COMMUNITY-BASED PSYCHIATRIC SYSTEM AND MANAGEMENT OF SCHIZOPHRENIA IN SOUTHWESTERN NIGERIA

BY

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CERTIFICATION

I certify that this dissertation is an original work carried out by Abdul-Lateef Bisi ADEOTI under my supervision, and submitted to the Department of Sociology, Faculty of the Social Sciences, University of Ibadan, Nigeria.

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DEDICATION

This work is dedicated to my late father, Pa Yekini Olalekan Adeoti who in spite of his non-access to western education during his lifetime strived hard to ensure that all his children acquired and benefited from western education. I pray to Allah to grant him Al-Jannah Firdaus

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ABSTRACT

Regimented treatment of People with Schizophrenia (PwS) in hospitals stigmatises and hinders their full recovery and makes their reintegration into the society difficult. Previous studies have focused mainly on the bio-medical model of management of PwS with little attention paid to the social dimension of its management. Community-based Psychiatric (CBP) Systems is a model of care that adopted de-institutionalisation of psychiatric care with global acceptance. This study, therefore, examined the social and community-based components (stigma, burdens and culture) of the management of people living with schizophrenia in southwestern Nigeria.

Structural-Functionalist Theory and Health Belief Model provided the framework. The cross-sectional descriptive survey design was adopted. Southwestern Nigeria was purposively selected because the region is reputed for having the highest deployment of collaborative community-based psychotherapy in the country. Oyo, Ogun and Ekiti states with community-based psychiatry were purposively selected. One urban and one rural area with CBP facility with Mental Health Personnel (MHP) were purposively chosen from each State. Three hundred and twenty eight family caregivers of PwS across the six CBP facilities were proportionately selected in Ogun (120), Oyo (112) and Ekiti (96) States. A standardised WHO questionnaire was adapted to elicit information on socio-demographic characteristics, knowledge about schizophrenia, reaction to stigmatisation and stereotyping, utilisation and people's satisfaction with CBP. Twenty four focus group discussion and 33 key informant interview sessions with selected community members and MHP were conducted respectively to complement information on the care and appropriateness of CBP services. Quantitative data were analysed using percentages, Chi-square and multi-nomial logit regression at $p \leq 0.05$, while qualitative data were content analysed.

The mean age of primary caregivers was 40±20 years; respondents were mostly female (61.6%) and employed (60.3%). Caregivers' knowledge about the etiology of schizophrenia due to mental affliction (20.7%) and that it is incurable (61.0%). The PwS were regarded as dangerous (30.5%) and perceived as failures (35.1%) but not considered suicidal (91.2%). About half (50.9%) claimed that health workers showed concern for PwS, 82.0% were satisfied with the care in the CBP, while 50.3% believed in the effectiveness of the treatment received from CBP**.** Patients stayed more with their mothers compared to the fathers (z=2.967), and individual who visit traditional healers before hospitalisation (z=1.87) were more likely to be stigmatised. Social acceptance (β=.19;t=3.20), perceived stability (β=.23;t=3.54), and social stigmatisation (β=-.17;-2.60) predicted the adequacy of community-based treatment [$F_{7,320}$=9.60, R^2 =.17]. Participants perceived PwS negatively, tracing schizophrenia to spiritual attack or punishment inflicted by humans. Social distance (avoidance) was the major reaction of people towards PwS and such category of people were regarded as weak, violent, worthless and uninformed. People believed in the effectiveness of CBP in addressing spiritual problems which are not within the realm of orthodox psychiatric therapy. The CBP services were also considered more humane, integrative and robust.

The community-based psychiatric system was perceived to reduce stigmatisation and stereotyping; Therefore there is the need to create awareness and sensitisation about the curability of schizophrenia and increase the capacity of stakeholders in community-based psychiatric care in southwestern Nigeria.

Keywords: Community-based psychiatry, mental health, People with Schizophrenia, Reintegration

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CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Around 1950s, the behavioral scientists started to tackle the questions about how the public perceived psychiatric disorders and the way the public behaved towards people who suffered from such disorders (Phelan, Link, Stueve, and Pescosolido, 2007). These scientists came up with different findings. According to Phelan, Link, Stueve, and Pescosolido, 2007), early investigations established that, not only were the peoples' perceptions to psychiatric illnesses largely unenlightened by the present psychiatric perspective of the moment, but also that the perceptions were widespread with negative stereotypes, fears, and rejections. Concerning the public's conceptualizations of psychiatric illness, Holmes (2004), on account of the discussion with more than 3,000 Americans, resolved that there was a strong feeling for people to equate psychiatric disorder with psychosis and to see other kinds of psychological, behavioural or personality disorders in non-mental health terms-as "an emotional or character difference of a non-problematic sort" (Holmes, 2004: 48).

Crocetti, Spiro, and Siassi (2004) and Dave (2002) posited that it was on account that psychiatric disorder was explained in such myopic and extreme terms that the people feared, rejected and devalued people with psychiatric illnesses. Without minding the origins of these pessimistic behaviours, their evidence was well established. Nunnally (2001), for example, noted that people were more likely or possibly to use a wide variety of dismissive adjectives such as violent, dirty, cold, worthless, bad, weak and unknowledgeable to describe an individual stereotyped as psychotic or neurotic than to an average individual.

Equally, Dave (2002) documented that many Americans, in their own words which explain the term "mental illness," included features such as "dangerousness" and "unpredictability". Blond and Blond (2007), investigating two communities in Saskatchewan, discovered that very many people preferred to create personal social distance with someone who had been emotionally-ill and that the investigators' efforts to change those behaviours were met with anxieties and hostilities. Moreover, Yarrow, Clausen, and Robbins (2005) established that the fear of negative attributes was a severe concern for spouses of mentally-ill persons.

The situation in Nigeria is almost the same as people often try to distance themselves from persons with psychiatric disorders. Psychologically-ill persons are believed to be violent and can easily bring shame and dishonour, this is not only peculiar to individual inflicted with the problem but the entire family. Within the Yoruba understanding of this illness, psychiatric disorder is regarded as equal with leprosy and other serious stigma-related illnesses. The Yoruba people always see psychiatric disorders as afflictions and Yoruba as an ethnic group disallow people to engage in marital relationship with a family that has history of psychiatric disorder (Babalola, 2003). Cases concerning the family history of patients of psychiatric disorder are some of the variables investigated into, (Babalola, 2003) to determine whether one should engage in marital relationship from a particular home or not in the country.

The Yoruba ethnic group consider death preferable to being afflicted with madness. Thus, the saying, '*iku ya ju esin aye'* (death is better than infamy). It is the worst of all illnesses, the complete shame and misery which is not just on the sick person but more significantly on the entire family. It is seen as the most severe illness; but the ill person does not feel the embarrassment. It can best be described as the peak of the calamity. The disease is described as '*arun ti o nsan ti oruko re ki i san'* (sickness that may be curable but the stigma incurable (Jegede, 2017).

The people's negative perceptions directed against psychiatric disorders also dove-tail to the psychiatrists who treat them. For example, Nunnally (2001) documented that people assessed mental health experts who manage psychiatric illnesses importantly with a bias than those who manage physical illnesses. Supporting this view, Featherstone (2006) said that the notion of seeing a professional mental experts enjoying few people's acceptance, with few people having knowledge of anyone who had seen a mental health expert or who they feel might be assisted by mental health expert. In fact, within the Yoruba culture, the doctors of the emotionally-ill persons are usually seen as being emotionally-ill themselves, hence, the saying that '*were lo* '*nwo were''*, meaning "it is only a mad man that cures a mad man" (Babalola, 2003).

These negative perceptions were demoralising to psychiatrists and revealing to investigators for many reasons. These imply that public enlightenment concerning psychiatric disorders has brought little result. Likewise, it implies that the individuals noticed as having psychiatric illness might suffer complete isolation and stigmatisation.

Also, it implies that many people, as a result of these perceptions, would not go for mental health treatments that might help them.

However, in recent years, there are factors that support the fact that perceptions against psychiatric illnesses have improved in the recent time, perhaps dramatically, since these early investigations were carried out. The beautiful improvement is that vast majority of individuals now go for psychiatric treatments. Whether calculated in terms of population surveys of self-reported help-seeking (Veroff, Kulka and Douvan, 2001; Regier, 2003), or on the basis of hospital-based records of health care delivery (Manderscheid and Henderson, 2008), the information indicate that the level of service use of psychiatry services has at least multiplied by two, and may have tripled since seven decades ago and today. This movement indirectly suggests that the people have come to think seperately about psychiatric disorders, that they now explain in a big line-up of problems in mental health terms and that there is less stigma attributed to these problems and their management. It is difficult to assume such sporadic increase in service usage in the absence of such changes.

Thus, there are evidences that significance changes in the public's knowledge about psychiatric disorder may have taken place since the 1950s. But the result is not strong. While the acceleration in service utilisation is incontrovertible, the degree to which changes in conceptions and behaviours to people that suffer from schizophrenia are responsible for this increase is not clear. It is also not clear how people react to community-based approach to psychiatric care. This is also compounded by issues of beliefs and attitudes regarding mental illnesses and the more crucial question of community-based model to psychiatry care or treatments.

Indeed, the resolutions that can be achieved from more direct scientific evidence on beliefs and attitudes are very small by incomparability of the investigations undertaken at different time points. These investigations have varied in the numbers of people they have used and specifically on the issue of stigma in the questions they have asked in the study subjects (Belson 2005; Bentz et al. 2007; Bloom, 2001).

In India, a large percentage of patients had personal conviction in magico-religious beliefs, and a large proportion of patients also agreed that people in their community had those beliefs. The widely held beliefs from the various magico-religious orientations include: sorcery and witchcraft *(Jaadi Tona)* followed by spirit of intrusion (*Oparikaser*) (Nehra, 2002).

The situation in Africa is very much the same as that in India. Indeed, it is common knowledge that Africa as a continent is vulnerable to conflict, particularly, Africa south of the Sahara. Majority of the nations have the features of low income, high incidence of infectious diseases, poor feeding, short life of existence and badly remunerated personnels services. In this situation, psychiatry cases often come last in the lists of the agenda for the government. High death rate recorded is due to communicable diseases and poor feeding, while the anguish and disability due to psychiatric disorder have received low budget allocation from the government. Health as a whole is not giving financial backing like other aspects of social facilities, in majority of African nations compared to other areas of social amenities. Truely, most nations in Africa have zero psychiatry policy scheme or blue print (Gureje and Alem, 2002).

In many of the African nations, the primary facilities of basic health provider were available and researches have indicated that those health workers in these facilities are trained with primary psychiatric service skills (Alem, Jacobsson, and Hanlon, 2008). Basic health care staffs who were assigned to mental health problems are thought to be needed for better delivery of care. In the African setting, the significance of the collaboration between community psychiatric service staff and the alternative doctors is now being emphasised. It is clearly recognised that a large variety of unorthodox provider confronts with psychiatric problems in local African nations: faith doctors, traditional healers, those engaging in divination and witchcraft as well as faith doctors based on the local orientation of the people. There was a quest for Pan- African to create an idea to start psychiatry services with reference to the unique requests and the social and cultural situations prevailing in the part of Sahara Africa (Alem, et al .2008).

There is an emerging recognition that the community-based psychiatry care which goes outside the boundary of hospital setting and which involves the villages as stakeholders have a big capacity for more reduction under-five death at lower cost. There are instances of locations where this has been experienced, these happened both in few numbers, small preminary projects with a bigger numbers are current schemes. Most current studies of this model show the capacity of this model as progressing, and that a desire in community-based primary health care (CBPHC) is growing. Current studies by some scholars have summarised this proof (Bhutta et al., 2008a; Bhutta et al. 2008b; Bhutta et al., 2005; Darmstadt et al., 2005; Hill et al., 2004; Jones et al., 2003). Therefore, the importance of the villages as stakeholders in the schemes has accorded low focus, in the way in which these true solutions have been correctly enforced at the local level.

In most sub-saharan African countries, Nigeria in particular, people have negative behaviours directed to people with psychiatric disorder (Kabir, Iliyasu, Abubakar, Aliyu, 2004; Gureje, Lasebikan, Ephraim–Oluwanuga, Olley, Kola, 2005). These scholars opined that psychiatric disorder is caused by genetic abnormality or inflicting harms on people by others witchcraft. These negative orientations result in mentally-ill persons being seen as outsiders and persons who should be ostracised (Gureje, Lasebikan, Ephraim- Oluwanuga, Olley, Kola, 2005). Another high rated traditional notion is that psychiatric patients are the cause of their ill health, particularly, when it is a case of alcohol or substance abuse. This label did not allow the psychiatric patients have the empathy from the public and understanding traditionally accorded to the sick patients in African community. (Varcolis, 2002; Dahiru, 2000). These behaviours and orientations towards psychiatric disorder equally, increased interest in community-based system of care for persons with emotional illness demanded for more need for their social and occupational rehabilitation (NAMHC, 1993; Lyons, McLoughlin, 2002; Glozier, Hough, Henderson, Holland-Elliot, 2006).

The merging of psychiatry concept by the World Health Organization (WHO) into basic medical service schemes as the 9th units is an attempt to spread the services of mental healthcare into communities for the advantage of every one and the emotionally ill patients (Caplan, 2013). The effective implementation of the WHO concept efficiently gives primary mental healthcare to patients seeking mental health services in a large spectrum of delivery settings and overall, encourages globally selected and preventive mental health solutions (Mrazek and Hagerty, 1994). However, community-based care is corroborated by literature, as a proto-type for accessing and increasing complete involvement and integration of service users within their community. (WHO, 2007). It is considered as a good practice for providing care to individuals with acute psychiatric difficulties in the least confined setting, with the least obstruction to their live.

1.2 Statement of the Problem

In spite of the advances in psychiatry and medicine, people's knowledge and perceptions concerning the etiology of psychiatric disorder and their interaction with the people experiencing psychiatric disorder have not witnessed significant improvement. Social stigma remains a major problem confronting psychiatric patients, friends and families as mental health care professionals are still being held with suspicion while commanding low prestige in the society, compared to their peers in different areas of medicine. The mentally ill patients are routinely subjected to negative treatment or stigmatized as people who should be confined to what Ervin Goffman (1961) described as "Total institution".

The patients are not only physically removed from their familiar surroundings but also subjected to regimented and standardized practices that reduce their individuality. The patients are also striped off their previous self with more conventional identities that portray them as unfit to cohabit with "normal" people. Persons suffering from severe psychiatric problem who are confined to total institutions are particularly vulnerable to a wide range of psychosocial problems, notably stigmatization, labeling and high cost of care. There are other socio-cultural problems which include inefficient service delivery and poor knowledge of community based psychiatric facilities. These affect the healing process and result in the patient's developing a negative self- concept, lack of self-worth and low self-esteem.

This is why the idea of community-based psychiatry is being promoted. Many researches have been conducted on bio-medical model of care. However, the research has focused on social and community-based components of mentally-ill patients, this approach to treatment has made attempt to help curtail the problems of regimenting and stripping patients of their previous identities as explained by Goffman. It is therefore imperative to investigate how the community-based approach to treatment has been addressing these issues of psychosocial concern. The study is planned to fill the vaccum in the literature by assessing the extent of utilisation of the community based psychiatric facilities in the treatment of psychiatry patients in South-western Nigeria.

1.3 Research Questions

This study intends to answer the following questions

a. how do people understand schizophrenic disorder?

b. In what ways do reactions to stigmatization and stereotypes shape the people living with schizophrenic disorder?

c. How does the community-based psychiatry services influence the coping patterns of the people with schizophrenic and their kin?

d. How is the community-based psychiatry deployed in the treatment of schizophrenic disorder?

1.4 Objectives of the Study

The general objective of this study is to determine the effectiveness of the community-based psychiatric system and management of schizophrenic in South-western Nigeria. The specific objectives of the research include:

a. to document peoples' knowledge about schizophrenia,

b. to investigate peoples' reactions to stigma and stereotyping of people with schizophrenia,

c. to identify the influence of the community-based psychiatric services on the coping patterns of the people with schizophrenic disorder and their kin,

d. to examine peoples' utilisation of the community-based psychiatry services and;

e. to assess people's satisfaction about the efficiency of the community-based service in the management of schizophrenic disorder.

1.5 Significance of the study

The information gathered from this study would expand the frontier of knowledge in the management of mental illness through the community based approach in an attempt to minimise the problems of stigmatization and speed up the level of acceptance of the emotionally-ill individuals in South-western Nigeria. The findings would also be valuable in the formulation of government policy. Many years ago, the focus or priority of the government has always been directed towards physical illness, which means that psychiatric cases often come last in the agenda of priority for the government. Meanwhile, it has been calculated that between 20 to 40 per cent of the patients visiting the state hospitals for clinical assistance may be nursing some forms of psychiatric disorders (Leighton et al, 1963). In addition, Odejide (2001) has associated the high (55.2 per cent) of the prevalence of poverty in Nigeria with the development of psychiatric problem. Therefore, a sound mental health policy will arrest the upsurge of psychiatric cases in the country.

The relatives of emotionally-ill individuals and persons who usually suffer stigma will also gain from the findings derived from this research. The data will enable them to plan in terms of the cost and benefit analysis to be derived from this approach. It has been confirmed that the community-based system de-stigmatizes mental illness (Erinosho, 2010). The study will also be an added advantage to the technical knowledge for professionals such as social workers and health educators in the creation of awareness and sensitization about the myths people associate with schizophrenia. In addition, the families with schizophrenia will be able to understand the reality on ground concerning the negative attributes in the context of the community-based psychiatry system.

1.6 Scope of the Study

The study examined the effectiveness of community-based psychiatric system and management of schizophrenia. The focus is to look at the dynamics of relationship in the management of the mentally-ill patient within the context of community- based approach in selected Yoruba ethnic group onf Southwestern Nigeria.

To obtain reliable data on schizophrenia (mental illness), respondents for the study were the caregivers who were the close or blood relations who took care of the patient and patient decision maker in traditional Yoruba household. Their views about the management of mental illness, stigma associated with the problem and its consequences were complimented by the mental health professionals and the community where the facility were located. The determination of the effectiveness of community-based approach in managing mental illness was limited to their knowledge, perceptions about mental illness of the sub-population of that categories. The study did not attempt any clinical or pharmacological of the health condition. The study attempted a clear understanding of how community –based approach can be deploy in the management of schizophrenia as a way of escaping stigma among the sub-population of the society.

1.7 Conceptual clarification

The following terms are operationalized to remove the ambiguity in their usage in this study:

- **Client:** A person who utilises the services or suggestion of a professional person or agency; it is sometimes used interchangeably with the word "patient", especially in a hospital setting.

- **Community-Based Psychiatry:** This is a sub-field of psychiatry that focuses on the evolution of a comprehensive planned programme of psychiatry service for those living in a specified catchment area.
- **Coping Patterns:** These are the specific processes and strategies adopted by an individual in an attempt to contend with a given situation or live with it.
- **De-institutionalization:** The system of changing long period of admission in mental hospital with small secluded community-based psychiatry care for people having psychiatric problem.
- **Hospital-Based Care:** This is an institutionalized setting where people receive care and management of various kinds of ailment, it is a formal kind of arrangement in terms of interrelationship between doctors and patients.
- **Management:** Treatment and care giving to patients in the stage of recuperating from sickness.
- **Mental health:** A state of comparative psychological balance for an individual making an agreeable sensible decisions, adjusting well with self and external forces and ensuring constant tolerable adjustment in the community.
- **Mental illness:** This simply means any kind of emotional, or cognitive problems that distort an individual's capacity to perform properly.
- **Neurosis:** A mild psychiatric health condition that interrupts the social function of an individual.
- **Psychosis:** Severe psychiatric health condition that affects an individual in their day-to-day functioning.
- **Schizophrenia:** This is referred to as "*aaganan*" in Yoruba parlance or understanding.
- **Stigmatization:** This is a negative attribute based on biases and wrong information that is activated by mark of illness.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

Literature review

Literature review was done on the previous works on the community-based psychiatry system and the management of schizophrenia in an attempt to device a right approach to the management of one of the most serious psychiatric conditions with high degree of stigma that pervades the community. On the basis of this, the review was done on the following themes: the community-based psychiatry; origin of the community-based approach; organization of the community-based psychiatry; that is, "modus operandi"; pervasiveness of psychiatric illness in global perspective; stigma and mental illnesses; schizophrenia and sub-types; classification of schizophrenia, causes of schizophrenia; stigma and self-stigma; epidemiology of psychiatric disorder; stigmatization, stereotypes and social change and sental health policy.

Two theoretical perspectives were adopted in this study to account for people's knowledge and quest for the community-based psychiatric system as a better model to psychiatry health care delivery in the community. These were the structural/functionalist and health belief models. While the structural/functionalist theory approaches the study from the group level or from the view of health care givers, the health belief model approaches the study from the individual or community level of care. The conceptual framework for the study presents a synthesis of the theoretical framework and the variables of the study in a diagrammatic representation.

2.1 Origin of the community-based psychiatry

The word community has been commonly used in psychiatry since the second world war. Therefore, no universal consensus regarding its explanation. Though, it is commonly equated as 'community-based settings,' practically, it may result into something from the set-up for affordable psychotheraphy for the need of the people and for total change of human relationship. The availability of outside hospital-based home cares to the emotionally-ill is not a strange subject matter. The Belgian Community-based model at Gheel has made accommodation available within the community funded programmes since the onset of 13th century. (Goldstein, Godemont Marc, 2003).

The first nation to start the de-institutionalization of psychiatry care and to commence psychiatric treatment outside hospital environment is Italy (Russo, Giovanni and Francisco, 2009) and it serves as a prototype of effective services, paving the way for the de-institutionalisation of mental patients (Russo et at, 2009). The Basaglia law started in 1978, and the Italian mental reformation brought to an end the Italian government hospital model in 1998 (Burti, 2001).

The changes were directed towards the slow removal of mental specialist clinic which necessitated a functional community psychiatric health programme. The aim of this model of care was to maintain the old tradition of long-behaviuor ways of seperating the psychiatric patients in hospital environment and to aid their amalgamation into a socially exciting location while considering reducing them to serious social pressure (Tansella, 1986).

The United State of America had withnessed two periods of de-institutionalization. The first movement started in the 1950s and focused on people with emotional problem (Stroman and Duane, 2003). The second wave started after one and half decade when the first movement started and it was focused on persons with a growth problem (e.g. mental deficit). De-institutionalization continues unabated, though the struggles are rising lesser as smaller patients are taken to hospitals.

In India, the beginning of the psychiatric services indicates an exciting movements during the period of four and half decades. The first piority focused on psychiatry institutions, which moved to the establishment of the government clinic mental health sections, which later changed to the community-based model. The notion of the community-based psychiatric service model in European nations is on account of the notion of either community psychiatric service centres (CMHC, USA) or with the globally accessible health delivery like the National Health Service in Europe. In a nutshell, it is the inclusion of a large psychiatry facilities that were available. In India, community-based service has come to perform various functions and relevance. Presently, it is viewed as a policy to give primary psychiatry service to a large number of people, momentarily, with little financial capability. In another dimension, it is an attempt to broaden the services to the grassroot, at the same time, to the establishment of technical facility. This new idea is exciting in that, the way for provision of psychiatry services is via the basic health centres in the local area and by amalgamation with state hospital services. The source of the community mental ideology in India is connected to a number of resolutions of the Association of Psychiatric Society in India. The first conference of Superintendents of Mental Hospitals at Agra in 1960 is well known.

At the beginning of 1964, Satyanand and Hussain carried out psychiatric outreach services at four small towns in Haryana. There were lectures/seminars on good mental health condition to lecturers, block development officers staff, panchayat officer among others. The other important success made were the Madurai seminar on priorities on psychiatric care held in 1971, the WHO training on community work for psychiatric care at Bangalore in 1973 and many other related trainings at Wardha and Trivendrum. All these discussions resulted to the commencement of preliminary survey within the country. The popular out of these was the set up of a prototype of grassroot mental health delivery at Raipur Rani, near Chandigarh and Sakalawara, near Bangalore. This type of model will help to identify emergencies and merge with the way the PHC was organised, the commencement of education seminar including books, utilisation of epidemiological instruments for assessment of the positive outcomes of the intercessions and so on. These first moves led to high interest by the Serious Psychiatric Morbidity study of ICMR since 1979, where the practicability of educating the health workers was evaluated at four locations namely: Bangalore, Baroda, Calcutta and Patiala. All these investigations and past knowledge acquired have made it practicable to contemplate the take off of community-based psychiatric care in a higher level.

The result of all the aforementioned succeses is the National Mental Health Program (NMHP) has been suggested for application by the Central Council of Health and Family Welfare with the following objectives :

1. To maintain access and be available as psychiatric service for everyone,
2. To support implementation of psychiatry knowledge in overall health service and;
3. To encourage village involvement in the psychiatric services development and to support efforts directed to individual in the society.

In the enforcement of the aforementioned aims, the NMHP recommended particular methods like merging the primary psychiatric care into secondary care, right allocation of funds and education of medical staff, para-medical officers, general health workers and anganwadi staffs. This will give assurance that the psychiatric health skills are dissemminated to the grassroot health centres. Since 1982, NMHP out of the other activities that was carried out, various seminar/conferences for state level initiators and managers, state level seminar/conferences for psychiatrists in differents states and seminars on the roles of hospital-based psychologists. Preliminary programs of seminar of health worker have just been introduce in virtually all the states and union boundaries. In March 1988, a training on psychiatry service was organised which suggested the commencement of higher engagement between the clinic and community-based set up. The NMHP was rigorously re-examined in June 1988 and at the end, the National Advisory Group on Mental Health (NAGMH) came into being in August 1988. The NAGMH suggested various things to deliver psychiatric care as part of the general health, welfare and enlightenment cares.

In European countries, the community-based psychistric care is a new dawn and it is being supported by the models for delivery of psychiatric care, as against the more specialized psychiatry institution. The WHO is an advocate of that model, not peculiar to developed nations of the Europe and America, but as well as in the third world nations. (WHO, 2001). In the developed countries, most of the countries are closing down the hospital settings and replacing them with the community-based settings while some general hospitals or tertiary institutions have a unit of psychiatric service. The community-based care consists of mental health care professionals and alternative healers who deliver outpatients and community services and supporting patients in their familiar environment wherever the location is. The basic health service works in connection with the community-based care, with the aspirations that most of the psychiatry problems will be treated in that particular environment by the community-based psychiatry staff who have acquired elementary psychiatry skills. The model usually contains working together between social services in the rural environment and establishment of intimate familiarity with parents, user groups, non-profit organisations and telephone messages and telephone assisted numbers.

The approach does not, therefore, have anything to do with the developing nations of black people in the continent, where virtually psychiatrists and provision of social facility are nothing to write home about, and where families, local traditionals and clergy usually perform the leading roles in caring for people with psychiatric illness. In some nations in Africa, the figures of psychatrist is insignificant. In Ethiopia, for instance, only

18 mental health experts per 77 million population, and there is zero behavioural scientist, absence of professional carer and only one 360-bedded psychiatry institutions cited in the political headquarters of Addis Ababa, (Alem A. 2004). Similarly, presently, all mental health doctors currently serving in Addis Ababa, although, nurses that are specifically trained in aspect of psychiatry render hospital-based service without admission in the regions (Gureje O, Alem A. 2001). The scenario is the same as in other African nations, where large numbers of the psychiatrists perform their services in the urban centres, giving rise to the abandonment of the local communities. (Saxena, Sharan, Garrido, Cumbrera. 2006). Large psychiatric working periods are concentrated to unofficial work as a consequence of poor emolument around the public health sector, continous degenerating of the care accessible to the large numbers of the masses.

WHO has recommended the birth of the community-based psychiatric services via merging of psychiatry service into the well established basic medical service and utilisation of peoples' fund. The model of the basic hospital in black nation of the continent is perfectly well-set up, but, with factors limiting the health desired outcome. The structure for basic hospital care is primarly hinged on two or three steps. Nearest to the locality is the health post, this entails one or two staff with little knowledge delivering primary health and public health service for the number of 1000-5000 people. Following that order is the health facilities, where accredited nurses and probably physicians are serving with a designated area of 20,000-100,000 people. After that level, there are zone clinics and area health institutions, where most of the time, there is availability of a professional or other specialized professionals psychiatric service staff, but usually always unavailable.(Saxena S, Sharan P, Garrido Cumbrera M. 2006).

The bedrock of care for the emotionally disturbed patients in pure African communities is not, however, utilised via basic medical service at the moment. In Ethiopia, for instance, only 33.4% of individuals with continuous severe depressive illness had visited public medical care in the past three months (Mogga, Prince, Alem,2006). Relatives and people around, thus provide the biggest part of the care. Making comparison with the developed countries, African communities are very much united, with both serious family pressure and higher social assistance. Most often here are large family members to confide in, and specially critically ill individuals are most of the time staying in their extended home, however, few of the emotionally-ill individuals may decide to roam about the streets, often becoming a vagrant. Except in more difficult issues of dangerous or acutely abnormal attitudes, or when the patients finance are depleted or exhausted, will psychologically deranged individuals be isolated from their relatives, although they might restrict his/her movement totally. Generally, however, it is the parent, and to a smaller extent people within the localities, who stand as the bedrock for psychiatric service in the African communities.

Famous local scholars in psychiatry took positive and hope rising ideas to join hands with the local health care providers and to reconstruct cares to the Africans. The Aro village model established by Adeoye Lambo at Abeokuta, Nigeria in 1954 is a well known one. Other similarities are from scholars like Henri Collomb in Senegal and Margaret Field in Ghana, who equally evolved collaborations with the local medicine man, and of Tigani El Mahi and Taha Baasher in Sudan, that set up good team work with the Muslim leaders to help in the recognition and movement to the secondary care and removal of stigmatization of individuals with psychiatric disorder.

2.2 Organization of community-based psychiatry

There were various kinds of community mental health programmes. These are: day and mobile psychiatric services that may be delivered at the grassroot level of facilities or in the out-patient clinics of state hospitals, specific community out-reach psychiatric care facilities, community-based approach mental promotion or prevention scheme, and mental care in major or general hospital. This setting is a complete difference from the psychiatry service in a local health centre which is usually characterised as a complete institution with all the negative labels (Goffman, 1961). Goffman believes that such psychiatric hospitals are likely going to have local sub-culture that increases labeling and stigma with serious repercursions for relapse.

The ideological change from the hospital-based service to the community-based psychiatric care is located on the expected gains of the latter. The gains could be social, spatial, cultural, psychological, monetary, and therapeutic. The community-based model utilises the assistant of the siblings in care and traditionally embedded rituals as well as variations in the treatment of the clients. Asides, the approach of service could be reduction in the cost of care and nearness to patients. For instance, the “Aro Village,’’or an Aro community-based model, was set up around communities in Aro, nearness to Aro Neuropsychiatric hospital, Abeokuta. Clients were managed in the environment that has proximity to their familiar home surroundings. The patients stayed in the local settlements with their family member and community dwellers through out the treatment period. This explains that the integration from care back into the local environment when discharged was no more as strenous as from hospital service to the local area (Erinosho, 1978).

This model was planned to reduce negative vibes that is usually related with hospital management and reduction in personnel cost. This model also identified the possible contribution of alternative healers to the management of the emotionally- ill clients, because it removed the phobia of patients who thought they were afflicted or their emotional problem was due to evil forces. Sacrifices for patients with strong beliefs in magic and witchcraft are believed to be potent (Erinosho, 1978).

2.3 Community–based psychiatry services

Community-based psychiatric service is a sub-field of psychiatry that focuses its attention with the development of details and co-ordinated programme of psychiatric services on residents of particular location (Mosby's 2009) while a community-based psychiatric service is "a non-centralised pattern of psychiatry service or other service for individuals with mental disorders".

Community psychiatric services popularly referred to as Community Mental Health Teams (CMHT) in Great Britain manage people with psychiatric illnesses (psychiatric disorder or developmental problems) in a home arrangement, instead of a mental hospital (confirnment/asylum). The various forms of community psychiatry cares differ based on the country in which the cares are delivered. It depicts a model of service in the client's locality, not a particular centre such as a clinic, it is the first point of health service for people living with psychiatric disorder.

The aims of community psychiatry care usually include details services than simply rendering non-admitting psychiatric services. Community care consists of: low housing schemes with complete or temporary supervision (including halfway homes), mental health wards of state hospitals (including temporary hospitalisation), community medical care, day centres or recreational facilities, community psychiatry facilities, and voluntary organisations for psychiatric service. The care could be delivered by government, non-govermental organisations and professional groups in the area of psychiatric service, including professionalised groups delivery health cares throughout a cacthment location, such as strong-willed community management and onset of psychosis groups. This could be delivered by individual or helping organisations. It can be based on group assistance and the users/survivor/ex-patient movement (Bentley, 1994).

WHO (2007) asserted that community psychiatric care are easy to locate, affordable and potent, reduce social isolation, and are proned to produce fewer expectations for the segregation and abuse of fundamental rights that were usually witnessed in psychiatric clinics. However, WHO claimed that in some nations, the downsizing of psychiatric institutions has not been followed by the establishment of community cares, abandoning a service empty with large numbers of people not receiving any care.

The idea of community psychistric service had begun in Nigeria (Osborne, 1969). Aro village mental health community system was established around 1950s by the foremost African Psychiatrist. The idea was to keep the patients very close to their familiar settings always and engaging important relative members in the care of the sick person in and outside the village heath facility. Clients were given employments in appropriate skills or vocations in the village settings. An assesment investigation revealed that the village model was excellent and functional (Boroffka and Olatawura, 1997). The same therapeutic medical care were experimented at Ibarapa area of Oyo and the capital city of Ogun state, all in southWestern Nigeria (Ayorinde and Erinoso, 1980).

Community-based mental care practice has gained increased credence in recent years in the country. This has been underscored by few numbers of health centres, psychiatrists and other professionals, with focusing of service in the barely few available mental institutions and mental wards of some secondary and tertiary health facilities (Odejide and Ohaeri 1997; Aina, Ladapo, Lawal, and Owoeye, 2007) Equally, with increase awareness among the people, this resulted to increased patronage of the few psychiatric facilities causing pressure on the available care centers, most importantly in other patients centres (Osibogun 2004; Boroffka, 1996). It ended up into the current requests in Nigeria for the pressure on hospitalisation in favour of the commuinty-based system as demonstrated in the developed nations (Gureje, Odejide, and Acha, 1995; Ladapo, Aina, Lawal, Adebiyi, Olomu, Aina, 2008; Amering, Stastny, Hopper, 2005; Macpherson, Dix, Morgan, 2005; and Ahanotu, Onyeizugbo, 2007).The benefits of the community-based cares are well recognized and based on profound study outcome of functionalities. (Chatterjee, Patel, Chatterjee, Weiss. 2003; Gureje, Chisholm, Kola, Lasebikan, Saxena, 2007). The 2001 World Health Report, Mental Health: New Understanding, New Hope

(WHO 2001) recommended changing traditional big psychiatry setting with the community-based social work care, which can deliver positive and immediate service.

The issues prevalent in the management of psychiatric illnesses is more importantly related to the village-level factors (Allen, Balfour, Bell, Marmot, 2014). The presence and collaboration of psychiatric services into villages can enhance utilisation, endorsement, finanacial capability, and scale-up of cares, as well as encouraging compliance to the management and speeding up of the tendency of good clinical results. (Druss, Esenwein, Compton, Rask, Zhao, Parker, 2010; Marmot, Friel, Bell, Houweling, Taylor, 2008; Goldberg, Huxley, 2012). In addition, the community cares can perform very important roles in encouraging psychiatry service sensitisation, lessening label and segregation, assisting recuperation and social engagement and avoiding of psychiatric disorders (Evans-Lacko, Corker, Williams, Henderson, Thornicroft, 2014; Jorm, 2012; Brekke, Kay, Lee, Green, 2005).

The Global Action Blue Prints and Procedures promotes the community psychiatric service. WHO, Mental Health Action Blue Print for 2013–2020 called for the delivery of wholistic, collaborative psychiatric service and social service plus promotion and control programs in villages merging the approaches and involvement of patients and relatives.WHO, 2013). The WHO Quality Rights Toolkit needs the set up of the community-based, emergency services WHO, 2012). Article 19 of the United Nations Convention on the rights of individuals with deficiency agrees that individuals with difficulties, including counselling difficulties should be delivered with assistance to live freely in the local environment, United Nations, 2006).

The World Psychiatric Association's (WPA) advice on community psychiatric service features community-focused service as having a number of people and government health attentions, community-based case evidence, cares presence within mid-day journey, involvement in taking a decision, individual assistance and friend's assistance for patients, treatment at the grassroot service centres and communities, scale up care, specialist monitoring, integration with non-profit organizations, and connections throughout services, communities, and traditional and faith-based experts.(Thornicroft, Alem, Antunes, Santos, Barley, Drake, Gregorio, Hanlon, Ito,Latimer, Law, et al. 2010; Thornicroft, Deb, Henderson, 2016). Equally, the third publication of the World Bank's Disease Control Priorities suggested community-based approaches for the these psychiatric service aspects: educating the primary care level of health care for quick recognition and provision of low-intensity psychosocial help, creating group and parent peers, creating sensitisation about dangerous chemical or drug use, enforcing office problem reduction schemes, encouraging community-based reintegration and introducing community schemes for young child's psychiatric problems such as family monitoring programs with focus on attention during pre-adulthood proper upbringing and life experiences for young children, (Patel, Chisholm, Parikh, Charlson, Degenhardt, Dua, Ferrari, Hyman, Laxminarayan, Levin, et al., 2016).

The necessitity of the community psychiatric service may have high importance in developing nations compared to developed nations. The vaccum between the problem of psychiatric illnesses and present reality services is that there is a wide-gap in developing nations. Meanwhile, one out of five individuals living with depression has access to little psychiatric care in developed countries, one out of 10 access care in developed nations, and one out of 27 in developing nations. (Thornicroft, Chatterji, Evans-Lacko, Gruber, Sampson, Aguilar-Gaxiola, Al-Hamzawi, Alonso, Andrade, Borges, et al., 2017). The situation has been similarly worse for serious psychiatric illness, where it is not uncommon for individuals with psychosis to spend above half a decade with continuous psychosis before research-based management is commenced.(Thirthalli, Channaveer achari, Subbakrishna, Cottler, Varghese, Gangadhar, 2011). The community approaches, such as the home, prayer ground, local healing shrines, and other faith-based churches or mosque, individuals with serious psychiatric disorder may have his or her movement restricted, kept in compulsory hide-out, and victim of sexual harrasment and other types of cheating against psychiatric patients (Drew, Funk, Tang, Lamichhane, Chávez, Katontoka, 2011; Asher, Fekadu, Teferra,De Silva, Pathare,Hanlon, 2017; Ofori-Atta, Attafuah,Jack, Baning, Rosenheck, 2018).Therefore, community psychiatric service to communities is important for peoples' rights safe guild. Good and functional facility-based mental health care are usually not enough to solve these negative social conditions of psychiatric service such as monetary inequality, tribal nepotism, endanger to tragic events, and supression of peoples' rights (Drew,et al, 2011; Patel, Burns, Dhingra,Tarver,Kohrt, Lund, 2018; . Lund, Stansfeld, De Silva, 2014).

Furthermore, the high degree of stigma against people living with psychiatric disorder among the population and mental health staff is a problem that requires specific psychiatric services (Semrau, Evans-Lacko, Koschorke, Ashenafi, Thornicroft, 2015). Another problem includes : lack of proof on investigation and discovery programs to recognize individuals requiring service, logistic problems to get to health location, paucity of trained health workers in psychiatric service, and non provision of psychological treatments at health centres. (Hanlon, Luitel, Kathree, Murhar, Shrivasta, Medhin, Ssebunnya, Fekadu, Shidhaye, Petersen, et al. 2014; Gwaikolo, Kohrt, Cooper, 2017; Angdembe, Kohrt, Jordans, Rimal, Luitel, 2017). With all these problems, it is crucial to find out how to properly and functionally work in communities and with community-based service professionals for psychiatric service delivery in developing countries.

2.4 The operational mode of the community-based psychiatry

Domesticating from “Aro Model” community-oriented approach, by establishing such proto-types at primary health care centres, particularly in the South-western Nigeria, and the whole country as a whole will make mental healthcare delivery in Nigeria more effective. This can be achieved by utilising the existing basic health care facilities and structures following that the mental health policy has been incorporated as the 9th components of the basic health care policy in Nigeria.The clinic organizes on weekly basis or bi-monthly, the training of medical officers of the primary health care centres, community health officers (Nurse), community health extension workers who were trained by a visiting psychiatrist and other existing basic health care personnel who have received education on mental health care for quick identification, cure of emotional –ill persons, then referral to a nearby psychiatric institution if the case is so serious. The other core staff members in the clinic are the community health officers (CHO), community health extension workers (CHEW), volunteer health workers VHW), health technicians (e.g. Pharmacy Technician) and traditional birth attendants (TBA). The community elders, the local healers and the clergy are also involved in the treatment process in form of collaborative struggles to enhance the health situations of clients.

2.5 Mental illness

There are some proofs that the understanding of disorder and implication of social responses may dictate the treatment of serious psychiatric disorder, independently of any thinking of orthodox treatment. Truely, it is now universally agreed that psychosis has a good management in most of the African nations than in the developed industrialised nations (Cohen, 1992). The few ratio of ‘poor result of patients in some growing nations of Africa established in the WHO global preliminary investigation of psychosis and the parameters of result carried out (Sartorius et al., 1986), have been described in the perspectives of the effect of variations in ascribing person's tasks for the disorder (Cooper & Sartorius, 1977; Warner, 2004) and various ideas of individual recognition (Horwitz, 1982). The importance rested on oneself in industrialised, mostly metropolitant way of life claimed to underline the social extrusion of long duration of mentally-ill persons who accept personal duties for their disorder, which results in a poor treatment..

Warner (2004) suggested that the etiologies of psychosis are linked to sex functions, levels and social identifications and to job changes. More particularly, job loss by the psychiatric patients in capitalist countries lead to a failure of self-confidence, rank and individual determination. In third world nations, the emotionally-ill person is less vulnerable to be ejected on account of a graduated housing of work to capability. Many scholars have advocated that developing nations are fairly more agreeable and peaceful, with definite social functions, free from making individual decision, and have categorisations of disorder that label forces outside this world as the etiology to the disorder (Waxler, 1979). Furthermore, small families which are more commonly the kind of system in developed nations claimed to be less acceptance of psychiatric disorder than the larger homes (El-Islam, 1979; Lefley, 1990; Cooper and Sartorius, 1977). This suggests that in non-industrialised nations weather condition for psychotic persons is, assisted and well received and (with) small chance of long period of neglect, isolation, isolation and institutionalization. The styles of quick family assistance to psychosis that postulate a poorer result within the developed nations may also define this divergency in treatment between nations in general (Leffet al., 1987).

There has been increase in the public recognition that parents are the first source of assistance for individuals with mental deficit and serious psychiatric disorder (Francell, Conn and Gray, 2008). Although, the research based evidence on the circumstances of parents who give continuous care to a family member with a deficit is growing (Cook and Pickett, 2007; Fisher, Benson and Tessler, 2000; Heller and Factor, 2001; Lefley, 2007; Seltzer and Krauss, 2004), small cases are aware about the implications on mature brothers or sisters in these families.With the reasoning that family care will definitely come to an end when the both parent pass on or become inactive, it is crucial to have knowledge about the potential responsibilty of siblings as the next categories of caregivers. Studies on the mature brother or sister's relationship when neither sibling has a deficit has displayed the special rank taking over by relatives among the various kinds of family links. Adult-sibling relationships are longer in duration than any other kinship ties (Cicirelli, 2002), based on a usual family life space (Ross and Dalton, 1981), and egalitarian (Avioli, 2008). These interactions tend to be characterised by supportiveness, emphaty and mutual love (Cicirelli, 2002); although, these styles are affected by sex (Rosenberg, 1982), social level (Brady and Noberini, 2007) and stage of life (Goetting, 2006).

There are few series of researches of the nature of the links between mature siblings when one sibling has a deficit, or of the consequences of sibling relationships for future care giving options (Horwitz, 2003; Krauss, Seltzer, Gordon, and Friedman, 2006; Reinhard and Horwitz, 2005; Riebsehleger, 2001; Seltzer, Begun, Seltzer and Krauss, 2001). The available study documented and similarly the individual histories dictate serious complex and many different sibling relationships and experiences, which differ across different levels of the life process, and which are coloured to a certain degree by the milieu of the family (Griffiths and Unger, 2004; Horwitz, Tessler, Fisher and Gamache, 2002; Berman, 2003). It is also a fact that the quality of the relationship between a sibling and his or her brother or sister with a deficit is affected largely by the explanations attached by the family irrespective of the nature of the deficit, the responses of parents to the problems of the deficit and the general styles of family living (Begun, 2006; Johnson, 2008; Swados, 2001; Zetlin, 2006).

There are three central contextual variations in the family orientations of adult siblings of individuals with serious psychiatric disorder as compared with mature siblings of individuals with mental-deficit. They include the exact period of the diagnosis in the family life circle, the fore-seeability of the route of the deficit and the stage of societal label and assistance for those with developmental deficit. First, the confirmation of mental deficit always happens at a largely beginning stage of family life. Specifically, individuals with mental deficit are usually known at the time of delivery or at a tender age. Consequently, many relatives of individuals with mental deficit are consistently aware that their siblings have serious deficits. Their begining years contained the satisfactions and problems of people living with a clear “difference in the family” (Featherstone, 2006), and most brothers or sisters, especially sisters, are push into ranks of acting as a parent (Stoneman, Brody, Davis and Crapps, 2007; Wilson, Blacher and Baker, 2001). Blood relatives of individuals with mental deficit, therefore, usually have a sibling relationships which are less egalitarian than normal sibling relationships, and in which family responsibilties for sibling care giving may have been obvious since beginning of childhood (Begun, 1989).

In contrast to the foregoing, severe psychiatric disorder is more usually confirmed during adolescence or pre- adulthood. Siblings of adults with psychiatric disorder usually utilised their younger period and adolescence more or less unknown of the impending psychiatric disorder and, hence, were more vulnerable to have created normative outcomes of the sibling relationship (Judge, 2004). Granted, the eventual confirmation of psychiatric disorder, in retrospect, may assist to clarify past episodes, but the prevailing family area during the sibling's younger age generally is given less attention on the likelyhood of deficit than on the sustainance of normative family connections. Second, the route of mental deficit is uniquely differ from the route of severe emotional disorder.

Psychiatric illness is characterised by instability on daily performance (Eyman and Widaman, 2007), even if it is at an agreement level. The sibling's familiarity with the capabilities and needs of a siblings with mental deficit may help to sustain a predictable relationship between them. Contrarily, individuals with severe emotional disorder are due to periodic relapse that may weaken the wellness of the nucleated and the extended family (Beeler, Cohler, Pickett and Cook, 2003). For instance, for the adult siblings who no longer stay together with their sibling, the lack of assurance in what can be hopeful from the sibling with emotional illness in everyday life can risk the maintenance of effective family relationships. Thus, the route of mental deficit is more welcomed in community than an individual with emotional disorder.

This difference is reflected in many ways, not the least of which is the level of public services and supports available to them. Although, individuals with mental deficit differ in the level at which their care desires are adequately met, overall, they have opportunity to various arrays of government finance supports and cares (Braddock, Hemp, Bachelder and Fujiura, 2005), including residential, day, therapeutic, respite, and social services. Persons with severe psychiatric disorder have far fewer services to utilise, and are at a much higher tendency of having zero service available, and even being without home than those with mental retardation (Rossi, Wright, Fisher and Willis, 2007). For siblings, the various community assistance and presence of cares may have large consequences for present and later care giving functions, specifically following the demise of their biological parents.

Uniquely, siblings of individuals with mental deficit can imagine or assume roles for their siblings in togetherness with a fairly well-functional system of cares. Siblings of individuals with psychiatric disorder, however, must realistically assume that they will have to manage more or less alone in the meaning of a much more fragmented system of cares. Although, families of elderly persons with mental deficit and families of elderly persons with severe psychiatric disorder face distinct challenges arising from these differences in the care giving contexts. There are also similarities between the two groups. Both groups of siblings face certain death of their parents in the future, which may place at least one sibling in the family in a position of assuming roles for the siblings with the deficit (Gordon, Seltzer and Krauss, 2006; Horwitz, 2003). The two categories of siblings face the prospect of merging the desires of the siblings with the constraints and demands of their own lifestyles and responsibilities, which may well be considerable (Krauss et al, 2006). Both groups of siblings fear the possibility of transmission of the disability to their own offspring (Harris, 2008; Judge, 2004; Marsh, 2002). Thus, the range of effects on the non-disabled siblings may be substantial in both groups; although, the intensity or valence attributed to these effects may differ as outcome of the manner of the disabilities.

On the bases of these contextual differences and similarities, the study posed three research questions. A first inquiry might be into the level at which both categories of siblings differ in their perceptions of how pervasively their siblings with the deficit has distorted their adult life. Then, whether or not the knowledge of having a sibling with a deficit has been mostly positive or mostly negative may also be examined. In this connection, it may be hypothesised that siblings of elderly person with mental retardations would report that more aspects of their lives have been distorted by their siblings deficit than siblings of adults with severe psychiatric disorder. One may base this hypothesis on the difference in the process of the sibling’s life route when the brother or sister’s disability was diagnosed.

At the begining of mental deficit, blood relations learn from younger age that significant life resolutions are made in the case of having a sibling with a deficit. In contrast, the timing of severe psychiatric disorder occurs much later in the sibling’s development, typically at a time when many siblings have begun to establish independence from their family. Thus, adult family members with severe emotional disorder may less vulnerable to the effects of deficit during their growing period than siblings of adults with mental deficit. Although, it is expected that siblings with deficit would have more pervasive impacts on life decisions than siblings of adults with mental deficit, it is hypothesised that siblings of elderly persons with severe psychiatric disorder would report more negative appraisals of the sibling’s experience.

Studies carried out on the personal experiences written by family members of mature individuals with emotional disorder narrate the heavy load they suffer, including breaking down in family and social connections, bereavement on the death of family member usually has intimacy with, and emotions of rebuke (Johnson, 2008; Marsh, Appleby, Dickens et al, 2003; Marsh, Dickens, Koeske, et al, 2004; Moorman, 2002). In contrast, the stability of mental retardation and its more limited degree of disruption of family life is expected to result in a considerably less negative set of effects on the sibling experience (Stoneman and Brody, 2003).

Regarding the frequency of contact, individual experiences by family members of persons with emotional issues indicate that many adjust with feelings of pain, unhappiness, loss and stigma that are linked with psychiatric disorder by avoiding parents, for instance, at the onset of the crisis (Johnson, 2008; Moornian, 2002). Grace, Camilleri and Ayres (2003) discovered in their samples that nearly, one third of the siblings of mature individuals with emotional problem coped by cutting off contact with their families, and another 20% limited their involvement to crisis situations. Nevertheless, some degree of contact tends to be common, as reported by Horwitz (2003), who found that majority of siblings in his sample saw the family members with serious emotional problem about once a month, and another quarter reported weekly contact. On the other side, several studies on contact between mature individuals and their blood relation with deficit revealed a upper level of in-person and telephone details, usually favoured by parental engagement with the family member (Griffiths and Unger, 2004; Seltzer, Begun, Seltzer and Krauss, 2001).

