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SOCIO-CULTURAL AND ECONOMIC FACTORS AFFECTING HEALTH SEEKING BEHAVIOUR ON MENTAL ILLNESS IN NIGERIA

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Abstract
Mental illness as a form of deviant behaviour that has failed to conform to the conventional norms is full of complexities and many uncertainties which therefore is disvalued by society. People suffering from mental illness have a number of ways of seeking for treatment, either from hospital, traditional, or spiritual. They may follow all of the above mentioned steps, or perhaps only one or two of them or may follow them in any order. Against this background, this study examined socio-cultural and economic factors affecting health seeking behaviour on mental illness in Nigeria. The study was a cross – sectional design. A survey of 1200 respondents from two selected south eastern states was used. Finding revealed that cost of treatment, distance to treatment facilities, efficacy of treatment method, attitude of personnel, and access to treatment facility were hindrances
/ factors affecting health seeking behaviour behaviour on mental illness. Hence, recommendations were made to reduce these constraints.

Keywords: Mental illness, treatment pathways, socio-cultural factors, health seeking behaviour

Introduction

Mental health refers to our cognitive, behavioural, and emotional wellbeing. It is all about how we think, feel and behave. Mental health can affect our daily life, relationships and even physical health. How we think, feel and behave could result into illness (mental illness). Mental illness could be seen as a severe and persistent malfunctioning of the mind that interferes with social function in such primary aspects of daily life as self care, interpersonal relationships, and work or schooling, and that may necessitate occasional hospitalization or crisis care.

Many people today who have a mental illness do not want to talk about it. But mental illness is nothing to be ashamed of, it is a medical condition, just like heart disease or diabetes (Szasz, 1960 in Henslin & Reynolds, 1974). Mental illness or conditions are treatable. Mental illnesses are among the most common conditions affecting health today, both in developed and developing countries. Mental illness does not discriminate; it can affect anyone regardless of age, gender income social status, race/ ethnicity, etc. While mental illness can occur at any age, three fourths of all mental illness begins by age 24 (APA, 2018).

Mental illness takes many forms. Some are mild and only interfere in limited ways with daily life, such as certain phobias (abnormal fears). Other mental health conditions are so severe that a person may need care in a hospital or other treatment pathways. Despite the increase in the rate of treatment methods most patients with mental illness do not receive treatment due to some socio- cultural and economic factors that affects their health seeking behaviour on mental illness.

Theoretical Framework

This study was hinged on cultural explanatory theory of Kleinman (2010) and Health belief model (HBM) of Gulliver, Griffiths, Christensen & Brewer (2012). These perspectives saw the role of culture in relation to individual's health status and how it affects their acceptability of so many options in order to find a lasting solution to their problems. It is postulated that belief system fuelled by ignorance, inefficacy of treatment, cost, stigma and other factors contribute in making people take inappropriate health behaviour when faced with the problem of mental illness. This relates to the way individuals conceptualize illness, how they give meaning and coherence to mental condition, and how they explain sickness. It also explains the choice among available methods of therapies, compliance with treatment and satisfaction which are also influenced and shaped by culture and social factors such as socio-economic status and education. Also, the second theory suitable for this study is the health belief model. The model posits that the decision to perform certain behaviour is dependent on the individual's benefits of the behaviour itself. It postulates that six (6) constructs predict health behaviour namely: risk susceptibility, risk severity, benefits to action, and barriers to action, self efficacy and cues to action (Champion & Skinner, 2008). The HBM consist of the perceived severity as well as perceived benefits and barriers in the treatment of mental illness.

Materials and Methods

The study adopted the cross-sectional survey methods which allowed the use of selected sample to describe and analyse a large population at a given time. The study was carried in the South Eastern part of Nigeria. Two states were randomly selected out of the five (5) south eastern states. The selected states were Enugu and Imo States. Enugu State was created in 1991 from old Anambra State while Imo State was created in 1976 from the defunct East Central State of Nigeria. Each state has three senatorial zones of which two were randomly selected from each state giving a total of four senatorial zones. Enugu state has 17 Local Government Areas (LGAs), while Imo state has 27 LGAs. Using World Bank (2017) projected growth rate of 2.6% the population of Enugu State in 2011 was calculated to be 3,608,748, while Imo State was 4,446,434. The sample size for this study was determined statistically using Cochran (1963) formula: $\mathbf{n = Z^2 (P\zeta) / e^2}$ which gives **13**44.

A multistage sampling plan that involved successive random sampling to choose LGAs, communities and towns, villages, streets, and respondents was carried. From each of the states, two senatorial zones were randomly selected making it a total of four (4) senatorial

zones on the whole study. The LGAs in each senatorial zone were clustered into urban and rural. One LGA was randomly selected from each cluster of zones. This gave a total of eight (8) LGAs or 4 LGAs from each state on the basis of 2 urban and 2 rural.

