FAWE Ethiopia Chapter

mastercard foundation Scholars Program

Prevalence and Determinants of Common Mental Disorders among FAWE-Ethiopia Scholars

A School-Based Study

Forum for African Women Educationalists-Ethiopia Chapter (FAWE-Ethiopia)

The Master Card Foundation-Scholars Program

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FAWE Ethiopia Chapter

FAWE Ethiopia Chapter is a member of the FAWE Network and works to replicate the FAWE Africa cause in Ethiopia. FAWE-ETH programs focus on influencing national education policies and practices provides comprehensive scholarships to bright yet disadvantaged students, advocates for gender-responsiveness of the curriculum and promotes a favorable school environment for both boys and girls.

Vision

FAWE-Ethiopia's Vision is to see a country in which there is no gender disparity in the education of the country.

Mission

In line with its vision, FAWE-ETH will foster innovations, promote positive policies/practice and provide opportunities for girls and young women, especially those in extreme adversity, to develop skills and competencies that will allow them to be productive members of their societies.

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ACRONYMS AND ABBREVIATIONS

CI	Confidence Interval
CMD	Common Mental Disorder
DAS	Depression, Anxiety and Stress
DALY	Disability Adjusted Life Years
DSM	Diagnostic Statistical Manual
FAWE	Forum for African Educationalists
FMOH	Federal Ministry of Health
GAD	Generalized Anxiety Disorder
ICD	International Classification of Disease
LMICS	Lower Middle Income Countries
MDD	Major Depressive Disorder
MI	Mental Illness
OR	Odds Ratio
PCP	Primary Care Physician
PSQ	Psychosis Screening Questionnaire
SQR	Self-Reported Questionnaire
WHO	World Health Organization

ABSTRACT

A mental illness is a disease that causes mild to severe disturbances in thought and/or behavior, resulting in an inability to cope with life's ordinary demands and routines. Common Mental Disorders (CMDs) are depressive and non-psychotic symptoms, anxiety, and somatic ailments that cause a problem with the performance of daily activities. [3] Mental illnesses are associated with distress and/or problems functioning in social, school, work, or family activities. [4] This study, therefore, examined the prevalence and determinants of common mental disorders among FAWE-ETH scholars and generates programmatic alternatives to systematically respond to the mental health needs of the FAWE-Ethiopia scholars. Additionally, the study assessed the level of mental health literacy among teachers.

A cross-sectional study was carried out in a sample of 117 FAWE-Ethiopia scholars who are currently pursuing their study in 8 public and private schools located in Addis Ababa, Adama, Hawassa & Bahirdar towns. Systematic random sampling was used to select the sample scholars and convenient sampling was employed to select teachers. SRQ-20 (with a cutoff point 7), and MAKS instruments were included within the structured questionnaire tool to determine CMD prevalence and the level of teachers' mental health knowledge. The Data was entered into and analyzed using SPSS version 26. Both descriptive and regression analysis (bivariate and multivariate analysis) methods were used to interpret and analyze the collected data.

The results of the study indicated a relatively higher level of CMD prevalence (25.4%) and a lower prevalence when compared to similar school-based studies conducted in other developing country settings. The study results also revealed that the level of knowledge among teachers was found to be low. More than half of the study participants demonstrated that they had poor knowledge of mental health. The likelihood of having mental distress was found to be higher among scholars, who were female, and who are not currently living with their biological parents. The present study also unveiled scholars who reported having examination anxiety, academic pressure and those who feel less connected with their school and report low self-satisfaction with their academic performance were at higher risk of developing mental distress.

To address the high level of CMD prevalence and the low level of mental health knowledge, the study recommends for the design and implementation of comprehensive scholar's mental health support services or initiatives to meet the mental health need of scholars and other students. Furthermore, implementation of school-based mental health promotion and communication interventions targeting both teachers and students is strongly recommended to improve the mental health literacy of the school community.

Key Words: Common Mental disorders, Mental Distress, Mental Health, Knowledge, and Prevalence

CHAPTER ONE

2. Introduction

1.1. Background

A mental illness is a disease that causes mild to severe disturbances in thought and/or behavior, resulting in an inability to cope with life's ordinary demands and routines. There are more than 200 classified forms of mental illness. Some of the more common disorders are depression, bipolar disorder, dementia, schizophrenia and anxiety disorders.[1] Parekh (2015) also defined Mental illnesses as health conditions involving changes in thinking, emotion or behavior (or a combination of these).[2] Common Mental Disorders (CMDs) are depressive and non-psychotic symptoms, anxiety and somatic ailments that cause problem with the performance of daily activities. CMD symptoms includes: difficulty in concentrating and forgetfulness, insomnia, fatigue, irritability, feeling of inutility and somatic ailments, among others.[3]

Mental illnesses are associated with distress and/or problems functioning in social, school, work or family activities. Modern scientific evidence indicates that mental and behavioral disorders are the result of genetics plus environment or, in other words, the interaction of biology with psychological and social factors. Mental health problems affect society as a whole, and not just a small, isolated segment. No group is immune to mental disorders, but the risk is higher among the poor, homeless, the unemployed, persons with low education, victims of violence, migrants and refugees, indigenous populations, children and abused women, the neglected elderly and adolescents.[4] The period of adolescence is characterized by physical, emotional and personality changes and these changes can lead to psychological stress, emotional and behavioral problems. It is estimated that 10-20% of adolescents worldwide experience mental health problems.[5]

A study conducted in UK have showed that there is a 10 % overall prevalence of CMDs among 5 to 15 years olds. The prevalence maybe as high as 25 % among adolescents who have been

enrolled to primary care services.[6] A study conducted in southern Brazil revealed that the prevalence of CMD among adolescents was 22.7 % (17.9% males and 26.5% females) and increased with age.[7] In spite of the fact that CMD affect individuals from all age groups, when present in children and adolescents, may be early and less specific manifestations of more serious mental and behavioral disorders, also creating problems in social relationship and academic performance.[8] In Ethiopia, some studies conducted to assess the prevalence and risk factors for CMD in the adult population and few studies evaluated CMD prevalence and risk factors among university students. [9-12] However, there are a dearth of studies conducted to examine prevalence and risk factor for CMD among school youth and literature on adolescent CMD is non-existent.

Understanding of CMD and its determinants among school youth can significantly contribute to the early identification, planning and implementation of interventions that can address common mental disorders among school youth and its negative impacts such as, low academic performance, and increased drop-out rates. It's also important to enhance the role of teachers as frontline mental health service providers for their students, yet with limited mental health literacy or training to provide care, teachers have little support to effectively execute this role. [13] It was with this background that FAWE-Ethiopia chapter and Impact Ethiopia Psychological Services and Public Health Consulting PLC collaborated to conduct this study to assess the prevalence and determinants of CMDs among FAWE-Ethiopia scholars to generate programmatic alternatives and interventions to address the mental health needs of FAWE-Ethiopia scholars and integrate mental health in its comprehensive scholarship program that aims at providing bright yet disadvantaged students with the necessary scholastic material and empowerment support.

To this effect, this study has focused on systematically examining the prevalence and determinants of mental disorders among FAWE-ETH scholars and generating programmatic alternatives to systematically respond to the mental health needs of the FAWE-ETH scholars.

1.2. Statement of the Problem

Community-based surveys across the world revealed that the prevalence of common mental disorders among the general population is very high. In the United States (US) national Comorbidity survey, the lifetime prevalence of mood and anxiety disorders was 20.8% and 28.8%, respectively. [14] Twelve-month prevalence estimates of mood and anxiety range from 6.6% to 18.1% across surveys from Australia and the US community. [15] Population-based surveys in Africa generally showed a higher prevalence of common mental disorder among the community from 10.8% in Kenya to 34.9% in South Africa. Whereas, a 12.1% of lifetime prevalence and 5.8% of 12-month prevalence of common mental disorders (CMDs) were shown in Nigeria. [16-17] Available community-based studies in Ethiopia conducted in Butajira, Addis Ababa, and Kombolcha town indicated that common mental disorders are the highest ranging from 17%-32.4%. [18-21]

The issue of mental health is critical during adolescence. According to Kessler et al (2005), most of the mental health problems diagnosed in adulthood begin during the period of adolescence. Half of the lifetime diagnosable mental health problems including anxiety, depression, severe emotional disorder, and attention-deficit/hyperactivity disorder start by age 14; this number increases to three fourths by age 24. [22] Global estimates on prevalence rates of mental illness among children and adolescents showed that it ranges from 1% to 50%. Community-based studies conducted in different countries and cultural contexts unveiled that the overall prevalence rate for mental disorders among adolescents is around 20 %.[23]

No group is immune to mental disorders but the risk is higher among the poor, homeless, the unemployed, persons with low education, and victims of violence, migrants, and refugees, indigenous populations, children and adolescents. [24-25] Moreover, poor mental health underlies risk behaviors, including smoking, alcohol, and drug misuse like khat and lack of exercise. Studies also showed that CMDs were associated with stress related to family, work, school, social isolation, chronic physical illness, and lifestyle pressures. [26]

Additionally, there is a positive association between mental health problems and negative school performance, and in some cases, serious mental illnesses require referrals for special education services. The emotional distress related to having a mental health issue can seriously compromise student learning potential, and contribute to absenteeism, poor grades, and school dropout. [8]

However, there are no school-based studies conducted in Ethiopia to examine the prevalence and determinants of CMD among school youth. Therefore, the purpose of this study was to examine the prevalence and determinants of CMD among FAWE-ETH scholars in program supported public and private schools located in four regions of Ethiopia, namely; Addis Ababa, Oromiya, Sidama & Amhara regions. The study has also examined the mental health literacy of school teachers and school principals or directors.

Thus, this study has systematically examined the prevalence and determinants of common mental disorders among FAWE scholars and generates programmatic alternatives or recommendations to systematically respond to the mental health needs of the FAWE-ETH scholars.

1.3. Objectives of the Study

1.3.1. General objective

The general objective of the study was to examine the prevalence and determinants of common mental disorders among FAWE scholars and generate programmatic alternatives to systematically respond to the mental health needs of the FAWE-ETH scholars.

1.3.2. Specific objectives

The study has the following specific objectives:

- Examine and estimate the prevalence of CMDs among scholars in FAWE-ETH supported schools.
- Identify the determinants of CMDs among FAWE-ETH scholars.
- Assess the level of mental health literacy of teachers and school administrators.

- Generate programmatic alternatives and recommendations so as to address the mental health needs of FAWE-ETH scholars.
- Address the critical research gap in the area of school mental health and inform policy development and program implementation.

1.4. Research Questions

Based on the aforementioned objectives of the study, the study formulated and tried to address the following key research questions:

- What is the prevalence of common mental disorders among FAWE-ETH scholars?
- What are the associated factors to mental illness among scholars?
- How is the level of mental health literacy among teachers?
- What possible program alternatives or interventions could be recommended to address the mental health needs of FAWE-ETH scholars?

1.5. Significance of the Study

The Master card foundation supported FAWE-Ethiopia's Scholars Program is a ten-year comprehensive scholarship program that aims at providing bright yet disadvantaged students with the necessary scholastic material and empowerment support. Over the 10 years, the program aims to support 800 (600 girls and 200 boys) academically talented but economically disadvantaged secondary school (grade 9 – 12) students to acquire essential knowledge and skills through quality education to enable them to have better access to livelihoods and contribute to household, community and national development.

However, the realization of this overarching goal of the program can be challenged by common mental disorders (CMDs) in which the program had no empirically validated evidence about the prevalence and its determinants among the scholars. Data from the 2004 NHIS showed that low-income adolescents had more than twice the rate of higher-income adolescents to have mental health difficulties. [27] Additionally, study findings stressed that mental health has a significant impact on academic performance and drop-out rates among school youth. [13] To this effect, the study will provide important insight about the

prevalence and determinants of CMDs among disadvantaged school youth to educationalists, health policymakers, program planners, researchers, and other actors whose work is related to mental health and education at all levels.

