An Ethnography of mental health care practices in Abẹokuta, Southwestern Nigeria

ALABI, TIMOTHY,OLANREWAJU

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Timothy Olanrewaju, Alabi

Department of Anthropology

Durham University

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Author: Timothy O. Alabi

Abstract

In the context of the rising global burden of mental illness, this PhD thesis explores the complex assemblages of mental healthcare practices in Abeokuta, Southwest Nigeria, a city renowned for innovative and eclectic practice in mental healthcare over the last century. The thesis draws on recent work in Medical Anthropology and related disciplines that has in various ways interrogated questions of multiplicity in biomedicine. Building on this literature, the thesis presents an in-depth ethnographic account of the production of medical multiplicity within Aro hospital, a large and well-known psychiatric hospital in Nigeria. The first part of the thesis follows the patient journey through this hospital. It develops arguments about the multiple nature of personhood that is part of shared understandings between staff, patients and caregivers in the hospital, before showing how this understanding of personhood shapes what it means to be a patient, with a particular focus on how understandings of dependency play out within the forms of patienthood that are produced in the hospital. From here, we see how treatment in the hospital responds to these multiplicities of personhood and patienthood, and is itself a set of multiple, distributed practices. The second part of the thesis zooms out to consider multiplicities of different scales and how this shape what happens at Aro hospital. The first focus is the therapeutic landscape in the area around the hospital, and how the practises of biomedicine of the hospital interrelate with those of the religious and 'traditional' healers who are often frequented by patients and caregivers who attend Aro hospital. The final ethnographic chapter situates the practises of staff at Aro within a global context, underlining how connections to an international order produce another form of multiplicity within the hospital.

Title page

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by

Timothy Olanrewaju Alabi

Supervised by

Professor Kate Hampshire and Dr Brown Hannah

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Department of Anthropology

Durham University

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TABLE OF CONTENTS

LISTS OF FIGURES

LISTS OF PLATES

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CHAPTER 1

INTRODUCTION

1.0 Overview

The burden of mental illness in Sub-Saharan Africa is reportedly huge, yet biomedical mental healthcare resources across the continent remain extremely limited, thus generating a significant 'treatment gap' (Abdulmalik et al., 2013, 2014; Amuyunzu-Nyamongo, 2013; Gureje & Alem, 2000; Kohn et al., 2004; Okechukwu, 2020; Vigo et al., 2016). The vast majority of studies on mental healthcare in Africa have focussed on 'treatment gaps', which means that only a minority of those suffering from mental illness might have received appropriate and timely biomedical care (e.g. Abbo et al., 2008; Catherine Abbo et al., 2009; Jack-Ide & Uys, 2013; Kohn et al., 2004; Odinka et al., 2014). Both the concept of, and studies on, treatment gaps have, however, typically failed to interrogate the totality of mental health care that people receive from different spaces and at different times of mental illness experience. In particular, the 'treatment gap' approach tends to overlook the different kinds of activities that may have occurred before, during, and after a mentally ill person is presented for hospital care and those who were never consider the biomedical system.

Building on a small but growing body of ethnographic work in this area (Cooper, 2016; Lovell et al., 2019), this PhD thesis consequently adopted an ethnographic approach to explore the totality of the experience of mental illness in a very particular setting in southwest Nigeria: Aro hospital and its environs. In what follows, I will document the multiple intersecting processes through which mental illness is produced, enacted, and managed in and around one of Nigeria's most celebrated psychiatric hospitals, 'Aro hospital'. Formally known as the Neuropsychiatric Hospital, Aro, Abẹokuta *(*see plate 2*)*, the hospital has a very distinctive historical, social, cultural, and clinical importance that provides a useful lens through which to explore the production and management of mental illness in Yoruba society. This is aimed at improving the understanding of the interaction of the global and the local in mental healthcare more widely.

1.1 The Global Mental Health 'Treatment Gap' and its limitations

Mental illness is both a public health and a social imperative globally. it is believed to be the leading cause of disability and premature deaths globally (Vigo et al., 2016; Whiteford et al., 2013). The term 'mental illness' covers a wide range of complex psychosocial disorders, including depression, eating disorders, and schizophrenia (WHO, 2013). Mental illness is believed to affect at least five percent of all populations at any one time (Patel, 2014: pg778), and one in three people experience some symptoms of mental illness at some point in their lifetime (Vigo et al., 2016). Based on the 2010 Global Disease Burden report on the African region, Charlson et al., (2014) projected that the burden of mental illness would increase by 28% - 198% by the year 2050, across Sub-Saharan Africa, with West Africa expected to be disproportionately affected. An earlier study by Gureje et al., (2006) had estimated the prevalence of mental illness among Yoruba adults in Nigeria to be one in 17 in a year; one in eight across their lifetime with limited care resources available to cope with in the region. Several authors (Adewuya & Makanjuola, 2008; Gureje et al., 2006; Patel, 2014; Ventevogel et al., 2013; Vigo et al., 2016) have argued that the prevalence of mental illness prevalence continues to be underestimated, especially in many African settings.

Individuals with mental illness are thought to be 40% to 60% more vulnerable to other morbidities, disabilities, and, or untimely death than those without such illness (WHO, 2013). A systematic review on the implications of mental illness from twenty-nine countries across six continents, including Africa, found that the majority (65.5%) of studies reported mortality rates more than doubled for those living with mental illness compared to the general population (Walker et al., 2015). Similarly, mental illness increases disruption of social life, impoverishment and psychological pains on family members as well as stigmatization, discrimination and socioeconomic deprivation on the part of the patient (Scheid, 1999; Ventevogel et al., 2013; WHO, 2013; Vigo et al., 2016). Prompt access to quality mental healthcare services and effective therapeutic measures can, however, reduce the burden of mental illness, as early recognition and effective management are widely considered a pre-requisite to mental health promotion (Ali & Iftikhar, 2006; Atilola, 2016; Gittelman et al., 1989; Kakuma et al., 2010). In many parts of the world, and particularly in Sub-Saharan Africa, the 'treatment gap' for mental illness remains reportedly huge, with limited availability and accessibility of biomedical treatment, especially human and

biomedical resources and psychotropic drugs; e.g. see, Gulliver et al., 2010; Jack-Ide & Uys, 2013; Mneimneh et al., 2014; Seedat et al., 2002). I shall discuss the sociocultural and political-economic contexts of health care provision using Nigeria experience in much detail in the next chapter.

In several African settings (including Nigeria), it has been reported that a large number of people in need of mental healthcare never receive it, while those that do often face long delays, especially in the rural settings (Adewuya & Makanjuola, 2009; Burns & Tomita, 2015; Cooper, 2015; Gureje et al., 2015; Keynejad et al., 2017; Kisa et al., 2016; Kohn et al., 2004; Read et al., 2009; Seedat et al., 2002; Ventevogel et al., 2013; Wang et al., 2007). Several factors are identified to contribute to the treatment gap in low- and middle-income countries (LMICs). The factors include unavailability of modern mental care resources (especially staff), lack or non or poor implementation of supportive national policies (Abdulmalik et al., 2014; Gureje & Alem, 2000; Saraceno et al., 2007; Tansella, 2000; World Health Organization, 1998); unequal access to effective mental care due to social stratification (Kienzler, 2019; Okechukwu, 2020; Varma, 2016); poor mental health illiteracy (Altweck et al., 2015; Aluh et al., 2018; Ferris, 2010; Kermode et al., 2009; LeVine et al., 2004) and poverty, among others. In a recent letter to the editor of the International Journal of Noncommunicable Diseases, Okechukwu, (2020) highlighted the shortage of biomedically-trained psychiatrists, poor biomedical psychiatric facilities and funding as the main barriers to mental healthcare delivery in Nigeria. The shortage of biomedical care available for mental illness, especially in the Global South, is crucially important. Although, arguably, a narrow focus on biomedical provision as the only kind of care worth considering is limited, particularly in contexts characterised by multiple, intersecting healing traditions and practices.

Across various African settings, three sources of mental healthcare are commonly acknowledged or identified: biomedical psychiatry (Akyeampong, 2015; Ayonrinde et al., 2004; Erinosho, 1979; Gureje & Alem, 2000; Kilroy-marac, 2019), traditional healing (Adelekan et al., 2001; Chukwuemeka, 2009; Kayode-Adedeji, 2017; Makanjuola & Morakinyo, 1987; Odejide et al., 1978) and 'faith-based' healing (Adegoke, 2007; Asamoah et al., 2014; Burns & Tomita, 2015; Kpanake, 2018; Mathews, 2008; Osafo, 2016; Read,

2019) although, as I will suggest in this thesis, these three are not necessarily discrete or bounded. Studies from parts of Nigeria and Ghana have shown that, despite acknowledging some benefits of biomedical psychiatric treatment, many patients still opted out - due to fear of being dependant on psychotropic drugs and their side effects, lack of possibility of a complete cure, belief in home or personal management, social influence, cost, and preference for non-biomedical treatments, among others (Adeponle et al., 2009; Adeponle et al., 2009; Read, 2012; Seedat et al., 2002). In addition, identification, experience, and history of mental illness are not homogenous across sufferers, locations and cultures (Akyeampong et al., 2015; Bartholomew, 2017; Heaton, 2014; Oloyede, 2002; Ventevogel et al., 2013). For instance, some symptoms, syndromes, and social behaviour indicative of mental illness in some localities are considered 'normal life events' in some others (e.g., see Aina & Famuyiwa, 2007; Bartholomew, 2017; Chukwuemeka, 2009). Ventevogel et al. (2013) explored some cultural understandings and local descriptions of mental illness-related syndromes across four African nations and reported that whereas conditions like depression and anxiety were neither regarded as mental illness nor deemed fit for medical intervention in some settings, they are in some others. Also, context matters in identifying mental illness within same spatial location. For instance, while in some churches, hearing voices and speaking in tongues may be considered normal, even desirable same behaviours might be seen to indicate psychosis in other spatial context, such as a supermarket or hospital. In Nigeria, studies have drawn attention to the multi-causal (natural, spiritual and hereditary) explanations of mental illness identified among Yoruba and Igbo populations (Adewuya & Makanjuola, 2009; Burns & Tomita, 2015; Chukwuemeka, 2009; Jegede, 2005; Osborne, 1969; Prince, 1960a).

Given the huge cross-cultural variation in how mental illness is understood, experienced, and managed, there is a need to move beyond narrow conceptualisations of 'treatment gaps', which tend to ignore non-biomedical healing pathways and what happens before and after a person receives treatment. For example, the WHO's mental health global action plan (mhGAP) has been criticised by some commentators (see e.g., Ecks, 2016; Keynejad et al., 2017; Kohn et al., 2004) for failing to recognise 'private treatment' and the role of traditional and faith healers as key actors, thus not accurately reflecting actual mental healthcare delivery and practices in many non-western settings such as Africa, including

Nigeria. Likewise, a narrow focus on 'recovery', which is also highly culturally contingent and variable (e.g. Hine et al., 2016; Kidd et al., 2015; Mcnamara & Parsons, 2016; Read, 2012) risks foreclosing important consideration of what else is going on before and or what leads to hospital admission, as well as what happens when a patient leaves the hospital. It is these important areas that this thesis seeks to address, moving beyond a narrowly-defined 'treatment gap' to produce a more holistic view of the experience and management of mental illness in Southwest Nigeria. As we shall see, it is an experience that goes far beyond individual patients in clinical settings, drawing in multiple intersecting people, places, practices, and connections.

1.2 Beyond the 'Treatment Gap': Anthropological contributions to Global Mental Health

Although psychiatry remains an essentially biomedical discipline that is largely associated today with pharmaceutical treatments alongside other forms of evidence-based therapy, there has long been recognition that mental health blurs the boundaries between mind and body, and between the medical and the social sciences. What we now think of as 'contemporary psychiatry' began in Europe and was heavily influenced by the European-American cultural view of mental illness, which emphasised individuals' biology, biography, and pathology in identifying mental illness and universal treatment approach (Mihanovi et al., 2005; White et al., 2017). Since nineteenth century, anthropologists and other social scientists have nonetheless noticed and described cultural diversity in the manifestations of mental illnesses and healing (Akyeampong, 2015; Sadowsky, 1997). Anthropologists like W H R Rivers and Prince have been part of psychiatry since its early days, and this trajectory continues to the present day through the work of scholars such as Kleinman and Patel. W H R Rivers' work, entitled 'on mental fatigue and recovery' was published in 1896, (Deregowski, 1998; Slobodin, 1998). Mental fatigue has recently resurfaced in the literature as one of the major mental health challenges among the educated youth in some parts of Africa (e.g. Ebigbo et al., 2014; Ebigbo et al., 2014). Meanwhile, W H R Rivers in this study, explored psychiatric issues with anthropological methods (Mihanovi et al., 2005). Also in 1897, Durkheim published his work on suicide, which sought to understand how the social conditions might trigger or prevent higher rates of suicide among certain social groups.

By early twentieth century, more studies in anthropology were focused on psychiatric subjects and methods, including identifying and describing occurrences, causes, and treatment of mental illness in 'other' cultures, especially in so-called 'primitive' settings (Jenkins, 2018). For instance, James Frazer, in his lecture at Cambridge in 1921, proposed Mental Anthropology as a subdiscipline within Social Anthropology that would focus on the evolution and pathology of the human mind (Frazer, 1922). Frazer (1922) argued that mental anthropologists would produce a 'scientific account' of how the human mind changes and progresses from a 'primitive' to a 'civilised' state. As such, the studies confirmed the existence of mental illness across different cultures, but this was seen as a sign of differences in human psychosocial development rather than a sickness that could affect anybody. Consequently, the practice of psychiatry served as a means of social control rather than a place for treatment, especially across colonised territories (Akyeampong et al., 2015; Heaton, 2014).

By the first half of the twentieth century, 'European psychiatry' had diffused into many parts of the world (e.g., see Akyeampong, 2015; Asuni, 1967; Fanon, 1952; Odejide et al., 1989; Lambo, 1955, 1956, 1963; Fanon, 1952). Studies from different settings however revealed that contexual cultural and social factors could influence both the interpretation of mental illness and treatment outcomes (e.g., Lambo, 1955, 1956, 1963). Bartoli in the 1960s (Kilroy-marac, 2019) argued that psychiatric care becomes more effective only when it resonates with patients' 'sociocultural world'; thus leading some anthroplogists to shift their lens towards ethno-psychiatry. Studies in this period generally sought to document local classifications, interpretations, and manifestation of mental illness in different settings, and how these influenced people's actions and treatments offered to those living with mental illness. Contrary to the early claims of 'European psychiatry' around the universality of mental illness manifestations and categories, evident in Diagnostic and Statistical Manual of Mental Disorders (DSMs) and International Classification of Diseases (ICDs) (Hughes, 1985; Whitley, 2014), anthropologists have emphasised the importance of social, cultural, political, economic and historical contexts in providing meanings for behaviours that are seen as atypical and problematic (Agar, 1973; Caudill, 1973; Maretzk, 1979; Patel et al., 1995; Rapoport, 1963; Ventevogel et al., 2013). These kinds of analyses began to challenge and undermine the applicability of European generalised psychiatric disease classification

and universal approach of treatment which regraded non-western culturally identified symptoms of mental illness as 'culture-bound syndromes' (Jenkins, 2018; Mihanovi et al., 2005)..

In general, anthropological studies cast doubt on claims by previous writers that certain mental health conditions (e.g. affective disorder) were rare among African populations except when exposed to 'western civilisation' (e..g., Carothers, 1951, 1954b, 1954a). For instance, studies from Ghana and Nigeria revealed no significant difference in the prevalence of mental illnesses, albeit that those illnesses were experienced and reported differently; for example, somatically (Akyeampong et al., 2015; Read et al., 2015). In other words, anthropologists have shown that mental illness nosology may vary cross-culturally. For example, while the importation of 'schizophrenia' as a mental disorder category into Africa may have been helpful, especially for therapeutic purposes, it failed to capture the totality of schizophrenia-related symptoms experienced in some African settings (Read et al., 2015). While the field of psychiatry has enhanced our understanding of the organic dimension of mental illness, it was anthropological study that established the nexus between culture and mental illness. Even though most anthropologists cannot diagnose or treat mental illness, arguably, anthropological studies have been vital in challenging the 'excess' of bio-psychiatry (Cooper, 2016). They also provide a corrective measure to culturally inappropriate notions of bio-psychiatry (Nader, 1973), and have helped to elucidate the complexities and dynamism of mental illness in different contexts (Myers, Lester, & Hopper, 2016; Price, Shea, Murray, & Hilditch, 1995).

Anthropologists have also employed a meaning-centred approach to understanding what is considered 'abnormal behaviour', and how others respond to the people displaying symptoms of mental illness (Jenkins, 2018). Robert Edgerton demonstrated this in his work on learning disabilities ('mental retardation') (Edgerton, 1984), noting the substantial cross-cultural variation in explanations, approaches to and treatment of people with learning disabilities. Around the same time, Kleiman developed a concept, the 'explanatory model' (Kleinma, 1985; Kleinman et al., 1978), with similar locus to the meaning-centre approach. Kleinman's concept rests on the basis that illness and treatment are culturally constructed. The term 'explanatory model' refers to 'the complex, culturally determined process of

making sense of one's illness, ascribing meanings to symptoms, evolving causal attributions, and expressing suitable expectations of treatment and related outcomes' (Dinos et al., 2017, p.106). Although the explanatory model was not illness-specific, it became a helpful framework for many anthropological studies to explore the cultural context within which mental illness was experienced and managed. This led to a distinction between *emic* and *epic* approaches (Patel, 1995; Patel et al., 1995). While organisation like WHO continued to work on etic assumptions about the universality of mental illness categories and treatment approaches, based on 'Western biomedicine', many anthropologists sought to explore cross-cultural approaches and conceptualisations of mental illness, especially in non-western settings (Maretzk, 1979). Aetiological explanations for mental illness also vary cross-culturally. The study in Tonga by Mike Poltorak, for instance, illustrates how religion (Christianity) influences the conceptualization of mental illness by connecting mental illness with individuals' social and moral lives (past, present, or future). As such, mental illness is construed as punishment for wrong deeds to the church or fellow human beings and, therefore, highly stigmatized (Poltorak, 2016). Even though mental illness is often explained based on organic causes in America, some anthropologists have sought some possible socio-political and socio-economic causes. For instance, Martin (2009) suggested that some affective mental disorders, such as depression in California and New Jersey (USA), were rooted in socioeconomic demands that emphasise competition, individualism, and capitalism. Among the Yoruba of southwest Nigeria, Erinoso & Oke, (1994) identified three causational disease models for mental illness in Yoruba society, comprising supernatural, preternatural, and natural models. Jegede's (2002) later work among this same cultural group suggested a fourth causal explanation: heredity. Some other studies have identified similar causal explanations in different African societies. For example, some studies across the west, east, and southern Africa have highlighted the belief that mental illness can have supernatural causes (through curses, violations of taboos, or deities) and are thus amenable to treatment by religious or traditional healers that deal in the supernatural. In some cases, mental illness is believed to be an omen to become a spiritual healer (Aghukwa, 2012; Bartholomew, 2017; Campbell-Hall et al., 2010; Gatarayiha et al., 1991; Kpanake, 2018; Monteiro et al., 2013; Patel, 1995) .

Notably, increased understanding of the cultural influence on local aetiologies, classifications, and treatments did not only change the mode of practice but also provided other perspectives for viewing mental healthcare, especially in the global south. The likes of Thomas Lambo in Nigeria, and Margaret Field in Ghana, for example, challenged the previous existing etic psychiatric perspective and changed the narratives about the practice in those localities (Akyeampong, 2015; Heaton, 2011; Leighton et al., 1963; Read et al., 2015). Subsequently, the bond between psychiatry and anthropology has become stronger as many scholars (not just non-anthropologists) started using anthropological methods and theories for mental health-related studies (e.g., see Leighton et al., 1963; Patel et al., 1995; Patel, 1995; Prince, 1960a, 1960b). Beyond its methodological contribution, the field of anthropology has broadened the horizon of the field of psychiatry by drawing attention to the importance of cross-cultural disease classification, analysis, and the notion of recovery (Jenkins, 2018; Kleinma, 1985; 1987). Nonetheless, the anthropology of mental healthcare took a new turn in the late twentieth and early twenty-first centuries with the idea of transnational healthcare and global mental health.

The last quarter of the twentieth century ushered in rapid social development and transformation due to technological advancement, globalisation, and neoliberalism, among other international policies which directly and indirectly impacted healthcare practices across the globe, including mental healthcare. In the late 1970s and early 1980s, the western countries, especially America, developed and approved several new pharmaceuticals (magic bullets) for treating mental disorders (Frank et al., 2005); and the free global market made these 'magic bullets' available even in places where other forms of mental healing were reportedly thriving (Ecks, 2014; Jenkins, 2018). Globalisation suggests that the whole world shares, if not the same, a similar socio-political and economic environment rooted in neoliberal ideology (Edelman & Haugerud, 2005). In the case of mental healthcare, this includes the adoption of international policies such as 'translational healthcare' with the aim of making healthcare widely available and accessible across all nations (Kirmayer & Pedersen, 2014; Lambo & Day, 1990). The idea of transnational healthcare notwithstanding, neoliberalism, which emphasises personal and private procurement of healthcare services deepens inequality between the rich and poor in terms of access to basic needs, such as quality healthcare (Homedes & Ugalde, 2005;

Teghtsoonian, 2009; Williams & Maruthappu, 2013). A major effect of this is that healthcare became seen as 'commodity' to be bought by those that can afford it rather than a 'right' or basic need for all and sundry irrespective of their socioeconomic status. As such, inability to procure effective mental care thus exacerbates 'treatment gap' and further widens the gap between the poor and rich people or communities (Kirmayer & Pedersen, 2014; Kohn et al., 2004). In this context, global mental health emerged as a new effort to 'scale up' access to mental healthcare, especially in resource-poor settings (Jenkins, 2018; Patel, 2007a; 2007b; Prince et al., 2007), and has become an 'object of study' in its own right for anthropologists of mental health (Lovell et al., 2019 p.520).

Although global mental health is relatively new in the field of mental health, it has stirred tumultuous reactions that brought significant changes in how mental healthcare is researched and practiced both in the fields of anthropology and psychiatry (Ecks, 2016; Jain & Orr, 2016). The concept of 'global mental health' was coined in 2001, and the field of global mental health developed in 2007 with the goal of developing and facilitating efficient modes of improving access to 'evidence-based' treatment through approaches such as 'task-shifting' or collaborations among different stakeholders to improve the lives of those living with mental illness irrespective of their location (Bemme, 2019; Bemme & Kirmayer, 2020; White et al., 2017). Since its emergence, anthropologists have contributed to the field of global mental health in various ways. From a historical perspective, some anthropologists have described this field as another transitional stage of globalisation (see Lovell et al., 2019, p.521-25). Other frontiers in the field of global mental health e.g., Vikram Patel and Kleinman claim that this new field is an attempt to develop an effective cross-cultural or culturally sensitive psychiatric care that will cater for all rather than relegating cultural influences in the art of care (Kleinman, 2009; Patel, 2012, 2014). For instance, Poltorak's (2016) ethnographic account demonstrates that Tonga's psychiatric practices in recent times reflect some features of global mental health, especially its emphasis on pharmaceutical drugs. However, further observation shows that the development of Tongan psychiatry was also internally influenced, essentially built on the personal influence of a famous practitioner – Puloka, and his ability to adapt biomedical nosology and therapy to the local cultural context (ibid). A related view portrays global mental health as a virtual place where different localities and cultures meet and together form a 'community'. This

view, and as this thesis will show suggests that, different people, organisations, and nations are continuously becoming homogenous through unified psychiatric policies, nosology, and therapeutic goals and practices of the global mental health (e.g., see. Lovell et al., 2019).

Others have examined the major schools of thought – the protagonist and antagonist in the global mental health field – with some seeking to reconcile the two (Cooper, 2016). Some anthropological studies have considered the seemingly universal classification and treatment ethos adopted by global mental health but from a meaning-centre approach. Those that share this perspective are often critical of the global mental health for exalting Euro-American nosology and therapeutic methods above other cultural interpretations (Jenkins, 2018; Sood, 2016). Others lament the ways that informal and non-biomedical elements of care (including from family, non-specialist treatment, and traditional healing) have been overlooked in much discourse on global mental health (Ecks, 2014). However, some anthropologists of global mental health have demonstrated that anthropological work can help resolve some contradictions within this field (Cooper, 2016; Ecks, 2016; Jain & Orr, 2016). To this end, some researchers have sought to draw the attention of stakeholders, especially policymakers and practitioners, to the sociocultural factors that enhance or inhibit the provision of effective mental healthcare globally. Read (2012) exemplifies this in her study among rural dwellers in Ghana. Read's accounts suggest that awareness of biomedical psychiatry and the potential benefits of psychotropics notwithstanding, people may choose to ignore mental therapeutic care that is incongruent with the culturally imbued notion of recovery.

The focus on global mental health as an object of study in its own right has also been associated with (and even precipitated) larger methodological shifts precipitated changes within the wider discipline of medical anthropology (Lovell et al., 2019). The last couple of decades witnessed a shift away from a focus on the 'exotic other' and ethnopsychiatry, towards new global structures and institutions that shape the production and treatment of mental illness around the world. This move has opened up new kinds of field-sites around the world, from large psychiatric hospitals to community mental health programmes, to NGOs and large multilateral organisations like WHO. Anthropologists now increasingly focus on socioeconomic factors and power relations shaping mental illness and care, recognising

global connections and assemblages than reifying 'local cultures' as bounded and removed from geopolitical processes, including colonialism.

Several researchers have drawn attention to the multiplicity of global mental health, which is better understood as a vast assemblage of practices rather than a single social phenomenon (see, for example, the work in India of Varma (2016) and Poltorak (2016)). Anne Lovell and colleagues note that global mental health is a collection of several events including, history, international political relations, knowledge, technologies, and social groups from far and near across the globe (Lovell et al., 2019). As such, mental health now is beyond an entity that can just be studied in one direction, for it comprises both local and global dimensions, production and consumption dimensions, political and social dimensions, and moral and medical dimensions, to mention but a few.

1.3 Situating this thesis

Building on the above discussion, the ethnography presented in this PhD thesis serves to demonstrate: (i) that the anthropology of global mental health is a continuation of the anthropology of mental health, which seeks to explore sociocultural factors that influence the understanding of mental illness and its treatment; and (ii) how multiplicity of mental healthcare is produced through an assemblage of 'global practice' and 'local understanding' in and around Aro hospital in southwest Nigeria.

This thesis demonstrates that global and local practices are two different but inseparable features of the current mental healthcare. The mental healthcare practiced in Aro hospital reflects global mental health, both in principle, through adoption of a 'scientific practice' or 'western approach', and in practice, particularly through the use of pharmaceutical products. Nevertheless, this care practice was nuanced by multiple contextual, sociocultural, and economic factors. This thesis emphasises the roles of history and local understanding of the person and interpersonal relationships in identifying and treating mental illness. As will be seen, mental illness remains a social phenomenon that is *made* and *shared* between and among several individuals. This understanding provides the basis for mental healthcare in this context. Developing from the meaning-centred approach, I will show that 'local culture' remains crucial to the enactment and management of mental

illness, but that it does so within a complex set of relationship between global and local practices.

The ethnographic account in this thesis not only supports the multiplicity of global mental healthcare (Lovell et al., 2019) but also presents the production and essence of mental healthcare multiplicity at different scales. Mental healthcare is a not a single phenomenon: practices at Aro hospital intersect with and are shaped by the local therapeutic landscape (of faith healers, 'traditional' healers, family carers, etc.) and by global standards, resources and technologies. Understanding the different scales at which multiplicity plays out is another key contribution of this thesis.

This study was guided by this overarching question: how was mental illness produced, enacted, and managed in and around Aro hospital in southwest Nigeria? This was further down into a series of more specific research questions:

i. How are 'abnormal behaviour' and mental illness produced, identified and categorised in the context of Southwest Nigeria, and how does this intersect with notions of 'personhood'?
ii. Through what processes and procedures do people become 'patients' at Aro hospital, how is patienthood enacted, and do people move between categories of in-patient, outpatient, and non-patient?
iii. How is mental healthcare currently practiced in Aro hospital, and how is psychiatric practice inflected by the local social, cultural and economic context?
iv. How do staff, patients and their families at Aro hospital interact with 'alternative' forms of care locally available ('traditional', faith-based, etc.), and to what extent can/should bio-psychiatric care be bracketed?
v. How do Aro hospital staff perceive and position their current practice within the global and local contexts of mental healthcare?

1.4 Structure of the thesis

The rest of the thesis proceeds as follows: Chapter 2 describes the research methods employed to carry out the study. It provides a description of the study location, research

design, methods of data collection, data management and analysis. It also covers research ethics and fieldwork approval.

Chapters 3-7 then address each research question in turn. Chapter 3 traces the processes through which individuals become designated as 'mentally ill'. My ethnographic data show that *becoming mentally ill* occurs within the context of social relations and understanding of personhood. Personhood in Yoruba society is *multifaceted* (see also Akiwowo, 1980; 1991; Comaroff & Comaroff, 2001; Kpanake, 2018; Makinde, 1988; Morakinyo & Akiwowo, 1981) and it is the loss of multiple aspects of personhood that precipitates the process of identifying someone as suffering from mental illness. As I will show, this process usually starts with family and friends, before patients are taken to Aro and diagnosis is confirmed by hospital staff.

Chapter 4 explores the processes of '*becoming a patient'*, speaking to the second research question. The chapter reviews the existing literature on patienthood, especially Parsonian Sick Role theory, patient agency, and 'assemblages' of practice (Barbot, 2006; Berg & Bowker, 1997; Lupton, 1993, 2013; Parsons, 1951, 1975). It then plots patients' journeys before, during, and after they enter Aro Hospital. The ethnographic accounts in this chapter demonstrate that patients are 'made' through a series of social processes, drawing in various human and non-human agents. The chapter also demonstrates that, although the making of patienthood *starts* in the hospital, it does not end there but can last for a lifetime. 'Becoming a patient' at Aro thus entails a life-long commitment, shifting often back and forth between categories of 'inpatient' and 'outpatient' but remaining, in one way or the other, 'one of ours'. Mental hospital patienthood is characterised by very limited agency, in contrast to some recent ideas about 'active patienthood' (e.g., Barbot, 2006; Landzelius, 2006; Lupton, 2013).

Chapter 5 describes mental healthcare as practised in present-day Aro hospital, in which biomedical practices are shown to be deeply embedded in the wider sociocultural context of Southwest Nigeria. The assemblages of practice observed in Aro are distributed across its multiple departments and cadres of clinical and non-clinical staff. Though apparently disparate in some senses, they also 'hang together' in attempting to restore multiple facets of 'damaged' personhood described in chapter 3.

Chapter 6 considers the wider therapeutic context in which Aro Hospital sits. My fieldwork data show that treatment at Aro hospital is not exclusive: many patients move between the hospital and other kinds of healers in ways that blur and challenge the boundaries of 'biomedical' and 'traditional' practice. In this chapter, I describe other sources and their practices especially the *Ibilẹ* ('traditional') and faith-based (Christian) psychiatric settings, exploring how and why people patronised multiple sources of care in a way that refines our understanding about medical pluralism and medical syncretism.

Addressing the final research question, Chapter 7 demonstrates that Aro hospital staff are torn between a pride in the distinguished history of Aro hospital as a ground-breaking 'experiment' in collaboration between Western Biomedicine and 'traditional' Nigerian forms of healing, and a desire to be part of 'global best practice' that has little room for 'crude' and 'unscientific' methods. Drawing on ideas of improvisation and hegemony, this chapter describes how the Aro hospital staff view the history and current context of mental healthcare practices in Aro hospital and the surrounding area, tracing the very particular ways that 'biomedical' and other forms of healing have been deeply interwoven for more than 60 years.

Finally, Chapter 8 revisits the overall research question: how mental illness is produced and managed in and around Aro Neuropsychiatric Hospital, Abẹokuta to reflect how the history, culture, globalisation have imparted mental healthcare practices in the study location. The chapter highlights the key contributions of the thesis, and also notes my thoughts on the future ethnographic research both in Aro hospital and mental healthcare practices in general.

CHAPTER 2

STUDY SITE AND METHODOLOGY

2.1 Study context

This section provides a short overview of the wider political, socio-economic and healthcare context (national and regional) in which the research took place.

2.1.1. National context

Following the discovery of oil, and 'oil boom' in the late 1960s and 1970s, Nigeria in its early post-independent decades witnessed economic prosperity, which underpinned various developmental plans (Emmanuel, 2019; Falola & Heaton, 2008). Despite a brutal civil war between 1967 and 1970 in which many lost their lives and many public infrastructures were damaged, the economic prosperity resulting from oil sales during this period enabled mass infrastructural development as more schools, barracks, and airports among others were built and the existing ones renovated (Falola & Heaton, 2008). During this oil boom period, government also built new healthcare facilities across the nation in order to expand access and availability of care to the population (Koce et al., 2019). As Fig. 1 shows, the Nigerian public healthcare system was organised into a three-tier classification, with primary, secondary and tertiary facilities and funding provided by the Local, State, and Federal government respectively (Asuzu, 2005; Iheanacho, 2014; Koce et al., 2019).

However, by the late 1970s and into the 1980s, the economic situation in Nigeria declined, which had impacts on public healthcare funding and provision. By the 1970s, oil had become the only major revenue source for the Nigeria state, accounting for over eighty percent of the total national income (Falola & Heaton, 2008), with other sources of gross domestic product (GDP) dwindling and neglected. This led to what some scholars described as 'a fluctuating GDP' for Nigeria's economy, highly dependent on global oil prices and demand, resulting in undependable and unstable growth (see Dauda, 2011). When global oil process fell in the late 1970s, the impact on Nigeria's economy was severe.

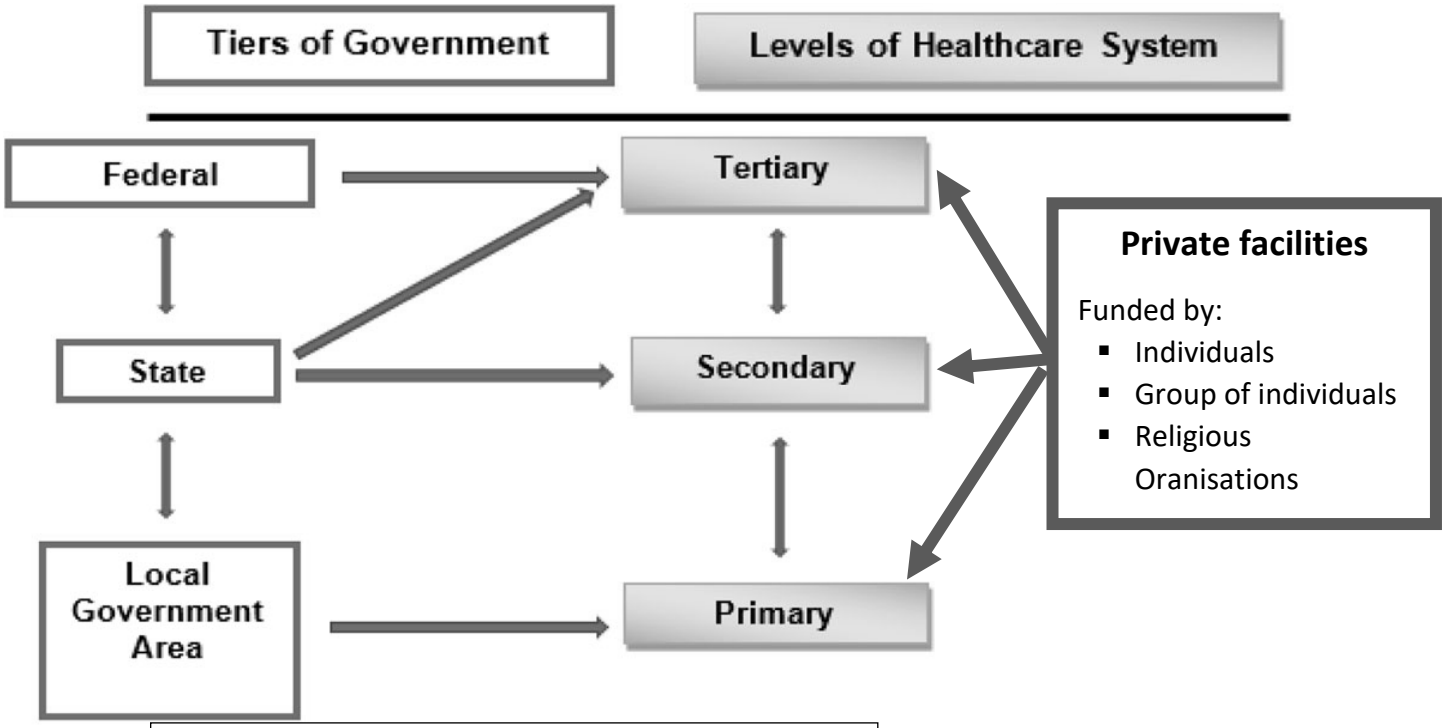


Figure 1: Nigeria healthcare system adapted from Koce et al., (2019)

At the same time, there were reportedly high levels of corruption and misappropriation (Falola & Heaton, 2008), with Nigerian government officials allegedly converting and diverting public funds into private purses. Some scholars have claimed that vast resources were directed to economically questionable projects during the oil boom, which came at the expense of proper investment in infrastructural development and adequate funding of government agencies including education and health sectors (Akyeampong, 2015; Falola & Heaton, 2008; Odejide et al., 1989).

Investment in public healthcare suffered directly as a result of the poor national political-economic policies. For instance, Ogunbekun et al., (1999) noted that federal government allocation for health dropped to less than 2% from 3.5% in the 1980s and 1990s while hospitals' subventions from the Federal Ministry of Health dropped in 1991 to 44% from 85% in the late 1980s. The Nigerian national healthcare system is facing multiple challenges across the country, with low levels of funding that impact on the day-to-day running (Lambo, 1982; Obansa & Orimisan, 2013; Uzochukwu et al., 2015). Many Nigerian public hospitals still carry out their operations in old and sometimes dilapidated infrastructure, and with deficient basic medical equipment including laboratory and human resources, coupled with

other social and administrative bottlenecks. Frequent industrial action and labour turnover, associated with poor working conditions and remuneration of staff, further hampers efficient healthcare delivery across the country (Koce et al., 2019; Ndukaeze, 2014).

Under-investment in the public healthcare system led both providers and patients (those that could afford it) to turn to private provision. Profit-oriented and privately-owned healthcare establishments began to proliferate in the 1980s, and have now become an integral part of Nigeria's healthcare system (Ogunbekun et al., 1999; Obansa & Orimisan, 2013; Olakunde, 2012). As well as providing higher-quality care for consumers who can afford it, working private facilities also offered opportunities for medical staff to supplement the poor remuneration from public establishments. The precise number of private healthcare currently operating in Nigeria is not known, but it is growing rapidly. It is however not clear the extent to which this proliferation is helping to meet the health needs of Nigeria's fast-growing population, or whether it is taking staff and resources away from the public system.

Presently, Nigeria has an estimated population of over two hundred million and with estimated GDP of about three hundred and seventy-five billon US dollars and ranks among the lower-middle-income countries (Aidi et al., 2016; Statista, 2022; Worldometer, 2022). Poverty is widespread and growing, with high inflation and continuing devaluation of Naira. For instance, official data from Nigeria's National Bureau of Statistics cited in a World Bank Bulletin show that 39.1 percent of Nigeria's population lived below the international poverty line – 1.9USD while another 31.9 percent lived on between 1.9USD to 3.2USD in 2018/2019 (Worl Bank, 2021). Currently, a 25kg bag of rice (a staple food across much of Nigeria), sells for about twenty-five thousand naira, almost equivalent to the monthly salary of a federal government worker on a low cadre (minimum wage). The situation has been compounded by social upheavals such as terrorism and banditry, coupled with global economic recession and the COVID-19 pandemic, which have significantly increased the poverty, unemployment, and inflation rates in Nigeria (MacrotrendsLLC, 2022; National Bureau of Statistics, 2020; Statista, 2022). This has direct consequences on livelihoods and wellbeing, including the ability to afford healthcare, which typically requires 'out-of-pocket' payment (Alloh & Regmi, 2017; Burns, 2015); it may also impact directly on disease burdens, especially mental illness

(Angermeyer et al., 1998; Deboutte, 2016; Ekhator-Mobayode & Abebe Asfaw, 2019; Kienzler, 2019).

2.1.2 Regional context and the Yoruba

Nigeria is a very diverse country, with more than 250 ethnicities and languages, mapping broadly onto religious affiliations. The major ethnic grouping in the north of the country is the Hausa/Fulani, who are predominantly Muslim. Igbo-speaking people in the southeast are mostly Christians and practitioners of tradition religions, while southwest of the country – where this research took place – is dominated by Yoruba-speaking people, with both Christianity and Islam coexisting with various traditional religious beliefs.

The Yoruba are regarded as the largest ethnic grouping in Nigeria and one of the largest in West Africa, with a long and celebrated historical civilisation and urban development (Agai, 2017). The Yoruba idea of city development and urban lifestyle can be dated back to the iron age (about 500 BC) and, by the eleventh century, the Yoruba had developed some great cities with dense populations that were overseen by a well-organised political organisation, (Obateru, 2006). Obateru further notes that some Yoruba cities such as Old Oyo, Ijebu-Ode, Benin City and Ondo have been on the world 'map' as great cities as far back as the 15th century. In the present, the Yoruba remain primarily an 'urbanised' people whose social life is built around becoming a full and accepted member of his/her city. Obateru succinctly put the Yoruba view of city and city lifestyle as follows.

> 'The permanent home of the Yoruba man [*sic.*] is the city: there he builds his permanent residential dwelling. No Yoruba man ever says he comes from a village. His pride is deeply hurt if you characterise him as a villager or countrysider. Every Yoruba man is an urbanite, even if he resides in a distant village of 15-25 kilometres from the city for the greater part of the year for agricultural production…' (Obateru,2006 pg.102).

The city has strong sociocultural, political-economic, and health-related significance among Yoruba people. Gregariousness is socially valued, and Yoruba often claim they prefer to live in the company of their kinsmen and (with the obvious exception of farmers) engage in city-based economic activities (Murphy & Leighton, 1963; Obateru, 2006; Trager, 2001).

The importance of the bond between people and their cities is also reflected in the Yoruba lexis regarding one's nativity[1] otherwise known as 'hometown' or 'native town' in Nigeria [2]. The Yoruba language usually frames such discussion in a way that portrays that persons *belong* to a city, or as a 'child' and of the city 'parent', rather than the city belonging to persons. For instance, to ask about a person's native town, the Yoruba would say *ọmọ ilu wo ni ẹ* which literally means: you are a 'child' of which city? or which city were you born to? (Leighton et al., 1963).

The Yoruba also attach magico-religious importance to their cities. There is a belief that there are 401 *orisa*: deities who mediate between *Olodumare* (God) and humans, with each deity having its local and territorial attachment. These deities, according to Obaetru are classified into four, namely 'national deities', 'ethnic deities', 'house deities' for those in the city' and 'personal deities' (Obateru, 2006 pg.337). In '*Psychiatric disorder among the Yoruba*' by Leighton, Lambo and their colleagues, this belief was described as 'unseen spirits' which their participants claimed that were responsible for 'success', and protection from 'sickness' and so forth in their locale (Leighton et al., 1963).

A closer look at some existing literature suggests that Yoruba ideas about bonds between cities and people may have significant influence on personal and public health as well as healthcare care provision and health-seeking behaviour. For instance, a person's gregariousness could easily make them susceptible in the event or outbreak of contagious diseases. City lifestyle could also complicate the process of choosing healthcare since the 'family' and 'friend' are often part of decision making even on some personal matters. Even though the traditional Yoruba city structures vis-à-vis 'city lifestyle' are now changing due to industrialisation, globalisation, migration, acculturation, western education, and paid employment among others (Falola & Heaton, 2008; Akintoye, 2014), the belief in the possibilities of a city providing protection has not been totally eroded among the Yoruba, and in some cases, the bonds between people and their native city is modified rather than

[1] **Nativity** also refers to as native town or city as conceived by the Yoruba is not necessarily a place of birth or residence for so long, but a place (city/town) believed to have been founded by one's lineage ancestor.

being annihilated. For example, Alabi & Aliyu, (2022) note that people of Akinlalu in Osun state still found refuge from external attack and pestilence in their town that was believed to be under protection of River Opa and Oloke. Studies have also shown that some Yoruba people who reside in other cities such as Lagos maintained bonds with their native city through various descendant union associations and *Aso ebi* (e.g., see Familusi, 2010; Ogbechie & Osemenshan, 2015),

In relation to the subject matter of this thesis, it is important to note the possible implications of Yoruba cultures and worldviews on healthcare utilisation. Studies on referral across various settings have noted that local sociocultural beliefs and practices can be more influential than formal rules (e.g., Koce et al., 2019; Okoli et al., 2017). In theory, in Nigeria, patients are supposed to be referred (if necessary) from primary healthcare providers to secondary facilities and from there, if need be, to the tertiary level. However this is not so in reality (Koce et al., 2019). A study of 1,416 patients at the University of Ilorin Teaching Hospital, a Yoruba dominated city in Kwara state, showed that more than 92% of the respondents neither entered from the lower level of care nor were referred by a competent healthcare professional (Akande, 2004). Another study by Okoli *et al.* (2017) also reports that patients are likely to jump referral procedure and present themself at the higher level of care. This practice is often referred to by scholars as 'self-referral', but in Yoruba contexts is better understood as relating to relations shaped by living in urban spaces where friends and family have significant influence on a person's behaviour.

The above notwithstanding, some studies on mental healthcare help seeking among the Yoruba indicate that perceived aetiology and the social networks of sick people, influence choice of healthcare more than professional recommendation (e.g., see Adewuya & Makanjuola, 2008b; Agara et al., 2008). In conclusion, the above has shown both the national and regional contexts for the health care provision in Nigeria. The combined influence of the two contexts on psychiatric healthcare provision and practices in the study area is discussed further in the next section.

2.2 The study site

The Aro hospital community, in the town of Abẹokuta (the capital of Ogun State, southwest Nigeria), was purposively selected for this fieldwork due to its history of traditional mental healing homes as well as hosting the foremost and most famous psychiatric specialist hospital in Nigeria (Akyeampong, 2015; Asuni, 1967; Heaton, 2011; Leighton et al., 1963; Osborne, 1969; Prince, 1960b). Aro hospital started in 1944 as a prison facility at Lantoro, Abẹokuta, and as an extension to Yaba psychiatric asylum in Lagos in southwestern Nigeria, and was made famous in the 1950s and 60s by its pioneering approach to integrating biomedical and 'traditional' forms of treatment and care.

The first asylum in Nigeria was built in 1903 at Yaba, Lagos and another one in Calabar, southern Nigeria, with others following. As in other colonial asylums, no treatment took place in any of the Nigerian asylums, with inmates' health conditions often deteriorating owing to overcrowding and poor facilities. This continued until the late 1920s, when a general practitioner doctor posted to Yaba asylum proposed medical treatment (Akyeampong, 2015; Odejide et al., 1983). The increased number of mentally ill people as a result of repatriated soldiers of the World War II thus led to the opening of more asylum centres, and some positive outcomes of the trial treatment recorded at Yaba asylum encouraged deployment of medical personnel and equipment to various asylum prisons across Africa (Akyeampong, 2015; Gatarayiha et al., 1991; Read et al., 2015).

To decongest the Yaba Asylum, a few patients considered to be the most 'notorious' were transferred to the former administrative prison at Lantoro, Abẹokuta with a handful of medical attendants to supervise them (Asuni, 1967; FNPHA, 2018; Ogedengbe, 1986). At the time, both the staff and public held the notion that the Lantoro facility was a home of criminal and convicted inmates, to the extent that in 1946, the first time a patient without a criminal record was admitted was noted as a remarkable event in the historical account of the institution; it remains today on their webpage (FNPHA, 2018). Perhaps, the criminal tag came about because admission into Lantoro facility was not voluntary but by court order according to the Lunacy ordinance of 1912 (Odejide et al., 1983; Ogedengbe, 1986).

