Mental Health Services at the Primary Health Care Level in Three States in Northern Nigeria

By

ANYEBE, Emmanuel Ejembi
PhD/SOC-SCI/16647/2011-2012

A PhD Thesis Submitted to School of Postgraduate Studies
Ahmadu Bello University, Zaria

In Partial Fulfillment of the requirements for the award of the
Doctor of Philosophy (PhD) in Sociology

Department of Sociology, Faculty of Social Sciences
Ahmadu Bello University, Zaria-Nigeria

September 2016

DECLARATION

I declare that the work reported in this thesis entitled ***Mental Health Services at the Primary Health Care Level in three States in Northern Nigeria*** was carried out by me in the Department of Sociology,Ahmadu Bello University, Zaria, and under the supervision of Dr. J.M. Hellandendu, Dr. J.E. Gyong and Dr. V.O. Olisah. The works of other investigators and authors have been duly acknowledged by means of references.

I declare also that this work has not been submitted elsewhere for a degree.

Emmanuel Ejembi ANYEBE _____
PhD/SOC-SCI/16647/2011-2012 **Sign/Date**

CERTIFICATION

This dissertation entitled ***Mental Health Services at the Primary Health Care Level in three States in Northern Nigeria*** meets the regulations governing the award of Doctor of Philosophy (PhD) in Sociology of Ahmadu Bello University, Zaria, and is approved for its contribution to knowledge and literary presentation.

_____ _____

Dr. J.M. Hellandendu **Date**
Associate Professor
Chairman, Supervisory Committee
Department of Sociology, Faculty of Social Sciences
Ahmadu Bello University, Zaria

_____ _____

Dr. J.E. Gyong **Date**
Associate Professor
Member, Supervisory Committee
Department of Sociology, Faculty of Social Sciences
Ahmadu Bello University, Zaria

_____ _____

Dr. V.O. Olisah **Date**
Member, Supervisory Committee
Department of Psychiatry, Faculty of Medicine
Ahmadu Bello University, Zaria

_____ _____

Dr. Y.K. Gandu **Date**
Associate Professor
Head of Department
Department of Sociology, Faculty of Social Sciences
Ahmadu Bello University, Zaria

_____ _____

Prof. Kabir Bala **Date**
Dean, School of Postgraduate Studies
Ahmadu Bello University, Zaria

DEDICATION

I dedicate this work to my late mother, Mrs. Maria Igba Anyebe (nee Ochigbo), who wished to see me educated to the highest level attainable but could not live to see this happen, and to late father, who never saw me grow up.

I also dedicate this work to my wife, Kate, and my children: Eneh, Edache, Enuwa, Epuhe and Enenche, much of whose time I have ‘stolen’ to do this work.

ACKNOWLEDGEMENTS

This study could not have been what it is if the Almighty God did not approve it; I am grateful to Him for the wisdom and opportunity He granted me to undertake this course. I am immensely grateful also to my supervisors, Dr. Joseph M. Hellandendu, Dr. Emmanuel J. Gyong, and Dr. Victor O. Olisah for making this study attain its current literary standard. I sincerely thank them for the painstaking period of protracted 'disturbances' and intrusions into their tight schedules. They have also endowed me with the desire to continue to investigate social phenomena in my environment. I remain forever grateful *Messrs.*

I thank all other lecturers in the Department of Sociology, Ahmadu Bello University Zaria who have contributed to my scholarly exploits in the social sciences, all past and present Heads of department and my teachers are highly appreciated for their contributions, to mention just but Prof. Okeshola, Prof. S.A. Nkom,Dr.S. Maliki, and the current Head of Department, Dr. Y.K. Gandu. I also thank Mr. Hussaini, Mr. Abel Agada in the Head of Department's office and Mrs Ajibola, and Mal. Rufai for their time and patience with me. They were never tired of my messages to my supervisors and answering our never-ending questions. The otherdepartmental staff in the general office, I thank you all.

Many people have contributed to my fieldwork and data processing. I thank my colleague and standby, Nurse Hadiza Lawal of ABU Teaching Hospital Zaria, who was my field partner throughout the period of data collection and management, and typing parts of the manuscripts. Under the sun, rain, bad roads and days of going hungry, she was with me. She was my note-taker, photographer and oftentimes encourager. God bless you. I thank 'my twin' brother, Mal Kassim Adamu, and Mal Idris as well as Mr. P.S. Wachihi and my sister Ms Felicia. Philip of ABU School of Nursing Zaria for their support and encouragement, entering all the villages and communities in Kaduna State for data collection.

I also thank Mrs. Cecilia Oduh, the Provost ofDr John Adah School of Health Technology Otukpo, for all her assistance and for coordinating the ten most outstanding students of her school to function as my research assistants. I equally thank these students for the wonderful job they did. They

were great in grasping the lectures on what they needed to do on the field and they did that very well. Similarly, I thank Pauline, the Principal Benue State School of Nursing, Makurdi for releasing her students to help in the community survey.I equally thank the students for a job well done. I also thank the staff and some students of Community Health Officers' Training ABUTH Zaria for assisting in the data collection as well especially Mal Yahaya Abubakar who coordinated the students, and Mr. Ayuba, a lecturer of the Gombe State College of Health Technology Kaltungo for the useful information and for the maps of theState and the LGAs. I thank all my informants, traditional rulers and other community leaders for their cooperation and time. I am indebted to the Executive Secretaries of SPHCDA in Gombe, Kaduna and Benue States for useful information and links to the PHC coordinators. God bless you sir. I also appreciate all the PHC coordinators in the nine LGAs and the PHC Heads for their cooperation and assistance. The heads of at Kaltungo, Giwa and Kaduna South are particularly appreciated for their express approvals to access all relevant information from their institutions. They also granted me interviews. The contributions of the facilitators made this research worthwhile. I am grateful to you all.

I thank my family immensely for their moral and physical supports throughout the period of this study especially my wife, AdaKate, and my children, Eneh, Edache, Enuwa, Epuche and Enenche as well as Faith. My appreciation also goes to the following people who have assisted at different stages of data analysis: Mr. John of IAR, ABU Zaria and Mike who processed the data on computer.Many of my 'ogas' and friends have stood by me all through the period of this study, notably are Prof. S.S. Danbauchi, Dr. E.R. Abah, Mr. Y.A. Domi, Dr. S.A. Opaluwa,my brother Mohammed Ibrahim Okeme and Dr. S.N. Garba. I must thank my class mates in the PhD class: Mfuh Anita, Idenyi Ibrahim, Adegboyega Kamorudeen and Madam Simbiat. My appreciation to my people in School of Nursing, Ahmadu Bello University Teaching Hospital, Zaria: Mrs. C.E. Momoh who remained a mother throughout, Hajia S. Ibrahim, Mrs. F. Yamah, and all others who stood by me through thick and thin. There are very many people who have been of immense assistance to me at different stages of this work who space would not allow for mention. May God reward you all!

ABSTRACT

Mental health disorders represent over 14% of global disease burden, and accountfor more than 30% of all years lived with disability (DALYs).Most of these disorders can be prevented or managed at the primary level of health care. Despite this, mental health services (MHS) at the Primary Health Care (PHC)level are grossly neglected in many communities. The level of MHS in States in northern Nigeria is not known. Thisstudy therefore examined the current state of MHS at the PHC level in three States in northern Nigeria, with particular reference to theavailability and acceptability of these services, as well as factors affecting these. This is with a view to suggesting a model for providing these services in the study areas. This exploratory, cross-sectional study adopted the Donabedian Model of Health System analysis (as a variant of Structural-functionalist approach) to explore MHSin Gombe, Kaduna and BenueStates. Two sets of questionnaires and in-depth interviews, focus group discussions, Medical Records, Observations of PHC centres and content analysis of PHC Training Curricula were used to collect data from 794 participants. These werePHC service providers, PHC service users, and community members in 45 PHC centres and their hosting communities,as well as health administrators in the State PHC Agencies,and mental health specialists (such as psychiatrists, psychiatric nurses, and traditional healers in the three States. The data collected were analysed descriptively,using Statistical Package for the Social Sciences(SPSS) Version 20.0, and thematically, for the qualitative data. These were then triangulated to meet the research objectives. Findings revealed thatvirtually all the PHC centres studiedlacked any government-organised MHS.Even mental health information services in form of posters or handbill are absent except in two PHC centres in one of the three States; withPHC service providers being ignorant of the existence of such posters. Two-way referral services of suspected mental disorders are also poor. Despite these scarce MHS in the study areas, there are identified cases of mental health challenges in the study areas, which could be classified as (1) Substance abuse and related disorders; (2) antenatal psychological problems among pregnant women; (3)Suicidal attempts, and (4) “Imported madmen.” (This is a situation in which relatives of mentally sick people take the sick to places where neither the sick nor the relatives are known and abandoned at the motor parks at night; thereafter the mentally sick person becomes a vagrant in the community.) The communities strongly desire MHSbut many obstacles to the provision of MHS at the PHC level were identified. These include policy gaps and lack of political will, which reflected as inadequate and poorly trained PHC staff, lack of mental health specialists or general duty doctor and service area for MHS, lack of funds,and weak data base for mental health disorders. There are also prospective socio-cultural barriers such as negative attitudes towards and incorrect perceptions of mental illness and people living with mental illness (PLWMI) by both health workers and community members. It is concluded that MHS in study areas are very scarce, due largely to government poor policy arrangement and other foreseeable social barriers in form of negative attitudes and stereotypes. However,enormous mental health challenges and high demand for MHS by community members are evident in the communities. Stimulating the government at all levels, and their partners, to initiate or activate policies in favour of MHS to address the burden of mental health problems prevalent in the areas andreorienting and training PHC workers to enable them kick-start MHS in their centres are suggested. A model activating the needed interplay between the three levels of health care, and a functional collaboration between the formal sectors and communities, will provide a template for effective and efficient community-based MHS delivery in the present era of de-institutionalisation.

TABLE OF CONTENTS

Title page …… i

Declaration…. …… ii

Dedication….. ……. …….. iii

Certification……. …… iv

Acknowledgements… …… v

Abstract…….. ……. vii

List of Tables …… xii

List of Figures ……xiii

Acronyms and Abbreviations …….. xiv

Chapter One: Introduction

1.1 Background of the Study - - - - - - - 1

1.1.1 Mental Health Policy and Legislation in Nigeria - - 7

1.2 Statement of the Problem - - - - - - - - 8

1.3 Research Questions - - - - - - - - 10

1.4 Aims and Objectives of the Study- - - - - - - 11

1.5 Justification of the Study - - - - - - - - 11

1.6 Scope of the Study - - - - - - - - 12

Chapter Two: Literature Review

2.0 Introduction - - - - - - - - - 13

2.1 Conceptual clarifications - - - - - - - 13

2.1.1 Primary Health Care - - - - - - - 13

2.1.2 Mental Health Services - - - - - 17

2.1.3 Mental Health, Mental Health Problem and Mental Illness - 19

2.2 Mental Health Services in PHC - - - - - 29
2.2.1 Forms of Mental Health services - - - - 29
2.2.2 Aavailability of MHS - - - - - - 33
2.2.3 Acceptability/Desirability of MHS - - - 39
2.2.4 Burden of Mental Health Problems - - - - 41
2.3 Factors affecting Availability of MHS - - - 44
2.3.1 Policy and Political Barriers - - - - 46
2.3.2 Socio-cultural Barriers- - - - - - 59
2.4 Models of Providing Community-based MHS - - 64
2.5 Theoretical Framework - - - - - - 68
2.5.1 Structural Functionalism - - - - - 68
2.5.1.1 Donabedian Structure-Process-Outcome Model - - 70
2.5.1.2 Limitation of Structural Functionalism - - - 75

Chapter Three: Research Methodology

3.1 Study Location - - - - - - - 76
3.2 Types and Sources of Data- - - - - - - 79
3.3 Method of Data Collection - - - - - - 80
3.4 Population, Sampling, and Sample Selection - - - - 83
3.5 Instruments for Data Collection - - - - - 91
3.6 Techniques of Data Analysis - - - - - - 95
3.7 Ethical Considerations - - - - - - 96
3.8 Methodological Challenges - - - - - - 97

Chapter Four: Current State of Mental Health Services in Study Areas

4.1 Socio-demographic Characteristics of Respondents - - - 100
4.2 Forms and Burden of Community Mental Health Problems - - 104
4.3 Mental Health Services (MHS) in PHC Centres - - - 117
4.3.1 Availability of MHS - - - - - - - 117

4.3.2 Community Desirability for MHS - - - - 126

Chapter Five: Factors Responsible Observed Level of MHS and Suggestions on Improving MHS

5.1 Barriers to Mental Health Services at PHC - - - - 136

5.1.1 Lack of Policy and Political Commitment - - - 136

5.1.2 Socio-cultural Barriers - - - - - 164

5.2 Towards providing functionalMHSat PHC Level: a suggested Model 187

Chapter Six: Summary and Discussion of Findings

6.1 Summary of key findings - - - - - - 199

6.2 Discussion of Findings - - - - - - 205

Chapter Seven: Conclusion and Recommendations

7.1 Conclusion - - - - - - - - 215

7-2 Implication of Findings - - - - - - 218

7.3 Recommendations - - - - - - - 219

7.4 Suggested Areas for further Studies - - - - - 220

Glossary - - - - - - - - - - 221

References - - - - - - - - - 223

Appendices:

Appendix A: Questionnaire for PHC workers - - - - 236

Appendix B: Questionnaire for PHC workers (English and Hausa versions) - 244

Appendix C: IDI Guide for State/LGA Health Administrators - - 262

Appendix D: IDI Guide for Community Leaders (English and Hausa versions) 266

Appendix E: FGD Guide for PHC service users (Patients/clients) - - 269

Appendix F: Checklist for Observation at PHC facilities/PHC centres - 272

Appendix G: Guide for Content of Training Curricula for CHOs/CHEWs - 273

Appendix 1: Copy of ABU/ABUTH Ethical Approval - - - 274

Appendix 2: Letter of Introduction Department of Sociology ABU - - 275

Appendix 3: Copy of Fed Psy Hospital Kaduna Ethical Approval - - 276
Appendix 4: Letter of Introduction Gombe State PHCDA - - - 277
Appendix 5:Letter of Introduction Kaltungo LGA PHC - - - 278
Appendix 6: Letter of Permission to collect Data - - - - 279
Appendix 7: Consent Form for Health Administrators - - - 280
Appendix 8: Consent Form for Community leaders - - - 281
Appendix 9: The only Mental Health posters found in a study area - - 282
Appendix 10: An example of trafficked mentally ill person found - - 283
Appendix 11: The only mental health-related NGO found - - - 284
Appendix 12: The Schema of the Proposed Model for MHS - - - 285
Maps of Nigeria showingthe three study States - - - - 286
Maps of Gombe State showing the three selected LGAs - - - 287
Maps of Kaduna State showing the three selected LGAs - - - 288
Maps of Benue State showing the three selected LGAs - - - 289

LIST OF TABLES

Table 2.1: Mental health, mental health problems and mental illness - - 24

Table 2.2: Global burden of mental illness and budget for mental health - - 51

Table 3.4.1: Samples of States, LGAs and their Populations - - - 87

Table 3.4.2: Community Respondents - - - - - 89

Table 3.5.1: Summary of Selected Respondents/informants - - - 94

Table 4.1.1: Socio-demographic characteristics of Health Workers - - 101

Table 4.1.2:Socio-demographic characteristics of Community Respondents - 102

Table 4.2.1: Perceived Burden of mental health problems by States - - 104

Table 4.2.2: Records of Mental Illness Psy Hospital Kaduna - - 105

Tables 4.2.3: Summary of substances abused in the study areas - - - 111

Table 4.2.4: Summary of Mental Health Challenges in Study Communities - 116

Table 4.3.1: Mental Health Programmes and Sponsors - - - 123

Table 4.3.2: Summary of Available MHS at PHC centres by Location - 114

Table 4.3.3: Community's Preferred Ways of mental health information - 127

Table 4.3.4: Community acceptance of MHS by States - - - 131`

Table 4.3.5: Assessing attitudes of PHC workers and acceptability of MHS - 132

Table 5.1.1: PHC workers' positions at PHC centres - - - - 141

Table 5.1.2: PHC workers' professions and positions at PHC centres - - 141

Table 5.1.3: PHC workers' educational attainment at PHC centres - - 144

Table 5.1.4: PHC workers' responses on need for training - - - 148

Table 5.1.5: Identified NGO/CBO on MHS by States - - - - 158

Table 5.1.6: PHC workers' perceptions about mental illness/PLWMI- - - 165

Table 5.1.7: PHC workers' stereotypes on the mentally ill - - - 166

Table 5.1.8: PHC workers' perception on causes of mental illness - - 167

Table 5.1.9: PHC workers' perception on treatment preferences of mental illness - 168

Table 5.1.10: PHC workers' perception on consequences of non-treatment of MI - 169

Table 5.1.11: Community perception on causes of mental illness by States- - 171

Table 5.1.12: Community perception on treatment of mental illness - - 175

Table 5.1.13: Community attitude towards mentally ill persons - - - 177

Table 5.1.14: Level of acceptance of PLWMI - - - - 179

Table 5.1.15: Health workers perception of PLWMI and mental illness - - 183

Table 5.1.16: WHO/WFMH 10-factor barrier to MHS - - - - 185

Table 5.1.17: Summary of identified Barriers to MHS - - - - 186

Table 5.2.1: Ways of Improving MHS at PHC level - - - 188

Tables 5.2.2: Ways of Eliminating stigma related to Mental illness - - 188

Tables 5.2.3: Other Suggested Ways of Eliminating stigma - - - 189

Table 5.2.4: Ways of Improving Training for PHC workers- - - 191

LIST OF FIGURES

Fig 2.1: Mental health-illness continuum - - - - - 20

Fig.2.2: Ideals of Donabedian Model - - - - - 72

Fig. 4.3.1: Other means of mental health information - - - 128

Fig. 4.3.2: Reasons for desiring MHS in community - - - - 134

Fig. 5.1.1: PHC workers' professional categories - - - - 140

ACRONYMS AND ABBREVIATIONS

AAS	Abuse Assessment Screening (Scale)
ANC	Antenatal care
CBM	Christofoel Blind Mission
CBOs	Community-based Organisations
CBC	Child Behaviour Checklist
CHEWs	Community Health Extension Workers
CHOs	Community Health Officers
CMH	Community Mental Health
CMHS	Community Mental Health Services
CORPS	Community Resource Persons
DALYs	Years lived with disability
DHHS	Department of Health and Human Services
FGD	Focus Group Discussion
FMOH	Federal Ministry of Health
FP	Family Planning
GSPHCDA	Gombe State Primary Health Care Development Agency
HND	Higher National Diploma
HTIs	Health Training Institutions
ICN	International Council of Nurses
IDI	In-depth Interview
ITNs	Insecticide Treated Nets
JCHEWs	Junior Community Health Extension Workers
KDSPHCDA	Kaduna State Primary Health Care Development Agency
LGA	Local Government Area
LGSC	Local Government Service Commission
MCH	Maternal and Child Health

MDAs	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
MHPs	Mental Health Problems
MHA	Mental Health Act
MHS	Mental health services
MI	Mental Illness
MSE	Mental Status (State) Examination
NBTE	National Board for Technical Education
NCE	National Certificate of Education
NDHS	National Demographic and Health Survey
NGO	Non-governmental Organisation
NPHCDA	National Primary Health Care Development Agency
OND	Ordinary National Diploma
OSMH	Orilla Solders' Memorial Hospital
PHC	Primary Health care
PHFN	Public Health Foundation of Nigeria
PNC	Postnatal Care
PLWMI	People living with mental illness
RN	Registered Nurse
RM	Registered Midwife
SCHEWs	Senior Community Health Extension Workers
SURE-P	Subsidy Reinvestment and Empowerment Programme
WHO	World Health Organisation
WFMH	World Federation for Mental Health

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Mental health services (MHS) at the Primary Health Care (PHC) level, also called Community-based Mental Health Services (CMHS), are all the plans, measures and interventions directed towards the promotion of mental health, prevention of mental illnesses, and the non-specialised treatment of some mental illness, including the rehabilitation of people living with mental illness (PLWMI) in non-hospital settings. The services should also include referral of detected mental disorders that cannot be managed at PHC centres to higher levels of care. Mental health services at the PHC therefore focus essentially on promoting the psychological and emotional well-being of all individuals throughout life (WFMH, 2009) as well as on the prevention, early detection and prompt management of mental health problems at all stages of life. The range of mental health problems that fall within the purview of PHC include those psychological, emotional and behavioural problems associated with pregnancy, childbirth, early and late childhood (infancy) through adulthood to old age at the primary care level. This conception justified the inclusion of "promotion of mental health" in the PHC components at its onset (WHO, 1978).

However, the practical integration of MHS into the at the PHC system to promote mental health have been reported to be problematic globally several years after its inclusion in the PHC declaration (World Federation for Mental Health, WFMH, 2009). Probably because of this, mental health problems have continued to increase in the community (Jegede, 2010). More than 450 million individuals around the world live with mental disorders that could have been forestalled by early diagnosis, interventions, treatments and supports through PHC (World Health Report, 2001; 2007). Evidences (Thornicroft and Tansella, 2003; WHO, 2012) show that mental disorders account for between 12% and 15% of the world's total disability, which also accounts for more than 30% of all years lived with disability (DALYs), and for an estimated 14% of the global burden of disease.

Almost three-quarters of which occur in low and middle-income countries, including Nigeria (Malvárez, 2008; WHO, 2010). This contributes significantly to morbidity and mortality (WFMH, 2004;National Coalition for the Homeless [NCH], 2004).

Despite this heavy burden, most mental health patients and clients cannot access treatment and other-related services (WHO, 2009; WHO, 2012), leaving treatment gaps as high as 80 – 90% in the developing countries (WHO, 2001). The few available ones are usually located in the urban areas and inequitably distributed and inefficiently used because these services mainly elitist and concentrated in tertiary-care hospitals (Ityavyar, 1983; FMOH, 1991; Makanjuola, 2015), basically providing only institutionalised care.