Additionally, the study will also address a huge research gap in the area of youth mental health problem in Ethiopia and inspires other youth and education program implementing actors and concerned government bodies to conduct further studies and generate policy and program alternatives to address the mental health needs of disadvantaged school youth.

1.6. Scope of the Study

The study was delimited to examine the prevalence and determinants of common mental disorders among FAWE scholars located in 8 public and private schools in Amhara, Oromiya, Addis Ababa city administration, and Sidama regions.

Chapter Two

3. Review of Related Literature

2.1. Background

2.1.1. Mental Health, Mental Health problems and, Mental illness

Mental health is integral to overall human health and wellbeing. However, when people narrowly define mental health, it may be conceptualized as the absence of mental illness. The terms 'mental health problems' and 'mental illness', while often contested, refer more specifically to the range of cognitive, emotional and behavioral disorders that interfere with the lives and productivity of people. Mental health problems are the most commonly reported type of mental health complaint and are commonly the result of a reaction to life stresses or negative life experiences. [28]

According to the Hunter Institute of Mental health (2013) mental health is a positive concept related to the social and emotional wellbeing of individuals and communities. The concept is culturally defined, but generally relates to the enjoyment of life, ability to cope with stresses and sadness, the fulfillment of goals and potential, and a sense of connection to others.[29] However, mental illness is a condition that seriously affects the individual ability to function in day to day social activities such as school activities. As Bland, Renouf and Tullgren (2009) pointed out, Mental illness doesn't occur in splendid biological or genetic isolation; it evolves out of the messy reality of our lives (epidemiological factors). The 'knock-on' effects of mental illness in our lives may include homelessness, poverty, estrangement from family and friends, underemployment or unemployment, and a myriad of other experiences that speak of our marginalization or otherness. This is the 'lived experience' of madness, and for each of us it is unique.[30]

Mental problems and illness alter the way people think and how they perceive their environments. They can affect levels of hope, trust, self-efficacy and personal relationships, thereby clearly having knock-on effects on community wellbeing. Mental illness comprises

the construction of our identities at a time when we are trying to make sense of who we are, meaningfully and coherently, in relation to ourselves, others and the wider society.[31]

Today, mental health problem is recognized as a public health problem in developed as well as developing countries. [32] The public health significance of mental and behavioral disorders is demonstrated by the fact that they are among the most important causes of morbidity in primary care settings and produce considerable disability.[33]

This literature review part of this proposal is therefore designed to review studies on common mental disorders and its determinants among school youth and the level of teacher's mental health literacy. The review will take a deep dive on determinants of CMDs including academic and non-academic risk factors and programmatic measures to address the problem of CMD among disadvantaged school youth. The review will also provide empirical evidences on the knowledge and perceived beliefs of mental disorders among school teachers. Therefore, the review will have three major three parts, the first part will discuss the findings of different studies on prevalence of CMD and determinants of CMD among school youth, the second part will go through the mental health literacy of school teachers and the third part of the review will discuss policy and program alternatives to address the problem of CMDs among school youth.

A search for peer reviewed journal articles and reports have been made using MEDLINE data base (pub med), Google scholar and DOAJ online internet sources. The search used Common mental disorders (CMD), mental disorders, mental illness, mental health literacy, prevalence, determinants and adolescent as a key word.

2.2. Prevalence and Determinants of Common Mental disorders

Epidemiological studies have consistently reported a high prevalence of psychiatric disorders worldwide, especially in developing countries. [34] Although disorders including insomnia, anxiety, fatigue, irritability, depressive moods, difficulty concentrating, and somatic complaints are very common among adults, they are quite often overlooked and effective treatment is not provided.[34, 35, 36, 37 & 38]

This set of symptoms comprises the group of common mental disorders (CMD). [34] CMDs refer to conditions of psychic distress that meets the nosological criteria of the ICD-10 and the DSM for the most prevalent disorders, including the groups of anxiety, depressive, and substance abuse disorders (mainly alcohol), in their mild or even moderate forms. They are well-known causes of major functional incapacity, which is often as significant as that seen in well-established psychiatric condition. In addition to the individual's distress, this condition has a considerable socioeconomic impact due to absenteeism and demands for health services, and thus represents a public health concern. CMDs have particularly significant implications regarding women's health and prenatal and childhood health. [36]

According to one cross-sectional survey of private households conducted in Santiago, Chile, to determine the prevalence of common metal disorders and socio-demographic correlates among adults, the most common symptom was 'worries', with a prevalence of 43%. Other non-specific symptoms were also common, such as fatigue, irritability and sleep problems. Specific psychiatric symptoms such as depression, anxiety or phobias were less common. All symptoms were more common in women than in men. [26] This study showed that the overall prevalence of CMD in Greater Santiago was 26.7% (95% CI 24.5-29.0), including both CIS-R cases and ICD-10 diagnosis. Approximately half of these individuals met ICD-10 criteria for at last one of the five diagnosis studied and the remaining half were cases of 'non-specific neuroses. Depressive and generalized anxiety disorders were the most common ICD-10 diagnosis found in this study. Taken as a whole 9.5% (95% ci 8.1 -10.9) of the preceding week. Women had higher prevalence rates than men in all diagnostic categories with the exception of the least prevalence diagnosis of obsessive compulsive disorder. [26]

Another study conducted in Agincourt, the rural Limpopo Province of South Africa, and in Khayelitsha, a Peri-urban township near Cape Town, using self-report instruments (SRQ) in two random population samples and among respondents at primary care and traditional healer settings, to assess common mental health problems shows that the symptoms scores in Khayelitsha were higher than in Agincourt. In Khayelitsha, more than one-third (34.9%) of the community sample reported high levels of anxiety or depression symptoms on the SRQ. Among the respondents from primary care and traditional healer samples high SRQ rates

were found among about three quarters of respondents (72.5 and 82.9%, respectively). In Agincourt, 27% of the community sample showed significant symptoms of depression, anxiety or other common mental health problems, while these symptoms were approximately twice as high in people attending primary care or traditional healer services.[39]

Regarding the prevalence of CMDs among school going adolescents, a study has been conducted in Chandigarh, India to determine the prevalence of depression, anxiety and stress among school going adolescents. According to the findings of this study, that overall comorbidity between all three disorders, i.e., DAS was 36.1%. On comparison of DAS among participants of 9th, 10th, 11th, 12th classes, it has been found that depression was higher in 12th class, anxiety was higher in 10th class, and stress was higher in 9th class. While comparing DAS among participant of non-board (9th + 11th) and board classes (10th + 12th), it was found that it was higher in board classes than in non-board classes. It was found that all types of depression (75.59%) and stress (53.52%) were higher in board classes than of non-board classes (57.2% and 41.63%, respectively).[40]

Another population based cross-sectional conducted Pelotas, a southern Brazilian city found a 28.8 prevalence of CMD among adolescents. CMD was measured with the Self-Report Questionnaire (SRQ-20). [41] A study conducted using data from using data from the 1992-1994 NHIS surveys examined the prevalence and impact of parent-reported disabling mental health conditions among U.S. children and adolescents. According to this study, about 3% (30.7/1,000) of 12- to 17-year-olds have school limitations due to mental health disorders. This includes those with mental retardation, learning disabilities, attention deficit and hyperactivity disorder and other disabling mental health problems such as depression, autism, anxiety, or oppositional defiant disorder. [42]

Concerning the risk factors or determinants of CMDs, the Santiago, Chile population based study found that CMDs were significantly more prevalent among women than men. Age was associated with the prevalence of CMD: the highest prevalence was found among those individuals aged 25-39 years and the lowest in the oldest group. Respondents who had been separated or widowed were more likely to be a case of CMD than single individuals. Both education level ($x2=14.07$, $d.f.=3$, $P<0.0001$) and social class according to occupation

(x2=27.68, d.f.=3, P<0.0001) had linear dose-response association with the prevalence of CMD. [26]

Two studies from Ethiopia assessed the prevalence of common mental disorders and its associated factors among residents of Jimma and Kombolcha towns. Both studies follow a community based cross sectional study design. A total of 526 (Kombolcha) and 745 (Jimma) were selected using a multi stage probability sampling technique. Both studies used a Self-Reporting Questionnaire (SRQ) to determine the prevalence of common mental disorders and a univariate, bivariate and multivariate analyses methods were considered in these studies.[43]

The results of the Kombolcha study revealed that considering seven as a cutoff point, about 166 (32.4%) of the respondents with 95% confidence interval (30.3-34.5%) scored above the cutoff point indicating presence of common mental disorders. More women (33%) than men, rural residents (33.3%) than urban residents, current khat chewers (39.2%) than non-chewers, current alcohol drinkers (42.2%) than non-drinkers, smokers (73.2%) than nonsmokers had common mental disorders. The prevalence of common mental disorders was found to be 40.5% in 55 and above age groups, 41.2% in widowed, 48.5% in those who had no formal education, 37.1% in those who had less than 400 Eth birr monthly income, 42.2% in casual laborers and 36% in daily users of khat. Of those who had family history of mental illness nearly two third of them had common mental disorders. Among respondents who reported at least one chronic illness, more than half (53.4%) of them had common mental disorders. [43]

Similarly, studies examined the risk factors or determinants of CMDs among adolescents or school youth. The study conducted in Chandigarh, India reported that Poor socioeconomic conditions and father's occupation (nonworking) were directly related with higher level of DAS. With increase in the education level of parents, level of DAS in their children decreased. As the parents love decreased, level of depression and stress in the participants increased. DAS was found to be more among students whose mothers were not alive. The level of anxiety was found higher in the participants belonging to the joint families. Students staying away from home in hostels and paying guest accommodations had higher levels of depression and stress. It was found that the prevalence of depression and stress was more

in students who were bullied by batch mates. It was also found that the prevalence of DAS was more in students who felt overburdened with test schedules. The level of stress was higher among the participants who were not self-satisfied with their academic performance and whose parents were not satisfied. Participants, who took alcohol and smoked, showed higher prevalence of DAS.[40]

Social media could also be a distant factor for children's and adolescents mental health. A systematic review of 11 studies assessing social media use and depressive symptoms in children and adolescents showed a small but statistically significant relationship. [44] Similarly, a meta-analysis of 23 studies revealed that there is a correlation between problematic Facebook use and psychological distress in adolescents and young adults. [45] Additionally, social support is found to be influencing the relationship between social media use and mental health of adolescents. According to studies, adolescents with low social support are more likely suffer from common mental disorders (e.g. depression, anxiety and psychological distress) compared to those with strong social support from friends, family and neighbor's. [46, 47]

According another study that assessed academic stress, parental pressure, anxiety and mental health among Indian high school students revealed that gender was found to be significantly associated with examination-related anxiety and psychiatric problems. That is, female students experience more examination-related anxiety and psychiatric problems than their male counterparts. The same study also assessed the effect of extra-curricular activities on students stress level as it is believed that that extra-curricular activity could be one of the mediating factors for academic stress. However, the study showed that there is no significant difference is found between the academic stress of students who are involved in extra-curricular activities and who are not. Furthermore, the study revealed that that 63.5% of the students are stressed because of academic pressure. There were no significant differences in academic stress across gender, age, class, and other factors.[48]

2.3. Mental Health Literacy (Knowledge and perceived beliefs about mental illness) among school teachers

Jorm et al [1997] introduced the term 'mental health literacy' and have defined it as "Knowledge and beliefs about mental disorders which aid their recognition, management or prevention. Mental health literacy includes the **ability to recognize specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking."**[49] The need for the public to have greater mental health literacy is highlighted by the high lifetime prevalence of mental disorders (up to 50%), which means that virtually everyone will either develop a mental disorder or have close contact with someone who does.[49] In some developing countries where more than half of the population may be illiterate the dimensions of mental health literacy are totally different from those in Western countries. Supernatural causes of mental disorders are more widely held and traditional sources of help, such as spiritual healers, are preferred over medical advice for a range of mental health problems in these countries. [50] This part of the review will therefore emphasize on the mental literacy of teachers including their ability to recognize mental disorders, their beliefs about the etiology of mental illness, and help seeking, and school level response for mental health problems.