Figure 2: Map of Nigeria showing Abeokuta in the southwest **Source:** https://www.worldatlas.com/maps/nigeria

Efforts and recommendations had been severally made from within and outside Nigeria to build a facility that could provide better care and improve the condition of the mentally ill patients, at Yaba since the early part of the 1900 (Heaton, 2011). For instance, *Alake,* the supreme king of the *Egba* land, donated 732 acres of land located on the Lagos-Abẹokuta route for the creation of a treatment-based facility for the people living with mental illness in the 1930s (Asuni, 1967; FNPHA, 2018). The call to build a new facility was, however, ignored by the colonial rulers. One of the responses of the government medical director in 1926 stated that:

> 'If government proposes to make itself responsible for the care and maintenance of all persons who are *so* useless to their friends and relations, and whom an alienist might classify as 'lunatics', considerably more than a million pounds a year would probably be required for the erection and

> maintenance of the necessary institutions. His Honour is not therefore entirely convinced of the desirability of contemplating action on a large scale.' (Heaton, 2011, p. 280).

In the run-up to the independence in the 1950s, the construction of the long-awaited 500-bedded neuropsychiatric specialist hospital started on the donated site, nearby the village of Aro, as it is famously known today (Asuni, 1967). Aro hospital started its operation at this permanent site with four principal wards (two wards each for male and female), together housing around 200 patients, and the Lantroro facility became seen as an Annex (see Asuni, 1967; Erinosho, 1979).

By the mid-1960s, according to an account by Asuni written in 1967, Aro hospital community already had several units and departments, including wards for inpatient admission, a pharmacy where drugs bought by the hospital were kept and resold to patients, a laboratory for medical tests, outpatient unit, and an Occupational Therapy Unit. There was also a cafeteria, where inpatients' meals were prepared and served; staff quarters to house the workers; a psychiatric postgraduate nursing school; students' hostels and a medical library. Asuni also noted a laundry unit and electrical unit for hospital's beddings maintenance and electricity/electrical respectively. A mini filling station for the use of hospital and staff, administrative buildings for the principal officers and staff offices, outpatient unit, psychogeriatric unit, clinical psychology, and social work, described at the time remain part of this hospital community (ibid).

The staffing process started while the construction of Aro hospital was ongoing, and a number of local people were employed and took up positions in the major offices. The foremost British-trained Nigerian psychiatrist, Thomas Adeoye Lambo (1923-2004) returned from England in 1954 and was employed to take over the affairs and oversee all the mental healthcare activities in Abẹokuta, including the ongoing Aro hospital project (Akyeampong, 2015; Heaton, 2011; Ogedengbe, 1986; Jegede, 1981). Lambo opened Aro hospital for public use with the assistance of two nurses and a chief nurse officer posted from Lantoro, before others later joined them (Asuni, 1967, 2009). At that time, there was no place for inpatient admission because only a few buildings were ready; however, Lambo met with the political

elites in Abẹokuta and made arrangements for patients to be accommodated in local villages and attend the clinic on a daily basis (Asuni, 1967).

It is important to understand Thomas Lambo's practice at Aro hospital within the wider historical context of the development of psychiatric care in Africa. The practice and writing of the early 'psychiatrists' who also doubled as colonial psychiatrists supported not only the racial ideology of cultural superiority of the colonial rulers, but also served as a tool for instilling social order across African colonies rather than 'objectively' interrogating mental illness (Akyeampong, 2015; Mahone & Vaughan, 2007; Sadowsky, 1997). The concept 'African mind', as reflected in the works of Carothers, Bruce Home and Robert Brown among others presumed that African are biologically and psychologically inferior to the Europeans. Early colonial psychiatrists also claimed that 'cultural conflict' – exposure to European culture was the major cause of mental illness .among the Africans (Carothers, 1951, 1954a, 1954b; Heaton, 2014; Sadowsky, 1997).

The narratives around psychiatric practices in Africa changed significantly in the 1950s and 1960s. The colonial racial explanation of psychiatric conditions later became weakening as some of the colonial practitioners and writers such as Frantz Fanon became critical of the colonial psychiatry while others like Carothers became liberal after encountering some African settings such as the Yoruba in Nigeria with more complex sociocultural organisation (see Fanon, 1952; Sadowsky, 1997). The new political environment birthed a new wave of psychiatric practitioners who directly challenged and even displaced some of the colonial psychiatric practice and assumptions in some African settings. The new crops of the psychiatric practitioners that took over from the colonial psychiatrists – e.g., El Mahi in Sudan, Henri Collomb in Senegal, and Thomas Lambo in Nigeria sought not only to provide a more humane psychiatric care to the people of their localities but also make such care culturally congruent and socially acceptable by collaborating with some local and traditional mental healthcare practitioners in their respective locations (Akyeampong, 2015; Giordano, 2014; Heaton, 2014; Kilroy-marac, 2019; Mahone & Vaughan, 2007; Read et al., 2015).

In Nigeria, Lambo challenged the existing paradigm of psychiatric practices through his new ideas and practice. Contrary to the widely-held belief of colonial psychiatrists, such as Carothers, that 'social and cultural dislocation is the main cause of mental illness among the

Africans' (Carothers, 1951, 1954a), Lambo believed that Africans experienced similar forms and causes of mental illness to other populations, albeit with symptoms and manifestations shaped by sociocultural context (Heaton, 2014; Lambo, 1955; 1956). As an *Egba* man who was acquainted with 'traditional' practices, Lambo combined Yoruba traditional mental care approach with biomedical regimens (e.g., pharmaceutical medicines, electroconvulsive therapy, and occupational therapy). Lambo did this through a collaboration with some selected traditional healers in the region to jointly diagnose and offer treatment: a ground-breaking experiment that became known as 'Aro Village System' (Asuni, 1967; Lambo, 1955, 1963; Jegede, 1981). The Aro Village System was a mini facility established in Aro village, about ten minutes' walk away from the main Aro hospital. The facility comprised of a medium size building for consultation and equipment, a small hall for collective activities such as meeting, and a 10-room sleeping quarters for staff and few patients that may not want to stay in the common village house.

The 'Aro village system' is historically important and socially relevant to current Aro hospital practice. Various studies noted that 'Aro village system' practice of this period was associated with quicker recovery, lower treatment burden and cost, and reduction of social stigma as well as generating income for the host community (Asuni, 1967, 2009; Jegede, 1981). Other benefits included facilitated community integration and bringing Aro hospital onto the world map (Jegede, 1981; Leighton et al., 1963; Osborne, 1969). Lambo showcased the 'Aro Village System' in well-known journals (international) and through the first Pan-African psychiatrists conference which he organised and hosted in the Aro hospital in 1962, a strategy that eventually earned both the Aro hospital and Lambo global recognition, relevance, and international collaborations (Asuni, 2009; Heaton, 2011, 2018; Jegede, 1981). For instance, the Lambo-led Aro hospital collaborated with a team led by Professor Leighton from Cornell University, in America for their famous comparative transcultural psychiatric study in the late 1950s and early 1960s (Leighton et al., 1963). Aro hospital was also part of WHO's research on schizophrenia in the 1980s (Asuni, 2009; FNPHA, 2018; Heaton, 2011). This fame also earned Lambo a position at University of Ibadan (Nigeria) and, later, a chair at World Health Organisation [WHO] in the early 1970s (Asuni, 1967, 2009; Heaton, 2011, 2018). The history of this period is well documented (e.g. Asuni, 1967; Heaton, 2011, 2018; Jegede, 1981; Lambo, 1955, 1956; Leighton et al., 1963). I explore what the international

collaboration means to the present Aro hospital staff and how it shapes their everyday practices in chapter 7.

Today, there is little left of the Aro Village System as conceived by Lambo. Lambo left Aro hospital for the University of Ibadan 1964, and that ended the bond between Aro Village system and Aro hospital, as he transferred the facility and its management to the University (Asuni, 2009; Heaton, 2011; Jegede, 1981). Nonetheless, Lambo's transcultural psychiatric ideas remained influential (Heaton, 2011). Similarly, as will be seen in chapter 5, Lambo's departure also led to the emergence of a related but different perspective which modified the thinking and practices in Aro hospital (Adebowale et al., 2018; Asuni, 1967; Asuni, 2009; Erinosho, 1979).

As of the time of my fieldwork, Aro hospital community has expanded with some additional buildings and units together with two special wards for the rehabilitation of people suffering from drug addiction (called DATER). The hospital now has an Assessment and Emergency Unit and a Health Centre commonly referred to as NHIS. Other additions include the Child and Adolescent Unit located few metres away from the DATER ward. This facility has four doctors' consulting rooms, its own record section, nurse station, changing room, and offices for therapists as well as two wards (male and female) for inpatients below age 18. However, at the time of fieldwork, only the offices and consulting rooms were in use; the other rooms were yet to be furnished with some necessary equipment. The 'Private Ward' is another recent addition to Aro hospital, designated for those who may desire more privacy and can afford to pay the extra costs: an 8-week admission costs about one hundred and fifty thousand naira, an amount equal to about five months' salary of a Nigeria Federal Government worker on minimum wage. There is also a new administrative block, which hosts offices of the principal officers including the provost. Other additions include a public toilet, gazebos which serve as canteens, and religious centres: a mosque and a church auditorium under construction.

Currently, Aro hospital is a WHO partner organisation and serves as a national and regional headquarters for mental health research and training in Nigeria and West Africa respectively (Ogedengbe, 1986). Following its contributions and involvement in transcultural psychiatric research and practice, WHO has made Aro hospital a regional research centre. As earlier

mentioned, Aro hospital offers biomedical psychiatric training and services, and operates twenty-four hours a day and seven days a week. It also offers short-term basic industrial training (IT) in psychiatry to students of various schools of nursing and medical colleges from across the country. At the time of fieldwork, Aro hospital had over hundred medical personnel out of which about 16 were consultants while others included resident doctors, nurses, clinical psychologists, social workers, pharmacists, nutritionists, occupational therapists, physiotherapists, and speech therapists.

2.2 Study Design and Methods

This PhD work is ethnographic by design and with a specific approach of hospital ethnography. Using an ethnographic approach allowed me to be involved with, and participate in, the production and management of mental illness in and around Aro hospital, and also to observe the social context in which these practices took place (Marvasti, 2004. p35-6). My work follows the main ethos of ethnography: doing fieldwork and being guided (but not determined) by pre-existing theories (Risjord, 2007). According to Malinowski, (1922), whose methodological commitment to ethnographic methods continues to inspire present-day anthropologists, 'One of the first conditions of acceptable ethnographic work certainly is that it should deal with the totality of all social, cultural and psychological aspects of the community, for they are so interwoven that not one can be understood without taking into consideration all the others.' (p. xii). As such, as I was also interested in situating experiences of mental illness within wider contexts, my fieldwork covered units and people of different cadres and specialities within the hospital, as well as various stakeholders within and outside the hospital.

Ethnographic fieldwork requires 'being there' (Craith & Hill, 2015; Hannerz, 2003) and 'immersion' (Watson, 1999). With the hospital ethnographic approach in mind, I approached the fieldwork with two different but related views about the Aro hospital as: (i) a social institution with the function of diagnosing mental illness and 'treating' mentally ill people using specific sets of medical traditions, ethos and technologies; and (ii) part of larger society that has a distinctive history, and has a sociocultural, economic, and political milieu of a specific time and space (Van Der Geest & Finkler, 2004). Recent studies have shown that hospital ethnography is often concerned with understanding how both the

hospital and wider society affect each other. For instance, Livingston, (2012); Street, (2012); and Street & Coleman, (2012) have shown that the prevailing socio-political and economic condition of the wider society permeate and shape the hospital physical settings and technologies. The hospital setting in turn also reflects the shared worldview and common practices of the context where it found (Brown, 2012; Kienzler, 2019; Macdonald, 2016). This understanding of the hospital as an institution that extends beyond its physical boundaries was helpful in my fieldwork, which sought to follow mental illness in this wider context.

2.3 Field Entry

I conducted fieldwork over a period of nine months (September 2018 to May 2019). I set foot on the Abẹokuta soil for the first time in mid-August 2018 and headed straight to Aro hospital, hoping to gain the relevant authority's approval to start my fieldwork there the following month. This was not my first my experience of ethnographic fieldwork. My M.Sc. thesis also entailed ethnographic fieldwork in a rural Yoruba community, albeit in another state. Considering my experience from previous qualitative studies with Yoruba people, coupled with the fact I am also from the Yoruba cultural group, I believed that entering the field site would be relatively straightforward. I had planned to start my fieldwork from Aro hospital, and from there connect (I assumed relatively easily) with some non-biomedical psychiatric healers around, expecting (based on prior knowledge and the literature) that many people would be using both biomedical and other forms of care (Adewuya & Makanjuola, 2009; Adewuya & Makanjuola, 2008b; Gureje, Nortje, et al., 2015).

Locating Aro hospital was not difficult, even for a stranger like me, because its location is well-known in present day Abẹokuta. Although the hospital lies on the outskirts of the city, everyone (both youth and adult) I asked at various locations throughout my stay in Abẹokuta claimed to know where Aro hospital is located and the service it offers: 'treating mad persons' as most claimed. When I asked the bus driver who conveyed me and other passengers from Ibadan how to get to Aro hospital, about four different passengers said immediately that locating Aro hospital in Abeokuta was very easy. One of the passengers, a woman, took me to the shared taxi that went to Aro hospital's gate.

Plate 1.1 Aro hospital entrance **Source:** Author's Fieldwork 2018

When I arrived, I found that Aro hospital was well guarded. It was encompassed by a tall fence with a massive iron gate at the entrance, as shown in the Plate 1.1. The entrance had two separate passages, one for the vehicles and the other for pedestrians. During the period of my fieldwork, both were permanently staffed by security men who were carefully monitoring movement in and out of the hospital. I joined other pedestrians that were entering the compound with some people ahead and others behind. But I had not covered ten metres when one of the security men trailed on a motorcycle and flagged me down. He asked me where I was coming from and heading and my intention in the hospital. I told him

I was a student of a foreign university and that I was there for research purposes; he then allowed me to go and he went his way. But I was surprised how he was able to single me out amidst about six different people that came in. Little did I know that my clothing (T-shirt and flip-flops) was similar to that of their inpatients, as will be seen in chapter 4 ('making the patient'). I went directly to the Assessment and Emergency Unit and met with one of the nurses on duty, Mr Osho, who directed me where he called 'research building' where I should process my ethical clearance.

Contrary to my expectation and planned schedule, entering Aro hospital for fieldwork was not straightforward. I met Mr Titi, the secretary to Aro Hospital's Ethics Committee, at the Research Building and he instructed me to file an application and submit all the necessary accompanying documents. These documents included certificates of three online free modules on research ethics, evaluation, and informed consent, alongside evidence of payment for application, research proposal, my CV, letter of support from my supervisor, plus printed copies of already filled online application form. Titi gave me the links to the online modules, and it took me another week to collate the said documents.

When I realised that Aro hospital would take some time to process my application, I modified my plans started to collect data from other sources of mental healthcare in Abẹokuta. Although this thesis focuses principally on practices at Aro hospital, this work with other practitioners proved invaluable to understanding the wider context and the way multiple sources of care are important to the people I worked with, as will be seen in chapter 6.

To help identify other sources of mental healthcare in Abẹokuta for the study, I started going to a newspaper joint owned by a man called *Pastor* at famous junction called *Ita Ọshin.* At Pastor's stand, different people came to buy a newspaper of their choice, but some people, who could not afford to buy, would come to read with a token payment. *Pastor's* stand usually receives a number of people who before and after reading the papers always discussed different topics ranging from political, sport and economics. The newspaper stand was therefore a good place to engage people in conversation. After reading newspapers on the second day, while different conversations were going on around me, I tactically digressed to the mental illness and the causes in the region. Then I asked

different people, sometimes a group of two or three, about local sources of mental healthcare (including, but not limited to, apart from Aro hospital). On the third day, I did the same but asked them to rank those sources of cares identified based on perceived popularity or their treatment efficacy as well as their locations.

Collating this information, I noticed three broad sources that were to shape my initial enquiries, namely: Aro hospital, 'traditional' and religious healing facilities. Aro was often mentioned first and by almost everybody. 'Traditional' healing was referred to as *Ibilẹ* (indigenous)*, 'traditional', Ẹsẹ-Ile* (spiritual approach or ritual practice)*, or Tiwa-n-tiwa*, (home remedy or locally made remedy), all of which referred to indigenous Yoruba approaches to healing. Two main types of religious healing were *Aladura* and *Alaafa* with the former referring to the Christian faith and latter referring to Muslim clerics. I will discuss these different forms of healing, and my experiences in doing ethnographic fieldwork with non-biomedical healers in detail in chapter 6.

2.3.1 Accessing Aro hospital facility and peoples

In late December 2018, I returned into Aro hospital and was finally able to start my ethnographic work there. It was only after this that I realised the advantage of not having been connected for the hospital for the first few months, as this affiliation affected how other people spoke to me about their experiences and views. I accessed Aro hospital facilities easily after obtaining ethical approval. I could remember TITI saying to me: *'this is the key to enter any place in Aro'* while he was explaining the ethics approval process to me in December 2018. He assured me access to any place of my choice as long as it is within the scope of my study once I had received approval from those in charge.

I began my fieldwork almost immediately after I got the approval. That same day, I returned to the Assessment and Emergency Unit (AEU) because I believed starting there would enable me to follow some patients from the onset of acute illness to its concluding stage. To be able to work with the different experts in the hospital, I went to the head of each unit to introduce myself and at times submitted a copy of my ethical approval. I carried out ethnographic work in many different parts of the hospital including wards, emergency and administrative areas, where I worked with a range of staff and experts from medical doctors and nurses to administrators, social workers, psychologists, records officers, security

officers. During my time in the clinical wards, I participated in several ward activities ranging from accompanying patients to the dinning, occupational therapy unit, and observing ward-rounds. I also spent time in the Occupational Therapy Unit, Department of Clinical Psychology, and Children and Adolescent Clinic. I also visited include some of the selected primary healthcare centres used for Aro hospital Programme which some staff regarded as the 'replacement of the Aro Village system'.

2.4 Fieldwork techniques

During my fieldwork, I engaged a range of techniques including participant and non-participant observation, formal/informal discussion, audio recording and photography to elicit data that could address the research questions (Atkinson et al., 1999; Katz & Csordas, 2003; Marvasti, 2004; Watson, 1999).

Throughout my time at Aro Hospital, I participated actively and passively (Bernard, 2006 p.342) in the hospital daily activities, and engaged in many informal conversations. I spent weeks observing the social dynamics of daily activities, movements, conversations, actions, and exchanges between and the staff, patients, and caregivers. I also observed how the hospital space was arranged, managed, and used for both treatment purposes and for social interaction across the hospital units. Often, my participation was limited to attending clinics and ward-rounds, staying in the consulting room and watching the doctors and nurses clerking the patient. On only a few occasions did I used more formal interviews (Marvasti, 2004). For the other facilities, my participation was limited to helping healers in preparing and arranging place and things without any interference with the treatment of their clients. All the conversations were either in Yoruba or English, but were often mixed in Aro hospital, especially when talking to the staff, who tended to switch between the two languages. I also collected images through photography whenever relevant and with permission from the people concerned.

I used a field diary and fieldnotes to record prospective daily activities and observation of actual daily practices respectively (Emerson, 1995; Newbury & Stanley, 2001). I often taped recorded conversations with a digital voice recorder and sometimes with a mobile phone except in the few exceptional cases where participants did not want them recorded.

2.5 Data analysis

All data, both the field notes and recorded verbal data, were transcribed in English Language on MS Words to allow for textual analysis (Bernard, 2006) following a grounded theory tradition (Tavory & Timmermans, 2009). All transcripts were read a number of times to help develop an analytical framework across the different data. Translating information obtained in Yoruba language to English was not difficult since I speak both languages fluently; however, some Yoruba words have been retained in the thesis where they lack an exact English translation. Excerpts of conversations, interviews and images are also used to support certain claims and to further illuminate my examples.

2.6 Data management and ethical considerations

This research work was designed and carried out in full compliance with ethical guidelines of the Association of Social Anthropologists of the UK and the Commonwealth, and in line with the national ethical guidelines for social and medical research in Nigeria. The research work obtained two different ethical approvals: from the Department of Anthropology's Ethical Committee, Durham University; and from Aro Neuropsychiatric Hospital, Aro Abeokuta, Nigeria (see appendices i & ii.)

2.7 Informed consent

All the participants gave explicit voluntary consent to partake in this study. Only verbal consent was sought and given due to the sensitivity of my study, and in line with the ethical guidelines of the Association of Social Anthropologists (ASA) which suggest that consent should be recorded in the most appropriate way in the study context. Using verbal consent helped alleviate the apprehension of many of the study participants about their identity, especially the identity of the patients and their caregivers. As such, writing or signing on a paper was avoided. As the fieldwork progressed, I obtained multiple or continuous consent from participants, having understood that just a single, one-off consent for participation was not sufficient because I often had reason to schedule multiple conversations and at times for different topics. In such cases, I kept renegotiating with the participants at any needed stage. It is however important to state here that I never engaged in any direct conversations with a patient or caregivers that were in crisis or very unwell. At most, I

observed them and activities around them with the permission of the care providers in charge.

2.8 Confidentiality

I assured all the participants and ensured that both the participants' identity and all data received remained confidential. No other person, except myself and my two supervisors have access to the raw data. Both the field diary and field notes were kept in a personal desk with a lock. All images and digitally recorded conversational data were removed from the recorder, mobile phone, and camera respectively, and were securely saved on a password-protected encrypted folder on my personal computer. The same procedures were followed for transcribed data. I have used pseudonyms and faceless images were used throughout the thesis to anonymise the participants. However, I am aware that pseudonyms may not be completely protective to anonymise some few individuals due to their unique roles, as some closer scrutiny of some hospital documents may reveal their identity. Fortunately, these individuals were mostly involved in the administrative processing of the study such assigning and not participants in the research *per se*. More so, these people were top-ranked officers who gave their express permission to be identified and with such a role

2.9 Harms and benefits

I sought to ensure throughout that my research would not pose any physical or other harms on anyone. I made it a point of duty to inform my participants at the first meeting and occasionally remind them that I am neither medical personnel nor hospital staff: I was not involved in handling hospital equipment or administering medications. Nevertheless, I acknowledged that discussing mental illness and its care can be upsetting even to the caregivers, not only because the mentally ill persons are vulnerable and need some extra care but because mental illness experience could be frustrating to the sick and its care burdensome for both the caregivers and care providers (Chien et al., 2007; Huang et al., 2016; Mavundla et al., 2009). I always exercised caution, encouraging participants to relax during conversation. I also reminded them that they could skip any topic not willing to discuss and often suspended some topics for another time if it became clear that participants were becoming too emotional. Similarly, I understood that ethnographic

interviews and conversations can be time-consuming, and that many Aro hospital staff were operating under severe time pressures, exacerbated by a shortage of human resources. As such, I would often offer to delay my discussion or postpone it until a convenient time such as break-time and less busy hours.

I equally understood that mentally ill persons are part of the vulnerable group of people that require some extra care and processes. As such, most data about the mentally ill persons were obtained through direct observations except some few cases. For instance, there were two addictive cases but admitted into the same ward due to lack of bed space reported in chapter 4.

2.10 Other ethical challenges

There were times I encountered an ethical dilemma especially when doing participant observation in Aro hospital. Despite the fact that I made it clear to all my participants that I was neither a medical professional nor Aro hospital staff, there were some few occasions where I was drawn into some official conversions especially during medical consultations either by the caregivers and even the staff. Similarly, there were about two occasions where I was asked by the staff to assist them to physically restrain some patients that they perceived unruly. These were difficult situations for me as they generated ethical tension between my role as participant observer and interference with official matters. In both scenarios, I attempted to carefully balance my role and ensure that my involvement was not too impactful. For instance, I tried to be neutral in my contributions during consultation and tried not to touch the patient during the process of restraining. Also worthy of note is the use of 'conversation' instead of more formal 'interviews. I often used conversational methods by raising a point and asked them to react to it, and then continuing to probe. This is because I noticed that participants, especially the staff, seemed uncomfortable by the idea of an 'interview' and then became careful and selective in the choice of words and discussion. As a matter of fact, one of the most frequently questions they asked, especially the staff at the beginning of our 'discussion' was *'are you interviewing me?'* or '*is this an interview or what?'* To overcome this, I would tell them that it was a mere discussion and that they should freely express their sincere opinion without fear, although making it clear

that this was all part of the research still. I only engaged the method to assure them of the confidentiality and that it is strictly for a research purpose.

2.11 Conclusion

This chapter has described the study settings and the study participants. The historical antecedent of Aro hospital and Abeokuta as the host of the first purpose built mental hospital in Nigeria made this setting a suitable place for the study. The chapter also discussed methods of the fieldwork and well as the ethical issues. I also noted in this chapter that doing participant observation among people caring for the mentally ill persons in the study setting could be emotionally and ethically challenging, and I described the steps I took to mitigate and manage these risks. In the next chapter, I will trace the processes of becoming mentally ill in the study location and explore the social activities and implications involved.

CHAPTER 3

BECOMING MENTALLY ILL

3.0 Overview

This chapter explores the state of being a mentally ill person and processes of identifying mental illness in Abeokuta. Specifically, it seeks answers to the following questions: how do people become seen as mentally ill? What are the processes through which mental illness becomes established or otherwise? Moreover, who is involved in these processes? It is essential to clarify that the goal here is neither to identify types or appropriateness of diagnosis (of which I lack the competence) nor to map the prevalence of mental illness but to provide a contextual understanding of mental illness and explanations of how people are judged to be a mentally ill person, as well as the processes that led to the identification of mental illness in Abeokuta.

The chapter argues that becoming mentally ill happens within the context of social relations and is mediated by particular understandings of personhood. My ethnographic material shows that, in Abeokuta, personhood is multifaceted because it comprises several aspects: parenthood, friendship, employment, and financial freedom. Different facets of personhood were produced via particular social practices and situated within webs of social relations. These facets of personhood often became more noticeable when relations were interrupted, and specific behaviours came to be regarded as mental illness.

Mental illness in this context entailed the breaking down of one or more (but not necessarily all) the facets of personhood, and the processes of identifying and diagnosing mental illness revealed the distributedness of personhood. The identification of mental illness was a relational processes that drew in multiple social relationships and 'social places' e.g., home, hospital, church etc. Processes of identifying mentally ill were nonlinear and entailed with complexities that could sometimes take years to resolve. The ethnographic material presented in this chapter adds to the growing body of literature on the theoretical understanding of personhood in anthropological discourse, particularly in relation to health and wellbeing. It draws on illness and medical histories given by the interlocutors from Aro hospital, as well as oral literature, such as adages, proverbs and

stories told during conversations that illuminate the management of personhood and mental illness in the study location. There are three sections in this chapter. The first presents anthropological literature regarding personhood and illness, while the subsequent two convey the ethnographic material and consider its contributions to anthropological knowledge in these areas.

3.1 Person, Personhood, and mental illness in the literature

Anthropologists first started thinking about persons and personhood in the early-mid 20th century and volumes of literature and diverse perspectives have since been emerging in this regard cross-culturally. While I will trace some of these works in this chapter, attention will primarily be paid to the more recent uses and framings of the concept, as well as the Yoruba worldview of personhood. Personhood can be understood as an embodiment of a certain historical, social, environmental, and cultural setting of the person. Being a human is different from being a person because the first is 'born' and the other is 'made' (Comaroff & Comaroff, 2001; Ikäheimo & Laitinen, 2007; Lambek, 2013). A person is made by, and reflects, the sociocultural backgrounds that produce them (Comaroff & Comaroff, 2001). Understandings of personhood can provide useful insights on people's life events such as illness, old age, birth and food among others (see e.g., Conklin & Morgan, 1996; Degnen, 2018; Pollock, 1996).

The World Health Organisation's definition of mental health as involving conscious and active role-playing within a society (Vigo et al., 2016; WHO, 2014) indirectly but clearly describes mental illness as a problem of persons rather than humans. Nonetheless, until recently studies that have explored how social and cultural backgrounds across Africa could modulate the understanding and treatment of mental illness cross-culturally have done so without much concern for personhood (e.g., Bartholomew, 2017; Beveridge et al., 2010; Iheanacho et al., 2015; Ingram & Faubert, 2004; Patel et al., 1995; Patel, 2011; Ventevogel et al., 2013).

Personhood influences the nature and course of mental illness, hence understanding it will usefully contribute to effective diagnostic and treatment measures (Strauss, 1992: 19). Strauss drew on a social constructivist perspective to argue that a person's mind, moulded by specific historical, environmental, and social backgrounds through which s/he constructs

realities that inform his/her behaviour, including their illness experience (ibid). However, this notion of 'person' is too narrow for two reasons: it limits personhood to the psychological being or 'self', which is just one of the three aspects of personhood identified by Harris (1989) – see below; and portrays 'person' as if it only applies to human beings (see Conklin & Morgan, 1996; Degnen, 2018). I will return to this in more detail later.

A body of anthropological literature on personhood and illness has been growing steadily over recent years; and central to it is that illness and health are not just experiences of, but part of what [un]makes a person. As Degnen, (2018) rightly observed, asking the question: 'what makes the 'person'?' may sound absurd and that we often take the concept of a person for granted due to daily visibility of and regular access to the 'person' as part of our everyday life. However, we often lack the awareness that a 'person' is *made* based on daily sociocultural activities and historical contexts of the place where it is found. Also, we hardly recognise the importance or potentials that such comprehension has for the understanding of our world (ibid:2). This lack of attention to the making of persons happens alongside everyday practices, including self-understanding and self-presentation, social interaction, and relations, among others that depend on notions of personhood. Before continuing, it is important to consider some existing views on personhood. I will return to details on personhood and health later in the chapter.

Conventionally, the seminar paper: 'A category of the human mind: the notion of person; the notion of self' by Marcel Mauss in 1935 is considered to mark the beginning of anthropological inquiry into personhood (Halls, 1985). In this essay, Mauss maintained that 'person' emerged from historical and sociocultural contexts as observable in 'self-representation' and 'self-understanding' (Halls, 1985; Kpanake, 2018a). Similarly, Radcliffe-Brown, as Degnen, (2018) noted, also furthered the explanation of personhood by distinguishing between 'individual' and 'person', describing the former as *biological entity,* and the latter as a *social being*. Another anthropologist, Harris, (1989) shared Radcliffe-Brown's idea of 'individual' and 'person' but added the third dimension – *self* to represent the psychological aspect of selfhood. These scholars made prominent contributions toward the understanding of personhood by unpacking the importance of social and cultural factors in making it and developing key terms that were central to anthropological thinking until the

1970s. However, these scholars have since been criticised for over relying on a Western orientation of personhood (Degnen, 2018; Kpanake, 2018a). Arguably, McKim (1976) provides one of the most notable critiques. Marriott McKim report stood in contrast to the Western perspective of 'personhood' which emphasised e.g., self-independence and self-sufficiency, and so on. Based on fieldwork in India, he coined the concept 'dividual' as against 'individual' to showed how a 'person' in that context was made and understood in the light of relationships with others. Nevertheless, the dichotomised (western vs non-western) view of personhood of McKim and others that shared this notion such as Craemer, (1983) have been flawed for creating boundaries in the way 'personhood' is made cross-culturally, when in reality, no boundary exist (Appuhamilage, 2017; Comaroff & Comaroff, 2001; Conklin & Morgan, 1996; Degnen, 2018).

Cross-cultural anthropological studies have improved our understanding about the nature and formational processes of personhood. There is no generally-agreed-upon definition of personhood in the anthropological literature, but there are some common understandings. One of such is Kpanake, (2018:2) that 'personhood, can be understood as a dynamic recursive process in which participation in a given cultural system of meanings, practices, and institutions affords and fosters characteristic psychological tendencies that serve, in turn, to integrate the person into the meanings and practices of a cultural community.' This is contrary to Strauss', (1992) position earlier mentioned that saw personhood as residing inside the mind. Personhood is not a social identity or personal perception of oneself but a 'relational and processual entity' to borrow the from Degnen (2018:16). In other words, a 'person' exists within and it is known in the context of others and ongoing series of social relations (Appuhamilage, 2017; Comaroff & Comaroff, 2001). Lambek (2013: 838), succinctly put it as 'persons are person in the context and in relation to other persons.' Moreover, personhood is not personal but marks an extension or relation to others. Several ethnographic studies have demonstrated that not all 'persons' are human beings and not all human beings are persons. Personhood can be ascribed, mediated, accumulated and stripped off through social relations within a specific sociocultural context. Taking infant status for instance, Maurice, (1992) showed that childbirth confirmed the full personhood of its parent among the Zafimaniry of Madagascar, while the infant only became a person after it develops certain social competences.

Studies also affirm that personhood may include substance or materials, e.g., harvest, wealth and tools and social places, e.g., village, town, house, farm or forest, as well as the otherworldly, e.g., ancestors and ghosts (see Conklin & Morgan, 1996; Degnen, 2018; Kpanake, 2018; Pollock, 1996). An example is the importance of body substances such as blood, milk, semen and food among the Northern American Amazonian Wari. (Conklin & Morgan, 1996; Pollock, 1996). Degnen (2018) put it as follows:

> '…who counts as a person is often a question answered with reference to place. In this way, personhood is an entity, a value that does not *always* and does not *only* reside in people, nor in the relations between people. Instead, personhood can rely on relations with place, on relations through place, and relations with the animated cosmos. In other words, the attributions of personhood can be deeply imbricated with ideas and experiences of place and brought into existence via these (often intersecting) relations' (pg.92).

Another salient factor of personhood discussed in the literature is that it is not fixed but fluid and precarious. Keeping one's personhood intact requires daily activities and continuous relations (Comaroff & Comaroff, 2001). As earlier stated, selfhood and the knowledge of others, for instance, infant, adult, old, mother, healthy, and sick etc. are embedded in contextual understandings of personhood. However, none of the above listed examples is fixed, firstly because what makes 'mother' or 'old' for instance varies cross-culturally just as in the case of infant status earlier cited (see also Craemer, 1983). Secondly, personhood changes based on changes in social relational status. For instance, Degnen, (2018) drew on fieldwork in the North of England to explore how changes in physiological functioning and the ability to participate in social life experienced in old age, changed or even shifted the personhood status completely. She also drew from other ethnographies to explain how personhood is perceived changing from a mother or father to grandparent and then, prospective 'ancestor' and ancestors or guardian ghost in Mangalihi, India (ibid:157-67). Katherine Lepani also described how sexuality, social independence of sexual expression and relations, as well as kinship formed the basis for being a 'girl' or 'mother' or 'married' among the Trobriand Islands (Lepani, 2015).

At the same, personhood can become diminshed, or lost altogether. Some studies have reported the possibilities of losing of some constituents of personhood earlier secured (e.g., Conklin & Morgan, 1996; Degnen, 2018; Kpanake, 2018). Gali Landsman's (2009) example, cited in Degnen, (2018:77), illustrates this well. An American woman delivered a baby girl in a hospital. After the birth, she made some contacts informing her social networks of her baby's birth who in turn showered wishes on the baby. However, the 'wishes' could not be sustained for so long and compliments began to trail off following the doctor's second announcement that her new-born baby had been diagnosed with disability; immediately the wishes and greetings dropped because the baby was seen a 'lesser person' with 'diminished personhood'. Degnen (2018), also noted that some of the effects of old age (e.g., fragility and frailty, social disengagement, etc.) interfere with personhood across cultures but do so differently. For instance, in Northern England characterised old age with progressive 'loss' and depicted a loss of personhood as being in line with 'real old age' and 'normal old age' but in contrast, the same process is considered a social to change or relieve responsibilities among Mangaldihi of Indian and Tuareg of Niger (Degnen, 2018:153-7).

3.2 Yoruba Personhood

Understanding the Yoruba concept of personhood requires some more profound knowledge of Yoruba understandings of human ontology (Morakinyo & Akiwowo, 1981:22). There are three different Yoruba words, namely *Eniyan, Ẹni* and *Asuwada* for person/personhood used in oral and print literature (Akiwowo, 1980; 1991; Makinde, 1988; Morakinyo & Akiwowo, 1981). The most commonly used word is *eniyan* which on the one hand denotes 'human being' and 'personhood/person' on the other. As such Yoruba people acknowledge the possibility of being a human and yet not a person, as evident in some common phrases of day-to-day conversations, for example …*o se eniyan:* literarily means s/he is being an *eniyan* to mean s/he is behaving in a socially approved manner; or *kii se eniyan rara* - s/he is not an *eniyan* at all when behaved otherwise.

In the Yoruba worldview, a human being comprises both a biological/physical body and spiritual or metaphysical dimensions that are usually explained in unitary dualism as

depicted in the Yoruba belief about *ori*[3] - 'head' vis-à-vis pregnancy conception and reincarnation[4] respectively (see e.g., Ademuleya, 2007; Akomolafe, 2016; Alabi, 2015; Alabi et al., 2021; Balogun, 2007; Bascom, 1956; Ekanola, 2006; Idowu, 1962; Ilechukwu, 2007; Lawal, 1977; Lucas, 1948; Odebode & Onadipe, 2011; Ogunjuyigbe, 2004; Tomšič, 2011). Unlike Cartesian dualism that holds the mind and body as separate and coexisting entities, Yoruba creation myths describe the duality of *eniyan* in the spiritual and physical body, seeing these as dimensions that are fused and the same (see e.g., Ademuleya, 2007; Bascom, 1956; Lawal, 2008). As Morakinyo & Akiwowo, (1981) succinctly put it, 'the body is mind and the mind is body' (ibid :27). An implication of this worldview is that whilst Yoruba people recognise the physical/biological, spiritual, and social body, the Yoruba language lacks an exact word for 'mental' processes, mind, or soul. Arguably, this explains why some illnesses, especially nonpsychotic disorders or emotions or feelings (e.g., depression, anxiety, and eating disorders etc) are usually expressed in somatic form due to lack of specific Yoruba nosology. For instance, *happiness* is called *idunu/inu didun* literarily, 'sweetened belly' and sadness as *ibanuje/inu bibaję* which literarily means spoilt or attenuated belly. It also helps explain why mental illness is viewed through the lens of personhood and relationships with others, rather than an understanding of the 'mind'.

In addition to its biological and spiritual dimensions, Yoruba personhood also has a social dimension. For Yoruba people, to be a person is to transform beyond a human being and into a social being (Makinde, 1988; Morakinyo & Akiwowo, 1981). Key attributes of a Yoruba 'person' include being an acceptable community member, sharing and actively working towards achieving goals including good health till old age, financial or economic prosperity, having an intimate relationship and love, valuing parenthood and having children, and assured self-actualisation, all of which are seen to be made possible through series of actions towards others, and certain behaviours or comportment (Akiwowo, 1980; 1991). These idealised forms of personhood vary across and within people of ages, social classes,

[3] Some explained duality of human being in the Yoruba belief in *ori* which *posits* that an individual has a spiritual/invisible head that is capable of pre-birth existence as well as a physical/biological body representing the 'head' in the unseen world. as such, so the two are one just like an object of self in the mirror.

[4] On the other hand, the Yoruba belief about pregnant conception, childbirth, and reincarnation suggested that human being human is perpetually spiritual and transitional. As such, pregnancy and childbirth neither be the beginning nor death be the end of human being but stages of the transitions of the human spirituality.

and status. So, the sense of proper personhood at childhood differs from adult personhood and *vis-a-vis* man and woman. For instance, a common proverb states '*bi ọmọde ban se bi ọmọde, agba gbodo se bi agba'* meaning whenever the children display some immaturity due to their age, the adult must demonstrate his/her maturity. As such, (Akiwowo, 1980; 1991; Morakinyo & Akiwowo, 1981) described how, and anyone who lacks one or more of the attribute of these idealised forms of Yoruba adult personhood could be considered an incomplete person. In other words, the Yoruba generally measure personhood against a myriad of qualities considered necessary for togetherness and individual success. The wholeness of a Yoruba person largely depends on how much s/he imbibes these qualities of personhood.

Forms of 'incomplete' personhood among the Yoruba are closely bound up with illness. As I will show in this chapter, illness, and especially mental illness, may contribute to a diminishment of personhood; at the same time, a loss of personhood can also effectively 'make' mental illness. Comparative ethnography from elsewhere in Africa reiterates many of these themes, including the importance of participation in social, cultural, and economic activities to be considered a full person, and how the loss of this capacity through illness can signify a loss of personhood (Pollock 1996). Kpanake (2018) similarly highlights that in many African settings a 'person' is a three-dimensional entity comprising social, spiritual, and individual dimensions and mental illness is seen to as a dysfunction in one or all of these dimensions. Finally, being a person among the Tswana of Southern Africa, as reported by Comaroff & Comaroff (2001), requires a perpetual progressive transformation. To remain a person, an infant must tranform to a youth, then to an adult, be married, a parent, be economically sucessful, become old, then an ancestor-in-the-making who is eventually embodied in new offspring… Stagnacy among Tswana means a 'social death' which people do everything to avoid (ibid:271).

In summary, this section has traced historical and cross-cultural understandings of personhood in anthropological literature. Evidence shows that personhood varies across and within cultural setting(s) and, most importantly, understanding the manifestations of personhood in a particular context can enhance understanding of lived events including health, illness, and healthcare practices. Mental illness is ubiquitous, yet its meaning and

experience varies cross-culturally. Nevertheless, understanding constructions of personhood and how they are affected by mental illness seems to be key across many of these contexts. In recent times, medical anthropologists have adopted personhood as an analytical concept to explain local understandings of illness, symptoms, and treatment in a specific sociocultural contexts. In the next sections I employ ethnographic materials to draw two related but distinct points: In Abeokuta (a) personhood is considered multifaceted, where mental wellbeing requires effective functioning of all its multiple facets, and mental illness equates to diminished personhood; and (b) the identification and initial diagnosis of mental illness entails social processes that draw on relational facets of personhood, involving several people (but not including the individual themselves) based on distributed social relationships.

3.3 The notion of multifaceted personhood and mental illness

This section discusses multifaceted personhood as a shared belief and the basis upon which mental illness is identified and described in Abeokuta. Participants usually described mental illness in connection with an archetypal understanding of personhood which suggested that a person is a collection of numerous interdependent facets including perception, reasoning, employment, gender, independence, age, and adulthood, among other biosocial processes. Each of facet of personhood involved specific practises and a minimum level of functioning was required to demonstrate so-called appropriate behaviour, moral attributes, and life achievements among others. When all the facets function as and when they should in an individual, such a person is considered a 'normal' fully-fledged person. A person is considered to be an 'incomplete' person suffering from illness when otherwise. As such, several of my research participants located and described mental illness as breakdown or loss of one or more facets of the personhood and considered the mentally ill to be lesser persons with invalid community membership. This section illustrates these processes ethnographically to demonstrate that mental illness is described based on shared notions of adult personhood.

Throughout my fieldwork in Aro hospital, Abeokuta, I witnessed more than sixty admissions to the hospital and closely followed more than ten new cases. One of the things I found so interesting during my fieldwork in Aro hospital was the nebulous the boundary between

'normal' (mentally healthy) and 'not normal' (mentally ill) persons. On some occasions there were cases where the symptom of illness was hidden to the extent that an outsider like me may be wondering about how such individuals became judged as mentally ill by the caregivers and hospital staff. One of these examples was Mr Alade, a fifty-two-year-old man from *Igbo Ora*, whose experience provides some insights not only on the conception of personhood but also how knowledge about its components became instrumental to the diagnosis of mental illness.

Mr Alade's younger sister and two brothers brought him to the hospital with his hands tied to his legs. According to them, his complaints included the fact that he was single and never married and he was hostile to the community dwellers, especially children. Remaining unmarried as an adult is considered a serious misfortune among the Yoruba. Chief Fag, an Ifa priest and one of the prominent chiefs in Abeokuta said, '*ire aya ati omo nini* (marriage and having own children) is the third in ranking of the major achievements in life according to the Yoruba traditional belief[5]. Alade's siblings also claimed that he had left his hometown for the mega city of Ibadan only to be a gateman[6], (a very low status job) and had returned to his hometown as a pauper many years later. They added that he had refused to eat or drink anything, particularly any food brought by his relatives, since the previous night. Asking Alade to react to the 'allegations', Alade coherently and unambiguously stated that nothing was wrong with him whatsoever. He claimed that his younger siblings and late parents had long been unsatisfied with his unmarried status. He also explained how and why he lost his job as a gateman and relocated back to *Igbo Ora. Neither* did he mince words about how his younger siblings deceived him under a guise of a family meeting the previous night, then overpowered him, tied and forcefully brought him to the hospital with a car that morning. Regarding his refusal of food, Alade claimed he had refused food for the fear of being poisoned. In his words, 'How would you expect me to eat from siblings that could conspire to the level of tying their elder brother like a goat to be slaughtered and put him in a car

[5] *'Ire aiku (life or being alive)* is the first, follows by *Ire Alafia* (sound health) and then *ire aya fifẹ ati ọmọ nini* (marry a wife and having owing children)….. ' Chief Fag during one of our conversions in 2018.

[6] **Gateman** is a person employed either in a private or public place whose primary duty is to monitor the vehicular and human movement at the entrance by opening and closing the entrance gate. However, it is considered derogatory or disrespectful in this social context to address such persons someone as such as a gateman in his/her presence, especially the younger ones.

without knowing where he was being taken?' However, despite Alade's coherence, comportment, and logic for his action and reaction, he was admitted.

I was curious to understand how the Aro hospital staff had deemed Alade suitable for admission. Since Bablo oversaw Alade's admission processing from the nursing side, I went to him to enquire about what indicated mental illness in Alade. Bablo laughed as a way of teasing my ignorance and told me that Alade was not only sick, but his sickness was severe. Bablo further reemphasised his conviction in that Alade was suffering mental illness and then advised me not to 'allow his dressing and coherent speech to deceive' me. This response, therefore, pointed my attention to Below is part of Bablo's remarks on Alade that illustrates the notion of multifaceted personhood and how it may relate to mental illness.:

> *''…Those people* [the nonpsychotic patients] *you will see them, may be very neat, and comported but when it comes to reasoning, when it comes to the belief, when it comes to perception, ah! This is where their problem lies. But to a layman that has not experienced these aspects* [with deficiencies]*, would think that they are normal….*
>
> *For us* [mental health care professionals]*, the area of concentration or what we look for when we say somebody is mentally well or not mentally well… Let me borrow from the WHO, ordinarily, health is a state of complete wellbeing spiritually, socially and all aspects of a person, and not mere absence of infirmity. Then in mental health, what we have is that there are some specific areas of our health that the brain controls. It is wellbeing of your brains that controls your feelings. It is when your brain is stable that it can control your thought and reasoning. Do you understand? It* [brain] *controls perception, which is the impulse. It controls your reasoning; it controls your thoughts; it controls your interpretation of impulses and controls your interpersonal relationship. …So, mental illness does not mean that there is 100% breakdown in all aspects of a person or in all those areas. It could be one or more of such aspects* [of a person] *that are affected. Also, the brain has different sections responsible for different aspects of a person. The section for perception or impulse might not be affected; it might be of the reasoning. Then it may be the perception* [that is deficient]*, while that of the memory will be intact.*

> [For example] t*his person may just be responding to voices or hearing the voices or seeing things that others are not seeing, that is perception. When it is the thought process, it will affect your belief… and delusion may set in. It might be the human relation aspect or the thought process, because it may just affect an area… Ordinarily, this person may appear well groomed when talking, he could be highly intelligent but let a little matter come up and see the way he/she will reason, then you will be asking yourself if a normal person can reason this way?...* ***Nurse Bablo, Aro Hospital PNO***

Arguably, the above explanation is influenced both by Bablo's medical training as evident in his description of the physiological functioning of brain, but also by the dominant worldview in his society. In the excerpt above, Bablo described a person as a biosocial figure with multifaceted personhood, each facet functioning under the control of the brain. Bablo's position, which was widely shared by others, is that an adult must demonstrate functioning facets of his/her person which include comportment, coherent speech, acceptable dressing, reasoning, belief, and shared valued for parenthood and financial independence, among others. As Bablo said, mental illness does not imply a total breakdown of all facets of the person but sometimes just a few of these. Different actors (e.g., caregivers, doctors, nurses, psychologists) sometimes emphasised different facets of personhood. In this case, Bablo did not see anything wrong in Alade's comportment and coherent speech but rather in his belief and perception. Alade's siblings identified lack of value for parenthood and poor socioeconomic status as evidence of mental illness, evidenced in their claim that Alade was neither married and nor did he see anything wrong in being a bachelor at age fifty-two years. One of his brothers told him that, '*o yẹ ki oju ti yin*', meaning that Alade ought to be ashamed as the eldest sibling. He added that being the first son and child of their parents, Alade ought to have married and be raising children ahead of his younger siblings and, at the demise of their parents, should have assumed the leadership role over them, his younger siblings. In a similar case, another patient was brought by his mother and maternal uncle for suicidal ideation, talking to himself and lack of interest in life which they blamed on his inability to impregnate a woman, thus meaning he lacked husbandhood and fatherhood.

