

THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF POST BASIC NURSING

(RN 420)

RESEARCH REPORT

SPK
MED
2001
2002

STUDY TITLE

**A study to determine the Knowledge and Practice of the
Family Towards Prevention of Relapses in Patients with
Schizophrenia in Lusaka Urban**

PRINCIPAL INVESTIGATOR

**Clara Mushokabanji Kwaleyela
25074938**

SUPERVISOR

Mrs Ndele

TABLE OF CONTENT

CONTENT	PAGE
Table of contents	i
List of appendices	iii
List of tables	iv
List of abbreviations	vi
Declaration	viii
Statement	ix
Dedication	x
Acknowledgement	xi
Abstract	xii

CHAPTER ONE

1. INTRODUCTION

1.1	Back ground information	01
1.2.	Statement of the problem	03
1.3	Factors contributing to/ influencing the problem	05
1.4	Diagram of problem analysis	09
1.5	Justification	09
1.6	Research objectives	10
1.6.1	General objective	11
1.6.2	Specific objectives	11
1.7	Hypothesis	11
1.8	Operational definitions of terms	11
1.9	Variables and cut off points	12

CHAPTER 2

2.0 LITERATURE REVIEW

2.1	Introduction	15
2.2	Global perspective	15
2.3	Regional perspective	20
2.4	National perspective	20
2.5	Conclusion	21

CHAPTER 3

3.0 RESEARCH METHODOLOGY

3.1	Research design	22
3.2	Research setting	23
3.3	Study population	24
3.4	Sample selection	24
3.5	Sample size	24
3.6	Data collection tool (Validity and Reliability)	25
3.7	Data collection technique	28
3.8	Pilot study	28
3.9	Ethical and cultural considerations	29
3.10	Plan for data analysis	30

CHAPTER FOUR

4.0 Data analysis and presentation of findings

4.1	Data analysis	31
4.2	Presentation of findings	31

CHAPTER FIVE

5.0 Discussion of finding and implication for the health care system

5.1	Characteristic of the sample	58
5.2	Implications to the health care system	70
5.4	Conclusion	73
5.5	Recommendations	74
5.6	Dissemination of findings	75
5.7	Limitations of the study	75

LIST OF APPENDICES

1. Interview schedule..... 78

2. Work schedule..... 87

3. Ghannt chart..... 88

4. Budget 89

5. Letters of permission to carry out study..... 91

LIST OF TABLES

Table

1: Variables cut off points and indicators	14
2: Demographic data table	31
3 Respondents relationship to the patient	34
4: Respondents' knowledge on condition of patient	35
5: Number of admissions	35
6: Respondents' knowledge of reason leading to relapses	36
7: Reason leading to relapses	36
8: Family's knowledge of prevention of relapses	36
9: Rejection from family members	37
10: Family members coping with the condition	37
11: Reasons for not coping with the condition	38
12: Respondents' knowledge on what treatment(s) patient is on and it's administration	38
13: Monitoring of treatment if response is no	39
14: Availability of drugs	39
15: Supply of drugs when not available at the hospital	40
16: Respondents level of knowledge	40
17: Ability to care for the patient at home	41
18: Reasons for not being able to care for patient at home	41
19: Type of care given by those able to care for the patients at home	42
20: Preference of care	42
21: Advantages of hospital care	43
22: Advantages of home care	43
23: Provision of information and skill regarding patient care	44
24: How skills provided help in patient care	44
25: Is chainama the nearest clinic	45
26: Respondents answer is no, reasons for attending reviews at Chainama	45
27: Manage coming for reviews whenever due	46

28: Reasons for not attending reviews	46
29: Respondents have cultural beliefs associated to patient's illness	46
30: Respondent's beliefs associated with the illness	47
31: Ways in which cultural beliefs affect the care	47
32: Availability of rehabilitation facilities for patients	48
33: Availability of community support groups offering support to patients	48
34: Respondents level of practice	48
35: Level of knowledge in relation to sex	49
36: Level of knowledge in relation to age	49
37: Level of knowledge in relation to marital status	50
38: Level of knowledge in relation to religious affiliation	50
39: Level of knowledge in relation to educational level	51
40: Level of knowledge in relation to occupation	51
41: Level of knowledge in relation to family income	52
42: Level of knowledge in relation to who supports the care of the family	52
43: Level of knowledge in relation to number of family members	53
44: Practice in relation to sex	53
45: Practice in relation to age	53
46: Practice in relation to marital status	54
47: Practice in relation to religious affiliation	54
48: Practice in relation to educational level	55
49: Practice in relation to occupation	55
50: Practice in relation to family income	55
51: Practice in relation to who supports the care of the family	56
52: Practice in relation to number of family members	56
53: Knowledge and Practice	57

List of figures

Figure 1	Diagram of problem analysis	09
----------	-----------------------------	----

ABBREVIATIONS

CSO.....	Central Statistics Office
ED.....	Executive Director
FOCA.....	Foundation for Community Action
IEC.....	Information, Education and Communication
MoH.....	Ministry of Health
MFGs.....	Multiple Family Groups
MHAZ.....	Mental Health Association of Zambia
MHUNZA.....	Mental Health Users Network of Zambia
NAC.....	New Apostolic Church
PHC.....	Primary Health Care
PBN.....	Post Basic Nursing
PNO.....	Principal Nursing Officer
PRP.....	Program for Relapse Prevention
RCC.....	Roman Catholic Church
TAU.....	Treatment As Usual
UCZ.....	United Church of Zambia
UNZA.....	University of Zambia
UNHCR.....	United Nations High Commissioner for Refugees
US.....	United States
UTH.....	University Teaching Hospital
UNDP.....	United Nations Development Plan
WHO.....	World Health Organisation

STATEMENT

I hereby certify that this study is entirely the result of my own independent investigations. The various sources to which I am indebted are clearly indicated in the text and references.

Signed: Ameyela Date: 16.04.08

DEDICATIONS

I dedicate this report to my father and late mother who without their encouragement who without their encouragement and support I would not have reached this far.

I would also like to dedicate this research to my family who tirelessly has been encouraging me despite denying them the most needed company and love.

ACKNOWLEDGEMENT

No task of this magnitude would have been completed without the assistance and commitment of other people.

Let me express my heartiest gratitude to Mrs. P. M. Ndele, my Supervisor for her tireless effort in providing guidance, tutorial and support in developing this research report.

I would also like to express my sincere gratitude to Mrs. C..M. Ngoma, my Lecturer for coordinating the course and her valuable guide in the course.

Lastly, I take the opportunity to express my deep sense of gratitude to my family for the emotional support and encouragement during this tedious exercise.

ABSTRACT

Families and significant others contribute a lot to their sick relatives and meet all their needs. These needs include the psychological, safety and security, love and affection, self esteem and self actualization needs.

The study, therefore, aims to determine the level of knowledge and practice of the family towards prevention of relapses in patients with schizophrenia.

With the deinstitutionalization movement, greater emphasis has been placed on viewing mentally ill people as members of the families and communities. Family members need to be strengthened to continue providing health care to their schizophrenic relatives at home. The extended families that provide the needed health care may have inadequate knowledge on how to go about caring for their sick.

A non interventional, descriptive qualitative and quantitative study was carried out to explore the level of knowledge and practice of the families towards prevention of relapses in patients with schizophrenia in Lusaka urban District; the pilot and the main study was conducted at Chainama Hills Hospital.

Data collection was conducted during the month of August and September. A sample size of (50) fifty respondents was selected using a convenient sampling method. Data was collected from the respondents through the use of a structured interview schedule with both open and closed ended questions. For a pilot study, 5 respondents were selected. The data collected was checked for completeness, coded, categorized and entered on a data master sheet. The data collected was then analyzed manually using a scientific calculator. Findings were presented using frequency tables and cross tabulation.

The data has been interpreted and the findings will be disseminated to Chainama Hills Hospital management and the Nursing services to help the institution

implement measures that will promote families of schizophrenia patients to have adequate knowledge and practice towards prevention of relapses in patients with schizophrenia.

The study revealed that the majority (58%) of the respondents were females. This could be attributed to the fact that there are more females than males in Zambia and also the fact there are more females are generally carers of the sick. The study also revealed that (45.5%) of the respondents whose highest level of education was college had very good knowledge while (18.2%) of the respondents whose highest level of education is primary education had poor knowledge. The findings could be due to the fact that the level of education influences the individual's understand of the information given on how to go about caring for their discharged relatives since they can follow instruction

The study also shows that the majority 13 (86.7%) of the respondents with adequate income had good practices of patient care while 7 (20%) of the respondents with inadequate income had bad practices. These findings show that the resources that the family has influences the type care given. Those with adequate income can afford to provide for their patients' requirement like follow up care, purchasing drugs and providing for activities of daily living. Therefore, we fail to reject the null hypothesis which states that "Socio-economic status of the family affects the type of care provided to a sick relative".

The study reveals that the majority (72%) of the respondents were able to provide home care. The study also shows that the majority of those who were able to care for the patients provided activities of daily living (69.4%) and monitored medication (58.3%). The findings of the study could be that mentally ill patient are incorporated in the family environment as soon as their conditions stabilizes in order to avoid institutionalization and hence this move has made the families to have improved skill in caring for the sick and the family environment significantly influences health outcome.

CHAPTER 1

1. INTRODUCTION

1.1 Back ground information

The republic of Zambia is situated in sub-Saharan Africa. The country is a landlocked country situated south of the equator and shares boundaries with eight countries namely: Malawi, Mozambique, Zimbabwe, Botswana, Namibia, Angola, Democratic Republic of Congo (DRC) and Tanzania.

Administratively, the country is divided into nine provinces and seventy-two districts. The country has a tropical climate with three seasons; cool and dry (May – August), hot and dry (September – October) and warm and wet (November – April), (Central Statistical Office, 2000).

The country has a population of about 10.3 million people, 73% of whom live below the poverty datum line that entails surviving on less than a dollar a day with rural areas more affected than urban areas (Central Statistical Office, 2002). Poverty levels in the Zambian context can be defined as lack of access to income, employment opportunities and entitlements for citizens to such things as freely determined consumption of goods and services, shelter and other basic needs of life (Ministry of Finance and National Planning, 2002). The population density ranges from 65 people per square kilometers in Lusaka province to five people per square kilometers in rural provinces (Central Statistical Office, 2002).

The concept of Primary Health Care (PHC) was adopted by the Zambian government through the Ministry of Health (MoH) in April, 1980. The vision of PHC is providing health for all by the year 2000. This concept emphasize that the health services should be provided as close to the family as possible through community participation and at the cost that families and communities can afford (Central Board of Health, 1992).

The emphasis was more on preventive than curative medicine. One of the 9 components of PHC was the promotion of mental Health.

According to Berkow et al, (1997), mental health (psychiatric) disorders involve disturbance in thinking, emotion and behavior. These disorders are caused by complex interactions between physical, psychological, social, cultural and hereditary influences.

Schizophrenia is a relatively common and serious mental disorder that is associated with psychosis (a loss of contact with reality and a decline in general functioning). Schizophrenia is defined as "a serious mental disorder characterized by loss of contact with reality (psychosis), hallucinations, delusions (false beliefs), abnormal thinking and disrupted work and social functioning (Berkow, 1997). Chainama Hills Hospital is a specialised hospital for mental illnesses and was built in 1961. It receives referral throughout the country. The hospital is situated in Lusaka district and there are eight mental annexes in all the other provincial headquarters. The district hospitals and the health centers have clinics that attend to mental illnesses though most of them are unable to manage psychiatric patients effectively. They have little time to do more than review prescriptions and refer cases for admission to the psychiatric hospitals. Even the health centers in Lusaka urban do not usually manage the mentally ill patient but they just refer them to Chainama hospital. This trend has led to an increase in relapses of schizophrenics because if the patient does not have transport money to go to Chainama hospital and can not receive any help from the nearby health center, his/her drug stocks will run out leading to relapsing.

When schizophrenic patients are discharged from the hospital, the family members and the community take over the responsibility of caring for the clients.

In Zambia, the social organization and social control among indigenous Zambians is based on the extended family system. The extended family include individuals beyond the nuclear family. Such members adhere to some definite norms and standard of behaviour in their relationship with one another.

The family gets concerned when there is sickness of the family member. They also attach great importance to the need for involvement. This is the time when mutual obligations, solidarity and responsibility are observed among family members. When a family member falls ill, others share the responsibilities of treatment and providing care for him in order to meet the needs of activities of daily living (ADL) which he cannot perform by himself.

It is observed that when a sick person is taken to the hospital, some family member will usually accompany him and when admitted, they will continue offering care to the client by providing the patient with all that is needed, for example, food and even buying the drugs that are not available in the hospital. By so doing, relatives feel they have a joint responsibility with health staff to care for the sick and to help the patient recover.

1.2. STATEMENT OF THE PROBLEM

Schizophrenia is a major public health problem throughout the world. According to the World Health Organization (WHO) and the National Institution of Mental Health, schizophrenia has a world wide prevalence rate of 1%. This disorder affects all races and cultures pretty much the same that's why the major focus has been on biological causes. It is a tremendous cost to society as more than 4.3 billion is spent annually in Canada on schizophrenic care. In the United States, people with schizophrenia occupy about one fourth of all hospital beds and account for about 20% of all social security disability days. It's also a great family burden (Berkow et al, 1997).

In South Africa, Freeman and colleagues' (2000) review of 672 medical records from 17 community clinics, and interviews with 114 patients, provide us with possibly the best available audit of patients attending psychiatric services in South Africa. Of 672 patients, 453 were black and 216 white; three of unknown race. The diagnoses included schizophrenia (52%), mood disorder (19%), and substance abuse (5%). Highly significant racial differences in the diagnosis of schizophrenia and mood disorders were evident. Schizophrenia was diagnosed in 68% of black patients compared with 19% of white patients; mood disorders were diagnosed in 9% of black patients compared with 41% of white patients.

This may mean that black patients are unlikely to receive care unless they have a major psychotic illness or that black patients are more likely to be diagnosed as having schizophrenia simply because it is believed to be more common among them; or black people may not be seeking care for other psychiatric illnesses, possibly due to social prejudice. Clearly, more studies are needed before we know the explanation of the high percentage of schizophrenia among black patients found in this study.

