ADDIS ABABA UNIVERSITY

COLLAGE OF HEALTH SCIENCE

SCHOOL OF NURSING AND MIDWIFERY

DETERMINANTS OF MENTAL HEALTH LITERACY AMONG ADOLESCENT STUDENTS IN GOVERNMENTAL SECONDARY SCHOOLS OF ADDIS ABABA, EHTIOPIA

BY: YODIT FELEGE (BSC)

A THESIS SUBMITTED TO ADDIS ABABA UNIVERSITY, COLLEGE OF HEALTH SCIENCES, SCHOOL OF NURSING AND MIDWIFERY DEPARTMENT OF NURSING, IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR A MASTER'S DEGREE IN PEDIATRIC AND CHILD HEALTH NURSING

May, 2024

ADDIS ABABA, ETHIOPIA

ADDIS ABABA UNIVERSITY

COLLAGE OF HEALTH SCIENCE

SCHOOL OF NURSING AND MIDWIFERY

DETERMINANTS OF MENTAL HEALTH LITERACY AMONG ADOLESCENT STUDENTS IN GOVERNMENTAL SECONDARY SCHOOLS OF ADDIS ABABA, EHTIOPIA

BY: YODIT FELEGE (BSC)

ADVISORS: MR ABDISA BOKA (ASSISTANT PROFESSOR, MPH/RH, MSC IN ICCMH, BSC)

SR. SOSINA WORKNEH (BSC, MSC ONN)

A THESIS SUBMITTED TO ADDIS ABABA UNIVERSITY, COLLEGE OF HEALTH SCIENCES, SCHOOL OF NURSING AND MIDWIFERY DEPARTMENT OF NURSING, IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR A MASTER’S DEGREE IN PEDIATRIC AND CHILD HEALTH NURSING

May, 2024

ADDIS ABABA, ETHIOPIA

APPROVAL SHEET

ADDS ABABA UNIVERSITY

COLLEGE HEALTH SCIENCE SCHOOL OF ALLIED SCIENCES

DEPARTMENT OF NURSING AND MIDWIFERY

I, the undersigned MSc pediatric and child health nursing student, declare that I have submitted my original work on a title of Determinants of mental health literacy among adolescent students in governmental secondary schools of Addis Ababa, Ethiopia for the examination.

Submitted by:

Yodit Felege Signature: ________________Date:__________________

this thesis work has been submitted for examination with my approval as an advisor.

Examiner____

Signature_____________________________ Date____________________________

Approved by:

1. Principal advisor

   Mr. Abdisa Boka Signature: _________________Date: ___________________

2. Co-Advisor

   Sr. Sosina Workneh Signature: _______________Date: __________________

STATEMENT OF DECLARATION

By my signature below, I declare and affirm that this thesis is my own work. I have followed all ethical principles of scholarship in the preparation, data collection, data analysis, and completion of this thesis. All scholarly matter that is included in the thesis has been given recognition through citation. I affirm that I have cited and referenced all sources used in this document. Every serious effort has been made to avoid plagiarism in preparing this thesis. This thesis is submitted in partial fulfillment of the degree of master in pediatric and child health nursing to AAU. I would like to declare that this thesis has not been submitted to any other institution anywhere for the award of any academic degree, diploma or certificate.

Principal investigator: Yodit Felege Signature _______________ Date _________________

Advisors: 1. Mr. Abdissa Boka Signature __________________ Date__________________

2. Sr. Sosina Workneh Signature ___________________Date___________________

AKNOWLEDGMENTS

First of all I would like to thank God all mighty for his protection and life guidance. Secondly I would like to express my gratitude to Addis Ababa University, College of Health Sciences, and Department of Nursing for giving me the opportunity to undertake this study. Next I would like to thank my principal advicor Mr. Abdisa Boka (Assist. Professor, MPH/RH, MSc in ICCMH, Bsc) and my Co advisor Sr. Sosina Workneh (Bsc, Msc ONN) for their unreserved support and guidance in the development of this thesis. It is an honour working with them. And my next acknowledgment goes to my family for their non stopping support and encouragements. Special thanks goes to my Dad. Finally I would also like to expand my deepest gratitude to my friends for their tireless assistance in data collection. This thesis wouldn't be done in such a short period of time without their support

ACRONYM AND ABBREVATIONS

AAU	Addis Ababa University
BoP	Bottom of the pyramid
CYP	Children and Young People
DEFF	Design effect
LMIC	Low and Middle Income Countries
MHL	Mental Health Literacy
MHLS	Mental health literacy score
MHLq	Mental health literacy questioner
PMI	Previous mental illness
SCQ-AS	Social Capital Questionnaire for Adolescent Students
YLDs	Years Lived with a Disability

Table of Contents

AKNOWLEDGMENTS V

ACRONYM AND ABBREVATIONS VI

LIST OF FIGURES IX

LIST OF TABLES X

ABSTRACT XI

1. INTRODUCTION 12

1.1. Background 12

1.2. Statement of the problem 13

1.3. Significant of the study 14

2. LITERATURE REVIEW 15

2.1. Introduction 15

2.2. Level of mental health literacy 15

2.3. Socio demographic 16

2.4. Social Media 16

2.5. Social capital 18

2.6. Source of information 19

Conceptual framework 20

3. OBJECTIVE 21

3.1. General objective 21

3.2. Specific objective 21

4. METHODS AND MATERIALS 22

4.1 Study area and Period 22

4.2. Study design 22

4.3. Population 22

4.3.1 Source population 22

4.3.2 Study Population 22

4.4. Eligibility Criteria 22

4.4.1. Inclusion Criteria 22

4.4.2. Exclusion Criteria 22

4.5. Sampling method 23

4.5.1. Sampling size determination 23
4.5.2. Sampling techniques and procedures 23
4.6. Study variable.. 26
4.6.1 Dependent variable 26
4.6.2. Independent variable... 26
4.7. Operational definition 26
4.8.1. Data collection tools 26
4.8.2Data collection procedure 27
4.8.3 Data quality assurance 27
4.9. Data analysis 28
4.10. Ethical considerations 28
5. RESULTS 29
6. DISCUSSION 37
7. STRENGTH AND LIMITATION OF THE STUDY 40
7.1. Strength of the study 40
7.2. Limitation of the study 40
8. CONCLUSION AND RECOMMENDATIONS 41
8.1 Conclusion... 41
8.2 Recommendation... 41
ANNEX.. 46
Annex I. Participant Information Sheet.. 46
Annex II. Consent sheet 47
Annex III. Adolescents assent form 48
Annex IV: Self administered questioner 49
Annex V: Amharic Version... 56

LIST OF FIGURES

Figure 1.: Mental Health Literacy conceptual framework review form different literatures........20
Figure 2: Schematic presentation of sampling procedure of the study.. 25
Figure 3: Source of information for study participants about mental health of the adolescent students in the selected governmental secondary schools of Addis Ababa, Ethiopia, February to March 2024 (n=833) 31
Figure 4: Type of social media used among the adolescent students in the selected governmental secondary schools of Addis Ababa, Ethiopia, February to March 2024 (n=833) 33
Figure 5: Frequencies of the dichotomized social capital score of the adolescent students in the selected governmental secondary schools of Addis Ababa, Ethiopia, February to March 2024 (n=833)... 34

LIST OF TABLES

Table 1 Socio-demographic characteristics of the adolescent students in the selected in governmental secondary schools of Addis Ababa, Ethiopia, February to March 2024 (n=833).. 29

Table 2 Source of information of the adolescent students in the selected governmental secondary schools of Addis Ababa, Ethiopia, February to March 2024 (n=833)... 31

Table 3: The social media engagement of the adolescent students in the selected governmental secondary schools of Addis Ababa, Ethiopia, February to March 2024 (n=833). 32

Table 4: The mean and maximum and minimum scores in each factors on the MHLq (N=833). 34

Table 5: Multiple linear regression analysis on determinants for mental health literacy among adolescent students in the selected governmental secondary schools of Addis Ababa, Ethiopia, February to March 2024 (n=833).. 35

ABSTRACT

Background: Mental health literacy is the knowledge and beliefs about mental disorders. Adequate mental health literacy is linked to better health seeking behavior and management of mental illness. It is particularly important during adolescence, a critical phase for developing social and emotional habits important for mental well-being to cope with the stresses of life, realize their ability, learn well and work well and contribute to their community

Methods: School based cross-sectional study was conducted February to March, 2024 G.C at selected secondary school in Addis Ababa. A total of 902 adolescent students in secondary school was selected using multi stage cluster sampling. The data was be gathered using self-administered structured pretested questionnaires. Data entered was exported to IBM SPSS statistics (version 26) for analysis for Kobo ToolBox. Multiple linear regression analysis was employed. A p-value of less than 0.05 was considered statistically significant.

Result: A total of 833 adolescent students aged 15-18 in selected schools of Addis Ababa participated. The mean social capital score was 27.09 (SD=2.78), and the mean mental health literacy score was 116.90(SD=23.07).In multiple linear regression analysis mental health literacy was significantly associated with study participants with single relationship status (ß =8.55, p=.005) students family size greater than 5(ß=4.89, p=.010), study participants who preferred following or watching transformative (educational and inspirational) and interactive contents on social media (ß=-4.43, p=.003) and (ß=3.85, p=.034) respectively. And also significantly associated who had good neighborhood social capital (ß=5.69, p=.005) and good trust in school or neighborhood on social capital (ß=3.97, p=.043).

Conclusion: The findings show the importance of interacting and connecting in increasing adolescents' mental health literacy. Specifically, study participants with larger family sizes, those who preferred interacting social media contents, and those with good social support networks and community cohesion were found to have increased mental health literacy.

Key word: Adolescent, Mental health literacy, Secondary school, Addis Ababa, Ethiopia

1. INTRODUCTION

1.1. Background

Mental health is a crucial component of overall health and wellbeing, which is also a fundamental human right. Better connections, functioning, coping, and thriving are all facilitated by mental health. There is a broad continuum of mental health, with experiences ranging from the best possible state of wellbeing to life-threatening situations involving intense emotional pain and suffering(1).

Mental health conditions are a major contributor to illness and impairment in adolescents. Around 14% of adolescents worldwide, who are between the ages of 10 and 19, suffer from a mental disorder.(1)Three of the top four causes of morbidity among adolescents in 2019 accounting 4.8 million years lived with a disability (YLDs) were anxiety, depression and behavioral disorders. These disorders dominated the global, regional, age- and sex-specific morbidity burden(2).

Adolescence is one of the most rapid and formative phases of human development(2). Most Mental illnesses first manifest in childhood or adolescence, impacting both physical and mental health and limiting potential of an individual to fully engage in their communities(3). The likelihood of acquiring mental health disorders might be raised by living in fragile and humanitarian circumstances, being exposed to violence, poverty, stigma, and isolation. Adolescents' mental health may also suffer from increased use of digital technology, however the evidence for this is still inconclusive(4).

The term "mental health literacy" originated by Jorm et al. in 1997, who stated it as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention". Mental health literacy consists of several components, including (a) the ability to recognize specific disorders or different types of psychological distress; (b) knowledge and beliefs about risk factors and cause; (c) knowledge and beliefs about self-help intervention; (d) knowledge and beliefs about professional help available; (e) attitudes which facilitate recognition and appropriate help-seeking; and (f) knowledge of how to seek mental health information(5).

1.2. Statement of the problem

Researches on “mental health literacy” are expanding quickly, mostly in high income countries. It is crucial for active countries and low and middle income countries to collaborate on research since many developing countries lack the infrastructure and knowledge necessary for conducting mental health literacy studies(6).

In low and middle income countries (LMICs) the rates of diagnosing and treating mental illness are significantly lower(7). Not many countries, particularly those in Africa, have ever considered mental health, much less adolescent mental health, to be a public health priority(8).

Evidence of recent systematic reviews shows that adolescents in sub-Saharan Africa are particularly at high risk of mental disorders. However, there are no policies to address this issue and mental healthcare facilities in the region poorly resourced(9). In Ethiopian public health discourse, health literacy in general and mental health literacy in particular have not received much attention.(8) And not many studies have been conducted in Ethiopia(10).

Cultural values and beliefs play a significant role in mental illness. Cultures can shape symptoms, make some subgroups more vulnerable, change beliefs and explanations of disorders, and influence and contribute to the causation of mental illnesses(11). However, the concept of MHL is still primarily derived from adult populations in high-income countries and western conceptions of mental health(12).

Recent research conducted in Indonesia has examined the prevalent ideas among child and young people (CYP) regarding mental health and illness, as well as the significant role of religion in Indonesian culture. These recent findings highlight how crucial it is to approach MHL with cultural awareness in order to maximize the effectiveness of future intervention programs(12).

There is also an important gap between mental health research and mental health practice (13).School nurses have a significant impact on the mental health and general wellbeing of adolescents. That being said, not all school nurses exhibit a high degree of mental health literacy(14).

