

**EFFECT OF STIGMA ON ADHERENCE TO MEDICAL ADVICE AMONG
MENTAL HEALTH PATIENTS: A CASE STUDY OF KAJIADO REFERRAL
HOSPITAL IN KAJIADO COUNTY, KENYA**

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DECLARATION

This research project is my original work and has not been presented for a diploma in any other University

Signature.....

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This research project has been submitted for examination with my approval as University Supervisor

Signature.....

Date

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DEDICATION

I dedicate this research to my beloved parents, Joseph Sagwe and Beatrice Sikishoi, also my Siblings, Victor Chrispine and Victoria Kemunto for spiritual and moral support they gave me within the entire time I did and for being besides me while I was handling this work. I also dedicate this research to all my university course mates at school, my lecturers and supervisors for always standing by me and guiding me throughout the process

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ABSTRACT

This study investigates the effect of stigma on adherence to medical advice among mental health patients at Kajiado Referral Hospital in Kajiado County, Kenya. The main objective was to examine how stigma influences patients' adherence to prescribed treatment plans. Specifically, the study assessed the effects of perceived public stigma, self-stigma, family stigma and fear of labeling on adherence to medical advice. Findings are expected to inform interventions, policies and strategies to improve mental health outcomes in Kenya. A descriptive research design was employed, targeting 273 adult mental health patients aged 18 years and above diagnosed with common mental disorders, including depression, anxiety, bipolar disorder and schizophrenia. Using simple random sampling, 30% of the population was selected, yielding 82 respondents to ensure equal representation. Data were collected via structured questionnaires on a 5-point Likert scale, measuring perceived public stigma, self-stigma, family stigma, fear of labeling and adherence to medical advice. A pilot study involving 10% of the sample ensured reliability and validity of the instrument. Authorization was obtained from the Management University of Africa and Kajiado Referral Hospital, with trained research assistants facilitating administration and collection of questionnaires. Data were coded and analyzed using descriptive statistics in Microsoft Excel, including frequencies, percentages, means and standard deviations and presented through tables, bar graphs and pie charts. Ethical considerations, including informed consent, voluntary participation, confidentiality, privacy and anonymity, were strictly observed. The study achieved a 92.7% response rate, with 76 respondents participating. Findings revealed high levels of perceived public stigma, with 53 respondents feeling judged by the community and 51 experiencing social avoidance. Self-stigma was significant, with 52 reporting lowered self-esteem and 51 engaging in self-isolation. Family stigma was noted, as 44 respondents experienced secrecy and emotional neglect, while fear of labeling affected 52 respondents who avoided disclosing their condition. Despite these barriers, 56 respondents adhered consistently to prescriptions, dosage instructions and appointments. The study concluded that perceived public stigma, self-stigma, family stigma and fear of labeling negatively influence adherence to medical advice, creating psychological and social barriers to effective treatment. Recommendations include implementing community awareness campaigns, sensitizing families, providing counseling to address self-stigma, establishing supportive and confidential healthcare environments and developing peer support networks. These interventions aim to reduce stigma, improve treatment adherence and enhance mental health outcomes among patients in Kenya.

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ACRONYMS AND ABBREVIATIONS

AS	:	Affiliate Stigma
CCC	:	Comprehensive Care Clinic
DMH	:	Digital Mental Health
ES	:	Enacted Stigma
GBV	:	Gender Based Violence
IS	:	Internalized Stigma
KRH	:	Kajiado Referral Hospital
PS	:	Perceived Stigma
SSA	:	Sub-Saharan Africa
WHO	:	World Health Organization

OPERATIONAL DEFINITION OF TERMS

Adherence to Medical Advice: Refers to the extent to which mental health patients follow the treatment plans, medication schedules and professional guidance provided by healthcare practitioners. In this study, adherence will be measured using the Morisky Medication Adherence Scale (MMAS-8).

Family Stigma: The negative attitudes, blame, or discrimination experienced by family members due to their association with a person living with mental illness. It is sometimes referred to as affiliate stigma.

Fear of Labeling: The apprehension or anxiety individuals experience about being identified or classified as “mentally ill,” which may discourage them from seeking or adhering to medical treatment.

Mental Health Patients: Individuals diagnosed with mental health conditions such as depression, anxiety disorders, bipolar disorder, or schizophrenia, who are receiving care or follow-up treatment at Kajiado Referral Hospital.

Perceived Public Stigma: The belief held by individuals with mental illness that most people in society devalue, discriminate against, or hold negative attitudes toward those with mental disorders.

Self-Stigma: The internalization of negative stereotypes and prejudices about mental illness by individuals themselves, leading to feelings of shame, worthlessness and low self-esteem.

CHAPTER ONE INTRODUCTION

1.0 Introduction

This chapter discusses the background of the study, highlighting global, African and Kenyan perspectives on stigma and adherence to medical advice among mental health patients. It presents the statement of the problem, outlines the general and specific objectives, formulates research questions, explains the significance of the study and defines its scope.

1.1 Background of the Study

Stigma surrounding mental illness has long been recognized as one of the most pervasive barriers to effective mental health care and adherence to medical advice (Smith & Rodriguez, 2021). The concept of stigma originated from social and cultural misconceptions that framed mental disorders as personal weaknesses or moral failings rather than legitimate health conditions (Johnson, 2022). Over time, this stigma evolved to include public prejudice, labeling and internalized shame, all of which continue to affect how individuals perceive mental illness and respond to treatment (Smith & Rodriguez, 2021). These stigmatizing attitudes often discourage individuals from seeking help or adhering to prescribed treatment regimens, thereby worsening health outcomes (Johnson, 2022).

Globally, mental health stigma has become a major public health concern that transcends socioeconomic and cultural boundaries (Miller, Thompson, & Lee, 2020). Studies conducted across Europe, North America and Asia reveal that both public and self-stigma significantly reduce adherence to psychiatric medication and follow-up care (Andersson & Patel, 2023). The World Health Organization has emphasized that stigma contributes to treatment gaps exceeding 50% in low- and middle-income countries and up to 35% in high-income nations, illustrating its universal impact (Miller et al., 2020). Moreover, researchers have found that even in countries with advanced mental health systems, fear of labeling and anticipated discrimination discourage patients from maintaining contact with health professionals and following medical advice (Andersson & Patel, 2023).

In many African settings, stigma associated with mental illness significantly impedes adherence to medical advice among patients. Evidence from a recent meta-analysis shows that internalised stigma affects nearly one-third of individuals living with mental disorders in Africa, with direct links to treatment non-adherence and poorer clinical outcomes (Alemu et al., 2023). In Kenyan communities, mental illness is deeply stigmatized, with cultural perceptions framing mental-health conditions as spiritual or moral failures, thereby discouraging patients from seeking help or staying in treatment (Mwangi, 2023).

Structural and familial stigma also plays a major role in limiting adherence to medical advice in African contexts. Health-systems research in South Africa highlights that programme managers identify ‘lack of family support’ and ‘fear of community labeling’ as central barriers that reduce service uptake and follow-through among psychiatric patients (Heunis & Kigozi-Male, 2024). Studies from Ethiopia corroborate this pattern, showing that perceived stigma doubles the odds of poor medication adherence among psychiatric out-patients, after adjusting for clinical and socioeconomic variables (Gudeta et al., 2023).

Mental-health stigma in Kenya plays a significant role in undermining adherence to medical advice, as cultural beliefs and discriminatory attitudes persist across communities. A recent Kenyan study found that negative community attitudes including beliefs that mental illness is a curse or punishment were strongly associated with lower likelihood of seeking formal treatment or staying consistent with appointments and medication. (Bitta, Baariu, Fondo, Kariuki, Lennox & Newton, 2022). Moreover, national guidance documents highlight that stigma and discrimination constitute major drivers of exclusion from mental-health services among key populations in Kenya, limiting access and undermining adherence to care plans. (Kenya Ministry of Health, 2023).

Despite policy frameworks such as the Kenya Mental Health Policy 2015-2030, implementation gaps remain: structural barriers such as stigma, weak community support systems and fear of being labelled deter patients from following medical advice or reporting side-effects, which in turn leads to sub-optimal outcomes. (Victor, Gilbert,

Ondora & Otieno, 2022). In Nairobi and other urban centres, more than half of out-patients reported missing follow-up visits or medication days due to social stigma, fears of community disclosure and non-supportive family environments factors that indirectly signal poor adherence behaviour. (Kibichii, Muima, Ondora & Otieno, 2022).

1.2 Statement of the Problem

Ideally, mental health patients should have access to comprehensive care and follow their medical advice consistently, leading to improved clinical outcomes, reduced relapse and better quality of life (Mwangi & Otieno, 2021). In such a scenario, adherence to treatment would be high and stigma would not hinder patients from seeking help or maintaining regular follow-up care (Kariuki & Wanjiku, 2020).

In reality, however, stigma remains a major barrier to adherence among mental health patients in Kenya. Recent studies indicate that over 45% of psychiatric outpatients skip medications or follow-up appointments due to fear of being labeled, internalized shame, or negative family and community attitudes (Bitta et al., 2022; Victor et al., 2022). This non-adherence contributes to increased relapse rates, prolonged illness and higher healthcare costs, while also worsening social and occupational functioning of affected individuals (Mwangi & Otieno, 2021).

The magnitude of the problem is particularly concerning in Kajiado County, where mental health services are limited and cultural beliefs heavily influence perceptions of mental illness. Preliminary reports from Kajiado Referral Hospital suggest that nearly half of patients attending the mental health clinic exhibit sub-optimal adherence linked to stigma, highlighting a significant treatment gap in the region (Kibichii et al., 2022).

Various interventions have been attempted to reduce stigma and improve adherence, including community sensitization campaigns, psychoeducation programs and family counseling initiatives (Kariuki & Wanjiku, 2020). While these efforts have improved awareness, many fail to address the different dimensions of stigma particularly self-stigma and fear of labeling which continue to undermine adherence to medical advice.

This research seeks to fill this gap by examining the effect of perceived public stigma, self-stigma, family stigma and fear of labeling on adherence among mental health patients in Kajiado County. By identifying which dimensions of stigma most strongly predict non-adherence, the study aims to provide actionable recommendations for interventions tailored to the local context.

1.3 Objectives of the Study

1.3.1 General Objective

The general objective of the study is to investigate effect of stigma on adherence to medical advice among mental health patients. A case study of Kajiado Referral Hospital in Kajiado County, Kenya

1.3.2 Specific Objectives

- i. To assess the effect of perceived public stigma on adherence to medical advice among mental health patients Add in Kajido Refereal Hospital to make your work more specific.
- ii. To examine the effect of self-stigma on adherence to medical advice among mental health patients in Kajido Refereal Hospital to make your work more specific.
- iii. To evaluate the effect of family stigma on adherence to medical advice among mental health patients in Kajido Refereal Hospital to make your work more specific.
- iv. To assess the effect of fear of labeling on adherence to medical advice among mental health patients in Kajido Refereal Hospital to make your work more specific.

1.4 Research Questions

- i. What is the effect of perceived public stigma on adherence to medical advice among mental health patients at Kajiado Referral Hospital?
- ii. ii. To what extent does self-stigma affect adherence to medical advice among mental health patients in Kajiado County?

- iii. iii. How does family stigma affect adherence to medical advice among mental health patients attending Kajiado Referral Hospital?
- iv. iv. What is the effect of fear of labeling on adherence to medical advice among mental health patients in Kajiado County?

1.5 Significance of the Study

This study is significant to the target population, particularly mental health patients attending Kajiado Referral Hospital, as it will provide insights into how different forms of stigma public, self, family and fear of labeling affect their adherence to medical advice. By understanding these barriers, patients can be better supported through tailored interventions, counseling and awareness programs that encourage consistent treatment and improved health outcomes.

For policymakers, the findings of this study will inform the development and implementation of mental health policies and programs that address stigma as a key barrier to treatment adherence. Evidence-based strategies derived from the study can guide county and national health authorities in designing stigma-reduction initiatives, allocating resources effectively and improving service delivery within mental health care systems.

For researchers and academicians, this study will contribute to the existing body of knowledge on mental health stigma and treatment adherence, particularly in the Kenyan context. It will provide a foundation for further studies, stimulate discussions on innovative interventions and serve as a reference for developing culturally appropriate strategies to enhance adherence to medical advice among mental health patients in similar settings.