This emphasis on institutional care is an aberration from the focus of PHC principles, and this has been reported to have compounded the mental health care situation especially in PHC settings. It is consistently acknowledged that in order to sufficiently address the increasing burden of mental health problems in the community, the need for providing functional MHS at the community level through the PHC system has been advocated (Thornicroft and Tansella, 2003; WHO, 2010; WHO, 2012). However, the current status of MHS at the PHC level in most countries is described as either chaotic or even non-existent (WHO, 2008; WFMH, 2009; Odejide *et al;* 2010).

For this purpose, the World Federation for Mental Health (WFMH) tagged the theme for World Mental Health Day 2009 as *"Mental Health in Primary Care: Enhancing Treatment and Promoting Mental Health,* to draw global attention to the enormity of mental health challenges. The Health Day urged all nations of the world to increase appropriate and equitable mental health services through PHC facilities. As enshrined in the Alma Ata Declaration of 1978 from which emerged the PHC, these aspirations are aimed at making health care services (including mental health care) available, accessible, acceptable, attainable and affordable by individuals in all

communities in the world (WHO, 1978; Abiodun, 1989; WHO, 2007; Asuzu, 2009; WFMH, 2009). At inception of the PHC system in 1978, the main concerns of the PHC were specified as follows:

> …the primary health care should include at least: education concerning prevailing health problems and the method of identifying, preventing, and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water, and basic sanitation; maternal and health care, including family planning; immunisation against the major infectious diseases; appropriate treatment of common diseases and injuries; promotion of mental health; and the provision of essential drugs (WHO/UNICEF, 1978:23-24).

While strategies to achieve many of the other components of the PHC such as immunisation, maternal and child health, treatment of endemic diseases among others have been given various degrees of official attention, developing the strategies for promotion of mental health (services) in the mainstream PHC has either been poorly articulated, ignored completely or even at best, chaotically implemented (World Mental Health Day, 2009; Odejide*et al;* 2010). Thus, it appears that mental health was only mentioned in passing as "promotion of mental health" in the Alma Ata document, after which nothing strategic has been said about it again in all other subsequent PHC operational plans (Atlas: Nurses in Mental Health, 2007; Asuzu, 2009; WFMH, 2009).

It is evident that after the Alma Ata Declaration in 1978, all other subsequent global health initiatives disregarded the promotion of mental health component of PHC. For instance, the Millennium Development Goals (MDGs) Initiative (from 2001 to 2015) as a continuum of "Health for All by the Year 2000" did not mention any specific goal or strategy for the promotion of mental health (WHO, 2000). It was until in 2015 that the promotion of mental health re-emerged in the consciousness of the United Nations. This indicates over four decades of neglect in policy formulation for mental health. Even then, it was only mentioned as one of the goals of non-communicable diseases in the World Health Assembly in designing the *Transforming our world: the 2030 Agenda for Sustainable Development SDGs- the New Agenda* thus:

> By 2030, reduce by one third preventive mortality for non-communicable diseases through prevention and treatment and promote mental health and well-being …..Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohols (UN, 2015: p.16)

Before this realisation, however, the need for effective provision of mental health services to promote mental health at the PHC level, as against psychiatric services, has been strongly advocated for (WHO, 2007; World Mental Health Day, 2009). This strong push for community-based MHS arose from the increasing prevalence of mental health problems in all communities including in Nigeria (Thornicroft and Tansella, 2003; Malvárez, 2008; WHO, 2010). Providing MHS at the PHC level is believed to increase access to the services by people with serious mental health problems and disorders (Harris, Harris and Roland, 2004).These services should necessarily be geared primarily towards promoting mental health and preventing mental disorders in the population. These types of MHS focus on meeting the mental health needs of over 70% of the population, meant to be served by any PHC system (WFMH, 2009; FMOH, 2012).

In Nigeria, similar neglect also prevailed at the national level. For example, it is shown that aafter being mentioned WHO 1978 declaration, it was only in 1991 that the Federal Government of Nigeria made an attempt to include mental health in the National PHC programme in Nigeria. In fact, the Federal Ministry of Health, FMOH (Nigeria) (1991:8) admitted that:

> The National Primary Health Care Programme, which is the vehicle for the achievement of 'Health for All by the year 2000 did not, until recently, have the necessary mental health care component. Even now, that it is being incorporated into the PHC, the mental health component would require time and adequate funding to catch up with the rest of the Programme.

Historically, provision of modern services for mental disorders in Nigeria is associated with an initial custodial (psychiatric) care was in asylums. At that time, in these asylums, mentally sick persons were somewhat treated in dehumanizing, cruel ways like 'criminals' segregated from 'normal' people. They were usually beaten and chained, and even imprisoned especially to prevent

aggressive behaviours manifested by the patients, and sometimes exhibited in 'zoos', where people paid money to go and watch them like animals. The first asylum in Nigeria was opened in Calabar in 1904, followed by the Yaba asylum in 1907.

However, formal institutionalized started in 1944, when mentally disturbed soldiers were brought back to Nigeria after the World War (WWI) and kept in asylums. The first sign of modern mental health care in Nigeria at that era was in the early 1950s, when in 1954, Prof Adeoye Thomas Lambo, the first Nigerian Psychiatrist trained in England reformed psychiatric services and training at Aro Abeokuta (Lambo, 1954). There he established the Neuro-psychiatric Hospital alongside a School of Psychiatric Nursing which had started earlier in 1950 with 27 nurses (four females and 23 males) under Mr Maxwell, a British mental health nurse. Focus was on institutionalized, hospital-based care.

In northern Nigeria, asylums were also later established in Kano, Zaria and Kaduna, with similar conditions to those in Calabar and Yaba. Agitations over the cruel custodial care for the mentally sick briefly culminated into the de-institutionalization movements: mentally ill persons were 'released' from total institutions to receive care in community-based settings. But this was short-lived, as another phase called trans-institutionalisation emerged, resulting in the return of the mentally ill people back to mental health institutions. Consequently, Nigeria's MHS became, and has remained, predominantly urban-based, institutionalized, with focus mostly on curative psychiatric care, provided by eight (8) Federal Government-owned Psychiatric Specialist Hospitals, three of which are in northern Nigeria (in Sokoto, Maiduguri and Kaduna), five units in Armed Forces Hospitals, and 12 Departments of Psychiatry in Nigerian major University Medical Schools (MHA, 2014). A few State-owned General Hospitals also provide such curative mental health services. These formal centres providing institutionalised care are grossly inadequate and often face competition from native herbalists and faith healing centres.

However, agitations for de-institutionalisation of MHS have continued (WHO, 2008), giving impetus to the current drive towards community-based MHS, as enshrined in the PHC system, but with specific focus on the promotion of mental health (WHO/UNICEF, 1978; WFMH, 2009). The need for the training of middle-level health care professionals to provide such services then became key (WHO, 2008; WFMH, 2009). Thus, at present, mental health care is meant to focus more on deinstitutionalization of care, which aims at mental health promotion, mental illness prevention, recovery plans (for the mentally ill persons), and rehabilitation of people living with mental illness (PLWMI) in the community. This formed the basis for the inclusion of the "promotion of mental health" at the declaration of PHC (WHO/UNICEF, 1978). This community-based PHC approach is based on PHC principles and strategies (WHO, 1978; WFMH, 2009; WHO, 2012). Nigeria was a signatory to the Alma Ata Declaration where these PHC objectives, principles and strategies were enacted. The extent to which these PHC enactments have been incorporated into Nigeria's health care delivery, especially in northern Nigeria, with particular reference to provision of the mental health care services, is empirically unsubstantiated.

Several models of providing MHS at the PHC level had been previously introduced, such as the Aro Village system in Nigeria (Lambo, 1954); a system which has become a model of providing community-based mental health care in many countries like Nigeria, Ghana and Europe (Asuni, 1996). This approach has however failed in Nigeria, and it is being replaced by the establishment of Directorates of Community Mental Health Services in tertiary mental hospitals in Nigeria (www.neuroaro.com, 2014), another new initiative from Neuro-psychiatric Hospital Aro. Currently involves the 23 LGAs in Ogun State, where each LGA works with the Aro Hospital, a tertiary specialist psychiatric institution to provide comprehensive MHS in at least one PHC centre in every LGA. Although at experimental stages of implementation, this system of MHS delivery at PHC level is currently being undertaken to establish community-based MHS. In view of these, this study has

become necessary to identify any possible model that can be used to provide these services in the selected States in northern Nigeria. Identifying an appropriate social model for effective MHS at the PHC level could become the template for the selected States in Northern Nigeria. But even this should have policy backing.

1.1.1 Mental Health Policy and Law in Nigeria

Mental Health Policy in Nigeria is traceable to laws governing the care of the mentally ill and practitioners which subsisted in the colonial period. Nigeria's first Mental Health Policy was formulated in 1988, and revised in 1991, aimed at, among other things, promoting mental health and reducingharmful effects and consequences on individuals, families and communities (FMOH, 1988; 1991). It also stressed the need for the formulation of strategies for promotion, prevention, management, treatment and rehabilitation of mental disorders and their subsequent disabilities through the most appropriate approach (FMoH, 1991; WHO-AIMS, 2006). The policy, however, lacks any clear legislation for mental health care in Nigeria.

Nigeria has been using the Mental Health Laws inherited from the colonial government. The Lunacy Act of 1890 (now abolished) formed the foundation of Mental Health Law in Nigeria, providing that admission of mentally ill patients through the magistrate courts. This portrays mental illness as form of criminality. Later, Act of 1930 abolished the Lunacy Act, allowing for voluntary admission for psychiatric patients with informed consent for treatment. However, the superseding Mental Health Act (MHA) of 1959 allowed patients to be admitted informally or be referred as informal patients. Nigeria still relies on this Act for mental health care. This Act is now believed to be outdated in view of new realities in mental health care in Nigeria. Subsequently, in 2003, a draft bill for a Mental Health Act was presented to the Nigeria's National Assembly. As at 2015, this draft was still at the floor of the National Assembly. Such legal documents provide for the security, fundamental rights PLWMI, and the safety of their property. It provides legal cover for mental

health care providers in the practice. It is believed that the need for a mental health law to facilitate effective MHS has been ignored by the National Assembly in Nigeria (PHFN, 2015); implying that mental health issues in Nigeria also receive very little legislative attention.This trickles to the services at the PHC level, with its roots in the absence of MHS delivery in communities.

1.2 Statement of the Research Problem

Various forms of mental health problems (MHPs) can be detected and managed (or referred) at PHC settings. Compelling evidences (RCOG, 2012; WHO, 2010; Atlas, 2014) show that during pregnancy, expectant mothers and families face many psychological problems which can be detected and managed during ANC at PHC clinics to prevent pregnancy-induced mental health disorders or post-partum mental health challenges such as puerperal psychosis. MHS at PHC should be able to address these pregnancy- and childbirth-related mental health problems alongside other routine antenatal and postnatal physical health care. Similarly, infants and older children who access PHC services for immunisation and the treatment of other common childhood ailments also need to be assessed for early signs of emotional problems, using short instruments called Child Behaviour Checklists (CBC) (WFMH, 2009) at PHC settings to forestall later life mental health disorders.WHO (2010) reported that about half of mental disorders in adulthood begin before the age of 14, which could have been prevented or detected early at PHC settings.

This requires that early MHS are in place to detect these on time for quick intervention. In addition, more than half of the people who kill themselves are aged between 15 and 44 years, 86% of which could have been prevented if Community-based MHS were effective (WHO, 2010). Thus, suicide prevention is also a focus of PHC activity, which could be in schools, communities and work places. Community-based MHS have also been found to help prevent family disorganisation divorce, deviance and address vagrant psychotics (WHO, 2012) through psycho-education.

In fact, WHO (2007) acknowledged that mental health indices globally and in Nigeria have continued to worsen due largely to a very weak PHC system. However, providing MHS at PHC settings has been a contentious policy issue globally, just as it has been in Nigeria (WHO, 2008; WFMH, 2009). Available data in some centres in the southern part of Nigeria such as Ibadan in Southwest Nigeria and Warri in South-south Nigeria have described community-based MHS as only rudimentary, and often uncoordinated (Odejide *et al;* 2010; Asuzu, 2009). This has caused a large unmet need of services and information for mental health problems, including substance abuse disorders among young people, prevalent in the communities in northern Nigeria (Abdul *et al*., 2009; Kabir, Iliyasu and Aliyu, 2004). There is also a dearth of empirical studies on the forms of such mental health challenges in the northern Nigerian communities and whether these communities perceive these mental health challenges as a problem, and whether the required MHS at the PHC system are available, and acceptable.

In the northern Nigerian region, casual observations by the researcher and other mental health professionals suggest an unclear status of MHS at the PHC centres (personal observations on clinical postings, psychiatric field trips, and pilot studies in Zaria and Kaduna). The level of MHS at the PHC level remains unclear due to a number of unconfirmed factors (Asuzu, 2009; WFMH, 2009). Political and policy issues are said to have acted as major determinants of MHS delivery especially at PHC level. In addition, several other factors are said to act physical and social barriers that hamper the provision of MHS at PHC centres (WHO, 2008). These challenges are believed to be fallouts of policy gaps, including lack of facilities, inadequate and unskilled primary health-care providers, non-availability of educational and training opportunities for this category of health care workers, and socio-cultural factors including incorrect perceptions and lack of legislation on mental illness and the persons living with mental illness (PLWMI) have been reported (WHO, 2006).

Similarly, community mobilization and participation are stated as important elements in providing PHC services including MHS to the rural communities. But studies (such as Hellandendu, 1991) have indicated that community participation in PHC activities is often hampered in northern Nigeria, by several conditions such as poor material support for volunteers and community health workers. These factors are said to pose serious challenges to MHS provision at the community level, and jointly contribute to the treatment gap for mental health problems (Osungbade and Siyanbade, 2010; Kabir, Iliyasu and Aliyu, 2004). The extents to which gaps in information and MHS exist in northern Nigeria are yet to be ascertained. In the same way, the conditions under which communities participate actively in organizing their own health services, with particular reference to mental health services in Northern Nigeria have not been empirically established.In addition, there are even calls to develop culture-specific models for providing MHS in communities. Several countries such as the United States, Australia, China, and Brazil have developed specific models that have improved MHS at the PHC level (Mauer and Reynolds, 2008; WHO/Europe, 2010). In Northern Nigeria, studies on the best practice principles for providing effective MHS at the PHC are absent despite the huge burden of mental health challenges in the region presented in isolated studies in the region such as Kabir, *et al.*, 2004; Abdul *et al*., 2009. This requires a critical assessment to determine the availability and acceptability of MHS at the PHC level in selected States, and to appraise the contributing factors to the low level of MHS. On the basis of the afore-mentioned, this study therefore sets out to answer the following research questions.

1.3 Research Questions

1. What is the current status of mental health services at the PHC level in the selected States in northern Nigeria in terms of availability and acceptability?
2. What are the forms of mental health problems that exist in communities that could be dealt with at PHC level in the study States?

3. What factors account for the observed level of mental health services in the study areas?
4. Are there ways of providing effective mental health care services in the study areas?

1.4 Aim and Research Objectives of the Study

This study aims at investigating the forms and status of mental health services at the PHC level in three selected States in Northern Nigeria, with the following specific objectives:

i. To assess the availability, and acceptability of mental health services at Primary Health Care level in three selected States in northern Nigeria;
ii. To explore the forms of mental health problems existing in communities that could be dealt with at PHC level in these selected States;
iii. To identify the factors responsible for the observed level of mental health services;
iv. To propose a model that can enhance the effective and efficient provision of mental health services at the PHC level in northern Nigeria.

1.5 Justification of the Study

Mental health services at the PHC level have been adjourned to be the best means by which mental health problems can be diagnosed early for prompt intervention and rehabilitation (WHO, 2012; WFMH, 2009). This is particularly relevant during pregnancy and infancy, adolescence and later life at community level. In spite of the vital position of the PHC to achieve this goal, the researcher's personal observations during clinical posting and psychiatric field trips to PHC centres in Zaria and Kaduna as a Psychiatric Nurse, revealed that in almost PHC centres visited for practical experiences, any mention of mental health part of the PHC services was scarcely made. In addition, pilot studies conducted in both Zaria and Kaduna gave further suspicion of a rather unclear status of community-based MHS. However, there have been calls for research studies in the community to explore and identify the best ways of effectively and efficiently providing MHS at PHC level in view

of worsening mental health statistics which can be forestalled at the PHC level (AHRQ, 2012). Polit *et al.;* (2007) asserts that "the world is searching for multi-cultural approaches, not only to study mental disorders, but to also develop models for services for these conditions at the PHC systems."

These assertions gave the impetus that necessitated this study, with the hope that findings of the study fill this information gap on community-based MHS, provide empirical evidence on the factors affecting community-MHS delivery, and generate baseline data towards developing socially acceptable model to provide effective MHS at the PHC level in States in northern Nigeria. These data should also provide a framework for policy makers, health experts and administrators who are crying out for such blueprints to guide mental health care planning and implementation at the PHC level, as part of the comprehensive system of PHC. The attitudinal and socio-cultural perceptions elicited from health workers and community members on mental illness and people living with mental illness (PLWMI) will also contribute to knowledge of mental health care towards correcting any prevailing misconceptions and enhancing de-stigmatisation endeavours.

1.6 Scope of the Study

This study aims at exploring the availability and acceptability of mental health care services at the primary health care level in three selected States in northern Nigeria (Gombe from the northeast, Benue from north central, and Kaduna from northwest geo-political zones of northern Nigeria). The choice of these States is informed by the differential health care deliveries in these three States. The study examines the availability and acceptability of mental health services in the selected States at the PHC level in view of the seemingly increasing prevalence of mental health disorders in communities, and the obstacles to the provision of these services, from views and the perceptions of health administrators, PHC workers, and community members.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.0 Introduction

This chapter presents literature on the mental health services (MHS) at the primary health care (PHC) level, based on the study objectives, covering conceptual and empirical reviews on the availability, and acceptability of MHS within the PHC system. The factors acting as barriers to the availability and acceptability of MHS, and models of providing effective community-based MHS are highlighted to explain the current push towards shifting MHS from mental health institutions to community-based care settings. Donabedian *Structure-Proces-Outcome* Model as a variant of structural-functionalist theory is discussed as the theoretical framework for this study to emphasise the system link and functioning of the health system in general and the PHC system in particular. The concepts of Primary Health Care (PHC) and mental health services (MHS) are also clarified.

2.1 Conceptual Clarifications

This section attempts to discuss the concepts of Primary health care, mental health services (MHS), mental health, mental healths problems, and mental illness or disorders. These terms need clarifcation due to the various contexts in which they are used and often misunderstood.

2.1.1 The Primary Health Care (PHC)

The slogan *Health for All by the Year 2000* was adopted at the 30th World Health Assembly in 1977 (a year before Alma-Ata Declaration) on PHC as a vision for the attainment by all peoples of the world by Year 2000 of a level of health that would permit them to lead socially and economically productive lives as a main social target of governments, international organizations and communities. The PHC Declaration was adopted in 1978 at a meeting on primary health care convened by WHO and UNICEF in Alma-Ata, capital of the Republic of Kazakhstan in the former Soviet Union. The meeting was attended by 134 countries and 67 international organizations. The Alma-Ata declaration endorsed PHC as the main strategy for attaining the target (WHO, 1978). The

ideology behind PHC is based on the recognition that health promotion and protection are essential for sustained economic and social development and contribute to better quality of life. The WHO (Alma-Ata Declaration, 1978) defines Primary Health Care as:

> essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self- reliance and self-determination.

PHC is regarded as a cost-effective approach of providing 'essential health care' which is universally accessible to individuals and families in the community and provided as close as possible to where people live and work; a decentralized care which is based on the needs of the population, that requires the active participation of the community and family (WHO, 1978). According to the WHO (2010), to achieve the ultimate goal of PHC of better health for all, there are some identified key elements: 1) reducing exclusion and social disparities in health (universal coverage reforms); 2) organizing health services around people's needs and expectations (service delivery reforms); 3) pursuing collaborative models of policy dialoque (leadership reforms); and 4) increasing stakeholders participation. These elements are intertwined and intricately mutually inclusive. These constitute its principles which include social justice, equity, human rights, universal access to services, community involvement and priority to the most vulnerable and underprivileged. This translates to universal access to services, community involvement, priority to the most vulnerable and underprivileged, including a care based on the "identified needs of the people, decentralisation, and active participation of individuals, families, and communities" (FMOH, 1991:1).

In Nigeria, like in many countries, the PHC system is the first point of contact with the healthcare system, meant to ensure the provision and maintenance of health infrastructure; planning and implementation of strategies to meet community health needs; provision of the ten primary

healthcare components to the community; training of personnel and logistic support for community mobilization and participation; and Management of health information system. The provision of health care at this level is largely the responsibility of Local Governments with the support of state ministries of health and within the overall national health policy. Private medical practitioners also provide health care at this level. But the policy on PHC lies with the Federal Government of Nigeria (FGN). In *The National Mental Health Policy for Nigeria,* the FGN has emphasied that:

> The logical and rational approach to reaching the population at large is through the incorporation of mental health into the Primary Health Care. In this way, the community shall have the opportunity to participate and determine the type of mental health care appropriate for it (FMOH, 1991:2).

The awareness of these reasons and the need for a functional provision of mental health care at the PHC level by primary health care workers is necessary to guide the provision of mental health care in their various communities. The Mental Health Policy document further specifies that the prescribed locations of such mental health care are the PHC centres in the communities. The aim of MHS at the PHC level, according to the document, is for the "reduction of incidence rate of mental disorder within the communities," while the methods of achieving this goal include:

> Reducing community-wide harmful influences e.g. health promotion, legislation; cognitive and emotional health (mental hygiene) education; provision of services to help people at times of crises; early and prompt crisis intervention strategies; and community based rehabilitation programmes (NPHCDA, 2007:41).

