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An Assessment of the Effectiveness of Communication Campaigns in Enhancing Knowledge of Mental Health among Secondary School Students in Nairobi County in Kenya

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Abstract:
Communication campaigns for mental health have been conducted in Kenya since 1992. These campaigns are conducted as part of the events to mark World Mental Health Day. Since studies indicate that adolescents and young adults are most at risk of mental illnesses and that early interventions help to prevent development of chronic mental illnesses, this study sought to find out whether the communication campaigns target secondary school students to enhance their knowledge of mental health.
Keywords*: Mental illnesses, communication campaigns for mental health, knowledge levels*

1. Introduction

Over 450 million people suffer from mental disorders worldwide and as many as one in four persons may experience mental or behavioural disorders during their lifetime (WHO, 2001; Williams et al., 2005). Furthermore, mental disorders are expected to be second only to heart disease as a leading source of the global burden of disease by the year 2020 (Murray & Lopez, 1996). Yet, efforts to increase levels of knowledge of mental health and accessibility to treatment have been minimal (WHO, 2010). Studies indicate that nearly two-thirds of those suffering from mental illnesses do not receive adequate care due to stigma, discrimination, neglect and poverty (Atwoli, 2011; Griffin, 2008; Brundtland, 2001).

Donovan et al (2006) observe that mental health problems and disorders are so prevalent that they have led to growing international interest in promotion, prevention and early intervention for mental health. Similarly, Scanlon and Raphael (2002) and Kiima and Jenkins (2010) assert that there is a large need for information about mental illness. They explain that understanding mental illness can contribute to reduction in stigma and discrimination against the mentally ill, as well as enhancing early detection and help-seeking. This underscores the need for effective communication campaigns for mental health.

1.1. Communication Campaigns for Mental Health

Since 1992, coordinated communication campaigns for mental health are held in Kenya mainly prior to and when celebrating the World Mental Health Day marked on 10th October every year (Kiima and Jenkins, 2010). The national event is held on a rotational basis in each province and presided over by the minister for health. The event is a culmination of a weeklong mental health activities carried out throughout the country at district levels. The minister's speech articulates the mental health issues contained in the theme for each year, accompanied by extensive media coverage. Mental health workers give lectures, symposia and workshops to create public awareness on mental health. Psychiatric hospitals and wards have open days too (Kiima and Jenkins, 2010). These takes place within the hospital premises.

In Nairobi County, the management of Mathari National Teaching and Referral Hospital prepares newsletters and leaflets which they distribute to their staff, patients, caregivers and other guests attending the event. These newsletters and leaflets contain messages on the mental health theme of that year. They also put a banner at the entry to the hospital indicating the theme of the year. Nurses also visit the community around the hospital to talk to them about the mental health theme of the year. They visit schools, community centres, churches and homes.

Apart from these activities that take place before the World Mental Health Day, the psychiatric nurses at Mathari Hospital visit the people around the hospital to sensitize them about mental health issues during the Nurses' Week in May every year.

Alone, these communication campaigns conducted once annually may not increase levels of knowledge of mental health. Barry and Jenkins (2007) argue that this is only achievable through comprehensive approaches that intervene at a number of different time periods rather than once off.

Indeed, in spite of these annual communication campaigns, studies indicate that knowledge levels of mental health are still low, the levels of stigma are high and access to treatment is low (Atwoli, 2011; KNCHR, 2011; Bocha, 2012).
To assess the effectiveness of these communication campaigns in enhancing knowledge of mental health, this study sought to establish the levels of knowledge of mental health among secondary school students. This is because studies indicate that young people aged 12-25 are most at risk of developing mental disorders, and that this is a life stage where concerted effort is required to prevent the development of adult and chronic mental health problems (Rickwood, 2010; McGorry et al, 2007; Kessler et al, 2005). Studies also indicate that adolescence and young adulthood is the age when many mental disorders first emerge (Seroczynski, Jacques & Cole, 2003; Wunderlich, Bronisch, Wittchen & Carter, 2001). Furthermore, enhanced knowledge of mental health among secondary school students has been found to reduce bullying, aggression and truancy. It enhances coping and problem solving skills and increases engagement, achievement and attendance (Jané-Llopis et al, 2005).