In general, less study has been done on the mental health literacy of young populations and other vulnerable groups, who are known to face particular obstacles and challenges in regards to receiving professional mental healthcare(15).

1.3. Significant of the study

One way to address the excessively high rates of mental illness and under treatment is to improve mental health literacy. In order to build an evidence base and develop interventions to improve literacy, it is crucial to first understand the current state of knowledge and belief regarding mental illnesses.

Studying MHL in adolescents can add to the body of knowledge on mental health education, helps evaluate the effectiveness of current programs, and direct the development of new interventions meant to enhance mental health outcomes in this age group. Research on exploring adolescent mental health literacy can help shape practices and policies that support mental health and reduce the impact that mental illness encounters on society.

2. LITERATURE REVIEW

2.1. Introduction

The phrase "mental health literacy" was first used in 1997 when Anthony F. Jorm and colleagues realized how crucial it was that non-practitioners comprehend mental health literacy. Mental health literacy (MHL) refers to a person's knowledge and beliefs about mental health that help to aid in recognition, management, and prevention of mental health disorders(16).

Although the concept of MHL has grown since 1997, its fundamental definition has not changed (17). The definition coined by Jorm et al is considered to be the standard in research surrounding the concept of MHL. MHL has grown to include stigma-related components, which was previously separately considered. MHL was expanded to include self-help strategies and the efficacy of help-seeking behaviors. Over time, many additions were made to improve the overall public's mental health as well as the welfare of individuals (18).

MHL is significant and applicable to individuals and entire communities. In addition to assisting in the diagnosis of mental health issues, MHL educates caregivers so they can support their family and loved ones and assists individuals in learning how to manage their illness(19).

2.2. Level of mental health literacy

In a study on secondary school in the North Alentejo region of Portugal, the teenagers' sample mean MHL knowledge score was 62.03, indicating a good level of MHL (20). Just 275 (16.4%) respondents, who were high school students in the South Western region of China, were deemed to have a sufficient level of mental health literacy (21). The mental health literacy score, with a mean of 135.98 and a standard deviation of 15.50, was found to be normally distributed in an urban Ethiopian cross-sectional survey (8).

2.3. Socio demographic

Socio demography has been reported to have a significant effect on the mental health literacy of adolescents (20,22,23).The Portuguese adolescents with higher levels of MHL were the oldest, in a higher year of school, female and those whose mothers are employed(20).A recent study in the USA indicated that adolescents from lower grades showed lower mental health literacy levels(23).Chinese adolescents from middle grades had higher mental health literacy level than those in primary grades, and college students were higher still(22).

A meta-analysis study was conducted to evaluate the awareness rate of mental health knowledge among Chinese adolescents. As a result, just 66% of Chinese adolescents were aware of mental health issues. University students had the highest awareness rate (73%), compared to junior middle school students (61%) and senior middle school students (62%) among teenagers (24).

In Saudi Arabia secondary school female students mental health literacy and observed that Students' awareness level showed that students with highly educated father recorded 1.5 times higher awareness than others with low educated fathers. Also, students of working mother had 4 times higher awareness compared to others. And students who live with their parents recorded 5 times higher awareness (25).

A study done in Dire Dawa, a city in Ethiopia mental health literacy was higher among female than male respondents (138.12 versus 133.84; $p<0.01$) and differently affected by socio-demographic factors. And the combined factors of ethnicity/cultural affiliation, school grade, and level of parental education accounted for 10.7% and 8.9% of the variability in mental health literacy of female and male respondents, respectively (8).

2.4. Social Media

Digital content is now more accessible to teenagers than ever before thanks to a range of devices, such as game consoles, laptops, desktop computers, tablets, and smart phones. The media environment of today is larger and more varied than it has ever been. A vital part of this ecosystem is social media. In its widest sense, social media encompasses any software or digital application that facilitates social interaction between users (26).

This media landscape has brought out new risks and worries regarding the mental health of young people, but it has also presented a number of special benefits and opportunities (27). According to a survey, American teenagers utilize Facebook, Twitter, Instagram, Snapchat, Twitch, WhatsApp, Reddit, and Tumblr, among ten other specialized online sites. Of all the sites examined, YouTube is the one that teenagers use the most frequently—95% of them claim to have used the website or app at least once. Furthermore, the majority report using TikTok (67%) as well as Instagram (62%) and Snapchat (59%) (28).

A better grasp of the increasingly positive discourse surrounding mental health and its reconceptualization on Twitter is provided by a study on mental health discourses on Twitter, which studied 1,200 randomly selected tweets recovered during Mental Health Awareness Week. Awareness campaigns must broaden their message, though; as the research also found that offline socio-cultural patterns of stigmatizing mental illness are replicated on Twitter. According to the research, there is a chance for health organizations and professionals to participate in the present Twitter debate, which is quite personal. It was also advised that companies would want to think about carefully partnering with influencers and celebrities to favorably steer the conversation in upcoming social media awareness initiatives (29).

A study on Effective use of social media platforms for promotion of mental health awareness state that, the Facebook page of mental health education was started in January 2016 and the Instagram page on September 2017, intending to promote the health and well-being of individuals and communities in the area of mental health and neurological sciences. The Facebook page of “Mental Health education” has 3285 followers. A total of 3205 people like the page. The Instagram page has 516 followers. However, the user friendliness of the Facebook page of Mental Health Education helped to reach more people. The maximum followers of both the Instagram and Facebook pages are females, around 71% for Instagram and 62% for Facebook (30).

Ghahramani and his colleagues reviewed 18 articles and the results found that ten (55.5%) of the research utilized quantitative methods, five (27.7%) used mixed methods, and three (16.6%) used qualitative methods. This has the effect of increasing the use of Facebook and YouTube for intervention aimed at altering health-related behavior. More people were using Twitter and Instagram to track changes in health-related behavior. Overall, the findings indicate that while

social media may help modify behavior, social media health campaigns are not equipped to estimate long-term behavior changes (31).

2.5. Social capital

An individual's relationships with communities and social networks have a significant impact on their health and well-being (32). Numerous researchers have discovered a connection between young people's mental health outcomes and social capital (33). In order to avoid mental health problems and enhance mental health in teenagers and other social age groups, interventions aimed at preventing these problems should incorporate social capital at the individual, neighborhood, and community levels (34).

A research finding evidence from a Bottom of the Pyramid (BoP) population done in 2018, demonstrated the great potential of cognitive social capital to support health intervention and the well-being of underprivileged communities. As a result, organizations involved in health intervention programs may be able to cultivate and reap the benefits of utilizing cognitive components of social capital (e.g. trust in neighborhood, sense of fairness, social harmony). claiming that these methods can be used in conjunction with social marketing techniques to encourage low-income individuals in rural areas to adopt preventive health behaviors (35).

A study in England found that many aspects of community "social capital" and family social support were linked to adolescent mental health and academic success. Social support from the family was very important when it came to mental health. However, the significance of community social capital appeared to be diminished; no component of community social capital was linked to poor mental health (33). A different study conducted on schoolchildren in England demonstrated the importance of social capital for the health of young people. A number of social capital indicators were shown to have statistically significant correlations with the health and health-related outcomes that were chosen for the study. It was discovered that in several cases, the influence of these bonds outweighed that of family (32).

According to the results of a study conducted among school-aged teenagers in eastern Ethiopia, the presence of mental health issues in adolescents is predicted by their in-school networks of friends, neighborhood or school trust, and neighborhood social cohesion. This demonstrates how

building stronger peer networks within schools, fostering trust within schools or communities, and fostering local social cohesiveness all significantly help to lowering difficulties (34).

2.6. Source of information

The mean score for the students who reported having mental illness previously (PMI) scored higher in MHLS at 7.6 points more than the students who did not report having mental illness previously, among the international postgraduate students in a public university in Malaysia but this difference yielded no statistical significance (p=0.27). On the other hand, previous studies done in UK, and Australia showed different results, both previous studies outcomes resulted in a significant statistical difference between students mentioned having mental illness previously compared to students who said otherwise (using the MHLS), with a mean difference of 14 and 5 points for UK, and Australia studies respectively (36,37).

The previous Australian study also yielded statistical significance when question has been asked about having a family member or a friend with mental illness, respondents who had a family member or a friend with mental illness got a higher score on the MHLS (36).

Parents and elders are typically the first people to be called in African contexts. This group can be the target of mental health awareness efforts because they have a lot of influence over teenagers and ultimately decide whether or not to seek professional treatment. Friends were the second most frequently suggested source of assistance. The significance of mental health literacy for all adolescents is once again proven by this study. Peer groups have therefore grown in importance as a source of support during adolescence, and in this context, a more structured program for teaching teenagers to recognize mental health issues in their friends would be beneficial (38).

Conceptual framework

This conceptual framework is adapted from different literatures(21, 31, 33, 37) showing that mental health literacy among adolescents is influenced by different factors like Socio demography factors, Social media, Source of information and Social capital.

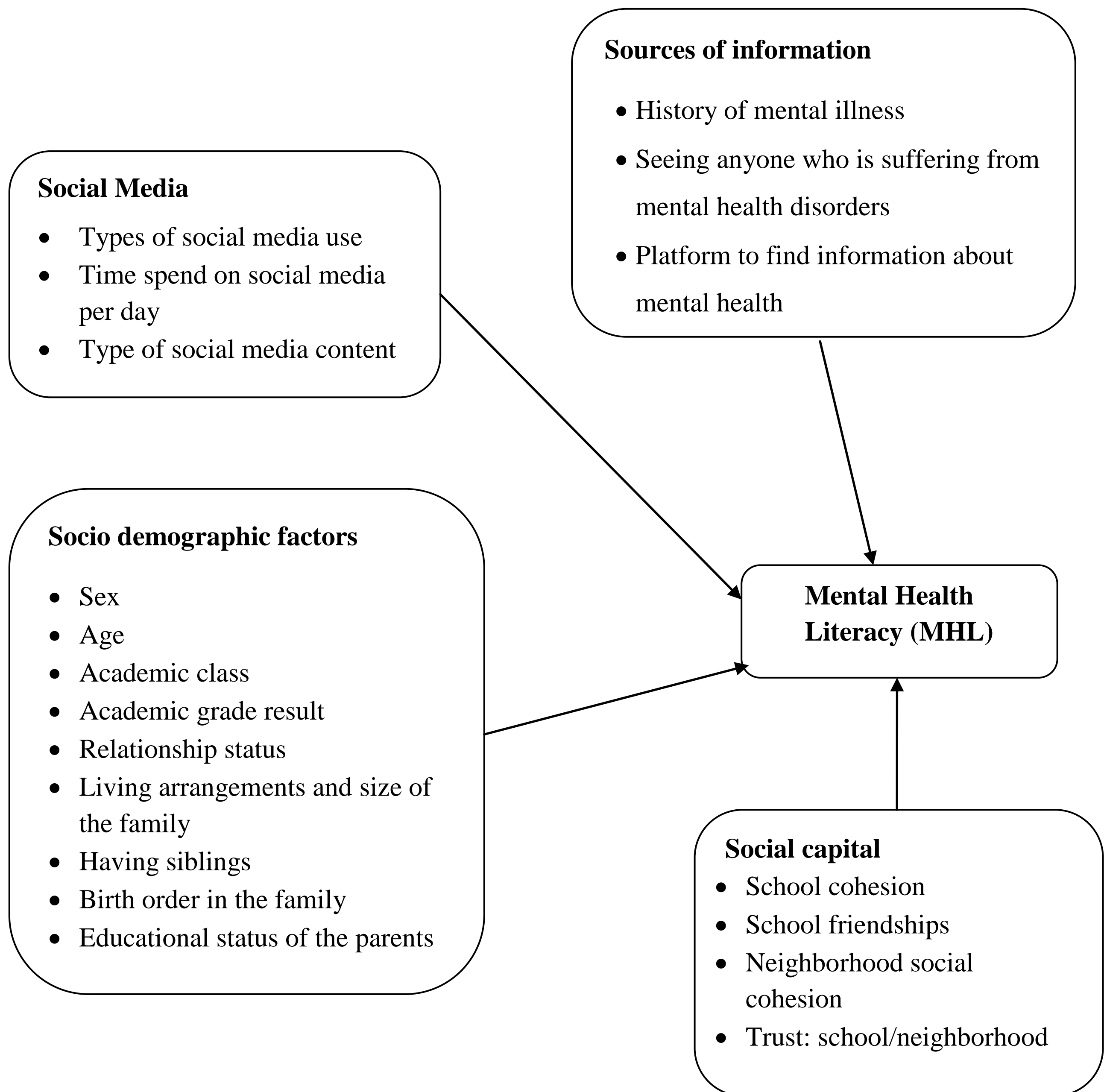


Figure 1: Mental Health Literacy conceptual framework review form different literatures.

3. OBJECTIVE

3.1. General objective

- To assess the determinants of mental health literacy of adolescent students in governmental secondary school in Addis Ababa in 2024.