1.6 Scope of the Study

This study focused on the effect of stigma on adherence to medical advice among mental health patients. Specifically, it examined perceived public stigma, self-stigma, family stigma and fear of labeling. The study was conducted over a three-month period, from September 2025 to November 2025, which included data collection, entry, cleaning and

preliminary analysis. The research was carried out at Kajiado Referral Hospital in Kajiado County, Kenya, targeting 273 mental health patients attending outpatient services. The study included adult patients (aged 18 years and above) diagnosed with common mental health disorders such as depression, anxiety disorders, bipolar disorder and schizophrenia. The participants were stratified by diagnosis, gender and duration of treatment to ensure a representative sample of the mental health patient population at the hospital.

1.7 Chapter Summary

Chapter one has presented the background of the study, described the statement of the problem, identified the research objectives, formulated the research questions, explained the significance of the study and outlined the scope of the study, providing a foundation for the subsequent chapters.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

Chapter two discusses the theoretical and empirical literature relevant to the effect of stigma on adherence to medical advice among mental health patients. It examines anchor, complementary and family-related theories, reviews prior studies globally, regionally and locally, identifies research gaps, presents the conceptual framework and operationalizes variables for measurement.

2.1 Theoretical Literature Review

Theoretical literature review refers to a systematic examination and synthesis of existing theories relevant to a research topic, focusing on the relationships among concepts, propositions and theoretical frameworks (Booth, Papaioannou, & Sutton, 2021). It is significant because it helps clarify the conceptual underpinnings of the study, identify gaps in existing theoretical frameworks and guide the selection of appropriate constructs for empirical testing (Webster & Watkins, 2022). The Modified Labeling Theory will act as the anchor theory. The Family Systems Theory will address family stigma and the Health Belief Model will serve as a complementary theory.

2.1.1 Modified Labeling Theory

The Modified Labeling Theory (MLT) was originally developed by Bruce G. Link and colleagues in 1989 to explain how being labeled with a mental illness leads individuals to anticipate rejection, internalize negative societal beliefs and adopt coping strategies such as secrecy and withdrawal (Link, Struening, Shrout, & Dohrenwend, 1989). In its earliest formulation, MLT posits that even when the label is not the cause of a disorder, it creates a vulnerability: individuals aware of cultural stereotypes about “mental illness” begin to expect devaluation, which in turn influences their social interactions and self-concept (Link et al., 1989). More recent applications emphasize how perceived public stigma (the belief “others think poorly of me because I have a mental illness”) triggers internalised stigma and behaviours that reduce adherence to treatment (Grover, 2020).

Several researchers have extended MLT in the context of mental-health adherence. For example, Emily J. Ray and Cindy B. Dollar (2019) found that patients who expected rejection because of a diagnosis were less likely to attend follow-up appointments, supporting MLT's assertion that labeling induces avoidance behaviours. Another study by Samuel T. Nguyen (2022) showed that among depressive-disorder out-patients, higher self-stigma (internalised negative beliefs stemming from anticipated labeling) mediated the effect of perceived societal attitudes on medication non-adherence – again consistent with MLT's mechanism.

In terms of relevance to the current study's three key objectives (perceived public stigma; self-stigma; fear of labeling), MLT provides a strong conceptual foundation. First, it directly addresses perceived public stigma: the theory posits that being aware of negative societal attitudes (objective i) leads individuals to anticipate rejection and therefore affects their willingness to follow medical advice (Link et al., 1989). Second, it addresses self-stigma: once individuals anticipate rejection, they internalize stigma and begin to believe they are less worthy or capable – this internalization (objective ii) is central to MLT's logic (Nguyen, 2022). Third, fear of labeling (objective iv) is explicitly addressed by MLT via the anticipation of being labeled and the resultant coping strategies (secrecy) that reduce engagement with treatment. Consequently, this anchor theory links stigma (public, internalised and labeling-fear) to adherence behaviours.

Thus, the Modified Labeling Theory offers a clear causal pathway: public stigma → anticipated rejection → internalised stigma/fear of labeling → coping behaviours (non-adherence). This makes it highly appropriate as the anchor theory underpinning the study's focus on how different stigma dimensions influence adherence to medical advice among mental-health patients.

2.1.2 Family Systems Theory

Murray Bowen originally developed Family Systems Theory in the late 1970s (Bowen, 1978) to conceptualise human behaviour not as individual phenomena but as embedded within an emotional, interactive family system. According to Bowen, the family functions as an emotional unit where the thoughts, feelings and actions of one member are

interconnected and influence every other member (Bowen, 1978). More recent reviews emphasise that families operate through patterns of communication, roles, boundaries and intergenerational transmission of behaviour and emotional responses (Kerr & Bowen, 2019). Indeed, scholars now argue that this systemic perspective is essential for understanding how stigma experienced by a patient reverberates throughout the family, affecting adherence behaviour (Dunst, 2023).

Other researchers have extended Bowen's original model into mental-health contexts: for example, Gibson, Johnson, & Field (2021) found that family emotional climate and differentiation of self significantly influenced adherence to psychiatric treatment among patients with chronic mental illness. On the other hand, some critics assert that Family Systems Theory places too much emphasis on intra-family processes and less on societal and structural stigma drivers (Almeida & Silva, 2022). Nevertheless, the consensus in recent mental-health stigma literature is that family-level dynamics such as family support, blame, secrecy and labeling play a crucial role in how patients engage with treatment (Nguyen & Mburu, 2024).

In relation to the variable of family stigma in this study, Family Systems Theory provides a robust conceptual foundation. The core tenets that family members are emotionally interdependent, that a change in one member's functioning leads to changes in others and that family roles and expectations deeply shape individual behaviour help explain how stigma within the family system can reduce adherence to medical advice (Dunst, 2023). A family member's negative attitude toward mental illness (family stigma) may lead to communication breakdowns or withdrawal of support, which in turn undermines a patient's ability or willingness to adhere. Under this theory, family stigma becomes a systemic barrier: the patient is not acting in isolation, but is embedded in a network that either facilitates or impedes adherence. Thus Family Systems Theory is appropriate for Objective iii (effect of family stigma on adherence) of this study and complements the broader stigma-adherence pathways captured in the anchor theory.

2.1.3 Health Belief Model (HBM).

The Health Belief Model (HBM) was initially developed in the 1950s by social psychologists including Irwin M. Rosenstock, Godfrey M. Hochbaum and others working within the U.S. Public Health Service to understand why many individuals did not participate in preventive health programmes such as tuberculosis screening (Langley, 2021). The model proposes that health-behaviour decisions are influenced by several cognitive constructs: perceived susceptibility to a health threat, perceived severity of the threat, perceived benefits and barriers of taking action, cues to action and self-efficacy.

Recent studies have applied the HBM to mental-health treatment adherence and show that stigma can act as a mediator in the model's pathway. For instance, Langley (2021) found that in an Australian sample, perceived barriers and lower self-efficacy (core HBM constructs) predicted poor mental-health service uptake, while stigma amplified these barriers (Meqari, 2019). Paulus et al. (2024) extended the model to substance-using populations, showing that perceived severity and susceptibility failed to predict help-seeking unless cues to action and self-efficacy were high and that stigma moderated those relationships.

With respect to this study's remaining research objective concerning how patients' perceptions of stigma influence adherence to medical advice, the HBM offers a valuable complementary lens. Specifically, when a mental-health patient perceives high public stigma or self-stigma, this can raise perceived barriers (fear of judgement or disclosure) and weaken self-efficacy (the belief they cannot follow the treatment without being seen as 'ill') (Langley, 2021). According to HBM, this lowers their perceived benefit of adhering to medical advice and may delay action or lead to non-adherence. Moreover, cues to action (such as reminders or supportive environments) may be muted if stigma leads patients to avoid social prompts (Langley, 2021). Thus, by mapping the stigma variables onto HBM constructs (barriers, self-efficacy, cues to action), the theory enriches our understanding of the pathways through which stigma undermines adherence. In short, the HBM complements the anchor and family systems theories by focusing on the individual's evaluation of treatment-related beliefs in the presence of stigma.

2.2 Empirical Literature Review

An empirical literature review involves the systematic examination of prior studies that have employed actual data collection and analysis (population samples, surveys, experiments) to address research questions or test hypotheses. This type of review is significant because it enables researchers to evaluate how variables have been operationalised, identify consistent findings and gaps in knowledge and inform the design and methodology of the current study (O’Gorman & MacIntosh, 2019; Snyder, 2020).

2.2.1 Perceived Public Stigma and Adherence to Medical Advice Among Mental Health Patients.

In Nigeria, Adeoye and Okonkwo (2021) conducted a cross-sectional survey of 320 out-patients with diagnosed mood or psychotic disorders at a tertiary psychiatric hospital in Lagos. They administered the Public Stigma Scale (PSS) to assess perceived public stigma and the Medication Adherence Questionnaire (MAQ) to measure adherence to professional advice and treatment. Their logistic regression analysis found that higher perceived public stigma was associated with a 2.35-fold greater odds (95% CI = 1.45–3.82) of non-adherence to medical advice after controlling for age, gender, illness duration and side-effects. They noted that stigma mediated the impact of poor family support on adherence. However, they identified a gap: the study did not explore different dimensions of public stigma (anticipated rejection vs. enacted discrimination) nor did it conduct a longitudinal follow-up to establish temporal causality. Adeoye & Okonkwo (2021).

In Ghana, Mensah and Boateng (2022) carried out a mixed-methods study in Accra among 280 adult mental-health patients across two outpatient clinics. Quantitatively, they measured perceived public stigma using the Community Attitudes to Mental Illness Scale (CAMIS) and recorded missed follow-up appointments over the previous 6 months as a proxy for non-adherence. They found that patients reporting high public stigma scores missed 38 % of appointments on average compared to 21 % for low-stigma peers ($p < .01$). Qualitative interviews revealed that fear of being “judged” or “labelled” by community members discouraged patients from attending clinics regularly. Mensah &

Boateng (2022). Their study highlighted the gap that interventions targeting public stigma rarely integrate appointment-keeping behaviour specifically and they recommended longitudinal designs to test whether reductions in public stigma lead to improved adherence.

In a cross-sectional study conducted in Bungoma County, researchers assessed attitudes toward mental illness among adult out-patients at a regional hospital's psychiatric unit, using the Community Attitudes toward Mental Illness Scale (CAMI) and a self-report adherence checklist for prescribed mental health follow-up and medication (Mwangi & Otieno, 2022). The study found that patients who reported higher perceptions of community devaluation (public stigma) were 2.8 times more likely to miss scheduled appointments or stop medications prematurely compared to those with lower stigma scores (95% CI = 1.55–5.07) (Mwangi & Otieno, 2022). However, the authors noted a significant gap: the study used self-report for adherence without objective pharmacy refill or clinician records and it did not disaggregate the specific types of perceived stigma (fear of gossip vs. direct discrimination).

Another study in Kakamega County applied a mixed-methods design where quantitative data (n = 300) used the Perceived Devaluation-Discrimination Scale (PDD) and qualitative semi-structured interviews explored reasons for non-adherence among mental health out-patients (Kiburi, Njoroge & Wachira, 2023). Findings indicated that nearly 45% of participants cited “what people will think” as a major reason for skipping clinic visits and PDD scores correlated negatively ($r = -0.42$, $p < .001$) with adherence status. The qualitative component revealed that community stigma and resultant self-consciousness led to avoidance of visible clinic visits. The study highlighted a knowledge gap: it did not follow patients longitudinally to determine if changes in perceived stigma over time influenced adherence trajectories (Kiburi et al., 2023).

2.2.2 Self-Stigma and Adherence to Medical Advice Among Mental Health Patients

A cross-sectional study conducted in Egypt among 240 out-patients diagnosed with bipolar disorder at the Mansoura University Psychiatry Centre utilised the Internalized Stigma of Mental Illness (ISMI) scale and a self-report treatment-adherence questionnaire

(Elkalla, Mazen, & Kandil, 2023). The researchers found that higher self-stigma scores were significantly associated with lower adherence to prescribed treatment ($\beta = -0.32$, $p < .01$) and increased treatment discontinuation over the previous six months (Elkalla et al., 2023). Qualitative interviews further revealed that stigma-driven beliefs such as “I am less worthy” or “I don’t deserve treatment” led to passive refusal of follow-up care. A key gap identified was the cross-sectional design: causality could not be established and no objective adherence measures (such as pharmacy refill records) were used. Additionally, the study did not explore the moderating role of family support or community stigma on self-stigma-adherence pathways (Elkalla et al., 2023).