1.1.1. objective of the Study
The objective of this study is:

- To assess the effectiveness of communication campaigns in enhancing knowledge levels of mental health among secondary school students in Nairobi County in Kenya.

1.2. Data Gathering and Analysis Methods
The study population was both male and female students in public secondary schools in Langata District. The district has five public secondary schools. The total number of students enrolled in all the five public secondary schools was 2,600. Out of these, there were 1,844 boys and 756 girls (Nairobi County Education Office, 2013). The schools are Langata High School, Langata Barracks, Raila Educational Centre, Olympic High School and Karen C.
Since Langata District had a total population of 2,600 secondary school students, a sample size of 325 respondents was selected. Mugenda and Mugenda (2003) and Ndati (2013) say that if the target population is less than 10,000, the sample size will be 325.
In order to get the sample size of the boys and girls who were to participate in the study, the formula below was used:
nf⁄N× n
Where:
nf is the sample size (325)
n is the population of boys or girls (1844 boys or 756 girls)
N is the total population (2600)
Therefore, the number of boys sampled was:
325/2600×1844= 230 boys
Similarly, the number of girls sampled was:
325/2600×756=95 girls
This therefore meant that the sample size of 325 respondents consisted of 230 boys and 95 girls.
Purposive sampling technique was used to sample the district in which the study was conducted. Therefore, langata district was purposively sampled because it has the largest informal settlement in the country (www.unhabitat.org).
Stratified random sampling technique was used in selecting respondents. A proportionate stratified sample was used as the sample size was drawn from each stratum (n) proportional to the population size of the stratum (N) (Frankfort-Nachmias & Nachmias, 1996). Therefore, the sample size from each of the five schools was calculated as follows:
Total number of boys in the school/ Total number of boys in the five schools × Total number of boys sampled
Langata High School had 737 boys, Langata Barracks had 201 boys and 122 girls, Raila Educational Centre had 255 boys and 170 girls, Olympic High School had 474 boys and 351 girls and finally Karen C had 290 boys and 177 girls.
Therefore from each school the following is the sample size that was obtained:

- Langata High School: 737/ 1844× 230=92 boys
- Langata Barracks: 201/1844×230=25 boys
- 122/756×95=15 girls
- Raila Educational Centre: 255/1844× 230= 32 boys
- 170/756× 95= 22 girls
- Olympic High School: 474/1844× 230= 59 boys
- 351/756× 95= 44 girls
- Karen C: 177/1844× 230= 22 boys
- 113/756× 95= 14 girls

Since from Form 1 to Form 4 there are four classes, respondents were selected from each class. The formula used was:
x/4 =z
where x is the number of boys or girls sampled from a school
4 represents the number of classes in the secondary schools from Form 1 to Form 4
z is the number of boys or girls sampled from a class
This formula applied for both boys and girls. The data collected was analysed using descriptive statistics and presented in tables.

1.3. Theoretical Framework
This study was guided by the theory of symbolic interactionism and the health belief model.

1.3.1. Symbolic Interactionism

According to Griffin (2009), symbolic interactionism was coined by Herbert Blumer. Blumer states three core principles of symbolic interactionism that deal with meaning, language and thought. These premises lead to conclusions about the creation of a person's self and socialization into a larger community.

First, Blumer bases symbolic interactionism on the premise that humans act towards people or things on the basis of the meanings they assign to those people or things (Griffin, 2009; Lindlof and Taylor, 2011). Meaning is seen as the construction of social reality.

Blumer's second premise is that meaning arises out of the social interaction that people have with each other (Griffin, 2009). Griffin explains that meaning is not inherent in objects or preexistent in a state of nature but negotiated through language- hence the term symbolic interactionism.