According to the Action plan for Chainama Hospital (2004 – 2006), the second leading cause of morbidity for mental illness is schizophrenia. In 2006, the diagnosis of admitted patients include acute psychotic disorder (24.2%), schizophrenia (20.4%), substance abuse (16.4%), mood disorders ((15.6%), and others (23.4). Filter clinic attendants for the same period include acute psychotic disorder (24.2%), schizophrenia (23.5%), substance abuse (7.3%), mood disorders (5.3%) and others (39.7%)

The real cause of schizophrenia is not known. The disorder has a biologic basis. Many authorities accept a "vulnerability stress" model in which schizophrenia is viewed as occurring in people who are biologically vulnerable (Rawlings et al, 1993).

Rawlings et al further stated that what makes people vulnerable aren't known but may include genetic predisposition; problems that occurred before, during and after birth; or a viral infection of the brain. In the vulnerable stress model, environmental stress such as stressful life events or substance abuse problems may trigger the onset and recurrence of schizophrenia in the vulnerable individuals.

There are a lot of stressful events in our environment that can trigger schizophrenia onset and recurrence. Stigmatisation, discrimination, rejection, lack of knowledge, bad practice and inadequate family support are some of the factors that can bring about stress in a schizophrenic patient and patients are subjected to these situations in everyday life and may lead to recurrences of the condition.

The adoption of PHC services in mental illnesses strengthened the involvement of the family in the care. Family support in caring for the schizophrenic patients is encouraged because the care givers are trying to avoid institutionalisation of patient. The family, therefore, should be educated on the processes of caring for their relative in order to improve understanding of the condition and be able to cope with the condition after discharge. The family should also be educated on how to administer drugs, their side effects and the importance of follow up care in order to encourage continuity of patient care because these clients will have to be taking psychotropic drugs throughout their lives to encourage drug compliance and avoid relapses. Family therapy helps to educate the family on how to interact with a patient, encourage adherence to treatment and avoidance of situations that bring about stress in the client so as to minimise relapses.

1.3 FACTORS CONTRIBUTING TO/ INFLUENCING THE PROBLEM

Factors contributing to the problem are categorised into service related, disease related and socio-economic factors.

1.3.1 Service related factors

1.3.1.1 Accessibility to mental health facilities

When schizophrenic patients and other mentally ill patients are discharged from Chainama hospital, they are referred back to the hospitals where they came from for continuity of care and the family is educated on the management of the client while at home in order to minimise relapses.

Most health centres have no specialised staff to attend to these clients and the situation is the same even in Lusaka urban. This has led to all the clients that are discharged from Chainama hospital to be attending reviews only at Chainama hospital and at University Teaching Hospital (UTH) clinic 6. Inadequate mental health facilities in the community have created long distance for clients who have to travel for more than 12 kilometers to attend reviews. Relatives, therefore, may be unable to bring their patients for review due to lack of transport money which consequently may result in the patient relapsing.

1.3.1.2 Inadequate sensitization

Mental health issues have not received much attention and sensitization in Zambia; hence, most of the Zambian population have little knowledge about mental health. The families and the communities have little knowledge about mental illness and the care that they should give to their affected relatives. Conditions that are well sensitised may be better managed by the families and communities than those that are not sensitised.

1.3.2 Socio-Economical and cultural factors

1.3.2.1 Educational level

The level of knowledge that the family caregivers have may influence the quality of care that they provide to their relatives with schizophrenia. High educational level may make it easier for the sick relatives to understand the information and knowledge on how to go about caring for their relatives.

Low educational level may lead to the relatives of the sick having inadequate information and knowledge on how to care for their discharged relatives which may result in patients relapsing.

1.3.2.2 Beliefs

Cultural and religious beliefs influence the type of care to be provided to sick relatives. Those who believe in witchcraft may take their sick relatives to a traditional healer believing that the patient has been bewitched. While the patient is being attended to by the traditional healer, he/she will be advised not to continue with the medical drug thus worsening the condition and resulting in a relapse. Patient may be brought to the hospital in a critical condition after the traditional healer has failed. Those who are religious may believe in divine power instead of modern medicine and treatment and consequently, may not take their patients to the hospital as they believe that prayers alone can heal the condition.

1.3.2.3 Stigma

Family members or relatives to the sick may reject and discriminate the sick and call them different names thus stigmatizing them due to the behavior that they portray. The family also may be socially stigmatized by the neighbors and the community may fail to interact with them and help them when in need for fear that the patient may harm them. For many consumers, this stigma is internalized, and contributes to the debilitating process of becoming a "mental patient" thus increasing the potential for relapses (Deegan 1990).

1.3.2.4 Socio-Economic status

Family income and occupation of the household determines the availability of resources to support the sick relative. Families with the good paying job may be able to provide good nutrition, hygiene and be able to be taking their sick relative for review whenever need be thus reducing the relapses.

The low income families may not adequately provide for the patient's needs and fail to take the client for reviews due to lack of transport money resulting in relapses.

1.3.3 Disease related factors

1.3.3.1 Chronicity nature of the condition

It has been observed that families and relatives give support to the schizophrenic patients during their early episodes of the condition. As the disease progresses, they tend to change their attitude and perception towards their patients. The chronic nature of the condition may lead to family being hopeless and fail to cope with the condition resulting in relatives rejecting the patient which leads to relapses.

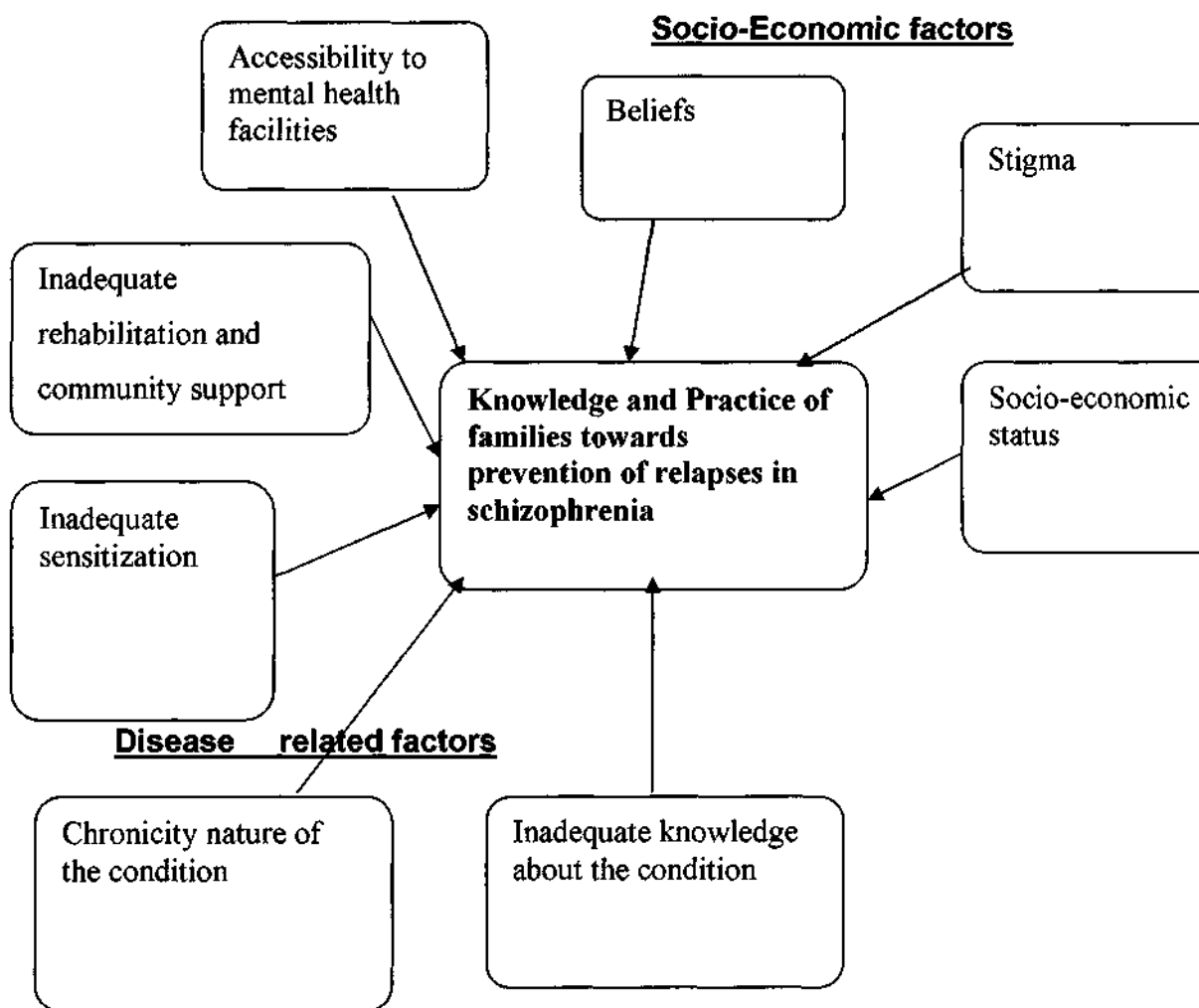
1.3.3.2 Lack of knowledge about the condition

The family members need to have adequate knowledge on how to care for the patients with schizophrenia whilst at home in order to prevent relapses. Inadequate knowledge on the condition, treatment and prognosis by the family members may lead to reduced willingness to care for the patients because they do not know how to go about caring for the client which may result in relapses.

1.4 Diagram of problem analysis

Figure 1

Service related factors



1.5 JUSTIFICATION

A movement in recent decades to bring mentally ill patients out of institutions has been made possible by the development of effective antipsychotic drugs (Berkow et al, 1997). With the deinstitutionalization movement, greater emphasis has been placed on viewing mentally ill people as members of the families and communities.

Today, the health care system world wide emphasizes the family involvement in the care of the mentally ill and the family can either improve or worsen mental illness depending on the emotional environment of the family. This study endeavours to determine the knowledge and practice of families towards the prevention of relapses in schizophrenia.

Adequate knowledge about the condition and practice may influences quality of care given to clients. Consequently, the levels of knowledge that families have towards prevention of schizophrenic relapses may affect/influence their response to care.

The findings of the study will help families and health management to identify areas of need as it relates to prevention of relapses for schizophrenia patients. The health practice may be improved by establishing policies, protocols and logistics on prevention of relapses that will enable health care providers to be efficient in dealing with schizophrenia. It will also help families to widen their knowledge in the care of their sick relatives while at home in order to prevent relapses.

The factors that lead patients to be having relapses may emerge from their home environments and the community, for example, stigma. Thus, this study will help the families realise the situations that lead to the client relapsing and be able to find measures to remedy the situation.

1.6 RESEARCH OBJECTIVES

1.6.1 General objective

To determine the knowledge and practice of the families of schizophrenic patients in the prevention of relapses.

1.6.2 Specific objectives

1. To determine the level of knowledge of the families towards prevention of relapses in patients with schizophrenia.
2. To determine the practices provided by the families with schizophrenic patients in the prevention of relapses.
3. To identify the experiences that the families undergo in caring for the patients at home
4. To determine the attitude of family members towards their involvement in patient care of a discharged patient.
5. To assess the relationship that exists between the health staff and family members in terms of communication.

1.7 Hypothesis

Uys and Basson (1996) define a hypothesis as a tentative prediction or explanation of the connection between two or more variables. It provides a statement of the presumed relationship between the variables.

1. Socio-economic status of the family affects the type of care provided to the sick relative.
2. The level of knowledge of the family on the condition, treatment and prognosis influences the care given to their relative at home.
3. Cultural and religious beliefs influence the type of care that is provided to the sick relatives at home.

1.8 Operational definitions of terms

Family	Composition of individuals united by birth, marriage or adoption, who live together
Knowledge	What family members know about providing care to their relatives with schizophrenia

Practice	This is the art or skill of caring for the patients with schizophrenia.
Patient	An individual who is ill or undergoing treatment.
Care	Attention or assistance being given to the patient in order to meet the activities of daily living and enhances his recovery.
Caregiver	Person who provides social, emotional and psychological health care to others.
Relapses	Recurrence of the disease
Prevention	Avoiding the condition/disease
Stigma	A "deeply discrediting" attribute.
Discrimination	To perpetrate an unjust action or inaction against individuals who belong, or are perceived to belong, to a particular group, in particular stigmatized groups.

1.9 Variables and cut off points

A variable is an attribute or characteristic that can have more than one value, such as height, weight and blood pressure (Dempsey and Dempsey, 2002)

There are two (2) major types of variables:

1. Dependent variables
2. Independent variables

1.9.1 Dependent variable

Dependent variable is a variable that changes as a result of manipulation of the independent variable, some examples include knowledge and practice (Dempsey and Dempsey, 2002)

A dependent variable is the variable that is hypothesized to depend on or be caused by another variable which is the independent variable (Polit and Hungler, 1997)

1.9.2 Independent variable

These are the variables that are believed to cause or influence the dependent variable in experimental research, the manipulated variables (Polit and Hungler, 1997). This is a variable that is purposely manipulated or changed by the researcher (Dempsey and Dempsey, 2002)

1.9.3 Identified variables

Dependent variables

- Knowledge
- Practice

Independent variables

- Educational level
- Accessibility to mental health facilities
- Sensitization
- Stigma
- Chronicity nature of the condition
- Beliefs
- Socio-economic status
- Rehabilitation and community support activities

1.9.4 Cut off points

These are the attributes used to explain the conceptual and operational definitions of variables used.

Table 1: VARIABLES CUT OFF POINTS AND INDICATORS

Variable	Cut off points	Indicator	Question Numbers
Knowledge	Very Good	8-10 correct responses	10 – 24
	Good	5-7 correct responses	
	Poor	Less than 5 correct responses	
Practice	Good	5 or more correct responses	25 - 37
	Poor	Less than 5 correct responses	

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

Literature review is a critical review of literature on available studies or information related to the research topic.

The purpose of literature review is to help the researcher determine what is already known about the topic under study so that there is no duplication of work that has already been done before. The review of literature also helps the researcher to become familiar with various types of research methodologies that might be used in a study. A convincing argument of why a particular research subject is needed can be drawn from literature review.

This literature review focuses on the knowledge and practice of the family towards prevention of relapses in patients with schizophrenia and also the state of family involvement in caring for patients with schizophrenia globally. The literature review is discussed under global, regional and national perspectives.