In the rural LGAs, two communities each were randomly chosen to give a total of eight (8) rural communities. In the sampled rural communities, the villages constituted another level of sampling. Here, two villages were selected from the list of villages by balloting. This also gave a total of 16 villages on the whole. Each village selected for the study were assigned 42 respondents in order to arrive at the 672 respondents in each state. The dwelling units in the sampled villages were listed according to the National Programme on Immunization (NPI) house numbering. The systematic random sampling technique in which every 'nth' number was selected was applied to this list to select the desired number of dwelling units for this study. In this therefore, the **nth** number was every 3rd building on each street and from there two respondents were drawn from each household until the required numbers of respondents are gotten. In each dwelling unit, two adults a male and a female (18 years & above) were purposively selected.

On the other hand, in the urban LGAs, the streets/roads constituted the unit of sampling similar methods were used. Data was collected with a combination of survey method and qualitative method. The major instrument chosen for collecting data for the study was the questionnaire. Qualitative data was also obtained through the use of Focus Group Discussions (FGDs) and In-depth interviews with carefully developed guides. These provided in-depth knowledge and information on the community perceptions, and attitude on mental illness. There was a pre-test of the instruments with 5% of the total population.

Results /Findings

Socio-Demographic Characteristics of the Respondents

The socio-demographic characteristics of the respondents were empirically examined using the survey data to determine their states, place of residence, sex, age, marital status, educational qualification, religion, occupation, and level of income.

Table 1: Distribution of Respondents by State

State	Frequency (n=1200)	Percentage
Enugu	600	50.0
Imo	600	50.0
Total	1200	100.0

Distribution Respondents by Place of Residence

Place of residence	Frequency	Percentage
Urban	600	50.0
Rural	600	50.0
Total	1200	100.0

Distribution of Respondents by Sex:

Sex	Frequency	Percentage
Male	600	50.0
Female	600	50.0
Total	1200	100.0

Distribution of Respondents by Age

Age	Frequency	Percentage
18-22	235	19.6
23-27	355	29.6
28-32	202	16.8
33-37	107	8.9
38-42	113	9.4
43-47	85	7.1
48-52	69	5.8
53-57	17	1.4
58 & above	17	1.4
Total	1200	100.0

Distribution of Respondents by Marital Status:

Marital status	Frequency	Percentage
Single	754	62.8
Married	401	33.4
Divorced	4	.3
Separated	5	.4
Widowed	36	3.0
Total	1200	100.0

Distribution of Respondents by Education

Highest level of education	Frequency	Percentage
No formal education	2	.2
FSLC	34	2.8
WASC/SSCE	564	47.0
A level/OND/NCE/Equivalent	166	13.8
First Degree/Equivalent	408	34.0
Higher Degree	26	2.2
Total	1200	100.0

Distribution of Respondents by Religion

Religion	Frequency	Percentage
Catholic	545	45.4
Protestant	300	25.0
Traditional religion	2	.2
Pentecostal	251	20.9
Seventh day Adventists	91	7.6
Jehovah witness	11	.9
Total	1200	100.0

Distribution of Respondents by Occupation

Occupation	Frequency	Percentage
Teaching	232	19.3
Student	401	33.4
Civil servant	265	22.1
Business man/woman	128	10.7
Artisan	32	2.7
Unemployed	87	7.2
Farming	46	3.8
Retired	9	.8
Total	1200	100.0

Distribution of Respondents by Income

Level of income (per annum)	Frequency	Percentage
₦0-N200,000	462	38.5
₦200,100-₦400,000	19	1.6
₦400,100-₦600,000	114	9.5
₦600,100-₦800,000	255	21.2
₦800,100-₦1,000,000	120	10.0
₦1,100,000 & above	230	19.2
Total	1200	100.0

The study took place in two south eastern states which were Enugu and Imo. These states had equal number of respondents which is 600 each out of 1200 questionnaires that was validly filled and completed.

These states (Enugu and Imo) were stratified into rural and urban areas and each state had 300 rural and 300 urban respondents giving a grand total of 600 urban and 600 rural respondents.

The focus here is on sex composition of the respondents. Efforts were purposively made to ensure equal number of respondents for both sexes into the sample. Females constituted 50% while males were made up of 50%. The table above showed the ages of the respondents that ranged from a minimum age of 18 and a maximum age of 58, with a mean

age of 31, a median age of 28 and modal age of 25 years (31 10.031 SD). The table shows the age being grouped into nine categories with an interval of five. Another important feature of the sample was to know the marital status of the respondents of which 62.8% were single while 37.2% were ever married (Divorced 0.3%, Separated 0.4% and widowed 3%).A look at the respondent's level of education shows that 2.2% had higher degree, first degree/equivalent (34%), A level/OND/NCE/equivalent (13.8%), WASC/SSCE/NECO (47%), and only 2.8% has First School Leaving Certificate, while 0.2% had no formal education. Christians dominated the sample with 98.8% (Catholic, 45.4%; Protestants, 25%; Pentecostal, 20.9%; Seventh day Adventists, 7.6%, and Jehovah Witness, 0.9%), and Traditional Religion has 0.2%. However, it is not surprising that Christians dominated in the study because the study took place in south eastern Nigeria which is a part of Nigeria that is predominantly Christians. Respondent's occupation showed that 19.3% were teachers, 33.4% were students, 22.1% were civil servants, 10.7% were business men/women, 2.7% were artisans, 7.2% were unemployed, 3.8% were farmers, while 0.8% were retirees. The level of income per annum of the respondents indicated that 38.5% of the respondents were within the income level of N0-N200,000, 1.6% earn between N200100-N400,000; 9.5% earn between N400,100-N600,000; 21.2% earn N600,100-N800,000. Also,10% of the respondents earn N800,100-N1,000,000 while 19.2% were within the income level of N1,100,000 and above per annum.