The third premise is that an individual's interpretation of symbols is modified by his or her own thought processes. Symbolic interactionists describe thinking as an inner conversation- inner dialogue minding (Griffin, 2009).

The concept of the self is important in this study as people's knowledge of mental illnesses and attitudes towards mental health and the mentally ill are socially constructed. If others have profound knowledge of mental health and their attitude towards the mentally ill is nondiscriminatory, then one will be compelled to be knowledgeable and nondiscriminatory towards the mentally ill.

Community is the composite mental image a person has of his or her 'self' based on community expectations and responses (Griffin, 2009). This study argues that people's attitudes towards the mentally ill are based on their communities' expectations and responses.

Symbolic interactionism will be used in this study to explain that people's knowledge, perceptions, attitudes and responses towards mental health issues are a consequence of the meanings and names they have assigned them. People's social reality of mental illnesses and the mentally ill is shaped by their levels of knowledge. The reality will be changed if knowledge levels are changed. Furthermore, the attitudes and perceptions people have are influenced by their interactions with each other through language.

1.3.2 The Health Belief Model

The health belief model was developed by Becker (1974) from the work of Rosenstock (1966) as an overarching framework on how to promote preventive behaviours. The model enables the examination of health beliefs and perceptions and encourages the assessment of their influence on preventive health behavior (Hester & Macrina, 1985). It can therefore be used as a pattern to evaluate or influence individual behavioural change (Corcoran, 2007).

The health belief model includes six constructs to help predict whether people will take action to prevent, screen for, and control illness (WHO, 2012). These constructs are: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action and self-efficacy (Rimer & Glanz, 2005).

The HBM also considers 'modifying factors' important to behavior change. These include demographic variables, socio-psychological variables and structural variables that influence how a person perceives the disease severity, threats and susceptibility. Factors such as age, gender, peer pressure or prior contact with the disease also impact on the decision-making process (Corcoran, 2007).

The health belief model will be used in this study to argue that if people are exposed to mental health promotion campaign messages that inform them about their susceptibility to mental illnesses, the severity of mental illnesses, the benefits of taking action to reduce risk or seriousness, the barriers involved such as stigma, factors that activate change, and confidence in one's ability to take action, then they will embrace behaviours to ensure their own and others' mental health. Communication campaigns for mental health will be analyzed for evidence of these concepts.

1.4. The Findings

1.4.1. Knowledge Levels of Mental Health among Secondary School Students in Nairobi County

The secondary school students who were sampled were 325. Of these, 230 were boys and 95 girls. Table 1 below indicates the ages and sex of the respondents.

Age (Years)	**Sex**		**Total**
	Boys	**Girls**	
13	-	3	3
14	11	8	19
15	39	23	62
16	74	28	102
17	97	30	127
Above 17	9	3	12
Total	230	95	325

Table 1: Age and sex of respondents
Source: Researcher 2014

Table 1 above presents the distribution of 95 girls and 230 boys, aged 13- 17 and above. The distribution of the respondents by their sex was proportional to their numbers in the study sample.
When the respondents were asked whether they were aware of any communication campaign for mental health conducted in their residential area or school, they responded as shown in Table 2 below.

Awareness of communication campaigns for mental health	n	%
Yes	11	3
No	314	97
Total	325	100

Table 2: Awareness of communication campaigns for mental health
Source: Researcher 2014

Of the 11 students who indicated that they were aware of communication campaigns for mental health, 7 were female and 4 male. Though insignificant, these responses could point to a possibility of female students being more informed about mental health issues than the male students. However, with 97% of secondary school students indicating being unaware of communication campaigns for mental health in Nairobi County, it is evident that the communication campaigns conducted lack the element of reach. Atkin (2001) says that one of the basic reasons why health campaigns do not have strong impact is their inability to reach the audience and attain attention to the messages. These communication campaigns do not also consider young people as a risk group that should be targeted for information on mental health issues with a view to identifying mental health problems early and intervening at an early stage to prevent the development of adult and chronic mental health problems (Seroczynski, Jacques & Cole, 2003; Wunderlich, Bronisch, Wittchen & Carter, 2001; Rickwood, 2010; McGorry et al, 2007; Kessler et al, 2005).
When the respondents were asked whether they have ever attended any communication campaign for mental health, they responded as shown in Table 3 below.

