concept**				
1.	I have enough knowledge about mental health concept				
2.	Mental health means the ability to enjoy life				
3.	Mental health means the persons' level of resilience				
4.	Mental health concept related to the ability to balance life				
5.	Mental health concept related to flexibility to deal with life difficulties				
6.	Mental health means being perfect				
B.	**Mental health illnesses**				
7.	I have enough knowledge about mental health illnesses				
8.	Mental health illness is infectious				
9.	There are differences between mental health illness and mental retardation				
10.	Mental health illness is familial disease				
C.	**Causes of mental health illnesses**				
11.	poor religious believes cause mental health illness				
12.	Poor ethics causes mental health illness				
13.	The death of dear person causes mental health illness				

Se. No.	Statement	Strongly agree	agree	disagree	Strongly disagree
14.	Economical problems lead to mental health illness				
15.	Excessive tension leads to mental health illness				
16.	Unemployment leads to mental health illness				
17.	Poverty leads to mental health illness				
18.	Familial problems lead to mental health illness				
19.	Wars lead to mental health illness				
D.	**Treatment of mental health illnesses**				
20.	Mental health illnesses can be treated				
21.	Mental hospital is the only place to treat mental health illnesses				
22.	mental health illnesses can be treated in primary health care centers				
23.	Love and support are important in treating mental health illnesses				

III. Level of attitudes toward mental health

SE. No.	Statement	Strongly agree	agree	disagree	Strongly disagree
A.	**Attitudes toward the concept of mental health**				
1.	I belief that mental health is important to every individual				
2.	I belief that mental health is the ability to cope with life				
3.	I belief that the person should be able to solve his problems				
4.	I belief that mental health is accepting life as it is				

5.	I belief that mental health based on believing in 'GOD'				
6.	I belief that mental health is the ability to understand my strengths and weaknesses				
7.	I belief that mental health is the ability to understand others strengths and weaknesses				
8.	I belief that, it is important to respect others opinion even if I disagree with it				
9.	I belief that, the family is an important part in achieving good mental health				
10.	I belief that, friends play an important part in achieving good mental health				
B.	**Attitudes toward mental health illnesses and their causes**				
11.	I belief that, mental ill person is unable to change his life				
12.	I belief that, every person could have mental illness				
13.	I belief that, every person under tension could become mentally ill				
14.	I belief that, mental illness is being failed in life				
15.	I belief that, mental illness is being stupid and inability to understand life				
16.	I belief that, any abnormal behavior is considered as mental illness				
17.	I belief that, mental ill person is a died person				
18.	I belief that, mental ill person is having swinging mood				
19.	I belief that, 'GOD' got angry on the mental ill person				
20.	I belief that, mental illness is made by devils				
21.	I belief that, mental ill person cause a bad reputation for his/her family				

C.	**Attitudes toward being with mental ill person**				
22.	I belief that, if any health person lives with other mentally ill will become mentally ill too				
23.	I feel frightened while being with mentally ill person				
24.	I feel exhausted after being with mentally ill person				
25.	I feel embarrassed if my neighbor is becoming mentally ill				
26.	I don't like visiting mentally ill persons				
27	I don't accept any mentally ill visitor				
28.	I feel embarrassed if my relative become mentally ill				
29.	I feel relaxed with mentally ill friend				
30.	I may propose my relative to marry a mentally ill person				
31.	I don't accept dealing with mentally ill person even after his / her recovery				
32.	I prefer to become specialized in mental health field				

IV. Level of practicing mental heath

1. Do the clients who attend the clinic complain of mental health problems ?

Yes ☐ sometimes ☐ No ☐ Not at all ☐

IT doesn't belong to my work ☐

1.1 If 'yes' how many do you meet every week?

1- 5 persons ☐ 6 -10 persons ☐ over 10 persons ☐

1.2 what is the most common mental health illness among them?

Repeated physical symptoms ☐ depression ☐ psychotic symptoms ☐

fits ☐ hysteria ☐ PTSD ☐ mental retardation ☐

worries and tensions ☐ others ☐

Se. No.	Question	Always	Some-times	No	Not at all	Not applicable
2.	Are there any patients come to the clinic complaining of mental health illnesses ?					
3.	Do you have enough capability to deal with these cases?					
4.	Do your practices change if the patient has any mental health complain?					
5.	Do the public attitudes (cultural attitudes) affect your practices toward patients with mental health illnesses ?					
6.	I understand the patients' mental condition in order to provide a better service.					
7.	Do you notice that physical omplains related to psychological complains for those clients?					