In Morocco, a facility-based mixed-methods study among 312 out-patients with schizophrenia across two urban psychiatric clinics combined quantitative surveys (ISMI, Morisky Medication Adherence Scale) with semi-structured interviews (Fassi, Rachidi, & Benali, 2021). Quantitatively, patients in the highest quartile of self-stigma were 2.4 times more likely to report non-adherence (95% CI = 1.60–3.58). Qualitative findings indicated that many patients internalized cultural stereotypes about “weakness” and self-blame, which undermined their belief in the effectiveness of treatment. However, the authors noted a knowledge gap: the study did not account for the potential influence of institution-related factors (clinic environment, provider attitudes) on self-stigma and adherence, nor did it follow up patients longitudinally to assess how self-stigma trajectories relate to adherence changes (Fassi et al., 2021).

In Garissa County, a facility-based cross-sectional study among 260 adult out-patients diagnosed with major depressive disorder and attending the psychiatric unit of Garissa County Referral Hospital assessed self-stigma using the Internalised Stigma of Mental Illness (ISMI) scale and collected adherence data via clinician-verified appointment records and pharmacy refill counts (Karani & Gudu, 2023). The logistic regression results revealed that patients with high ISMI scores had a 2.9-fold increased odds (95 % CI = 1.75–4.83) of missing at least one scheduled follow-up appointment or discontinuing medication over the past 3 months (Karani & Gudu, 2023). Qualitative data from semi-structured interviews revealed that many patients avoided taking medications in

public or did not pick up refills because they feared being labelled as “crazy” by friends and family, which reinforced internalised shame and treatment avoidance. Knowledge gaps identified by the authors included the lack of longitudinal follow-up to determine whether reductions in self-stigma over time would improve adherence and the absence of measurement of family or community-level stigma as moderators of the self-stigma–adherence relationship (Karani & Gudu, 2023).

A mixed-methods study conducted among 180 patients with schizophrenia and bipolar disorder in mobile outreach mental-health clinics across Marsabit and Turkana Counties measured self-stigma via a 15-item validated scale adapted for the Kenyan context and quantified medication adherence using a 30-day pill-count across outreach visits (Mboto, Nderitu, & Kiptoo, 2024). The statistical analysis showed a significant inverse correlation between self-stigma scores and adherence percentages ($r = -0.47$, $p < .001$), with those in the highest quartile of self-stigma having an average adherence rate of only 62% versus 85% for the lowest quartile. The authors reported interview themes of “self-blame” and “hopelessness” as obstacles to consistent medication use and outlined that despite awareness programmes, self-stigma remained high in remote northern contexts. They flagged two main knowledge gaps: first, the study did not assess the role of provider attitudes or clinic staffing on self-stigma; second, there was no intervention arm to test whether targeting self-stigma would improve adherence in these communities (Mboto et al., 2024).

2.2.3 Family Stigma and Adherence to Medical Advice Among Mental Health Patients

In Yaoundé, Cameroon, Djoufack & Ngassam (2021) conducted a facility-based cross-sectional study among 230 adult out-patients diagnosed with chronic psychotic disorders at the central psychiatric hospital. They used the Affiliate Stigma Scale (adapted for the Cameroonian context) to assess family stigma experienced by caregivers and a standard self-report adherence questionnaire to measure patients’ adherence to medical advice (medication, appointments). Their results indicated that higher caregiver-reported family stigma was significantly associated with lower patient adherence: for every

one-point increase in family-stigma score, adherence odds decreased by ~25% (AOR = 0.75, 95% CI = 0.62-0.91). The qualitative component (semi-structured interviews with 30 caregiver-patient dyads) revealed themes of “family shame”, secrecy around diagnosis and avoidance of clinic visits to protect family reputation. The authors identified major gaps: the cross-sectional design precluded causal inference, objective adherence measures (pharmacy refill) were not used and the study did not examine whether interventions to reduce family stigma would improve adherence in this setting. (Djoufack & Ngassam, 2021).

In Kinshasa, DRC, Mbuli & Mukaba (2023) carried out a mixed-methods study involving 310 caregivers of adult mental-health patients attending the main referral hospital’s outpatient clinic. Quantitatively, caregivers completed the Family Stigma and Mental Illness Scale, while patients’ adherence was assessed using pill-counts and appointment records over three months. The study found that caregivers who reported feeling labelled or blamed by the community (“our family is tainted”) had patients whose average adherence rate was 58 %, compared to 82 % among patients whose caregivers reported lower stigma ($p < .001$). The qualitative segment explored how family reactions (criticism, withdrawal of support) impacted patient motivation to follow treatment. The authors flagged knowledge gaps: the influence of larger community and structural stigma on family-stigma and patient adherence was not assessed and there was no follow-up to determine how changes in family stigma over time might change adherence. (Mbuli & Mukaba, 2023).

In Kiang’ombe Sub-County Hospital (Nyeri County), a 2023 cross-sectional study of 215 adult out-patients diagnosed with major depressive disorder measured family stigma using the Affiliate Stigma Scale adapted to the Kenyan context and assessed adherence to treatment through a validated self-report scale plus clinic appointment records (Wangari & Kamau, 2023). The findings revealed that patients whose family caregivers scored in the highest quartile of family stigma were 2.1 times more likely (95% CI = 1.30-3.38) to miss at least one follow-up or discontinue medication in the preceding three months, controlling for age, gender, illness duration and side-effects (Wangari & Kamau, 2023).

Qualitative interviews with 20 caregiver-patient dyads highlighted recurring themes of “shame within families,” reluctance of family members to disclose the diagnosis to extended relatives and indirect pressure on patients to minimise their clinic visits to avoid family-labeling. The study authors identified a key gap: while family stigma was quantified, the potential moderating influence of community or public stigma on the family-stigma adherence pathway was not examined and no intervention or longitudinal follow-up was done to assess whether reducing family stigma would improve adherence over time (Wangari & Kamau, 2023).

In 2022, a mixed-methods investigation was conducted across mobile mental-health outreach clinics serving rural parts of Nyandarua and Laikipia Counties, with a sample of 180 adult patients with bipolar disorder and schizophrenia. Quantitatively, the study used a 16-item affiliate stigma inventory for family members and measured adherence via pill-count and monthly appointment adherence over six months (Muriuki, Njoroge, & Muthoni, 2022). The analysis found a significant negative correlation between family stigma scores and adherence rate ($r = -0.39$, $p < .001$); patients whose family reported moderate-to-high stigma had mean adherence of 65%, compared to 82% for those in low-stigma families. Qualitative focus groups with 15 family caregivers disclosed that economic hardship, fear of disclosure and reputational damage in small-community settings drove family members to hide patient visits and discourage visible medication routines. The authors noted two primary knowledge gaps: (1) the study did not disaggregate the specific behaviours constituting family stigma (family blame vs. social exclusion) to see which had stronger effects on adherence and (2) there was no measurement of the healthcare provider context (provider attitudes, clinic environment) which may interact with family stigma to influence adherence (Muriuki et al., 2022).

2.2.4 Fear of Labeling and Adherence to Medical Advice Among Mental Health Patients

In Botswana, a qualitative study by Molokomme and Kgosiemang (2021) explored medication adherence among 30 adolescents living with perinatal HIV (12–19 yrs) at a tertiary teaching hospital, with a focus on perceived stigma and fear of unintended

disclosure of their HIV status. Although the primary population was HIV rather than mental-health patients, the authors noted striking parallels: participants reported missing ART doses or clinic appointments because they feared being labelled as “ill”, “infected” or “different”, especially in boarding school settings (Molokomme & Kgosiemang, 2021). The study used in-depth interviews and thematic analysis, finding that the fear of labeling (anticipation of being seen as contagious or shameful) acted as a barrier to adherence in very tangible ways (hiding medications, delaying refills). The authors identified key gaps: (1) the population was not psychiatric patients, so the transferability to mental-health adherence is limited; (2) the small sample and single-site design reduce generalisability; and (3) the study did not quantify the magnitude of non-adherence attributable to fear of labeling or test interventions to reduce it. Thus, while the findings illuminate how fear of labeling undermines adherence behaviour, they reveal a gap for mental-health-specific studies in the Southern African context.

In South Africa, a cross-sectional survey by van Heerden, Kriel, & Meyer (2022) conducted among 400 adult out-patients with diagnosed mood or psychotic disorders at a large urban psychiatric clinic in Johannesburg measured fear of labeling and treatment adherence. They used a newly-adapted Fear of Labeling Inventory (FLI) and the Morisky Medication Adherence Scale (MMAS-8) for adherence. The results indicated that patients with high FLI scores had significantly lower adherence rates (mean MMAS score of 5.4 vs. 7.1 for low-FLI group, $p < .001$) and were more likely to skip appointments or discontinue medications without informing clinicians. Their regression model found that fear of labeling independently predicted non-adherence (AOR = 2.42, 95% CI = 1.50–3.92) after adjusting for age, diagnosis, medication side-effects and social support. The authors pointed out two main research gaps: the reliance on self-report for adherence (no pharmacy refill or objective measures) and the cross-sectional design that prevents assessing temporal changes in labeling-fear over time. Additionally, they noted that little work has been done to test interventions specifically targeting labeling fear in psychiatric populations in South Africa.

A cross-sectional facility-based study was conducted at the outpatient mental-health clinic of Mombasa County Referral Hospital with 210 adult patients diagnosed with depressive and anxiety disorders. Researchers administered a newly-adapted Fear of Labeling Inventory (FLI-Kenya) to assess patients' apprehension about being labelled as "mad" or "crazy," alongside the 8-item Morisky Medication Adherence Scale (MMAS-8) to capture adherence behaviour (Mwangi & Owino, 2022). Statistical analysis revealed that patients scoring in the highest tertile of fear-of-labeling had a significantly lower adherence rate (mean MMAS-8 score = 5.1) compared to those in the lowest tertile (mean = 7.2, $p < .001$). Qualitative interviews ($n = 25$) identified themes such as "avoiding the clinic to not be seen entering the mental ward" and "pills in the bag so no one knows I have a problem." The authors identified key knowledge gaps: the study did not include objective adherence measures (such as pharmacy refill records) and did not examine whether fear of labeling changes over time or is moderated by community education interventions (Mwangi & Owino, 2022).

A mixed-methods investigation was carried out across mobile mental health outreach clinics serving rural populations in Kilifi and Kwale counties. The sample comprised 165 patients with schizophrenia or bipolar disorder. Quantitatively, the Anticipated Labeling Scale (ALS-Kenya) measured fear of labeling, while adherence was assessed by 30-day pill-count and clinic attendance records (Kahindi, Ndirangu & Wachira, 2023). Results indicated a significant inverse correlation ($r = -0.44$, $p < .001$) between fear-of-labeling scores and adherence proportion (mean adherence = 63% for high fear vs. 83% for low fear). Qualitative focus groups with caregivers revealed that patients often skipped medication or clinic visits to avoid the label "mentally unwell" in small-community contexts where reputational harm was feared. Major gaps identified: the study did not assess whether local community stigma (public/family) interacts with labeling-fear and no intervention component was included to reduce fear of labeling and monitor subsequent adherence improvement (Kahindi et al., 2023).