Attendance of communication campaigns for mental health	n	%
Yes	3	1
No	322	99
Total	325	100

Table 3: Attendance of communication campaigns for mental health
Source: Researcher 2014

That 99% of the students had not attended communication campaigns for mental health clearly shows that communication campaigns for mental health do not achieve widespread reach among secondary school students in Nairobi County. This could mean that these communication campaigns are not conducted in schools, which are the most strategic venues where they could target the highest number of students possible. This could therefore indicate that most secondary school students in Nairobi County do not have adequate knowledge of mental health issues. It could however be important to note that all the three students who indicated that they had attended communication campaigns for mental health were female. One was aged 17 and in Form three while two were aged 18 and in Form 4. This could therefore point to a possibility of female older students being more informed about mental health issues than male and young students.
When asked when they attended the communication campaign for mental health, the respondents responded as shown in Table 4 below.

Year attended communication campaign	n	%
2011	0	0
2012	0	0
2013	3	100
Total	3	100

Table 4: Year attended communication campaign for mental health
Source: Researcher 2014

The three respondents who answered this question attended the campaigns in 2013. To the question on the venue of the communication campaign they attended, the respondents responded as shown in Table 5 below.

Venue of the communication campaign attended	n	%
School	0	0
Church	0	0
Hospital	3	100
Any other place	0	0
Total	3	100

Table 5: Venue of the communication campaign attended
Source: Researcher 2014

All the 3 respondents who had attended communication campaigns for mental health attended them in a hospital. Kiima and Jenkins (2010) say that communication campaigns for mental health in Kenya take place in hospitals that have psychiatric units.
On who conducted the communication campaign(s) that the respondents attended, the respondents responded as shown in Table 6 below:

Who conducted campaign	n	%
Guidance and Counselling Teacher	0	0
Speaker Hired by School	0	0
Psychiatrist	3	100
NGO Personnel	0	0
Preacher	0	0
Total	3	100

Table 6: Who conducted communication campaign?
Source: Researcher 2014

The responses indicate that the 3 respondents attended communication campaigns for mental health conducted by psychiatrists. This means that the campaigns by the Ministry of Health prior to and on World Mental Health Day do not reach a wide audience. It is therefore clear that the messages disseminated annually on mental health during World Mental Health Day do not reach many secondary school students.
On whether the communication campaigns contained messages on susceptibility to mental illnesses, the respondents responded as shown in Table 7 below.

Susceptibility to mental illnesses	n	%
Yes	3	100
No	0	0
Total	3	100

Table 7: Susceptibility to mental illnesses
Source: Researcher 2014

The fact that the communication campaigns had messages on susceptibility to mental illnesses shows that communication campaigns for mental health have one of the components of the health belief model which is perceived susceptibility.
The Health Belief Model predicts that as an individual's level of risk assessment regarding a disease increases, chances of compliance with recommended prevention measures also increase. Generally, positive correlations between perceived severity and susceptibility and compliance with treatment or prevention options have been reported (Snyder & Rouse, 1992; Mickler, 1993). It is therefore expected that when secondary school students get messages on how susceptible they are to mental illnesses, they will stop behaviours that put them at risk of contracting mental illnesses or seek treatment immediately they detect they are mentally ill. Studies indicate that those who are at risk of contracting mental illnesses are those who are excluded from income generation and employment opportunities, those who lack educational opportunities, those who have reduced access to health and social services, those with chronic health conditions, those who are excluded from participating fully in society, those who are exposed to violence and abuse and those who abuse drugs (WHO, 2010, 2012; Othieno et al., 2008; Palmer, 2011; Patel, 2005; Patel & Jané-Llopis, 2005; WHO, 2010; Barry & McQueen, 2005; Bhugra, 2004; Danso, 2002).
The secondary school students in Langata district draw most of their students from Kibera, the largest informal settlement in Africa (www.unhabitat.org). These students are therefore susceptible to mental illnesses because of the levels of poverty they grow up in, they have reduced access to health and social services and they are exposed to violence, abuse and drugs.
On whether they were given any information on the severity of mental illnesses during the communication campaigns, the respondents responded as shown in Table 8 below.