3.2. Specific objective

- To assess the association between socio demographic factors and the mental health literacy of adolescent students in governmental secondary school in Addis Ababa.
- To determine the association between social media and the mental health literacy of adolescent students in governmental secondary school in Addis Ababa.
- To determine the association between social capital and the mental health literacy of adolescent students in governmental secondary school in Addis Ababa.
- To assess the association between source of information and the mental health literacy of adolescent students in governmental secondary school in Addis Ababa.

4. METHODS AND MATERIALS

4.1 Study area and Period

This study was conducted in Tikur Anbesa, Bole general, Shimeles Habte and Tesfa Birhan governmental secondary schools of Addis Ababa. Addis Ababa is the capital city of Ethiopia, surrounded with Sheger city of Oromia region. Addis Ababa has 11 sub-cities. The selected schools are located in Arada, Bole,kirkos and Yeka sub cities respectively. According to Minster of Education in 2021/22 there is net enrolment of 2,808,762 secondary school students in Ethiopia. There are 210 secondary schools in Addis Ababa, accounting 132 nongovernmental and 78 governmental schools. Secondary schooling lasts from Grade 9 to Grade 12.

This study was conducted from February to March, 2024 in Addis Ababa governmental secondary schools.

4.2. Study design

A school based cross-sectional study was conducted.

4.3. Population

4.3.1 Source population

All adolescent students attending governmental secondary school in Addis Ababa.

4.3.2 Study Population

All adolescent students attending in the selected governmental secondary school in Addis Ababa fulfilling study criteria and present during the data collection.

4.4. Eligibility Criteria

4.4.1. Inclusion Criteria

- The study included all students who attend in the selected governmental secondary school that age 15-18.

4.4.2. Exclusion Criteria

- Student who is not able to understand and can’t complete the questionnaire.
- Student parents/guardian who cannot be reached for consent before data collection time.

4.5. Sampling method

4.5.1. Sampling size determination

The sample size was calculated by using a single population proportion formula. We have taken the standard deviation mental health literacy score of 15.5 from a research done in Dire Dawa(8), Ethiopia on mental health literacy of adolescents and the effect of socio-demographic characteristics. We took 95% confidence level, 15% margin of error.

$$n = \frac{\left(z\alpha/_2\right)^2 SD^2}{e^2}$$

$$\frac{(1.96)^2 \times (15.5)^2}{(1.5)^2} = 410.1975$$

$$n = 410$$

An estimated minimum sample size (n=410). Where n desired sample size, $z\alpha/_2$ critical value at 95% CI (1.96), SD standard deviation of the measure in the population (15.5), and e margin of sampling error (e=1.5)

For possible non- response during the survey the final sample size was increase by 10% to n=410+10% which is 41 = 451

In order to achieve the precision that the effective sample size would give us with a simple random sample, we used Design effect (DEFF)

Cluster sample size= Effective sample size x DEFF

451x 2=902

4.5.2. Sampling techniques and procedures

Sample students were selected from secondary schools using probability proportionate to size using multi stage cluster sample technique. At first stage, there are 78 governmental schools in Addis Ababa. These schools are distributed according to the 11 sub cities. And four sub cities were selected randomly, which is Kirkos, Arada, Bole and Yeka subcities each containing 4, 7 ,6 and 7 numbers of governmental secondary schools respectively . Then four schools were selected randomly from each selected sub cities. Tikur Anbesa secondary school form Arada sub city,

Bole general school form Bole sub city, Tesfa Birhan secondary school from Yeka sub city and Shimeles habte secondary school from Kirkos sub city. Tikur anbesa secondary school has 26 class rooms for 9-12 graders. 9th grade has 6 class sections, 10th grade has 5 class sections, 11th grade has 6 class sections and 12th grade has 9 class sections. Tesfa birhan secondary school has 33 class rooms for 9-12 graders. 9th grade has 9 class sections, 10th grade has 10 class sections, 11th grade has 7 class sections and 12th grade has 7 class sections. Bole general secondary school has 37 class rooms for 9-12 graders. 9th grade has 7 class sections, 10th grade has 9 class sections, 11th grade has 8 class sections and 12th grade has 13 class sections. Shimeles habte secondary school has 35 class rooms for 9-12 graders. 9th grade has 11 class sections, 10th grade has 9 class sections, 11th grade has 8 class sections and 12th grade has 7 class sections.

Out of this we randomly selected two class sections from each grade and each class room contains 40 students. And lastly students within 9-12th grade who accept to participate were included by systematic random sampling.

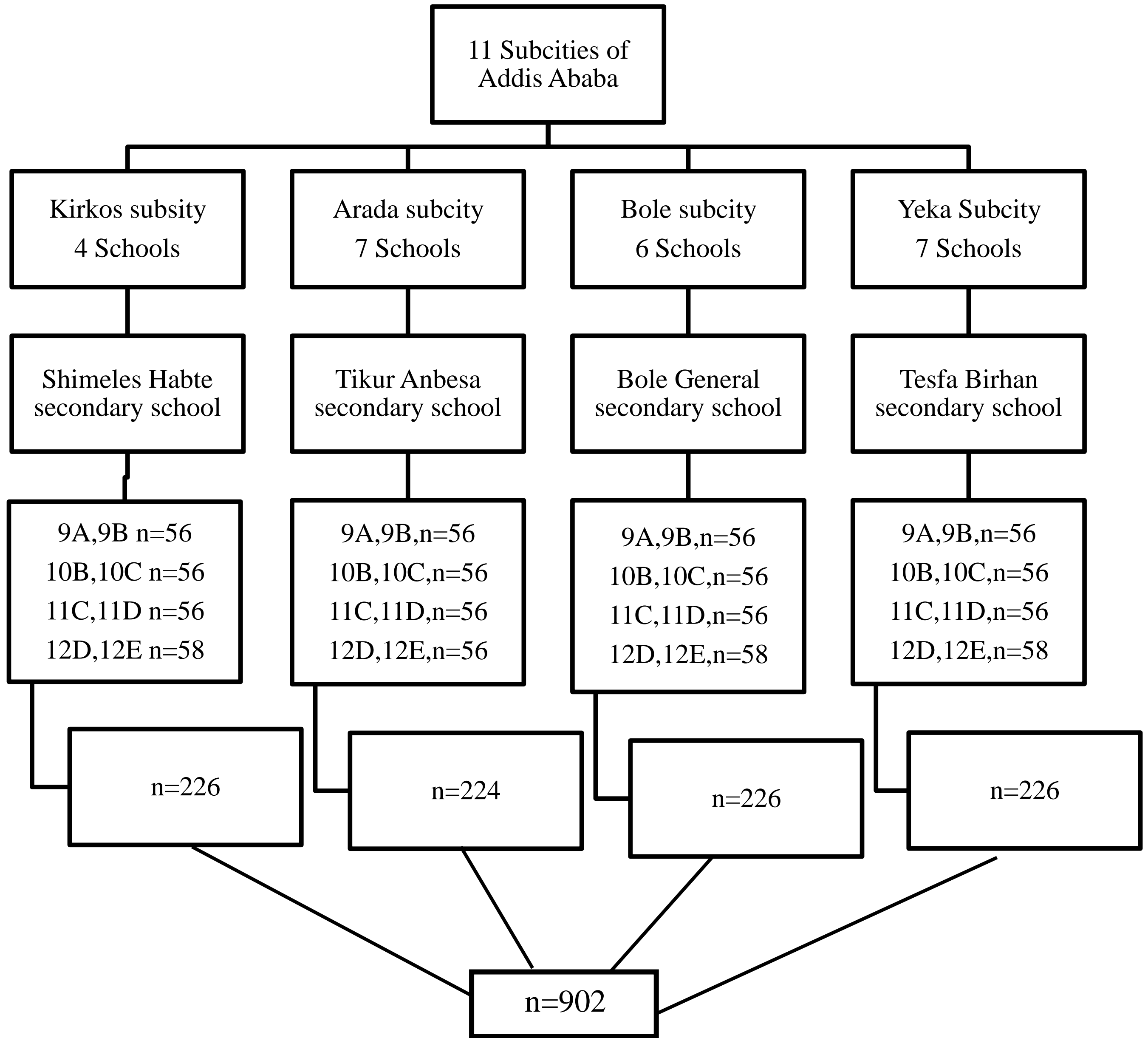


Figure 2: Schematic presentation of sampling procedure of the study

4.6. Study variable

4.6.1 Dependent variable

- Mental health literacy

4.6.2. Independent variable

- Socio demographic factors
- Source of Information
- Social Media
- Social Capital

4.7. Operational definition

- **Adolescent** - Age between 15-18 years.
- **Secondary School** –9th to 12th Grade
- **Mental health literacy**- Mental health literacy is the knowledge and beliefs about mental disorders which aid their recognition, management or prevention (5).
- **Social capital** - Social capital is referred to features of social organization, such as networks, norms, and social trust that facilitate coordination and cooperation for mutual benefit (39).
- **Good social capital** - Good social capital is defined when greater or equal to the mean score is obtained within each subscale of School cohesion, School friendships, Neighborhood social cohesion and Trust in school/neighborhood.
- **Poor social capital** - Poor social capital is defined when lesser than the mean score is obtained within each subscale of School cohesion, School friendships, Neighborhood social cohesion and Trust in school/neighborhood.

4.8.1. Data collection tools

The socio demography questionnaire was developed based on a review of relevant literatures focusing on school going adolescents. Containing 12 factors like age, gender, academic class grade, last semester academic grade result, how many siblings they have, relationship status, living arrangements, size of a family, birth order in the family, educational status of both parents, activities they are engaged in after school and also it includes 4 sources of information related questions and 6 social media related questions(39,25, 37)

Social Capital Questionnaire for Adolescent Students (SCQ-AS) was used to assess social capital of the students which is made up of 12 items. This questioner's overall scale exhibits very good internal consistency (Cronbach's alpha: 0.71). The 12 items were divided into four subscales: School Social Cohesion, School Friendships, Neighborhood Social Cohesion and Trust (school and neighborhood). In order to calculate scores, each subscale uses a Likert scale with the response alternatives I disagree, I don't know or have no opinion, and I agree (41). Additionally, a reliability test was conducted on a Harari study that revealed (Cronbach's alpha=0.71) (42).

A data collection tool is adapted from the Mental Health Literacy questionnaire for the study to assess MHL. The MHLq is a useful, valid, and reliable instrument for detecting gaps in knowledge, attitudes, and behavioral intentions in sizable populations. This makes it possible to design and assess interventions meant to support young people's mental health. It was created at Portugal's Catholic University. The MHLq- version that was utilized in this investigation included 33 components, the score ranging from 33-165 stating that the higher the score the level of mental health literacy increases. A five-point Likert scale (1=strongly disagree, 2=slightly disagree, 3=neither agree nor disagree, 4=slightly agree, 5=strongly agree) was used for each topic to elicit a response. The questionnaire demonstrated strong test-retest reliability and good internal consistency (total score α=0.84; Factor 1 first aid skills and help seeking α =0.79; Factor 2 knowledge/stereotypes α =0.78; Factor 3 self-help strategies α =0.72), the ICC for the total score of MHLq was 0.88 (43). Further tested for its reliability (Cronbach's alpha=0.834) on a study done in Dire Dawa (8) and (Cronbach's alpha=0.968) on this present study.

4.8.2Data collection procedure

The data was collected from the adolescent students attending on the selected governmental school between Februarys to March, 2024, for a period of around one month. The information was gathered through self-administered questioner using a Kobo ToolBox. The researcher's careful supervision, with three data collectors the data collectors were facilitating data gathering from respondents.

4.8.3 Data quality assurance

To enhance the quality of data, two days training was given for data collectors. Language experts were involved because of the questionnaire was converted to Amharic for data collection then back to English for data analysis. Face validity assessment was done. The questionnaire was pre-

tested on 5% adolescent students in Minilik secondary governmental schools before the main study and appropriate modification was made based on the pretest.

4.9. Data analysis

Kobo ToolBox was used to collect the information. The data from Kobo ToolBox was exported to IBM SPSS statistics (version 26) software for analysis after the data was checked for completeness. Reverse scoring was performed for negatively-keyed items (Q9, Q11, Q13, Q19, Q21 and Q24) of the MHLq and (Q11 and Q12) on SCQ-AS before computing each individual's mean score. Descriptive statistics was performed to summarize the data and present the study variables. Then the data was presented using a table and bar graph accordingly. linear regression analysis was employed to assess the mean of MHL, p-value and 95% confidence interval (CI) was used in judging the significance of the associations. A p-value of less than 0.05 was considered statistically significant.

4.10. Ethical considerations

Ethical clearance was obtained from the Institutional Review Board (IRB) of the College of Health Sciences, Addis Ababa University with protocol number of SNM/22/2024, which was approved on a meeting, held on January 25/ 2024. Written informed consent was obtained from all study participants. Student's parents/legal guardians in the different grades was asked for consent of their child(less than 18 years old) to participate in this study, two days before data collection after explaining the objectives of the research and confirming confidentiality of data. Also assent was taken from the underage participants whose parents/legal guardian gave consent to participate in the study. Students who are 18 years old were consented directly. Individual information was kept confidential by avoiding possible identifiers such as the names of the study participants.