2.2 Global perspective

Schizophrenia is a serious mental illness with widespread human and economic cost implications. It strikes one in 100 people worldwide with over 250,000 people in the UK being treated at any one time (Nursing times, 2003:28). It is a chronic lifelong condition with a high risk of relapse, even in patients who appear to be responding well to initial therapy. There is no cure for schizophrenia. The symptoms, the peculiar mannerisms sometimes brought on by medication, the association with violence and the fear of an illness which is poorly understood all contribute to the enormous stigma attached to the diagnosis of schizophrenia.

Despite this, innovative advances in the treatment of schizophrenia have already begun greatly to improve the outcomes for many individuals with this illness and for many there is now a real chance of recovery.

The traditional therapies - the typical or conventional antipsychotics - that are often still used to treat schizophrenia have long been associated with a poor side effect profile. While these medications, such as chlorpromazine and haloperidol, relieve "positive" symptoms (hallucinations and delusions) they have a limited effect on important and common "negative symptoms" (apathy and social withdrawal) and "affective" symptoms (depression and anxiety associated with schizophrenia) (Nursing times, 2003:28). They are also commonly associated with movement disorders that can stigmatize the patient further, which can possibly lead to poor patient compliance and an increased risk of relapse (Nursing times, 2003:28).

Relapse has many unwanted implications including admission to hospital and more importantly it can be a devastating personal setback of the individual relapsing. Literature shows that although the course of schizophrenia varies, most patients have a chronic course with frequent relapses, typically characterized by bouts of psychosis and rehospitalisation (Uys and Middleton, 1997). Each successive relapse can reduce the length and completeness of the next remission increasing disability, and lessen future responses to treatment (Kane, 1999). Preventing relapses is therefore a major aim of maintenance treatment of people with schizophrenia (Kane, 1999)

Reducing the incidence of relapse not only produces benefits in terms of patient quality of the life, but may also result in significant cost savings to health services by reducing the number of hospital admissions required by these patients.

Schizophrenia is a costly illness in every sense. Rehospitallisation and treatment costs, following patient relapse, account for a large proportion of the direct costs of schizophrenia. Enhanced compliance, relapse prevention and reduced time in hospital are key to the reduction of inpatient direct costs and burden on the National Health System (Nursing times, 2003:99,28).

The recent decrease in hospital stay of patients makes it more imperative to understand how family members can be assisted in their care giving efforts for the patients with schizophrenia. Lave, (1997) indicates that decrease hospital stay have shifted hospital stay to home care, meaning that informal carers, usually families and friends provide care at home.

A Controlled Study on Relapse Prevention in schizophrenia was conducted at University of Rochester Medical Center by (Herz et al, 2000). This study examined whether a Program for Relapse Prevention (PRP) is more effective than Treatment As Usual (TAU) in reducing relapse and rehospitalization rates among outpatients with schizophrenia. Eighty-two outpatients with schizophrenia disorder were randomly assigned to receive either PRP (experimental group, n = 41) or TAU (control group, n = 41) and were followed up for an 18-month prospective controlled study. The findings were that PRP was effective in detecting prodromal symptoms of relapse early in an episode. Crisis intervention including increased antipsychotic medication use during the prodromal phase reduced relapse and rehospitalization rates.

According to William et al (1995), earlier studies of family psychoeducation and clinical reports on multiple family groups (MFGs) have reported substantial reductions in relapse rates for patients with schizophrenia. These groups offer an expanded social network and thereby may confer a margin of protection against relapse.

William et al, (1995), conducted a study on Psychoeducational Multiple Family Groups (MFGs): Four-Year Relapse Outcome in Schizophrenia. The advent of family psychoeducational and behavioral management strategies provided the basis for an experimental, three-way comparison of psychoeducational MFGs to psychoeducation in a single-family format and to MFGs without psychoeducation, using symptomatic relapse as the outcome criterion. After 4 years, the psychoeducational MFGs were significantly more effective in extending remission than the single-family format, while the MFGs without psychoeducation approximated outcome in the psychoeducational MFGs. The respective relapse rates at 4 years were 50%, 78%, and 57%; MFGs averaged 12.5% and 14% per year.

These results point toward an enhanced and independent, long-term therapeutic effect for multiple family groups, when combined with antipsychotic medication and psychoeducation, with especially promising cost-effectiveness.

Another study, conducted at Colorado University-Boulder, compared the effectiveness of family focused therapy with less intensive crisis management in schizophrenia patients who were receiving medications. Earlier research had shown that medication alone, no matter how specific the drug regimen, was less than adequate in preventing recurrences.

"Schizophrenia disorder is a highly recurrent illness," said Miklowitz. "People go in and out of episodes, and some people can't work even though they are relatively stable. This is a very complicated and tough illness for sufferers and their families. "Medications reduce relapse rates considerably, but just taking medication is not enough" (<http://archpsyc.ama-assn.org/cgi/content/full/60/9/904>).

The randomized controlled study trial, involving 101 patients diagnosed with schizophrenia disorder, assigned participants to family focused therapy and medication or a less intensive crisis management intervention and medication. The family focused therapy was conducted in families' homes and consisted of 21 sessions stressing illness education, communication training and development of problem-solving skills. Crisis management consisted of two sessions of home-based family education and crisis intervention sessions as necessary.

Both treatment plans lasted nine months, with patients receiving medication for two years. Of the 70 participants in the crisis management protocol, 54 percent experienced disease relapse within two years, 17 percent did not experience relapse and 6 percent were unchanged. Twenty-three percent stopped participating in the study before its completion.

In comparison, of the 31 family focused therapy participants, only 35 percent experienced disease relapse within two years, 52 percent did not experience relapse and 3 percent were unchanged. Ten percent ended participation prematurely.

The findings indicated that if patients were in family focused therapy and medication, they had fewer relapses, longer periods of wellness and less severe schizophrenia symptoms. Among the advantages of family focused therapy, are that family involvement can improve the patient's adherence to medication, and family members become able to recognize early signs of relapse and intervene before an episode is full-blown. Family communication improved during the course of treatment. Conflict gave way to more positive attitudes – family members and patients became more empathetic, and they listened better and showed more positive nonverbal behavior toward each other. Miklowitz said that when patients' interactions with their family members improved, so did their clinical conditions.

Family members start recognizing that this is an illness, not something the patient is doing to make people angry or reflection of an ill temperament. When families start thinking of the behaviors associated with the disorder as biologically or genetically driven, they tend to be more tolerant."

2.3 Regional perspective

In the region, the families and communities still remain an important context in caring for the sick.

In Nigeria, Ohaeri (1998) in a study of perception of the social support role of the extended family network with schizophrenia and affective disorder patients revealed that as in many African countries, the social support role of the extended family is taken for granted, so much that people commonly refer to 'the African family system' as it were peculiar to Africa. Furthermore, the study revealed that the members of the extended family that provide support included parents, full siblings, uncle/ aunts, first cousins and in-laws. Though these people provided the material, social and emotional support, discontinuation of visits contributed to long or indefinite patient stay or discharge from hospital and frequently un able to return to the villages and become homeless.

2.4 National perspective

In Zambia, where traditionally there has been fairly strong bond through the extended family, the family has been and still is the greatest source of care for the sick. The family feels a strong natural obligation and responsibility to care for the sick relatives. In case of schizophrenia, the families face some problems and these are related to loss of control in care giving tasks, patient behavioral problems experienced in care giving and the degree of patient dependency needs.

Family members are involved in health care provision to their sick relatives. It has been observed that care providers at family level do not have adequate experience, training and knowledge in caring for chronically ill patients.

Chindi (1997) study revealed that most of the respondents involved in caring for their sick relatives lack information about their relatives' illness thus placing them at a risk of stigmatization.

Another problem was fear of how to go about caring for the patient and how to cope with condition. The study also revealed that the care givers had a task of cooking, washing and comforting the patient meaning that considerable time will be spent on patient limiting the activities of the caregivers' time for economically productive activities as most patients needed care for a long period of time, which is life long.

1.5 Conclusion

Literature has shown that family focused therapy and medication leads to fewer relapses, longer periods of wellness and less severe schizophrenia symptoms. Family involvement can improve the patient's adherence to medication, and family members become able to recognize early signs of relapse and intervene before an episode is full-blown. It has further shown MFGs were significantly more effective in extending remission than the single-family format. Family involvement improves interaction among family members, hence they start recognizing that this is an illness, not something the patient is doing to make people angry or reflection of an ill temperament.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

INTRODUCTION

Research methodology can generally be assumed to be the technique used by the researchers to collect and order data, to use statistical manipulation and to arrive at a logical conclusion (Treece and Treece, 1996). The goal of research methodology is to ensure reliability and validity in the data collection tools.

3.1 Research design

A research design is a researcher's plan for obtaining answers to the research questions or for testing the research hypothesis (Polit and Hungler, 2001). The researcher decided on which approach would best answer the research question or meet the objective. A research design serves as a guide for the investigator and it is used as a frame work for the research process.

In this study, a descriptive non-experimental research design was used. The study was descriptive because it involved identification and exploration of the knowledge and practice of families towards prevention of relapses in schizophrenia patients. Data was collected systematically and presented in order to give a descriptive picture of a particular situation designed to discover new meaning and to provide new knowledge when there was little known about a phenomena of interest

The study was a quantitative study as the findings of the interview schedule have been used for recording the discussion and the interview content have been analysed. It was also a qualitative study as it explored those human experiences that could not be quantified.

3.2 Research setting

The research setting as described by Polit and Hungler (2001) is a physical location and the conditions in which data collection takes place in a study.

This study was conducted in Lusaka Urban District and the respondents were accessed as they brought their relatives for reviews at Chainama Hills Hospital. The hospital provides specialized high quality medical and psychiatric care to patients in form of psychotherapeutic, rehabilitative and physical interventions in collaboration with the patients' family, friends and employers.

Chainama Hills Hospital is situated along Great East Road and it's about 15 kilometers (km) from Lusaka city centre. It lies between Mumana Pleasure Resort on the Western side, Bennie Mwiinga houses on the Southern and Eastern side and Mine stone on the Northern side, separated by Great East Road. It is a third level psychiatric hospital, the only one of its kind in the country. Chainama Hills Hospital has a bed capacity of 210. It consists of six wards, including a fee paying ward. The hospital serves as a referral centre for the University Teaching Hospital (UTH), Provincial and District hospitals and private hospital.

Lusaka District is the headquarters of Lusaka Province. It shares borders with Chongwe District on the east, Kafue District on the south, Mumbwa District on the west, and Chibombo District on the north. Lusaka urban has an estimated population of two (2) million and major languages spoken are English, Nyanja and Bemba.

The researcher chose to carry out the study in Lusaka urban district because not much research had been conducted in this area on the topic and this is where the biggest mental specialised hospital is based. The researcher is also familiar with the town under study.

The district consists of educated and non educated people whose knowledge and practices towards health and illness differ.

3.3 Study population

A study population is the total group of individual people or things meeting the designated criteria of interest to the researcher, (Dempsey and Dempsey, 2000). The researcher did not gather data from the whole population under study. Therefore, a sample that was representative of the total population with which the researcher dealt with was obtained.

The study population comprised of male and female, educated and non educated family members who were looking after the discharged schizophrenic patients. The study population included all family caregivers of patients with schizophrenia in Lusaka urban.

3.4 Sample selection

Sample selection is the "process of selecting a portion of the population to represent the entire population" (Polit and Hungler, 2001). For the purpose of this study, a non-probability sampling method was used and this was convenient sampling. Convenient sampling entails the use of the most conveniently and readily available people or objects for use as subjects in a study.

3.5 Sample size

A sample size is the total number of subjects in a sample, (Polit and Hungler, 2001). It's the actual number of participants who will take part in the study. A sample of 50 respondents who are family members caring for schizophrenia patients at home was sort. The sample size was 50 and was arrived at because of the convenience and logistic problems in terms of finances and distance.

A convenient non probability sampling was used to select the respondents. Since the period of the study was short, the sample of 50 was manageable.

3.6 Data collection tool (validity and reliability)

A data collection instrument is a device or technique that a researcher uses to collect data (Polit and Hungler, 2001). The data collection tool may take a form of questionnaire, interview schedule, focus group discussion, checklist or projected device. The interview schedule was the instrument used in the study. The interview schedule is a quantitative method in which the questions and wording are fixed and identical for all respondents.

The instrument comprised of a series of questions that were both open and closed ended. The responses were filled in by the interviewer. The method was used because it accommodated both the literate and illiterate respondents. It was also preferred because it gave the researcher a face to face interaction with the respondents.

Advantages

The following are the advantages of conducting an interview schedule:-

1. Data from each interview are usable.
2. Depth of the responses can be assured, since the researcher can pursue a question of special interest.
3. In an explorative study, the researcher may decide to use the interview technique to determine which questions would be most valuable in a questionnaire.
4. If the interviewee does not understand the questions during the interview, he or she may ask to have it repeated to make the question more meaningful.

5. No items are overlooked by the interview method.
6. A higher proportion of responses are obtained from potential respondents as most respondents will consent to the interview.
7. The interview procedure may save time for the interviewee, because she/he does not have to go through the process of returning the instrument.
8. The respondent cannot be influenced in answering the current questions by referring to other items as often may occur with the questionnaire.

Disadvantages

The following are the disadvantages in selecting the interview as the method for obtaining data:-

1. The interview procedure requires many long hours of effort and would probably entail the assistance of a specially trained staff, which would add to the cost of the project.
2. It may be difficult to make a comparison of one interviewer's data with another interviewer's data unless rigid procedures are followed at all times.
3. Bias may result because of differences in question order which would invalidate some of the information obtained.
4. The interviewee usually has little or no choice in the date or the place of the interview due to limited time in which to complete the research project.
5. In large research projects, the director will need to hire interviewers and suitable persons may not be available. Training interviewers adds to the expense of the project.

3.6.1 Validity

Validity according to (Polit and Hungler, 2001) is the degree to which an instrument measures what it is supposed to measure. One of the ways to measure validity is through content validity. Content validity is the extent to which the research instrument samples the factors or situations under study (Treece and Treece, 1986). In this study, the content was related to the variables and objectives of the study. This ensured that validity was measured, the investigator asked questions in relation to the objectives and the variables of the study. A pilot study was conducted to try out the procedure for data collection in order to determine if the instrument measured what it was supposed to measure.

3.6.2 Reliability

Reliability according to Polit and Hungler, (2001) refers to the degree of consistency or accuracy with which an instrument measures an attribute that it is designed to measure.