Severity of mental illnesses	n	%
Yes	3	100
No	0	0
Total	3	100

Table 8: Severity of mental illnesses
Source: Researcher 2014

The findings indicate that communication campaigns for mental health contain messages about severity of mental illnesses. This also shows that communication campaigns for mental health contain another component of the health belief model which is perceived severity.
Mental health problems such as depression can lead to other serious problems including substance abuse, social withdrawal, a breakdown in family and personal relationships and poor academic and work performance (Burns et al., 2009). Depression is also linked to substance abuse, eating disorders and implicated in many cases of youth suicide (Rao, Daley & Hammen, 2000).

Furthermore, mental health problems can lead to disability and premature mortality, stigma and discrimination, social exclusion and impoverishment (WHO, 2012).

On whether the students were told of the benefits of preventing mental illnesses or seeking medical treatment for mental illnesses during the communication campaigns, the responses were as shown in Table 9 below.

Benefits of preventing or treating mental illnesses	n	%
Yes	3	100
No	0	0
Total	3	100

Table 9: Benefits of preventing or treating mental illnesses
Source: Researcher 2014

The findings show that the communication campaigns for mental health contain the third component of the health belief model which is perceived benefits.

Positive mental health is associated with improved learning and academic achievement, increased participation in community life, reduced sickness, improved productivity, reduced risk-taking behavior, improved physical health and reduced mortality, among others (NICE, 2009).

Responses to the question on barriers to seeking knowledge of mental health or treatment for mental illnesses are as shown in Table 10 below.

Barriers to knowledge of mental health or treatment for mental illnesses	n	%
Fear people could see you and say you are mentally ill	3	19
Feeling that you are not susceptible to mental illnesses	3	19
Belief there is no prevention or cure for mental illnesses	3	19
Belief only witchdoctors can cure mental illnesses	3	19
Lack of money	3	19
Lack of time	1	6
Total	16	100

Table 10: Barriers to seeking knowledge of mental health or treatment for mental illnesses
Source: Researcher 2014

The findings show that communication campaigns for mental health contain messages on perceived barriers to seeking knowledge of mental health or treatment for mental illnesses. Perceived barriers are another component of the health belief model. From the responses, the barriers to seeking information on mental health or treatment for mental illnesses cited are an indication of a society that has high levels of ignorance of mental health. Such ignorance is the main cause of stigma. Stigma arises from the meanings or social reality that people have given mental illnesses, the language people use when talking about mental illnesses and the thoughts that they have about mental illnesses. Meaning, language and thought are tenets of the symbolic interactionism theory.

Rickwood et al., (2007) say that young people remain reluctant to access face-to-face services due to preference for informal support and for working out personal problems by themselves, lack of familiarity with and mistrust of mental health services, fear of the stigma attached to mental illness and mental health service use, confidentiality concerns regarding service access, and lack of access to appropriate youth-friendly services.

On whether the respondents learnt about factors that could drive one to seek information on preventing or seeking treatment for mental illnesses, the responses were as shown in Table 11 below.

Factors driving one to seek information on prevention or treatment	n	%
Close relative or friend becomes mentally ill	3	20
Close relative or friend seeks information on mental health	3	20
Mentally ill close relative or friend goes for treatment and recovers	3	20
Statistics on the number of the mentally ill	3	20
Information about susceptibility to mental illnesses	3	20
Total	15	100

Table 11: Factors that could drive one to seek information on preventing or treating mental illnesses
Source: Researcher 2014

The 3 respondents ticked more than one factor. From the responses, it is clear that communication campaigns for mental health have messages on factors that could drive one to seek information on prevention or treatment of mental illnesses. They therefore have the fifth component of the health belief model which is cues to action.