5. RESULTS

The socio demographic characteristics of the study participants

Form the total sample size 833 participants were able to answer the questionnaires within one month that make response rate 92.35%. The age range of the participants is 15–18 years. More than half 498(59.8%) of respondents were female. Two-third of 570(68.4%) were in 11th and 12th grade. Majority of the participants relationship status was single 762(91.5%) and 708 (85%) lives with their parents. And more than half of the study participants 569 (68.3) family size was less than and equal to 5. The educational status of both mother 531(63.8%) and father 513(61.6%) of the study participants were in primary and secondary school. (Table 1)

Table 1 Socio-demographic characteristics of the adolescent students in the selected in governmental secondary schools of Addis Ababa, Ethiopia, February to March 2024 (n=833)

Variables	Category	Frequency	Percent
Sex of the respondent			
	Female	498	59.8
	Male	335	40.2
Age Distribution			
	15-16	263	31.6
	17-18	570	68.4
Academic class			
	Grade 9-10	398	47.8
	Grade 11-12	435	52.2
Last semester academic grade result	Maximum	99.1	
	Minimum	48	
	Mean (SD)	69.38 (9.69)	
Relationship status			
	Single	762	91.5
	Have a boy/girl friend	71	8.5
Living arrangement			
	With parent/Parents	708	85
	With families	116	14
	Alone	7	0.8
	With Cohabitant	2	0.2
Family size			
	Less than and equal to 5	569	68.3
	Greater than 5	264	31.7

Number of siblings	0-2 >2	471 362	56.5 43.5
Birth order	The only child The eldest The middle one The youngest	51 228 342 212	6.1 27.4 41.1 25.5
Father's educational level	No formal Education Primary and Secondary Education College or above	128 513 192	15.4 61.6 23.0
Mother's educational level	No formal Education Primary and Secondary Education College or above	191 531 111	22.9 63.8 13.3
Engaged in after school activities	Helping family Using social media Reading books Watching and playing sport activities Others	419 377 424 229 27	50.3 45.3 50.9 27.5 3.2

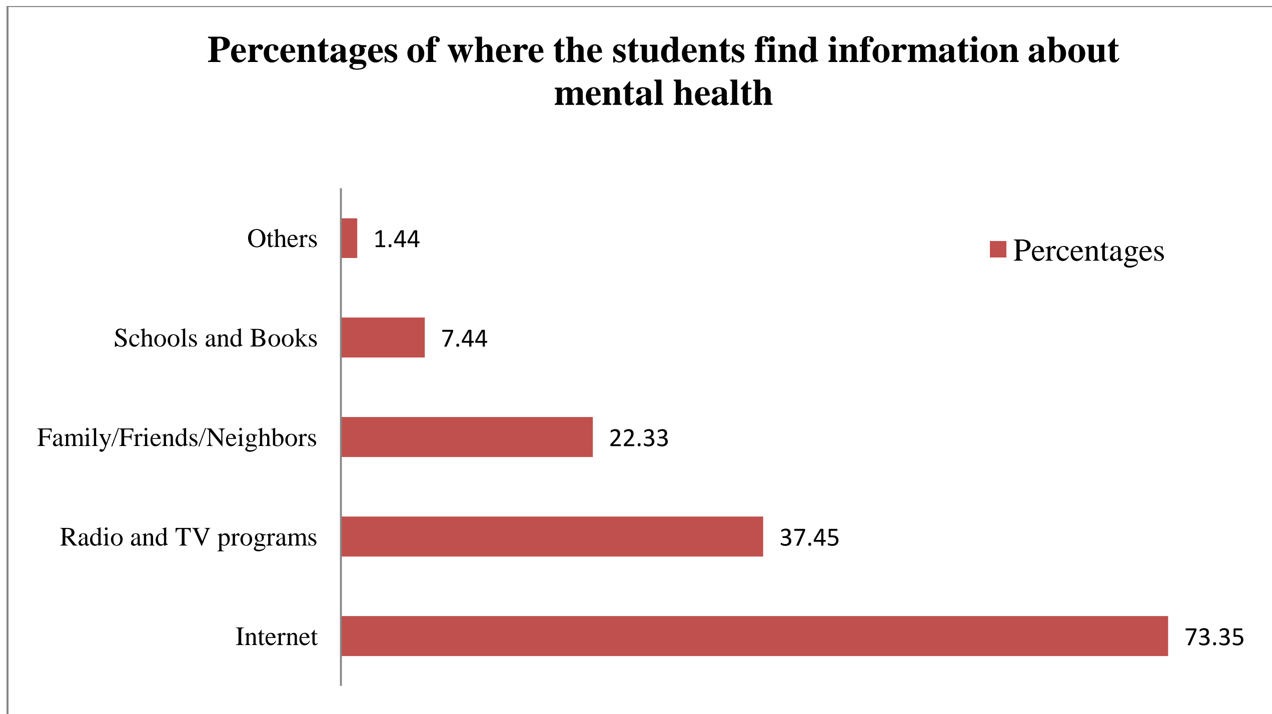
Note: Others= Going spiritual places ,working ,watching movies, playing mobile games, doing arts, attending other classes

The source of information of the study participants

Out of the participating students 38 (4.6%) had a history of mental illness. 360 (43.2%) of the adolescents have seen someone who is suffering from mental health disorders. And majority of the participants find information about mental health from the internet 611(73.35%). (Table 2) (Figure 3)

Table 2 Source of information of the adolescent students in the selected governmental secondary schools of Addis Ababa, Ethiopia, February to March 2024 (n=833).

Variables	Category	Frequency	Percent
History of mental Illness			
	Yes	38	4.6
	No	795	95.4
Seen anyone who is suffering from mental health disorders			
	Yes	360	43.2
	No	473	56.8
If yes, who			
	Families	82	9.8
	Friends	75	9.0
	Others	203	24.4



Note: Others=Health center and spiritual places

Figure 3: Source of information where students find information about mental health in the selected governmental secondary schools of Addis Ababa, Ethiopia, February to March 2024 (n=833).

The social media engagement of the study participants

Majority of the study participants 675(81%) use social media, mostly video sharing social medias like Tik tok 529(63.51%) and YouTube 382 (45.86%)and messaging social medias like Telegram 579 (69.51%), and social networking social medias like Instagram 357 (42.86%). The study participants prefer following or watching transformative (educational and inspirational) contents 514(61.7%). More than the half of the study participants that use social media heard information about mental health on social media is that it will be recovered if it get early intervention 449 (53.9%). (Table 3)

Table 3: The social media engagement of the adolescent students in the selected governmental secondary schools of Addis Ababa, Ethiopia, February to March 2024 (n=833).

Variables	Category	Frequency	Percent
Do you use any social media?			
	Yes	675	81.0
	No	158	19.0
Minutes spent per day on social media	Minimum minute/day	15	
	Maximum minute/day	660	
	Mean (SD)	144.49 (112.95)	
Social media content preferred to follow/watch	Entertaining	497	59.7
	Transformative	514	61.7
	Interactive	209	25.1
	Newsworthy and promotions	111	13.3
Have you seen or heard about mental health campaign on social media?	Yes	291	43.1
	No	384	56.9
Information aspects heard about mental health on social media?	That it will be recovered if it get early intervention	449	66.5
	That it is common among young populations	95	14.1
	I have never heard about mental health on social media	73	10.8
	That it is like any other diseases	43	6.4
	That it is something to be ashamed of	15	2.2

Note: Transformative=educational and inspirational

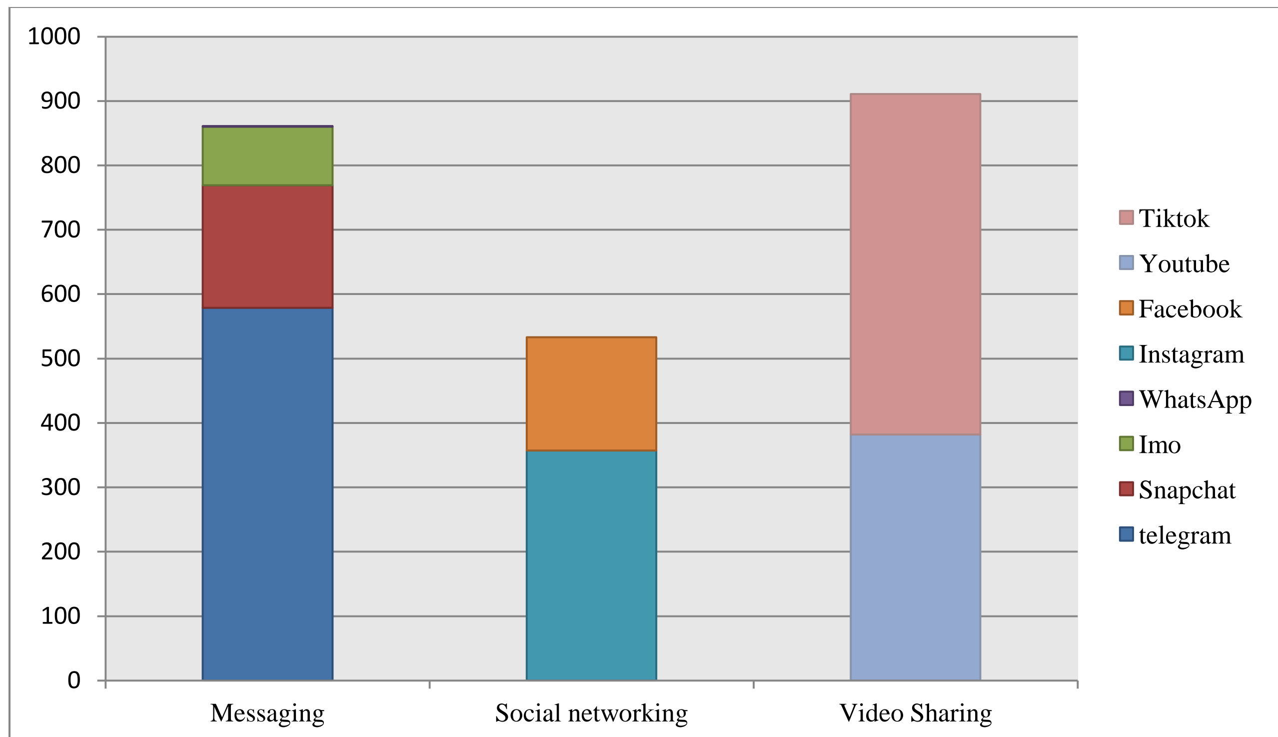


Figure 4: Type of social media used among the adolescent students in the selected governmental secondary schools of Addis Ababa, Ethiopia, February to March 2024 (n=833).

Social capital of the participants

The total social capital score of the 833 adolescent participants ranged within 17 to 35 with mean score of 27.09 + 2.78.And each subscales account differently such as, School cohesion with the range of 4 to 12 and with the mean score 7.76 (SD=1.25), School friendship subscale with the range of 3 to 9 and with the mean score 8.11 (SD=1.243), neighborhood subscale with the range of 2 to 6 and with the mean score 4.75 (SD=1.29), And the trust school /neighborhood subscale score ranged within 3 to 9 and with the mean score 6.47 (SD=1.26).

The social capital scale (SCQ-AS) score was categorized by the mean score and dichotomized as "poor" when the value of each subscale scores is less than the mean score and "good" when the value is higher or equal to the value of the mean score.