According to an ecological model study to assess school-based mental health services for urban low-income aggressive children, there has been found a strong association between teacher mental health literacy, and child outcomes, such as the child's mental health, behavior, educational engagement, and academic performance. [51] Addressing mental health literacy during the period of adolescence also has the potential to foster an understanding of mental health and mental disorders that will serve young people through subsequent life stages. [52] However, failure to detect adolescent's internal symptoms such as depression and anxiety is a serious barrier in responding to the problem. Detection of student's behavioral and internal symptoms is limited by low mental health literacy of teachers. [53]

A study conducted by Daniszewski (2013) to examine teachers' mental health literacy and capacity towards student mental health showed that . . .

> *"Teachers were most knowledgeable about the signs and symptoms of student mental health (M = 3.26, SD = 8.6) and least knowledgeable about legislation related to mental health issues (M = 2.75, SD = 1.07). Knowledge about the appropriate actions to take and school system services (M = 3.16, SD = .89; M = 3.02, SD = .97, respectively) hovered just above the midline, 'somewhat knowledgeable'. Teachers' mean ratings of their comfort levels in talking with students about mental health (M = 3.36, SD = 1.12), providing support to students (M = 3.38, SD = 1.06), and accessing school and system services for students with mental health issues (M = 3.36, SD = 1.06) were approximately equal. However, teachers' comfort levels in talking with parents about their child's mental health were, on average, lower (M = 3.05, SD = 1.15)."* [54]

Miller et al. (2009) puts teachers in a unique position in their study to explore the role of positive psychology in school based interventions. The study stressed that . . .

> *"Teachers are in a unique position to promote positive mental health among students by practicing positive psychology principles, such as health promotion, resilience and subjective well-being, integrating these with academics. For example, an intervention targeted towards students with internalized behavior problems such as anxiety or depression is to assist them in defining clear goals, discover there are many paths to reach these goals, and garner the self-efficacy and motivation to achieve them. This type of intervention, sometimes termed 'hope therapy', has been found to decrease depression and anxiety and may protect against school-dropout by building hope and optimism in youth participants."* [55]

2.4. Programmatic Alternatives to Address CMDs in Schools

School based programs or interventions are necessary to narrow the gap between student's mental health needs and the availability of mental health resources. According to Santor et al. (2009), School based mental health service can be defined as "any mental health or substance abuse service or program that can be delivered in a school setting." [56]

The study conducted in Chandigarh, India, suggested different evidence-based school-based interventions that need to be delivered in a school setting. According to this study, to address the problem of depression, anxiety and stress among students, provision should be made for a natural mentoring program for the children as well as adolescents. Psychological health should be the prime concern of school authorities, and it should be integrated with school health programs. [40]

Additionally, child-centered activities including individual mental health consultation and specific problem-focused interventions as well as more general classroom programs to improve **coping skills, social support, and self-esteem** . Although school health program is running in various schools mental, psychological, and emotional dimensions are not given adequate attention, it is recommended that school health program should be strengthened by including above-mentioned aspects. Child psychologists should be recruited on permanent basis in government schools. There should be counseling sessions for students and their parents. [40]

Current studies also stressed the importance of integrating psychological and emotional support services in schools as it's effective in improving student's social and emotional competence which can positively influence academic performance. This is demonstrated in research findings that schools which have expanded mental health care services (i.e. school-based mental health clinics and programming) report higher grade point averages, fewer dropouts and better attendance among students who receive services in the school setting.[57]

Chapter Three

4. Research Methodology

3.1. Background of the Study Areas

This study was conducted in **8 public and private schools** located in 1 city administration and 3 regions of Ethiopia namely; **Addis Ababa City Administration, Sidama, Oromiya & Amhara** regions. Currently, 529 academically talented but economically disadvantaged scholars are pursuing their education in these 8 schools under the Master Card Foundation supported FAWE-ETH scholars program. According to the 2007 population census, the study areas or the regions are characterized by high population density. The Oromia region (36.7%), the Amhara region (23.3%), and Addis Ababa City Administration (3.7%) were among the highly-populated regions. [1]

Figure 1: Map of Study Areas



[1] Federal Democratic Republic of Ethiopia Population Census Commission, 2007)

A Joint Press release by CSA and UNICEF (17 January 2019) indicated that given their large population sizes, Oromia, Amhara, and Sidama (previously part of SNNPR) regions are the largest contributors to multi-dimensional child (under the age of 18) deprivation in Ethiopia. The three regions jointly accounted for 34 of the 36 million deprived children in Ethiopia, with Oromia having the highest number at 16.7 million, SNNPR at 8.8 million, and Amhara at 8.5 million.[2] Education is one of the key dimensions of deprivation. The regions are also characterized by a relatively higher level of gender disparities in secondary school attendance rates.

Thus, the study targeted 8 schools located in 4 cities: Addis Ababa, Hawassa, Bahirdar & Adama to examine the prevalence and determinants of common mental disorders among FAWE-ETH scholars. The below table (table 1) depicts the distribution of FAWE-ETH scholars by region, type of school, and sex of scholars.

Table 1: distribution of FAWE-Ethiopia scholars by region, city and Sex, and type of school

Sex	Addis Ababa		Total	Sidama		Total	Oromia		Total	Amhara		Total	Total		G.Total
	Bashswam	Millinium		BNB	Tabor		Nafyad	Goro		B.Academy	Tana Haik		Private	Government	
Male	25	11	36	26	13	39	25	16	41	19	17	36	95	57	152
Female	71	29	100	62	31	93	68	17	85	55	44	99	256	121	377
Total	96	40	136	88	44	132	93	33	126	74	61	135	351	178	529

3.2. Study Design

A school-based cross-sectional (descriptive and analytical) study was conducted to examine the prevalence and determinants of common mental disorders among FAWE-ETH scholars pursuing their study in 8 public and private schools in Addis Ababa city administration, Amhara, Oromiya, and Sidama regions, Ethiopia.

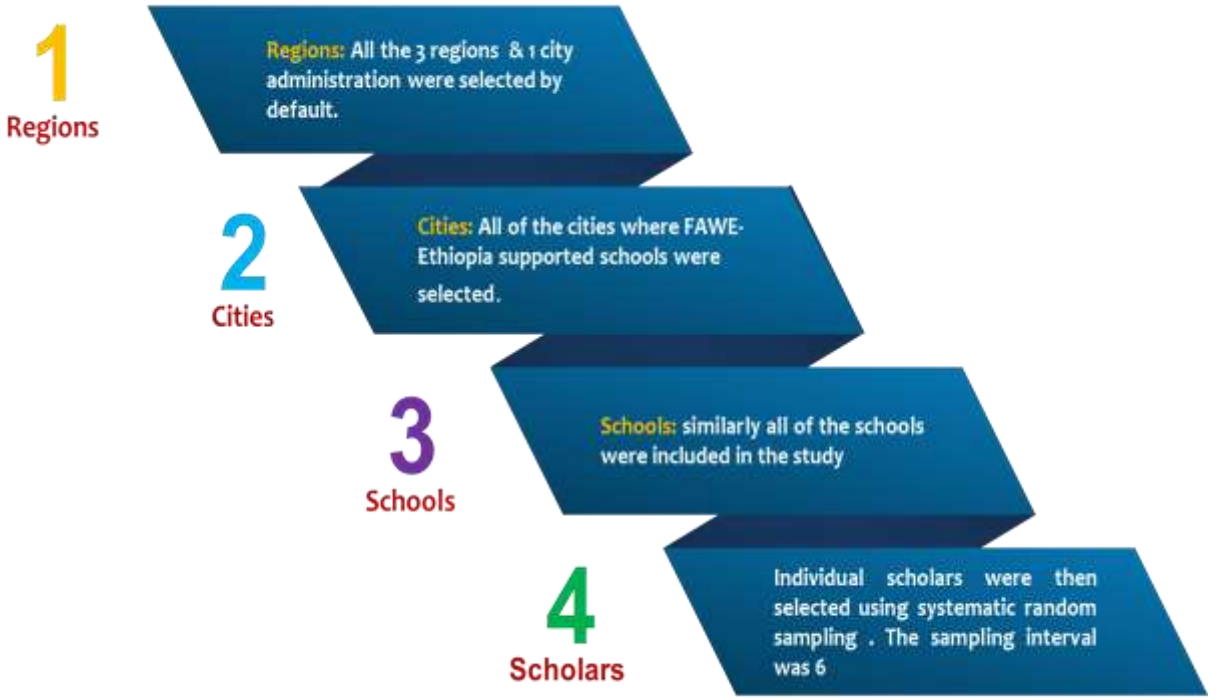
2 https://www.unicef.org/ethiopia/press-releases/nearly-36-million-children-ethiopia-are-poor-and-lack-access-basic-social-services

3.3. Sample Size and Sampling Technique

The sample for this study was drawn from 8 schools located in one city administration and 3 regions. The schools were selected as they are the only schools teaching FAWE-ETH scholars. A study conducted in southern Brazil revealed that the prevalence of CMD among adolescents was 22.7 % (17.9% males and 26.5% females) and increased with age.[7] Even though, CMD affects individuals from all age groups, when present in children and adolescents, may be early and less specific manifestations of more serious mental and behavioral disorders, also creating problems in social relationship and academic performance.[8]

Hence, the study sample was selected using a systematic random sampling technique from each school using the list of FAWE-Ethiopia scholars as a sampling frame. The sample size has been distributed to each school according to **probabilities proportional to size.** The below diagram depicts the sampling procedure used in the study:

Figure 2: Schematic presentation of the sampling procedure of the study.



3.3.1. Sample size determination

As there are no school-based studies in Ethiopia that examined the prevalence and determinants of common mental disorders among students, this study took a 20 % CMD prevalence using the studies conducted in developing countries context as a reference to calculate the sample size. The period of adolescence is characterized by physical, emotional and personality changes and these changes can lead to psychological stress, emotional and behavioral problems. It is estimated that 10-20% of adolescents worldwide experience mental health problems.[5] Consequently, the sample size for this study was calculated using the prevalence rate of 20 % to obtain a maximum sample size at 95 % certainty, ± 6 % margin of error, and 5 % non-response rate. This provided a sample size of **129** out of a total of **516** FAWE-Ethiopia scholars. (See the steps for sample size calculation below). Additionally, 2 teachers and 1 school director/principal from each school were included in the study using a convenience sampling methodology to assess their mental health literacy. Therefore, a total of 16 teachers and 8 school directors/principals were part of this study.

The sample size (n) is calculated according to the formula: $n = [z^2 * p * (1 - p) / e^2] / [1 + (z^2 * p * (1 - p) / (e^2 * N))]$

Where: z = 1.96 for a confidence level (α) of 95%, p = proportion (expressed as a decimal), N = population size, e = margin of error.

z = 1.96, p = 0.2, N = 516, e = 0.06

$n = [1.96^2 * 0.2 * (1 - 0.2) / 0.06^2] / [1 + (1.96^2 * 0.2 * (1 - 0.2) / (0.06^2 * 516))]$

$n = 170.7378 / 1.3309 = 128.289$

$n \approx 129$

3.4. Data Type and Source

The study examined the prevalence and determinants of common mental disorders among FAWE-ETH scholars pursuing their study in 8 public and private schools in Addis Ababa city administration, Amhara, Oromiya, and Sidama regions, Ethiopia. Both quantitative and

qualitative data has been collected from randomly selected **118** FAWE-ETH Scholars, and conveniently selected 17 school teachers and school directors/principals.