Socio Cultural and Economic Factors affecting Health Seeking Behaviour

Here, we looked at the socio cultural and economic factors that affect health seeking behaviour for mental illness. This is presented in figure 1 below.

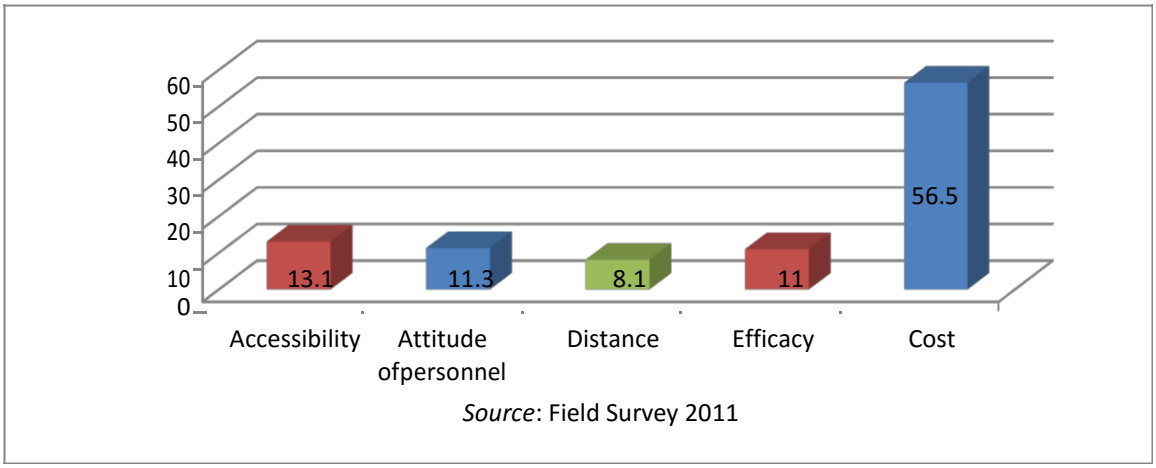

Figure 1: Bar chart showing percentage distribution of respondents by socio cultural and economic factors influencing health seeking behaviour for MI

All the respondents in the sample survey noted that there are socio cultural factors that influence health seeking behaviour for MI. As can be seen from figure 1 above, these

factors include: cost of treatment (56.6%), access to treatment facility (13.1%), attitude of personnel (11.3%), efficacy of treatment method (11%), and distance to treatment facility (8.1%). This means that cost of treatment is the major socio economic factor influencing health seeking behaviour. In one of the FGD sessions, one of the respondents noted that, "if any of his relation has mental illness, he would take him to a place where he will be completely cured no matter how much it will cost, even if it is in London". Another participant commenting on the cost of treatment stated thus,

> I would consider the cost of the place. If I want to take any of my relation for treatment, I would consider the one that will give me what I want and that is cheap because there is hardship in the country now, things are hard (Male FGD participant, Ajuona Obukpa, Nsukka).

An IDI participant, speaking on cost of treatment, access to treatment facility and distance reiterated that,

> Finding a good place where such person will be treated is always difficult. You will be asking and people will tell you go there or the other place. I know of one family, one of the daughters one day started going mad and people told them to go to Enugu, that there is a hospital there, but this family was very poor. They could not afford the expenses so what they did was to take the girl to a native doctor (Male FGD participant, Ugbawka, Nkanu, Enugu State).

Commenting on the attitude of personnel, another FGD participant stated thus:

> I would take my relation to a place where he or she will be treated and not where they will beat the person up like animal. Sometimes, madness is seen to be attack of evil spirit which should be flogged out of the person. That is what I don't like. (Female FGD participant, Enugu)

Also commenting on the attitude of personnel, a male participant stated thus: When you are sick and you go to the hospital or where you will be treated, you find that it is not sickness that is now the problem, but how the workers there are behaving towards you. Sometimes they treat you as if you are nobody, talking to you anyhow, even the ones you know perfectly

> well they cannot talk to you if it were to be outside (Male FGD participant, Enugu).

On the efficacy of treatment method, one of the female FGD participants stated thus;

> It is not about going to treat your own person that has problem. The problem is the treatment. Are you going to get good treatment? Not the one you just go and waste your money without good result. You know today we have many people finding money in any way, they will tell you they can cure it but at the end, you see you have wasted your money and no result. So sometimes you worry of where to get good treatment (Female FGD participant, Owerri Municipal).

All these show that there are indeed socio cultural factors that affect the choice of treatment for MI. However, one is left to ponder what cost of treatment means to the various individuals and how it affects their choice of treatment. Could it be in terms of specified amount to be paid in a hospital in terms of consultation fee or is it in terms of estimated bills that are frequently paid with traditional healers or faith healers? Ones' views could affect his//her perception of efficacy of treatment method. If the cause of the illness is attributed to spiritual attack and one is taken to the hospital for treatment, there is the likelihood of perceiving treatment received as ineffective; likewise attitude of personnel, distance to and access to treatment facility.