Thus, it may be hypothesised that severe psychiatric disorder would have less contact with their siblings than siblings of adults with mental deficit. Although, Horwitz (2003) discovered that most of the siblings of elderly persons living with serious psychiatric disorder felt somewhat nearness to their sick brother or sister, (Pruchno, Patrick and Burant (2006) reported that relatives of erderly persons with developmental problems enjoined good affective connections with their siblings than of adults with schizophrenia. Mature family members with emotional disorder face serious crisis in ensuring close contact because of the problems in individual engagement that are related with the symptoms of severe emotional problem. Also, it is expected that siblings may attempt to place some emotional distance between each other and their relatives with psychiatric disorder to minimise the bad effects on their lives; this restriction, in turn, will limit the degree of closeness in the sibling relationships. The available evidence about the level of emotional closeness in adult sibling pairs when one has mental deficit suggests that positive sentiment persists into adulthood (Begun, 2005; Pruchno et al, 2006).Therefore, it was hypothesised that relatives of elderly persons with serious psychiatric problem will announce less closeness in the current link than relatives of elderly persons with mental retardation. One evidence-based question asked is “what are the predictors of emotional well-being in mature family members with mental retardation and mature family members with emotional illness?” For this research question, it is hypothesised that three aspects of the sibling relationship would be critical to the psychological well-being of the sibling: (1) his or her feelings of emotional closeness to the siblings with the deficit; (2) the sibling’s perception of the pervasiveness of the impact of having a sibling with a deficit on his or her own life, and; (3) the sibling’s appraisal of whether having a family member with a deficit has been majorly a good or mostly a negative experience.

For the sample of siblings of adults with mental deficit, it is expected that having a close relationship with the siblings will be a good determinant of the sibling’s emotional well-being, as such, a relationship will contribute to the non-disabled sibling’s feeling of being valued and having a purpose in life. In addition, the timing of the diagnosis of mental retardation in the sibling’s life course contributes to the likelihood that the closeness of the relationship will be predictive of his or her psychological well-being. That is, as most siblings in the sampled population were children when the brother or sister was diagnosed, their early psychological development and identity formation were inextricably linked with a sibling with retardation (Gamble and Woulbroun, 2003). It is likely that the non- disabled sibling’s psychological well-being remains vulnerable to variation in a better nature of the sibling’s connection, even into adulthood. It was hypothesised, therefore, that siblings of adults with mental deficit that experience greater closeness in the relationship with their siblings would report higher degree of psychological well-being.

A different pattern was expected for mature family members with severe psychiatric disoder. The gains of having an intimate relationship may be counter-balanced by the values incurred in attempt to ensure an intimate relationship with a family member with emotional disorder. These values are many and vary from feelings of no hope because there is no much a person can give to reduce the agony of a loved one, going about with high levels of unpredictability because the manner of emotional disorder is undetermined (Wasow, 2005). Thus, it may be hypothesised that for siblings of adults with severe psychiatric disorder, the closeness of the relationship would be unrelated to the sibling’s level of emotional well-being. For both groups of siblings, it was further expected that the pervasiveness of the impact of the siblings with disabilities on the sibling’s life would influence the sibling’s level of psychological well-being. However, the expectation was that the direction of this influence would depend on whether the sibling’s evaluation of the experience of having a siblings with a deficit is mostly good or mostly negative. It was hypothesised that if the siblings viewed this experience as mostly positive, perceiving more pervasive effects of the brother or sister would magnify the good effects on the sibling's emotional well-being. However, if the siblings viewed the experience as mostly negative, perceiving more pervasive effects would predict yet, poorer well-being in the sibling.

On a general note and with regards to this study, there is need to narrow down to specific aspects of the mental illnesses, especially the one that shows high degree of societal stigmatisation which is referred to as schizophrenia.

2.6 Prevalence of mental illness in global perspective

World Health Organization conducted a study of 26 countries in all the continents of the world on global classification of Disease and Diagnostic System Manual (DSM) criteria (WHO, 2014). Of the disorders examined, anxiety disorders happens to be widely frequent in all but one nation (prevalence before one year duration of 2.4 to 18.2 per cent) and mood disorders follows as the most common in all but two nations (one year prevalence of 0.8 to 9.6 per cent), while drug abuse (0.l to 6.4 per cent) and impulse-control disorders (0.0 to 6.8 per cent) were persistently low frequent (Demyttenaere, Bruffaerts and Posada-Villa 2004). The United State, Colombia, the Netherlands and Ukraine likely to have greater incidences accounts throughout most types of disorders, while Nigeria, Shanghai and Italy were persistently low, and widespread was lower in Middle East nations in overall. Issues of disorders were measured as minor (prevalence of 1.8 to 9.7 percent), medium (prevalence of 0.5 to 9.4 per cent) and severe (prevalence of 0.4 to7.7 per cent) (Demyttenaere et al, 2004).

World Health Organization made a publication all over the world the occurence and widespread accounts of individual illnesses. Obsessive-compulsive disorder is two to three times as frequent in Latin America, Africa and Europe as in Asia and Oceania (Ayuso-Mateo and Luis, 2000; Demyttenaere, Bruffaerts and Posada-Villa, 2004). Psychosis seems to be the most frequent in Japan , Oceania and Southeastern Europe and least frequent in Africa (Ayuso-Mateo and Jose Luis, 2000). Bipolar disorder and anxiety disorder have equal rates at the global level. There are close to 54 million people globally with serious emotional disorders such as psychosis and bipolar affective disorder (manic-depressive illness) (WHO, 2007). Further more, 154 million people undergo pains from depression. People living in the third world countries unequally suffered. Emotional illnesses are continuously wide spread in the third world countries as a result of resistants poor economic situations, the demographic movement, man made crisis or conflicts in weak states and natural destruction, more than 50% of third world countries fail to make provision in term of care for persons with emotional illnesses in the community (Warner, 2004). These emotional illnesses are significantly difficult, not only to those with emotional problem, but also their carers, particularly the parents, given the absence of mental health resources found in third world countries. As a result, 90% of patients with major depressive disorders in developing countries are inadequately treated (WHO, 2007).

In Nigeria, the large number of people living with psychiatric burden in the community are commonly attended to at the first point of care (Goldberg, Kay, and Thompson,1976; Barrett, Barrett, Oxman, and Gerber, 1988;(Schulberg, 1991; Badamgarav, Weingarten, Henning et al., 2003; Halverson and Chan, 2004), with prevalence levels varies from 16 to 43% of general practice users (Goldberg, et al, 1976; Varma and Azhar, 1995;Weich and Lewis, 1998; Ansseau, Dierick, Buntinkx et al., 2004). In different nations at the global level, the pervasiveness of psychiatric illnesses in the first level of care has been comprehensively examined and, in elders, falls between 10% and 60% (Ansseau, Dierick, Buntinkx et al., 2004; Araya, Wynn, Leonard, and Lewis, 1994). The most prevalent psychiatric illnesses attending basic health care settings are: depression, 5% to 20% (Ansseau, Fischler, Dierick, Mignon, and Leyman, 2005), generalized fear disorder, 4 per cent to 15 per cent (Kroenke, Spitzer, Williams, Monahan, and 2007), harmful alcohol intake and dependence, 5% to 15% (Agabio, Nioi, Serra, Valle, and Gessa,2006), and somatization disorders, 5% to 11% (Duran, Sanders, Skipper et al., 2004).

Researches of young and adults have shown a high statistical rate of psychiatric illnesses in the first level of health care settings. For instance, about 20 per cent of young person and adults have been diagnosed of psychiatric problems in Ibadan, Nigeria. (Gureje, Omigbodun, Gater, Acha, Ikuesan, and Morris, 1994), 30% of teenage from ages 6 to 11 years in Valencia, Spain, Pedreira and Sardinero,2003), and 43 per cent of teenage ages 6 to 18 years in United Arab Emirates (Eapen, Al-Sabosy, Saeed, and Sabri, 2004).The pervasiveness of psychiatric illness tends to be high as 33 per cent in the adult age bracket, treated at the grassroot level of care (Almeida, Forlenza, Costa Lima et al.,1997; Olafsdottir, Marcusson, and Skoog, 2001). The most frequently diagnoses are depression and dementia (Argyriadou, Melissopoulou, Krania, Karagiannidou,Vlachonicolis, and Lionis, 2001).

Several other investigations at the basic levels of care have calculated the pervasiveness of other particular psychiatric illness, on account of their health importance to the populace. The pervasiveness of afterbirth depression was 14 per cent in Turkey (Danaci, Dinc, Deveci, en, and Icelli,2002), and 19 per cent in Nigeria (Abiodun,2006). In spite of this high pervasiveness, basic health care doctors have problems in diagnosing close to one-third of persons with psychiatric disorders, (Badamgarav, Weingarten, Henning et al.,2003; Indran,1994; Deva, 1997). This can be explained by several factors, for instance information showing that patients looking for care at the grassroot level of care tend to display their emotional problem, thereby showing the medical signs instead of hidden emotional signs (Scicchitano, Lovell, Pearce, Marley, and Pilowsky, 1996). Moreover, patients medical history is usually taken with self-approval and little secrecy, thereby, not allowing clients divulg very touching parts of their emotional problem (Varma and Azhar, 1995). In addition, the doctors at the grassroot level have problems in confirming and managing mental illnesses (Pini, Berardi, Rucci et al,1997; Spitzer, Williams, Kroenke et al., 1994) and often have small time to get a mental history(Spitzer, et al,1994).

Epidemiological studies and international screening for mental illneses in basic health care can enhance the identification rate and may be supported by disallowing serious repercursions of undetected and untreated mental morbidity. However, the prevalence of psychiatric disorders is on the increase in Nigeria. According to WHO (2007), there were 20 per cent of Nigerians that were affected psychologically within an estimates of 150 million. This simply implies that about 30 million Nigerians are burdened by psychiatric illnesses (Attoh, 2013).

Mental health professionals are particularly at risk of experiencing psychotic disorder due to the nature of their profession, which is often stressful and of features of their call-duty hours, shift work, irregular work hours, and a high demanding environment, (Ahmed, Devitt, Keshet, Spicer, Imrie, Feldman, et al. 2014; Keller. 2014; Ripp, Privitera, West, Leiter, Logio, Shapiro, et al. 2017). In North America, several doctors work in private hospitals with no access to formal government assistance, which predicted higher cases of social separation Dyrbye, Shanafelt. 2011; McClafferty, Brown. 2015).

Researches on physicians' mental health is increasing, partly due to general worries about mental well-being of health care workers and partly due to recognition that health care workers worldwide are not happy with their profession, which predicted a burnout and attrition from the workforce Ripp, Privitera, West, Leiter, Logio, Shapiro, et al. 2017; Sikka, Morath, Leape, 2015. As a result, emphasis have been made worldwide to enhance doctors mental health and wellness, which is known as "The Quadruple Aim." Sikka, Morath, Leape. 2015. While researches on mental health is growing, however, it has not been systematically summarized. This makes it difficulty to recognise what is being done to enhance doctors wellbeing and which way out are specifically encouraging (Cass, Duska, Blank, Cheng, NC dP, Frederick, et al. 2016; Ripp, Privitera, West, Leiter, Logio, Shapiro, et al. 2017; Shiralkar, Harris, Eddins-Folensbee, Coverdale, 2013; West, Dyrbye, Erwin, Shanafelt, 2016; Williams, Tricomi, Gupta, Janise, 2015).

Currently, there are major conflict-induced humanitarian crises in numerous countries, including Afghanistan, Iraq, Nigeria, Somalia, South Sudan, Syria, and Yemen. United Nation accounts indicated that more than 68·6 million people worldwide have been compulsorily forcibly relocated by violence and conflict, the highest number of people affected since second World War (United Nations Office, 2019). This increase in people affected by conflict coincides with a growing interest in mental health, as exemplified by the recently approved 10-year extension of the Mental Health Action Plan by 194 WHO member states. (WHO, 2013). Interest is especially high in the mental health of people affected by humanitarian emergencies (WHO, 2013).

In 2005, WHO accounted that the prevalence of mental disorders among people affected by humanitarian emergencies. (van Ommeren M, Saxena, Saraceno B, 2005). These figures have been constantly repeated in policy documents, (WHO, 2013; United Nation Office, 2013; World Bank, 2017). News media, Miller G. 2005). And appeals and funding proposals for help for people living through the world's worst crises. WHO emphasised that these figures represented averages across emergency situations and that observed prevalence estimates would differ by affected population and evaluation approach. (van Ommeren, Saxena, Saraceno, 2005). However, WHO's 2005 accounts were not based on applicable systematic reviews of proof.

Epidemiological researches in war zone areas typically present different outcomes, making their interpretation difficult (Rodin, van Ommeren M. 2009). And their statistical

heterogeneity is extremely on the rise (Steel, Chey, Silove, Marnane, Bryant, van Ommeren. 2009; Charlson FJ, Flaxman, Ferrari, Vos, Steel, Whiteford, 2016). WHO accounts of the prevalence of mental illnesses in war zone area affected populations by current scientific literature reviews for after war crises and depression
Epidemiological studies and international screening for mental illneses in basic health care can enhance the identification rate and may be supported by disallowing serious repercursions of undetected and untreated mental morbidity. However, the prevalence of psychiatric disorders is on the increase in Nigeria. According to WHO (2007), there were 20 per cent of Nigerians that were affected psychologically within an estimates of 150 million. This simply implies that about 30 million Nigerians are burdened by psychiatric illnesses (Attoh, 2013).

2.7 Epidemiology of mental illness

Epidemiology is the spread of diseases within a given number of people both in space and in time and of the factors that encourage this spreading. Studies have shown few important ethnic racial variations in the rates of psychiatric disorder unlike with regard to affective illnesses (depression or manic crisis). These disorders affect African Americans more easily and Hispanics less often than they affect non-Hispanic whites, without regards to individuals' social determinant factors (Kessler et al, 1994). In addition, scholars have noted that African Americans have markedly greater prevalences of emotional trauma than it affect the whites counterparts. This overlaps with but is not the same as identifiable mental illness. These ethnic variations in the levels of distress happens at all income levels, although, they disappear as income improves. Scientists theorise that emotional trauma among African Americans results from the daily stress of living with colour differences and reduces at higher income levels because those with higher salaries can better remove themselves from at least some of the negative impacts of ethnocentrism (Kessler and Neighbours, 1986).

WHO (2001) noted "that one out of four people or 25 per cent of persons suffers from one or more emotional illnesses at any point in life, both in advanced countries and in the developing nations. These illnesses can then be stigmatised as dependably and precisely as many of the frequent problems. Some illnesses can be avoided; the whole can be brilliantly cared for and cured."

As regards the situation in Nigeria, there is dearth of accurate data on the general distribution of psychiatry disorder, aside from the 1963 Leighton/Lambo Research work carried out among the Yoruba in Abeokuta (Osborne, 1969). The outcomes showed that the cases of psychiatry disorder in the country might be constant with the projection values of many third world nations by the World Health Organization. By this expectation, one per cent of the total estimates of people would be affected with burden from deficient mental and neurological problems such as psychosis, depression, seizure disorder, mental disability and demential. Going by the total estimates, close to 1.5 million populace could be expected to be affected. Between 10-20% of the total figure of people might be suffering from minor but also disabling emotional illnesses such as depression, stress-related and anxiety health conditions. Moreover, it is also calculated that between 20-40% of the clients visiting secondary health services clinic for medical assistant may be experiencing one form of mental health problems or the other. Furthermore, Odejide (2001), posited that due to the high level of impoverishment in Nigeria, 55.2% has been related to the commencement of psychiatry disorder.

Psychiatric problem is very common, and the world financial and social burden of psychiatric illnesses is expected to reach 15 per cent by the next one and half year from today. By this time, it is accounted that frequent psychiatric problems e.g; anxiety, depression and drug misuse/abuse/related problems, will affect large population than serious danger coming out of AIDS, coronary heart disease, injury cases and conquests all together (Ngui, Khasakhala, Ndetei , Roberts , 2010). This is suprising and indicative of a high statistic which gives urgent questions as to why psychiatric illnesses have not been accorded much more priorities that they presently receive.

However, In Nigeria, it is calculated that between 20 per cent and 30 per cent of our population suffer from mental illnesses. (Onyemelukwe C. 2016). This is a very large number, looking at the fact that Nigeria has a precise population of over 200 millions. Regretably, the priority accorded to psychiatric illnesses in Nigeria is at best, fleeting the level of sensitisation of the Nigerian populace about psychiatric health cases is also well known to be very poor and the false beliefs concerning psychiatric health have advanced forward.

The 2006 WHO-AIMS document on psychiatry service in Nigeria attempted some salient findings. It reported that “there is high abandonment of psychiatry affairs in the country. The old mental health Ddcument report in Nigeria was passed into law in 1991. Since its creation, no review has occured and no official evaluation of how the progress of the enforcement has been investigated……There is no single standby officer created in the government offices at any stage for psychiatric cases and barely four per cent of public spendings on health was allocated to psychiatry.” (Ministry of Health, 2006). It also ridiculed other cases related to mental health. These pertain to the non availability of generic drugs at health facilities, absence of medical officers to oversee basic medical health care centres in the local settings and the inhibitions to the prescription of psychiatric drugs. It further recognized that there were very few private firms engaged in personal help programmes such as talk therapy, housing, or as support groups. It is agreed that "in broad terms, many countries in Africa are better equipped with regards to specialists in the area of psychiatry. Countries like South Africa, Egypt, and Kenya have enough mental health specialists per 100,000 population and also have greater percentages of mental hospital beds. In addition, several nations in Africa also deliver expert staff that focus on psychiatric cases."(Ministry of Health, 2006).

The above figures are alarming and in the spirit of the current cases of suicidal phenomenon reported in different parts of Nigeria especially, Lagos (which are clearly a tip of the iceberg), it forces a redirection in our overall behavious to psychiatric cases and querries our present sustainance of the preent order. As regards the present economic meltdown in the country, it is mandatory to also focus on the economic burden of psychiatric illnesses. In the U.S., it was calculated thus, close to 79 billion dollars represent the non-direct costs related with these problems; of these, 63 billion dollars translated to the absence of occupational engagement on account of illness. In Canada, the financial heavy load of psychiatric disorder in 2003 was calculated to be about $34 billion ($1056 per capita), with depression and psychosis totalling about $5 billion and $2.7 billion yearly. (Ngui etal..2010). The WHO in 2005 calculated that psychiatric cases cost between 3 per cent and 4 per cent of the total national product in European members nations (Ngui et al.,2010). As regards the policy affairs, there are at least some facts that there are presently some ongoing changes in the country. The new National Health Policy (2016) documented the rising cases of individuals with psychiatric problems and the import to correct psychiatric issues. In addition, a law for psychiatric cares provision was developed in 2013, even though many of the important provisions of the policy, including developing an agent at the Federal Ministry of Health to be directed on psychiatric service, have not been implemented .

The Nigerian Medical Association (NMA) agreed to work in conjuction with the National Assembly to pass an all encompassing bill on psychiatric cases in Nigeria as part of its corporate social responsibility on mental health community and the society as a whole. The emphasy is to work on the fundamental rights of people who suffer mental disorder by giving them respect and human sanity. A national approach to address psychiatric issues in Nigeria by the government at all stages is required, one which should lay emphasis on prevention." (Vanguard, News. 2017). It is a desired hope that these pronouncements are backed up with the required action so that the country develops and implements both a policy and legal framework to address psychiatric problems. It has become crucial that the psyciatric service is an aspect of grassroot health service and not merely an afterthought added to other health issues which are viewed as more important. These scholars, Charles and Van Weel observed from time immemorial, psychiatric illnesses have been completely ignored as part of the improvement of basic service. That is, in spite of the fact that psychiatric cases reported in all nations, in both gender, at all levels of life, among the have and the have-not, and in both local and urban environments. Furthermore, in spite of the fact that merging psychiatric service into basic health care enhances client-focused and complete cares, and as such, is frontliner to the values and philosophies of the Alma Ata Declaration."(Ngui et al, 2010; WHO/WONCA, 2008). In addition, it is necessary to undertake the wide coverage of sensitization of the Nigerian people on the identification of psychiatric illness as a disease and the import for societal and family support and the avoidance of stigmatization of people suffering from schizophrenia.

2.8 Schizophrenia and sub-types

The history of schizophrenia dated back to the time immemorial and it is unequall with any other forms of mental disorders. The observation made by John Haslam in 1809 on *Madness and Melancholy* refers to what he called ''a form of insanity''. Haslam mentioned some of the symptoms that portray our present thought about schizophrenia. Within the same period, Haslam was explaining this health condition in United Kingdom, another scholar in France was also describing the people suffering from same health condition (Pinel, 1801/1962, 1809). Five decades after, French scholar, Benedict Morel used his local language *demence* (amnesia) *precoce* (stillbirth), on the account that the beginning of the disorder is commonly at teenage stage of life. At about the end of 19th century, Emil Praepelin, a German mental health expert built on the work of other previous scholars and arrived on what remains till date as the most oldest explanation and classification on psychosis. Two of his outstanding contributions to the study of schizophrenia is the combination of many signs of madness that had commonly been seen as dictating different and specific illnesses: catatonia, hebephrenia, and paranoia.

The other scholarly contribution was the ability to differentiate dementia praecox from manic-depressive disorder (bipolar illness).

Schizophrenia is a multiplex disorder that unavoidably has a long lasting effects on an individual afflicted by the disorder and his or her relative. This illness hinders a person's orientation, thinking, speech movement and virtually all spheres of everyday activities. Despite the significant improvements in treatment, total cure from psychosis is unrealistic. Obviously, this severe illness takes a large psychological impacts on member of his or her family. Added to the emotional trauma, the financial loss is huge. In 1991, the financial implication on the management of psychosis in America valued at 65 billion dollar when other considerations are also considered, such as home-care, job loss wages and treatment were also considered (Wyatt, Henter, Leary, and Taylor, 1995). This is because psychosis is so diffused, affecting about 1 out of every 100 persons at some stages in the course of their existence, and on the ground that its implications are serious, studies on the etiologies and management have proliferated.

Schizophrenic sub-types

Scholars have recognised three areas within this health condition. These are **catatonic** alternate immobility manic), **hebephrenic or disorganized** (silly and immature emotionality), and **paranoid** (delusions of grandeur or false belief) (Black and Andreasen, 1999).

Catatonic schizophrenia: Persons with catatonic schizophrenia most often showcase strange behaviours with their human physiology and facial appearance, for instance, they frown (American Psychiatric Association, 2000a) and usually imitate the speech of other people (echolalia). This cluster of behaviour is relatively uncommon and there are some debates concerning whether it should stand classified as a distinct variations of schizophrenia (McGlashan and Fenton, 1991). Its infrequency may be due partly to the help of medication.

Hebephrenic or disorganised schizophrenia: People with this type of schizophrenic illness showcase inappropriate affect such as laughing inappropriately at unexpected hours (American psychiatry Association, 2000a). They also seem unusually self-absorbed, and may utilise large period of their time looking at themselves in the mirror (Black and Andreasen, 1999). Persons with this problem are likely going to display signs of difficulty early, and their illnesses are normally chronic, without recuperation (improvement of symptoms) that is common with other forms of the disorder (McGlashan and Fenton, 1991).

Paranoid schizophrenia: Individuals having paranoid type of schizophrenia usually get the attention of the public because of their false belief and hearing of voices; similarly, their mental process and effects are comparatively not affected. They do not have unorganised statement or emotionless, and they quite have a good management than persons with different types of psychosis. The false beliefs and hearing of voices most often have a theme, such as grandeur or false belief (American Psychiatry Association).

2.9 Classification of schizophrenia

The diagnostic and statistical manual of mental dsorder (DSM) explains the accurate terminology by which doctors, investigators and the public health staffs in America arrive at a diagnosis of psychiatric disorders. The present publication of the DSM, the fifth review (DSM 5) APA, 2013. This process signals the first time significant re-examination of diagnostic criteria and classification since the DSM-IV, APA, 1994. From long time ago, WHO making its own way of psychiatric disorder classification, the International Classification of Diseases (ICD), commonly utilised for compensation reasoning and gathering national and global health information. However, following 1982 world gathering on psychiatric illness classification in Copenhagen, (Jablensky A, Sartorius N, Hirschfeld R. 1983). There was global concensus for the ICD to accept more detailed diagnostic requirement in explaining psychiatric illnesses that favoured the 1980 model of DSM III, APA, 1980. After ten years of meetings between the American Psychiatric Association (APA), initiators of the DSM-IV and the WHO initiators of the ICD-10, assisted by a mutual agreement between the National Institute of Mental Health and the WHO (Sartorius, 2001), there was an agreement on a parameter to be utilised to explain the forms of mental illness organized by NIMH and WHO.

Symptoms of schizophrenia: Positive signs usually consist of the more energetic indicators of unusual conduct, or an extreme or twist of positive conduct. These include false belief and hearing voices (American Psychiatric Association, 2000a). Negative signs include reductions in normal behaviour, for instance, making statement and interest (Carpenter, 1994; Earnst and Kring, 1997. Disorganised signs consist of rambling speech, erratic behaviour and laughing at unexpected hours (Andreasen et al, 1995).

Positive symptoms

Delusions: This is an opinion that is formed by everybody in the community as opposite of reality which is referred to as problem of thinking, or false belief. For its significance in psychosis, false belief is regarded as “the main features of crazyness” (Jaspers, 1963). Patients of this category usually believe that people that are close to them will harm them, therefore, they are not ready to take anything from them.

Hallucinations: It is the experience of sensory events without any information from the external environment. Hearing voices can involve any of the five senses, although hearing things that are not real. Auditory hallucination is the most frequent form researched by people with psychosis. These orientations are true and happen frequently. The research also suggests that when one is unoccupied, people tend to experience hallucinations more frequently (Margo, Hemsley and Slade, 1981).

Negative symptoms: In contrary to the positive signs of psychosis, the negative signs commonly show deficit of normal behaviour. They include psychological and isolation from people, apathy and low speech (Carpenter, 1992).

Avolition: Avolition is a difficulty to commence and sustain in any excercise. Persons with this sign show slight willingness in doing the most simplest daily tasks, including those linked to personal cleaness.

Alogia: Alogia simply means temporary loss of communications. An individual with alogia may attend to questions with very few replies that have little meaning, and may behave unconcerned in the discussion. Recent study also recommends that persons with alogia may have problem getting the appropriate terms to develop their thinking (Alpert, Clark and Pouger, 1994).

Anhedonia: This is derived from the word “hedonic”, regarding to enjoyment. Anhedonia is the assumed absence of pleasurable feelings by few individuals with psychosis. For instance, some of the emotional distorted problems, anhedonia indicates an unconcerned about activities that would usually be regarded pleasurable, for instance food intake, social networking and conjugal relations.

Affective flattening: People that display what is termed as flat affect are the same as people who wear masks as disguise on account of not demonstrating interests as expected. They atimes look at you loosely, make statement in an emotionless and silent ways, and seem unconcerned by things happening in the area. However, although they do not responnd publicly to psychological issues, they might indeed be answering on the internally. (WHO,1973).

Disorganized symptoms: People with this kind of schizophrenia commonly loose full remission, a sensitisation that ther is the existence of a problem. Also, they feel what Bleuler refered to as "associative splitting" and what Paul Meehi called "brain slippage" (Blueler, 1908; Meehi, 1962). Once in a while, they move on from one topic to another and at sometimes they talk without making sense out of it.

2.10 Causes of schizophrenia

There are many illustrations that show the difficulty and fascinating mystery of hereditary influences on behaviour as they relate to the issue of psychosis (Bassett, Chow, Waterworth and Brzustowicz, 2001). **Genes** are predisposing factors which explain that many persons are prone to develop schizophrenia. Kallmann (1938) examined siblings of over 1,000 individuals diagnosed with psychosis in a mental hospital in Berlin Germany, and many of his investigations continued to direct investigation on psychosis. The outcomes indicated that the seriousness of the parents' illness affected the probability of the child's developing psychosis. The more serious the family's psychosis, the likely tendency for the offsprings to have problem. Then, all types of schizophrenia (e.g. catatonic, paranoid) occur around family lines.

Kendler et al., (1993) conducted a research in the west of Ireland, on the risk to the relatives of persons with psychosis. The outcome was similar with Kallmann's study. The investigations showed that families in which a member had schizophrenia were more prone to have other siblings with psychosis or other related psychotic disorder. Families who have a relative with psychosis are vulnerable not just for psychosis only, nor for all emotional disorder; instead, there seems to be some familiar vulnerable for a spectrum of schizophrenic disorder linked to mental illnesss.

Psychological and social influences: The influence of these factors contribute important roles in the emergence of this disorder. Stress has been known as a very dominant elements in the onset of schizophrenia. Scholars (Dohrenwend and Egri, 1981) have recognised variety of push factors on schizophrenia. They noticed that people without illness who involve i*n* war conflicts usually show amnesia that are similar to psychosis. In another related development, scholars (Ventura, Nuechterlein, Lukoff and Hardesty, 1989) recognised 30 people who display psychotic recently and who are on one year follow up. The subjects were engaged for discussion at every two weeks to uncover whether they had past records of any difficult life happenings and whether their signs had disappeared. The study investigated the factors that predicted the relapse of schizophrenic symptoms after a period of remission of 11 of the 30 people who had a major relapse, which means their illness came back.

The other frequent opinion about what is responsible for the emergence of schizophrenia offers a baseline for putting other results of the study in context. The opinion relating to etiology are critically related with stigmatising behaviours to emotional disorder (Bhugra, 1989; Hayward and Bright, 1997; Haghighat, 2001). The realisation suggests that perceptions about psychiatric case is very low in Nigerian society. The prevalence opinion or assumption that incorrect use of medications can predispose psychiatric illness which may be viewed as better, in the perspective of its likely hindrance effect on the abuse of psychoactive drugs or chemical. Therefore, since this is only certain for very few cases of psychiatric illnesses, and since the people usually see the abuse of drugs as a character failure or moral decadence, this opinion may signify a concept of psychiatric disorder as being self-afflicted. Such a perspective has a tendency to generate criticism rather than cooperation or concern (Weiner et al, 1988). Apart from chemical intake, the most available consumption of substance in Nigeria is india hemp. It is not rare for the people in Nigeria to believe that individual smoking india hemp will develop psychiatric problem or individual with psychiatric problem has uses wrongly the india hemp. Definitely, deviant behaviour is equally commonly added in the causal relationship. Thus, the intake of india hemp is commonly seen as denoting a deviant tendency and other way round.

Another important etiology of psychiatric disorder is the justification that it could result to affliction by wicked people, and this perspective was given by as many as one third of the respondents. Also, almost one out of ten in the society beliefs that psychiatric disorder might be a sanction from God. Such explanations, aside from further indicating that individuals having psychiatric problem might be reaping their wicked acts, have significant ramifications for the pathway for orthodox care by the sufferer. A mythtological perspective of the source of psychiatric problem may denote that western medical management would be a failure and that assistance of the faith-based and traditional healers would be more appropriate. Truely, earlier investigations in Nigeria have revealed that treatment for psychiatric problem is largely common access for those healers (Gureje et al, 1995) and that a perspective relating to African mythological etiology of psychiatric disorder is believed by the healers. In providing a medical etiology of psychiatric problem, the feedback can be negative, either intentionally or by consuming harmful local medicine, this is commonly viewed as the etiology of psychiatric illness.

In India and other third world countries, studies have demonstrated that explanatory approaches of psychosis as accepted by the relatives and members of the family of the patients with psychosis (Kulhara, Avasthi, Sharma, 2000; Adebowale, Ogunlesi, 1999; Holzinger, Kilian, Lindenbach, Petscheleit, Angermeyer, 2003; Phillips, Li, Stroup, Xin, 2000; Kurihara, Kato, Reverger, Tirta, 2006; Angermeyer, Matschinger. 1996; Srinivasan, Thara,2001). Investigations have examined ordinary people's opinions about etiology of psychiatric illnesses (Adewuya, Makanjuola, 2008; Furnham, Chan, 2004). Large number of these studies recommend that opinion about African mythological factors is very common in ordinary people and members of family of mentally-ill patients (Kulhara, Avasthi, Sharma, 2000; Adebowale, Ogunlesi, 1999; Holzinger, Kilian, Lindenbach, Petseheleit, Angermeyer, 2003; Phillips, Li, Stroup, Xin, 2000; Kurihara, Kato, Reverger, Tirta, 2006; Angermeyer, Matschinger, 1996; Srinivasan, Thara, 2001; Adewuya et al, 2004; Jegede, 2005; Motunrayo and Nwokocha 2014). Research also showed that some patients and their caregivers access care from faith-based healers to recover from the patient's symptoms (Kuihara et al, 2000). It has equally indicated that African methods of healings are regarded as alternative to the orthodox care of the disorder (Saravanan, Jacob, Deepak, Prince, David and Bhugra, 2008). This perspective about the etiology of psychiatric illness and health pathway action is also consistent with the views and Yoruba belief system in Nigeria.

Psychosis is also related to gestational and perinatal serious health conditions, plus Rh factor conflict, fetal hypoxia, and prenatal exposure to viral infection during the second three months, and prenatal poor feeding imbalance. Researches of monozygotic twins differences for psychosis have documented neuroanatomic variations between affected and family members who are not affected, supporting a "twostrike" causes comprising both hereditary factor and nuture. The latter might entail localized hypoxia during important levels of cognitive formation (Mahmuda Naheed, Khondker Ayesha Akter, Fatema Tabassum, Rumana Mawla, Mahmudur Rahman, 2012).

2.11 Management of schizophrenia disorders

Treatment Across Culture: Cultures differ, the management of psychosis and its provision of health care are different from one nation to another and across cultures within nations. Hispanics, for instance, are less prone than other groups to look for care in hospital environments, depending instead on home assistance. (Dassori, Miller, and

Saldana, 1995). In China, the most commonly used treatment is antipsychotic drug, although, 7 per cent to 9 per cent of patients also received local herbal medicine and acupunture (Mingdao and Zhenyi, 1990). For social-cultural reasons, many patients in China are managed in community settings above that of developed countries. In many countries in Africa, persons with psychosis are housed in asylum, primarily on the ground of enough subtitudes (Mustafa, 1990). Generally, the paradigm shift from keeping people in big hospital setting to community care is increasing in many developed nations.

Medications

The first management for psychosis and other kinds of illnesses is drug. Unfortunately, adherence to drug procedure is usually one of the greatest problems linked with the present management of psychosis. Because persons who live with psychosis usually decide to abandon their medications in the course of their lives, the consequences of non compliance with the drugs are severely felt by the sufferer alone, but by his or her immediate relatives. Recently, a new management alternative has set to assist and ensure that patients complied with their drugs regimen. Called long-acting treatment (LAT) or long-acting injectables (LAI), drugs are administered to the patients via an injection. Therefore, it can be achieved by injecting it anywhere from one in a week or one at interval of two or three months, ensuring prolong-duration signs of getting better before drugs are taken orally, excellent management of psychosis, therefore, relies upon a continuous medications combined with drug and counselling therapy. Medication assists to direct the signs and schizophrenia related with psychosis (e.g., the false belief and hearing voices), not in terms of seeking for job for individual person, trying to be active in social connections, enhancing personal adjustment skills, and assisting patients to interact and perform creditably with colleagues. Poverty, not having accommodation and non availability of job are commonly linked with this illness, but they do not have to be the case. If the person finds correct management and adheres to it, an individual with psychosis can live a joyful and positive life.

First, getting over from the initial signs of psychosis can be an intensely solitary past feelings. Persons coping with the start of psychosis for the first episode in their lives need all the assistance that their relatives peers and societies can offer. With that assistance, readiness, commitment, and psychology of someone who has psychosis can manage and endure with it for rest of their lives. But consistency with this illness implies adhering to the management procedure between the patient and physician and their doctor, and sustaining the equlibrium given by the drug and management. Ending medication abruptly will usually lead to a reoccurrence of the signs related with psychosis and followed by slowly healing process as management is recommended.

Psychotherapy

Large number of people are of the opinion that psychotherapy does not perform a crucial function in the management of schizophrenia, a good number of research recommends otherwise. Psychosis, like all psychiatric disorder, is not an actual brain or genetic disorder. Therefore, managing psychosis with correct social work intervention is neccessary. Study documented in 2015, for example, showed that persons that suffered their initial experience of schizophrenia (usually in their 20s) derived the positive results when a group therapy management model was applied. The group management model integrated counselling, small levels of antipsychotic drugs, family sensitization, awareness and assistance, follow-up case, and job opportunity or school programme assistance. Together with proper drug regimen, counselling can sustain a person undergoing treatment, help to acquire important social skills, and assist individual on weekly aims and activities in their domains. These include: counselling, giving him/her hope, training, modeling, target setting, and reality testing with professional expert. Assistance in putting up little goals and achieving them can always be fruitful. Persons living with psychosiss alway have troublesome period doing minor skills such as domestic work and individual hygiene together with connecting people in their home and office place. Reintegration treatment can reassure an individual on how to handle themselves and spend a purposeful life. Group treatment, along with medications, gives better outcomes aside medication only, most especially with psychotic out-patients. Better outcomes are prompt to be achieved when group treatment direct its attention on future prospects, problems, and connections; social work functions and connection; combined with medication and discussion of its shorcomings; or some real social activities. This assisted group treatment is very useful especially in minimising social segregation and speed up practical examination (Long, 1996).

Parent approach can seriously reduce recedivism of the prevalence for the psychotic family member. In homes that are vulnerable to stress, psychotic patients who receive comprehensive after-care reoccurrence spend 50-60% of the time in the initial period outside institution settings. Assisted family treatment can minimise the reccurent rate to less than 10 per cent. This treatment allows parents to organise group therapy anytime an issue comes up, in order to deliberately lay down the specific the nature of the crisis, to enumerate and suggest other ways out, and to make choice and enforce all agreeable ways out.(Long, 1996). Many treatments flow from medium-to-strong evidence support in managing psychosis. Heavily collaborated, the study for psychosis and other similar disorders, is cognitive behavioral therapy (CBT). Management is not directed on a "cure" but on sign suppression and better living condition.

The mindfulness-based acceptance and commitment therapy (ACT) was used to cure many cases of health problems, which include psychosis. By design, the sole objective of ACT is not to minimise schizophrenia signs; rather, ACT target is to surpress a patient's pains and difficulties by promoting their capacities to allow psychotic signs by enhancing knowledge and endorsement of their situations. With adequate sensitisation, they can then minimise their attention on signs (and their effect) and refocus it to their main importance.

Other type of research evidence management for psychosis, with this acronmy as "ACT" (is quite different from acceptance and commitment therapy) is assertive community treatment. ACT is a collaborative system, usually among all the mental health professionals. It is a discourse system on detail patient management in which members of the group share part of the work, engage in high rate of patient's visit (possibly once weekly), and deliver out-patient clinic to patients in the locality. ACT management is usually continuous and highly personalised to individual client's changing desires. The aims of ACT is to minimise admission rates and assist patients adjust with life in the local setting. ACT is most accurate for persons who are vulnerable for continuous admissions and have problem of staying in psychiatric specialist hospital for treatment.

Cognitive remediation (CR) is a temporary measure for improving cognitive skills needed for daily social/vocational performance in persons with psychosis, example, using micro-softs and hold paper and pencil tasks. Many CR approaches in addition take into cognisance the inducement and psychological disabilities that are very common in psychosis. There are some research-based study that are of the opinion that the temporary cognitive training treatments can change natural relationship as indicated by some investigations in neuropsychological examination. It is not clear, however, whether these cognitive performing enhancements are maintained and translated to function.

Equally, cognitive adaptation treatment (CAT) direct its attention to the cognitive obstacles of psychosis that affect everyday performance, for instance indifference, passionate or emotional and trouble taking the mental procedures needed for crisis intervention. CAT entails many repeated client's home visits. At that moment, the doctor will develop an approach that will assist patients to cope with problems. For instance, they may prepare things in the client's locality, make a reminders, or go over a normal check with a patient (Grohol, 2018).

Factor determining the result of psychosis

World Health Organization, posited that schizophrenia disturbs close to 24 million population globally. In underdeveloped nations, about 90 per cent of individuals with psychoiss did not have access to treatment. But the result of schizophrenia showed that it is better in poor and developing nations (Isaac et al., 2007). There are many reasons that may encourage the result like job, marital status, sex, home assistance among others.

Gender- Gender variations can cause a specific disorder that can bring significant evidences concerning its pathogenesis.The clues for a gender variety in the vulnerability of psychosis has not ended. No important gender variations were made known in the investigations from third world nations (Aleman et al., 2003). That is, psychosis is equal in both sex. In a research work that took place with fifty psychotic patients in Bangladesh, it was discovered that 54 per cent were males and 46 per cent females were having psychosis (Ahammad et al., 2009). This establishes that in issue of psychosis, sex variation is not a major risk factor in developing nations. However, gender variation is not an important cause in psychosiss, it has been reported that the medical prognosis and recuperation is more in feminine than masculine (Carpiniello et al., 2012).

Employment-Physical and psychological alertness performs very significant roles in seeking for job opportunity. These two factors are prerequisite in securing appointment in many nations. Individuals living with psychosis in developing nations are more prone to secure job than their developed nations. In 1997, Srinivasan & Thara document a yearly rate of appointment of 63-73 per cent in the first one decade of continuous studies in a group of 90 people with first-crisis of psychosis (Srinivasan et al., 1997). In addition, within the untreated Indian population with psychosis, almost one-third secured job (Padmavathi et al., 1998). Generally, more employment levels (up to 75%) have been established in India (Thara et al., 2004). A equall progress is explained among Chinese patients; close to half were capable of working after 5, 10 and 15 years of continuous investigations (Tsoi etal., 1991).

The above level of job opportunity are significantly better than those with similar numbers of people in developed nations (Mueser et al., 2001). It has been reported earlier that about 90 per cent schizophrenic patients stand without treatment in underdeveloping nations, meanwhile their prognosis indicates positive outcome, this is as a result of job opportunities. When a psychotics patient is engaged in a work, he relates with the communities and normal work environment; which helps to live a good life. In developing nations, social togethernes is very powerful and work place peers are very supportive. Even, research indicated that office mates are seen to be generally friendly in third world nations (Srinivasan et al., 2005).The employment opportunity in the United Kingdom, more than twenty years among people living with psychosis falls from 4 to 31 per cent; whereas most researches in the developed nations documented a rate between 10 and 20 per cent (Marwaha et al., 2004). It is therefore understood that in developing countries, a large number of people with psychosis were without care. Uncare patients performed in vocational work in their active life, they become parts of the community and seek assistance from the home environments before assuming member of the community, It encourages patients to lead a good life and get assistance in quick recovery.

Marital status In developing countries of the world, community performs a very critical function in marriage. In these nations, conjugal is regarded as a social recgnition for an individual. In third world nations, conjugal blessing is once in the course of existence and it is related to a high level of social endorcement. The socio cultural reasons dictating conjugal and its sustenance are significantly different from people in the developed nations. Conjugal life can be referred to as a measurement of achievement, as its sustenance relies on consistency and activism of both couples. Psychosis appears significantly at a maturity age (i.e. around the 20s). Many researches from the western countries have documented few frequencies of union for patients with psychosis (Nanko et al., 1993, Harrison et al., 2001). Differently, a decade of continuous investigation from India documented a large marital rate of 70 per cent(Thara et al., 1996). So the marriage rate of psychotic patients in low income nations is more than those of the western nations. The reason is that in low-income nations of the world, psychotic patients stay with their spouses and share their opinions and emotions. The psychological assistance assists patients to function in a normal life and also influences their result. Patients, who experience divorce, furthermore, the problem of their emotional problem, encounter crisis from close associates and are disapproved by the community.

Home and social asistance play critical functions in the outcome of psychosis. Present researches suggested that assisted and healthy behaviours among siblings and the society at large contributed to the possitive results (Kurihara et al., 2000, Kurihara et al., 2005). In the third world countries, higher numbers of people maintain the extended families. Schizophrenic patients from these parents mainly stay in the compound in the extended nature where relatives are plenty. Since they live in the extended compound and get better treatment from the siblings, their result increase in developing countries. The little period admitted in the clinic by persons with psychosis is about a fifth in Bali when making similarity with Tokyo (Kurihara et al., 2000). Researches from Middle East nations indicated that as low as 10 per cent were admitted in the clinic during continuous visit, which indicates too much of parents engagement in client management (Ganev et al., 1998). Movement, growing cities, changes in home system and social assistance connection, in addition with the rapid economic downtown and big gap in social differences which are clear evident in developing nations will affect the social assistance accessible for persons with psychosis and affect patients result (Patel et al., 2006).

Illness misconceptions: An important impediment in looking for help for persons with psychosis has been documented in developing nations. The idea behind that could be lack of knowledge, paranoid and misrepresentations of the disorder. However, present researches have indicated that individuals still believed in African mythological explanatory dimensions alone as the etiology of psychosis (Srinivasan et al., 2001). In a research carried out with Indian patients, forces outside this temporary world were regarded as causes, it was found out that only 12 per cent of families had minute psychosis (Srinivasan et al., 2001). The family's heavyload of financial commitment to the care is associated with variant of traditional factors of a country. As in developing nations, most of the patients live with their families. Therefore, the heavyload of financial commitment is somewhat costly in developing nations when making comparison with the developed nations. In a survey, it was established that, six aspects of heavyload commitments exist, for instance; monetary, family procedure, recreation, engagement, effects on medical health and effects on psychological condition (Pai et al., 1982) .

Furthermore, lack of care towards others, unpredictable responses of the patients and poor health care from health caregivers can also be regarded as problem. Most of the members of the family abandoned their patients in psychiatric wards in the clinic for prolonged hours, as a consequence of this, the result followed negative pattern. Study showed that family care burden reduced with minimal client's complaints and drug compliance. Decrease in family expenses is related with positive result and social performance (Paiet al., 1982).

Period of non-treated psychosis Resarches in western countries indicated that the period of psychosis that were not properly treated, is related to negative result with the association being the strongest in the first period of schizophrenia (Drake et al.,2000).This is especially possible in developing nations where a large population of patients come behind for medical attention. Reasons put forward for this are: non creation of awareness, belief in spirituality forces or having beliefs in religious philosophy as explanations for the etiology, poor entry into healthcare models and zero existence of community service (Isaac et al., 1981, Padmavathi et al., 1998). Non compliance with the drug regimens as it exposes patients with psychosis at a serious likelyhood vulnerable of psychistric disorder increases and brings back the illness (Lacroet al., 2002). There is an indication that there is an an inverse association between take home pays and period of untreated illness in developing nations. The financial implication of management is an inhibition of service and low-cost antipsychotic drug in enhancing the avalability to treatment and the result of schizophrenic disorder in poor and medium income nations. The average mean period of psychosis not properly treated in a research in developing nations was 125.0 weeks when making similarity with 63.4 weeks in the survey area in developed nations (Large et al., 2008).

2.12 Schizophrenia, stigma and self-stigma

Schizophrenia assumes difficult not only by the symptomology of the disorder, but also by longstanding community opinion of the disorder. From the past, patients with psychosis were rejected from the community and seen as being ‘crazy’ and unable to get well. Through the years, prejudicial and discriminatory stereotypes began to form; such as: “They're violent”, “I don't like those mad people”, and “They shouldn't be allowed to move freely in the community”. The label against persons with psychosis ignited a different opinion in the community of the ‘us and them’ mentality (Beck et al., 2009; Vauth, 2007; Corrigan et al., 2009). As these views remained stagnant over time, psychological health stereotypes started. Patients were given bad attributes as socially unwelcome and were cared for as a distinct part of the community. Devaluation through labelling ignited a constant failure to adjust with the disorder, resulting in the feelings of hopelessness, decline in self-esteem, soletary, not capable, failure, and loss of reality of life with tendency to commit suicide. In due course, negative attributes of cares as became main obstacle to gain full remission by reducing the patient's self- worthy and personal ability, bringing poor desire for change. Researchers (Calveti et al., 2011; Hendrichs, 2005; Onken, Craig, Ridgway, Ralph & Cook, 2007; Ritsher et al., 2003; Kleim et al., 2008; Lysaker, Davis, Warman, Strasburger, & Beattie, 2007) established that clients diagnosed with psychosis showed a likelyhood of having depression and a reduction in self-worth due to internalized stigmatization during the 6-month follow-up studies. Low self-esteem in individuals with schizophrenia is common; however, self-confidence is also adversely affected by stigma (Beck et al, 2009). Although, low self-esteem is expected among negative symptoms, the construct of stigma remains unaddressed and hidden within symptomlogy and poor treatment outcomes (Cavelti et al., 2011). Unfortunately, there were few scientific study to address this quagmire (Knight, 2006; Lysaker et al., 2007; Ritsher & Phelan, 2004; Sibitz, et al., 2011; Vauth. 2007). The self-esteem of patients with schizophrenia can be diminished by self-stigma if they identify with negative stereotypes of incompetence (Corrigan, 1998; Corrigan & Watson, 2002; Angermeyer et a!., 2004). Regardless of the level of discrimination that the patients encounter, their beliefs and perceptions of being devalued by stigma are the elements that greatly affect their self-confidence (Link, 1987; Link et al., 1991; Rogers, Chamberlin, Ellison & Crean, 1997; Corrigan & Penn, 1999; Corrigan, Faber, Rashid, & Leary, 1999; Wright et al., 2000; Link & Phelan, 2001; Camp, Finlay & Lyons, 2002). Negative self-views lead to self-isolation in order to protect themselves from the perceived stigma (Lencz, Smith, Auther, Correll & Cornblatt, 2004). Several studies have established that psychological harm caused by self-stigma delays treatment by eroding the patient's self-esteem, self-efficacy and his or her belief in recovery (Rosenfie1cf 199Y: Angermeyer & Matschinger, 1999; Sirey et al., 1999; Cooper et a!., 2003; Phelan, Link, Stueve & Pescosolido, 2000; Link et a., 1991; Wright et al, 2000; Link & Phelan, 2001; Perlick et al., 2001; Struening et al.. 2001; Sirey et al., 2001; Vauth 2007). Corrigan, Rafacz, & Rusch, 2011) posited that after the mentally-ill patients became conscious of associated stereotypes, they agreed with them, and internalized the stigma, their levels of hopelessness and self-esteem were negatively impacted. Results of this study were consistent at the 6-month follow-up, indicating the stability of stigma and its poor impact on self-confidence and assurance of recovery (Corrigan, Rafacz, Rusch, 2009).

Psychological distress tends to increase as self-stigmatization and diminished self-esteem become a part of the patient's schema (Masuda & Latzman, 2011). Cavelti, Kvrgic, Beck, Rusch, & Vauth, 2011) examined the connections between personal-stigma, beliefs and demoralization among persons with psychosis. Evidence was found that patients with the beliefs of self-stigma experienced higher levels of demoralization. This demoralization also showed an adverse effect on the patients' good and bad signs of psychosis. This study highlighted the way in which stigma increases demoralization via helplessness, negative self-confidence and depression, thus, altogether resulting in poor recovery for the patients (Cavelti et al., 2011; Staring, Van der Gaag, Ven den Berge, Duivenvoorden & Mulder, 2009).

Further evidence supported the fact that the maintaining factor between self-stigma and demoralization is the patient's ability to change his or her belief or self-schema (Masuda & Latzman, 2011; Masuda, Price, Anderson, Schmertz, & Calamaras, 2009). Therefore, taking an active role in treatment is essential in order to help clients change or alter their beliefs. Unfortunately, some scholars (Tsang, Fung. & Chung, 2010) found that patients with self-stigma often withdraw and limit their collaboration with others (Perlick et al., 2001; Corrigan, 2004; Vauth et al., 2007). Multiple investigations have affirmed that the cycle of stigma produce low self-confidence and feelings of hopelessness, cause the patients to doubt the benefits of treatment, and frequently result in withdrawal (Corrigan & Watson, 2002; Corrigan, 2004; Fung, Tsang, Corrigan, Lam & Cheng, 2007; Fung et al., 2008; Rosenfield, 1997; Watson & Corrigan, 2001).