The source population for the study was students of grade 11 and 12, and beneficiaries of the FAWE-ETH scholars program. Additionally, the study assessed the level of mental health literacy among teachers and administrators of the schools where the scholars are being supported. Individuals or students, who are seriously ill, cognitively impaired to consent, and those who are unable to hear and recall events were excluded from the study.

3.4.1. Variables

Independent Variables

Socio-demographic and economic characteristics of scholars including age, sex, academic performance, religion, educational status, family occupational status, family income, and size were taken as independent variables. Behavioral variables such as substance use, level of social and family support, level of school connectedness, academic-related stress factors, financial difficulty, and previous mental and medical illness history related variables such as a history of mental illness, and chronic physical illness were taken as independent variables.

The Dependent Variables or Outcome Variables

Mental distress [yes/no]

Mental health knowledge [Good Knowledge/Poor Knowledge]

3.5. Data Collection Tools and Procedure

The required qualitative and quantitative data were collected using a structured questionnaire. The questionnaire was initially prepared in English and later translated into Amharic. The content of the questionnaire designed for students included socio-demographic variables, substance use behavior indicators, physical & emotional complaints, school connectedness measures, and academic-related stress factors, and SRQ-20 items to determine the prevalence and associated factors of mental distress.

The Self-reported questionnaire (SRQ-20), which was developed by WHO was used to assess the prevalence and presence of CMD *(see table 2)*. The SRQ was originally designed as a self-administered scale but was also found to be suitable for an interviewer-administered questionnaire because of the low literacy rate in developing countries. Each of the 20 items is scored 0 or 1. A score of 1 indicates that the symptom was present during the past month; a score of 0 indicates that the symptom was absent. A cut-off point of 7/8 (7'yes's' a non-case, 8 'yes's a case) will be used which is the most commonly used cut off point in developing countries. [58] The SRQ was used in previous community-based studies in Ethiopia.[59] The validity study of SRQ-20 by Youngman showed that specificity (83%) and sensitivity (89.5%) were optimum at 7/8 cutoff points.[60]

Table 2: SRQ Item- WHO, Division of mental health, Geneva, 19194

SRQ Item	*Yes*	*No*
1. Do you often have headaches?		
2. Is your appetite poor?		
3. Do you sleep badly?		
4. Are you easily frightened?		
5. Do your hands shake?		
6. Do you feel nervous, tense or worried?		
7. Is your digestion poor?		
8. Do you have trouble thinking clearly?		
9. Do you feel unhappy?		
10. Do you cry more than usual?		
11. Do you find it difficult to enjoy your daily activities?		
12. Do you find it difficult to make decisions?		
13. Is your daily work suffering?		
14. Are you unable to play a useful part in life?		
15. Have you lost interest in things?		

16. Do you feel that you are a worthless person?		
17. Has the thought of ending your life been on your mind		
18. Do you feel tired all the time?		
19. Are you easily tired		
20. Do you have uncomfortable feelings in your stomach?		
SRQ-20 Total Score (total of yes)		

Another standardized tool adopted and used for this study was a mental health knowledge schedule (MAKS) to determine the level of teacher's mental health literacy. MAKS comprises 12 items. Six items are related to stigma-related mental health literacy areas such as help-seeking, ability to give advice, support, employment, treatment, and recovery, and 6 items inquire about knowledge of mental illness diagnoses. Items are responded to on a 5-point scale ranging from 1 = strongly disagree to 5 = strongly agree. Higher scores indicate better mental health literacy. [61] A median point of the first 6 items was used to determine the level of mental health knowledge among study participants. The instrument was pre-tested in students that are not selected for the study. The questionnaire was administered using interviewers (FAWE-ETH vocational and career counselors) after thorough data collectors training was provided by the study team to collect the data. And the interview was conducted for the respondents in a private setting with close supervision of the principal investigator and other supervisors.

3.6. Operational Definitions

- **Mental distress:** in this study, scholars who have a received 7 or more "yes" responses for the SRQ-20 questions were considered having a mental distress.
- **Mental health Knowledge:** this study used a median point of the first 6 items of the MAKS result and teachers and administrators who have a result of 22 and above were considered having a good knowledge of mental health.

3.7. Methods of Data Processing and Analysis

The paper-based data collected by the vocational and guidance counselors was entered into SPSS version 26 for analysis. Results obtained from questions designed to assess teacher's mental health literacy were interpreted and analyzed descriptively using proportions, percentages, means, range, and measures of central tendency. Bar charts and graphs were also used for the interpretation of results. The prevalence of mental distress among scholars was estimated from a cutoff point defined according to the number of positive answers for symptoms. Subjects were classified as suspected of mental distress cases when they have 7 or more "yes" responses for the SRQ-20 items.

To explore associations and identify independently associated variables with patterns of mental distress, both bivariate and multivariate analyses were conducted by entering each independent variable separately into the bivariate analysis. Then, variables with statistically significant association including those variables with a p-value of less than 0.25 on bivariate analysis will be entered into multivariate logistic regression once. Then, variables having a p-value of less than 0.05 on multiple logistic regressions were finally be considered as significantly associated with the pattern of mental distress. The strength of association of the variables was determined using the odds ratio and 95% confidence level.

3.8. Ethical Consideration

Ethical clearance was obtained from regional education bureaus. Written consent was also obtained from all of the respondents who participated after the data collectors briefed them on all the terms and conditions of participating in this study. Privacy and confidentiality of the information provided by the study participants were kept properly and to keep the respondents anonymous respondent unique code was used. Study participants who have been identified as having mental distress are counseled and supported by the data collectors to contact a psychiatrist or mental health professional.

Chapter Four

5. Results and Discussion

This chapter describes the results of the descriptive and empirical findings of the current study. In this chapter, the prevalence of MD (mental distress) and its associated factors among FAWE-ETH scholars, level of teachers, and school administrators MHK (mental health knowledge) are presented and discussed. This chapter used different methods of data interpretation and presentation such as Odds ratio, proportions, percentages, range, and measures of central tendency. Bar and pie charts were also used for the interpretation and presentation of results.

4.1. Socio-demographic Characteristics of FAWE-ETH Scholars

The socio-demographic characteristics of FAWE-Ethiopia scholars are presented in **Table 3**. A total of 218 grade 11 and 12 students were participated in this study with a response rate of **91.4 %,** comprising **38:32.2**% males and **80:67.8**% females. The mean age of scholars was 18.61 **[SD=1.36].** Study participants aged 17-19 years constituted the largest age group in this study **[94:79.7%].** The majority of study participants **[80:67.8%]** were followers of the Orthodox Christian religion followed by Muslims **[23:19.5%]. 67:56.8**% of the scholars were grade 12 while the remaining 51:43.2% are grade 11.

68:57.6% of study participants were found to be not living with their biological parents and it has been reported that **62:52.5** % of parents are currently married and living together. **68:57.6**% of the study participants reported that they are living in a family with a size <5, and while the remaining **50:42.4**% of the participants reported having a family size of >5. **46:39**% of the scholars reported having an average gross monthly family income of less than 1000 ETB and **20:16.9**% of them reported an average family income that ranges from 2001 to 3000 ETB while the remaining **19:16.1**% reported having a family income greater than 3001 ETB.

Table 3: Socio-demographic and economic characteristics of FAWE-ETH, April, 2021 [n=118].

Scholars Characteristics		Frequency	%
Sex	Male	38	32.2
	Female	80	67.8
Age	14-16	1	.8
	17-19	94	79.7
	20 and above	23	19.5
Parental Marital Status	Married & living together	62	52.5
	Unmarried but living together	1	.8
	Divorced or separated	33	28.0
	Widowed	20	16.9
	Both parents deceased	2	1.7
Religion	Orthodox Christian	80	67.8
	Muslim	23	19.5
	Protestant	14	11.9
	Others *	1	.8
Grade Level	Grade 11	51	43.2
	Grade 12	67	56.8
Gross Family Income	<1000	46	39.0
	1001-2000	33	28.0
	2001-3000	20	16.9
	> 3001	19	16.1
Family Size	<5	68	57.6
	> 5	50	42.4
Scholars Living with parents	Yes	43	36.4
	No	68	57.6
	Other**	7	5.9
Note: *Catholic ** Living with relatives and siblings			

4.2. School connectedness, Behavioral and other Health Related Characteristics of Participants

To meet the principal study objective, additional school connectedness, social support, behavioral and health-related variables were collected from study participants ***(See table 4).*** **112:94.9%** of the scholars reported that they are not using alcohol while few study participants reported occasional use of alcohol **[6:5.1%]**. All of the study participants **(100%)** were found to be non-smokers and non-khat users.

Regarding participant's history of chronic physical illness, **77:65.3%** of the scholars reported that they had no history of physical illness within the last year while the remaining **41:34.7%** of the participants reported that they had a history of serious and chronic physical illness. The scholar's history of accident or traumatic experience was assessed and it has been found that a large majority of the respondents **[105:89%]** disclosed that they had no experience of an accident or any traumatic event. Only **13:11%** of the scholars reported having a history of traumatic life events or experience of tragic accident within the last year.

Concerning school connectedness and levels of social support, **56:47.5%** of the scholars rate themselves having a moderate level of social support from family, friends, and others while **52:44.1%** of them reported having a strong level of social support. Contrary to this, few scholars **[9:7.6%]** expressed that they have poor social support from family, friends, and relatives. Concerning school and social connectedness issues, a bigger majority of the study participants expressed feelings of connectedness with their school while some **11:9.3%** reported that they have low feelings of connectedness with their school. Participation in extracurricular activities was also assessed as part of school connectedness and it has been observed that more than of the scholars **[69:58.5%]** participate in extracurricular activities only some time while **25:21.2%** of the participants have never been taking part in extracurricular activities. Furthermore, the study assessed levels of teacher's responsiveness when students need emotional or any other support, **69:58.5%** of the study participants reported that they are receiving any kind of support from their teachers mostly

and **44:37.3**% of the scholars reported that they are receiving emotional and other types of supports only some times.

Table 4: Characteristics of study participants by sense of school connectedness, social support, history of chronic physical & mental illness, substance use patterns and other Behavioral characteristics, FAWE-ETH, April 2021 [n=118].