Traditional/Cultural Factors affecting Health Seeking Behaviour on Mental Illness

In this sub section, traditional/cultural factors that affect health seeking behaviour were examined. This is also presented in the chart below.

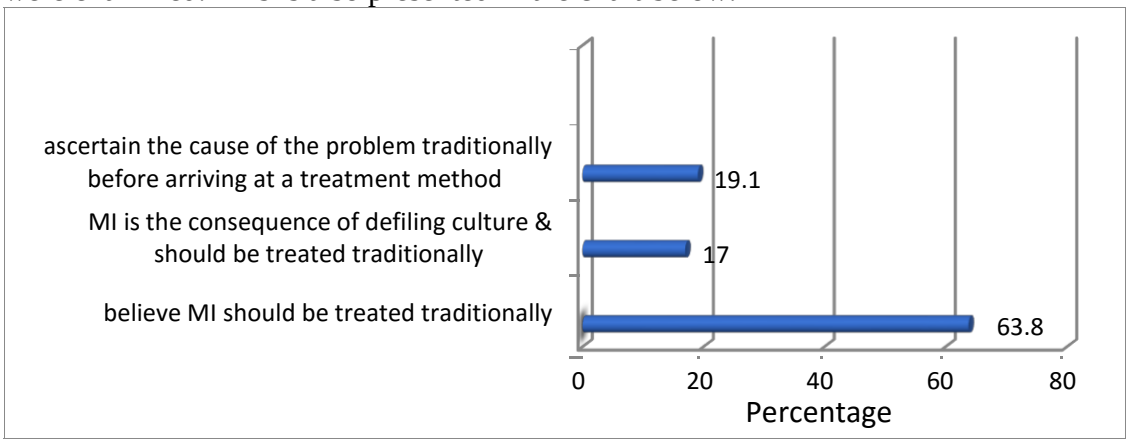

Figure 2: Percentage distribution of respondents by cultural/traditional factors affecting health seeking behaviour for MI

Figure 4 shows the views of respondents on the role of culture/tradition on the health seeking behaviour for MI. About 63.8% of the respondents believed that MI should be treated traditionally, while 17% said MI is the consequence of defiling culture and should be treated traditionally. About 19.1% noted that traditionally, the cause of MI should be ascertained traditionally before arriving at a treatment method. During one of the FGD sessions, one of the participants explained that "some of these problems come as a result of people going against the rules of the community. Therefore the only way to treat these people is to go through traditional process, go to a native doctor". Another participant stated that "madness is a spiritual problem because you see the person talking to things only him or her is seeing and even talks to those things. So the person should be taken to a native doctor to cure him of the madness". Another participant, laying emphasis on ascertaining the cause noted thus:

> In treating madness, it is better to go to a traditional healer who will check if it is as result of ancestral curse or man-made. In my community, anybody that sleeps with the sister or brother will go mad. You know, so the best thing to do is to first consult the traditional doctor (Male IDI participant, Ajuona Obukpa, Nsukkka).

These also indicate that there are indeed cultural/traditional factors that affect the choice of treatment for MI.

Religious/Cultural Factors affecting Health Seeking Behaviour for MI

Our focus here is on religious factors that affect health seeking behaviour for the treatment of people with mental illness. The result is presented in the chart below.

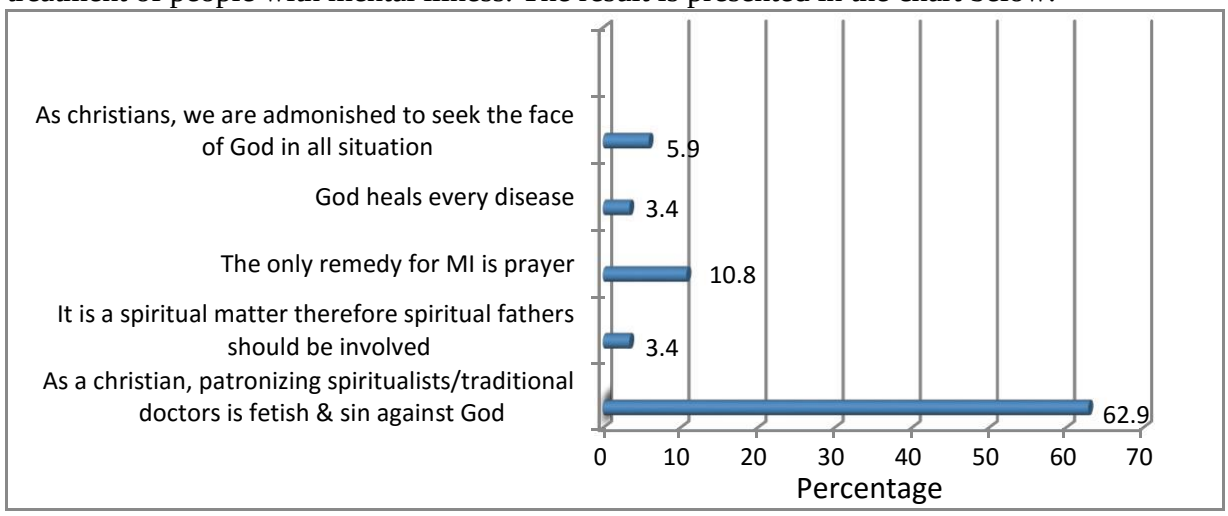

Figure 3: Percentage distribution of respondents by religious factors affecting health seeking behaviour for treatment of MI