Reliability of the interview schedule was achieved by carrying out a pilot study in order to determine the ability of the data collecting device (interview schedule) to obtain consistent or accurate results. When examining the results of the pilot study, the researcher discovered some changes that had to be made. It was noticed that some respondents did not meet the criteria for the sample, the subjects did not understand the items, the given question were not eliciting the desired information or were irrelevant, important items had been omitted or there were gaps between some of the questions. Reformulation of information was necessary or additional questions were required in order to make the instrument reliable.

3.7 Data collection technique

This is a procedure of collection of data information needed to address a research problem (Polit and Hungler, 2001). There are several methods that can be used to collect data, some of which are: interviewing, administering questionnaire, review of records, observations, focus and group discussion. For the purpose of this study, an interview schedule was used with both closed and open-ended questions to collect data, since the study population consisted of both illiterate and literate persons. Instructions were given and the purpose of the study explained; the use of the findings and the assurance of privacy and confidentiality were explained. The interview schedule was checked for completeness after interviewing the respondents.

3.8 Pilot study

According to (Polit and Hungler 2001), a pilot study is a small study or trial run, done in preparation for the major study. In other words, it is a small-scale study, which is conducted before the main study on a limited number of subjects selected from the same population as that of the actual study. The pilot study for this research was done at Chainama Hills Hospital.

It was important that all steps in the pilot study were carried out, because it is only by completing a full procedure that weaknesses can be identified. When tabulating the data, hidden problem areas like poor wording, ambiguous answers were identified. Subjects may not give the responses required or rather high proportion of respondents may refuse to be interviewed and all point to corrections that should be done before the research tool is used in a major study.

The purposes for conducting a pilot study are:

1. To detect any errors in the scheduled interview questionnaire for the main study.

2. To assess the appropriateness and clarity of questions.
3. To set the feasibility, validity and reliability of the interview schedule questionnaire and to estimate the time each interview will take.

The pilot study also helped to determine the reactions of respondents to the research procedure. The aim of a pilot study is to identify and correct errors once identified before the main study is conducted. A sample for a pilot study is 10% of the total anticipated study sample, which is 50, in this case. Therefore, the sample for the pilot study was 5. The 5 respondents were selected using convenient sampling.

3.9 Ethical and cultural considerations

Ethics can be defined as 'a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligation to the study participants'(Polit and Hungler, 2001)

The ethical considerations involves an understanding of the ethical codes and guidelines for protecting the rights of the research subjects (Dempsey and Dempsey, 2000)

Any research that is done on human beings, must take into consideration the rights of the research participants. Research subjects have the right to privacy and dignity, which have to be upheld. To achieve this, permission was obtained from the relevant authorities, that is, the Executive Director (E.D) for Chainama Hills Hospital, the Principal Nursing Officer (P.N.O) and ward in-charges. Permission was also sought from the respondents for them to take part in the study. The purpose of the study was explained to all the respondents involved so as to enable them understand the nature of the study to which they are consenting to, as well as enabling them participate in the study willingly. There was no identity of the respondents on the interview schedule questionnaire, that is, name or address to ensure anonymity and confidentiality.

1.10 Plan for data analysis

Data analysis is a systematic organization and synthesis of research data and testing of research hypothesis using those data (Polit and Hungler, 2001). A plan for data processing and analysis had to be done before the data was collected in the field. Data analysis helped the researcher to ensure that all information was collected in a standardized manner. It also helped the researcher to collect necessary data, which has been summarized.

Data was sorted out by serial numbering the interview schedules and way of piling them was found. Quality control checks were performed through editing and cleaning the data. During editing, the interview schedule was checked for completeness of responses immediately after collection from the respondents and logical inconsistencies were corrected by asking for clarifications from the respondents.

Data was arranged in measurable values into selected descriptive indexes. Data was also categorised and coded before being entered on the data master sheet. The data master sheet contained the total number of respondents for each alternative of each item.

Data was processed manually with the help of a scientific calculator. This helped the researcher to fully understand the data collected. Frequency tables cross tabulations and numerical descriptions were prepared to show the relationship between variables.

CHAPTER FOUR

4.0 DATA ANALYSIS AND PRESENTATION OF FINDINGS

4.1 DATA ANALYSIS

Data analysis is the systematic organization and synthesis of research data, and testing of research hypothesis using those data (Polit and Hungler, 1995). The methods used in analysis of data were varied. The data master sheet was partitioned into three categories. These were demographic data, knowledge and practice of the family in prevention of relapses in patients with schizophrenia. The categories for knowledge and practice were further graded to allow for categorization into very good, good and poor for knowledge and good and bad for practice.

4.2 PRESENTATION OF FINDINGS

The results have been presented in frequency tables and were cross tabulated. It was suitable to use tables because they summarize results in a meaningful way enabling the reader to understand the author's intentions in the study. Cross tabulations are helpful as they show the relationship among variables from which one can draw meaningful inferences.

Responses from open ended questions were categorized and suitable terms used to bring all related data together for better presentation.

SECTION 2

Table 2: DEMOGRAPHIC DATA TABLE

Distribution of Respondents (n=50)

VARIABLE	FREQUENCY	RELATIVE FREQUENCY (%)
SEX		

Male	21	42
Female	29	58
TOTAL	50	100
AGE IN YEARS		
20-29	7	14
30-39	10	20
40-49	13	26
50-59	15	30
60-69	5	10
TOTAL	50	100
MARITAL STATUS		
Single	7	14
Married	33	66
Separated	0	0
Divorced	3	6
Widowed	7	14
TOTAL	50	100
RELIGIOUS AFFILIATION OF RESPONDENTS		
Roman Catholic Church	11	22
Reformed Church of	5	10
United Church of Zambia	5	8
Pentecostal church	11	24
Seventh Day Adventist	8	16
New Apostolic Church	2	4
Jehovah's Witness	7	14
Others (Moslem)	1	2
TOTAL	50	100
EDUCATIONAL LEVEL		
Never been to school	5	10
Primary	11	22
Secondary	23	46

College	11	22
TOTAL	50	100
OCCUPATION/EMPLOYMENT STATUS OF RESPONDENT		
Formally employed	10	20
Self employed	21	42
None	19	38
TOTAL	50	100
FAMILY INCOME ENOUGH FOR RESPONDENTS		
Yes	15	30
No	35	70
TOTAL	50	100
SUPPORT FOR CARE OF THE FAMILY		
Children	09	25.7
Siblings	08	22.9
None	18	51.4
TOTAL	35	100
RESPONDENTS TRIBE		
Nyanja	14	28
Lozi	5	10
Bemba	13	26
Tonga	7	14
Luvale	2	4
Kaonde	7	14
Rwandies	1	2
TOTAL	50	100
NUMBER OF FAMILY MEMBERS		
1-4	7	14
5-8	28	56
9-12	15	30
TOTAL	50	100

The demographic data shows that the majority 29 (54%) of the respondents were female and the majority 15 (30%) age range was between 50 to 59 years old.

The majority 33 (66%) of the respondents were married and most 49 (98%) of them were Christians except one (2%) who was a Moslem.

The highest level of education that the majority respondents 23 (46%) have attained is secondary education and the majority 21 (42%) of the respondents are self employed. The majority 35 (70%) of the respondents stated that there finances were not adequate to support their families and out of this 35 (70%), the majority 18 (51.4%) did not get any support from other family members. The majority 14 (28%) of the respondents were Nyanjas. The majority 28 (56%) of the respondents had their families ranging from 5 to 8.

SECTION B: KNOWLEDGE DATA

Table 3: RESPONDENTS RELATIONSHIP TO THE PATIENT (n=50)

Relationship with patient	Frequency	Relative frequency
Grand parent	3	6
Parent	10	20
Spouse	5	10
Uncle/Auntie	3	6
Children	24	48
Sibling	5	10
Total	50	100

The majority 24 (48%) of the respondents were parent who caring for their children.

Table 4: RESPONDENTS' KNOWLEDGE ON CONDITION OF PATIENT (n=50)

Knowledge of the condition	Frequency	Relative frequency
Do not know	47	94
Knows	3	6
Total	50	100

The table shows that most 47 (94%) of the respondents did not know the actual illness that their patient was suffering from.

Table 5: NUMBER OF ADMISSIONS (n=50)

Number of admissions	Frequency	Relative frequency
One	3	6
Two	9	18
Three	5	10
Four	7	14
Five	9	18
More than five	17	34
TOTAL	50	100

The table shows that the majority 17 (34%) of the respondents had more than five (5) admissions.

Table 6: RESPONDENTS' KNOWLEDGE OF REASON LEADING TO RELAPSES (n=50)

Reasons leading to relapses	Frequency	Relative frequency
Yes	22	44
No	28	56
TOTAL	50	100

The majority 28 (56%) of the respondents did not know the reasons that led to their patients relapsing.

Table 7: REASON LEADING TO RELAPSES (n=22)

Reasons leading to relapses	Frequency	Relative Frequency
Correct	20	90.9
Not correct	2	9.1
TOTAL	22	100

The table shows that the majority 20 (90.9%) of the respondent who stated that they knew the reasons that leads to their patients relapsing mentioned the correct reasons.

Table 8: FAMILY'S KNOWLEDGE OF PREVENTION OF RELAPSES (n=50)

Family knowledge of prevention of relapses	Frequency	Relative Frequency (%)
Knows	36	72
Do not know	14	28
TOTAL	50	100

The table above shows that the majority 36 (72%) of the respondents knew how to prevent their patients from relapsing, while 23 (46%) of the respondents did not know.

Table 9: REJECTION FROM FAMILY MEMBERS (n=50)

Rejection from members of the family	Frequency	Relative Frequency (%)
Yes	17	34
No	33	66
TOTAL	50	100

Out of 50 respondents, 33 (66%) of them do not have members of the family who reject their clients because of their illness while 17 (34%) have some family members who reject the clients.

Table 10: FAMILY MEMBERS COPING WITH THE CONDITION (n=50)

Family members coping	Frequency	Relative Frequency (%)
Yes	33	66
No	17	34
TOTAL	50	100

Out of 50 respondents, the majority 33 (66%) of them were coping with their patients' condition, while 17 (34%) did not.

Table 11: REASONS FOR NOT COPING WITH THE CONDITION (n=17)

Reasons for not coping	Frequency	Relative Frequency (%)
Violent and restless behavior	7	76.5
Lack of finances	1	5.9
Chronicity of condition	2	11.7
Inadequate family support	1	5.9
TOTAL	17	100

The table shows that out of the 17 (34%) of the respondents who did not cope with the condition, the majority 7 (76.5) of the respondents said they did not cope because they were not able to manage violent and restless behavior.

Table 12: RESPONDENTS' KNOWLEDGE ON WHAT TREATMENT(S) PATIENT IS ON AND IT'S ADMINISTRATION (n=50)

Knows patient's treatment and administration	Frequency	Relative Frequency (%)
Yes	34	68
No	16	32
TOTAL	50	100

The above table shows that the majority 34 (68%) of the respondents knew the treatment their patients were on and how to administer it while 16 (32%) of the respondents did not know.

Table 13: MONITORING OF TREATMENT IF RESPONSE IS NO (n=16)

Monitoring of treatment	Frequency	Relative Frequency (%)
Another family member	3	18.8
Follows instructions	11	68.7
Patient	2	12.5
TOTAL	16	100

The table shows that out of the 16 (32%) of the respondents did not know the treatment that their patients were on and how to administer it, 11 (68.7%) monitored patients in taking of drugs through following instructions, 3 (18.8%) had another member of the family monitoring taking of drugs and 2 (12.5%) had their patients monitoring their own taking of medication.

Table 14: AVAILABILITY OF DRUGS (n=50)

Availability of drugs	Frequency	Relative Frequency (%)
Yes	28	56
No	22	44
TOTAL	50	100

The table shows that the majority 28 (56%) of the respondents had drugs readily available while 22 (44%) of the respondents stated that the drugs were not readily available.

**Table 15: SUPPLY OF DRUGS WHEN NOT AVAILABLE AT THE HOSPITAL
(n=22)**

Supply of drugs	Frequency	Relative Frequency (%)
Buy the drugs	18	81.8
Stay without drug	4	18.2
TOTAL	22	100

This table shows that out of the 22 (44%) of the respondents whose patients drugs were not readily available, the majority 18 (81.8%) of the respondents purchase the drugs whenever they are out of stock at the hospital and 4 (18.2%) stay without drugs.

Table 16: RESPONDENTS LEVEL OF KNOWLEDGE

Level of knowledge	Frequency	Relative Frequency (%)
Poor (0 to 3 points)	4	8
Good (4 to 7 points)	38	76
Very good (8 to 10 points)	8	16
TOTAL	50	100

The table shows that the majority 38 (76%) of the respondents had good knowledge on patient care.

SECTION C: PRACTICE DATA

Table 17: ABILITY TO CARE FOR THE PATIENT AT HOME

Ability to care for patient at home	Frequency	Relative Frequency (%)
Yes	36	72
No	14	28
TOTAL	50	100

The table above shows that the majority 36 (72%) of the respondents were able to provide home care while 14 (28%) of the respondents were not able to provide home care.

Table 18: REASONS FOR NOT BEING ABLE TO CARE FOR PATIENT AT HOME (n=14)

Reasons for not being able to care	Frequency	Relative Frequency (%)
Not educated on the care	5	35.7
Inadequate skill to manage violent and restless behavior	9	64.3
TOTAL	14	100

This table shows that out of the 14 (28%) of the respondents who were not able to provide home care, 9 (64.3%) were not able to provide care because they had inadequate skill to manage violent and restless behavior while 5 (35.7%) were not taught by the health provider on how to provide home care.

Table 19: TYPE OF CARE GIVEN BY THOSE ABLE TO CARE FOR THE PATIENTS AT HOME (n=36)

Type of care given	Frequency	Relative Frequency (%)
Providing safety	6	16.7
Providing activities of daily living	25	69.4
Monitoring medication	21	58.3
Committing to the lord	2	5.5
Providing love	5	13.9
Involving patient in activities	2	5.5
Follow up	2	5.5

N.B: Multiple responses

This table shows that the majority 25 (69.4) of the respondents stated that they provided activities of daily living to their patients.

Table 20: PREFERENCE OF CARE (n=50)

Preference of care	Frequency	Relative Frequency (%)
Hospital care	7	14
Home care	23	46
Depends on patient's condition	20	40
TOTAL	50	100

The table above shows that 23 (46%) of the respondents prefer home care, 20 (40%) stated that it depends on the patient's condition and 7 (14%) prefer hospital care.