Both the Primary Health Care workers and community members are expected to share these reasons, to encourage active community mobilisation and participation respectively.

At inception, eight basic components of the Declaration were identified. These components included health education (on methods of preventing and controlling prevailing health problems); promotion of food security and proper nutrition; adequate safe water supply and basic sanitation;

maternal and child health care, including family planning; vaccination against major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries, provision of essential drugs, and promotion of mental health. The mental health promotion requires mental health services (MHS) in the PHC systems, which are meant to reduce the incidence of mental health disorders (FMoH, 2007). It is expected to follow the PHC guidelines: health promotion, disease prevention, early detection and prompt treatment of diseases, use of standing orders, availability of essential drugs, rehabilitation and reduction of disabilities, with the full participation of the community. Using these PHC guidelines are in turn expected to provide functional MHS (WHO, 1978; Bower, 2002).

Since the Alma Ata declaration, WHO (2008) has stressed that governments across the world need to see mental health as an integral component of primary health care. It states that countries need to change policy and practice so as to provide "the essential mental health services to the tens of millions in need." The PHC envisaged a universal coverage of all basic services. But while most of the PHC components have attracted specific strategic plans to provide the stated services, the promotion of mental health lacked any strategic implementation. In fact, other later components like the Dental Care, Primary Eye Care, Primary HIV/AIDS Care, Primary ENT Care, among others, have received attention and developed Primary Care Training manuals for PHC workers (NPHCDA, 2007). Many studies such as those condcuted by FMoH (2007)and Saving Newborn lives in Nigeria (2009)have analysed these elements in relation to other PHC services such as Family planning, immunization, Maternal and Child Health Services, among other. but available literature on the MHS is scanty in Nigeria, especially Northern Nigeria with particular reference to service delivery components. In MCH situation, the Federal Government policy on MCH strategies were praised. Saving Newborn lives in Nigeria (2009) reported that Nigeria has demonstrated a high degree of positive policy will toward MNCH as shown in the various strategies on maternal and child health.

WHO/Wonca (2007) identified a number of advantages for providing mental health at the PHC level. Among these merits are reducing stigma for people with mental disorders and their families, improving access to care (Alma Ata Declaration, 1978), reducing chronicity and improving social integration of people with mental disorders in their households, and the communities. Despite these enormous merits of a deinstitutionalised mental health care, if PHC mental health services are made functional, readily available, accessible and acceptable to all communities at any level of their social development (WHO, 1978), the provision of these services at the primary health care level has not attracted any empirical investigation in States in northern Nigeria. Such studies require finding out the link between the MHS in the PHC system in relation to the other levels of health care. Hence, a structural functionalist approach could serve as a veritable framework for this analysis of MHS.

2.1.2 Mental Health Services

Mental health services are described as the means by which effective interventions for mental health are provided (WHO, 2003). Those provided at PHC level are called community-based MHS. Mental health services at the Primary Health Care is a situation where promotion of mental health, as a component of the PHC, is fully combined with or incorporated into the routine activities of the PHC centres for the effective delivery of holistic health care to people, on day to day basis. The goal MHS in the PHC system is mental health promotion, and this covers a variety of strategies, all aimed at having a positive impact on mental health. This is the focus of this study. Most of mental health services (MHS) in most countries are in form of institutionalised psychiatric care, described as mainly curative, and predominantly available at urban centres (Asuzu, 1998; WHO-AIMS, 2008; mhGAP, 2012). Hence, the term MHS are often confused with the term "psychiatric care" or services. Psychiatric care focuses primarily on curative services for mentally ill patients and those with other recognisable emotional problems who seek intervention at mental health institutions like

psychiatric hospitals or psychiatric units of General or Teaching Hospitals. But MHS are much broader than this, encompassing mental health promotion, and prevention of mental disorders.

Mental health promotion involves actions that create living conditions and environments to support mental health and allow people to adopt and maintain healthy lifestyles (FMOH, 2004). This includes a range of actions that increase the chances of more people experiencing better mental health. Mental health promotion involves actions to create living conditions and environments that promote mental health and allow people to adopt and maintain healthy lifestyles. These include a range of actions to increase the chances of more people experiencing better mental health. A climate that respects and protects basic civil, political, socio-economic and cultural rights is fundamental to mental health promotion. Several documents and studies point to the core advantages of providing mental health care services in the mainstream PHC. For instance, WHO/Wonca (2008) presents seven reasons for the need for the functional provision of mental health care in primary health care centres.

In this study, MHS would mean all interventions and plans available at the PHC centres or within the community directed towards the promotion of mental health, prevention of mental health problems and the treatment of mental illness, as well as the rehabilitation of people living with mental illness (PLWMI) in all stages of life and life events. They are measured by the availability of mental health information at PHC centre and in the community, using posters or health education; referral services of mental disorders to other levels of health care; and treatment (using psychotropics or drugs used for mental illness) and restorative care given (rehabilitative centres/arrangements) to those mentally ill or in need of mental or psychological attention. Mental health services thus address promotion of mental health, and intervention and treatments for mental health problems including mental illness.

2.1.3 Mental Health, Mental Health Problems and Mental Illness

The terms mental health, mental health problems and mental illnees are also often wrongly used interchangeably. Mental health is defined as a state of well-being in which an individual realizes his or her own abilities, able to cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community (WHO, 2004). It is also seen asthe successful performance of mental functions, such as resulting in the ability to engage in productive activities, enjoy fulfilling relationships, and cope with adversity (2012; WHO, 2013). It provides people with the capacity for rational thinking, communication skills, learning, emotional growth, resilience, and self-esteem (The U.S. Department of Health and Human Services, DHHS, 1999). In 1991 the Australian Health Ministers' (AHM) Conference provided a definition of mental health as a starting point for discussion. This definition asserted that mental health is

> ...the capacity of individuals within the groups and environment to interact with one another in ways that promote subjective well-being, optimal development and use of mental abilities (cognitive, affective and relational) and collective goals consistent with justice (AHM, 1991:5)

Mental health is said to be dynamic; it swings within a narrow range of what is considered as normal or abnormal. As described by Kozier and Erb (2008), all human behaviour lies somewhere along a continuum of mental health and mental illness. The normal represents the mental health while the abnormal is either mental health problem or illness. In defining mental illness and mental health, Fie (2009) argues that evaluating an individual's behaviour occurs in two dimensions, namely, on a continuum from *adaptive* to *maladaptive* and on a continuum from *constructive* to *destructive.* The Mental Health for Canada (2008) illustrates this dynamic nature of mental health-illness on two separate continuums on the vertical axis, namely optimal mental health and serious mental illness (Figure 2.1). The optimal mental health, referred to as mental well-being or mental wellness, is at one end of the continuum, while poor mental health, also referred to as "languishing", is at the other

end. It also shows the horizontal axis, having a serious mental illness is at one end of the continuum on the left, while having no symptoms of a mental illness is at the other end (on the right).

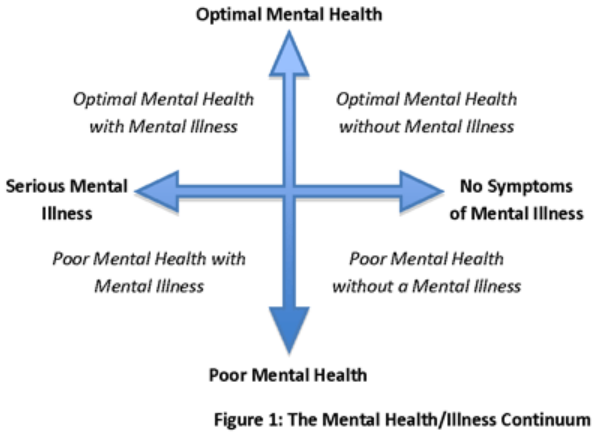


Fig. 2.1: Fie Model of Mental Health-Illness Continuum

From this figure 2.1, it is conceptualised that an individual can be mentally healthy with a mental illness (people living with mental illness, PLWMI) and that someone can have poor mental health without a mental illness. Conversely, one can have poor mental health without any mental illness. From the foregoing, it is concluded that mental health problems do not necessarily constitute mental illness neither is living with mental illness synonymous with being mentally ill. As pointed by MHF (2013), good mental health is not simply the absence of diagnosable mental health problems, but the ability of an individual to 1) make the most of his/her potential, 2) cope with life, 3) play a full part in one's family, workplace, community and among friends. The term "mental health" is also called emotional health, mental wellbeing, or psychological health.

While mental illness and mental disorders must meet certain criteria as defined by either the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual Fifth Edition (DSM-V)*(WHO:ICD, 2010; DSM-V, 2013), mental health problems are either subjective or psychological/emotional issues interfering with acitivties of living or functioning. The term 'mental illness' however, remains loosely defined and controversial as various arguments on what constitutes

mental illness remains unresolved, even among mental health profesionals. For example, Thomas Szaz (1970), a consultant psychiatrist, argues in his book *The Myth of Mental Ilnness* that there is no such thing as mental illnes but merely the medicalisation of psychological and behavioural problems. His argument suggests that mental illness is just labelling.

According to Hogan (2006), medicalization refers to the increasing attachments of medical labels to behaviours required as socially or morally undesirable. It is also viewed as the way in which increasing areas of social life are seen as falling under the remit of doctors (Haralambos and Holborn, 2004). Critics of modern medicine use the term to connote that doctors have too much political influences in issues when they are not in fact professionally competent to make judgment. The implication is that modern medicine claims to cure all problems (including vandalism, alcoholism, homosexuality, dangerous driving and political deviance) as all these are recognized as diseases. In his contribution to this criticism, Giddens (2010) argues that effectiveness of scientific medicine is over rated. He claimed that improvement in overall health can be attributed far more to social and environmental changes than to medical skill. Haralambos and Holborn (2004) also corroborated this by stating that living conditions are more important than medicine in combating disease. They argued that level of illness and death actually began to decline before the advent of modern medical techniques. They further stressed that if health and illness are simply the results of physiological factors, illnesses should spread randomly across the various social classes, and to a lesser extent gender and 'race', suggesting that social factors play a more important role in health and illness.

Other critics of modern medicine and scholars in the past had called attention to the harm caused to society by modern medicine. For example, Ivan Illich (1975) reported that modern medicine has done more harm than good because of iatrogenesis or societal "self-caused" diseases, claiming that medical treatment makes the patient worse or creates new conditions (medical

iatrogenesis). He also states that modern medicine has also caused "social iatrogenesis," where medicine expands into more and more areas, creating an artificial demand for its services, which in turn has led to "cultural iatrogenesis" where the ability to cope with challenges of everyday life is progressively reduced by medical explanations and alternatives. The first person to draw attention to medicalization is Eliot Friedson (1970), who suggested that the high status ascribed to medicine has caused social problems such as gambling, drug use and crimes. The idea was taken up by Irving Zola (1981), who suggested that "medicine is becoming a major institution of social control, nudging aside, if not incorporating the more traditional institution of religion and the law". Ivan Illich (1976) further explored this and concluded that activities and conditions that may have been ignored or seen as a social problem or normal part of life have all come to be defined as medical issues, which fall under the expertise of the medical profession. In this realm, mental illnesses are believed to be a form of this expansionist expedition of modern medicine. Using feminist perspective, Ehrengeich and English, between 19th and 20th century, menstruation and pregnancy were treated as abnormal and as forms of sickness. Women's activities and behaviour became restricted under the guise of medical concern. Hysteria was later coined, while women's reproduction became controlled with contraceptive

In a similar vein, gambling which is purely social ailment became illness from immoral act (Conrad and Schneider). Thus, a medical condition called pathological gambling emerged, with attendant explanation and therapy (DSM IV, 2000). Illich (1975), using Marxist approach to medicalization, argued that the health care system is itself a part of a wider process of oppression, arguing that biomedical model shaped by ideology of capitalization but emphasized the individual nature of illness and ignores the social patterns of disease, are closely related to social class. It is therefore argued that modern medicine posits itself as superior to any alternative form of medicine or healing. However, this belief is being undermined by the growing popularity of alternative medicine

such as homeopathy and acupuncture. There is currently an upsurge of interest in the potential of alternative medicine.

Consequently, mental illness has several socio-cultural connotations. Modern medicine defines mental illness as pathologies to maintain its relevance in the soci0-political atmosphere as much as the society itself defines the individual in a particular way and makes predictions about human behaviour. For instance, the Yorubas of Western Nigeria defines mental illness from a cultural perspective and labels the individual *'were'* when his behaviour is of non-conformity with the approved way of life, especially when such a behaviour is on the extreme (Jegede, 2000). From the non-medical point of view, every departure from the approved way of behaviour especially those in the extreme are considered as mental illness, thus depicting social instability and, in this situation, a pathological condition. In a study conducted among traditional healers and diviners in Ibadan, Nigeria, Jegede (2010) reported that the informants defined '*were'* as a pathological problem of social relations in which the individual loses his/her sense of reasoning and control. It is thus a relational problem.

Despite these arguments and connotations, mental health, mental health problems and mental illness have been distingushed on a number of objective grounds, as shown in Table 2.1.

Table 2.1: Mental Health, Mental Health Disorder and Mental illness

Healthy	**Reacting (Mental Health problems)**	**Injured (Mental Health problems)**	**Illness**
Calm, steady Normal mood fluctuations Fit, fed, rested In control (*physically, mentally, emotionally*) Performing well Behaving ethically and morally Sense of humour Relaxing, recreating Socially active Proactive behaviour Confident in self & others	Nervousness, anxiety Irritability, anger Impatience Trouble sleeping Low energy/fatigue Muscle tension/headaches Forgetfulness/ procrastination Decreased productivity Often late for work Occasional loss of emotional control Poor concentration Negative attitude Reactive nature Increased swearing/cursing	Excessive anxiety/panic Angry outbursts Noticeable fatigue Forgetting important things Regular loss of emotional control Impaired decision making Taking risks Inappropriate aggression Insubordination Absenteeism/Presenteeism Increased accidental injuries Overlooking details in appearance	Excessive anxiety Regular panic attacks Poor coherence Angry outbursts Noticeable fatigue Severe memory lapses Cannot concentrate Cannot perform duties Significant change in behaviour Loss of control Suicidal ideation/intentions Legal charges Avoiding or withdrawing Neglecting hygiene

From Table 2.1, mental health corresponds with the criteria present in Column 1 (healthy), while mental health problems would include all "reacting" and "injured" psychological and emotional events (Columns 2 and 3) in an individual. Mental illnesses are those in the "illness" column. It thus means that mental illness includes all clinically diagnosable disorders as defined by DSM-IV-TR and ICD-10; that is, all conditions that require the diagnosed by trained, competent mental health practitioner and require the attention of medical practitioners for treatment. This information in Table 2.1 further implies that not all mental health problems are mental illnesses, but all mental illnesses are mental health problems. According to Mental Health Foundation, MHF, (2013), mental

health problems range from the worries individuals experience as part of everyday life to serious long-term conditions. Mental health disorders are therefore used interchangeably with mental illness.

In Nigeria, mental health, mental health problems and mental illness have been clearly delineated by the National Mental Health Policy document thus:

> In the context of this document, mental health refers to the capacity of an individual, a group and the environment to interact with one another in ways that promote subjective wellbeing. This entails the optimal development and use of mental abilities (such as cognitive, affective and relational); the achievement of individual and collective goals consistent with justice; and the attainment and preservation of conditions of fundamental human rights. A disruption which affects the interrelation of the individual, the group and the environment in the above context could manifest as mental health problem. When such a problem is accompanied by significant cognitive and affective impairment, it then reaches the dimension of medically diagnosable mental illness or disorder (FMoH, Nigeria, 1991:1-2).

Mental health problem is conceptualised here as a deviation from acceptable norms of social interaction as determined by a particular society. It is characterised by significant departure from prescribed social behaviours. From this perspective, mental illness occurs when this impaired social interaction has significant concurrent cognitive and affective impairments, disrupting normal social functioning.

For the purpose of this study, therefore, mental health consists of all behaviours, activities, feelings, and thoughts that enable an individual to be at peace with self and others, and allows the individual to carry out his social roles optimally, and live a productive functional life. The level of this performance of roles however swings within ranges of excellent and good. It is both a subjective and an objective parameter. On the other hand, any behaviours, activities, feelings and thoughts which impair the performance of these social activities constitute mental health problems, which is also both subjective and objective. Mental health problem is therefore the absence of peace with self and others, characterised by an individual's inability to adapt to the constantly changing physical and psychosocial environment of the individual. However, mental illness is a pathological state of the

mind, based on certain diagnostic criteria exercised by competent specialists (such as psychiatrists, medical doctors or nurses trained in mental health) using either the International Classification Diseases Version 10 (ICD-10) by the WHO or using the Diagnostic and Statistical Manual of Mental, Neurological and Behavioural disorders Fourth Edition Revised Version (DSM-IV-TR) (APA, 2000) to establish diagnoses. Mental illnesses require standard clinical attention by those trained in the curative management of such ailments.

As a continuum, the mental health of any person at any point in time is determined by multiple biological, psychological, and social factors. The social determinants of mental health disorders are many. As defined by the World Health Organization (WHO, 2008; p. 6):

> The social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.

The social determinants are therefore major contributors to mental wellbeing, which lead to other concepts such as health inequities (systematic and avoidable inequalities), social justice and morality (Jones, 2010), and public health policy (Satcher, 2010). Poor mental health is therefore said to be associated with social dynamics such rapid social changes, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyles, risks of violence and physical ill-health and human rights violations. Mental Health for Canadian (2008) also identifies what they consider as the three most significant determinants of mental health, namely, freedom from discrimination and violence, access to economic resources, and social inclusion. It means that deprivation of social and economic opportunities predispose mental health issues.

A lot of descriptive studies, concept analyses, programme evaluation, and calls for action, have focused on these social dimensions of mental illness. For instance, Jegede (2010) argued that persisting socio-economic downturn for communities are recognized as risk factors for mental health. In a similar vein, Cochrane (1983) has argued that

> social factors are largely responsible for the creation of mental health differentials…and these differences are far outweighed by the impact of the social situation in which people find themselves, and even more importantly, the definition that is placed upon the situation" (p.1-2).

He concludes that different social groups are more or less vulnerable to the onset of mental disorders because of their social characteristics, which largely determine the way in which individuals respond to the psychological problems they experience. These social propensities therefore predispose certain sections of the populations to variable psychological problems and put them at more or lesser risks. In adition, a social milieu which entrenches respect and protection of basic civil, political, socio-economic and cultural rights are also fundamental to mental health promotion. Though, there are also specific psychological and biological causes (Sadock and Sadock, 2003), the greater vulnerability of disadvantaged people in each community to mental health disorders may also be explained by such factors as the experience of insecurity and hopelessness, rapid social change, and the risks of violence and physical ill-health (Townsend, 2006).

Cochrane (1983) has noted that in human populations, diseases are usually differentially distributed along socio-economic and gender lines, as well as the developmental stages of the people through life span. Thus, individuals particularly vulnerable to mental health disorders have been identified by various authorities and experts: in mental health studies, there are also certain groups within any given population who have an elevated risk of developing mental disorders. This vulnerability is brought about by the environments in which they live. Vulnerable groups for mental health problems have been found by a report according to WHO (2010) to include those excluded from participating fully in society; those with reduced access to health and other social services. The

Report also showed that exclusion from income generation and employment opportunities and increased disability and premature death precipitate mental health disorders. Using developmental taxonomy, Townsend (2006) categorized those at high risk of mental disorders based on life span challenges. According to her, the types of crises that individuals experience place them in the life event categories: namely, maturational crisis and situational crisis. While situational issues are accidental, she believes that the populations at risk in maturational crises, which requires planned mental health services at the stages of adolescence, marriage, parenthood, midlife, and retirement. These are periods of high maturational challenges which demand deliberate psychological support otherwise, mental problems might ensue.

On the other hand, situational crises, defined as "acute responses that occur as a result of an external circumstantial stressor" (Townsend, 2006), also make people prone to mental health problems. Based on this, she identified people with the following life situations as particularly prone: poverty, high rate of life change events (for example, loss of loved ones, disappointments, loss of jobs, loss of body part or function, etc), environmental conditions (e.g. natural disasters), and traumatic experiences outside the range of usual human experience (e.g. torture, military combat, kidnap or assault).

In a similar vein, Malvárez (2008) in discussing global perspectives on mental health identified the vulnerable groups to mental health problems as children and adolescents, indigenous populations, women and older adults, and disabled individuals. Others mentioned by the Global Initiative include migrants, victims of violence, conflicts and disasters, individuals with long-term mental health disorders, and mental health patients who are long-term hospitalized.

These life stages are fraught with intense psychosocial challenges requiring specific interventions highlighted (Townsend, 2006; Murray and Zenter, 2001), and thus require specific mental health interventions such as community-based psycho-education, effective communication

and sound human social interactions, anticipatory guidance, and other mental health promotion strategies. Cochrane (1983) contends that a person's values and general outlook influence the extent to which the individual's responses will become defined as indicative of mental illness. Thus, coping with such psychological problems depends also on the social characteristics.

Mental health and mental health problems are therefore individual and group events in relation to the environment, determined by multiple social, psychological, and biological factors at any point of time such as socio-economic pressures such as rapid social change, stressful work conditions, social exclusion, poverty, low levels of education, unhealthy lifestyle, risks of violence and physical ill-health and human rights violations. Some studies associate it with poor housing and poor income. It also means that vulnerable groups to mental illness will differ across countries, and socio-economic status (SES), even within the same environment. A consistent finding in the analysis of mental health disorders is the inverse relationship between SES and mental illness: the lower the SES of an individual is, the higher is his or her risk of mental illness. The major social status variables which impact on these disorders include social class differences, sex differences, environmental influences, migration, culture, and stress (Cochrane, 1983; WHO, 2009; Jegede, 2010; WHO, 2012). In providing MHS at the community level therefore, the views of people on what causes mental disorders and how these disorders can be treated should be explored to guide proper psychoeducation and other mental health interventions. Such evidences are lacking in northern States in Nigeria.