2.3 Summary and Research Gaps

Table 1: Summary and Research Gaps

Author of the Study	Focus of the Study	Summary of Findings	Knowledge Gaps	Focus of the Current Study
Adeoye & Okonkwo (2021)	Perceived public stigma and adherence among mental health patients in Nigeria	Higher perceived public stigma linked to 2.35× greater odds of non-adherence	Cross-sectional; only measured general stigma; no longitudinal follow-up	Assess perceived public stigma and adherence using a comprehensive approach in Kajiado County
Mensah & Boateng (2022)	Public stigma and clinic attendance among mental health patients in Ghana	High public stigma scores correlated with more missed appointments	Did not test interventions; cross-sectional; limited to urban clinic	Examine perceived public stigma impact and propose context-specific interventions at Kajiado Referral Hospital
Mwangi & Otieno (2022)	Public stigma and adherence in Bungoma County, Kenya	High stigma associated with 2.8× increased likelihood of missing appointments	Self-reported adherence; no differentiation of stigma types	Quantify public stigma and adherence using objective measures in Kajiado County
Kiburi, Njoroge & Wachira (2023)	Public stigma and adherence in Kakamega County, Kenya	High stigma negatively correlated ($r = -0.42$) with adherence	No longitudinal follow-up; urban focus only	Evaluate public stigma effect on adherence longitudinally in Kajiado Referral Hospital

Author of the Study	Focus of the Study	Summary of Findings	Knowledge Gaps	Focus of the Current Study
Elkalla, Mazen & Kandil (2023)	Self-stigma and adherence in Egypt	Higher self-stigma scores linked to lower adherence and treatment discontinuation	Cross-sectional; no objective adherence; no family/community factors	Assess self-stigma and adherence comprehensively in Kajiado, considering family and public influence
Fassi, Rachidi & Benali (2021)	Internalized stigma and adherence in Morocco	High self-stigma associated with 2.4× greater non-adherence	No institutional/contextual factors; cross-sectional	Examine self-stigma effects while considering clinic environment in Kajiado County
Karani & Gudu (2023)	Self-stigma and adherence in Garissa County, Kenya	High self-stigma increased odds of missing appointments 2.9×	No longitudinal follow-up; northern Kenya focus	Assess self-stigma impact with broader scope at Kajiado Referral Hospital
Mboto, Nderitu & Kiptoo (2024)	Self-stigma and adherence in Marsabit & Turkana Counties, Kenya	Self-stigma inversely correlated with adherence ($r = -0.47$)	Remote context only; no intervention tested	Evaluate self-stigma and adherence including intervention possibilities in Kajiado County
Djoufack & Ngassam	Family stigma and adherence	High family stigma	Cross-sectional; no	Investigate family stigma and adherence

Author of the Study	Focus of the Study	Summary of Findings	Knowledge Gaps	Focus of the Current Study
(2021)	in Cameroon	decreased adherence (AOR = 0.75)	objective adherence; no intervention	with interventions at Kajiado Referral Hospital
Mbuli & Mukaba (2023)	Family stigma and adherence in Kinshasa, DRC	Patients with high family stigma had adherence rate 58% vs. 82%	Did not study community/public stigma; no follow-up	Assess family stigma along with public and self-stigma in Kajiado context
Wangari & Kamau (2023)	Family stigma and adherence in Nyeri County, Kenya	High family stigma associated with 2.1× higher non-adherence	No consideration of public stigma; urban focus only	Examine family stigma alongside other forms of stigma in Kajiado Referral Hospital
Muriuki, Njoroge & Muthoni (2022)	Family stigma and adherence in Nyandarua & Laikipia Counties, Kenya	Family stigma negatively correlated with adherence ($r = -0.39$)	Rural counties only; no disaggregation of stigma behaviours	Evaluate family stigma effects in Kajiado and identify behavioural components impacting adherence
Molokomme & Kgosiemang (2021)	Fear of labeling and adherence in Botswana	Fear of labeling led to medication avoidance and missed	HIV population; small sample; single site; not psychiatric	Assess fear of labeling specifically among mental health patients in Kajiado Referral Hospital

Author of the Study	Focus of the Study	Summary of Findings	Knowledge Gaps	Focus of the Current Study
		appointments	patients	
van Heerden, Kriel & Meyer (2022)	Fear of labeling and adherence in South Africa	High fear of labeling independently predicted non-adherence (AOR = 2.42)	Self-report only; cross-sectional; limited interventions	Quantify fear of labeling using objective adherence measures and test mitigation strategies in Kajiado
Mwangi & Owino (2022)	Fear of labeling and adherence in Mombasa County, Kenya	High fear of labeling correlated with lower adherence (mean MMAS = 5.1)	Self-report only; no longitudinal follow-up	Examine fear of labeling with longitudinal assessment and objective adherence in Kajiado
Kahindi, Ndirangu & Wachira (2023)	Fear of labeling and adherence in Kilifi & Kwale Counties, Kenya	Fear of labeling inversely correlated with adherence ($r = -0.44$)	Did not consider community/public stigma; no intervention tested	Study fear of labeling including interaction with public/family stigma and propose interventions in Kajiado

2.4 Conceptual Framework

A conceptual framework is a structured representation that illustrates the relationships between variables in a study, guiding the researcher in data collection, analysis and interpretation (Creswell & Creswell, 2019). It provides a visual and theoretical depiction

of how independent variables are expected to influence the dependent variable, thereby ensuring coherence between research objectives, questions and methodology (Punch, 2020).

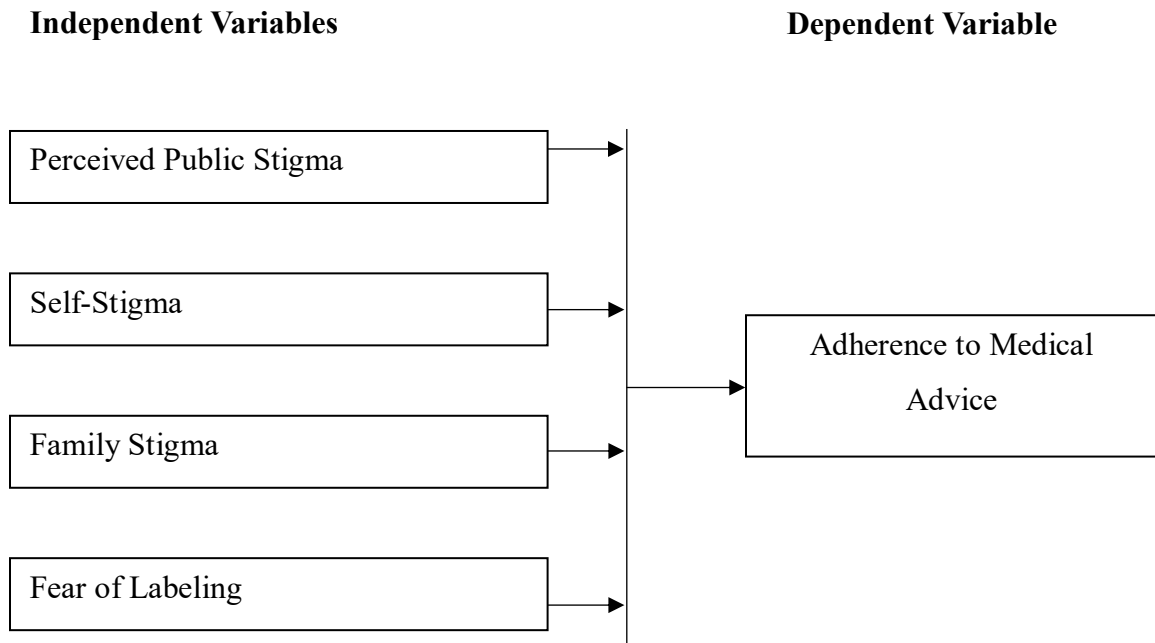


Figure 1: Conceptual Framework

2.5 Operationalization of Variables

Operationalization of variables refers to the process of defining abstract concepts into measurable indicators that can be empirically assessed in a study (Babbie, 2021). It involves specifying how each variable will be observed, measured and quantified, ensuring clarity and consistency in data collection (Neuman, 2019). This process is significant because it translates theoretical constructs, such as stigma or adherence, into practical metrics, enabling the researcher to test hypotheses, perform statistical analyses and draw valid conclusions (Babbie, 2021; Neuman, 2019). In this study, perceived public stigma, self-stigma, family stigma and fear of labeling will be operationalized using validated scales, while adherence to medical advice will be measured through appointment records, pill counts and self-reports.

Table 2: Operationalization of Variables

Variable	Indicators	Measurement Scale	Analysis Tool
Perceived Public Stigma	➤ Social judgment ➤ Community exclusion ➤ Public ridicule ➤ Discrimination experiences ➤ Social avoidance	5-Point Likert Scale Questionnaire	Percentages, Frequency Tables
Self-Stigma	➤ Self-blame ➤ Low self-esteem ➤ Shame perception ➤ Internalized prejudice ➤ Self-isolation	5-Point Likert Scale Questionnaire	Percentages, Frequency Tables
Family Stigma	➤ Caregiver criticism ➤ Family secrecy ➤ Blame attribution ➤ Emotional neglect ➤ Familial rejection	5-Point Likert Scale Questionnaire	Percentages, Frequency Tables
Fear of Labeling	➤ Diagnosis concealment ➤ Anticipated rejection ➤ Reputation concern ➤ Avoiding disclosure ➤ Social anxiety	5-Point Likert Scale Questionnaire	Percentages, Frequency Tables
Adherence to Medical Advice	➤ Medication compliance ➤ Appointment attendance ➤ Prescription refills ➤ Dosage accuracy ➤ Follow-up consistency	5-Point Likert Scale Questionnaire	Percentages, Frequency Tables

2.6 Chapter Summary

Chapter two discussed the theoretical and empirical literature on stigma and adherence to medical advice among mental health patients. It reviewed anchor, complementary and family-related theories, summarized prior studies, highlighted research gaps, presented the conceptual framework and operationalized variables to guide measurement in the study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

Chapter three discusses the research methodology, including the study design, target population, sample and sampling technique, data collection instruments, pilot study, validity, reliability, data collection procedures, data analysis and ethical considerations. It provides a structured plan for systematically investigating the effect of stigma on adherence to medical advice among mental health patients.

3.1 Research Design

A research design is the overall strategy and blueprint that outlines how a study will be conducted, including the methods for data collection, analysis and interpretation, to ensure that the research objectives are systematically addressed (Creswell & Creswell, 2019). It provides structure, direction and coherence to the study, ensuring the reliability and validity of findings (Mugenda & Mugenda, 2019).

This study adopted a descriptive research design, which was aimed at systematically describing characteristics of a population or phenomenon of interest without manipulating variables (Kothari, 2022). Descriptive designs were appropriate for studies that sought to measure variables and establish relationships among them, particularly when investigating attitudes, perceptions, or behaviors such as stigma and adherence among mental health patients (Bryman, 2019). The choice of a descriptive design in this study was justified because it allowed for detailed examination of the levels and patterns of perceived public stigma, self-stigma, family stigma and fear of labeling and their association with adherence to medical advice, within the natural setting of Kajiado Referral Hospital.

3.2 Target Population

The target population refers to the entire group of individuals, events, or objects to which a researcher intends to generalize the study findings and from which a sample can be drawn for data collection (Creswell & Creswell, 2019). It is critical to define the target

population clearly to ensure that the study findings are representative and applicable to the population of interest (Mugenda & Mugenda, 2019).

For this study, the target population consisted of 273 mental health patients attending outpatient services at Kajiado Referral Hospital. The study focused on adult patients aged 18 years and above who had been diagnosed with common mental health disorders, including depression, anxiety disorders, bipolar disorder and schizophrenia. The target population was justified because these patients were directly affected by stigma, which could influence their adherence to medical advice. Selecting adult patients ensured that respondents could provide informed consent and reliable self-reported data on adherence and stigma experiences (Creswell & Creswell, 2019; Mugenda & Mugenda, 2019).

Table 3: Table: Target Population

Category	Target Population	Percentage
Depression	90	33
Anxiety disorders	70	26
Bipolar disorder	55	20
Schizophrenia	40	15
Other diagnoses	18	6
Total	273	100

Source Kajiado Referral Hospital

3.3 Sample and Sampling Technique

A sample refers to a subset of the target population selected to participate in a study, representing the characteristics of the larger population to allow for generalization of findings (Creswell & Creswell, 2019). Sampling is the process through which researchers select participants from the target population in a systematic manner to ensure that the sample is representative and adequate for analysis (Mugenda & Mugenda, 2019).

The study adopted simple random sampling to select participants from the target population of 273 mental health patients at Kajiado Referral Hospital. Simple random

sampling was appropriate because it gave each member of the population an equal chance of being selected, which minimized selection bias and enhanced the representativeness of the sample (Mugenda & Mugenda, 2019).

Using this technique ensured that the sample reflected the diversity within the target population, including patients diagnosed with depression, anxiety disorders, bipolar disorder and schizophrenia and allowed for generalization of findings to the larger population (Creswell & Creswell, 2019). For this study, 30% of the total target population was sampled, resulting in approximately 82 participants. This proportion was sufficient to provide reliable data for descriptive and inferential analyses while remaining manageable for data collection within the study’s timeline and resources (Bryman, 2019).