Characteristics		Frequency	%
Alcohol Use	Daily	-	-
	1 or more per week	-	-
	Occasionally	6	5.1
	Non users	112	94.9
Cigarette smoking	Daily	-	-
	Occasionally	-	-
	Non-smokers	118	100
Khat Use	Daily users	-	-
	1 or more per week	-	-
	Occasionally	-	-
	Non-users	118	100
History of chronic physical illness	No	77	65.3
	Yes	41	34.7
Level of social support	Poor	9	7.6
	Moderate	56	47.5
	Strong	52	44.1
History of accident or traumatic life events	Yes	13	11.0
	No	105	89.0
Difficulty in social and intimate relationship	Yes	11	9.3
	No	107	90.7
Average time spent in social media	< 1 Hr.	75	63.6
	1-3 Hrs.	33	28.0
	>3 Hrs.	-	-
	Non-users	10	8.5
Participation in extracurricular Activities	Mostly	13	11.0
	Sometimes	69	58.5
	Rarely	11	9.3
	Never	25	21.2
Feeling connected with school	No	11	9.3
	Yes	107	90.7
Teachers responsiveness for emotional need	Mostly	61	51.7
	sometimes	44	37.3
	Rarely	6	5.1
	Never	7	5.9
Feeling comfortable asking friends/classmates for help with problem	No	30	25.4
	Yes	88	74.6

4.3. Academic related Stress Factors

In this study, data related to academic stress factors were collected ***(see table 5).*** According to the results obtained from the collected data, nearly half of the study participants **[56:47.5%]** were found to be unsatisfied with their current academic performance and the remaining **62:52.5%** reported that they are satisfied with their academic performance. **67:56.8%** of the study participants disclosed that they feel stressed due to academic pressure while the rest of the respondents **[51:43.2%]** report no feelings of stress due to academic-related pressures. Parental pressure for good academic performance was also assessed and **64:54.2%** of the scholars reported that they are being pressured by parents for good academic performance while the rest of the respondents reported no parental pressure. Another stress factor that was assessed by this study was feelings of burden experienced by students due to frequent examinations and the majority of the study participants **[78:66.1%]** expressed feelings of burden when they are overburdened by frequent examination. Similarly, more than half of the study participants reported that they had examination anxiety **[67:56.8%].**

Table 5: Academic related stress factors, FAWE-ETH, April 2022 [n=118]

Scholars Characteristics		Frequency	%
Satisfaction with current academic performance	No	56	47.5
	Yes	62	52.5
Feelings of stress because of academic pressure	No	51	43.2
	Yes	67	56.8
Parental pressure for good academic performance	No	52	44.1
	Yes	64	54.2
Feelings of burden due to frequent examination	No	40	33.9
	Yes	78	66.1
Examination anxiety	No	51	43.2
	Yes	67	56.8

4.4. Magnitude of Common Mental Disorders (CMDs) Among FAWE-ETH Scholars

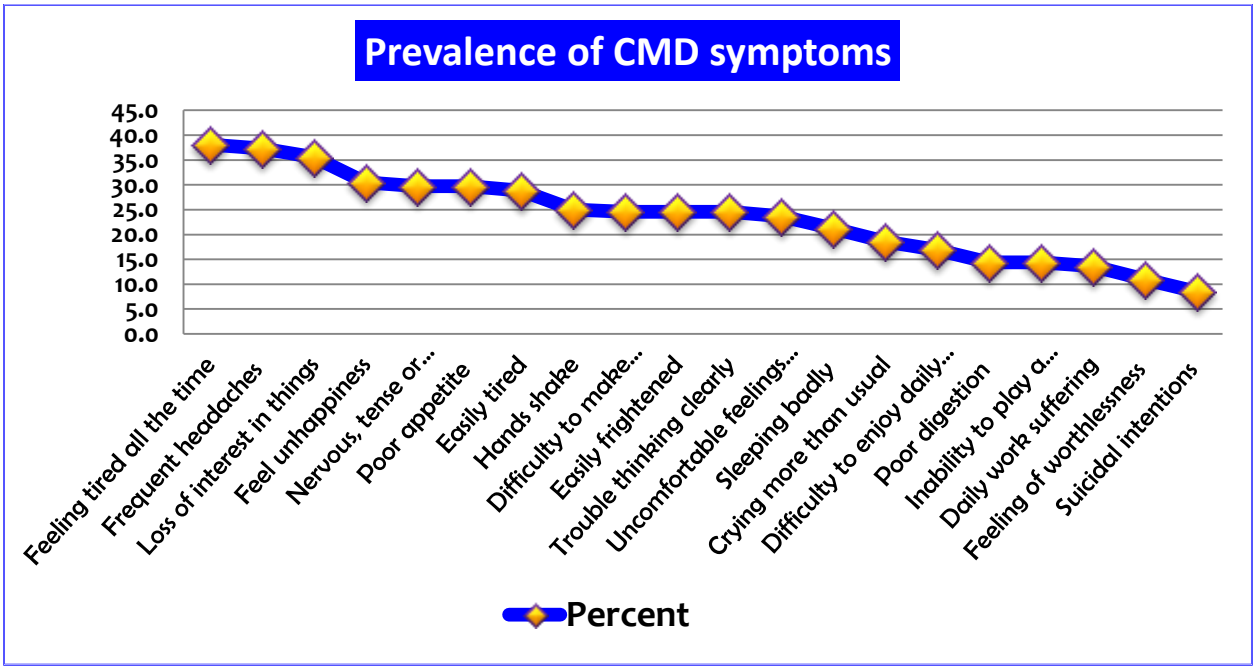
In this study, a locally validated self-reported questionnaire-20 (SRQ-20) was used as a screening tool to assess the presence of common mental disorders among FAWE-ETH scholars. The point prevalence of mental distress in this sample was therefore found to be **25.4% [95% CI: 16.9 - 34.8].** The prevalence of CMDs was found to be remarkably higher among female **[28.75%]** scholars than their male **[18%]** counterparts.

Table 6: Prevalence of common mental disorders (CMDs), FAWE-ETH, April 2021 (n=118)

Prevalence of CMDs		Frequency	Percent	95% Confidence Interval	
				Lower	Upper
	Non-cases	88	74.6	65.2	83.1
	Cases	30	25.4	16.9	34.8
	Total	118	100.0	100.0	100.0

The most prevalent symptoms *(see figure 2)* were found to be feeling tired all the time [45:38.1%], frequent headaches [44:37.3%], and loss of interest in things. The least reported symptoms of CMD were suffering of daily activities or work [16:13.6%], feelings of worthlessness [13:11%], and suicidal intentions [10:8.5%].

Figure 3: Prevalence of MD symptoms among FAWE-ETH Scholars, April 2021 (n=118)



4.5. Factors Associated with Common Mental Distress

Findings from the enter approach showed that the probability of MD was higher among females than males [OR=.570, 95 percent CI: .449 -.723]. The age of the scholars was also found to have a significant statistical association with CMDs. The prevalence of CMDs found to be relatively higher among older scholars than the youngest ones. Scholars who are not living with their parents are found to have an increased likelihood of having CMDs as compared to the scholars living with their biological parents [OR= .387, 95% CI: .166 -.905].

Examination anxiety was significantly associated with the risk of developing common mental disorders. The likelihood of CMD was more than two folds higher among scholars who have reported that they have experience of examination anxiety [OR= 2.628, 95% CI: 1.057- 6.533]. Similarly, Feelings of overburdened due to frequent examination were also found to be a risk factor for developing CMDs. It's been found that feeling overburdened due to frequent examination increase the likelihood of CMD risk by ten folds [OR=10.640, 95% CI: 2.385-47.460]. A feeling of stress because of academic pressure was also one of the factors found to be strongly associated with the risk of developing common mental disorders. According

to the results of the present study, stress related to academic pressure was attributed to a seven-fold increase in the risk of developing CMDs [OR= 7.451, 95% CI: 2.400 - 23.134]. The level of satisfaction with academic performance was also found to have a significant association with CMDs [.346, 95% CI: .145 - .826].

Feeling of connectedness with the school was one of the factors found to be associated with CMDs. Scholars who think that they are not connected with their school showed an increased chance of developing CMDs [OR=.241, 95% CI: .068 - .859]. Another school connectedness factor found to be significantly associated with CMDs was the scholar's participation in extra-curricular activities. A pattern of social media use among scholars was also found to be significantly associated with CMD risk [OR=.500, 95% CI: .119 - 2.101].

History of accident or experience of traumatic life events was significantly associated with CMD. Study participants who reported experience of an accident or traumatic life events during the last year were found to have a relatively higher risk of developing CMDs as compared to study participants who reported no traumatic event or experience in the last year [OR=.071, 95% CI: .018 - .280]. Similarly, previous diagnosis and treatment of serious or chronic physical illness were found to be significantly associated with CMD. Scholars with a previous history of physical illness were having 2 times [OR=2.385, 95% CI: 1.020 -5.577] higher CMD than study scholars with no history of physical illness.

Table 7: Bivariate and multivariate analyses of factors associated with MD [n=118]

Characteristics		*CMD		OR [95% - CI]	P Value
		Non-Cases	Cases		
Sex	Male	31	7	Reference	-
	Female	57	23	.570 [.449 - .723]	<0.01
Age	14-19	72	23	Reference	-
	>20	16	7	.447 [.318 - .628]	<0.01
Living with Parents	Yes	56	12	Reference	-
	No	32	18	.387 [.166 -.905]	<0.05
Examination Anxiety	No	43	8	Reference	-

	Yes	45	22	2.628 [1.057- 6.533]	<0.05
Overburden due to frequent examination	No	38	2	Reference	-
	Yes	50	28	10.640 [2.385-47.460]	<0.05
Academic Pressure	NO	47	4	Reference	-
	Yes	41	26	7.451 [2.400 - 23.134]	<0.01
Satisfaction with academic performance	NO	36	20	.346[.145 - .826]	<0.05
	Yes	52	10	Reference	-
Feeling connected with school	No	5	6	.241 [.068 - .859]	<0.05
	Yes	83	24	Reference	-
Extracurricular activities	Mostly	10	3	Reference	-
	Sometimes	56	13	.277 [.061 - 1.254]	-
	Rarely	10	1	.214 [.080 - .577]	<0.05
	Never	12	13	.092 [.010 - .833]	<0.05
Time spent on social media	< 1 Hr	61	14	.230 [.058 - .902]	-
	1-3 Hr	22	11	.500 [.119 - 2.101]	<0.05
	Never use social media	5	5	Reference	-
Feeling connected with school	No	5	6	.241 [.068 - .859]	<0.05
Experience of accident or traumatic Event	Yes	3	10	.071 [.018 - .280]	<0.01
	No	85	20	Reference	-
Physical illness	No	62	15	Reference	-
	Yes	26	15	2.385 [1.020 -5.577]	<0.05

*CMD: Common Mental Disorder

4.6. Teachers Mental Health Literacy

The present study also assessed the level of teacher's mental health literacy as it has been supported by empirical pieces of evidence that there is a strong association between teacher's mental health literacy, and student outcomes, such as student's mental health, behavior, educational engagement and, academic performance. To this effect, the study

adopted and applied a standardized 12 item tool called mental health knowledge schedule (MAKS) to examine the level of mental health literacy among teachers and school administrators. Below, the results obtained from the data collected from teachers and school administrators are presented.

4.6.1. Socio-demographic Characteristics of Teachers

A total of 17 teachers and school administrators were included in this study to explore their level of mental health literacy. Details of socio-demographic characteristics of the study participants are shown in Table 8 below.

Table 8: Socio-demographic Characteristics of teachers, FAWE-ETH, April, 2021 (n=17)

Characteristics	Number (%)
Sex	
Male	12 (70.6%)
Female	5 (29.4%)
Age	
25-34	3 (17.6%)
35-44	6 (35.3%)
>45	8 (47.1%)
Educational Status	
Bachelor's Degree	11 (64.7%)
Master's Degree & Above	6 (35.3%)
Years of Experience	
3 - 10 Years	4 (23.5%)
11 - 17 Years	6 (35.3%)
18 -25 Years	1 (5.9%)
>25 Years	6 (35.3)
Subject	
Social Studies	3 (17.6%)
Language	4 (23.5%)
Natural Science	6 (35.3%)
Others	4 (23.5)
Previous *MD History	
Yes	4 (23.5%)
No	13 (76.5%)
Having a friend or relative with MD	
Yes	4 (23.5%)
No	13 (76.5%)

*MD: Mental Disorders

4.6.2. Mental Health Knowledge among Teachers

Table 9 shows teacher's responses to Mental Health Knowledge Schedule items (MAKS part A & B). According to the findings from the first part of MAKS items (Part A), 2:11.8% of the study participants disfavor the notion that most people with mental health problems want to have a paid employment while 11:64.7% favors the idea that people with mental illness can have a paid job or employment.

A large majority of the study participants [13:76.4%] gave a positive response for the item "If a friend had a mental health problem, I know what advice to give them to get professional help". 6:35.3% of the study participants expressed their disagreement with the notion that medication can be an effective treatment for people with mental health problems while 5:29.4% of them supported the notion. Additionally, a significant number of study participants responded "don't know" for similar MAKS items. 5:29.4% of teachers who took part in this study reported that they don't exactly know if psychotherapy can be an effective treatment for people with mental health problems while the majority of the respondents positively expressed their views that psychotherapy can be an effective treatment for people with mental health problems.