Table 21: ADVANTAGES OF HOSPITAL CARE (n=50)

Advantages of hospital care	Frequency	Relative Frequency (%)
Adequate medication	23	46
Specialized care	27	54
Restricted movement	18	36

N.B: Multiple answers

This table shows that the 27 (54%) of the respondents stated that one of the advantages of hospital care is that patients receive specialized care, 23 (46%) of the respondents stated that patients are given medication accordingly and 18 (36%) of the respondents stated that patients' movements are restricted.

Table 22: ADVANTAGES OF HOME CARE (n=50)

Advantages of home care	Frequency	Relative Frequency (%)
Individualised care	23	46
Provision of activities of daily living	7	14
Provision of love and support	8	16
Spiritual care	3	6
Familiar environment	7	14
Reducing transport expenses	6	12

N.B: Multiple answers

The table above shows that the majority 23 (46%) of the respondents stated that one of the advantages of home care is that individualised care is provided to the patients.

**Table 23: PROVISION OF INFORMATION AND SKILL REGARDING
PATIENT CARE (n=50)**

Provision of information and skill	Frequency	Relative Frequency (%)
Yes	24	48
No	26	52
TOTAL	50	100

This table shows that 26 (52%) of the respondents were not provided with information and skills regarding caring for the patients, while 24 (48%) of the respondents stated that they were provided with knowledge and skill regarding patient care.

Table 24: HOW SKILLS PROVIDED HELP IN PATIENT CARE (n=24)

Skills provided help in patient care	Frequency	Relative Frequency (%)
Drug administration	12	50
Provision of love	7	29.2
Handling patient	5	20.8
TOTAL	24	100

The table above shows that the majority 12 (50%) of the respondents stated that the information and skill provided helped them in administering client's medication.

Table 25: IS CHAINAMA THE NEAREST CLINIC (n=50)

Is Chainama the nearest clinic	Frequency	Relative Frequency (%)
Yes	4	8
No	46	92
TOTAL	50	100

The table above shows that Chainama Hospital is not the nearest clinic to the where majority 46 (92%) of the respondents live. Only 4 (8%) of the respondents stated that Chainama Hospital was their nearest health facility.

Table 26: RESPONDENTS ANSWER IS NO, REASONS FOR ATTENDING REVIEWS AT CHAINAMA (n=46)

Reasons for attending reviews at Chainama	Frequency	Relative Frequency (%)
Lack of psychotropic drugs in other clinics	28	60.9
Not been referred	18	39.1
TOTAL	46	100

This table shows that the majority 28 (60.9%) of the respondents stated that the reasons why they attended reviews at Chainama hospital was that the clinics near to where they live did not stock psychotropic drug while 18 (39.1%) stated that they had not been referred to their nearest clinics.

Table 27: MANAGE COMING FOR REVIEWS WHENEVER DUE (n =50)

Manage coming for reviews	Frequency	Relative Frequency (%)
Yes	33	66
No	17	34
TOTAL	50	100

The table shows that the majority 33 (66%) of the respondents managed to bringing their patients for review whenever they are due.

Table 28: REASONS FOR NOT ATTENDING REVIEWS (n=17)

Reason for not attending reviews	Frequency	Relative Frequency (%)
Lack of transport money	12	70.6
Patient stabilized	2	17.6
Go to the nearest clinic	3	11.8
TOTAL	17	100

This table shows that the majority 12 (70.6%) of the respondents who failed to bring their patients for review lacked transport money.

Table 29: RESPONDENTS HAVE CULTURAL BELIEFS ASSOCIATED TO PATIENT'S ILLNESS (n=50)

Respondent have cultural beliefs	Frequency	Relative Frequency (%)
Yes	19	38
No	31	62
TOTAL	50	100

This table shows that the majority 31 (62%) of the respondents did not have cultural beliefs associated with their patients' illnesses while 19 (38%) of the respondents believed that there are cultural beliefs associated to their patients' illnesses.

Table 30: RESPONDENT’S BELIEFS ASSOCIATED WITH THE ILLNESS (n=19)

Beliefs associated with the illness	Frequency	Relative Frequency (%)
Demon possessed	8	42.1
Bewitched	11	57.9
TOTAL	19	100

The table shows that the majority 11 (57.9%) of the respondents believed that their patient have been bewitched while 8 (42.1%) believe that their patients were demon possessed.

Table 31: WAYS IN WHICH CULTURAL AND RELIGIOUS BELIEFS AFFECT THE CARE (n=19)

Cultural beliefs affecting the care	Frequency	Relative Frequency (%)
Traditional healers	6	31.5
Prayer	3	15.9
Does not affect	10	52.6
TOTAL	19	100

This table shows that the majority 10 (52.6%) of the respondents stated that the cultural beliefs did not affect the care that they provided to their patients. Those whose care was affected by cultural beliefs took their patients to traditional healer 6 (31.5%) and 3 (15.9%) took their patients for prayers.

Table 32: AVAILABILITY OF REHABILITATION FACILITIES FOR PATIENTS (n=50)

Availability of rehabilitation facilities	Frequency	Relative Frequency (%)
Yes	0	0
No	50	100
TOTAL	50	100

The table shows that all (100%) communities did not have rehabilitation facilities in the communities where they live.

Table 33: AVAILABILITY OF COMMUNITY SUPPORT GROUPS OFFERING SUPPORT TO PATIENTS (n=50)

Availability of community support groups	Frequency	Relative Frequency (%)
Yes	0	0
No	50	100
TOTAL	50	100

The above table shows that (100) of the carers stated that there were no community support group for the mentally ill.

Table 34: RESPONDENTS LEVEL OF PRACTICE

Level of practice	Frequency	Relative Frequency (%)
Bad (0 to 5 points)	17	34
Good (6 to 10 points)	33	66
TOTAL	50	100

The table shows that the majority 33 (66%) of the respondents had good practice

CROSS TABULATION

Table 35: LEVEL OF KNOWLEDGE IN RELATION TO SEX

Level of knowledge	Sex		Total
	Male	Female	
Poor	2 (9.5%)	2 (6.9%)	4 (8%)
Good	17 (81%)	21 (72.4%)	38 (76%)
Very good	2 (9.5%)	6 (20.7%)	8 (16%)
TOTAL	21 (42%)	29 (58%)	50 (100%)

The table shows that the majority 17 (81%) of male respondents and 21 (72.4%) of females had good of knowledge.

Table 36: LEVEL OF KNOWLEDGE IN RELATION TO AGE

Level of knowledge	Age					TOTAL
	20-29	30-39	40-49	50-59	60-69	
Poor	1 (20%)	1 (10%)	0 (0%)	2 (13.3%)	0 (0%)	4 (8%)
Good	3 (60%)	8 (80%)	12 (2.3%)	11 (73.3%)	3 (60%)	37 (74%)
Very	3 (60%)	1 (10%)	1 (7.7%)	2 (13.3%)	2 (40%)	9 (18%)
TOTAL	5 (10%)	10 (20%)	13 (26%)	15 (30%)	5 (10%)	50 (100%)

The table shows that the majority 8 (80%) of the respondents aged between 30 and 39 had good knowledge and 3 (60%) of those age between 20 and 29 had very good knowledge.

Table 37: LEVEL OF KNOWLEDGE IN RELATION TO MARITAL STATUS

Level of knowledge	Marital status				TOTAL
	Single	Married	Divorced	Widowed	
Poor	1 (14.3%)	4 (12.1%)	0 (0%)	0 (0%)	5 (10%)
Good	4 (57.1%)	25 (75.8%)	3 (100%)	6 (85.7%)	38 (76%)
Very good	2 (28.6%)	4 (12.1%)	0 (0%)	1 (14.3%)	7 (14%)
TOTAL	7 (14%)	33 (66%)	3 (6%)	7 (14%)	50 (100%)

The table shows that 1 (14.3%) of the single respondents had poor knowledge, 3 (100%) of the divorced respondents had good knowledge and 33 (66%) of the married respondents had very good knowledge.

Table 38: LEVEL OF KNOWLEDGE IN RELATION TO RELIGIOUS

Level of knowledge	Occupation				TOTAL
	Catholics	Protestants	Pentecostals	Moslem	
Poor	1 (9.1%)	3 (11.1%)	0 (0%)	0 (0%)	5 (10%)
Good	8 (72.7%)	21 (77.8%)	8 (72.7%)	1 (100%)	37 (74%)
Very good	2 (18.2%)	3 (11.1%)	3 (27.3%)	0 (0%)	8 (16%)
TOTAL	11 (22%)	27 (42%)	11 (22%)	1 (2%)	50 (100%)

The table shows that the majority 3 (27.3%) of the Pentecostals had very good knowledge.

Table 39: LEVEL OF KNOWLEDGE IN RELATION TO EDUCATIONAL LEVEL

Level of knowledge	Educational level				TOTAL
	None	Primary	Secondary	College	
Poor	0 (0%)	2 (18.2%)	2 (8.7%)	0 (0%)	4 (8%)
Good	5 (100%)	8 (72.7%)	18 (78.3%)	6 (54.5%)	37 (74%)
Very good	0 (0%)	1 (9.1%)	3 (13%)	5 (45.5%)	9 (18%)
TOTAL	5 (10%)	11 (22%)	23 (46%)	11 (22%)	50 (100%)

The table shows that 5 (45.5%) of the respondents whose highest level of education was college had very good knowledge while 2 (18.2%) of the respondents whose highest level of education is primary education had poor knowledge.

Table 40: LEVEL OF KNOWLEDGE IN RELATION TO OCCUPATION

Level of knowledge	Occupation			TOTAL
	Formally employed	Self employed	None	
Poor	1 (10%)	3 (14.3%)	1 (5.3%)	5 (10%)
Good	6 (60%)	16 (76.2%)	15 (78.9%)	37 (74%)
Very good	3 (30%)	2 (9.5%)	3 (15.8%)	8 (16%)
TOTAL	10 (20%)	21 (42%)	19 (38%)	50 (100%)

The table shows that majority 3 (14.3%) of the respondents who were self employed had poor knowledge, 15 (78.9%) of those who were not employed had good knowledge and 3 (30%) of those who were formally employed had very good knowledge.

Table 41: LEVEL OF KNOWLEDGE IN RELATION TO FAMILY INCOME

Level of knowledge	Adequacy of family income		TOTAL
	Yes	No	
Poor	1 (6.7%)	3 (8.6%)	4 (8%)
Good	9 (60%)	28 (80%)	37 (74%)
Very good	5 (33.3%)	4 (11.4%)	9 (18%)
TOTAL	15 (30%)	35 (70%)	50 (100%)

The table shows that the majority 28 (80%) of the respondents with inadequate family income had good knowledge while 5 (30%) of those with adequate income had very good knowledge.

Table 42: LEVEL OF KNOWLEDGE IN RELATION TO WHO SUPPORTS THE CARE (n=35)

Level of knowledge	Family support			TOTAL
	Children	Siblings	None	
Poor	0 (0%)	2 (25%)	1 (5.6%)	3 (8.6%)
Good	7 (77.8%)	6 (75%)	15 (83.3%)	28 (80%)
Very good	2 (22.2%)	0 (0%)	2 (11.1%)	4 (11.4%)
TOTAL	9 (27.7%)	8 (22.9%)	18 (51.4%)	35 (100%)

The table shows that the majority 15 (83.3%) of the respondents with inadequate family income and not supported by any other member of the family had good knowledge while the respondents 2 (22.2%) supported by their children had very good knowledge.

Table 43: LEVEL OF KNOWLEDGE IN RELATION TO NUMBER OF FAMILY MEMBERS (n=50)

Level of knowledge	Number of family members			TOTAL
	1 -4	5 -8	9 – 12	
Poor	0 (0%)	2 (7.2%)	2 (13.3%)	4 (8%)
Good	7 (100%)	20 (71.4%)	10 (66.7%)	37 (74%)
Very good	0 (0%)	6 (21.4%)	3 (20%)	9 (18%)
TOTAL	7 (14%)	28 (56%)	15 (30%)	50 (100%)

The table shows that the majority 2 (13.3%) respondents with family members ranging between 9 and 12 had poor knowledge while 6 (21.4%) of family members ranging between 5 and 8 had very good knowledge.

Table 44: PRACTICE IN RELATION TO SEX (n=50)

Practice	Sex		TOTAL
	Male	Female	
Bad	7(33.3%)	11 (37.9%)	19 (38%)
Good	14 (66.7%)	18 (62.1%)	31 (62%)
TOTAL	21 (42%)	29 (54%)	50 (100%)

The table shows that the majority 14 (66.7%) of the males had good practices of patient care.

Table 45: PRACTICE IN RELATION TO AGE (n=50)

Practice	Age					TOTAL
	20 – 29	30 -39	40 – 49	50 – 59	60 – 69	
Bad	1 14.3%)	3 (30%)	5 38.5%)	6 (40%)	1 (20%)	15(30%)
Good	6 85.7%)	7 (70%)	8 61.5%)	9 (60%)	4 (80%)	35 (70%)
TOTAL	7 (14%)	10 (20%)	3 (26%)	15 (30%)	5 (10%)	50 100%)

The table shows that the majority 6 (85.7%) of the respondents aged between 20 and 29 had good practices of patient care.

Table 46: PRACTICE IN RELATION TO MARITAL STATUS (n=50)

Practice	Marital status				TOTAL
	Single	Married	Divorced	Widowed	
Bad)	2 (28.4%)	14 (42.4%)	1 (33.3%)	2 (28.6%)	19 (38%)
Good	5 (71.6%)	19 (57.6%)	2 (66.7%)	5 (71.4%)	31 (62%)
TOTAL	7 (14%)	33 (66%)	3 (6%)	7 (14%)	50 (100%)

The table show s that the majority 14 (42.4%) of the respondents who were married had bad practices of patient care while 5 (71.6%) of those who were single had good practice.

Table 47: PRACTICE IN RELATION TO RELIGIOUS AFFLIATION (n=50)

Level of knowledge	Occupation				TOTAL
	Catholics	Protestants	Pentecostals	Moslem	
Bad	3 (27.3%)	6 (32.3%)	2 (18.2%)	0 (0%)	5 (10%)
Good	8 (72.7%)	21 (67.7%)	9 (81.8%)	1 (100%)	28 (74%)
TOTAL	11 (22%)	27 (54%)	11 (22%)	1 (2%)	50 (100%)

The table shows that the majority 1 (100%) of the respondents who are moslem had good practices of patient care.