2.2 Mental Health Services at the Primary Health Care Level

Mental health services (MHS) at the PHC level are also referred as community-based MHS. This section presents the forms, availablity, and the acceptability of these services in the community. The section also highlights the burden of mental health problems in the community.

2.2.1 Forms of Mental Health Services in PHC

WHO (2007) describes various low cost but high impact evidence-based interventions to promote mental health at the community level. These interventions are targeted at general populations and specific segments of the populations shown to be more at risk of developing mental health problems, to help promote mental health and prevent mental illness. According to the Organization of Services for Mental Health, OSMH/WHO (2003), mental health services are in form of outpatient facilities, mental health day campaigns, treatment facilities in psychiatric wards in a general hospital or specialist mental institutions, community mental health teams, supported housing in the community, and mental hospitals. Several other types of MHS are also been identified (WHO, 2007; NPHCDA, 2007) to include mental health promotion, screening for early detection, prompt and adequate treatment for identified cases, and rehabilitative interventions for those convalescencing and those with residual disability or dysfunction.

In discussing the mental health promotion, Mental Health Atlas (2011) identifies dissemination of mental health information as the key form of MHS, focusing on the promotive aspects of mental health. This is usually carried out using informational materials and means, such as posters, handbills and the media (Townsend, 2006; WHO, 2007). Other mental health information formats such as Mental Health (Awareness) Day slated for October 1 every year are also means to sensitise people on mental health (WFMH, 2000). The use of these informational materials in the providing PHC services, other than MHS, within the PHC system is well established. For instance, according to NPHCDA (2007) and FMoH (2014), they are veritable means which have been used successfully on immunisation services, antenatal information, family planning, malaria prevention and quite recently Ebola disease prevention, for sensitising community members and PHC service users. Other forms of promotive aspect of MHS in PHC include violence prevention programmes., mental health promotional activities in schools, mental health interventions at work (e.g. stress

prevention programmes). However, the use of information strategies for mental health information has not been in documented in States in northern Nigeria.

Another form of MHS identified to be useful,for early detection, at the PHC level is the screening for mental health problems for different segments of the population, including Childhood community-based mental health screening exercises. The WHO (2010) has consistently emphasised the need for early childhood interventions at PHC level such as home visits for pregnant women, pre-school psycho-social activities, combined nutritional and psycho-social help for disadvantaged populations, and support to children (e.g. skill building programmes, child and youth development programmes). It is reported that the quality of services for emotional and behavioural health provided within primary care for children remain poor. Providing this form of MHS as part of childhood routine care at PHC has been strongly justifed and recommended, because of the high rates of mental health and emotional problems among children. As identified by Van-Cleve *et al.;* (2013) in their US-based study on providing MHS at PHC level, mental health services such as screening, evaluating, and managing children with concerns about behaviour are important but are found to be lacking, and time consuming.

There is also mental health needs of pregnant women, where antenatal clients are screened for psychological and emotional problems during pregnancy. According to the Royal College of Obstetrics and Gynaecology (2011), in the United kingdom, the mental health needs of pregnant women have been severally evaluated in primary care settings. This assessment is believed to improve maternal outcome. In addition, mental health services may take the form of the general mental health assessment of the general populations (OSMH/WHO, 2003). In Nigeria, studies on these strategies are quite scarce. This large gap requires empirical verification and filling.

Providing prompt and adequate treatment for identified common health problems, including mental health problems, is also one of the prerogatives of PHC system. WHO (2011) listed early

intervention and treatment of identified mental disorders as a cardinal function of PHC function. This takes the form of use of psycho-social interventions such as counselling, psychotherapy, social therapy and psychotropic drugs. These drugs are expected to be part of the essential drug list (FMoH, 1991; NPHCDA, 2007). Where such cases cannot be treated, referral to other levels of care is required.

Rehabilitative interventions constitute another form of MHS that should be available at PHC centres (WHO, 1978, WHO, 2012). Rehabilitative PHC interventions include occupational therapy, social support for elderly populations such as "befriending initiatives", community and day centres for the aged, and psycho-social interventions after disasters. Other forms of MHS specified by the WHO (2012) include socio-economic empowerment especially ot the poor and women such as improving access to education and microcredit schemes, housing policies (e.g. housing improvement) and community development programmes. In addition, Malvárez (2008) also identified some categories of services for specific target groups, including community and self-based intervention strategies. The model emphasizes PHC intervention strategies, including community and self-based strategies. This model is hinged on the fact that there are different vulnerabilities to mental health problems, requiring specific, individualised interventions. On the basis of such inclination, Townsend (2006) categorized mental health interventions into three phases, primary, secondary and tertiary interventions. These coincide with the primary care model, which require community-based psycho-education, effective communication and sound human social interactions, anticipatory guidance, and other mental health promotion strategies. This suggests that MHS should be tailored towards individual community needs as well as individual client needs.

However, Van-Cleve *et al.;* (2013) pointed out that in performing these categories of MHS, skills in interviewing, use of standard scales, skills in behavioural management, counselling as well

as the use of medications are required by PHC workers for providing these services but these are found to be lacking. The study recommends that primary health care workers providing these services to children at the PHC level require skill training as identified, and also expressed the urgent and important need "to integrate prevention, early screening, and identification of mental health problems into the routine paediatric health visits" at the primary care level (Van-Cleve *et al.;* 2013, p.248). Data on these in northern Nigeria are found to be lacking. For the purpose of this study, the forms of community-based MHS are mental health information using of posters and mental health campaigns, general mental health services such as mental health screening for children, pregnant women and the general population with concerns about behaviours, referral of mental health cases from PHC to other level of care, and rehabilitation of PLWMI. There is no data on these forms of MHS in the study areas. The situation of mental health information is particularly uninvestigated.

2.2.2 Availability of Mental Health Services in PHC

Availability of MHS at the PHC level is the extent to which the various forms of community-based MHS are present at the PHC centres and accessible to clients and to the hosting communities, as measured by *The Minimum Standards for PHC in Nigeria* (NPHCDA, 2007). Availability increases access; acess being the opportunity or ease with which consumers or communities are able to use appropriate services in proportion to their need (Harris, Harris and Roland, 2004). Studies on availability of community-based MHS in northern Nigeria are quite limited. Non-availability of MHS would mean that accessibility can hardly be measured. According to the WHO (2011:4),

> Governments tend to spend most of their scarce mental health resources on long-term care at psychiatric hospitals. Today, nearly 70 per cent of mental health spending goes to mental institutions. If countries spent more at the primary care level, they would be able to reach more people, and start to address problems early enough to reduce the need for expensive hospital care.

As can be deduced from the statement above, providing specialized health services - such as mental health services - at the PHC level is one of WHO's most fundamental health care recommendations.

The aims of such recommendations are to develop community-based mental health services, and to make mental health care services at the primary health care effective and efficient, available and accessible to majority of the citizens who reside in rural settings, instead of providing such care in large psychiatric hospitals (WHO, 2012; WFMH, 2010). Similar calls and arguments for community-based MHS have been made by many other authorities and studies (Thornicroft and Tansella,2003) for the functional mental health services in the primary health care. However, across the low-and middle-income group of countries, more than three quarters of people needing mental health care do not even receive the most basic mental health services (WHO, 2008). In the case of Nigeria, the WHO-AIMS [Nigeria] (2006) situation analysis of Nigeria's mental health system has shown that the primary (community-based) MHS are not available and accessible to all the population at the PHC system. This report further indicated that these services have been ignored by the government in Nigeria in favour of hospital-based curative mental health care. In fact, an earlier survey by FMoH in 2001 had shown that there are no forms of MHS care being offered in most PHC centres; the centres are also said to lack MHS facilities. It stated that

> There are essentially no mental health facilities in most PHC centre in Nigeria. Most rural communities as well as urban areas are served by large number of traditional healers who practice diverse mental health therapies (p.8).

This was in 1991. This may have a detrimental effect on health seeking behaviours. However, current data on this assertion are still not available. Recently, in their qualitative study of 20 participants (10 caregivers and 10 patients) in neuro-psychiatric hospital on barriers to mental health services in Niger Delta region in Nigeria, Jack-Ide and Uys (2012) found that participants reported the complete absence of MHS in their PHC centres. Participants said that they had to come to the psychiatric hospitals to access services for all types of mental health conditions. This study was conducted in a tertiary level hospital. The state of MHS at PHC and the community perceptions on the availability were not assessed in the study.

The situation of MHS in PHC in some countries is different. For instance, following assistance and supports from WHO, some countries like China, Brazil, and India and other have made significant progress in scaling up their services. For example, WHO (2007) reported that China has scaled up its programme to provide care for epilepsy patients in 19 provinces, building on successful experience in a small number of pilot programmes in provinces. Subsequently more than 40 million people, about 10% of the population, are now covered by this programme in China. Other large, developing countries like Brazil, India and Thailand are also preparing to make rapid advancements in scaling up care through their national health programmes. Although, the level of coverage for these countries were not specified, attempts are said to have been made to ensure MHS at the community level in these countries.

WHO (2008) shows that more than 75% of people suffering from mental disorders in the developing world receive no treatment or care, highlighting the huge treatment gap for a number of mental, neurological and substance use disorders. Across Africa for example, as pointed out by WHO (2008), nine out of ten people suffering from certain mental illness especially epilepsy go untreated, and unable to access simple and inexpensive anticonvulsant drugs which cost less than US$5 a year per person. It is also stated that in any one year, one-third of people living with schizophrenia, more than half of those suffering from depression, and three-quarters of those with alcohol use disorders are unable to access simple and affordable treatment. Worldwide, every 40 seconds, one person dies of suicide, which is one of the leading causes of death among young adults. Suicide is a condition that is preventable. This WHO report indicates a wide treatment gap of between 30 (for schizophrenic patients) to 90% for patients with seizure disorders. Those with depression and substance-related disorders have 50 to 75% intervention gaps respectively. These conditions are common clinical problems in Nigeria. According to PHFN (2015), the intervention gaps are as much as 90% for Nigeria.

Globally, in response to the call by many health organisations calling on governments, donors and mental health stakeholders to urgently increase funding for basic mental health services to close this huge treatment gap, the WHO initiated programme known as *Mental Health Gap Action Programme (mhGAP): Scaling up care for mental, neurological and substance use disorders*. This asserts that with proper care, psychosocial assistance and medication, tens of millions of which could be treated for diseases such as depression, schizophrenia, and epilepsy to lead healthy lives, even where resources are scarce. The *mhGAP* focuses on the gap between what is needed to treat a range of priority mental disorders and what is actually available worldwide. In Chile, the national primary care programme now includes treatment of depression for all who need it bringing much needed care to hundreds of thousands of people. Similarly, an epilepsy project in Thailand and China integrated a model of epilepsy control into local health systems. The model achieved excellent results in the two countries. This confirmed that epilepsy could be treated with an inexpensive anti-convulsant medicine by baisc health trainees. The project which started in six provinces extended to 15 provinces and tens of thousands of sufferers have been treated. Such basic treatment and training is the focus of mental health in PHC across the world. Although studies on this approach are shown to be limited in other communities, the situation in northern Nigeria also is yet to be investigated.

Various other attempts by global bodies to promote mental health have been made. For example, Richard C. Hunter, the Deputy Secretary General of World Fedration of Mental Health envisioned that a World Mental Health Day would be a global and unified effort to promote greater public awareness and understanding of mental health and mental illness as a way of promoting mental health (WFMH, 2010). Their effort whcih started from 1983 through 2002, culminated into the World Mental Health Day on 10th of October every year, which is now celebrated annually in over 100 countries since its inception in 2002! It is a day for creating awareness about mental health

and mental illness. For example, in Kenya and the Gambia, it is reported that the Minsiters of Health in the two countries carried out some countryside campaigns on such days (WHO, 2010).

In Nigeria, similar mental health awareness programmes were held though not designated as mental health days. Eaton and Agomoh (2008) in a study reported the impact of a community-based mental health awareness programme carried out in Abia State, Nigeria. It was reported that nurses who were used for the programme were recruited from their respective communities. The result of the study revealed that community-based mental health awareness programmes changed people's attitudes towards the mentally ill in the township. According to them, such changes in attitudes can only be sustained if similar awareness programmes are repeated at regular intervals. The awareness activities were done in the cities not in rural communities, and the level of community participation in this programme was not established. Because available services such as mental health awareness campaigns are done only in the urban areas, even the focus of such activities has been criticised severally as being elitist, digressing from the broad objective of creating community awareness (Chiejina, 2013). The extent to which such awareness programmes are carried in northen Nigeria has not been documented. In addition, data on the the levels of ommunity participation and committment of the local and state health authorities in the awareness celebration ommunities participate ommunities participate ommunities participate are not available.

Other services expected at the PHC level include screening for early detection of mental health problems, prompt and adequate treatment for identified cases, and recovery and rehabilitative interventions. Studies indicate that these other services are lacking. For instnce, Mwape *et al;* (2007) study of PHC workers in Zambia found that although the workers were willing to provide the MHS at the PHC level, to facilitate early detection and intervention for mental health problems, they lacked the necessary knowledge and skills to provide such services. These services were therefore

absent. However, this study did not specify what types of MHS were assessed and how these services were measured. The study also disregarded the target population for the MHS.

In efforts to make MHS available at PHC level, the WHO/Wonca (2008) has identified principles set out by the world health authorities have been said to serve as a framework for assessing the provision of mental health at the primary level of health care in Nigeria. According to the WHO (2008), these principles are not negotiable for integrated primary mental health care services in general. The Federal Government of Nigeria, in 2007 through the National Primary Health Care Development Agency produced the *Minimum Standards for PHC in Nigeria.* In its guidelines for "emerging PHC services", it states that for mental health in PHC, there must be a section or room of a PHC centre for MHS, and that the following PHC service personnel are required: i) a general duty doctor whose job is see all patients and diagnose and treat mental health illness where possible or refer cases as may be necessary; ii) a nurse/midwife CHO where possible, preferably one who has psychiatric training in addition to general duty nurse to assist in educating and counselling patients; iii) a social worker, CHEW (community health extension worker), JCHEW (junior community health extension worker) or CORPS (community Resource Persons) to counsel patients; iv) a trained caregiver to give necessary care and to make home visits and follow up of cases; v) others community health personnel as may be available (such as Public Health Nurses, Medical Social Workers, and Health Educator) (NPHCDA, 2007:41). In measuring availability of MHS in PHC, these minimum criteria, in addition to the forms of MHS at the PHC level, will be used. With this, it is expected that for MHS to be available, all PHC centres in Nigeria must have these minimum standards. There is no available study that such data are available in States in northern Nigeria, particularly in Gombe, Kaduna and Benue.

2.2.3 Acceptability of Mental Health Services

Acceptability of MHS is the extent to which both health workers and community members take in or are willing to take in mental health information and other available services, as expressed by both the PHC workers and community; the extent to which health workers and community members would wish to have MHS in their places of residence or work. The level of acceptability for health services including MHS depend on several factors. Beliefs about the nature of an illness and the attitudes of health workers to clients would go a long way in determining acceptance of services (Kabir, *et al;* 2004).

Belief about causes and treatment of mental health problems thus affect acceptability. According to Jegede (2010), Nigerians believe that mental illness can result from four perspectives – natural causes such as those resulting from accidents or drugs; supernatural or mystical causes such as those resulting from the anger of the gods; preternatural sources usually caused by witchcraft; and lastly the inheritable ones. The Yorubas do not believe that mental illness can be permanently cured. It is rather seen as a continuous process because a mentally ill person is considered to be controlled by spirits, due to natural or other factors; hence among the Yorubas there is therefore the concept of '*alawoka',* meaning semi-controlled, which is a stigmatised perception of former mentally ill person. In a study of diviners in southwest Nigeria, Jegede (2010) reported that the diviners argued that once the appropriate rituals are performed the patient would maintain stable mental state. However, the problem can relapse if the victim flagrantly violates the taboos of the gods. This is said to be synonymous with the biblical injunction on the relationship between sin and illness in which Jesus Christ commanded that "Go and sin no more so that more dangerous illness does not come upon you." The study reported that diviners argue that human beings should revere gods and ancestors, indicating that to remain steadily healthy after treating mental illness; one would be perpetually tied to the aprons of the gods. The issue and stigma is associated with the beliefs about the disease.

In an earlier analysis of acceptance of health care services, Jegede (2001) presented the traditional concept of disease as a strong influence on health behavior in any socio-cultural environment. He argued that the decision to use health care services depends, to a large extent, on how the target health problem is perceived. In his study of three communities among the Yoruba in Oyo State and Bomadi in Delta State, Jegede (2002) found different perceptions of diseases of childhood. About 48% of the key information indicated that certain diseases such as mental illness cannot be within modern medicine because they believe the disease is caused by evil spirit.

In discussing the acceptance of health care services, Read (1966) listed four categories of people, namely the early adopters, late adopters, early drop-out, and non-adopters. The first category involves those who used the health service a lot, after awareness program while the second category involves those who take curse from the early adopters in the community. Individuals in the community will then begin to cooperate with health facility meant to treat and control localized or endemic decision. This will increase acceptability of services. The third category is those who use health services early and drop-out due to certain reasons. In his study some reasons such as side-effects, health workers arrogant behaviours and perceived waste of time at health centres. He found that although the earlier accepted the service and used it, alternative therapy. The last category involves those who would not use the health service at all. They have not changed their attitude because they believe that modern medicine cannot permanently cure or prevent disease. In his study, he found that some still hold on to the cultural perception of illness. It side effects of vaccination constituted a great hindrance to the use of modern immunization service.

Given the success of service acceptance in categories one and two in Jegede's analysis, it is important to know the channels through which new ideas about MHS can reach rural/community population. Similarly, the issues of health worker's attitude and length of stay in health centres reflected in third category require empirical exploration in states in Nigeria (northern). In the same

vein, there is also need to provide data in the study areas about inferences from the fourth category to determine the extent to which community members still hold on to cultural perception of mental illness, and this would change primordial attitude toward MI /PLWMI. This may act as barriers to accepting MHS if available. In northern Nigeria, data are unavailable on the extent to which communities in northern Nigerian States are willing to accept mental health services at the domains.

The implication of the cultural conception of mental illness is the likelihood of wrong diagnoses (Oke, 1995); many problems caused by natural factors are usually attributed to the supernatural or preternatural causes. This causes delay in seeking appropriate modern medical care and, in some cases, outright rejection of modern MHS. This is probably why the streets are filled with destitutes (Jegede, 2001), some of whom are mentally ill. The result is a high prevalence of mental illness in the society, which is a source of social problem to the government.

2.2.4 The Forms and Burden of Mental Health Problems in the Community

Mental health indices globally and in Nigeria have continued to worsen due largely to a very weak PHC system (WHO, 2007). According to Saxena, *et al;* (2010), tens of millions of people are living with mental illness such as depression, schizophrenia, epilepsy, and other mental health problems. These people need support to lead normal lives, but countries need to see this burden to provide the needed support (PHFN, 2015). According to WHO (2010), this support has become urgent because of the enormous burden of mental health disorders globally. In its report, the WHO portrayed the prevalence and burden of mental health problems in communities worldwide thus:

> About half of mental disorders begin before the age of 14. Around 20% of the world's children and adolescents are estimated to have mental disorders or problems, with similar types of disorders being reported across cultures. Yet, regions of the world with the highest percentage of population under the age of 19 have the poorest level of mental health resources. Most low- and middle-income countries have only one child psychiatrist for every 1 to 4 million people.

This early onset of mental disorders requires that early MHS are in place to detect these on time for quick intervention. MHS are meant to address this if antenatal and postnatal services will include such services. Among the health facts presented by the WHO (2012), mental illness is ranked as the leading cause of disability worldwide. This report is supported by other authors. Thornicroft and Tansella (2003) and (Malvárez, 2008)show that mental disorders are responsible for between 12% and 15% of global burden of disease, almost three-quarters of which occur in low and middle-income countries. More recently, it has reported that mental health disorders alone account for over 17% of the overall global disease burden (WHO, 2012), contributing significantly to physical morbidities and mortality (WFMH, 2004). For instance, mental disorders are one of the most prominent and treatable causes of suicide. According to WHO (2010), on the average about 800 000 people commit suicide every year, 86% of them in low- and middle-income countries. More than half of the people who kill themselves are aged between 15 and 44. In addition, mental disorders are among the risk factors for communicable and non-communicable diseases, and these can also contribute to unintentional and intentional injury.

Although most of these burden are exist globally, many countries have differential burden because some burdens may not be as impacting in one country as they are in other countries and life stages. For instance, suicide does not pose any worrying dimension in Nigeria as in India (WHO, 2010), while substance abuse is a likely distressing issue mong youths than in the elderly (Abdul, *et al;* 2010). This suggests that there must be factors responsible for this state of mental health care at the PHC level in different countries, and even in different locations within the same country. There is no substantively reliable data on the overall epidemiology of mental illness in Nigeria apart from the 1963 Leighton/Lambo study of the Yorubas, in Abeokuta. The Federal Ministry of Health (Nigeria) stated that "there is paucity of concrete nationally based data on the prevalence of various types of mental disorders in Nigeria, in spite of the magnitude of the problem" (FMoH, 1991:2).

This same concern was again expressed recently by Makanjuola (2015) during a Webinar Online Conference on Mental Health Care in Nigeria. He had lamented the lack of coordinated national data on the prevalence and burden of mental health problems in Nigeria. However, results of isolated hospital-based studies indicate the incidence of mental illness in Nigeria might be consistent with the projected estimates for developing countries by WHO (2004). Using this projection, 1% of the population would be suffering from incapacitating mental and neurological disorders such as schizophrenia, and depressive psychoses, epilepsy, mental retardation and dementias. Between 10 and 18% of the general population may be suffering from milder but also disabling mental or psychological disorders such as anxiety, depressions, psychosomatic disorders and hysteria. In addition, it is also estimated that between 20 and 40% of patients attending general health services clinics for medical help may be suffering from some form of mental health problems. In Nigeria, however, Makanjuola (2015) stated that from these projections it is assumed that over 63 million Nigerians suffer from some form of mental illness. He further stated that one in every four Nigerian will suffer from a diagnosable mental health problems in his/her lifetime.