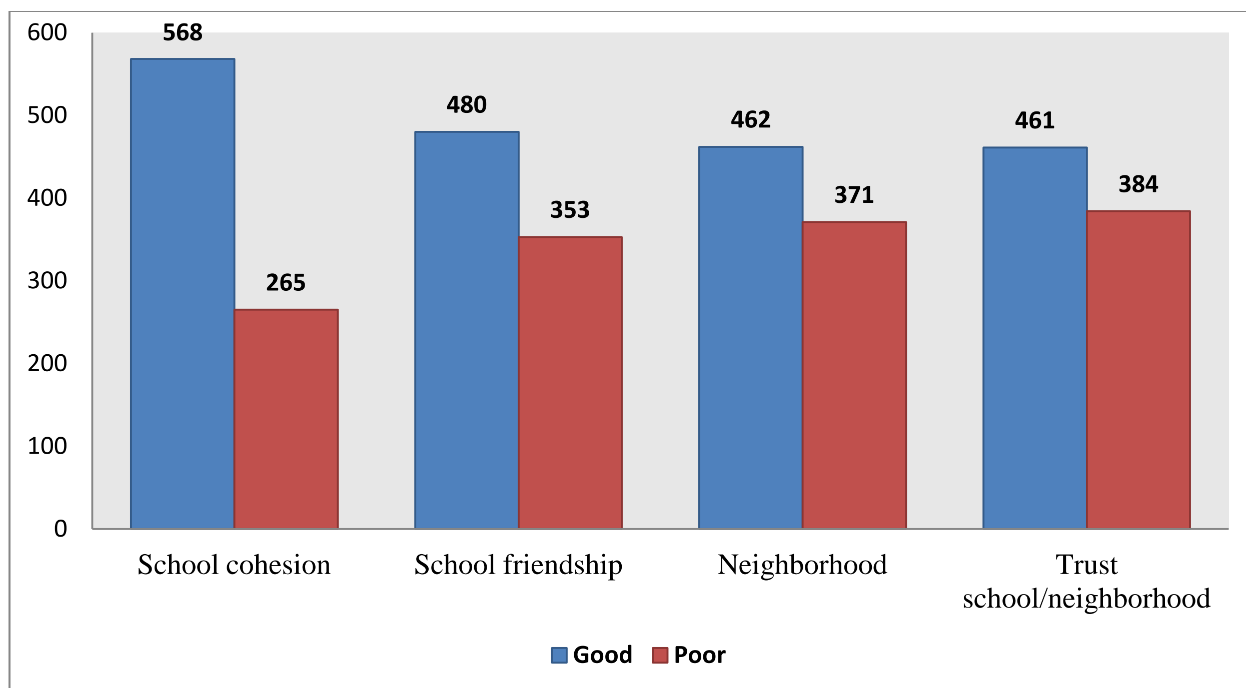


Figure 5: Frequencies of the dichotomized social capital score of the adolescent students in the selected governmental secondary schools of Addis Ababa, Ethiopia, February to March 2024 (n=833).

Mental Health Literacy of the study participants

The mental health literacy mean score of the adolescent students from the selected schools in Addis Ababa is 116.90 $\pm$ 22.07, with the minimum score of 54 and maximum score of 155. (Table 5)

Table 4: The mean and maximum and minimum scores in each factors on the MHLq (N=833).

MHLq	Mean(SD)	Min-Max
Factor1-first aid skills and help seeking	35.52 (9.96)	11-50
Factor2-knowledge/stereotypes	63.33(10.24)	34-85
Factor3-self-help strategies	18.06(6.43)	5-25

Factors associated to mental health literacy

A simple linear regression analysis was done between each independent variable and the dependent variable, variables with P-value ≤ 0.2 were selected for multiple linear regression. Accordingly, seventeen variables were entered into multiple-linear regression.sex, single relationship status, family size greater than 5, social capital in neighborhood and trust in school or neighborhood and content preferred to follow or watch were found to be statistically significant (p<0.05) to mental health literacy. The model could explain 10.2% of the variation in the determinants of mental health literacy, and the remaining other factors can explain 89.8% (R square =0.102, unadjusted R square = 0.932).

In the multiple linear regression analysis, mental health literacy had a positive linear association with female, study participants with single relationship status, study participants who preferred following or watching interactive contents on social media and also who had good neighborhood social capital. But study participants who prefer to watch and follow transformative social media content showed a negative linear association. (Table 6)

Table 5 Multiple linear regression analysis on determinants for mental health literacy among adolescent students in the selected governmental secondary schools of Addis Ababa, Ethiopia, February to March 2024 (n=833).

Variables	Unadjusted Unstandardized ß 95% CI of β	Adjusted Unstandardized ß 95% CI of β
Sex of the respondent		
Female	-2.15(-5.35,1.05)**	-3.04 (-7.00,.92)
Male	**Ref**	
Relationship status		
Single	10.36(4.79, 15.94)**	8.55 (2.55,14.55)*
Have a boy/girl friend	**Ref**	
Family size		
Less than and equal to 5	**Ref**	
Greater than 5	3.73(.37, 7.10)**	4.89 (1.19,8.59)*
Mother's educational level		
No formal Education	**Ref**	
Primary and Secondary Education	4.06(.81, 7.32)**	3.17(-1.22,7.57)
College or above	-6.48(-11.07, -1.88)**	-1.23(-7.44, 4.99)

Seen anyone who is suffering from mental health disorders		
Yes	-2.80(-5.96, .37)**	1.98(-4.29,8.25)
No	**Ref**	
If yes, who		
Families	**Ref**	
Friends	-.41(-5.89, 5.08)	-4.31(-12.41,3.79)
Others	-3.73(-7.37, -.08)**	-5.58(-12.29,1.12)
Minutes spent per day on social media	.02(-.04, -.004)**	-.01(-.02,.01)
Type of social media used		
Messaging	**Ref**	
Video sharing	-1.95(-4.50, .60)**	-.67(-3.58,2.23)
Social Networking	-2.66(-5.08, -.23)**	-1.63(-4.40,1.14)
Neighborhood social capital		
Good	5.33(2.20, 8.47)**	5.69(1.72,9.65)*
Poor	**Ref**	
Trust social capital		
Good	5.16(2.02, 8.30)**	3.97(.13,7.81)*
Poor	**Ref**	
Total social capital		
Good	3.49(.36, 6.62)**	-.99(-5.28,3.31)
Poor	**Ref**	
Social media content preferred to follow/watch		
Entertaining	-2.17(-6.09, 1.76)	-.11(-4.53,4.31)
Transformative	-4.32(-6.94, -1.70)**	-4.43(-7.356,-1.51)*
Interactive	3.67(.15, 7.19)**	3.85(.29,7.42)*
Newsworthy and promotions	**Ref**	
Where Students find information about mental health		
Radio and Television programs	**Ref**	
Internet	-5.97(-9.00, -2.93)**	2.82(-6.49,.84)
School and books	-2.62(-5.88, 65)	-1.59(-5.45,2.28)
Family/Friends/neighbors	-1.90(-5.67, 1.87)	-2.61(-6.94,1.72)
Others	6.27(-6.90, 19.44)	-11.10(-29.43,7.2)
Engaged in after school activities		
Helping family	**Ref**	
Using social media	-6.15(-9.28, -3.03)**	-1.08(-4.96,2.80)
Watching and playing sport activities	-.71(-4.22, 2.81)	.29(-4.17,4.76)
Reading books	.73(-1.82, 3.27)	2.94(-.19,6.07)
Others	4.89(-3.97, 13.74)	1.70(-7.95,11.34)

Notes: constant=110.662, R=.320, R Square=.102, unadjusted R Square=0.932, Std. Error of the Estimate=22.21335, **significance value < 0.2, *Significance value <0.05, Dependent variable: Mental health literacy, Max VIF 3.452 (no Multi-collinearity: VIF <10).

6. DISCUSSION

The study aimed to assess the determinants of mental health literacy among adolescent students in governmental secondary schools in Addis Ababa in 2024. The findings highlight the importance of interacting and connecting in increasing adolescents' mental health literacy. Specifically, study participants with larger family sizes, those who preferred interacting social media contents, and those with good neighborhood and good trust in school or neighborhood social capital were found to have increased mental health literacy.

The findings from various studies shed light on the complex relationship between gender and Mental Health Literacy (MHL). In this study, female respondents were not significantly associated with MHL while some studies suggest that females generally have higher MHL than males. For example, a study conducted in Dire Dawa, Ethiopia (8), discovered that women have higher MHL than men. In a similar vein, a UK study discovered that women's ratings of mental health literacy were much higher than men's (37). Additionally, a study in New York observed that girls had higher MHL than boys for depression and social phobia vignettes (44). This difference between current study and the others might be due to the social standard difference between Addis Ababa from Dire Dawa and the other western countries.

Individuals with previous mental health problems and those with exposure to mental health issues through their family member exhibit higher levels of MHL.A study in the UK revealed that individuals with previous mental health problems exhibited significantly higher levels of MHL than those who had no previous mental health problems (37). And also individuals with family member with a mental illness was associated with higher mental health (40). This suggests that personal experiences or exposure to mental health issues may play a crucial role in enhancing one's understanding and awareness of mental health disorders. Interestingly, comparing with our finding the source of information did not emerge as a significant factor affecting mental health literacy in the discussed study this variation may be due to the fact mental health illnesses are often associated with negative stereotypes and stigma. Students may be hesitant to disclose their personal experiences or exposure to mental health issues within their families due to fear of being judged by their peers.

During adolescents, peer groups have become an increasingly influential source of support. (45) In this study most adolescents seek and find information about mental health was found to be the internet but in other study found that family (32.4%) and friends (29.1%) were the most recommended source of help (45). Family size and mental health literacy may not have been explicitly explored in studies but this study showed that adolescent students with family greater than 5 had increased MHL. The reason for this might be because of the wider opportunity to learn about mental health and mental health resources because of the shared information and experience increase as family size get bigger.

Despite the widespread use of social media among the study participants, a concerning revelation is that a significant portion (46.1%) reported never encountering mental health campaigns on these platforms. Whereas a total of 2058 people saw the message that aims to raise awareness of the critical need of suicide prevention on Facebook and Instagram campaign (46). This underscores a potential gap in leveraging social media as a tool for promoting mental health awareness and education.

A review on Interactive social media interventions to promote health equity, showed several potential benefits of social media interventions that facilitate bidirectional communication, like social networks, blogs, discussion forums, online community applications, and media sharing, have been shown to enhance interpersonal connections. Increased accessibility, exchange, and customization of data expanded availability and accessibility of health information, Peer/social/emotional support (47). Similarly, to this study participants who prefer to follow interactive type social media contents had a positive association to the adolescent's mental health literacy. But transformative contents like educational and inspirational tend to have inverse influence on MHL. The possible reason for the transformative contents to negatively associate to MHL would be is that there is no age focused intervention on social media to include adolescents to participate on mental health promotion and interventions making the students to participate on other topics found or there is a misinformation about mental health on the social media they watch or follow.

This study highlights the significant relationship between neighborhood and trust school /neighborhood social capital with mental health literacy. This study found a statistically significant positive association between higher neighborhood social capital scores and greater

mental health literacy among students. And higher in trust school or neighborhood were also found significantly associating with mental health literacy. This suggests that neighborhoods with stronger social connections, trust, and community engagement can foster an environment that supports the development of mental health knowledge and awareness among young people .A research from England city found that young individuals with low involvement in their neighborhood were nearly twice as likely to report poor health and additionally, low neighborhood involvement was strongly linked to poor health-promoting behaviors (32). This might be because of the crucial role that neighborhood social capital plays in shaping overall health and well-being, and mental health literacy.

When it comes to higher trust in school and neighborhood, a study conducted in Harari, Ethiopia, highlighted the significant impact of trust in school and neighborhood on adolescent mental health. Adolescents with the highest trust in school or neighborhood had a 50% lower level of mental health problems compared to those with the lowest trust (42). Besides, in our study adolescents with higher trust in school or neighborhood were found 4 times higher mental health literacy than those with lower trust, indicating the positive influence of trustworthiness in facilitating social support from neighbors and friends. This enhanced social support fosters faith in the community, enhances resilience, and reduces vulnerability to mental health issues by receiving support from peers.

7. STRENGTH AND LIMITATION OF THE STUDY

7.1. Strength of the study

The strength of this study was that we

- Used standardized valid tool to assess the level of MHL.
- We used multi stage sampling method.

7.2. Limitation of the study

- This study was focused on governmental secondary schools. Further holistic mental health literacy research needed across Addis Ababa schools containing both private and governmental secondary schools.
- And also this was a cross sectional study, relationship between variables can only be identified, rather than explained.
- Limited study done in the region about mental health literacy of adolescents.

8. CONCLUSION AND RECOMMENDATIONS

8.1 Conclusion

This study results have important implications for the development of targeted interventions to improve mental health literacy among adolescents by identifying the determinants for mental health literacy. The findings suggest that educational initiatives in terms of mental health should focus on promoting interactive and connecting activities, leveraging social media platforms, and fostering social support networks and community cohesion. By creating environments that promote trust, social support, and community cohesion, adolescents are more likely to develop better mental health literacy, resilience, and overall well-being.

8.2 Recommendation

Encouraging mental health literacy among adolescents not only benefits individuals but also fosters a stronger, more resilient community. It's crucial to equip young people with the knowledge, skills, and support to prioritize their mental well-being.

Educators and school leaders should advocate for integrating mental health education into the curriculum, tailored to the students' age and needs. This could involve incorporating modules into health classes, organizing assemblies on mental health topics, and inviting speakers to share their personal experiences.

Utilizing technology and social media platforms can help disseminate mental health resources in formats that resonate with adolescents. Influencers, celebrities, and public figures can leverage their platforms to raise awareness and create engaging content like videos, podcasts, and interactive quizzes.

Healthcare professionals, along with educators, parents, and community leaders, play a pivotal role in promoting help-seeking behavior among adolescents. By providing clear information about available mental health resources, they not only empower young individuals but also contribute to building social capital within the community. This collective effort strengthens social bonds and creates a network of support that is essential for promoting mental well-being among adolescents.