On whether the students gained confidence in seeking information on prevention of mental illnesses or seeking treatment as a result of the information got from the communication campaigns, the respondents gave the responses shown in Table 12 below.

Gaining confidence in seeking information on prevention of mental illnesses or seeking treatment	n	%
Yes	3	100
No	0	0
Total	3	100

Table 12: Gaining confidence in seeking information on prevention of mental illnesses or seeking treatment
Source: Researcher 2014

The responses obtained indicate clearly that communication campaigns for mental health contain messages that enhance self-efficacy (confidence), the sixth component of the health belief model.
Self-efficacy is an important component of health messages because people who have a strong sense of self-efficacy regarding health and self-care behaviours are more likely to have a healthy lifestyle, to seek and follow medical advice when ill, to avoid life crises, to cope with crises that do occur, and to establish closer personal ties so that social support is available to buffer against illness (Peterson & Stunkard, 1989). Conversely, those with low self-efficacy think of themselves as helpless; they are more likely to become ill and to cope ineffectively with medical problems (Bandura, 1997; Brown et al., 1997).
The next question in the questionnaire was what the respondents believed causes mental illnesses. The responses are as shown in Table 13 below.

Causes of mental illnesses	n	%
Witchcraft	38	9
Curses	33	8
They are hereditary	53	13
Drug abuse	200	50
Infections	29	7
Injuries	32	8
Other diseases	17	4
Total	402	100

Table 13: What respondents believed causes mental illnesses.
Source: Researcher 2014

Two hundred respondents answered this question. All the respondents chose more than one cause of mental illnesses. It is important to note that 50% of the respondents indicated that mental illnesses are caused by drug abuse. Indeed, studies indicate that drug and substance abuse enhance susceptibility to mental illnesses (WHO, 2012). The respondents therefore have knowledge of the fact that one of the risk factors to mental illnesses is drug abuse.
The respondents who indicated that mental illnesses are caused by witchcraft and curses show that they lack knowledge of the causes of mental illnesses. This, in line with the tenets of meaning, language and thought as expressed in the symbolic interactionism theory, may be an indication that in the respondents' society, people believe that mental illnesses are caused by witchcraft and curses. This respondent's meaning of mental illnesses, thoughts and language will reflect lack of knowledge according to the symbolic interactionism theory. The respondents are also likely to have stigma against the mentally ill.
On the question of who or what made the respondents to hold the belief they did about the cause(s) of mental illnesses, the responses obtained are as shown in Table 14 below.

Source of the belief on the cause(s) of mental illness	n	%
Family and friends	197	24
Teachers	184	23
Religious people	65	8
Witchdoctors	22	3
Medical personnel	78	10
Communication campaigns	3	0
Books	87	11
The media	167	21
Total	803	100

Table 14: Source(s) of the belief about the cause(s) of mental illnesses
Source: Researcher 2014

One hundred and ninety seven respondents answered this question. The respondents chose more than one source of these sources. It is important to note that the respondents cited the leading sources of their knowledge of the causes of mental illnesses as family and friends followed by teachers and then the media. This is consistent with findings by other studies on the sources of health information for adolescents (Masatu et al., 2003; Jones et al., 2011).
Family, friends, teachers and the media play a significant role in the formation of attitudes regarding mental health. Therefore, according to the symbolic interactionism theory, the meaning given to mental illnesses, the language used to construct this

meaning and the thoughts these students have regarding the causes of mental illnesses are influenced by the beliefs and expectations of their families, friends, teachers and the media.

On the question of what you would do to a mentally ill relative or friend, the respondents responded as shown in Table 4.1.15 below.