In Figure 5 above, about 62.9% of these respondents noted that as Christians, patronizing spiritualists/native doctors is fetish and sin against God while 5.9% believe that as Christians, they were admonished to seek the face of God in all situations. Also about 10.8% stated that the only remedy for the treatment of MI is prayer whereas 3.4% remarked that God heals every disease. Likewise 3.4% asserted that mental illness is a spiritual matter; therefore spiritual fathers should be involved. During the FGD sessions, one of the participants remarked;

> Mostly, as a Christian, I believes that with God all things are possible. Seeking the face of God in all things is my way of doing things. Whatever comes my way, that is any problem that I face, I first take it to God in prayer. So if I have a relation that is mad, I will first seek Gods face (Male FGD participant, Ugbawka, Nkanu, Enugu State).

Another participant, reiterating her faith in God noted that, "believing and having faith in God is the most important thing, that God can take care of every problem". Also an IDI participant demonstrating her belief as a Christian declared that, "she has to seek the face of God first before going to any place. That mental illness is a spiritual, a psychological and an emotional problem. So she would take the person to the church and seek the face of God".

We further evaluated the views of the respondents on socio cultural factors affecting health seeking behaviour for the treatment of MI by cross tabulating with some demographic variables. This is presented in the table 1 below.

Table 2
Socio-demographic Characteristics of Respondents and Socio cultural and economic Factors Affecting Health Seeking Behaviour for MI (% in parenthesis, n= 1200)

Demographic variables	Socio cultural and economic factors affecting health seeking behaviour					Total	Significance		
	Distance to treatment facility	Cost of treatment	Efficacy of treatment method	Attitude of personnel	Access to treatment facility		χ^2	df	p
State									
Enugu	70 (72.2)	373 (55.0)	25 (18.9)	77 (56.6)	55 (35.0)	600 (50.0)	93.274	4	.000
Imo	27 (27.8)	305 (45.0)	107 (81.1)	59 (43.4)	102 (65.0)	600 (50.0)			
Residence							3.563	4	.468
Urban	46 (47.4)	352 (51.9)	61 (46.2)	70 (51.1)	71 (45.2)	600 (50.0)			
Rural	51 (52.6)	326 (48.1)	71 (53.8)	66 (48.5)	86 (54.8)	600 (50.0)	57.568	4	.000
Sex									
Male	28 (28.9)	336 (49.6)	64 (48.5)	56 (41.2)	116 (73.9)	600 (50.0)	52.384	4	.000
Female	69 (71.1)	342 (50.4)	68 (51.5)	80 (58.8)	41 (26.1)	600 (50.0)			
Age		552 (81.4)							
Younger	69 (71.1)	126 (18.6)	128 (97.0)	111 (81.6)	152 (96.8)	1012 (84.3)			
Older	28 (28.9)		4 (3.0)	25 (18.4)	5 (3.2)	188 (15.7)			

Source: *Field Survey, 2011*

Table 2 examined the socio cultural and economic factors that affect health seeking behaviour for the treatment of mental illness. Responses showed that for state, 72.2% of the respondents from Enugu and 27.8% of those residing in Imo State considered distance to treatment facility as the social cultural factor that affect their health seeking behaviour while 55% of those from Enugu and 45% of those from Imo States considered cost of treatment. About 18.9% of the respondents in Enugu and 81.1% in Imo States considered efficacy of treatment method as the affecting factor whereas 56.6% of the respondents in Enugu and 43.4% of those from Imo States considered attitude of personnel as the factor affecting their health seeking behaviour. Likewise, 35% of the respondents from Enugu and 65% of those from Imo states considered access to treatment facility as the factor that affects their health seeking behaviour for the treatment of MI.

Responses on residence show that 47.4% of the respondents residing in urban and 52.6% of those in rural area considered distance to treatment facility as the social cultural factor that affect their health seeking behaviour while 51.9% of those in urban and 48.1% of those in rural area considered cost of treatment. About 46.2% of the respondents in urban and 53.8% of those in rural considered efficacy of treatment method as the affecting factor whereas 51.1% of the respondents in urban and 48.5% of those in rural area considered attitude of personnel as the factor affecting their health seeking behaviour. Likewise, 45.2% of the respondents in urban and 54.8% of those in rural area considered access to treatment facility as the factor that affects their health seeking behaviour for the treatment of MI.

Information on sex show that 28.9% of the male and 71.1% of the female respondents considered distance to treatment facility as the social cultural factor that affect their health seeking behaviour while 49.6% of the male and 50.5% of the female ones considered cost of treatment. About 48.5% of the males and 51.5% of the females considered efficacy of treatment method whereas 41.2% of the male and 58.8% of the female considered attitude of personnel. Likewise, 73.9% of the male and 26.1% of the female ones considered access to treatment facility as the factor that affects their health seeking behaviour for the treatment of MI.