Reference

1. World mental health report: transforming mental health for all. Geneva: World Health Organization; 2022.

2. Global Accelerated Action for the Health of Adolescents (AA-HA!) Guidance to Support Country Implementation Second Edition [Internet]. Available from: https://www.who.int/publications/i/item/9789240081765

3. Guidelines on mental health promotive and preventive interventions for adolescents: helping adolescents thrive. Geneva: World Health Organization; 2020.

4. George MJ, Russell MA, Piontak JR, Odgers CL. Concurrent and Subsequent Associations Between Daily Digital Technology Use and High- Risk Adolescents' Mental Health Symptoms. Child Development. 2018 Jan;89(1):78–88.

5. Jorm AF. Mental health literacy: Public knowledge and beliefs about mental disorders. Br J Psychiatry. 2000 Nov;177(5):396–401.

6. Sweileh WM. Global research activity on mental health literacy. Middle East Curr Psychiatry. 2021 Dec;28(1):43.

7. Thornicroft G, Chatterji S, Evans-Lacko S, Gruber M, Sampson N, Aguilar-Gaxiola S, et al. Undertreatment of people with major depressive disorder in 21 countries. Br J Psychiatry. 2017 Feb;210(2):119–24.

8. Hassen HM, Behera MR, Jena PK, Dewey RS, Disassa GA, Manas Ranjan Behera, Pratap Kumar Jena, Dewey RS, Disassa GA. Mental Health Literacy of Adolescents and the Effect of Socio-demographic Characteristics: A Cross-sectional Study in Urban Ethiopia. Online Journal of Health and Allied Sciences [Internet]. 2021 Dec;20(4). Available from: https://www.ojhas.org/issue80/2021-4-6.html

9. Sodi T, Quarshie ENB, Oppong Asante K, Radzilani-Makatu M, Makgahlela M, Nkoana S, et al. Mental health literacy of school-going adolescents in sub-Saharan Africa: a regional systematic review protocol. BMJ Open. 2022 Sep;12(9):e063687.

10. Ababu H, Kassaw C, Temesgen K, Sileshy B, Negash M. Mental health literacy and associated factors among residents living Dilla town, Gedeo zone, Ethiopia, 2022 [Internet]. In Review; 2022 Aug [cited 2023 Nov 30]. Available from: https://www.researchsquare.com/article/rs-1893026/v1

11. Dinesh Bhugra, Cameron Watson & Rajiv Wijesuriya. Culture and mental illnesses. International Review of Psychiatry. 33:1-2, 1–2.

12. Brooks H, Prawira B, Windfuhr K, Irmansyah I, Lovell K, Syarif AK, et al. Mental health literacy amongst children with common mental health problems and their parents in Java, Indonesia: a qualitative study. Glob Ment Health. 2022;9:72–83.

13. Girlanda F, Fiedler I, Becker T, Barbui C, Koesters M. The evidence–practice gap in specialist mental healthcare: Systematic review and meta-analysis of guideline implementation studies. Br J Psychiatry. 2017 Jan;210(1):24–30.

14. Bjørnsen HN, Espnes GA, Eilertsen MEB, Ringdal R, Moksnes UK. The Relationship Between Positive Mental Health Literacy and Mental Well-Being Among Adolescents: Implications for School Health Services. The Journal of School Nursing. 2019 Apr;35(2):107–16.

15. Mendenhall AN, Frauenholtz S. Mental Health Literacy: Social Work's Role in Improving Public Mental Health. Social Work. 2013 Oct 1;58(4):365–8.

16. Jorm AF, Korten AE, Jacomb PA, Christensen H, Rodgers B, Pollitt P. "Mental health literacy": a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. Medical Journal of Australia. 1997 Feb;166(4):182–6.

17. Ratnayake P, Hyde C. Mental Health Literacy, Help-Seeking Behaviour and Wellbeing in Young People: Implications for Practice. The Educational and Developmental Psychologist. 2019 Jul 1;36(1):16–21.

18. Katz J, Mercer SH, Skinner S. Developing Self-concept, Coping Skills, and Social Support in Grades 3–12: A Cluster-Randomized Trial of a Combined Mental Health Literacy and Dialectical Behavior Therapy Skills Program. School Mental Health. 2020 Jun;12(2):323–35.

19. Jorm AF. Mental health literacy: Empowering the community to take action for better mental health. American Psychologist. 2012 Apr;67(3):231–43.

20. Nobre J, Calha A, Luis H, Oliveira AP, Monteiro F, Ferré-Grau C, et al. Mental Health Literacy and Positive Mental Health in Adolescents: A Correlational Study. IJERPH. 2022 Jul 3;19(13):8165.

21. Lam LT. Mental health literacy and mental health status in adolescents: a population-based survey. Child Adolesc Psychiatry Ment Health. 2014;8(1):26.

22. Yu Y, Liu Z wei, Hu M, Liu X guang, Liu H ming, Yang JP, et al. Assessment of mental health literacy using a multifaceted measure among a Chinese rural population. BMJ Open. 2015 Oct;5(10):e009054.

23. Lee HY, Hwang J, Ball JG, Lee J, Albright DL. Is health literacy associated with mental health literacy? Findings from Mental Health Literacy Scale. Perspect Psychiatr Care. 2020 Apr;56(2):393–400.

24. Guo S, Yang Y, Liu F, Li F. The awareness rate of mental health knowledge Among Chinese adolescent: A systematic review and meta-analysis. Medicine. 2020 Feb;99(7):e19148.

25. Abonassir A, Siddiqui A, Abadi S, Al-Garni A, Alhumayed R, Tirad R, et al. Mental health literacy among secondary school female students in Abha, Saudi Arabia. J Family Med Prim Care. 2021;10(2):1015.

26. Gupta C, Jogdand DrS, Kumar M. Reviewing the Impact of Social Media on the Mental Health of Adolescents and Young Adults. Cureus [Internet]. 2022 Oct 10 [cited 2024 Jan 9]; Available from: https://www.cureus.com/articles/109723-reviewing-the-impact-of-social-media-on-the-mental-health-of-adolescents-and-young-adults

27. Monica Anderson, Jingjing Jiang. Teens, Social Media & Technology 2018. PEW RESEARCH CENTER [Internet]. 2018 May 31; Available from: https://www.pewresearch.org/internet/2018/05/31/teens-social-media-technology-2018/

28. Emily A.Vogels, Risa Gelles-Watnick, Navid Massarat. Teens, Social Media and Technology 2022. Pew research center [Internet]. 2022 Aug 10; Available from: https://www.pewresearch.org/internet/2022/08/10/teens-social-media-and-technology-2022/

29. Makita M, Mas-Bleda A, Morris S, Thelwall M. Mental Health Discourses on Twitter during Mental Health Awareness Week. Issues in Mental Health Nursing. 2021 May 4;42(5):437–50.

30. Latha K, Meena K, Pravitha M, Dasgupta M, Chaturvedi S. Effective use of social media platforms for promotion of mental health awareness. J Edu Health Promot. 2020;9(1):124.

31. Ghahramani A, De Courten M, Prokofieva M. “The potential of social media in health promotion beyond creating awareness: an integrative review.” BMC Public Health. 2022 Dec 21;22(1):2402.

32. Morgan A, Haglund BJA. Social capital does matter for adolescent health: evidence from the English HBSC study. Health Promotion International. 2009 Dec 1;24(4):363–72.

33. Rothon C, Goodwin L, Stansfeld S. Family social support, community “social capital” and adolescents’ mental health and educational outcomes: a longitudinal study in England. Soc Psychiatry Psychiatr Epidemiol. 2012 May;47(5):697–709.

34. Hunduma G, Deyessa N, Dessie Y, Geda B, Yadeta TA. High Social Capital is Associated with Decreased Mental Health Problem Among In-School Adolescents in Eastern Ethiopia: A Cross-Sectional Study. PRBM. 2022 Mar;Volume 15:503–16.

35. Limbu YB, Jayachandran C, McKinley C, Choi J. Exploring how structural and cognitive social capital influence preventive health behavior: Evidence from a Bottom of the Pyramid (BoP) population. HE. 2018 Jul 24;118(5):370–85.

36. O’Connor M, Casey L. The Mental Health Literacy Scale (MHLS): A new scale-based measure of mental health literacy. Psychiatry Research. 2015 Sep;229(1–2):511–6.

37. Gorczynski P, Sims-schouten W, Hill D, Wilson JC. Examining mental health literacy, help seeking behaviours, and mental health outcomes in UK university students. JMHTEP. 2017 Mar 13;12(2):111–20.

38. Aluh DO, Anyachebelu OC, Anosike C, Anizoba EL. Mental health literacy: what do Nigerian adolescents know about depression? Int J Ment Health Syst. 2018 Dec;12(1):8.

39. Coleman JS. Social Capital in the Creation of Human Capital. The American Journal of Sociology. 1988;94:S95–120.

40. Tariku Seboka B, Hailegebreal S, Negash M, Mamo TT, Ali Ewune H, Gilano G, et al. Predictors of Mental Health Literacy and Information Seeking Behavior Toward Mental Health Among University Students in Resource-Limited Settings. IJGM. 2022 Nov;Volume 15:8159–72.

41. Paiva PCP, Paiva HND, Oliveira Filho PMD, Lamounier JA, Ferreira EFE, Ferreira RC, et al. Development and Validation of a Social Capital Questionnaire for Adolescent Students (SCQ-AS). Montazeri A, editor. PLoS ONE. 2014 Aug 5;9(8):e103785.

42. Hunduma G, Deyessa N, Dessie Y, Geda B, Yadeta TA. High Social Capital is Associated with Decreased Mental Health Problem Among In-School Adolescents in Eastern Ethiopia: A Cross-Sectional Study. PRBM. 2022 Mar;Volume 15:503–16.

43. Campos L, Dias P, Palha F, Duarte A, Veiga E. Desarrollo y propiedades psicométricas de un nuevo cuestionario de evaluación de alfabetización en salud mental en jóvenes. Univ Psychol. 2016 Sep 20;15(2):61.

44. Coles ME, Ravid A, Gibb B, George-Denn D, Bronstein LR, McLeod S. Adolescent Mental Health Literacy: Young People’s Knowledge of Depression and Social Anxiety Disorder. Journal of Adolescent Health. 2016 Jan;58(1):57–62.

45. Aluh DO, Anyachebelu OC, Anosike C, Anizoba EL. Mental health literacy: what do Nigerian adolescents know about depression? Int J Ment Health Syst. 2018 Dec;12(1):8.

46. Latha K, Meena K, Pravitha M, Dasgupta M, Chaturvedi S. Effective use of social media platforms for promotion of mental health awareness. J Edu Health Promot. 2020;9(1):124.

47. Welch V, Petkovic J, Pardo Pardo J, Rader T, Tugwell P. Interactive social media interventions to promote health equity: an overview of reviews. Health Promot Chronic Dis Prev Can. 2016 Apr;36(4):63–75.

ANNEX

Annex I. Participant Information Sheet

Research Title: Mental health literacy among adolescent students in governmental secondary schools of Addis Ababa, Ethiopia.

Researcher: Yodit Felege

Dear Respondent:

I am a Master's student (ID number: GSR 1304/15) at Addis Ababa University, College of Health Sciences, School of Nursing Department of Pediatric and child Health. I kindly request you/your child to participate in a study that is aimed at assessing the mental health literacy among adolescent students. The participation in this study is voluntary; you/your child can also withdraw at any time from the study if you feel uncomfortable. Refusal to participate will not affect your/your child's study or care you/your child shall seek at any of the school facilities in any way. Confidentiality will be ensured by not using your name or address on the questionnaire and final thesis report. There are no risks involved in participating in this study. The study has no immediate benefits to the respondents, but will have benefits later in enhancing mental health literacy among adolescents can lead to better understanding of mental health issues, fostering correct attitudes towards helping seeking, and promoting early intervention for mental health problems.

I welcome any question if you have any about the study and your participation. Should you have any questions about the research or any related matters, please contact the researcher at +251922455242

Email:yoditfelege14@.gmail.com

Annex II. Consent sheet

I, the under signed, understand the nature of the study, benefits, right to voluntary participation, confidentiality and withdrawal from the study without any victimization. I have had the opportunity to ask questions and answered to my satisfaction. I hereby freely consent to take my child/myself to be part in this study.

Signature of the participant parents or legal guardian/ the participant ____________________

Date__________________

Supervisor Name ___________________________

Date_____/_______/____E.C. signature_____________

Name of interviewer ______________________

Date ______/_____/________E.C. signature____________

Your child/your participation will be greatly appreciated. Yours Faithfully

Annex III. Adolescents assent form

I have been told that my parents/ guardian have said it is okay and have given the permission for me to participate, if I want to in a study of determinants of mental health literacy among adolescent students in governmental secondary schools of Addis Ababa, Ethiopia.

And I know that I can stop at any time I want to and it will be okay if I want to stop.