Caregivers, doctors, nurses, and occupational therapists were also likely to identify adulthood independence, self-awareness, and capacity to actively engage in economic activities as important aspects of an adult personhood, attributes that could be affected by mental illness. The hospital staff often claimed that mentally ill people lacked 'insight': consciousness of themselves and their actions or their behavioural changes. Mrs. Ore, a senior nurse, was among the numerous staff that expressed this view. She said *…'In fact, the majority of them don't have insights. They don't believe that anything is wrong with them…'* Relatedly, Dr. Falah once told me that mental illness is whatever hinders a person to successfully cope with daily life stress and contribute meaningfully to the community. He went further to say that the mentally ill were 'non-functional' and 'dependent' because mental illness often deprives the sufferer of a 'thoughtful existence' and 'planned life.' Similar views were expressed by a consultant, Dr. Show, who said: *'To me, a mentally ill person is someone who cannot do any job and not capable of relating within his community; and when I said the community, I mean the self, his family, and his environment.'* Other staff from the occupational therapy unit of Aro hospital also claimed that the mental illness deprived the sick person the required aspects for carrying out what they termed 'necessary daily occupations' such as cooking, work, and leisure.

For the caregivers, mental illness robbed its victims of a 'decent' employment as required of an adult based on his/her gender and education. In the case of Alade being a gateman, his siblings cried, 'he left his hometown only to become a gateman in Ibadan. The use of gateman here, both in context and presentation insinuates that the status of his job was a sort of embarrassment to their entire family – not a 'respectable' job. Another example is Saturday. He was a graduate of sociology from one of the state universities. He was tricked into the Aro hospital in 2019 by Dipe his half-brother for treatment. According to Dipe, Saturday's shortcomings included failure to attend his father's burial and that he preferred domestic chores instead of seeking respectable employment after his graduation, unlike his colleagues who were already earning good salaries (see also Chapter 5). Saturday thereby violated gender norms in addition to his lack of respectable job. Although the distribution of domestic tasks is changing, domestic chores such as childcare, cleaning, and cooking are still considered women's responsibility among the Yoruba to no small extent. At the same time, the highly paid white-collar job is considered an important goal for men, especially educated

men like Saturday. Hence, preferring home chores meant for women without acquiring the masculine trait of employment was identified as a symptom of mental illness. At one point, Dipe was teasing Saturday by telling the nurses that 'He is a good cook ooo... in case you would like to employ him. Don't look down on him (because he is a man) there is no type of soup he cannot prepare, and you can confirm from him if you think I am lying or exaggerating.'

Some other caregivers added that mental wellbeing should be devoid of certain things such as financial imprudence and promiscuity, among others. Like Saturday, Segun was also a graduate of Sociology and had never worked in any organisation since his graduation in 2012. According to his retired widow mother and 'uncle'[7] who cared for him, Segun had never bothered to secure employment or been ready to work for money, but always requested money from his aged mother, and if she refused to give him, he would either steal it or threaten to injure her until he got the money. His mother also claimed that she was the one cleaning the house, including Segun's room and laundry. All that Segun loved doing was to flirt around ladies in Town, get drunk, and litter their sitting room and living room with vomit. She added that Segun had no savings and always spent any money that came his way most often on ladies and drinks.

Others, especially the psychologists, identified some facets of personhood slightly different from what other experts earlier identified and then explained mental illness in terms of the harmonic function among these facets or performance levels. Unlike nurses who emphasised facets that depended largely on the brain, the psychologists identified age, speech, action, and experience among others as necessary dimensions of personhood. For example, Lasun, one of the *ad hoc* staff[8] in the psychology unit said, 'We are interested in all aspects of their life (patients) including their educational history, family background, occupational history and drug history to know where defects are and how to intervene.' They also claimed that those aspects must function interrelatedly and at some certain levels to achieve good mental health. Another psychologist called Happiness claimed that age,

[7] **Uncle** was not Segun's uncle but his elder brother's friend who lived in Abeokuta and help them arranged with some Aro hospital staff and tricked Segun into the admission. so, Segun called him uncle

[8] **Adhoc staff** in this work refers to those that worked in Aro hospital but not a direct or permanent staff of the hospital. these include Serving NYSC Corps members and students on IT and Internship training posted to Aro hospital

education, sight, and memory were necessary aspects of a person. Happiness added that she would not ask 'what is winter' [one of the questions in the diagnostic scale] from a patient that came from a 'village who has never attended any form of school or travelled abroad, because that has not been part of his/her life'. In her remark on her former 'client' (patient) during our conversation, she said, *'Can you imagine; I asked a client who was more than twenty years old to write 1,2,3, and he was writing rubbish. Even after showing him, yet he was writing rubbish…in that case, do you need anybody to tell you that the person was not normal? Something is definitely wrong somewhere!* As such, history, experience, reasoning, and environment among others are not only necessary facets of a person that must work harmoniously as and when due otherwise mental illness.'

Interestingly, Happiness indirectly used my own behaviour to make some points on how improper functioning of one of a few aspects of personhood could indicate a disorder. In my case, she hypothesised a possible trait of personality disorder because I said I could be 'critical at times' during a discussion (I was in fact seeking to extend an interview to get more information).

***Me**: 'I'm sorry for taking more of your time than I thought I would…Don't also be angry with me for asking too many questions. It is just that I love asking questions… probably because I can be critical sometimes before I get convinced.'*

***Happiness: '…**what makes you critical? Tell me!* Do *you know that it might be a disorder? Yes! Your being critical! Yes, it can be! That is why I would like you to fill this MMPI and lets somebody analyse it for you… You know, I told you that different aspects of a person could develop a disorder. All aspects of a person must be functioning in the middle* (moderate)… *It must not be too high or too low because it becomes a disorder once it reaches either of the extremes. It might not necessarily be a disorder, but it may be a trait, and if that is the case, you must be watchful so that it will not elevate…'*

Happiness wanted me to fill one of the diagnostic measurements that they use for assessing personality disorders. She argued that any aspect of a person that functions either below or

above the accepted level recommended by their manuals[9] was defective. She went further that the severity of such disorder or illness is determined by the degree of its variance from the middle. Using me as an example, Happiness claimed the possibility of the sick person who is not aware of his/her sickness, can connotes a symptom of mental illness. This encounter and my rejection to fill the manual recommended by Happiness, provided more insight on power play between and among the sick, caregivers, and care providers. If I had been taken there by a friend or family member for example, Happiness would have perhaps held my refusal to fill the manual as a confirmation of illness, as in the case of Alade and others. In other words, mentally ill people were always considered as lacking full personhood and by implication they were often treated as lesser adults or persons.

In summary, most of the mental healthcare professionals and caregivers I encountered in this study perceived the mentally ill as 'incomplete' persons but in different ways. Some caregivers described mentally ill people as incomplete persons, while the hospital staff often described them as 'non-functioning' or 'dependents', and 'not normal'. A final example is that of Omo Benue. He was twenty-eight years old when his paternal uncle and his younger brother brought him to the Aro hospital. He hailed from Benue State and had relocated to Lagos more than a decade ago. Since moving to Lagos, Omo Benue *had been engaging in 'substance abuse'* of marijuana, cigarettes, and alcohol. He *was* diagnosed as mentally ill and was treated during 2014 but relapsed and was brought by his uncle to Aro hospital in 2019. According to his uncle '*…This is not a boy I used to know before the death of my brother…. he's no more 'complete'* Dr. Falah also asked his younger brother to speak on Omo Benue's person before illness; speaking in pidgin, '…All I can say is that he used to be very smart and brilliant and he used to lead our class when were in school but since he has relapsed, he has been so dull as if there was no bone in his body, and I believe he too would know that he is not himself.'

In this section I have demonstrated with various example that in Abeokuta, personhood is considered to be multifaceted and adult personhood essentially entails having or wanting to have a job, parenthood, moral comportment, and independence. These attributes, among

[9] **Manuals** was the term used to describe booklets that contain the scales or test e.g. Multiphasic Personality Inventory (MMPI) used by the psychologists to assess or diagnose people and interpret the results.

others, enable an adult to actively participate in family and community life. More importantly, the section described mental illness as loss or lack of some facets of personhood hence, arguing that participants considered the mentally ill people as 'incomplete' and 'not normal' persons and by implication that mental illness invalidates their full membership of their community. As such, the mentally ill persons were only seen as living in but not part of the community. In other words, mentally ill people were human beings but not full persons. In the next section, I will show how this understanding of personhood formed the basis upon which mental illness was identified and diagnosed.

3.4 The social processes of identifying and diagnosing mental illness Abeokuta

In Abeokuta, one of the facets required for full personhood is relational agency, with each person connecting and relating with several others based on religious, residential, familial, other forms of relatedness. This section will discuss two broad points: (i) the importance of relational dimensions of personhood in diagnosing mental illness; (ii) the distributedness of personhood across social spaces and relationships. Firstly, I will demonstrate that relational personhood is crucial to the identification and definition of mental illness on two grounds: as earlier said, the family and other relational agents are necessary facet of one's personhood and when they are broken down it may be seen as a symptom of mental illness. It is also through this web of relational personhood that mental illness is identified and interpreted, as identifying and diagnosing mental illness usually involved several individuals related to the sick person, but typically with little or no involvement of the sick person themselves. As such, different individuals had different understandings of what was going on based on (among other things) their relationship to the sick person and their understandings of the causes of mental health, which could include cosmological, medical, and relational influences.

Secondly, the section will show that these relational agencies and activities are distributed in two major senses: they take place through members of different relationships, e.g., family, neighbour, organisation, etc.; and in different places e.g., home, school, hospital, etc. Social place in this this context means a place where a meaningful action and reaction occur (Degnen, 2018:93-4). People's understandings of the symptoms of illness varied and changed over time and social places, but usually without them accepting the possibility of

mental illness until other possibilities were eliminated. These social processes of identifying, diagnosing, and interpreting mental illness symptom were usually long, complicated, overlapped, and sometimes lasted for years. Each of the processes was a set of several social activities that were sometimes characterised by ambiguity, contradictions, and tensions, and people often fluctuated between acceptance and rejection of a mental illness diagnosis. Again, these processes usually took some extended time ranging from days to years before the sick person would be (if at all) referred to the hospital.

To take one example, Flaky, a lady aged about nineteen, had apparently been 'mentally sick' for almost two years before she was brought to the Aro hospital by her father and mother in March 2019. While in the doctor's consulting room, Flaky sat in between her parents in front of the doctor and was busy writing and drawing on a small notebook she had brought with her. According to Flaky's parents, they brought her to the psychiatric hospital because she no longer recognised her parents' authority, she was talking incoherently and to herself, not observing personal hygiene, and was disturbing the neighbours with noise. According to her father:

> *'Flaky's problem started from school sometimes in 2017. She gained admission into a Polytechnic in Niger State in 2017 and was around seventeen years old then. I and Flaky used to speak on phone almost every day when she was there except for some few days before this issue began. My calls neither went through nor did she call for about two consecutive days. I think it was on the third day that somebody called me on the phone asking if I were Flaky's father and I said yes. He said he was one of Flaky's friends and that she had been sick for about two days. He said they were together in a class one day and noticed that Flaky remained silent and would not talk to anyone after which she was not attending classes anymore. So, they* [her friends] *decided to visit Flaky in her room that day and on getting to her, they could not fathom what was happening to her… So, I went there on the following day to bring her down to Lagos, and since then, we have been on it.'* ***Baba Flaky, - caregiver in Aro hospital***

Flaky was one of the new cases I observed during my fieldwork, and I will be returning to her story intermittently due to its relevance to various points in this section. Here, I make the

point that Flaky's example evidences how social relationship or relatedness is an important aspect of a person in the study location. Prior to her illness episode, Flaky though was physically away from home yet maintained relatedness with her parents through frequent phone calls; and within a short period of her relocation, Flaky had formed a relational agency (with friends and classmates) who could notice her silent mode, absence in class, located her residence, and accessed her father's phone number. Earlier studies have reported that forming and maintaining social network with family and friends and even community is essential component of living in some African cultures (e.g., Kpanake, 2018), including the Yoruba (Akiwowo, 1980; 1991; Makinde, 1988). The Yoruba believe that life is more beautiful and secure when you are in the company of others, as evidenced in their common saying: *eniyan laso mi* which literarily means, 'People are my dress/protector'. On the other hand, whoever fails to associate with others is likened to an animal. In some other cases, the relational agency or social network includes coresidents or a person's spouse.

This was the case with my neighbour's wife, Ìyá Ìjọ, in an incident which occurred a year before my fieldwork in Abeokuta. Ìyá Ìjọ was an unemployed university graduate, mother of two, and in her late 30s. Her husband was a teacher in one of the Nigerian public universities located about 260 kilometres away from Abẹ́òkúta, where Ìyá Ìjọ was residing. Ìyá Ìjọ lived in a rented apartment with her two children where the husband joined them fortnightly during term-time. According to her husband, Ìyá Ìjọ maintained a friendly relationship with other flatmates in the compound. While away at his workstation at some point in October 2018, he received a phone call from one of his wife's neighbours at dead of the night that his wife was sleepless and talking to herself, at some points incoherently.

While the two stories elucidate relatedness as a facet of personhood, they also show that breaking down of this facet suggests illness. This echoes the observations in the previous section when Alade was judged mentally ill for allegedly being hostile and Saturday because he did not attend his father's burial. Flaky's father and friends analysed her mental ill health based on her relationship with them and the gap in phone communication, non-recognition of parental authority, disturbing the neighbours, as well as quietness and absence in class while Ìyá Ìjọ was described as withdrawing from other residents and talking to herself.

These examples also show that identifying mental illness follows social processes that involve one's different relational agents and at different time. It was a general trend from most cases I encountered that it was people 'close' to the sick person, rather than the individual themselves, who began noticing and identifying some symptoms of mental illness as significant social and behaviour changes and who raised the alarm. These agents often engaged in frequent social relation and interaction, for example as friends, coresidents, and co-workers among other. As in Flaky's case, her father only noticed an unusual trend of communication, but it was her course-mates who had closer physical relations who identified and raised the alarm. The above examples also suggest that social networks differ based on roles, relationship, and limit of expected actions regarding identifying mental illness. The first-to-notice relational network seems very important for identifying symptoms and providing preliminary support. However, it is perhaps limited in the kind of care it can provide because of a lack of knowledge of illness or the limit of their socially-expected role according to the nature of their relationship. Similarly, Akiwowo (1980) noted that *ajobi* - (blood ties) are the primary and *ajogbe* (coresidents) the secondary source of assistance and sustenance among the Yoruba. As such, the first-to-notice relational agents always inform those believed to be closer and have a duty of care to her, such as a father and husband as the examples of Flaky and Ìyá Ìjọ respectively. Once the alarm was raised, other relational agents continued the process where the previous stopped but, in some cases, continued with the process but through different kinds of relationship, as will be seen Wosila's example.

After people first notice unusual symptoms, the next stage in the process of diagnosing mental illness involves interpretation of those behaviours, and this is done by several others too. Wosila was in her 20s, was brought to the Assessment and Emergency Unit of the Aro hospital around 10am on Monday 25, March 2019. Wosila was presented to the hospital in the company of her husband and two other men and women. Wosila wore a white gown and a cap commonly worn by members of syncretic churches (generally called 'white garment church' in the region). According to them, Wosila, had given birth to the baby some five weeks before her hospital admission with one those women carrying the baby on her behalf. In her husband's statement, he had arrived home one evening (some six days before coming to the hospital), to find that his wife had prepared the dinner for the family as usual,

and they all ate. However, he noticed that she was singing continuously, but he believed Wosila was just happy, and he was not worried until he realised that Wosila kept singing throughout that night and she started 'speaking in tongues.' Being glossolalic, he thought his wife had been 'in the 'spirit', and by the dawn, he called on his father, who was also a pastor and founder of a white garment church. After briefing his father about the development, his father sent some church officers to bring Wosila to the church that morning. At church, they attempted to relieve Wosila of the spirit possession so that she could take care of her new-born baby. But all their efforts proved abortive and after five days the father referred her to the Aro hospital.

Although the above story contains information about illness management related practices in the study stetting which I will explore more thoroughly in the next chapter, it also elucidates interpretation processes relating to mental illness including the kind of relational agent involved, in this case – elderly, close relations, especially blood ties, religious leaders and spouse, and some reasons for their involvement. It is noteworthy that the interpretation of symptoms varied based on the personal experiences of the interpreters, their knowledge of the sick person, and the time symptoms had elapsed. For example, Flaky's course-mates identified absenteeism and self-isolation and interpreted it as 'sickness' and her parents saw non-recognition of their authority, and so on. Wosila husband initially saw happiness and glossolalia. The caregivers, often the parents, siblings and spouse gathered as many as possible interpretations and eliminating other possibilities before conceding to mental illness as an explanation.

To dig deeper into the case of Ìyá Ìjọ, her husband recounted how he sought interpretation from his wife's elder siblings and his pastors. Part of their interpretations include evil machination from an 'enemy', as Ìyá Ìjọ had become suspicious of one of her neighbours who had threatened to kill her in a dream some ten months ago prior to her first episode. Dreams are often connected with mental illness episodes among the Yoruba (see also Aina & Famuyiwa, (2007). Meanwhile Ìyá Ìjọ had been complaining of heart burn and chest pains weeks before her first illness episode. Interestingly, Ìyá Ìjọ was first taken to a teaching hospital where she was referred to the psychiatric unit of the hospital. Her husband and pastor, however, turned down the initial hospital interpretation and brought her back home

to continue praying for her. According to her husband: 'Everybody, except one of her sister's husband, was just saying the same thing, that it was an attack[10]. Only that man, who is also an ulcer patient himself said that she was suffering from ulcer. He maintained that a chronic ulcer was responsible for those symptoms she was manifesting, including the chest pains, heart burn, and hallucination.'

As will be seen in the next chapter, the interpretation of mental illness and elimination of alternatives is better understood when it is considered alongside other factors such as available treatment options and the time required to seek 'effective treatment'. The illness histories I collected from patients admitted to Aro suggests that almost every interpretation occurred alongside an attempt to manage the illness (see chapter five). As Ìyá Ìjọ's case implies, accepting an interpretation suggests the acceptance of a relevant management approach.

The importance of multiple social relationships on a person's diagnosis pathway also partly explains why a person's symptoms sometimes featured contradictions, as observable in the case of Ìyá Ìjọ, where some offered spiritual explanation and solutions, and another described a medical condition – an ulcer – as responsible for the same episode. Also, the degree of relatedness between and among caregivers and eventual interpreter of mental illness seemed to influence the weight of interpretation in some cases. Recall that it was a spiritual father of Wosila's husband that decided when and where to take her after different interpretations while *Iya Ijo* was taken a psychiatric unit in late November 2018 based on the advice of her eldest brother who also doubled as pastor.

It is noteworthy that people were reluctant to describe a close friend or relative someone as being mentally ill, generally referring to them as a 'sick' or 'unwell' person. This therefore could generate a contradiction and tension between what caregivers *said* (not admitting that their relative has mental disorder) and their actual practices (bringing their relative to psychiatric hospital). Thus, while Aro hospital was widely understood as a place for treating mentally ill persons, many care-givers would not want their patients in the hospital to be

[10] **Attack** as used here referred to an evil machination or spell or affliction usually inflicted remotely on the victim by some invisible agents

labelled as mentally ill. I will explore this in more detail in chapter six. The tension was also acknowledged by the hospital staff who shared the Yoruba belief that 'it is fun only to see *were* (mad person) in the market/public space, but not as one's child'. Another senior nurse justified it as follow: 'You know our people, because of the stigma and other issues related to mental illness, they do not want to admit that this [mental illness] is the problem.'

In conclusion, this chapter has explored two separate but related issues: how people became seen as suffering from mental illness, and the conceptions of personhood that were embedded within understandings of mental illness. It has demonstrated that identifying and interpreting mental illness symptoms largely depend on the dominant understandings of personhood that were present in the study location. Previous studies (e.g., Conklin & Morgan, 1996; Degnen, 2018; Ikäheimo & Laitinen, 2007), have noted that the notion of personhood differs cross culturally. This study has noted the existence in Abeokuta of a multifaceted personhood comprising different aspects such as job, age, gender, belief, financial independence, and interpersonal relationship among others, which are all distributed across various social places. Personhood is also contingent on a person's position in the lifecycle and their gender. As such, this chapter further expands understanding of how the social, personal, and spiritual dimensions of personhood identified in other African settings intersect (Kpanake, 2018a). Importantly, I have shown that mental illness was characterised with lack or loss of one or more aspects of the personhood thus made the mentally ill people unfit to be a person. Consequently, participants claimed that an effective mental health care must also be multifaceted in nature and aim at restoring the mentally ill person back into the society, a point that is fully explored in the next chapter.

CHAPTER 4

PATIENTHOOD: BECOMING AND BEING A PATIENT IN THE ARO HOSPITAL

4.0 Overview

Building on the understanding of personhood and multiplicity developed in the last chapter, this chapter explores how constructions of personhood shaped what it meant to be a patient in Aro hospital. The chapter adds to the empirical knowledge and theoretical understanding of doctor-sick person relationships and ideas of 'patienthood' that have developed over the last six decades. First, the chapter traces the academic discourse of patienthood and doctor-patient relationships and highlights various perspectives that have emerged so far. It then presents some accounts of patienthood and doctor-patient relationships as found in Aro hospital, Abeokuta. Through ethnographic materials, the chapter posits that patienthood takes a multiple form in that, on the one hand, it varies based on places (in or outside the hospital and from one facility to another) and nature of care (provided by hospital staff or family/relative), and on the other, the processes that produce it are also multiple. I maintain that patienthood forms the bedrock of mental health care and it is produced by 'assemblage practices' (Berg & Bowker, 1997; Collier, 2006; Collier & Aihwa Ong, 2007). The chapter shows how several human and nonhuman agents in the hospital produced and reproduced patienthood. The chapter also demonstrates that the processes that produced patienthood were distributed and shared by a range of actors and agents that rendered the agency of the patient passive. While the chapter aligns with some contemporary understandings of 'assemblages', it also resonates partly with an idea of 'passive patient' that goes back to much older literature (e.g., Parsons, 1951, 1975). However, contrary to Parsons' claim that illness was responsible for the patient's weak agency, ethnographic data in this chapter suggests that it is the mental hospital treatment and peoples' notions of the patienthood associated with mental illness that primarily cause or exacerbate loss of the patient's agency. Finally, the chapter concludes that patienthood is made in and belongs to the hospital but does not end there. In this setting, patienthood lasts for a long time, if not a lifetime, as do its effects on the patients' life and social identity.

4.1 Patienthood in the literature

The 'patient' always occupies a strategic position in the care and treatment process. It is almost impossible for care and treatment to take place in biomedicine without a doctor-patient interaction, thus making patienthood a crucial aspect of medical care. Despite this, doctor-patient relationship was not part of academic discourse either in health sciences or social sciences until the mid-twentieth century. Perhaps the first person ever to notice and made effort to fill this gap was Henderson in his article titled 'physician and patient as a social system' in the 1930s. In this (1935) article, Henderson likened patient and physician to separate 'agents' with different characteristics but bound together by their 'sentiment' and 'interest' to enable the formation of the 'social system' (ibid). However, Henderson acknowledged that the topic could be better studied by social scientists, especially sociologists and psychologists. More so, his idea lacked empirical evidence and he could not explain many of his major concepts including 'interest' and 'sentiment'. Nevertheless, this article seemed to have influenced Talcott Parsons some fifteen years later as reflected in his book which he also titled 'Social System' (see the footnote in Parsons, 1951: pg288).

All issues around 'disease', diagnosis, and treatment remained solely in the purview of the health professionals and academics in health sciences until Talcott Parsons' sick-role theory was developed in 1951, which brought these concerns into sociological purview (Barbot, 2006; Mol, 2002) This longer history notwithstanding, Talcott Parsons is the one widely credited by several authors for integrating 'medical setting' and doctor-patient relationship into social science discourse. In chapter ten of Parson's book titled 'Social Structure and Dynamic Process: The Case of Modern Medical Practice', Parsons offered a functionalist perspective to the understanding of health care setting as well as the roles of the patients and physician. His analysis has implications for the agency of patients which I will discuss later. As a functionalist, Parsons explained the medical setting as a social institution while he held physician and patient as social statuses, each with certain roles and responsibilities. To Parsons, physician is the only competent person to be recognised to diagnose and treat illness while patient has the right to be treated but also duty-bound to surrender self to and cooperate with the physician; an analysis he termed 'sick-role' theory.

Healthcare activities and doctor-patient relationships have since become a major topic of social science inquiry and analysis. The influence of sick role theory was long lasting because it was the first social theory of medical care, and it became a catalyst for other social studies of health. As such, the concept of the sick role dominated discussions on doctor/patient relationships and patienthood, especially in medical sociology, up until the 1970s. During this time, discussion around the doctor-patient relationship focused on the role and performance of medical staff and the invisibility and powerlessness of individual sick people (see Moore, 2004). For instance, some argued that every mental hospital is a purposive social institution deliberately created to discharge mental health and that everybody, including the patients within the hospital setting, must work towards achieving this primary goal (see e.g., Goffman, 1961; Pine & Levinson, 1961; Waitzkm, 1971). As such, many studies of the time including Pine & Levinson, (1961) presented patienthood as surrendering one's belief or idea and identity and imbibe the hospital created identity and responsibilities.

From the 1970s, critiques of Parsons's functional perspective vis-à-vis sick-role theory began to emerge, among which was the claim that his ideas were 'infantilising' sick people and allotted a problematically passive agency to the patient (Mol, 2002; Moore, 2004; Parsons, 1975). The 1970s thus welcomed new perspectives that focused more on the agency of the patient and their direct or indirect control on their illness experience and involvement in decision regarding treatment. Weaknesses of the functionalist sick role perspective were the starting points of the new perspectives that emerged at this time. A number of other perspectives, notably Marxism, interactionism, and feminism among others offered alternative social analysis of the patient /doctor relationship and patienthood in the 1970s (Barbot, 2006; Mol, 2002:14-17). While Marxists explained patienthood as means of structural 'control' and illness as a result of violence and uneven distributions of resources and power in the society and viewed the instrumentality of hospital as one of the tools to sustain it; interactionists focused on individuals' capacity to evaluate and exercise right to choose (see e.g., Mechanic & Volkart, 1960, 1961; Moore, 2004: 295-6; Scambler et al., 1981). The 1970s also featured a moved towards theories of a 'customer approach' (see e.g., Eisenthal et al., 1979; Lazare et al., 1975), as well as 'labelling theory' which was

concerned with analysing illness as concepts and healthcare practices as sanctions of the dominant socio-political idea (Markowitz, 2013; Myles, 1978).

This concern with individuals' control and agency continued to shape debates in the 1980s and 1990s. Neoliberalism regimes and concomitant deregulation in the 1980s placed responsibilities of health and treatment increasingly on individuals. As such, patienthood became viewed as about how individuals managed their illness and maintained their health in the face of scarce resources and within an ambit of freedom to choose among alternatives of care (Kawewe & Dibie, 2000). One of such studies by Scambler et al., (1981) was conducted among women in Canada in the early 1980s. This study established that women, rather than being passive in the processes of health care, actively decided whether to access hospital and adhere to doctors' recommendations after considering various suggestions from family and friends.

Similarly, and not incidentally, these decades also witnessed a high incidence of chronic diseases, especially HIV/AIDS (which was initially considered a 'death sentence' before ART) and diabetes among others. These conditions are characterised both by increased long-term medical interventions or medication use and 'social' implications such as stigma, isolation, change of lifestyle and diet, among others. The nature of chronic diseases often means that patients get actively involved both in recognising the symptoms and treatment administration (Mol, 2008:p19). These changing circumstances in the 1980s and 90s led some scholars such as Deborah Lupton to centre their discussion on 'active patienthood' resulting in new models for thinking about doctor-patient relationships such as clientship, 'partnership' or 'negotiated' relationships that fought back against doctor domination. For example, in (1993) Lupton studied how patienthood was constructed in advertisements in a major Australian medical magazine. Although she reported that between the last and first quarters of 1991 and 1992, more than half of the advertisements had no representation or indication for the patient either in image or texts; Lupton noted the shift of emphasis (a significant change of 4% to 39% of the images) from a doctor-centred representation to a patient-centred representation compared to past decades among those advertisements that used images. Also, in her book 'The imperative of health' published in 1997, Lupton argued that no matter the instrumentality of government enjoyed by the public health

practitioners, individual patients possess a certain degree of 'power' that cannot be relinquished to self-determine his or her health related practices (Lupton, 1997). For Lupton, the 'active patient' is not negotiable, not even among socially or economically marginalised people such as HIV/AIDS patients, especially in the light of various 'activist groups' that have emerged in the interest of the 'voiceless' (ibid:133).

More recently, social scientists have expanded the discussion around patienthood beyond the context of doctor-patient interaction, to include other parties that are involved in accessing care. As earlier mentioned, some chronic illnesses are not only characterised by 'no cure' but also attract social condemnation and stigma (Whyte, 2014a). As such, some social activists and pressure groups have become increasingly involved in the process of health seeking and treatment, especially for 'marginalised' people (Barbot, 2006; Lupton, 1997). Considering some recent developments such as in the area of HIV/AIDs, some scholars (e.g. Barbot, 2006; Mol, 2008; Whyte, 2014b) have adopted concepts of 'clientship' to analyse a kind of 'mediated patienthood' where some groups of individuals now 'procure' medication or pay for the treatment for 'others' to enjoy. For example, in Uganda, Whyte *et al* have shown that anti-retroviral treatment for HIV/AIDS became accessible to more people but often on the condition that people possessed membership of an organisation that supported patients. They have describe how people could often only seek medical help only the clinic where that organisation enrolled or referred him/her (Kajubi & Whyte, 2014; Whyte et al., 2014). Similarly, others have emphasised that lived experience of disease could make the patient-doctor relationship take a form of customer-merchant relationship. These pressure groups, in their various forms and operations, tend to share the notion that patients would have gathered relevant experiences that could enable them participate actively and beneficially in the treatment processes due to their frequent interactions with various medical personnel over a long time of their chronic illness (Barbot, 2006).

Another major innovation in recent literature has been a focus on explaining the different structural and material processes under which patienthood emerges. Rather than being a single object in the arena of care and treatment, patienthood became seen by these scholars as a sum of different activities and by various agents, with scholars drawing on ideas of 'assemblage' that were becoming prominent in anthropology and science studies at

the time (e.g. Collier & Aihwa Ong, 2007; Marcus & Saka, 2006). For example, Berg & Bowker, (1997) conceived of patient care as encompassing multiple tasks from different personnel and units collated as one in objects like medical records. Contrary to the idea that diagnosis makes an individual a patient, Berg & Bowker, (1997) argued that hospital treatment 'created bodies' and focused their attention on identifying the 'bodies' that were produced, those involved in the production of 'bodies', and how tools such as medical records made these processes possible. According to Berg and Bowker, the hospital produces and reproduces different 'types of bodies' (e.g., medical bodies, bodies politics, and bodies of knowledge) through processes that include time, space, persons, and objects such as documents and medical tools (Berg & Bowker, 1997). Adapting this approach to this work broadens our understanding of doctor/patient relationship and patienthood by considering them as assemblage of several activities, persons, and units.

It is notable that the majority of literature on patienthood reviewed above (with the exception of some of the work on HIV by Whyte and colleagues) has focused on contexts in the Global North. In a hospital-based study from northern Ghana, Andersen, (2004) shows hospital patienthood as a bye-product of socio-economic status that usually emerges from day-to-day interaction. She maintains that hospital was an extension or replicate of a wider Ghanaian society where the social value and recognition attached to a person is a function of his/her socio-economic and socio-political status. In this Ghanian context, as narrated by Andersen, patienthood is not fixed but varies. On the one hand, patienthood (for the poor) requires that the care seeker assumes a subservient position, always exercises patience, and is respectful of the hospital staff. On the other hand, patienthood for wealthier patients suggests a more egalitarian relationship between the healthcare seeker and provider, which is reflected in the mode of dressing and social exchanges that include both tangible (e.g., gift) and intangible (e.g., ability to communicate) aspects. Studies from Kenya also suggest that patienthood in some Kenyan hospitals is influenced by the social status of the patient and social closeness to the medical staff though. The studies also characterised patienthood with 'social lowness', respectfulness and obedience to the medical staff, and perhaps with little or no empathy thus suggesting a kind of subordinate/superordinate doctor-patient relationship (Brown, 2010, 2012).

Some studies, e.g., Fox & Goemaere (2006), Whyte (2014), Whyte et al, (2014), from Uganda and South Africa have also reported a kind of 'mediated patienthood' in the case of patients in need of ART for the HIV/AIDs treatment. Patienthood, in this case, is portrayed as a joint task requiring cooperation among the hospital staff, the social group sponsoring the ART and the patient. As such, being a patient requires membership in a certain social group and involves adhering to the rules and regulations guiding the process of ART provision, such as clinic attendance and adherence to doctors' prescription.

The above notwithstanding, more reflection is required on patienthood in general and psychiatric patienthood in Africa. Many of the existing patient-related studies across African settings, especially in Nigeria have focused more on investigating factors that might encourage or hinder hospital usage rather than exploring the nature and dynamics of patienthood. These studies include patients' perception and satisfaction with the process and contents of care received (see, e.g., Abioye Kuteyi et al., 2010; Afolabi & Erhun, 2012; Arije, 2018; Odusanya & Babafemi, 2004; Ogaji et al., 2016; Ogunfowokan & Mora, 2012). Some other studies were also concerned with the patients' attitudes and behaviour towards care and or care providers (e.g. Anyanwu et al., 2011). Patient's attitude and behaviour towards staff and other patients in the hospital has been seen as a greater concern in the cases of psychiatric patients (James et al., 2011), while others reported how some social and legal policies define and redefine the right, obligations and responsibilities of psychiatric patients (Moosa & Jeenah, 2008). In such a case, the emphasis is on the new national and international policies that have prescribed more humane treatment of psychiatric patients, such as the abolition of involuntary hospital admission, among other inhumane treatments.

The ethnographic material from Aro hospital that I present in this chapter draws on the existing literature from the global South, particularly that reflecting on the importance of different hierarchies in shaping care. I go on to show that in this context, patienthood is both an 'assemblage practice' (Berg & Bowker, 1997) and involves practises that highlight the enduring relevance of the 'older' perspectives, especially some of Talcott Parsons' ideas. Parsons described illness as a disruptor of 'normal social' roles (Parsons, 1951, 1975), perhaps because of the prevailing experience of the time, that is, infectious diseases, which could halt some daily activities and incapacitate people. More so, it is possible that most of

those who emphasised 'active patienthood' (e.g., Barbot, 2006; Lupton, 1993; Whyte et al., 2014) were influenced by the boom in technologies through which knowledge about some chronic diseases (e.g., diabetes, HIV/AIDs, and high blood pressure) was amplified, and the growing use of home devices that empowered individual to discuss, monitor, and administer their own treatment (Sosnowy, 2014; Whyte et al., 2014). On the contrary, my ethnographic data suggests that patients with mental illness patient may not be actively involved in their treatment process as those with other chronic diseases partly because severe mental illness has always been defined in relation to 'disability', 'disruption', and 'low functionality' (see e.g., Goldman & Grob, 2006; Phelan et al., 2000; Wahl et al., 2002).

Lastly, in Nigeria, like many other developing nations, mental health care has not experienced the growth in public acceptability and favourable socio-political interventions of the kind which have been reported as giving power to the 'powerless' and voice to the 'voiceless', in the case of HIV/AIDs and diabetes in western and some African nations (Barbot, 2006; Landzelius, 2006). Mental health care is one of the most neglected areas of medicine (Andrade et al., 2014; Oye Gureje, Abdulmalik, et al., 2015). As such, the nature of mental illness and the absence of activist groups for mental health care perhaps reduced the chances of making 'active patients' rather than a weak agency in Aro hospital. The above notwithstanding, bringing these approaches together draws attention to the fact that patienthood varies in time, space, and ill-health conditions. In what follows, I will show that the making of patienthood in the Aro hospital follows a complex way that reflected the *assemblage practices* (Berg & Bowker, 1997) and the impacts of it on the patients who navigate care in relations of often extreme hierarchy.

This chapter, therefore, explores how patienthood emerged and was sustained during the period of admission in Aro Hospital and beyond. In Aro hospital, Abeokuta, numerous human and non-human agents together produced and sustained patienthood through several heterogenous social activities and relations. Although family members or caregivers paid for hospital treatment like customers, medical staff conferred patienthood on the 'sick person' and retained its 'ownership' through a web of bureaucratic processes involving various hospital units. More so, unlike the process of 'becoming mentally ill' (as in chapter three) that usually started gradually and outside the hospital setting, a 'sick-person'

immediately transformed into a 'patient' in the hospital once admitted into medical treatment. Whilst patienthood started inside the hospital, a mental health diagnosis did not end with the patient's discharge and could last almost a lifetime. The chapter describes two types of Aro patienthood: in-patienthood and out-patienthood. Both types of patienthood have implications on the agency of the patient. In the following sections, the first part describes the production of 'patienthood' and its features, and then I show how patienthood forms the basis for Aro mental healthcare. Here I demonstrate that patienthood is a multiple or assemblage practices and highlights various agents and practices that together produced it. The second part discusses the two variants of Aro hospital patienthood and some effects of patienthood on the agency of patient and their social relations.

4.2 The production of 'patienthood' and its features: how a 'sick person' transforms into a 'patient' (inpatient) in Aro hospital

In Aro hospital, all treatment started with and built on patienthood. Nobody came into the Aro hospital as a 'patient'; they only became a 'patient' in Aro hospital. The caregivers presented their relative to the hospital as a 'sick' or 'unwell' person, and the hospital staff also regarded them as such. Following this, the first noticeable thing that the hospital staff always did was to make the 'unwell person' a 'patient' through a series of bureaucratic and social processes. Let me illustrate this with one of the several of such encounters for a better understanding.

It was day off for Iya Prof., one of the senior nurses in the hospital. I was not expecting to see her at work, so when I saw her, I asked if her day off had been called off. She replied in the Yoruba language that she was on leave still but briefly came to lend her support to family friends who were bringing **their** '**sick person'** to the hospital. What caught my attention in her response was the use of the identifier – 'sick person' and the possessive pronoun – 'their' in the statement.

Throughout my fieldwork, I noticed that the staff in Aro did not address a newly brought person into the Aro hospital as a 'patient' but as a 'sick person'. Patienthood was the first mandatory step for anyone accessing Aro hospital mental care. The staff commonly used the

term' patient' as a third person identifier such as ‘she’s our patient’ rather than in direct dyadic conversation where they used the person’s name or relevant pronoun. No sick person had a right to any form of treatment until his or her patienthood was successfully made. Those whose caregivers could not fulfil the requirements for the transformation into a patient remained a ‘sick person’ for as long those requirements could not be met. As such, there were some occasions where ‘patienthood’ was delayed for hours and/or even denied. Meanwhile, the hospital staff had no duty-bound responsibility towards such a ‘sick person’, as will be seen in following examples.

Adewale, a young man in his mid-twenties with his hands and legs tied, was brought by his father and another three adult men to Aro hospital. Adewale was aggressive and ferociously demanding that he should be loosened immediately and allowed to go his way. According to his father, Adewale was tied because he had attacked several family members, including himself. Even at the hospital, Adewale remained aggressive and restless, frantic to break off the rope, to the extent that the staff warned everybody to keep a distance from him. Perhaps, one would expect that staff rushed and started the treatment immediately. The hospital staff, especially the nurses, were ready to attend to him, but when they realised that Adewale was a first timer, they asked the father to ‘open a file’ for him before they could do anything.

The father was ready to start the process until a senior nurse told him, ‘You will need close to a hundred thousand naira if your son will be admitted, but just open the file for him first, so that we can quickly arrest the situation.’ At this point, Adewale’s father became dazed and said he had less than three thousand naira on him. Despite all his appeals and considering Adewale’s condition, vis-à-vis the possible danger that Adewale may pose to his family and community if not treated, the staff on duty, including the doctors, insisted that nothing could be done until ‘due process was followed’ i.e. the family had made the payment for registering Adewale, actions that would make him a patient.

At the end, Dr. Show, the consultant in charge arrived, and was briefed about Adewale’s case and told that the caregiver could not afford the registration fee. Show invited the father into his office and told him that the ‘rules could not be bent’. Show however advised him to solicit funds from other caregivers and staff to raise at least ‘money to open a file’ (a cost of

6,500 naira), so that they could give his son an emergency treatment for the next twenty-four hours. Dr. Show further added '…I also hope that the arrangement would give you some time more to source for the required amount for the admission, and if after then you cannot raise it, we can discharge the young man to go home while he continues the rest of his treatment as an 'outpatient.' Show was the first to donate and some of us too offered our support, and Adewale got registered eventually after our donations but not without about five hours delay.

The above example reveals the imperative of patienthood in the Aro hospital treatment processes. Adewale's example demonstrates that patienthood always preceded diagnosis. The staff regarded this process as 'regulation', 'procedure' or 'due process'. The 'due process' was known to all the staff and it was considered essential that it was adhered to by everybody including the caregivers and the 'sick person'. Being in the Aro hospital did not automatically guarantee treatment until such patienthood was acquired. In other words, the Aro hospital staff only treated 'their patients' and when there was no patienthood, there could be no treatment. This is in line with some other studies which have shown that patienthood in mental hospital sometimes involves 'compliance' with rules and regulations (e.g. Pine & Levinson, 1961; Topo & Iltanen-tähkävuori, 2010).

The above example also shows that patienthood is made by the staff through explicit rules. This finding is contrary to the impression given by some medical scientists (e.g. Woo & Keatinge, 2008) that psychiatric patienthood is a by-product of diagnosis and treatment rather than a distinctive component amongst several others that constitute mental health care in the hospital settings, that is made with conscious efforts. The findings at Aro hospital are in line with a recent ethnographic study among the post-war Kosovo residents by Hanna Kienzler. Kienzler's study reveals that mental healthcare personnel 'make' patients through a process that is influenced by shared historical, social, and political, and ecological experiences (Kienzler, 2019). Lastly, the example above demonstrates that making patienthood in Aro hospital involves some people, activities, and obligations such as 'opening of file' payment and admission, among others, or what I am describing as an assemblage of practices that *make* patients., The following section will unpack in more detail the process, activities, and agents involved in making patienthood in the study setting.

4.2.1 Patienthood as a collection of several practices through various human and nonhuman agents

In Aro hospital, patienthood is produced through a sociolegal contract between the hospital staff and the caregivers with the aid of some nonhuman agents. As I will show in a short while, Aro hospital patienthood is about responsibilities and obligations which may involve both the staff and caregivers and at some cost. For now, this section will demonstrate how the 'sick person' is transformed into a 'patient' with the view of demonstrating that Aro hospital patienthood is a collection of several activities that are shared among different agents, including humans and nonhumans, and through bureaucratic processes. I will further show that even though it starts in the hospital, patienthood does not end there, and it may last for a lifetime.

Let us consider Mr. Saturday's example again. Saturday was one of the major characters in the previous chapter. Recall that Saturday was tricked into Aro Hospital in March 2019 for an in-hospital treatment by his elder half-brother, Mr. Dipe. Being a first timer, at his arrival, the staff addressed him as **Mr. Saturday** until the procedures for producing patienthood were completed. As will be seen shortly, the prefix, 'Mr' in that context was a sign of respect. Dipe's friend, one of the nurses, told him that he had to register Saturday before anything regarding treatment could be done. So, he directed Dipe to the office of the account officer, where he paid about six thousand naira (about £10) for the registration. The account officer asked whether Dipe was paying for himself or another person. 'It is for my younger brother' Dipe replied. As Dipe was talking, the account officer was writing and in about two minutes, he presented Dipe a receipt and instructed him to present the receipt in the next room where he would be attended to. The room he referred Dipe to was the recording officer's office and here he met Mr. Cash, the officer in charge. On the table was a large register book and Mr Cash brought out an unused office file from his cabinet with a small card and placed them on his table.

Cash welcomed Dipe and offered him a seat. Just as Cash was asking Dipe to sit, he was simultaneously stretching his right hand to collect the receipt from Dipe. Without prior discussion, Cash looked at the receipt and called the name aloud, 'Mr. Saturday Ogun!' Then Dipe replied, 'Yes, it is my brother.' Cash further confirmed from Dipe if Saturday was in the hospital in person, 'Yes sir!' He replied. Cash asked and recorded some sociodemographic

data, medical histories, and next of kin details for Saturday on the large register in front of him. He also filled some spaces provided on both sides of the files, and inserted a few loose ruled sheets and the small card before he gave both the file and little card to Dipe to give to the nurses at the reception. A nurse collected the file from Dipe and asked him to wait for Saturday's turn to be called. The nurse at their stand brought out a blue booklet from their drawer, copied Saturday's information, including his name, from the file to the booklet, and inserted it before dropping the file on their table. A few minutes later, Saturday was called and Dipe went with him to sit in front of the nurses. The nurses then asked them questions and documented his illness history and their diagnosis in the file. After that, the nurse told them to go back to sit down and be attentive to the doctor's call. After writing several pages and recoding Saturday's 'vital signs', the nurse closed the files, packed them together with two other files, and took them to the consulting room A.

It took about another hour before Saturday was called. Standing at consulting room's door with the file was a doctor. 'Saturday Ogun!' Dr. Falah called with a very loud voice. At this time, no 'Mr' was added. Falah offered Saturday and his brother a seat each to sit at the opposite of his table. Falah started asked various questions of Dipe and Saturday and documented their replies on the ruled sheets in the same file to form medical history, complaints, and diagnoses. Falah too added some other smaller coloured sheets for medical tests (blood and urine samples) and prescriptions. He wrote on each sheet the name and other information of Saturday such as his gender and age. As Dipe and Saturday left the consulting room, the doctor told them to go and see the social workers and occupational therapist along the corridor for the next actions. Then he gave a copy of a drug prescription to Dipe to present at the Pharmacy. The doctor again informed Dipe that he and Saturday should return to the nurses with those drugs so that the nurses could administer them once they had finished seeing the social workers and occupational therapists.

The above shows the agents, bureaucratic process, and financial commitments that produce patienthood in Aro hospital. Producing the label 'patient' involved some explicit roles of different categories of the units and staff, such as the account officer, medical recording officer, nurse, doctors, and social workers, and caregivers among others. The caregivers paid for the production of patienthood and played a supportive role by moving around and

providing information that enabled those personnel to produce and confer the title of patient on the 'sick person'. Each of these activities e.g., payment, registration etc. was a complete task in its own sense because it is also made of several smaller activities that took place in a different space and time (see Berg & Bowker, 1997:pg529-32).

Saturday's example also shows that some nonhuman agents, especially documents and documentations featured prominently in the process of making patient. By documents, I mean various materials or physical objects such as receipts, files, cards, and nurses' booklets among others, that were generated at one point or the other while interacting with a unit or person in the process of securing patienthood. The documents used in Aro had two major functions (1) they symbolised the multiple nature of patienthood and (2) they reproduced the patient. As in Saturday's case, every patient had a file that was filled with different documents from various units of the hospital that each person had ever directly or indirectly interacted with. So, just as a file always had several sheets that contained different information and were prepared by different people, so too was patienthood, produced by different actors in different parts of the hospital.