Action taken	n	%
Take them to hospital	192	97
Take them to a witchdoctor	5	3
Detain them at home	0	0
Leave them to just move around	0	0
Eject them from home	0	0
Total	197	100

Table 15: What would you do to a mentally ill relative or friend?
Source: Researcher 2014

One hundred and ninety seven respondents answered this question.

The fact that 97% of the respondents indicated that mentally ill people should be taken to hospital for treatment shows that the respondents knew that mental illnesses are treatable. Since 97% of the respondents had indicated that they were not aware of communication campaigns for mental health and 99% had indicated that they had not attended them, it can only be concluded that they obtained this knowledge from other sources in the community such as their parents, teachers and friends.

On the question of whether they would accept back and freely interact with a close relative or friend who was mentally ill but has recovered, the respondents responded as shown in Table 16 below.

Acceptance and interaction with a person who has recovered from a mental illness	n	%
Yes	194	98
No	4	2
Total	198	100

Table 16: Acceptance and interaction with a close relative or friend who was mentally ill but has recovered
Source: Researcher 2014

The responses show that the respondents do not stigmatize those who have been mentally ill but have recovered. This could also be an indication that the respondents know that mental illnesses are treatable. The fact that 98% of the respondents had indicated that they would readily accept back to the community and interact with those who have recovered from mental illnesses and yet 99% had indicated that they had not attended any communication campaign for mental health points to the likelihood of strong influence from family members, friends, teachers and the media. According to the symbolic interactionism theory, individuals' behaviours and attitudes towards others or situations are determined by the meanings, language and thoughts they have about them. These meanings, language and thought are shaped by the self and the community (Griffin, 2009).

The next question was on the number of young people who are mentally ill the respondent knew in his or her community. The responses were as shown in Table 17 below.

Number of young people who are mentally ill in the community	n	%
None	52	26
Less than 5	78	40
Between 5-10	32	16
More than 10	35	18
Total	197	100

Table 17: Number of young people who are mentally ill the respondent knows from his or her community
Source: Researcher 2014

The responses show that there are young people in the community who are mentally ill. This therefore makes it necessary to have communication campaigns for mental health targeting young people so that if they are mentally ill they can be treated early to avoid the mental problems worsening.

The last question was how in the respondent's opinion communication campaigns for mental health should be made more effective. The responses obtained were as shown in Table 18 below.

How communication campaigns should be made more effective	n	%
They should be held more regularly	81	45
They should use language that people understand	16	9
They should not be held in hospitals alone	25	14
All the above	57	32
Total	179	100

Table 18: How communication campaigns for mental health should be made more effective.
Source: Researcher 2014

The responses obtained show that communication campaigns for mental health should be held more regularly in order to be more effective. With 45% of the students saying that the campaigns should be held more regularly and 14% saying they should not be held in hospitals alone, the respondents show that they are not reached by these communication campaigns.
Since only three respondents answered most of the questions in the questionnaire, it is therefore evident that communication campaigns for mental health are not conducted in schools and many secondary school students are unaware of them. This makes them highly susceptible to mental illnesses since they lack adequate knowledge of mental health.