Sign this form only if you:

- Have understood what you will be doing for this study
- Have had all your questions answered
- Have talked to your parents/or legal guardian about this project, and
- Agree to take part in the research

Signature of Adolescent _______________________ Date______________________

Name of Person Obtaining Assent______________________________________

Date______________________ Signature of Person Obtaining Assent __________________

Annex IV: Self administered questioner
PART 1: socio demographic

No.	Questions	Response
1.	Sex of the respondent	1. Male 2. Female
2.	Age respondent	____________________
3.	What is your academic class?	1. Grade 9 2. Grade10 3. Grade 11 4. Grade 12
4.	What is your last semester academic grade result? (by %)	___________________
5.	What is your relationship status?	1. Single 2. Married 3. Have a boy/girl friend 4. Other___________.
6.	What are your living arrangements?	1. With Father or Mother only 2.With Father and Mother 3. Alone 4. With girlfriend/ boyfriend 5. Living with husband/wife 6.living with grandparents 7. other, specify___________
7.	What is the size of your family?	1 .less than 3 2. 3-5 3.6-8 4. More than 8
8.	How many siblings do you have?	1.None 2. 1-2 2. 3-4 3. more than 4
9.	What is your birth order in your family?	1.The eldest 2.the middle one 3.The youngest 4.The only child

10.	What is the educational status of your father?	1. No formal Education 2. Primary Education 3. Secondary Education 4. College or above
11.	What is the educational status of your mother?	1. No formal Education 2. Primary Education 3. Secondary Education 4. College or above
12.	What type of activities are you engaged in after school?	1.Studyig 2.Using social media 3.Helping family 4.reading non-academic books 5.Other,specify_____________
	Source of Information	
13.	Do you have a history of mental Illness?	1.Yes 2.No
14.	Have you seen anyone who is suffering from mental health disorders?	1.Yes 2. No
15.	If yes on Q16, who was it?	1.Father 2.Mother 3.Sister 4.Brother 5.Other family members 6.Fiends 7.Others
16.	Where do you find information about mental health?	1.Social media 2.Radio and television programs 3.family, friends, neighbor 4.Search engine 5.School 6.Books
	Social media involvement	

17.	Do you use any social media?	1.Yes 2.No
18.	What type of social media do you use?	1.Tik Tok 2.Telegram 3.Facebook 4.Instagram 5.YouTube 6.Snapchat 7.Other,specify_____________
19.	Relatively how much time so you spend on social media per day?	____________minuets
20.	What type of social media content do you prefer to follow/watch?	1.Educational 2.Inspirational 3.Interactive 4.Connecting 5.Promotion 6.Newsworthy 7.Entertaining
21.	Have you seen or heard about mental health campaign on social media?	1.Yes 2.No
22.	What aspects of information have you hear about mental health on social media?	1.That it will be recovered if it get early intervention 2.That it is something to be ashamed of 3.That it is common among young populations 4.That it is like any other diseases

Social Capital Questionnaire for Adolescent Students (SCQ-AS)

No.	Questions	Agree	I do not know, have no opinion	Disagree
	School cohesion (score: 4 to 12)			
1	The students at my school stay together:			
2	I feel like I belong at this school, as if it were mine:			
3	I feel safe at this school:			
4	My parents get along with my teachers:			
	School friendships (score: 3 to 9)			
5	The students at my school have fun together:			
6	I trust my friends at school:			
7	I can ask my friends at school for help:			
	Neighbourhood social cohesion (score: 2 to 6.)			
8	I trust my neighbours:			
9	I can count on my neighbours for help:			
	Trust: school/neighbourhood (score: 3 to 9)			
10	The teachers at my school are sympathetic and give us support:			
11	My neighbours would try to take advantage of me:			
12	My classmates would try to take advantage of me:			

Part 2 : Mental Health Literacy Questionnaire (MHLq)

Factor 1. First aid skills and help seeking

No.	Questions	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
1	If a friend of mine developed a mental disorder, I would encourage her/him to get medical support.					
2	If I had a mental disorder I would seek for professional help (psychologist and /or psychiatrist).					
3	If a friend of mine developed a mental disorder, I would encourage her/him to look for a psychologist.					
4	If a friend of mine developed a mental disorder, I would talk to the form teacher or other teacher.					
5	If a friend of mine developed a mental disorder, I would talk to her/his parents.					
6	If I had a mental disorder I would seek for my family's help.					
7	If I had a mental disorder I would seek for my friends' help.					
8	If a friend of mine developed a mental disorder, I would offer her/him support.					
9	If a friend of mine developed a mental disorder, I wouldn't be able to help her/him.					
10	If a friend of mine developed a mental disorder, I would listen to her/him without judging or criticising.					

Factor 2. Knowledge/ stereotypes

No.	Questions	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
11	Mental disorders don't affect people's behaviours.					
12	Mental disorders affect people's thoughts.					
13	Mental disorders don't affect people's feelings.					
14	A person with anxiety disorder may panic in situations that she/he fears.					
15	People with schizophrenia usually have delusions (i.e., they may believe they are constantly being followed and observed).					
16	A person with schizophrenia may see and hear things that nobody else sees and hears.					
17	One of the symptoms of depression is the loss of interest or pleasure in most things.					
18	Brain's malfunctioning may cause the development of mental disorders.					
19	Depression is not a true mental disorder.					
20	A person with depression feels very miserable.					
21	Only adults have mental disorders.					
22	The sooner mental disorders are identified and treated, the better.					
23	The symptoms' length is one of the important aspects to determine whether a person has, or has not, a mental disorder.					

24	People with mental disorders come from families with little money.					
25	A person with anxiety disorder avoids situations that may cause her/him distress.					
26	Drug addiction may cause mental disorders.					
27	Alcohol use may cause mental disorders.					
28	Highly stressful situations may cause mental disorders					

Factor 3. Self-help strategies

No.	**Questions**	**Strongly disagree**	**Disagree**	**Neither disagree nor agree**	**Agree**	**Strongly agree**
29	Having a balanced diet helps to improve mental health.					
30	Good sleep helps to improve mental health.					
31	Physical exercise helps to improve mental health.					
32	Doing something enjoyable helps to improve mental health.					
33	Talking over problems with someone helps to improve mental health.					

Annex V: Amharic Version

አባሪ I. ለጥናቱ የተሣታፊ መረጃ ወረቀት/ የስምምነት ቅጽ

የጥናት ርዕስ፡ በአዲስ አበባ፣ ኢትዮጵያ የመንግስት ሁለተኛ ደረጃ ትምህርት ቤቶች በጉርምስና ዕድሜ ላይ የሚገኙ ተማሪዎች የአእምሮ ጤና እውቀት የሚወስኑ ምክንያቶች።

ተመራማሪ፡ ዮዲት ፈለገ

ውድ ተጠሪ፡-

እኔ (መታወቂያ ቁጥር፡ GSR 1304/15) በአዲስ አበባ ዩኒቨርሲቲ፣ የጤና ሳይንስ ኮሌጅ፣ የነርሲንግ ትምህርት ቤት የሕፃናት ጤና ትምህርት ቤት የማስተርስ ተማሪ ነኝ ። ልጅዎ በጉርምስና ዕድሜ ላይ ያሉ ተማሪዎችን የአእምሮ ጤና እውቀት የሚወስኑ ምክንያቶችን ለመገምገም በተዘጋጀ ጥናት ላይ እንዲሳተፍ/እንድትሳተፍ በአክብሮት እጠይቃለሁ።በዚህ ጥናት ውስጥ ያለው ተሳትፎ በፈቃደኝነት ነው::እርስዎ ወይም ልጅዎ ምቾት የማይሰማዎት ከሆነ በማንኛውም ጊዜ ከጥናቱ መውጣት ይችላሉ። ለመሳተፍ ፈቃደኛ አለመሆን የልጅዎን ጥናት፣ እንክብካቤ፣መገልገያዎች መጠቀም ወይም በማንኛውም የትምህርት ቤት መንገድ ላይ ልጅዎን አይጎዳም::

ሚስጥራዊነት የሚረጋገጠው ስም ወይም አድራሻ በመጠይቁ እና በመጨረሻው የቲሲስ ዘገባ ላይ ባለመጠቀም ነው። በዚህ ጥናት ውስጥ ለመሳተፍ ምንም አይነት አደጋዎች የሉም:: ጥናቱ ለምላሾቹ አፋጣኝ ጥቅም የለውም፣ ነገር ግን በጉርምስና ዕድሜ ላይ ያሉ ወጣቶች የአእምሮ ጤና እውቀት በማጎልበት ጥቅማጥቅሞችን ያመጣል ስለአእምሮ ጤና ጉዳዮች የተሻለ ግንዛቤ እንዲኖር፣ ትክክለኛ አመለካከትን ማዳበር እና ለአእምሮ ጤና ችግሮች ቅድመ ጣልቃ ገብነትን ያበረታታል።

ስለ ጥናቱ እና ስለ እርስዎ ልጅ ተሳትፎ ማንኛውም ጥያቄ ካለዎት እቀበላለሁ. ስለ ጥናቱ ወይም ተያያዥ ጉዳዮች ማንኛቸውም ጥያቄዎች ካሉዎት፣ እባክዎን ተመራማሪውን በእዚ አድራሻ ያግኙ

+251922455242

ኢሜይል: yoditfelege14@.gmail.com

አባሪ II. የወላጆች/የህጋዊ አሳዳጊ የስምምነት ቅጽ ወረቀት

እኔ ስር የተፈራረምኩት የጥናቱ አይነት፣ ጥቅማጥቅሞች፣ በፍቃደኝነት የመሳተፍ መብት፣ ሚስጥራዊነት እና ምንም አይነት ተጎጂ ሳይሆኑ ከጥናቱ የመውጣት መብት ተረድቻለሁ። ጥያቄዎችን ለመጠየቅ እድሉን አግኝቻለሁ እናም መልስ አግኝቻለሁ። ልጄ በዚህ ጥናት ውስጥ እንዲሳተፍ በነጻነት ተስማምቻለሁ።

የተሳታፊ ወላጆች/ህጋዊ አሳዳጊ ፊርማ ___________________________

ቀን ______/________/_____

የተቆጣጣሪ ስም/ Supervisor Name _______________________________

ቀን ______/________/_____ ፊርማ_______________

የጠያቂው ስም/ Name of interviewer ________________________________

ቀን_______/______/_________ ፊርማ______________

የልጅዎ ተሳትፎ በጣም አድናቆት ይኖረዋል።

ከሰላምታ ጋር

አባሪ III. በጉርምስና ዕድሜ ላይ የሚገኙ ወጣቶች የስምምነት ቅጽ ወረቀት

በአዲስ አበባ ኢትዮጵያ የመንግስት ሁለተኛ ደረጃ ትምህርት ቤቶች በጉርምስና ዕድሜ ላይ ያሉ ተማሪዎችን የአእምሮ ጤና እውቀት የሚወስኑ ምክንያቶች ጥናት ለማድረግ ወላጆቼ/አሳዳጊዎቼ እንድሳተፍ ፍቃድ እንደሰጡኝ ተነግሮኛል። እና በፈለግኩት ጊዜ ማቆም እንደምችል አውቃለሁ እና ማቆም ከፈለግኩ ምንም ችግር የለውም።

ይህን ቅጽ የሚፈርሙ ከሆነ ብቻ፡-

- ለዚህ ጥናት ምን እንደምታደርጉ ተረድተዋል
- ለሁሉም ጥያቄዎችዎ ምላሽ አግኝተዋል
- ስለዚህ ፕሮጀክት ከወላጆችዎ/ወይም ከህጋዊ አሳዳጊዎ ጋር ተነጋግረዋል፣ እና
- በምርምርው ለመሳተፍ ተስማምተዋል

በጉርምስና ዕድሜ ላይ የሚገኘው ወጣት ፊርማ______________________________ ቀን_____________________________

ፈቃዱን የሚቀበል ሰው ስም____

ቀን_____________________________ ፍቃዱን የሚቀበል ሰው ፊርማ ________________________

ክፍል 1፡ ሶሺዮ ዲሞግራፊ/ Socio demographic

ቁጥ.	ጥያቄዎች	መልሶች
1	ምላሽ ሰጪው ጾታ	1. ወንድ 2. ሴት
2	ምላሽ ሰጪው ዕድሜ	______________________
3	የእርስዎ የትምህርት ክፍል ምንድን ነው?	1. 9ኛ ክፍል 2. 10ኛ ክፍል 3. 11ኛ ክፍል 4. 12ኛ ክፍል
4	የመጨረሻው ሴሚስተር የአካዳሚክ ውጤትህ/ውጤትሽ ስንት ነው? (በ%)	______________________
5	የግንኙነትህ/ የግንኙነትሽ ሁኔታ?	1. ያላገባ 2. ያገባ 3. ወንድ/ሴት የፍቅር ጓደኛ ያለው 4. ሌላ ___________________
6	የኑሮ ሁኔታህ/ሁኔታሽ ምንድን ነው?	1. ከአባት ወይም ከእናት ጋር ብቻ 2. ከአባት እና ከእናት ጋር 3. ብቻውን 4. ከሴት የፍቅር ጓደኛ / ከወንድ የፍቅር ጓደኛ ጋር 5. ከባል/ሚስት ጋር 6. ከአያቶች ጋር 7. ሌላ፣ ይግለጹ_________________
7	የቤተሰብዎ መጠን ስንት ነው?	1. ከ 3 ያነሰ 2. 3-5 3. 6-8 4. ከ 8 በላይ
8	ስንት እህትቾች/ ወንድሞች አሉህ?	1. የለኝም 2. 1-2 3. 3-4 4. ከ 4 በላይ
9	በቤተሰብህ/በቤተሰብሽ ውስጥ የትውልድ ቅደም ተከተልህ/ተከተልሽ ምንድነው?	1. ታላቅ 2. መካከለኛ