Documents also seemed to be a replica of the patient. The idea of one-patient-one-file can be better understood by looking at how the documents emerged and were interacted with by different actors during the patient-doctor relationship. Until they were filled in, these documents had very little importance. For instance, I once sought permission of Falah to snap some of the documents on his table. He told me that he could only allow me to snap 'ordinary paper' (pointing at the remaining unidentified copies on the table) and not the one he had written on because he would not want the identity of the patient to be captured. By implication, each of the documents was regarded as 'ordinary' until it became attached to a sick person and began to relate with others to become 'documents' and 'important'. The documents came to life through 'documentation' – the process of recording information of the sick person on an object in manner that their counterpart could decode. As the example depicts, writing these documents cut across all the sections and interactions that produced patienthood in Aro hospital.

Similarly, documents were made to speak about the patient to the experts reading them (Berg & Bowker, 1997). The example of Saturday demonstrates how inter-unit relationships

at the hospital could work smoothly. At the registration office, Cash and Dipe only exchanged greetings as commonly practiced among the Yoruba. He needed not to mention his brother's name to him as the receipt alone was able to inform Cash the name and the purpose of Dipe's presence. Cash only requested further information necessary for his office, and this was also the case in all other units. So, each document replicated the patient to the extent that was needed for any particular office to relate smoothly with the patient and other offices, while the whole file acted as a complete 'replica' of the patient's trajectory in the hospital. In another words, staff reproduce a patient via nonhuman agents such as receipts which did not only represent Saturday but also mediated the triangular relationship of the medical staff, Account Officer, Cash, and patients. Such reproduction continued with files, and cards, nursing booklets, and doctors' prescriptions and so on.

4.2.2 Patienthood as an enduring Aro form of hospital citizenship

Patienthood symbolically denotes induction into the mental hospital organisation, and it is usually the lowest position in the hospital hierarchy (Topo & Iltanen-tähkävuori, 2010). Recall that Iya Prof. referred to a prospective patient as 'their sick person' rather than a patient. Once a 'sick person' became a patient, such a person was seen as 'belonging' to the hospital and would be addressed as 'our patient', as the next example will illustrate.

Becky relapsed and was rushed to the emergency unit by two men and her mother on a Wednesday afternoon in March 2019. According to her mother, Becky was a 32-year-old divorcee. Becky's marriage had yielded no surviving child and had barely survived two years before collapsing because of her illness. Medical staff described how Becky exhibited hallucinations and a voracious appetite. Despite her considerable weight and protruding belly, she wanted to eat almost every thirty minutes. When she arrived, the nurses on duty asked Becky and her caregiver to take their seats to allow the account officer to return to the office so that Becky could start the 'due process' of registration, just like in the case of Saturday. Then, Nurse Ore, the ward manager, arrived from the seminar they usually held every Wednesday. Looking at the corner of the hall where the new entrants usually queued up before they are attended to, she saw Becky and her mother, and their discussion in Yoruba was as follows:

Manager: Ha! Ha! It is you again! What has happened this time?

Becky's Mother: That is what we saw. The day before yesterday, she was complaining about something, and as I attempted to speak on it, she just flared up and I kept quiet. The following morning, she told me that she was going out and that was all. The next thing we heard was that she was sitting [aimlessly] at a junction…

When the junior nurses saw that their superior recognised Becky and was speaking with Becky's mother in such as friendly manner, one of them, Mrs Beauty joined the conversation (she allowed Becky's mother to complete her response, then she asked her senior colleague Mrs Ore):

Beauty: Ha! Do you know them? [But it could also mean: Are they your relations?]

Manager: 'You mean the lady?' she pointed towards Becky

Beauty: 'Yes'

Manager: I know her very well now. She is our patient. So, you have not met have before?...

Becky and her mother were already sitting while those junior nurses were preparing to make Becky a 'patient' before the arrival of the manager, who informed them that she was already 'our patient'. As such, instead of taking Becky's mother through the process which Dipe/Saturday was subjected to, the nurses only asked for her hospital card before they retrieved Becky's files from the hospital's outpatient department and transferred her to the female ward. From the files, the nurses realised that Becky had been 'their patient' for about fifteen years.

The Becky's case is revealing. First, it demonstrates how patients are part of the hospital. Even though Becky had not been in the hospital for a long time, her patienthood was symbolised by her hospital card and her previous treatment in the hospital. Secondly, the example shows that 'patienthood', once successfully created, lasts for a very long time, if not for a lifetime. Becky's patienthood had been produced more than a decade ago and was still

as valid as when newly produced. One of the nurses also informed me that Becky's file showed that her mother was also 'their patient' and had been for about three decades. A senior Psychologist once told me a story of 'their diseased patient' whom they treated for years before his death. More so, the staff's common phrase, 'once your patient is always your patient,' further highlights that patienthood was seen as an enduring social status. On another occasion, when discussing this topic with a consultant, he said:

> ***Dr Show:*** Our patient remains our patient for life. It will be ethically wrong to marry your patient. The ethics of medicine do not permit that. However, there are some exceptions for that, at least when the person is no longer your patient. But in psychiatry, our patients don't cease to be our patients…

Thirdly, the example shows that the Aro hospital staff regarded patients as 'theirs' not just because they produced patienthood, but also because the caregivers ceded some caring and other responsibilities to the hospital staff. Different conversations among the hospital staff suggest a shared notion that hospital remained the owners of the patienthood. This notion was reinforced by the perpetual hospital residence of the document that stood in as the patient's replicant i.e. the file and card which contained information of the person. Similarly, transferring Becky to the Female Ward implied that the hospital would be responsible for certain needs and care earlier provided by her caregiver/relative, such as accommodation, feeding, and dressing, vis-à-vis monitoring of her daily activities among others, as will be seen in chapter five. For example, one of the occupational therapists, Mot said, 'We are doing everything to keep the patients informed and updated so that it would not be like they are totally cut out of the society.'

The 'everything' in Mot's statement (as seen in the next chapter) implies that influence of patienthood, including but not limited to the treatment, control, and care, extended beyond the physical hospital environment. The clinical staff often claimed they were ready to go the extra mile for their patients. For instance, one day, there was an incident of police arrest of one of the Aro hospital's patients. I was in the ward-round clinic with the clinical team led by Dr. Ibu. As the session continued, Ibu received a call that lasted for about four minutes. When Ibu dropped the call, he told his second in command, Dr. Mrs Pricilla that the call was from the security personnel at the gate. Ibu explained that a patient and his caregiver who

were coming for that clinic had been arrested by some members of the Nigeria police force close to the Aro hospital gate. Ibu immediately excused himself from the clinic and left with his car for the police station where those people had been taken. About two hours later, Ibu returned to the hospital with those individuals. Discussing the matter after the clinic, Dr. Ibu told us that it was part of their responsibilities to always support their patients wherever, and in any situation where they can.

The above section has described patienthood as an important aspect of Aro hospital mental health care. It has demonstrated that patienthood is not assumed automatically by presenting the self as a sick person at the hospital as some older studies maintained (Parsons, 1951; Tischler et al., 1975) portrayed, and does not map onto understandings either of 'clientship' or a simple dyadic relationship between doctor and patients (Emery et al., 1978; Lupton, 1993, 2013) portrayed. This section has presented Aro hospital patienthood as a product of different bureaucratic practices involving various experts and units of the hospital. It also demonstrated that patienthood is a sociolegal contract that involves the transfer of ownership, control, and caring responsibility of the sick person from the caregivers/family to the hospital staff, where it can last for almost a lifetime. However, in Aro this patienthood can take different forms, as either inpatient or outpatient. Each of the two has its own features and implications which I will discuss in the next section.

4.3 Types of patienthood and agency of the Aro hospital patient

The academic discourse around patienthood in the last three decades has focused on people's active participation in their healthcare processes and decision-making. Two major reasons for this are the influence of neoliberal governance regimes and 'rebellion' against medical paternalism (Levina, 2012; Sosnowy, 2014). As a result, the patienthood-related literature in this era is skewed towards concepts such as 'self-care', 'patient activism', patient empowerment', 'participatory patienthood' and so on. Several studies (e.g. Barbot, 2006; Landzelius, 2006; Lupton, 2013; Mol, 2008; Sosnowy, 2014; Whyte et al., 2014) have found the 'activeness' and involvement of the patients (with chronic diseases) in their treatment process is socially important and medically beneficial. However, the kinds of the treatment available and access to them differ across different locations and social classes (Andersen, 2004). As such, the level of the 'activeness' and 'involvement' of patient in their

treatment process would also perhaps differ based on the nature of disease, location, sociocultural belief, and social classes, among others.

Psychiatric patienthood is different from patienthood in other chronic diseases. This section describes the types of Aro hospital patienthood. I will argue that while some 'old orders' such as elongated hospital confinement and asylum in mental health care are giving way to a 'new order' that includes a shorter admission time and hospital practices that enable inpatient and outpatient treatment (Friedman et al., 1966; Varma, 2016), treatment in Aro hospital also retains some 'old ideas' of psychiatric patienthood, especially the passive agency and dependency of the patient (Parsons, 1975).

Aro hospital began its operations with outpatient clinics (Asuni, 1967; Ogedengbe, 1986; Jegede, 1981) and now admits patients, but only when it is necessary and for a limited time ranging from days to weeks. Dr Show's remarks in the previous section as to whether Adewale would be admitted or should continue his treatment as an outpatient reveal that Aro patienthood does not necessarily mean the person remains in the hospital. Aro hospital patienthood relives caregivers of their responsibilities to care for their sick person, and also hands over some of the personal rights and forms of adult independence of patients to the hospital staff. Going back to Saturday's case, it was clear that Aro patienthood wass often produced by the staff and desired by the caregivers but that this occurred without the consent or approval of the sick person. Recall, all that was done was resisted by Saturday, but done in his name and coercively. Before I continue, it is necessary to know that patienthood is a new status and identity, and both forms of patienthood usually begin with inpatienthood.

Inpatienthood may be short. All new 'sick persons' are start as an 'inpatient' and only later become transferred into an 'outpatient'. For the patient, transforming from a 'sick person' to a 'patient' is abrupt and usually meets them unprepared. Being an 'inpatient' means sharing some social spaces such as the dining hall, sleeping areas, and playground with unknown others (Goffman, 1961 p.297) More so, this transformation often happens within few hours without prior notice, thus leaving some patients feeling confused. Let me use another major character – Segun (who reappears in chapter five) to illustrate this suddenness and accompanied disorientation. Like many other patients Segun was initially

recalcitrant and was cajoled into patient registration. However, immediately after the registration, the doctor informed Segun that he would be admitted for a while. Perhaps Segun was not aware of the significance of his patienthood, and he raised his voice saying he was not going to stay. Unlike before, nobody, including the doctor argued with or persuaded him. The Doctor just passed his file and whispered to the nurses that Segun was not ready to cooperate. He came back to the room and informed Segun and his caregivers that he was finished, and they should meet with the nurses before going.

Segun was the first to step out of the room and in did so in annoyance. As he stepped into the main hall with aim of going outside, a male nurse quickly stood in his way and with a command tone said, 'Don't move beyond that place!' Before Segun knew what was happening, three of the other nurses had surrounded him, and from the back, a person held his two hands together. Segun eventually surrendered and was moved to the bed where other staff joined them to physically restrained him with 'four points' (i.e. by tying his hands and legs to the four poles of the bed). Segun became powerless and calm on the bed and a nurse injected him, then he slept. When Segun woke up after some hours later, he was pleading that his hands be loosened. By the following morning when I arrived in the hospital, he had changed his dress to shorts and round-neck top on rubber slippers footwear to look like a proper Aro hospital inpatient.

4.3.1 How Aro hospital inpatienthood infantilises adulthood and ascribes passive agency to patients

While Segun's illustration demonstrates how disoriented and unprepared patients could be to encounter the suddenness of Aro hospital inpatienthood, this status also challenges certain features of adulthood, despite the staff's claimed that all their patients were adults[11]. Aro hospital inpatients had limited freedom of choice even in areas as dressing which is an important aspect of the Yoruba sociocultural life, especially for adults. For instance, most adults, especially women, would not dress in the manner expected of them in the hospital they were if allowed to make a choice. The hospital staff determined what patients should wear even when it contradicted the patient's person opinion, as in the case of Iya Somefun below.

[11] Adult in the context of Nigeria and as applied in Aro NPH is eighteen years and above

Iya Somefun was in her sixties and was made to dress in a wrapper[12] even in a way that was different from how women patients normally dressed in Aro hospital (a top on a skirt or trouser). Iya Somefun was the only one covering her body with a wrapper in the female Ward I on that Sunday. She was neither allowed to go to the kitchen nor for any outdoor meeting like others in the ward. The two female nurses, Alhaja and Kehinde on duty were in their late thirties and had been working with Aro hospital for about ten and five years, respectively. When I asked nurse Alhaja why Iya Somefun was dressed differently she Alhaja started giggling and called her colleague Kehinde to answer my question. This was a way of making fun of Iya Somefun's situation, another rejection of adulthood that will be explained in a short while. After a while of giggling, Kehinde said in Yoruba language that 'Seems you do not know Iya Somefun! Just because you are seeing her looking innocently, she is so crafty.' Then, Alhaja went over to Iya Somefun and asked whether she would dare them to wear another cloth apart from the one on her. Kehinde added that Iya Somefun was her 'friend', but she trusted her that she would not dare them. 'We are the ones that kept her cloth away from her and gave her this bedsheet to tie so that she would not abscond because she has attempted it'. Kehinde added.

Dressing has lot of sociocultural significance in the Yoruba world as it can be noted in their maxim *irinisi n'ise ẹni lọjọ* meaning the way you dressed is the way you will be addressed. Almost every aspect of Yoruba dress including colour, size, and placement has a meaning and purpose such as communicating sexuality, elegance (Alaba, 2004), and social status (Sprague, 1978). While dressing is personal to an individual among the Yoruba, it is never private because it has social implications and significance. For instance, headwear alone (type of material, style, and dress/placement), such as *fila* (head cap) and *gele* (headgear) on Yoruba men and women respectively can tell the marital status, social status, intention, and importance of the wearer. Therefore, the individual Yoruba adult is free to dress as s/he may like, but only in such a way that aligns with the social context and their social status. Despite this social significance, especially important for Yoruba women, the nurses deprived Iya Somefun of the ability to dress herself and forced her to wear a bedsheet which fell short of expectations for an elderly woman of her status.

[12] **Wrapper** is a type of loose pieces of cloth that Yoruba women tie around their waist while they cover the upper body with a blouse or top

The nurses also treated Iya Somefun as she was younger than heractual age. Aro hospital patienthood in general denied patients some of their gerontocratic rights. Yoruba culture is passionately gerontocratic (Lloyd, 1954). Age is an essential factor in the Yoruba socio-political setting and old age is always accorded with respect. *Ọmọluabi* is the most 'honourable' appellation or description signifying a highly virtuous person in the Yoruba setting, and everyone will aspire to be called so (Adebisi, 2015; Oyekale, 2017). Part of the criteria for *Omoluabi* is respect for elders (Adeniyi, 2011). Age-related respect among the Yoruba is of so much importance that it is considered an art of disrespect and totally frowned at for a younger adult to call an older adult by name or look at his/her face when talking. The importance of 'respect for elders' (as it is commonly referred to) in social relations is evident in the adoption of the English language terms in the Yoruba language. For instance, the words *buọda* and *aunti* as well as *'sa*' and *'ma'* from the English words 'brother' and 'aunty' and 'sir' and 'ma' have been incorporated into the Yoruba langue as a prefix to a person's name and suffix to mean an older male and female respectively rather than the actual English meaning of sibling and affinal relations. The manner in which the nurses in the above case related to *Iya Somefun* by laughing when relating to an older adult being discussed would have been considered an act of disrespect and totally unacceptable outside of the hospital because of the age difference. More so, neither of the nurses, Alhaja or Kehinde, would have accepted such behaviour from anybody. A similar event in the same ward on the same day underlines this.

On that same Sunday morning of May 5, 2019, at Female ward 1, two women came to collect patients for the Sunday service. Almost all the patients in the ward had dressed up, and some were already coming towards the nurses' stand to write down their names before going. Alhaja was the one writing down the names one after the other as the patients formed a line. Alhaja had registered about six people, and another person was standing before her when she sighted Dunmi sleeping on her bed after dressing up. Dunmi was in her mid-twenties and one of the youngest patients in the Ward. Alhaja called her by name, 'Dunmi! Ha! Ha! are you not a Christian? Perhaps she was wondering why Dunmi did not want to go to the church. However, there was no response from Dunmi, Alhaja, angrily raised her voice and called her a second time. Then, Dunmi raised up her head on the bed

and said 'Yes ma'[13]. Although nobody could establish whether Dunmi heard the first call, Alhaja accused Dunmi of pretence, claiming that she was audible enough for Dunmi to hear her considering the short distance, suspecting disrespect. Then, Alhaja, in a commanding tone, asked Dunmi to come, and she verbally reprimanded her for 'lack of training' as she described it. Dunmi told Alhaja she had heard her but only once and she responded immediately. The other nurse and the women from the church asked Dunmi to apologise.

After apologising, she attempted to go back to bed, but Alhaja angrily asked Dunmi if she had instructed her to leave. Again, it was considered unrespectful for a younger person to walk away from the elderly. So, Dunmi got another round of rebuke. Dunmi said she would like to rest before going to the church because she had a headache. After threatening to pour a bucket of water on her bed, she was forcefully enrolled for the service. Anyway, such authoritative relationship between the nurses and Dunmi was understandable in the context of the age difference, however, the Aro hospital inpatients were not getting the same age-related privilege but always treated as if they were younger or infant.

These examples have revealed the suddenness of inpatienthood and how it could render adults passive and patients powerless while in Aro hospital. While some inpatients might have had their minds about what they wanted to do, including plans, and methods of execution that were expected of adults, they had no freedom to express this. Instead, all daily activities were centrally controlled by the hospital staff. Inpatients were always monitored and before engaging in any personal or collective activities they had to get permission from the staff, never mind that such a such staff may be younger and perhaps less experienced and less educated than the patient concerned. The infantilisation of mental hospital patients can be considered institutional because it is inherent in the mental hospital structure which ranks patients the lowest the hospital hierarchy (Topo & Iltanen-tähkävuori, 2010). However, once dependency is created and instilled in an inpatient, it does not end there but is transferred to the caregiver and medications in outpatienthood status.

[13] The Yoruba usually add a 'sir' or 'ma' as a sign of respect whenever talking to someone that is older than them or someone they hold in high esteem.

4.3.2 Becoming an outpatient and its implications

All inpatients are prospective 'outpatients' except those who die as an inpatient. There is a designated unit for outpatients in the Aro hospital, popularly called OP. The unit has a big hall that serves as a reception with some rooms on the two extremes of this building used for consulting rooms and offices, as well as a medical record office. In the hall, the nurses stationed at two stands attend to patients as they arrive. The unit receives a large number of outpatients and caregivers who come to the clinic all week long except on the weekends.

According to the staff, all discharged patients are reintegrated and reside with their various families and their files are moved to the outpatient unit. While the outpatients live among others in the community, they have certain social characteristics that differentiate them from other community members. As Becky's case suggests, being away does not stop them from being patients but turns them into long-term card-carrying hospital members.

More importantly, outpatienthood does not terminate dependency of the patient, it only modifies it. To discharge an inpatient is to transfer his or her care and control from the hospital to the caregivers. When an inpatient becomes an outpatient, the responsibility of care and control of the patient also changes hand from the hospital staff to the caregivers. As such, the patient is still expected to be dependent but on relatives or caregivers rather than hospital staff, as the following example describes.

On my first day observing Dr Ibu's ward round, two visitors arrived, an older man and his son, who was in his late thirties or early forties. As Ibu wanted to ask his team to invite the next inpatient, Nurse Khan informed Ibu of their visitors. He explained that the young man that the team discharged a few weeks back was around with his aged father and that he missed the initial appointed clinic day - a week before, because he could not secure enough fare for their travel. Then, they invited the man and his son to speak to the doctor.

After welcoming them, speaking in Yoruba language, Ibu asked both the father and son some general and specific questions and at a different time. For instance, from the father Ibu asked about the residence, co-residents, and condition of living of his son – their outpatient. Other questions touched on areas such as his health and social behaviour within and outside the family. In his response to some of Ibu's questions, the father said his son

could no longer go back to Lagos - his place of residence and job because there was nobody to take care or monitor and provide for him there. So, he had relocated him to be living tother with him and the mother at his personal house in his hometown.

On the health-related topics, Ibu asked whether the father or his mother noticed any strange behaviour such as aggression, agitation or any other 'antisocial behaviour' that worried them. He also asked about who was keeping his medication for him and ensuring that he takes it when due and correctly as well as whether he was heeding to their instructions of abstinence from smoking including marijuana. Responding to some of these, the father said that they were satisfied with his behaviour because nobody asked him to do anything, so he always slept. He further confirmed that he was overseeing his medication and always make sure he adhered to the regimen. Eventually, Dr Ibu prescribed medication for the father to buy and instructed them to return in a month's time unless there was any emergency.

The above demonstrates that 'outpatients' were also not independent but the under control of others, partly the hospital and partly the family. Despite the age of the young man in discussed above, both the structure and contents of the above discussion between the old man (his caregiver) Dr. Ibu, implied that the young man was not in control over himself. During the discussion most of the questions such as the choice of residence, behaviour, and medication were directed towards the caregiver and not the patient. Apart from transference of care responsibility, the story also confirms elongated hospital patienthood as in the Becky's example previously discussed. Outpatienthood in Aro hospital also involves periodic hospital appointments. Although not all the outpatients adhered to their appointments, the staff confirmed that all their patients were attached to a particular consultant and would have a specific time to meet them based on the consultant's evaluation of the patient's condition.

Furthermore, the various examples given suggest, that outpatienthood in Aro hospital was essentially characterised by what some of the staff termed 'medication lifestyle'. This implies placing a patient on a course of medical regimen on a regular basis for a long period of time by the mental healthcare practitioner as seen in the above example. Staff described 'medication lifestyle' as a necessity with two major effects, which were: (a) aiding and sustaining patients' recovery and keeping them 'stable'; and (b) preventing the patients

from relapsing. The staff often instilled in their patients that their 'completeness' (i.e. return to full personhood) depended on taking their medication. For instance, Mot said:

> *'We do psycho-education and tell them how they supposed to live their lives and we also incorporate this medication thing into it, because to very many people, it is not easy to key in into the medication lifestyle and still maintain it. It is quite difficult because it has been not part of the normal regimen or daily activities. So, medication management is another thing that needs to be inculcatde into their daily life which has not been part and if it is not properly manage, it will lead to relapse…'* **Aro Hospital staff - Mot, a senior occupational therapist**

The above suggests that it is mental health care, rather than illness as functionalists claimed, that makes patients passive and dependent. Medication lifestyle is an essential component of care of Aro hospital, and it has a huge impact on how the patients view their self, work-life, and social status. Hospital staff also reflected that medication often disrupted both social and economic life for lots of their patients. For instance, many staff affirmed that medications often increased the need for food and weakened some patients, making them sleep more than other members of the society. As a consequence, medication lifestyle could deplete finance, lead to loss of skills or even job loss, and thus further make patients more dependent and passive.

In addition, medication lifestyle indirectly marked a new social identity of the Aro hospital patient. Career and financial status are among the essential aspects of social identity which were directly or indirectly attacked by the medial lifestyle. Some hospital staff lamented that many of their patients were of lower socioeconomic status compared to other people in the society as reflected in a nurse's comment below:

> *'…You see, I do pity many of our patients because many of them are extremely poor. You know, many of drugs make them eat very well and sleep for some hours whenever they took it and that reduces the type of work they can do and even the hours to work. Besides, they would need to buy mediation come to the hospital all which requires money… don't also forget that some of the do not*

have helper…some have been abandoned by their husband or wives…they should subsidise pyshcotropic drugs if at all they cannot make it free…' **Aro hospital staff – Mrs Ore, a senior nurse.**

In addition to the cost of medication, periodic hospital appointments, relocation, family and social life disruption all directly or indirectly modify or create a new social identity for the patients. As Ore stated in the above, while medication denied some patients the opportunity to work, there were other economic cost attached to keeping hospital appointments apart from direct travel cost. All these factors further impoverished patients thus making them economically dependent on others. Relocation and family disruption were commonly reported among the patients. A consultant also confirmed this that though he believed that some patients discharged from Aro hospital could still do their respective jobs only that ,'Our people in the society, once they are aware that the person had been to Aro, they may not allow him'. Several studies have linked social identity to mental illness and recovery. Some maintain that sudden interruptions of social identity can be stressful and predispose a person or group of persons to mental illness (Kirmayer et al., 2000), others suggest that social identity can be critical to the process of full recovery from mental health (Hine et al., 2016; Mcnamara et al., 2017; Mcnamara & Parsons, 2016). More importantly, beyond the implication of social identity both as a predisposing factor for mental illness and full recovery, this chapter suggest that even the treatment involved in mental healthcare can also affect a person's social identity and agency in a negative way.

So far, I have described the production of patienthood and how the transition from being a 'sick person' to 'inpatient' to 'outpatient' occurs in the Aro hospital setting. It is noteworthy that the transition between these forms of patienthood is neither liner nor rigid, as it can be cyclical. The example of Becky typified how an outpatient today can become an inpatient the next day. The case of Meme was another example of complexity in patienthood and nonlinear transition. Meme's illness history revealed that she used to be a patient of another psychiatric hospital years before assuming patienthood of the Aro hospital (I will discuss Meme case in more detail in chapter 6). Similarly, Segun (mentioned above) used to be a patient of another hospital and only later gained patienthood at Aro hospital. These two cases confirmed the possibilities of multiple patienthoods. There are different reasons for

assuming multiple patienthood. The reason could range from loss of confidence in the treatment from or distrust in the hospital but detail discussion of such is beyond the scope of this chapter.

This chapter has discussed various literature on patient/doctor relationship and how it has shaped our views of patienthood. While the previous accounts dichotomised patients into 'passive' and 'active' categories (Barbot, 2006; Parsons, 1951, 1975; Pine & Levinson, 1961), this chapter has bridged the gap between the two. I have shown that the mental healthcare professionals did not have sole autonomy of making patienthood as the caregivers (often relatives) also actively played crucial roles. The chapter equally revealed that patienthood differs based on illness and facilities. While several recent perspectives on personhood have emphasised patients involvement in the process of their healthcare and treatment, such 'activeness' is challenged because in mental hospital such as Aro hospital, patients were considered incapacitated to make informed decisions, and therefore regarded as passive in planning and processing of their care. More so, this chapter has shown that patienthood is multiple as it has demonstrated that various types of patienthood exist within Aro. While the two patienthoods found in Aro hospital were made once and through same bureaucratic processes that were shared among different experts and units (Berg & Bowker, 1997), they were not the same. Patienthood, though made in the hospital by human and nonhuman agents, it could last for a long time and extend beyond the hospital. Patienthood in Aro hospital wass characterised by a new social identity which attached dependency to the agency of the bearer. Similarly, other mental healthcare facilities also made their own 'patienthoods', hence the reason one person may possess more than one patienthood. It is also worthy to mention that patienthood is not only the multiple medical realities in Aro hospital, but treatment is also a medical complex, and has a multiplicity of its own, as will be seen in the next chapter.

CHAPTER 5

ARO HOSPITAL MENTAL HEALTH CARE: A REFLECTION OF MULTIPLICITY IN TREATMENT

5.0 Overview

Over the last chapters, I have described how perceptions of failed morality and relations are ascribed to mentally ill personhood among patients at Aro hospital, and how patienthood is a complex, and multiple process. In this chapter, I explore the forms of treatment at Aro hospital, showing that treatment is designed to respond to these forms of damaged personhood and multiplicity. Staff described nonbiomedical aspects of personhood as essential indicators of mental well-being and saw their role as trying to treat these aspects of personhood formally, in addition to providing biomedical treatments. Treatment was, therefore ,multiple, covering biomedical, moral and practical aspects of personhood, and also required patients to enact proper forms of dependency, for example, through reward and sanction processes, conforming to the forms of patienthood I described in Chapter Four. This multiplicity sometimes required hospital staff to go beyond what they considered 'global best practices.' In exploring these facets of treatment, I provide a rich ethnographic example of the multiplicity of biomedicine that echoes insights from other recent work in medical anthropology

There are three sections in this chapter. The first presents the review of some previous studies on the multiplicity of biomedical practices. In the second, I present four core ethnographic examples from my fieldwork that show examples of how care was directed at different components of personhood. The last section of the chapter discusses how these ethnographic examples demonstrate the two core arguments of the chapter, that treatment practises are multiple and require certain forms dependency. Overall, this chapter adds to the growing body of literature on hospital ethnography and biomedical health care delivery and practices, especially the multiplicity of biomedicine and medical objects.

5.1 Biomedicine and its multiple cares and practices

Arguably, one of the major contributions of hospital ethnography to our anthropological understanding of care delivery and practices is that biomedicine is not universally homogeneous but multiple. The practice of biomedicine, particularly biomedical psychiatry differs cross-culturally based on variations in training of practitioners, historical and

sociocultural contexts, and infrastructural resources (see e.g., Abdulmalik et al., 2013, 2014; Finkler, 2004; Keynejad et al., 2017; Kienzler, 2019; Varma, 2016). Until recent decades, ethnographers did not consider hospital settings a study field site nor biomedical activities because they were seen as a component of modernity and therefore were erroneously assumed to be universally homogenous (Van Der Geest & Finkler, 2004). As such, most ethnographic studies focused on non-biomedical systems, or at best comparisons between biomedicine and 'other' medical practices (Baer, 2004; V Bhasin, 2008; Pool, 1994; Reis, 2002). However, ethnographic studies of hospitals in last three and half decades have shown that biomedicine is multiple in two broad ways: first, it varies across the world according to the socio-cultural context; and second, it varies even within a single hospital setting.

Medical historians have shown that historical antecedence is crucial to the understanding of the current form and practice of biomedicine in a given space and time (Akyeampong, 2015; Heaton, 2011, 2014, 2018). Even though biomedicine diffused from its European origins to other parts of the world, this happened at different times, followed different processes and the influence of European biomedicine on indigenous medical practices differed (Finkler, 2004). For instance, Robert Whitaker, (2010) put forward an argument as to how the institutional treatment of mentally ill people changed as a British model was exported to America, in his book - *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill* . He explained that biomedical psychiatric care in England evolved from commercial care homes that were set up by some individuals for people to keep their mentally ill relatives for a fee. This therefore partly explains the development of more 'patient-centred' treatment approaches and minimal political interference on mental health care in the UK, compared to the American context, where the development of mental health care was not only politically moved but was also created to serve political interests. According to Whitaker, some community leaders in the United States demanded that 'psychiatric hospitals' be established in their localities to offer treatment to the mentally ill people as was the practice in the UK. However, the colonial rulers of the U.S. adopted the motion to build facilities for the mentally ill but rejected the idea of 'hospital'. Instead, they built 'jail-like buildings' that aimed to keep the 'sane' from the 'terrors' of the 'insane' rather than provide treatment in a hospital (ibid 3-17).

Hospital care can be an analytical frame for the explanation and understanding of differences in activities and practices within a hospital setting and between different hospitals. Empirical evidence shows that biomedical care varies from one hospital to another. Using oncological care for example, anthropologists have shown how the organisation of oncological wards vary cross-culturally in terms of funding, available resources, and the methods of medical practice they employ (Livingston, 2012; Macdonald, 2016). Livingston's ethnographic study of a Botswanan oncological ward suggested that the lack of resources in the Botswanan oncology ward required a different practice of care based on improvisation. She revealed how economic necessity could effectively engineer difference in biomedical practices. More so, Livingstone shows how cancer ontologies in Botswana differed from those of other places, as did methods of diagnosis and care. For example, apart from differences in epidemiological records and mortality rates, 'precancer' is a frequently-used term in the southern American oncological world whereas it was lacking in Botswanan nosology and treatment (ibid). Biomedical treatments for cancer also differ. For instance, American oncologists often use aggressive chemotherapy and more costly medications than any other parts of the world; meanwhile in Botswana, due to limited available resources, practitioners had to borrow, adjust, or even deny relevant imported medical knowledge (Livingston, 2012). Macdonald, (2016) also reported that oncological care at a Mumbai Cancer Hospital suggested some improvised care, yet, she also showed that the available human and infrastructural resources meant the Indian hospital setting was starkly different from Livingston's description of Botswanan Ward. Macdonald also noted some differences in the social usage between American and Indian oncological hospital spaces, with patients in the former having several greeting cards around their bed, and the latter having family members present and involved in the hospital oncological care (Macdonald, 2016).

Finally, by and large, biomedical care is just one out of various forms of care that takes place in hospitals. Several hospital ethnographers have noted that family, parental, religious, and friendship care also take place in hospital spaces alongside biomedical treatment., Hospitals can be understood as an enabling 'care' in its broad sense and as heavily shaped by the prevailing sociocultural context (Brown, 2012; Macdonald, 2016).

The multiplicity of biomedicine is apparent not just *between* different hospitals in different contexts. The biomedical realities of disease, treatment and diagnosis can also have multiple existences even within the same hospital setting. Hospitals, including specialist hospitals, are bureaucratic and departmental and each section has its own way of creating, interpreting, and relating with medical realty (Mol, 2002). For instance, Berg & Bowker, (1997) have shown that the medical record means different things and used for different purposes across the hospital setting (see also Chapter 4). According to them, medical records are created by several units and individuals in the hospital. More so, a patient can be a person or file in the same hospital depending on the unit and purpose (Berg & Bowker, 1997; Brown, 2012).

Philosopher and ethnographer, Annemarie Mol, (2002) has also described the multiple realities, or, more precisely, the multiple practices, through which an apparently single disease entity itself becomes multiple within a biomedical setting. Mol noted that a medical object such as a disease, body, diagnosis, or treatment 'is more than one but less than many' (ibid:55). Through a careful ethnographic exploration of a Dutch hospital, Mol argued that medical reality is always made by different people and through numerous social relations and processes. To her, every 'medical object' always means different thing to different person within hospital a setting such as pathologists, vascular surgeon, and patient, and each of them has their peculiar method through which the biomedical object is made. For instance, the condition atherosclerosis meant a painful leg to the patient but palpitation and lack of oxygen to a vascular surgeon. Procedures for enacting diseases also differed from person to person; while those in outpatient units felt the leg's pulsation with fingers and wrote about it, patients took a few distance walks to feel it, and in the pathologists' laboratory, microscopes and chemicals were used (ibid :54). Like Mol's 'multiple bodies', mental health care generally, and Aro hospital treatment specifically is a collection of several medical and social processes in a way that suggests multifacetedness. Each treatment facet is also made of several social and relationship processes. However, Unlike Mol's study, this was not a setting where enactments of 'multiple bodies' was equal to one medical object. The ethnographic material in this chapter shows that something more specific was happening in Aro hospital, where the multiplicity of mental health care

practices directly reflected the multiple facets of damaged personhood. Also, in this context, informal treatment practices were as important as the formal ones.

5.2 Multiple practices in Aro hospital

Multiplicity was at the core of the way that staff at Aro hospital saw mental illness and therapy. As MOT, one of the occupational therapists, said:

> '*psychiatric patients usually present with so many complaints, or half presentation depending on their conditions. Firstly, there are some things they have been doing before, and they have a problem with doing it now because of their ill health…''*

By many complaints' and 'some things they have been doing,' MOT meant that mentally ill people usually exhibit multiple deficiencies. These symptoms could include poor concentration, personality disorder, and 'moral disorder'. Each required a different treatment approach, hence the multidisciplinary approach. A consultant, Dr. Show noted,

> *'…we run a multidisciplinary team here because everybody must be involved. We* [*Emergency Unit] have medical social workers, occupational therapists, psychologists, pharmacists, accountant, nurses, health workers, and attendants…including porters who assist in getting the job done and doctors…'*

In what follows, I present four ethnographic examples to show how therapeutic practices in Aro were multiple in the two ways I have described above, i.e. they are situated and embedded in terms of both global biomedicine and the local-socio-cultural context, and they are multifaceted, reflecting the multiple dimensions of damaged personhood that mental illness in this context entails.

5.2.1 Doctors and nurses – brain biology ('the head')

Staff claimed that treatment at Aro hospital focused on examining and treating the biological body, especially neurology and brain biology. This was the responsibility of doctors and nurses. Both doctors and nurses always watched out for conditions that could directly or indirectly explain patients anatomical or physiological malfunctioning during the process of diagnosis and this they did by interrogating the patient's past and directly

examining his/her body. A senior nurse, Bablo, claimed that illness usually has to do with the functioning of the brain and some neurotransmitters. To understand what affected such aspects of a patient and how, another nurse, Iya Prof. noted,

> *'…as for us [nurses], we have our own questions that we asked and we have what we are looking for in the patient…we want to know what his or her developmental stage was like, conditions around the pregnancy, birth and growth, family history, perhaps the person has been involved in accident'.'*

As such, doctors and nurses were often seen touching and discussing different parts of the body and using tools such as sphygmometer, thermometer, and stethoscope among others. They also collected body fluids such as blood and urine after measuring body temperature, weight, and blood pressure. Each doctor had a separate consulting room where she or he attended to patients one after the other. As plate 5.1 depicts, despite its small size (around 8ft X 10ft), doctors always arranged their consulting rooms in a manner that allowed for a bed where patients could lie down to allow for the doctor's examination that involved touching and pressing a patient's body, and in a way that covered the patient's nakedness from others.

The doctors' practices are exemplified by the case of Baba, an elderly man, who was diagnosed as suffering from dementia. Baba was brought to Aro hospital by his daughter and carer. His daughter complained that he was often aggressive, forgetful, and indiscriminately used spaces at home, for example eating, urinating and defecating in the bedroom. After obtaining illness histories from the caregivers, Dr. Falah, trying to educate them about Baba's illness, explained that just the same way all other parts of the body could get sick so too can 'our head', and the sickness Baba was suffering is called dementia. Falah recommended a scan of the skull which he claimed would enable him to assess the areas of the brain and see the extent to which it had been affected. Handling Baba's scan result and pointing at the black negative film, Falah explained that dementia has degraded Baba's brain and would progressively continue to do so. Plate 8 shows Dr. Falah's treatment intervention Baba as he prescribed some dugs, which he said would not cure but would slow down the progress of damage. Also, Falah collected blood samples and requested a urine

sample from Baba. According to him, the blood and urine were for laboratory tests in case of comorbidity.

The nurses, like doctors, also generally offered biological and neurological causal explanations for mental illness. Nurses focused their diagnosis activities on detecting the responsible biological part of the body or factor such as injury, genes, and abnormal growth that might be causing mental illness. The nurses treated mental illness by administering drug therapies daily directly on the sick person to control the aspect of the body that was affected. Plate 5.3 shows that the nurses had access to the patients at any hour of the day to observe and administer medication.

My chat with a group of nurses in the emergency unit of the hospital adequately captured the nurses' reliance on psychotropic drugs not only for treatment but also to sustain recovery. It was a Wednesday afternoon after the weekly educational seminar for hospital staff, and some nurses were telling me why some patients relapsed. They unanimously blamed relapse on stoppage of psychotropic drug or nonadherence to medication regimens. Here are the responses of two of their responses by Mr. Osho and Bablo.

> Osho: *'…if the patient heed to the warning, for instance, not to continue to smoke weeds* – [marijuana] *and is taking his/her drugs regularly as prescribed, s/he cannot relapse. Besides, many of them, once they are ok [made some recovery] after taking drugs for a while, they would think it has all gone, and then discontinue their drugs…'*

Bablo continued where Osho stopped that:

> '*…there are some hormones that the body always released into our brain to ensure it functions normally but only with the adequate amount of these hormones. Although our body should naturally regulate them, but in some patients, it is the medication that regulates those hormones to ensure there is no excess or shortage of them. Nevertheless, the patients do not know. …once the supply of the regulators stooped, what do you expect?...'*

Plate 5.1: One of the two doctors' consulting rooms at Aro hospital's Emergence Unit. It was arranged in a nway that patient could remove the dressing but behind every other person except the doctor.
Source: Author's Fieldwork, 2019

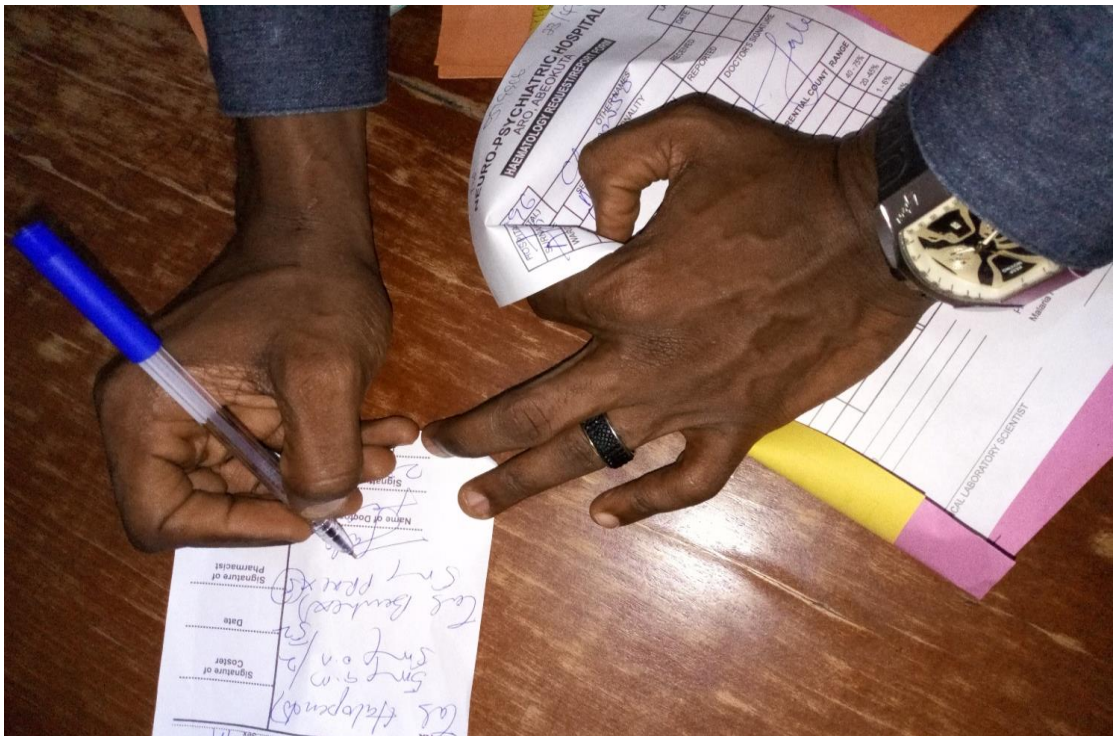


Plate 5.2: A Doctor doing what he knows best to treat his patient at The Emergency Unit in March 2019.

At times, doctors claimed that they were interested in other facets of patient's personhood such as work and finance; however, further explanation showed that any time a doctor or nurse inquired about other aspect of patient, it was in a bid to understand the how other facets of the person could help them in understanding the possible biological causes of his/her mental illness as well as the appropriate medication to be prescribed. For instance, a consultant said:

> *'There are some certain mental illnesses that are particular to certain profession. For example, suicide is more common in some certain professions such doctors and lawyers and the likes. So, getting to know your patient's profession could help us to know the cause of the illness. Then there are certain mental illnesses that are more common in some certain areas, or certain countries or certain settings or tribes or geopolitical or regional location within the world. Those things are the essence of asking for occupation and places. Aside from understating the background, it also gives us* (doctors) *a guide to your socioeconomic stability thus gives us a guide on the kinds of medication we can prescribe by having an idea of the limit to which a patient could afford.'*
>
> **Aro hospital staff – Dr. Show, a consultant**

Plate 5.3: A nurse in the Ward dispensing patients' drugs in the morning before they would come back from the dining hall for breakfast
Source: Author's Fieldwork, 2019**.**

It is noteworthy that even as doctors and nurses claimed to focus on treating brain biology, their illustrations and use of language sometimes juggled between the concepts 'brain' (biomedical) and 'head' (sociocultural). There were occasions I heard both doctors and nurses describing mental illness as the 'sickness of the head' perhaps to demystify mental illness or explain it in a locally understandable way just as Falah refers to dementia in the earlier illustration. All the same, just as Dr Show acknowledged, doctors and nurses emphasised the importance of pharmaceutical medication treating brain or head sickness, but also indirectly suggested that doctors would not treat other facets of personhood

affected by mental illness. In the hospital it was the responsibility of other experts, for instance, the occupational therapists, to treat other aspects of the mentally ill person.

5.2.2 Occupational Therapy

As we saw in chapter 3, a failure to work appropriately in an 'appropriate place' was often seen as an indicator of mental illness. In Aro, these facets of illness were dealt with by a separate unit and set of experts: Occupational Therapy. My understanding of the hospital staff and caregivers' conception of 'work' suggests that it entatiled two broad connotations: physical activities, that is, the ability and skills to perform certain tasks; and conceptions of morality which were established via the appropriateness of the tasks performed and the methods used to perform them. While both connotations were prominent in descriptions of mental illness, especially among the caregivers, the concern with physical activity seemed more prominent regarding treatment. This subsection explores these forms of treatment.

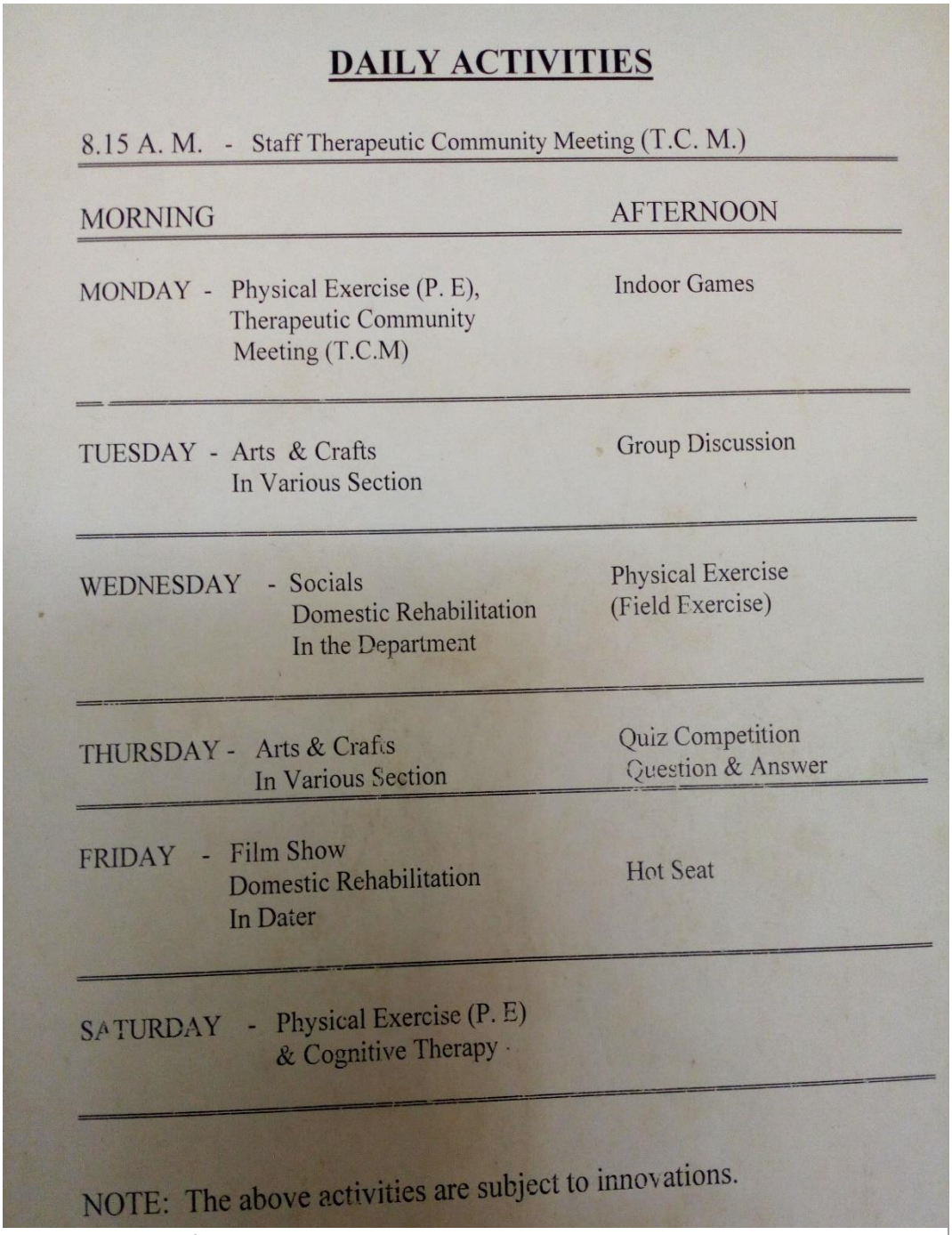
During a discussion with one of the occupational therapy experts, MOT, noted as follows:

> *'Occupation Therapy is part of the paradigm…so we have some areas that it covers… psychiatric patients present with so many complaints depending on their conditions which we (therapists) prefer to call it occupation…. in our own parlance, what occupation means is what you engage in doing. There are three major categories of occupation, namely self-care activities, …the self-care activities are all that you engage yourself in doing in caring for yourself. Washing, bathing, eating, sleeping, and all that you do for yourself. The second, work and productivity - those are basically job, economic, it may be paid or unpaid… the third one, Play, and leisure. In the adult, we call it leisure, in children, we call it play…'* **Aro Hospital staff: Mot, a senior occupational therapist**

The above shows that Occupational Therapy occupied a strategic position in Aro hospital multidisciplinary treatment. As the staff claimed, patients often presented with an inability to work because mental illness never allowed them to have such ability and skills, or they had lost the skills to the illness. MOT further explained how mental illness could affect occupational abilities of a person and how the expert identified and treat these issues.