2.13 Stigmatization, stereotype and social change

This section describes the psychology of stigma and also goes further to describe the link between the stigma and the following : management access/involvement/adherence. Investigators make a distinction between general stigma (the manner in which the everbody responds to a group based on stigma concerning the group) and personal stigma (the responses individuals turn against on the account of being a member of a labeled group). Behavioural scientists have recognised different cognitive and attitudinal structures that make up stigma. The psychology of these conceptual structures is significant for devising plans to minimise stigma and enhance entrance to care. Stereotypes are systematised knowledge structures that cordinate the orientation of peer group (Augoustinos and Ahrens, 2004; Esses, Haddock and Zanna, 2004; Hamilton and Sherman, 2004; Hilton and von Hippel, 2006; Judd and Park, 2003; Krueger, 2006; Mullen, Rozell and Johnson, 2006).

Study has recognised four categories of labellings that are really difficult for psychiatric disorder (Taylor and pear, 2000).These include: (1) Persons with psychiatric problems are fearful and should be given social distance. (2) Persons with emotional problems are to be responsible for their deficiencies that commence from inability to do things by themselves (3) They are not capable to make rightful decision and require significant others to decide on their behalf. (4)They are small childen and benefit from important family persons to look after them. These are referred to as the good stereotypes and equal the third opinion that came out of the beliefs concerning persons living with psychiatric disorder as not capable of taking rightful decisions on their own. Bias is agreement with bad labels: (that is right; all persons with emotional problem are fearful!) that results into a psychological response: (1 am scared of all the fearful emotionally-disturbed persons!), (Devine, 2005; Hilton and von Hippel, 2006; Krueger, 2006).

Prejudice is the behavioural implication of discrimination (Crocker, Major and Steele, 2008); for instance, “I am going to distance myself from fearful emotionally-disturbed persons on account of creating fear on a person.” The range of current behavioural reactions to the general stigma of psychiatric disorder has been divided into four categories: not rendering assistance (deciding not to help individual with psychiatric illness because he or she is agreed to be the cause of his or her failure in life); social distance (good examples of social distance are; house owners who refuse to allow their houses to be rented to individuals with psychiatric problem or owner of a firm who refuse give them employment); discrimination (actions that encourage taking people away from their traditional village into hospital environments where they can receive adequate management or be properly monitored); and forced (compulsory admission or criminal justice behaviour on the account of the opinion that persons with emotional problem could not make expert life determinations) (Corrigan et at, 2001).

With regards to personal-stigma, large people with psychiatric disorder are conscious of the labels attributed to them (Bowden, Schoenfield and Adams, 2000; Kahn, Obstfeld and Heiman, 2007; Shurka, 2003; Wright, Gronfein and Owens, 2000). Like the public, many of these people will consent with the labels (Hayward and Bright, 2007) and ascribe them to each patient, burden and pains reduced self-confidence and competency as a result. Persons with reduced ability due to personal-label are not likely to enforced in employment or live in rented houses (“Persons who is emotionally-disturbed like myself can’t perform a stable vocation!”).

The people ordinarily cannot assume that an individual is psychotic by mere engaging in discussion. Prospective patients may be labelled emotionally-disturbed on account of many social engagements; prominent among these is working in mental hospitals. Hence, possible patient may decide not to attend psychiatric service as a way to escape this attribute and then resulting to segregation. The approach indicates many points for reducing stigma and enhancing a person's happiness with involvement in care management.

It has been established that individuals may not receive health care or follow psychiatric cares pathway on account of assumed financial implications or due to stigma. They are not willing to be stigmatised with individuals that believe they are not capable, have poor moral behaviour, and that they are fearful. Hence, generally, replacing public behaviours as regards emotional disorder will reduce expected financial implcations to psychiatric care. The different ways to remove public label have been categorised into three different methods: demonstrate, training and contact (Corrigan and Penn, 1999). Demonstration blueprints enumerate the unfair treatment of a particular stigma and result to begging for people to end their perceptions in that perspective: rebuke on all for believing such disgrace thinking about psychiatric disorder.

Unscientific proof recommends that this model may appear better in achieving stigmatising images of psychiatric disorder changed from the print and communication outfits (Wahl, 2005). However, behaviour reductions have been established to lead to a boomerang impact so that biases concerning a particular set of people remain the same or eventually lead to bad situation (MacRae, et al, 2004; Corrigan, River et al., 2001). Therefore, demonstration may be potent in having media access to communications to end displaying stigmatizing label of emotional disorder, which later increase general stigma, it should be used carefully.

According to Crocker et al (2001), there are several ways abound for demonstrating against public stigma: These include:

Writing campaigns – Most often, those in music or film industry, publishing houses and other groups label psychiatric disorder not looking at the effects. In these instances, a message directly resolving the crisis and showing a way out may be enough to thwart the behaviour. Most of the groups facilitators enumerated in the materials have anti-stigma protests that finance advertisement and campaigns (Crocker et al, 2001).

Phone calls: If putting biro and paper did not work out, telephone calls conversations may achieve more rapid result. The same procedures apply; be ready to particularly resolve the crisis and recommend a remedy (Crocker et al., 2001).

Public condemnation: Addressing a general feeling of non endorsement of a stigmatising behaviour can be result oriented when individual's means of communication prove abortive. One approach of making it general is to write to the editor of the community print media. Organisations, facilitator of groups and professional groups looking for a wider effect might signal out a press statement explaining the concerns and the group's position. Press statements can be released to newapaper houses, radio and television outfits.

Marches and sit-ins: Most people will recollect the stand still and protests around 1960s and 1970s in Europe. They were highly fruitful in determining behaviours about ethnic difference and the Vietnam War. The two necessitate good planning and a consistent group of demonstrators. Ensure to inform the security agency of your intensions and secure a permit if requested (Crocker et al, 2001).

Boycotts: Do not patronise the goods of the firms that produce stigmatising goods, that of theft advertisers as the print location that carry their location can forward a specific serious financial sarbotage. Do not patronise one good; refuses all the goods of that firm, Ensure to inform the organisations that you participated in a boycott, and they should realize that it will continue unabated until your requests are attended to. Ensure you make known your avoidance through news paper publications or bulletin release and phone calls to your geographical boundary (Crocker et al, 2001).

Education programmes and stigma

As part of the demonstration strategies, enlightenment and reaching out to people are important means in influencing peoples' behaviours about psychiatric disorder (Corrigan and Penn, 1999). Outcomes of studies on external study approaches have indicated that barely short training programmes can result to importantly enhanced behaviours about pychiatric illness (Corrigan and Penn, 1999). Education programmes assist people to recognise the incorrect negative attributes with regards to psychiatric disorder and changing of those labels with real messages. This can be achieved by giving major evidences concerning psychiatric disorder to a listener, or by cheking the difference between false and genuine information with regards to psychiatric disorder. The objective is not to make the audience professionals on psychiatric disorder, but rather to give small genuine information so that most of the incorrect information about psychiatric disorder be destroyed completely. A graphical demonstration concerning psychiatric disorder should resolve what the past feelings of psychiatric disorder is like, and explain how it is determined and perfectly managed (Corrigan et al, 1999).

Eight myths and corresponding realities about psychiatric disorder: According to Devine, 2005), there are eight basic assumptions and corresponding realities about psychiatric disorder. These include:

1. **Once crazy, always crazy***:* Patients do not recoverd fully. Continous follow-up study recommends that a lot of people with bad cases of psychosis and other serious psychiatric problems are fortunate to enjoy a fruitful and functional lives.

2. **All persons with psychiatric disorder are the same***:* Individuals with psychiatric disorder are from different ethnic backgroung. Saying all people with psychiatric disorder are the same is the equal to say all Latinos are the same. Not real!

3. **Serious psychiatric disorders are scarce, just like lepers:**. Really, serious mental illnesses such as psychosis, manic-depression, and severe depression are likely to give an estimate of up to 8% to 10% of the people. That is about 640,000 people in an urban area, the size of Chicago, enough folks to fill Oklahoma, Nebraska and Des Moines and Iowa altogether.

4. **The emotionally-disturbed patients are dangerous, one step away from a maniacal killing spree**. The reality is that minute individuals with psychiatric disorder ever kill someone. Indeed, individals with psychiatric disorder are usually no more dangerous than the remaining populace.

5. **The emotionally-disturbed persons can never live in the society**. The large majority of patients living with psychiatric illnesses live individual fruitful life in the communities.

6. **The emotionally-disturbed persons will never take the advantage of psychotherapy**. Carefully monitored study has indicated that assistant and reintegration have important effecte on the lives of individuals with psychiatric disorder.

7. **The emotionally-disturbed persons cannot function at high level cadre but at the lowest cadres**. Persons living with psychiatric disorder functions at all job levels, just like the remaining people.

8. **Bad parenting and poor upbringing lead to serious psychiatric disorder**. Psychosis and the other severe psychiatric disorders are medical problems, hereditary or other embryological factors are responsible, not our parents.

Contact and replacing stigma contact with persons with psychiatric disorder also produce important enhancements in behaviours about psychiatric disorder. Investigation indicates that among the populace who have knowledge about psychiatric illness are less possibly to approve prejudicial behaviours (Corrigari and Penn, 1999). In addition, members of the populace who had conversation with individual with psychiatric disorder as part of an anti-protest stigma programme indicate importants improvements in their behaviours about psychiatric disorder (Corrigan, River et al, 2001; Corrigan, Rowan et al, 2004). These investigations have indicated that behaviour modifier which came out of interaction ensure status-quo for long period is linked to an improvement in attitude.

Ensuring speedy connection between people with psychiatric disorder and others may look like a complex assignment. Most people with psychiatric disorder are refused to relate their experiences for fear of dejection. Therefore, organisations like, the national alliance for the mentally-ill have speakers' bureaus via their local affiliates. These organizationa or agencies give persons readiness to talk about their past feelings with psychiatric problem to house of God, civic societies, educational institutions and businesses (Corringan, River et al, 2001; Corringan, Rowan et al, 2004).

A brilliant show case about personal past feelings with psychiatric disorder should be tangible and focussed to the main idea, but not to protocol. When techinical words are used, they should be explained, to avoid misrepresentation. The speaker should be honest, but only deliberate on issues he or she is satisfied discussing. The address should be brief and straight to the point, with particular reference to the disorder used to show a particular points. The effect of stigma should be resolved piontedly; the speaker should explain how stigma has caused the feeling of psychiatric disorder more deteriorating. Giving a chance for feedback and delibration is also very useful (Corringan, River et al, 2001; Corringan, Rowan eta!, 2004).

The main idea is that persons with psychiatric illness can function well, stay and perform equally with other persons. Many reasons may improve the impacts of linking with resource interventions on peoples' behaviours. It is significant that contact slowly disproves stereotypes concerning psychiatric disorder. Past information that varies sporadically from general stereotypes (E.g 'in spite of my psychiaitric problem', 'I came out in flying colour in my legal college class and I am presently a judge in high court") may be seen as unneccessary to the case of psychiatric disorder or simply ignored. Past information that are regular with stereotypes are the same as difficult as they are possibly to enrich old stereotypes. Thus, it is significant that information are shown in a way that both accept usual worries concerning psychiatric disorder and challenge the stigma (Corringan, River et al, 2001; Corringan, Rowan et al, 2004). For instance, a speaker may talk about his efforts and the necessity for present management and assistance, and his involvement in home, job opportunity and social engagements. More variables that may improve the gains of connection consist of: showing a well formed associations with the approval of the team spoke persons, and encouraging consistent gains for most often actual life connection.

Changing self-stigma

People may be unable to have a follow-up psychiatric treatment on the ground of internalising self-stigma; it signifies that they may agree with stereotypical messsages that weaken their sense of self-worth. For instance, many individuals may agree that their conditions are not redeemable, such that management will not produce concrete advantages. Therefore, they ask themselves: why involvement in or stick to care delivery? Few researches have tried to reduce self-stigma. In a single system, Kingdon and Turkington (2001) applied a cognitive behavioural model to assist individuals to withdraw stigma as a usual activity. The recommendation for resolutions were totally-accepted by patients and seemed to produce more endorsement of their problem. Unfortunately, the 1991 publication did not document an examination of the normalisation strategy in a probability monitored investigations. Thereafter, researches have more cautiously evaluated the effect of the same cognitive treatments on psychiatric signs, self- statements and health care delivery (Beck and Rector, 2000; Gould, Mueser et al, 2001; Turkington and Kingdon, 2000). Meanwhile, the entire work of the study has not only directed on replacing personal-label like the 1991 research by Kingdon and Turkington recommend, that cognitive withdrawal may give a better instrument for replacing personal-label.

Personal-stigma is reduced when individuals learn scientific evidence-based information that are against it. Thus, enlightening people who self-stigmatises about psychiatric can assist them confront their force beliefs. However, even after understanding the truth concerning psychiatric disorder, some people will go ahead to perceive negatively as regards each other on the basis of personal-stigma. Beck's (Alford and Beck, 2007) model that directly confronts painful behaviours concerning the self and changes them with orientations that do not reduced individual personal-confidence into the stop self have been incorporated in this research.

Stigma worksheet

The worksheet queries individual to enumerate the painful perception; explain the speculations surrounding the orientation; confront the notions by probing reliable persons if they agree with them; collect and document result that confronts the speculations, emphasises the behaviour without being hurtful or discuss the approach that opposses the first orientation. This workpaper can be done individually or with an advisor. Persons who self-stigmatises can expresses their perceptions and face and assist one another. In addition, this group work speeds up a sense of individual prowess. Master plan that promotes enhancement may also diminish self-stigma. The study focuses on personal motivation as the definite way in which persons see each other and in which they relate with the society. Motivated persons who possess better self-confidence, assume that they can do well in life, and are also sure about tommorow. They may also indicate good temperament against bias and solicit each other in the society and the psychiatry care approach. Psychiatrists can utilize the enhancement system to service design and delivery, at the same time, they advise patients to engage in group therapy and works that advance motivation.

The seven ways to enrich empowerment

According to Alford and Beck, 2007), there are seven ways to enrich empowerment. These include:

1.**Non-compliance to collaboration:** This is a change in dimension from expecting patients to ignorantly obeying the management in making medical care actions that are conducive to patients.

2. **Patient contentment and other input on services:** At the complete level, schemes that improve involvements are required to be well accepted to those members. In addition, these schemes required to get support from patients in other to give hope that the programme design reflects what they desire.

3. **Accommodations and recreation houses:** Over thirty years, the psychiatric services have assisted management plans that were totally organised by individuals with psychiatric problems. Lodges are housing schemes in this mold; recreation houses are social and service schemes.

4. **Assertive community treatment and supported employment:** Unlike patients visiting the doctors or therapists, the best management happens when the doctor or therapist visits the patient, and in all areas, the patients need help. Delivery of cares in

individual locality is the peculiarity of assertive community treatment (or ACT). Services in real-world job places are assisted job opportunity.

5. **Consumers as providers:** Many individuals with psychiatric disorder are taking decisions to go back to academic, get important entry results, and start working in a psychiatry service as hospital workers. Through this, they can influence the process from within.

6. **Personal-help, mutual assistance, and other consumer operated services:** Fifty years ago, when the scheme was started by individuals with psychiatric disorder to assist groups. These schemes make locations available to give and collect assistance from persons with the same problems.

7. **Participatory action research:** Most of the present studies on mental deficit and reintegration show the views of the present psychiatric service. Individuals with psychiatric problem must be on the same page in the study bussines for future researches to reflect the various desires of patients.

Disclosure and self-stigma

Private motivation and self-solicitor are likely to have good impacts in form of minimising personal-label. Doctors should be extral careful when counselling patients about telling people as regards disclosing psychiatric condition (Link, and Phelan, 2002), conjectured that the effects of personal-label might be addressed by educating the patients on coping strategies. The coping schemes particularly on decisions about not disclosing their personal mental health history, correct manners of teaching people concerning their past feelings and distance from points where rebuke might happen. However, the solutions produced no important improvements, in that very important factors as the stigma-related problems of social discomfort, dejection, and lack of job opportunity. Link et al (2002) posited that stigma is strongly increased by way of life; its results are not freely conqured by the strategic efforts of persons. Citing Mills' (1967) distinction, they resolved that labeling and stigma are "social problems" that must be resolved through govenment perspctives not "personal problems" that are tackled by personal treatment.

Unfortunately, government perspectives hope to minimise stigma, patients, have to conclude on whether to divulge their situation or not or decide to allow their problems remain private or distance themselves from individuals and locations that may label them. The values of this perspectives are the failure of chances to get assistant and the emotion and offence of hiding something confidential. Discriminating revelation leaks patients to the danger of isolation, but encourages them to look for a small people that knows and gives assistance. Complete divulge removes the fear of being exposed and promotes a sense of encouragement. However, many individuals may utilise this message to label and isolate patients. Doctors or therapists can assist patients in making open up decisions by reflecting on the prices and gains of opening up in various circumstances.

Legal remedies to stigma and segregation

The impacts of stigma are far more than the absence of confidence and individual pains experienced by persons living with psychiatric disorder. These effects are also medico-legal issues. The Americans with Disabilities Act (ADA) (1990) disallows segregation towards individuals with deficits in all ramifications of peoples' life: job opportunity, movement, information dissemination and relaxation. Title 'I' of the ADA specifically disallows work segregation on account of health problem and needs organisations, to give affordable houses that gives individuals with deficiencies to do particular job functions. The explanation of affordable housing is somewhat not clear, but may entails giving an individual headphones to stop extraneous noise, modyifying monitoring styles, and giving additional education resources.

Individuals having psychiatric problems are also covered from accommodation segregation by the Fair Housing Act (FHA). The FHA disallows unjust estate allocation politics and needs house owners to make affordable accommodation to laws and processes overseeing their buldings. Affordable accommodation for housing needs of persons living with psychiatric disorder is still a virgin discipline. However, they might contain: permitting a co-signers on a rentage; permitting a witness or housing agent to pay rent, or permitting house owner or agent whole entry to the building. Doctors may decide to send patients who assume their rights have been tramped in line with the ADA or FHA to the news and agencies.

The label attributed to psychiatric disorder is the major problem in improving psychiatry service and enhancement of the betterment of the lives of individuals who suffer from the disorder, the relatives, the communities and the health service staff that attended to mental illnesses. Stigma is damaging and there are signs that in spite of the progress made in psychiatry and medicine, it continues unabated and has hurtful implications for patients and families. In 1996, the WPA started an international protest against the stigma and segregation due to psychosis. The 'Open the Doors' programme has since been executed in more than 20 nations and engaged nearly 200 different anti-stigma programmes. Some of the suggestions given to those seeking to join this international efforts or start similar efforts to eliminate stigma and segregation are:

- Looking inwards into one of the first world initiatives to fight the stigma associated with psychiatric illness;
- looking inwards into special joint efforts of people suffering psychiatric disorder and their relatives with psychiatrists and other healthcare workers, journalists, governments and non-profit organisations and;
- unique learning points and suggestions from struggle in 20 different nations.

2.14 Evolution of existing mental health legislation

Long time ago, the mental health law that was passed in 1916 (see *Laws of Nigeria*, 1948) evolved close to forty five years before Nigeria was freed from the colonial government. The foreign impacts in its terminology and dividends of democracy are thus quite clear. The law was passed two years after the integration of the two regions into one country in 1914, it was a point of regional laws that looked like the country emerged into regions thereafter. It represents the levels of a law rather than an ordinance in 1958. The present law in the country has been gazzetted into state legislations within the entire country. The newest copies of these legislations have some small changes with regards to language and particular variable requirements (e.g.size of fine), for the purpose of justifying immediate facts, but the philosophy of the legislation have maintained the same (*Laws of Ogun State*, 2006). While the present psychiatry laws, derisively referred to as the ‘lunacy law’, has the capacity to resolve particular factors having something to do with psychiatric health care, its old (almost ten decades) certainly recommends that it must suffer from some crises and truely it does so in four core aspects which are:

a.changes in administration and social environment,

b. old meanings and concepts,

c. non-application of later commencements in psychopharmacology,which truely give alternatives to hospital service,and;

d. lack of integration of certain fundamental rights charters (United Nations, 1948, 1991).

The main factors that are truly linked to the aforementioning points are the current WHO documentation suggestions for documenting satisfactory and functional psychiatry law (WHO, 2005). The aspects of shortcomings in the present legislation contain its inability to explain ‘psychiatric illness’ or ‘mental deficit’and its overall emphasis on hospital service without enough facilities for management at the grassroot level. The use of some highly condemnable concepts such as ‘asylum’, ‘lunatic’, ‘idiot’and ‘weak mind’ shows its old usage of the terms. The legislation did not make particular provision for the risk groups who may have the problem. Despite all these challenges, it has tried to maintain high level of adherence with WHO suggestions in the aspects of provisions for severe and forceful hospitalisations (although not different from treatment), total reference to the level of ability needed for the diagnosis of psychiatric illness, delivery of oversight and re-evaluated systems (by way of ‘visiting committees’) including a unit that has to do with professional misconducts involved by the hospital staffs and the definite punishments.

Our country, Nigeria mental health law was initially enacted in 1991 and consists of the following segments: advocacy, promotion, prevention, treatment and rehabilitation. These segments are resolved in the following way:

- **Persons with mental, neurological and psychosocial disorders have equal rights to treatment as individuals with physical illnesses:** There is disequilibrium in terms of rights to the management of the persons living with psychiatric, neurological and emotional illnesses with an individual having physical illnesses in Nigeria. This is corroborated by (Gureje and Alem, 2000) that psychiatric disorder is so nearly linked to the risk, both in its etiologies and in its impacts; the patients are at a extreme disadvantage in showing their feelings about achieving their goals. The social services are not available to them, especially health services. Psychiatric laws are supposed to handle this, and set procedures to tackle it. However, in developed countries of the world, mental health care is taken seriously in the same patterns as physical illness. There is constant review of mental health law based on the needs of people.
- **Collaboration of psychiatric service into general health care services at all levels of healthcare:** No single local government in the country has this aspect of health care delivery. This examination is similar to what has been initially documented by (Ohaeri and Odejide, 1994; Odejide and Morakinyo, 2003). No single evidence that progresses have been recorded to harness and create awareness on the member of the district on community-based psychiatric service approach. These are based on the Federal Ministry of Health’s effort at sensitising the offices of PHC and all the departments of all the states of the federation so as to inform them about the availability of the document and advise them to draw out the programme and to enforce it. Unexpectedly, it was only few states (23.3%) that made the document exist. Unexpectedly too, the National

Mental Health programme drawn by the ministry of health to merge psychiatric service as ninth segments of PHC services as reported by (Ekpo et al, 1996) was not found in any of the 30 states that has PHC. This attitude eventually led to the slow pace at integrating the policy into the primary health care service.

- **Assertaining total coverage via the provision of psychiatric services via primary health care:** This component of mental health policy is what the policy document intends to do but it has not been implemented, since 1991 when the policy was formulated. The world health report also agreed with this observation. Unlike other units of PHC programmes, psychiatric service seems to get little allocation from the federation account and other stakeholders. For instance, in the aspects of HIV/AIDS, malarial control, immunization, mother and child health, these key actors were reported to have committed heavy financial commitments in the PHC centres to minimize sharply the cases and prevalence of transmitted infections and maternal death' in Nigeria (WHO, 1978). However, the bill for the merger of psychiatric service was improved upon and passed last year in 2012 to ensure the delivery of mental health care service at the basic health care level. Yet, the major problem of this provision is the problem of competent personnel to oversee almost 774 local government areas across the country when the nation could not boast of 200 psychiatrists, let alone other paramedical workers.
- **Appropriate training of mental healthcare personnel:** The training of professional psychiatric service personnel has not been taken very seriously as stipulated by the psychiatric health policy. Going by the proportion of the psychiatric service professionals on ground and the Nigeria populace, there were 0.06 psychiatrists to 100,000 populace, 0.02 psychologists to 100,000 populace, 0.19 psychiatric nurses to 100,000 population, and 0.09 other therapist doctors to 100,000 population (WHO, Mental Health Atlas, 2011). The encouragement of the mental health providers has been given much attention in line with the component of the policy on the issues bordering training and re-training of mental health workers. This was supported by the following: Harding et al, 1983; World Health Organization, 1984, 1990. The main training procedure of these programmes in many third world nations do not address the clerking and caring of psychiatric illnesses. The educating schemes do not give the mandatory training, nor do they transfer the ability needed to manage psychiatric illnesses.
- **Intersectoral collaboration to be promoted with the aim of enhancement in the quality of life:** Efforts have been made in several quarters that resulted in better enhancement in the quality of mental life. Media outfits, especially radio

and television, are especially useful in sensitising the uneducated groups about the awareness of psychiatric illness. Moreover, the present psychiatric services also help to minimise stigma and speed the demand for mental health care services.

- **Promotion of healthy attitudes and positive socio-cultural attributes particularly among youths:** In most parts of the continents, public behaviours against psychiatric disoder are deeply influenced by Africa local orientations in unscientific causes and solutions (Makanjuola, 1987). This orientation system usually ended up in health-damaging responses to psychiatric disorder, to stigmatisation of emotionally-ill individuals and those with depressive disorders, and not willing or sometimes exhibit delay in looking for correct care for these problems (Gureje, 1996). Such orientations affect the delivery of psychiatric service for the needy; thus, governments are usually of the perception that psychiatric disorder is totally not curable or, at any rate, not responding to western health practices: (Desjarlaiset al, 1995). The training of the people should be given important consideration in the start up of psychiatric laws in Africa because large parts of psychiatric service need the potent involvement of the community. Reintegration of the emotionally-ill is a good example in the community. Knowledge and awareness of the community are also crucial in an efforts targetted at minimising stigma and segregation. In virtually all areas of the continents, the family stands an important source of support and care of patients with psychiatric illnesses (Giel et al, 1983) and relatives with emotionall-ill individuals can only be helped in this function if they are not made to suffer isolation and knowledge of understanding of the community. In this part of the continents, peoples' behaviours againsts the emotionally-ill patients have been negative and engendered by the belief that there may not be permanent cure for psychiatric disorder, this is supported by the observation of Makanjuola (1987) that public behaviours against the emotionally-ill patients are still largely determined by the traditional orientations in local beliefs of external causes and remedies. This orientation system usually ended up in health damaging responses to psychiatric disorder. Gureje (1995) also affirmed that such belief systems cause delay or reluctance in seeking appropriate help for the condition.
- **Removal of stigma via the encouragement of positive behaviours towards the mentally-ill in the society:** Assiduous efforts have been made either as an individual, group, or at the level of the government to reduce or remove stigmatisation and discrimination of emotionally-ill individuals in our society.

Indeed, in so many forums across the country, there have been many programmes/workshops that sensitise the public about their attitudes against the emotionally-ill persons in our society. While people's perceptions concerning psychiatric patients have been impinged on somewhat, they are still usually being stigmatised. Duane (2003) who formed the advocacy movement aimed at minimising stigma and segregation and speed up of support for the psychiatric patients. However, there was contradictory reports on the findings conducted by Fabrega (1991) that stigmatization of psychiatric illness has been very low in third world nations. In fact, as observed by Murthy (2002), the stigmatisation of psychiatric disorder may be found all over the world, even though the ways and manners of the illness might differ throughout ethnic grouping. A survey carried out by Hayward and Bright (2007) indicated that the majority of people in the society were always fearful to have audience with someone known to have psychiatric illness and that only small people would like to associate with such a person.Thus, less than 4% were ready to engage someone with psychiatric illness in marriage. However, Odejide and Olatawura (1979) posited that bad behaviours towards psychiatric illness may be less common among the highly educated. Such results indicate that the behavior of that group does not reflect those of the society in general.

- **Use of correct preventive therapeutic and rehabilitative measures to minimise the challenges of substance and drug abuse:** There is no appropriate measure put in place to minimise the problem of substance and drug abuse. If there is any such mechanism, it is very inactive because the production of alcoholic drinks is pervasive in the country and measures to control the production and consumption of these substances are not evident. However, the National Agency for Food, Drug, Administration and Control (NAFDAC) has tried tremendously in the last decade to minimise the use of hard drugs in the country. Yet, the youth, through their sinister operation still indulge in hard drug consumption, such as cocaine, heroine and so on. These hard drugs have affected human health in a negative form. In fact, substantial numbers of our psychiatric cases are products of drug abuse and alcoholic intake. This position is supported by (Lasebikan, 2012) who opined that chronic alcohol use has a wide variety of physical, emotional and social consequences. Physical consequence of chronic alcohol use includes: high risk of coronary heart disease, hypertension, and other cardiovascular diseases, such as stroke, exacerbation of sleep problems and so on. In addition, substance may exacerbate Parkinson's disease in elderly men and delirium tremens is linked with higher death rates in some age group.

- **Special attention to be delivered to different disadvantaged minority groups in the community**: Those suffering from neurological and psychological problems are in the minority group, though there may not be a dependable information on the epidemiology of psychiatric disorder. However, studies conducted by (Leighton and Lambo, 1963) showed that the cases of psychiatric disorder in the country might be constant with the expected populations of many third world nations by the World Health Organization. That means that, one per cent of the people is experiencing pains from unfit or disabling mental and neurological illnesses such as psychosis, seizure disorder, depression, mental deficit and dementia; about 1.5 millions are affected by these problems. On the contrary, there was no adequate provision for this category of this sub-population. Large numbers of psychiatric patients are seen roaming the streets without any attempt from the government to take care of this minority group, especially in our major urban cities across the country.
- **Promotion of NGOs in the promotion, preventive and rehabilitative aspects of psychiatric services:** This part of psychiatric policy has been the most outstanding and unique area in which individuals, non-governmental organizations, especially the pentecostal churches, welfare agency have contributed immensely to the sub-population of Nigerians who are with mental health burdens. They have committed substantial resources to the services of this category of people. Erinosho (2010) supported this argument that the activities of the pentecostal churches had impacted on the old churches, such as Roman Catholic, Anglican, Methodist and Baptist. These churches organised healing services, anointing services to cure the members with psychological problems. Erinosho (2006) also affirmed that some Muslim clerics engaged in the healing process with powerful recitations from the Quran. He claimed that some of the clerics possess extensive knowledge of traditional herbal medicines.
- **Collaboration with appropriate international agencies with relevant aims:** The psychiatric policy has not been well implemented in the practical sense of it; and collaboration with international organisation has followed the same trend. However, in terms of staff training and retraining, most of our earlier psychiatrists (such as Adeoye Lambo and his followers) were trained in universities abroad. Training improves qualitative mental health care delivery service to the sub-population that needs the services. This has been relatively achieved with the universities in Nigeria, engaging in exchange programmes with various universities in the western countries in the areas that will benefit the

country. Scholars in Nigeria go to these countries and their scholars visit Nigeria for the purpose of collaborations and exchange of ideas.

- **Periodic review of legislation governing the care of the mentally ill:** At the beginning of 1990s, only 23.4% of part of African region states of WHO were documented and claimed to operate psychiatric laws that contained substance and drug abuse preventive mechanism (Uznanski, 1997). Even where it is available, the law recommendations for matters concerning psychiatric disorder in African nations are usually old and in quest of review. Majority of those laws were created by the British governments which were later ammended as their own laws to show present realities on the nature of psychiatric disorder. The old legal provisions do not identify the rights of the psychiatric patients, nor do they give special attention or privileges to the nature of their problem with reference to deserving blame for violations that they have committed. Mental health policy in Africa needs to be updated. The fundamental rights of the emotionally-ill must be accorded high consideration with appropriate laws. While the security and well-ness of the community are guaranteed, laws must be detailed as regards the situations of a patient before an emotionally-ill individual can be mandatorily hospitalised and managed. The need to recognised and to allow a patient's refusal of treatment while recognising that medical perspectives on the need for treatment may sometimes be objected by a patient's desire. The law for the protection of the psychiatric patient from unfair segregation now exists in most advanced nations. Such laws need to be embraced by African nations. In drafting up laws, that have to do with psychiatric patients, African nations should be controlled by the philosophies for the protection of people with psychiatric disorder as listed in the United Nations General Assembly Resolution 46/119 of 1991.

Nigerian government has not reviewed the 1991 policy on mental health care till date. That explains the reasons for not merging the mental care with primary health care service. Attoh (2013) argued that although Nigeria passed a mental health law in 1991, dealing with psychiatric problems and its segments which includes : advocacy, promotion, prevention, treatment and rehabilitation, it has not undergone any reviewed ever since. In addition, no official evaluation has been carried out to see the stage of utilisation.

- **Promotion and funding of mental health related research:** Funding of health generally has been very low and insignificant when compared with other spheres of the economy. Even within the health care practices, mental health care has not been funded like others. This assertion is supported by Ohaeri and Odejide and (1994); Odejide and Morakinyo, (2003). It was observed that psychiatric services seems to get minimal attention from the levels of various government and other stakeholders. For instance, in the area of immunization, HIV/AIDS, malarial control, mother and child health, these actors are acclaimed to have spent huge amount of money in the primary health care facilities. However, if such equal focus is accorded to psychiatric care, it will contribute considerably to the recognition and management of psychiatric illnesses (WHO, 1978).

A failed trial at revision of the mental health bill

The current effort to review mental health law was done during civilian era in the 4th democratic dispensation between (1999–2003). Within that period, the mental health proposal was presented as a legislative bill in the Red chamber of the National Assembly. This assignment was sponsored by two former lawmakers who were also medical professionals, and one of them was a mental health expert (now late). Fortunately, the bill underwent its first stage at the National Assembly. In Nigeria, propose bills for new laws or amendments must pass through the third stage and get presidential signature before it assumes the status of a law. Unexpectedly, in the period in- between the first and second stage, the propose bill faced a set back with the end of that democratic dispensation and the demise of the principal sponsor. Presently, actions are on course to re-present it as a government bill to be facilitated by the Federal Ministry of Health. Therefore, it is also mandatory to evaluate the stage of follow-up of this proposed bill with the suggestions of the WHO in 2005, (although these were made two years after this proposed law was drafted). It must be aware that while these suggestions are not inviolable, they reflect adaptable schema upon which current draft laws can be situated.

Generally speaking, the present bill tends to include better provisions in all aspects of the WHO checklist on Mental Health Legislation (WHO, 2005): Explanations of psychiatric illnesses with good coverage of this social personality disorder and alcohol use disorders; rights of families or other caregivers of patients; mental capacity issues (although, no clear explanation of ability in the propose Nigerian law); normal hospitalisation and management; compulsory hospitalisation (not clearly distinguished from management); improper agreement for management; crises periods; specification of expert needed for diagnosis of psychiatric illnesses; supervision and review sysems (mental health courts, judicial revision at the state level high court); security official functions; provisions for underage within the mental health and justice systems; and an explanation of violations under the law with appropriate punishmets.

However, it is disheartening to hear that the expected bill is deficient in some of its important sections. It could not provide a clear message on the put it into practise the basic human rights of persons who have psychiatric problem and does not particularly respect the rights of patients who access psychiatric service facilities in connection to medical principle such as keeping information secret. It is silent on deliveries concerning 'non-demonstrating' patients and compulsory management in community areas. The intended bill does not control particular treatments such as electroconvulsive therapy (ECT), the use of isolation and delay, factors linked to medical and laboratory investigation (agreement in particular),and socio-political factors such as segregation, accommodation job opportunity, pension matters, civil issues (e.g. political rights, parental rights) including protection of other vulnerable groups, like women and tribal minorities. When all these aspects are further separated into units parts, the general level of adherence with WHO suggestions may be far lower than is superficially recommended by this examination.

With all the points listed above, the chances for a successful evaluation of the current legislation are hopeful given many local issues. Presently, the Association of Psychiatrists in Nigeria (APN), the main de-facto in mental healthcare, is at the front of struggle to ensure that psychiatric law review and mental health advocacy is gaining ground. Recently, a desk officer for mental health has been employed at the Federal Ministry of Health, partly with an instruction to work in conjuction with other groups who are involved in gathering inputs for the bill to be facilitated as an executive proposal. In addition, the National Human Rights Commission adopts current charters that enhance human rights and thus constitutes a likely friend and stakeholders in the present struggle to review the existing law. The WHO's suggestions for developing nation that certains mental health law that is required, forced by human rights, wholistic in perpectives and culturally sensitive give practical procedures for the drawing up of a new law. Together with these are the very many law related resources which the WHO has made widely available and which enables the chance to copy from more current law in other nations. In addition, present epidemiological information to recognise psychiatric service needs are available (Gureje *et al*, 2006) and they give a research-based for the needs-based approach of the WHO. In addition, the suggessted professional ability needed to pass new law is found in the country. In accordance with the WHO suggestions, main players (including the medical directors of current federal psychiatric institutions in the Nigeria) are presently brainstorming and involving the Federal Ministry of Health with a perspective to speed up the passage of the propose bill.

THEORETICAL FRAMEWORK

Two theoretical perspectives are utilised to account for people's perceptions of and quest for community-based psychiatric system as a better option to mental healthcare delivery in the South-west of Nigerian communities. These are the structural functionalist approach and the health belief model. The structural functionalist model approaches the study from the view points of health care givers or from group perspectives whereas the health belief model approaches the study from the individual and community perspectives.

2.2.1 Structural functionalism

Functionalism is no doubt one of the most resilient theories in sociology till date. Although it has been variously argued that the theory has waned in relevance and importance (Haralambos and Holborn 2008; Ritzer and Goodman 2004; Ritzer, 2008; Mills 1959), its near omnipresence in theoretical discourses suggests an obvious and appreciable degree of relevance and timelessness. Functionalism analysis has been for sometimes in sociology. It was the mostly used theory in the work of Augustus Comte (1798 — 1857) and Herbert Spencer (1820 — 1903). It was later developed by Ernile Durkheim (1858 — 1917) and refined by Talcott Persons (1902 — 1979). During 1940s and I 950s, functionalism is the most widely used sociological theory in American sociology.

The structural functionalism mirrors the society as a system. In other words, it views the society as part of many units combined together to form a complete entity. The main segment of the analysis is society and its different segments are understood basically with regards to their relationship to the whole. The forefathers of this theory usually make a similarity between the society and the living organism, for instance, human body. They advocated that the knowledge of any sensitive part of the body, like the the heart or lungs entails a knowledge of its connection with other parts and, most especially, its inputs towards the sustainance of the living being. Similarly, a knowledge of any segment of society needs an explanation of its connection to other segments and most significantly, its input to the sustainance of the community. The functionalists advocated that just the way an organism has certain fundamental needs that must be achieved if it is to live, so does the community has important needs that must be achieved if it is to continue to exist. Thus, the social agencies such as the health, family, religious, politics among others are interpreted as parts of the social systems rather than as isolated segments. In particular, they are understood with regards to the inputs they contribute to the system as a complete entity (Haralambos and Holborn, 2008).

In applying these theoretical assumptions to the research on community-based psychiatry system and psychiatric service, all the social institutions which include: health, religion, politics, mass media, education and family are considered. Each of these parts therefore performs different roles in order to keep the society going smoothly. On issues of psychiatric disorder, the impact of these social institutions in the maintenance of wellness in the society cannot be disregarded. It is the combination of the roles of these various institutions that will ensure orderliness in the society. The function of health institutions in the management of psychiatric disorder should not be left to psychiatrists or other modern mental health professionals but rather should be shared by other stakeholders or institutions such as family, religion institutions, traditional system, political system, educational system and the mass media to ensure equilibrium or balance in the health status of people in the society.

Family Institution: This is the first place a child belongs to, whatever a child becomes in later life reflects his or her upbringing from home, children internalize cultural values and norms of the society through the socialization process at home. When a family produces good children, the society is at peace and orderliness is assured. All these functions are prerequisites for the society to be at peace and to maintain social order. Traditionally, the family provides social support functions to the individual patients during the period of ill-health to ensure sense of belonging which to a large extent performs certain functions in the healing process. In fact, it gives assurance to the patients that the family has not abandoned him or her.

Religious Institution: The Muslim clergy and their Christian counterpart represent the religious institutions, these institutions play very significant roles in the society, it is the only means by which people communicate to their God and seek for forgiveness, especially during the period of ill-health. The religion gives us the essence of life and everything that is assured in this temporary world. This therefore directly or indirectly performs certain functions for the survival of the society. The religious institutions perform very significant roles in the treatment of psychiatric disorder. For instance, the church, mosque and the traditional healer give explanation on the causes of psychiatric disorder. This is also similar to what Adeoye Lambo conceptualized when he established 'Aro Village' in 1954. Other examples are the collaborations made by Willams in Senegal and Margaret Field in Ghana, who commenced collaborations with the alternative healers and Tijani El Mahi and Taha Baasher in Sudan, who started up a working relationship with Islamic clerics to help in recognition, referral and de-stigmatization of individuals with psychiatric disorder. The above illustrations reflect the socio-cultural variables that shape the ways in which sickness is perceived and acted upon and the pathway to health care, cited by Erinosho (2010).

Political Institution: This institution is very central in any society because it shapes or determines how other social institutions are going to look like. This entails the government and governance. What obtains in the capitalist system might not be the same thing in the socialist system of government. Therefore, political institution plays a critical role in shaping the way other social institutions will be determined. The political institution also make their own contributions by way of enacting law and policy that will agree to the take off of this community-based approach, this was underscored by the enactment of psychiatric law at the basic level of care in 2012, by the Jonathan government which will enable psychiatric disorder to be attended to at the grassroots level of care across the country.

Education: The functionalist perspective examines education in terms of the functions it fulfils for the society. Apart from the family institution that ensures internalization of culture, customs to the younger generation, education is a bigger organization that inculcates the values, norms of the society to the younger generation so that all these values do not go into extinct. Education is also a means to an end; it liberates people from the shackles of poverty and any society that must develop, its educational system must be dynamic and robust in terms of its policies and implementations. All these were to ensure the continuity of the society.

Mass Media: This is another vital institution in the society, this includes, radio, television, newspaper and internet facilities to provide information to the entire people in the society. These medium are also used to create awareness and sensitize people on what goes on around in the world including any new discovery on health issues.

Criticism of structural functionalist theory

The theory of functionalism has witnesses various degrees of critique. The criticism is focused at the science of functionalist's method of investigation. It is advocated that its type of explanation is teleological, which opines that the segments of an approach exist on account of its usefulness implications for the approach in general. The major argument to this understanding is that it treats an effect as a cause, but in reality, an effect cannot clarify a cause, since causes must always precede effects. It can also be advanced that members of a society unknowingly react to stimulus, and so initiate the institution needed for the sustainance of society. However, there is no scientific proof of the existence of such unconscious motivation.

The capability of explaining change within functionalism has been a contentious issue over time. While critics are of the opinion that the concept of value consensus and moving equilibrium negates change, Merton argued against this opinion. Within functionalism in general, however, the criticism may subsists a while, especially as it affects abrupt change in 'modern' societies which are believed to be radical. It may also subsists especially as values are persistently in a state of instability due to the tidal effects of globalization and its ancillaries, particularly information and communication technology, which may trigger abrupt actions and reactions as people are exposed to happenings in other societies. The functionalists' account for social change is thus considered inadequate for the contemporary societies in search of adequate explanation from sociologists. However, health belief model fills the gap to explain the grey areas.

2.2.2 Health belief model

Health belief model was conceived by three prominent thinkers of social psychology - Godfrey Hochbaum, Stephen Kegels, and Irwin Rosenstock. The model explains that belief and attitude of people determine their health related behaviour. This model is based on the perception of an individual in any given health condition. The model is not concerned with only the prevention of chronic illnesses or stigmatised health conditions but also with behaviours related to them. The model states that a person will act in order to avoid a disease or health problem if he or she believes that he or she is personally vulnerable to it; that the recurrence of the illness that faces at least moderate seriousness on some components of his/her to life and that taking certain behaviuor would in definitely be useful by minimizing its vulnerability to the illness or, if the illness occurs, by minimising its seriousnesss. It is also based on the belief that it would not entail surmounting significant emotional hindrances such as cost, convenience, pain and shame.

Perceived susceptibility: Each person has his/her own orientation of the tendency of experiencing health challenge that would seriously affect his/her health. People differ markedly in their orientation of vulnerability to a health challenge. Those who have the orientation of contacting a disease with low end of the high denies the likelyhood of infecting viral serious health condition or disease. Such persons will be less likely to spend on their health care even if they have the wherewithal to do so in terms of cost. Persons in a medium category agree to a statistical likelyhood of disease vulnerability. Persons at the high topmost of vulnerability assume there is real harm, that they will witness negative consequences or particular illnesses. Individuals in this category are likely to be willing to spend on their health care if resources are available.

Perceived seriousness: This implies the beliefs an individual holds regarding the effects which certain health situation would have on his/her condition of health. These impacts can be seen from the perspective of the problems that a disease will occur. Examples are discomfort and pain, loss of work-time, economic burdens, difficulties with family members and links as well as vulnerability to future condition. Individuals who perceive a very serious effect may be moved to seek medical care because this is one of the health conditions that are highly stigmatized.

Perceived benefits of taking action: Action taking disallows the seriousness of an health condition or helps in tackling an illness and this is followed by an individual's acceptance of the susceptibility of a disease and recognising it as serious. The attention of taking action that an individual decides will be facilitated by the orientations concerning the action. Hence, if an individual perceives that it is beneficial to use hospital care or community-based care for health condition, he or she will do so, and will not, if he or she does not.

Barriers to taking action: In line with the above, people might decide not take action despite the fact that a person might believe that the advantages to decide in taking an action is potent. It might be on account of several hinderances which may include the anxiety to recover fully. It may be due to hinderances linked to the features of a treatment which may be easy, it may be costly, non-pleasant, and painful. These features may mislead a person from taking the expected action of seeking and paying for health care (Rosenstock, 1974).

The model also consists of **cues to action,** for example, having a reminder note for oneself, campaigning from media or sick relation with similar disease as significant factors in eliciting or maintaining attempt of behaviour. The construct of self-confidence, or an individual **self-efficacy** in his or her capacity to graciously conclude a task, has added to the model (Rosenstock, 1974), perhaps allowing it to explain for their normal behaviour, such as a physically exercise and active way of life. The HBM depends mainly on the subjective explanations and meanings that individuals give to signs and ill-health.

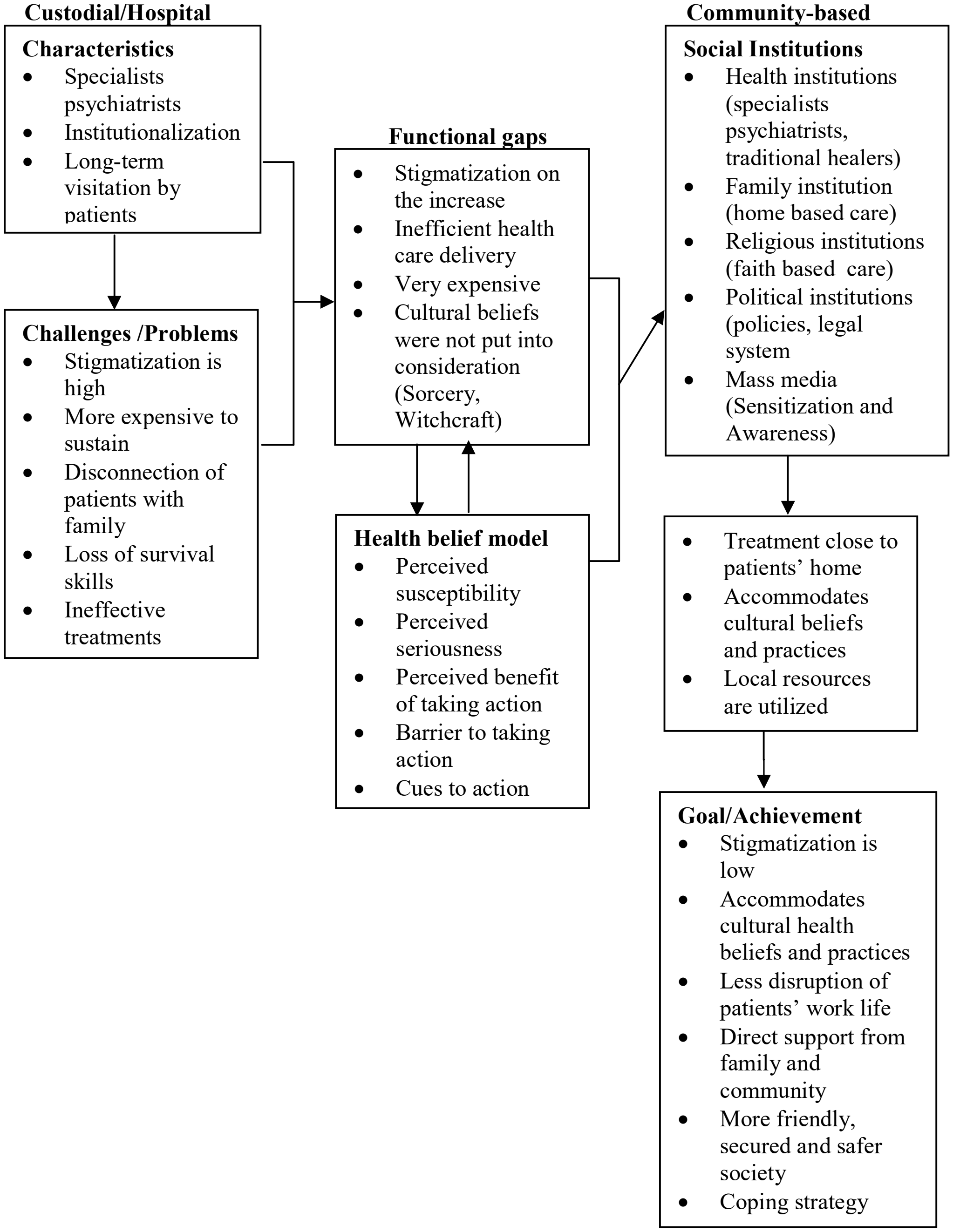
In summary, the health belief model formulates an idea on a decision to take a rightful health behaviour as encouraged by assumed threat, either vulnerability to a particular issue, or the orientation that the condition is serious and decision concerning the hinderances and advantages related with specific changes in action. The perceptions of people about psychiatric disorder will influence the importance attached to individual's health and attitude towards maintaining a good health as well as paying for it. However, when symptoms are not perceived as severe or life threatening, people are likely to underutilise healthcare and be less anxious regarding their health status. This, they do to save cost and utilise income to meet other responsibilities which are considered more important than their personal health.

The health belief system can be further modified into two distinct large headings: pathway to health seeking treatment and taking a particular decision. For you to be healthy, you must decide and respond to action. Decisions depend on human nature; they are often informed by culture and the environment. Others are biological and pattern of health-seeking behaviour. Relatives of a psychiatric patient, for instance are reinforcing one's behaviour. These variables become highly significant using the approach to explain and forecast very difficult way of life or health behaviours that need to be sustained over a period of time, such as mental illness with long period of treatment in some cases.

Criticism

psychiatric problem is one of the most serious disorders that has affected human beings from the time immemorial. A psychiatric patient who is having schizophrenic, depression, mania, or bipolar disorder does not have a sense of judgment to decide on which mode of treatment best suits him/her because he or she is out of touch with reality. He does not know the seriousness of the condition and whether there is the need to take actions or not, even when the available financial resources are bountifully available. He does not have the sense of reasoning as regards taking a particular action that will be beneficial to him/her (see Kelly and McKenna, 1997; Berzins et al, 2003). This includes having bad orientations like people who say that persons living with psychiatric disorder are callous and therefore cannot take decisions on their own. However, this particular model can only be relevant to the immediate family of the patients (caregivers) who will take major decisions on his/her behalf, in terms of the susceptibility, severity as regard to action taken to surmount the health challenges. In terms of the therapeutic approach, the family will decide for the sick person whether he or she should be taken to the hospital for treatment or seek alternative therapy based on the socio-cultural beliefs of the client.

Figure 1: A framework of the community-based psychiatric system and the management of schizophrenia showing a paradigm shift from the hospital based to the community based care.



2.2.3 Conceptual Framework

The conceptual framework structural functionalist theory and health belief model are synthesised in further explaining the paradigm movement from custodial care to the community-based psychiatry system and the management of schizophrenia in South-western Nigeria. The interaction of the relevant factors is illustrated in the diagram in an effort to indicate the connection between dependent and independent variables in the framework. The framework shows that health institution meant to provide good health care services in the society is failing in its responsibility. It is this functional gap that warrants the quest for community-based system in which the community is involved with their socio-cultural beliefs inculcated into the treatment process in response to the prevailing norms, values and customs, which dictate how sickness is understood and behavior response and the pathways to health care in accordance with the particular desires and the local situations happening in sub-Saharan of Africa.