		3. ታናሽ 4. ብቸኛ ልጅ
10	የአባትህ/የአባትሽ የትምህርት ደረጃ ምን ያህል ነው?	1. መደበኛ ትምህርት የለውም 2. የመጀመሪያ ደረጃ ትምህርት 3. የሁለተኛ ደረጃ ትምህርት 4. ኮሌጅ ወይም ከዚያ በላይ
11	የእናትህ /የእናትሽ የትምህርት ደረጃ ምን ያህል ነው?	1. መደበኛ ትምህርት የላትም 2. የመጀመሪያ ደረጃ ትምህርት 3. የሁለተኛ ደረጃ ትምህርት 4. ኮሌጅ ወይም ከዚያ በላይ
12	ከትምህርት በኋላ ምን አይነት እንቅስቃሴዎችን ታደርጋለህ/ታደጊያለሽ?	1. ማጥናት 2. ማህበራዊ ሚዲያን መጠቀም 3. ቤተሰብን መርዳት 4.አካዳሚክ ያልሆኑ መጻሕፍትን ማንበብ 5. ሌላ፣ ይግለጹ__________________
	የመረጃ ምንጭ/ Source of Information	
16	የአእምሮ ሕመም ታሪክ አለህ/አለሽ?	1. አዎ 2. አይ
17	በአእምሮ ጤና መታወክ የሚሰቃይ ሰው አይተህ ታቃለህ/ታቂያለሽ?	1. አዎ 2. አይ
18	በQ16 ላይ አዎ ከሆነ፣ ማን ነበር?	1. አባትህ/አባትሽ 2. እናትህ/እናትሽ 3. እህትህ/እህትሽ 4.ወንድምህ/ወንድምሽ 5.ሌሎች የቤተሰብህ/የቤተሰብሽ አባላት 6. ጓደኞችህ/ጓደኞችሽ 7.ሌሎች

19	ስለ አእምሮ ጤና መረጃ የት ታገኛለህ/ታገኚያለሽ?	1. ከማህበራዊ ሚዲያ 2. ከሬዲዮ እና የቴሌቪዥን ፕሮግራሞች 3. ከቤተሰብ, ጓደኞች, ጎረቤቶች 4. ከ የፍለጋ ሞተር/ search engine 5. ከትምህርት ቤት 6. ከመጽሐፍት
	የማህበራዊ ሚዲያ ተሳትፎ/ Social media involvement	
20	ማንኛውንም ማህበራዊ ሚዲያ ትጠቀማለህ/ትጠቀሚያለሽ?	1. አዎ 2. አይ
21	ምን አይነት ማህበራዊ ሚዲያ ነው የምትጠቀመው/የምትጠቀሚው?	1. ቲክ ቶክ 2.ቴሌግራም 3. ፌስቡክ 4. ኢንስተግራም 5.ዩቲዩብ 6. ስናፕ ቻት 7. ሌላ, ይግለጹ_______________
22	በአንፃራዊነት በቀን ምን ያህል ጊዜ በማህበራዊ ሚዲያ ላይ ታጠፋለህ/ታጠፊለሽ?	______________ ደቂቃዎች
23	ምን አይነት የማህበራዊ ሚዲያ ይዘትን መከተል ወይም መመልከት ትመርጣለህ/ትመርጫለሽ?	1. ትምህርታዊ 2. አነሳሽ 3.መስተጋብር ፈጣሪ 4.መገናኛ ብዙሃኖች 5.ማስተዋወቂያ 6.ዜናዎች 7. አዝናኝ

24	በማህበራዊ ሚዲያ ላይ ስለ የአእምሮ ጤና ዘመቻ አይተዋል ወይም ሰምተዋል?	1. አዎ 2. አይ
25	በማህበራዊ ሚዲያ ላይ ስለአእምሮ ጤና ምን አይነት መረጃ ሰምተሃል/ሰምተሻል?	1.ቀደም ብሎ ከታከመ ይድናል 2.ይህ የሚያሳፍር ነገር ነው 3. በወጣቶች መካከል የተለመደ ነው 4.ይህም እንደሌሎች በሽታዎች ነው

ለታዳጊ ተማሪዎች የማህበራዊ ካፒታል መጠይቅ/ Social Capital Questionnaire for Adolescent Students (SCQ-AS)

ቁጥ.	**ጥያቄዎች**	**እስማማለው**	**አላውቅም፣ አስተያየት የለኝም**	**አልስማማም**
	የትምህርት ቤት ጥምረት (ውጤት፡ 4 እስከ 12)			
1	በትምህርት ቤቴ ያሉ ተማሪዎች አብረው ይቆያሉ			
2	እኔ በዚህ ትምህርት ቤት ውስጥ እንደሆንኩ ይሰማኛል፣ የእኔ እንደ ሆነ			
3	በዚህ ትምህርት ቤት ደህንነት ይሰማኛል			
4	ወላጆቼ ከመምህራኖቼ ጋር ይስማማሉ			
	የትምህርት ቤት ጓደኝነት (ውጤት: 3 እስከ 9)			
5	ትምህርት ቤቴ ያሉ ተማሪዎች አብረው ይዝናናሉ			
6	ትምህርት ቤት ጓደኞቼን አምናለሁ			
7	ትምህርት ቤት ጓደኞቼን ለእርዳታ መጠየቅ እችላለሁ			

	የጎረቤት ማህበራዊ ትስስር (ውጤት፡ 2 እስከ 4)			
8	ጎረቤቶቼን አምናለሁ			
9	ለእርዳታ ጎረቤቶቼን መተማመን እችላለሁ			
	እምነት፡ ትምህርት ቤት/ ሰፈር (ውጤት፡ 3 እስከ 9)			
10	በእኔ ትምህርት ቤት ያሉ አስተማሪዎች ርኅራኄ አላቸው እና ይረዱናል			
11	ጎረቤቶቼ ሊጠቀሙብኝ ይሞክራሉ			
12	የክፍል ጓደኞቼ እኔን ሊጠቀሙብኝ ይሞክራሉ			

ክፍል 2፡ የአእምሮ ጤና እውቀት መጠይቅ/Mental Health Literacy Questionnaire (MHLq)

ምክንያት1. የመጀመሪያ እርዳታ ችሎታ እና እርዳታ መፈለግ/ First aid skills and help seeking

ቁጥ.	ጥያቄዎች	በጣም አልስማማም	አልስማማም	አስተያየት የለኝም	እስማማለሁ	በጣም እስማማለሁ
1	አንድ ጓደኛዬ የአእምሮ ችግር ቢያጋጥመው፣ እሷ/እሱ የህክምና ድጋፍ እንድታገኝ አበረታታታለሁ					
2	የአእምሮ ሕመም ካለብኝ የባለሙያ እርዳታ (የሥነ ልቦና ባለሙያ እና / ወይም የሥነ-አእምሮ ባለሙያ) እፈልግ ነበር					
3	አንድ ጓደኛዬ የአእምሮ ችግር ቢያጋጥመው፣ እሷ/እሱ የሥነ ልቦና ባለሙያ እንዲፈልግ አበረታታታለሁ					
4	አንድ ጓደኛዬ የአእምሮ መታወክ ቢያጋጥመው፣ ለቅርብ አስተማሪውን ወይም ሌላ አስተማሪን አነጋግር ነበር					
5	አንድ ጓደኛዬ የአእምሮ መታወክ ቢያጋጥመው ለወላጆቹ እናገራለሁ					
6	የአእምሮ ሕመም ካለብኝ የቤተሰቤን እርዳታ እፈልግ ነበር።					
7	የአእምሮ ሕመም ካለብኝ የጓደኞቼን እርዳታ እፈልግ ነበር።					
8	አንድ ጓደኛዬ የአእምሮ ችግር ቢያጋጥመው፣ ለእሷ/እሷ ድጋፍ እሰጣታለሁ።					
9	አንድ ጓደኛዬ የአእምሮ ችግር ቢያጋጥመው እሷን/እሱን መርዳት አልችልም ነበር።					
10	አንድ ጓደኛዬ የአእምሮ ሕመም ቢያጋጥመው፣ ሳልፈርድበት ወይም ሳልነቅፍ እሷን/እሱን አዳምጣለሁ					

ምክንያት 2. እውቀት Knowledge/ stereotypes

ቁጥ.	ጥያቄዎች	በጣም አልስማማም	አልስማማም	አስተያየት የለኝም	እስማማለሁ	በጣም እስማማለሁ
11	አእምሮ መታወክ የሰዎችን ባህሪ አይጎዳም					
12	የአእምሮ መዛባት በሰዎች አስተሳሰብ ላይ ተጽዕኖ ያሳድራል					
13	የአእምሮ መዛባት በሰዎች ስሜት ላይ ተጽዕኖ አያሳድርም					
14	የጭንቀት መታወክ ያለበት ሰው በሚፈራው/በምትፈራው ሁኔታ ሊሸበር ይችላል					
15	ስኪዞፈሪንያ (schizophrenia) ያለባቸው ሰዎች ብዙውን ጊዜ የማታለል ስሜት አላቸው (ማለትም፣ ያለማቋረጥ እንደሚከተሏቸው እና እንደሚታዘቡ ያምናሉ)					
16	ስኪዞፈሪንያ(schizophrenia) ያለው ሰው ሌላ ሰው የማያይና የማይሰማውን ነገር ማየትና መስማት ይችላል					
17	የመንፈስ ጭንቀት ምልክቶች አንዱ በአብዛኛዎቹ ነገሮች ላይ ፍላጎት ወይም ደስታ ማጣት ነው					
18	የአንጐል ስራ መበላሸቱ የአእምሮ መታወክ እድገትን ሊያስከትል ይችላል።					
19	የመንፈስ ጭንቀት እውነተኛ የአእምሮ ሕመም አይደለም.					
20	የመንፈስ ጭንቀት ያለበት ሰው በጣም የመንሳቋል/አሳዛኝ ስሜት ይሰማዋል					
21	የአእምሮ ሕመም ያለባቸው አዋቂዎች ብቻ ናቸው					
22	በቶሎ የአእምሮ ሕመሞች ሲታወቁ እና ሲታከሙ የተሻለ ይሆናል					
23	የምልክቶቹ ርዝመት አንድ ሰው የአእምሮ መታወክ እንዳለበት ወይም እንደሌለበት ለመወሰን አንዱ አስፈላጊ ገጽታ ነው					

24	የአእምሮ ችግር ያለባቸው ሰዎች ትንሽ ገንዘብ ካላቸው ቤተሰቦች የመጡ ናቸው					
25	የጭንቀት መታወክ ያለበት ሰው እሷን/እሱን ሊያስጨንቁ የሚችሉ ሁኔታዎችን ያስወግዳል					
26	የአደንዛዥ ዕፅ ሱሰኝነት የአእምሮ መዛባት ሊያስከትል ይችላል					
27	አልኮሆል መጠቀም የአእምሮ ሕመም ሊያስከትል ይችላል					
28	ከፍተኛ አስጨናቂ ሁኔታዎች የአእምሮ መዛባት ሊያስከትሉ ይችላሉ					

ምክንያት 3. እራስን የማገዝ ስልቶች/ Self-help strategies

ቁጥ.	**ጥያቄዎች**	**በጣም አልስማማም**	**አልስማማም**	**አስተያየት የለኝም**	**እስማማለሁ**	**በጣም እስማማለሁ**
29	የተመጣጠነ ምግብ መመገብ የአእምሮ ጤናን ለማሻሻል ይረዳል					
30	ጥሩ እንቅልፍ የአእምሮ ጤናን ለማሻሻል ይረዳል					
31	የአካል ብቃት እንቅስቃሴ የአእምሮ ጤናን ለማሻሻል ይረዳል					
32	አንድ አንድ አስደሳች ነገር ማድረግ የአእምሮ ጤናን ለማሻሻል ይረዳል.					
33	ከአንድ ሰው ጋር ስለችግር ማውራት የአእምሮ ጤናን ለማሻሻል ይረዳል.					