Table 48: PRACTICE IN RELATION TO EDUCATIONAL LEVEL (n=50)

Practice	Education level				TOTAL
	None	Primary	Secondary	College	
Bad	1 (20%)	2 (18.2%)	4 (17.4%)	1 (9.1%)	6 (12%)
Good	4 (80%)	9 (81.8%)	19 (82.6%)	10 (90.9%)	31 (62%)
TOTAL	5 (10%)	11 (22%)	23 (46%)	11 (22%)	50 (100%)

The table shows that the 1 (20%) of the respondents who have never been to school had bad practices of patient care while 10 (90.9%) of those who attained college education very good practices.

Table 49: PRACTICE IN RELATION TO OCCUPATION (n=50)

Practice	Occupation			TOTAL
	Formally employed	Self employed	None	
Bad	1 (10%)	3 (15.8%)	3 (15.9%)	8 (16%)
Good	9 (90%)	18 (84.2%)	16 (84.1%)	42 (84%)
TOTAL	10 (20%)	21 (42%)	19 (38%)	50 (100%)

The table shows that the majority 9 (90%) of the respondents who were formally employed had good practices.

Table 50: PRACTICE IN RELATION TO FAMILY INCOME (n=50)

Practice	Adequacy of family income		TOTAL
	Yes	No	
Bad	2 (13.3%)	7 (20%)	9 (18%)
Good	13 (86.7%)	28 (80%)	41 (82%)
TOTAL	15 (30%)	35 (70%)	50 (100%)

The table shows that the majority 13 (86.7%) of the respondents with adequate income had good practices of patient care while 7 (20%) of the respondents with inadequate income had bad practices.

Table 51: PRACTICE IN RELATION TO WHO SUPPORTS THE CARE OF THE FAMILY (n=35)

Practice	Family support			TOTAL
	Children	Siblings	None	
Bad	0 (0%)	3 (37.5%)	5 (27.8%)	8 (22.8%)
Good	9 (100%)	5 (62.5%)	13 (72.2%)	27 (77.2%)
TOTAL	9 (18%)	8 (16%)	18 (36%)	35 (100%)

The table shows that the majority 9 (100%) of families with inadequate income and are being support by their children had good practices of patient care.

Table 52: PRACTICE IN RELATION TO NUMBER OF FAMILY MEMBERS (n=50)

Practice	Number of family members			TOTAL
	1 – 4	5 -8	9 -12	
Bad	2 (28.6%)	7 (25%)	4 (26.6%)	13 (26%)
Good	5 (71.4%)	21 (75%)	11 (73.4%)	37 (74%)
TOTAL	7 (14%)	28 (54%)	15 (30%)	50 (100%)

The table shows that the majority 2 (28.6%) of the respondents whose members of the family range from 1 to 4 had bad practices and 21 (75%) of those between the range of 5 and 8 had good practices.

Table 53: KNOWLEDGE and PRACTICE

Scores	Knowledge and Practice	
	Knowledge	Practice
0-4	4 (8%)	5 (25%)
5-7	38 (76%)	33 (66%)
8-10	8 (16%)	12 (24%)
TOTAL	50 (100%)	50 (100%)

The table shows that the majority 12 (24%) of the respondents had good practice than knowledge of patient.

CHAPTER FIVE

5.0 DISCUSSION OF THE FINDINGS AND IMPLICATION FOR THE HEALTH CARE SYSTEM

5.1 INTRODUCTION

The results of the study were based on the analysis of the responses from a sample of fifty (50) families caring for patients with schizophrenia in their homes. The study determined the knowledge and practice of families in the prevention of relapses in patients with schizophrenia.

5.2 CHARACTERISTICS OF THE SAMPLE

5.2.1 DEMOGRAPHIC DATA

Sex: The majority of the respondents (58%) were females while (42%) were males. These results are in line with the 2002-2003 Demographic and Health Survey which shows that there more females (51%) than males (49%) (CSO, 2003). The other reason could have been that females are naturally carers of the sick according to their traditional roles. This is also in agreement with Sorensen and Luckmann report (1986) that stated that "Nursing has traditionally been a women's occupation". On the other hand, the results could show majority of women as a result of the harsh situation prevailing in the country which force men to go out working or looking for money while women stay at home caring for the families.

However, the difference between the males and the females isn't very wide. This could be due to the new approach to care where males are taking more responsibility to patient care. Men are also more involved in caring for the violent patients as they need to be restricted in their activities.

Age: The results revealed that majority (30%) of the respondents were aged between 50-59 years. This finding probably may be due to the fact that respondents in this age group may be out of employment and most of the times at home.

Hence, they have more time of nursing their children or their spouses or on the other hand their parents as they have no other busy tasks to do at home.

Marital status: The majority (66%) of the respondents were married while (6%) were widowed. The findings could be due to the fact that in the Zambian context, marriage is considered to be a universally acceptable norm and women view marriage as a social security or supportive environment due to their social vulnerability.

Religion: Majority of the respondents (22%) were Christians from the Roman Catholic Church and (22%) from the Pentecostal churches. Only (2%) of the respondent was none Christian which was Moslem. The finding could be due to the fact that Zambia is predominantly a Christian Nation which was declared by the second republican president, Dr F.T.J. Chiluba in December, 1994. Religious groupings generally do advocate for good values, morals and are involved in caring for the needy in society which means church could influence its members to be carers of the sick.

Educational level: The majority (46%) of the respondents have attained secondary school education. The findings could be due to the fact that the study was carried out in the urban setting where most people appreciate the importance of education. High educational level may make it easier for the sick relatives to understand the information and have knowledge on how to go about caring for their discharged relatives since they can follow instruction.

Occupational status: The majority (42%) of the respondents were self employed and only (20%) were in formal employment. Those doing nothing were (38%).

The findings could be due to the fact that the self employed and those doing nothing are the ones who are left with the responsibility of caring for the sick because they do not need to get permission from anyone in order for them to stay at home and attend to their patients and they are always at home respectively. Those in formal employment need to get permission from their working places in order to escort their patients for reviews or stay home and care for their sick relatives which is not an easy thing to do.

Family income: The majority of the respondents (70%) indicated that they did not get enough income to support and take care of the family and their sick relatives while (30%) get enough income. Out of the (70%) of those who did not have enough income, (25.7%) were helped by their children, (22.9%) were helped by their siblings and (51.4%) were not helped by any one. The observation could be due to the fact that the majority of the respondents were not in formal employment due to the unemployment situation that is prevailing in Zambia and delays in giving retirement packages which increases the poverty levels. According to the Human Development Report, 64% of the population is living in absolute poverty (less than US\$1 per day) and 73% is living under the national poverty line (UNDP, 2005). Those who are self employed do not earn much to support their families and sick relative and those doing nothing depend on hand outs. The findings also show that people get most of the help from the nuclear family

Tribe: Most (28%) of the respondents was Nyanjas and there was a variety of other tribes from all provinces of Zambia. The observation could be that the study was carried out in Lusaka which is the urban setting and it is represented by all tribes. There was only one non Zambian, a refugee from Rwanda and does not stay in a refugee camp but stays in Kanyama compound.

This finding shows that there are a lot of illegal immigrants in Zambia who are not under the custody of United Nations High Commissioner for Refugees (UNHCR).

Number of family members: The majority (56%) of the respondents had their family size ranging from 5 to 8 followed by (30%) that ranged from 9 to 12. The observation is that the families are large and this could be attributed to the fact that traditionally, Zambian families tends to be large coupled by the extended family practice.

5.2.2: KNOWLEDGE DATA

The study revealed that majority (48%) of the respondents were parents looking after their offspring (mother-child relationship). These findings could be due to the fact that parents had to take care of their children as one of their parental roles and that parents can meet most of their children's needs adequately. The observation could also be due to that a lot of families are shifting from extended families to nuclear families.

The study also shows that the majority (94%) of the respondents did not know the actual condition that their relative were suffering from and 56% did not know the reasons that led to their patients' relapsing. These findings could be due to the reason that the health care providers do not explain the patients' conditions to the relatives and its part of our socialization not to finding out the information of the sick from the care givers. The study further revealed that the majority (72%) of the respondents knew how to prevent their patients from relapsing, (66%) did not reject/stigmatize their patients, (66%) were coping with their patients' conditions and (68%) of the respondents knew the treatment that their patients are taking. This could be attributed to the fact that people are now alert and aware of sicknesses commonly occurring.

There is increased family involvement in the care of patients which the health care system world wide emphasizes in the care of the mentally ill (Berkow, 1997) and increased Information, Education and Communication (IEC) being done by the media on signs and symptoms of diseases, how to diagnose or investigations usually carried out and what type of treatment options available. Roller et al (1986) state that family members need to be incorporated in the care because the family environment significantly influences health outcome.

The majority (66%) of the respondents were able to cope with their patients' condition because they felt it was their responsibility to care for the patients as a family. The majority (76.5%) of those who did not cope with their patients' condition stated that they were unable to cope with violence and restless behaviors portrayed by their patients because they did not know how to manage these behaviors and this leads to patients being stigmatized.

Despite the majority (66%) of the respondents not stigmatizing their patients, (44%) of the respondents still stigmatize their patients revealing that stigmatization is still rampant. 'Stigma is internalized, and contributes to the debilitating process of becoming a "mental patient" thus increasing the potential for relapses' (Deegan 1990).

The majority (68.7%) of those who did not know the treatment which their patients were taking just followed instruction given at the hospital when administering drugs and (18.8%) had the patient taking drugs on their own. This finding could be due to inadequate knowledge as a result of low education and therefore, relatives tend to have problems with assimilation of information during health talk given to them and may be unable to read and write.

For those patients who are not monitored in taking medication, this may be a source of relapses because the patient can stop taking medication as he/she may feel that they are no longer ill when the symptoms subside or they may be skipping some of the dosages.

The study shows that the majority (56%) of the respondents had drugs readily available whenever they came for reviews and among those whose drugs were not readily available, (81.8%) purchase their drugs and (18.2%) go without drugs. The variation in availability of drugs could be due to differences in drugs that the patients are taking. Some drugs are always available while some are not. Families who do not purchase their patients drugs when they are not available at the hospital increase the chances of their patients relapsing. Medications, such as chlorpromazine and haloperidol, relieve "positive" symptoms (hallucinations and delusions) they have a limited effect on important and common "negative symptoms" (apathy and social withdrawal) and "affective" symptoms (depression and anxiety associated with schizophrenia) (Nursing times, 2003:28).

5.2.3 DEMOGRAPHIC DATA IN RELATION TO KNOWLEDGE

The study reveals that the majority (81%) of the male respondents had good knowledge towards caring while (20.7%) of the female respondents had very good knowledge towards caring. This can be attributed to the fact that women always have been seen to be in the forefront in taking care of the sick and this leads them to be experienced. Dolan et al (1983) states that "caring for the sick emerged at the inception of the history of humanity and when everyone was unwell, family members especially the women used to take care of the sick in the homes".

The study also revealed that the majority 8 (80%) of the respondents aged between 30 and 39 had good knowledge and 3 (60%) of those aged between 20 and 29 had very good knowledge.

These findings could be due to the fact that the people in these age groups are still young and energetic hence they are eager to learn. The literate levels in these age groups may also be high leading to them understanding the importance of providing care to their sick relative.

The study also revealed that (45.5%) of the respondents whose highest level of education was college had very good knowledge while (18.2%) of the respondents whose highest level of education is primary education had poor knowledge. The findings could be due to the fact that the level of education influences the individual's understanding of the information given on how to go about caring for their discharged relatives since they can follow instruction. Therefore, we fail to reject the null hypothesis that states "the level of knowledge of the family on the condition, treatment and prognosis influences the care given to their relative at home."

In the study, the majority (14.3%) of the respondents who were self employed had poor knowledge, (78.9%) of those who were not employed had good knowledge and 3 (30%) of those who were formally employed had very good knowledge. These findings could also be influenced by the individual's understanding of the information given on how to go about caring for their discharged patients since they can follow instruction based on their level of education. Those who are not in employment had good knowledge because they are not involved and attached to any kind of work and hence tend to participate more in providing care and by so doing, they gain experience.

The study revealed that the majority (8.6%) of the respondents with inadequate income had poor knowledge while (33.3%) of the respondents with adequate income had very good knowledge. In the study, respondents with low family income had low level of knowledge.

This could be attributed to the fact that family members in this category may have low education background hence it is difficult for them to understand and learn about how to look after the sick. The other reason could be the unavailability of resources for providing care to the patient. As a result, family members may not be able to render the required care actively due to inadequate resources hence they lack experience and knowledge on how to provide care. The study also showed that the majority 15 (83.3%) of the respondents with inadequate family income and not supported by any other member of the family had good knowledge while the respondents (22.2%) supported by their children had very good knowledge. This finding shows that family support improves the quality of care that the family offers to the patients. According to William et al (1995), family psychoeducation and clinical reports on Multiple Family Groups (MFGs) have reported substantial reductions in relapse rates for patients with schizophrenia. These groups offer an expanded social network and thereby may confer a margin of protection against relapse.

The study also revealed that the most (21.4%) of family members consisting of 5-8 had very good knowledge in the provision of health care while (13.3%) of family members consisting of 9-12 had good knowledge. This could be attributed to the fact that an average family unit is able to share responsibilities and knowledge without much difficulties than a large family with members of diverse behavior and characters which are difficult to contain.

5.2.4: PRACTICE DATA

The study revealed that the majority (72%) of the respondents were able to provide home care. The study also shows that the majority of those who were able to care for the patients provided activities of daily living (69.4%) and monitored medication (58.3%).

The findings of the study could be attributed to the fact that mentally ill patient are incorporated in the family environment as soon as their conditions stabilizes in order to avoid institutionalization and hence this move has made the families to have improved skill in caring for the sick and the family environment significantly influences health outcome. Berkow et al (1997) states that "With the deinstitutionalization movement, greater emphasis has been placed on viewing mentally ill people as members of the families and communities".

Despite all respondents providing care at home, not all were able to offer adequate care. The reason was that they were not taught on how to provide care and had inadequate skill on how to manage violence and restlessness. Therefore nurses should have a responsibility of explaining the condition, treatment and management of the patient to every family member who gets involved in patient care. Dyk (1995) states that for family members to participate effectively in patient care, nurses must keep in mind their important roles of educating and counseling through which they can impart their knowledge on the patient and family members.