Even the community at large has expressed concern over the rising incidence and dangers of substance abuse in Nigeria. For example, there are indications that vagrant psychotics are many on the streets of Nigeria but no accurate data on them (PHFN, 2015). Such local issues should constitute the major mental health challenges for MHS. For instance, the World Mental Health Day celebrated on the 10th October of every year should focus, in order to create mental health awareness among the members of the community (Chiejina, 2013). Based on the prevailing mental health challenges in communities, therefore, mental health services required in countries may differ. For intance, Abdul *et al;* (2010) found in their study of marijuana use among senior secondary schools students in Kaduna Nigeria that in many communities , substance abuse and its related mental health disorders among in- and out-of school youths constitue a major problem, as against say depression and suicide

problem elsewhere. Empirical hospital statistics indicate a rising trend in incidence of drug and alcohol abuse among youths and adults in Nigerian communities (PHFN, 2015), but community-based data are limited especially in northern Nigerian communities.

Some factors are said to have even worsened the mental disease burden. WHO (2010) listed wars and other major disasters as having a large impact on the mental health and psychosocial well-being. It emphasised that rates of mental disorder tend to double after emergencies and disasters. Makanjuola (2015) added that the mental health challenges of Nigerians have worsened in recent times because the world is now infiltrated with increased levels of negative stress, images of war, terror, death and destruction. He further stated that mental health of individuals is affected by external factors. This has given rise to a variety of mental health problems in communities.In Northern Nigeria, what constitue mental health problems in the communities and the committment of the Local and State Health Authorities in the region, lack sufficient empirical evidence.

2.3 Factors Affecting the Provision of Mental Health Services at the PHC Level

Access to health care services including MHS is determined by a variety of factors. These include the availability of the services within a certain distance, their affordability and acceptability, perception of quality, and attitudes regarding nature of disease. According to FMoH (2007), approximately 71% of Nigerians have access to a PHC facility located within 5km radius of their house, in which MHS are expected to be provided. However, many of these PHC centres are not functional due to frequent stock-outs, a lack of equipment, essential supplies and qualified staff (FMOH, 2007). Even the functional ones do not provide MHS. The WHO/WFMH (2009) reported that certain factors inhibit provision of MHS at the PHC level. The WHO (2010:2) insists that:

> In order to increase the availability of mental health services, there are five key barriers that need to be overcome: the absence of mental health from the public health agenda and the implications for funding; the current organization of mental health

> services; lack of integration within primary care; inadequate human resources for mental health; and lack of public mental health leadership.

Therefore, the factors cut across policy issues and socio-political dimensions, structural issues such as facilites and human resource, and resource allocation. The Federal Government of Nigeria acknowledged that at the top levels of health administration, both at the Federal and State Ministries of Health, there are no scheduled mental health officers in relevant departments with cognate experience to assist in the formulation, initiation, motivation and co-ordination of mental health programmes in the country (FMoH, 1991). It also acknowledged the challenges of qualified staff and negative community attitudes to mentally ill. In a related way, it stated that there is serious knowledge gap about mental health in the existing curricula for the training of PHC workers. In addition there is also lack of interest among health care professionals to undertake specialized courses in mental health.

In discussing the specific obstacles to providing MHS at community-based settings, WHO/WFMH (2009) had identified 10 barriers. These barriers have not been examined in previous study in the northern part of Nigeria. These are assessed in the study areas in this study to examine how these factors account for the present level of MHS in these communities. On their part, Butler, *et al.;* (2008) and AHRQ (2012), haveidentifiedthese barriers include service provider factors, financial and funding challenges, cultural issues and organizational barriers. Butler, *et al.;* (2008) identified other specific issues such asPHC workers unwilling to take additional responsibility, poor referral system and follow up against the recommended two-referral system. Others identified barriers are lack of operational blueprints such as lack of Standing Orders and essential drugs to treat minor to moderate mental health problems).

For Mulligan (2013), barriers to MHS are social barriers, physical barriers, communication barriers, attitudinal barriers, and policy barriers. To him, the social barriers which include negative

attitudes and cultural messages, and discrimination in employment, while physical barriers include access to building, schools, clinics, transports, roads, paths. Communication barriers (that is, written and spoken information in the media) are in form of flyers, internet, and community meetings; while policy barriers include such issues as legislation that discrimination against PLWMI and an absence of legislation that might otherwise provide an enabling framework. He further added that attitudinal barriers including stereotype of PLWMI, social stigma and other overt discriminations. These barriers are discussed, broadly, as policy barriers, and socio-cultural barriers.

2.3.1 Policy Gaps and Political Will as Barriers to PHC Mental Health Services

The policy thrust on mental health is captured by what WHO (2010:10) refers to as "the three most important recommendations for the development of policy, strategic plans and for organizing MHS." These are to: 1) deinstitutionalise mental health care; 2) integrate mental health into general health care; and 3) develop community mental health services. According to the WHO, this should serve as part of the technical support to policy makers and service planners (of mental health care). Any mental health policy should address these fundamental issues. A mental health policy is the official statement of a government, which defines the vision and details an organized set of values, principles, objectives and areas for action to improve the mental health of a population (WHO, 2011). A National Mental Health Policy, however, exists for Nigeria (FMOH, 1991; WHO-AIMS, 2006), and this document is hinged on the Primary health care principles, with emphasis on community participation and collaboration among the various sectors.

Despite the emphasis, the Federal Government has reportedly not paid sufficient attention to PHC, as shown by poor resource allocation and poor system designs for health care (FMoH, 1991). This is acknowledged even by government functionaries. For example, in 2007 at the Lancet Lecture on Friday 9 November, Professor Grange, the then Minister of Health for Nigeria, said:

> (In Nigeria) There is enough in terms of knowledge initiatives, strategies, tools, drugs and treatment protocols to cure disease and prolong life, but the reality is that the systems designed to bring about these outcomes are inadequate at best or even non-existent.

The above statement indicates the weak Nigerian political system in activating existing (or in designing appropriate) policies to make health care available to particularly high risk members of the society, especially for the mentally sick and vulnerable. Prior to this 1991 Federal Government policy statement on mental health, Ityavyar (1983) had stated that the problems of health care delivery in Nigeria including PHC services are deeply rooted in the socio-political climate of the country. He predicted that rural PHC services are deliberately sub-optimally provided, and distributed in terms of funds allocation and maldistribution of health workforce and related resources. In Zambia, Mwape *et al.*; (2007) found a weak political will in their attempt to integrate MHS into the PHC. They suggested that providing effective mental health care at the PHC would require "increased consensus, commitment and political will" from government to place mental health on the national agenda and secure funding for the sector. The study also indicated that providing mental health at the primary care level would reduce stigma and the promote human rights for people with mental health problems, and thus require the political commitment.

In Nigeria, a country wide study, WHO-AIMS (2006), found that the Local Governments are presently ill-equipped to dispense the much needed primary health care to millions of Nigerians. The study reported poor policy implementation in Nigeria as the major factor against the effective provision of MHS. Similarly, a comparative study of mental health services in South Africa and Nigeria indicated that although MHS in Africa has its cradle in Nigeria (from Aro Hospital), Nigeria's MHS especially at the PHC level is crippled due to lack of policy and political inattention (Jack-Ide, Uys and Middleton, 2012). The study implicated the poor policy and political unwillingness to lack of vision for MHS in Nigeria. A Nigerian health economist working with

WHO's Department of Chronic Diseases and Health Promotion, refers to this as "the misguided attempts to develop PHC in Nigeria" (Abegunde, 2013). To him, this policy failure is because health care instituted by the colonialists was organized primarily to meet the needs of the colonialists. The argument holds further that after independence, the new government naturally adopted the colonialist health system, focusing primarily on the needs of the post-colonial elites.

Mental health policies are weakly implemented, resulting in lack of plans and legislations in Nigeria. Mental health Atlas (2011) describes a mental health plan as the strategies, activities, timeframes and budgets that will be implemented to realize the vision and achieve the objectives of the policy as well as the expected outputs, targets and indicators that can be used to assess whether implementation has been successful (WHO, 2011). On May 27, 2013, the World Health Assembly adopted the Comprehensive Mental Health Action Plan 2013–20201 that has great potential to change the direction of mental health in all countries around the world in the next 8 years. This action plan and the accompanying resolution—a first in the history of WHO—represent a formal recognition of the importance of mental health for WHO's 194 member states, which collectively committed themselves to take specified actions to improve mental health and to contribute to the attainment of a set of agreed global targets. According to the WHO (2013:10), the four-fold objective of the Action Plan is:

> To strengthen effective leadership and governance for mental health; provide comprehensive, integrated and responsive mental health and social care services in community-based settings; implement strategies for promotion and prevention in mental health, and; strengthen information systems, evidence and research for mental health.

Implementation of the action plan faces many challenges; one in particular is the many years of inadequate investment into human and financial resources for mental health care, which needs to be quickly reversed. Health policy planners and health professionals are to turn this around by ensuring that promoting, protecting, and restoring good mental health represents an integral part of their

responsibilities. Local leaderships will need to develop to support this process. With concerted action by all stakeholders, WHO hopes to overcome these challenges and assist countries to deliver health care and other services that conform to WHO's definition of health,which places emphasis on mental and social wellbeing. In 2007, the Republic of the Gambia, in collaboration with WHO, completed its first-ever mental health policy and strategic action plan (Chiejina, 2013). Major objectives of the Gambia's mental health policy include de-institutionalisation of the Campama Psychiatric Unit; the provision of equitable, accessible, cost-effective, and good-quality mental health and substance abuse services in the community; and the promotion and protection of the rights of people with mental and substance use disorders. Northern Nigeria has no data on such plans.

Mental health legislation, or mental health provisions integrated into other laws (e.g. anti-discrimination, general health, disability, employment, social welfare, education, housing, and other areas), may cover a broad array of issues including access to mental health care and other services, quality of mental health care, admission to mental health facilities, consent to treatment, freedom from cruel, inhuman and degrading treatment, freedom from discrimination, the enjoyment of a full range of civil, cultural, economic, political and social rights, and provisions for legal mechanisms to promote and protect human rights (e.g. review bodies to oversee admission and treatment to mental health facilities, monitoring bodies to inspect human rights conditions in facilities and complaint mechanisms) (Mental health Atlas 2011; WHO, 2011).

In addition, Anosike, (2015), a public analyst said that policy-makers understood as health as grand, big elephants, 50- to 100-bedded hospitals somewhere, whose services are not designed to respond adequately to the needs of the people but for few urban elites Thus, many other authors such as Ayorinde, Gureje and Lawal (2004) insist that point to poor leverage and thwarting of mental health care delivery in Nigeria is occasioned by a lack of political will and poor policy-making that

failed to share responsibilities effectively between federal, state and local governments. This, they believe, has resulted in PHC services lacking the appropriate staff and sufficient funds, hence the chaotic situation in the health sector which some health commentators call "vague rhetorics that mean nothing to the average Nigerian" (Ihekweazu & Anya, 2006).

To overcome such limitations, Ihekweazu and Anya (2006) have argued that the systems delivering health services in Nigerian cities need radical policy reforms. Such reforms should be a collection of measurable policies and strategies with well-defined, measurable outcomes such as setting targets for PHC mental health services and the number of PHC centres with MHS units that are built as against being measured in terms how many teaching hospitals are re-furbished or indeed how many tons of (fake) drugs are burnt. Unfortunately, the promotion of mental health seems not to be of any concern to the Nigerian government, despite the burden of the problem. In 2006, Nigeria's then Minister of Health, Professor Grange suggested in developing Nigeria's National Health Investment Plan (NHIP), there is need to address the key areas like involving communities and healthcare workers in its design, with the hope of standardising approaches to health delivery in Nigeria and emulate best practice from other countries. In her paper, she stated the key priority areas of concern thus: "to eradicate polio, control malaria, reduce maternal mortality, and reduce levels of disease, particularly in the most vulnerable groups." Again, no mention was made of mental health, despite the huge burden of mental disorders (WHO, 2012; WFMH 2011).

To buttress the neglect further, the most recent Nigeria National Demographic and Health Survey (2013) and earlier editions had no data on mental health problems in Nigeria (NPC, 2014). All the common health problems as captured in the PHC components, among other health conditions, except mental disorders. The exclusion of data on mental health conditions of Nigerians suggests the "deliberate neglect of mental health" in Nigeria (Anosike, 2004).

From the foregoing, there is a failure of policy thrusts and deliberate neglect in Nigeria to create a unified system to address structural and process issues such as mental health facilities, financing and staffing for competent local leadership at the PHC system in Nigeria to provide MHS at the community level. The mental health policy in Nigeria did not articulate the structural and manpower needs for mental health services at the PHC level in Nigeria. As a result, lack of structures for services, poor resource allocation, weak database for mental health, human resource challenges, and lack of inter-sectoral collaboration including community non-participation, have become specific barriers to MHS in Nigeria. Some of these specific barriers are discussed as follows.

2.3.1.1 Funding and Budgetary Allocation

WHO (2011) reported the global underinvestment in mental health care, despite the burden of mental illness worldwide. For example, the world body indicates that one in four people will require mental health care at some point in their lives but in many countries only two per cent of all health sector resources are invested in mental health services. According to the WHO's *Mental Health Atlas* (2011), the average global spending on mental health is still less than US$ 3 per capita per year but in low income countries, expenditure can be as little as US$0.25 per person per year. In her analysis of financial resource allocation to mental health services, Malvárez (2008) juxtaposed the burden of mental disorders and the budgetary allocations, as summarised in the Table 2.2.

Table 2.2: Country burden of Mental illness and Budget for Mental Health

Income of Country	Burden of mental disorders	Budget for mental disorder
Low	7.88	2.26
Lower middle	14.50	2.62
Higher middle	19.56	4.27
High	21.37	6.88
All	11.48	3.76

*Source:*Malvárez (2008) of *Global Perspectives on Mental Health*

A number of other imbalances in resources allocation in mental health are found in other scenarios. For instance, on human resource, Dr Shekhar Saxena, Director, Mental Health and Substance Abuse at WHO stated that "almost half of the world's population lives in a country where, on average, there is one psychiatrist (or less) to serve 200 000 people" (WHO, 2007). He stated further that "many low-income countries have less than one mental health specialist per one million population". In addition to insufficient resources, the little that is available is inequitably distributed and inefficiently used as these meagre resources are again diverted to mainly services that serve relatively few people, especially those in institutionalised (curative) care.

Good mental health services focus equally on providing patients with a combination of medicinal regimens and psychosocial care. In lower income countries, however, shortages of resources and skills often result in patients only being treated with medicines. The lack of psychosocial care in form of community-based care and strong social support, reduces the effectiveness of such treatments. A study conducted by WHO (2008) showed that in low-income countries, scaling up a package of essential interventions for three mental disorders – schizophrenia, bipolar disorder and depression – and for one risk factor – hazardous alcohol use – requires an additional investment as low as $US 0.20 per person per year.

Although these mental challenges are common in many developing countries, specific fund allocation for them has not been substantiated by empirical evidence. Such low budgetary allocations in low-income countries have been found in Nigeria. In fact, the total allocation for mental health services in general has been grossly low (Adeluye, 2008). Nigeria, like most African governments scorned the promise to commit 15% of their budgets to health as contained in the Abuja Declaration. But in Nigeria, the total expenditure on healthcare as percentage of Gross Domestic Product (GDP) is 4.6%, while the percentage of Federal government expenditure on healthcare is only about 1.5%

(Al-Olugbenga and Adebimpe, 2010). Although recent allocations have shown some increase in the budgetary allocation to 3.5% (which is still insignificant) of its National budget to the sector, Nigeria ranks just above Burundi in Africa in budgetary allocation on health. This is far below the standard set by the Conference for African Heads of State and Government ten years previously in Abuja which pledge for governments to allocate at least 15% of their national budget to the health sector. Only a few of the African countries has been able to meet or pass this target. These include Rwanda, Botswana Republic of Niger, Malawi, Zambia and Burkina Faso (Adefuye, 2011). As a result, among other health conditions, mental health problems and illnesses are said to be on the increase; although the actual magnitude is unclear due to poor statistics.

But it has been established that Nigeria, like most African governments, does not keep its promise to commit 15% of her budgets to health as contained in the Abuja Declaration to PHC. This meagre allocation leaves mental health with virtually no budget. More so, more paltry allocation is given to mental health care and the primary health care system. During Webinar world platform discussion, Gureje (2015) lamented that Nigeria allocates only 4% of her health budget to mental health as a whole, a far cry from the mental health budget. It argued further that all the budgetary allocation from the Federal Government of Nigeria goes to services at the Psychiatric Hospitals and Departments of Psychiatry in Nigerian Medical Schools; virtually nothing is allocated to MHS at the PHC level. Scaling up mental care services especially at PHC level requires investing more resources at the primary care level (WFMH, 2010). States in northern Nigeria have no available records of such allocation.

2.3.1.2 Human Resources for MHS in PHC

According to Alwan (2010), improvement in mental health services require increasing the capacity of the PHC system for delivery of an integrated package of care, not sophisticated and expensive technologies. WHO (2010:3) states that:

> There is huge inequity in the distribution of skilled human resources for mental health across the world. Shortages of psychiatrists, psychiatric nurses, psychologists and social workers are among the main barriers to providing treatment and care in low- and middle-income countries. Low-income countries have 0.05 psychiatrists and 0.42 nurses per 100 000 people. The rate of psychiatrists in high income countries is 170 times greater and for nurses is 70 times greater

This suggests that human resource training for PHC workers is the basic and most fundamental prerequisite to enhance effective and efficient MHS. In 2008, WHO launched its Mental Health Gap Action Programme (mhGAP) to assist countries to scale up services for mental, neurological and substance use disorders. The programme provides knowledge and skills to primary health care providers such as general doctors, nurses and other health care workers to identify and manage these disorders. Many countries have adopted this strategy in training the operators of their PHC systems to help integrate MHS into the PHC. As reported by WHO/WFMH (2009), Jordan is making progress with a programme for priority mental disorders in this direction while Panama has begun training its primary care providers on a systematic basis.

In Africa, Ethiopia and Nigeria are reported to have begun training their primary health care personnel to identify and treat priority mental disorders. The Ministries of Health of both countries have committed to sustain the programme for lasting impact. In Nigeria, the content of this training has not been analysed to determine whether or not its current design could meet the need of trainees to provide effective MHS in presence of current community and social realities.

In other parts of Africa, such as Zambia, Kenya, and South Africa, few isolataed studies have shown the role of PHC workers' training and perceptions on the provision of MHS. For instance, in their study, *Integrating mental health into primary health care in Zambia: a care provider's perspective* in Zambia, Mwape *et al;* (2007) identified a strong support from primary health care workers in Zambia for providing effective and efficient mental health services at the primary health care level, as a way of facilitating early detection and intervention for mental health problems. However, the health care providers felt they require basic training in order to enhance their knowledge and skills in providing health care to people with mental health problems. This indicates, as the need for the health workers to have some training to be able to provide MHS.

It has been reported by officials of WHO that doctors in Jordan and medical assistants in Nigeria (i.e. CHEWs and nurses/midwives) should be able to treat children with epilepsy (Saxena, 2010). These two conditions are commonly encountered in primary care, but neither identified nor treated due to lack of knowledge and skills of the health care providers. The *Intervention Guide* will help scale up care for mental, neurological and substance use disorders - which is the aim of WHO mental health Gap Action Programme (mhGAP). Even PHC workers lack the skills to carry out these services (Van-Cleve *et al.;* 2013). The level of knowledge and skills among PHC workers in States in northern Nigeria has not been found in available literature.

Similarly, lack of the mental health personnel is a big challenge in providing MHS in Nigeria. In the Mental Health Situation Analysis in Nigeria, Mental Health Leadership and Advocacy Programme (mhLAP, 2014) reported that people with clear cut mental disorders cannot access care and treatment due to shortage of mental health specialists and bed space. According to this source, in all hospitals in Nigeria, there are only 2, 856 bed spaces for mentally sick individuals in the whole country for in-patient care. Similarly, the mental health specialists in Nigeria for a population over 150 million is estimated as: Psychiatric nurses – 1460, Psychiatrists (psychiatric

doctors) – 149, Psychologists – 69, Occupational therapists – 35, and Social workers – 114. This translates to a psychiatrist to about 1, 400, 000 people, and a nurse to 1,027, 739 population, reflecting gross inadequacy compared to the WHO recommended ratio per 100,000 population. Despite this serious shortage, it is reported that some of the specialists are posted to non-mental health departments and units where they are not needed (WHO-AIMS, 2006). The number of these specialists available at the PHC level and distribution to provide services at that level in the States in northern Nigeria is empirically unsubstantiated.

2.3.1.3 Weak database

Low level of research on mental health in general and MHS in particular has been documented as a factor hindering functional services at the PHC level. In Nigeria, data on mental disorders especially at the community level are lacking and appear not to be a focus of large government-sponsored surveys. This is reflected in the absence of statistics on mental health in recent demographic and health surveys (NDHS, 2013).

Odejide *et al.*, (2008) also pointed out this dearth of such research activities at the Primary Health Care system in Nigeria. They lamented that there are only few isolated studies, and even these are uncoordinated. According to them, this situation has not favoured the pooling of data for any effective and efficient mental health service delivery. Boerma (2015) of the World Health Organisation has argued in this regards that accurate and complete data is essential for good decision making and health planning. According to WHO-AIMS (Nigeria) (2006), this neglect has resulted in the underestimation of mental illness in Nigeria, and thus weak service plans and implementation. The role of database in planning a functional mental health service system has no empirical support in northern Nigeria.