1.4.2. Discussion of Results

The results obtained show that the levels of knowledge of mental health issues among secondary school students in Nairobi County are inadequate. This is because communication campaigns for mental health held in Nairobi County do not target secondary school students yet these young people are most at risk of contracting mental illnesses (Rickwood, 2010; McGorry et al, 2007; Kessler et al, 2005). With only 3% aware of these communication campaigns and 1% having attended, these campaigns lack reach (Atkin, 2001; US Office of Disease Prevention and Health Promotion, 2000). This could be as a result of the choice of venue of these campaigns, the inability to target young people who are most at risk, the occasional nature of the campaigns and the mass communication strategies used.
Effective health communication campaigns are characterized by at least three important factors. First, these campaigns are more likely to use mass communication and behavior change theory as a basis for campaign design. Second, they are more likely to use formative research such as focus group to develop messages and inform campaign strategy. Third, they are more likely to link media strategies with community programs thus reinforcing the media message and providing local support for desired behavior changes (Wallack & Dorfman, 2001). From the literature review and findings of this study, the communication campaigns for mental health conducted in Nairobi County use mass communication and behavior change theory as a basis for campaign design. However, they do not use media that has wide reach.
Several media campaigns have been held to challenge stigma and promote increased awareness of, and positive attitudes towards mental health issues. These include You in Mind (Hersey et al., 1984; Barker et al., 1993); the Norwegian Mental Health Campaign (Sogaard and Fonnebo, 1995); "Changing Minds" by the Royal College of Psychiatrists in the UK; and the World Psychiatric Association's campaign "Open Doors" (Sartorius, 1997). For instance, the Norwegian Mental Health Campaign was a nationwide mass media-based publicity and information strategy over a six month period, culminating in a six hour television broadcast. It achieved wide penetration, putting mental health issues on the cultural agenda in Norway and changing the knowledge of and attitudes towards mental health problems (Sogaard and Fonnebo, 1995). In the UK, the 'You in Mind' television series had a positive impact on mental-health-related understanding and behavioural intentions of a large and diverse national audience (Barker et al., 1993). In the USA, the media-based San Francisco Mood Survey Project, aimed to target depression and depressive symptoms in the population. Delivered through television, it led to a significant reduction in depressive symptoms in those individuals who initially scored at high levels of depressive symptoms and watched the segments during the intervention's broadcast (Munoz et al., 1982).
This evidence shows that targeted, well-planned and well-executed mass media campaigns, supported by local community action, can increase knowledge, reduce stigma and discrimination, increase the use of mental health services, bring mental and physical health care closer to each other, as well as impact positively on mental health literacy at the community level (WHO, 1986, 2003, 2007; Rogers, 1996; Jané-Llopis, Margaret Barry, Clemens Hosman and Vikram Patel, 2005).
The results also indicate that the students know most of the causes of mental illnesses. Only 17% indicated that mental illnesses are caused by witchcraft and curses. 83% gave correct causes of mental illnesses. 24 % of the students indicated that they got the beliefs they had on the causes of mental illnesses from family and friends, 23% from teachers and 21% from the media. 0% indicated that they got their beliefs from communication campaigns. These responses could be useful to future mental health communication campaigns because they could be more effective in enhancing knowledge among young people if they use influencers such as parents, teachers and media practitioners. These sources are always accessible to the adolescents and they are also believed to be credible (Masatu et al., 2003; Jones et al., 2011).
The students also know that the mentally ill are supposed to be taken to hospital for treatment and that they can be treated and fully recover. These responses clearly indicate that the students have some important information about mental health and mental illnesses, though not obtained from mental health communication campaigns. If appropriate communication strategies are used, this knowledge will be enhanced.

2. Conclusions

The findings of this study show that communication campaigns for mental health in Nairobi County are not effective in enhancing knowledge of mental health among secondary school students. This is because the campaigns do not specifically target this group that is highly susceptible to mental illnesses (Rickwood, 2010; McGorry et al, 2007; Kessler et al, 2005), the campaigns take place within the precincts of the Mathari Hospital and the area around it. Therefore many schools and people in Nairobi County who are living far from Mathari National Teaching and Referral Hospital are never reached. The campaigns also use workshops, symposia, newsletters, leaflets and banners as the only ways of reaching their audience. They therefore have very low reach.

Kakuma et al (2010) report that in South Africa, newspapers, television shows, performing arts, radio shows, brochures and pamphlets are used for international events such as World Mental Health Day and Mental Health Awareness month. The mental health communication campaigns held in Kenya can be more effective by involving secondary schools students especially in performing arts.

For these campaigns to reach secondary school students and effectively enhance their knowledge levels, the campaign planners need to take these campaigns to the schools, community centres, places of worship and homes throughout the county. They should also use mass media such as radio, television and newspapers to ensure wide reach. In addition, these communication campaigns should be held regularly.

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