Table 4: Table: Sample Size

Category	Target Population	Sample Size
Depression	90	27
Anxiety disorders	70	21
Bipolar disorder	55	17
Schizophrenia	40	12
Other diagnoses	18	5
Total	273	82

Source Kajiado Referral Hospital

3.4 Instruments

Data for this study was collected using questionnaires administered to the selected participants. The questionnaire consisted of closed-ended questions measured on a 5-point Likert scale, ranging from “Strongly Disagree” (1) to “Strongly Agree” (5). The Likert scale allowed the measurement of participants’ attitudes, perceptions and behaviors regarding perceived public stigma, self-stigma, family stigma, fear of labeling and adherence to medical advice in a standardized and quantifiable manner (Creswell & Creswell, 2019).

The choice of questionnaires was justified because they were efficient for collecting data from a relatively large sample and provided uniformity in responses, facilitating easy coding and statistical analysis (Mugenda & Mugenda, 2019). Using closed-ended questions ensured that responses were concise, comparable and less prone to interpretation bias, which increased the reliability and validity of the data (Bryman, 2019).

3.5 Pilot Study

A pilot study is a small-scale preliminary study conducted to evaluate the feasibility, time, cost and validity of the data collection instruments and procedures before the main research (Creswell & Creswell, 2019). It helped identify potential challenges, refine questionnaires and ensure clarity and reliability of the items (Mugenda & Mugenda, 2019).

In this study, the pilot was conducted on 10% of the sample population, which was approximately 8 respondents drawn from mental health patients attending outpatient services at a facility similar to Kajiado Referral Hospital. These respondents did not participate in the main study to prevent bias and contamination of the final results (Bryman, 2019).

The pilot study was necessary to test the reliability and validity of the 5-point Likert scale questionnaire, assess the clarity of closed-ended questions and determine whether the instrument effectively captured data on perceived public stigma, self-stigma, family stigma, fear of labeling and adherence to medical advice. This step ensured that the final data collection was accurate, efficient and capable of generating meaningful and valid findings (Creswell & Creswell, 2019; Mugenda & Mugenda, 2019).

3.5.1 Validity

Validity refers to the extent to which a research instrument measures what it is intended to measure, ensuring that the results accurately reflect the concept under investigation (Creswell & Creswell, 2019). It determines the credibility and trustworthiness of the data

collected and ensures that the inferences made from the study are meaningful and accurate (Mugenda & Mugenda, 2019).

In this study, validity was achieved through content and face validity. Content validity was ensured by designing the questionnaire items based on a thorough review of literature and the study objectives, making sure that all aspects of perceived public stigma, self-stigma, family stigma, fear of labeling and adherence to medical advice were adequately captured. Face validity was assessed by consulting experts in mental health and research methodology to review the questionnaire for clarity, relevance and appropriateness of the items (Bryman, 2019). Additionally, the pilot study helped refine ambiguous or unclear questions, further strengthening the instrument's validity and suitability for the main study.

3.5.2 Reliability

Reliability refers to the consistency and stability of a research instrument over time, indicating the extent to which it produces similar results under consistent conditions (Creswell & Creswell, 2019). A reliable instrument ensures that the measurements are dependable, reproducible and free from random errors, thereby enhancing the credibility of the study findings (Mugenda & Mugenda, 2019).

In this study, reliability was assessed through the Cronbach's alpha coefficient during the pilot study. A coefficient of 0.79 was considered acceptable, indicating internal consistency of the questionnaire items measuring perceived public stigma, self-stigma, family stigma, fear of labeling and adherence to medical advice (Bryman, 2019). Any items with low item-total correlations were revised or removed to strengthen the overall reliability. Additionally, the pilot study results guided adjustments to wording and sequencing of questions to reduce ambiguity and ensure consistent responses across all participants.

3.6 Data Collection Procedure

Data for this study was collected using structured questionnaires administered to the selected participants at Kajiado Referral Hospital. The process began with obtaining a

research authorization letter from the Management University of Africa, which formally introduced the researcher and outlined the purpose of the study. This letter was then presented to the management of Kajiado Referral Hospital to seek permission to conduct the study among mental health outpatients.

Once permission was granted, research assistants were trained on the objectives of the study, ethical considerations and proper administration of the questionnaires. The questionnaires were distributed to the participants in person, ensuring that instructions were clearly explained and confidentiality was maintained. Participants were given one week to complete the questionnaires, after which the research assistants collected the filled questionnaires. This process ensured sufficient time for participants to respond thoughtfully while maintaining a structured timeline for data collection. Throughout, adherence to ethical standards, voluntary participation and confidentiality was strictly observed.

3.7 Data Analysis and Presentation

Data analysis refers to the process of inspecting, cleaning, transforming, and modeling data to discover useful information, inform conclusions, and support decision-making (Kothari, 2022). It involves reducing accumulated data to a manageable size, developing summaries, looking for patterns, and applying statistical techniques to answer the research questions. In this study, the data collected from the questionnaires was analyzed using descriptive statistics to summarize and organize the information. This included calculating frequencies, percentages, means and standard deviations for each variable, allowing the researcher to identify patterns, trends and relationships among perceived public stigma, self-stigma, family stigma, fear of labeling and adherence to medical advice. Microsoft Excel was used for this analysis due to its efficiency in handling numerical data and generating basic statistical outputs.

The analyzed data was presented using tables to provide a clear and organized view of the findings. Additionally, visual presentations such as bar graphs and pie charts were used to illustrate distributions, comparisons and proportions of responses for each variable. This

approach facilitated easier interpretation of the data and enhanced clarity for readers, making patterns and relationships among the variables more comprehensible.

3.8 Ethical Considerations

Ethical considerations in research refer to the principles and guidelines that ensure the protection of participants' rights, dignity and well-being throughout the research process (Creswell & Creswell, 2019). They involved obtaining informed consent, ensuring confidentiality and anonymity, avoiding harm and maintaining honesty and integrity in data collection, analysis and reporting (Mugenda & Mugenda, 2019). Ethical considerations were essential to maintain the credibility of the research, foster trust between the researcher and participants and ensure compliance with institutional and national research regulations.

3.8.1 Informed Consent

Participants were fully informed about the purpose, objectives, procedures, risks and benefits of the study. They signed a consent form before participating, indicating their understanding and agreement to take part voluntarily.

3.8.2 Voluntary Participation

Participation was entirely voluntary and participants were free to withdraw at any stage without any negative consequences, ensuring autonomy and freedom of choice.

3.8.3 Confidentiality

All information provided by participants was treated with strict confidentiality. Data was securely stored and access was restricted to the research team only.

3.8.4 Privacy

Data collection was conducted in a private setting to prevent unintended disclosure of personal or sensitive information, ensuring participants' comfort and safety.

3.8.5 Anonymity

Participants' identities were kept anonymous by using codes or pseudonyms in place of names in all records, reports and publications, ensuring that no individual could be identified from the study findings.

3.9 Chapter Summary

Chapter three discussed the research methodology employed in the study, covering the study design, target population, sample and sampling technique, data collection instruments, pilot study, validity, reliability, data collection procedures, data analysis and ethical considerations. It outlined the systematic approach used to investigate how stigma affects adherence to medical advice among mental health patients.

CHAPTER FOUR

PRESENTATION, ANALYSIS AND INTERPRETATIONS OF FINDINGS

4.0 Introduction

The chapter presents findings on demographic characteristics, perceived public stigma, self-stigma, family stigma, fear of labeling and adherence to medical advice. Data are analyzed using tables, graphs and pie charts to highlight patterns and relationships. Limitations of the study are identified to contextualize the findings and inform conclusions and recommendations.

4.1 Presentation of Research Findings

The study presents its findings using tables, graphs and pie charts, providing a clear analysis of each research objective. The presentation highlights how perceived public stigma, self-stigma, family stigma and fear of labeling affect adherence to medical advice. Conclusions and recommendations are drawn directly from these analyzed findings.

4.1.1 Response Rate

The study included the response rate to determine the proportion of participants who completed the survey compared to those targeted. This information helped assess the reliability, validity and representativeness of the collected data for making accurate conclusions about stigma and adherence.

Table 5: Response Rate

Category	Frequency	Percentage
Response	76	92.68
Non-Response	6	7.32
Total	82	100

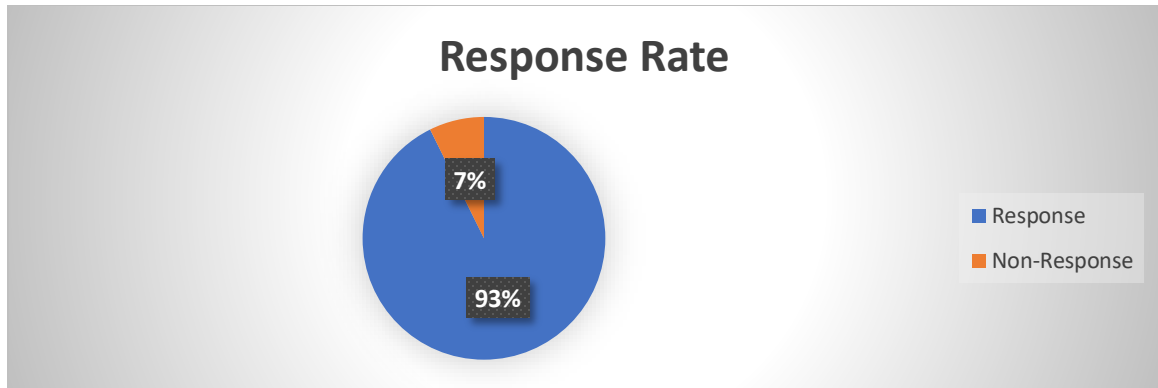


Figure 2: Response Rate

The study achieved a response rate of 92.7%, with 76 out of 82 targeted participants completing the survey. This high response rate suggests that the data collected is reliable and representative of the mental health patients at Kajiado Referral Hospital, providing a solid basis for analyzing the effects of stigma on adherence to medical advice.

4.1.2 Background Information

The study collected general background information to contextualize participants' demographic and social characteristics. This helped identify patterns and relationships between stigma, personal factors and adherence to medical advice among mental health patients.

4.1.2.1 Gender Distribution of the Respondents

The study collected information on gender distribution to identify whether adherence to medical advice and experiences of stigma differed between male and female patients. Understanding gender patterns helped the study analyze potential disparities in stigma perception and its effect on treatment adherence.

Table 6: Gender Distribution of the Respondents

Category	Frequency	Percentage
Male	32	42.11
Female	44	57.89
Total	76	100

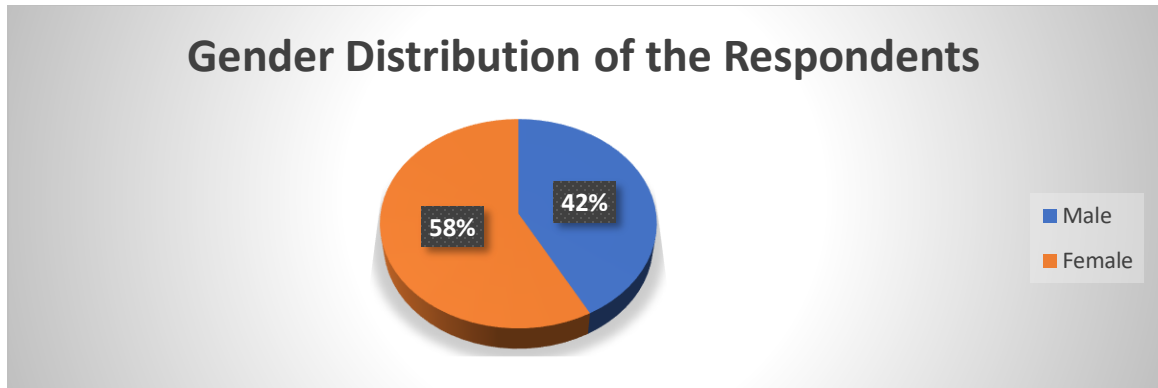


Figure 3: Gender Distribution of the Respondents

The study's respondents comprised 32 males (42.1%) and 44 females (57.9%), indicating a slightly higher female participation. This distribution allows analysis of whether gender influences experiences of stigma and adherence to medical advice, providing insights into potential differences in how male and female mental health patients respond to social pressures and treatment recommendations.