The study further shows that the majority (46%) of the respondents prefer home care while (40%) stated that the care that the patient should receive depends on the state in which the patient is in. These findings could be due to the fact that home care is preferred to hospital care because hospital care is expensive in terms of transport expenses required for patient visitations in the hospital and provision of activities of daily living like food. Home care is also preferred because patient are nursed in a supportive and familiar environment that support quick recovery and families are now aware that they have a right to be incorporated in the care of their patients and feel honored when they are allowed to do so.

In the study, the majority (52%) of the respondents were not provided with information and skills regarding caring for the patients and half (50%) of those respondents who were provided with information and skill regarding patient care stated that the information and skill helped them in drug administration. The study shows that to some extent, the health care providers offer information and skills regarding caring for the patients to the patients' families and these skills have helped in improving the care given by the families and hence reducing on relapses.

The study also revealed that the majority (92%) of the patients who attends reviews at Chainama Hospital live in communities that are more than 12 km from Chainama and (66%) stated that they manage coming for reviews each time they are due. These findings could be due to the fact that Chainama Hospital is a referral hospital for the mentally ill and patients are referred back their for further management. The majority (60.9%) of the respondents stated that they attend reviews at Chainama Hospital because the clinics next to where they stay do not stock psychotropic drugs. These clinics may not even have specialized staff to attend to mental patients. The findings could also be due to the fact that the family members feel obliged to continue bringing their patients for reviews as it is their responsibility to offer support and provide for the patient in order to prevent relapses which creates more costs. The majority (70.6%) of those who do not manage to come for reviews stated that they are constrained by lack of transport money. This shows that long distance hinders accessibility to health facilities.

Other respondents (17.6%) stated that they do not bring their patients for reviews because they had stabilised and this can be attributed to inadequate knowledge about the condition and the importance of follow up and continuity of care.

The study shows that the majority (62%) of the respondents did not have cultural and religious beliefs associated to their patients' illnesses and those respondents with beliefs stated that their patients were bewitched (57.9%) and (42.1%) stated that their patients were demon possessed. These findings shows that there are cultural and religious beliefs associated to schizophrenia such as witchcraft and demon possession. These beliefs influences the type of care provided to the sick relative in that those who believe that their patients have been bewitched took their patients to traditional healers and in the process, the patients may be made to stop taking drug leading to relapses. Those who believe that their relatives are demon possessed took their patient to religious organisations for prayers and may also be made to stop taking drugs hoping that they will be healed by prayer and this also leads to relapses. Therefore, we fail to reject the null hypothesis which states that "Cultural and religious beliefs influence the type of care that is provided to the sick relatives".

The study shows that there are no rehabilitation facilities and community support groups offering support to the mentally ill patients in their communities. This shows that the only institution offering rehabilitation facilities in Lusaka urban is Chainama Hospital which focusses its services mostly on in-patients. There are various support group such as the Mental Health Association of Zambia (MHAZ), the Foundation for Community Action (FOCA) and Mental Health Users Network of Zambia (MHUNZA), hence the study reveals that there is inadequate sensitization of availability of these facilities. Therefore, many patients and their relatives do not know much about them and the services that they offer.

5.1.5 DEMOGRAPHIC DATA IN RELATION TO PRACTICE

The study shows that the majority (66.7%) of the males had good practices of patient care.

This finding could be due to the nature of schizophrenic patients of becoming violent and need to be restrained and men take a leading role in doing that and hence they gain the skill. The other reason could be that the new approach to patient care where males are taking a more active role in patient care has seen more males being involved in patient care leading to improved skill in patient care. The study also shows that the majority (85.7%) of the respondents aged between 20 and 29 had good practices of patient care.

The finding could be due to that the nature of mentally ill patients involves restraining them when they become violent and this age group can easily do that as they are still young and energetic and hence improving their skill in patient care.

The study further shows that the majority (42.4%) of the respondents who were married had bad practices of patient care while (71.6%) of those who were single had good practice. The finding may be due to that the single are not committed to any spouse and hence are free and called upon by family members to care for sick.

The study shows that the majority (90.9%) of the respondent who attained college education had good practices of patient care while (20%) of respondents who have never been to school had bad practices. The study reveals also that (90%) of the respondents who were formally employed had good practice of patient care. These findings show that educational level influences the assimilation of information and skill taught to the relatives.

The study also shows that the majority 13 (86.7%) of the respondents with adequate income had good practices of patient care while 7 (20%) of the respondents with inadequate income had bad practices. These findings show that the resources that the family has influences the type care given.

Those with adequate income can afford to provide for their patients' requirement like follow up care, purchasing drugs and providing for activities of daily living. Therefore, the study accepts the null hypothesis which states that "Socio-economic status of the family affects the type of care provided to a sick relative".

The study also shows that respondents with inadequate income and not supported by any member of the family had good practice of patient care. This could be due to the fact that they have no one else to turn to hence they feel they have a responsibility to do their best in caring for the patient. The study also revealed that the majority and (75%) of family members consisting of 5-8 had good practice in the provision of health care. This could be attributed to the fact that an average family unit is able to share responsibilities without much difficulties than a large family with members of diverse behavior and characters which are difficult to contain.

5.3 IMPLICATIONS TO THE HEALTHCARE SYSTEM

The provision of care to patients with Schizophrenia falls onto the healthcare system. Caring for the Schizophrenic patients clearly represent one of the most dramatic challenges to the public health system in Zambia. The management of patients with Schizophrenia requires the involvement of both the community and the health care providers. In a Zambian health care system, there is an urgent need to expand the knowledge, skill and involvement of the families in the care of Schizophrenic patients.

The study results revealed that the majority of the families with schizophrenic patients had good knowledge and skills in caring for their patients. This means that the majority of patients receive adequate care needed. Despite the majority having good knowledge, those with poor knowledge contribute to relapses and readmissions, hence increasing the burden on the health care system.

Therefore, the health care providers should intensify giving of Information, Education and Information (IEC) to families and the community as a whole, on the condition, care of the patient and the importance of continuity of taking medication and follow up. The Ministry of Health in collaboration with the various community support groups should work hand in hand in the dissemination of information to the public on the care of patients with schizophrenia. When families acquire high levels of knowledge and skill on management of patients with schizophrenia, they would provide adequate care needed to their patients, thus improving patient outcomes in care and treatment adherence.

Despite other respondents having poor knowledge and skills in caring for their patients, there are others who have very good knowledge and skills. This can be attributed to the education levels of individuals that determine the assimilation of information taught by health care providers.

The other reasons could be that incorporation of the mentally ill patient in the family environment as soon as their conditions stabilizes as a way of reducing institutionalization has led to families having improved knowledge and skills in caring for the schizophrenic patients. This is because family environment plays a very significant influence on the health outcome

The study also revealed that the entire Lusaka Urban has no rehabilitation facilities where patients can relearn the lost skills so that they can be integrated well in the community. Because of this, patients do not recover fully as they are not able to work, shop, care for themselves, manage a household and get along with others. Patient who undergo rehabilitation and supported by the community may take long to relapse than those who do not undergo rehabilitation and lack community support activities.

The Ministry of Health should consider opening up more rehabilitation centers where patients can be referred to on discharge for continuity of training in self-help skills. This would improve accessibility to the services as patients would go to the training and rehabilitation centres next to their homes.

The health centres in Lusaka urban district do not provide psychiatric services. The beefing up of specialized psychiatric health care providers such as the Registered Mental Health Nurses and Clinical Officer Psychiatry is on course, therefore, there is need to open up psychiatric services in all Clinics in Lusaka Urban and even the country as a whole. This will improve accessibility to psychiatric facilities because the vision of the MoH of "taking health facilities as close to the family as possible" will be fulfilled and relapses will be minimised.

5.4 CONCLUSION

The study was carried out to determine the knowledge and practice of the family in prevention of relapses in patients with schizophrenia in Lusaka urban. Its purpose was to highlight the prevailing situation and some of the factors that affect the knowledge and practice of the families in providing care and support to patients with schizophrenia after discharge so as to encourage family support system and avoid institutionalization of patient.

The study results revealed that the majority of the families with schizophrenic patients had good knowledge and skills in caring for their patients. More still needs to be done in order to increase the knowledge and skills of the families in caring for patients at home such as intensifying IEC on the condition, care of the patient and the importance of continuity of taking medication and follow up.

The healthcare delivery system advocates for continuity of care in the communities hence, there is need to collaboration with the community support groups in the dissemination of information to the public on the care of patients with schizophrenia and provision of economic and social support to both the patients and their relatives.

There is also need to consider opening up rehabilitation centers where patients can be referred to on discharge for continuity of training in self-help skills so that they can be integrated well in the community.

5.5 RECOMMENDATIONS

5.5.1 The Ministry of Health

a) Collaborating with support groups

The Ministry of Health in collaboration with the various community support groups should work hand in hand in the dissemination of information to the public on the care of patients with schizophrenia.

b) Rehabilitation facilities

The Ministry of Health should consider opening up more rehabilitation centers where patients can be referred to on discharge for continuity of training in self-help skills so that they can be integrated well in the community.

c) Introduction of psychiatric services in clinics

The Ministry of Health should consider opening up psychiatric services in all Clinics in Lusaka Urban and even the country as a whole since beefing up of specialized psychiatric health care providers like the Registered Mental Health Nurses and Clinical Officer Psychiatry is on course.

5.4.2 Chainama Hospital

a) Intensifying I.E.C programmes

The health care providers should intensify giving of Information, Education and Information (IEC) to families and the community as a whole, on the condition, care of the patient and the importance of continuity of taking medication and follow up

b) Referring patients and relatives to the support groups

Discharged patients and their relatives should be referred to the support groups such as the Mental Health Association of Zambia (MHAZ), the foundation for community action (FOCA) and Mental Health Users Network of Zambia (MHUNZA) that provide support such as economic and social

support to both the patients and their relatives, home based care programmes, rehabilitation of patients through skills training and establishing income generating activities.

c) Home visiting

Nurses should be provided with the logistics such as transport so that they start conducting home visiting activities which enable them identify the problems that the family and the patient are facing in relation to the patient's condition and finding ways of solving them.

5.6 DISSEMINATION OF FINDINGS

The findings of this study will be disseminated through sending a copy of the research report to Chainama Hills Hospital management and the Nursing Services Department to help the institution implement measures that will promote families of schizophrenia patients to have adequate knowledge and practice towards prevention of relapses in patients with schizophrenia. A meeting will be arranged with the management for presentation of findings at the end of the project. Bound copies will be submitted to Post Basic Nursing (PBN) and the Medical Library of the School of Medicine at UNZA, my sponsors the Ministry of Health and the investigator.

5.7 LIMITATIONS OF THE STUDY

It was not possible to conduct the study on a large scale with a large sample size due to limited time in which the study was to be completed and submitted to the University of Zambia. The funds were also not enough for a large scale with a large sample size study to be conducted. Therefore, the findings cannot be generalized to a larger population.

REFERENCES

1. Anthony, W., Cohen, M., & Farkas, M. (1990). Psychiatric rehabilitation. Boston: Center for Psychiatric Rehabilitation, Boston University.
2. CBoH.<http://www.org/html/zambia-s-healthsystem.html>
3. Central Statistical Office (2000), Living conditions monitoring survey, Lusaka, Zambia.
4. Central Statistical Office (2001-2002), Zambia Demographic Health survey, Lusaka, Zambia
5. Chindi, E. M (1997) A study to determine the knowledge, attitude and practice of community towards Home Based Care Services for HIV/AIDS Patients in Kitwe urban District, UNZA, Lusaka, Zambia
6. Deegan, P. E. (1990). How Recovery Begins. Presented at the Eighth Annual Education Conference of the Alliance for the Mentally Ill of New York State, Binghamton, New York.
7. Dempsey, P.A and Dempsey, A.D. (2000) Using Nursing Research, Lippincott, New York. USA
8. Dolan, etal (1983) Nursing in Society, A Historical Perspective W.B. Saunders Company, Toronto.
9. Dyk, V.A (1995) From curing to caring, Nursing news Volume 19, number8, page 18, Canada.
10. Freeman. M, Lee. T, Vivian W. (2000) Evaluation of mental health services in the Orange Free State. Parktown, South Africa: Centre for Health Policy, Department of Community Health, Wits Medical School, Orange Free State.
11. <http://archpsyc.ama-assn.org/cgi/content/full/60/9/904>
12. <http://www.blackwell-synergy.com/doi/ref/10.1111/j.1545-5300.1995.00127.x>
13. Kane, J.M Pharmacologic Treatment of Schizophrenia, Biol Psychiatry, 1999;46:1396-1408

14. Mowbray, C. T. et al (1997). Consumers as Providers in Psychiatric Rehabilitation. Columbia, MD: International Association of Psychosocial Rehabilitation Services.
15. New challenges in family interventions for schizophrenia. *Expert Review of Neurotherapeutics* 7:1, 33
16. Polit, D. F. and Hungler, B. P. (1996), Essentials of Nursing Research, Lippincott, Philadelphia
17. Polit, D.F. and Hungler, B.P. (2001), Essentials of Nursing Research, Lippincott, Philadelphia
18. Polit, D.F. and Hungler, B.P. (1997), Using of Nursing Research, Lippincott, Philadelphia
19. Potter, et al (1989) Fundamental of Nursing Concepts process and Practice Mosby Company, Toronto.
20. Rawlings PR et al (1993) – A holistic life cycle approach, 3rd edition, Mosby, St. Louis .
21. Reidy, D. (1994). The Mental Health System as Agent of Stigma Resources 6(3), 310.
22. Treece, E.W and Treece J.W (1986) Elements of Nursing Research Mosby Company, St Louis.
23. United Nations Development Programme (UNDP 2005), Human Development Report 2005. New York, New York: United Nations Development Programme.
24. Uys L. and Middleton. L, (1997), Mental Health Nursing - A South African Perspective, Third Edition, Juta and Company Ltd, Cape Town.
25. William et al (1995) Family process Blackwell synergy pubMed, Colombia 34 (2), 127
26. W.H.O. <http://www.int/schizophrenia/repo/9609>

THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE
DEPARTMENT OF POST BASIC NURSING
STRUCTURED INTERVIEW SCHEDULE FOR PATIENT'S RELATIVES

**TOPIC: A STUDY TO DETERMINE THE KNOWLEDGE AND PRACTICE OF
THE FAMILY IN PREVENTION OF RELAPSES IN PATIENTS WITH
SCHIZOPHRENIA**

INTERVIEW DATE

PLACE OF INTERVIEW.....