Regarding recovery from mental illness, 3:17.6% of the study participants disclosed their disagreements about the idea that people with mental health problems can fully recover. 5:29.4% of the participants reported that they don't have any idea whether people with mental health problems can fully recover or not while 9:53% of the participants demonstrate their agreement with the notion that people with severe mental health problems can fully recover. According to the results of the present study, only 3:17.6% of the participants reported that they think that most people with mental health problems go to a healthcare professional to get help while 7:41.2% of the study participants showed their disagreement with the notion. The remaining 7:41.2% of the participants reported that they don't know where people with mental health problems should go to get help.

In the second part of MAKS, the participants were asked to classify various conditions as mental illness. To this effect, 5:29.4% of study participants were failed to recognize

depression as a mental illness while the remaining 12:70.6% of the study participants recognize depression as a mental illness. Stress was classified by the majority of the study participants [12:70.6%] as a mental illness and only 5:29.4% of the respondents classify stress as a non-mental illness condition. 10[58.8%] of the study participants responded that schizophrenia is a mental illness while the remaining 7:41% of the respondents recognized schizophrenia as a non-mental illness condition.

Bipolar disorder (manic-depression) was recognized by 15:86.2% of the study participants as a mental illness while the remaining 2:11.8% of the participants responded that it is not a mental illness or a mental health condition. Only 5:29.4% of the participants were able to recognize drug addiction as a mental health condition but a significant number of study participants [12:70.6%] were failed to recognize drug addiction as a mental health condition. Grief was classified as a mental health condition by 4:23.5% of study participants. However, a majority of the study participants [13:76.5%] were able to recognize grief as a non-mental health condition.

Table 9: Teachers Mental Health Knowledge Schedule items (*MAKS Part: A & B), (n=17)

	Responses [n,%]				
MAKS Part A (knowledge)	**Strongly Disagree**	**Disagree**	**Don't know**	**Agree**	**Strongly Agree**
Most people with mental health problems want to have paid employment.	[-] -	[2] 11.8%	[4] 23.5%	[9] 52.9%	[2] 11.7%
If a friend had a mental health problem, I know what advice to give them to get professional help.	[-] -	[2] 11.8%	[1] 5.9%	[11] 64.7%	[2] 11.8%
Medication can be an effective treatment for people with mental health problems.	[-] -	[6] 35.3	[6] 35.3	[4] 23.5%	[1] 5.9%
Psychotherapy (e.g. talking therapy or counseling) can be an effective treatment for people with mental health problems.	[-] -	[-] -	[5] 29.4%	[6] 35.3%	[6] 35.3%
People with severe mental health problems can fully recover.	[-] -	[3] 17.6%	[5] 29.4%	[7] 41.2%	[2] 11.8%
Most people with mental health problems go to a healthcare professional to get help.	[2] 11.8%	[5] 29.4%	[7] 41.2%	[3] 17.6%	[-] -

MAKS Part B (Recognition of Mental disorders)		
Conditions	**True**	**False**
Depression (True)	[12] 70.6%	[5] 29.4%
Stress (False)	[12] 70.6%	[5] 29.4%
Schizophrenia (True)	[10] 58.8%	[7] 41%
Bipolar disorder (manic-depression) (True)	[15] 86.2%	[2] 11.8%
Drug addiction (True)	[5] 29.4%	[12] 70.6%
Grief (False)	[4] 23.5%	[13] 76.5%
****Mental health knowledge schedule MAKS 10 © 2009 Health Service and Population Research Department, Institute of Psychiatry, King's College London.***		

To have a summarized view of the mental health knowledge of study participants, mean, median, SD, and std. Error was calculated for the mental health knowledge schedule (MAKS Part A) items (Table 10). The mean total score for the MAKS Part A (6 items) was 20.4118 [SD =2.42536, Median=20, range= 17– 25]. Inspection of the confidence interval determines that at the 95% confidence level, the true population Mean lies within the 19.3529 – 21.6456 range. Thus, results of the present study indicated that 9:52.9% of the study participants had poor knowledge of mental health [Median score < 20] while the remaining 8:47.1% of the study participants demonstrated that they have a good knowledge of mental health [Median Score >20].

Table 10: Descriptive statistics of MAKS Part A, i.e. Mean, Median, Standard Deviation (SD), Range and Standard Error.

	Mean	Std. Error of the Mean	Median	SD	95 % of confidence Interval		Range	
					Lower	Upper	Min	Max
MHK	20.4118	.58824	20.00	2.4253	19.352	21.6456	17	25

Note: n=17

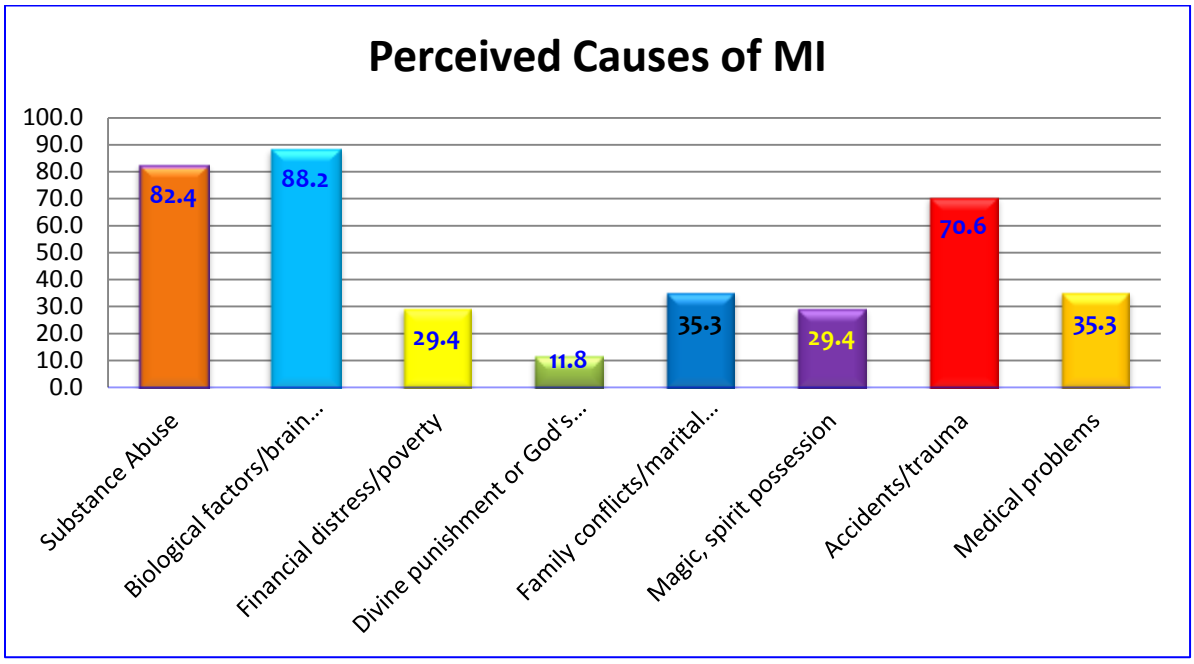
MHK: Mental Health Knowledge

4.6.3. Perceived Beliefs of Teachers about Causes of MD & Preferred Source of Help for MD

4.6.3.1. Perceived Causes of Mental Distress

A large majority of the study participants [15:88.2%] expressed the view that biological causes could cause mental distress (Figure 3). The second most commonly endorsed cause of mental distress was found to be substance abuse or use. 14:82.4% of the study participants reported mental distress can be caused by substance use or abuse. The third most commonly reported cause of mental distress was accident or trauma [12:70.6%]. Divine punishment or God's will [2:11.8%], financial distress/poverty [3:29.4%], and magic, spirit possession [5:29.4%] were the least reported causes of mental distress.

Figure 4: Most Commonly Reported Causes of Mental Distress [n=17]



4.6.3.2. Preferred Sources of Help for Mental Distress

The study participants were asked to respond to the question "do you think mental and behavioral disorders are treatable?" to assess their perception before they are asked to report their preferred sources of help for mental distress. To this effect, all of the study

participants [17:100%] reported that mental and behavioral disorders can be treated or people with mental distress can fully recover or be cured.

Following the question concerning the treatability of mental illness, participants of the study were also asked to report their preferred source of help for mental distress. As it is indicated below (Table 11), psychiatrists were the most preferred sources of help for mental distress followed by psychologists and health professionals. They were reported by 17:100%, 12:70.6 %, & 11:64.7% of the study participants respectively as preferred sources of help for mental distress. Priests were also favored by 9:52.9% of the study participants as preferred sources of help for mental distress. Friends or relatives and Traditional healers were the least preferred sources of help for mental health problems. 7:41.2% and 2:11.8 % of the study participants preferred friends or relatives and traditional healer's sources of help for mental distress respectively.

Table 11: Preferred Sources of Help for Mental Distress (n=17)

Preferred Sources of Help	Yes	No
Psychiatrists	**17 [100%]**	**0 [-]**
Psychologists	**12 [70.6%]**	**5 [29.4%]**
Health Professionals	**11 [64.7]**	**6 [35.3%]**
Priests	**9 [52.9%]**	**8 [47.1%]**
Holly water	**9 [52.9%]**	**8 [47.1]**
Friend or relatives	**7 [41.2%]**	**10 [58.8%]**
Traditional Healers	**2 [11.8%]**	**15 [88.2%]**

4.7. Discussions

4.7.1. Prevalence & Associated Factors of Mental Distress among FAWE-ETH Scholars

The prevalence of common mental disorders among FAWE-ETH scholars was found to be 25.4% [95% CI: 16.9 – 34.8]. As there are no similar school-based studies conducted in Ethiopia, the study used school-based studies conducted in developing countries setting as a reference. To this effect, a study conducted in Chandigarh, India to determine the prevalence of depression, anxiety, and stress among school-going adolescents found that the overall prevalence of three common mental disorders as depression, anxiety, and stress was found to be 36.1%. 40 Another population-based cross-sectional conducted Pelotas, a southern Brazilian city found a closer rate of prevalence of CMD (28.8%) among school-going adolescents and the study used SRQ-20 to measure and determine the prevalence of CMDs.41 Methodological differences and a small number of samples could be a likely reason for the low level of CMDs among FAWE-Ethiopia scholars compared to the study findings conducted in other parts of the world.

Regarding the factors associated with CMDs, the current study showed that the likelihood of MD was found to be higher among females as compared with males [OR=.570, 95 percent CI: .449 -.723]. Community-based studies conducted in different parts of the world and Ethiopia such as South Africa, [17] southwest and northern parts of Ethiopia [43] and Chile [26] obtained a similar result. Similar to the current study, a study that assessed academic stress, parental pressure, anxiety and mental health among Indian high school students revealed that gender was found to be significantly associated with examination-related anxiety and psychiatric problems. That is, female students experience more examination-related anxiety and psychiatric problems than their male counterparts.[48] However, since 70% of FAWE-Ethiopia sponsored scholars are females, the number of female samples in this study was substantially higher than male scholars, which may result in a methodological limitation in correctly predicting the gender gap in CMD prevalence among FAWE-Ethiopia scholars.