2.3.1.4 Inter-sectoral Collaboration in the Provision of Mental Health Care Services

> Governments, donors and groups representing mental health workers, patients and their families need to work together to increase mental health services, especially in low- and middle-income countries (WHO (2010; Fact 10).

This statement emphasises the role of collaboration; and these activities are multisectoral (Herrman, Saxena and Moodie, 2005). FMoH (1991) and (WHO, 2010) encourage the involvement of NGOs in the promotion, preventive and rehabilitative aspects of mental health services; collaboration with appropriate international organizations with relevant objectives. To address mental health services, the WHO-AIMS Report (2006) on Nigeria recommends that inter-sectoral collaboration to be fostered with the aim of improvement quality of life. In her *The National Mental Health Policy for Nigeria*, the FGN has emphasied that:

> The logical and rational approach to reaching the population at large is through the incorporation of mental health into the Primary Health Care. In this way, the community shall have the opportunity to participate and determine the type of mental health care appropriate for it (FMOH, 1991:2).

This emphasises universal coverage with community participation. According to WHO Factsheet (2007), the role of intersectoral partners, alongside mental health policies, in addressing the socio-economic and environmental factors related to mental health. According to this source, these collaborations are required to promote mental health and effective MHS provision. In 1991, Hellandendu reported the low community involvement in PHC services in northern Nigeria. Similarly, Jegede (2010), in his study of southern Nigeria communal effort in health care services established that level of community participation in modern health care delivery is generally low in Nigeria. To him, this is because:

> Modern health care programs are designed and brought to communities. The people are not involved at the planning stages. Although it benefits the people, yet they consider it as a government program, rather than the people's program (Jegede, 2010; p.96)

On organizations representing the interest of people with mental illness, no organization of nationwide function or spread exists. In the Mental Health Situation Analysis in Nigeria, the Mental Health Leadership and Advocacy Programme (mhLAP, 2014), some NGOs and family support groups exist at the local level, the oldest of which was established less than 5 years ago. Others are recent in set-up. They include the following active and not so active organizations:Mental Health Foundation, Lagos (Registered); Lifecare Trust Initiative, Osogbo, Osun state (Registered); Health and Restoration Centre for Psychiatric Illness, Agboke, Otukpo, Benue State (Registered); Allah's Megaphone Foundation, Ibadan Oyo State (Unregistered); Foundation for Mental Health Law, Rights and Restoration, Ibadan Oyo State (Registered); and Family Support Group, UCH, Ibadan Oyo State (Unregistered).

Other socio-cultrual determinants such as religion, which influence health care in general also impinge on the integration of mental health into PHC (Oluwabamide and Umoh, 2011; Abiodun, 1989; Asuzu, 2009). For example, the role that religious leaders, as community leaders, play in the mental health the role of religious leaders have been highlighted in studies elsewhere in Nigeria, pointing to their incorrect perceptions (Igbinomwanhia, James and Omoaregba, 2013). Studies have however shown that mental health promotion strategies are themselves ignored by health workers (WHO, 1978; WHO-AIMS, 2006; Odejide *et al;* 2010; WHO, 2007; WMHF, 2009) and community members' alike (Abiodun, 1989; Mwape *et al;* 2010).

The policy barriers include lack of mental health policy and political commitment in the selected States, lack of mental health units at PHC centres, weak data base for mental health disorders at the PHC centres, shortage of trained PHC workers, and lack of collaboration. There is paucity of data on the level of developing MHS at community level in the effort of deinstitutionalising mental health care and integrating into the general at the PHC level in northern

Nigeria, particularly in Gombe, Kaduna and Benue States. However, available literature indicates that all the different health policy attempts in Nigeria have been unsuccessful in addressing MHS at the PHC. But data on such policies and specific programmes in northern Nigeria are lacking.

2.3.2 Socio-cultural Barriers to PHC Mental Health Services

The socio-cultural barriers are negative attitudes and misconceptions about the causes and treatment of mental illness as well as the social stigma against PLWMI which hinder, or have the potential to hinder, the utilisation of MHS at the community level. The social issues range from incorrect perception of the illness, through social stigma, and negative attitude toward PLWMI, and the individual's family. According to WHO (2010), PLWMI share common challenges related to their socio-cultural and economic challenges, including stigma and discrimination, abuse, and restrictions in exercising civil and political rights (Townsend, 2006). These usually act as barriers to MHS. The socio-cultural barriers often arise from the social reaction to mental illness and labelling of people of living with mental illness (PLWMI). These socio-cultural barriers cut across attitudes towards mental illness, and stigma and discrimination against PLWMI.

2.3.2.1 Attitude towards the PLWMI

Beliefs such as preternatural causes, anger of the gods and spells as underlying mental illness are prevalent (Jegede, 2010), and this generates a variety of attitudes and perceptions toward mwntal illness. In their study of the perception and attitude of public and medical students towards mental illness in Oman, Al-Adawi, Dorvlo , Al-Ismail, *et al;* (2002) found that that both medical students and the public considered mental illness as caused spirits, indicating that traditional beliefs about mental illness did not change despite exposure to a biomedical model of mental illness. The perceived causes of mental illness by both health professionals and medical laity (community members) are determinants of the pathways to treatments and of modern therapeutic interventions.

Jegede (2010) observed that workers attitude constitute great hindrance to health care utilization, because they expect scientific outlook from the majority of the people, and at the same time expect them to comply immediately without adequate evaluation of the services. The need to make health professionals appreciate culture differences in various societies is believed to have eluded may a health workers. This has created a great gulf between the two groups. This situation of PHC workers' and lay perception of mental illness and their attitudes towards PLWMI requires empirical evidence in northern Nigeria.

Oman,*et al;* (2002) found that most people believe that people with mental illness (PWMI) tend to have stereotypical appearances, and the majority of them preferred that facilities for psychiatric care should be located away from the community. The study also revealed that neither socio-demographic factors nor previous exposure to PWMI was related to attitudes towards PWMI: traditional beliefs on mental illness did not change despite exposure to a biomedical model of mental illness. Their study largely supports the view that the extent of stigma towards mental illness remains a concern and varies according to the cultural and sociological backgrounds of each society, and not necessarily the knowledge about mental illness. They however did not assess the role of age and gender differences in their study.

This aspect was explored in a study by Ward,Wiltshire, Detry, and Brown (2013) in which they investigated the attitude of 272 community-dwelling African Americans aged 25-72 years African American men and women's toward mental illness. They also evaluated the respondents' perceptions of stigma, and preferred coping behaviours, using an exploratory, cross-sectional survey design. The findings revealed that depression was the most common mental illness in the study community. Participants were also found to be knowledgeable about some of the symptoms and causal factors of mental illness. However, their attitudes suggested they are not very open to acknowledging psychological problems, are very concerned about stigma associated with mental

illness, and are somewhat open to seeking mental health services, but they prefer religious coping. Significant gender and age differences were evident in attitudes and preferred coping.

The finding therefore suggests gender- and age-specific psycho-education (mental hygiene) interventions or community awareness programs designed to increase openness to psychological problems and reduce stigma. Also, exploration of partnerships between faith-based organizations and mental health services could be helpful to African Americans. The situation is not different in many other parts of Afrcia, including Nigeria. In Nigeria, few available studies conducted in parts of northern Nigeria show similar results. For example, in a study of the perceptions of mentally ill patients and their relatives in Zaria about mental illness and treatment, Anyebe *et al;* (2008) found that mental illness is viewed as being mainly caused by evil spirits and as being inflicted by enemies through sorcery. However, many respondents mentioned the biomedical causation of mental illness. From these studies, it can be concluded that most people still view mental illness as being caused by forces outside normal human experiences and so fear and stigmatise mentally ill persons as having evil forces. This carries with it discriminatory tendencies especially avoidance as the disease bear a connotation of being transmissible contagions. This may affect acceptance of modern MHS in PHC.

The WHO (2012) had initiated as part of global action programmes to assist countries implement coherent and comprehensive mental health policies, plans and legislation, and to ensure efficient and effective provision of mental health care at the community level. These action programmes include changing attitudes, raising awareness, improving human rights, empowering mental health service users and families and replacing psychiatric institutions with community care, and increasing investment in mental health including development of the human resources and adopting policies. Strengthening human rights laws and services are also suggested. Most of these activities are targeted at the communities where people exhibit these attitudes. Available literature

shows limited data on the perceptions and attitudes of both PHC professionals and the public towards people with mental illness and PLWMI in northern Nigerian communities.

2.3.2.2 Stigma and Discrimination

WHO (2010) stated that stigma about mental disorders and discrimination against patients and families prevent people from seeking mental health care. Human rights violations of psychiatric patients are routinely reported in most countries. These include physical restraint, seclusion and denial of basic needs and privacy. Few countries have a legal framework that adequately protects the rights of people with mental disorders.As reported by WHO (2011), people living with mental illness (PLWMI) face discrimination on a daily basis in all fields, especially in the areas of education, employment and housing. The WHO (2006) reported that PLWMI around the world face a wide range of human rights violations; that they are often ostracized and denied the care they require. In some communities, they are naked or in rags. They are beaten and left to go hungry. Similar situations occur, even, in many modern mental hospitals. Patients are sometimes to be restrained with metal shackles, confined in caged beds, locked up in separate rooms and deprived of clothing, decent bedding, clean water and other routine needs. Some countries even prohibit people with mental disorders from voting, marrying or having children (WHO, 2012).

In South Africa, a public survey showed that most people, contrary to expectations expressed high levels of stigma about PLWMI; and these were higher in urban areas and among people with higher levels of education. As pointed out by Benedetto Saraceno, Director of WHO's Mental Health and Substance Abuse Department (WHO, 2008), people with mental disorders are stigmatized and are subject of neglect and abuse. As she stressed, all societies are to "ensure that people with these disorders are not denied opportunities to contribute to social and economic life and that their human rights are protected". Despite this appeal, stigma of PLWMI remains a problem, exhibited by both the publc irrespective of level of education and even health professionals. For example, in South

Africa, a public survey showed that, contrary to expectations, levels of stigma against PLWMI were found to be even higher in urban areas and among people with higher levels of education (WHO, 2012).In a similar vein, in Zambia, Mwape *et al.;* (2007) a survey of health care workers revealed that many Primary Health Care providers still had stigmatising attitudes towards the mentally ill.

In their study of African American men and women on their perceptions of stigma of mental illness in the United States, Ward et al.; (2013) found that despite good knowledge of mental illness, the respondents expressed strong primordial sentiments and stigma about mental illness. The study revealed that the respondents preferred recourse to religious intervention instead of modern medical treatment. Similarly, in South Africa, a public survey showed that most people thought mental illnesses were related to either stress or a lack of willpower rather than to medical disorders, and their views suggested stigma about mental illness. In Nigeria, Gureje (2013), a Professor of Psychiatry at the University College Hospital, Ibadan, highlighted that:

> Attitude to mental illness is characterised by intolerance of even basic social contact with people known to have such illness. In a society in which poor health facilities and poverty make the care of people with mental illness a major burden for both patients and their families, the degree of stigma experienced by individuals with mental illness suggests an unusual level of illness-related burden.

These have caused discriminations against PLWMI at different levels and in a variety of patterns in Nigeria (Gureje, 2013). In a study of the perceptions of mentally ill patients and their relatives in Zaria about mental illness and PLWMI, northern Nigeria, Anyebe *et al;* (2008) had found that mentally ill people are perceived as dangerous, even by their relatives and some health workers. They concluded that the awareness of such perceptions by PLWMI add more burden to the psychologically (mentally) ill persons. They then became labelled (Szaz, 1970; Cochrane, 1983; Jegede, 2010) due to such belief about the mentally ill. As a cardinal social reaction to mental illness;

> Labeling is the single most important cause of chronic mental illness. This is because the labelling of an individual who exhibits deviant behaviour as mentallly ill tends to stabilise or reinforce that pattern of behaviour. If, on the other hand, exactly the same initial behaviour is either not labelled or defined in some other way, such as due to intoxication, then it will more likely be transient and not come to affect the person's self identity (Scheff, 1966; p.67)
>
> .

Cochrane (1983) also beleives that labelling is main cause of residual deviance and secondary deviance, which eventually pertuates as chronic mental illness. The individual with psychological problems who becomes so labelled, assumes the mentally sick role with all other attendant social consequences. This would attract a variety of discriminatory reactions such as avoidance and ostracism. Such stigma hinders PLWMI from accessing MHS even if these services are available, probably because of labelling and stereotypes. However, studies of this nature in Northern Nigeria, how these discriminatory tendencies limit MHS delivery at the community level unavailable.

From the foregoing, barriers to effective MHS at the PHC level include inconsistent and sometimes non-existent mental health policies, lack of political will and facilities, uncoordinated services, lack of appropriate PHC providers at the centres, lack of collaboration and socio-cultural issues such as wrong community perception about mental health problems, among other barriers. According to Herrman, Saxena and Moodie (2005), the WHO has actively been making efforts to address the barriers that prevent access to mental health care, and campaigning for the full incorporation of mental health into public health in several countries and communities across the globe. In northern Nigeria, available literatures have not been able to show any empirical evidence of these efforts in relation to MHS at PHC level in States in this region.

2.4 Models of Providing Mental Health Care Services in PHC

Models for providing MHS are specific arrangements and organisational characteristics used to provide mental health services in primary care (PC) settings (Bird, et al, 1998). WHO/Europe (2010) has shown some models of PHC system have improved PHC delivery in general, thereby

improving national health indices in resource-poor settings. According to the source, the bottom-up PHC approach (primary-secondary-tertiary) has successfully improved community health outcomes in countries such as China and Brazil. Several other models of providing MHS at the PHC level have been developed and reported. Butler, *et al.;* (2008) reported the development and success of some integrated care programs tested for specific mental health disorders such as depression, anxiety, alcohol disorders, and persons with severe mental illness in primary care settings. Using the Deinstitutionalisation Model, it is being advocated that mental health globally should shift MHS from mental institutions to familiar, community-based settings, aimed at an integrated approach, with treatment and promotion and prevention as equally important components.

In both developed and developing countries, this bottom-up primary healthcare approach has successfully improved health outcomes (WHO/Europe, 2010). In the United States, the *Four-Quadrant Clinical Integrated Care Model* is implemented. It involves collaborative planning for addressing the needs of population subsets (not individuals) in each local system (National Council for Community Behavioural Healthcare, 2009). The experience in 12 sites across the US showed some level of effectiveness of this model (Mauer and Reynolds, 2008). Its drawback is that it does not specify in which quadrant individuals should receive care. Persons living with serious mental illness, if seeking primary care, should have developed protocols that spell out how acute cases or high-risk individuals will be supported. Similarly, there is no clarity in this model how people living serious mental illnesses, who are stable in their recovery, based upon personal choice can be supported through community collaboration.

In other places in US, the Wagner Chronic care Model is being used. This model involves team based care supported but an organisational and informational technology infrastructure, which is the basis PHC. Developed by Ed Wagner and colleagues, this model is in a variety of health care settings, providing a structural approach for clinical improvement

(http://www.improvingchroniccare.org, 2014). It has been to develop specific approaches for people living with diabetes mellitus, cardiovascular diseases, asthma, depression, and other chronic health conditions. It is run by Institute of Health care Improvement (IHI), a not-for-profit organisation. Its use in PHC settings is not ascertained. Other models used in the US include the Project IMPACT Model, and Patient-centred Medical Home, which are associated with better access to care, more preventive screenings, higher quality of care, and fewer racial and ethnical disparities.

In Australia, different models of providing comprehensive services including MHS have developed. In a systematic review of primary care delivery model in rural and remote Australia, Wakerma, Humphreys, Wells, *et al;* (2008) identified models such as 'Discrete primary care services', Integrated services, comprehensive primary care services, and Telehealth and Telemedicine. They reported improved overall health quality of citizens by over 70%.

The promotion of mental health in these countries has been made of the overall PHC coverage as an integrated comprehensive service delivery. The need to have such a model in Nigeria has been emphasised and in fact the Enhancement-Linkage Model has been proposed. The enhancement and linkage models of providing mental health services emerge as a dominant service model and with minor modifications, all suggested models fall into either category (i.e. enhancement and linkage) (Bird et al, 1998; Feltz-Cornelis et al, 1997). Enhancement refers to the training of PC workers to recognise, diagnose and treat mental illness, and carry out other mental health services independently, while linkage occurs when mental health professionals leave their hospital bases to provide mental health services in PC settings. Thus the model is actually a mix of two separate models: enhancement and linkage.

According to Omigbodun (2001), the Enhancement Model has been commonly used approach in developed and developing countries, based on the recommendation of WHO which states that PHC workers must be the first point of contact for mental health care. The enhancement

component is for all PHC workers because they all require enhancement. It is also cost-effective, and unlike other areas of health, which require costly technology, all that is required is the training of PHC staff to provide psychological support and relatively inexpensive drugs. With the low cadre of staff available, enhancement has to be accompanied by ongoing supervision from mental health professionals. Hospital based training alone is not effective and goes to waste if not followed up. If properly practised, this model caters for the vast majority of patients who present in primary care with problems neither physical nor psychological but a mixture of both.

The linkage component focuses on the broader scope of MHS which will be available to many more patients, and reduce stigma since patients receive mental health care at the same site they receive other primary care services. Though very costly due to numbers of highly trained staff required, the reality for developing countries like Nigeria is that there is an inadequate trained staff. However where it is practised, the effectiveness is high. In view of the high cost of linkage model in its pure form, a systematic structuring of linkage, using culturally and socially relevant means and agents of change can be rewarding, data on which are lackin and which this study seeksto provide.

This is particularly since most of the models accessed in this review are developed and operated in developed and Western countries; socially and economically privileged settings. They are alien to resource-poor settings like Nigeria. Several reasons have been advanced for Nigeria's failure to develop a successful model to provide a comprehensive and efficient health for Nigerians especially with Primary health care as the anchor, including weak mental health policies reflecting lack of strategies, mental health plans and legislation and Nigeria's colonial past (FMoH, 1991; Jegede, 2000; Abegunde, 2012). Nigeria is in the progress of developing a model. The Linkage-Enhancement Model being proposed MHS at the PHC in Nigeria has no data on its effectiveness. Adding a social component to this model of MHS delivery has not been undertaken in Nigeria.

2.5 Theoretical framework

This study is anchored onStructural-functionalist approach (using the Donabedian Structure-Process-Outcome Model of Quality Health Care) to explain the inter-relationship and inter-dependence of the three tiers of the health care system in Nigeria, and the inter-relationship and inter-dependence of the various components of the PHC system itself, and the social actors of the system, including clients/patients and service providers. It also captures the link between health and non-formal health sectors, with implications for a modified enhancement-linkage model for MHS.

2.5.1 Structural Functionalism (the Donabedian Model of Quality of Care)

Structural functionalism is a macro sociological theory that examines social patterns and structures of society as having interrelated parts (Ritzer, 2012). The basic theorem of the theory holds that a social system is a real system in which the parts perform essential functions for the persistence of the whole and therefore are interdependent and more or less completely integrated. The fundamental assumption of structural functionalism is the idea of an organismic analogy, which sees society as a system of interdependent parts, and consensus of values where parts are seen to function to maintain the whole (Parsons, 1951), existing on order and stability (consensus, universality). The consensus idea presupposes that the system works on a supposed agreement. Therefore, in structural functionalism, social reality and social processes are visualized as a system made up of interdependent and inter-related parts. This can used in the analysis of mental health services within the health care system and within the PHC system.

In this case, the health care delivery system in Nigeria as a social reality is viewed as a system with three interdependent and inter-related parts, namely, the Primary, Secondary and Tertiary Levels of care. Furthermore, the health system is in constant with the non-health systems (such as the political, family and economic systems) which also function inter-relatedly. The three

tiers and the other social systems must work interdependently to ensure the health of the population, including the mental health of the citizens. In addition, functionalism presupposes that society also possesses needs that must be met for survival. In this case, health care services including mental health care services are a societal need required its survival, and society has means to be met to survive. Parson (1951) categorises these needs, referred to functional prerequisites, into four: Adaptation, Goal maintenance, Integration and Latency or pattern maintenance (AGIL). Put differently, there are functional needs of a system, based on certain functional prerequisites such as procreation, role allocation, association, and adaptation (including providing goods and services to members of the society), in this case mental health care services. In this functional analysis, the role of institutions (for example, the health care system) and the types of behaviour (of health care workers and community members) are explored. This captures the target population in examining the integration of mental health care services at PHC centres, as part of health care system.

In Parsonian functional prerequisites, which refer to the strategic, basic and fundamental conditions a society must satisfy to be considered healthy and surviving (Olayinka and Olutayo, 2013), adaptation in this case points to the adjustment that the PHC system has to make to accommodate the changing models of delivering mental health care services. These MHS will be deinstitutionalised to community-based care using integration models. Goal attainment represents the need for survival of the (PHC) system. This requires continuous input of resources to provide the required services for the presentation generation of mental health patients/clients and the even the future patients/clients. The resources will include physical health facilities, financing and human resources (training and re-training);

Integration, according to Parsons (1951), is a challenge for any society that wants to survive. Since different parts must contribute to the maintenance of the whole, in diverse and sometimes overlapping ways, there is need for the collaboration or combination of parts. In this case, the PHC

requires inter-sectoral and interdisciplinary cohesion to provide adequate mental health care services in northern Nigeria. In addition, political leaders, health care workers, and community members must work synergistically to ensure availability, accessibility and acceptability of mental health services and even the PLWMI (the mentally ill) in the society as a whole.

Latency or pattern maintenance, which is the ability of a system to maintain and refresh the 'cultural patterns,' create and sustain individual motivation. The health care system, and the PHC system itself, perform functions that may not necessarily be positive or unifying. Mental health clients may therefore express various opinions on some latent functions of the system. If these functional prerequisites are not met, the system will be in danger of disintegration and becoming extinct. The health care system, as well as the PHC system faces obvious dysfunctional states, if these Parsonian prerequisites fail. There are many specific models for health care analysis based on these structural-functionalist ideals, a variant of which is the Donabedian *Structure, Process and Outcome* Model. This theory anchors the analysis of MHS at the PHC level in northern Nigeria.