NAME OF INTERVIEWER.....

SERIAL NUMBER.....

INSTRUCTION TO INTERVIEWER

1. Introduce yourself to the respondent.
2. Explain the purpose of the interview
3. Assure respondent of confidentiality and anonymity
4. Obtain verbal consent from the respondent before the interview.
5. Tick against the box corresponding to the correct answer or state responses in the space provided
6. Thank the respondent at the end of the interview.

SECTION A: DEMOGRAPHIC DATA

FOR
OFFICIAL
USE

1. What is your sex?

a. Male

☐

b. Female

☐☐

2. What was your age on your last birthday?

☐

3. What is your marital status?

a. Single

☐

b. Married

☐

c. Separation

☐

d. Divorced

☐

e. Widowed

☐☐

4. Which religious denomination do you belong to?

a. Roman Catholic Church

☐

b. Reformed Church

☐

c. United Church of Zambia

☐

d. Pentecostal Church

☐

e. Seventh Day Adventist

☐

f. New Apostolic Church

☐

g. Jehovah's Witnesses

☐

h. Others (specify).....

☐

5. What is your highest educational level?

a. Never been to school

☐

b. Primary

☐

c. Secondary

☐

d. College

☐☐

e. University ☐

6. What do you do for your living?

a. Formally employed ☐

b. Self employed ☐

c. None ☐

d. Others (specify).....

7. Are your finances adequate to support your family?

a. No ☐

b. Yes ☐

8. If no, who supports you for the care of the family?

.....
.....

9. What tribe are you?

a. Ngoni ☐

b. Lozi ☐

c. Bemba ☐

d. Tonga ☐

e. Others (specify) ☐

10. How many are you in your family?

a. 1 - 4 ☐

b. 5 - 8 ☐

c. 9 - 12 ☐

SECTION B: KNOWLEDGE

11. How are you related to the patient?

- a. Mother ☐
- b. Father ☐
- c. Grand parent ☐
- d. Auntie ☐
- e. Uncle ☐
- f. Others (specify) ☐

☐

12. What is your patient suffering from?

☐

13. How many admissions has your client had?

- a. One ☐
- b. Two ☐
- c. Three ☐
- d. Four ☐
- e. Five ☐
- f. Others (specify) ☐

☐

14. Do you know the reasons that lead to patient relapsing?

- a. Yes ☐
- b. No ☐

☐

15. If yes, give reason why you think your patient relapses

☐

16. As a family, do you know what can be done to prevent relapses of the illness?

.....
.....
.....

☐

17. Does any member of the family reject the patient?

a. Yes

b. No

☐☐☐

18. Give reasons to your answer

.....
.....

☐

19. Is the family able to cope with condition?

a. Yes

b. No

☐☐☐

20. If the answer to question 19 is no, give reasons why you are not able to cope with condition?

.....
.....
.....

☐

21. Do you know the drugs that the client is taking and how to administer them?

a. Yes

b. No

☐☐☐

22. If the answer to question 21 is no, who monitors the patient in taking of drugs?

☐

.....

23. Are the drugs readily available?

- a. Yes ☐
- b. No ☐

☐

24. If the answer to question 23 is no, where do you get the supply of drugs?

☐

.....

SECTION C: PRACTICE

25. Are you able to care for the patient whilst at home?

- a. Yes ☐
- b. No ☐

☐

26. If no, give reasons why you are not able to care for your patient?

☐

.....
.....
.....

27. If yes, list the type of care you give to your patient.

.....
.....
.....

☐

28. What type of care do you prefer?

- a. Hospital care ☐
- b. Home care ☐
- c. Others' specify.....

☐

29. What are the advantages of hospital care?

.....
.....
.....

☐

30. What are the advantages of home care?

.....
.....
.....

☐

31. Do the health care providers provide you with
information and skills regarding caring for your patient?

- a. Yes ☐
- b. No ☐

☐

32. If your answer to question 34 is yes, how do the information and skills
help you in caring for your patient?

.....
.....
.....

☐

33. Is Chainama Hospital your nearest clinic?

☐

34. Explain your answer to question 30

.....

☐

.....
.....

35. Do you manage to come for reviews every time the client is due for a review?

- | | | |
|--------|--------------------------|--------------------------|
| a. Yes | <input type="checkbox"/> | <input type="checkbox"/> |
| b. No | <input type="checkbox"/> | |

36. If the answer to question 37 is no, what prevents you from coming for reviews?

.....	<input type="checkbox"/>
-------------------------	--------------------------

37. Do you have any cultural beliefs related to the client's illness?

- | | | |
|--------|--------------------------|--------------------------|
| a. Yes | <input type="checkbox"/> | <input type="checkbox"/> |
| b. No | <input type="checkbox"/> | |

38. If the answer to question 39 is yes, what are the beliefs?

.....	<input type="checkbox"/>
-------------------------	--------------------------

39. How do these cultural beliefs affect the care that you give to the patient?

.....	<input type="checkbox"/>
-------------------------	--------------------------

40. Are there any rehabilitation facilities where you take the patient to learn some skills?

a. Yes

b. No

☐☐

41. If the answer to question 42 is yes, what skills has he/she learned?

.....

.....

☐

42. Are there any community groups that offer support to patients with schizophrenia in your area?

a. Yes

☐

b. No

☐☐

43. If the answer to question 44 is yes, what services do they offer?

.....

.....

.....

☐

END OF INTERVIEW
THANK YOU VERY MUCH

APPENDIX II

WORK SCHEDULE

TASK TO BE PERFORMED	WEEKS	DATES	PERSONNEL ASSIGNED TO TASK	PERSONAL DAYS REQUIRED
Literature review	Continuous		Principal Investigator	Continuous
Finalizing research proposal	Week 1-13	1 st May to 31 st July 2007	Principal Investigator	92
Clearance from ethics committee	Week 14 – 15	1 st Aug to 19 th Aug. 2007	Principal Investigator	19
Formulation of Data collection tool	Week 12- 13	16 th to 27 th July 2007	Principal Investigator	11
Field testing the research tool	Week 18	27 th Aug – 2 nd Sept, 2007	Principal Investigator	7
Data collection	Week 13 – 17	3 rd Sept. to 30 th Sept. 2007	Principal Investigator	28
Data analysis	Week 18 – 22	1 st Oct. to 10 th Nov. 2007	Principal Investigator	41
Report writing and submission	Week 23 – 27	11 th Nov. to 31 st Dec. 2007	Principal Investigator	52
Dissemination of findings		2 nd Jan – 25 th Jan, 2008	Principal Investigator	24
Monitoring and Evaluation	Continuous by the Researcher			

APPENDIX III

GANTT CHART

	TASKS TO BE PERFORMED	RESPONSIBLE PERSON	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
1.	Finalizing research proposal	Principal investigator										
2.	Literature review	Principal investigator										
3.	Clearance from National/Funding authority	Principal investigator										
4.	Pilot study	Principal investigator										
5.	Data collection	Principal investigator										
6.	Data analysis	Principal investigator										
7.	Report writing and submission	Principal investigator										
9.	Dissemination	Principal investigator										
10.	Monitoring and evaluation	Principal investigator										
11.	Submission of report	Principal investigator										

APPENDIX IV

BUDGET FOR THE RESEARCH STUDY

	ITEM	UNIT COST		TOTAL	
		K	N	K	N
1	Field work and travel expenses				
a.	Lunch allowance for the researcher and research assistants	30,000 per day x 10 days		300,000.00	
b.	Transport allowance for the researcher and research assistants	20,000 per day x 10 days		200,000.00	
	Subtotal			500,000.00	
2.	Secretarial services				
a.	Typing and editing of the study	3,000 per page x 200 pages		600,000.00	
b.	Photocopying of report	200.00 per page x 100 pages		20,000.00	
	Sub total			620,000.00	
3.	Stationery				
a.	Pens	500.00 per pen x 5		2,500.00	
b.	Pencils	500.00 per pencil x 5		2,500.00	
c.	Eraser	1 box of eraser at 10.000		10,000.00	
d.	Ream of paper	30,000 per ream x 3 reams		90,000.00	
e.	Staples	10,000 per box x 1 box		10,000.00	
f.	Stapler	10,000 x 1 stapler		15,000.00	
g.	Scientific calculator	85,000 per calculator x 1		85,000.00	
h.	Flip chart	40,000 per chart x 1		40,000.00	
i.	Ruler	5,000 per ruler x 1 ruler		5,000.00	
j.	Rubber	2,000 per rubber x 2 rubbers		4,000.00	
	Binding of research proposal	10,000 per proposal x 2 proposals		20,000.00	
	Binding of reports	35,000 per report x 4 reports		140,000.00	
	Sub total			424,000.00	
4.	Dissemination workshop	2,000,000.00		2,000,000.00	
	Sub total			2,000,000.00	
5.	Contingent funds (10% of the total budget)	3,544,000		354,400.00	
	GRAND TOTAL			3,898,400.00	

BUDGET JUSTIFICATION

Stationery

The researcher needed stationary such as ream of paper for writing and typing, photocopying the interview schedule, research proposal and the report. Pens and pencils used for writing data, collection and analyzing data, rubber and tipex for erasing mistakes, flip chart for analyzing data. The stapler and staples were for putting the work in an orderly manner and the scientific calculator for analysing data, folders and clips for filing research documents.

Secretarial Services

Finances were required for secretarial services such as typing, photocopying and binding the research proposal and the final report. The interview schedule needed to be photocopied after being typed.

Dissemination workshop

Dissemination of research findings is one of the major requirements of research. The researcher is mandated to disseminate findings to the community where the study was conducted as well as to other interested stakeholders. In this study, dissemination workshops will be held for Chainama Hills Hospital management where doctors, nurses, clinical officers and some of the research participants will be communicated to about the research findings and the recommendations.

10% contingency of total budget

The 10% contingency is to cater for any rise in the prices during the course of the research.

University of Zambia
School of Medicine
Department of Post Basic Nursing
P.O Box 50110
Lusaka
27th July, 2007

The Executive Director,
Chainama Hills Hospital,
P.O Box 30043,
Lusaka.

UFS: The Head of Department
School of Medicine
Department of Post Basic Nursing
P.O Box 50110
Lusaka

Dear sir/madam,

RE: PERMISSION TO UNDERTAKE RESEARCH STUDY

I am a fourth year (4th) student at the above institution pursuing the Bachelor of Science in Nursing. I am expected to carry out a research study as part of the requirements for the fulfillment of the degree in nursing.

This letter serves to request permission from you to undertake a study at your hospital on knowledge and practices of the families towards prevention of relapses in patients with schizophrenia. Data collection will commence on 27th August, 2007 to 28th September, 2007.

Your assistance will be greatly appreciated

Yours faithfully


Clara. M. Kwaleyela

University of Zambia
School of Medicine
Department of Post Basic Nursing
P.O Box 50110
Lusaka

12th August, 2007

Executive Director,
Kilimanjaro Hospital,
30043,

The Head of Department
School of Medicine
Department of Post Basic Nursing
P.O Box 50110
Lusaka

Madam,

MISSION TO UNDERTAKE RESEARCH STUDY

I am a fourth year (4th) student at the above institution pursuing the Bachelor of Science in Nursing. I am expected to carry out a research study as part of the requirements for the completion of the degree in nursing.

I hereby request permission from you to undertake a study at your hospital on the knowledge and practices of the families towards prevention of relapses in patients with schizophrenia. Data collection will commence on 30th September, 2007 to 29th October,

Your assistance will be greatly appreciated.

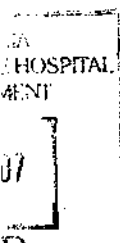
Faithfully

epk

A. Kwaleyela

N.S.M

Kindly facilitate
[Signature]



30-8-07

Received & Voted

[Signature]

[Signature]

University of Zambia
School of Medicine
Department of Post Basic Nursing
P.O Box 50110
Lusaka

12th August, 2007

The Executive Director,
Chainama Hills Hospital,
P.O Box 30043,
Lusaka.

UFS: The Head of Department
School of Medicine
Department of Post Basic Nursing
P.O Box 50110
Lusaka

Dear sir/madam,

RE: PERMISSION TO UNDERTAKE RESEARCH STUDY

I am a fourth year (4th) student at the above institution pursuing the Bachelor of Science in Nursing. I am expected to carry out a research study as part of the requirements for the fulfillment of the degree in nursing.

This letter serves to request permission from you to undertake a study at your hospital on knowledge and practices of the families towards prevention of relapses in patients with schizophrenia. Data collection will commence on 30th September, 2007 to 29th October, 2007.

Your assistance will be greatly appreciated.

Yours faithfully

Clara M. Kwaleyela

Clara. M. Kwaleyela

N.S.M

Kindly facilitate

[Signature]

TOP CHAINAMA
COLLEGE HOSPITAL
MANAGEMENT

16 2007

30-8-07

Received & noted

[Signature]

[Signature]

University of Zambia
School of Medicine
Department of Post Basic Nursing
P.O. Box 20110
Lusaka

12th September 2007

The Executive Director,
Chinama Hills Hospital,
P.O. Box 30043,
Lusaka.

cc-S: The Head of Department
School of Medicine
Department of Post Basic Nursing
P.O. Box 50110
Lusaka

Dear sir/madam,

RE: PERMISSION TO UNDERTAKE RESEARCH STUDY

I am a fourth year (4th) student at the above institution pursuing the Bachelor of Science in Nursing. I am expected to carry out a research study as part of the requirements for the fulfillment of the degree in nursing.

This letter serves to request permission from you to undertake a study at your hospital on knowledge and practices of the families towards prevention of relapses in patients with schizophrenia. Data collection will commence on 30th September, 2007 to 29th October, 2007.

Your assistance will be greatly appreciated.

Yours faithfully

Clara M. Kwaleyela

Clara. M. Kwaleyela

N. S. M

Kindly facilitate

[Signature]

UNIVERSITY OF ZAMBIA
COLLEGE HOSPITAL
MANAGEMENT

AK 2007

RECEIVED

30-8-07

Received & Voted

[Signature]

[Signature]

*Property of UNZA Library



3 3729 00481 9251