This study revealed that the prevalence of CMDs was found to be higher among older students than among younger students in this sample. Similarly, the Chandigarh, India study uncovered that among participants of 9th, 10th, 11th, 12th classes, it has been found that depression was higher in 12th class or older students.[40] According to findings of the current study scholars who are not living with their parents showed an increased likelihood of having CMDs as compared to the scholars living with their biological parents [OR= .387, 95% CI: .166 -.905]. During the literature search, this study doesn't come across studies that support this claim. However, some studies show that the prevalence of CMD was higher among students whose mothers were not alive. The level of anxiety was also found to be higher in the participants belonging to the joint families. Students staying away from home had higher levels of depression and stress.[40]

The present study revealed that examination anxiety was significantly associated with the risk of developing common mental disorders among FAWE-Ethiopia scholars. The likelihood of CMD in the present study was more than two folds higher among scholars who have reported that they have experience of examination anxiety [OR= 2.628, 95% CI: 1.057- 6.533]. Similarly, Feelings of overburdened due to frequent examination were also found to be a risk factor for developing CMDs. A feeling of stress because of academic pressure was also one of the factors found to be strongly associated with the risk of developing common mental disorders. According to the results of the present study, stress related to academic pressure was attributed to a seven-fold increase in the risk of developing CMDs [OR= 7.451, 95% CI: 2.400 - 23.134]. The level of self-satisfaction with academic performance was also found to have a significant association with CMDs [.346, 95% CI: .145 - .826]. These findings are somehow in agreement with other studies conducted on school-going adolescents. It was found in a similar study that the prevalence of CMD was more in students who felt overburdened with test schedules. The level of stress was higher among the participants who were not self-satisfied with their academic performance. In another study designed to assess academic Stress, Parental Pressure, Anxiety and Mental Health among Indian High School Students, it has been found that 63.5% of the students are stressed because of academic pressure. [48]

In this study, feeling connectedness with the school was one of the factors found to be associated with CMDs. Students who think that they are not connected with their school showed an increased chance of developing CMDs [OR=.241, 95% CI: .068 - .859]. Another school connectedness factor found to be significantly associated with CMDs was the scholar's participation in extra-curricular activities. These findings of the study found to be partially supported by a study that assessed the effect of extra-curricular activities on students stress level as it is believed that that extra-curricular activity and strong levels of social support could be the mediating factors for academic stress.[47] Additionally, the pattern of social media use among scholars was also found to be significantly associated with CMD risk [OR=.500, 95% CI: .119 - 2.101]. However, empirical findings claimed that social media could be a distant factor for children's and adolescents mental health. A meta-analysis of 23 studies revealed that there is a correlation between problematic Facebook use and psychological distress in adolescents and young adults. [45]

This study found that history of accident or experience of traumatic life events was significantly associated with CMD. Study participants who reported experience of an accident or traumatic life events during the last year were found to have a relatively higher risk of developing CMDs as compared to study participants who reported no traumatic event or experience in the last year [OR=.071, 95% CI: .018 - .280]. Similarly, Scholars with a previous history of physical illness were having 2 times [OR=2.385, 95% CI: 1.020 -5.577] higher CMD than study scholars with no history of physical illness. However, these two factors were not assessed by the school-based studies reviewed for the purpose of this study.

4.7.2. Mental Health Literacy of Teachers

The current school-based study employed a mental health knowledge schedule (MAKS) items to measure the mental health knowledge of teachers. According to the findings of this study, the mean total score for the MASK Part A (Six Items) was 20.4118 [SD=2.4253, 95% CI: 19.352 – 21.6456. The results of the present study also indicated that more than half [9:52.9%] of the study participants had poor knowledge of mental health [Median score < 20] while

the remaining 8:47.1% of the study participants demonstrated that they have a good knowledge of mental health [Median Score >20]. Since there are no similar school-based studies conducted using **MAKS** in Ethiopia and other developing countries setting, it was mandatory for the current study to crosscheck the findings with community based studies conducted in developed countries.

Thus, a study conducted at Walden University to examine the effectiveness of an educational mental health program found a mean total mask score of 24.46 [SD=2.42) which is relatively higher than the results obtained by this study. The disparity might be explained by presence of different mental health education programs implemented to improve community mental health knowledge in developed countries. Similarly, another study conducted at the University of Tennessee showed that the highest MAKS score of 30 and the mean score among participants was 25.88(2.25). The median and mode was 26. The minimum score was 20 and the maximum was 30.[62]

The second part of MAKS was designed to examine the teacher's ability to recognize a mental disorder and it was found that 12:70.6% of study participants were able to recognize depression as a mental illness. Due to the limited application of the MAKS score, the findings of this study were compared with the results of other community-based studies obtained using a different methodology. A study conducted in Gimbi, Ethiopia, found that only 29 % of the respondents identified Major Depressive Disorder as a mental health condition. [63] The disparity might be due to the educational background of the study participants as the study samples in this study are teachers who have a bachelor's degree and above. The methodological difference can also be attributed to the disparity as the latter used a vignette of the condition based on the ICD-10 criteria while the present study asked the participants to respond by saying "True" or "False" by just naming the condition without providing detail description of the condition. Another comparative study conducted in Australia and Japan revealed that 65.3 % of Australia and 22.6% of the Japan participants were able to correctly identify the depression vignette.[49]

Stress was classified by the majority of the study participants [12:70.6%] as a mental illness and only 5:29.4% of the respondents classify stress as a non-mental illness condition. This could be due to the fact that the equivalent Amharic term for stress (ጭንቀት) might be confusing for the teacher participants. 10[58.8%] of the study participants responded that schizophrenia is a mental illness while the remaining 7:41% of the respondents recognized schizophrenia as a non-mental illness condition. However, a community based study conducted in Agaro town uncovered that 74% of the participants identified schizophrenia as a mental health problem. [63]

Only 5:29.4% of the participants were able to recognize drug addiction as a mental health condition but a significant number of study participants [12:70.6%] were failed to recognize drug addiction as a mental health condition. The common assumption that addiction isn't a problem as long as it doesn't harm others and the individual is able to regulate his addiction-related actions might be the reason why a significant number of study participants failed to recognize drug addiction as a mental health condition.

6. Chapter Five

5. Conclusion and Recommendations

5.1. Conclusions

The general objective of this school-based study was to examine the prevalence and determinants of common mental disorders (CMDs) among FAWE-ETH scholars and generate programmatic alternatives to systematically respond to the mental health needs of the FAWE-ETH scholars. Based on the data collected from FAWE-ETH scholars currently pursuing their study in 8 schools located in Addis Ababa, Hawassa, Bahirdar, and Adama towns, the current study has come up with the following key findings and conclusions:

The result of this school-based study showed a relatively higher level of CMD prevalence (25.4%) and a lower prevalence when compared to similar school-based studies conducted in other developing country setting. Feeling tired all of the time and frequent headaches were found to be the most common CMD symptoms among FAWE-ETH scholars, while suicidal intent was the least reported symptom.

The likelihood of having mental distress was found to be higher among scholars, who were female, and who are not currently living with their biological parents. The present study also unveiled scholars who reported having examination anxiety, academic pressure and those who feel less connected with their school and report low self-satisfaction with their academic performance were at higher risk of developing mental distress. Further, the study found that study participants who had a history of accident or traumatic life events and previous physical illness diagnosis and treatment were at higher risk of developing mental distress.

The current study assessed the level of teacher's mental health literacy in order to obtain additional information to obtain additional information to supplement the data obtained from scholars and the results revealed that the level of knowledge among teachers was

found to be low. More than half of the study participants demonstrated that they had poor knowledge of mental health. A large majority of the study participants were failed to recognize stress as a mental distress. Similarly, a substantial number of study participants were unable to recognize drug addiction as a mental health condition. The study also revealed that all of the study participants believed that mental distress is treatable.

5.2. Recommendations

Research Implications: the findings of this study have a variety of future research, practice, and policy implications. According to the pieces of literature reviewed for this study, there has been a dearth of systematic school-based studies on the area of common mental disorders prevalence & associated factors, and teacher's mental health literacy in Ethiopia. Thus, it's highly recommended that future studies survey this topic using similar instruments (SRQ-20 & MAKS), similar population and a broad sample size to learn more about common mental disorders among school-aged adolescents, and validate the results of the current study.

Program Implications: This study discovered that there is a relatively higher level of CMD prevalence among scholars and low levels of mental health knowledge among teachers. This necessitates the design and implementation of comprehensive scholar's mental health support services or initiatives to meet the mental health need of scholars and other students. Furthermore, implementation of school-based mental health promotion and communication interventions targeting both teachers and students is strongly recommended to improve the mental health literacy of the school community.

It is also suggested that it is critical to building the capacity of school guidance & vocational counselors, teachers, school administrators, school health clubs, and teacher mentors on the area of mental distress or its identification on scholars/students, appropriate sources of help for mental distress outside of the school, and misconceptions associated with mental distress to ensure the effective roll-out of school mental health services. Below some additional program-specific recommendations are presented:

- The mental and psychological health of scholars and other students should be the prime concern of FAWE-ETH, educational authorities at all levels including school administrators, and other key mental health or health-related program implementers or partners, and mental health should be integrated with the national school health and nutrition strategy.
- The findings of the current study showed that academic pressure, examination anxiety, and low self-satisfaction with academic performance were among the factors found to be associated with the risk of developing CMDs among scholars, and to address academic-related stress it's highly suggested to integrate psychological and emotional support services with FAWE-Ethiopia scholars support program or provision should be made for mentoring support for scholars as well as other students with academic pressure and examination anxiety.
- The present study uncovered that sense of disconnectedness with school and low participation in extracurricular activities were found to be associated with the risk of CMD and it is recommended that extracurricular activities should be strengthened by giving due emphasis on school-health clubs by including psychological and emotional health components.
- It is also important to support and work with schools to initiate and expand student mental health care services including school counseling centers and mental health programming to ensure the provision of student-centered support services to build communication skills, social care, and self-esteem of scholars and other students.

Policy Implications: Ethiopia remains one of the few countries in the world without a mental health policy, which has resulted in a lack of attention and commitment from educational policymakers, curriculum managers, and decision-makers to school mental health. Even though, the ministry of education developed and endorsed a national school health and nutrition strategy but school mental health was missed out. Thus, it is highly recommended to integrate mental health in the strategy to aid high level decision making and guide the effective implementation of school mental health programs.

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Appendix A – English Version Questionnaire and Consent Form

FAWE-Ethiopia

Survey Questionnaire

I. Subject Information Sheet

Hello/Good Morning/Good Afternoon,

My name is _____, I am here to have an interview with you for the study that is being conducted to examine the prevalence and determinants of mental disorders among FAWE scholars and generate programmatic alternatives to systematically respond to the mental health needs of the FAWE scholars. The study will provide important insights about the level of students or youth mental health problems and their risk factors to educationalists, mental health policy makers, program implementers like FAWE-Ethiopia, researchers, and other actors whose work is related to youth empowerment, mental health and educational development.

Your participation in this study is voluntary. You may respond to all the questions or not respond to the questions you don't want to respond. You also have the right to withdraw from the interview any time without providing any reason to do so. You have to be informed that your identity or any personal information you provided in this study are confidential.

There is no any risk/harm or benefit for participating in this study. The interview will take about 30-40 min and if you need any further information or explanation regarding this study, please don't hesitate to contact via the address stated below:

Name: Alemayehu Tibebe (PI) Tel No: 0911776783 Email: impact2ethiopia@gmail.com

Do you agree to participate in the study? **YES** ☐ **NO** ☐

If you answer "yes" for the above question, please sign the consent form to participate in this study.

II. Informed Consent

I have been informed about the aim of this study. I have also been informed of what will be expected from me and what will happen to me if I take part in the study and also informed that I may

withdraw from this study at any time without providing any reason. Based on the information provided above, I have agreed to participate in this study.