Responses on age show that 71.1% of the younger and 28.9% of the older respondents considered distance to treatment facility as the social cultural factor that affect their health seeking behaviour while 81.4% of the younger and 18.6% of the older ones considered cost of treatment. About 97% of the younger and 3% of the older considered efficacy of treatment method as the affecting factor whereas 81.6% of the younger and 18.4% of the older respondents considered attitude of personnel as the factor affecting their health seeking behaviour. Likewise, 96.8% of the younger and 3.2% of the older ones considered access to treatment facility as the factor that affects their health seeking behaviour for the treatment of MI.

Table 2 contd

Socio-demographic Characteristics of Respondents and Socio cultural and economic Factors Affecting Health Seeking Behaviour for MI (% in parenthesis, n= 1200)

Demographic variables	Socio cultural and economic factors affecting health seeking behaviour					Total	Significance		
	Distance to treatment facility	Cost of treatment	Efficacy of treatment method	Attitude of personnel	Access to treatment facility		χ^2	df	p
Marital Status									
Single	50 (51.5)	405 (59.7)	110 (83.3)	90 (66.2)	99 (63.1)	754 (62.8)	32.488	4	.000
Married	47 (48.5)	273 (40.3)	22 (16.7)	46 (33.8)	58 (36.9)	466 (37.2)			
Level of education							40.784	8	.000
Lower	36 (37.1)	344 (50.7)	73 (55.3)	65 (47.8)		600 (50.0)			
Medium	19 (19.6)	92 (13.6)	3 (2.3)	35 (25.7)		166 (13.8)			
Higher	42 (43.3)	242 (35.7)	56 (42.4)	36 (25.5)	82 (52.2)	434 (36.2)	85.206	16	.000
Religion					17 (10.8)				
Catholic	46 (47.4)	326 (48.1)	20 (15.2)	71 (52.2)		540 (45.0)			
Protestant	23 (23.7)	177 (26.1)	51 (38.6)	32 (23.5)	58 (36.9)	300 (25.0)			
Traditional	0 (.0)	2 (.3)	0 (.0)	0 (.0)		2 (.2)	24.402	8	.002
Pentecostal	26 (28.4)	166 (24.5)	60 (45.5)	29 (21.3)		343 (28.6)			
Jehovah witness	2 (2.1)	7 (1.0)	1 (.8)	4 (2.9)		15 (1.2)			
Income					77 (52.2)				
Lower	25 (25.8)	265 (39.1)	59 (44.7)	49 (36.0)	17 (10.8)	481 (40.1)			
Medium	35 (36.1)	204 (30.1)	41 (31.1)	45 (33.1)	0 (.0)	369 (30.8)			
Higher	37 (38.1)	209 (30.8)	32 (24.2)	42 (30.9)	62 (39.5)	350 (29.2)			
					1 (.6)				
					83 (52.9)				
					44 (28.0)				
					30 (19.1)				

Source: *Field Survey, 2011*

Respondents' marital status revealed that 51.5% of the respondents that were single and 48.5% of those that were ever married considered distance as the socio cultural factor that affect their health seeking behaviour while 59.7% of the single and 40.4% of the ever married ones considered cost of treatment. About 83.3% of the single and 16.7% of the ever married respondents considered efficacy of treatment as the affecting factor whereas 66.2% of the single and 33.8% of the ever married ones considered attitude of personnel. Likewise, 63.1% of the single and 36.9% of the ever married ones considered accessibility as the factor that affects their health seeking behaviour for the treatment of MI.

Information on respondents' level of education show that 37.1% of the respondents with low, 19.6% of those with medium, and 43.3% of those with higher level of education

considered distance to treatment facility as the social cultural factor that affect their health seeking behaviour while 50.7% of the respondents with low, 13.6% of those with medium, and 35.7% of those with higher level of education considered cost of treatment. About 55.3% of the respondents with low, 2.3% of those with medium, and 42.4% of those with higher level of education considered efficacy of treatment method as the affecting factor whereas 47.8% of the respondents with low, 25.7% of those with medium and 25.5% of the respondents with higher level of education considered attitude of personnel as the factor affecting their health seeking behaviour. Likewise, 52.2% of the respondents with low, 10.8% of those with medium and 36.9% of those with higher level of education considered access to treatment facility as the factor that affects their health seeking behaviour for the treatment of MI.

Information on respondents' religion show that 47.4% of the respondents that were Catholics, 23.7% of the Protestants, 0% of ATRs, 28.4% of the Pentecostals, and 2.1% of Jehovah Witnesses considered distance to treatment facility as the socio cultural factor that affect their health seeking behaviour while 48.1% of the Catholics, 26.1% of the Protestants, 0.3% of the ATRs, 24.5% of the Pentecostals and 1% of the Jehovah Witnesses considered cost of treatment. Also about 15.2% of the Catholics, 38.6% of the Protestants, 0% of the ATRs, 45.4% of the Pentecostals and 0.8% of the Jehovah Witnesses considered efficacy of treatment as the affecting factor whereas 52.2% of the Catholics, 23.5% of the Protestants, 0% of the ATRs, and 21.3% of the Pentecostals and 2.9% of Jehovah Witnesses considered attitude of personnel. Likewise, 52.2% of the Catholics 10.8% of the Protestants 0% of the ATRs 39.5% of the Pentecostals and 0.6% of the Jehovah Witnesses considered accessibility as the factor that affects their health seeking behaviour for the treatment of MI.