4.1.2.2 Age Range of the Respondents

The study gathered information on respondents' age range to determine whether age influenced experiences of stigma or adherence to medical advice. This helped identify age-related trends that could affect how mental health patients perceived and responded to stigma.

Table 7: Age Range of the Respondents

Category	Frequency	Percentage
Less than 18 years	3	3.95
18–25	15	19.74
26–35	24	31.58
36–45	18	23.68
46–55	10	13.16
56 and above	6	7.89
Total	76	100

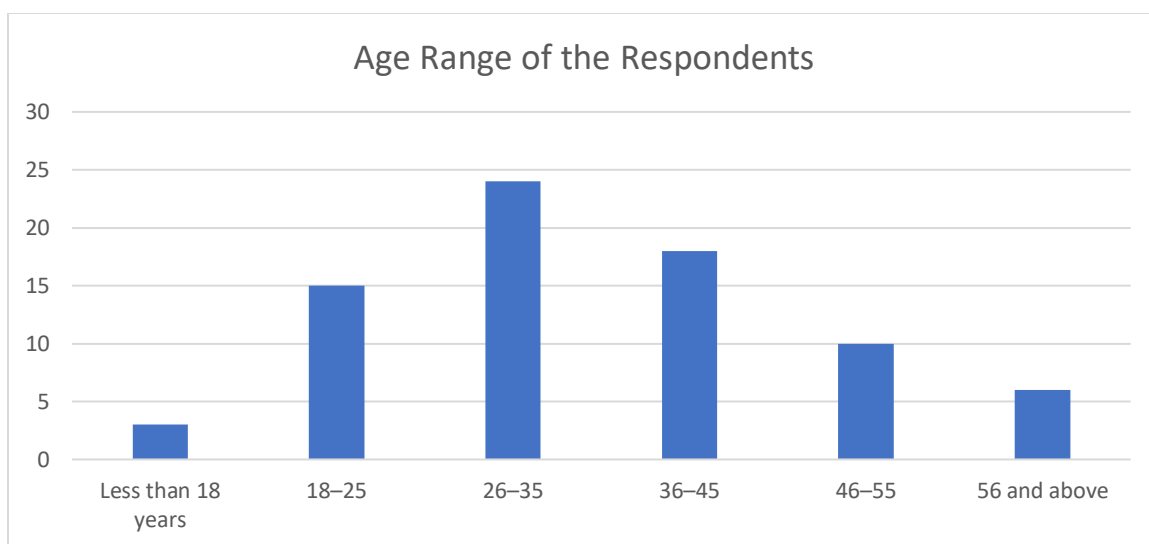


Figure 4: Age Range of the Respondents

The respondents' ages ranged from under 18 to over 56 years, with the majority (24) aged 26–35, followed by 18 aged 36–45. This distribution suggests that young and middle-aged adults formed the largest proportion, allowing the study to explore how age-related factors influence experiences of stigma and adherence to medical advice among mental health patients.

4.1.2.3 Level of Education of the Respondents

The study collected data on respondents' education levels to assess whether educational attainment affected understanding of medical advice or perceptions of stigma. This helped determine if education affect adherence behaviors among mental health patients.

Table 8: Level of Education of the Respondents

Category	Frequency	Percentage
No formal education	5	6.58
Primary education	19	25.00
Secondary education	23	30.26
Tertiary/College	18	23.68
University degree	11	14.47
Total	76	100

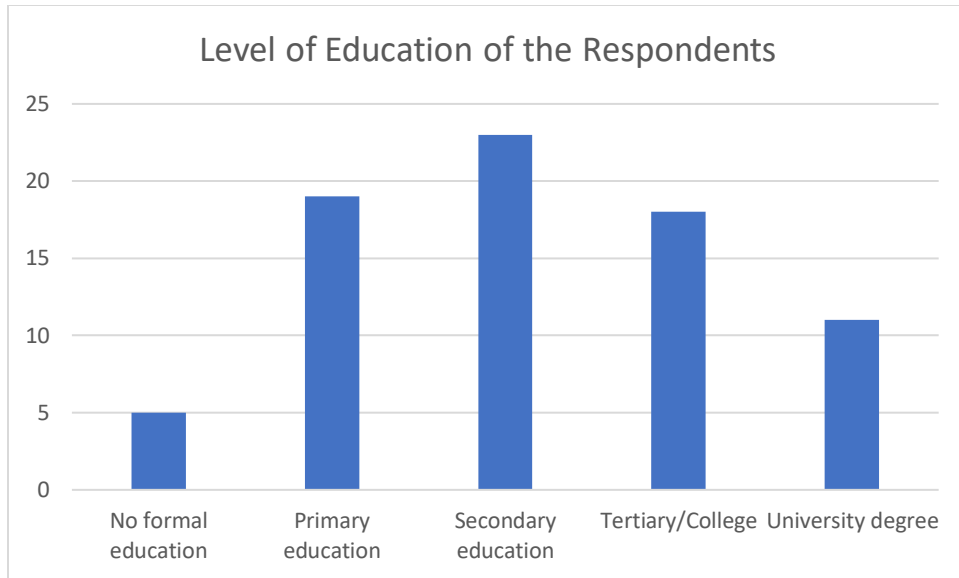


Figure 5: Level of Education of the Respondents

The respondents' education levels varied, with most having secondary (23) or tertiary/college (18) education, while 5 had no formal education. This variation enables analysis of how educational attainment influences understanding of medical advice, perceptions of stigma and adherence behaviors among mental health patients.

4.1.2.4 Marital Status of the Respondents

The study sought information on marital status to examine whether social support from a spouse or lack thereof influenced experiences of stigma and adherence to medical advice among mental health patients.

Table 9: Marital Status of the Respondents

Category	Frequency	Percentage
Single	29	38.16
Married	33	43.42
Divorced	8	10.53
Widowed	6	7.89
Total	76	100

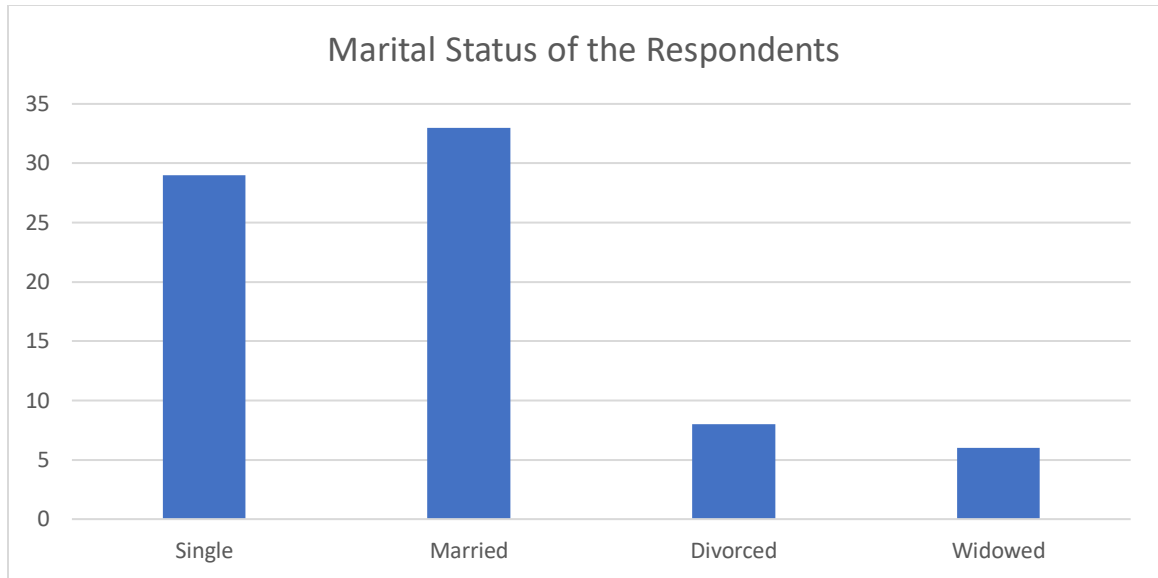


Figure 6: Marital Status of the Respondents

The respondents' marital status showed that 33 were married, 29 single, 8 divorced and 6 widowed. This distribution allows the study to examine how social and familial support or lack thereof influences experiences of stigma and adherence to medical advice among mental health patients.

4.1.2.5 Frequency of Medical Appointments

The study gathered information on the frequency of medical appointments to evaluate patients' consistency in following medical advice and determine how stigma might affect their regular attendance at mental health clinics.

Table 10: Frequency of Medical Appointments

Category	Frequency	Percentage
Weekly	21	27.63
Bi-weekly	16	21.05
Monthly	28	36.84
Quarterly	11	14.47
Total	76	100

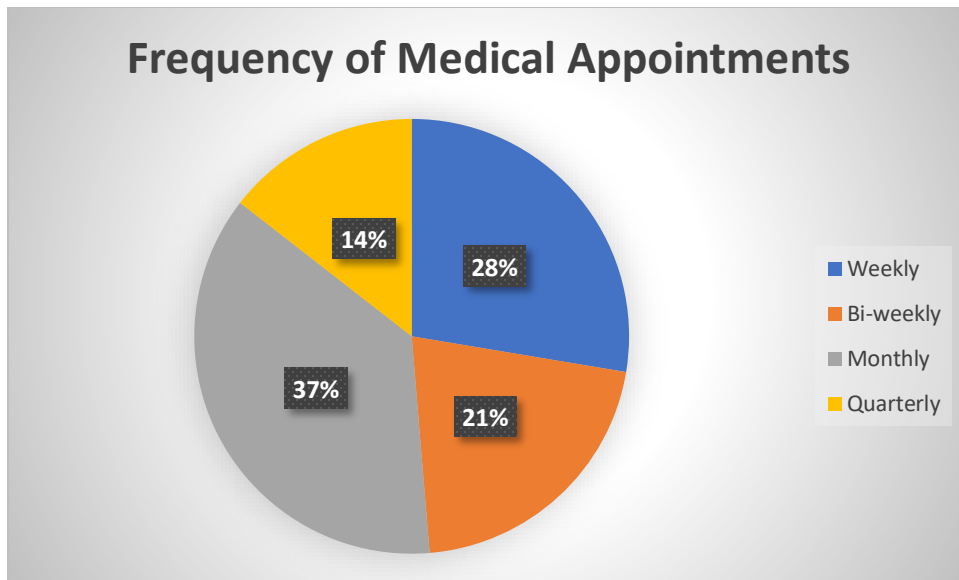


Figure 7: Frequency of Medical Appointments

The respondents' frequency of medical appointments varied, with most attending monthly (28), followed by weekly (21), bi-weekly (16) and quarterly (11). This pattern provides insight into patients' adherence behaviors and helps assess how different forms of stigma may influence regular attendance at mental health clinics.

4.1.3 Study Objectives

The study focused on the four objectives to examine different dimensions of stigma perceived public stigma, self-stigma, family stigma and fear of labeling and how each uniquely influenced adherence to medical advice. This allowed a comprehensive understanding of the multifaceted impact of stigma on mental health treatment compliance.

4.1.3.1 Perceived Public Stigma

The study investigated perceived public stigma to determine how patients' beliefs about society's negative attitudes toward mental illness affected their willingness to follow medical advice. This helped assess the external social pressures influencing treatment adherence.

Table 11: Effect of Perceived Public Stigma

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I feel that members of my community judge me because of my mental health condition.	25	28	10	8	5
I am often excluded from community activities due to my mental health condition.	20	26	12	11	7
People make fun of me or ridicule me because of my mental health condition.	22	24	14	9	7
I have experienced discrimination in public spaces because of my mental health condition.	18	25	16	10	7
I notice that people avoid interacting with me due to my mental health condition.	24	27	11	8	6

A total of 53 respondents (25 strongly agree, 28 agree) felt judged by community members because of their mental health condition. This indicates that a majority perceived negative societal attitudes, suggesting that perceived public stigma is prevalent and may discourage patients from openly seeking or adhering to medical advice. Forty-six respondents (20 strongly agree, 26 agree) reported being excluded from community activities due to their mental health condition. This shows that social marginalization is common and likely contributes to isolation, which can negatively impact adherence to prescribed treatments.