Name of respondent_____ Signature _____Date _____

Name of data collector _____Signature _____Date _____

Supervisor Comment:

_____

III. Additional Information's

Date of interview _____Time started _____Time completed_____

Interview Result: (to confirm for completeness)

A.	Questionnaire completed	**YES**	☐	**NO**	☐
B.	Questionnaire partially completed	**YES**	☐	**NO**	☐
C.	Participant refused	**YES**	☐	**NO**	☐
D.	Others (please Specify) _____				

Checked by Supervisor:

Supervisor's Name _____Signature _____Date _____

IV. Interview Questions

Section A: Household Location Information

Question Code	Household Location Detail	Alternatives/Responses	Remark
A101	Region		
A102	City/Town		
A103	Sub-City/Kebelle		

Section B: School Related Information's

Question Code	School Detail	Alternatives/Responses	Remark
B201	School Name		
B202	School Type	1. Private 2. Public/Government	
B203	Region		
B204	City/Town		
B205	Sub-City/Kebelle		

Section C: Socio-demographic Information

Question Code	Questions	Alternatives	Remark
C301	Gender	1. Male 2. Female	
C302	Age	1. _____	
C303	What class/grade are you in?	1. _____	
C304	What is your religion?	1. Orthodox Christian 2. Protestant 3. Catholic 4. Muslim 5. Traditional 6. Other, Specify _____	
C305	Are you living with your parents?	1. Yes 2. No 3. Other, Specify,	

		_____	
C306	What is the marital status of your parents?	1. Married & living together 2. Unmarried but living together 3. Divorced/separated 4. Widowed	
C307	Monthly family income	1. _____	
C308	Family Size	1. _____	
C309	Father Educational Status	1. Illiterate 2. Primary school 3. Secondary school 4. Technical/Vocational School 5. Diploma 6. Bachelor's degree or higher 7. Other, specify_____	
C310	Mother Educational Status	1. Illiterate 2. Primary school 3. Secondary school 4. Technical/Vocational School 5. Diploma 6. Bachelor's degree or higher 7. Other, specify_____	
C311	Father occupational Status	1. Not working 2. Daily laborer 3. Petty trade 4. Privately owned business 5. Government employee 6. Non-government employee 7. Other, specify _____	
C312	Mother occupational Status	1. Not working 2. Daily laborer 3. Petty trade 4. Privately owned business 5. Government employee	

		6. Non-government employee 7. Other, specify _____	
C313	Academic Performance	1. Good/Very good 2. Moderate 3. Not so good	
C314	Time spent on social media per day	1. < 30 min 2. 30 – 1 hr. 3. 1- 2 hr. 4. 2-3 hr. 5. > 3 hr. 6. Never use social media	

Section D: Substance use habit

Question Code	Questions	Alternatives/Responses	Remark
D401	Do you currently consume alcohol?	1. Yes, daily 2. Yes, weekly 3. Yes, monthly 4. Yes, once/twice a year 5. No never	
D402	Do you currently smoke cigarette?	1. Yes, daily 2. Yes, weekly 3. Yes, monthly 4. Yes, once/twice a year 5. No never	
D403	Do you currently use/chew Khat?	1. Yes, daily 2. Yes, weekly 3. Yes, monthly 4. Yes, once/twice a year 5. No never	

Section E: School connectedness and Social support

Question	Questions	Alternatives/Responses	Remark

Code			
E501	How do you rate your level of social support both in school and within the family?	1. Poor 2. Moderate 3. Strong	
E502	Extracurricular activities	1. Mostly 2. Sometimes 3. Rarely 4. Never	
E503	Do you feel that school is the right place for you or connected with your school?	1. Yes 2. No	
E504	Do your teachers give you extra help when you need it?	1. Mostly 2. Sometimes 3. Rarely 4. Never	
E506	Do you feel comfortable asking most of your classmates and friends for help with a problem?	1. Yes 2. No	

Section F: Physical and emotional complaints

Question Code	Questions	Alternatives/Responses	Remark
F601	Have you ever been diagnosed with any chronic physical illness within the last one year?	1. Yes 2. No	
F602	Have you experienced any accident/traumatic event within the last one year?	1. Yes 2. No	*Check "yes" if the person had a history of traffic accident, or other emotional events such as death of loved ones or family.*
F603	Have you ever experienced difficulties (conflicts or disputes) in your relationship with your friends or intimate relationship	1. Yes 2. No	
F604	Do you have difficulty in sleeping?	1. Yes 2. No	

Section G: Academic related Stress Factors

Question Code	Questions	Alternatives/Responses	Remark
G701	Are you satisfied with your academic performance?	1. Yes 0. No	
G702	Do you feel stressed because of academic pressure?	1. Yes 0. No	
G703	Do your parents pressure you for good academic performance?	1. Yes 0. No	
G704	Do you feel overburdened by Frequent examination?	1.Yes 0. No	
G705	Do you have any anxiety related to examination?'	1. Yes 0. No	

Section H: SRQ-20 items to determine the prevalence of common mental disorders

Question Code	**Questions**	**Alternatives**	**Remark**
H801	Do you often have headaches?	1. YES 0. NO	
H802	Is your appetite poor?	1. YES 0. NO	
H803	Do you sleep badly?	1. YES 0. NO	
H804	Are you easily frightened?	1. YES 0. NO	
H805	Do your hands shake?	1. YES 0. NO	
H806	Do you feel nervous, tense or worried?	1. YES 0. NO	
H807	Is your digestion poor?	1. YES 0. NO	
H808	Do you have trouble thinking clearly?	1. YES 0. NO	
H909	Do you feel unhappy?	1. YES 0. NO	

H810	Do you cry more than usual?	1. YES 0. NO	
H811	Do you find it difficult to enjoy your daily activities?	1. YES 0. NO	
H812	Do you find it difficult to make decisions?	1. YES 0. NO	
H813	Is your daily work suffering?	1. YES 0. NO	
H814	Are you unable to play a useful part in life?	1. YES 0. NO	
H815	Have you lost interest in things?	1. YES 0. NO	
H816	Do you feel that you are a worthless person?	1. YES 0. NO	
H817	Has the thought of ending your life been on your mind	1. YES 0. NO	
H818	Do you feel tired all the time?	1. YES 0. NO	
H819	Are you easily tired	1. YES 0. NO	
H820	Do you have uncomfortable feelings in your stomach?	1. YES 0. NO	

FAWE-Ethiopia

Survey Questionnaire

V. Subject Information Sheet

Hello/Good Morning/Good Afternoon,

My name is _____, I am here to have an interview with you for the study that is being conducted to examine the prevalence and determinants of mental disorders among FAWE scholars and generate programmatic alternatives to systematically respond to the mental health needs of the FAWE scholars. The study will also assess the level of teacher's mental health literacy. Thus, the study will provide important insights about the level of students or youth mental health problems and their risk factors to educationalists, mental health policy makers, program implementers like FAWE-Ethiopia, researchers, and other actors whose work is related to youth empowerment, mental health and educational development.

Your participation in this study is voluntary. You may respond to all the questions or not respond to the questions you don't want to respond. You also have the right to withdraw from the interview any time without providing any reason to do so. You have to be informed that your identity or any personal information you provided in this study are confidential.

There is no any risk/harm or benefit for participating in this study. The interview will take about 30-40 min and if you need any further information or explanation regarding this study, please don't hesitate to contact via the address stated below:

Name: Alemayehu Tibebe (PI) Tel No: 0911776783 Email: impact2ethiopia@gmail.com

Do you agree to participate in the study? **YES** ☐ **NO** ☐

If you answer "yes" for the above question, please sign the consent form to participate in this study.

VI. Informed Consent

I have been informed about the aim of this study. I have also been informed of what will be expected from me and what will happen to me if I take part in the study and also informed that I may withdraw from this study at any time without providing any reason. Based on the information provided above, I have agreed to participate in this study.

Name of respondent_____ Signature _____Date _____

Name of data collector _____Signature _____Date _____

Supervisor Comment:

_____

VII. Additional Information's

Date of interview _____Time started _____Time completed_____

Interview Result: (to confirm for completeness)

E. Questionnaire completed **YES** ☐ **NO** ☐
F. Questionnaire partially completed **YES** ☐ **NO** ☐
G. Participant refused **YES** ☐ **NO** ☐
H. Others (please Specify) _____

Checked by Supervisor:

Supervisor's Name _____Signature _____Date _____

VIII. Interview Questions

Section A: Household Location Information

Question Code	Household Location Detail	Alternatives/Responses	Remark
A101	Region		
A102	City/Town		
A103	Sub-City/Kebelle		

Section B: School Related Information's

Question Code	School Detail	Alternatives/Responses	Remark
B201	School Name		
B202	School Type	3. Private 4. Public/Government	
B203	Region		
B204	City/Town		
B205	Sub-City/Kebelle		

Section C: Teachers characteristics

Question Code	Questions	Alternatives	Remark
C301	Gender	3. Male 4. Female	
C302	Age	2. _____	
C303	What is your religion?	7. Orthodox Christian 8. Protestant 9. Catholic	

		10. Muslim 11. Traditional 12. Other, Specify _____	
C304	Years of teaching experience	1. _____	
C305	Educational Background	1. Technical/Vocational School 2. Diploma 3. Bachelor's degree 4. Master's degree or above	
C306	What subject do you teach?	1. Social Studies 2. Language 3. Communication technology/ICT 4. Science 5. Other _____	
C307	Have you ever received training or any other capacity building support in students mental health issue?	1. Yes 2. No	
C308	Have you ever been diagnosed or treated with any mental disorder or illness within the past one year?	1. Yes 2. No	
C308	Friend/relative received mental health treatment?	1. Yes 2. No	

Section D: Knowledge about mental illness, available treatments, and recovery (MASK)

MASK Part A: Rate the following statements from 1 up to 5.			
Question Code	**Questions**	**Alternatives**	**Remark**
D401	Most people with mental health problems want to have paid employment.	1. Strongly disagree 2. Disagree 3. Undecided 4. Agree	

		5. Strongly agree	
D402	If a friend had a mental health problem, I know what advice to give them to get professional help.	1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	
D403	Medication can be an effective treatment for people with mental health problems.	1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	
D404	Psychotherapy (e.g. talking therapy or counseling) can be an effective treatment for people with mental health problems.	1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	
D405	People with severe mental health problems can fully recover.	1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	
D406	Most people with mental health problems go to a healthcare professional to get help.	1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	
MASK Part B: : Say "true" if you think each condition is a type of mental illness or "false" if you think it's not			
D407	Depression	0. False 1. True	
D408	Stress	0. False	

		1. True	
D409	Schizophrenia	0. False 1. True	
D410	Bipolar disorder (manic-depression)	0. False 1. True	
D411	Drug addiction	0. False 1. True	
D412	Grief	• False • True	

Section E: Knowledge and Beliefs about the cause of Mental illness

Question Code	**Questions**	**Alternatives**	**Remark**
E501	What do you think is the cause of mental disorders or illness?	1. Substance abuse 2. Divine punishment, God's will 3. Magic, spirit possession 4. Accidents/trauma 5. Heredity 6. Family conflicts/marital disharmony 7. Financial distress/poverty 8. Medical problems 9. Biological factors/brain disease 10. Don't know 11. Others, specify _____	*****More than one response is possible.*

Section F: Knowledge and Beliefs about Appropriate Help Seeking

Question Code	Questions	Alternatives	Remark
F601	Do you think that mental and behavioral disorders are treatable?	1. Yes 2. No	Skip to section F602 if the answer is no to F601
F602	Where do you think people with mental illness should go to seek help or support to recover from their illness?	1. Psychiatrists 2. Psychologists 3. Friends/relatives 4. Priests 5. Holy water 6. Traditional healers/herbalists 7. Health professional 8. Don't know • Others, specify ____	**More than one response is possible.*

Section G: Additional Questions

G701: Do you think that your students are experiencing mental health problems? Please give instances of a situation a student experiencing any emotional, behavioral, or mental health problem.

_____

_____

_____

G702: What kinds of support services are available in your school to support students with academic, psychological/emotional, behavioral and mental health problems?

_____

_____

_____

G703: What would you do if you think that one of your students is experiencing emotional or psychological problems?

_____

_____

_____

G704: What do you think should be done to improve the mental health literacy of teachers and other school support staff?

_____
_____
_____

G705: Any recommendation or suggestion regarding student's mental health and school mental health support services?

_____
_____
_____