Responses on respondents' level of income show that 25.8% of the respondents with low, 36.1% of those with medium, and 38.1% of those with higher level of income considered distance to treatment facility as the social factor that affect their health seeking behaviour while 39.1% of the respondents with low, 30.1% of those with medium, and 30.8% of those with higher level of income considered cost of treatment. About 44.7% of the respondents with low, 31.1% of those with medium, and 24.2% of those with higher level of income considered efficacy of treatment method as the affecting factor whereas 36% of the respondents with low, 33.1% of those with medium and 30.9% of the respondents with higher level of income considered attitude of personnel as the factor affecting their health seeking behaviour. Likewise, 52.9% of the respondents with low, 28% of those with medium and 19.1% of those with higher level of income considered access to treatment facility as the factor that affects their health seeking behaviour for the treatment of MI.

In summary, we found that more of the respondents in Enugu state, those residing in rural area, females, younger respondents, those that are single, respondents with lower level of education, Catholics, and those with lower level of income had socio cultural and

economic factors affecting their health seeking behaviour. This is for the fact that they had more concern on the distance to treatment facility, cost of treatment, efficacy of treatment, attitude of personnel, and access to treatment facility.

Strategies for Dealing with the Socio-Cultural Factors Affecting Health Seeking Behaviour on Mental Illness

Here, the focus is to look at the strategies to deal with the socio cultural factors affecting health seeking behaviour on mental illness. This is presented in figure 6 below.

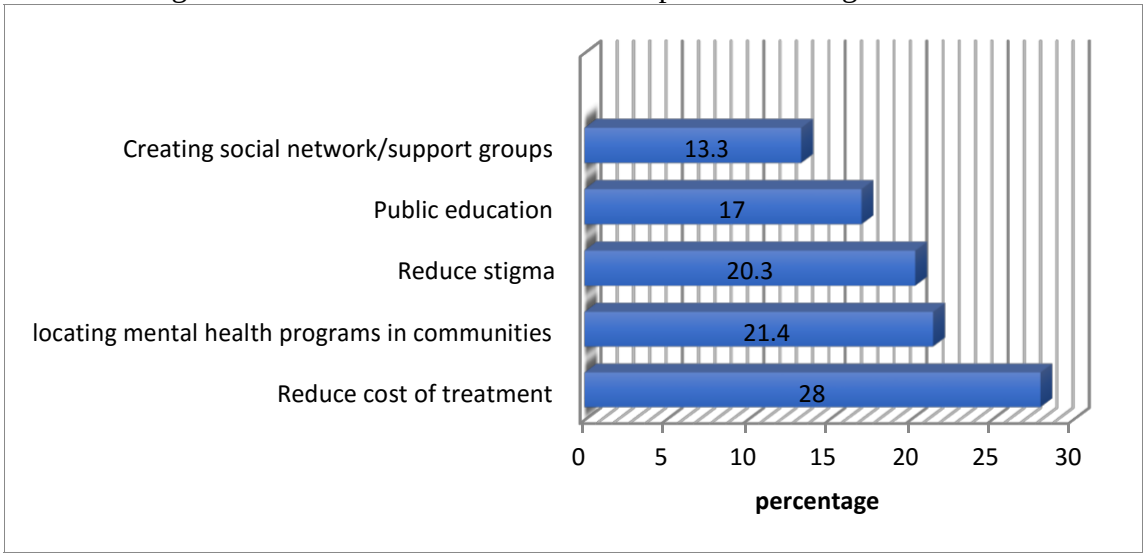

Figure 4: A bar chart showing percentage distribution of respondents by strategies to deal with socio cultural factors affecting health seeking behaviour.

Figure 4 shows strategies suggested by the respondents for dealing with the socio cultural factors that affect health seeking behaviour. The result showed that about 28% of the respondents were of the opinion that cost of treatment be reduced while 21.4% suggested locating mental health programs in communities. Likewise, about 20.3%of the respondents suggested reduction of stigma whereas 17% suggested public education. Only 13.3% of the respondents suggested creation of social network/support groups as a way out. During the FGD, one of the female participants noted thus;

> If only the money that is charged to treat mental illness is reduced, then we can be able to go to a better place for treatment. Why some people go to, may be, the spiritualists is because of the money involved. But you see that at the end one still spend a lot of money. I have a friend whose brother ran mad because of Indian hemp and they could not afford the money to take him to the hospital. They went from one place to the other without success until one of their

> family members helped to take him to the hospital (Female FGD participant, Enugu)

Commenting on reducing stigma, a male case study participant reiterated his experience on stigma. He said thus:

> The worst experience I had about this illness was not the illness itself but the stigma, the avoidance from people. Even when you are in a meeting and you make some contribution, your contribution will not be regarded as being relevant. I have had my share of this thing, you know, even your family members, when you do what ordinarily every other person is doing, yours will be looked at as if it has come back, that is, the illness. Sometimes I feel like running away, changing environment. I think that reducing stigma will really help and also public education (Male Case study, Nsukka).