'Some of them [patients] *will present with attention and concentration problem. They are unable to attend to things. For instance, they could…lack interest in doing things, not motivated, the resultant effect of the condition will now tell on the patient's functioning in all those categories of occupations. A person may have some reduction or deficiency in the aspect of caring for oneself. That is why you have some not taking their bath regularly, some would not engage in work and productivities, some have issue with attending to their work, leisure, and play…basically, what we do is to engage patients in activities that will help them return to functionality, and independent function. First, whether there are some things they have been doing before and they have problem doing it again because of their health; we call that one rehabilitation. There are some situations whereby there are some things they supposed to be doing, but they are not doing it even before their health condition, we call that one habilitation.'*

Therapists used rehabilitation to restore skills lost to mental illness or as a practical reminder and platform for the patients. These were undertaken while in the hospital to avoid losing skills such as culinary skills that they could not continue with due to their hospital residence and which were considered crucial for being a 'normal person'. On the other hand, therapists claimed that some patients never had those skills before and to bring them to 'completeness' required that therapists instil this in them, a process they referred to as 'habilitation'.



DAILY ACTIVITIES

8.15 A. M. - Staff Therapeutic Community Meeting (T.C. M.)

	MORNING	AFTERNOON
MONDAY -	Physical Exercise (P. E), Therapeutic Community Meeting (T.C.M)	Indoor Games
TUESDAY -	Arts & Crafts In Various Section	Group Discussion
WEDNESDAY -	Socials Domestic Rehabilitation In the Department	Physical Exercise (Field Exercise)
THURSDAY -	Arts & Crafts In Various Section	Quiz Competition Question & Answer
FRIDAY -	Film Show Domestic Rehabilitation In Dater	Hot Seat
SATURDAY -	Physical Exercise (P. E) & Cognitive Therapy	

NOTE: The above activities are subject to innovations.

Plate 5.4: A guide of various treatment methods and daily activities used by the therapist was pasted on the wall at Occupational therapy unit **Source:** Author's Fieldwork, 2019

The occupational therapy unit organised their treatment methods into different programmes and activities such as art and skills learning, film shows, sports activities, parties, and competitions as shown on plate 10. As shown on plate 5.4, Occupational therapy had various subunits such tailoring, head making, computer, arts - drawing and painting, and kitchen, among others to drive those highlighted treatment methods.

> *'We have a tailoring unit, head making [hair cut/dressing], computer section, and arts section, which comprise drawing, painting, and the likes. We have a kitchen for domestic rehabilitation. …film shows, we sometimes go to the field to exercise and play football. On Wednesdays, we have a social section where we organise just a mini party, something like that, not a party like that. However, like a get-together, section to socialize and play music and call for dancers… all those things are to inculcate in the patients…for instance now, a housewife, she is performing the role of a housewife at home, but now in the hospital, she is in the ward, she is not doing such again, only taking drugs, and will go to the cafeteria and eat and come back. She is not performing her culinary skills, which can be gradually lost if they are not practiced. That is why we have a kitchen for them to be using, they use it ….* **Aro hospital staff – MOT, Senior therapist**

The staff in this unit claimed a single therapeutic activity could be used for more than one treatment purpose. For instance, plate 5.5 shows the place and some gadgets used for film shows and live Radio or Television programmes to test and treat the attention and concentration of the patients, but these activities, especially the radio and television programmes also served the purpose of reminding and reconnecting the patients to the larger society which they were being repaired for.

Another approach in occupational therapy was using occupation to treat other defective aspects of the sick person. This approach also shows that several therapeutic measures can be used to treat a single deficiency. Unlike vocational activities where re-habilitation to certain kinds of livelihoods is the concern, here the therapists used occupational engagement to repair other affected aspects of the patients such as concentration and interpersonal relations. As a therapist claimed for instance, drawing can be used to treat poor concentration and lack of coordination in patients and debates, games, and parties to

treat poor interpersonal relations such as timidity and low self-esteem which may be a personality disorder.

‘ *…it depends on what we want to achieve…as it is serving a vocational purpose, it can also serve treatment purposes. Okay, let us take drawing as an example. What do you need if you want to draw apart from the materials? You need your eye-hand coordination, you need your five fingertips to be working well, and you need attention, concentration, and other things. So, with that, peradventure, we noticed that a patient has been going up and down or restless; we can use drawing to calm them…This film show too is part of engaging them, testing them, and some of their cognition. Their attention, concentration, and memory to know they will be able to recall. After the section we do ask them, what can you say about the film? There is immediate recall; there is long-term recall… in the ward, it is only men-to-men interaction or vice versa, there maybe or no emotion attached…So, that also has its own therapeutic advantage, like self-esteem, because some people cannot feel relaxed or talk once in the midst of the opposite sex. We also create some environment for that too. For instance, in some of our sessions, as they came for movies the other time, at times, we do have sections of group discussion, a therapeutic community, for example. We will ask them to stand in front to make their contributions. I remembered of a patient, he was a withdrawn type in nature, predominantly introverted and the majority of them are like that; the illness just magnifies their personality….* ***Aro hospital staff – MOT, senior therapist***

The occupational therapists claimed that their treatment programme was formal and that most of the contents and methods were ‘standard’ practices because they adapted them from other countries, especially from the UK and US. This notwithstanding, Aro hospital occupational therapists acknowledged that patients required some other treatments which were not formally available and yet considered necessary, such as relating to moral aspects of work, and informal social relationships, including relating with natural and spiritual objects. The occupational therapists and other hospital staff rendered these treatments informally. Before I discuss the additional and informal relational treatment, it is important to note that these more informal treatments were not only offered by occupational

therapists but also other experts, such as social workers and psychologists who concerned themselves with treating other certain aspects of interpersonal relationships e.g., relating to family and religious belief.

Plate 5.5: The hall and some gadget used at Occupational Therapy for film shows through which patients were reminded of and reconnected to the larger society.
Source: Author's Fieldwork, 2019

Plate 5.6: Tailoring Unit, one of the sub-units of the Occupational Therapy where Aro Hospital patients gain occupational skills
Source: *Author's Fieldwork, 2019*

(1) Social Workers therapy

At Aro hospital, familial and coresident relations were viewed as crucial in the treatment of mental illness, just as they were in the process of identifying mental illness (see chapter 3). In Aro hospital, the social work unit specialised in diagnosing and treating the familial and environmental relational facets of the patient. Contrary to the doctors and nurses' view of mental illness, the social workers sought to understand how marriage, residence, and parenting style among others could be used in understanding and treating mental illness.

Social workers often explained mental illness as being caused by failed or strained relationships, especially intimate relationships. One social worker, Mummy Yard, claimed that her experience over the years had shown her that most of the women that suffered mental illness had a history of one or more forms of domestic maltreatment, family break-up or marriage dissolution, and in some cases, the sudden death of their spouse. She cited some specific instances where a woman became mentally ill after some years of frequent marital conflicts and domestic violence, which according to her was a common phenomenon in the region, particularly among the polygamous families. Mental illness among single young men, she believed, was often a consequence of failed relationships

such as poor parenting and loose family ties, and the loss of forms of collective welfare to forms of unhealthy competition which [in]directly precipitated anti-social behaviours including substance abuse.

As such, Aro hospital social workers worked to repair the damaged familial relations of their patients, as shown in the next example. A 55-year-old widow and mother of five known as Pastor Mrs manifested breakdown of family relations by claiming a false husband and refuting her true marital status. Pastor Mrs was admitted into Female Ward 2 in Aro hospital, and I met her during the ward round. The nurse in charge of her Ward emphasised that Pastor Mrs frequently hallucinated. According to the Pastor Mrs' hospital records, her husband had died some eight years before and she had not remarried. Instead, she became a full-time pastor in one of the largest Nigerian churches, Mountain of Fire and Miracle Ministry, but had never had any personal contact or relationship with the founder, commonly referred to as GO [general overseer] of this ministry in all her pastoral career.

However, Pastor Mrs during her illness and even in the hospital ward kept claiming that she was the wife of 'Daddy GO'. The consultant and the leader of the health care team sought the intervention of the social worker. The social worker then introduced a 21-year-old lady whom he had invited for the ward round. Pastor Mrs recognised the lady as her daughter and second born. He further questioned Pastor Mrs about her daughter's name and asked who her father was to the Pastor Mrs. At a certain point, pastor Mrs accepted that her daughter's father was her husband. During this process, the social worker also noted that Pastor Mrs' children seemed to have kept distance from her which he referred to as 'being technically deserted'. Then he recommended that Pastor Mrs's children should visit her regularly as a way of reminding her actual marital status and for her full recovery of her family relations.

The social workers also used familial relations to sustain other forms of treatment and help prevent relapse. As earlier noted, the social workers tried to do this by repairing strained family relations and resolving social and environmental risk factors. For instance, Alaba was another Aro hospital patient with family and relational problems. I met Madam Alaba in a Ward-Round in March 2019. According to the hospital records, Alaba was a childless woman in her fifties. Before her mental illness, she had married a man, but the marriage collapsed

after many years of childlessness. While in that marriage, she sold some of her properties such as gold and clothes including her trading capital in search for a cure for childlessness but to no avail. In the end, the marriage crumbled, and she returned to her family house but in poverty. Some five years back, Alaba remarried Taiwo but remained childless even in the new marriage. Then Alaba developed mental illness, was diagnosed with schizophrenia, and was admitted to Aro in February 2019. According to the nurse, Alaba's health had improved but she was still hallucinating. During her hallucinations, Alaba was reportedly asking for her child and complaining that someone called Aduni[14] wanted to kill her. During the experts' deliberation on Alaba's case, Mr. Akin, the social worker in the team, asked Alaba who Aduni was, but there was no response. Akin insisted that he must find out the connection between the two and the team requested that the Alaba's caregivers should be invited to unravel Alaba' relationship with Aduni in the next ward round.

The next ward round had in attendance Alaba's brother and Taiwo, her husband. Ibu, the consultant asked Alaba about her relationship with Aduni. Then it became apparent that Aduni was Taiwo's niece and coresident. But Aduni was unhappy and became belligerent towards Taiwo because he had been living in Aduni father's house free of charge, an aggression Aduni also transferred to Taiwo's wife, Alaba. After a lengthy discussion about Alaba and her health, the staff identified Alaba's place of residence as the triggering factor of her mental illness and the social worker recommended that Taiwo relocate Alaba once she was discharged to maintain her health and forestall a relapse.

The social workers usually referred to interventions of the kind they did in the case of Alaba and Pastor Mrs above as 'family therapy'. In Aro hospital, family therapy was a tool to settle family conflicts and reconcile members to guarantee peaceful coexistence to enhance and sustain the recovery of their patients. Social workers also claimed that they used family therapy to medicate discharged patients. While the official duty of the social work unit was relational treatment and to serve as the official link between the Aro hospital and caregivers, however, the social workers, like other health care staff, also engaged in other kinds of treatment. This treatment was usually provided informally with the aim of

[14] Aduni is a Yoruba feminine name

restoring nonmedically aspects of 'damaged' personhood. I discuss these forms of treatment in detail in the next subsection.

5.2.3 Aro hospital informal therapies

While the three sections described above, medical treatment, occupational therapy and social work, have shown different aspects of formal therapy practices at Aro hospital, informal practices were equally important in the hospital. Informal treatments in Aro hospital focused on repairing some dimensions of personhood that were viewed as 'failed' or 'damaged' in some way, for example in moral terms. These aspects of mental illness included things such as drunkenness, promiscuity, and imprudent spending as well as 'impaired belief' which included religious practices and forms of spirituality that were identified with mental illness. These treatments tended to be provided informally. The 'rules' of prescription were often unspecified and sometimes were personal initiatives based on staff experience, could involve synergy and interdependent practices among different experts, and sometimes included the use of reward and sanction. These forms of nonmedical treatment facets sometimes ascribed additional roles and responsibilities to the hospital staff.

The hospital staff acknowledged the importance of religious belief and spirituality as a dimension of full personhood but also recognised that some kinds of religious practice could be a sign of mental illness. Recall that in Chapter3, the Wosila story demonstrated how mental illness and religious belief linked. Even though Aro hospital staff denied offering faith-based healing, they maintained that spirituality was an essential aspect of everybody, including in their patients. They added that religious belief must not be eroded, not even when they were in the hospital; hence the reason for what they called 'belief-centred treatment' . Support for religious practice happened in two different but related ways. On the one hand, the staff claimed that participating in religious activities while in Aro hospital helped both the staff and patient to maintain their 'normal religious life' Below is a staff comment regarding treating belief personhood facet.

> *'we still recognize spirituality, that is why we encourage our patients, those that are Christians are taken to the church on Sunday, and I, while I was coming to the mosque, those who are Muslim that I saw, we came to the mosque together*

before they went back to their halls. We still encourage it because it still part of our life. We believe that it has some role it would play in our lives and the life of a mentally ill person. so, you can't rule it out.' ***Aro hospital staff – Mot, a senior occupational therapist***

This view cut across different units in Aro hospital. As Mot said, hospital staff encouraged their patients to go for religious activities. Sometimes, as the case of Dunmi in the preceding chapter suggested, patients could be forced to participate even when they seemed uninterested in those activities because the staff considered it necessary for maintaining this facet of their personhood. On the other hand, staff claimed that participating in religious activities provided some psychotherapeutic measures for the patients' repair. In other words, religious rites were viewed as a form of treatment for rehabilitating patients whose religious personhood had been affected by mental illness,

'Yes, at times, some people have a problem that has to do with their religion like Christianity and Islam. …Some [mental illness] *have to do with religious belief and that religious belief is delusion of belief. Do you understand those kinds of things? We use the Imam and pastors as part of the psychotherapeutic team because they [patients] see him as a religious figure like a pastor, like Imam... They tend to respect them and believe whatever they say'* **Aro hospital staff - Dr. Ifa, a consultant**

While the staff acknowledged these religious activities as therapeutic, they all claimed that such treatment was 'informal'. The activities in church for instance, include praying, singing, dancing reading of Bible passages, and encouragement among others. However, Dr Ifa noted that Aro hospital had not officially employed anyone either an imam or a pastor to provide a religious-based treatment or therapy, but they had some volunteered members of staff who were performing these roles in addition to their official responsibilities in the hospital as extracurricular activities and charitable contributions to the hospital.

These informal modes of treatment were possible because the patients were residing in the hospital wards. The staff noted that being in the hospital community was therapeutic, especially for rehabilitating antisocial behaviour including dressing, substance abuse and

promiscuity. Explaining how the ward lifestyle informally treated antisocial behaviour, Nurse Kan reminded me about a newly admitted patient, Mr Chelsea. Chelsea was in his early twenties and was admitted into the Male Ward 2 due to his aggression, destructive behaviour, and incoherent speech. At the point of admission at the Emergency Unit, Chelsea wore a blue 'Chelsea jersey' with jeans and was carrying a partially grown-out yellowish tinted hairstyle which to the staff was unacceptable in the hospital community. On getting to the ward, Chelsea was asked to change from his jeans to shorts and slippers and was immediately led to the place to cut his hair, where it was shaved to the skin level. The nurses were so particular about Chelsea's hairstyle which was described as being like those of 'tout' and 'yahoo-yahoo' boys[15]. Another nurse in the same ward said that eight weeks of hospital admission without access to drugs or sexual partners could go a long way in getting rid of addiction in the patient. This was indirectly confirmed by Taju, a 25-year-old patient in male Ward 2 who told me that the last two weeks of his admission had been tough for him because he had been deprived of sexual intercourse. When I asked him whether he was married he said no but always patronised some commercial sex workers. This example corroborates the therapeutic view of the hospital staff, however, Taju considered it deprivation, thus, suggest the need for more insight in this regard.

Living in the hospital wards also allowed various forms of informal therapeutic staff-patient relations, especially where the nurses were concerned. The nurses sometimes related with their patients by taking the roles of guardian, friend, counsellor, or adviser in order to carry out some informal therapies in the form of encouragement, warnings, and counselling. Different placard decorations on walls in various hospital wards reflected these patterns of nurse/patient relations (see plate 13). The nurses also took advantage of this relationship to repair what they saw as unhygienic behaviours and imprudent spending by the mentally ill patients. In this way, the roles of nurses went far beyond administering medication to include coordinating and monitoring all the patients' activities and enforced socially approved habits. The nurses instilled daily hygiene such as toothbrushing, bathing, and dressing by daily announcements. Activities for the day and the instructions were always made known to the patients in the ward by the nurses on duty and began as early as

[15] **Yahoo boy** in Nigeria is a common slang for those involving in internet fraud

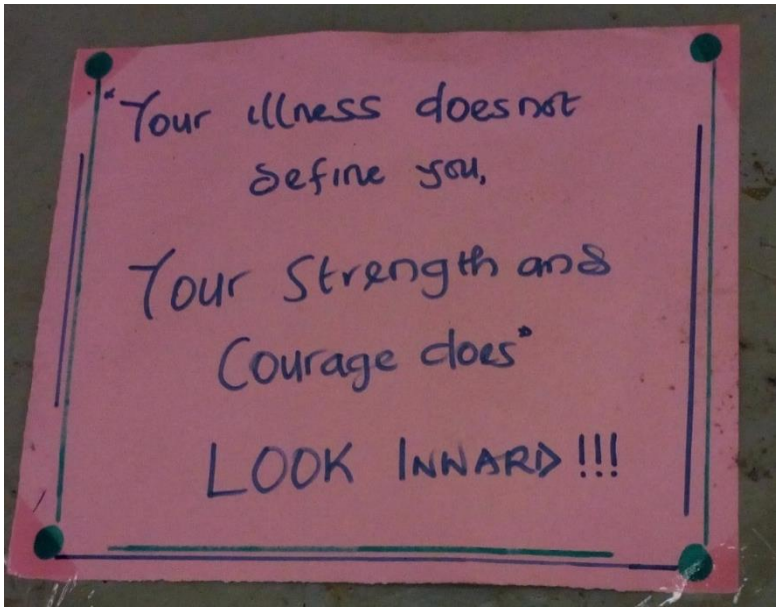
between 6:30-7:30 in the morning. Patients who refused to carry out personal hygiene were punished. The nurses instilled prudent financial habits by imposing a ceiling of a hundred and twenty naira[16] per day for each person except if buying medications. However, the methods for doing this differed across broad and Wards were partly based on the staff experience, initiatives and opportunities.

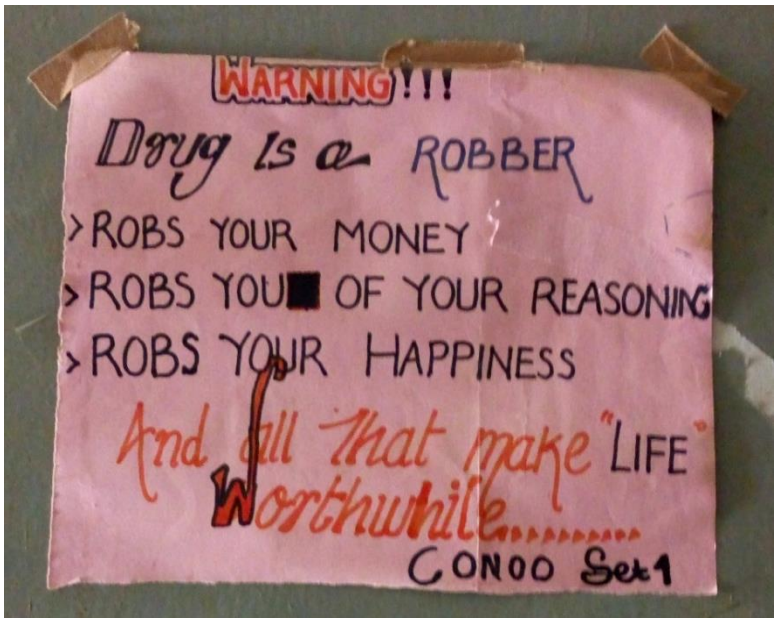
Some nurses used reward and sanction approaches to get the desired result from the patients. In Male Ward 2, one of the methods used was commendations and appreciation including publicly thanking and gift giving to any patient that did well. Gifts were in the form of extra food and or additional freedom for participating in social activities such as going for games, occupational therapy, and religious activities in the hospital community. However, the nurses at times employed sanctions to enforce obedience, especially among those classes as 'defaulters' and to deter others. Sanctions used included verbal scolding, physical restrain threatening with extended admission, or restrictions on movement such as going to the Gazebo[17] for food.

Having characterised mental illness as manifest in poor hygiene, imprudent spending, and disobedience of the form also seen in chapter 3, the nurses used these sanctions and rewards to help instil 'financial discipline,' 'obedience,' and hygiene into the patient. Due to the types and frequency of medications usually administered to patients, they often needed extra food beyond the three meals provided by the hospital. Patients had 'pocket money' given to them by their relatives which was kept in the custody of the nurses. The nurses on duty determined how and when patients could spend this money and kept records of daily spending for each patient. The patients therefore get extra food but from their 'pocket money' with the approval of the nurses on duty. The extra food was tagged 'gazebo' and it was usually bought around 3:00-4:00 in the evening.

[16] **Naria** is a Nigeria currency with 1 GBP = 475.45200 NGN

[17] **Gazebo** is a small cafeteria where food are sold in the Aro Aro Hospital.





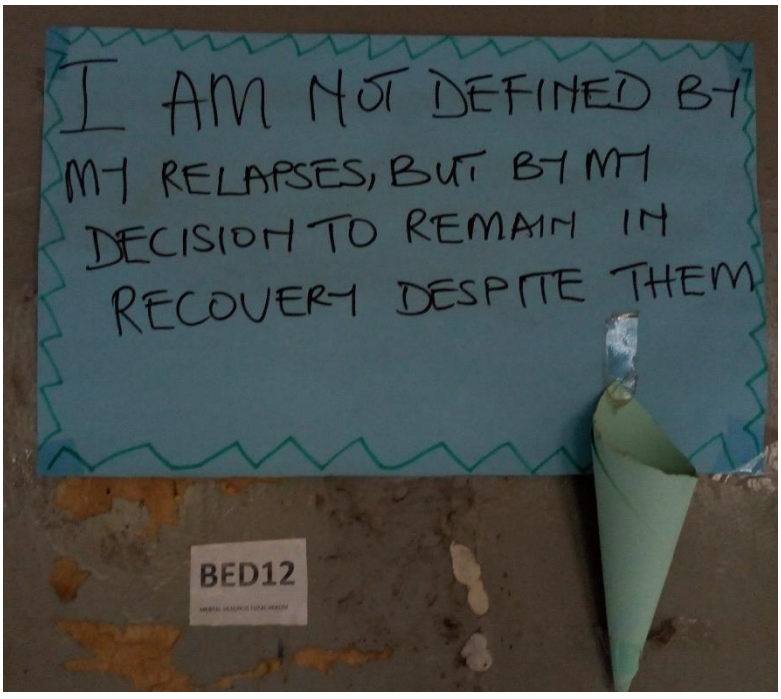


Plate 5.7: Some of the wall decorations in Male Ward 2 suggeting Wardlife informal therapies e.g., encouragement, warning, and emphaty **Source:** Author's fieldwork 2019

Gazebo time was always sociable and time patients anticipated it happily, especially the hungry ones. At times in the male wards, some patients would sit on their beds watching the time and start queuing up in front of the nurse on duty, even five minutes before gazebo time. However, gazebo was more than food but was also part of informal treatment approaches. For instance, Abu was a young man in his 20s and one of the patients in Male Ward 2. On one evening at gazebo time, patients had queued up in front of the nurse with their food plates at hand and smiles on their faces and Abu was in the third position in the line. As the nurse was getting set to approve the amount of food for each person, the Ward manager[18] came out of her office and said to the nurse, *'look here, don't give Abu gazebo o'*. Still on the queue, Abu replied with a pitiable voice, '*Ah! Ah! Mummy, what have I done*?' the nurse turned Abu's request down as instructed. Abu was still not attended to even after the manager had finished with all other persons. Abu started begging profusely, but the nurse told him to beg the manager. However, the manager insisted that Abu would not get a gazebo because he had refused to bathe in the morning. Abu apologized and promised to bathe immediately after the gazebo meal, but the manager insisted. The junior nurse also informed the manager that Abu's underwear was dirty and smelling foul when she administered an injection on him after breakfast. She had instructed Abu to change his shorts and wash them immediately before he slept, but he refused. Instead, Abu wore another short on top of the dirty one. When Abu realised that his appeal was not yielding, he quickly went inside, removed his underwear, got the nurse's soap, rushed to wash, and came to show the manager and bathed before he was allowed. Gazebo was also used as a reward for good conduct by promising or awarding *'double gazebo'* to such a patient.

Informal treatment at Aro sometimes required cooperation that bridged the boundaries between different experts. For instance, 'pocket money' was usually collected from the caregivers by the social workers and remitted to the Ward managers, who delegated it to the other nurses that would administer it to the patient daily. However, the idea of restoring the patient back to the baseline health through 'all means' possible which often made Aro hospital staff to employ both 'formal' and 'informal' treatment methods raises the question about the legal framework governing psychiatric practice in this context.

[18] **Manager** is usually a senior nurse and administrative head of the ward

5.2.4 Nigerian legal framework and Aro hospital treatment

In recent times, concern about the protection of human rights and humane treatment of those living with mental illness has grown, with major international organisations like the WHO and United Nations calling for reforms in psychiatric care and providing some guiding principles to protect the right of psychiatric patients, especially in developing countries (Read et al., 2009; Sugiura et al., 2020). The Aro hospital staff are not ignorant of this push for a more 'liberal' treatment and protection of the rights of people living mental illness globally. Indeed, as I will demonstrate later in this thesis, Aro staff portray themselves as being firmly aligned with 'modern day' psychiatry and following 'best global practice'. However, in practice, staff at Aro often ended up forcing patients to accept treatment, claiming that patients' right to treatment and medical staff's obligation to treat should not be compromised by an unwilling patient, whose capacity to know what is in their best interests has been compromised.

Several staff members specifically referenced the 'Lunacy Act' of 2912, which specifies the scope of psychiatric operations in Nigeria, claiming that their treatment approaches are within the purview of this law and are in the best interests of the patients and society at large. While some acknowledged that the Lunacy Law was perhaps outdated and needed revision, there was general agreement that patients effectively forego some of their normal rights by entering a facility like Aro. The following comment, from a consultant at Aro, acknowledges some of the tension between the requirements of the (unrevised) law and the reality of some situations that require 'improvisation' (Livingston, 2012) and managing things within the local context:

> *'…currently we are still operating based on the 1912 lunacy law. Although, there is a new Mental Health Bill that has passed the second reading at the Senate…. However, your coming (the coming of a patient) to the hospital shows that you have conceded some of your rights to us (hospital staff) too because you have consented to the treatment….So, what we currently have* (Nigeria Constitution) *permits to have the patient treated if we have the court backing or letter from the court. Nevertheless, we do not necessarily do that. What we generally do is that people come with members of relatives, and the caregivers stand as the*

authority that would give consent, and the patient would be treated.' ***Aro hospital staff – Dr Show, a consultant***

5.3 Conclusion

This chapter has explored Aro hospital mental healthcare, Abeokuta. Through the four ethnographic examples above, I argue that: (i) treatment reflected the prevailing sociocultural beliefs of the location; and (ii) practices suggested multifacetedness of biomedicine and mental health care.

In chapters 3 and 4, I described how people in the study location often described mental illness in terms of different aspects of personhood, which went on to shape the ways in which people became patients at the institution and how patienthood was understood and practiced. As the examples in this chapter reveal, treatment at the hospital focused on repairing different facets of personhood including the biological body, social or relational personhood, and moral personhood. Hospital treatment comprised formal and informal treatments. Formal treatments were offered by various experts. Informal treatments focused on the nonmedical aspects of mental illness, such as imprudent spending, poor family relations, unhygienic practices, and failed moral lifestyle including drunkenness and promiscuity. Informal treatment was often practiced based on the personal experience, discretion, and charisma of individual staff. Informal treatments were as crucial as formal treatments. Staff saw the burden of multiple roles and additional job responsibilities as part of their job, and considered it part of their responsibility to provide informal forms of treatment.

As those examples suggest, biomedince at Aro hospital is different from other biomedicines elsewhere. The Aro hospital staff believed that effective mental healthcare must be, and indeed was targeted at each of the aspects of personhood damaged by or lost to the mental illness. I showed that doctors and nurses treated brain biology, and the occupational therapists treated work-related facets of personhood, while the social workers focused on repairing relational personhood, especially in its familial and residential dimension. Staff also devised informal treatment approaches to manage other facets of personhood such as failed morality, informal relations, and the production of other kinds of socially normative behaviour that the official professional treatment did not cover.

The chapter has shown that within the Aro hospital setting, treatment is multifaceted. As in the example described by Mol, (2002), different hospital units sometimes provided different explanations for a similar mental illness manifestation. For example, the social workers explained mental illness in terms of failed or strained family relationships, whilst doctors usually offered biological causal explanations. As such, mental illness entailed multiple medical realities across the hospital units and to different mental health care experts. In the Aro hospital context, all explanations given by different experts stand and each of them offered treatments to repair their specialised facet of personhood. While the social workers offered family therapy, the doctors would prescribe medications, and the nurse would administer them.

The same also applied within the other Aro hospital units; treatment is mutiple even at this level. Each of the Aro hospital treatments was a collection of several activities and relations shared among a number of staff and/or treatment approaches. In occupational therapy for example, there were several subunits and treatment approaches, allowing for multiple tretament activities. As the therapists confirmed, sometimes they combined different treatment approaches to treat a single aspect of a personhood such as concentration. Therapists also used a signle treatment approach with the aim of treating more than one facet of personhood. The doctor and nurse treatment also reflect multiple medical relaities then they combined explanatory models that included both the biological explaination of the 'brain' and sociocultral illustariton of the 'head'.

In conclusion, Aro hospital treatment typified biomedical multiplicity at different scales. The treatment was multifaceted, and its goal was to repair all affected aspects of the mentally ill personhood as a way of returning him or her to a 'normal person' as much as possible. Discharging a patient from the Aro hospital did not necessarily mean that person was healed, but was an expression that the different experts in the hospital had certified the patient to have regained diverse components of personhood to the extent that s/he could now 'function' in the larger society. Such capabilities included but were not limited to a biologically improved 'brain' or 'head', the presentation of socially acceptable perceptions and beliefs, acceptable relation with others, and a hygienic lifestyle. Staff believed that demonstrating these aspects of personhood that would enable patients to successfully

engage with his/her social, economic, spiritual, and political environment. However, notwithstanding the multiple forms of treatment that existed at Aro hospital, the multiplicity of mental healthcare extended beyond that of the hospital multiple treatments. In the chapter that follows I will explore some of the forms of mental health care in Abeokuta that existed outside of the hospital, the reasons people patronised them, and how these forms of treatment interacted with those of the hospital.

CHAPTER 6

MULTIPLICITY OF MENTAL HEALTHCARE BEYOND BIOMEDICINE

6.0 Overview

Even though this thesis primarily focuses on mental healthcare practices at Aro hospital, it is important to note that mental health care practice in Abeokuta is not only offered in the Aro hospital or in biomedical settings. Other well-known and often highly socially acceptable sources, such as 'traditional' psychiatry and faith-based centres, also offer mental health care in this region. This chapter describes these other sources of mental health care and explores the reasons why people patronised them. I show how the multiplicities of mental ill health that I described in the first part of the thesis, in terms of personhood, patient-hood and the practices of biomedical treatment, extended into the environment beyond the hospital, where a range of further treatment possibilities existed to help manage the multiple and ambiguous nature of the mental illness.

The ethnographic material I present in this chapter has some theoretical implications for conceptualisations of medical pluralism (Baer, 2004; Leslie, 1980) and medical syncretism (Muela et al., 2002). Traditional healers, faith-based healers, and biomedical personnel mapped out their practices as distinct from each other thus drawing some boundaries, in a system of what might be framed 'medical pluralism' according to Baer's, (2011) definition. Mapping out boundaries between these health care traditions is necessary to show how these boundaries provided a sense of social relevance, recognition, and status to the different healers. I am not claiming that all traditional or faith-based healers are homogenous, rather I use the concepts of traditional and faith-based healing in the broader sense to mean the practitioners whose epistemological stance and medical ethos were derived from Yoruba healing systems, Christianity, or Islam.

In this Chapter I also describe how and why people sought care from these diverse practitioners. I show that caregivers and users also derived some kinds of psychological relief and hope from this treatment, not only because multiple mental healthcare traditions resonated with their interpretation of mental illness (see chapter 3) but also because using other forms of health care gave a sense of choices, and not least because many of these

practitioners promised what they called a ‘complete cure’, something that was often absent from biomedical treatment at Aro, where people remained patients for life.

However, contrary to the notion of exclusive boundaries and separation of different medical traditions as the concept of medical pluralism suggests in the above, my fieldwork shows that people also practiced syncretic mental health care. Many caregivers and users sought help from different sources either sequentially or simultaneously with little or no regard for the boundaries earlier identified. People deliberately engaged in syncretic practices partly due to ambivalences attached to each of the identified medical traditions as well as the ambiguity and complexity associated with mental illness in the region. In this regard, boundaries between different traditions of mental health care became blurred such that care users and caregivers used all these traditions of medical practices as if they constituted a single caring system.

While caregivers and users often practised syncretic mental health care by blurring the boundaries between different traditions, health care providers in the biomedical sector often practised theirs by defending these boundaries. Even though all practitioners reified divides between the contents and methods of treatments, in each case, and even among biomedical practitioners, some boundaries could be shifted to allow inclusion of certain practices earlier disowned. To explore these processes, this chapter triangulates the views of mental health care practitioners, caregivers, and care users to maintain that both medical pluralism and medical syncretism are useful analytical tools to the understanding of the mental healthcare practices in Abeokuta. Nevertheless, neither medical pluralism nor medical syncretism can singly explain mental health care practices. Instead, each provides a lens that other cannot displace. The former offers invaluable insights into mental health care provision in the region. It helps us understand how of individual practitioners reinforced their social importance and gained social rewards, including status, recognition, economic benefits. The latter offers insights into how, where, and why people in the region seek treatment for their mentally sick persons, and the ways people move between and combine the different options available to them.

6.1 Medical pluralism and medical syncretism

Effectiveness and quality of health care are often linked to the medical systems (Arthur Kleinman, 1980) and methods that produce them (Catherine Abbo, 2011; Catherine Abbo et al., 2009; Veena Bhasin, 2007). One of the foremost ways that medical anthropologists have engaged the understanding of health care practices of different people in their locales is through the concept of medical pluralism. Coined by Charles Leslie in the 1970s in his work on medical practices in Asia, the term medical pluralism has since become a useful analytical tool for studying and explaining health care practices (Baer, 1995; Baer et al., 2003; Ernst, 2002; Hörbst et al., 2017; Penkala-Gawęcka & Rajtar, 2016).

Various anthropologists including scholars from other health related fields have drawn on the idea of pluralism to identify and explain several issues around medical practices, ranging from a simple tracing of various historical medical traditions and how they evolved over time to an *in situ* analysis of the coexistence of several traditions of medical systems as well as internal boundaries within each system and their effects in the studied societies (Baer, 1995; Campbell-Hall et al., 2010; Ernst, 2002; Fabrega, 1997; Feierman, 1981; Green, 1988; Washington-weik, 2009). Studies in this regard have emphasised the importance of understanding and describing different forms and methods of medical practices of a given group of people (Ohnuki-Tierney, 1988), and explored relationships between different practitioners (Feierman, 1981), and possibilities of collaboration of practices (Green, 1988).

The growing body of literature on medical pluralism notwithstanding, the concept has been criticised for downplaying the impact of colonialism and its consequential effects, and the hegemony of biomedicine that has permeated many societies and forced many medical systems into two classes (biomedicines and others), rather than being genuinely pluralistic medical systems (Singer, 2004). Others (e.g. Leach et al., 2008; Muela et al., 2002) have maintained that no absolute boundaries exist among healthcare traditions. Even if boundaries exist, studying or 'bracketing' their differences is of less importance compared to understanding the meaning and function that health care (irrespective of the forms and types) have and perform in the population where they are found (Baer, 2011; Hörbst et al., 2017).

Undoubtedly, the idea of medical pluralism and most of its previous applications failed to recognise the realities of globalisation on medical practices (Ernst, 2002; Penkala-Gawęcka & Rajtar, 2016). People nowadays access and assess health services and medical information from different parts of the world on the Internet (Pool & Geissler, 2005:101). Globalisation has not only facilitated the rapid spread of new technologies and increased transnational movement of goods, services, and people, but has also altered the mode of provision, distribution, and consumption of health care in a way that further challenges boundedness of different medical traditions that is implicit in the idea of medical pluralism.

Recent ethnographic studies on healthcare provision have also suggested greater hybridity and eclecticism than the straightforward concept of medical pluralism implies. For instance, Hampshire & Owusu, (2013), in their work in Southern Ghana, have challenged some assumptions of medical pluralism and ethnomedicine/traditional medicine. Medical pluralism assumes that each society has a set of distinctive medical systems with each system based on a sperate ethos and epistemology, which are also varied from one society to another (Baer et al., 2003). On the contrary, Hampshire & Owusu, (2013) reported hybrid use of therapeutic practices in southern Ghana as traditional healers adapted their 'indigenous' healing practice to incorporate some biomedical and Chinese knowledge and tools to provide care. Furthermore, ideas of medical pluralism often assume healers as belonging only to their locales, but some of the healers operated studied by Hampshire and Owusu operated beyond their locality and region as they exported their products overseas. In other words, information and communication technology, biomedicine, traditions (both local and borrowed), and popular culture together produced an eclectic 'landscape' of healthcare practices that defied the boundedness implicit in ideas of medical pluralism.

The increasing blurring of boundaries between medical traditions has made some scholars in the last three decades shifted attention from a 'professional-centred' (Arthur Kleinman, 1980) concept that Leach et al. (2008) termed an 'academic categorisation of health system' towards more user-centred concepts such as 'medical diversity' (Parkin, 2013), 'medicoscape' (Hörbst et al., 2017), 'therapeutic landscapes' (Leach et al., 2008; Madge, 1998; A. Williams, 1998; Wood et al., 2013, 2015), and 'medical syncretism' (Muela et al., 2002; Pool & Geissler, 2005). All these concepts are similar except in the areas of emphasis

and regions of usage. For instance, while 'medical diversity' emphasises synthesis of ideas and methods of health services by borrowing from several medical traditions (Parkin, 2013), the idea of 'therapeutic landscapes' which emphasises holistic consideration of care practice, that is, the resources of care (e.g., knowledge, skills, facilities, social and physical space etc) and processes of care - all deliberate efforts directed at providing care as Leach et al., (2008) demonstrated with infant healthcare seeking and practices in Guinea. 'Medical syncretism' usually focuses on understanding and analysing how and why a particular person or group would mix or blend different perhaps contradictory medical traditions and explanatory models together as prevalent in the recent time (Padmawati et al., 2014). Medical syncretism allows recognition of several traditions of medicine that coexists but without absolute boundaries (Pool & Geissler, 2005:44). Several scholars have noted different medical traditions and using various perspectives of different medical practices across Africa, what is absent in the literature is pitching both medical pluralism and syncretism together to enhance our understanding of the recent medical practices in the region especially in mental health.

6.2 Syncretism and Pluralism in Mental Healthcare in Nigeria

Mental healthcare practices in Nigeria became a serious academic discourse in global transcultural psychiatry in the late 1950s on the basis of what Matthew Heaton described as 'decolonised' and 'transformational' psychiatry (Heaton, 2011). Heaton's idea of 'decolonised psychiatry' suggests a recognition of multiple traditions (traditional and biomedical) of mental health, as well as a politics that created and sustained each of them, and even the contestation that exists between them. As described in Chapter 2, reports at the time described Aro hospital as a leading site for biomedical psychiatry in Nigeria, where Lambo was pioneering mental health care that was jointly provided by biomedical and traditional mental health care personnel, an endeavour that continued throughout the late 1950 and early 60s (Heaton, 2011, 2018; T. Adeoye Lambo, 1956, 1963; Odejide et al., 1978, 1989; Orley & Wing, 1979). This blended treatment is what Heaton referred to as 'transformational psychiatry' (Heaton, 2018). Recent studies have found traditional practitioners remain actively engaged in the provision of mental health care services in communities across Nigeria (Adelekan et al., 2001; Adewuya & Makanjuola, 2009; Agara et al., 2008; Chukwuemeka, 2009; Jegede, 2005). Nevertheless, these recent studies have only

discussed mental healthcare in Nigeria in the light of what Singer, (2004) termed 'plural' practices, as if each of these services are completely discrete and bounded both in delivery and consumption. For instance, scholars (e.g. Agara et al., 2008; Ayonrinde et al., 2004; Gureje & Alem, 2000; Nortje et al., 2016) have analysed biomedical psychiatric settings and portrayed practitioners therein as holding only biological and environmental views of mental illness. Others who focused on nonbiomedical facilities also described traditional healers as lacking biological or biomedical explanations of mental illness, but drawing on supernatural aetiological explanations such as evil eyes, and notions of incongruent relationships between the natural and preternatural world, where mental ill-health is blamed on witches, spiritual forces, and ancestors (Adelekan et al., 2001; Adewuya & Makanjuola, 2009; Adewuya & Makanjuola, 2008; Jegede, 2005).

On the contrary to this dichotomic view, my fieldwork suggests ambiguity and complexity both in explanations for mental illness (including both aetiology and symptomatology) and therapeutic activities for mental illness across practitioners working across different traditions, including biomedical practitioners. On the one hand, each of the care providers who I will describe below, traditional healers, faith-based healers, and biomedical personnel, mapped out their practices as a distinct medical system that was independent of the others, in a similar way to concepts of 'medical pluralism'. The lines of demarcation they identified frequently included training and qualification, methods and contents of treatment as well as the scope of healing. Others demarcated different practices according to different aetiological explanations and methods of accessing each of the systems. These 'pluralistic' views were also reinforced by the 'benefits' accorded to the different practitioners, such as social recognition and status as well as sense of professionalism. On the other hand, at other times, the boundaries became much more blurred. For instance, Aro hospital staff occasionally alluded to supernatural aetiological explanations of mental illness and even believed in the efficacy of some religious rites such as prayer, thus reflecting forms of medical syncretism. According to some of these staff, accepting such explanation and those religious activities was a proof of 'being African'. People consciously engaged in 'syncretic' practices because they were ambivalent about the likely success of different methods of treatment, and due to preconceived notion of mental illness, as well as the goal of care.

In the next section, I present the backgrounds of healers from both the *Ibilẹ* (indigenous) or *'traditional'* and *aladura – 'faith-based'* traditions in the study location. Following this, I discuss the syncretic practises of Aro hospital personnel to illustrate how and why mental health care was syncretic in this context.

To give some further context, the term *Ibilẹ* which means 'born on the soil' and *Aladura* which literally 'means the praying one'*,* are used because they were the most commonly used concepts by both the practitioners and users to describe and denote the practices of 'traditional' medicine that I describe in this chapter. The *Ibilẹ* medical tradition represents those whose medical ethos and practices followed the Yoruba indigenous beliefs, religion, epistemology, and practices. Other terms also used by some participants to describe these traditions included *abalye or adayeba,* meaning 'from the ancestors or forebears', *t'ile, '*the one of home' or 'ours', 'traditional' and 'Yoruba science'. *Aladura,* was also sometimes referred as 'religious -based', 'deliverance' 'church' and *alafa* was a term used to describe Muslim clerics.

6.3 Pluralistic Mental health care: Ibilẹ Psychiatry as a source of mental health care in Abeokuta

Ibilẹ healers are one of the main providers of mental healthcare services in Abeokuta. In Abeokuta, *Ibilẹ* psychiatric treatments are healing practices based on Yoruba religions. The examples of participants and healers in this study suggest that *Ibilẹ* psychiatric treatment in this location used little or no foreign products or equipment in diagnosis and treatment processes. *Ibilẹ* practitioners had low levels of formal education, had usually never worked under or with a biomedically trained personnel, and had never travelled out of the country. The two *Ibilẹ* mental healthcare healers who I discuss in this Chapter, Chief Fag and Chairman, only had primary school and secondary school education, respectively.

'Traditional' healers in Abeokuta perceived their lack of higher western education level or biomedical training was part of their destiny and saw it as a plus to their credibility. Chief Fag opined that if he had pursued western education beyond the primary school, he would have been in overseas like some of his siblings or ventured into other fast money-making business, and perhaps failed in his destiny to become a healer. He further expressed his conviction that traditional healing was his predestined occupation, which to him was the

reason behind his 'success', which was marked by having a personal car, although gifted by one of his clients, building his personal house, and having wives and children. Chairman also expressed similar beliefs. To him, he did not really like traditional healing, which had been his father's occupation. He had undergone a motorcycle mechanic apprenticeship for about two and half years before establishing his own workshop. However, he did not consider himself successful in this occupation and when he enquired from his elders, the traditional priests, the reason behind his misfortune, he was told that he had deviated from his predestined occupation, that is, traditional healing. Chairman claimed that his misfortune has been overturned since he had begun traditional healing.

The art of traditional healing practice seemed to be more culturally recognised and socially acceptable when it was inherited rather than learned in Abẹokuta. When asked about the process of acquiring the healing skills, both Chief Fag and Chairman claimed that they learned the art of mental healing from their fathers and some of their fathers' friends in the industry. In Chairman's word, he was *'abimo',* born with it, and Chief Fag also said '*…mo ba ni ile ni',* I was born into it. Beyond the claim of inheriting the skill, the way these healers expressed their destiny suggested some feeling of competence and social acceptability. However, both healers maintained that there is neither a ceiling nor end to learning of traditional healing. As Chief Fag put, 'a*kọfa mọ'fa nii jẹ Babalwo',* meaning that being a good *Babalawo* [*Ifa*[19] priest] requires that the person keeps learning more of *Ifa* daily.

The two healers specialised in mental healthcare practices and had facilities where mentally ill people were treated. Chairman was in his early 50s and claimed to be an *Onisegun* [herbalist] who specialised in mental health care, providing *Awure* remedies for personal, business, occupational, and financial misfortune; and *Isọra*, a kind of prevention or security from external attack, in addition to other illnesses. Chief Fag on the other hand was around 67 years of age, and a *Babalawo* [Ifa priest] who started independent practice in 1967, two years before the death of his father. He specialised in *Babalawo* [Ifa priesthood] and mental health care as well as childbirth attendance.