Forty-six respondents (22 strongly agree, 24 agree) indicated experiencing ridicule. This suggests that mockery and public humiliation are significant aspects of perceived public

stigma, potentially reducing patients' confidence in following medical advice or attending appointments. Forty-three respondents (18 strongly agree, 25 agree) reported facing discrimination in public settings. This finding highlights that encounters with discriminatory behavior are frequent, which can reinforce avoidance of medical environments and hinder adherence to treatment plans. Fifty-one respondents (24 strongly agree, 27 agree) felt that people avoid interacting with them. This underscores that social rejection is a key component of perceived public stigma, contributing to stress and reduced motivation to comply with medical advice.

The findings indicate that perceived public stigma is widespread among mental health patients at Kajiado Referral Hospital. Most respondents reported feeling judged, excluded, ridiculed, discriminated against, or avoided by others. This pervasive stigma likely undermines adherence to medical advice, as patients may feel unwelcome, ashamed, or fearful of public interactions, highlighting the need for community sensitization and supportive interventions to improve treatment compliance.

4.1.3.2 Self-Stigma

The study examined self-stigma to understand how internalized negative beliefs about one's own mental illness influenced patients' adherence to medical advice. This helped reveal the psychological barriers affecting treatment compliance.

Table 12: Effect of Self-Stigma

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I blame myself for having a mental health condition.	21	20	15	12	8
My mental health condition has lowered my self-esteem.	27	25	10	8	6
I feel ashamed of having a mental health condition.	23	24	13	9	7

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I believe negative stereotypes about mental health apply to me.	19	23	14	12	8
I tend to isolate myself from others because of my mental health condition.	25	26	11	8	6

Forty-one respondents (21 strongly agree, 20 agree) reported blaming themselves for their condition. This indicates that self-directed negative thoughts are common and may reduce motivation to adhere to medical advice. Fifty-two respondents (27 strongly agree, 25 agree) felt their condition lowered their self-esteem. This suggests that diminished self-worth is a significant barrier to treatment adherence. Forty-seven respondents (23 strongly agree, 24 agree) expressed shame. This highlights that internalized stigma is prevalent, potentially causing reluctance to seek care or follow medical advice.

Forty-two respondents (19 strongly agree, 23 agree) believed negative mental health stereotypes applied to them. This reflects acceptance of societal prejudices internally, which can hinder proactive health behaviors. Fifty-one respondents (25 strongly agree, 26 agree) reported isolating themselves. This indicates that self-stigma fosters social withdrawal, limiting support networks and reducing adherence to medical recommendations.

The findings reveal that self-stigma is widespread among mental health patients, manifesting as self-blame, low self-esteem, shame, belief in stereotypes and social isolation. These internalized attitudes likely impede adherence to medical advice, as patients may avoid appointments, feel unworthy of treatment, or withdraw from supportive social interactions, emphasizing the need for psychological interventions to reduce self-stigma.

4.1.3.3 Family Stigma

The study explored family stigma to assess how negative attitudes or discrimination from relatives impacted patients' adherence to medical advice. This helped identify the role of familial support or pressure in influencing treatment compliance.

Table 13: Effect of Family Stigma

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
My family members criticize me because of my mental health condition.	16	22	14	13	11
My family prefers to keep my mental health condition a secret from others.	20	24	15	10	7
My family blames me for having a mental health condition.	17	21	15	14	9
I feel emotionally neglected by my family due to my mental health condition.	18	26	14	10	8
I have experienced rejection from family members because of my mental health condition.	15	23	16	12	10

Thirty-eight respondents (16 strongly agree, 22 agree) reported being criticized by family members. This indicates that familial judgment contributes to stress and may reduce adherence to medical advice. Forty-four respondents (20 strongly agree, 24 agree) stated their family preferred to conceal their condition. This suggests a lack of open support, potentially increasing isolation and affecting treatment compliance.

Thirty-eight respondents (17 strongly agree, 21 agree) reported being blamed for their mental health condition. This shows that family-induced guilt may undermine patients' motivation to follow medical advice. respondents (18 strongly agree, 26 agree) felt emotionally neglected. This indicates that lack of familial support can exacerbate stigma's negative effects on adherence. Thirty-eight respondents (15 strongly agree, 23 agree) experienced family rejection. This highlights that familial rejection reinforces stigma, potentially discouraging patients from attending appointments or adhering to treatment.

The findings reveal that family stigma is prevalent, manifesting as criticism, blame, secrecy, emotional neglect and rejection. Such negative familial attitudes create a stressful environment that undermines adherence to medical advice among mental health patients, emphasizing the importance of family-focused interventions to improve treatment support and compliance.

4.1.3.4 Fear of Labeling

The study investigated fear of labeling to determine how patients' concern about being identified or judged as mentally ill affected their adherence to medical advice. This helped reveal the influence of anticipated social judgment on treatment compliance.

Table 14: Effect of Fear of Labeling

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I try to hide my mental health diagnosis from others.	26	27	10	7	6
I worry that people will reject me if they know about my mental health condition.	24	28	11	8	5
I am concerned about how my mental health condition affects my reputation.	22	26	13	9	6

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I avoid disclosing my mental health status to others.	27	25	12	7	5
I feel anxious in social situations because of the possibility of being labeled.	25	24	14	8	5

Fifty-three respondents (26 strongly agree, 27 agree) reported hiding their diagnosis. This indicates that patients fear social judgment, which may limit openness with healthcare providers and adherence to medical advice. Fifty-two respondents (24 strongly agree, 28 agree) worried about being rejected if others knew about their condition. This highlights that anticipated social rejection discourages patients from seeking support or following treatment.

Forty-eight respondents (22 strongly agree, 26 agree) were concerned about reputational impact. This suggests that fear of stigma affects patients' willingness to disclose or adhere to prescribed care. Fifty-two respondents (27 strongly agree, 25 agree) avoided disclosure. This behavior indicates protective strategies that may limit engagement with medical advice and support networks. Forty-nine respondents (25 strongly agree, 24 agree) felt anxious socially due to labeling concerns. This shows that fear of labeling generates stress that may interfere with treatment adherence.

The findings reveal that fear of labeling is a major barrier for mental health patients, leading them to hide their diagnosis, worry about rejection and avoid disclosure. This fear-induced anxiety and protective behavior reduce engagement with medical advice, highlighting the need for stigma-reduction initiatives and supportive environments to improve adherence and mental health outcomes.

4.1.3.5 Adherence to Medical Advice

The study assessed adherence to medical advice to measure the extent to which mental health patients followed prescribed treatments. This served as the key outcome variable to evaluate how different forms of stigma influenced treatment compliance.

Table 15: Adherence to Medical Advice

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I take my prescribed medication as instructed by my healthcare provider.	30	25	11	6	4
I attend all scheduled medical appointments without missing them.	28	27	10	7	4
I consistently refill my prescriptions on time.	26	28	12	6	4
I follow the prescribed dosage instructions for my medications accurately.	31	25	10	6	4
I adhere to all follow-up visits and medical advice provided by my healthcare provider.	29	27	11	5	4

Fifty-five respondents (30 strongly agree, 25 agree) reported taking medications as instructed. This suggests a generally high level of adherence, despite the presence of stigma. Fifty-five respondents (28 strongly agree, 27 agree) attended all appointments. This indicates that most patients maintained regular contact with healthcare providers, reflecting moderate treatment compliance.

Fifty-four respondents (26 strongly agree, 28 agree) consistently refilled prescriptions. This shows commitment to maintaining their treatment regimen. Fifty-six respondents (31 strongly agree, 25 agree) adhered to dosage instructions. This demonstrates careful attention to medical guidance. Fifty-six respondents (29 strongly agree, 27 agree) followed all follow-up advice. This indicates overall good adherence behavior among patients.

The findings show that most mental health patients at Kajiado Referral Hospital adhere to medical advice, including taking medications, attending appointments, refilling prescriptions and following dosage instructions. Despite challenges posed by perceived public stigma, self-stigma, family stigma and fear of labeling, patients demonstrate relatively high commitment to treatment, suggesting resilience and the effectiveness of current healthcare support in promoting adherence.

4.2 Limitations of the Study

The study faced several limitations, alongside measures taken to mitigate their impact. First, the sample was restricted to patients at Kajiado Referral Hospital, which may limit the generalizability of the findings to other regions with different cultural or healthcare contexts. To address this, the study provided a detailed description of the setting and sample characteristics, allowing for transferability of findings to similar contexts. Future research is recommended to include multiple sites.

Second, the reliance on self-reported data may have been affected by social desirability bias, particularly regarding sensitive issues like stigma and adherence. To mitigate this, the study ensured strict anonymity and confidentiality, used standardized and validated scales in the questionnaire, and trained research assistants to create a non-judgmental environment to encourage honest responses.

Third, some participants were initially reluctant to disclose personal experiences due to fear of judgment. This was overcome by thoroughly explaining the ethical protections in place, using informed consent procedures that emphasized voluntary participation, and allowing participants to complete the questionnaires privately.

Finally, resource constraints limited the sample size and the depth of qualitative exploration, potentially reducing the comprehensiveness of insights into stigma's effects on adherence. Despite this, the study achieved a high response rate (92.7%), and the use of a structured questionnaire with both Likert-scale and demographic sections allowed for a robust quantitative analysis that effectively addressed the research objectives.

4.3 Chapter Summary

The chapter presented findings on respondents' demographics, perceived public stigma, self-stigma, family stigma, fear of labeling and adherence to medical advice. Data were analyzed through tables, graphs and pie charts, highlighting key patterns. Limitations encountered during the study were discussed to contextualize the findings and guide conclusions and recommendations.

CHAPTER FIVE

SUMMARY, RECOMMENDATIONS AND CONCLUSIONS

5.0 Introduction

Chapter five presents a summary of findings, conclusions and recommendations based on the study objectives. It highlights the influence of perceived public stigma, self-stigma, family stigma and fear of labeling on adherence to medical advice. The chapter also suggests areas for further research to enhance mental health treatment outcomes.

5.1 Summary of Findings

The study assessed the effect of perceived public stigma on adherence to medical advice among mental health patients. Findings revealed that a majority of respondents experienced stigma from the community. Specifically, 25 strongly agreed and 28 agreed that they felt judged by community members, while 20 strongly agreed and 26 agreed that they were often excluded from community activities. Additionally, 22 strongly agreed and 24 agreed that people made fun of them and 18 strongly agreed with 25 agreeing that they experienced discrimination in public spaces. Moreover, 24 strongly agreed and 27 agreed that people avoided interacting with them due to their mental health condition. These results suggest that perceived public stigma is highly prevalent, affecting social interactions and potentially influencing treatment adherence. The consistent reporting across multiple indicators demonstrates that patients frequently encounter negative attitudes, ridicule and exclusion. This finding aligns with the study by Adeoye and Okonkwo (2021) in Nigeria, which also found that higher perceived public stigma was associated with a significantly greater odds of non-adherence to medical advice. Such societal pressures may discourage open engagement with healthcare services, attendance at appointments and proper adherence to prescribed treatments, highlighting the need for public awareness and stigma reduction initiatives to support mental health patients' compliance with medical advice.

The study examined the effect of self-stigma on adherence to medical advice among mental health patients. Findings indicated that internalized stigma was prevalent. Forty-one respondents (21 strongly agree, 20 agree) reported blaming themselves for their condition, while 52 (27 strongly agree, 25 agree) indicated that their mental health

condition lowered their self-esteem. Forty-seven respondents (23 strongly agree, 24 agree) felt ashamed of having a mental health condition and 42 (19 strongly agree, 23 agree) believed negative stereotypes about mental health applied to them. Furthermore, 51 respondents (25 strongly agree, 26 agree) reported isolating themselves from others due to their condition. These results suggest that self-stigma significantly impacts patients' adherence to medical advice. This finding is consistent with the work of Elkalla, Mazen, & Kandil (2023) in Egypt, who also found that higher self-stigma scores were significantly associated with lower adherence to prescribed treatment and increased treatment discontinuation. Internalized blame, shame and low self-esteem can reduce motivation to attend appointments, follow prescriptions, or engage openly with healthcare providers. Social withdrawal further limits support networks and may exacerbate treatment noncompliance. The findings underscore the importance of psychological interventions, counseling and stigma reduction programs to help patients overcome self-stigmatizing beliefs and improve adherence to prescribed mental health treatments.