These theories are relevant to the community-based psychiatry system and management of schizophrenia in Southwestern Nigeria because it involves the triangulation of the structural/functionalism theory and health belief model in further explaining how those that suffer mental health problems can receive efficient and effective treatments. In this connection, individuals with psychiatric disorders will be expected to go for healthcare at the traditional institutions and other community based alternatives as ways of escaping from stigma because they are closer to them and involve family members and relatives. Therefore, the framework explains the functions of the mental health care providers in health institutions through community people themselves in health-seeking behaviour. In this regard, the health belief model encourages collaborative efforts by involving people that matter in the treatment process, taking into consideration the socio-cultural background of the individuals. Therefore, health belief model becomes necessary in order to fill the gap created by structural functionalism by looking beyond the germ theory as it was emphasized by structural functionalism.

There is a functional gap or vacuum created by the institutional based care because it is very expensive, there is a disconnection of patients with family, high stigmatization, and loss of survival skills after staying a long period on admission, therefore, the community-based care is ready to offer certain services which will be more environmental friendly and accommodating, taking the cognizance of the belief system and attitude of an individual with reference to the prevailing norms and socio cultural situations existing in sub-saharan Africa.

CHAPTER THREE
METHODOLOGY

Undertaking a study of this nature requires methods that are suitable to gather the needed information on the study objectives. To this end, the methodology reflected a combination of appropriate quantitative and qualitative methods of data collection, analysis and interpretation to achieve the objectives of the study.

3.1 Research design

The study adopted cross-sectional descriptive survey design. Data combination of both methods was done by combining both the qualitative (KIIs and FGDs) and quantitative (Questionnaire) method of data collection.

3.2 Study area

The areas from which the study was conducted are: Oyo, Ogun and Ekiti States in the South-western parts of Nigeria. The region was selected because the South-western Nigeria has been reputed since independence for having the highest deployment of collaborative community-based psychotherapy, (Erinosho, 2010). The 2006 population census indicated that Oyo State had an estimate of 5,591,589; Ogun State had 3,658,098; while Ekiti State had 2,384,212. However, the current estimated population of Nigeria is 200 million (CIA Fact Sheet, 2018).

Oyo State is regarded as the pacesetter state. The state is among the thirty six states of the federation. It is not the same thing with the city of Oyo Town. It is surface land area in South-western Nigeria, with the political headquarters located in Ibadan, the former capital of old western Nigeria. It is surrounded in the north by Kwara State, in the east by Osun State, in the south by Ogun State and in the west partly by Ogun State and partly by the Republic of Benin. It was established in 1976 from Western State, and comprised Ọsun State, which was balkanised in 1991. Oyo State has similar characteristicsis, mainly made up of the Yoruba ethnic stock who are basically farmers but have preference for well urbanized settlement. The original people comprise the Oyos, the Oke-Oguns, the Ibadans, the Ogbomosos and the Ibarapas, all claimed to have migrated from Ile-Ife. Ibadan was the political headquarters of the defunct Western Region, from the periods of European colonisation. Other well known town and cities, and the towns in Ọyọ State include: Ọyọ, Ogbomọsọ, Iseyin, Igbo-Ora, Eruwa, Lanlate, Okeho, kishi, Saki, Iroko, Oje-Owode, Ago-Amodu, Ogbooro, Sepeteri, Ilora, Awe, Ilero, Igbeti, Igboho and Out. Oyo State has geographical boundary area of about 28,454 square kilometers and is ranked 14th by size. The landmass consists of old hard rocks and dome shaped hills, which rises gently from about 500 meters in the southern part and reaching a height of about 1,219 metre above the sea level in the northern part. Some important rivers such as Ogun, Oba, Oyan, Otin, Ofiki, Sasa, Oni, Erinle and Osun river originate in this highland. Oyo State contains a number of natural features including the Old Oyo National Park. There was an earlier habitat for the dangerous African wild dog, (*Lycaon pictus*; C. Michael Hogan. 2009). However, this frank is believed to have been locally eliminated at the moment.The weather is equatoria, prominent with dry and wet seasons with comparatively high steaminess. The dry weather had a duration period of five months from November to March while the raining season commences from April and ends in October. Average daily temperature varies between 25 °C (77.0 °F) and 35 °C (95.0 °F), virtually in a year period.

University of Ibadan is the first academic institution in Nigeria as a University college of London, and it is referred to as the University of Ibadan founded in 1948, and later renamed as a full fledge autonomous university in 1962. The other universities in the State are: Lead City University, Ibadan, Ajayi Crowther University, Oyo and the Ladoke Akintola University of Technology, Ogbomoso. The Polytechnic, Ibadan is located in Oyo State. There are 324 secondary schools and 1,576 public primary schools in the State. Other noteworthy institutions in the city include: the University College Hospital; the first teaching hospital in Nigeria and the International Institute of Tropical Agriculture (lITA). Cocoa House was the first skyscraper built in Africa. The state is home to NTA Ibadan, the first television station in Africa, and the Obafemi Awolowo Stadium, a stadium with a capacity of 35,000. Other major tourist attractions located in the state include: Agodi Botanical Garden, Ado-Awaye Suspended lake, Mapo Hall, University of lbadan Zoological Garden, Ido Cenotaph, Trans-Wonderland Amusement Park, Old Oyo National Park located in the historical site of the ancient capital of the famous old Oyo Empire, Iyamopo and Agbele Hill in Igbeti, Bowers Tower and the Cultural Centre, Mokola.

List of other high institutions include: Dominican University, Ibadan, Kola Daisi Univerisy, Ibadan-Oyo Road, Oyo State Technical University, Ibadan. Atiba University, Oyo, Cornerstone University, Ibadan. List of polytechnics in Oyo State aside the Polytechnic of Ibadan are: The Ibarapa Polytechnic, Eruwa. The Oke-Ogun Polytechnic, Saki, of which they have secured full autonomy and Tsaf Polytechnic, Iseyin, Oyo Road owned by a private person.

The colleges of education in the state are: Federal College of Education (Special), Oyo, Emmanuel Alayande College of Education, Oyo, Oyo State College of Agriculture and Technology, Igbo-Ora, Oyo State College Of Nursing And Midwifery, Eleyele Ibadan, Oyo State College of Heath Sciences and Technology Eleyele Ibadan, The College of Education, Lanlate. A number of accredited private polytechnics were also established in Oyo State: The Kings Poly, Saki, City Polytechnic, Ibadan, Tower Polytechnic, Ibadan, Bolmor Polytechnic, Ibadan among others.

Ibadan North is a local government within Ibadan metropolis. It's headquarters stood at Agodi in Ibadan. It has an area of 27 km² and a population of 306,795 at the 2006 census. It also has bustling academic and economic activities with the presence of the first premier university in Nigeria, the University of Ibadan, founded in 1948, and The Polytechnic, Ibadan established in 1970.

The political domain of Ibadan North Local Government Area is located at Agodi. One of the five local government areas created out of the old Ibadan municipal government in 1991. The geographical area spread to a landmass of 132.500 square kilometres with heavy population base of 2,626 persons per square kilometre. Using a growth rate of 3.2% from 2006 census, the 2010 expected figure for the particular area is approximately 347,998. The local government area also houses the seat of the local council chairman and Government House where the Governor and his family officially resides.

Akinyele and Lagelu Local Government Areas surrounded it to the north, Egbeda Local Government to the east, Ibadan North West to the west and Ibadan North East to the south. Ibadan is not an agrararian settlement, it is an urban centre. Majority of the food crops planted outside the area are being refined in the local government area. It is a place for small, medium and large-scale industries. Selling and buying and other business engagements are also common in the area. It accommodates the highest volume of virtually all different ethnic ethnic groups in the country. Two well known federal agencies or parastatals are within its boundary, the University of Ibadan and the

University College Hospital (UCH) are sited within the land mass. Ibadan North government is subdivided into 12 wards: all the six centres in Oyo State are located within the geographic entity of Ibadan North Local Government of the State. The two community-based psychiatry centres that are selected are based on urbanity and rural are: **Idi-Ogungun PHC**, and **Basorun PHC.**

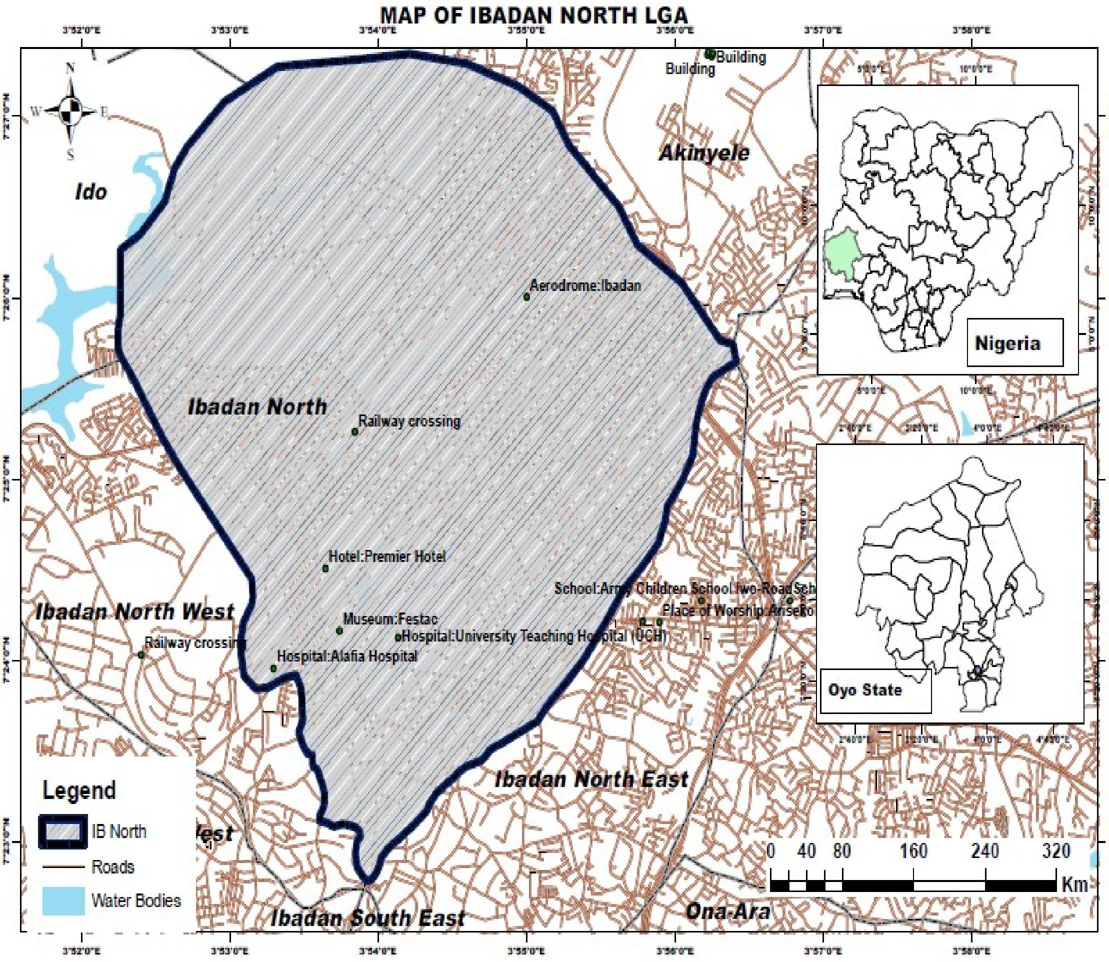


Figure 2: Map of Ibadan North in Oyo State showing the study area.

Ogun State is located in the south-west of Nigeria with a total land area of 16,409.26 square kilometers and an estimated population of about 4 million (National Population Commission, 2006). The state contains 20 local government areas, categorised into four areas: Egba, Yewa, Remo and Ijebu with five local government areas in each zone. There are more than 300 PHC facilities in Ogun State, with primary care personnel ranging from 4 to 20 at each centre (Adebowale, Onofa, Gater, Akinhanmi, Ogunlesi, et al., 2014). In 2011, the Neuro-psychiatric Hospital Aro, Nigeria (the first modern specialised tertiary psychiatric facility in Nigeria) started on the primary care psychiatric services in chosen primary healthcare facilities throughout the state, Onofa, 2013). Ogun State has forty (40) community-based centres, two in each local government, one is cited in urban centre while the other one is located in the rural area throughout the twenty local governments that constitute Ogun State.

Abeokuta North has its headquarters at Akomoje in Iberekodo area of the state capital. It emerges on the 27th of Sept 1991 when the Federal Government of Nigeria created new local government to meet with the demand for government to be closer to the grassroots. It shares common boundaries with Odeda Local Government in the north, Ifo in the south and Egbado north and Abeokuta South in the east and west respectively with a projected population of 229.249 made up of Oke-ona, Gbagura, Owu, and Oke-Ona. Until the recent creation of local council development areas (LCDAs) by the state governmentt. The major language is Yoruba entwined with different dialects. Predominantly farmers but with the move in time, they now engage in other forms of occupations such as quarrying, dye making among others. There is freedom of religion. There is **Iberekodo PHC** that operates on community-based psychiatry service.

Ikenne Local Government -It was established in September 1991 out of the old Remo Local Government. It is fairly semi-urban settlement, made up of five main towns, namely : Iperu, Ilisan, Ogere, Irolu and Ikenne, the headquarter. With a land mass area of about 137.13 sq.km surrounded on the west by Obafemi-Owode Local Government, on the south by Sagamu Local Government, on the east and north by Odogbolu Local Government. Ikenne Local Government Area is one of the existing local council areas in Ogun State, the southwestern part of the country. This local government is dominated with farming and trading as their major occupations. Irolu town is a rural community in Ikenne Local Government Area**.** Community-based psychiatry services aer made available through a primary heathcare facility **Irolu, PHC.**

The local government area (LGA) houses some of the tertiary institutions in the state including the privately owned Babcock University at IIisan, the Ogun State University and the Obafemi Awolowo College of Health Sciences Campus of Ogun State University. Ikenne LGA has good road networks that link villages to the major districts and then to Lagos-Sagamu-Benin Express road. The local government chairman and other elected officials always strive to make this LGA stand out among other areas. The state government has some establishments in this local government area which are construction of Zonal Agriculture Complex, comprising of parastatals like Agro Service Corporation, Ogun State Agriculture Development Project, International Institute of Tropical Agriculture and the Institute of Agricultural Research and Training.

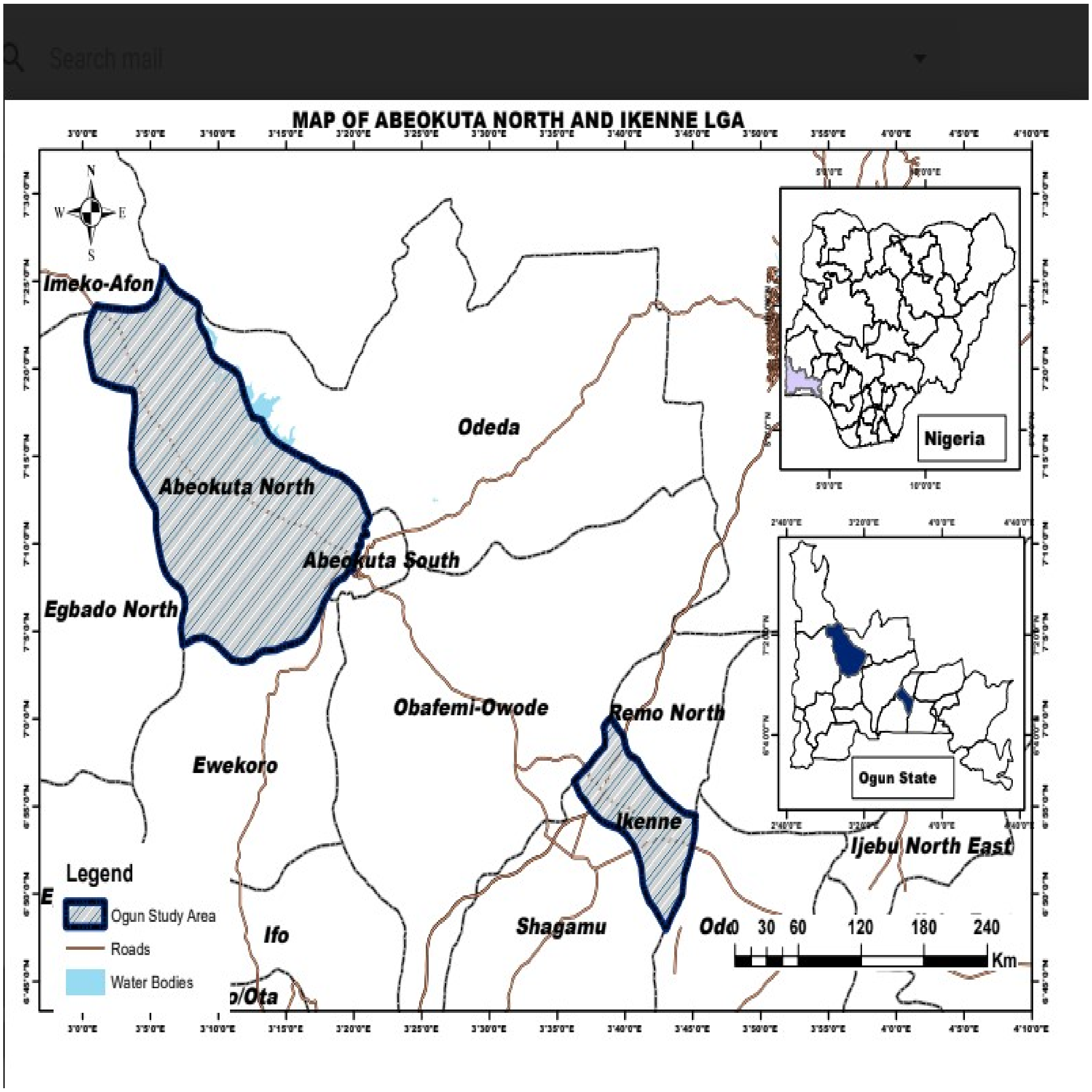


Figure 3: Map of Ogun State Showing the two study local government areas.

Ekiti State became an autonomy state before the English war. Ekiti was one of the many Yoruba states in what is referred to in Nigeria. Ekiti State is cited in the Southwestern Nigeria, evolved on October 1, 1996 together with five other newly created states by the military ruler, General Sani Abacha. The state, carved out from old Ondo State, which includes the old twelve local government areas that comprised of Ekiti Province of old Ondo State; however, on establishment, it kicked-off with sixteen local government councils, with addition of four carved out of the old ones. Ekiti State is one out of the thirty-six states plus the Federal Capital Territory, Abuja that sum up the entire country.

The Ekiti, whose forefather left Ile-Ife happened to be one of the biggest ethnic stocks in Yorubaland. The Ekitis have the same culture and they have cmmon Yoruba dialects known as Ekiti. The unique nature of Ekiti gave the state some specialty among the states of the federation. Minor variations are identified in Ekiti local language from the Yoruba language spoken by other states. For instance, the Ado people in the Local Government Area do not speak the same dialect with the people of Ijero Local Government Area while the people of Ikole area speak different dialect from the people of Ikere area. The communities affected by their locations include: Otun (Moba land) that speaks a dialect close to the one spoken by the Igbominas in Kwara State. The people of Oke-Ako, Irele, Omuo have the same dialect with that of Ijesas of Osun State. However, part of the uniqueness of the Ekitis is that they understand one other very well within the state in spite of the dialectal differences. Moreover, all towns in Ekiti State assume a common suffix, "Ekiti," after their names.

Ado Ekiti Local Government was balcalised from the existing defunct Ekiti Central Local Government by the Ibrahim Babangida Administration in May 1989. It is a local Government that represents a one town local government with various farm settlements for instance, Igirigiri, Ilamuo, Ago Aduloju, Igimo-Kogo, Ago-Aso, Emirin, Temidire Esunmo, Ureje among others. From the period of Lord Lugard amendments of 1916, Ado-Ekiti has been accorded a special administrative feat as a linchpin of administration when it was made the headquarter of Ekiti Divisional Council, it sustained this status until 1952 when Ado-Ekiti District Council was established and commenced operating in this capacity in 1955. In 1996, when Ekiti State was carved out, Ado-Ekiti was the state headquarters. Ado-Ekiti Local Government was seen as the most populous local government in Ekiti State with reference to the 2006 population figure which put the figure at 308,621. Presently, the local government is expected to have a population estimates of 4,3986 person per kilometer.

By geographical location, it is situated on latitude 7^o35 and 74^o47 north of the equator and longitude 5^o11 and 5^o16 east of the greenwich meridian. It is surrounded in the North and West by Ifelodun/Irepodun Local Government and east and South by Gbonyin, Ikere and Ekiti Southwest Local Governments. Its longest North-south extent is 16km and the longest East-west stretch is about 20km. Ado-Ekiti Local Government is one town local government that doubles as local government and state capital which is about 200m above the sea level in the south eastern part of Ireje stream and 500m above the sea level in the North east limit. The landscape is dotted with rounded in selbergs and steep sided hills of volcanic origin such as Ayoba hill central to the region are gently undulating slopes which form the source of streams like Amu, Awedele, Ajilosun , Adere Among others. The Local Government is delienated into 13 wards by the Federal Government. The central city of Ado-Ekiti carries 12 (twelve) out of these, while the other villages share the remaining wards.

The local government is endowed with large number of both skilled, semi-skilled and unskilled labour and middle and high level personnel of the Ekiti State University, Ekiti State University Teaching Hospital **(EKSUTH, Outreached Centre**), Federal Polytechnic, Ado-Ekiti, Government Technical College, School of Nursing, Ado-Ekiti, Crown Polytechnic, Odo, Ado-Ekiti (privately owned), Afe Babalola University, Ado-Ekiti and the several post primary institutions situated within the cities and communities. Also, the Federal/State ministries/institutions and private institutions provide a broad variety of job availabilities for numerous cadres of able staff.

The tourist attraction, especially looking from the scenic beauty formed by the dome shaped inselbergs and vegetation covered valley cum the gently undulating landscape, Ado –Ekiti is also endowed with artificial tourist centres. The place of cultural importance is the ancient Ewi's palace which serves as the cultural administrative arena for Ado and its adjourning villages. It is situated at the very psyche of an average indigene and will certainly be of importance to visitors is the Fajuyi Memorial Park. This is the point where the yearly Remembrance Day Activities for our past leaders is organised.

Ido-Osi Local Government is one of the local government areas in Ekiti State, the place is completely agrararian rural towns and villages. It has proximity to other local governments: Moba, Ijero, Ilejemeje and Ado. The local government includes towns such as: Aaye, Ido, Usi, Ayetoro, Ilogbo, Osi, Ifaki, Orin, Ora, Igbole and some other smaller villages. The local government headquarters is located at Ido with the secretariat sited in-between Ido town and Usi. Among her contemporary in Ekiti State, **Ido-Osi** was endowed with highly educated people with early siting of churches and elementary school in Usi Ekiti.The population census of Ido-Osi Ekiti is 160.001 while the projection estimate of the population of the same local government is put at 218.100 in the year 2016.

Id-Osi- is mainly an agrararian economy with people going into farming activities such as tuber crops and grains such as: yams, cassava, maize, rice among others. Very few textile industries in the local government devoted mainly to adding values to the agricultural produce. Other Industrial undertakings are in the areas of printing, bakeries, weaving, carpentry among others. The lucrative industries in the local government include :Timber/Saw mills which are situated in Ido-Ekiti Sawmill, Ora-Ekiti Sawmill, Usi-Ekiti Sawmill, and Osi-Ekiti Sawmill, **(Federal Medical Centre, Outreached Centre, Ido).** Virtually all the towns in the local government areas have traditional festivals periods which are comemmorated at various particular period of time.

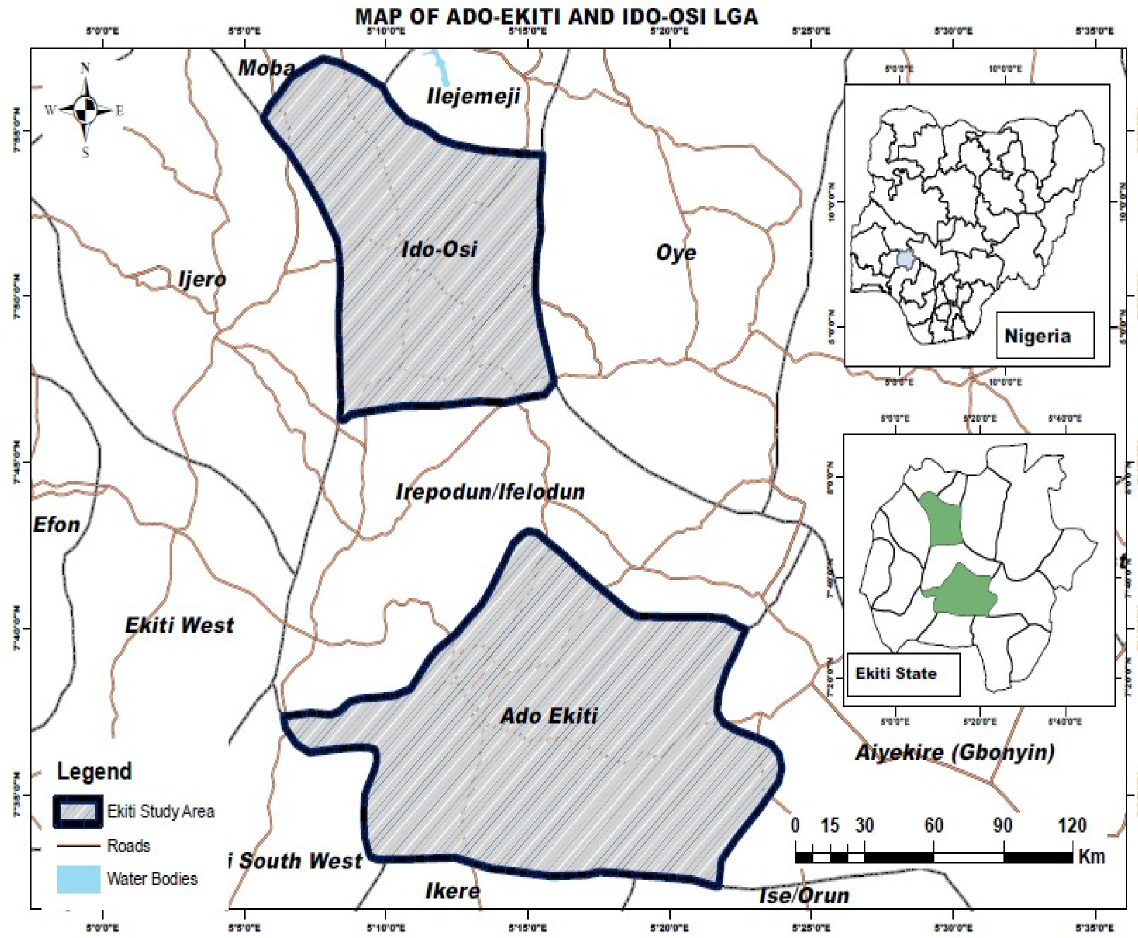


Figure 4: Map of Ado Ekiti and Ido-Osi Local Government areas in Ekiti State showing the study areas

Table 1: Location of the CBP centres across the three states in South-western Nigeria

S/N	COMMUNITY BASED PSYCHIATRY CENTRES IN SOUTH WEST, NIGERIA			
	OGUN	**OYO**	**EKITI**	
1.	**Egba Zone:** Comprises five local governments, two centres in each local govt. One in the rural area and one in the urban centre.	**Idi-ogungun:** Primary health centre, (PHC), Agodi-Gate.	**Ido-Osi:** Outreach programme of the Federal Medical Centre, located in rural area of Ekiti State.	
2.	**Yewa Zone:** Comprises five local governments. Two in each local government, one in the rural area, one in the urban centre.	**Bashorun:** Primary health centre, (PHC), Basorun Ibadan.	Outreach programme of Ekiti State University Teaching Hospital, situated in the urban centre, Ado-Ekiti.	
3.	**Ijebu Zone:** Comprises five local governments, two in each local govt., one in the rural area and one in the urban centre.	**Sango:** Primary health centre, (PHC), Sango, Ibadan.		
4.	**Remo Zone:** Comprises five local governments, two in each local govt., one in the rural area and one in the urban centre.	**Agbowo:** Primary health centre, Agbowo, (PHC), Ibadan.		
5.		**Barika:** Primary health centre, Barika, (PHC), Ibadan.		
6.		**Dominican** Brother's Samonda, (PHC), Ibadan.		

Source: Pilot study, 2018

3.3: Study population

The study population consists of the relatives of the psychiatric patients, mental health professionals or psychiatric service providers and the community.

3.4 Sample size and sampling procedure

Table 2 shows the sample size of the caregivers (relatives) of the schizophrenic patients that were selected for the management of schizophrenia in the community-based centres in South-western Nigeria. The total figure of the registered schizophrenic patients gotten from the hospital records in all the selected centres was one hundred and sixty four (164). Though there were other forms of mental health problem been treated at the centres such as depression, mania, bipolar disorder, affective disorder, anxiety disorder, and others. The study focused primarily on schizophrenic patients. However, two caregivers (relatives) who accompanied the schizophrenic patients to the hospital for treatment were selected for the sample size, totaling 328 respondents for this study.

Table 2: Total numbers of patients and their respondents- caregivers across the South-western, Nigeria

S/N	**STATES**	**LOCATION "A"**	**LOCATION "B"**	**TOTAL NO OF PATIENTS**	**TOTAL NO OF THE RESPONDENTS RELATIVES FOR THE SELECTED STATES**
1	Ogun	Ikene PHC, Irolu = 30 Px	Abeokuta North PHC, Iberekodo, Abeokuta, =30 Px	60	60 x 2 = **120**
2	Oyo	Basorun PHC, Basorun Ibadan =26 Px	Agodi Gate, Idi-Ogungun PHC, Ibadan. = 30 Px	56	56 x 2 = **112**
3	Ekiti	Out-reach Prog. Of FMC, Ido-Osi. =20 Px	Out-reach Prog. of Ekiti State University Teach. Hosp. Ado-Ekiti =28 Px	48	48 x 2 = **096**
			TOTAL	**164 patients**	**328 respondents**

Source: Hospital Records, 2018 Px = Patient

Table 3: The table below shows the sample size of the respondents who are mental health professionals in the community-based centres across the selected states. The table indicates that there are psychiatrists, Social workers, Community health extension workers (CHEW), Faith-based healers and trado-madical practitiopners, all present across all the community-based centres identified for this study. Overall, 33 professionals were sampled from all the community based centres.

Table 3: Community-based centres' professionals in the selected states

S/N	NO OF HEALTH PROFESSIONALS	OGUN	OYO	EKITI	TOTAL	DATA COLLECTION INSTRUMENT
1.	Psychiatrists	2	2	2	**06**	KII
2.	Social Workers	2	1	2	**05**	
3.	Community-health officers (CHO) Nurses	2	2	2	**06**	
4.	Community health Extension Workers (CHEW)	2	2	2	**06**	
5.	Faith-based healers	2	1	2	**05**	
6.	Trado-medical practitioners	2	1	2	**05**	
	TOTAL	**12**	**09**	**12**	**33**	

Source: Hospital Records, 2018

Sampling procedure

The study adopted the multi-stage sampling technique to select the participants in this study. First, the study adopted purposive sampling technique to select south west from the six geo-political zones of Nigeria. South west has been reputed since independence for having the highest collaborative psychotherapy; and these are: Oyo, Ogun, and Ekiti States. Second, purposive sampling method was utilized to choose Oyo, Ogun and Ekiti States based on the existence of community-based centres in the three selected states. Third, cluster sampling technique was adopted to select one primary health centre PHC in the rural area and another primary health centre PHC in the urban centre. Fourth, the purposive techique was adopted to select one centre in the local setting and another centre in the urban centre based on its functionality and availability of personnel.

Table 4:Multi- Stage Sampling Procedure

Stages	**Sampling techniques**
1st stage	Purposive sampling technique was adopted to select South-west from the six-geo-political zones in Nigeria.
2nd stage	Purposive sampling technique was adopted to select Oyo, Ogun, and Ekiti States where community-based facilities exist.
3rd stage	Cluster sampling technique was adopted to choose one centre in location **A,** regarded as the centre in **rural** area and another centre in location **B**, regarded as the centre in **urban** area.
4th stage	Purposive sampling technique was adopted to choose one centre in the rural area and another centre in urban centre based on its functionality and avilability of personnel.

3.5 Method of data collection

Both quantitative and qualitative methods of data collection were adopted in this study.

Quantitative

Three hundred and twenty eight (328) copies of a standardized questionnaire were administered to the families of the patients with schizophrenia. This took place at the facility during the clinic sessions. The questionnaire was administered to at least two significant relative members, one of the parents and a sibling. The questionnaire was administered among relatives of all the patients found registered in the facilities used.

Qualitative

This study conducted key informant interview (KII) with the psychiatric service professionals across all the states. KII was conducted with thirty three (33) professionals to elicit information on the care of the clients, the appropriateness of the community based system to psychiatric service, its potential at reducing level of stigmatisation, stereotyping and discrimination in the community.

Focus group discussions (FGDs) were basically used in the communities where the facilities are located across the three states. Four FGDs were conducted per each location and a total of eight FGDs per state, totalling 24 FGDs across the three states. It was conducted among male adult, female adult, male youth and female youth in each of the two centres.

Inclusion criteria:

- The families of schizophrenic patients who have already spent at least six months visits to the facility.
- One of the parents, for instance, father/mother and a sibling to be included.

3.6 Instrument of data collection

The instruments for data collection include: key informant interviews guide, focus group discussion guide and questionnaire. These instruments were used to gather data from the participants, discussants and respondents respectively.

3.6.1: Key Informant Interviews: A total of thirty three key informant interviews were conducted to collect important information for the study. The respondents were selected across all the trained mental health workers from the selected centres

3.6.2: Focus Group Discussions: For this study, twenty four sessions of focus group discussion were conducted among the community people where the facilities are located with the projection of a minimum of six respondents per session. This was conducted among the male adults, female adults, male youths and female youths. FGD is ideal among the community people given the admonition by Kelly and McKenna, (1997) and Berzins et al, (2003), that a psychiatric patient does not have a sense of judgment to decide on issues pertaining to his/her status because he or she is out of touch with reality. Also, language was a criterion that was considered, that is, the researcher made sure that all the respondents selected understand and can speak well the language that was used in the moderation. In addition, each of the research instruments was made up of two sections. Section A and B centred on the socio-demographic variables of respondents and the subject matter of the study. The research instruments were translated to Yoruba Language to cover for situations where interviews and focus group discussions in that particular language spoken in the community.

3.6.3: Questionnaire: Three hundred and twenty eight (328) copies of questionnaires were administered to the families of the patients with schizophrenia. This took place at the facility during the clinic session. The questionnaires was administered on at least two significant relatives member, either the father or the mother and a sibling who accompanied the patients to the centres during the clinic session.

Table 5: Data collection matrix by objectives

Objectives	**Questionnaire**	**FGD**	**KII**
Objective 1	√	√	√
Objective 2	√		√
Objective 3	√		
Objective 4	√	√	√
Objective 5	√		√

The research instrument for the survey was a structured questionnaire consisting of five sections: A .B. C. D and E**.**

Section A: This examines the socio-demographic items which requires the participants to respond to the socio-demographic variables such as: age, gender, marital status, education qualification, income, religion and number of dependants among others.

Section B: This relates to the public knowledge about schizophrenia, contains probing questions on community-based psychiatry and opinion about etiology of mental illness.

Section C: This captures the public stigmatization and stereotyping of patients or the public's knowledge on stigmatization and stereotyping of mentally ill patients. Attribution Questionnaire Short Form (AQ-9) is relevant here. This 9-item scale examines nine stereotypes about people living with psychiatric disorder. These labels include: blame, anger, pity, help, violence, fear, avoidance, discrimination, and coercion. Item-responses are coded on 9-point opinion scales (ranging from "not at all" to "very much). The regularity of the scale, measured by coefficient alpha was 0.956.

Section D: This is the coping patterns of the psychiatric patients and their kins. The scale measures the extent to which the respondents' perceive the patient stigmatisation. The respondents responded YES or NO with further probing questions.

Section E: This deals with the relative care burden. The information will assist us to have knowledge about caring aspects and respond to their answer more properly.

Section F: This is connected to the patronage and utilization of the community psychiatry. The health care utilization was measured using the scale developed by Akaah and Lund (1994). This scale measured the extent to which the respondents patronize and utilize the community psychiatric.

3.6.4: Selection and training of field assistance

Field assistants were important and necessary in view of the different locations of the study that cut across the three states in the Southwestern part of the country. Two research assistants were recruited from each of the three states, particularly those who are knowledgeable in carrying out research in hospital related studies. The field assistants were trained on how to go about collecting the data and how to handle the instruments of data collection. The field assistants were recruited from the different targeted state areas because of their familiarity with the study areas, the people and their culture. The local dialects is also considered. Those selected were unemployed university graduates who understood the purpose of the study and the problems encountered in any social research.

Some of those recruited in Oyo State were those being used to conduct research with National Institute of Social and Economy Research (NISER) Ibadan, while those engaged in Ekiti and Ogun State were those unemployed graduates who were volunteer members of staff with those community-based centres. They were paramedic graduates who needed job experience. However, they were all supported by medical social workers who were attached to some of the community-based centres.

3.6.5: Field supervision

Each group of the interviewers in each of the community-based centres in the three states of the study areas in the Southwestern parts of the country had a supervisor. These supervisors commanded the respect of the public in their differents communities. The supervisor, in each group assisted the investigator in the conduct of the research work. He provided daily information to the investigator about field activities and also assisted in planning for everyday excercise.

3.6.6: Data collection procedure

At the beginning of the field work, or data gathering, permission of the management of the community-based centres was secured and the main aim of the research was disclosed. The primary information was secured via the use of questionnaires, Key Informant Interview (KIIs) and Focus Group Discussion (FGD) guides. Questionnaire was administered to elicit information (Quantitative data) while KII and FGD guides were utilized for interviews, to collect qualitative data to complement the findings. The questionnaire was administered to the relatives of the patients suffering from schizophrenic disorder and through the help of the trained research assistants.

The Yoruba version of the quetionnaire was made available, but entry was done in English version for easy analysis. Each respondent was informed about the purpose of the research, his or her approval was obtained. The begining of data collection started by the principlal investigator by administering the questionnaire. The number of the questionnaire administrator allocated to each research assistant was dictated by the allocation of the sample size earmarked to each community-based centres across the three states. The numbers of KII were based on the numbers of the different cadres of staff working with the community-based centres, while the FGD selection was based on the standard procedure in community studies of at least six people and not exceeding twelve people in conducting the focus group discussion. The interview was recorded with powerful recording machine by the research assistants who were trained on qualitative techniques. The researchers and interviewers also act as facilitators whom were assigned with taking notes during interviews and discussions which were later developed after the interview. Both research techniques, that is, quantitative and qualitative technics of data collection were done simultaneously.

3.6.7: Data management

Data were secured via the process of collation, storing, and processing of data. The information gotten were sorted and stored to ensure that none was left out in the process. Interviews were recorded on audio tape and notes were taken simultaneously. The recorded interactions and engagements were transcribed and entered into the computer. The recorded interviews in the external CD drive were kept safe. Copies of questionnaires were administered and received from the field accordingly to ensure that all the copies of the questionnaire were retrieved. Computer backup files of all the data (both quantitative and qualitative) was done on an external CD drive and kept in a secured place.

3.7 Method of data analysis

Quantitative data

The data generated through quantitative technique was analysed using the statistical package for the Social Science (SPSS). The analysis involved univirate, bivariate and multivariate.

Univariate analysis

The univariate analysis was used for simple statistics to examine and describe the variation in a single variable. The univariate analysis describes and examines the background characteristics and distribution of respondents according to the socio-demographic variables. Frequency distribution tables and percentages were employed to highlight the responses of the respondents according to individual characteristics. It was also used to determine the variability of the variables used in further analysis,

Bivariate analysis

This involves examining and describing the relationship between the variables. The tests was employed for cross tabulation and Chi-square. Chi-square test is a non-parametric statistical method that deals with the difference between frequencies observed in the sample and expected frequencies obtained from the distribution. Given that the correlation is the most common test for significance of the relationship, it was therefore used in this study to verify the connection between the socio-demographic variables of participants and the patients' satisfaction with the community-based psychiatric services

Multivariate analysis

The multivariate analysis was done through multiple regressions that predict the variables and patterns of links between the socio-demographic variables and the care giving attitude connected with the perceived stigmatisation of the persons living with scizophrenic illness.

Qualitative data

Qualitative data were transcribed, and translated from Yoruba to English in some cases before being transcribed to English. The qualitative data were analysed based on the objectives of the study, and content analysis guided the interpretation of the data. Content analysis in relation to devising exactly and accurately categories that applied to the material analysed in accordance with details formulated rules and procedures was adopted. Prior to the coding, transcription was read and re-read. The researcher then proceeded to the two phases of identifying and sorting out responses. Similar thoughts expressed across the participants during KIIs and FGDs were identified based on the objectives of the study.

The approaches allowed for free association of thematic issues and adoption of frequently reappearing idea in sorting and synthesizing large volume of data. Finally, the cassettes contain ning the recording of the interview were kept in cassette and, after the transcription into the computer, were properly kept and locked up in a safe. Reliability was achieved by the use of inter-coder reliability.

3.8 Ethical consideration

The study was reviewed for ethical consideration to deal with the integrity of the researchers and protection of the study population. Approvel was sought and obtained from the Social Science and Humanities Ethics Review Committee (SSHERC), University of Ibadan with approval number UI/SSHEC/2016/0020. Consent of all the people involved in the study was sought at different levels. Individual consent was sought and obtained at the community level, household and during the interviews. The professionals were respected for their time and responses, and their consents sought in line with their professional ethics. At the overall level, the following ethical issues were addressed: Confidentiality of data, No harm to the participants, Voluntariness, Beneficence and Justice.

Confidentiality: Before the commencement of the interview sessions, participant were given assurance of protection of their identities. None of the data instruments required their names, addresses, and any contact traceable to the particiopants. Only identification number or nickname were assigned to each participant in order to protect their identity. Therefore, all the responses that were given by the respondents were handled confidentially.

No harm to the participants/respondents: This refers to the process of protecting the participants in the conduct of the research from harms either in the course of the research or as a consequence of it.

Voluntariness: Involvement of the respondents in the research was voluntary. Written and informed consents were obtained for voluntary participation in the study. These were necessary because they served as evidence that the process actually took place and respondents gave authorization to be involved in the study. The respondents were free to refuse to involve in the research and they can disengage from the research without penalty or punishment.

Beneficence: This refers to the responsibility of researchers to maximise the benefit, that is value added to the health or welfare of individuals or the society as a whole.

Justice: Before the commencement of the interviews, participants were given assurance of fair and just in terms of their presentation of their view without alteration. Participants were also given assurance of their righjt to information about the outcome of the study was guatanteed. They were also assured of non-denial of any incidental benefit arising from the conduct of the research.

3.9 Limitation of the Study

This work is a collaborative study that ought to have sought for financial assistance as it dealth on mental health of an individual in the society, it therefore represent the knowledge and perceptions of people as regards the mentally–ill persons in the society. The study did not deal with the clinical aspect of the treatment but relied on the assessment of the health condition of the mentall-ill individual in the community, from the perspective of the caregivers, mental health providers and the community.

There are limitation of survey that depend on recalls and beavioural study, It is important to identify reported cases of mental illness among the sub-population might not be accurate as clinical assessment as lack of knowledge about mental illness might also lead to under-reporting. The health challenges could also have been over-reporting because some other forms of mental health problem aside from schizophrenia have similar symptoms. This could affect the degree of accuracy in terms of diagnosis. However, effort were made to minimize this problem to the barest minimum level by using different questions as checks for previous responses to similar questions and adoption of triangulation of sampling techniques, using both quantitative and qualitative instruments to corroborate the different findings.

Ability to also follow the ethics in research assisted to gather reliable information. Most interviews were conducted for the mentally-ill persons. The approach helped to gain more reliability and validity for the study.

CHAPTER FOUR

DATA ANALYSIS AND INTERPRETATION

This section shows the analysis of the field work which was conducted on the community-based psychiatric service model and the management of schizophrenia in South-western Nigeria. The study made use of questionnaires which were analysed with statistical package of the social science and interview method which was transcribed and the result presented in this chapter.The study focused on three hundred and twenty eight questionnaires administered across the three states with at least two centres per each state. In Oyo State, Idi-Ogun Primary Health Centre (PHC) and Basorun Primary Health Centre (PHC), in Ogun State, Iberekodo Primary Health Centre (PHC) in Abeokuta North Local Government and Irolu Primary Health Centre (PHC) in Ikenne Local Government and the outreached Centre of Ekiti State University Teaching Hospital, Ado Ekiti, and Outreached Centre of Federal Medical Centre, Ido-Osi.

Qualitative data was secured through the key informants interviews (KIIs) and focus group discussions (FGDs). The key informant interviews had considerations for those that required specialised knowledge about psychiatric disorder, the etiologies and the management of the disorder while focus group discussions had considerations for gender balance and age group. It was conducted among the young male, young female, adult male, and adult female. This was conducted around the venue where the facilities were located, their general opinion was sought especially in this part of the world where causes and management concerning mental illness were rooted in magic and spirituality and explanation towards the etiology and treatment were explained in the same philosophy.

4.1a Socio-demographic characteristics of patients

Table 6 shows that the majority (54.3%) of the participants were 21-30 years of age, it shows high percentage of the population of the patients that falls within the age brackets which is an indication that most of the cases of schizophrenia are commonly diagnosed at late teenage and early adulthood in the course of one's life, (Judge, 2004). 20.4% were 31-40 years of age, 14.9% were 10-20 years, 4.6% were 51-60 years while 5.8% were 41-50 years. The table further states that the majority (61.9%) were male, which is an indication that apart from genetic, men are prone to develop schizophrenia because of the environmental and life style factors which predispose them when they engage in drug and other substance while 38.1% were female.The table further shows that 43.6% were married, 47.0% were single, 9.1% were separated, while 0.3% were divorced. The table further reveals that 19.2% had no formal education, 14.3% had primary school certificates, 28.4% had secondary education, 9.8% had OND, 8.2% had HND, 16.5% acquired a university degree, while 3.7% had certificates. Table shows that the majority (56.4%) were Christians, 22.6% were Muslims, 6.1% were traditional worshippers while 14.9% had other gods.The table also reveals that the majority (67.1%) were Yoruba, this is expected because of the location of the study. 11.9% were Hausa, 15.2% were Igbo while 5.8% were from other ethnic groups The table reveals that 16.2% were civil servants, 26.5% were self- employed, 6.7% were artisans, 2.4% were students, 26.8% were farmers,16.5% worked in private establishments while 4.9% were unemployed.

Table 6: Distribution of socio-demographic characteristics of the patients

Socio-demogrphic		Frequency	Percentage
Age	10-20	49	14.9
	21-30	178	54.3
	31-40	67	20.4
	41-50	19	5.8
	51-60	15	4.6
Sex	Male	203	61.9
	Female	125	38.1
Marital status	Single	154	47.0
	Married	143	43.6
	Separated	30	9.1
	Divorced	1	.3
Education status	No formal education	63	19.2
	Primary school certificate	47	14.3
	Secondary school certificate	93	28.4
	OND	32	9.8
	HND	27	8.2
	University degree	54	16.5
	Others	12	3.7
Religion affiliation	Christian	185	56.4
	Muslim	74	22.6
	African traditional religion (ATR)	20	6.1
	Others	49	14.9
Ethnic group	Yoruba	220	67.1
	Hausa	39	11.9
	Igbo	50	15.2
	Others	19	5.8
Occupation	Civil servants	53	16.2
	Self-employment	87	26.5
	Artisans	22	6.7
	Farmers	88	26.8
	Students	8	2.4
	Work in private establishments	54	16.5
	Unemployed	16	4.9

Field Survey, 2018

4.1b Socio-Demographic variables of respondents caregivers

Table 7 presents socio-demographic variables of participants primary caregivers across the three selected states in Nigeria: Oyo, Ogun, and Ekiti respectively. Table 7 shows that 56.4% of the respondents were 20-30 years of age, 20.7% were 31-40 years of age, 17.7% were 41-50 years while 5.2% were 51-60 years.This shows that age 20-50 years is the age bracket when one is expected to be more active with the capacity of taking care of dependants without serious stress. The table also reveals that 61.6% were females while 38.4% were males. It was further shown that 46.3% were married, 41.2% were single, 7.6% were separated, 3.4% were divorced while 1.5% were widowed.

The respondents' educational level reveals that the majority of the respondents (33.2%) acquired university education. The table further reveals that 10.4% had no formal education, 11.9% had primary school certificates, 20.7% had secondary education, 10.7% had OND certificates , 6.7% had HND certificates, 2.4% possess a master degree certificates while 4.0% had other forms of education. The table shows that 54.0% were Christians, 39.0% were Muslims 1.2% were traditional worshippers while 5.8% had others.

The table 7 also reveals that 63.1% were Yoruba, this is expected because the study was conducted within the Yoruba ethnic regions of the country (South-west). Only about 23.2% were Hausa, 12.5% were Igbo while 1.2% were from other ethnic groups .Equal proportion (19.2%) were civil servants and self- employed. About 5.2% were artisans, 25.3% were students, 8.5% were farmesr, 8.2% works in private establishments. The proportion of those that were unemployed is 13.1%. Very few (1.2%) had other occupations. In terms of their place of residence, 14.9% stay with their father, 12.2% stay with their mother, 23.2% stay with their siblings, 16.2% stay with their step parents while 33.5% stay with their other relations.

Table 7: Distribution of socio-demographic characteristics of caregivers

Socio-demographic		Frequency (N=328)	Percentage
Age	20-30	185	56.4
	31-40	68	20.7
	41-50	58	17.7
	51-60	17	5.2
Sex	Male	126	38.4
	Female	202	61.6
Marital status	Single	135	41.2
	Married	152	46.3
	Separated	25	7.6
	Divorced	11	3.4
	Widowed	5	1.5
Educational status	No formal education	34	10.4
	Primary school certificate	39	11.9
	Secondary school certificate	68	20.7
	OND	35	10.7
	HND	22	6.7
	University degree	117	35.6
	Certificate	12	3.7
Religion affiliation	Christian	177	54.0
	Muslim	128	39.0
	African traditional religion (ATR)	4	1.2
	Others	19	5.8
Ethnic group	Yoruba	207	63.1
	Hausa	76	23.2
	Igbo	41	12.5
	Others	4	1.2
Occupation	Civil servant	63	19.2
	Self-employment	63	19.2
	Artisan	17	5.2
	Student	83	25.3
	Farmer	28	8.5
	Work in a private establishment	27	8.2
	Unemployed	47	14.3
Relationship with patient	Father	49	14.9
	Mother	40	12.2
	Sibling	76	23.2
	Step parent	53	16.2
	Neighbour	110	33.5

Source: Field Survey 2018

4.2: Peoples’ knowledge about schizophrenia

4.2.1: Public knowledge about schizophrenia

Table 8 shows that larger percentage 38.4% reported that their wards started having schizophrenic about one year ago while 6.1% reported being diagnosed of mental illness since four years back. The table reveals that a larger percentage (36.6%) reported that people had some knowledge about mental illness while very few (10.4%) reported that they had no knowledge. The table further shows that a larger percentage (23.5%) reported that they were scared with the patients while small percentage (14.0%) reported that they were cordial with the patients. The table also reveals that the majority (20.7 %) reported that scizophrenic was caused by afflictions while others had various explanations on the causes. Table 8 reveals that larger percentage 45.7%, were paranoid cases, this also reflects the most common of all schizophrenic disorders all over the world.The table further indicates that the majority about 30.5% reported that such patients are dangerous while 18.0% reported that they are unpredictable. The table reveals that the majority (69.5%) reported that the illness brings shame into the family. The table shows that some (22.6%) reported that the common symptoms of scizophrenia was talking to self or hallucination while others expressed other forms of signs and symptoms.The table shows that 61.0% reported that a complete recovery is rare while 11.6% reported that the illness can be managed. The table further reveals that almost half of the respondents, 45.7%, reported that it can be prevented while few, 14.7% reported that it is contagious. The table reveals that the 31.1% reported that visitation to the hospital usually come last in the health seeking behaviour of most people while few, mostly educated seek help first from the hospital before going to other sources.