[19] 'The word *Ifa* refers to the mystical figure *Ifa* or *Orunmila*, regarded by the Yoruba as the deity of wisdom and intellectual development' (https://www.unesco.org/archives/multimedia/document-3742)

Unlike Aro hospital (in common with many other psychiatric hospitals in Nigeria), which is situated on the outskirts of the city, with a tall fence that shielded it away from the rest of Abeokuta community and unauthorised social intercourse, the traditional facilities run by Cheir Fag and Chairman were situated in the heart of Abeokuta city within a cluster of residential buildings without any physical barriers in between them. For instance, Chief Fag had inherited his facility from his father. The facility had a shared boundary with about six different unfenced residential buildings and a public primary school (See plate 7:1). The Chairman's facility was a rented apartment with a church at the back and residential buildings in front and to the left while a recreational hall popularly called 'beer parlour' bordered the facility to the right. Chairman shared the building with two other tenants who occupied two rooms in the building (see plates 7:2 and 7:3).

Plate 6:1: Front view of Chief Fag's facility where neighbours collected water whenever it rains
Source: Author's Fieldwork, 2019

Both Chief Fag and Chairman claimed they engaged Yoruba indigenous methods and technologies for the diagnosis of illness and preparation of medications. Each of these practitioners prepared their own medications (see plate 7:3) used for treatment and would

not use pharmaceutically made drugs. These healers usually described pharmaceutical medications as *'oyinbo'* or '*whiteman drugs' and* would not use these for treatment as they believed their own drugs were more efficacious. The healers also portrayed using pharmaceutical drugs as an act of betrayal of their predecessors. For instance, Chief Fag once said '*...that was what weakened my bond* [i.e. friendship] *with one of them* [a psychiatrists/medical doctor]*; he wanted me to be to be using t'oloyinbo – 'Whiteman' drugs for my patients, and I told him that I did not see my father doing such and I cannot start it…when my father was alive it was the Whiteman that used to come here to learn [from us]…'*

Plate 6:2: The author helping Chairman to mash some materials while Chairman was preparing medication during fieldwork in 2019

Plate 6:3: Chairman parking one of the prepared medications
Source: Author's Fieldwork, 2019

As an *onisegun,* Chairman had two *Ogun* [god of iron] shrines and occasionally make divination for propitiation purposes. Chief Fag had more shrines than Chairman, and these

included shrines for deities like *Esu, Ogun,* and *Ẹgbẹ*[20]*,* among others. Each of the healers had a garden where they had planted different herbs and they manufactured their medications from plants, water, animal products, and some semifinished local products such as *ọsẹ dudu* literally meaning black soap (a locally made soap), and gin among others (see plate 7:3). The equipment used in preparing mediations included mud and iron pots, wooden and iron mortar, pestles, and grinding stones, among others. The typical way of storing finished medications was to wrap them in paper, nylon, used bottles, covered plates or pots and bowls.

The healers engaged in similar treatment approaches but used different medications and methods when treating mentally ill persons. Both Chairman and Chief Fag claimed that they approached each case of mental illness independently and based on the perceived cause and severity of the illness. Chief Fag added that occupation, affordability, and personality of the sick person could also be an influencing factor for the treatment method he would use. Both healers usually admitted mentally sick persons into their facilities for treatment.

The healers said that mental illness was characterised by extreme aggression, unpredictability, restlessness, dullness, absent mindedness, wandering, and dangerous behaviours. As such, the healers said vigilance and incarceration were an important aspect of treatment. Both Chairman and Chief Fag had numerous shackles and chains of different forms, shapes, and sizes for ancles, wrists, and neck as the tools to restrain their clients (See plate 7.4&5). Their treatment methods can be broadly categorised into 'tangible' and 'intangible'. Tangible treatments included the use of substances called '*oogun'* (medications or charms in the form of powder, liquid, cream, and ornaments) applied on or through the patient. Techniques commonly used in administering these medications included incision, oral, burying in the ground, wearing, sniffing, and washing/bathing among others (See plates 7.6&7).

[20] ***Esu*** according to the Yoruba (Ifa) religion is a powerful deity that always serves as a intermediary between human and *Olodumare* – God
Ogun is a deity considered to be a god of iron'
Egbe is considered as a group of some spiritual forces in the world beyond

Intangible forms of treatment commonly used by these healers comprised prayers, warnings, and appeasement. Both healers claimed that the importance of spoken words, especially curses and blessing or prayers could not be overemphasised both in the aetiology and treatment of mental illness. Chairman maintained that mental illness could be inflicted by placing a curse, especially *epe Ijebu*[21] [a curse from an Ijebu person] as a way of punishing someone or as a way of taking revenge. Chairman added that a curse-induced mental illness was common in the area because many people in the region has access to *epe Ijebu*. To Chief Fag, spoken words were very important and one of the most effective forms of traditional medication, even when all other forms of medicines seem not to be effective.

Plate 6.4: One of the female rooms with Chain at Fagbamila's facility.
Source: Author's Fieldwork, 2109

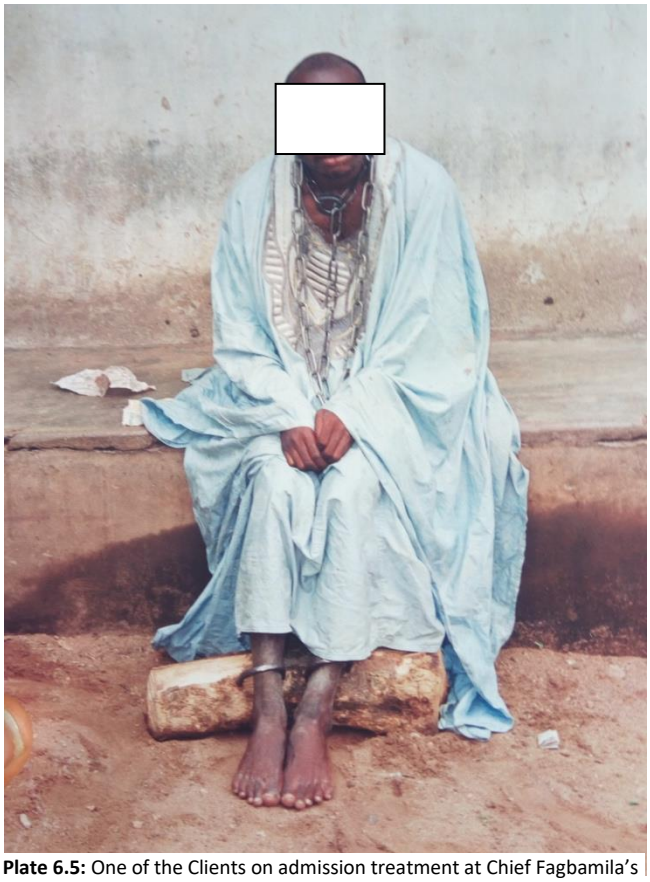


Plate 6.5: One of the Clients on admission treatment at Chief Fagbamila's facility **Source:** Authors' Fieldwork, 2019

He believed that spoken words always remained potent at any time of the day. As he put it, *'ilẹ ki su ohun', '*darkness cannot not hinder or stop the voice/sound from traveling or being heard even at night, no matter how thick the darkness.' Both Chief Fag and Chairman maintained that mental illness inflicted by the *epe* (curse) or *aye* (bewitching) could not be cured by biomedical treatment.

[21] **Ijebu** is a neighbouring Yoruba subcultural group to the Egba [Abeokuta] and were believed to have some metaphysical power or charms to place and enforce a curse.

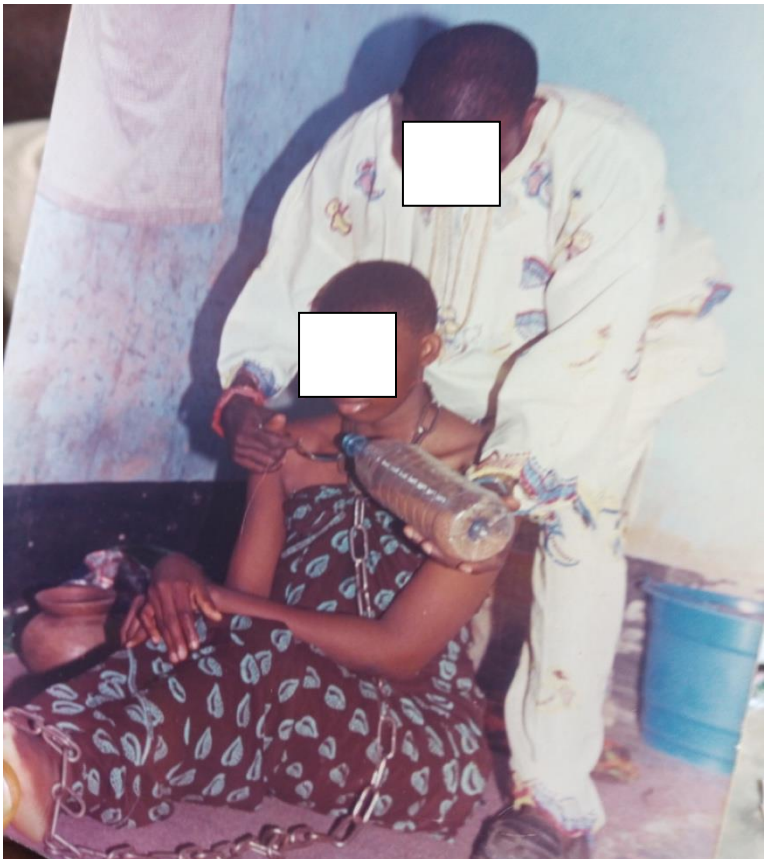


Plate 6.6: Chief Fagbamila administering oral medication on one of his clients - Picture taken from his album by the author during the fieldwork in 2019

Plate 6.7: Chairman applying medication after incision on the head of the newly admitted patient in 2019. **Source:** Author's Fieldwork

In addition, the healers believed their treatment was comprehensive, and better than biomedical treatment. Both Chief Fag and Chairman shared a view that biomedical treatment only offered temporary relief to patients and not a full cure. For instance, Chairman claimed that those he had treated did not need to return for medication or check-ups, unless they had not received the full course of their treatment regimen before they left, either due to lack of finical capability required or for the required any other reason. To Chief Fag the ability to offer a 'complete cure' marked traditional psychiatry as different from biomedical forms of psychiatric care. According to him:

> '*The only thing I can say in that regard, if that remains, is that Western psychiatry believes that once anybody has a mental health challenge, such a person would be on the medication until his/her death. That is what I heard. But that of Yoruba, if the person or the caregiver can afford it, there is what we called asepari – 'the*

complete cure'. Once asepari is done for a sick person, that person would not be taken any mediation further and cannot relapse except a new one comes because there are numerous predisposing conditions to psychiatric disorder. That is what we called asepari or ika – grand finale. But I don't know if the western medicine now stop their patients from taking medicine at a point too… That is the difference between our own [medicine] and the Oyinbo's [white people's]. The second difference is that we [traditional healers] *sometimes tell our clients to avoid taboo. For instance, we forbid them from eating beans, chicken…it may even be a type of cloth or colour and so on.'* ***Ibilẹ*** **healers - Chief Fag**

The charges and cost of treatment in *Ibile* facilities was not like Aro hospital where most costs were fixed. Both healers claimed that they charged based on the condition of the clients but also considered the financial capacity of the caregivers as well. According to them, the factors influencing the cost included the required materials for the treatment. They maintained that some people would require no major medication but warned that some may require appeasement with goat, pigs, or even cow as part of the ingredient. However, *'In all these, we will still need to consider the amount that the caregivers/relatives could afford…'* Chief Fag said. Chairman also said that he would consider the person that referred them to his facility, for example, whether they were a close relative or friend, because he would not want to charge a close friend or relative the same price as strangers. They also charged 'capturing' and feeding costs. Chief Fag said that in most cases, he would be the one to go and 'capture' the sick person, especially the violent ones, because they were often so aggressive that nobody, including their relatives, would not go near them for fear of attack. Then, for those caregivers that could not be staying with the patient to provide for their food and other needs, either because they lived too far away or were unavailable, the cost of feeding would be added. Notwithstanding several factors associated with charges and cost, Chief Fag said the cost might range from twenty thousand to one hundred and fifty thousand naira while Chairman put his price to range from twenty-five to one hundred and fifty thousand naira (±£40 to £300.) Both healers, however, gave examples of some instances where they had either treated free of charge or voluntarily reduced the charges for some people either because the person could not afford it or because of their relationship with the sick person or their carer.

6.4 Pluralistic Mental health care: Faith-based healing as a source of mental health care in Abeokuta

In Abeokuta, religious figures and organisations were also actively involved both in interpreting mental illness and providing care for mentally ill people. Although not all the religious organisations in this region engaged in healing mental illness, those that did so were not only proud of it, but also described their practices as the best that any mentally ill person could receive. As I will show, faith-based healers distinguished themselves clearly from other healers, representing their practices as a discrete and bounded 'system' based on a calling from God. This section is based on discussions and interviews with faith-based healers to describe those factors that marked religious organisations that were involved in offering mental health care in Abeokuta as different from other kinds of health care providers. These factors included the source of healing qualities, methods of treatment, as well as the cost and effectiveness of their treatment. The religious organisations that provided care for the mentally ill had become famous for this work, and their members had gained a sense of social relevance and fulfilment. Many community members saw faith-healing as a separate source of mental health care in the region.

Faith-based mental health care here refers to practitioners drawing on Christian or Muslim spiritual healing. There were a range of faith-based healing practices in Abeokuta, spanning multiple denominations, but practitioners were primarily Christian rather than Muslim. As a matter of fact, only two Muslim clerics were mentioned to me that they were engaging in mental health care, one at Abule Olomore and the other at Sabo Area, all in Abeokuta city. Of the two Muslim clerics people identified, one was referred to derogatorily as a 'self-acclaimed healer' by one person, because they said that as far as they knew nobody had ever received mental care from him. So, only the man at Sabo area had an established facility and some mentally ill people as patients at the time of my fieldwork. Unfortunately, this man declined to participate in the study at the first visit claiming that he had neither interest nor time for the study.

However, my interlocutors identified several churches or pastors/prophets offering mental health care both within and outside Abeokuta. An appreciable number of participants said that healing practice was most common to the Syncretic Churches which some referred to

as *Ijọ-Alasọ-Funfun*[22] [white garment churches], and told me that these churches were especially well-known for providing mental health care. I remembered that my house agent Mr. Ade once told me that locating some religious organisations that offered treatment to mentally ill people in Abeokuta was not going to be a difficult thing for me at all because there were plenty of them around,

> *'…we have them plenty here. That I can assure you that we have numerous white garment church here and that is what they specialised in. I can mention several of them in this area alone. The Obaf Church is at Ita-Oshin there. There is also this man's church, ehn, ehn, ehn, Odunm… he too is healing mad people ...just ask anybody there, even the youngest person at Ita-Oshin will tell you their location…'* **Abeokuta resident - Mr. Ade, Olomore Area.**

Out of about seven different churches that different residents mentioned to me (of which two were said to be located at nearby villages), I located four of them that were closest to the Aro Hospital. One at Oke-Ata, two at Ita-Oshin, and one at quarry area. The people in charge of the church at Oke-Ata denied operating any mental care facility and claimed they only organised different programmes such as revivals and deliverance services[23] which often attracted different people due to several testimonies of deliverance from various problems and illnesses. The pastor of this church declined to participate, leaving me able to do fieldwork in three remaining Churches, Christ the Emmanuel popularly known as Oba's Church, and two white garment churches, Cherubim and Seraphim church (also known as Odunm's Church) and Celestial Church, known as *Ijo Mimo* respectively. All were independently founded and owned.

The faith-based healing settings at the three churches varied in size and the types of buildings used, structure as well as how the healing environment was organised. The most distinctive facility was the Celestial, and this also illustrates some differences between their faith healing.

[22] ***Ijo* Alaso-funfun** in this context refers to those syncretic churches mostllyy Cherubim and Seraphim and Celestial Church of Christ whose members always wear white garment to perform most of their religious rite.

[23] **Deliverance service** in this context refers to a special religious activities purposely organised to set participants free from their afflictions e.g sickness, bad luck, poverty, unemployment etc) from demons and devils

Although accounts from the three churches differed slightly, these faith healers all claimed that God founded their churches and gave them healing virtues as one of the mandates of their calling, especially for mental illness. Furthermore, rather than being trained either by enrolling in a formal school as in the biomedical tradition or inheriting skills from a predecessor as in the case of the traditional healers, healing in the faith-based tradition is described as 'talents' or 'spiritual gift'. The healers could not separate how they became healers from how their ministries began. The founders all attributed the ownership of the church, the power of healing, and the skill and methods of healing to God, while they described themselves as a mere minister-in-charge and 'tools' that God uses. However, at other times of discussion I noted some expressions such 'I established', 'our church', or 'his church' from the founders and their members which suggested that they also not only claimed the possession of the church but also the healing skills.

For example, one of the faith-based healers claimed that healing mentally ill people and detecting thieves were part of the mandates that God gave him when he established his church some years back. However, in some two to three years before my visit, God had withdrawn those two mandates from him, and he has since stopped performing them.

> *'Yes, I was healing mad people truly and I can't remember how many people had been delivered from various such bondages. But recently, God has told me to stop some of certain aspects of these mandates, especially healing the mad people and catching* (detecting) *thieves…'* **Most Revrd Prophet Odunm – Faith-based healer**

To prove that healing and other activities that he performed were God's ordained will, Odunm shared an unfortunate incident that made him stop admitting mentally ill persons. According to him, after being warned by God to stop, someone came to him to inquire of him who stole his money few years back, and he prayed about it. Initially he thought God would not reveal it to him due to the warning, but on the contrary, God did, and he told them the name of the person whom Odunm referred to as a 'troublemaker'. So, those people left, and he thought they would settle the matter amicably at home, but he was surprised to see some policemen few days later who arrested him for making a 'false accusation'. Odunm said the case was terrible for him because he narrowly escaped being

imprisoned. Since then, he had not only stopped detecting thieves but also treating the mentally ill. That day Odunm also declined to participate further in my study on the same grounds. However, he did not call for a withdrawal of data that had been gathered prior to this point.

The conception and interpretation of mental illness among faith healers was somewhat similar to the beliefs of the traditional healers but was different from those healers in Aro hospital who practised biomedicine. Faith-based healers believed that mental illness was usually caused by 'wicked' people and malevolent spirits. For example, Obaf described mental illness as a sudden illness that may not give any sign prior to its first episode. To him, the mentally ill person was one who had lost consciousness of self and environment, and thus could not embark on a meaningful or purposive task nor live a fulfilled life. He also believed that mental illness could be the repercussion of an evil or immoral act or caused by the wrath of God, but in most cases he believed it was caused by bewitchment by *Aye* (evil forces) or *ọta* (an enemy). He further noted that out of their wickedness, enemies usually inflict mental illness in an attempt to thwart Gods' plans or the destiny of the victim.

In separate discussions with Ontop and Carplar, the other faith-based healers I worked with, they both explained mental illness and stroke as handiwork of the 'wicked ones' such as enemies intended either to punish the victim or their relatives. Other causes for mental illness they identified were curses, inherited conditions, and God's infliction. According to Carplar, treating all forms of mental illness was not an easy task, but it became more complicated if the cause was inherited. Carplar also claimed that he could treat all forms of mental illness except the one inflicted by God, which he believed was incurable except by God Himself. Like Obaf, Carplar claimed that it is very rare to see same type of mental illness in more than one person. He believed that though two mentally ill person may exhibit similar symptoms, but the cause may not be the same and the cause would determine the cure.

Methods of healing also varied among faith-based healers, but all claimed that it was God that determined the path of healing. Obaf treated mentally sick people with prayers and fasting, and not with the use of drugs. He claimed that God had used him to cure different diseases form so many people, especially the mentally ill. According to him, *'these people*

are so numerous for me to remember all of them.' Pastor Obaf claimed that he treated each case of mental illness differently, but he never used any medication to cure their illness other than reading Psalms, waters, prayer and fasting. He claimed that once he had started praying for the person, the holy spirit would tell him the psalms to read into the water which the person will be drinking and bathing with, as well as the number of days he would instruct the sick person to observe what he called 'marathon fasting'.

> *'Healing the mentally ill people also started the same way. It was the spirit of God that told us to be treating mentally ill people. It all started when God instructed me to be assigning them birirbiri [marathon fasting). They will neither eat nor drink anything some for seven days, some fourteen days. But it is God that would determine how many days. Before you know it, the sickness would vanish away. We will prevent them from eating and drinking and we will be praying for them continuously. Yes, all we will do is to put them in a room and pray for them.'*
>
> **Pastor/Prophet Obaf S., Faith-based healers**

For Carplar and Ontop healing took a different dimension than it did with Obaf. They mentioned an array of materials that could be used for different purposes at different stages of healing. Among these were names (personal, family, mothers, and fathers etc), place, animal products, plants, different waters (rain, tube well, river, and ocean etc), coconut, *imọlẹ* meaning light but denoting candle, soap, anointing oil, prayers, and songs. Other significant aspects affecting healing that was mentioned mentioned were time (night or day), utterance or voice, place, and processes. Some of the items mentioned were often found within the church environment, however, both pastors obscured from me actual purpose of these different materials and the ways they were used.

During the fieldwork, I saw different people coming to seek the services of faith-based healers frequently for different challenges. On one occasion, a woman rushed her husband into one of these churches in mid-November 2018. According to Carplar, the husband was down with a 'stroke' and he could neither move his body, recognise anyone, nor talk when he was brought in. Although, I could not see the man after he had been taken in and laid in the church, but some four days after, I heard that the man had received a call from his wife.

I saw the wife wearing a smiling face and chatting with other people in the church compound which seemed to me a sign of relief.

Like traditional healers, faith-based healers also claimed that their treatment aimed at 'healing', saying that it constituted a complete cure and not a temporal relief of the kind they claimed other healing traditions, especially biomedicine, offered. Talking about assurance of their healing and its efficacy, Mrs Obaf confirmed Obaf's account that the church recorded a high success rate in treating mentally ill people and told me that some of their former clients had turned into pastors and members in their church. Both Obaf and his wife maintained that their clients did not experience a relapse because the healing had always been permanent. However, when I probed if they had recorded a hundred percent success of treatment outcome for all the years they have practised, Mrs Obaf confirmed some few occasions where people left without being healed and she adduced this condition to unbelief or non-adherence to the instructions by the caregivers. According to her:

> *'I don't think that such scenario* [being discharged without being healed] *was more than one or two cases. That usually happened to those that their caregivers would not follow the protocol. For instance, they will be told that no food should be offered to the sick person maybe for like seven or fourteen days. The relative may considered it too grievous thing to do, or may consider it threatening his/her life and then be giving him/her food secretly. So, people like that did not have faith in the process.'* **Mrs Obaf – Faith-based healer, Abeokuta.**

Carplar also said he was very confident in the treatment he offered and explained that they sometimes asked some of their clients to go back to the hospital for a check-up to confirm that they have been cured. He said *'…look at you, if it is what I cannot handle I would have rejected the person immediately. In fact, after they are healed, I would also encourage them to go and confirm from their doctors. I usually asked people to go and confirm at Oke Ilewo hospital.'* Like in the Obaf church, Carplar also ruled out the possibility of relapse in anybody he had healed.

Faith-based healing is also different in terms of charges and cost. Treating mentally ill people at Emmanuel's Church was not without a price but without a charge. To access

mental health care at Obaf's church, Mrs Obaf noted that a form would be given to the caregivers/relative of the sick person free of charge to fill. The information to be provided in the form included contact details and permanent addresses of both the relative and sick person as well as details of relationship between the caregivers and sick person, among other things. She explained that they required that a relative stay with the sick person to provide the necessary assistance and basic needs, especially reading the Bible to them. However, Obaf claimed that accessing care in his church did not involve a direct financial commitment. Each individual caregiver and sick person would be asked to make a pledge of what they would do should God heal them of their illness.

> *'I don't charge them. Once they brought them, we will put them in a room, and when it is time, they will go to the alter themselves to make a vow of what they would do when they are healed. The family member or caregiver will buy him/her a bible. Then when she [referring to his wife] goes there to treat them, she will inform the relative to buy a Bible for him/her so as to register it in the person that s/he is in the church. She usually does this once she has realised that the person is getting better and can no longer destroy things or tear the Bible into pieces. Once the person is healed, it is compulsory that he/she be taught the way of Jesus and Baptised before he/she is allowed to leave. We have even seen about three or four among those that we healed that have become ministers of God (pastors) and are very fervent in the ministry. So, after they were healed, they come for the thanksgiving that they would pay whatever they promised. The way we operate is this. Thank God that despite healing numerous with mental illness, till today, we have not recorded any mental illness among our children in this family.'*
>
> **Pastor/Prophet Obaf S., Faith-based healers**

Carplar also insisted that faith-based treatment was not often costly except for the required materials that the caregiver would incur, and that there was no fixed price for treatment. However, he noted that many people in the region can be parsimonious when it comes to spending on their health. He also maintained that faith-healing and healers are famous for being considerate and efficacious.

As Carplar noted above, apart from possible economic gain, being involved in healing practices positioned the healers highly in the region. As earlier reported, most churches involving in the mental healing practices were famous. In the words of Obaf, *'the name of the church has been so pronounced during the event* [referring to an event that involved being in trance for twenty-four days without any food and water] *…So, people were trouping in for prayer and they were receiving miracles, especially healing to the extent that I became popular figure even at the Aro Hospital.'*

Lastly, it is noteworthy that working with the religious healers was one of the most challenging aspects of my fieldwork. Religious healers seemed uninterested or reluctant to share information regarding themselves, their organisation, and their practices. Some of them declined to participate or dropped out from the research, something which did not happen with other participants. Even among those that participated it was common for them not to answer questions directly or to decline to answer at all, perhaps thinking that such knowledge was not meant for strangers. As such, I relied more on accounts and discussion with participants than on observation, and became especially reliant on accounts from Ontop and Carplar because I was limited in many capacities. Firstly, I could neither enter the church nor participate in anything because I was an outsider. To do anything in the 'White Garment Churches', one must wear 'Sultana', which they told me involved a rite that took at least three years to complete. Secondly, I was not allowed to take pictures of the religious environment or any of the objects used in healing. There remained many gestures and objects that I encountered about which I still lack understanding.

To cite one of many of such experiences, one evening, I found a coconut that was bound with three candles with palm fronds and some names written on it. This object was placed beside the church wall close to the entrance of the church. On many occasions, I had seen people coming out of the church holding a bunch of candles that were bound with palm fronds in three places and watched them walk around the church for a number of times. When I asked Ontop about the meaning of this object and implication, his response was *'no comments on that*'. Similar was the case of those running around the church. I was not permitted to tape record our discussions and neither was I permitted to photograph several scenes and objects. This notwithstanding, as I will show below, faith-based healers were

widely accepted in the wider community, including by some Aro hospital staff. In the next section, I will discuss how Aro hospital staff perceived these different non-biomedical sources of mental health care as well as their interaction with these healers.

6.5 Single system of caring, different practices: the ambiguity and ambivalence of mental health care in Abeokuta

In the previous chapter, I reported that Aro hospital personnel often discredited and dissuaded their patients from patronising nonbiomedical treatments, especially *Ibilẹ* practices. Despite their efforts, many hospital outpatients from Aro still sourced treatment from other sources either sequentially or simultaneously to their admission to hospital. Just as Obaf claimed to be famous in Aro hospital for healing some of their patients, the two *Ibilẹ* healers described above also claimed to have treated several Aro hospital patients after they had left the hospital and were yet still suffering from illness. Chief Fag said that Aro hospital patients had been coming for treatment since the time of his late father. People brought their sick person to him after they had spent a lot of money and waited for long on Aro hospital treatment but without the desired results. Since the death of his father, he too had treated several Aro patients. What is more, Chief Fag also claimed that even some staff from the Aro hospital patronised his services.

> *'…few of them* [Aro hospital staff] *that know that I can do it* [cure mental illness] *and those who have tried Aro for long and realized there was no substantive changes. After trying that of white medicine or church and there was no desirable change do bring them to me.'* ***Ibilẹ*** **healer – Chief Fag**

Chief Fag told a story of one Aro hospital staff whose wife was mentally sick and had been treated at hospital, yet the woman kept relapsing, so he brought the wife to Chief Fag. According to Chief Fag, it was the admission of this woman that ushered him into traditional birth attendance because the women was pregnant and yet experiencing severe mental illness that even the husband could not handle. He added that he did not only treat the woman but he also delivered her child. Even though the incident happened more than twenty years ago, Chief Fag had since then continued practicing birth attendance alongside mental health care. Like Chief Fag, many of Chairman's customers had been to the Aro hospital at certain points before they went back to him.

Almost all the people that I met at Chairman's facility claimed to have visited the Aro hospital and/or retained Aro patienthood. Chairman claimed to be aware that many of the people he was treating had gone to some other places, including Aro hospital before they came to him. According to him, people came to him or sought *Ibilẹ* care either because they were poor or after they had spent all they money they had and without much success. Chairman buttressed his point with the story of a lady 'Jugbun' who was brought in late October 2018. He described how Jugbun had been brought to him by her mother some three years ago, after she had been discharged from the Aro hospital.

> *'…that same lady, she was brought here the other time after they had spent so much in Aro and eventually when they discharged her, …[her relatives]… saw that there was no much difference…. the time they brought her, she was so dull and would be looking like this.'* ***Ibilẹ*** **healer - Chairman**

Although this lady relapsed and was brought back into Chairman in 2019 by her younger sister Alhaja, Chairman claimed that she did not spend more than two weeks in his facility before she got well and went back to her normal life. Prior to that she had spent about two months in Aro hospital and without much success. Jugbun's younger sister Alhaja also confirmed this claim during our discussion on her sister's condition.

Another reason identified for combining the Aro hospital treatment with traditional treatment was because patients believed that healers had a better understanding of their problem. Both healers and caregivers described *ibilẹ* mental health care as *ẹsẹ-ile abalaye* and *tiwa-n-tiwa* to show that it was more or less part of their cultural life. As such, the caregivers seemed to believe that the traditional healers could understand their condition better than the biomedical personnel, while the healers also assumed that they possessed good understanding of the local people and their health challenges. For instance, a woman of 50 years old called Iya Biu brought her 70-year-old mother Iya Nut to the Chairman's facility in October 2019 for some treatment. According to Iya Biu, Iya Nut was talking incoherently, restless, and sleepless. Worse still, Iya Nut would wake up when everybody had slept and leave the house and sometimes walk down the street to sleep. So they always locked the door to prevent her from wandering. This problem started some months back and Iya Nut's children had taken her to the Aro hospital. At Aro hospital, Iya Nut was able to

answer all the questions that doctor asked her correctly. After few days and medical examinations at Aro hospital, the staff concluded that nothing was wrong with Iya Nut, so they only prescribed some medication for her which always made her dull. Despite the medication at Aro, the sleepwalking persisted, Iya Biu alleged. Iya Biu said that people advised them to seek an indigenous remedy and when met Chairman that he told us that Iya nut was suffering from *Akọ igbona,* male measles*.* So, according to to Iya Biu the fact that Chairman acknowledge that Iya Nut was sick and his ability to name the illness was a sign of better understanding.

People also combined Aro treatment with traditional medicine because they claimed that they wanted a 'complete' cure for their sick one. Almost all the caregivers said they had been somewhere before coming to consult either Chairman or Chief Fag. Some caregivers claimed to have been patronising Aro hospital for years but instead being cured, they kept prescribing medications which would apparently be required endlessly.

More importantly, some caregivers expressed the view that the mentally ill people often suffered from multiple conditions, each of which required a distinctive tradition of healing. I have shown that people in the study location believed that mental illness was multifaceted in chapter 3, and that mental health care must be multiple in chapter 5. One way that these notions played out was that caregivers often combined different healing practices to guarantee full recovery, as Merci's example will illustrate.

Merci was admitted into the Chairman's facility Saturday 17, but I met him on Monday, November 19, 2018. In my view, Merci related well with others just like every 'normal' person around both in verbal and gestures. He was coherent in conversation, dressed well, and was well comported. I met Merci sleeping on small locally made mat with shackles on his legs. He wore a polo shirt over a cloth wrapper (usually only worn by women) because he said he had been compelled to remove his trousers to prevent him from absconding (See plate 7.8.) Despite Merci's incarceration, he seemed happy as I met him and was singing different Christian songs, thanking God, and occasionally clapping on his mat.

According to his father, Merci was admitted into Chairman's facility because he was a drunkard, and was smoking, wandering, and of unwillingness to work. Merci's father

stressed further that his son Merci has been a trouble for the whole family for about eight years. Talking about the onset of Merci's illness, his father said that in 2011 Merci started to have a high body temperature, could not talk, and was vomiting. They took him to a private hospital where he was treated. Later, the father claimed that Merci started 'talking rubbish' and if given any chance, he would be roaming the streets. Merci was taken to Aro hospital where he spent several months before he was calmed. The father also confirmed that Merci still had some medication given to him at Aro hospital. However, after leaving Aro hospital, Merci had not stopped smoking, wandering about, and was not ready to work. Merci also spent any available money and carelessly, regardless of whom it belonged to or what purpose it was meant for. Hence, he brought Merci to the Chairman to assist them to '*yọ kuro l'oju rẹ'* meaning to remove spell from his eyes.

Plate: 6.8: Patients' lifestyle: Merci sleeping on his mat with shackles on his legs during his admission at Chairman's facility, Abeokuta
Source: Author's Fieldwork, November 2018

Merci also confirmed that he had been to many places and had been taking different types of medications. He explained that he had stopped taking them because he was not sick and could not see a reason to take them. Moreover, he was afraid of being affected by those

drugs. Merci considered his stay in Aro a waste and a boring time for him as he was held down there without doing anything. He also expressed his belief that coming to the Chairman's facility was for his good and would alleviate his problem. However, he did say that he wanted Chairman to remove his shackles since he was not a criminal and because of the injuries that they inflected on him. He further claimed that he had attended several 'church programmes' and many prayers sessions had been organised to get a 'solution to his life's challenges'.

My understanding of Merci and his father's reasons for using combined treatments is that Merci's illness has three dimensions: somatic, psychiatric, and moral. Firstly, Merci was taken to a private hospital at the onset of his illness to fix his inability to eat and sleep well which are recognised as serious illnesses among the Yoruba (Jegede, 2002). Then he was taken to Aro hospital to treat incoherent speech, before coming for the spiritual healing to fix his moral challenges such as smoking, wandering and laziness. Throughout this time, Merci was also going for different church programmes, perhaps for deliverance. Because both Merci and his father believed that Merci was not living up to his destiny as ordained by God, because all his other siblings, including those younger than him, were already working and financially independent. Merci's father added that most of the money spent on Merci's illness came from his younger siblings and mother.

Other people combined Aro hospital treatment with other treatments at the discretion of the family/caregivers because they considered Aro hospital treatment a foreign practice that lacked full understanding of the local illness and therefore unable to deliver a complete cure. Other reasons mentioned for the use of faith healers include lower costs and more flexible payment schedules, as some healers, especially faith-based healers claimed they did not charge but only received offering or pledges which could be in cash or kind. This allowed for flexibility in payment unlike at the hospital.

6.6 How Aro hospital staff talked about differences in treatments and medical ambivalences

Aro hospital staff were aware of the multiple forms of mental heath care practices that existed outside the hospital. Some staff would verbally scold or even threaten the patient and caregivers that they would not attend to the patient once they suspected such person

had engaged in what they called 'combined treatment'. The case of a 20-year-old secondary school student who was threatened with the withdrawal of treatment when brought to the Aro hospital for exhibiting side-effects after being given holy water at a church was an example. I also witnessed some occasions when Dr Falah would be counselling the patients not to listen to what he usually called a 'super story' from the traditional healers that their sickness was due *epe* forces (a curse or spell). Each time I asked him why, he always told me that if mental illness were due to a curse or spiritual forces, *Oyinbo* [Whiteman] medication would not have been curing it. This view was not shared by Falah alone but the vast majority in this hospital. One of the therapists also said this:

> *'…if it* [mental illness) *is viewed from the spiritual angle, that is, coming from the religious aspect, they will say it is spiritually caused or an attack. But we would want to come from the medical aspect to say it [spiritual causes] is not real* [he said this very softly and sluggishly as if he was not confident of the statement]. *Reason being that we have had several cases, I mean several cases that people would say it was an attack* [caused by evil forces or spiritual agents] *and so on and so forth. This person is hearing voices and this and that. They will say they have taken him/her to the mountain or Alfas but eventually they would bring the person down to the hospital and within 3 to 4 weeks, the person is now getting better. Now, we are not saying, it was not an attack but why should western medication be potent in treating such? People would be saying it is spiritual attack, and then spiritual remedy should be the one to be curing a spiritual attack.* **Aro hospital staff - Mot, a senior occupational therapist**

However, the Aro hospital setting could not be said to be completely free from medical syncretism despite all the negative things its staff said about nonbiomedical practice and practitioners. Apart from the fact that the staff were aware of that some of their patient engaged in the practice, some staff demonstrated similar beliefs, especially around faith-based healing, such as belief in the spoken words and prayers.

Even though the staff generally argued that Aro Hospital was not offering faith healing within the hospital setting, some staff nonetheless exhibited a belief that mental illness

could be spiritual or related to evil forces. For example, when one of the nurses expressed her personal belief that an evil spirit was responsible for a patient's illness symptoms, which included hallucination and delusion, she began warding off what she called 'the curses' with 'Jesus name', which she said was more powerful than the 'forces' working in the patient. Like this nurse, many of the staff maintained that they needed God to be able to perform the treatment, hence many of them including the senior staff always prayed once they resumed duty and before they did anything. Some staff even claimed that those religious activities were part of the treatment they provided. One of such views is as follows:

> *'that is why I said we could not rule the spirituality out in Africa. We have incorporated it. …we still recognise spirituality, and that is why we encourage our patients. Those Christians are taken to the church on Sunday, and I, while I was coming to the mosque, those who are Muslim that I saw, came to the mosque together before they went back to their hall. We still encourage it because it still part of our lives. We believe that it* [religion] *has some role it would play in our life and also in the life of the mentally ill person. So, you can't rule it out! Also, there have been some works [i.e. research publications] that talk about spirituality and the role of spirituality, but what is there is that it is very rare to see medical personnel that will be advocating for spirituality. It is like those religious leaders are to advocate spirituality and not the medical professionals. It is as if they are saying their drugs/medications are not efficacious in a tricky way…. There is no doubt about it; we are Africans! That mentality you cannot take it away from us'* **Aro hospital staff - Mot, a senior occupational therapist**

Mot's comments not only confirmed staff awareness of combined treatments, especially faith healing, but also acknowledged their potential efficacy and place as an important component of mental health care. Like others that shared a similar view, Mot said that many people in the region would always prefer a multiple approach to treating mental illness because of what they termed 'being an African.' There were occasions that some staff members told me what they called 'sincere talk' or 'being sincere with ourselves' when discussing causes and treating mental illness. For example, a staff that who spoke under anonymity said '…this one is off record o! off record now! Let us be sincere with ourselves!

You are a Nigerian, and I know you know what is going on. Do you think all these things are ordinary? *Ki se oju lasan!* - it is beyond ordinary. *Yoruba si so wipe oju lasan ko se wo were!'* – a Yoruba popular saying states that treating a mad person cannot be ordinary. So, these staff believed that some religious activity such as prayers should be combined with medical treatment to guarantee maximum positive outcomes.

I witnessed a few occasions where the staff advised their patient to pray and caregivers to pray for their sick person. Again, during my stay in the Emergency unit, there was a time that the nurses were calling a new patient for clerking. At the Emergency, staff attended to those that came on first-come, first-serve basis. So, it was this person's time and the nurse called him. Instead of answering the call by the caregivers and move towards the table with the sick person as usual, the woman was waving the nurse to signify that she heard but needed some minutes. Looking at her, I saw her holding the phone to the ear of the sick person. The manager moved towards the direction to tap the person; in case they did not hear. On getting there, the manager saw that he was receiving call and when she moved closer, the woman -caregiver told her that it was her pastor that was praying for the man on phone.

I thought that the manager would ask them to allow the doctor and nurses first to do their job and then attend to their pastor later. On the contrary, the manager turned back to the nurses (junior to her) and said, *'E dakun, e mu suru fun won die',* Somebody is praying with him,. *Se, ẹ gbọ? Won so wipe pastor n pray fun lowo'* – A pastor is praying with him, please, exercise some patience with them. Did you hear me? So, I engaged the manager later that day for her explanation to have allowed a virtual prayer to take close to twenty minutes of their tight time. As she was packing her bag in preparation to leave the office that day, she replied, 'Eh, my brother, you see, here, *ọgbon lo gba o. ogbon Ọlorun* [working here requires wisdom of God] because we too, it is God that we are relying on, and since it was prayer, then why should we not allow them?' The manager told me that both the staff and patients needed prayer. Therefore, it was not only that they did not stop the prayer, but they also encouraged it.

Regarding the *Ibilẹ* (traditional) healers, my fieldwork suggested that Aro hospital staff were also not completely dismissive of those 'nonbiomedical healers'[24]. Some staff even claimed that these healers helped to lessen the treatment gap for mental illness in the region given that Aro hospital lacked sufficient resources, especially human resources, to get their treatment across to everybody that needed it. As such, to close the gap left by a 'grossly inadequate shortage' of biomedically trained personnel as Dr Show termed it, some staff believed that traditional healers could be incorporated to the industry or workforce to increase the access to treatment. Like Show would say:

> *…Just like in some other professions where some nonprofessional could join by learning, whosoever like to be involved can now. They* [faith-based and traditional healers] *can be involved to a certain extent just like in any other fields where they have others helping them. But to the level of expertise and in different activities, once they can be regulated, I don't see any issue in that.* **Aro hospital staff - Dr Show, a consultant**

Although the above raised other issues such as the nature of the relationship the medical staff wanted with the nonbiomedical healers which I would discuss later, Show's comments indicate that staff saw some relevance of traditional and faith-based healers and demonstrated readiness to work with non-biomedically trained healers.

Some staff also raised some concerns about the efficacy of non-biomedical treatment, but other staff also raised some views to the contrary. One of those who directly acknowledged the efficacy of traditional medicine was a doctor, Bottlereje. He admitted that some healers did have good knowledge of different plants and their uses and could treat mentally ill people effectively. He added that people would not have been consulting them if it were otherwise. He maintained that majority in the region still patronised healers, and many got healed by them.

> *'It is not that we* [people with indigenous knowledge of healing] *don't have the means* [to treat mental illness], *we do. In fact, let me explain to you, even*

[24] **Non-biomedical in this context** refers to the *Ibilẹ/traditional* and faith-based healers in Abeokuta.

though, when you came here you see patients, it is the minority that comes here, not the majority. The majority still goes to traditional and faith-based healers. In fact, there is some statistics, I mean, there is a paper, a research paper. A research conducted about three years ago shows the pathway of care. Where do patients go to, where their relatives take them to and I am sure that unlike this our settings, over 80% first go to the other settings (nonbiomedical settings), and many that go there, they get well. This place [Aro hospital] *is like last resort. It is like they have tried Babalawo-herbalist, they have tried the church* [for faith healing] *and they said ok let us just try there* [Aro/biomedical hospital]*, let us just for the sake of completeness, that is it.'* **Aro hospital Staff - Dr. Bottlerej**

Bottlerej's comments reemphasised what had been earlier established by many other staff, that a lot of people would consult nonbiomedical facility[ies] before considering hospital. For instance, Olopa, one of senior nurses in-charge of the Aro community primary mental healthcare programme confirmed that several healers had an appreciable number of mentally ill person that they were treating in their various facilities.

'we too have been to many places including some churches. We were once told about a church with about 50 patients, and by the time we got there, we met about 20 there that day but as they saw us, they [the healer] *rushed out and started covering them with cloth and taking them into the church…We try to convince him that we were not there to take away those people but just to allow us to examine them and place them on medication but our effort was unsuccessful.'* **Aro hospital staff – Nurse Olopa**

Beyond public patronage and preference for nonbiomedical healers, Olopa's comments indicate another important point earlier also mentioned by Show, that Aro staff did not completely write the healers off but had started to work with them despite their largely negative disposition to these healers and their practices.

Aro hospital staff said they would work with the healers because they were socially respected and accepted in their communities. Some staff expressed that working with

nonbiomedical healers, especially religious leaders could increase the social acceptability of Aro hospital treatment in the region and consequently increase the number of their patients. Some Aro hospital staff suggested that bad relations with religious leaders, could have a dire effect on their doctor's instructions and patient adherence to the regimen. For instance, Nurse Beauty said, *'some of our people here respect their pastors more than anybody. They prefer obeying their pastor to adhering to the doctor's instruction.* Beauty corroborated her point with two related but different stories. She further relayed some past experiences where some patients relapsed and were brought back to the hospital because their pastors asked them not to continue with their medication as in the below.

> *'…we then asked from his caregivers whether he was taking his medication as and when due, it was then they said he had gone to a mountain*[25] *and undergone deliverance*[26] *and the pastor said it had gone forever…'* ***Aro hospital staff – Nurse Beauty***

As Olopa's earlier comments imply, some staff, especially those that were managing the Aro primary mental healthcare programme had developed a relationship with several healers. They sometimes visited them, and during their visitations, they introduced biomedical treatment, especially pharmaceutical medications, to the people living with mental illness under their care. To Olopa, the idea of involving non-biomedical personnel to expand Aro hospital treatment and ethos and boost patienthood was very important. She also maintained that non-biomedical practitioners remained a good source for gaining more patients for the Aro hospital because they usually have numerous people receiving mental health care in their facilities. She further confirmed that working with these healers had helped them a great deal to reach out to more people that needed treatment.

> *Yes o! It is possible. You see, the approach matters in everything we do. The man* [a healer] *in Imeko came to the centre himself telling us that his wife was at the centre when we gave a health talk that anybody that has mentally ill patients at home should bring them down to the centre, that they will be well treated and be*

[25] **Mountain** is a hilly (and sometimes not) location usually a secluded expanse of land with or without shed where some churches conduct some special spiritual activities in the southwestern part of Nigeria.

[26] **Deliverance programme** is a religious rite commonly organised by some churches and Muslim cleric in Nigeria where those religious leaders purported setting a person free from supernatural forces and activities that cause his/her problem

given medications. He now said he had been treating the mentally ill and would like us to com and look at them. Immediately, we followed him together in our Hilux vehicle[27]*. When we got to the place, we assessed the clients and about 7 or 8 of them, we placed on medication. Then we told him that we were not taking them away from him, that they would remain in his custody, and he will be administering the medication on them, and that was what happened…* **Aro NPH staff – Nurse Olopa, a senior nurse**

The above comment clearly depicts how the staff went about seeking to extend Aro hospital treatment outside the hospital setting and to encourage some people who probably would not have accepted Aro hospital treatment to accept it. However, the comment also reinforces another view that many of the staff shared about the nature of collaboration and the kind of relationship that they would want with the healers. Unlike the collaborative treatment that Lambo developed with some healers in the past, which reportedly afforded a patient to receive both biomedical and non-biomedical forms of treatment, Olopa's account showed that the staff collaborated with the healers, but only to enforce biomedical treatment. According to her, they exclusively worked with healers ready to adopt biomedical diagnosis and treatment ethos. Also, both the comments and the tone of the presentation suggest that the Aro hospital staff believed their treatment was superior and more effective than the other healers. This belief was echoed in Olopa's remarks about healers who declined to take Aro Hospital's offer of medication:

For instance, I and Dr Majek …met some traditional healers there who had been in the business for a long time and there were many patients there that were tied down for long too. We tried to introduce them to the use of our medication [pharmaceutical drugs] *but they rejected it. They claimed to have some medication such that once the patient uses it, it will not take long before she or he gets healed. Imagine that!... We try to convince him* [another healer] *that we were not there to take away those patients from him but just to allow us to*

[27] **Hilux van** is considered expensive and commonly used by wealthy organisation, especially top government officials and affluent people in this part of Nigeria. So, mentioning it was as an emphasis or proof that Aro hospital has better tools than healers.

examine them and place them on medication but all to no success…' **Aro NPH staff – Nurse Olopa, a senior nurse**

This view of superiority was also reflected in the kind of relationship that Aro hospital staff in this case wanted to maintain with the healers. The staff considered healers to be of lower professional status, too 'local', and perhaps unhygienic, to the extent that some staff would refrain from eating with them:

…..So, he [one of the healers partnering with Aro community primary mental healthcare] *later called us on phone* [Aro hospital community mental healthcare team] *that he would like to invite his colleagues to come and gain from our experience and he invited them. Before we got there, they have prepared rice and boiled eggs* [she started laughing]. *My colleagues were like how do we eat from these people? I told them, we must eat because, they made so much effort and wasted energy to prepare the food, so we need to eat…* **Aro NPH staff – Nurse Olopa, a senior nurse**

Hierarchies between biomedical staff and other healers were expressed in different ways by different Aro hospital staff. The doctors were more direct in expressing their belief that healers should be subdued to them. They emphasised the importance of training and regulating the treatment practises of such healers (cf. Green, 1988; Singer, 2004). For instance, Show did not only emphasise the need to regulate healers but also described current nonregulation or independent practice of healers as a major 'problem'. According to him *'*what we have is the problem and ability to regulate*'.*

Show referred to Lambo's historical collaborative treatment and described the traditional healers that worked in the now defunct 'Aro village system' as if they learned the practice from Lambo. At a point, I asked whether he thought the learning or training he suggested could be symbiotic and he further clarified his view as in the below conversation.