Another female FGD participant narrating the ordeal of a family in her community and the need for public education stated thus:

> I remembered this family in my community. Their son used to smoke *igbo* without the family knowing. At a time, he ran mad and they were busy accusing a man in their family as being responsible. They took the boy to one spiritualist in a Sabbath church who also helped in compounding the problem. This created serious problem in the family to the extent that they were to go to a shrine to swear. If not for the intervention of a family friend who suggested going to psychiatric hospital at Enugu, the family would go for the swearing. The boy got himself and it was then they knew he smoked Indian hemp. So people need to be educated about this sickness (Female FGD participant, Anara, Okigwe).

These assertions show the different views of the participants on how to deal with socio cultural and economic factors that affected their health seeking behaviour for mental illness.

Discussion

Findings on the factors affecting health seeking behaviour on MI revealed that there are socio-cultural, economic, and religious factors that affect health seeking behaviour. This findings is congruent with those of Rickwood, Deane & Wilson (2007) whose findings indicate that there are individual and structural barriers to seeking professional help and that in general, individual barriers to seeking help from mental health services (i.e.

attitudes, beliefs, knowledge, stigma) have a greater impact on the use of mental health services than structural barriers (such as financial barriers and referral pathways) (Kovess-Masfety, Saragoussi, Sevilla-Dedieu, Gilbert, Suchocka, Arveiller, Gasquet, Younes & Hardy-Bayle, 2007).

The socio cultural and economic factors found to affect help seeking behaviour include cost, accessibility, attitudes of personnel, efficacy, and distance. Cost of treatment was found to be a prominent factor in seeking help in this study. Service users experience financial burden in accessing mental health care, keeping follow-up appointments and paying for treatment. The need to pay for services results in many individuals being unable to sustain treatment, with the continuous use of prescribed medications being necessary to maintain an improved mental state. This finding is similar to studies on the burden of schizophrenia on rural and urban families, and barriers to mental health services utilization in the Niger Delta region of Nigeria (Martyns-Yellow (1992); Jack-Ide & Uys, (2013), which showed that rural families experienced a heavy burden, mainly financial, as most are poor and have less disposable income to pay for transportation and treatment. Another study of caregiver's burden and psychotic patient's perception of social support in Nigeria (Ohaeri, 2001) also showed that users without any form of social welfare net had higher burdens, experienced more family disharmony and poor illness outcomes. Evidence has shown that poverty and the absence of a social welfare net for mental health service users increases the burden of mental disorders, with poor mental health outcomes (Wang, Aguilar-Gaxiola, Alonso, Angermeyer et al (2007), Magliano, Fiorillo, De Rosa, & Maj (2006), Thornicroft, (2007). Studies have shown that there are concerns about cost, transportation or inconvenience, confidentiality, other people finding out, feeling like they can handle the problem on their own, and the belief that the treatment will not help (Mojtabai 2001). Similar concerns have been found in a rural population, with the addition of worry that the care will be unavailable when needed, about being treated unkindly, and not knowing where to go (Fox, Blank, Rovnyak, & Barnett (2001). Gulliver, Griffiths & Christensen (2010) has also found that lack of accessibility (e.g., time, transport, cost) was a prominent barrier particularly in the studies of rural populations. Likewise, some studies have found that the characteristics of the potential provider of help (e.g., psychologist, general practitioners etc.) could be deterrents to seeking help. This included features such as the ability of the provider to provide help, qualities of potential providers, their credibility, and attitude (Helms, (2003), Lindsey & Kalfat, (1998).

Conclusion

Socio-economic status of a person forms part of the factors that influences choice of treatment method. This tends to push people away from seeking help from the treatment method of their choice when they are mentally sick, makes them to go to places where they feel that it is affordable to them and in return show a much higher premature termination; and have more unfavourable impressions regarding treatment.

Finding on influence of social cultural factors on pathways to treatment show that people choose to go to where they have treatment because of some factors. In this study, we found that due to far distance to treatment facility, high cost of treatment, and ignorant of treatment facility majority of the respondents would choose to go to the hospital. Likewise, due to ineffectiveness of treatment method and negative attitude of personnel, they would go to spiritual home/church. Irrespective of these factors, majority of the people chose to go to the hospital for treatment. However, one is left to ponder on the nature of hospitals visited for treatment, whether private hospitals/clinics, health centres, general hospitals or specialist hospitals (Neuropsychiatric).

Far distance to treatment facility may increase the difficulties that people encounter when seeking mental health care. With many individuals experiencing significant poverty and low socio-economic status, far distance and transportation could be a major factor in reducing the numbers of individuals who access mental health treatment. Economic and policy literature have suggested that a major factor that determines the use of health services in general and mental health care in particular is the extent to which individuals have financial resources. Data reflecting the impact of economic factors are inconsistent across the field of mental health services research, particularly among mental health economists.

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