The study evaluated the effect of family stigma on adherence to medical advice among mental health patients. Findings revealed that negative family attitudes were common. Thirty-eight respondents (16 strongly agree, 22 agree) reported being criticized by family members, while 44 (20 strongly agree, 24 agree) indicated that their family preferred to keep their mental health condition a secret. Thirty-eight respondents (17 strongly agree, 21 agree) stated that their family blamed them for having a mental health condition. Additionally, 44 respondents (18 strongly agree, 26 agree) felt emotionally neglected and 38 (15 strongly agree, 23 agree) experienced rejection from family members due to their condition. These results suggest that family stigma significantly affects adherence to medical advice. This finding is supported by Djoufack & Ngassam (2021) in Cameroon, who similarly found that higher caregiver-reported family stigma was significantly associated with lower patient adherence to medication and appointments. Criticism, blame, emotional neglect, secrecy and rejection may reduce patients' willingness to attend appointments, follow treatment instructions, or seek support. The findings highlight the crucial role of family support in promoting treatment compliance. Interventions aimed at educating families about mental health, reducing stigma and

fostering supportive behaviors are essential to improve adherence and overall treatment outcomes for patients.

The study assessed the effect of fear of labeling on adherence to medical advice among mental health patients. Findings showed that most respondents were concerned about social judgment. Fifty-three respondents (26 strongly agree, 27 agree) reported hiding their mental health diagnosis from others, while 52 (24 strongly agree, 28 agree) worried about being rejected if people knew about their condition. Forty-eight respondents (22 strongly agree, 26 agree) were concerned about their reputation and 52 (27 strongly agree, 25 agree) avoided disclosing their mental health status. Additionally, 49 respondents (25 strongly agree, 24 agree) felt anxious in social situations due to the possibility of being labeled. These results suggest that fear of labeling creates a barrier to adherence. This finding corroborates the study by van Heerden, Kriel, & Meyer (2022) in South Africa, which also found that fear of labeling independently predicted non-adherence, with patients skipping appointments or discontinuing medications to avoid being identified. Anticipated stigma leads patients to conceal their condition, avoid disclosure and experience social anxiety, which may reduce engagement with healthcare providers and adherence to prescribed treatments. The findings underscore the need for stigma-reduction programs, supportive counseling and community sensitization to minimize labeling fears and improve compliance with medical advice among mental health patients.

5.2 Recommendations

The study recommended that public awareness campaigns on mental health be strengthened to reduce negative attitudes and promote acceptance within the community. Community-based programs and workshops were suggested to educate members on mental health issues, dispel myths and encourage supportive behaviors toward patients. Collaboration with local leaders and media outlets was advised to amplify anti-stigma messages and normalize positive social interactions for mental health patients. Additionally, the study recommended integrating mental health education into schools and community forums to foster long-term attitudinal change. Support groups and peer

networks were encouraged to provide patients with safe spaces to share experiences and build resilience against public stigma. Policies promoting inclusion and non-discrimination were also emphasized to enhance treatment adherence.

The study recommended that mental health patients be provided with targeted psychological counseling and therapy sessions to address internalized negative beliefs and improve self-esteem. Programs promoting self-acceptance and resilience were advised to help patients manage feelings of shame, blame and social withdrawal. Mental health practitioners were encouraged to integrate cognitive-behavioral interventions and supportive group therapy into routine care to reduce self-stigmatizing attitudes. Additionally, the study recommended establishing peer support groups where patients could share experiences and learn coping strategies, fostering a sense of belonging and empowerment. Educational workshops on mental health were suggested to challenge internalized stereotypes and enhance patients' confidence in adhering to treatment. Regular monitoring and mentorship programs were also advised to sustain progress in reducing self-stigma and improving treatment compliance.

The study recommended that families of mental health patients be sensitized through structured education programs to reduce negative attitudes and promote supportive behaviors. Counseling sessions targeting both patients and family members were advised to improve communication, empathy and understanding of mental health conditions. Mental health practitioners were encouraged to involve family members in treatment planning to strengthen emotional support and adherence. Additionally, the study recommended the establishment of family support groups to provide guidance, share coping strategies and foster positive engagement with patients. Policies promoting family inclusion in mental health care were emphasized to reduce secrecy, blame and neglect. Community outreach initiatives were also advised to educate families on the importance of emotional support in enhancing treatment outcomes and adherence.

The study recommended that mental health awareness campaigns be intensified to reduce societal labeling and normalize discussions around mental health. Patients were encouraged to participate in counseling and psychoeducation programs aimed at building

confidence and reducing anxiety related to social judgment. Health practitioners were advised to create confidential and supportive environments to enable patients to seek care without fear of exposure. Additionally, the study recommended the establishment of peer support networks where patients could share experiences and coping strategies, fostering resilience against labeling fears. Collaboration with community leaders and media outlets was suggested to promote positive narratives about mental health. Policies advocating non-discrimination and social inclusion were also recommended to minimize labeling and improve adherence to medical advice.

5.3 Conclusion

The study concluded that perceived public stigma significantly influenced adherence to medical advice among mental health patients. Community attitudes and societal judgments created barriers that affected patients' willingness to engage fully with treatment and attend medical appointments. The study highlighted that negative perceptions from the broader community could discourage patients from following prescribed care, reducing overall treatment effectiveness. It further concluded that addressing public stigma through awareness campaigns, community sensitization and inclusive social practices was essential for improving adherence. By fostering a more supportive and understanding environment, mental health patients could feel more accepted, motivated and confident in complying with medical advice, ultimately enhancing their mental health outcomes and quality of life.

The study concluded that self-stigma had a considerable impact on adherence to medical advice among mental health patients. Internalized negative beliefs, feelings of shame and low self-esteem created psychological barriers that hindered patients' motivation to follow treatment plans or attend appointments consistently. The study emphasized that addressing self-stigma was crucial for improving adherence, as patients' perceptions of themselves directly influenced their engagement with healthcare providers. Interventions aimed at enhancing self-acceptance, resilience and coping strategies were identified as essential for reducing internalized stigma.

The study concluded that family stigma significantly influenced adherence to medical advice among mental health patients. Negative attitudes, criticism, blame, emotional neglect and lack of support within the family created barriers that undermined patients' confidence and willingness to comply with treatment. The study emphasized that family involvement and supportive behaviors were critical in promoting adherence, as patients relied on emotional and practical support from relatives to manage their condition effectively. Addressing family stigma through education, counseling and engagement programs was identified as essential for improving treatment outcomes. By fostering understanding, empathy and acceptance within families, mental health patients could experience enhanced motivation, reduced stress and greater compliance with medical advice, ultimately improving recovery and overall well-being.

The study concluded that fear of labeling considerably affected adherence to medical advice among mental health patients. Concerns about being identified, judged, or socially rejected led patients to conceal their condition, avoid disclosure and experience anxiety in social interactions, which hindered full engagement with healthcare services. The study highlighted that fear of labeling acted as a psychological barrier, reducing patients' willingness to attend appointments, follow treatment instructions, or seek support. Addressing this fear through stigma-reduction initiatives, counseling and the creation of confidential, supportive healthcare environments was deemed essential.

5.4 Suggestions for Further Study

The study suggested that future research could explore the effect of stigma on adherence to medical advice across multiple mental health facilities to improve generalizability.. Additionally, research on the effectiveness of targeted interventions, such as family counseling, community sensitization and peer support programs, in reducing stigma and improving adherence was suggested to provide evidence-based strategies for enhancing mental health outcomes.

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APPENDICES

APPENDIX I: LETTER OF INTRODUCTION

Dear Participant,

My name is Vellary Kwamboka Sagwe, a student at the Management University of Africa conducting a research study titled **Effect of Stigma on Adherence to Medical Advice among Mental Health Patients: A Case Study of Kajiado Referral Hospital in Kajiado County, Kenya**. The purpose of this study is to understand how perceived public stigma, self-stigma, family stigma and fear of labeling influence adherence to medical advice among mental health patients.

You have been selected to participate in this study. Your participation is entirely voluntary and you may withdraw at any time without any consequences. The information you provide will be treated with strict confidentiality and anonymity and will only be used for academic purposes.

The questionnaire will take approximately 10–15 minutes to complete. Your honest responses are highly valuable and will contribute to generating meaningful insights that can help improve mental health care and patient adherence in Kenya.

Thank you very much for your cooperation and time. Your participation is greatly appreciated.

Sincerely,

Vellary Kwamboka Sagwe

DCP 17/00062/1/24

Management University of Africa

APPENDIX II: RESEARCH STUDY QUESTIONNAIRE

This questionnaire is part of a research study on the effect of stigma on adherence to medical advice among mental health patients at Kajiado Referral Hospital. Your honest and accurate responses will help understand how stigma influences adherence to treatment. All responses will remain confidential and anonymous.

Section A: Demographic Information

Please provide the following information by ticking (✓) the option that appropriately matches your profile in each category. Your responses will be treated with strict confidentiality and used solely for academic purposes.

1. Gender:

Male { }

Female { }

2. Age (in years):

Less than 18 years { }

18–25 { }

26–35 { }

36–45 { }

46–55 { }

56 and above { }

3. Level of Education:

No formal education { }

Primary education { }

Secondary education { }

Tertiary/College { }

University degree { }

4. Marital Status:

Single { }

Married { }

Divorced { }

Widowed { }

5. Frequency of Medical Appointments:

Weekly { }

Bi-weekly { }

Monthly { }

Quarterly { }

Section B: Study Objectives

1. Perceived Public Stigma

Kindly respond on this section based on the above objective by ticking on the appropriate box that best matches your opinion on a scale of 5 to 1 where 5= Strongly Agree, 4= Agree, 3= Neutral, 2 = Disagree and 1= Strongly Disagree.

Statement	5	4	3	2	1
I feel that members of my community judge me because of my mental health condition.					
I am often excluded from community activities due to my mental health condition.					
People make fun of me or ridicule me because of my mental health condition.					
I have experienced discrimination in public spaces because of my mental health condition.					
I notice that people avoid interacting with me due to my mental health condition.					

2. Self-Stigma

Kindly respond on this section based on the above objective by ticking on the appropriate box that best matches your opinion on a scale of 5 to 1 where 5= Strongly Agree, 4= Agree, 3= Neutral, 2 = Disagree and 1= Strongly Disagree.

Statement	5	4	3	2	1
I blame myself for having a mental health condition.					
My mental health condition has lowered my self-esteem.					
I feel ashamed of having a mental health condition.					
I believe negative stereotypes about mental health apply to me.					
I tend to isolate myself from others because of my mental health condition.					

3. Family Stigma

Kindly respond on this section based on the above objective by ticking on the appropriate box that best matches your opinion on a scale of 5 to 1 where 5= Strongly Agree, 4= Agree, 3= Neutral, 2 = Disagree and 1= Strongly Disagree.

Statement	5	4	3	2	1
My family members criticize me because of my mental health condition.					
My family prefers to keep my mental health condition a secret from others.					
My family blames me for having a mental health condition.					
I feel emotionally neglected by my family due to my mental health condition.					
I have experienced rejection from family members because of my mental health condition.					

4. Fear of Labeling

Kindly respond on this section based on the above objective by ticking on the appropriate box that best matches your opinion on a scale of 5 to 1 where 5= Strongly Agree, 4= Agree, 3= Neutral, 2 = Disagree and 1= Strongly Disagree.

Statement	5	4	3	2	1
I try to hide my mental health diagnosis from others.					
I worry that people will reject me if they know about my mental health condition.					
I am concerned about how my mental health condition affects my reputation.					
I avoid disclosing my mental health status to others.					
I feel anxious in social situations because of the possibility of being labeled.					

5. Adherence to Medical Advice

Kindly respond on this section based on the above objective by ticking on the appropriate box that best matches your opinion on a scale of 5 to 1 where 5= Strongly Agree, 4= Agree, 3= Neutral, 2 = Disagree and 1= Strongly Disagree.

Statement	5	4	3	2	1
I take my prescribed medication as instructed by my healthcare provider.					
I attend all scheduled medical appointments without missing them.					
I consistently refill my prescriptions on time.					
I follow the prescribed dosage instructions for my medications accurately.					
I adhere to all follow-up visits and medical advice provided by my healthcare provider.					

THANK YOU FOR YOUR PARTICIPATION