Me: *'I don't want to assume here that I understand what you mean training and regulation? Who is to be trained and regulated and by who?*

Dr Show: *The spiritualist and herbalists, or whatever they are called, they need to be regulated and they need to be trained by the mental health physicians. Well, we do a lot of training on that…*

Therefore, the staff clearly wanted traditional healers to be involved but certainly neither as *Ibile* or *faith-based* healers. The staff were proposing a conversion rather than the incorporation of the nonbiomedical practitioners, especially when it came to traditional healers. This was because incorporation might have entailed an arrangement that would enable an official recognition of traditional practitioners and perhaps facilitate some forms of collaboration such as referrals and the inter-employment of personnel. On the contrary, the staff wanted the nonbiomedical healers trained in biomedical ethos and their practices strictly monitored by the biomedical personnel.

6.7 Conclusion

Baer, (2011) viewed medical pluralism as involving separate sub-medical 'systems' that coexist. The views of both the mental health care practitioners and users in the examples I have presented lend credence to the importance of pluralistic mental health. All the practitioners drew some boundaries between their tradition of practice from other types of healing found in the study location. Aro hospital staff differentiated their treatment practices from both traditional and faith-based healers The traditional healers also marked their boundaries with biomedical and faith healing in terms of training, medications they offered and their methods of treatment.

Just as some Aro hospital expressed doubts about the efficacy of the 'non-biomedical' treatment, so too did the *Ibilẹ* and faith-based healers, including doubt as to whether biomedical setting was comprehensive enough to treat all types of mental illness. They also talked-down of biomedicine for lacking a 'complete cure'. Unlike at Aro hospital the *Ibile* and faith-based stressed that they offered a complete cure and lower rate of relapse, as they claimed they were able to treat those that Aro hospital could not treat. While Aro hospital personnel believed that they were superior to 'non-biomedical' healers, the healers too claimed that they were more professional than the biomedical personnel. For instance, Chief Fag said those in hospital only have mastery of just an aspect of the treatment, unlike the *Ibile* who does everything including drug manufacturing.

In Abeokuta, caregivers developed different notions of appropriate care depending on how they interpreted symptoms. Caring for the mentally ill left a huge psychological burden on the caregivers (Chien et al., 2007; Mavundla et al., 2009). However, the pluralism of mental health care services in the context of this study seemed to offer some therapeutic relief to both the care users and caregivers. In the case of Iya Biu and her mother, Iya Nut, for example, Iya Biu told me that she felt so relieved when one of her friends informed her of Chairman's facility and that her mind was at rest that day that the Chairman eventually admitted her mother. Both Merci and his father expressed the same feeling felt because they knew that the private hospital was there to treat some aspect of his illness, Aro hospital was there for other forms of treatment, and the traditional care that Merci required for the moral aspect of his illness could be provided by the traditional healer. As such, having pluralistic medical systems around through which choices could be made gave the caregivers some emotional relief and hope and allowed people to respond to the multiplicity of mental illness via a multiplicity of treatment options.

How mental illness was defined in the study location necessitated this mixed use of different mental health care services. I have argued in this thesis that people explained mental illness as an illness condition that affected multiple aspects of a person that must be treated separately. In the same vein, participants were ambivalent about each mental healthcare facility because they recognised that each had its limitations, particularly when it came to permanently curing mental illness. Moreover, practitioners from diverse backgrounds shared some notions about mental illness and cure, for example in the idea that 'treating mentally ill cannot be ordinary' and that mental illness is often linked to supernatural processes among others, and many agreed they would refer their relative to a traditional or faith-based healers or therapy in certain conditions.

In conclusion, Abeokuta's mental health care practices contained elements of medical pluralism and medical syncretism. All the practitioners demonstrated some boundaries and explained how and why their treatment practices differed from others. People practiced medical pluralism because it presented the healers some socioeconomic benefits and the caregivers and users some therapeutic advantages. However, medical pluralism cannot solely explain all the medical activities in the region. At the same time, people combined

treatments from all the available sources in a form of medical syncretism that helped them to produce a 'complete' care for their mentally ill person. Given the multiple nature of mental illness, and the multiple problems that constituted the damaged personhood of the mentally ill, it is not surprising that people also relied upon multiple forms of treatment that were available the therapeutic landscape around them.

CHAPTER 7

'SCIENTIFIC PRACTICE': POSITIONING CARE IN ARO HOSPITAL

7.0 Overview

This chapter situates the multiplicities of health provision described earlier in the thesis within a global context and specifically through the provision of what has become known as 'global mental health'. As a specialist psychiatric hospital, Aro Hospital has been providing mental healthcare to the general population and this has earned the hospital a global recognition over the years. During my fieldwork in this hospital, both the management and staff described Aro hospital practice as purely biomedical in a way that suggested biomedical hegemony. They claimed that Aro hospital was best of its kind in Nigeria, one of the African best and of an 'international standard'. However, the staff were so much concerned with 'international reputation' that it became the catalyst for the hospital's medical, physical, and social everydayness. According to them, biomedicine and psychiatry was 'modern' and a practice of the 'international community' where Aro hospital belonged. Aro hospital staff believed that being in the international community required aligning themselves with certain practices and distancing themselves from others. One important way of doing this was by pursuing a type of mental health care that they classed as 'science-based' or 'scientific practice'.

Drawing from my observation of the staff's daily activities and interaction, and purposive discussions with some members of the medical team of this hospital, 'science-based' or being 'scientific' was usually conceived and expressed in two different but related ways: (i) by comparing the form and contents of their practice with those non-biomedical mental health providers in the region; and (ii) through alignment of their practice with the global mental health care guidelines and by identifying in various ways with international organisations in 'developed' world. As such, Aro hospital space can be understood in the context of Foucault's concept of heterotopia in that several other places and activities were configured and reconfigured within it. The concept of heterotopia provides insights into the contradictions and tensions associated with 'scientific practice' in Aro hospital. At the same time, the concept of heterotopia provides a helpful insight into understanding another kind of multiplicity in Aro hospital by holding together of diverse (non-commensurate) ideas and

practices, given that due to shortages and lack of resources, hospital staff often failed to deliver on the promises of 'scientific practice' and follow the ideals of 'global mental health'.

This chapter is divided into five sections. The first is a review of literature on the rise of biomedical practices and the hegemonic force of biomedicine, as well as the contributions of the concept of heterotopia as analytical frame in hospital ethnography. The next section is an ethnographic report on how biomedical hegemony permeated Aro hospital mental healthcare practice and its implications on healthcare practitioners' relationships. Then, in the subsequent section I explore the idea, meaning, and implications of 'scientific practices' in the Aro hospital. In the fourth section, I identify and discuss contradictions and tensions generated by scientific practice, while the last section discusses and summarises all the points by arguing that Aro hospital was both nested in and a mirror of the international community in a way that is better understood in the framework of heterotopia.

7.1 The rise of biomedicine, biomedical hegemony and hospital heterotopia

This section discusses two theoretical perspectives in relation to the practices of biomedicine, and, more particularly, biomedical psychiatry in Africa. Firstly, I discuss the rise of biomedical psychiatry and its hegemony in most parts of the world including Africa. Then, I show that biomedical psychiatry is not just one among other sources of mental health care systems, but an insignia of modernity, the most influential, and with greater international repute and support. Then I discuss Foucault's concept of heterotopic places. Some scholars have found biomedical hospitals, including psychiatric settings, to be heterotopic, a field where many activities other than biomedical treatments are coordinated. The section thus discusses the importance of heterotopia in hospital ethnography as well as some other identified activities within hospital places.

Biomedical psychiatry diffused from its European origin into almost every region of the world, expanding across Africa nations by the mid of twentieth century, and since then, both biomedical and nonbiomedical psychiatric institutions have been coexisting and remain important sources of mental health care for the African population (Adelekan et al., 2001; Adewuya & Makanjuola, 2009; Akyeampong, 2015; Asuni, 1967; Erinosho, 1979; Heaton, 2014; Van Der Geest & Finkler, 2004; Ventevogel et al., 2013). To some scholars,

biomedical psychiatry signifies modernity and development (Asuni, 1967, 2009; Prince, 1960a; Street, 2012).

The coexistence between biomedical and nonbiomedical psychiatric institutions has been asymmetrical. Biomedical psychiatry has since been spreading, improving technologically, and becoming more influential than nonbiomedical psychiatry across African settings, given that it enjoys more recognition and support from various governments and agencies nationally and globally. Even though biomedical psychiatry differs from one setting to another as discussed in chapter 5 , to a large extent, all of them are guided by a common philosophy. Biomedical mental health care practice from across the world is anchored on empiricism, favouring naturalistic causal explanation of mental illness and emphasising evidence-based treatment ethos. This shared philosophy underscores the idea of creating a globally unified explanation and classification of mental disorders and therapeutic approaches as evident in DSMs and ICDs (see Aggarwal et al., 2013; Ajaelu, 2004).

Biomedical psychiatry operates within a global network. Various international organisations, including the WHO and Movement for Global Mental health (MGMH), have been involved in the planning, provision, and funding of mental health care across the globe. These organisations organise and support various research agendas vis-à-vis making policies that in a way further foster cooperation and collaboration among different biomedical psychiatric institutions globally (Daar et al., 2014; Goldberg, 2000; Keynejad et al., 2017; Kohn et al., 2004; Patel, 2014; Tansella, 2000; Wig, 2000; World Health Organization, 2013). For instance, the WHO affirmed that global burden of mental illness is huge and that only a tiny proportion of those that need mental health care could receive it, especially in the middle- and low-income countries (Patel, 2014; Patel et al., 2007; Vigo et al., 2016; Whiteford et al., 2013; Wittchen et al., 2011). WHO then launched mental health Gap Action programme (mhGAP) in 2008 to reduce the treatment gap and also recommended that mental healthcare be integrated into primary healthcare and that some primary healthcare workers be included in the treatment processes (Keynejad et al., 2017). These international organisations e.g., WHO and MGMH also work closely with various national governments and this has yielded in the construction of some new biomedical settings and renovations of the old ones, as well as mental health care training across many nations,

including Nigeria (see e.g., Abdulmalik et al., 2014; Adebowale et al., 2018; Gureje et al., 2015; Varma, 2016).

The transnational proliferation of biomedical psychiatric settings and networks enabled through international organisations, can be understood in what Noelle Sullivan called 'a global system of health governance ' (Sullivan, 2012: pg.58). A frequently taken-for-granted idea is that all the biomedical psychiatric institutions do is to offer [mental] healthcare. On the contrary, literature has it that biomedical psychiatric facilities also perform other functions including a demonstration of socio-political strength, development, and/or to prove membership within the international community (see e.g., Heaton, 2011, 2014, 2018; Street, 2012). In other words, biomedical psychiatric settings could be more than just a place where mental health care is provided. Instead, they are physical and social places that can also be understood within Foucault's concept of *heterotopic space* (Foucault & Miskowiec, 1986) in that other activities take place within them, such as inter-institutional and interpersonal relations, making psychiatric hospitals sites where international relations are configured, and reconfigured, juxtaposed by and within the global community.

Foucault's idea of heterotopic place maintains that human physical place is always heterogenous and not independent of the sociocultural milieu of its context. (Burlacu, 2017; Foucault & Miskowiec, 1986; Patr et al., 2019; Rousseaux & Thouvenin, 2009). Foucault's idea of heterotopia of place is dialectic. It states that heterotopic space is made through several social processes and relational activities on the one hand, and those activities and relationships are also made by the place itself (Burlacu, 2017). In other words, understanding a setting is key to the knowledge of the activity therein, and to understand such a setting, its history and its relationship with other places and objects are also required. The dialecticism is also apparent in Foucault's typology of unreal [utopias] and real [heterotopia] places where the former is created through but also reflects the latter, thus make the latter more important.

Foucault identified heterotopic places as including prisons, aged caring homes, and most importantly for my argument, mental institutions, which he saw as 'heterotopia of deviance' (Foucault & Miskowiec, 1986 pg.25). The concept 'heterotopia of deviance' is useful for depicting a 'normal' place for 'abnormal' social behaviours. However, since Foucault's

death in 1984, the growth of global mental health suggests important new directions for the concept. Heterotopia as a concept has become an analytical frame in many fields of study including medical anthropology, particularly hospital ethnography.

In hospital ethnography, heterotopia has been an important analytical tool used to explore and analyse the roles of hospital space in understanding the forms and contents of health care and other activities. Street & Coleman, (2012) in their introduction to a special edition on heterotopia of the hospital settings acknowledged that hospital place is of multiple identities which they termed 'multiformal space' (ibid pg. 5). This because the hospital constitutes both an esoteric world that is exclusively bounded for various medical equipment, technologies, personnel, and patients on the one hand, and an extension of the society that is characterised by social stratification, cultural belief, social interactions, and relationships such as love, conflict, cooperation, and competition (Finkler, 2004; Van Der Geest & Finkler, 2004). Contrary to the hospital image and binary categorisation [society versus hospital worlds] portrayed by the earlier scholars (e.g., Goffman, 1961) who argued that hospital setting is a complete separate world a different world, Street and Coleman argue that hospital is a complex social space characterised by 'order and disorder, stability and instability' that permeated hospital's everydayness.

Also, Brown (2012) explored the heterotopia of a Kenyan hospital where she reported that 'home space', and 'religious space' were reconfigured in the hospital. She demonstrated that several forms of care existed in the Luo sociocultural context such as familial or relational care, body care, and medical care with each of them meeting different needs of the patients. Attached to each of these types of care was therefore a sense of an appropriate space for its exhibition. Since all these types of care were required of the patients on hospital admission, the District hospital space where she worked thus became a place for all these different forms of care, i.e. a heterotopia. As such, Brown mapped out the social and spatial boundaries based on who was responsible for what e.g., hospital staff, relatives, and friends who provided them. In other words, heterotopic analysis of the hospital helped to understand how domestic care and relations were reconstituted in the Kenyan hospital ward, and coexisted with formal biomedical care. Also brought to the fore is that this hospital space housed both formal actors e.g., nurses, and doctors, and informal

actors such as parents, friends, and siblings and all of them performing their role within the new emerging spatial [re]order, contradictions, and complementarity.

Furthermore, (Street, 2012) analysed how hospital environments such as buildings and equipment in Papua New Guinea performed political and national building functions in addition to healthcare role. According to the author, Madang general hospital occupied the centre of political history of Papua New Guinea as a relic of defunct colonial rule and as a symbol of an independent nation that was plagued with unequal access and opportunities in the present. In the 1960s, Madang hospital connoted government presence, as well as political concern and will for the national development generally, and citizens' health specifically. Nevertheless, some 50 years later, the same hospital space has become a fossil, a historical space or a memorial of colonisation. It also served as a medium through which the present government and political machineries were evaluated, and the national future of the Papua New Guinea be forecast. Street also maintained that the hospital buildings, available medical resources and access to them reflected the prevailing social stratifications and ruling class of their times (see also Street & Coleman, 2012). While the author's hospital heterotopic analysis suggests a local social space with national historical, political, and developmental issues embedded in it, Sullivan's, (2012) work shows the hospital as a place where local and international spaces met and coexisted. She studied Kiunga district hospital in the northern part of Tanzania and demonstrated that this hospital space was divided alongside physical and medical infrastructures in a way that reflected local, national, and global 'governance'. Sullivan's heterotopic account of Kiunga district hospital suggested that collaboration and support from international organisations and government created some new places not only for medical practices but also created and redefined relationships between hospital spaces and actors locally and transnationally.

In summary, biomedical psychiatry has been found to be an important source of mental healthcare globally, especially in many African settings but also with hegemonic force. Like the general biomedical system, biomedical psychiatry enjoys greater social and political support than other forms of psychiatric care, which has enabled its global coverage faster and with some advantages over other mental healthcare systems. However, beyond treatment provision, biomedicine and its infrastructure also perform some socio-political

roles within the communities where they are found and are often expressions of relationships with places outside of the hospital itself. In what follows, I will show with ethnographic data that the hegemonic force of biomedical psychiatry has a lot of influence on how mental healthcare is practiced in their various locations. Relatedly, heterotopia provides a frame for understanding how global ideas and practices reflect in the local setting on the one hand and illustrate how various local settings are linked together to form the global. As such, I will also demonstrate that psychiatric hospital space is not a single place but a place where other places are configured and juxtaposed on the one hand, and place for several activities other than biomedical mental healthcare.

7.2 Hegemonic force and Aro hospital biomedical practices

In this section, I will show how Aro hospital management and staff embraced and identified with biomedical psychiatry, which they believed to be 'modern' and prestigious. As such, they made efforts to align with biomedicine as they described nonbiomedical psychiatry, especially traditional practices as 'uncivilised', 'crude' and unfit for 'educated people' and the 'modern' era.

Aro hospital staff believed that biomedicine, particularly biomedical psychiatry, was the world's leading mental healthcare system claiming that it was modern and had global support and prestige. On various occasions, staff described biomedical psychiatric practices as belonging to the 'modern days' and 'developed' world while they characterised nonbiomedical psychiatry, especially traditional practices, with 'old' generations, or an 'uncivilised era' and described its methods as archaic. This they often portrayed this by putting traditional healing practices within historical context such as '*igba aye awon baba wa'* (in our forefathers' days), and 'our father's knowledge' as captured in the below.

> *Can you imagine? In the twenty-first century! It's funny! Isn't it? That many of our people still believe so much in those uncivilised practices…even when their condition is not improving. I don't know what's wrong with our people…*
>
> ***Aro hospital Staff – Nurse Opa***

Aro hospital practice was influenced and fashioned by overseas models, especially from the UK and US, countries considered leaders in biomedicine. To many of the staff, biomedical

psychiatry was the most globally acceptable and respectable form of mental health care. As will be seen in the next section, Aro hospital staff aimed at being on a par with other biomedical psychiatric institutions in developed countries. As such, staff often borrowed methods and ideas of mental healthcare practices form overseas institutions such as the WHO, and universities from the UK and US. The staff and management also expressed the view that Aro hospital practice was only made perfect when it aligned with policies from overseas, via processes staff termed *'scientific practice'* or *'best practice'* which I will explain in detail in the subsequent section.

Interestingly, in the process of aligning to what they considered global and best practice, some staff attempted to deny a crucial component of the 'Aro Village System' which many staff and authors acknowledged had originally brought Aro hospital into the limelight. It is on record (e.g. Olukayode Jegede, 1981; Osborne, 1969) that Aro village System involved collaborations between the Lambo-led Aro hospital and Yoruba traditional healers, and some of my interlocutors within and outside Aro hospital also confirmed this. Even though many staff acknowledged that Thomas Lambo and Aro village System were crucial to Aro Hospital's international reputation, some older staff members declined to comment on Lambo and this history. Some older and management staff denied that Lambo ever engaged the services of traditional healers, and some of those who confirmed collaboration with traditional healers' did not want to be quoted because, as many claimed, such collaboration was considered to go against their present practices. During our only discussion in his office, Dr. Awe, a member of the senior management team telling me (with a frowning face) that such things have never happened. According to him, *'what do you mean? Oh, you think he* (Lambo) *could have been there with babalawo* (traditional priest) *treating the patient or what? That never happened…*' At the same time, some younger staff declined to comment on the matter, claiming to have little or no knowledge of Lambo's tenure as the Medical Director of the hospital, perhaps to rescue themselves form such controversial topic as illustrates below.

> '*Well Lambo's programme started in 1954, so what year are we now?* [He asked me, and I replied '2019.' Then he continued] *so how many years now? Well, I*

don't know much about the programme o… you can just go online and search for it, and I will also read more about it'. ***Aro NPH Staff: Dr. Bottlereje***

As the above suggests, Aro hospital staff associated the hospital with biomedical psychiatric practice and encouraged only this kind of medicine. On many occasions, the staff would not only deride the nonbiomedical healing systems, especially when it came to 'traditional' medicine, but also discouraged their patients from patronising them. The staff sometimes did this by threatening patients that they would not attend to them or withhold subsequent service should they notice that a patient patronised traditional healer (see also chapter 6). It was apparent that many staff were reluctant to acknowledge nonbiomedical mental healthcare practice as a credible source of care in the region, rather they would enthusiastically identify with biomedical psychiatric institutions and methods of practice from overseas. They also acknowledged that only biomedical psychiatry enjoyed both constitutional recognition and budgetary support from the Nigerian state. In the next section, I discuss how much Aro hospital space was saturated with the ideas and practises of overseas institutions.

7.3 Aro hospital as a place where other places are configured, reconfigured and compared

This section presents the view of the Aro hospital staff about the 'international community' and how it affects their mental health care practice. It shows that the staff conceived the international community as a big umbrella for all mental institutions and a pacesetter for their practice. As such, the section demonstrates that both the management and staff made efforts to be and remain part of this community by depicting it in their physical environment and committing to practices, creating a heterotopic space that continually referenced and enacted the importance of other places. The section concludes that 'international community' was crucial to the practices of biomedicine in Aro hospital and that failure to recognise this, might cause a backlash from staff.

Mental health care is a practice of the global community. Both Aro hospital management and staff overtly expressed an awareness of a community which some of them identified as 'global' and others 'international'. According to them, mental healthcare ethos and 'best practice' were defined and learned only in the 'international community'. No staff gave a

geographical or demographic description of this 'international community', but they identified some actors within it, with WHO being the most frequently mentioned. Others mentioned include some universities in the global north e.g., Cornell University and Manchester University in the US and UK respectively. Also mentioned were some funding agencies such as 'Lancashire Trust', 'NHS' and some mental health care expatriates with international recognition. An appreciable number of the staff believed that Aro hospital was part of the international community. For instance, statements such as 'Lambo led Aro hospital to the international community'; 'Aro village system put Aro on the world map'; and 'Aro is part of a global community' were made on different occasions and by different staff discussions on various topics such as history, physical environment, therapeutic methods, and treatment contents among others. In other words, staff portrayed Aro hospital space and the international community for mental healthcare practices as inextricable by portraying the former as a subset of the latter on the one hand, and the former as representative of the latter on the other.

Sometimes the staff portrayed the 'international community' as a single wide community and suggested that Aro Hospital was part of it. Like many other staff, during our discussion, Mr. Bola, a member of the management team, remarked that Aro hospital had gained a space in the 'international community' in the 1960s through the Lambo's 'Aro village system'. Bola and others seemed to view the international community as one big community encompassing Aro hospital. They emphasised this through a claim that Aro hospital community had hosted a number of international community events such as a research collaboration between Aro hospital and Cornell University in the US, and the first ever Pan African Psychiatrists' conference in the 1960s. Also referred to was the WHO's selection of Aro hospital as a research centre. Apart from verbal accounts, all of this information was also intentionally captured and displayed on the hospital institutional website (see FNPHA, 2018).

In my view, some staff also conceived of the 'international community' as a distinct space with a 'perfect' mental healthcare practice that served as a prototype for all biomedical psychiatric institutions across the world. This view seemed to believe there was an international standard for biomedical mental care institutions measurable by the availability

of a certain level of human and technological resources. As these staff claimed, only some of the institutions abroad met this standard and those were the ones that Aro hospital was seeking to emulate, although it was not yet there. As such, the hospital management and staff 'domesticated' the 'international community' within the physical hospital space and adapted their practices to conform with the 'overseas' practices as part of their efforts to be aligned with 'international community'.

At the heart of Aro hospital were the well-designed tombs of Thomas Adeoye Lambo and his wife, and close to it was his statue (see plate 7.1). Lambo's images of various sizes were strategically positioned in different places, including the principal's offices and various halls across this hospital. Although some staff claimed that having Lambo's images in the hospital was normal as he was one of the past directors and due to his contributions to the hospital's historical achievement, other staff remarked that Lambo was an 'international icon in psychiatry' to used Bola's words, because he worked with WHO and rose through their ranks to the peak. As such, staff seemed to recognise Thomas Lambo as a symbol of international recognition within the hospital space. More so, the inscription on the well-decorated plaque also stationed close to the Lambo's statue (plate 7.2) further established this point. This plaque had two logos with the Aro hospital logo on the top and that of WHO at the bottom, as well as the inscription conspicuously displaying WHO's recognition and selection of the Aro hospital as part of psychitaric training centers.

Figure 7.1: Tombs of Lambo and his wife **Source:** Author's Fieldwork

Plate 7.2: Lambo's Statute at the heart of the Aro hospital

Plate 7.3: A plaque showing some Aro hospital's link with international community

Furthermore, the management and staff wanted the Aro hospital space to be seen and acknowledged as a reflection or an extension of the international community. Plate 7.4 shows an example of a beatiful framed statement that was strategically placed in offices and places in the hospital to remind staff and visitors of what Aro hospital stood for. These same statements also featured on the institutional Webpage in bold ink to underscore their

significance and another way of reiterating its commitment to the international space by through the medium of its local space.

Plate 7.4: The Aro Hospital Vision and Mission in the Frame **Source:** Author's Fieldwork

Being seen as an extension of the international community was of both institutional and personal importance in Aro hospital. Staff ideas about these transnational relations suggest that many of them had internalised the idea of Aro Hospital as part of an international landscape and of themselves as actors in this community. During my field work in the hospital, I observed that the staff liked making comparisons with 'overseas' more often than with other Nigerian or African practices. Many of the staff talked about the experiences of contacts who were overseas, described their own future aspirations for a life outside Nigeria. As a matter of fact, my insensitivity to this fact almost cost me all the data obtained in this hospital. My encounter with Mr Titi, one of the key actors in the ethical approval process for research at Aro hospital, gave me a perfect idea of what international

recognition could mean in Aro hospital. I first met Titi at the beginning of my fieldwork in early August 2018 when I was seeking ethical approval. Having told me the processes for obtaining ethical approval for my research which to me seemed lengthy and time consuming (see chapter two), I asked Titi as we were rounding off our discussion if he could oblige me to suggest a method which I think if adopted would help his office to make Aro NPH's ethical application more accessible and less stressful to both his office and the applicant. I told him that putting the application for ethical approval online would make it a lot easier, both for the applicants, especially those coming from abroad, and even for the ethics committee. However, doing so would require that the institutional website become visible and accessible to everybody irrespective of their location. I went on to inform him of my inability to access and apply for ethical clearance through their website while in the UK in May 2018. Titi's countenance changed immediately. ''No! That can't be true! Our website is visible all over the world, and we have people coming from different parts of the world, including America and the UK." He said this not just as a response but as a rebuttal. He also told me that many people do call and send emails to him from abroad, and besides, Aro hospital has been partnering with many European institutions. 'Aro is known all over the world, and it is through our website that we are ranked the best hospital in Nigeria', he emphasised. I did not figure out what was wrong immediately but I noticed that Titi was not comfortable with my 'visibility' comment, I tried to calm him down. 'I didn't mean to belittle your organisation; besides, I am aware that Aro hospital is a great institution, of course, that is why I am here, and it is because of that I am just advising.' I replied. I used these and other kind words to win Titi's confidence back, and we later became friends. On another occasion regrading international visibility, an executive said: "We have many people in London calling us from time to time, and many are partnering with us all over the world. Aro is very popular even in the UK, and you are saying you could not find us...those people that ranked us the first in Nigeria never came here now, the web biometric of a thing."

The above shows that Aro hospital staff recognised a community known as 'global' which they conceived wider beyond their immediate environment. They also believed that the hospital was part of the global community, and the hospital's physical space was used in several ways to reflect the international community. More so, the staff claimed that Aro Hospital became part of international community through its previous mental health

activities, and to retain this space also required that they align with certain practices and distance themselves from others. In this sense, the hospital was a heterotopic place, where other places were also brought into being. In the next section, I will discuss the practice the staff and management considered necessary to retain the space and how it manifested in their daily practice and interactions.

7.4 'Scientific' and 'crude' practice as categories mental healthcare practices

This section introduces 'scientific practices' in Aro Hospital and the meaning this term has for the staff and management. It demonstrates that scientific practice is a concept used in the Aro hospital to register staff commitment to an assumed ethos of the international community and the biomedical more broadly. The section shows that scientific practice in its broad sense denoted all treatment activities, including hospital and the meaning this term has for the staff and management. It demonstrates that scientific practice is a concept used in the Aro hospital to register staff commitment to an assumed ethos of the international community and the biomedical more broadly. The section shows that scientific practice in its broad sense denoted all activities including medical and interactional activities as well as the facilities of the Aro hospital, and at the same time the term differentiated the mental healthcare at Aro hospital from other kinds of care, especially traditional healing in the region.

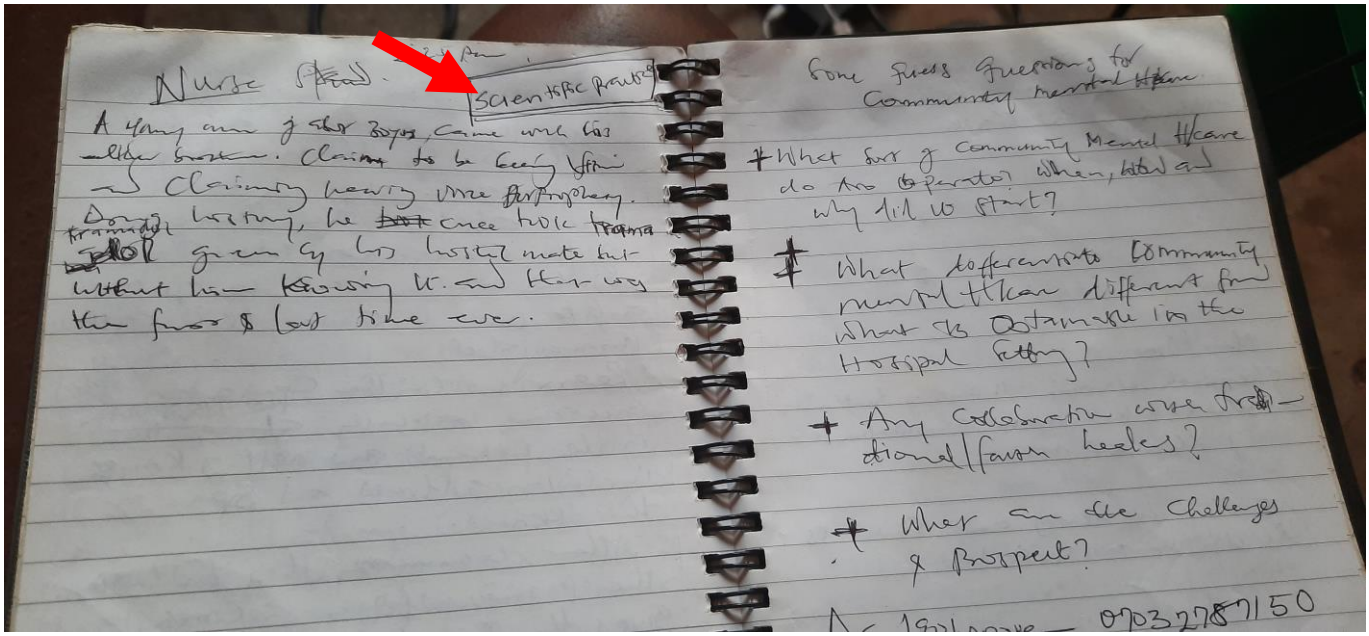
In practical terms, Aro hospital staff demonstrated that the way to retain their place in the global space of mental health care was to actively engage in what they referred to as 'science-based', 'evidence-based', or 'scientific practice.' When I began my fieldwork in Aro hospital, one of the first things I noted was the frequent use of the adjectival word 'scientific' which I realised was a daily conversational occurrence. There is almost no limit to what this adjective could qualify in Aro hospital. As one person was saying, 'scientific method' another would be saying 'scientific care' and even using it to qualify 'meetings', as conspicuously written on the banner below on plate 7.5. Above all, the word 'scientific practice' seemed to be the most frequently used. I will discuss but a few of them. At some points, the staff used 'scientific practice' as an instructive or corrective language particularly to instil what they perceived as a normal way of interacting with their patients. For instance, at the beginning of my fieldwork at the emergency unit of the hospital, almost all the staff I

worked with told me that their practice was ‘scientific’. Therefore, the use of derogatory words to describe patients such as ‘mad’ or ‘crazy,’ was prohibited within and outside hospital. At another point, the term ‘scientific’ was used as a reminder to the staff the kind of service they were expected to render.

Plate 7.5: A meeting poster, another way of showcasing 'scientific practice'

More importantly, the staff used ‘scientific practice’ as a: (i) watchword and verbal expression of being in the ‘international community’ of mental health care practice, and (ii) category of mental healthcare practice. Firstly, in the Aro hospital, the staff considered the word ‘scientific practice’ as a suggestive of ‘best’ mental health practices which they characterised as being aligned with the international community or constituting ‘global’ mental health care practice. The Aro hospital staff usually made conscious efforts to adapt their practices to the international organizational practice guide, especially the WHO ethics and standards of practice. As such, the use of pharmaceutical drugs which some referred to as ‘western medications’, ‘western’ methods, and ‘programme’ of events in treating mental illness were all considered ‘scientific practices’ by the staff.’ One of such frantic efforts to align Aro hospital mental health care with that of international practice can be illustrated in one of the hospital’s recent healthcare programmes called the Aro Primary Mental Health Care Programme (APMHC). Aro hospital had been running the APMHC programme for about a decade. APMHC was a form of biomedical mental healthcare that involved treating the

mentally ill as outpatients at some selected Primary Health Centres within their locality, and there were about 40 centres of APMHC across the Ogun State.



Many staff, especially the top officials, were interested in discussing APMHC and its connection to the WHO programme and collaborations with European institutions. As shown in the narrative below by one of the APMHC key actors, Aro hospital started the programme mainly to demonstrate its commitment and compliance to WHO programme and its recommendations.

> *'We started the pilot* [Aro NPH Primary Mental healthcare] *in February 2010. In October 2009, WHO celebrated world health day, the topic then was talking about having mental healthcare treatment at the primary healthcare level. We* [at Aro NPH] *bought into the whole concept…You know Aro, …we had done it before* [referring to Lambo's Aro village System]. *We then said, why don't we just do something, I mean do the same in our locality? …so we celebrated it* [WHO world health day]. *Following that celebration, and we got the commitment of the Abeokuta North and South local governments that are in our immediate catchment area, we got the commitment of chairmen of those local governments… After that, we did some collaboration with The University of Manchester, …and NHS Trust and Lancaster or something….in the University of*

Manchester then. There were three experts (he was trying to mention their names) *Hume, or Gater and Clarhomy…that one is a nurse, they came down [from the UK], and they were here for about two weeks. Initially, we spent some days to develop the manual. The MHGaP is the document that was meant to be used to train people in middle and low resource countries where they don't have manpower just like ours. Even that MHGap, that document itself, is like it's high tech […laughing…]because they were talking about CT Scan and all those…all that we don't even have in the tertiary institutions here not to talk of primary healthcare. So, we have to, you know, adapt it to suit our environment… So, we were able to adapt it to suit our local circumstances… The programme is going and by the grace of God I have had opportunity to present the programme both in the South Africa, in Ghana and in the UK. I have got about two bursaries to go there to present*…[he was laughing and sighed with fulfilment]… **Aro NPH Staff – Dr Ifa**

APMHC is just one out of many attempts made by Aro hospital in aligning to or demonstrating the practice of global community psychiatric practice. APMHC reveal the efforts and commitment of Aro hospital staff towards de-institutionalisation of psychiatry as enshrined in the global mental health. The staffs, mostly the nurses and doctors that oversee APMHC claimed that the hospital purposively partnered and trained some selected staffs of the selected Primary Health Centers in those various locations to provide basic psychiatric care on out-patient basis for those in need of it in their locale firstly to mitigate the barriers of distance and cost of transportation and secondly to decongest even the Aro hospital facility. The Aro hospital drug addiction treatment and rehabilitation programme called DATER and the occupational therapy unit were other examples. MOT, one of the therapists in the unit, gladly explained how Occupational Therapy Unit adopted some of its programmes from the Western world.

'On Mondays, we have a programme we called TCM, Therapeutic Community Meeting. That [programme] *is actually meant for the Drug Abuse Ward (DATER)… we feel that it is useful because the programme is part of a model, a therapeutic community model used in the US, and we just adapt it.*

Those people [trainers] *came from the US to train our people* [Aro NPH staff] *in DATER on how to use the programme. We too just felt like we could borrow the idea'* **Aro NPH Staff – Mot, a senior occupational therapist**

On the other hand, Aro hospital staff used 'science-based' treatment and 'scientific practice' to distinguish their mental health care from others, especially the 'traditional' healers in the region. In Aro hospital, mental health care was usually considered through binary of 'scientific' *versus* 'crude' practice. While the staff regarded their practice as 'scientific', they associated 'crude' practice with traditional mental health care. According to them, features of scientific practice included the physical setting of the hospital comprising of beautiful hospital buildings, equipment such as beds and wards and so on, biomedically trained staff often referred to as a 'multidisciplinary' team, and the ability to give a 'logical' aetiological explanation of mental illness. Staff also made comparisons based on treatment practices such as the use of various drugs and injections, and the different functions, methods of handling patients, and job division present among their community of experts. The 'crude' practice was considered to be lacking those 'scientific' elements.

The staff talked about and praised their 'scientific' treatment and claimed that it was superior to traditional medicine, mostly when they encountered some patients they perceived to be difficult, uncooperative, and unresponsive to their efforts. An example was a Sunday morning at the Emergency Unit, when those on the night shift were narrating their experience with an uncooperative old man with dementia called *Baba* and another 'unruly' caregiver. The staff considered *Baba* dangerous to the other patients and staff because he was aggressive, agitative, and noncompliant. According to them, *Baba's* age was too advanced to receive 'chemical restraints' hence they used physical restraints by tying his two hands and legs separately to the bed. The caregiver on the other hand was perceived as disrespectful in the way she responded to one of the nurses on morning duty. While reacting to these, one of the staff on duty, a social worker said, 'All that they [patients and caregivers] are enjoying here, do they get it from the traditional care where they usually go? Do they appeal to them there to eat or pampering them and encouraging them the way we do here? They will rather beat them in those traditional centres.' One of the nurses also said, 'Now, can you see what we're doing and passing through here?' This was typical of

how Aro staff contrasted their 'scientific practice' to that of 'crude' practice of the traditional practitioners.

The Aro hospital staff considered their physical environment as a necessary component of their practices. At Aro hospital, various activities and jobs were not only divided among different departments and experts, but also coordinated under different roofs and rooms. For instance, there was a separate building for admission and treatment, a cafeteria, church and mosque for religious activities, a pharmacy for drug storage and dispensation, an occupational therapy unit for social and occupational activities, and separate facilities for women and men. The existence of these buildings connoted scientific practice to the staff. The phrase earlier stated by one of the staff 'What they are enjoying here?' perhaps suggested the importance of such facilities in the hospital environment. The speaker also pointed out that such facilities are not in traditional mental healing settings. This also resonated with what Mr. Titi of the Ethical Committee told me about how the environment of Aro hospital had attracted different people from various places to come and work or do research there. Of a particular note for Titi was his claim that a foreign student had once made Aro hospital's structural buildings his dissertation topic. On another occasion, a nurse claimed that having beds, mattresses, and a tiled floor was no small factor in differentiating Aro Hospital from traditional mental healthcare settings in the region. She further claimed that patients in those settings were made susceptible to some other diseases, particularly dermatological disease because those healers made them sleep outside and or on the bare floor.

Scientific practice also referred to the multidisciplinary health care team comprising experts from various medically related disciplines. One of the management team for instance, Mr. Bola, claimed that Aro hospital had 'a community of experts' which to him signified the Aro Hospital trademark of advanced and scientific practice,

'*…Since it (Aro NPH) was taken over by the Federal Government, so many disciplines have developed. We have a school, OT - occupational therapy, clinical psychology, and food therapy. Our personnel are multidisciplinary team…we have the doctors; we have people in Child and Adolescent, NHIS, forensic, and drug abuse. Name it!*' , showing his confidence that Aro hospital reaches the measure for a 'standard' psychiatric hospital. Staff considered

Aro hospital's mental health care scientific because a team of professional offered it. However, the traditional psychiatric centres in the region lacked such multidisciplinary capacity.

Aro hospital staff also claimed that scientific practice was devoid of nonbiomedical causal explanations of mental illness. Mr. Triangle, an Aro hospital senior librarian, once told me that working in Aro hospital had helped him understand that mental illness is naturalistic, 'just like headache' and not personalistic. To him, the common causes of mental illness were severe negative life events such as jilting, divorce, and disappointment rather than the spiritual causes such as bewitchment that people usually think of, adding that he had also thought in this way before joining the system. Other staff also shared this view that 'scientific practice' meant the rejection of religious-influenced aetiological explanations and care. I once asked whether Aro hospital subscribed to faith healing given the construction of religious edifices in the hospital community. The reaction of those staff immediately suggested to me that my question sounded absurd. Almost all of them registered both verbal and gestural (by frowning face) dissatisfaction with my question. 'No!' about three or more people replied very sharply at almost the same time. Then followed some answers, one after the other. 'Such is not allowed here!' said the social worker on duty. Another nurse also said, 'We don't do crude practice here!' The most senior nurse on duty also said, 'We only practice scientific treatment here, and traditional [care] is against our practice.' A male nurse also called my attention to the Servicom frame hanging on the wall behind the nursing stand, which had some phone numbers written on it to call should anyone feel they had not been served 'right.' On another occasion, an occupational therapist said, *'It is very rare to see any medical personnel that will be advocating for spirituality [as a form of treatment] because it contradicts what he preaches. It is those religious leaders that advocate spirituality and not medical professionals.' As such, o*ffering a religious causal explanation for mental illness thus amounted to a 'crude' practice because it contradicted the practices of Aro hospital as stated earlier.

Another feature of the Aro hospital scientific practice was the ability of the staff to offer a 'logic-based' causal explanation that explicitly made connections between people's actions and the human body. A senior nurse also distinguished scientific treatment based on

aetiological explanations. She used the example of money rituals known as *yahoo-yahoo* or *yahoo plus,* a practice whereby an individual contracts herbalist for a magic to make him or her 'rich'. In her illustration, she said if a person with a weak personality gets involved in these 'mind-blowing' money rituals, it could lead to mental illness because the ritual usually involves different activities that might require murdering someone, sleeping in the cemetery, or other gruesome activities. She added that many of such cases that culminated in mental illness had been reported in the region, especially among young men. While she agreed that ritual activities could cause mental illness she however, claimed that traditional healers could not logically explain how the involvement in ritual activities could lead to a mental breakdown because their explanations lack 'science,' which, of course, Aro NPH staff have.

> *'It* [money ritual culminating in mental illness] *may be possible! You know, as an African person, it may be possible. Firstly, these yahoo-yahoo* [generic name for those that engage in money rituals] *people are young people. What they put eyes into* [i.e., expose themselves to]*, their mental capacity may not be able to comprehend* (withstand) *it in most cases. For instance, the oath and other rituals they may be asked to do, and some other things like that; you know, they are still young and have no mental capacity that could comprehend it. So, they may be so frightened. And coupled with the fact that most of them, before they can gather the strength and boldness to do that kind of 'things'* [referring to some gruesome act e.g., murdering], *might require them to act under the influence of drugs. So, all those things, when they come together, coupled with the type of personality of the person. You know, we have a different coping mechanism. If the person is of a weak personality and cannot cope, the person may breakdown. But people may attribute it to what they did, but with science, we* [biomedically trained people] *can explain it. These African people* [healers] *would not be able to explain it.* **Aro NPH Staff: Nurse Ore, the AEU Manager**

Scientific and crude practices were again differentiated through the use and administration of medications. Some Aro staff described their medication as a 'magic bullet,' while other

regarded it as 'Western medicine'. 'Magic bullets' were drugs including oral tablets, syrups, capsules and injectable liquids produced by pharmaceutical companies and prescribed by doctors. For example, there was a time that a twenty-year-old secondary-school student was brought to the emergency unit complaining of a twisted tongue. Seeing the patient, the nurses suspected that it was a side effect of pharmaceutical drugs, but the young woman had not been brought to the hospital before and her caregivers denied giving her any drugs. So, the nurses were wondering what could have happened. The nurse called the doctor on duty and after several questions from the nurses to those who brought her, they confessed that the patient started manifesting the symptom a few hours after she was given some prayer water by a religious healer whom she was taken the previous day and that when the healer could not find any antidote, he asked them to bring her to the hospital. When I discussed this with the doctor on duty after the scene, the doctor told me

> *'That is the handiwork of those crude healers; we don't really know how they do get our drugs, they will then ground it to powder and mix it with water and be giving their patients. Meanwhile, they will be telling them that it is prayer water, but they don't get the antidote, and that is not the first time we will see a case like that.'*

The above example shows that staff considered crude practice to include not only the non-usage of pharmaceutical products but also instances when such medication was not used in the hospital or prescribed and administered by a doctor or nurse.

Some Aro hospital staff also used the notion of 'evidence-based' to distinguish between the crude and scientific practices, especially when considering treatment efficacy. The staff members, especially doctors, claimed that their 'magic bullets' were more effective and worked faster compared with traditional medicine. To them, the use of pharmaceutical medications and other biomedical techniques were considered 'evidence-based' because they could be tested and measured. Crude practice, on the other hand, was believed to be shrouded in secrecy, and its efficacy might be challenging or impossible to be evaluated. Evidenced-based care, according to Aro staff, was efficacious, transparent, and predictable,

> *'Traditional healers try and do more of one-medicine-solution for all illnesses, and it actually doesn't work. For example, if you say something works* [here in Aro], *we can find evidence. What we do here is practice evidence-based medicine. It is not just to say it works but let see how it works. Our practice is not shrouded in secrecy, so if you are doing things that cannot be evaluated, and then studied, ... even if they are getting results, there is no evidence to show that they have results, I think that is the problem.*" **Aro NPH Staff: Dr Show, a consultant**

The above demonstrates that Aro hospital staff used 'scientific practice' as an expression of their space in the international community and as a way of mapping mental health care practices. Aro hospital was described by its staff as the leading hospital in Nigeria and one of the ten best in Africa. Most of the top officials, including those in the clinical departments such as nursing, doctors, and psychologist, and administrators informed me that Aro hospital was rated the best hospital in Nigeria by Biometric Web ranking in 2015. Being 'scientific' was also another way aligning to the international mental health care environment. While they characterised scientific practice as demonstrated by the presence of a multidisciplinary medical team, a serene physical hospital environment that is equipped with beds, naturalistic aetiology, and transparent, or testable, medication; crude practice was considered to lack a well-built facility and community of experts, to draw upon metaphysical causal explanation, involve chaining down the patients, beating patients, making the patient sleep on the floor or outside, and non-usage of pharmaceutical medications or its usage without doctor's prescription. However, while the management remained committed to aligning to and offering mental health care like the 'developed' world, the staff were confronted with and limited by some political-economic and socio-cultural constraints, thus generating tensions and contradictions in discharging their daily responsibilities. The following section, therefore, traces, presents, and discusses the tensions, contradictions, and improvisation that were manifest in daily activities in Aro hospital.