Table 8: Peoples' knowledge about schizophrenia

Knowledge	Response	Frequency(N=328)	Percent
Time range about the existence of mental challenge	1 Year	126	38.4
	2 Years	44	13.4
	3 Years	82	25.0
	4 Years	20	6.1
	5 Years	56	17.1
Awareness about schizophrenia	Mental illness	120	36.6
	Physical illness	93	28.4
	Environmental induced	81	24.7
	I dont know	34	10.4
Relationship with patients	Avoidance	75	22.9
	Distance	68	20.7
	Scary	77	23.5
	Cordial	46	14.0
	Suspicious	62	18.9
Perceived cause of schizophrenia	Genetics	50	15.2
	Drug use	65	19.8
	Punishment from God	35	10.8
	Afflictions	68	20.7
	Evil spirit	50	15.2
	Environmental factors	60	18.3
Types of schizophrenia	Catatonic	92	28.1
	Hebepheric	86	26.2
	Paranoid	150	45.7
Nature of schizophrenia	Dangerous	100	30.5
	Non predictable	59	18.0
	Weak	79	24.1
	Dirty	90	27.4
Fatality of schizophrenia	Can kill	45	13.7
	Bring shame and disgrace	228	69.5
	Cannot kill	55	16.8
Signs and symptoms of schizophrenia	Talking to self	74	22.6
	Laughing inappropriately	30	9.1
	Not sleeping at night	50	15.2
	Poor personal hygiene	51	15.5
	Physical and verbal aggression	42	12.8
	Restlessness	36	11.0
	Abnormal behaviour	10	3.0
	Making illogical statements (talking rubbish)	15	4.6
	Claiming people are talking about him/her	9	2.7
	Claiming people are planning to harm him/her	5	1.5
	Refuse to do his/her usual activities for no reason	1	0.4
	Keeping to self	1	0.4
	Hoarding rubbish	4	1.2
Curability	Total cure available	90	27.4
	Not curable	200	61.0
	Management	38	11.6
Prevention	Preventable	150	45.7
	Not preventable	130	39.6
	Contagious	48	14.7
Treatment pathways	Hospital+Traditional+Prayer	60	18.3
	Traditional+prayer+Hospital	60	18.3
	Prayer+Traditional+Hospital	102	31.1
	Traditional+Hospital+Prayer	63	19.2
	Prayer+Hospital+Traditional	24	7.3
	Hospital+Prayer+Traditional	19	5.8

Source : Field Survey 2018

Schizophrenia was identified by the caregivers as disease with psychotic syptomology causes by drug use, ancestral curse, witchcraft and relapse. They perceived this disease in a negative sense that it may result from direct attack or punishment inflicted by man and spiritual forces. Psychosis is a difficult psychiatric disorder that can be destructive for those who suffers from the disorder. Signs across persons exist in a different forms but definately fall within a certain group: persecutory hearing voices, wild behaviour, incoherent speech and ‘‘negative signs’’ (reductions in brain performance, general encouragement, and affect, not having interest in self cleaness or social discussion). Not long ago, the better signs are easily manageable whereas the poor signs are very difficult to manage with drugs.

Stigma, in the form of label (‘‘they’re violent’’), biases (‘‘I hate the mentally-ill persons’’), and segregation (‘‘they should not come out on the street’’), are quite frequent with regards to psychosis. Frequent misbeliefs include that psychosis is a many dimension personality illness and that people affected with psychosis are usually more dangerous and violent than the general populace. Many even find it difficult to categorise psychosis as a disease and link the etiology of the illness to abuse of substance, poor family upbringing or that they are justs ‘‘mad’’.

The respondents also alluded to the explanations given by the medical model, however, a large numbers of the respondents believed in local explanations of the disease and its remedies. There was a diverse opinions concerning the cause and non- availability of absolute cure as far as the health condition is concern.

> A community based health centre observed that this form of mental illness has varieties of causes and that permanent cure is possible if prompt action are taken at the appropriate time. They opined that:
>
> > Schizophrenia is a psychotic disorder which may be caused by heredity, ancestral curse, spiritual attack, “thinking, fear, alcoholism, excess use of hard drugs.” They feel, “there is cure if the people take adequate treatment before it worsens.”**(FGD Male Adult, Iberekodo, Abeokuta).**

A Muslim clergy based on his wide knowledge on health and illness noted that reciting certain verses of the holy Qurian and the Hadith of the prophet can ward off all kinds of afflictions regardless of the nature of medical condition since Islam is a complete way of life. He noted that:

> From islamic perspective, psychiatric disorder might enter into the body system, therefore, reciting verses of the holy

> Quri'an and hadith, in form of ''Rukia'' in order to ward-off the jinn from the sufferrer. Islam is a religion and a complete way of life, the answers to any afflictions that comes to our ways can be found in the Qur'an and Sunnah of the Prophet Muhammad
> (SAW)"(**IslamicCleric/Male/Respondent/KII/Idi-Ogungun/Agodi-Gate).**

An FGD that comprised of Alhaja, Hajia, Excel, Pretty, Gold, and Silver based on their lay man knowledge about mental illness also share these as the causative factors and management of mental illness. They opined that:

> Schizophrenia is a mental illness which may be caused by poverty, emotional instability (disorder), spiritual attack, accident, pregnancy induced mental problem, disappointment from marriage and it could be treated and cured."**(FGD, Female Youth, Iberekodo, Abeokuta).**

A female nurse based on her modern medical training noted that it is a medical condition with many symtomps at the onset of the problem, she, however opined that it can be cure medically. She noted that:

> Schizophrenia is an affliction that affects people which can be cured with medications in the hospital, when somebody you used to joke with suddenly could not sleep at night. Suddenly believed that you are planning to kill him or her without any physical evidence. Then, start hearing voices is that not spiritual? schizophrenia starts with spiritual problems"**(KII/ Female, Nurse/Irolu PHC, Ijebu-Ikene, 2018).**

A female psychiatrist with years of experienced on the job asserted that treatment of mental illness is not the same as treatment of malaria that one expect the problem to disappear after one or two days, managing someone with mental health condition has to endure overtime. She asserted that:

> People believe it is caused by evil spirit. They believe is incurable. They see it as a spiritual and incurable illness which they later modify their taught about when they see patients recover from the illness, since psychiatric problem is not a disorder that can be cured in just a week, thus most people see it as spiritual.It depends on the people's perception of the illness. Some believe it can't be cured. Thus they tend to avoid people living with schizophrenia on many cases."**(KII/ Female/Psychiatrist at EKSUTH, 2018).**

A faith based healer established that all evils, sickness, barrenness are all spiritual and that mental illness is inclusive, most people suffering from this problem are been directed by the spirit and he also belief in the power of holy spirit to ward off the afflictions. He noted that:

> The major way is spiritual. Most people see it as a spiritual attack. On rear cases, they perceive it as heredity. Some also see it as an ancestral curse. Because they see it as spiritual, they decide to bring them to the church, mosque, or traditional healers." **(KII/Male/Pastor, Ado-Ekiti, 2018).**

A traditional healer who is well known in the community as a guru in the treatment of mental illness comfirmed that the sufferer need some spiritual bathing, sacrifices and ritual if the mental illness is to be cure. He observed that:

> ... 'Ode-Ori' is a mental disorder, very mysterious and it is commonly believed in our communities that this disorder is caused by spiritual forces, it might be as a response to a violation of taboo or a fall out money making ritual, some are bewitched out of envy. What is certain is that a mentally challenged person is directed by evil spirits. Therefore, such patients need to undergo spiritual bathing, ritual and sacrifices to appease the gods. ''It is only mental illness caused by supernatural that can successfully be treated in the traditional homes, because it has supernatural undertones, the patients will never get better unless sacrifices are performed''.**(Traditional healer/Male/respondent KII/Ido-Osi/Ekiti/2018).**

Another respondent corroborated the earlier respondent on the need for spiritual bathing, ritual, sacrifices if remedies is required from African treatment of mental illness or the concept of 'Ode-Ori'. He emphasis that:

> ...Mental disorder or what is called 'Ode-Ori' to be local specific is caused by spiritual forces, it is a violation of taboo, some are bewitched out of envy. To resolve this problem, such patients need to undergo spiritual bathing, ritual and sacrifices to appease the gods. **(Traditionalhealer/Malerespondent/KII/Idi-Ogungun/2018).**

Another respondent from Islamic perspective posited that investigation into the causes of psychiatric disorder is very crucial through "Rukia" if a solution is needed. He opined that:

> From islamic point of view, people suffering from mental illness are said to be possessed, therefore such people need''Rukia'' to be performed by a qualified Malam in order to ward-off the jinn from the sufferer. Islamic religion has answers to any afflictions or problem we

> experience in life. Qur’an has explained everything and Sunnah of the Prophet Muhammad (SAW)” **(Islamic Clergy/Male/respondent/KII, /Iberekodo/ Abeokuta North).**

Another respondent from our indigenous traditional knowledge posited that the occurrence of some of this problem might be as a result of violation of taboo or rites in the traditional Yoruba parlance. He explained that:

> ... ‘Ode-Ori’ is a mental disorder, very pathetic and it is commonly believed in our communities that this disorder is caused by affliction, it might be as a response to violation of taboo or some are bewitched out of envy. What is certain is that a mentally challenge person is controlled by evil spirits. Therefore such patients need to undergo ritual cleansen and sacrifices to appease to the gods. **(Traditional healer/Male/respondent/KII/Irolu/Ijebu-Ikene/2018).**

From the above presentation of qualitative study different narratives were gathered through the qualitative study conducted on the field, it was evidence, that schizophrenia was seen as a disease that was caused by spiritual attack, excess use of hard drug and substance abuse, some even see it as ancestral curse, some see it as a punishment from evil people who are trying to inflict pain on the other person while some see it as heredity or genetic make up. The respondents also alluded to the explanations given by the medical model, however, a large numbers of the respondents believed in local explanations of the disease and its remedies. There was a diverse opinions concerning the cause and non- availability of absolute cure as far as the health condition is concern.

4.3 Reactions to stigma and stereotyping of people living with schizophrenia

Table 9 shows that 33.8% of the respondents reported that they would pass over the application of a mentally-ill patient in favour of another candidate sometimes, 25.3% reported that they would not treat a psychiatric patient as they could treat anyone, 41.2% reported that they would refuse to have sexual relationship with a man/woman who has been admitted for a psychiatric disorder, 29.3% reported that people do not take those with mental health opinions seriously, 35.1% reported that stigma may sometimes not allow people to perform in public functions, 31.4% reported that stigma may sometimes affect the relationship in the community, 23.8% reported that the status has denied their members in the society of landed property, 27.4% reported that mental health condition has sometimes denied their family members of chieftaincy titles, 24.1% reported that mental illness has not denied their family member marriage opportunity while 33.4% reported that mental health has not denied their family member of political ambition.

Table 9: Level of societal stigmatization of PwS

Stigmatisation of PwS	Not at all	A little	Some	A lot	A great deal
People treating a former mentally-ill patient like others	65(19.8%)	43(13.1%)	78(23.8%)	83(25.3%)	59(18.0%)
Willingness to date a man/woman who has medical history of psychiatry	41(12.5%)	135(41.2%)	42(12.8%)	63(19.2%)	47(14.3%)
If the public know a person' mental health condition, most people will take his or her opinions less seriously	96(29.3%)	64(19.5%)	48(14.6%)	68(20.7%)	52(15.9%)
Stigma affect peoples' performance at public functions	86(26.2%)	47(14.3%)	115(35.1 %)	37(11.3%)	43(13.1%)
Stigma has affected the relationship of the victim and others in the community	79(24.1%)	51(15.5%)	103(31.4 %)	28(8.5%)	67(20.4%)
The health status has denied them ownership of landed property in the society	78(23.8%)	74(22.6%)	78(23.8%)	50(15.2%)	48(14.6%)
Mental health conditions has denied people of chieftaincy title	80(24.4%)	83(25.3%)	90(27.4%)	32(9.8%)	43(13.1%)
Mental illness has denied people of marriage opportunity	79(24.1%)	70(21.3%)	68(20.7%)	79(24.1%)	32(9.8%)
The status of mental illness has denied their family members of political ambition in the community	99(30.2%)	112(34.1%)	45(13.7%)	41(12.5%)	31(9.5%)

Source: Field Survey 2018

The findings from this study reveal that peoples’ reactions to people living with schizophrenia are usually negative. Though, few of the relative members of the people living with psychosis, who are educated, do show some positive reactions. It was found that majority of people do not socialize freely with them.

4.3.1 Public negative reactions to stigma and stereotyping of people living with schizophrenia

Table 10: shows that 32.6% of the respondents reported that they are willing to accept an individual who attends psychiatric service as an intimate friend a little, 29.6% reported that they believe that a person who is reciving treatment in a psychiatric facilities is equally as intelligent as the average person, 28.7% sometimes believe that a mentally-ill patient is honest, 30.5% reported that they would not accept a emotionally-ill patient as a teacher, 35.1% do not believe that being admitted in a mental health facility is a sign of personal failure, 30.8% reported that he/she cannot hire a psychiatric patient to care for their offspring, 43.9% reported that they sometimes think less of a person who has been well for some time, 25.3% reported that if they were an employer, they would not hire a mentally-ill patient even if he/she is qualified.

Table 10: Public acceptance and non-stigmatisation of patients of PwS

Stigmatisation	Not at all	A little	Some	A lot	A great deal
The public's willingness to accept an individual who receives mental health services as a close friend.	98(29.9%)	107(32.6%)	28(8.5%)	69(21.0%)	26 (7.9%)
People believe that a person who has been in a mental health facility is just as intelligent as a person who has no traces of mental health.	95(29.0%)	97(29.6%)	85(25.9%)	38(11.6%)	13(4.0%)
People believe that a former mentally - ill patient is just as trustworthy as other persons.	102(31.1%)	80(24.4%)	94(28.7%)	51(15.5%)	1(0.3%)
People accept a fully recovered former mentally-ill patient as a teacher of their children in a public school.	102(31.1%)	100(30.5%)	42(12.8%)	34(10.4%)	50(15.2 %)
The public believe that being admitted in a mental health facility is a sign of personal failure.	115(35.1%)	41(12.5%)	74(22.6%)	53(16.2%)	45(13.7 %)
People's decisions to engage a former mentally-ill patient to take care of their children, when he or she has recovered fully for quite some time.	79(24.1%)	101(30.8%)	52(15.9%)	51(15.5%)	45(13.7 %)
People think less of person who has been in a mental health facility.	79(24.1%)	63(19.2%)	144(43.9 %)	40(12.2%)	2(0.6%)
As an employer, willingness to hire a former mentally-ill patient if he/she is qualified for the job.	83(25.3%)	26(7.9%)	83(25.3%)	73(22.3%)	63(19.2 %)
As an employer, willingness to pass over the application of a former mentally-ill patient in favour of another applicant.	97(29.6%)	111(33.8%)	60(18.3%)	29(8.8%)	31(9.5%)

Source: Field Survey 2018

Through the various narratives gathered from the field data, it was clear, that the perceptions of schizophrenia present a mix of opinions. View abounds about the origin of the disease conditions reflected in respondents' consideration of schizophrenia. It was expressed that persons with schizophrenia are mostly isolated, which as a matter of fact has the capacity to worsen their health condition. There was an affirmation of the fact that stigmatisation abounds in considering the social status and acceptability of persons living with scizophrenia. The following excerpts from the narratives support the preceding discussion.

The excerpt of this narrative supported the various responses, that the perceptions of schizophrenia present a different views, opinion abounds about the origin of the disease conditions reflected in respondents' consideration of schizophrenia. Various views are stated below:

> People should try to see them as human, their condition is as a result of one thing or the other, thus, people should show more love to them they suffer from isolation by people. They feel that they are not part of the society. They suffer stigmatization, showing more love will assist them in quick recovery"**(KII, Female Social Worker, Idi-Ogungun, Agodi-Gate, 2018).**

> People don't really accept them well in the society. People stigmatize against mentally ill people and isolate them. They face problem like stigmatization and low attention from people"**(FGD, Male Adult,/Iberekodo/Abeokuta/2018).**

> People discriminate and stigmatize them. The patients do regret when people know about their problems because they believe people would then tend to avoid them. Receptivity is low. Stigmatization is high. But they are improving on the attitude towards them, but its improving with more enlightenment given to people."**(KII, Male/Resident Psychiatrist, Idi-Ogungun, Agodi-Gate, 2018).**

A female nurse who is well observant about the social conditions that usually characterised the relationship between people with mental illness and the extended family in terms of long duration of care. He observed that:

> Mentally ill people face isolation from people and family members. Some lose their job and end up as a beggar, the family member even created a social distance in order to

> avoid shame from the public. The family member did not even assist them with getting a partner/spouse who will live with them forever" **(KII/Female/Psychiatry/Nurse at EKSUTH, 2018).**

4.3.2 Public positive reaction to stigma and stereotyping of people with schizophrenia

It is very important to note that despite the common positive reaction to stigma and stereotyping of people living with schizophrenia, people are beginning to develop a change of attitude in their reaction to the image of people suffering from schizophrenia. The results of the analysis presented below reveal the new development.

A Senior Registrar in Community Psychiatry Hospital from the Department of Psychiatry UCH, based on their experienced overtime that people thought that there no cure for such illness. She therefore, noted that:

> The experience is that often times when a patient is brought to the centre, the family member usually loose hope. But later after few period of treatment, they are usually amazed with the positive change."**(KII, Female/Community Psychiatry Hospital, PHC, Basorun, 2018).**

A health assistant who worked with community-based mental health service that given them support, acceptance and playing with them will give them sense of belonging and reduce stigma to the barest minimum level. She therefore noted:

> The community accept, support and embrace them. They relate well with them. The community people do not stigmatize the people living with psychosis, the community do talk to them and play with them. Also, their family members usually follow them and give them utmost support.**(KII, Female/CHEW, Idi-Ogungun, Agodi-Gate, 2018).**

A psychiatrist observed that stigmatization from family members may be very painful than stigmatization fron an outsiders therefore inculcating family theraphy into the treatment plan is a welcome development. He opined that:

> Since the patients are very much familiar with their family members, thus, stigmatization from family members may be more painful. The center have also organised family therapy or psychotherapy where the family members are enlightened."**KII, Male/ Psychiatrist at EKSUTH, 2018).**

4.4 : Identify the influence of the community-based psychiatric services on the coping patterns of people living with schizophrenic disorder and their kin

Table 11: shows that 90.5% of the respondents reported that they attend church or mosque regularly, this indicates that when all approaches fail in terms of the treatment methods for mental illness, most patients recourse back to God, the creator who has the power of healing, while 9.5% do not attend regularly. On how future look like 9.5% reported that the future was hopeless,18.3% reported that the future was fair, 15.9% reported that the future was great, 26.2% reported that the future was good, 13.1% reported that the future was hopeful, 15.9% reported that the future was bright while 1.2% reported that the future was promising to them. On suicidal attempt 8.8% of the respondents reported that they had the thought of committing suicide while 91.2% do not have the thought. Compliance with drug 67.7% of the respondents reported that they took drugs regularly while 32.3% did not take regularly. Doctors' regimen 67.7% of the respondents reported that they did not follow the drug regimen as prescribed by the doctor while 32.3% followed it. On the stoppage of drug 67.7% did not respond, 22.9% reported that he/she did not stop the drug while 9.4% reported that he never liked taking drug. On interaction with people of similar problem 55.5% of the respondents reported that he/she shared his or her opinion with friends with similar problem while 44.5% did not. On the awareness of association called PwS 78.7% of the respondents were not aware of the association called PwS, while 21.3% were aware. Feelings about relief 50.9% of the respondents reported that they were relieved of the problem, 15.5% were not relieved while 12.2% thought that they could solve it, while 21.3% reported that he/she was shy to relate with friends. Avoidance of unhealthy situation for peoples' knowledge about their problem 79.9% of the respondents reported that they avoided situations where people would know about the problem while 20.1% did not avoid the situation. 20.4% did not respond,18.3% reported that they hid themselves, 16.8% reported that they would leave, 22.9% reported that they stayed in good mood during this period, 20.1% reported that they were reserved, 0.3% kept mute in the midst of people while 1.2% reported that they were withdrawn during this period. 79.9% did not respond while 20.1% of the respondents managed the situations by moving freely. 86.6% were engaged in recreational activities while 13.4% did not engage in recreational activities. 13.4% did not respond, 41.5% reported that they liked table tennis, 20.1% liked football while 25.0% liked basketball. 23.5% did not respond, 26.8% reported that their family encouraged him or her, 21.6% reported that their friend encouraged

them, 10.1% reported that their father encouraged them, while 17.7% reported that their husband encouraged them. 18.6% reported that he/she has participated in national or state competitions while 81.4% did not participate. 18.6% reported that they stayed away from stressful situation to avoid embarrassment while 81.4% did not stay away from stressful situation, 81.4% did not respond, 9.1% liked to dance and sing, 7.6% liked to be included in fight or showing at each other while 1.8% liked all strenuous work.

Table 11: Coping patterns among PwS

Coping Patterns	Response	Frequency (N=328)	Percentage
Patient attends church or mosque regularly	Patient does attend church or mosque regularly	226	90.5
	Patient does NOT attend church or mosque regularly	102	9.5
Describe briefly	No response	31	9.5
	Fair	60	18.3
	Great	52	15.9
	Good	86	26.2
	Hopeful	43	13.1
	Bright	52	15.9
	Promising	4	1.2
Any suicidal thought	Likely suicidal thought	29	8.8
	There is no suicidal thought	299	91.2
Regular intake of drugs by PwS	Compliance with drugs	222	67.7
	No compliance with drugs	106	32.3
Patient follows the drug regimen as prescribed by the doctor	Compliance with doctor's instructions	106	32.3
	No compliance with doctor's instructions	222	67.7
Possibility of side effects for those who do not follow drug prescriptions	No response	222	67.7
	Any possible side effect	75	22.9
	He dosn't like taking drug	31	9.4
Sharing of opinion with friend with similar problems	Patient shares his/her opinion with friends of similar problem	182	55.5
	Patient hides his/her opinion from friends of similar problem	146	44.5
Family awareness of association of PwS	Awareness about the existence of association of PwS	258	78.7
	No awareness about the existence of association of PwS	70	21.3
Feelings of relief about the problem when in association	No response	70	21.3
	Feelings about relief	167	50.9
	No Feelings about relief	51	15.5
	He think that can solve it	40	12.2
If no, patient relationship with friends	No response	258	78.7
	Shy	70	21.3
Avoidance of public knowledge of the problem	People hide their problem	262	79.9
	People display their problem during crisis	66	20.1
Methods of management of the problem from public awareness	No method	67	20.4
	By hiding	60	18.3
	Leaving public domain	59	18
	By being in good mood during this period	75	22.9
	Reserved	67	20.4
If no, patient relationship with people	No response	303	92.4
	Mixing freely	25	7.6
Engagement in recreational activities e.g. football, table tennis	People engaged in sport activities	284	86.6
	People did NOT engaged in sport activities	44	13.4
Types of recreational activities engaged in	Not interested	44	13.4
	Table tennis	136	41.5
	Football	66	20.1
	Basket ball	82	25.0
Provider of encouragement	Outsiders	77	23.5
	The family	88	26.8
	Friends	71	21.6
	Father	33	10.1
	Husband	59	18.0
Participation in any national or state competitions	Patients participate in national/state competition	61	18.6
	Patients do not participate in national/state competition	267	81.4
Staying away from stressful situation to avoid family or friends embarrassment	Avoiding any stress because of shame	61	18.6
	Do not avoid any stress because of shame	267	81.4
Mention one or two stressful events	No response	267	81.4
	Dancing & singing	30	9.1
	Getting in a fight or shouting at each other	25	7.6
	All the activities were strenuous work	6	1.8

Source: Field Survey 2018

4.4: Stigmatisation of PwS after the exposure to community based centres among caregivers

Table 12 shows that 50.3 per cent of the participants reported that psychiatric disorder can be managed outside institutional settings compared to 49.7% per cent who disagreed. The respondents believed that psychiatric disorder should be treated outside the hospital settings because; the illness could be demonic attack (27.7%), the hospitals may not give proper treatment (21.6%), Ignorance of community-based treatment (17.7%) inability to address spiritual sources of the problem (32.9%). The larger percentage (43.0%) perceived level of susceptibility danger (57.05%) compared to the respondents who did not perceive any danger, people with psychiatric disorder are violent with the following reasons: the way they behave (37.8%), difference between mad man on the streets and the one in the hospital (12.2%), they have lost conciousness (15.2%) and they can do and undo (12.5%), they (18.6%) reported that due to the community care experience likelihood, marrying someone with illness compared to 81.4% did not experience likelihood marriage, reasons are that they cannot barely with live people (23.8**%),** it is dangerous to their family (26.5%), they do not want it to occur in their family(0.3%), they do not want their children to have mental illness (1.5%), they can do and undo (1.2%), and they do not see people to care for them, 36.0% reported that due to the community care experience, people with psychiatric problem are public nuisances compared to 64.0% that did not care about people with psychiatric disorder while the reason for care experiences of caregivers for people with psychiatric disorder are as follow: it depends on how they are treated (20.1%), social support (24.7%), they have no affective toward loves ones (17.7%), they constitute nuisance (18.9), some are still manageable (5.5%) and (13.1%) are still using drug.

Table 12: Exposure to the community based centres among caregivers

Service delivery	Response category	Frequency (N=328)	Percentage
Mental illness can be better managed outside the hospital settings	Management of mental illness can be sought outside of hospital settings	165	50.3
	Management of mental illness cannot be sought outside hospital settings	163	49.7
Rationale for adopting treatment outside of hospital settings	Demonic attack	91	27.7
	Hospitals cannot give proper treatment	71	21.6
	Ignorance of the community based treatment	58	17.7
	The health condition has a spiritual source	108	32.9
Increases suceptibility to danger and violence	It increases the susceptibility to danger and violence	141	43.0
	It does not increase susceptibility to violence and danger	187	57.0
Reasons put across why people with mental illness are dangerous	Because of the way they act or behave	124	37.8
	The difference between the mad man on the streets and the one in the hospital is social support	40	12.2
	They have lost touch with reality	50	15.2
	They can do and undo	41	12.5
	For every of their behaviour, government believe it is out of unconsciousness	41	12.5
	If they are taking their drugs	32	9.8
The likelihood of marrying someone with mental illness	Community-based experienced care-givers encourage people to marry people with mental illness	61	18.6
	Community-based experienced care-givers do NOT encourage people to marry people with mental illness	267	81.4
Reasons for your choice	Cannot live with the patients	78	23.8
	They are dangerous to the family	87	26.5
	They do not have feelings or show emotions	67	20.4
	They show no love or have affections	76	23.2
	Do not want it to occur in the family	1	.3
	Do not want any children to have it	2	.6
	Having money to care for them	5	1.5
	He/she can do or undo	4	1.2
	If there are people to care for them	8	2.4
People with mental illness are public nuisance	Community based experienced care givers do not make people with mental illness a public nuisance	118	36.0
	Community based experienced care-givers make people with mental illness a public nuisance	210	64.0
Explanations	It depends on how they are treated	66	20.1
	Social support	81	24.7
	They have no affection towards their love ones	58	17.7
	They constitute nuisance	62	18.9
	Some are still manageable, they can still cope	18	5.5
	Since they will be on medications	43	13.1

Source: Field Survey 2018

Table 13 shows that (26.2%) community based care givers are willing to have conversation with PwS compared to (73.8%) not willing to have conversation with PwS. The reasons for the willingness include :being a professional (25.3%) as it makes no difference talking with PwS, information acquisition (19.2%), lightens their mood with friendship (21.6%), stable coping behaviour (0.3%) and based on meaningfulness of their expression (0.3%), while those unwilling gave reasons such as fear of being attacked (17.4%), acting suspiciously (11.3%), psychotic symptoms (0.3%), unpredictability (1.2%) and being on medication (1.5%) and bizarre behavior (1.2%).

After the community care experiences, 31.7% of the caregivers still reported being ashamed of letting people know their relative member was diagnosed with psychiatric disorder compared to 68.3% who reported more positive behaviours towards the relative members being diagnosed with psychiatric problem. Those who have adjusted to the positive attitudes gave reason that; nobody is immuned from mental illness (23.2%), mental illness can be cured (12.5%)and being educated about psychiatric disorder (14.3%) while those that were ashamed gave reasons that mental illness can be fatal (16.8%) and the negative attitudes towards psychiatric disorder as a bad illness (14.0%). About 28.0% reported beliefs that mental illness runs in the family compared to 72.0% who did not agree. Those who disagree gave reasons that it might be due to drug abuse (47.9%), depression (11.0%) life events (29.6%). Some also believed that it is not genetic since their father (1.5%) sister or (1.2%) and none of their family members (1.2%) have history of mental illness reported. Those who believed that it runs in the family believed that it was due to genetical abnormality of psychological disease (6.1%)and heredity (0.6%).

Table 13: Exposure to community based centres among caregivers

Stigmatisation after exposure	Response category	Frequency (N=328)	Percentage
Willingness to have conversation with PwS	Because of the community based experience, people are willing to engage in conversation with PwS	86	26.2
	Because of the community based experience, people are NOT willing to have conversation with PwS	242	73.8
Reasons	Being a professional, it makes no difference talking with PwS	83	25.3
	It will improve my knowledge	63	19.2
	Lighten their mood with friendly conversation	71	21.6
	They might beat me up	57	17.4
	They are very suspicious	37	11.3
	Because they could interact normally and they are now stable	4	.3
	Since they are on treatment	5	.3
	They are not predictable	4	.3
	Nothing negative can happen	4	.3
Ashamed if people get to know someone in the family is being diagnosed with mental illness	Because of the community based care experinence, people may be ashamed if someone in the family knows that one is being diagnosed with mental illness	104	31.7
	Because of the community based care experinence, people are NOT ashamed if someone in the family know one is being diagnosed with mental illness	224	68.3
Reasons	It could happen to anyone	76	23.2
	Because of the stigma	63	19.2
	It is a bad illness and it is not a thing of happiness	46	14.0
	I will just educate people about the illness	47	14.3
	Because it is diagnosed so it can be cured	41	12.5
	Because it cannot kill	55	16.8
People's perception that mental illness runs in the family	Because of the community based care experience, people think mental illness runs in the family	92	28.0
	Because of community based care experience, people do not think mental illness runs in the family	236	72.0
Explanations	it might happen due to drug abuse or drug addiction	157	47.9
	It may be due to depression in some family	36	11.0
	It happens to almost all of them	97	29.6
	There is what we call genetical abnormally in the psychological disease that are transmitted from parents	20	6.1
	Because some illness are hereditary	3	.9
	Mental disorder can be inherited	2	.6
	Because my father did not have	5	1.5
	My sister and I do not have it	4	1.2
	Because no one has it	4	1.2

Source: Field Survey 2018

Table 14: shows that there was significant joint influence of rationale for adopting treatments outside the hospital settings, increase insusceptibility to danger and violence, the likelihood of marrying someone with psychiatric disorder, people with psychiatric problem are public nuisance, willingness to engage in conversation with PwS, ashamed if people get to know someone in the family is being diagnosed with mental illness, people's perception that mental illness runs in the family on mental illness being managed outside hospital settings [F(7,320) = 9.60, $R^2 = .174$; $p < .05$] with the variables accounting for 17% of the variance in mental illness being managed outside hospital settings. Further results show that likelihood of marrying someone with mental illness (β=.19; $p<.05$), willingness to engage in conversation with PwS (β=.23; $p<.05$), ashamed of someone in the family is being diagnosed with psychiatric disorder (β=-.17; $p<.05$), and people's perception that mental illness runs in the family (β=.14; $p<.05$) significantly predict mental illness being managed outside hospital settings. While rationale for adopting treatments outside the hospital settings (β=.08; $p>.05$), increase in susceptibility to danger and violence (β=.07; $p>.05$) and people with mental illness being public nuisance (β=.00; $p>.05$) did not significantly predict mental illness being managed outside hospital settings.

Table 14: Summary of Multiple Regression table showing joint and independent influence of the variables

Predictors	B	T	P	R	R^2	F	P
Rationale for adopting treatments outside the hospital settings	.077	1.415	> .05	.417	.174	9.60	< .05
Increases susceptibility to danger and violence	.067	.961	>.05				
The likelihood of marrying someone with mental illness	.188	3.202	<.05				
People with mental illness are public nuisance	.002	.045	>.05				
Willingness to engage in conversation with PwS	.228	3.545	<.05				
Ashamed if people get to know someone in the family is being diagnosed with mental illness	-.168	-2.460	<.05				
People's perception that mental illness runs in the family	.135	2.236	<.05				

Source: Field Survey 2018

The result of this analysis is an indication of the patterns of treatment and the pathway to health seeking behaviour of health conditions that relate to mental illness, the idea has been that one approach is not adequately sufficient to solve mental illness and other available approaches are utilised to bring about a positive desire result especially in sub-sahara of Africa region where etiology of mental illness is rooted in religious/magico belief system of the people.

4.5 Examine peoples' utilisation of community-based psychiatry services

Table 15: shows that 26.5% of the caregivers gained support from their friends/family, paid careers coming into the home (26.2%), paid careers delivering services away from the home (2.4%), socially assisted activities outside the home (16.5%) their patients (2.4%) and others sources (7.3%). The larger percentage of the caregivers (82.0%) reported being satisfied with the current level of care recived compared to 18.0% who were dissatisfied with the care recived. Satisfaction was motivated with clothing and shelter provided (15.9%), constant and frequent care for patients (16.5%) and significant improvement in the patient's care (39.6%). More than half (50.9%) of the respondents reported the act of kindness shown to patients compared to 22.9% who showed poor attitude to patients, lackadasical attitude and lack of compassion compared to 10.7% who recorded that the staff were helpful and friendly with the patients. 12.8% reported that their wards recieved gesture of kidness such as food and motivational word from the cargivers, 11.9% reported that the staff gave them their best services, 14.9% reported that the cargivers showed eargerness to work with patients.

Close to half (45.1%) of the participants reported that the staff of the centre are ready to assist while 28.0% are not ready to work. 8.5% reported that they supported those with psychiatric disorder, 14.0% reported that they are ready to work all times, 12.8% reported that they can easily confide with them, 5.5% reported that the really care for the patient, 1.5% reported monetary aspect, 1.8% reported that there may be lack of financial resources while 0.9% reported that they give them advice.

Table 15: Satisfaction with community-based mental health program

Service assessment	Response category	Frequency (N=328)	Percentage
Type of support recieved by the patients and caregivers	No real support	60	18.3
	Friends/family providing for the patients at home	87	26.5
	Paid careers coming into the home	86	26.2
	Paid careers providing care away from the home (e.g. care home)	8	2.7
	Received support for activities out of the home	63	18.9
	Others	24	7.3
Satisfaction with the care	Satisfied	269	82.0
	NOT Satisfied	59	18.0
Action and activities which motivate the level of satisfaction	No real action	59	18.0
	The clothing and shelter	52	15.9
	Constant attention and care for patients	54	16.5
	Significant improvement in the patients' condition	154	46.9
	Health workers showed genuiness and empathy towards patients	9	2.7
Disposition of health workers towards showing kindness to patients	Could not describe any	86	26.2
	Health workers show concern	167	50.9
	Health workers do not show concern	75	22.9
Reasons for the poor disposition of health workers towards showing kindness to patients	Indifferent	253	77.1
	They display indifference and lack of care to patients	75	22.9
Reasons for the good disposition of health workers towards showing kindness to patients	No reason	161	49.1
	Giving attention and being cordial with the patients	35	10.7
	Providing of food and given motivational words	42	12.8
	Showing great effort towards care of patients	39	11.9
	Showing eargerness and positive attitude to work	51	15.5
The staff of this centre always available and ready to assist	Indifferent	88	26.8
	Always available and rendered assistance	148	45.1
	Not available and they do not assist	92	28.0
If yes, give example	No response	180	54.9
	Mental illness now get support and also they receive care	28	8.5
	Prepare to work at all times	46	14.0
	You can easily confide in them	42	12.8
	Just to care for the patients	18	5.5
	Monetary wise	5	1.5
	In case there is no money	6	1.8
	Giving advise	3	.9

Source: Field Survey 2018

The above quantitative data is supported by the responses from the qualitative data that community-based centres has the capacity to cure mental illness because of the collaborative nature of the centres infact people were referred from modern hospital to the centre because of the belief people have in the centre. They noted:

> ‘’Most of them are being referred from UCH. They take their drugs as prescribed and show up on every appointment given. People used health centre because they want to be cured from the illness. And it was built to take care of sick people and give adequate treatment”**(KII, CHEW, Agodi-Gate, Idi-Ogungun, Ibadan)**
>
> ‘’The major perception of people is that mental illness is spiritual. Based on different taught of people, they choose to go to places where they feel is the origination of their problems for treatments.They are happy coming to the health centre, because the doctors are relating well with them. And they are taking their mediation well.”**(KII/Male/Pastor/Ido-Osi, Ekiti, 2018)**

The results revealed that people perceived that the community-based service in the management of schizophrenic disorder is efficient. In view of this, a Chief Nursing Officer, said:

> ‘’It is usually effective but it takes time for them to recover fully but they need more equipment at the center. They are building their confidence. We have built it well, through continuous counselling.” The health centers are trying their best and putting in lots of effort to ensure that this people are cured.” **(KII/Female/CNO/Irolu, Ikene-Ijebu, 2018).**

A Social Worker noted that people developed mindset that there is hope in the centres together the expertise from professional social worker. He noted :

> They have developed positive mindset towards it after witnessing series of patients being treated here.“ They believe we are helping them.” “It varies with individuals. We try to get out the best to patients to help them get better.”
> **(KII/Male/ Social Worker/Irolu/Ijebu-Ikene, 2018).**

FGD community based health centre concluded that the centre has qualified personnel that are capable to treat the problem because of the special knowledge they have acquired overtime. The group noted:

> ‘’The community-based health centre here gives us the belief that the person with mental illness would receive

> adequate treatment for the problem if he or she comes here. We believe the care givers at the centre are professionals who have adequate knowledge about mental illness treatment."**(FGD/ Female/Agodi-Gate/Idi-Ogungun/2018).**

A faith based healer said with their knowledge of the community-based centre alluded to the fact that the centre is capable to treat people suffering from mental illness as the process was all encompassing. He admitted that:

> ''They admit people on both inpatient and outpatient basis depending on the nature of illness. They give counseling to people (Cognitive therapy), administer drugs, take people on admission, and do check-up for patients." **(KII/Male/Faith based healer, Agodi-Gate, 2018).**

The utilisation has been very encouraging and progressive, the idea of the community-based care was to allow patient's in home environment always and engage important family members in the treatment of the ill members in and out of the community care centres, patients were also deployed with relevant occupational skills in the village setting. The philosophy behind the community-based care is in tune with the peoples' perceptions about the causes and management of the illness, of which the community-based care subcribed to.

The results from the analysis show that there exist measures to encourage patients' attendance and patients were also shown emphaty unlike in the custodian settings that were not environmental friendly.

4.6: Assess people's satisfaction about the efficiency of the community-based service in the management of schizophrenic disorder

Table 16: shows that 27.4% of the respondents reported that they took the patients to the traditional healers, 12.8% used home remedies, 45.7% took them to the hospital, 9.8% took them to the churches while 4.3% took them to the mosques. About 40.5% of the respondents gave them orthodox treatment, 3.0% were given traditional treatments, 27.1% were given combined therapy, 19.5% were given prayer while 9.8% were given prayer + holy-water. Some 33.8% of the respondents reported that the patients were relapsed so they took the second action of another pathway, 35.1% reported that people suggested to them to take the action while 11.9% reported that there was no

improvement from the first pathway, A few 19.2% reported other actions. 36.6% of the respondents reported that the attention given to their patients was prompt, 50.6% reported that the attention was moderate while 13.1% reported that the attention given to them was slow. 54.0% of the respondents reported that the treatment given to them was good, 27.1% reported that the treatment given to them was fair while 18.9% reported that the treatment was poor. 61.9% of the respondents reported that the family members were involved which is an indication that the family members are the significant order in case of ill-health in the hospital environment, even in the face of law, the relatives are very crucial. 10.7% reported that the neighbours were involved, 11.6% reported that the orthodox health workers were involved, 12.8% reported that their friends were involved, 1.2% reported that their co-workers were involved while 1.8% reported that their church members were involved. 45.4% of the respondents reported that the father's decision is final, the larger percentage of the respondents agreed with their father.

In the traditional Yoruba settings, the father is regarded as the head of the family, therefore, any decision to be decided upon required the father's consent, this also demonstrated the patriarch nature of Yoruba culture. 30.2% reported that the mother's decision is final, 11.3% reported that the family member's decision is final, 5.8% reported that the religious institution's decision is final, 4.0% reported that the community leaders' decision is final while 3.4% reported that other people's decisions are final. 16.5% of the respondents reported that they get to know it through the radio, 4.9% reported that they knew about it through the television, 48.2% knew it through friends, 21.0% knew it through family member while 9.5% knew it through the health workers.

Table 16: The efficiency of community-based service in the management of PwS

Service delivery	**Response**	**Frequency (N=328)**	**Percent**
The first path way before the option of the community-based centre	Traditional healer	90	27.4
	Home remedies	42	12.8
	Hospital	150	45.7
	Church	32	9.8
	Mosque	14	4.3
Reasons for taking 2nd pathway (health seeking behaviour)	The patient relapsed	111	33.8
	People's suggestion	115	35.1
	No improvement from the first option	39	11.9
	Others	63	19.2
The kind of treatment received	Orthodox	133	40.5
	Traditional	10	3.0
	Combined therapy	89	27.1
	Prayer only	64	19.5
	Prayer+holy water	32	9.8
Attention received by the patients	Prompt	119	36.3
	Moderate	166	50.6
	Slow	43	13.1
Treatment received at the community-based centre	Good	177	54.0
	Fairly	89	27.1
	Poor	62	18.9
Those involved in the decision making to visit the community-based centre	Family members	203	61.9
	Neighbour	35	10.7
	Orthodox health worker	38	11.6
	Friends	42	12.8
	Co-workers	4	1.2
	church members	6	1.8
The person or bodies that take final decision	Father	149	45.4
	Mother	99	30.2
	family member	37	11.3
	religious institution	19	5.8
	Community leader	13	4.0
	Other	11	3.4
Information about the existence of the community based centre	Through radio	54	16.5
	Through television	16	4.9
	Through friends	158	48.2
	Through family members	69	21.0
	Through health workers	31	9.5

Source: Field Survey 2018

Impact of the community-based service on the level of stigmatisation by caregivers and the public

Table 17 reveals that 51.8% of the caregivers perceived that living and associating with mental illness has increased the patient's level of resilience as a survivor recovering from mental illness compared to 48.2% who did not perceive any significant change in the patients resilience. Living in the same house and community was perceived to increase resilience due to the following: the strong support for their treatment (19.5%), support coping with families and friends (15.5%), feelings of inclusiveness and belonginess (6.1%), being identified as members of the family (4.9%), care and financial support received (4.5%) and the care support received from significant others (1.2%). Only 36.9% of the caregivers reported that members of the public were unwilling to associate or get close to their patients because of the mental illness compared to 63.1% who reported that the public accept their patients. The public reactions due to the perception that the illness look contagious shows that 14.0% acknowledge the belief that associating with people with mental illness has spiritual implication while 22.9% reported that though the public believed that it is not contagious but for fear of being attacked. The perception of the relative ease of getting the financial resources for patients in the community-based service shows that it was very difficult to get the money for 36.9% of the respondents, 39.3% reported that it was difficult while 8.5% reported that it was not difficult and not easy to get the money.

Table 17: Assessment of resilience among patients

Assessment	Response category	Frequency (N=328)	Percentage
Living in the same house and community with patients suffering from psychiatric disorder increases the resilience of the patients (made them a tough survivor)	Living in the same environment make the patients tough survivor	170	51.8
	Living in the same environment does not make them tough survivor	158	48.2
Living together affects PwS	No response	158	48.2
	Support for their treatment	64	19.5
	Coping with families and friends	51	15.5
	The feeling of inclusiveness and belonginess	20	6.1
	Being counted among other members of the family	16	4.9
	The care and finanacial support received	16	4.5
	Care support received	4	1.2
Willingness of the public towards associating or moving close to patients in the community-based service treatment	Willingness to interact with patients	121	36.9
	Non-willingness to interact with patients	207	63.1
If yes,any reaction due to the perception that the illness look contagious	No response	207	63.1
	There is the belief that associating with people with mental illness has spiritual implications	46	14.0
	It is not contagious but the fear that they may go violent	75	22.9
Relative ease of getting the financial resources for patients in the community-based service	No response	50	15.2
	Very difficult	121	36.9
	Difficult	129	39.3
	Not difficult and not easy	28	8.5

Source: Field Survey 2018

4.7 Caregivers burden and living with people in the community-based service treatment programme

Table 18: This shows that 72.9% reported that they cared for 1-10 mental health while 16.5% reported that they cared for 1-20 people. 72.9% reported that they have taken off 1-5 hours while 1.5% have taken 6-10 hours. A few 11.0% did not respond, 69.2% reported that they had spent 1-10 hours looking for someone with mental illness while 19.8% reported that they had spent 11-20 hours. 62.5% of the respondents reported that they started caring for someone with mental illness between1-10 years while 20.4% reported that they started to care for them between 11-20 years. 50.0% reported that they lived each other at the moment, 20.1% lived with each other some of the time while 29.9% do not live with them at all. 70.1% did not respond, 15.2% of the respondents reported that they lived in their rented accommodation, 3.0% lived in a supported accommodation, 4.9% lived with other family members, 3.7% used the care home while 3.0% lived in the hospitals.

Table 18: Burden of care

Period of Caring	**Response**	**Frequency (N=328)**	**Percentage**
Number of people with mental health problems you are currently caring for	No response	35	10.7
	1-20 mental health	239	72.9
	1-30 mental health	54	16.5
Numbers of hours you have taken off paid work in the past weeks to care for the person with psychiaric problem	Did not know	84	25.6
	1-5 hour	239	72.9
	6-10 hour	5	1.5
Numbers of hours spent in the last weeks caring for someone with psychiatric problem	Do not know	36	11.0
	1-10 hours	227	69.2
	11-20 hours	65	19.8
Numbers of years spent in caring for someone with mental illness	No response	56	17.1
	1-10 years	205	62.5
	11-20 years	67	20.4
Living together with the patient (s)at the moment	Living with patients	164	50.0
	Sometimes	66	20.1
	Do not live with patients	98	29.9
The kind of house lived in with patients	Personal house	56	34.1
	Supported/Rented Houses	61	37.2
	With other family member/friend (s)	25	15.2
	care home	12	7.3
	Hospital	10	6.1

Source: Field Survey 2018

The results of the quantitative and qualitative data revealed that the treatment at the community-based centre was good, effective, prompt and attention given. Counselling and enlightenments enabled patients to cope well and also build their confidence.

4.8 The regression analysis between the socio-demographic characteristics of caregivers and other variables with PwS

Table 19: shows the results of the multinomial logistic regression of age, sex, marital status, education, religion, ethnic group, relationship with patients, health initiated and health seeking pathways on social stigma. Results show that marital status (z= -1.66, *p*<.05) was significant associated with social stigma. The results further indicated that having primary school certificates (z= -5.62, *p*<.05), OND (z= -5.92, *p* <.05), and university degrees (-6.104,*p*<.05) significantly associated with social stigma compared to formal education. Also, the result shows that respondents who are Muslim (z= 2.353, p <.05) significantly influence the social stigma. The result also shows that ethnic group

(z=.9708, p <.05) significantly influences social stigma. Also, the result shows that respondents who stay with their mothers (z= 2.967, p <.05) significantly influence social stigma. Respondents who consult traditional healer (z= 1.872, p <.05) significantly influence social stigma. Further, results show that traditional+prayer+hospital= 2.122 , p <.05), traditional+hospital+prayer (z= -2.918 , p <.05), prayer+hospital+traditional (z= -3.590, p <.05) significantly influence social stigma.

Table 19: Socio-demographic characteristics and care giving behaviors associated with perceived stigmatization of PwS disorder

Social stigma	Coef.	Std. Err.	Z	Sig.	Odds Ratio
Location	0.01	0.16	0.09	0.93	1.01
Caregivers Age	0.20	0.41	0.48	0.63	1.22
Patients Age	0.35	0.36	0.98	0.33	1.42
Sex	0.26	0.80	0.33	0.75	1.30
Sex of Patients	0.03	1.08	0.03	0.98	1.03
Marital status	-1.66	0.51	-3.28**	0.00	0.19
Educational status					
No formal	0	0	0	0	0
Primary school certificates	-5.62	1.40	-4.00**	0.00	0.00
Secondary school certificates	-2.58	1.43	-1.80	0.07	0.08
OND	-5.92	1.54	-3.84**	0.00	0.00
HND	-0.90	1.96	-0.46	0.64	0.40
University degree	-6.10	1.42	-4.29**	0.00	0.00
Master degree	0.00	(empty)			1.00
Others	0.00	(empty)			1.00
Religion					
Christian	0	0	0	0	1.00
Muslim	-2.35	0.71	-3.30**	0.00	0.10
African traditional religion (ATR)	0.00	(empty)	0	0	1.00
Others	2.18	3.79	0.57	0.57	8.82
Ethnic group	0.97	0.49	1.98*	0.05	2.64
Relationship with patients					
Mother	2.97	1.44	2.06**	0.04	19.44
Sibling	1.20	1.04	1.16	0.25	3.31
Step parents	-0.40	2.00	-0.20	0.84	0.67
Others	0.05	1.34	0.03	0.97	1.05
Health initiated					
Traditional healer	-1.87	0.79	-2.36**	0.02	0.15
Home remedies	0.14	0.93	0.15	0.88	1.15
Church	0.17	1.01	0.17	0.87	1.18
Other	1.28	1.04	1.23	0.22	3.61
Health seeking Pathway					
Traditional+ prayer+ Hospital	2.12	0.95	2.22*	0.03	8.34
Prayer+ Traditional+ Hospital	0.88	1.09	0.81	0.42	2.42
Traditional+ Hospital+ Prayer	-2.92	1.47	-1.98*	0.05	0.05
Prayer+ Hospital+ Traditional	-3.59	1.68	-2.14*	0.03	0.03
Hospital+ Prayer+ Traditional	-0.49	1.30	-0.38	0.71	0.61
_cons	4.60	2.68	1.72	0.09	99.52

*p<.05, **p<.01

Table 20: This shows the results of the logistic regression of age, sex, marital status, education, religion, ethnic group, relationship with patients, health initiated and health seeking pathways on caregiver self-stigma. The results show that the age range of 31-40 years (z= -2.12, *p*<.05) and 41-50 years (z= -3.63, *p*<.05) were significantly associated with the caregiver's self-stigma. The results further indicated that having primary school certificates (z=3.30 *p*<.05), secondary school certificates (z=2.22 *p*<.05), HND (z= 2.33, *p* <.05), university degree certificates (z=3.30,*p*<.05) and others (z=3.89 *p*<.05) are significantly associated with caregiver self-stigma. Also, the result shows that respondents who are yorubas (z=-3.86, p <.05) significantly influence caregiver self-stigma. Also, the result shows that respondents who stay with their father (z=-2.87, p <.05), mothers (z=-3.76, p <.05) and others (z=-4.32, p <.05) significantly influence caregiver self-stigma. Respondents who consult traditional healers (z=2.25, p <.05) significantly influence caregiver self-stigma. Further, the results show that the decisions are made by their fathers (z=-2.18, p <.05) and religious institutions (z=3.41, p <.05) significantly influence caregiver's self-stigma.