Se. No.	Question	Always	Sometimes	No	Not at all	Not applicable
8.	Is there any protocol in your clinic guiding you in dealing with patients with mental health illnesses ?					
9.	I listen carefully to the patients' mental health complains.					
10.	I need more time to listen to the patients' mental health complains.					
11.	Are there any patients come to the clinic complaining of mental health illnesses ?					
12.	Do you have enough capability to deal with these cases?					
13.	Do your practices change if the patient has any mental health complain?					
14.	Do the public attitudes (cultural attitudes) affect your practices toward patients with mental health illnesses ?					
15.	I understand the patients' mental condition in order to provide a better service.					
16.	Do you notice that the physical complains related to the psychological complains for those clients?					
17.	Is there any protocol in your clinic guiding you in dealing with patients with mental health illnesses ?					

ملخص الدراسة

يحتفل العالم في العاشر من أكتوبر كل عام باليوم العالمي للصحة النفسية والذي حمل شعار" الصحة النفسية مسئولية الرعاية الصحية الوالية" حيث يهدف هذا الشعار لاحتواء المرضى النفسيين في المراكز الصحية الأولية ومنحهم الحق في العلاج والتأهيل في المراكز الصحية القريبة من مناطق سكنهم. لذلك من الضروري تثقيف مقدمي الخدمات الصحية العامة عن الاضطرابات النفسية وكيفية التعامل معها فكثير من الاضطرابات النفسية لها تأثير على الصحة العامة.

هدف الدراسة: استقصاء مستوى المعرفة، الاتجاهات، و الممارسات تجاه المرضى النفسيين لدى العاملين الصحيين في مراكز الرعاية الأولية في وكالة الغوث الدولية بقطاع غزة. لقد تم أخذ كل مجتمع الدراسة (594) عامل/عاملة صحية كعينه للدراسة، و كانت نسبة التجاوب 74% (عدد=410). و لقد طورت الباحثة مقياس استنبط من دراسات سابقه مماثلة لنفس الموضوع، و علي عينه مماثله لعينة الدراسة.

النتائج: بلغ مستوى المعرفة لدى العاملين الصحيين بالمشاكل النفسية 78.3%، مستوى الاتجاهات 75%، ثم مستوى الممارسات 74.4%. كذلك تبين أن هنالك تناسب طردي بين مستويات كل من المعرفة، المعتقدات، و التعامل. و قد أظهرت الدراسة أن 94.4% من العاملين أقروا بأن فعلا هنالك مرضى يعانون من مشاكل نفسية يترددون علي المراكز الصحية.

المشاكل النفسية الأكثر شيوعاً هي: الاكتئاب، التوتر، الآلام جسديه، الاضطرابات ما بعد الصدمة، التخلف عقلي، و الهستيريا. و من المهم بالذكر أن هنالك 91% من العاملين ينصحون المرضي النفسيين بالذهاب إلي أخصائيين نفسيين، بينما 81.2% ينصحوهم بالذهاب إلي المعالجين التقليديين (المشعوذين). في نفس الوقت 82.9% من أفراد العاملين الصحيين يوافقون علي دمج الصحة النفسية في مراكز الرعاية الأولية لتقديم خدمة أفضل، 70.1% لديهم القدرة علي التعامل مع المرضي النفسيين بالرغم من أن 63.6% يشعرون باختلاف تعاملهم عندما يعرفون أن المريض لديه اضطراب نفسي. و بالمثل 73% من العاملين الصحيين يتأثرون بوجهة نظر المجتمع تجاه الصحة النفسية و اضطراباتها.

أظهرت الدراسة أن النساء لديهن مستوي اتجاهات عن مفهوم الصحة النفسية أعلي من الرجال، لكن الرجال قادرين علي ممارسة و تطبيق أسس الصحة النفسية علي المرضي أكثر من النساء. وأن مستوي المعرفة و الاتجاهات أعلي لدي الفئة العمرية 30 عاماً فأقل من الفئات الأكبر سناً. كذلك بينت الدراسة أن العاملين ذوي درجة التعلم الجامعي فما أكثر لديهم مستوي معرفة، اتجاهات، و قدرة علي ممارسة الصحة النفسية أفضل من الدرجات العلمية الأخرى. فلذلك كانت فئة الأطباء أكثر معرفة و تفهم ، ثم فئة التمريض، ثم فئة العاملين الصحيين المساعدين الأقل معرفة وتفهم.

تستخلص هذه الدراسة إلى توعية وتثقيف الفريق العلاجي الذي يضم الأطباء والممرضين والفئات التخصصية المساندة لتحمل المسئولية ومشاركة الأهالي لتخفيف العبء عليهم في خدمة المرضى النفسيين. و تشير إلى أن الوقت قد حان لأن تتبنى الحكومات والأنظمة الخدمات الصحية ضمن أولى أولوياتها لابتكار مقاربة مدمجة للرعاية الصحية من شأنها أن تعزز الصحة وذلك عن طريق شمل كل أوجه المرض والصحة في نظام علاجي واحد.