7.5 Tensions and contradictions of providing 'scientific' mental healthcare in Aro NPH

In this section, I show the contradictions that were inherent in the so-called Aro hospital 'scientific practice' and the tensions it generated in the hospital setting. My observations revealed that actual practices in Aro hospital did not fully support the claim that the staff only practiced biomedical psychiatry and nor did they provide them in the same way as the western world. As such, this section presents some ethnographic material that shows that Aro hospital provided culturally influenced and improvised mental care due to the infrastructural deficit and staff personal beliefs. The section concludes that the contradictions sometimes generated tensions both in the practices of care and interpersonal relations in the hospital.

The same staff at Aro hospital that branded hospital space part of the international community and praised their practices as scientific also decried unconducive working environments, shortages of medical infrastructure and other resources at other times. On various occasions, I heard the staff complaining that Aro hospital was far below 'international standards' particularly in the areas of human resources, working space, and medical equipment, especially where medical and safety technologies were concerned. To start with, there were only two consulting rooms for the doctors at the Emergency Unit which the staff considered inadequate considering the number of cases received each day. The consulting rooms were small (8ftX9ft) and staff had to squeeze in when using them, especially when there were students on posting. These rooms were usually dark even during the day because they were poorly ventilated and because of an unstable power supply. Both the patients and staff complained of heat. The unit had a generator and the doctor and nurses could often be seen leaving their patients and rushing out to it put on when there was a power failure. I also experienced a couple of times where they complained of lack fuel for the generator and when one of the doctors on duty volunteered to fuel the generator out of his own pocket.

Similarly, the staff complained of insufficient infrastructural facilities including beds and safety gadgets. For instance, on Sunday 24 of March 2019, there were five patients on beds sleeping. They had each been admitted for more than three days except for an old man of about 70 years of age with dementia who had been admitted the day before. During their

break, the staff explained that the Emergency Unit was designed only to attend to the new and emergency cases brought to the hospital for the maximum of forty-eight hours, after which the patient should either be transferred to the ward or discharged and the case referred to the outpatient unit for further treatment. In this case, however, the four young men had not been transferred to the ward before the weekend due to lack of bed space in the male ward, rather they were on the waiting list until some patients in the ward were discharged.

As this shows, the Aro hospital 'scientific' practice was limited by the available facilities, contradicting the staff claim of having 'everything' that I described in the previous section. The number of available wards and bed space for admission in the hospital was grossly inadequate. According to the staff, the hospital started experiencing a rapid increase in demand for admission in the second half of 2018 that had persisted until the time of my study in 2019. Other staff claimed that the hospital admission space had never been fully engaged the way it was in late 2018 and early 2019, when I did fieldworkd, however, the fact was that at the time of my fieldwork the hospital ran out of beds, both in the wards and Emergency Unit, especially for male patients. Although some new facilities had been built including an extension of the Assessment and Emergency Unit and a Child and Adolescent Ward, they were not yet furnished. It was not only the case that some patients overstayed at the Emergency Unit, but some new emergency cases were rejected for lack of a bed space to admit them. Some officers in the ward who did not want such information credited to them confessed that they sometimes received pressure to discharge patients earlier than the four weeks usually paid for, to accommodate those on the waiting lists or those considered too dangerous for home management.

During my stay in the Male Ward, I met two patients with sickle cell anaemia who were brought for rehabilitation because they were addicted to some pain relief drugs that had done a lot of damage to their skin. Rather than sending these young men to the drug addict rehabilitation unit known as DATER, they were admitted into Male Ward 2 which was meant for the mentally ill, on the basis of lack of space. According to the two of them, despite registering their displeasure with the hospital for keeping them in the Ward, they remained there. Occupational Therapy Unit was not an exception. I saw patients sitting too closely

together because of the small size of the hall compared to the number of patients. The staff also frequently complained about lack of serviceable safety equipment.

Another item near the top of the list of complaints was what many of the staff described as 'acute shortage' of human resources. The shortage of staff was mentioned virtually in all the units that I consulted, starting from the Assessment and Emergency Unit to the Occupational Therapy. I observed that in most cases at the Wards, only two or three nurses were usually on duty per shift, including the night shift, to care for an average of twenty-one or eighteen psychiatric patients in male and female Wards respectively. The nurses seemed most affected and concerned with this and this had been generating some tension between them and the management. As such, some of the nurses expressed the belief that Aro hospital did not represent 'the international community' nor was it aligned with global best practice,

> *'The normal plan is three nurses to a patient, but we are just three to eighteen patients here. So, we are not doing the standard practice here. Can you imagine? We have only 3 to 18, and they want us to do our best. Now, you can see! Two of them* (nurses) *were attending to a patient and you are here engaging me… In a ward of 33 patients and we have only 15 nurses, so how do you want us to manage it? We must cover all the shifts, and make up for those on leave and night-shift-off, so how do you want us to manage it? Only 15 nurses to a Ward, so how do we manage it?'* ***Aro NPH Staff – Nurse Are***

A consultant, Dr. Show, also confirmed that the staff-patient ratio was very poor at Aro hospital. According to him, the 'employment rate in Aro hospital grows arithmetically while the number of patients grows geometrically'- meaning that the hospital had been recruiting more workforce but this had not been commensurate with the hospital workload. I witnessed two occasions at the Emergency Unit when the manager called for the assistance of non-professional people such as security men, including me, to assist in restraining aggressive patients. Another area of internal contradiction on staffing was the need for the crisis intervention team. Many staff, primarily the nurses, believed that there was a need for the hospital to create a new Unit for staff safety which they called the 'Crisis Intervention Management Team'. Those who shared this view claimed that the primary assignment of

this Unit would be to curb the aggressive patients, which they believed would reduce the incidence of assault and attack on the staff. The Aro hospital management, however, opposed this view claiming that it was not 'international standard practice' and most especially because the proposed personnel – 'bouncers' are usually trained for riot and not to handle psychiatric patients.

Lack of resources at times blurred the boundary between the so-called 'scientific' and 'crude' practices. Even though the staff categorised using physical restraints such as tying and chaining as a 'crude' practice, they however used these same methods in some cases as will be seen the following ethnographic examples. One incident took place in the morning during the time that those on the morning shift were taking over from those on the night duty. The handing over was done by giving each patient's file over to the incoming staff by the patient's bedside after a short briefing. On getting to *Baba'*s bedside, we met him tied to his bed, by both the hands and legs, and he was fast asleep and snoring. The leading nurse started lamenting that night had been 'bad' and full of imbroglio because *Baba* was restless and troublesome. Another nurse added that *Baba* was vehemently agitating and would not obey instructions. 'All our efforts to calm him were in vain' he added with a strained voice. The team leader continued, 'When he was becoming unbearable, we firstly put him on two points (tying either the two (usually) hands or legs) but when the agitation persisted, we put him on four points (tying both the two hands and legs). 'So, just allow him to be enjoying himself like that' [a sarcastic way of saying that is what he deserves], the nurse concluded and continued to explain other things in his file to them.

A nurse, Mr *Osho* noticed that I was surprised by seeing *Baba* tied to the bed, he later called me, trying to make me see the *Baba's* restraint as normal. According to him, *Baba* was a demented patient and due to his advanced age, the nurses must not administer chemical restrain on *Baba* as it might lead to his death. In this case, *Baba*'s age was used as an excuse for doing what they would consider a crude practice if were to be found in other settings. However, I witnessed other cases where younger persons were also physically restrained and even with chain and padlocks as in the case of Meme below.

Meme was in her 30s and married with three children. Meme was newly admitted in early April 2019 into Female Ward 1 for a reported relapse case. Female Ward 1 was an eighteen-

bed ward with fourteen beds in the main hall arranged in two rows with seven beds each. There were also two smaller rooms towards the back with two beds each. The beds were placed somehow distant from each other. On duty this morning there were two female nurses, one in the nursing office arranging some files while the other nurse was at the nursing stand at the entrance of the central ward to observe and monitor the activities of patients.

On this day, everything was calm to an extent. Some patients sat, and some were lying on their beds except for Meme, who was shouting and agitating aggressively. Meme's hands were tied to the bed with a bandage and her two legs were tied with chains and padlocks. I asked the nurse why Meme was tied to the bed. She pointed to another patient, an older woman who appeared to be in her early 60s, and asked me to look at her face. I noticed that one side of her face, from the forehead down to her cheek was black despite her fair complexion, and that her eye was red. The nurse then said to me, 'That is the handiwork of Meme.' She went on to explain that Meme wanted to attack another patient (she pointed to the patient that was Meme's primary target), who had escaped, and the injured older patient woman became the victim of this unfortunate incidence. She added that one of the nurses on duty also suffered a brutal attack and was rushed to NHIS (Aro hospital Health Centre) for treatment. 'So, she (Meme) is on four points [physical restraint] because she is too aggressive and poses a danger to herself, other patients, and the staff. She would not be restrained forever, but for now, that is what she needs, and that is why we isolated her bed by taking it to the far back there.' Nurse Are Added.

Physically restraining patients by tying them with a rope or chain is thereby not particular to the traditional healers as earlier projected. Even though many of the staff claimed that restricting patients with rope or chain was a 'crude practice' and unscientific, as Meme's case and others revealed, Aro hospital staff sometimes engaged similar methods. ''The nurses' comments, 'Let him be enjoying himself like that', and 'That is what she needs now', in Baba's and Meme's case respectively suggest that that 'crude' practice can be relative. In the above cases, the staff seemed to consider physical restraint as a 'crude practice' only when it was done by traditional healers, but regarded it as a necessity when it was done in Aro hospital. The above account also points to infrastructural deficiency earlier mentioned

as well as inadequate equipment and improvisation. Consider the following remarks from a senior nurse of the hospital,

> *The management knows what we urgently need; it is only that they are not ready to do the necessary things. Number one, they* (management) *are just exposing the life of the people that are working here to danger, including the doctors too. We supposed to have some crisis intervention management team like maybe bouncer or some hefty men that will be handling patients. How much are we collecting* [earning] *as a hazard allowance? I don't have enough strength that can withstand an aggressive patient but those people* (referring to bouncers)*, even their appearance speaks volume. Then the gadget that they supposed to provide, like the tranquilizer and the like, we don't have any. If a patient is attacking you…see this bell* [pointing to the bell above]*, it has been there since the military era, if the patient wants to attack you, you will just press the bell, and it will ring round even to the security post. If it rings once, they know the meaning, and if it is twice, they know the meaning. All those are no longer in place, but they want the best form you. But with all we are doing, their priority is the welfare of the patient more than the welfare of the staff; they will say you must not injure the patient. The way that the patient is beating the nurses, had it been they* [the nurse] *retaliate, and the patient sustains fracture or bruise, they will now be given query upon queries.*
>
> **Aro NPH Staff – Nurse Are.**

Female ward 1 is one of the oldest building structures in Aro hospital (see chapter two on facilities for details). This ward has a television hung up, a ceiling fan, and multiple windows. It also has offices used by the ward's official, lavatory, and a kitchenette where patients washed their used plates. However, due to shortage of water supply, there was a 200 litre plastic container used to reserve water by the cleaners and also for the use of the patients. Also, apart from the main hall, every other part of the Wards such as the passage, rooms at the back, and offices the main hall were always dark due to irregular power supply. The nurses usually used rechargeable lamps or mobile phone for illumination to allow them read or write. The fans and television were also less useful due to the frequent power outage. Some beds in this ward lacked a plastic chair for the patient to sit down and relax while

some other equipment such as the bell and intercom phones were no longer functioning. As such, the staff often used their personal phone number for the official contact when necessary or make physical appearance in some instances. In addition, many staff, especially the nurses described staff safety and welfare as 'poor' and 'discouraging.'

Relatedly, the staff claim of drug efficacy was also challenged in some other stances. I once overheard the nurses complaining about the reduced efficacy of some of their drugs, but which they said they have no power over. This point was also confirmed by another nurse, Are. She informed me that Aro hospital had sometimes formally written to some concerned bodies about their concerns about the low quality some drugs which some staff considered hindering 'world-class' practice. According to Nurse Are:

> *'the potency of the drugs they are now supplying, they are not good. Immediately you give 20m of MTPZ…ehhn…Lagatin….uunnnn.. or Failure …. and 150m of MTPZ…in the next few minutes, you will see the patient standing up'* **Aro NPH Staff – Senior Nurse Are**

The above presents and explains various contradictions attached to the claims of scientific practice. All the factors discussed e.g., facilities, equipment, human resources, and medications among others are of a more structural nature, often beyond the influence of individual staff, and would take an institutional approach to address. Nevertheless, there were other contradictions that are directly related to the staff's cultural and religious beliefs. These factors often generated tensions between the official claim of following 'scientific practice' and individual beliefs on the other hand. For instance, the inclusion of religious centres as separate entities in the hospital community signalled the staff believed that religious approach and explanation were not scientific. However, at some other times, some staff claimed that religion could be used as part of psychoanalytic therapy. During one of my discussions with Mr Mot at the mosque on one Friday, the following was his position.

> *'we* (perhaps some staff or entire Aro NPH) *still recognize spirituality, that is why we encourage our patients, those that are Christians are taken to the church on Sunday, and I, while I was coming to the mosque, those who are Muslim that I saw, we came to the mosque together before they went back to their hall. We*

still encourage it because it still part of our (silence) …we believe that it (attending religious programmes) *has some role it would play in our lives and also in the life of a mentally ill person'* **Aro NPH Staff- Mr. Mot, a senior occupational therapist.**

Mr. Mot's view in the above shows that Aro hospital's staff and patients did attend and participate in some religious programmes claiming that it plays some roles in their treatment. Further investigation shows that religious beliefs was beyond mere attending religious programmes but that the belief also influenced the staff's sense of vulnerability to diseases and 'attacks', health, and safety in Aro hospital. Further insight into Meme's case provides more explanation on this.

As Meme remained tied to her bed, she was still very agitative and aggressive. It was clear that Meme was hallucinating because she was calling different names and moving from one topic of discussion to another, and at some points cursing both her relatives and the nurses. Although Meme's utterances were incoherent, yet they were intelligible. Meme speaks the Yoruba language, which most of the staff also understand most often use to communicate with the patients, except for the non-Yoruba speaking patients. Meme started causing the nurses saying '*bi o se fi ara ni mi, ara ma ni e ku ni. Ati iwo ati gbogbo family e ati irandidiran yin. Iwo na ko ni ri anu gba'.* Meaning: may you, and all yours (family/generation) spend all your days in afflictions without mercy just as you have been afflicting me. These and many more things said Meme. To my surprise, the nurse on duty was also replying each time Meme placed a curse or said any negative thing to the nurses. Some of her common responses were ''mo da ina sun gbogbo awon emi ti on gba enu e soro Meme ni oruko Jesu - I set all those spirits speaking through you ablaze in Jesus name. *'Meme, I reject it in Jesus name!' 'Meme, I rebuke you in Jesus's' name.'*

I asked the nurse why she was responding to Meme, since she claimed that Meme was hallucinating. The nurse said it was not in her habit to be responding to the patients, but the case of Meme was different. The nurse continued that the reason she would not spare Meme's words was because Meme's utterances were what she regarded as a kind of supernatural power. Providing a basis for her action, the nurse said that a visitor, also a staff member in the hospital but from another unit, came to pay a visit to one of her senior

colleagues on duty a few days ago. The two of them were having a discussion at the nursing stand. Meanwhile, the Meme just started saying some things to the visitor that she should not be worried anymore about her patient because the 'assignment' has been concluded on the patient and she would surely die. 'Even my *oga* [senior colleague] did not know that her visitor truly had a patient in the hospital. Then the visitor did not respond to Meme even though everybody knew that she was the one that Meme was talking to because she kept emphasising it. So, nobody cares about all that Meme said because we all believed that she was just hallucinating until the following day that the woman called my colleague that everything our patient Meme said yesterday had come to pass, and that her patient had died overnight'. The nurse then asked me, 'Who told Meme?' 'How did she know that the woman had a sick person?' The nurse then concluded that Meme was not an ordinary patient. That is, the nurse believed that Meme in that state, could see the invisible and could invoke supernatural power that could affect her. To further justify her belief about Meme, the nurse added said 'This is the first time they would bring her here [Aro hospital] because she was rejected in Yaba [another specialist psychiatric hospital in Lagos] where she was initially registered and managed for years. So why did they reject her in that hospital if there was nothing attached?' To the nurse, Meme must have been rejected in the previous hospital for a similar reason.

Meme's case is just one out of several, and this also pointed to the existing tensions between the practices and beliefs of the staff in Aro NPH. The staff claimed that accepting spiritual aetiological explanation was both unacceptable and unprofessional, yet their actual practice shows otherwise. The nurse's response to Meme is into two dimensions. First, some responses e.g., 'I rebuke you Meme' were directed to the person of Meme as an actor who perhaps deliberately engaged in those activities. The second kind of response to, 'the spirit speaking through you' depicted Meme as a medium through which a metaphysical force operates. The nurse's action and responses perhaps suggested that she perceived herself vulnerable and used what she perhaps believed to be the higher force of Jesus to ward off the negative words of Meme. This could also mean that the nurse shared the common Yoruba belief about the potency of utterance and prayers as against the pharmaceutical drugs which they claimed. In both instances this contradicts the claim that mental illness is only explained with logic and science as the staff often claimed.

Furthermore, a series of observations and interactions with other staff suggests that many, if not all Aro hospital staff often swing between what some of them called 'being African' and a biomedical ethos. A nurse in Male Ward once told me that 'main source' of some patients' problem is a generational curse, but he quickly added that such must not be said during the ward round. As earlier stated, during my stay at the Emergency Unit, I witnessed a case where a senior nurse asked her colleagues to suspend attending to a patient because his pastor at home was praying for him on phone. At psychology department, Oga, one of the senior personnel told me that they had sometimes had two strange cases where they could not ascertain the problem of those patients. 'The unfortunate thing is that we finally lose them, but up till now, I am telling you nobody can give any satisfactory scientific explanation of those cases, and to date, we have never used either of those cases for our review.', he said. Another principal nursing officer, Nurse Babalo, said a chronic manic patient could prophesy, and see revelations.

> *'In my own view or let me say in my own observation, which I have made over the years is that certain mental illnesses, most especially when they come up in a very acute form, the manic phases, that is, bipolar disorder in manic phase, when you hear them talking ferociously, in that state, some of them give revelation and prophesies that come through. But the connection between that* [acute bipolar disorder] *and the spiritual aspect is what I don't know. Another intriguing aspect of it to me as a person is that by the time the acute state is taken care of and now become mentally stable, everything they were saying then, they would not remember again. That comes to the say that when the brain charged, maybe when their hyper-charged or sensitive to a certain level, they are capable of doing certain things because there is an example. There was a case of somebody quote and unquote called lunatic. He was a vagrant psychotic, just roaming the street. When he was yet in the state of acute mental ailment, I think he studied engineering, those who were close to said that there is no mathematical problem that is brought to him in that state that he would not solve. He would solve it and get the answer. But by the time he was eventually helped, somebody by virtue of providence picked him up, and through an NGO brought him down to the psychiatric hospital where he was treated, and he became healed, but after that,*

he became dull to the extent of not being able to sum one plus one.' **Aro NPH Staff – Nurse Bablo,**

Some other staff members expressed a similar view which some adduced was an aspect of an 'African identity'. The staff claimed that giving a spiritual or metaphysical aetiological explanation to mental illness is inherent in being 'African'. As Nurse Ore once said in the previous section, she thought that it is possible that money ritual causes mental illness with a clause 'as an African person'. This phrase thus assumes that spiritual explanation is a trait of 'African.' It is, therefore, clear from the above that Aro psychiatric practice is considered 'scientific' in comparison with the local and nonbiomedical methods and alignment with the developed world. However, Aro hospital is limited in various ways due to scarcity of resources, thus making their actual practices more of 'improvised psychiatry.' In other words, Aro mental health care practice could be characterized by 'necessity' and 'availability' sometimes rather than a stipulated global method, and 'discretion' may take pre-eminence over formal guidelines when the safety matter arises.

7.6 Conclusion

This chapter has explored how Aro hospital management and staff situated the mental healthcare they offer in the global context of psychiatric practices, using the concept of the heterotopia to think through the ways in which global practises were enlisted and reinterpreted at Aro hospital, making 'other-spaces' present in the hospital. The ethnographic data shows that Aro hospital care was influenced by the hegemonic force of biomedical psychiatry which portrays biomedicine as modernism on the one hand, and Yoruba traditional mental healthcare practice as primordial and uncivilised on the other (Prince, 1960b, 1960a). Some previous studies have argued that biomedical hegemony in some non-western nations including Nigeria is caused by 'colonisation' and 'medialisation' (e.g. Filc, 2004; Heaton, 2014). The Aro hospital experience, however, suggests that biomedical hegemony can be both externally and internally reinforced. As the ethnographic examples show, the ethos, methods, and policies guiding practice at Aro mostly came from overseas, nonetheless, and it was the desire of the institution and its staff to be at a par with mental healthcare institutions in the UK and US as observed in their everydayness. The obsessive appetite for the prestige, international support, and collaboration which they

claimed that global biomedical psychiatry offered reinforced xenocentricism among the hospital staff. As such, the Aro hospital medical, physical, and social environments were made to reflect 'international community' of mental healthcare practice and its associates.

Drawing on Foucault's heterotopic analytical lens (Foucault & Miskowiec, 1986), we can see Aro hospital environment was a 'multiformal space' to borrow the concept of Street & Coleman, (2012). I suggest that mental healthcare at Aro was creating a new social space which the Aro hospital staff termed as 'international' or 'global' community. This social space of an 'international community' configured and reconfigured identity, practices, relationships, and contradictions in Aro through its connections to biomedical mental healthcare systems across other regions of the world. In this way, the staff saw 'international community' as a space that allowed Aro hospital to relate and be compared with other mental health institutions.

The concept of heterotopia also helps us understand how the local psychiatric hospital environment was imbued with global priorities and in ways that shaped the identity of Aro hospital and its personnel. Different new mental healthcare policies and suggested methods of practising introduced by various international organisations such as WHO and MGMH had shaped the local hospital space, and these global activities were evaluated within the terms of local medical understanding, actors, and apparatus. In other words, the 'international community' served as a mirror for the Aro hospital space through which Aro hospital was viewed. Aro hospital also became a physical place where international community was actualised.

The workings of the so-called 'international community' also reordered previous social order and created new ones through which the practitioners or institutions could distinguish self from others in processes which Bochow & Dijk, (2012 p.331) called 'topographies of distinction.' As Aro hospital became aligned to the 'best practice' of the overseas actors, new ways of interrelating occurred within the local health care institutional space. This happened at two different levels: (a) between Aro hospital and other psychiatric healing systems, especially forms of 'traditional' medicine; and (b) within Aro hospital regarding how the staff approached their jobs. The Aro hospital staff defined themselves and evaluated their practices based on their membership within the global mental healthcare

community and what they perceived to be acceptable practices within this community. As such, they always wanted to distance themselves and practices from the traditional healers, by consequence widening the gap and chances of collaboration among the two. Secondly, the staff encountered tension in reconciling the past to the present. The past, that is, Aro Village System, was so important to their present but some of the contents of that history contradicted their present practice and therefore sometimes triggered denial. The concept of heterotopia thus helps in understanding why Aro hospital staff were concerned with both local distinction and global alignment as well as the contestation and conflict between the past and present and among the practitioners as evident in the notion of 'scientific practice'.

Chapter 8

Summary, Contributions to knowledge, and suggestions

8.0 Overview

In the context of global upsurge of mental illness and differential mental care resources, this PhD thesis has built on the small but growing body of anthropological literature on the complex nature of global mental health by exploring the totality of mental healthcare practice within and around a renowned Neuropsychiatric hospital in Abeokuta, Nigeria. I commenced this thesis with an overview of the relevant existing social sciences studies on the burden of mental illness and its management. I showed that both the epidemiology and effects of mental illness raised public health and social concerns (Charlson et al., 2014; Oye Gureje et al., 2006; Vikram Patel, 2014; Vigo et al., 2016; WHO, 2013). Then, I discussed the concept of the treatment gap as an approach to improving mental healthcare delivery globally (Beals et al., 2005; Gureje et al., 2006; Patel, 2007; Prince et al., 2007; Vigo et al., 2016; Wittchen et al., 2011); but argued that the concept of the treatment gap often has a narrow focus that is capable of obscuring many ways in which mental illness is managed in diverse settings, including outside clinical settings (Cooper, 2016; de Jong, 2014; Kirmayer & Pedersen, 2014; Read, 2012).

I then traced the contributions of anthropologists to our understanding of mental illness, the field of psychiatry, and global mental health. In particular, I highlighted the contribution of anthropologists in the twentieth century, who drew attention to cross-cultural variation in the interpretation and management of mental illness (Bartholomew, 2017; Makanjuola & Morakinyo, 1987; Patel et al., 1995; Patel, 1995; Ventevogel et al., 2013). I also introduced some more recent anthropological scholarship on global mental health that has emphasised its dynamic and multiple nature (Cooper, 2016; Jenkins, 2018; Jain & Orr, 2016; Kohrt & Mendenhall, 2016; Lovell et al., 2019; Sood, 2016; White et al., 2017). This work shows that mental healthcare generally, and global mental health specifically, should be understood as assemblages of multiple realities and practices enacted across time and space.

Based on nine months of ethnographic research in and around Aro Hospital, I sought to build on this scholarship, by developing a holistic account of how mental illness is produced,

enacted, and managed in this context, paying careful attention to the multiplicity of biomedicine and mental healthcare that is positioned within both local and global modes of practice. This concluding chapter presents a summary of the findings and highlights the key contributions of the thesis. It also makes some suggestions for future ethnographic studies in this area.

8.1 Revisiting the research questions

In describing the research site (chapter 2), I showed the historical, sociocultural, and political significance of Abẹokuta and Aro hospital, in relation to mental healthcare in (Southwest) Nigeria (Asuni, 1967; Jegede, 1981; Osborne, 1969). I also drew attention to how the historical formation of the 'Aro Village System' reflected international politics of care, and how the contemporary Aro hospital community and practices were made to reflect the goals of the international community (Heaton, 2011, 2014, 2018; T. Adeoye Lambo, 1956). I discussed both the dominant sociocultural system of Abẹokuta and the historical and socio-political background of Aro hospital, both of which I later showed were directly and indirectly very influential to the current practices at the hospital.

Following the work of previous anthropologists who have noted the cross-cultural variation in the experience and interpretation of mental illness, I then explored how people in Abẹokuta explained 'abnormal behaviours' and categorised them into mental illness and understood the processes that produced them. Personhood has been found to be inextricably connected with an understanding illness behaviour and recovery (Comaroff & Comaroff, 2001; Degnen, 2018; Kpanake, 2018a) and, in chapter 3, I demonstrated the importance of the multifaceted Yoruba notion of personhood in understanding the production of mental illness in this context. In Abẹokuta, full adult personhood entails several aspects, including productive work, relational, spiritual, social, and physical aspects among others. It is when these become compromised, affecting social interactions and interpersonal relations, that mental illness is suspected. Those who are designated as mentally ill are still 'human', but they lack some elements of personhood that are required to be a full member of society. I showed that observing such a breakdown in the relational aspects of personhood generally marked the beginning of the making of mental illness.

The process of ‘lay diagnosis’ undertake before any hospital admission usually involved multiple people with varying degrees of closeness to the sick person, but typically with little or no consent of the sick person. During this process, the sick person may be seen to manifest a range of states and identities, from ‘happy’ to ‘unruly’ or even ‘unwell’, before eventually being labelled as a mentally sick person

Following lay diagnosis, when an individual is presented at Aro Hospital, there begins a long and complex journey of becoming a ‘patient’. I traced this journey chapter 4, showing how patienthood as a social status was ‘made’ and ‘conferred’ within the hospital setting but then endured after discharge from the hospital, indefinitely in some cases. I argued that Aro hospital patienthood emerged from a series of ‘assemblage practices’ (Berg & Bowker, 1997) entailing both human and non-human agents and encompassing a range of different activities such as conversations, exchange of some caring responsibilities, payment and the use of documentation, among others, that took place in different places at different times. In contrast to some recent studies in western settings that have emphasised the agency of the ‘active patient’ (e..g., see Barbot, 2006; Lupton, 1993, 1997), patients in Aro had quite limited agency. Nonetheless, the designation of patienthood conferred certain responsibilities, rights, and privileges which were not available to those who had not secured this status or designation. Aro hospital patienthood was also notable for its effects which seemingly last for almost a lifetime while shifting back and forth between categories of ‘inpatient’ and ‘outpatient’.

It is now well established that biomedicine is not the same everywhere, despite claims of its universality. Mental healthcare practices in a hospital like Aro reflect the local historical and sociocultural contexts as Van Der Geest & Finkler, (2004) have argued. In chapter 5, I showed that Aro hospital mental healthcare entailed multiple forms of treatment practices that reflected the multiple facets of ‘lost personhood’ that I had earlier noted. As such, staff at Aro hospital attempted to offer treatments that matched these various aspects of damaged personhood, with the aim of restoring the mentally ill person back to participating as a full member of society. These included treating biological dysfunction, as well as seeking to restore appropriate moral behaviour, working practices, and conformity to expected gender roles, among others. Attempts to provide all-encompassing care forced

Aro hospital staff to be engaged not only formal but also some informal care practices including religious and relational approaches such as 'prayers' and 'family therapy' to cater for what have been referred to as spiritual, social, and relational agencies of personhood (Comaroff & Comaroff, 2001; Kpanake, 2018).

However, treatment at Aro hospital is not exclusive. Many patients moved between the hospital and other kinds of healers in ways that blur and challenge the boundaries of 'biomedical' and 'traditional' practice. In Chapter 6, I explored the extent to which different traditions of mental healthcare in Abẹokuta should be bracketed and how the various stakeholders involved, including hospital staff, patients, and caregivers interacted with 'alternative' (i.e., non-biomedical) care. The biomedical care offered at Aro hospital, religious healing and *Ibilẹ* (indigenous) healing all coexisted in Abẹokuta. Despite the multifacetedness of the Aro hospital mental care, many people still thought that it was not broad enough to cover all the aspects of damaged personhood. As such, they patronised multiple healing traditions, either concurrently or sequentially, especially when they believed that the recovery process was not satisfactory in a particular healing location. As discussed in chapter 6, various healers attempted to draw some boundaries around their practices (i.e. 'traditional', 'faith-based', etc.) in a way that suggested medical pluralism (e.g., Baer, 2004; 2011). However, in practice, blurring and latticing of practices suggested medical syncretism rather than pluralism (Muela et al., 2002; Pool, 1994; Pool & Geissler, 2005).

In the final main chapter, I returned to Aro hospital to consider the ways that staff and other actors positioned their practices in relation to global and local contexts of mental healthcare using the concept of heterotopia. The celebrated history of the 'Aro Village System' and recent developments in global mental health care both shaped the experiences and perceptions of the staff in complex and sometimes ambiguous ways. Many staff categorised mental healthcare practices in the region into the binary of 'scientific' and 'crude' practices, describing Aro hospital and its care practices as 'scientific', which they also regarded as superior to the 'crude' practices of religious healers and *Ibilẹ*. Hospital staff were proud of Aro as an influential African hub within global mental healthcare and were keen to show how their practices were 'evidence-based' and in line with 'global best practice'. However,

this apparent biomedical hegemony (Csordas, 1988; Filc, 2004) was nonetheless challenged both by the severe resource constraints that meant it was not always possible to follow 'global best practice' and also by the beliefs of hospital staff about the spiritual elements of mental illness, which required other kinds of care (prayers, religious rituals, etc.). As such, Aro hospital could be better understood as a heterotopic space (Foucault & Miskowiec, 1986; Rousseaux & Thouvenin, 2009) due to different activities and efforts that were continuously taking place to position the hospital within a local and global context, where the practices and values of other places were embodied.

8.2 Key contributions to knowledge

This PhD research work has contributed to existing knowledge on the mental healthcare delivery in diverse contexts around the world, in this case Nigeria. Empirically, this thesis provides new insights into the provision of mental healthcare that brings together multiple, distributed practices that cut across different traditions of care. It demonstrates that sociocultural and historical context remains a major factor in understanding and providing mental healthcare practices.

Most importantly, this thesis adds to the small but growing literature on multiplicity of biomedicine (Finkler, 2004; Van Der Geest & Finkler, 2004), medical objects (Mol, 2002; Setchell et al., 2018), and global mental health (Jain & Orr, 2016; Lovell et al., 2019). Building on this literature, the thesis presents an in-depth ethnographic account of the production of medical multiplicity within Aro hospital by following the patient journey through this hospital. It develops arguments about the multiple nature of personhood that was part of shared understandings between staff, patients, and caregivers in the hospital.

This thesis does not seek to establish a single 'truth' about these practices and their consequences. Instead, it approaches multiplicity from an ontological perspective by focusing on how the 'existing phenomenon', in this case, personhood, mental illness, and mental healthcare became framed; and how interrelation between them shapes and reshapes each of them. Hence, the thesis presents multiple facets or elements of a person as understood in southwest Nigeria (encompassing elements such as parenthood, friendship, employment, and financial freedom), which are the object of treatment in Aro,

instead of seeing the body as a single biological object that can be cured through physiological and pharmacological treatments alone. The fact that all stakeholders – staff, patients, and caregivers shared this idea demonstrates how this understanding of personhood shapes what it means to be a mentally ill person and patient.

Mental illness is thus both *made* and *managed* through the identification of damaged elements of the 'person multiple'. This happens within a web of social interactions that comprises different human and nonhuman agents that are time- and place-bound. Resonating with Mol's account of hospital management of atherosclerosis in '*The Body Multiple*' (Mol, 2002), mental illness in Aro and its surroundings is made over and over again, but by different people and in different places. For instance, friends and colleagues saw self-withdrawal, while family and parent saw disobedience or violation of gender roles, and healthcare practitioners saw mental illness. The process that produces mental illness in this context comprises the framing and reframing of events through a complex set of processes that involves contradiction, rejection or elimination, and acceptance of various illness explanations. Similarly, it is with these understandings that notion of dependency plays out within the forms of patienthood that are produced in the hospital.

Multiplicity also plays out in care practices within the hospital, which respond to these multiplicities of personhood and patienthood, and are themselves multiple and distributed. Mental healthcare is divided into various facets (e.g., medication, occupational therapy, religious, financial discipline, hygiene) each targeting a different element of damaged personhood.

The second part of the thesis zooms out to consider multiplicities of different scales and how this shapes what happened at Aro hospital. It does this first by showing the therapeutic landscape in the area around the hospital with various expertise being marked out in practice (e.g., doctor and nurses treating biological body, psychologists treating psychosocial, occupational therapists) and places (using different physical and social spaces for treatment). While practitioners within and outside the hospital were often engaged in 'boundary work' to delineate and distinguish what they did from others, in practice there was considerable blurring between healing 'traditions'. What happened within the hospital was strongly influenced by the local healing context, confirming the observation that both

the setting and practice of biomedicine is always multiple (Finkler, 2004; Van Der Geest & Finkler, 2004). The practises of biomedicine, in this case, psychiatric practices in Aro hospital, were interrelated with those of the religious and 'traditional' healers who are often frequented by patients and caregivers who attended Aro hospital.

The final ethnographic chapter situates the practises of staff at Aro within a global context, underlining how connections to an international order produce another form of multiplicity within the hospital. Staff at Aro explicitly align their practices with 'best practice' in 'global mental health', not least by rejecting and disparaging the 'crude practices' of other healing traditions (see e.g., Adebowale et al., 2017, 2018; Akyeampong, 2015; Jegede, 1981; Kilroy-marac, 2019). As Lovell et al. (2019) posit, global mental health is an assemblage of hundreds of organisations, spanning through governmental and nongovernmental, international agencies, and charity, and thousands of individuals, including researchers, funders, practitioners and policy makers across the globe that together formed what is today known as global mental health. Aro hospital, as seen in this study presented itself as one those assemblages. However, some contradictions and tensions are inherent in Aro hospital care practice. Firstly, the staff were striving for 'global best practice' but lacked adequate resources to provide it. Secondly, the staff were disparaging of nonbiomedical practices while still believing in some spiritual elements.

A second contribution of the thesis is to confirm the limitations of the 'treatment gap' approach (Kohn et al., 2004) in capturing the totality of mental healthcare practices in the study location. As we have seen in the chapters 3, 4, and 5, hospital mental care is just one of several modalities of care that people utilised. Mental healthcare in the study location always started at home (or outside formal care settings) with different people such as family, friends, neighbour, and religious leaders who identified and interpreted symptoms, offering the first line of care.

Similarly, a narrow 'treatment gap' approach would also fail to recognise after-hospital care. As already discussed, this research work showed that mental healthcare did not end in the hospital but continued indefinitely. This is evident in the concepts of patienthood, which has been shown to last for a long time, if not for a lifetime, including the long-term adoption of a 'medicating lifestyle' which emphasises the continuation of care even after the hospital

care as illustrated in chapters 4, 5, and 6. Rather than termination of mental health care at dischargement of the hospital, mental care activities and responsibility for them only change hands form the caregivers and to the hospital staff and vice versa.

Thirdly, this thesis also provides a new insight into the reasons that nonbiomedical forms of psychiatry that continue to keep thrive in Abẹokuta. As shown in this study, personhood offers a clearer perspective of what mental illness is in Abẹokuta, adding greater depth to previous accounts that noted spiritual, natural, and preternatural aetiological explanations for mental illness this cultural context (Adewuya & Makanjuola, 2008; Aina & Famuyiwa, 2007; Chukwuemeka, 2009; Jegede, 2005; Prince, 1960a, 1960b). Many of those previous studies focussed on identifying 'causal factors' such as curse, violations of taboo, gods, or heredity among others, rather than appreciating the multifaceted nature of personhood that become damaged through mental illness.

Lastly, the study describes mental healthcare as a social responsibility of the family and friends as well as patients. I have shown that identifying and interpreting symptoms of mental illness was usually done by those within patients' social circles, such as friends, family, religious leaders, and neighbours, based on their understanding of cosmology and individual involved. By implication, mental healthcare related programmes should be done in a way that will factor these people in. For instance, policy making and planning for mental health promotion, mental health education, and/or intervention should not only allow for cross-cultural and locational adaptation but the processes of its making and execution should include both the professional and socially relevant people such as religious leaders, technocrats and older male and female members off the society

8.3 Suggestions for future ethnographic research

This thesis has explored the processes of making mental illness and how mental healthcare is constituted and practiced in the present day at Aro hospital. Nonetheless, this work has some limitations. For instance, my fieldwork covered only those who accessed at least one mental healthcare facility in Abẹokuta, especially Aro hospital. However, juxtaposing the population of Nigeria (above 216 million) or the Yoruba (above 40 million) (World Population Review, 2022), with mental illness prevalent rate of 1 of 8 across lifetime among

the Yoruba (Gureje et al., 2006) shows that this study covered but only a small portion of these people. Therefore, it would be useful to explore how mental illness is made and treated among those who, for whatever reason were not able to go to the hospital (or perhaps any other mental healthcare facility) and have thus been completely left out of this study. As previous studies have shown, those without sufficient financial, political, and social capital often struggle to access effective healthcare, especially in LMIC settings where universal health coverage is yet to be achieved (e.g., Darin-Mattsson et al., 2017; Homedes & Ugalde, 2005; Williams & Maruthappu, 2013). A community-based ethnography may be a more effective way to reach those who themselves never reach a formal healthcare facility.

Furthermore, this thesis may not reflect the experience of economic and political elites in southwest Nigeria. No one of these social classes was observed in the hospital and, indeed, some hospital staff claimed that the rich people (especially politicians and their families) would not want to be identified with Aro hospital and its connotations of 'madness'. This could have knock-on negative implications for the continued public funding of such institutions, as well as possibly perpetuating the myth that mental illness only affects the poor, thus intensifying social stigma. An ethnographic exploration of mental illness experiences and healthcare practices among the social and political elites could thus be a useful addition. Conducting ethnographic fieldwork among elites presents numerous challenges, however, especially in contexts like this where people may be reticent to speak openly of their experiences, and where lives are lived behind closed doors, making it difficult to reach people.

Finally, it would be useful to explore further the journey beyond hospital: at what happens as 'patients' are reintegrated into society, and how their lives are shaped by the experience of having been (or still being) a 'patient' at facilities like Aro hospital. Given that such a high proportion of the global population can expect to experience an episode of mental illness at some point in their lifetime, understanding not just what happens at an acute phase, but what recovery means in the longer term and how people manage to pick up the threads of their former lives – or weave new ones – should be a priority.

Appendix I

Final Ethical Approval - Timothy ALABI

LEGG, JENNIFER <jennifer.legg@durham.ac.uk>
Thu 02/08/2018 12:54
To: ALABI, TIMOTHY O. <timothy.o.alabi@durham.ac.uk>
Cc: HAMPSHIRE, KATE R. <k.r.hampshire@durham.ac.uk>; BROWN, HANNAH R.G. <hannah.brown@durham.ac.uk>; CARRITHERS, MICHAEL B. <m.b.carrithers@durham.ac.uk>

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Research
Ethics
and Data
Protection Committee
Department of Anthropology
Dawson Building, Durham, DH1 3LE

NOTIFICATION OF ETHICAL APPROVAL

Date: Thursday 2nd August 2018

Dear Timothy

Re: Ethnography of Mental Healthcare Practices and Quality of Care in Southwestern, Nigeria

I am pleased to confirm that the above research project has been granted ethical permission by the Anthropology Department Research Ethics Committee. You can now start your research.

Approval is subject to the following general conditions:

1. Ethical approval is specific to this Project.
2. You are required to keep all data about living persons securely. It would be best to use a shared drive provided by the University IT Service. Where access to a shared drive is difficult or intermittent, you should keep such data on your personal computer either in an encrypted form, or at least behind a solid password. Any paper records should similarly be kept as securely as possible.
3. If significant changes to the Project become apparent, please notify the Ethics Committee.
4. If any unanticipated problems or adverse events arise that involve risk to participants or others, please report these to the Committee. The Committee may ask you to write a formal report about the problem, and may suggest amendments to your project.
5. After completion of the project, please submit an 'end of project' report which can be found on the DUO ethics pages.
6. Your application has been considered formally by email with the external Committee (July 2018), and has been approved.

Best wishes for your research!

Professor Michael Carrithers
Chair, Anthropology Ethics Committee

Jennifer Legg
Administrative Assistant (Research)
Anthropology Department, Durham University
A: Dawson Building | South Road
Durham | DH1 3LE | United Kingdom
T: +44 191 3341620 | **F:** +44 191 3341618
E: jennifer.legg@durham.ac.uk

Durham University

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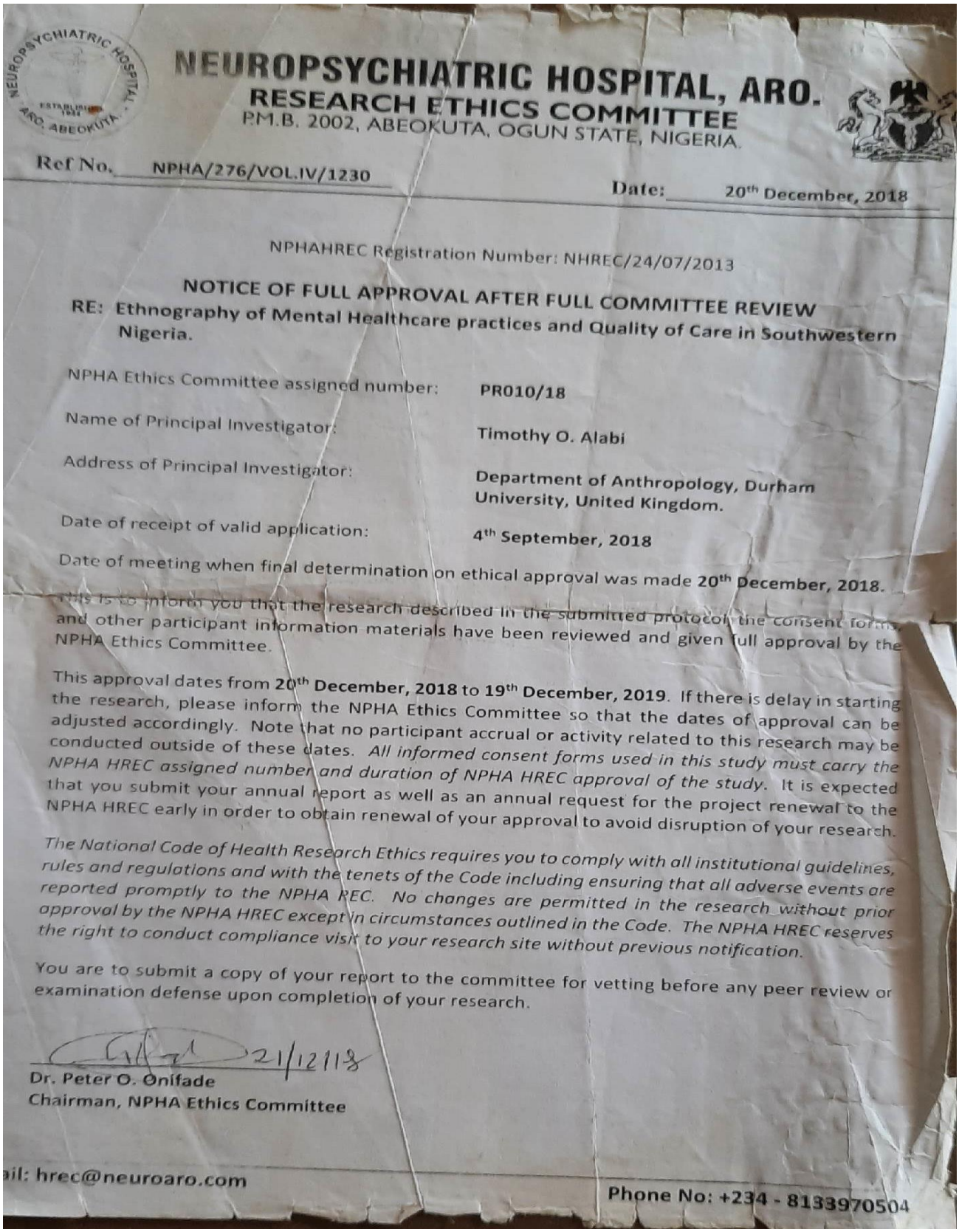
Appendix II



NEUROPSYCHIATRIC HOSPITAL, ARO.
RESEARCH ETHICS COMMITTEE
P.M.B. 2002, ABEOKUTA, OGUN STATE, NIGERIA.

Ref No. NPHA/276/VOL.IV/1230

Date: 20th December, 2018

NPHAHREC Registration Number: NHREC/24/07/2013

NOTICE OF FULL APPROVAL AFTER FULL COMMITTEE REVIEW

RE: Ethnography of Mental Healthcare practices and Quality of Care in Southwestern Nigeria.

NPHA Ethics Committee assigned number:	**PR010/18**
Name of Principal Investigator:	**Timothy O. Alabi**
Address of Principal Investigator:	**Department of Anthropology, Durham University, United Kingdom.**
Date of receipt of valid application:	**4th September, 2018**

Date of meeting when final determination on ethical approval was made **20th December, 2018.**

This is to inform you that the research described in the submitted protocol, the consent forms and other participant information materials have been reviewed and given full approval by the NPHA Ethics Committee.

This approval dates from **20th December, 2018** to **19th December, 2019**. If there is delay in starting the research, please inform the NPHA Ethics Committee so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. *All informed consent forms used in this study must carry the NPHA HREC assigned number and duration of NPHA HREC approval of the study.* It is expected that you submit your annual report as well as an annual request for the project renewal to the NPHA HREC early in order to obtain renewal of your approval to avoid disruption of your research.

The National Code of Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the NPHA REC. No changes are permitted in the research without prior approval by the NPHA HREC except in circumstances outlined in the Code. The NPHA HREC reserves the right to conduct compliance visit to your research site without previous notification.

You are to submit a copy of your report to the committee for vetting before any peer review or examination defense upon completion of your research.

21/12/18

Dr. Peter O. Onifade
Chairman, NPHA Ethics Committee

ail: hrec@neuroaro.com

Phone No: +234 - 8133970504

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