Table 20: Socio-demographic characteristics and care giving behaviors associated with self stigmatization among the caregivers of people living with schizophrenic disorder

Variables	Odd ratio	Std. Err.	Z	P>|z|
Location				
Oyo	0.00	0.00	0.00	0.00
Ogun	0.89	0.37	-0.28	0.78
Ekiti	0.72	0.30	-0.80	0.43
Sex	0.57	0.35	-0.91	0.36
Age of caregiver				
31-40	0.24	0.16	-2.12*	0.03
41-50	0.05	0.04	-3.63**	0.00
51-60	1.00	(empty)	0.00	0.00
Educational status				
Primary school certificate	53.69	64.83	3.30**	0.00
Secondary school certificate	7.34	6.60	2.22*	0.03
OND	0.09	0.12	-1.80	0.07
HND	193.32	436.96	2.33**	0.02
University degree	22.50	21.22	3.30**	0.00
Master degree	1.00	(empty)	.00	1.00
Others	12555.63	30440.57	3.89**	0.00
Ethnic group				
Yoruba	0	0	0	
Hausa	0.07	0.05	-3.86**	0.00
Igbo	0.84	0.61	-0.24	0.81
Others	1.00	(empty)	0.00	1.00
Relationship				
Father	0	0	0	0
Mother	0.07	0.07	-2.87**	0.00
Siblings	0.07	0.05	-3.76**	0.00
Step parents	0.67	0.67	-0.40	0.69
Others	0.03	0.02	-4.32**	0.00
Health Seeking				
Traditional healers	0	0	0	0
Home remedies	10.53	11.02	2.25**	0.02
Hospital	0.58	0.38	-0.82	0.41
Religious groups	0.28	0.53	-0.67	0.50
Decider				
Father				
Mother	0.30	0.17	-2.18**	0.03
Family member	2.61	1.90	1.32	0.19
Religious institutions	154.11	227.71	3.41**	0.00
Community leader	1.00	(omitted)	0.00	0.00
Other	0.36	0.73	-0.51	0.61
Cons	7.69	10.15	1.54	0.12

4.22: Socio-demographic characteristics and care giving behavior associated with health seeking outcomes among caregivers of people living with schizophrenic disorder attending community basedhealth service programme

Table 21: shows the results of the multinomial logistic regression of age, sex, marital status, education, religion, ethnic group, decider of health initiated and health seeking pathway, social stigma and health stigma on the treatment outcomes.The results demonstrated the age of the care givers (z= -3.45, *p*<.05), religious affiliations (z= -2.57, *p*<.05), ethnic groups (z= -4.62, *p*<.05), illness duration (z= -3.19, *p*<.05), decider of the health seeking pathway (z= 2.75, *p*<.05), social stigma (z= -2.40, *p*<.05) and self stigmatisation (z= -2.54, *p*<.05) associated with treatment outcomes.

Table 21: Health Seeking Outcome among PwS disoder

Health seeking outcomes	Coef.	Std. Err.	Z	Sig.
Location	-0.14	0.19	-0.71	0.48
CGAge	-1.16	0.34	-3.45**	0.00
Sex	0.67	0.60	1.12	0.26
Marital status	-0.30	0.36	-0.84	0.40
Educational status	-0.03	0.19	-0.15	0.88
Religion	-1.18	0.46	-2.57**	0.01
Ethnic group	-3.00	0.65	-4.62**	0.00
P Age	1.24	0.47	2.64	0.01
Sexp	1.05	0.57	1.84	0.07
Illness duration	-0.68	0.21	-3.19**	0.00
Family history illness	-0.76	0.80	-0.95	0.34
Health seeking decision	0.58	0.27	2.11	0.04
HS initiator	-0.23	0.34	-0.68	0.50
HS decider	0.70	0.25	2.75**	0.01
Self-stigma	-1.27	0.53	-2.40**	0.02
Social stigma	1.38	0.54	2.54**	0.01
Cons	3.61	2.10	1.71	0.09
Cons	-0.68	0.21	-3.19	0.00

4.19 The Regression analysis between the socio-demographic characteristics of caregivers, stereotyping of people living with schizophrenia, coping patterns of people living with schizophrenic disorder and perception of the community-based psychiatry services

Table 22: shows that a significant association exists between gender and the first path way before visiting community based centre (X^2=**26.41**, *p*= 0.00). This means that a larger percentage of the respondents visited the hospitals while a few reported going to the mosques. This shows that gender significantly influences the first path way before visiting community based centre.

Table 22: Summary table of crosstab association between gender and the first pathway before visiting community based centre

Gender	The first path way before the option of community based centre					X^2	Df	Sig
	Traditional healer	Home remedies	Hospital	Church	Mosque	**26.413**	**4**	**.000**
Male	**22(6.7%)**	**11(3.4%)**	**79(24.1%)**	**12(3.7%)**	**2(0.6%)**			
Female	**68(20.7%)**	**31(9.5%)**	**71(21.6%)**	**20(6.1%)**	**12(3.7%)**			

Source: Field Survey 2018

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Table 23: shows that a significant association exists between gender and the kind of treatment given (X^2=**29.70**, *p*= 0.00). This means that a larger percentage of the respondents reported that they were given orthodox treatments while a few reported traditional treatments. This shows that gender significantly influences the kind of treatment given.

Table 23: Summary table of crosstab association between gender and the kind of treatment given

Gender	The kind of treatment given					X^2	Df	Sig
	Orthodox	Traditional	combined therapy	Prayer only	Prayer+holy water	**29.695**	**4**	**.000**
Male	**50(15.2%)**	**8(2.4%)**	**39(11.9%)**	**29(8.8%)**	**0(0.0%)**			
Female	**83(25.3%)**	**2(0.6%)**	**50(15.2%)**	**35(10.7%)**	**32(9.8%)**			

Source: Field Survey 2018

Table 24: shows that there is no significant association between gender and the kind of attention given (X^2=**3.69**, *p*= .158). This means that larger percentage of the respondents reported that they were given a moderate attention while a few reported being given a slow attention. This shows that gender did not significantly influence the kind of attention given.

Table 24: Summary table of crosstab association between gender and the kind of attention given to the patients

Gender	**The kind of attention given to the patients**			X^2	Df	Sig
	Prompt	Moderate	Slow		**2**	**.158**
Male	**50(15.2%)**	**65(19.8%)**	**11(3.4%)**	**3.685^a**		
Female	**69(21.0%)**	**101(30.8%)**	**32(9.8%)**			

Source: Field Survey 2018

Table 25: shows that a significant association exists between gender and the kind of treatment received at the community based centre (X^2=**25.69**, p= 0.00). This means that a larger percentage of the respondents reported that they were given good treatment at the community based centres while a few reported poor treatment. This shows that gender significantly influences the kind of treatment received at the community based centres.

Table 25: The summary table of crosstab association between gender and the kind of treatment received at the community based centres

Gender	The kind of treatment received at the community based centres			X²	Df	Sig
	Good	Fairly	Poor	**25.690ª**	**2**	**.000**
Male	**90(27.4%)**	**19(5.8%)**	**17(5.2%)**			
Female	**87(26.5%)**	**70(21.3%)**	**45(13.7%)**			

Source: Field Survey 2018

Table 26: shows that a significant association exists between gender and the people involved in the decision (X^2=**25.69**, p= 0.00). This means that a larger percentage of the respondents reported that the family members decide to take them to the community based centre while a few reported that their co-workers decided to take them to the community based centres. This shows that gender significantly influences the people involved in the decision.

Table 26: Summary table of crosstab association between gender and the people involved in the decision

Gender	Who were involved in the decision to take him/her to community based centre?						X^2	Df	Sig
	Family members	Neighbour	Orthodox health workers	Friends	Co-workers	Church members	**55.595^a**	**5**	**.000**
Male	**58(17.7%)**	**14(4.3%)**	**18(5.5%)**	**36(11.0%)**	**0(0.0%)**	**0(0.0%)**			
Female	**145(44.2%)**	**21(6.4%)**	**20(6.1%)**	**6(1.8%)**	**4(1.2%)**	**6(1.8%)**			

Source: Field Survey 2018

Table 27: shows that a significant association exists between gender and the people involved in the final decision (X^2=**32.30**, *p*= 0.00). This means that a larger percentage of the respondents reported that the father took the final decision while a few reported that other people took the decision for them. This shows that gender significantly influences the people involved in the final decision.

Table 27: Summary table of crosstab association between gender and the those who took the final decision

Gender	**whose decision is final?**						X^2	Df	Sig
	Father	Mother	Family members	Religious institutions	Community leaders	Others	**32.295^a**	**5**	**.000**
Male	**50(15.2%)**	**35(10.7%)**	**16(4.9%)**	**13(4.0%)**	**1(0.3%)**	**11(3.4%)**			
Female	**99(30.2%)**	**64(19.5%)**	**21(6.4%)**	**6(1.8%)**	**12(3.7%)**	**0(0.0%)**			

Source: Field Survey 2018

Table 28: shows that a significant association exists between gender and the information about the existence of the community based centre (X^2=**19.16**, p= 0.00). This means that a larger percentage of the respondents heard the information about the community based centre through friends while a few who reported that they heard it through television. This shows that gender significantly influences information about the existence of the community based centres

Table 28: Summary table of crosstab association between gender and the information about the existence of the community

Gender	Information about the existence of the community based centre					X^2	Df	Sig
	Through radio	Through television	Through friends	Through family member	Through health workers	**19.157^a**	**4**	**.001**
Male	**24(7.3%)**	**12(3.7%)**	**57(17.4%)**	**29(8.8%)**	**4(1.2%)**			
Female	**30(9.1%)**	**4(1.2%)**	**101(30.8%)**	**40(12.2%)**	**27(8.2%)**			

Source: Field Survey 2018

Table 29: shows that a significant association exists between gender and the treatment of mental illness outside hospital settings (X^2=**28.75**, p= 0.00). Also a significant association exists between gender and the belief that people with mental illness are public nuisance (X^2=**4.206**, p= 0.00). However, a significant association exists between gender and movement of psychiatric disorder in the family (X^2=**8.214**, p= 0.00).

Table 29: Summary table of crosstab association between gender and the coping patterns of people living with schizophrenic disorder

	Gender	Yes	NO	X^2	Df	Sig
Mental illness can be treated outside hospital settings	Male	12(32.4)	8(21.6)	28.750^a	1	.000
	Female	8(21.6)	9(24.3)			
People think that persons with mental illness are dangerous because of violent behaviors	Male	57(17.4%)	69(21.0%)	.423^a	1	.516
	Female	84(25.6%)	118(36.0%)			
Disposition to marry someone with mental health	Male	20(6.1%)	106(32.3%)	1.003^a	1	.317
	Female	41(12.5%)	161(49.1%)			
People with mental illness constitutes public nuisance	Male	54(16.5%)	72(22.0%)	4.206^a	1	.040
	Female	64(19.5%)	138(42.1%)			
Willingness to have conversation with PwS	Male	32(9.8%)	94(28.7%)	.072^a	1	.789
	Female	54(16.5%)	148(45.1%)			
I think I will be ashamed if people know someone in my family is being diagnosed with psychiatric disorder	Male	37(11.3%)	89(27.1%)	.518^a	1	.472
	Female	67(20.4%)	135(41.2%)			
Mental illness runs in the family	Male	24(7.3%)	102(31.1%)	8.214^a	1	.004
	Female	68(20.7%)	134(40.9%)			

Source: Field Survey 2018

Table 30: shows that a significant association exists between age and the first path way before visiting community based centres (X^2=**94.40**, *p*= 0.00). This means that a larger percentage between age 20-30 years visited the hospital while few of the respondents between 51-60 years reported that they use home remedies. This shows that age significantly influences the first path way before visiting community based centre.

Table 30: Summary table of crosstab association between age and the first pathway before visiting community based centre

Age	The first path way before the option of community based centre					X^2	Df	Sig
	Traditional healer	Home remedies	Hospital	Church	Mosque	**94.395**[a]	**12**	**.000**
20-30	**49(14.9%)**	**30(9.1%)**	**94(28.7%)**	**11(3.4%)**	**1(0.3%)**			
31-40	**22(6.7%)**	**82.4%)**	**24(7.3%)**	**2(0.6%)**	**12(3.7%)**			
41-50	**9(2.7%)**	**2(0.6%)**	**27(8.2%)**	**19(5.8%)**	**1(0.3%)**			
51-60	**10(3.0%)**	**2(0.6%)**	**5(1.5%)**	**0(0.0%)**	**0(0.0%)**			

Source: Field Survey 2018

Table 31: shows that a significant association exists between age and the kind of treatment given (X^2=**70.064**, p= 0.00). This means that larger percentage between the age 20-30 years of age reported that they were given orthodox treatments while respondent between 31-40 years of age were given traditional treatments. This shows that age significantly influences the kind of treatment given.

Table 31: Summary table of crosstab association between age and the kind of treatment given

Age	**The kind of treatment he/ she was given**					X^2	Df	Sig
	Orthodox	Traditional	Combined therapy	Prayer only	Prayer+holy water	**70.064**	**12**	**.000**
20-30	**84(25.6%)**	**7(2.1%)**	**53(16.2%)**	**33(10.1%)**	**8(2.4%)**			
31-40	**31(9.5%)**	**1(0.3%)**	**21(6.4%)**	**9(2.7%)**	**6(1.8%)**			
41-50	**7(2.1%)**	**2(0.6%)**	**9(2.7%)**	**22(6.7%)**	**18(5.5%)**			
51-60	**11(3.4%)**	**0(0.0%)**	**6(1.8%)**	**0(0.0%)**	**0(0.0%)**			

Source: Field Survey 2018

Table 32: shows that a significant association exists between age and the kind of attention being given (X^2=**56.15**, *p*= .000). This means that a larger percentage of the respondents between age 20-30 years reported that they were given a moderate attention while a few respondents between 41-50 years reported being given a slow attention. This shows that age significantly influences the kind of attention being given.

Table 32: Summary table of crosstab association between age and the kind of attention given to the patient

Age	The kind of attention the patients was given			X^2	Df	Sig
	Prompt	Moderate	Slow	**56.150^a**	**6**	**.000**
20-30	**76(23.2%)**	**89(27.1%)**	**20(6.1%)**			
31-40	**26(7.9%)**	**27(8.2%)**	**15(4.6%)**			
41-50	**6(1.8%)**	**50(15.2%)**	**2(0.6%)**			
51-60	**11(3.4%)**	**0(0.0%)**	**6(1.8%)**			

Source: Field Survey 2018

Table 33: shows a significant association exist between age and the kind of treatment received at the community based centre (X^2=**28.03**, p= 0.00). This means that a larger percentage between age 20-30 years reported that they were given good treatment at the community based centre while a few respondents between 41-50 years of age reported being given poor treatment at the community based centre. This shows that age significantly influences the kind of treatment received at the community based centre.

Table 33: Summary table of crosstab association between age and the kind of treatment received at the community based centre

Age	The treatment the patient received at the community based centre			X^2	Df	Sig
	Good	Fairly	Poor	**28.026**[a]	**6**	**.000**
20-30	**95(29.0%)**	**39(11.9%)**	**51(15.5%)**			
31-40	**40(12.2%)**	**19(5.8%)**	**9(2.7%)**			
41-50	**33(10.1%)**	**23(7.0%)**	**2(0.6%)**			
51-60	**9(2.7%)**	**8(2.4%)**	**0(0.0%)**			

Source: Field Survey 2018

Table 34: shows that a significant association exists between age and the people involved in the decision (X^2=**108.43**, *p*= 0.00). This means that a larger percentage of the respondents between age 20-30 years reported that the family members decided to take them to the community based centres while respondents between 41-50 years reported that the orthodox health workers decided to take them to the community based centres. This shows that age significantly influences the people involved in the decision.

Table 34: The summary table of crosstab association between age and the people involved in the decision

Age	Those involved in decision making to take him/her to the community based centre						X^2	Df	Sig
	Family member	Neighbuor	Orthodox health worker	Friends	Co-worker	Church member	**108.432**	**15**	**.000**
20-30	**131(39.9%)**	**20(6.1%)**	**30(9.1%)**	**4(1.2%)**	**0(0.0%)**	**0(0.0%)**			
31-40	**39(11.9%)**	**5(1.5%)**	**7(2.1%)**	**11(3.4%)**	**0(0.0%)**	**6(1.8%)**			
41-50	**24(7.3%)**	**8(2.4%)**	**1(0.3%)**	**21(6.4%)**	**4(1.2%)**	**0(0.0%)**			
51-60	**9(2.7%)**	**2(0.6%)**	**0(0.0%)**	**6(1.8%)**	**0(0.0%)**	**0(0.0%)**			

Source: Field Survey 2018

Table 35: shows that a significant association exists between age and the people involved in the final decision (X^2=**113.99**, *p*= 0.00). This means that a larger percentage between age 20-30 years reported that the father took the final decision while few respondents between 41-50 years reported that the community leaders took the decision. This shows that age significantly influences the people involved in the final decision.

Table 35: The summary table of crosstab association between age and those who took the final decision

Age	**Those who make a decision**						X^2	Df	Sig
	Father	Mother	Family member	Religious institution	Community leader	Others	**113.99**	**15**	**.000**
20-30	**97(29.6%)**	**48(14.6%)**	**28(8.5%)**	**1(0.3%)**	**0(0.0%)**	**11(3.4%)**			
31-40	**21(6.4%)**	**18(5.5%)**	**7(2.1%)**	**10(3.0%)**	**12(3.7%)**	**0(0.0%)**			
41-50	**26(7.9%)**	**27(8.2%)**	**2(0.6%)**	**2(0.6%)**	**1(0.3%)**	**0(0.0%)**			
51-60	**5(1.5%)**	**6(1.8%)**	**0(0.0%)**	**6(1.8%)**	**0(0.0%)**	**0(0.0%)**			

Source: Field Survey 2018

Table 36: shows that a significant association exists between age and the information about the existence of the community based centre (X^2=**73.58**, p= 0.00). This means that a larger percentage between age 20-30 years heard the information about the community based centre through friends while few between age 41-50 reported that they heard it through television and radio. This shows that age significantly influences information about the existence of the community based centre.

Table 36: A summary table of crosstab association between age and the information about the existence of the community

Age	Medium of awareness about the existence of the community based centre					X^2	Df	Sig
	Through radio	Through television	Through friends	Through family member	Through health workers	**73.583^a**	**12**	**.000**
20-30	**35(10.7%)**	**11(3.4%)**	**96(29.3%)**	**27(8.2%)**	**16(4.9%)**			
31-40	**16(4.9%)**	**2(0.6%)**	**14(4.3%)**	**25(7.6%)**	**11(3.4%)**			
41-50	**3(0.9%)**	**3(0.9%)**	**43(13.1%)**	**5(1.5%)**	**4(1.2%)**			
51-60	**0(0.0%)**	**0(0.0%)**	**5(1.5%)**	**12(3.7%)**	**0(0.0%)**			

Source: Field Survey 2018

Table 37: shows that a significant association exists between age and the treatment of mental illness outside hospital settings (X^2=**12.45**, p= 0.00). Moreover, a significant association exists between age and disposition to marry someone with mental health (X^2=**33.74**, p= 0.00). Also, a significant association exists between age and the belief that people living with psychiatric disorder are public nuisance (X^2=**31.77**, p= 0.00). Furthermore, a significant association exists between age and the assumption that people in their family has mental illness (X^2=**12.44**, p= 0.00). However, a significant association exists between age and the movement of mental illness in the family (X^2=**15.74**, p= 0.00).

Table 37: A summary table of crosstab association between age and the coping patterns of people living with schizophrenic disorder

	Age	Yes	NO	X^2	Df	Sig
Mental illness can be treated outside hospital settings	20-30	77(23.5%)	108(32.9%)	12.451^a	3	.006
	31-40	42(12.8%)	26(7.9%)			
	41-50	32(9.8%)	26(7.9%)			
	51-60	12(3.7%)	5(1.5%)			
People think that persons with mental illness are dangerous because of violent behavior	20-30	79(24.1%)	106(32.3%)	5.852^a	3	.119
	31-40	27(8.2%)	41(12.5%)			
	41-50	23(7.0%)	35(10.7%)			
	51-60	12(3.7%)	5(1.5%)			
Dispositions to marry someone with mental health	20-30	38(11.6%)	147(44.8%)	33.737^a	3	.000
	31-40	3(0.9%)	65(19.8%)			
	41-50	9(2.7%)	49(14.9%)			
	51-60	11(3.4%)	6(1.8%)			
People with mental illness are public nuisance	20-30	51(15.5%)	134(40.9%)	31.768^a	3	.000
	31-40	28(8.5%)	40(12.2%)			
	41-50	23(7.0%)	35(10.7%)			
	51-60	16(4.9%)	1(0.3%)			
Willingness to have conversation with PwS	20-30	55(16.8%)	130(39.6%)	6.676^a	3	.083
	31-40	14(4.3%)	54(16.5%)			
	41-50	10(3.0%)	48(14.6%)			
	51-60	7(2.1%)	10(3.0%)			
I think I will be ashamed if people know someone in my family is being diagnosed with mental illness	20-30	61(18.6%)	124(37.8%)	12.444^a	3	.006
	31-40	30(9.1%)	38(11.6%)			
	41-50	11(3.4%)	47(14.3%)			
	51-60	2(0.6%)	15(4.6%)			
Mental illness runs in the family	20-30	51(15.5%)	134(40.9%)	15.740^a	3	.001
	31-40	12(3.7%)	56(17.1%)			
	41-50	27(8.2%)	31(9.5%)			
	51-60	2(0.6%)	15(4.6%)			

Source: Field Survey 2018

Table 38: shows a significant association exists between the relationship with patients and the first path way before visiting community based centre (X^2=**92.63**, *p*= 0.00). This means that a larger percentage of the respondents visited the hospitals while a few reported going to the mosque. This shows that the relationship with patients significantly influences the first path way before visiting community based centres.

Table 38: A summary table of crosstab association between the relationship with patients and the first pathway before visiting community based centres

Relationship with patients	The first path way before the option of community based centres					X^2	Df	Sig
	Traditional healers	Home remedies	Hospital	Church	Mosque	**92.632**[a]	**16**	**.000**
Father	**12(3.7%)**	**10(3.0%)**	**27(8.2%)**	**0(0.0%)**	**0(0.0%)**			
Mother	**15(4.6%)**	**6(1.8%)**	**17(5.2%)**	**2(0.6%)**	**0(0.0%)**			
Siblings	**26(7.9%)**	**8(2.4%)**	**39(11.9%)**	**1(0.3%)**	**2(0.6%)**			
Step parents	**1(0.3%)**	**2(0.6%)**	**32(9.8%)**	**18(5.5%)**	**0(0.0%)**			
Others	**36(11.0%)**	**16(4.9%)**	**35(10.7%)**	**11(3.4%)**	**12(3.7%)**			

Source: Field Survey 2018

Table 39: shows a significant association exists between the relationship with patients and the kind of treatment given (X^2=**201.37**, *p*= 0.00). This means that a larger percentage of the respondents reported that they were given orthodox treatments while a few reported traditional treatments. This shows that relationship with patients significantly influences the kind of treatment given.

Table 39: A summary table of crosstab association between the relationship with parent and the kind of treatment given

Relationship with parent	The kind of treatments received at community-based centre					X^2	Df	Sig
	Orthodox	Traditional	Combined therapy	Prayer only	Prayer+holy water	**201.365**	**16**	**.000**
Father	**30(9.1%)**	**3(0.9%)**	**8(2.4%)**	**0(0.0%)**	**8(2.4%)**			
Mother	**22(6.7%)**	**6(1.8%)**	**6(1.8%)**	**0(0.0%)**	**6(1.8%)**			
Siblings	**27(8.2%)**	**1(0.3%)**	**47(14.3%)**	**1(0.3%)**	**0(0.0%)**			
Step parents	**12(3.7%)**	**0(0.0%)**	**2(0.6%)**	**21(6.4%)**	**18(5.5%)**			
Others	**42(12.8%)**	**0(0.0%)**	**26(7.9%)**	**42(12.8%)**	**0(0.0%)**			

Source: Field Survey 2018

Table 40: shows a significant association exists between the relationship with patients and the kind of attention being given (X^2=**108.94**, *p*= .000). This means that a larger percentage of the respondents reported that they were given a moderate attention by their step parents while a few reported being given a slow attention by their siblings. This shows that relationship with patients significantly influences the kind of attention being given.

Table 40: A summary table of crosstab association between relationship with patients and the kinds of attention given to the patient

Relationship with patients	**The kinds of attention given to the patient**			X^2	Df	Sig
	Prompt	Moderate	Slow	**108.938^a**	**8**	**.000**
Father	**17(5.2%)**	**32(9.8%)**	**0(0.0%)**			
Mother	**21(6.4%)**	**7(2.1%)**	**12(3.7%)**			
Siblings	**29(8.8%)**	**46(14.0%)**	**1(0.3%)**			
Step parents	**3(0.9%)**	**50(15.2%)**	**0(0.0%)**			
Others	**49(14.9%)**	**31(9.5%)**	**30(9.1%)**			

Source: Field Survey 2018

Table 41: shows that a significant association exists between relationship with patients and the kind of treatment received at the community based centres (X^2=**77.19**, *p*= 0.00). This means that a larger percentage of the respondents reported that they were given good treatment at the community based centres while a few reported poor treatment at the community based centres. This shows that relationship with patients significantly influences the kind of treatments received at the community based centres.

Table 41: A summary table of crosstab association between the relationship with patients and the kinds of treatment received at the community based centres

Relationship with patients	The kinds of treatment received at the community based centres			X^2	Df	Sig
	Good	Fairly	Poor	**77.189^a**	**8**	**.000**
Father	**24(7.3%)**	**19(5.8%)**	**6(1.8%)**			
Mother	**12(3.7%)**	**23(7.0%)**	**5(1.5%)**			
Siblings	**57(17.4%)**	**8(2.4%)**	**11(3.4%)**			
Step parents	**30(9.1%)**	**23(7.0%)**	**0(0.0%)**			
Others	**54(16.5%)**	**16(4.9%)**	**40(12.2%)**			

Source: Field Survey 2018

Table 42: shows a significant association exists between the relationship with patients and the people involved in the decision (X^2=**195.96**, p= 0.00). This means that a larger percentage of the respondents reported that the family members decided to take them to the community based centres while a few reported that their co-workers decided to take them to the community based centres. This shows that the relationship with the patients significantly influences the people involved in the decision

Table 42: A summary table of crosstab association between relationship with patients and the people involved in the decision

Relationship with patients	**Those involved in the decision to take the patient to the community based centre**						X^2	Df	Sig
	Family members	Neighbour	Orthodox health workers	Friends	Co-workers	Church members	**195.959**	**20**	**.000**
Father	**20(6.1%)**	**23(7.0%)**	**5(1.5%)**	**1(0.3%)**	**0(0.0%)**	**0(0.0%)**			
Mother	**11(3.4%)**	**7(2.1%)**	**9(2.7%)**	**7(2.1%)**	**0(0.0%)**	**6(1.8%)**			
Siblings	**53(16.2%)**	**0(0.0%)**	**13(4.0%)**	**6(1.8%)**	**4(1.2%)**	**0(0.0%)**			
Step parents	**30(9.1%)**	**5(1.5%)**	**0(0.0%)**	**18(5.5%)**	**0(0.0%)**	**0(0.0%)**			
Others	**89(27.1%)**	**0(0.0%)**	**11(3.4%)**	**10(3.0%)**	**0(0.0%)**	**0(0.0%)**			

Source: Field Survey 2018

Table 43: shows a significant association exists between the relationship with patients and the people involved in the final decision (X^2=**124.31**, *p*= 0.00). This means that a larger percentage of the respondents reported that the father took the final decision while a few reported that other people took the decision. This shows that relationship with patients significantly influences the people involved in the final decision.

Table 43: A summary table of crosstab association between the relationship with patients and those who took the final decision

Relationship with patients	Those with final decision						X^2	Df	Sig
	Father	Mother	Family members	Religious institutions	Community leaders	Others	**124.312**	**20**	**.000**
Father	**28(8.5%)**	**13(4.0%)**	**7(2.1%)**	**1(0.3%)**	**0(0.0%)**	**0(0.0%)**			
Mother	**8(2.4%)**	**10(3.0%)**	**16(4.9%)**	**6(1.8%)**	**0(0.0%)**	**0(0.0%)**			
Siblings	**30(9/1%)**	**29(8.8%)**	**14(4.3%)**	**2(0.6%)**	**1(0.3%)**	**0(0.0%)**			
Step parents	**30(9.1%)**	**23(7.0%)**	**0(0.0%)**	**0(0.0%)**	**0(0.0%)**	**0(0.0%)**			
Others	**53(16.2%)**	**24(7.3%)**	**0(0.0%)**	**10(3.0%)**	**12(3.7%)**	**11(3.4%)**			

Source: Field Survey 2018

Table 44: shows that a significant association exists between the relationship with patients and the information about the existence of the community based centres (X^2=**19.16**, *p*= 0.00). This means that a larger percentage of the respondents heard the information about the community based centre through friends while a few reported that they heard it through television. This shows that the relationship with patients significantly influences information about the existence of the community based centre.

Table 44: A Summary table of crosstab association between the relationship with patients and the information about the existence of the community

Relationship with patients	Information about the existence of the community based centre					X^2	Df	Sig
	Through radio	Through television	Through friends	Through family members	Through health workers	**64.771^a**	**16**	**.000**
Father	**14(4.3%)**	**3(0.9%)**	**24(7.3%)**	**4(1.2%)**	**4(1.2%)**			
Mother	**8(2.4%)**	**1(0.3%)**	**9(2.7%)**	**11(3.4%)**	**11(3.4%)**			
Siblings	**6(1.8%)**	**5(1.5%)**	**45(13.7%)**	**16(4.9%)**	**4(1.2%)**			
Step parents	**12(3.7%)**	**3(0.9%)**	**36(11.0%)**	**2(0.6%)**	**0(0.0%)**			
Others	**14(4.3%)**	**4(1.2%)**	**44(13.4%)**	**36(11.0%)**	**12(3.7%)**			

Source: Field Survey 2018

Table 45: shows a significant association exists between the relationship with patients and the treatment of mental illness outside the hospital settings (X^2=23.98, *p*= 0.00). Also, a significant association exists between the relationship with patients and the thought that person with mental illness are dangerous (X^2=31.58, *p*= 0.00). However, a significant association exists between the relationship with patients and the disposition to marry someone with mental illness (X^2=20.99, *p*= 0.00). However, a significant association exists between the relationship with patients and the belife that people with mental illness are public nuisance (X^2=21.82, *p*= 0.00). A significant association exists between the relationship with patients and willingness to have conversation with PwS (X^2=38.96, *p*= 0.00). Moreover, a significant association exists between the relationship with patients and the assumption that people in their family have mental illness (X^2=21.29, *p*= 0.00) while a significant association exists between the relationship with patients and movement of mental illness in the family (X^2=31.27, *p*= 0.00).

Table 45: A summary table of crosstab association between the relationship with patients and the coping patterns of people living with schizophrenic disorder

	Relationship with patients	Yes	NO	X^2	Df	Sig
Mental illness can be treated outside hospital settings	Father	**12(3.7%)**	**37(11.3%)**	**23.977[a]**	**4**	**.000**
	Mother	**27(8.2%)**	**13(4.0%)**			
	Siblings	**48(14.6%)**	**28(8.5%)**			
	Step parents	**23(7.0%)**	**30(9.1%)**			
	Others	**53(16.2%)**	**57(17.4%)**			
People think that persons with mental illness are dangerous because of violent behavior	Father	**11(3.4%)**	**38(11.6%)**	**31.581[a]**	**4**	**.000**
	Mother	**9(2.7%)**	**31(9.5%)**			
	Siblings	**27(8.2%)**	**49(14.9%)**			
	Step parents	**32(9.8%)**	**21(6.4%)**			
	Others	**62(18.9%)**	**48(14.6%)**			
Dispositions to marry someone with mental health	Father	**7(2.1%)**	**42(12.8%)**	**20.997[a]**	**4**	**.000**
	Mother	**5(1.5%)**	**35(10.7%)**			
	Siblings	**11(3.4%)**	**65(19.8%)**			
	Step parents	**3(0.9%)**	**50(15.2%)**			
	Others	**35(10.7%)**	**75(22.9%)**			
People with mental illness are public nuisance	Father	**15(4.6%)**	**34(10.4%)**	**21.818[a]**	**4**	**.000**
	Mother	**19(5.8%)**	**21(6.4%)**			
	Siblings	**21(6.4%)**	**55(16.8%)**			
	Step parents	**32(9.8%)**	**21(6.4%)**			
	Others	**31(9.5%)**	**79(24.1%)**			
Willingness to have conversation with PwS	Father	**5(1.5%)**	**44(13.4%)**	**38.962[a]**	**4**	**.000**
	Mother	**8(2.4%)**	**32(9.8%)**			
	Siblings	**35(10.7%)**	**41(12.5%)**			
	Step parents	**2(0.6%)**	**51(15.5%)**			
	Others	**36(11.0%)**	**74(22.6%)**			
I think I will be ashamed if people know someone in my family is being diagnosed of mental illness	Father	**18(5.5%)**	**31(9.5%)**	**21.287[a]**	**4**	**.000**
	Mother	**2(0.6%)**	**38(11.6%)**			
	Siblings	**35(10.7%)**	**41(12.5%)**			
	Step parents	**15(4.6%)**	**38(11.6%)**			
	Others	**34(10.4%)**	**76(23.2%)**			
Mental illness runs in the family	Father	**7(2.1%)**	**42(12.8%)**	**31.273[a]**	**4**	**.000**
	Mother	**4(1.2%)**	**36(11.0%)**			
	Siblings	**13(4.0%)**	**63(19.2%)**			
	Step parents	**20(6.1%)**	**33(10.1%)**			
	Others	**48(14.6%)**	**62(18.9%)**			

Source: Field Survey 2018

Table 46: shows there is no significant association between gender and patients who are tough survivor (X^2=**.005**, *p*= .945). This means that a larger percentage of the respondents reported that mental illness has made the patients a tough survivor compared to respondents who reported that it has not. This shows that gender did not significantly influence patients who are tough survivors.

Table 46: A summary table of crosstab association between gender and mental illness has made the patients a tough survivor

Gender	**Living with mental illness increases the resilience of the patients (made them a tough survivor)**		X^2	Df	Sig
	Yes	No	**.005^a**	**1**	**.945**
Male	**65(19.8%)**	**61(18.6%)**			
Female	**105(32.0%)**	**97(29.6%)**			

Source: Field Survey 2018

Table 47: shows that a significant association exists between gender and getting closer to people with mental illness (X^2=**13.27**, *p*= .000). This means that a larger percentage of the respondents reported that they get close with people with mental illness compared to the respondents who reported that they avoid close contact with PwS. This shows that gender significantly influences getting closer to people with mental illness.

Table 47: A summary table of crosstab association between gender and closeness to people with mental illness

Gender	**Nobody would be interested in getting close to the victim (s) of the mental illness**		X^2	Df	Sig
	Yes	No	**13.267**[a]	**1**	**.000**
Male	**31(9.5%)**	**95(29.0%)**			
Female	**90(27.4%)**	**112(34.1%)**			

Source: Field Survey 2018

Table 48: shows that there is no significant association between gender and how they get financial resources (X^2=**2.605**, *p*= .000). This means that a larger percentage of the respondents reported that it is difficult to get financial resources compared to the respondents who reported that it is not easy and not also difficult. This shows that gender did not significantly influence how they get financial resources.

Table 48: A summary table of crosstab association between gender and how they get financial resources

Gender	Is it easy to get the financial resources				X^2	Df	Sig
	No response	Very difficult	Difficult	Not difficult and not easy	**2.605[a]**	**3**	**.457**
Male	**23(7.0%)**	**44(13.4%)**	**46(14.0%)**	**13(4.0%)**			
Female	**27(8.2%)**	**77(23.5%)**	**83(25.3%)**	**15(4.6%)**			

Source: Field Survey 2018

Table 49: shows that there is no significant association between gender and the number of people they currently care for (X^2=**2.605**, *p*= .345). This means that a larger percentage of the respondents reported that they currently cared for 1-10 mental health people while few cared for 11-20 mental health patients. This shows that gender did not significantly influence the number of people they currently care for.

Table 49: A summary table of crosstab association between gender and the number of people they currently care for

Gender	Number of people with a mental health problem you are currently caring for			X^2	Df	Sig
	No response	1-10 mental health	11-20 mental health	**2.127^a**	**2**	**.345**
Male	**17(5.2%)**	**91(27.7%)**	**18(5.5%)**			
Female	**18(5.5%)**	**148(45.1%)**	**36(11.0%)**			

Source: Field Survey 2018

Table 50: shows that a significant association exists between gender and the number of hours they care for mental health people (X^2=**14.25**, *p*= .001). This means that a larger percentage of the respondents reported that they use 1-5 hours to care for mental health people while few use 6-10 hours to care for them. This shows that gender significantly influences the number of hours they care for mental health people.

Table 50: Summary table of crosstab Association between gender and the number of hours they care for mental health people

Gender	**Number of hours you have taken off paid work in the past week to care for the person with a mental health problem**			X^2	Df	Sig
	No response	1-5 hour	6-10 hour	**14.253^a**	**2**	**.001**
Male	**20(6.1%)**	**106(32.3%)**	**0(0.0%)**			
Female	**64(19.5%)**	**133(40.5%)**	**5(1.5%)**			

Source: Field Survey 2018

Table 51: show a significant association exist between gender and the number of hours they spent looking after mental health people (X^2=**13.63**, p= .001). This means that larger percentage of the respondent reported that they use 1-10 hours last week to care for mental health people while few use 11-20 hour last week to care for them. This shows that gender significantly influence number of hours they spent looking after mental health people.

Table 51: A summary table of crosstab association between gender and the number of hours they spent looking after mental health people

Gender	Number of hours you spent last week looking after someone with a mental illness			X^2	Df	Sig
	No response	1-10 hours	11-20 hours	**13.625^a**	**2**	**.001**
Male	**10(3.0%)**	**102(31.1%)**	**14(4.3%)**			
Female	**26(7.9%)**	**125(38.1%)**	**51(15.5%)**			

Source: Field Survey 2018

Table 52: shows that a significant association exists between gender and the number of years they started to care for those with mental health people (X^2=**13.63**, *p*= .001). This means that a larger percentage of the respondents reported that they use 1-10 years to care for mental health people while few use 11-20 years to care for them. This shows that gender significantly influences the number of years they start to care for those with mental health people.

Table 52: A summary table of crosstab association between gender and the number of years they started to care for those with mental health people

Gender	Numbers of years you have started caring for someone with mental illness			X^2	Df	Sig
	No response	1-10 years	11-20 years	**15.520**[a]	**2**	**.000**
Male	**10(3.0%)**	**81(24.7%)**	**35(10.7%)**			
Female	**46(14.0%)**	**124(37.8%)**	**32(9.8%)**			

Source: Field Survey 2018

Table 53: shows that a significant association exists between gender and living together with mental health patients (X^2=**6.27**, p= .044). This means that a larger percentage of the respondents reported living together with the patients while few people live with the patients some of the time. This shows that gender significantly influences living together with mental health patients.

Table 53: A summary table of crosstab association between gender and living together with mental health patients

Gender	The apartment you live together in with the patients at the moment			X^2	Df	Sig
	Yes	Some of the time	No	**6.266**[a]	**2**	**.044**
Male	**63(19.2%)**	**33(10.1%)**	**30(9.1%)**			
Female	**101(30.8%)**	**33(10.1%)**	**68(20.7%)**			

Source: Field Survey 2018

Table 54: shows that there is no significant association between age and patients with tough survivor (X^2=16.15, p= .000). This means that a larger percentage of the respondents reported that they have negative behaviour toward patients with tough survivor compared to respondents who reported that they did not have negative behavior toward patients with tough survivor. This shows that age significantly influences patients with tough survivor.

Table 54: A summary table of crosstab association between age and how mental illness has made the patients tough survivors

Age	Living with mental illness increases the resilience of the patients (made them tough survivor)		X^2	Df	Sig
	Yes	No	**16.146**[a]	**3**	**.001**
20-30 years	**80(24.4%)**	**105(32.0%)**			
31-40 years	**39(11.9%)**	**29(8.8%)**			
41-50 years	**42(12.8%)**	**16(4.9%)**			
51-60 years	**9(2.7%)**	**8(2.4%)**			

Source: Field Survey 2018

Table 55: shows that a significant association exists between age and getting closer to people with mental illness (X^2=**61.85**, *p*= .000). This means that a larger percentage of the respondents reported that they would not get close with people with mental illness compared to respondents who reported that they will. This shows that age significantly influences getting closer to people with mental illness.

Table 55: A summary table of crosstab association between age and closeness to people with mental illness

Age	**Nobody would be interested in getting close to him/her because of the mental illness**		X^2	Df	Sig
	Yes	No	**61.846[a]**	**3**	**.000**
20-30 years	**63(19.2%)**	**122(37.2%)**			
31-40 years	**49(14.9%)**	**19(5.8%)**			
41-50 years	**3(0.9%)**	**55(16.8%)**			
51-60 years	**6(1.8%)**	**11(3.4%)**			

Source: Field Survey 2018

Table 56: shows that a significant association exists between age and how they get financial resources(X^2=**66.56**, *p*= .000). This means that a larger percentage of the respondents reported that it is difficult to get financial resources compared to the respondents who reported that it is not easy and not also difficult. This shows that age significantly influences how they get financial resources.

Table 56: Summary table of crosstab Association between age and how they get financial resources

Age	**It is easy to get the financial resources**				X^2	Df	Sig
	No response	Very difficult	Difficult	Not difficult and not easy	**66.555**[a]	**9**	**.000**
20-30 years	**27(8.2%)**	**76(23.2%)**	**80(24.4%)**	**2(0.6%)**			
31-40 years	**4(1.2%)**	**28(8.5%)**	**25(7.6%)**	**11(3.4%)**			
41-50 years	**19(5.8%)**	**11(3.4%)**	**20(6.1%)**	**8(2.4%)**			
51-60 years	**0(0.0%)**	**6(1.8%)**	**4(1.2%)**	**7(2.1%)**			

Source: Field Survey 2018

Table 57: show a significant association exist between age and the number of people they currently care for (X^2=**32.00**, *p*= .000). This means that larger percentage of the respondent reported that they currently care for 1-10 mental health people while few care for 11-20 mental health patients. This shows that age significantly influence the number of people they currently care for.

Table 57: A summary table of crosstab association between age and the number of people they currently care for

Age	Numbers of people with a mental health problem you are currently care for			X^2	Df	Sig
	No response	1-10 mental health	11-20 mental health	**32.001^a**	**6**	**.000**
20-30 years	**15(4.6%)**	**146(44.5%)**	**24(7.3%)**			
31-40 years	**11(3.4%)**	**48(14.6%)**	**9(2.7%)**			
41-50 years	**9(2.7%)**	**28(8.5%)**	**21(6.4%)**			
51-60 years	**0(0.0%)**	**17(5.2%)**	**0(0.0%)**			

Source: Field Survey 2018

Table 58: shows that a significant association exists between age and the number of hours they care for mental health people (X^2=**63.88**, *p*= .001). This means that a larger percentage of the respondents reported that they use 1-5 hours to care for mental health people while few use 6-10 hour to care for them. This shows that age significantly influences a the number of hours they care for mental health people.

Table 58: A Summary table of crosstab association between the age and the number of hours they care for mental health people

Age	Number of hours you have taken off paid work in the past weeks to care for the person with a mental health problem			X²	Df	Sig
	No response	1-5 hour	6-10 hour	**63.877ª**	**6**	**.000**
20-30 years	**40(12.2%)**	**140(42.7%)**	**5(1.5%)**			
31-40 years	**7(2.1%)**	**61(18.6%)**	**0(0.0%)**			
41-50 years	**37(11.3%)**	**21(6.4%)**	**0(0.0%)**			
51-60 years	**0(0.0%)**	**17(5.2%)**	**0(0.0%)**			

Source: Field Survey 2018

Table 59: shows that a significant association exists between age and the number of hours they spent looking after mental health people (X^2=**21.18**, *p*= .001). This means that a larger percentage of the respondents reported that they use 1-10 hours last week to care for mental health people while few use 11-20 hour last week to care for them. This shows that age significantly influences the number of hours they spent looking after mental health people.

Table 59: A summary table of crosstab association between age and the number of hours they spent looking after mental health people

Age	Number of hours you spent last week looking after someone with a mental illness			X^2	Df	Sig
	No response	1-10 hours	11-20 hours	**21.184**[a]	**6**	**.002**
20-30 years	**20(6.1%)**	**130(39.6%)**	**35(10.7%)**			
31-40 years	**8(2.4%)**	**51(15.5%)**	**9(2.7%)**			
41-50 years	**3(0.9%)**	**34(10.4%)**	**21(6.4%)**			
51-60 years	**5(1.5%)**	**12(3.7%)**	**0(0.0%)**			

Source: Field Survey 2018

Table 60: shows a significant association exists between age and the number of years they started to care for those with mental health people (X^2=**19.09**, *p*= .001). This means that a larger percentage of the respondents reported that they use 1-10 years to care for mental health people while few use 11-20 years to care for them. This shows that age significantly influences the number of years they started to care for those with mental health people.

Table 60 : A summary table of crosstab association between age and the number of years they start to care for those with mental health people

Age	**Numbers of years you have started caring for someone with mental illness**			X²	Df	Sig
	No response	1-10 years	11-20 years	**19.086^a**	**6**	**.004**
20-30 years	**40(12.2%)**	**105(32.0%)**	**40(12.2%)**			
31-40 years	**13(4.0%)**	**43(13.1%)**	**12(3.7%)**			
41-50 years	**1(0.3%)**	**42(12.8%)**	**15(4.6%)**			
51-60 years	**2(0.6%)**	**15(4.6%)**	**0(0.0%)**			

Source: Field Survey 2018

Table 61: show that a significant association exists between age and living together with mental health patients (X^2=**39.96**, *p*= .000). This means that a larger percentage of the respondents reported living together with the patients while few people live with the patients some of the time. This shows that age significantly influences living together with mental health patients.

Table 61: A summary table of crosstab aassociation between age and living together with mental health patients

Age	The apartment you live in together with the patients at the moment			X^2	Df	Sig
	Yes	Some of the time	No	**39.959**[a]	**6**	**.000**
20-30 years	**86(26.2%)**	**48(14.6%)**	**51(15.5%)**			
31-40 years	**50(15.2%)**	**0(0.0%)**	**18(5.5%)**			
41-50 years	**17(5.2%)**	**18(5.5%)**	**23(7.0%)**			
51-60 years	**11(3.4%)**	**0(0.0%)**	**6(1.8%)**			

Source: Field Survey 2018

Table 62: shows that there is no significant association between biological relationship and patients with tough survivor (X^2=8.72, p= .068). This means that a larger percentage of the respondents reported that mental illness made their patients tough survivors compared to the respondents who reported that it did not. This shows that biological relationship with patient did significantly influence patients with tough survivor

Table 62: A Summary table of crosstab association between the relationship with patients and how mental illness has made the patients a tough survivor

Relationship with patients	**Living with mental illness increases the resilience of the patients (made them a tough survivor)**		X^2	Df	Sig
	Yes	No	**8.720**[a]	**4**	**.068**
Father	**27(8.2%)**	**22(6.7%)**			
Mother	**14(4.3%)**	**26(7.9%)**			
Siblings	**36(11.0%)**	**40(12.2%)**			
Step parent	**34(10.4%)**	**19(5.8%)**			
Others	**59(18.0%)**	**51(15.5%)**			

Source: Field Survey 2018

Table 63: shows that a significant association exists between the relationship with parents and getting closer to people with mental illness (X^2=**47.58**, *p*= .000). This means that a larger percentage of the respondents reported that they would not get close with people with mental illness compared to respondents who reported that they will. This shows that age significantly influences getting closer to people with mental illness.

Table 63: A summary table of crosstab association between the relationship with patients and closeness to people with mental illness

Relationship with patients	**Nobody would be interested in getting close to the victim because of the mental illness**		X^2	Df	Sig
	Yes	No	**47.580^a**	**4**	**.000**
Father	**10(3.0%)**	**39(11.9%)**			
Mother	**14(4.3%)**	**26(7.9%)**			
Siblings	**36(11.0%)**	**40(12.2%)**			
Step parent	**2(0.6%)**	**51(15.5%)**			
Others	**59(18.0%)**	**51(15.5%)**			

Source: Field Survey 2018

Table 64: shows that a significant association exists between the relationship with patients and how they get financial resources (X^2=**63.81**, *p*= .000). This means that a larger percentage of the respondents reported that it is difficult to get financial resources from other people compared to the respondents who reported that it is not easy and not difficult to get financial resources from the step parents. This shows that the relationship with parents significantly influences how they get financial resources.

Table 64: A summary table of crosstab association between the relationship with patients and how they get financial resources

Relationship with patients	It is easy to get the financial resources				X^2	Df	Sig
	No response	Very difficult	Difficult	Not difficult and not easy	**63.808[a]**	**12**	**.000**
Father	**12(3.7%)**	**23(7.0%)**	**10(3.0%)**	**4(1.2%)**			
Mother	**0(0.0%)**	**22(6.7%)**	**13(4.0%)**	**5(1.5%)**			
Sibling	**12(3.7%)**	**31(9.5%)**	**23(7.0%)**	**10(3.0%)**			
Step parent	**19(5.8%)**	**16(4.9%)**	**16(4.9%)**	**2(0.6%)**			
Others	**7(2.1%)**	**29(8.8%)**	**67(20.4%)**	**7(2.1%)**			

Source: Field Survey 2018

Table 65: shows that a significant association exists between relationship with patients and the number of people they currently care for (X^2=**74.35**, *p*= .000). This means that a larger percentage of the respondents reported that they currently care for 1-10 mental health people while few care for 11-20 mental health patients. This shows that the relationship with patients significantly influences the number of people they currently care for.

Table 65: A summary table of crosstab association between the relationship with patients and the numbers of people they currently care for

Relationship with patients	Numbers of people with a mental health problem you are currently caring for			X^2	Df	Sig
	No response	1-10 mental health	11-20 mental health	**74.349[a]**	**8**	**.000**
Father	**0(0.0%)**	**47(14.3%)**	**2(0.6%)**			
Mother	**0(0.0%)**	**40(12.2%)**	**0(0.0%)**			
Siblings	**1(0.3%)**	**60(18.3%)**	**15(4.6%)**			
Step parent	**9(2.7%)**	**24(7.3%)**	**20(6.1%)**			
Others	**25(7.6%)**	**68(20.7%)**	**17(5.2%)**			

Source: Field Survey 2018

Table 66: shows a significant association exists between relationship with patients and the number of hours they care for mental health people (X^2=**77.19**, *p*= .000). This means that a larger percentage of the respondents reported that they use 1-5 hours to care for mental health people while few use 6-10 hours to care for them. This shows that the relationship with patients significantly influences the number of hours they care for mental health people.