2.5.1.1 Donabedian *Structure, Process and Outcome* Model

One of most used approaches for assessing quality of health care is the Donabedian *Structure, Process and Outcome* Model (Donabedian, 1980). Developed by Avedis Donabedian to address dwindling quality of health care in 1980s, this model explains that the quality of any health care services can be examined based on data collected about the three elements of the model; namely, i) the Structure (i.e. the context in which the care was provided), in this case, the PHC system; ii) the Process (i.e. the transactions between the consumers of care (here, community members and PHC clinic attendees) and the service providers (i.e. PHC workers in this analysis) during the period of healthcare service delivery); and iii) the Outcome (i.e. the effect of the care on the health status of the consumer and others).

According to Donabedian (1980), *structural factors* in the health care sector include hospital buildings (in this case Mental Health Units at PHC centres); financing (fund allocation); equipment; human resources (in terms of number and capabilities of PHC workers); policy environment; and administrative activities such as staff training and remuneration. These can be measured to provide an estimate of the availability of care. In this study, they are examined in explaining the availability of MHS in the selected study areas. Similarly, Donabedian classified *process factors* as technicaland interpersonal. The technical aspects cover diagnosis (in this case, early detection of mental health problems in PHC clients using short mental health screening inventories), treatment (if a problem is detected), and patient education, etc. It also considers the interpersonal transactions between the community members and PHC clinic attendees and the PHC workers during the service provision as an important factor. Since measuring the process entails measuring the manner in which care was delivered, process measurement is almost the same as measuring quality of care (Donabedian, 1980). *Outcome factors*, on the other hand, cover patient's (consumer's) satisfaction and changes in his or her knowledge, behaviour, and health status, compliance with discharge instructions, among others. Outcomes are often considered as the most important of the three because change in health status including recovery is the main purpose of healthcare.

It is assumed that the structure affects the process and the process in turn affects the outcome; because either or both the structure and process can affect the outcome, and sometimes, mediating factors from the patient and / or his environment (as social agents) could also influence the outcome. It is a well-known fact however, that improving the structure and process components of healthcare increases consumers' perception of quality of care (Rademakers, Delnoij, de Boer, 2011).Since the estimation of outcome takes a long time, and utilization of services is not exclusively in the power of the practitioners, some authors (such as Amin, Das and Goldstein, 2008) have suggested that the proper index of measurement of a facility's performance is its capacity to provide services. Data for

status of care could be obtained from medical records, interviews with consumers and providers of care, or through direct observation.

In the studys of the provision of MHS, these data collecting methods are all relevant, and are used by the researcher. In describing the availability of MHS therefore, there is focus on the particular situation for availability and acceptability of services, the evaluation tools and methods, and the improvement on the quality of care as required (Cooperberg, Birkmeyer and Litwin, 2009). Indicators used to assess these mental health care services measure important aspects of mental health care activities against the set standards by the Federal Government of Nigeria (NPHCDA, 2007). The quality of mental health care is analysed on fundamental ideals some of which are illustrated in Figure 2.2 below in Donabedian typology.

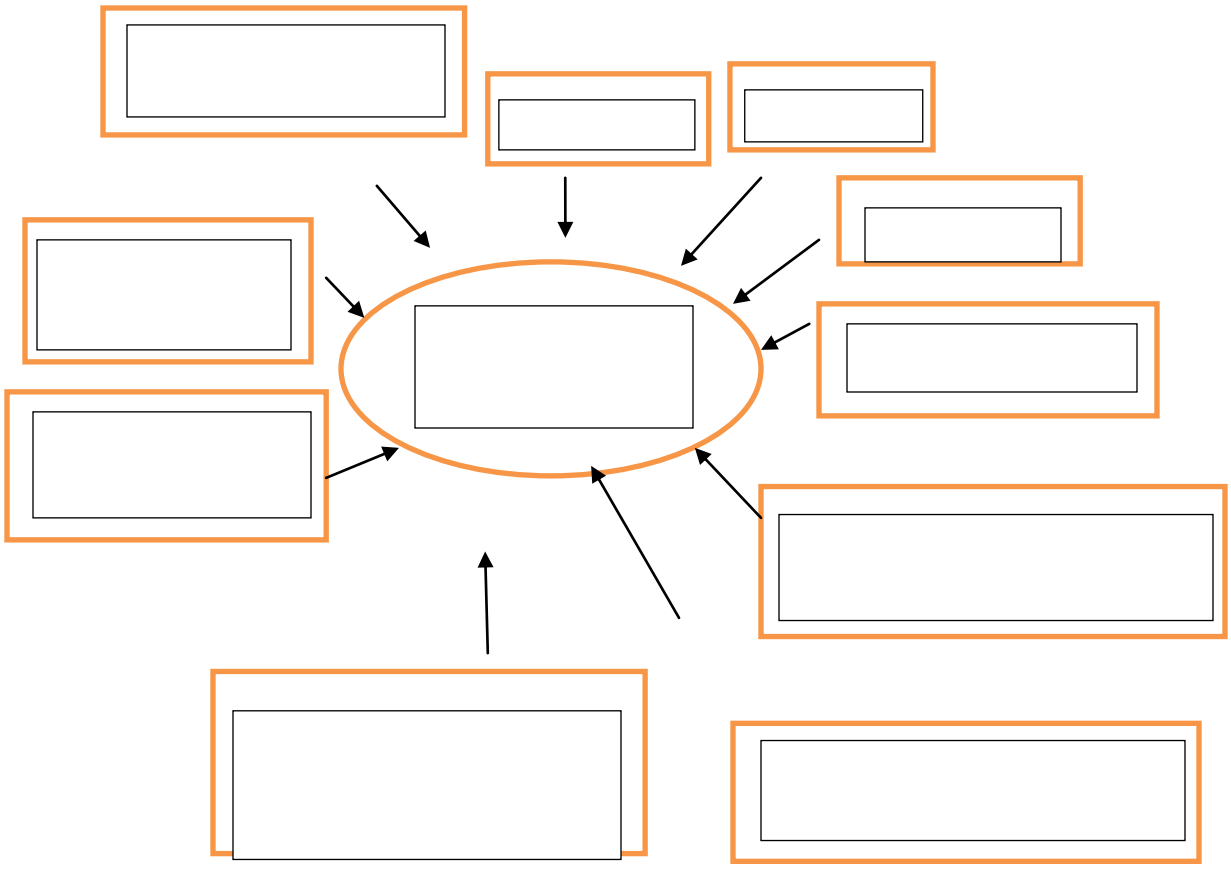


Figure 2.2: Some ideals of quality mental health care as adopted from Donabedian model
Source: Donabedian Model of Quality Health Care (1980)

The ten basic tenets Donabedian Model, as shown in Fig 2.2, form the basis for the analysis of health care services, often referred to as the ideals of Donabedian Model of Quality Care. These are:

i. Evidence-based best product/method: Through continuing professional training of PHC workers andevidence-based practice, the best care is provided to the patient.

ii. Accessible: Best practices in mental health are a priority agenda (policy) of organizations. PHC mental health professionals must advocate for equity and social justice in resource allocation and access to best health care (ICN, 2012), and advise governments accordingly and advocate for services to be accommodated in the budget (Rochefort and Clarke, 2010).

iii. Acceptable: The PHC worker provides accurate and timely information on care to enable the consumer to make culturally acceptable intelligent decision about care, respecting the rights of patients while care should be non-discriminatory and professional (ICN, 2012). This will involve eliciting consumers' perceptions and appropriately instituting activities to address negative percetions and misconceptions. This is critical in mental health care services.

iv. Affordable: Financial cost of the care and the systemic bureaucratic issues involved are at user friendly levels and non-discriminatory. Equity should be emphasised.

v. Effective and Efficient: The objectives of mental health interventions are not only achieved, but achieved within shortest possible time, and sustained at minimal cost. Continuity of care is encouraged, and avoidable repeated visits discouraged. This is attainable in PHC settings

vi. At No (or minimal unavoidable) risk to patient/client: No harm including psychological harm is intentionally caused to the patient/client. Ethical standards are maintained, and informed consent secured at all times (ICN, 2012). Missed care or unfinished care i.e. tasks left undone, should not endanger patients' wellbeing.

vii. At No (or minimal unavoidable) risk to others: No harm is intentionally caused to others - other colleagues and staff, relatives, etc. informing all about the care and their expected roles

and behaviour. Standard precautionary measures are universally observed, while specific precautions are adequately taken where necessary.

viii. No threat to relational coordination: The patient is the focus of care. Relationship between PHC workers and significant others remains cordial in the interest of the patient / client. Intra / inter professional wrangling is not allowed to jeopardize care. Professionals promote shared knowledge, goals, respect and effective communication. Relational coordination between nurses and other providers is critical to overall quality of care in the expected direction; for example, as relational coordination increased, nurses reported decrease in adverse events such as hospital acquired infections and medication errors.

ix. Patient/client Report Satisfaction: Patient satisfaction is fundamental (Otani, Waterman, Faulkner, Boslaugh and Dunagan, 2010), with the attitude and technical ability of the health professional as responsive, compassionate, trustworthy and honest. Higher percentages of highly trained professionals are strongly related to better patient outcomes, thus increasing patient satisfaction and willingness to recommend their hospital (Otani *et al;* 2010).

x. WorkersReport Satisfaction: The PHC worker is expected to be motivated so that her ability to provide care is not compromised.Supportive environment is important to the job satisfaction of workers. Adequate staffing with worker: patient ratio of 1:15 per shift has been recommended because poor staffing has been associated with staff dissatisfaction, burnout, and poor quality of care (Aiken, Clarke and Sloane, 2012).These ten ideals of this model will form the basis of the data to be generated, and for the analysis of MHS in the three States in northern Nigeria, as postulated by the Donabedian *Structure, Process and Outcome* Model, as a variant of structural functionalist paradigm.

2.5.1.2 Limitation of the Theory

A criticism of Structural Functionalism, however, is its ahistorical dimensions (Ritzer, 2012), which connotes its incompetence in explaining drastic changes, as may be expected in the current de-institutionalisation movement for mental health care (i.e. services at primary care levels outside mental hospitals). The structural functionalist view is mainly concerned with status quo, and is unable to explain social change, especially those of rapid nature due to its leaning on value consensus, order and stability. It sees conflict as abnormal – something society can do without. In reality, however, conflict is enshrined in society, as often seen in the health care system. This theory is therefore unable to deal with conflicts that are common place within the levels of care in the health sector in Nigeria (Asuni, 2008), and thus completely disregard power differentials in society (in the health care system). It also de-emphasises or fails to give recognition to individual actors' behaviours (deterministic), since it focuses on large structures.

Despite these pitfalls, structural functionalism serves as a veritable theory for this study because the focus of the study is the state of MHS within the framework of PHC system, which is itself part of the general health care system in Nigeria. The health system operates as a whole to provide health care, particularly MHS. The theory therefore believes that the PHC is interdependent on and inter-related to the other parts of the health system to maintain health care as a whole. Similarly, PHC itself is made up of various components, of which the mental health is the ninth, in order to make health care services available, accessible and acceptable to all the population. Therefore, implementing all its components should maintain the PHC as a system, within which the mental health exists. This contributes to the maintenance of the general health framework to provide health, as defined by WHO, to the population. The theory is thus a suitable basis for this study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Location of Study

The areas selected for this study were Gombe, Kaduna and Benue representing the northeast, northwest and north-central geo-political zones in Northern Nigeria respectively (Maps, pp.288-292). The choice of the area arises from reports of a general poor and worsening health indicators and services (especially mental health care services) in the region (WHO-AIMS, 2006). Health indices in the region are reportedly poor, with widespread inequalities in health and health care and poor health indices (National Strategic Health Development Plan, NSHDP, 2010-2015; Abegunde, 2013). Given the prevailing poor health indices in these States, with many citizens living in abject poverty, over 70% of the population cannot access health care when required (NPHCDA, 2007). But even at this, while other health care services such as maternal and child health, communicable diseases, endemic health problems, among other have been investigated copiously, analysis of mental health situation particularly at the primary care level in these areas has not been documented in any comprehensive study. There are both private and public sector involvement in health in the three States, operating the 3-tier health care system.

The selection of these States was premised on the following factors. Firstly, there is a differential distribution of health care services among in these three States, with particular reference to mental health services, characterised by the categories or types of mental health care institutions available in these States differ. Some States have tertiary (Federal) Specialist Mental Health Institutions e.g. in Kaduna state there are the Federal Neuro-psychiatric Hospital (in Barnawa-Kaduna) and a Department of Psychiatry at the Ahmadu Bello University Teaching Hospital (Zaria). These tertiary level psychiatric hospitals could influence the provision of mental health services (MHS) at the other levels (secondary and primary) of care. In Ogun State, the Federal Neuro-

psychiatric Hospital, Aro is involved in the initiating primary mental health services in all the 26 LGAs in the State. In Kaduna State, two mental health institutions, that is, the Federal Neuro-psychiatric Hospital, Barnawa and the Department of Psychiatry at the Ahmadu Bello University Teaching Hospital, Shika-Zaria, have similar status with the Federal Neuro-psychiatric Hospital, Aro. The need to investigate the extent to which these two institutions in Kaduna State could positively facilitate MHS at the PHC level, as in the case of Aro Hospital, justify the selection of Kaduna State as one of the States for this study.

On the other hand, in Benue State, there is just a State Specialist Mental Hospital and a Psychiatry Unit at the Federal Medical Centre Makurdi, a less endowed State than Kaduna State in term of MHS facilities. These two institutions provide psychiatric services at the secondary and tertiary levels in the State. However, in Gombe State there is no clearly organized public mental health institution except a unit of Specialist Hospital Gombe. The Federal Teaching Hospital, Gombe, was yet to establish a Department of Psychiatry as at the time of this study. Kaduna, Benue and Gombe States were thus selected to explore if these differential availability mental health institutions has any effect on the availability of MHS at the PHC level in the respective States.

Secondly, the current security challenges in the Northern region forms another guide for selection of the study States. The selected States are those adjourned, through various consultations, to be relatively accessible and safe for the study (based on prevailing security reports). In the north-eastern part of the northern Nigeria, Gombe State was thus considered as safer than most of the other States in the region, and therefore included for the study. And thirdly, the researcher's familiarity with the three states, because the researcher had conducted some pilot studies in all three States before the commencement of the main work. These considerations have guided the careful selection and choice of these states. All these States operate their health system based on the national policy.

The Nigeria health care system provides tertiary, secondary and primary level care, each with varying degree of capacity and over-sight roles: Tertiary level services are highly specialized and found mainly on curative care, teaching and research. The Federal Ministry of Health is responsible for policy formulation, technical assistance and service provision through tertiary and especially teaching hospitals. At the secondary level, the State Ministries of Health coordinates service through the General Hospitals and private health services within them. The private sector accounts for 72% of secondary level of health care facilities (FMOH 2007). There is a lack of national data on the number of missionary and faith based organizations, for profit private health facilities and not for profit private facilities and NGOs in health service delivery. The public sector in these States consists of secondary level care provided in general hospitals, administered by the States, and the primary health care provided by the local government councils.

Primary level services include ideally basic care including mental health promotion, health education, etc. However, practically this is far cry from what is on ground at the PHC centres. The LGA is the major health implementation unit in Nigeria. There are 774 LGAs in Nigeria, each sub-divided into 7 to 15 wards. The community or village level forms the support structure for the implementation of PHC services. The 1988 National Health Policy made provisions for the creation of PHC management and technical committees at the LGA level, which coordinate the ward development committees (WDC) and the community/village development committees (CDC). However, a survey by FMoH in 2001 showed that only 27% of PHC committees are functional. In the study States, only functional PHCs are the focus of this study.

The PHC centres and the hosting communities will constitute the study areas in the selected States. There are a number of primary health care centres operating in all the local governments in the States. These constitute the portals for the provision of all components of the PHC, including mental health where at all available. Each State is divided into Local Governments Areas (LGAs),

which are administered by Local Government Councils, each with a Department of Health, which is responsible for administering the Primary Health Care system. Each LGA is divided into three senatorial districts or zones in every State. These zones (three in each State) will constitute the clusters (i.e. nine senatorial zones in all) for this study. The primary care level in these clusters and their communities as well as the coordinating Ministries of Health in the selected States formed the focus of this study, in terms of location.

3.2 Types and Sources of Data

WHO (2012) recommends the use of *The Primary Care Evaluation Tool* to examine all services at the PHC level. This tool consists of three separate questionnaires on: firstly, the situations of primary care policies and structures at national and state levels; secondly, for PHC workers; and thirdly, for patients (PHC service users). This tool therefore formed the basis for formulating question items for this study for the various categories of respondents and key informants as well as content analysis of some official documents. The data collected were from both primary and secondary sources. The primary data were obtained from the responses from survey questionnaires, information from IDIs and FGDs; while the secondary data were obtained from medical records and registers at the PHC centres and Federal Neuro-psychiatric Hospital, Kaduna (consisting of mental health-related cases seen and/or treated at PHC centres), and Curricula of Training for CHEWs and CHOs. The analysis of the mental health component of Community Health Workers' Training Curriculum was obtained to generate some secondary data.

Thus, both quantitative and qualitative data were collected. The quantitative data for this study consisted of the responses to two sets of questionnaires, namely questionnaire for PHC workers (Appendix A) and another for household members (Appendix B). The items on the

questionnaires were adapted from some standard scales, from WHO/WFMH (2009), WHO/Wonca (2008); Mental Health Foundation, (2010) and the WHO Primary care Evaluation (2010) Data Tools as well as from the WHO Ten Facts of Mental Health, (2012). These were modified to suit the aims of this study.

The qualitative data, on the other hand, were generated from two sets of IDIs (from health administrators and mental health professionals (Appendix C), and community leaders (Appendix D), FGDs for PHC service users (Appendix E), health records at PHC centres (Appendix F), and curricula of PHC workers' Training Manual which were obtained from the Training Institutions (Appendix G). The probing questions are constructed from health policy documents and review of previous works on the provision of health care services across the world, especially the studies of the mental health care services and cultural perception of mental health situations in African communities (WHO/WFMH, 2009; Mwape *et al;* 2007; Jegede, 2010).

3.3 Method of Data Collection

An exploratory and descriptive (cross-sectional) design was adopted to examine the various components of mental health services at the Primary Health Care system in the three States. The study therefore explored and described mental health services at the primary care level as well as factors like the political and social dimensions of mental health and mental illness in communities from three selected States of Gombe, Kaduna and Benue. The mixed method research approach (combining quantitative and qualitative methods) was adopted because of its more suitability over single method approach in social research (Johnson, Onwuegbuzie and Turner 2007; Babbie, 2010). WHO (2012) recommended that to adequately assess any PHC service, information is required from different administrative levels, and from the supply and demand sides, that is, from health care providers and patients. Hence, the sources of data for this study include health administrators (i.e.

State Directors and PHC coordinators at the LGAs), PHC workers and PHC clients as well as community members).

Data were collected by the researcher and some trained, experienced field assistants (selected from among students and graduates of health-related disciplines and Sociology). In Gombe State, students from the Gombe State School of Nursing and College of Health Technology Kaltungo and a graduate of Sociology who lectured at the College were the research assistants. All of them spoke the Hausa and their local languages. Similarly, in Benue State, students from School of Nursing Makurdi and College of Health Technology, Otukpo who were fluent in English and either Tiv or Idoma languages were used as the research assistants. In Kaduna State, three lecturers in both Nursing and Community Health Officers' Training Programme in Ahmadu Bello University Teaching Hospital, Zaria, two registered nurses, and eight (8) nursing students were used. An MSc Sociology graduate was also used as a field assistant in Kaduna State.

All the field assistants underwent one-week training, in each State, on the objectives of the study and the best ways to carry out the study. They had practical sessions on administering the questionnaires, IDIs, and the FGDs to ascertain their level of proficiency in data collection procedure. Following this training and practice, they assisted in administering the questionnaires to respondents at the selected PHC centres and communities. Some also acted as note-takers, moderators or even anchor persons during IDIs and FGDs. Most of the FGDs and in-depth interviews were conducted by the researcher himself, except in Yamaltu-Deba, Giwa and Kaduna South where female research assistants had to conduct the FGD sessions because the women who participated would only accept female interviewers. Each IDI lasted between 30 minutes and one hour while the FGD sessions took between 40 minutes and one and half hour. Both the FGDs and IDIs were conducted in English or the native of the respective communities (Hausa, Idoma and Tiv). Hausa was a generally spoken language in Kaduna and Gombe States. These were audio-recorded.

Interpreters were used in some cases. The ability of the research assistants and the researcher to speak the local languages (Hausa, Tiv and Idoma) boosted the quality of the data collected and facilitated the entire data collection process.

Similarly, FGDs were to be conducted for only female PHC service users, because, in all the centres visited, male clients/patients were quite scarce. The researcher met only two male patients in all 45 PHC centres studied. Therefore, the few males met were all interviewed (IDI), while the female PHC attendees constituted the group discussants to explore what they believe to be mental health and mental illness and acceptability of PHC mental health services.

In-depth Interviews were also conducted with health administrators/coordinators (those in charge of PHC centres) at the LGA headquarters and community leaders/opinion leaders in the respective communities. The researcher personally conducted these IDIs as specific information was expected to be explored on the state of MHS in all the States visited. In addition, records of mental health services provided at PHC centres were to be accessed at all the centre over a specified period (past one to three years) to examine the mental health services being provided and documented at PHCs. However, in all the PHC centres visited no centre had any of such records: they had no data on mental cases seen, because of lack of appropriate entry format from Federal Government of Nigeria. Instead, medical records at one of the Psychiatric Hospitals within the study areas accessed, to serve as a proxy pointer to the burden of mental cases in the community.