Table 66: A summary table of crosstab association between the relationship with patients and the number of hours they care for mental health people

Relationship with patients	Number of hours you have taken off paid work in the past weeks to care for the persons with a mental health problem			X^2	Df	Sig
	No response	1-5 hour	6-10 hour	**77.188^a**	**8**	**.000**
Father	**10(3.0%)**	**39(11.9%)**	**0(0.0%)**			
Mother	**0(0.0%)**	**40(12.2%)**	**0(0.0%)**			
Siblings	**12(3.7%)**	**60(18.3%)**	**4(1.2%)**			
Step parent	**36(11.0%)**	**17(5.2%)**	**0(0.0%)**			
Others	**26(7.9%)**	**83(25.3%)**	**1(0.3%)**			

Source: Field Survey 2018

Table 67: shows a significant association exists between the relationship with patients and the number of hours they spent looking after mental health people (X^2=**53.44**, *p*= .000). This means that a larger percentage of the respondenta reported that they use 1-10 hours last week to care for mental health people while few use 11-20 hours last week to care for them. This shows that the relationship with patients significantly influence the number of hours they spent looking after mental health people.

Table 67: A summary table of crosstab association between the relationship with patients and the number of hours they spent looking after mental health people

Relationship with patients	Number of hours you spent last week looking after someone with a mental illness			X²	Df	Sig
	No response	1-10 hours	11-20 hours	**53.442ᵃ**	**8**	**.000**
Father	**2(0.6%)**	**45(13.7%)**	**2(0.6%)**			
Mother	**0(0.0%)**	**38(11.6%)**	**2(0.6%)**			
Siblings	**16(4.9%)**	**49(14.9%)**	**11(3.4%)**			
Step parents	**1(0.3%)**	**32(9.8%)**	**20(6.1%)**			
Others	**17(5.2%)**	**63(19.2%)**	**30(9.1%)**			

Source: Field Survey, 2018

Table 68: shows that a significant association exists between the relationship with patients and the number of years they started to care for those with mental health people (X^2=**15.47**, *p*= .051). This means that larger percentage of the respondents reported that they use 1-10 years to care for mental health people while few use 11-20 years to care for them. This shows that the relationship with patients significantly influence the number of years they started to care for those with mental health people.

Table 68 : A summary table of crosstab association between relationship with patients and the number of years they started to care for those with mental health people

Relationship with patients	**Numbers of years you have started caring for someone with mental illness**			X^2	Df	Sig
	No response	1-10 years	11-20 years	**15.472**^{a}	**8**	**.051**
Father	**13(4.0%)**	**25(7.6%)**	**11(3.4%)**			
Mother	**7(2.1%)**	**29(8.8%)**	**4(1.2%)**			
Siblings	**9(2.7%)**	**51(15.5%)**	**16(4.9%)**			
Step parents	**3(0.9%)**	**35(10.7%)**	**15(4.6%)**			
Others	**24(7.3%)**	**65(19.8%)**	**21(6.4%)**			

Source: Field Survey, 2018

Table 69: shows that a significant association exists between the relationship with patients and living together with mental health patients (X^2=**69.800**, *p*= .000). This means that a larger percentage of the respondents reported living together with the patients while few people live with the patients some of the time. This shows that the relationship with patients significantly influences living together with mental health patient.

Table 69: A summary table of crosstab association between the relationship with patients and living together with mental health patient

Relationship with patients	The apartment you live together in with the patients at the moment			X^2	Df	Sig
	Yes	Some of the time	No	**69.800**^{a}	**8**	**.000**
Father	**33(10.1%)**	**15(4.6%)**	**1(0.3%)**			
Mother	**30(9.1%)**	**4(1.2%)**	**6(1.8%)**			
Siblings	**46(14.0%)**	**7(2.1%)**	**23(7.0%)**			
Step parents	**11(3.4%)**	**23(7.0%)**	**19(5.8%)**			
Others	**44(13.4%)**	**17(5.2%)**	**49(14.9%)**			

Source: Field Survey, 2018

Table 70: shows that there is no significant association between gender and the kindness of the mental health staff (X^2=**5.35**, *p*= .069). This means that a larger percentage of the female respondents are usually kind while few of the male respondents are kind. This shows that gender did not significantly influence kindness of the members of the mental health staff .

Table 70: A summary table of crosstab association between gender and the kindness of the mental health staff

Gender	The staff of this mental health unit are usually kind			X^2	Df	Sig
	No response	Yes	No	5.352[a]	2	.069
Male	42(12.8%)	58(17.7%)	35(10.7%)			
Female	44(13.4%)	109(33.2%)	32(9.8%)			

Source: Field Survey, 2018

Table 71: shows that a significant association exists between gender and the readiness of the mental health staff to assist the patients (X^2=**7.85**, *p*= .020). This means that a larger percentage of the female respondents that are ready to assist while few male respondents also assist. This shows that gender significantly influence the readiness to assist the mental health patients.

Table 71: A summary table of crosstab association between gender and readiness to assist the mental health patient

Gender	The staff of this centre are always available and readily to assist			X^2	Df	Sig
	No response	Yes	No	**7.854**[a]	**2**	**.020**
Male	**4(12.8%)**	**45(13.7%)**	**39(11.9%)**			
Female	**46(14.0%)**	**103(31.4%)**	**53(16.2%)**			

Source: Field Survey, 2018

Table 72: shows that a significant association between the relationship with patients and the kindness of the mental health staff (X^2=**24.06**, *p*= .000). This means that other people currently show kindness to the mental health patients while few reported a negative kindness from their step parents. This shows that the relationship with patients significantly influence the kindness of the health staff.

Table 72: A summary table of crosstab association between the relationship with patients and the prompt care of the mental health staff

Relationship with patients	The staff of this mental health units are usually kind			X^2	Df	Sig
	No response	Yes	No	**24.062[a]**	**8**	**.002**
Father	**13(4.0%)**	**22(6.7%)**	**14(4.3%)**			
Mother	**10(3.0%)**	**23(7.0%)**	**7(2.1%)**			
Siblings	**25(7.6%)**	**30(9.1%)**	**21(6.4%)**			
Step parents	**13(4.0%)**	**39(11.9%)**	**1(0.3%)**			
Others	**25(7.6%)**	**53(16.2%)**	**32(9.8%)**			

Source: Field Survey, 2018

Table 73: shows a significant association between the relationship with patients and the readiness of the mental health staff to assist the patients (X^2=**22.07**, *p*= .000). This means that other people currently assist the mental health patients while few reported negative care from their step parents. This shows that relationship with patients significantly influences kindness of the health staff

Table 73: A summary table of crosstab association between the relationship with patients and readiness to assist the mental health patients

Relationship with patients	The staff of this centre are always available and readily to assist			X^2	Df	Sig
	No response	Yes	No	**22.069^a**	**8**	**.005**
Father	**13(4.0%)**	**20(6.1%)**	**16(4.9%)**			
Mother	**12(3.7%)**	**10(3.0%)**	**18(5.5%)**			
Siblings	**25(7.6%)**	**26(7.9%)**	**25(7.6%)**			
Step parents	**13(4.0%)**	**32(9.8%)**	**8(2.4%)**			
Others	**25(7.6%)**	**60(18.3%)**	**25(7.6%)**			

Source: Field Survey, 2018

Table 74: shows a significant association between age and the kindness of the mental health staff (X^2=**55.90**, *p*= .000). This means that the respondents between 20-30 years of age are usually kind to the mental health patients while few respondents between 41-50 years of age reported a negative kindness towards the mental health patient. This shows that relationship with age significantly influences kindness of the health staff.

Table 74: A summary table of crosstab association between age and the kindness of the mental health staff

Age	The staff of this mental health units are usually kind			X^2	Df	Sig
	No response	Yes	No	**55.902^a**	**6**	**.000**
20-30 years	**45(13.7%)**	**78(23.8%)**	**62(18.9%)**			
31-40 years	**22(6.7%)**	**34(10.4%)**	**12(3.7%)**			
41-50 years	**8(2.4%)**	**49(14.9%)**	**1(0.3%)**			
51-60 years	**11(3.4%)**	**6(1.8%)**	**0(0.0%)**			

Source: Field Survey, 2018

Table 75: shows a significant association between age and the readiness of the mental health staff to assist the patients (X^2=**38.95**, p= .000). This means that respondents between 20-30 years of age are usually assisting the mental health patients while few respondents between 51-60 years of age reported a negative kindness towards the mental health patients. This shows that age significantly influences kindness of the health staff

Table 75: A summary table of crosstab association between age and readiness to assist the mental health patients

Age	The staff of this centre are always available and ready to assist			X^2	Df	Sig
	No response	Yes	No	**38.949[a]**	**6**	**.000**
20-30 years	**45(13.7%)**	**83(25.3%)**	**57(17.4%)**			
31-40 years	**24(7.3%)**	**19(5.8%)**	**25(7.6%)**			
41-50 years	**8(2.4%)**	**42(12.8%)**	**8(2.4%)**			
51-60 years	**11(3.4%)**	**4(1.2%)**	**2(0.6%)**			

Source: Field Survey, 2018

4.9 Discussion of Findings

Majority of the caregivers were below 40 years who were largely married females with university education. The larger percentage was Christians, civil servants or self employed. The caregivers stayed with family members. The majority were Yoruba. Compared to the patients, the larger percentage was below 30 years of age. The greater percentage has qualification of ordinary diplomas and below. The larger percentages of the patients were Christians. The care for mental illness were still lagely undertaken by the extended family. However, in evaluating the way informal care was structured for people with psychosis in South Africa, Den Hertog and Gilmoor (2016) documented that the nuclear family upheld the main tasks of caring for a relative living with psychosis. Although caring functions were shared among the relatives, poverty reduced the amount of the care provided, often forcing patients to resort to asking for alms to supplement the family's revenue.

Public knowledge about schizophrenia revealed that it was identified by the caregivers as disease with psychotic syptomology caused by drug use, ancestral curse, witchcraft and relapse. They perceived this disease in a negative sense that it may result from direct attack or punishment inflicted by man and spiritual forces. Stigmas, in the form of stereotypes violence are easly common with regards to psychosis. Common misinformation include that psychosis is a multi-dimensional personality illness and that individuals with psychosis are basically more dangerous and unpredictable than the other people. The consensus is that psychosis is a psychiatric illness associated with dysfunctional thought process, anxiety, alcoholism, excess use of hard drugs, poverty, emotional instability (disorder), spiritual attack, injury and it could be treated and managed. The respondents advocated both spiritual cure and hospitalization for positive outcomes. These findings support the constituent view in the Nigeria literature that the general populace lack adequate knowledge about the etiologies and symptoms of schizophrenia. This poor knowledge shapes the pattern of responses and attitudes towards the treatment and management of people living with schizophrenia (Adebowale and Ogunlesi 1999; Kabir, Iliyasu, Abubakar, Aliyu, 2004; Gureje, Lasebikan, Ephraim–Oluwanuga, Olley, Kola, 2005; Jegede 2005; Motunrayo and Nwokocha 2014).These scholars reported that the community view of psychiatric illness as caused by familial defect or the 'handwork of evil machinations' (demons, evil spirits) and excessive drug use. These negative orientations led the mentally-ill patients being perceived as an outcast and persons to be ostracised (Gureje, Lasebikan, Ephraim- Oluwanuga, Olley, Kola, 2005).It was however noted that there is significant improvement in the attitude of schizophrenia in the present study which may be due to exposure to the community-based treatment programme. These findings contrast Patel et al 2006; Gureje et al, 2005) which have demonstrated the preponderance of negative attitudes towards schizophrenic in treatment and management centres. In some African countries, Nigeria to be precise, the people have negative attitude against people with psychiatric disorder (Kabir, Iliyasu, Abubakar, Aliyu, 2004; Gureje, Lasebikan, Ephraim–Oluwanuga, Olley, Kola, 2005). Other frequent traditional orientations is that emotionally-imbalance individuals are responsible for their health condition, most importantly when it is a case of substance consumption. This stigmatization did not allowd psychiatric patients accorded with the empathy from the public and meaning originally accorded to the ill persons in African community. (Varcolis, 2002; Dahiru, 2000). These behaviours and beliefs against psychiatric disorder equally, increased interest in the community-based system of care for persons with psychiatric disorder warranted accelerated demand for their social and vocational reintegration (NAMHC, 1993; Lyons, McLoughlin, 2002; Glozier, Hough, Henderson, Holland-Elliot, 2006).

The second objective which investigated peoples' consequences of reaction to stigma and stereotyping of people living with schizophrenia found a robust outcome. Findings demonstrated that people with psychosis usually experience big problems in their struggles towards having a better life of existence. Social distance was identified by the caregivers as a major consequence stigmatization, therefore stigma was found to increase the signs of the disorder as it rendered people with psychosis socially isolated, self-stigmatizing. The caregivers reported that many feel largely that "they are not part of the people. They are not fully accepted into the society. Stigmatization by the family members was found to be more painful. However, there appeared a significant number of caregivers ready to accept and absorb them back into the mainstream societal activities such as work, marital relations and cohabitations. There was a significant perceived re-orientation from the treatment centres and exposure to family therapy or psychotherapy for the educated families. These findings collaborated with the outcome from some African countries, Nigeria to be precise, the people have negative attitudes against people with psychiatric disorder (Kabir, Iliyasu, Abubakar, Aliyu, 2004; Gureje, Lasebikan, Ephraim–Oluwanuga, Olley, Kola, 2005). These findings show that there is improvement in the health care delivery for schizophrenics than in the last decades.

These finding are in contrast with Patel, et al. (2006) who identified more proof describing the human rights abuse of persons with psychosis in third world nations; new proof from groups in developing nations showing a much dark reality than originally believed; and, speed social and economic changes are undermining family care systems for people with psychosis in developing nations.

The third objective which identified the influence of the community-based psychiatric services on the coping patterns of people living with schizophrenic Disorder and their Kin.The initial belief about schizophrenia fuels the pattern of health seeking behavior among cargivers. Before bringing the patients to the community based programmes, the patients would have first sought spiritual and trado-medical help before being taking to the hospital. The larger percentage were first taken for spiritual or traditional help before hospitalization. These decision to take them for hospitalization and subsequent community based therapy were taken under the the advise of the older family members and significant others within the household and neighborhood. The caregivers became aware of the community based therapy through the mass media (radio, television) word of mouth (through friends and family members) through the health workers advocacy and awareness. The community psychiatric practice has gained increased importance in recent years in the country. This has been underscored by small numbers of health centres and psychiatrists and other experts in that area, with focusing of care in the fairly few available psychiatric institutions and mental health sections of some secondary and tertiary health facilities (Odejide and Ohaeri 1997; Aina, Ladapo, Lawal, and Owoeye, 2007). Equally, increase in awareness among the people resulted to increased patronage of the few psychiatric facilities which overstretched the available services most importantly in other patients centres (Osibogun 2004; Boroffka, 1996). This prompted the current requests in Nigeria and for the emphasis of hospitalisation in favour of the commuinty-based system as been demonstrated in developed nations (Gureje, Odejide, and Acha, 1995; Ladapo, Aina, Lawal, Adebiyi, Olomu, Aina, 2008; Amering, Stastny, Hopper, 2005; Macpherson, Dix, Morgan, 2005; and Ahanotu, Onyeizugbo, 2007).

The fourth objective which examined peoples' utilisation of the community-based psychiatric services on patients living with schizophrenic disorder and their kin was supported. The result demonstrated that there was a significant decline in the negative and subjective attribution of causes and behavior of the patients. The caregivers have become more receptive and supportive of their patients than in the pre-admission period.

Also, the combination of the different types of approaches improved. The patients' level of isolation, stigmatization and dysfunctional belief and behaviours were greatly reduced. There was increase in the participation of sports and religious activities. Many of the respondents expressed willingness to give them jobs and offers of marriage. They avoid publicly embarrassing them and making them anxious. In Nigeria, a research looked at long duration of social results among a cohot of individuals with psychosis who were attending out-ptient services. Contrary to the outcome that traditional family links and assistants would help these patients against drifting down in the socioeconomic levels, these patients continued to witness some levels of social deficits in various areas (Patel, et al. 2006). Abbo et al. (2012) documented same results which produce improvements in psychotic symptoms overtime. They warned that these improvements may have been confounded by the majority of participants concurrently using both traditional and modern mental health psychiatric services.

Objective five assess peoples' satisfaction about the efficiency of the community-based psychiatry services in the management of schizophrenic disorder. The patients were able to access clinical service in the health care systems such as basic health care facilities, general hospitals and community psychiatry service centres, where a professional mental health personnel offers evaluation and treatment, including medications, psychological and social interventions. Such services embraced wide variations in practice. They reported more humane and less stigmatised services compared to the traditional centres and hospital based services through the support from family and friends. The patients perceived community based treatment as more effective compared to full hospitalization. Therefore, the results revealed that people perceived that the community-based service in the management of schizophrenic disorder is efficient. These findings are the same to the results by Abbo et al. (2012) who demonstrated that patients benefit more from the health care delivery which combined biomedical services and traditional healings for people experiencing psychotic symptoms. These findings support the findings from South Africa, spirituality and prayer was recognised as an important source of resilience and addressing the issue of stigma in people's journey of recuperation (de Wet et al. 2015).

The effect of the community-based service on the level of stigmatization by caregivers and the public findings demonstrated that stigmatization is on the decline. The findings revealed that the community-based programme has the capacity with the help of the caregivers to take care of the patients. They showed readiness for social interaction such as marriage, living condition and work. The caregivers reported giving adequate financial, moral and emotional support to the patients. These findings in line with the studies of Asmal et al. (2014) posited that family interventions helped accelerate their understanding of psychosis. Kotze et al. (2010) documented that both patients and caregivers expressed the need for psychosocial and outpatient programmes that included illness education, social work and day care centres. The findings in line with the results of Asher et al. (2015) that utilised the effectiveness of a community-based reintegration intervention documented that training the community about psychiatric disorder minimised stigma. The advantages of the community-based care are well recognized and have strong scientific proof of effectiveness. (Chatterjee, Patel, Chatterjee, Weiss, 2003; Gureje, Chisholm, Kola, Lasebikan, Saxena (2007).The 2001 World Health Report, Mental Health: New Understanding, New Hope (WHO2001) suggests changing big psychiatric institutions with community psychosocial rehabilitation services which can deliver good and prompt care and that are more humane in terms of human rights and can help to minimise the stigma of psychiatric management.

Logistic regression of age, sex, marital status, education, religion, ethnic group, relationship with patient, health initiated and health seeking pathway on social stigma. Having primary school certificate, OND and university degree were significantly related with social stigma compared to those without formal education. Also, being a Muslim was significantly associated with social stigma compared to Christianity. The result also shows that ethnic groups were significantly associated with social stigma. Also, the result shows that the respondents who stayed with their mother significantly associated with social stigma. The respondents who consulted traditional healers significantly reported social stigma. Further the result shows that traditional+prayer+hospital, traditional+hospital+prayer, prayer+hospital+traditional significantly were associated with social stigma**.** Results show that the middle age range of 31-40 years and 41-50 years were significantly related with the family self-stigma. Further, it indicated that having primary school certificates , secondary school certificates HND certificates, university degree and other were significantly associated with caregiver self-stigma. Also, the result shows that respondents who are Yorubas significantly associated with caregiver self-stigma. Likewise, staying with their fathers, mothers and others were significantly related with caregiver self-stigma. Consulting traditional healers was also significantly related with the caregiver self-stigma. Health seeking decisions made by their fathers and religious institution were significantly related with caregiver personal-stigma**.**

The results of the multinomial logistic regression of age, religion, ethnic group, health care initiator and stigmatisation pathway were associated with treatment outcome. Beginning of the occurrence of the illness, type of diagnosis, and poor premorbid adjustment during teenage period were linked with a longer duration of untreated psychosis (Bechard-Evans, Schmitz, Abadi, Joober, King, Malla, 2007). Familial and people's perceptions about psychiatric disorder and phobia of stigma are equally linked to delayed in management (Franz, Carter, Leiner, Bergner, Thompson, Compton, 2010). Among the Southeast Asian populace, for instance, in Cambodia, poor education on psychiatric illnesses and inaccurate public orientations about the etiology affected prompt help seeking (Coton, Poly, Hoyois, Sophal, Dubois, 2008). Equally, behaviours and orientations about the world of spirits as an explanation on the etiology of psychiatric disorder were very significant factors in the help seeking towards treatment pathways (Chong, Mythily, Lum, Chan, McGorry, 2005). In another way, many forces may lead to immediate treatment seeking. This include: family capacity (Goulding, Leiner, Thompson, Weiss, Kaslow, Compton, 2008), family engagement in seeking psychiatric service (Morgan, Abdul-Al R, Lappin, 2006), previous family history with mental illness (Chen, Dunn, Miao, 2005), and basic positive signs of psychotic or aggressive-violence behaviour (Franz et al., 2010), all of which have been linked to immediate help seeking behaviour.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary

Majority of the caregivers were below 40 years who were largely married females with university education. The larger percentage were Christians, civil servants or self employed. The caregivers stayed with family members. The majority were Yoruba. Compared to the patients, the larger percentage was below 30 years of age. The greater percentage has qualification of ordinary diplomas and below. The larger percentages of the patients were Christians. The care for mental illness were still lagely undertaken by the extended family.

Public knowledge about schizophrenia showed that it was recognised by the caregivers as disease with psychotic syptomology caused by natural, preternatural, supernatural and heredity. Stigmas, in the form of stereotypes violence are easly common with regards to psychosis. Common misinformation include that psychosis is a multi-dimensional personality illness and that individuals with psychosis are basically more dangerous and unpredictable than the other people. The consensus is that psychosis is a psychiatric illness associated with dysfunctional thought process, anxiety, alcoholism, excess use of hard drugs, poverty, emotional instability (disorder), spiritual attack, injury and it could be treated and managed.

The study investigated peoples' consequences of reaction to stigma and stereotyping of people living with schizophrenia found a robust outcome. Findings demonstrated that people with psychosis usually experience big problems in their struggles towards having a better life of existence. Social distance was identified by the caregivers as a major consequence stigmatization, therefore stigma was found to increase the signs of the disorder as it rendered people with psychosis socially isolated, self-stigmatizing.

The study also identified the influence of the community-based psychiatric services on the coping patterns of people living with schizophrenic Disorder and their Kin.The initial belief about schizophrenia fuels the pattern of health seeking behavior among cargivers.

Before bringing the patients to the community based programmes, the patients would have first sought spiritual and trado-medical help before being taking to the hospital. The larger percentage were first taken for spiritual or traditional help before hospitalization. These decision to take them for hospitalization and subsequent community based therapy were taken under the the advise of the older family members and significant others within the household and neighborhood.

The study examined peoples' utilisation of the community-based psychiatric services on patients living with schizophrenic disorder and their kin was supported. The result demonstrated that there was a significant decline in the negative and subjective attribution of causes and behavior of the patients. The caregivers have become more receptive and supportive of their patients than in the pre-admission period. Also, the combination of the different types of approaches improved. The patients' level of isolation, stigmatization and dysfunctional belief and behaviours were greatly reduced. There was increase in the participation of sports and religious activities. Many of the respondents expressed willingness to give them jobs and offers of marriage. They avoid publicly embarrassing them and making them anxious.

The study also assess peoples' satisfaction about the efficiency of the community-based psychiatry services in the management of schizophrenic disorder. The patients were able to access clinical service in the health care systems such as basic health care facilities, general hospitals and community psychiatry service centres, where a professional mental health personnel offers evaluation and treatment, including medications, psychological and social interventions. Such services embraced wide variations in practice. They reported more humane and less stigmatised services compared to the traditional centres and hospital based services through the support from family and friends. The patients perceived community based treatment as more effective compared to full hospitalization.

Logistic regression analysis further showed that age, sex, marital status, education, religion, ethnic group, relationship with patient, health initiated and health seeking pathway on social stigma. Having primary school certificate, OND and university degree were significantly related with social stigma compared to those without formal education. Also, being a Muslim was significantly associated with social stigma compared to Christianity. The result also showed that ethnic groups were significantly associated with social stigma. Also, the result showed that the respondents who stayed with their mother significantly associated with social stigma. The respondents who consulted traditional healers significantly reported social stigma. Further the result shows that traditional+prayer+hospital, traditional+hospital+prayer, prayer+hospital+traditional significantly were associated with social stigma**.** Results show that the middle age range of 31-40 years and 41-50 years were significantly related with the family self-stigma. Further, it indicated that having primary school certificates , secondary school certificates HND certificates, university degree and other were significantly associated with caregiver self-stigma. Also, the result shows that respondents who are Yorubas significantly associated with caregiver self-stigma. Likewise, staying with their fathers, mothers and others were significantly related with caregiver self-stigma. Consulting traditional healers was also significantly related with the caregiver self-stigma. Health seeking decisions made by their fathers and religious institution were significantly related with caregiver personal-stigma**.**

5.2 Conclusion

The perception of people living with schizophrenia was still largely on the negative side with strong beliefs in spiritual forces. There was a significant perceived re-orientation from the treatment centres after the exposure to the community based service. There was a decline in the stigmatisation after the exposure to the community based service, probably because the centres inculcate family therapy or psychotherapy into its treatment approach. The study showed that there are existing measures to encourage patients' attendance and patients were also shown emphaty unlike the custodian settings that are not environmental friendly.The community based are adjudged to be more humane because of the supports from family, friends and more importantly the community-based health workers. There were prompt responses and commitments from the parts of the community based health workers and their services were more effective and efficient as the patients interacted and integrated well with the members of the community without being stigmatised.

5.3 Theoretical Implications

The findings from this study generally support previous conclusions in literature on the usefulness of the Health Belief Model and structural functionalism in relation to health perceptions and attitude towards people living with schizophrenic disorder in the management within the context of micro and macro level of practice towards management of psychotic disorder via community-based approach on subjective norms.

Health Belief Model which was developed to help understand why people did or did not use health services identifies individual predisposition towards a given approach to health behaviour which is governed by beliefs and attitudes. Some of the basic features of the health belief model that influence health seeking behaviour and decision making were highlighted in the results of this study. First, the belief about the severity of the illness, which may be defined in terms of physical harm or interference with social functioning, projected among majority of the people living with schizophrenic patients who expressed their perception of the severity of the mental illness and stigma condition. Results from the quantitative study show that majority of the respondents viewed schizophrenic as incurable with high level of societal stigmatisation as a relatively severe disease. This was also supported by responses from qualitative study who accepted the severity of the schizophrenic disorder.

Such perceived severity of schizophrenic has its role to play in individual's health seeking behaviour. The health belief model proposes that individuals who perceive mental illness as serious are more likely to engage in behaviours to seek for health care or prevent the health problem from occurring (or reduce its severity). Perceived seriousness encompasses beliefs about schizophrenic as a disease being life threatening, bringing shame to the family and friend, causing pain, leading to financial burden as well as broader impacts of the disease on functioning in work and social roles such as social expectations and social stigma. These perceptions motivate family of the patients or the caregivers to seek treatment for schizophrenic from various sources.

Respondents' knowledge and perception of the benefits associated with actions to reduce the level of severity of mental illness was also highlighted as an associated factor to health seeking behaviour among respondents. While some of the respondents opted for community-based approachs treatment of schizophrenic due to its perceived benefits over other methods, other respondents preferred orthodox methods due to their perceived benefit from other methods. This variation shows that the preference of treatment options and outlets for schizophrenic patient are based on the patients' perceived benefits from treatments.

In addition, evaluations of potential obstacles connected with the proposed actions, were also highlighted in this study. In seeking for schizophrenic treatment, the caregivers of schiphrenic patients had to consider a variety of limitations to assessing preferred treatment options and outlets such as the cost and inconveniencies involved in seeking a particular health care service. Income and cost of treatment limited some of the participants' access to preferred treatment options and outlets. Closeness to community-based centre also emerged as a potential obstacle to health seeking behaviour.

The health belief model posits that a cue, or trigger, is necessary for prompting engagement in health-promoting behaviours. It is a modifying variable. Cues to action can be internal or external. As obtained in this study, various psychological cues prompted many of the participants to seek treatment such as the various symptoms associated with schizophrenic. The intensity of cues needed to prompt action varies between individuals by perceived susceptibility, seriousness, benefits, and barriers.

Structural/Functionalism which was developed and refined by notable names in sociology to help people explain how an institutions work in the society especially the community-based psychiatric system in terms of managing people with schizophrenic disorder. Structural/functionalism borrowed the idea from human biology, that human organism comprises of many organs in the body, such as lung, heart, liver etc, these organs are interconnected and interrelated, each of these organ perform different roles in order to ensure the survival of human organism, the idea was copied to explain how the community-based psychiatric system works, there are many stakeholders in the community-based centre, these stakeholders are trained mental health experts, such as the psychiatrist, trained mental health Nurse, trained medical social worker, Muslim cleric who are verse in Rukia knowledge, the Pastor who are also powerful in casting demons, the traditional healer who are powerful in dealing with spiritual forces, and others with their respective functions.

Results from the quantitative study show that majority of the respondents viewed schizophrenic as incurable with high level of societal stigmatisation. This was also agreed with the responses from the qualitative study that the etiology of schizophrenia revolved round the natural, preternatural, supernatural, and heredity as the cause of schizophrenic disorder. Structural/functionalism belived in the institutional structures of the community-based centre that each of the stakeholders have different roles to play in order to keep the centre working, the perceptions of the public is that one approach is not adequate enough to manage people living with schizophrenic disorder, majority of the respondents still strongly believed in the spirituals forces and its remedies, therefore, all available approaches must be deployed in order to manage this problem and to minimize the stigma affecting the patients and their respective families.

5.4 Recommendations

- The study recommends that all stakeholders need to pay more piority to the mechanisms that will address the negative attitudes and behaviours toward the mentally ill, with the desire to ameliorate the stigmatisation, discrimination and public violence against the mentally ill, the service providers as well as the caregivers.

- Community-based psychiatric service delivery should be domesticated and synergies with the African traditional healers for a research breakthrough, particularly, with the promotion of the community-based approach as it is gaining ground across the world.
- Funding is very crucial for the implementation and take-off of this approach, most of the developing countries usually budget less than 2% of their national annual budgets to mental health which can equally be a take up ground for us.
- Scale-up of the mental health gap needs to be intensified in the area of training and re-training of professionals at the grassroots level such that the knowledge of the community–based mental healthcare will be domesticated to the health workers so as to be able to recognise, treat and refer patients when necessary.

5.4 Contributions of the study to knowledge

- It has expanded the frontiers of knowledge in the management of schizophrenia through the community-based approach.
- It is less expensive when compare with the custodian setting because it is seen as communal service.
- It remain a policy document for our policy maker and political office holders
- It has helped in the removal of vagrant from the major streets and rural communities
- Creation of access to half-way home for the patients between the community-based care and re-integration back into the community
- It provides an evidence-based research to support the adoption of community psychiatry as an effective tools of reducing stigmatisation of people living with schizophrenia.
- It has made the process of rehabilitation and re-integration of PwS with community-based care seamless and more effective.
- It has shown the adoption of structural/functionalism as a practical theoretical model in the adoption of CBP approach in the management of PwS.

- It provides increment in the level of utilization of health facilities and positive outcomes.

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APPENDIX 1

DEPARTMENT OF SOCIOLOGY
FACULY OF THE SOCIAL SCIENCES
UNIVERSITY OF IBADAN, IBADAN

Dear respondent,

My name is ADEOTI ABDUL LATEEF, a PhD student in the Department of Sociology, Faculty of the Social Sciences, University of Ibadan. I am conducting a research on community-based psychiatric system and management of schizophrenia in South western Nigeria. This questionnaire is designed to elicit information on the attitude towards mental illness. The questions here are meant to understand your relationship with the people living with mental illness. This information is for academic purpose only and in no way will it be divulged to any other source. So your honesty and sincere response are highly required and important to this study. Thank you for your support and cooperation. I therefore request your consent before proceeding on this data collection exercise. Thank you.

Name of the community.........................LGA...................

State..

Date and signature:………………

Location ....Rural ( ) Urban ( )

SECTION A (1) (Socio-Demographic Characteristics of the Respondents Patient Relatives)

S/N	Question	Response categories	Coding
1.	Age	:...	
2.	Sex:	Male Female	1 2
3.	Marital Status:	Single Married Separated Divorced Widowed	1 2 3 4 5
4.	Educational status:	No formal education Primary school certificate Secondary school certificate OND HND University Degree Master Degree Others specify..............................	1 2 3 4 5 6 7 8
5.	Religious affiliation	Christian Muslim African traditional religion (ATR) Others (specify)..................	1 2 3 4

6.	Ethnic Group:	Yoruba	1
		Hausa	2
		Ibo	3
		Others (specify)......................	4
7.	Occupation:	Civil servant	1
		Self-employment	2
		Artisans	3
		Student	4
		Farmer	5
		Work in private establishment	6
		Unemployed	7
		Other (specify......................	8
8	Relationship with patient	Father	1
		Mother	2
		Sibling	3
		Step parent	4
		Others (specify)	5

SECTION A (2) (Socio-Demographic Characteristics of the patients)

S/N	Question	Response categories	Coding
9	Age	--	
10	Sex	Male	1
		Female	2
11	Marital Status	Single	1
		Married	2
		Separated	3
		Divorced	4
		Widowed	5
12	Educational Status	No formal education	1
		Primary school certificate	2
		Secondary school certificate	3
		OND	4
		HND	5
		University Degree	6
		Master Degree	7
		Others specify-----------------------	8
13	Religious affiliation	Christian	1
		Muslim	2
		African traditional religious (ATR)	3
		Others (specify)------------------------	4
14	Ethnic Group	Yoruba	1
		Hausa/Fulani	2
		Igbo	3
		Others (specify)---------------------	4
15	Occupation	Civil servant	1
		Self-employment	2
		Artisans	3
		Farmer	4
		Student	5
		Work in private establishment	6
		Unemployed	7
		Others.......................	8

Section B (1): This section requires you to describe how you feel about people living with schizophrenic disorder and your relationship with them as persons. Please give your true **perceptions and opinion** of the relationship

	Perception about PwS	**Response**	**Coding**
16.	The year your patient has been diagnosed as having mental challenges	1years 2years 3years 4years 5 years and above	**1** **2** **3** **4** **5**
17.	The way you get to know that he/she has the problem	(1) People around reported (2) His/her behaviour shows (3) Parents observed (4) Doctors' Diagnosis (5) Others...........................	**1** **2** **3** **4** **5**
18	The care of the patient is handled by	(1)My son/daughter (2)My partner/spouse (3)My brother/sister (4)My parent (5)Other *(please specify*...............................	**1** **2** **3** **4** **5**
19	The type of mental health condition	(1) Psychosis/schizophrenia (2) Bi-polar disorder/manic depression (3) Depression (4) Anxiety (5) Other mental health problems	**1** **2** **3** **4** **5**
20	He/she born is with this problem	(1) Yes (2) No	**1** **2**
21	Any family history of mental illness	(1) Yes (2) No	**1** **2**
21	The signs you noticed	(1) Talking to self (2) Laughing inappropriately (3) Not sleeping at night (4) Poor personal hygiene (5) Physical and verbal aggression (6) Restlessness (7) Very abnormal behaviour (8) Making illogical statement (talking rubbish) (9) Claiming people are talking about him/her (10) Claiming people are planning to harm him/her (11) Refusing to do his/her usual activities for no reason (12) Keeping to self	**1** **2** **3** **4** **5** **6** **7** **8** **9** **10** **11** **12** **13**

		(13) Hoarding rubbish (14) Others...........................	**14**
22	The first step you took when you noticed the signs in your patient?	(1) Opinion to take him to the hospital (2) Opinion to take him to a traditional healer (3) To provide home remedies (4) Opinion to take him to a religious healers (5) Others.........................	**1** **2** **3** **4** **5**
23	The suggestion of the second step was initiated by the....	(1) Father (2) Mother (3) Sibling (4) Others	**1** **2** **3** **4**
24	The outcomes	(1) Getting better (2) No change at all (3) Getting worse (4) Improving gradually (5) Others......................	**1** **2** **3** **4** **5**

S/N	QUESTIONS	RESPONSE CATEGORIES	CODING
25	He/she was taking to where as first action	(1) Hospital (2) Traditional healer (3) Home remedies (4) Church (5) Mosque (6) Others.....................	1 2 3 4 5 6
26	The outcome	(1) Getting better (2) No change at all (3) Getting worse (4) Improving gradually	1 2 3 4
27	The next place after the first action	(1) Hospital (2) Traditional healer (3) Home remedies (4) Church (5) Mosque (6) Others.................	1 2 3 4 5 6
28	The following steps described the pathways to treatment that you have followed	(1) Hospital+Traditional+Prayer (2) Traditional+Prayer+Hospital (3) Prayer+Traditional+Hospital (4) Traditional+Hospital+Prayer (5) Prayer+Hospital+Traditional (6) Hospital+Prayer+Traditional	1 2 3 4 5 6
29	The outcome	(1) No change at all (2) Getting worse (3) Recuperating gradually (4) Recovering fast	1 2 3 4
30	What prompted you to take 2nd action?	(1)The patient relapsed (2) Peoples suggestion (3) No improvement from the first option (4) Others.................	1 2 3 4
31	The place you went last before he/she was brought to the community-based centre	(1) Traditional healer (2) Home remedies (3) Hospital (4) Church (5) Mosque	1 2 3 4 5

S/N	QUESTIONS	RESPONSE CATEGORIES	CODING
32	The kind of treatment was he/she given?	(1) Orthodox (2) Traditional (3) Combined Therapy (4) Prayers only (5) Prayer + holy water	1 2 3 4 5
33	The kind of attention given to your patient	(1) Prompt (2) Moderate (3) Slow	1 2 3
34	The kind of treatment he/she received here in the communty-based centre	(1) Good (2) Fairly (3) Poor	1 2 3
35	Those who were involved in the decision to take him/her to community-based centre	(1) Family member (2) Neighbour (3) Orthodox health worker (4) Friend (5) Co-worker (6) Church member	1 2 3 4 5 6
36	The person that has the final decision	(1) Father (2) Mother (3) Family member (4) Religious institutions (5) Community leader (4) Others...................	1 2 3 4 5 6
37	The awareness about the existence of community-based centre	(1) Through Radio (2) Through Television (3)Through Friends (4)Through Family menbers (5)Through health workers (6) Othersd...............	1 2 3 4 5 6

Describe the **knowledge and perception of the public** about people living with schizophrenic **(PwS)** and **peoples' reaction** to **stigma.** Pick yes or no, give reasons for your response

S/N	**Opinion and perception about mental illness**	**Response categories**	**Coding**
38	Mental illness can be treated outside hospital setting	Yes No	1 2
39	Give reasons for your response		
40	People with mental illness are dangerous because of violent behaviour	Yes No	1 2
41	Give reasons		
42	Willingness to marry someone with mental illness	Yes No	1 2
43	Give reasons for your answer		

44	People with mental illness are public nuisance	Yes No	1 2
45	Explain		
46	Being afraid to have coversation with PwS	Yes No	1 2
47	Give reasons		
48	Being ashamed if people know someone in your family has been diagnosed with mental illness	Yes No	1 2
49	Explain		
50	Mental illness runs in the family	Yes No	1 2
51	Explain in details		
52	The mothers always show more concerns to the sick person than the fathers	Yes No	1 2
53	Give reasons		
54	The economic input of the ill person has been declined since the illness started	Yes No	1 2
55	Explain in details		

STIGMA MEASURES

Devaluation-Discrimination Scale (DD)

Please answer the questions below based on how you would respond when interacting with Schizophrenic patients in various situations.

S/N	Corespondence categories	1 Not at all	2 A little	3 Some	4 A lot	4 A great deal
56	I would willingly accept an individual who receives mental health services as a close friend					
57	I would believe that a person who has been in a mental health facilities is just as intelligent as the average person					
58	I believe that a former mentally- ill patient is just as trustworthy as the average person					
59	I would accept a fully recovered former mentally- ill patient as a teacher of my young children in a public school					
60	I believe that being admitted in a mental health facility is a sign of personal failure					
61	I would not hire a former mentally-ill patient to take care of any children, even if he or she has been well for some time					
62	I think less of a person who has been in a mental health facilities					
63	If I were an employer, I would hire a former mentally-ill patient if he/she is qualified for the job.					
64	If I were an employer, I would pass over the application of a former mentally-ill patient in favor of another applicant					
65	I would treat a former mentally-ill patient just as I would treat anyone.					
66	I would be reluctant to date a man/woman who has been hospitalized for a serious mental disorder.					
67	If people know a person is in a mental health facility, most people will take his or her opinions less seriously.					
68	How stigma may not like people to perform in public functions.					
69	How stigma has affected their relationship in the community.					
70	The status has denied their members in the society of landed property.					
71	Mental health condition has denied their members of chieftancy title					
72	Mental illness of their member has denied them of marriage opportunity					
73	The status of mental illness has denied their family members of political ambitions in the community					

Section C: This section requires you to describe the **coping strategies** employed by the patients and their reactions to mental illness using **Yes** or **No** answer.

S/N	**Coping strategies**	**Response categories**	**Coding**
74.	He/she attends church or mosque regularly	Yes No	1 2
75	If yes, your future look promising		
76	If no, any thought of commiting suicide		
77.	He/shetake the drugs regularly	Yes No	1 2
78	If yes, the drug regimen were followed as prescribed by the Doctor		
79	If no, he/she stop the drug, the implication might be severe		
80.	He/she shares his or her opinion with friends with similar problem	Yes No	1 2
81	Is the family aware that that the victim is PWS	Yes No	1 2
82	If yes, does he/she feel relieve of the problem?		
83	If no, how does he/she manage to relate with friends?		
84.	He/she needs to avoid situations where people will know about the problem	Yes No	1 2
85	If yes, he/she manages to do it		
86	If no, he/she manages such situation		
87.	He/she engages in recreational activities e.g. football, table tennis etc.	Yes No	1 2
88	If yes, mention one of the games		
89	The encouragement was given to him or her		
90	Has he/she ever participated in any national or state competitions?	Yes No	1 2
91.	He/she stays away from stressful situations to avoid family or friends' embarrassment	Yes No	1 2
92	If yes, mention one or two stressful events		
93.	He/she attempts to ignore people who don't take him/her seriously	Yes No	1 2
94	If yes, in what way?		
95	If no, mention the coping strategies		
96.	Living with mental illness has made the patient a tough survivor	Yes No	1 2
97	If yes, in what capacity?		
98.	Nobody would be interested in getting close to him/her because of the mental illness.	Yes No	1 2
99	If yes, the illness is a contagious one		

SECTION E: RELATIVE CARE BURDEN

THE CARING FOR CARERS SURVEY REPORT 2015:

The following information will help us to understand your caring situation better and interpret your answers more effectively.

100 The financial resources used for the care of a member of the family, how easy is it for you to get it?
(a)Very difficult (b) Difficult, (c) Not difficult and not
easy, (d) Easy, (e)Very easy

101 How many people with a mental health problem do you currently care
for?..................................

102. Please estimate as best as you can how many hours you have taken off paid work in the past weeks to care for the person with a mental health problem?...

103 Please estimate as best as you can how many hours you spent last week looking after someone with a mental
illness?..

104. When (in year) did you first start caring for someone with a mental illness? (If you don't remember the exact year, please give an estimate of the year you started
care...................................

105. Do you live with each other at the moment?
Yes ☐☐☐
Some of the time ☐☐☐
No

106. If no, where are they currently living?
Own/rented accommodation ☐☐☐
Supported accommodation ☐☐☐
With other family member/friend ☐☐☐
Care home ☐☐☐
Hospital ☐☐☐
Other *(please specify)*...

107. Which of the following statements best describes your role as a carer at the moment?
I am the **only** caregiver ☐☐☐
I **share** caring responsibilities with
others, but **I** am the **main** caregiver ☐☐☐
I **share** caring responsibilities equally
with others ☐☐☐
I share caring responsibilities, but
someone else is the **main** caregiver ☐☐☐
Other *(please specify* ....

108. Which of the following types of support, if any, do they allow you to take a break from caring? *(Tick more than one box if required.)*
(a) Friends/family providing temporary care,
(b) Paid carers coming into the home,
(c) Paid carers providing care away from the home (e.g. care home),
(d) Supported activities out of the home,
(e) for the person you care for,
(f) Supported breaks for you and the person you care for away from the home,
(g) Other respite care (please specify below);
(i)I'm unable to take a break from caring,
(ii)I do not need support to take a break from caring.

SECTION F: Relative satisfaction with community-based care

This section requires you to describe how you feel about the treatment they have received so far at this centre. Please give your true perception of the situation by ticking any of your choice opinion in the response category.

S/N	Question	Response categories	Coding
109	Satisfaction with the care	Yes No	1 2
110	If yes, give example		
111	If no, give reasons		
112	The staff of this mental health unit are usually kind	Yes No	1 2
113	If yes, give example		
114	If no, explain		
115	The staff of this centre are always available and ready to assist	Yes No	1 2
116	If yes, give an example		
117	If no, give your past experience		
118	The patient has improved tremendiously since he/she came here	Yes No	1 2
119	If yes, in what aspect of the treatment ?		
120	If no, explain why you are not satisfied		
121	I can recommend this mental health unit to somebody with the same problem and the same history	Yes No	1 2
122	Give reasons for your answer		

APPENDIX II

Focus Group Protocol for the community

Instructions: Ask each participant to choose an alias (pick a name) that will be used for the recording. Before beginning the lead-in ask each participant to clearly state his or her alias/name for a tape recorder operations check.

(Suggestion for a lead-in): Today, we want to talk with you about problem/issues people with mental health challenges face in today's society. This is a very informal group discussion, so please feel free to say what you really think. The only ground rule is that you allow each other to finish speaking before you jump in.

Module 1: Mental Health Services utilization and belief

Instructions: Use participant-generated words/descriptions to probe questions

(1) Since when have the patients been attending the community-based health centre?

(2) What motivates them to come to this centre?

(3) Who among the following take a major decision about pathway to health care? e g. (a) father, (b) mother, (c) sibling, (d) Other specify......................

(4) Why?

(5) Have they been consistent with the appointment with the mental health practitioners?

(6) What are the peoples' perceptions about mental illness in your area since they have been attending this centre?

(7) Give examples?

(8) What do you think are some of the biggest issues facing people with mental health challenges in your communities today?

(8) What is your own personal belief regarding the causes and treatment of mental health?

(9) Can you justify this your assertion with regards to treatment pathways?

(10) Some people have different beliefs about mental health as you have mentioned above (name the issues that they mention) how has it affected people's reaction to the people attending the community based health centre?

(11) What is the reaction of people when they see them attending the community-based health centre for the treatment?

Module 2: coping with mental illness

We've discussed how people react to mental illness and coming to the community-based health centre for professional help, now we are going to switch to discussing how they feel about knowing and reacting to their present health challenges.

(12) How do they cope with the way people talk concerning individuals living with a mental illness and reaction to it?

(13) (If mentioned): I see that some of them mentioned avoiding people. Do you think that it is ok for a person to avoid others who stigmatize them?

(14) How do they manage to cope with stigmatization from family members?

(15) How confident are they to confront people stigmatizing and calling them names?

(16) Do they still participate in common social activities with people who know they are attending a community-based health clinic? If yes

(17) What do they think of the patients and those attending the mental health clinic?

(18) Do they have any course to regret people being aware that they attend the community-based health centre?

(19) If yes for what reasons

Module 3: Perceptions of Mental Health Professionals

Now that we have discussed problems that should be handled by a psychiatrist, nurse, social worker, community health extension worker, trado-medical, faith-based healer and how we feel about seeing a mental health expert, let us discuss how the patient view the workers?

- Psychiatrist,
- Nurse,
- Social worker
- Community Health Extension Worker
- Trado-medical
- Faith-based healer

(20)What is your impression concerning the health care workers at the centre?

(21) What is the modus operandis of the centre?

(22) How well do you think they have been assisting to cope with patients health challenges?

(23) What is their reaction to people, family and friends stigmatizing them? Calling them names

avoiding patients or making bad remark about them

(24) How well have they built your confidence in managing people's reaction and stigmatization?

(25) What messages or experiences have you had that influenced your current impressions of mental illness?

(26) Are mental health workers mentally sick as some people have been saying?

(27) When have you been living around this community-based centre?

Thank you for talking freely.

Ask them if they have any follow-up questions.

IMPORTANT: Ask them to fill out demographic questionnaire using Name /Alias they chose at the beginning.

APPENDIX III

Key Informant Interviews with Hospital Officials

Introduction to the interview

Thank you for agreeing to participate in this interview.

The purpose of the interview (state duration - 1 hour)

I will be asking you some questions to start our discussion, and you are free to contribute as you feel comfortable. There are no right or wrong answers to the questions; we are interested in your opinions based on your experiences or the experiences of others you know. Participation in the interview is voluntary, so if you do not want to answer a particular question, you do not have to, and you are free to leave at any stage.

Remind participants that the discussion will be recorded.

Date and signature…………………………………

Instructions: Use participant-generated words/descriptions to probe questions

Designation:…………………………………………………………………………………………………
……………………

(1) How many years have you spent at the centres?:...

(2) Describe how the system of community-based psychiatry operate?:...

(3) How often do you open the clinic?:..

(4) Describe the patterns of admission: e.g (a) out-patient (b) in-patient,..

(5) What are the types of services rendered at the centre?...

(6) Describe the distance of the centre to the community?...

(7) How do people perceive mental illness in this community?:..

(8) How do you think people perceive you as health caregiver in this community?

(9) What are the modus operand of the centre?

(10) How do people get to know about the existence of this centre? (a) Radio, (b) Television (c) Bulettin (d) Through friends.

(11) Do you think the cost of treatment is very costly at this centre?

(12) Are the patients observing the appointment given by the health caregivers?

(13) What are the peoples' perceptions about mental illness since patients have been attending this centre?

(14) What do patients think are some of the biggest issues facing people with mental health challenges in their communities today?

(15) Some people believe differently about mental health as mentioned above (name the issues that they mention) how does it affect how people react to attending the community-based health centre?

(16) What is the reaction of people to the patients attending the community-based health centre for treatment?

(17) How do patients cope with the way people talk about and react to patients' problems?

(18) How do patients manage to cope with stigmatization from family members?

(19) How confident are patients in confronting people who stigmatizes and called them names?

(20) Do patients still participate in common social activities with people who know they are attending a community-based health clinic? if yes

(21) What do you think of patients and those attending the mental health clinic?

(22) Do patients have any course to regret people being aware that they attend the community- based health centre?

(23) If yes for what reasons

(24) How well do patients think you have assisted to cope with their health challenges?

(25) What is the reaction of patients to people, family and friends stigmatizing them?

(26) How well have you built patients confidence in managing people's reaction and stigmatization?

(27) What messages or experiences do the patients have that had influenced their current impressions of mental health professionals?

Thank you for participating.

ÀSOMỌ́ 1

Yoruba translation of questionnaire for the primary caregivers (Relatives)

UI/SSHEC/2016/009

ẸKA ẸKỌ́ ÌMỌ̀ ÀWÙJỌ (ṢOṢIỌ́LỌ́JÌ)

ÀKÓPỌ̀ ẸKA ÌMỌ̀ ÌJÌNLẸ̀ ADÁLÓRÍ ÀWÙJỌ

YUNIFÁSÍTÌ ÌBÀDÀN, ÌBÀDÀN

Sí Akópa,

Orúkọ mi ni ADEOTI ABDUL LATEEF, akẹkọ̀ọ́ àgbà ni Ẹ̀ka ẹ̀kọ́ ìmọ̀ àwùjọ (Soṣiọ́lọ́jì),

tí ó wà ni àkópọ̀ ẹ̀ka ìmọ̀ ìjìnlẹ̀ adálórí àwùjọ, ni Yunifásítì ìbàdàn, ìbàdàn. Mo ń ṣe iṣẹ́ ìwádìí lorí Ìlànà ìtójú ààrun ọpọlọ Alábẹ̀lé àti ÌṣàkósoArùn ọpọlọ (Schizophrenia) ni agbegbe ìwọ̀ oòrun Nàìjíríà. Àtòjọ-ìbéèrè afiṣèwádìí yìí ní a gbé kalẹ̀ láti wádìí ihà tí àwùjọ kọ sí àwọn alárùn ọpọlọ. Àwọn Ìbéèrẹ tí a n bèèrè wọ̀nyìí ní láti mọ èrò yin nípa àwọn tí wọn ní Ààrùn ọpọlọ. Gbogbo ohun tí ẹ bá sọ fún wa yóò jẹ lílò fún Isẹ ìwádìí yìí nìkan. Nítorí ìdí èyí, a bẹ̀ yín kí ẹ fi òótọ́ inu àti òdodo dahun àwọn ìbẹ́èrè wa wọ̀nyìí. Ẹ ṣeun púpọ̀ fún ìfọwọsowọ́pọ̀ yín. Fún ìdí èyí, mo rọ̀ yín kí ẹ fọwọ́ sí iwé pé ẹ faramọ́ . Àtòjọ-ìbéèrè afiṣèwádìí yìí, kí a lè tẹ̀síwájú. A dúpẹ́.

Orúkọ-Agbègbè…………….…..Ìjọba Ìbílẹ̀…………………

Ìpínlẹ̀…………………

Ìgbèríkó(   )   Ilú- Ńlá (   )

Ọjọ́ àti ìfọwọ́sí

ÌPÍN A (1) (Ìṣọwọ́pọ̀-Àdámọ́ Àwùjọ àwọn ìbátan aláìsàn)

S/N	Ìbéèrè	Ìdáhùn	Iye
1.	Ọjọ́ orí:	....	
2.	Akọ-n-bábọ:	Akọ Abo	1 2
3.	Ipò Ìgbéyàwó:	Àpọ́n Abilékọ/Aláya-n-le Ìpínyà ti wáyé Ìkọ̀sílẹ̀ ti wáyé Opó	1 2 3 4 5
4.	Ipò Ẹkọ́:	Kò sí ànfààní ẹkọ́ mọ̀-ón kọ-mọ̀-ọ́n kà Ilé ìwé alákọ̀ọ́bẹ̀ẹ̀rẹ Ilé ìwé sẹ́kọ́ńdìrì OND HND Ikẹ́kọ̀ọ́gboyè àkọ́kọ́ ni Yunifasiti Ikẹ́kọ̀ọ́gboyè ìjìnlẹ̀ ni Yunifasiti Ikẹ́kọ̀ọ́gboyè mìíràn(Kọ ó)…………........	1 2 3 4 5 6 7 8
5.	Ẹ̀sìn:	Onígbàgbọ́ Mùsùlùmí	1 2

		Ẹlẹ́sìn àbáláyé Ẹ̀sìn mìíràn (kọ ọ́)..................	3 4
6.	Ẹ̀yà:	Yorùbá Hausa Ibo Ẹ̀yà mìíràn (kọ ọ́)..................	1 2 3 4
7.	Iṣẹ́:	Òṣìṣẹ́ ìjọba Ẹni-ń-ṣiṣẹ- ara rẹ̀ Oníṣẹ-ọwọ́ Akẹ́kọ̀ọ́ Àgbẹ̀ Òṣìṣẹ́ ní ilé-iṣẹ́ aládàáni Iṣẹ́ mìíràn (kọ ọ́)..................	1 2 3 4 5 6 7 8
8	Ìbáṣepọ̀ pẹ̀lú aláìsàn:	Bàbá Màmá Ẹ̀gbọn/Àbúrò ọmọ-ọkọ/ọmọ aya Ẹ̀yà mìíràn (kọ ọ́)..................	1 2 3 4 5

ÌPÍN A(2) (Ìṣọwọ́pọ̀-Àdámọ́ Àwùjọ àwọn aláìsàn)

S/N	**Ìbéèrè**	**Ìdáhùn**	**Iye**
9	Ọjọ́ orí:	--	
10	Akọ-n-bábọ:	Akọ Abo	1 2
11	Ipò Ìgbéyàwó:	Àpọ́n Abilékọ/Aláya-n-le Ìpínyà ti wáyé Ìkọ̀sílẹ̀ ti wáyé Opó	1 2 3 4 5
12	Ipò Ẹkọ́:	Kò sí ànfààní ẹkọ́ mọ̀-ón kọ-mọ̀-ọ́n kà Ilé ìwé alákọ̀ọ́bẹ̀ẹ̀rẹ Ilé ìwé sẹ́kọ́ńdìrì OND HND Ikẹ́kọ̀ọ́gboyè àkọ́kọ́ ni Yunifasiti Ikẹ́kọ̀ọ́gboyè ìjìnlẹ̀ ni Yunifasiti Ikẹ́kọ̀ọ́gboyè mìíràn(Kọ ó)……….........	1 2 3 4 5 6 7 8
13	Ẹ̀sìn:	Onígbàgbọ́ Mùsùlùmí Ẹlẹ́sìn àbáláyé Ẹ̀sìn mìíràn (kọ ọ́)..................	1 2 3 4
14	Ẹ̀yà:	Yorùbá Hausa Ibo Ẹ̀yà mìíràn (kọ ọ́)..................	1 2 3 4
15	Iṣẹ́:	Òṣìṣẹ́ ìjọba Ẹni-ń-ṣiṣẹ- ara rẹ̀ Oníṣẹ-ọwọ́ Akẹ́kọ̀ọ́ Àgbẹ̀ Òṣìṣẹ́ ní ilé-iṣẹ́ aládàáni N kọ níṣẹ́ lọ́wọ́ Iṣẹ́ mìíràn (kọ ọ́)..................	1 2 3 4 5 6 7 8

Ìpín B (1):

Ní ìpin yìí, a máa fẹ́ kih ẹ ṣàlàyé èrò yín nípa àwọn ènìyàn tí wọn ní ààrùn ọpọlọ àti ìbáṣepọ̀ tí ẹ ni pẹ̀ú wọn gẹ́gẹ́ bí ọlọ́danni. Ẹ jọ̀wọ̀ ẹ báwa ṣọ bí ó ti rí gẹ́lẹ́ àti èrò yín ní pàtó.

Èrò yín nípa PwS **Ìdáhùn** **Iye**

16.	Láti ìgbà wo ni àyèwò ti fihàn pé ẹ̀nìyan yín yìí ní àìsàn ọpọlọ?	Ọdún kan Ọdún méjì Ọdún mẹ́ta Ọdún mẹ́rin Ọdún márùn-ú tàbí jù bẹ́ẹ̀ lọ	**1** **2** **3** **4** **5**
17.	Báwo ni ẹ ṣe mọ̀ pé ẹni náà ni irúfẹ́ ìṣoro yìí?	(1) Awọn ará àdúgò ní wọ́n pe àkíyèsí sí i (2) Ìwùwàsí rẹ̀ ni ó ṣe àfihàn (3) Àwọn òbí ní wọn fura (4) Dókítà ni ó sẹ àyẹ̀wò (5) Ọnà mìíràn................	**1** **2** **3** **4** **5**
18	Tani ó jẹ ọ́ lógún?	(1)ọmọkùnrin/ọmọbìnrin mi (2)Aya/Ọkọ/Àfẹ́sọ́nà mi (3)Ẹ̀gbọ́n/ Àbúrò mi (4) Ọ̀bí mi (5)Ẹlòmìíràn*(jọ̀wọ́ sọ ní pàtó*..............................	**1** **2** **3** **4** **5**
19	Irúfẹ́ Ààrùn ọpọlọ wo ni?	(1) Iwín/ Aágànná (2) Bi-polar rúdurùdu/ ìrẹ̀wẹ̀sì/ Ìdágùdẹ̀ (3) Ìrẹ̀wẹ̀sì (4) Àibalẹ̀ọkàn (5) awọn Àarun ọpọlọ mìíràn	**1** **2** **3** **4** **5**
20	Ṣé Àbímọ́ ni ìṣòro yìí?	(3) Bẹ́ẹ̀ni (4) Bẹ́ẹ̀kọ́	**1** **2**
21	Ǹjẹ́ ẹbi kankan ti ní irúfẹ́ àìsàn yìí rí?	(1) Bẹ́ẹ̀ni (2) Bẹ́ẹ̀kọ́	**1** **2**
21	Irúfẹ́ Àpẹẹrẹ wo ni ẹ ṣe àkíyèsí?	(1) Dídásọ̀rọ̀ (2) Ẹ̀rín òdì (3) Àìsùn (4) Àìní-ìmọ́-tó-tó (5) ìwùwàsí àti ìsọ̀rọ̀sí pẹ̀lú ìgbéjàkoni (6) Àìnísinmi (7) Àwọn ìwà tí ó lòdì gbáà (8) Àwọn ìpèdè tí kò bára mu (sísọ kátikàti) (9) Níní èrò pé ọ̀rọ rẹ̀ ni àwọn ènìyàn ń sọ (10) Níní èrò pé àwọn ènìyàn fe jàǹbá sí i (11) kíkọ̀ láti ṣe àwọn ohun tí ó yẹ láti ṣe láì ní ìdí kan pàtó (12) Dídáṣe (13) fífí àwọn nǹkan ẹ̀gbin pamọ́ (14) ohun mìíràn	**1** **2** **3** **4** **5** **6** **7** **8** **9** **10** **11** **12** **13** **14**

22	Àwọn ìgbésẹ̀ wo ni ẹ̀yin ẹbí gbé, ní ìgbà tí ẹ ṣe àkíyèsí àwọn àmì wọ̀nyìí lára ènìyàn yín?	(1) Ìmọ̀ràn láti gbé e lọ sí ilé ìwòsàn (2) Ìmọ̀ràn láti gbé e lọ sí ilé oniṣègùn ìbílẹ̀ (3) Ìmọ̀ràn láti ṣe ìtọ́jú abẹ́lé (4) Ìmọ̀ràn láti gbé e lọ sí ọ̀dọ̀ àwọn ẹlẹ́sìn fún ìwòsàn (5) Ìmọ̀ràn mìíràn........................	**1** **2** **3** **4** **5**
23	Tani ó mú àbá àti àwọn ìgbésẹ̀ wọ̀nyí wá?	(5) Bàbá (6) Ìyá (7) Ẹ̀gbọ́n/Àbúrò (8) Ẹlòmìíràn	**1** **2** **3** **4**
24	Kíni àbáyọrí awọn ìgbẹ́ṣẹ̀ wọ̀nyìí?	(1) Ara rẹ̀ ń yá (2) Kò sí ìyàtọ̀ rárá (3) Ó ń burú sí i (4) Ìyàtọ̀ díẹ̀díẹ̀ ń wà (5)Àkíyèsí mìíràn.....................	**1** **2** **3** **4** **5**

S/N	**Ìbéèrè**	**Ìdáhùn**	**Iye**
25	Ibo ni ẹ kọ́kọ́ gbé e lọ gẹ́gẹ́ bí ìgbẹ́ṣẹ̀ àkọ́kọ́?	(1) Ilé ìwòsàn (2) Ilé oniṣègùn ìbílẹ̀ (3) ìtọ́jú abẹ́lé (4) Ilé ìjọsìn Onígbàgbọ́ (5) Ilé ìjọsìn Mùsùlùmí (6)Ibòmìíràn........................	1 2 3 4 5 6
26	Kíni àbájáde èyí?	(1) Ara rẹ̀ ń yá (2) Kò sí ìyàtọ̀ rárá (3) Ó ń burú sí i (4) Ìyàtọ̀ díẹ̀díẹ̀ ń wà	1 2 3 4
27	Ibo ni ẹ gbé e lọ lẹ́yìn náà?	(1) Ilé ìwòsàn (2) Ilé oniṣègùn ìbílẹ̀ (3) ìtọ́jú abẹ́lé (4) Ilé ìjọsìn Onígbàgbọ́ (5) Ilé ìjọsìn Mùsùlùmí (6)Ibò mìíràn........................	1 2 3 4 5 6
28	Èwo nínú àwọn tí a kà sílẹ̀ wọ̀nyìí, ni o jọ mọ́ ìlànà ìtọjú tí ẹ gbà?	(1) Ilé ìwòsàn + ìbílẹ̀+ Àdúrà (2) Ìbílẹ̀+ Àdúrà+ Ilé ìwòsàn (3) Àdúrà+ Ìbílẹ̀+ Ilé ìwòsàn (4) Ìbílẹ̀+ Ilé ìwòsàn+ Àdúrà (5) Àdúrà+ Ilé ìwòsàn+ Ìbílẹ̀ (6) Ilé ìwòsàn+ Àdúrà+ Ìbílẹ̀	1 2 3 4 5 6
29	Kíni àbájáde èyí?	(1) Kò sí ìyàtọ̀ rárá (2) Ó ń burú sí i (3) Ìyàtọ̀ díẹ̀díẹ̀ ń wà (4) Ìyàtọ̀ púpọ̀ ń wà	1 2 3 4
30	Kí ni ó ṣẹlẹ̀ tí e fi gbé e lọ sí ibi ìkejì?	(1)Àìsàn náà padà (2) Ìmọ̀ràn láti ọ̀dọ̀ àwọn ènìyàn (3) kò sí ìyàtọ̀ lẹ́yìn ibi àkọ́kọ́ (4) Nǹkan mìíràn.................	1 2 3 4
31	Ibo ni ẹ gbé e lọ kẹ́yìn kí ó tó wá sí community-based centre?	(1) Ilé oniṣègùn ìbílẹ̀ (2) ìtọ́jú abẹ́lé (3) Ilé ìwòsàn (4) Ilé ìjọsìn Onígbàgbọ́ (5) Ilé ìjọsìn Mùsùlùmí	1 2 3 4 5

S/N	QUESTIONS	RESPONSE CATEGORIES	CODING
32	Irúfẹ́ ìtọ́jú wo ni wọ́n fún un?	(1) Àbáláyé (2) Ìbílẹ̀ (3) Àkànpọ̀ (4) Àdúrà nìkan (5) Àdúrà + Omi Àdúrà	1 2 3 4 5
33	Kí ni ohun tí ẹ fẹ́ràn nípa irúfẹ́ ìtọ́jú tí wọ́n fún ènìyàn yín?	(1) kíákíá (2) kò burú (3) Ó falẹ̀	1 2 3
34	Irúfẹ́ ìtọ́jú wo ni wọ́n fún un ní communty-based centre?	(1) ó dára (2) kò burú (3) ó burú	1 2 3
35	Tani ó mú àbá wá láti mú aláìsàn wá sí community-based centre?	(1) Ẹbí (2) Aládùúgbò (3) Àwọn òṣìṣẹ́ Àbáláyé (4) Ọ̀rẹ́ (5) Alábàáṣiṣẹ́ (6) ọmọ ìjọ	1 2 3 4 5 6
36	Ìmọ̀ràn tani ẹ tẹ̀lé?	(1) Bàbá (2) Ìyá (3) Ẹbí (4) Ìjọ (5) Olorí ìlú (4) Ẹlòmìíràn....................	1 2 3 4 5 6
37	Báwo ni ẹ ṣe gbọ́ nípa community-based centre?	(1) Láti orí Rẹ́díò (2) Láti orí Tẹlifíṣàn (3)láti ọ̀dọ̀ ọ̀rẹ́ (4)Láti ọ̀dọ̀ ẹbí (5)láti ọ̀dọ̀ oníṣẹ́ ìlera (6) láti ọ̀dọ elòmíràn................	1 2 3 4 5 6

Ṣàpèjúwe èrò àwùjọ nípa àwọn ènìyàn tí wọ́n ní **(PwS)**àárùn ọpọlọ àti ìhà tí àwùjọ kọ sí ìdẹ́yẹsí.

Yan bẹ́ẹ̀ni tàbí bẹ́ẹ̀kọ́, ṣàlàyẹ ìdí ìdáhùn rẹ.

S/N	**Èrò àti Ojú Ìwòye nípa àarun ọpọlọ**	**Ìdáhùn**	**Iye**
38	Ṣé ẹ lérò wípé àárùn ọpọlọ le è dí wíwòsàn láì dé ilé ìwòsàn?	Bẹ́ẹ̀ni Bẹ́ẹ̀kọ́	1 2
39	Kíni ìdí ìdáhùn rẹ?		
40	Ṣé o léro pé àwọn ènìyàn tí wọn ní àárùn ọpọlọ léwu nítorí ìwà ewu tí wọ́n ń wù?	Bẹ́ẹ̀ni Bẹ́ẹ̀kọ́	1 2
41	Kíni ìdí ìdáhùn rẹ?		
42	Ǹjẹ́ o le fẹ́ ẹni tí ó ní àárùn ọpọlọ?	Bẹ́ẹ̀ni Bẹ́ẹ̀kọ́	1 2
43	Kíni ìdí ìdáhùn rẹ?		
44	Ṣé o léro pé àwọn ènìyàn tí wọn ní àárùn ọpọlọ máa fa wàhálà sáàárín ìlú?	Bẹ́ẹ̀ni Bẹ́ẹ̀kọ́	1 2
45	Ṣàlàyé ìdih ìdáhù rẹ		
46	Ṣé ẹ̀rù máa bà ọ́ láti bá ẹni tí ó ni PLWMI sọ̀rọ̀?	Bẹ́ẹ̀ni Bẹ́ẹ̀kọ́	1 2
47	Kíni ìdí?		

48	Ṣe ojú máa tí ọ́ tí àwọn ènìyàn bá mọ̀ wípẹ ẹnìkan nínú ẹbí rẹ ń ààrùn ọpọlọ?	Bẹ́ẹ̀ni Bẹ́ẹ̀kọ́	1 2
49	Kí ló dé?		
50	Njẹ́ o lérò wípé ààrùn ọpọ̀lọ jẹ ààrùn ìran-dé-ran?	Bẹ́ẹ̀ni Bẹ́ẹ̀kọ́	1 2
51	Ṣàlàyé ní ẹ̀kúnrẹ́rẹ́		
52	Ṣe o lérò wípé màmá máa ń kobiara sí ẹni tí ó ń ṣe àìsàn ju bàbá lọ?	Bẹ́ẹ̀ni Bẹ́ẹ̀kọ́	1 2
53	Kíni ìdí rẹ?		
54	Ṣe o lérò pé ipa tí ẹni náà ń kó nínú ètò ọrọ̀ ajé ti dínkù láti ìgbà tí àìsàn yìí ti bẹ̀rẹ̀?	Bẹ́ẹ̀ni Bẹ́ẹ̀kọ́	1 2
55	Ṣàlàyé ní ẹ̀kúnrẹ́rẹ́		

ÒDIWỌ̀N ÌDẸ́YẸSÍ

Devaluation-Discrimination Scale (DD)

Ẹ jọ̀wọ́ ẹ dáhùn ìbéèrè abẹ́ yìí, gẹ́gẹ́ bih ẹ ti máa dáhun tí ẹ bá ń bá ẹni tí ó ní ààrùn ọpọlọ sọ̀rọ̀

S/N	Ìsọ̀rí Olùfèsì	1 láílái	2 péréte	3 Díẹ̀	4 Dáadáa	4 Púpọ̀
56	Màá finú fẹ́dọ̀ yan ẹni tí ó ń gba ìtọjú ààrùn ọpọlọ gẹ́gẹ́ bí ọ̀rẹ́ mi					
57	Mo máa gbàgbọ pé ẹni tí ó ti gba ìtọ́jú ààrùn ọpọlọ rí náà lè ní ìmọ̀ kíkún bí ẹni ti kò ì ní ààrùn náà ri					
58	Mo ní ìgbàgbọ́ pé ẹni tí ó ti ní ààrùn ọpọlọ ri ṣe e gba ẹrí rẹ̀ jẹ́ bí ẹni ti kò ì ní ààrùn náà ri					
59	Mo lè gba ẹni tí ó ti ní ààrùn ọpọlọ rí, tí ó sì ti gbádùn láti ṣiṣẹ́ gẹ́gẹ́ bí olùkọ́ àwọn ọmọdé ní ilé ìwé ìjọba					
60	Mo gbàgbọ́ pe ị̀jákulẹ̀ ọlọ́danni ni o ṣe okùnfà ȁàrun ọpọlọ					
61	Mi ò ni gba ẹni tí ó ti ní ààrùn ọpọlọ rí, tí ó sì ti gbádùn láti tọ́jú àwọn ọmọ kékèké, yálà ara rẹ̀ ti yá fún ìgbà díẹ̀ tàbí kò ì yá					
62	Ẹni tí ó ti ní ààrùn ọpọlọ rí kò já mọ́ nǹkan kan ní ojú mi					
63	Tí mo bá jẹ́ agbanisíṣẹ́, mo máa gba ẹni tí ó ti ní ààrùn ọpọlọ rí ṣiṣẹ́, tí o bá kún ojú ìwọn fún iṣẹ́ náà.					
64	Tí mo bá jẹ́ agbanisíṣẹ́, mo máa gba eni ti kò ni ààrun ọpọlọ ṣíṣẹ́ sáájú ẹni tí ó ti ni ààlrùn ọpọlọ rí					
65	Ọgbọọgba ni mo máa hùwà sí ẹni tí kò ni ààrun ọpọlọ rí àti ẹni tí ó ti ni ààrùn ọpọlọ rí					

66	Ara kò lè yá mi láti mú ẹni tí ó ti ni ààrùn ọpọlọ rí gẹ́gẹ́ bí àfẹ́sọ́nà mi					
67	Tí mo bá mọ̀ pé ẹnikan ti ni ààrùn ọpọlọ rí ọ̀pọ̀ ènìyàn ni kò ní kobi ara sí ọhun tí ó bá ń sọ					
68	Bí dídíyẹsì ṣe lè má gba ènìyàn láyé láti kópa ní àwùjọ					
69	Bí dídíyẹsì ti ṣe fa ìpalara sí ìbáṣepọ̀ àwọn tí wọ́n ti ni ààrùn ọpọlọ rí láwùjọ					
70	Ipò wọn ti fa ìpàdánù ẹgbẹọlọ́kan-ò-jọ̀-kan fún wọn					
71	Ààrùn yìí ti ṣe okùnfa ìpàdánù Oyè ọlọ́kan-ò-jọ̀-kan fún wọn					
72	Ààrùn yìí ninú ẹbí ti ṣe okùnfà ìpadánù ìgbéyàwó fún elòmíìràn					
73	Ààrùn yìí ti ṣe okùnfa ìpàdánù ipò òṣèlú ọlọ́kan-ò-jọ̀-kan láàárín ìlú fún ọ̀pọ̀ wọn.					

Ìpín C:Ìpín yìí gba kí a ṣe àlàyé lórí ọnà tí àwọn aláìsàn wọ̀nyìí ń gbà farada àti ìhà tíwọ́n kọ́ sí ààrùn ọpọlọ nípa lílo bẹ́ẹ̀ni tàbí bẹ́ẹ̀kọ́

S/N	**Ọ̀nà Ìfaradà**	**Ìdáhùn**	**Iye**
74.	Ṣé àláìsàn máa ń lọ sí ilé ìjọ́sìn déédé?	Bẹ́ẹ̀ni Bẹ́ẹ̀kọ́	1 2
75	Tí ó bá jẹ́ bẹ́ẹ̀ní, báwo ni ẹ ṣe rí ọjọ́ iwájú rẹ̀ sí?		
76	Tí ó bá jẹ́ bẹ́ẹ̀kọ́, ṣé ẹ lẹ́rò pé ó le gba ẹ̀mí ara rẹ̀?		
77.	Ṣé ẹni náà máa ń lo oògùn rẹ̀ déédé?	Bẹ́ẹ̀ni Bẹ́ẹ̀kọ́	1 2
78	Tí ó bá jẹ́ bẹ́ẹ̀ní, ṣe ẹ máa ń tẹ̀lé bí dókità ti ṣètò lílò rẹ̀?		
79	Tí ó bá jẹ́ bẹ́ẹ̀kọ́, ṣe nitorí àwọn ohun tí oògun náà ń fà sára ló fà á ìdádúró?		
80.	Ṣe aláìsàn yìí máa ń bá àwọn ọ̀rẹ́ tí wọ́n ní irúfé ìṣòro kan náà dámọ̀ràn?	Bẹ́ẹ̀ni Bẹ́ẹ̀kọ́	1 2
81	ṣe ẹbí yín mọ̀ nípa Àjọ **PwS**	Bẹ́ẹ̀ni Bẹ́ẹ̀kọ́	1 2
82	Tí ó bá jẹ́ bẹ́ẹ̀ní, ṣé ọkàn ẹni náà balẹ̀ lórí ìṣòro yìí?		
83	Tí ó bá jẹ́ bẹ́ẹ̀kọ́, báwo ni ó ṣe ń ṣe láàrín àwọn ọ̀rẹ́?		
84.	Ṣé irú ẹni bẹ́ẹ̀ máa ń yẹra fún àwọn ibi tí wọ́n ti le mọ̀ pé ó ní ààrùn náà?	Bẹ́ẹ̀ni Bẹ́ẹ̀kọ́	1 2

85	Tí ó bá jẹ́ bẹ́ẹ̀ní, báwo ni o ṣe ń ṣe ẹ́?		
86	Tí ó bá jẹ́ bẹ́ẹ̀kọ́, báwo ni o ṣe ń yanjú irú ìṣòro yìí?		
87.	Ṣé ẹni náà máa ń gbìyànjú àwọn eré ìdárayá? Bí i , Bọ́ọ̀lù àfẹsẹ̀gbá, tẹníìsì abbl	Bẹ́ẹ̀ni Bẹ́ẹ̀kọ́	1 2
88	Tí ó bá jẹ́ bẹ́ẹ̀ní, irúfẹ́ eré ìdárayá wo?		
89	Tani ó mú ìmọ̀ràn yìí wá?		
90	Ṣé ẹni náà ti kópa nínú ìdíje orílẹ̀-èdè tàbi ti ìpínlẹ̀?	Bẹ́ẹ̀ni Bẹ́ẹ̀kọ́	1 2
91.	Ṣé o máa ń sá fun àwọn iṣẹ̀lẹ̀ tí ó lè fa wàhálà láti yẹra fún àbùkù láàrín ẹbi tàbí ọ̀rẹ́?	Bẹ́ẹ̀ni Bẹ́ẹ̀kọ́	1 2
92	Tí ó bá jẹ́ bẹ́ẹ̀ní, dárúkọ ọ̀kan lára àwọn ìṣẹ̀lẹ̀ wọ̀nyìí		
93.	Ṣé o máa ń gbìyànjú láti sá fún àwọn ènìyàn tí wọn kìí kobiara sí i?	Bẹ́ẹ̀ni Bẹ́ẹ̀kọ́	1 2
94	Tí ó bá jẹ́ bẹ́ẹ̀ní, lọ́nà wo?		
95	Tí ó bá jẹ́ bẹ́ẹ̀kọ́, báwo nio ṣẹ máa ń yanjú rẹ̀?		
96.	Níní ààrùn ọpọlọ ti sọ àwọn aláìsàn wọ̀nyìí di ènìyàn líle	Bẹ́ẹ̀ni Bẹ́ẹ̀kọ́	1 2
97	Tí ó bá jẹ́ bẹ́ẹ̀ní, ní ọ̀nà wo?		
98.	Kò sí ẹni tí yóò fẹ́ láti súnmọ́ wọn nítorí ààrùn ọpọlọ tí wọ́n ní	Bẹ́ẹ̀ni Bẹ́ẹ̀kọ́	1 2
99	Tí ó bá jẹ́ bẹ́ẹ̀ní, ṣe àìsàn aránmọ́ni ni ààrùn yìí ni?		

ṢIṢETỌJU FUN AWỌN AṢETỌJU

Àwọn ohun tí ẹ ba sọ fún wa wọ̀nyìí máa ràn wá lọ́wó láti ní òye kíkún nípa ètò ìṣètójú kí a sì lè yànnànà ìdáhùn yín ní ẹ̀kún rẹrẹ

100. ìnáwó tí ẹ ń ṣe lórí aláìsàn niínú ẹbí yín, báwo ni ó ṣe rọrùn tó fún yín láti rí owó náà?
(a) Ó le púpọ̀ (b) O le, (c) Kò le, bẹ́ẹ̀ni kò rọrùn,
(d) Ó rọrùn, (e)Ó rọrùn púpọ̀

101 Àwọn enìyàn tí o ní ààrùn ọpọlọ bíi mélòó ni ẹ ń ṣe ìtọ́jú lọ́wọ́?..

102. Ẹ jọ̀wọ́, ẹ ṣirò iye wákàtí tí ẹ ti fi pa ibi- iṣẹ tí ẹ ti ń gbowo jẹ látàri wípé ẹ fẹ́ tọ́jú aláàrùn ọpọlọ lẹnu ọsẹ̀ tí ó kọjá?...

103 Ẹ jọ̀wọ́, ẹ ṣirò iye wákàtí tí ẹ ti lò láti tọ́jú aláàrùn ọpọlọ lẹnu ọsẹ̀ tí ó kọjá?...
....

104Ìgbà wo (ọdun) ní ẹ bẹ̀ẹ̀rẹ̀ ṣíse ìtọ́jú aláàrùn ọpọlọ? (tí ẹ kò ba rántí ọdún náà ní pàtó, o kan sọ ọdun tí ó ṣe é ṣe ki ó jẹ́) ....

105. Ṣé ẹ jọ ń gbé lọ́wọ́lọ́wọ́?Bẹ́ẹ̀ni (   ) Kìí ṣe ní gbogbo ìgbà (   ) Rárá(   )

106.Tí ó bá jẹ rárá, ibo ni wọ́n ń gbé lọ́wọ́lọ́wọ́?
Ilé ara wọn/ilẹ tí wọn yá gbé ( )
Ilé tí wọn gbà fún wọn ( )
Wọn ń gbé pẹ̀lú ẹbi/ọ̀rẹ́( )
Ọgbà Ìtọ́jú ( )
Ilé Ìwòsàn( )
Ibùgbé mìíràn *(ẹ jọ̀wọ́, ẹ sọ ní pàtó)*..

107. Èwo nínú àwọn gbólóhùn ìsàlẹ̀ wọ̀nyíí ni ó so nipa ipa rẹ, gẹ́gẹ́ bí olùtọ́jú lọ́wọ̀lọ́wọ́?
Èmi nìkan ni Olùtọ́jú
Èmi àti àwọn kan ni à ń pín ìtọ́jú náà ṣe, ṣùgbọ́n èmi ni mo ń kó ipa tíó pọ̀ jùlọ ( )
Èmi àti àwọn kan n pin ìtọjú ṣíṣe ní ọgbọọgba ( )
Èmi àti àwọn kan ni à ń pín ìtọ́jú náà ṣe, ṣùgbọ́n elòmìíràn ni ó ń kó ipa tí ó pọ̀ jùlọ ( )
Òmìíràn *(ẹ sọ ní pàtó*...

108. Èwo nínú àwọn irúfẹ́ ìrànlọ́wọ́ yìí, ni o máa ń fi àyè gbà ọ láti sinmi díẹ̀ ní ṣíṣe ìtọ́jú? *(o lè yàn ju ẹyọkan lọ tí ó bá wù ọ́.)*
(a) Ọ̀rẹ́/Ẹbí ṣíṣe ìrànwọ́ fún ìgbà díẹ̀,
(b) wíwáléỌ̀ṣìṣẹ tí o ń gba owó fún itọ́jú
(c) Awọn Òṣìṣẹ́ tí wọn ni ilé ìtọjú tí wọ́n tí máa ń ṣe ìtọ́jú
(d) ètò ìrànwọ́ lóríṣiríṣi tí kò sí lábẹ ilé
(e) fún ẹni tí ò ń tọ́jú
(f)Ìrànwọ́ ìsinmi tí kì í ṣe ti abẹ ilé fún ẹ̀yin àti ẹni tí ẹ̀ ń ṣe ìtọ́jú
(g)Àwọn ìrànwọ́ mìíràn (Ẹ jọ̀wọ́, Ẹ kọ ọ́ sábẹ́);
(i)mi ò lè gba ṣe lái ṣe ìtójú
(ii)mi ò nílò ìrànlọ́wọ́, lati gba ìsinmi ni ṣíṣe ìtọ́jú

ÌPÍNF: Ìtẹ́lọ́rùn Ìbátan pẹ̀lú ìtọ́júCommunity-based.

Ìpín yìí gba kí a ṣe àlàyé kíkún nípa ìhà tí a kọ sí ìtọ́jú tí àwọn aláìsàn ti gbà sẹ́yìn ni sẹ́ńtà yìí.

Ẹ jọ̀wọ́, a fẹ́ kí ẹ sọ bí ó ti rí gẹ́lẹ́ nípa yíyan èyíkéyìí tí ó wù yín lábá ìsọ̀rí Ìdáhùn.

S/N	**Ìbéèrè**	**Ìdáhùn**	**Iye**
109	Ṣé ìtọ́jú yìí tẹ́ ẹ yín lọ́rùn?	Bẹ́ẹ̀ni Bẹ́ẹ̀kọ́	1 2
110	Tí ó bá jẹ́ bẹ́ẹ̀ní, ṣe apẹẹrẹ		
111	Tí ó bá jẹ́ bẹ́ẹ̀kọ́, fún wa ní ìdí		
112	Ṣé àwọn òṣìṣẹ ibi iṣẹ́ ìlera yìí máa ń ṣe dáadáa ní gbogbo ìgbà?	Bẹ́ẹ̀ni Bẹ́ẹ̀kọ́	1 2
113	Tí ó bá jẹ́ bẹ́ẹ̀ní, fún wa ní apẹẹrẹ		
114	Tí ó bá jẹ́ bẹ́ẹ̀kọ́, Ṣàlàyé?		
115	Ṣé àwọn òṣìṣẹ ibi iṣẹ́ ìlera yìí máa ń wà ní àyíká láti ṣe ìrànlọ́wọ́ ní gbogbo ìgbà?	Bẹ́ẹ̀ni Bẹ́ẹ̀kọ́	1 2
116	Tí ó bá jẹ́ bẹ́ẹ̀ní, fún wa ní apẹẹrẹ		

117	Tí ó bá jẹ́ bẹ́ẹ̀kọ́, fún wa ní apẹẹrẹ ìrírí rẹ		
118	Ṣé o lérò pé ìyàtọ̀ ti bá aláìsàn rẹ láti ìgbà tih ó ti de sí ibi?	Bẹ́ẹ̀ni Bẹ́ẹ̀kọ́	1 2
119	Tí ó bá jẹ́ bẹ́ẹ̀ní, irufẹ́ ìtọ́jú wo ni ó fa èyí		
120	Tí ó bá jẹ́ bẹ́ẹ̀kọ́, Ṣàlàyé idi tí kò fi tẹh ọ lọ́rùn		
121	Ǹjẹ́ o le è gba ẹni tí ó ní irúfẹ́ ìṣoro kan náà ní ìmọràn láti wa gba ìtọjú ni ẹka iṣetọ́jú yìí?	Bẹ́ẹ̀ni Bẹ́ẹ̀kọ́	1 2
122	Kíni idi àwon ìdáhùn rẹ?		

ÀSOMỌ́ II

Yoruba translation of interview guide for the community

UI/SSHEC/2016/009

Ìgbésẹ̀ ẹlẹ́gbẹ́jẹgbẹ́ fún Àwọn Ará Ìlú

Ìlànà: Sọ fún akópa kọ̀ọ̀kan, kí ó yan àlàjẹ (yan orúkọ) tí a máa lọ fún ìgbohùnsílẹ̀. kí a tó bẹ̀ẹ̀rẹ̀, ẹni tí ó ń dárí máa ri dájú pé ó sọ fún àwọn tí wọ́n ń kópa, kí wọ́n pẹ́ àlàjẹ́ wọn síta dáadáa/Orúkọ fún àyẹ̀wò ìgbohùnsílẹ̀ (Àmọ̀ràn fún Olùdarí): ní òní, a fẹ́ bá a yín sọ̀rọ̀ nípa ìsọ̀ro/àwọn ìdọjúkọ tí àwọn tí ó ní ààrùn ọpọlọ ń kọjú ní òde òní. ẹgbẹ́ yìí jẹ́ ẹgbẹ́ tí ó gbẹ̀fẹ́, nítorí náà, kí olúkúlùkù túraká láti sọ èrò ọkan rẹ̀ jáde. Òfin kan soso tí ó de ẹgbẹ́ yìí ni wípẹ, a gbọdọ̀ fi àyè sílẹ̀ fun ẹni tí ó ń sọ̀rọ̀ lọ́wọ́ láti parí, kí a tó ṣọ tiwa.

Ọ̀nà ìgba-ṣe-nǹkan 1:

Ìṣàmúlò àti ìgbàgbọ́ Ìtọ́jú Ààrùn Ọpọlọ

Ìlànà:lọ àwọn ọ̀rọ̀/àpàjúwe tí a ti gbékalè láti béèrè ìbéèrè

(1) láti ìgbà wo ni aláìsàn yìí ti ń wá sí sẹ́ńtà Ìlera ti community-based yìí?

(2) kí ni ìwúrí tí o ń mú wọn wá sí sẹ́ńtà yìí?

(3) Èwo nínú àwọn wọ̀nyìí ni ìpinnu rẹ̀ múlẹ̀ jùlọ lóri ìlànà ìlera? Fún àpẹẹrẹ (a) Bàbá, (b) màmá, (c) Ẹ̀gbọ́n/Àbúrò (d)Àwọn mìíràn......................

(4) kí ló dé?

(5) Ṣé wọ́n ń wá sí ọ̀dọ̀ àwọn aṣètọ́ju aláàrùn ọpọlọ dẹ́édé fún ìtọ́jú?

(6) Kí ni èrò àwọn ènìyàn nípa ààrùn ọpọlọ ní agbègbè rẹ láti ìgbà tí wọ́n ti ń wá sí sẹ́ńtà yìí?

(7) Fún Àpẹẹrè?

(8) Kíni o rò pé ó jẹ́ àwọn ìṣòro tí ó pọ̀ jùlọ tí ó ń kọjú àwọn ènìyàn tí wọ́n ní ààrùn ọpọlọ ní agbègbè rẹlónìí?

(8) Kíni ìgbàgbọ tìrẹ nípa okùfa àti ìtọ́jú ààrùn ọpọlọ?

(9) Ṣe o lè lo ìgbàgbọ́ rẹ, láti fi gbe àwọn ìlànà ìtọ́jú lésẹ̀?

(10) Àwọn ènìyàn kan ní ìgbàgbọ́ tí ó yàtò gbá à nípa ìtọ́jú ààrùn ọpọlọ gẹ́gẹ́ bí o ti sọ sokè (dárúkọ àwọn ìṣòrotí wọn dárúkọ) báwo ni o ṣe ni ipa lóri wíwá àwọn ènìyàn si sẹ́ńtà ìlera community based yìi

(11) Ìhà wo ni àwọn ènìyàn tí wọ́n rí pé wọ́n ń gba ìtọ́jú ni sẹ́ńtà ìlera community based kọ si wọn?

Ọ̀nà ìgba-ṣe-nǹkan 2:

Fífarada Ààrùn ọpọlọ

A ti jíròrò lórí ìhà tí àwọn ènìyàn kọ sí Ààrùn ọpọlọ àti wíwà sí sẹ́ńtà ìlera community based fún ìrànlọ́wọ́ tí ó kún ojú òṣùwọ̀n, báyìí, a ó padà sí ìjíròrò lórí bí àwọn ìhà tí aláìsàn wọ̀nyìí kọ sí mímọ̀ nípa àìlera àti ìṣòro tí wọ́n ń kọjú.

(12) kí ni ìhàtí wọ́n kọ sí bí àwọn ènìyàn ṣe ń sọ̀rọ̀ nípà olúkúlùkù tó ní ààrùn ọpọlọ yìí

(13) (tí ẹ ba sọ̀rọ̀ dé ibẹ̀): mo rí i pé àwọn kan sọ̀rọ̀ nípa yíyẹra fún ènìyàn. ṣe ẹ lérò pẹ ó bójúmu láti yẹra fún àwọn tí wọ́n ń dẹ́yẹsí wọn?

(14) báwo ni wọ́n ṣe fẹ́ ṣe pẹ̀lú Ìdẹ́yẹsi láti ọ̀dọ̀ àwọn ẹbí

(15) Ǹjẹ wọ́n ní ìgboyà tó láti kọjú àwọn tí wọ́n ń dẹ́yẹ sí wọn, tí wọ́n sì ń pè wọ́n ní oríṣìríṣi orúkọ?

(16) Ǹjẹ́ wọ́nsì lè kópa nínú àwọn ìsẹ̀lẹ̀ àwùjọ pẹ̀lú àwọn tí wọ́n mọ̀ wípẹ́ wọ́n ń lọ gbà ìtọ́jú ni sẹ́ńtà ìlera community based? Tí ó bá jẹ́ bẹ̀ẹ̀ni,

(17) kí ni èrò rẹ nípa àwọn Aláìsàn àti àwọn tí wọ́n ń gba ìtọ́jú ní ilé ìwòsàn aláàrùn ọpọlọ?

(18) Ṣé ó yẹ kí wọn ní ìdí láti kábààmọ̀ pẹ àwọn ènìyàn kan mọ wípẹ àwọn ń gba ìtọ́jú ní sẹ́ńtà ìlera community based

(19) Tí ó bá jẹ́ bẹ̀ẹ̀ni, kí ni ìdí èyí?

Ọ̀nà ìgba-ṣe-nǹkan 3:

Ojú ìwòye Àwọn Òṣìṣẹ́ Ìlera ọpọlọ

Lẹ́yìn tí a ti jíròrò lórí ìṣòro tí ó yẹ kí àwọn onímọ̀ ààrùn ọpọlọ, nọ́ọ̀si, òṣìṣẹ àwùjọ, òṣìṣẹ́ ìlera ní agbègbè, dokítà ìbílẹ̀, àwọn afìgbàgbọ́ ṣèwòsàn gbé yawò àti bí o ṣe máa ń rí lára wọn tí wọ́n bá rí ẹni tí ó ní ààrùn ọpọlọ, ẹ jẹ kí a jíròrò lóri bí àwọn ààrùn ọpọlọ gangan se rí àwọn òṣìṣẹ́ wọ̀nyìí

- àwọn onímọ̀ ààrùn ọpọlọ
- nọ́ọ̀si,
- òṣìṣẹ àwùjọ,
- òṣìṣẹ́ ìlera ní agbègbè,
- dokítà ìbílẹ̀,

- àwọn afîgbàgbọ́ ṣèwòsàn

(20)kíni èrò rẹ nípa àwọn òṣìṣẹ́ ìlera ni sẹ́ńtà yìí?

(21) kiní ọ̀nà Ọ̀nà ìgba-ṣe-nǹkan sẹ́ńtà yìí?

(22) báwo ni o ṣe rò wípẹ wọ́n ń ṣe ìrànlọ́wó pẹ̀lú ìlera àti ìṣòro àwọn aláìsàn?

(23) kí ni ìhà tí wọ́n kọ sí àwọn ènìyàn, ẹbí àti ọ̀rẹ́ nipa ìdẹ́yẹsí? Sẹ wọ́n máa ń pè wọn ní oríṣirísi orúkọ ni, wọ́n máa ń sá fún àwọn aláìsàn tàbí wọ́n máa wọ́n máa ń tàbùkù wọn?

(24) ṣé wọn ti kópa lórí bí o ṣe ri ildẹ́yẹsí àti ìhà tí àwọn ènìyàn kọ sí ọ?

(25) irúfẹ́ ìrírí wo ni o ti rí, tí o ti nípa lórí èrò rẹ lórí ààrùn ọpọlọ?

(26) Ǹjẹ àwọn Òṣìṣẹ ẹ̀tò Ìlera àwọn aláàrùn ọpọlọ náà ní ààrùn ọpọlọ bí àwọn ẹ̀nìyàn kan ti máa ń sọ?

(27) Ìgbà wo ni o ti ń gbé ni agbègbè sẹ́ńtà ìlera community-based yìí?

Ẹ ṣeun tí ẹ fèsí dáadáa

Bẹ́èrè bóyá wọ́n tún ni ìbéèrè tí wọ́ fẹ́ fi kún èyí ti wọ́n ti bèèrè sẹ́yìn.

PÀTÀKÌ: so fún wọn, kí wọn dáhùn àtòjọ-ìbéèrè afiṣèwádìí nípa lílo Orúkọ/Alàjẹ́ ti wọ́n mú ni ìbẹ̀ẹ̀rẹ̀

ÀSOMỌ́ III

Yoruba translation of interview guide for professionals mental health care providers

UI/SSHEC/2016/009

Ìfiwánilẹ́nuwò tí ó ṣe kókó fún àwọn òsìṣẹ́ ilé ìwòsàn

Ìfáàrà sí Ìfiwánilẹ́nuwò

Ẹ ṣeun tí ẹ gbà láti kópa ninu Ìfiwánilẹ́nuwò yìí

Pàtàkì Ìfiwánilẹ́nuwò (Àkókọ̀- wákàtí kan)

Mo máa bèèrè àwọn ìbéèrè kọ̀ọ̀kan lọ́wọ́ yín láti bẹ̀ẹ̀rẹ̀ ìjíròrò wa, bákan náà sì ni, àyè ṣí sílẹ̀ fún yín láti ṣe àfikún pẹlú ìfọ̀kànbalẹ̀. Kò sí ìbéère o gbà ẹ, tàbí o ṣì í; ohun tí ó jẹ wá lógún ni èrò yín nipa ìrí yí, tàbi ìrírí ẹni tí ẹ mọ̀ rí. Ìwọ̀fún ni kíkópa ninú Ìfiwánilẹ́nuwò yìí, nítorí náà, tí ẹ bá fẹ́ dáhùn ìbéèrè kan, kò pọn dandan, bẹkan nàà sì ni, ìgbà tí ó bá wù yín ni ẹ lè sọ wípé ẹ kò ṣe mọ́.

Rán àwọn akópa léti pé a máa gba ohun wọn sílẹ̀

Ọjọ́ àti Ifọwọ́bọ̀wé………………………………

Ìlànà: lọ àwọn ọ̀rọ̀/àpàjúwe tí a ti gbékalè láti béèrè ìbéèrè

Ipò:………………………………………………………………………………………

(1) Ọdún mélòó ni o ti lọ̀ ní sẹ́ǹtà yìí ?:...

(2) Ṣàlàyé bí bí sẹ́ǹtà yìí ṣe ń ṣiṣẹ́ ?:..

(3) Ẹ̀ẹ̀mélòó ni wọ́n máa ń ṣí i?:..

(4) Ṣe àpèjúwé bí ẹ ṣe ń gba àwọn aláìsàn tójú: fún àpẹẹrẹ (a) gbígba àwọn Aláàsàn sí ilé ìwòsàn fún ìtọ́jú títí ara fi máa yá (b) títọjú àwọn aláìsàn tó ń lọ ilé bọ̀ títí ara yóò fi yá,..

(5) Irúfẹ́ àwọn ìrànwọ wo ni ẹ máa ń ṣe fún àwọn aláìsàn ní sẹ́ǹtà yìí ?...

(6) Ṣe àpèjúwe bí sẹ́ǹtà yìí ṣe jìnà sí ìlú sí ?..

(7) Ìhà wo ní àwọn ènìyàn agbègbè yìí kọ sí ààrùn ọpọlọ?:..................................

(8) kíní èrò àwọn ará ìlú nípa sẹ́ǹtà yìí gẹ́gẹ́ bí sẹ́ǹtà yìí gẹ́gẹ́ bí ibi iṣẹ́ ìlera

(9) kí ni àwọn Ọ̀nà tí ṣẹ́ńtà yìí ń igba ṣe àwọn nǹkan wọn?

(10) Báwo ni àwọn ènìyàn àwùjọ ṣe ń gbọ́ nípa ṣẹ́ńtà yìí (a) Rédíò, (b) Tẹlifísàn (c) ìwé pélébé (d) láti ọ̀dọ̀ àwọn ọ̀rẹ́

(11) Ṣé ẹ lérò wípẹ owó ìtójú aláìsàn ní ṣẹ́ńtà yìí kò pọ̀?

(12) Ṣé àwọn aláìsàn máa ń wà sí ṣẹ́ńtà yìí gẹ́gẹ́ bí àwọn tó ń tójú wọn sẹ ṣètò sílẹ̀ fún wọn?

(13) Ìhà wo ní àwọn ènìyàn agbègbè yìí kọ sí àárùn ọpọlọ láti ìgbà tí àwọn aláìsàn ti ń wá sí ṣẹ́ńtà yìí?

(14) kí ni àwọn aláìsàn rò wípé ó jẹ́ ìsòro tí ó tóbi jùlọ, tí ó ń kọjú àwọn tí wọ́n ní àárùn ọpọlọ ní agbègbè wọn lónìí?

(15) Ìgbàgbọ́ àwọn ènìyàn kan sí ìtọ́jú àárùn ọpọlọ yàtọ̀ sí àwọn tí wọ́n ti ménu bà lókè (dárúkọ àwọn tí wọ́n ti ménu bà lókè) irú ipa wo ni ó ní lórí bí àwọn ènìyàn ṣe ńlọ sí ṣẹ́ńtà yìí?

(16) irú ìhà wo ní àwọn ènìyàn kọ si àwọn aláìsàn tí wọ́n ń lọ gba ìtọ́jú ní ṣẹ́ńtà yìí?

(17) Báwo ni àwọn aláìsàn ṣe ń farada bí àwọn ènìyàn ṣe ń sọ̀rọ̀ nípa ìṣòro wọn tàbihùwà si wọn?

(18) báwo ni àwọn aláìsàn ṣe ń farada Ìdẹ́yẹsi láti ọ̀dọ̀ àwọn ẹbí?

(19) Ǹjẹ wọ́n ní ìgboyà tó láti kọjú àwọn tí wọ́n ń dẹ́yẹ sí wọn, tí wọ́n sì ń pè wọ́n ní oríṣìríṣi orúkọ?

(20) Ǹjẹ́ àwọ́n Aláìsàn wọ̀nyí sì ń kópa nínú àwọn ìsẹ̀lẹ̀ àwùjọ pẹlú àwọn tí wọ́n mọ̀ wípé wọ́n ń lọ gbà ìtọ́jú ni sẹ́ńtà ìlera community based? Tí ó bá jẹ́ bẹ̀ẹ̀ni,

(21) kí ni èrò rẹ nípa àwọn Aláìsàn àti àwọn tí wọ́n ń gba ìtọ́jú ní ilé ìwòsàn aláàrùn ọpọlọ?

(22) Ṣé ó yẹ kí wọn ní ìdí láti kábàámọ̀ pẹ àwọn ènìyàn kan mọ wípẹ àwọn ń gba ìtọ́jú ní sẹ́ńtà ìlera community based

(23) Tí ó bá jẹ́ bẹ̀ẹ̀ni, kí ni ìdí èyí?

(24) báwo ni àwọ́n aláìsàn ti ṣe rò wípẹ o ti ṣe ìrànlọ́wọ́ fún ìlera àti ìṣòro wọn gẹ́gẹ́ bí aláìsàn?

(25)) kí ni ìhà tí wọ́n kọ sí àwọn ènìyàn, ẹbí àti ọ̀rẹ́ tí wọ́n ìdẹ́yẹsí àwọ́n aláìsàn?

(26) kí ni ipa tí ẹ ti kó láti ran àwọn aláìsàn lọ́wọ́ lórí bí o ṣe ri ildẹ́yẹsí àti ìhà tí àwọn ènìyàn kọ sí wọ́n?

(27) irúfẹ́ iṣẹ́ tàbí ìrírí wo ni àwọn ènìyàn ni, tí o sì ti nípa lórí èrò wọn nípa iṣẹ́ ìtọjú aláàrùn ọpọlọ?

Ẹ ṣeun tí ẹ fèsí dáadáa.