A content analysis of the Training Curricula of Community Health Workers and the PHC Operational Plan was also undertaken to assess the scope of the community health professionals' training and its appropriateness for providing mental health care services at PHC system.

3.4 Sampling Procedure

3.4.1 Population of Study

Community members, PHC Administrators and PHC Coordinators at the State Ministries of Health and the Local Government Areas, respectively, the primary health care providers, and PHC service users (i.e. clients) form the population for the study. Psychiatrists (psychiatric doctors) and psychiatric nurse specialists and their patients at secondary and tertiary level of health care were also part of population of study. Only functional PHC centres in the selected LGAs and their hosting communities constitute the study sites. Functional PHC centres are those providing PHC services at the time of data collection.

The PHC workers (those currently in the employment of the government, working at PHC centres), key specialist psychiatric doctors and nurses (especially of community psychiatric units) in Tertiary and Secondary Mental Health institutions (i.e. psychiatric hospitals), some patients in such institutions, PHC service users (patients/clients), and community members (the people living in all the Local Government Areas of Gombe, Benue and Kaduna States) constitute the pool from which the study population was sampled. The PHC workers included PHC administrators and coordinators at State and LGA levels, as well as professional PHC service providers at the PHC centres, while the community members included PHC service users, psychiatric patients attending outpatient clinics, household members and community leaders (including traditional healers and religious leaders). These constituted the target population of the study. The doctors, nurses and patients in selected psychiatric hospitals for the study also formed part of the accessible population.

3.4.2 Selection and Sampling

Inclusion criteria

i. Trained primary health care professionals in functional PHC centres available at the time of the study, and mental health professionals in tertiary mental health institutions in key positions were included.

ii. PHC service users (clinic attendees) who come for routine health care service(s) to the selected PHC centres at the time of the study, who are healthy enough and willing to participate in the study were included.

iii. Consenting community leaders, household heads and their spouses (or other recommended adults by household heads capable of giving the required information) were included.

Exclusion criteria

i. Non-professional PHC workers such as cleaners and environmental officers were excluded.

ii. Non-functional PHC centres (those not providing other PHC services) were excluded.

iii. All non-consenting respondents and informants were excluded.

iv. Clinic attendees who are too sick to participate in the study were also excluded.

3.4.3 Sample size and Sample Selection

3.3.3.1 Sample size determination

For the sample size of this study, the formula is: $s = X\,2NP(1-P) \div d\,2\,(N-1) + X\,2P(1-P)$.

Where:
s is the required sample size.
*X*2 is the table value of chi-square for 1 degree of freedom at the desired confidence level (3.841).
N is the population size.
P is the population proportion (% affected)
d is the degree of accuracy expressed as a proportion (.05).

From a Table (*Table for Determining Sample Size from a Given Population),* constructed based on this formula, for researchers (Krejcie and Morgan, 1970), the adequate sample size for this study was determined (N=800). Adding 10 – 20 % for incomplete answers or non-response rate (Araoye, 2004), the total number was between 880 and 960 respondents/participants. This was used as a guide for adequate sample size for this study.

3.4 Study Community, Site and Sample Selection

A quota sampling approach was used to select the study sites and individual research participants in phases. In the first stage, from northern Nigeria, three States (namely Gombe, Benue, and Kaduna States) were purposively selected to represent Northeast, North-central, and North-West geo-political zones respectively. This purposive selection of these States is premised on the type of mental health services available, the safety of the study area in view of the security situation in northern Nigeria at the time of data collection (November 2014 to May 2015), and the researcher's familiarity with the selected States (as discussed earlier under Section 3.1: location of study).

The second stage involved dividing each State into three zones, based on the geo-political division in each state (using the Senatorial Districts); grouped into rural and urban Local Government Areas, based on population, availability of social facilities including health care services, and social arrangement, to indicate differences in socio-cultural perceptions and available of mental health care services including personnel. On the basis of these and for the purpose of this study, all Municipal Councils (LGAs in State capitals) and local government headquarters were considered the urban LGAs while all others were rural. Each senatorial district has LGAs from which three were purposively selected.

In the third stage, three LGAs from each State were selected; that is, one LGA from each of the three senatorial districts in each of the three States. Apart from the municipal Councils and LGA

headquarters purposively selected from the State Capitals and other LGAs selected on the basis of available Mental Institutions, Vandeikya and Nafada were selected by simple random technique: for the rest of the LGAs that had not met these criteria, the names of the LGAs in each of their respective senatorial zones were written on pieces of papers and dropped in two separate containers, from where one was picked. This was done in Gombe North and Benue Zone B only. This process generated a total of nine LGAs from the three states.

In Gombe State, Nafada LGA was so selected, but during the ethical review process, the Executive Secretary of the Gombe State Primary Health Care Development Agency (GSPHCDA) substituted Nafada LGA with Yamaltu-Deba LGA for security reasons. Kaltungo LGA was also purposively selected based on the presence of the College of Health Technology there. Gombe Yamaltu-Deba and Kaltungo LGAs were thus selected in Gombe state for administrative and security reasons respectively.

In Kaduna State, however, all the three LGAs were purposely selected. These are Kachia, Kaduna South and Giwa LGAs because some form of MHS were located there. In Benue State, Makurdi and Otukpo LGAs were also purposively selected as the State Capital where there are mental health facilities and Otukpo where a Mental Health NGO and a College of Health Technology were said to exist respectively. But Vandeikya LGA was selected by simple random from Zone B.

In each of the selected LGAs, a list of functional PHC centres was obtained from the PHC coordinators. The actual sample for this study (i.e. the accessible population) was obtained from three LGAs in each of the three States (n=9 LGAs) selected from all the 23 LGAs in Kaduna, the 23 LGAs in Benue and the 11 LGAs from Gombe States (N=57 LGAs) which form the sample pool. The selected LGAs are shown in Table 3.4.1 below.

Table 3.4.1: The Sample of States, LGAs and their Populations

State	LGA	LGA Hqrts	Population	Male	Female
Benue	Vandeikya	Vandeikya	230120	114811	115309
	Makurdi	Makurdi	297398	157295	140103
	Otukpo	Otukpo	176647	91563	85084
Gombe	Gombe	Gombe (city)	268,000	141947	126053
	Yamaltu/Deba	Deba Habe	255,248	135281	119967
	Kaltungo	Kaltungo	149,805	144746	110502
Kaduna	Kachia	Kachia	244274	124655	119619
	Kaduna South	Kakuri	402390	210486	191904
	Giwa	Giwa	286427	144218	142209

Source: www.benuestate.gov.ng, 2013 (Benue State official website); Gombe State official website; NPC, 2006

Then Primary Health Care centres in each of the nine (9) LGAs were listed, according to the number of wards into which each LGA was divided; only functional PHC centres formed the sampled units. There are 3*36 primary health care clinics*, and 257 health posts in Benue State (www.onlinenigeria, 2013), Kaduna State has 1,011 primary health centres in 255 wards and about 234 in Gombe State (NDHS 2008; Gombe State Strategic Health Development Plan 2010), but only 40 per cent (of these centres are functioning (Lemuel, 2013). These constitute the centres providing all components of the PHC, including the mental health and study sites for this study.

In the fourth stage, five (5) Primary Health Care centres purposively selected from each LGA [nine LGAs in all, three from each State i.e. 45 centres (15 from each state), from the list of functional PHC centres in the nine LGAs. Two other PHC centres (ABUTH Yakawa Comprehensive centre in Giwa LGA in Kaduna State, and Adoka PHC in Otukpo LGA in Benue State) were added. The Yakawa centre was added as a tertiary hospital PHC while Adoka was an NGO-based centre) to see the influence of these organisations on the community mental health services. From these 47 PHC centres, between two and five primary health care professionals (PHC care providers) (average per centre is 3) were selected from the functional PHC centres in the nine (9) LGAs (i.e. three LGAs from each State). Availability (and convenience) method was used to select 191Professional PHC

service providers. These constituted the main respondents for providing mental health care services at the PHC centres. A comprehensive list of these workers in each of the States was not feasible. Between three and five PHC workers from each of the five centres in the selected LGAs A total of 191 PHC service providers in the three States (see Table 3.5.1 below) responded to the questionnaire (Appendix A).

Communities in which the selected PHC centres were located were also included for a community survey. Four hundred and ninety-five community respondents participated in the household survey. The selection of households was a combination of a systematic sampling and availability methods. For households in identifiable regular street mappings and numberings such as main streets, as in Wadata, Otukpo Comprehensive, Air force PHC Makurdi (in Benue State) and Gombe MCH Clinic and Tudunwada (in Gombe State) and Gangara, Barnawa PHC and Makera 1 (in Kaduna State, the researcher employed systematic selection. Other places like Ningev, Tsuwa and Yakawa among others were not so structured and were selected haphazardly as they were available and convenient at the time of the visit.

Thus both male and female adult community members (aged 15 years or older) residing in communities in which the selected PHC centres were located formed the sampling frame for the household survey (see Table 3.1). Respondent identification involved selecting the household heads (mostly a male) and an adult female (mostly married females) or the most senior female found in each household during the survey visit, to provide their perception about mental health and illness, the mentally ill person as well as services available in those communities. Household members constituted an important segment of the study. They provided information on the awareness and perception (including their attitudes) towards the mentally ill and the required care for mentally ill patients in their communities.

A total of 252 households, with a total of 504 respondents, were selected from the three selected States as respondents to the household survey (Appendix B). However, nine of these completed questionnaires were not properly completed and so were discarded; leaving a total of 495 respondents for the three States for analysis (see Table 3.4.2).

Table 3.4.2: Number of Community Respondents by State

State	No of Respondents	Percentage
Gombe	136	27.5
Kaduna	191	38.6
Benue	168	33.9
Total	**495**	**100.0**

3.4.1 Selection of Key Informants for In-depth Interviews (IDIs)

Health administrators/PHC coordinators: Three directors of PHC or their representatives (one in each of the three State Ministries of Health, and 8 PHC coordinators at the LGAs (three in Kaduna State, three in Gombe State and two in Benue State) were selected for IDIs to provide key information on PHC mental health services, mental health policies and plans, and other correlates of such services such as the training and educational needs of PHC workers (see Appendix C: guide for IDI for PHC administrators/coordinators). Therefore, in all, 11 PHC administrators were interviewed.

For community IDIs, the community leaders including traditional and religious leaders were identified by the Health Department of each selected LGA and purposively included for the IDIs to provide information on community and social perception about mental health and illness, the mentally ill as well as services available in those communities. Fifteen community leaders were thus identified and interviewed: five leaders in Kaduna State, four in Gombe State and six in Benue State. These were made up of two youth leaders, two religious leaders and eleven traditional leaders.

The proposed number of community leaders increased from nine to 15 because the need arose during the course of data collection for additional information. For example, the researcher did not propose interviewing any youth leader but during the qualitative data collection, there were many pointers to substance abuse by the youth in paricular that needed to have some information from youth leaders, especially in Otukpo LGA in Benue State. As noted by Walsh and Downe (2006), although a rationale for selection for sample size estimation is necessary for qualitative data collection, it is commonly sequential rather than pre-determined. It is the light of this also that, for example, there were some identified traditional mental health care providers that needed to be interviewed: and two of these were interviewed (using the IDI Guide: Appendix D) although the researcher had not proposed that *abinitio*.

3.4.2. Selection of Participants for Focus Group Discussions (FGDs)

PHC service users (clinic attendees) (average per week = 25) at each ANC and Child Welfare clinics were selected by availability method as participants in FGDs. PHC service (end) users (Patients or Clients) were chosen for FGD. In all, eight FGDs were conducted (four in Kaduna State and two each in Benue and Gombe States) on ANC and Immunisation clinic days. Kaduna State had two additional FGDs (in Shika and Barnawa PHC centres) added to explore if there was any difference in service users' perceptions and experiences with their proximity to two Specialist Mental Health Institutions (in ABUTH Shika and FNPH Kaduna respectively). Each FGD session was made up of between six and eight members (all females). These patients/clients are vital to the study because the opinions of these "end users" of PHC services are critical in assessing services at PHC centres (AHRQ – Agency for Healthcare Research and Quality, 2012*).*

Thus, a total of 8 FGDs were conducted involving a total of 58 participants. The FGD participants (i.e. patients or clients who are the PHC service users) were chosen by availability on different clinic days, in at most two PHC centres in a State. PHC attendees who came for routine

visits or seeking treatments to the centres and were willing to participate in the study were recruited. Patients/clients are vital to the study because the opinions of the "end users" of mental health services are critical in assessing services at PHC centres (AHRQ, 2012*)*. There were no male services users in all the PHC centres under study (as often observed at PHC centres) to constitute a group for an FGD, except at Sev-Av Specialist HIV/AIDS Clinic in Vandeikya LGA where there were quite a number but the doctor in charge would not allow the patients to participate in FGDs. Elsewhere one or two males in separate PHC clinics were seen but could not constitute an FGD group; so two of them (at Danmahawayi PHC centre and FSP Makurdi) were interviewed individually using the same instrument (IDI Guide: Appendix E). In sum, between a total 779 persons participated in this study (see Table 3.5.1 below).

3.5 Instruments of Data Collection

3.5.1 Survey Questionnaires

Two sets of survey questionnaires were used to collect quantitative data. These instruments are constructed from previous works across the world including Nigeria. Some of the scales used were modified from a pre-existing Stigmatisation Scales from WHO (Ten Facts of Mental Health, 2012; Mental Health Foundation, 2010). The two sets of questionnaire include:

3.5.1.1 A survey questionnaire for PHC workers (Appendix A): This was used to collect information from Primary Health Care workers to assess their opinions of the workers on the mental health care services at the primary care level; and to elicit their views on the factors they perceive as accounting for the existing level of integration of mental health care services at their centre. The questionnaire also assesses the extent to which the objectives of mental health care in PHC have been met as well as their perception about mental illness. The questionnaire has three sections Section A, B and C.

Section A consists of nine questions on the Primary Health Care workers' socio-demographic profile, while *Section B* is divided into three sub-sections, consisting of questions measuring the

availability of mental health care services at the PHC centres (i.e. the level of integration), questions on the accessibility of the services, including the affordability of such services, and the acceptability of MHS at the primary care level. The section also consists of questions the barriers to the provision of mental health care services at the primary health care level. These questions items are modified from WHO/Wonca (2008) Scales for measuring*Integrating Mental Health into Primary Care: A Global Perspective.* WHO Primary care Evaluation Tool, 10 Facts of Mental Health (WHO, 2010), literature on Nigerian PHC system assessment. These are combined with stipulated components of Mental Health Policy in Nigeria.

Section C centres on the Primary Health Workers' perceptions about mental illness and their educational attainment and needs. The questions focus on evaluating their perceptions and attitudes toward mental illness and the mentally ill persons. The questions are based on modified pre-existing Stigmatisation Scale. Questions assessing PHC Workers' Knowledge of Mental Health and their education/training needs are derived from The WHO (2010) *New Intervention Guidelines* for the management mental health problems at the PHC centres (and modified), to assess how much of its content Primary health care workers are conversant with in the assessing and treating mental illness.

3.5.1.2 A Survey Questionnaire for Households (Appendix B): This was used to assess community attitudes and perceptions about mental health, mental illness and the pathways to mental health care. It also assesses community members' perception of mental illness and the desire or otherwise for the provision of mental health services in their communities. It is based on a modified version of Scheff Scale for assessing Community Perceptions of Mental Illness and the Mentally Ill.

3.5.2 In depth Interviews (IDIs), Focus Group Discussions (FGDs) and Others

These are unstructured question items to probe the views, subjective meanings and perspectives of key informants. There are two sets of IDIs Guides and one for FGDs participants. These comprise of the following:

3.5.2.1 In-depth interviews (IDIs) (Appendix C) for health administrators (PHC coordinators At the Ministries of Health of selected States, and those in charge of the PHC services at the Local Government Areas), to find out policies of mental health care, the level of mental health care at the Primary Health Care system, and factors affecting the MHS, and to explore the challenges observed from the community that the PHC system serve respectively;

3.5.2.2 In-depth interviews (IDIs) for community leaders (Appendix D) to explore the community perception of mental health and illness, the arrangement and challenges of mental health services in the community, and community participation in PHC services;

3.5.2.3 Focus group discussions (FGDs) (Appendix E) for PHC service users (patients/clients)

At the PHC centres to discuss issues surrounding what community members who use the PHC services consider as mental health and illness, the services they think they need, the desirability or otherwise of such services. This complemented the data generated from the household survey and other information given by primary health care workers.

3.5.2.4 Records of mental health services (mental health problems diagnosed, as well as the care and treatments provided at the PHC centres to explore if any form of mental health care is being provided at any centre. However, this was not feasible because no PHC centre had any record of mental health case recorded. A guide for the records (Appendix F) was to be used. However, medical records of in- and out-patients admission and follow up cases from 2012 to 2014 were collected from the Federal Neuro-Psychiatric Hospital, Kaduna, as proxy to the burden of mental problems in the community.

3.5.2.5 Content analysis of Training Curricula of Community Health Workers (Appendix G) The WHO-recommended training guidelines (mhGAP) is adopted to evaluate the training scope of the community health professionals and its appropriateness for providing mental health care services at

PHC centres. A content analysis of the Training Curricula of Community Health Workers will be undertaken to assess the scope of the community health professionals' training and its appropriateness for efficient and effective mental health care services at PHC. Similarly, a document on LGA PHC operations, titled the *Primary Health Care Agency LGA Health Operational Plan Manual 2014* was also analysed to situate the mental health operation at the LGA level, if any, within the other PHC services.

3.5.2.6 Observation: Using the Minimum Standards for PHC services (FMOH, 2012) and the WHO (2006) facility assessment tool for PHC services, mental health care facilities at the selected PHC centres were observed and documented.

The study instruments had been validated by five independent senior academics and the supervisors of this thesis. They were piloted in some centres in five PHC centres in Zaria and on 10 randomly selected households in the hosting communities. Results of the pilot study were used to modify content and wording of the questionnaire, if the need arises.

Table 3.5.1: Summary of Respondents/Informants for Selected States

Respondents/ Tool	**Gombe State**	**Benue State**	**Kaduna State**	**Total**
PHC service Providers (Questionnaire – A)	58	67	66	191
Household Members (Questionnaire – B)	136	168	19	495
PHC Managers (IDI Guide – C)	4	3	4	11
Community Leaders (IDI Guide – D)	4	6	5	15
PHC service users (FGD Guide – E)	13 (2FGDs)	11 (2FGDs)	35 (4FGDs)	58 (8FGDs)
Total	**215**	**255**	**301**	**771**

There were others who were interviewed such as psychiatrists (5), psychiatric nurses including CBM Trainees (6), traditional medical practitioners (3) and hospital administrators (1), outpatients (8). These 23 informants were selected purposively. Therefore, the total research participants were 794.

3.6 Techniques of Data Analysis

The data analysis consisted both qualitative and quantitative methods. The quantitative data collected from the two sets of survey questionnaires (Appendices A and B) were edited, coded (a codebook was constructed), and then entered into a Microsoft Excel Spread sheet and loaded on the SPSS software. The data were then processed through Statistical Package for Social Sciences (SPSS) Version 20. The quantitative analysis also adopted univariate, bivariate, and multivariate approaches. The univariate and bivariate analysis was purely descriptive, utilising frequency counts and percentages to present the data.

The qualitative data were derived from FGDs, in-depth interviews, and official documents (namely, Medical Records, Training Curricula). Those from FGDs and IDIs, and those in local languages (Hausa, Idoma and Tiv), were first translated into English, and along with others transcribed, sorted and labelled. Translation and transcription to English was done by an expert translator proficient in both English and the local languages. The qualitative data handling and management was done through content analysis, and thematic clustering. All the data analysed were placed under the following themes: availability of MHS, forms of mental health problems prevalent in the community, the prospective level of acceptance of MHS, the barriers to availability and acceptability of MHS and suggestions on how to improve the provision of MHS.Thus, verbatim quotations, summaries and content analysis were done. Attempts to use NVIVO 8 software were not feasible, because of the cost of getting the software. Similarly, content analysis of the Case Registers at the PHC centres and Medical Records from a Psychiatric Hospital, and the Training Curricula for

Community Health Workers was done to assess any evidence of the MHS at the PHC centres and the level of mental health content being taught the PHC workersduring training, respectively.

Data from both the qualitative (IDIs, FGDs, observations, official documents) and quantitative (questionnaires) sources were triangulated to meet the objectives of the study. This synergy is meant to strengthen findings of the study as they complement each other (Babbie, 2010).

3.7 Ethical Considerations

Ethical clearance for this study was obtained from the Health Research Ethics Committee (HREC) of Ahmadu Bello University, Zaria ((Ethical Clearance Certificate No: **ABUTH/HREC/K028/2014**) (Appendix 1). In addition, clearance was further ensured by the presentation of the research proposal at a Departmental staff-graduate Postgraduate Seminar in compliance with social research ethics of Ahmadu Bello University, Zaria. Following the successful seminar, with modification to the proposal presented by the researcher at this stage, the researcher finally obtained a Letter of Introduction (Appendix 2) from the Department of Sociology, ABU Zaria to ease identification of the researcher by gate-keepers at the selected sites of study. With this letter and the Ethical Clearance, permission was sought from coordinators of PHC at the Ministries of Health in the States, Supervisory Councillors for Health, and Heads of the PHC centres at the respective LGA Headquarters and PHC centres, and community leaders. This was always preceded by an adequate explanation of the aims of the study.

Some of the States and Hospitals still subjected the research proposal to their scrutiny before granting permission to study their respective institutions while others just gave express, verbal approval. In Gombe State, the State Primary Health Care Development Agency in a Letter gave approval for the study (Appendices 4 and 5), but changed one of the LGAs proposed to another for "security reasons", as the Executive Secretary during an interaction with the researcher. Similarly, in

Kaduna State, the Federal Neuro-psychiatric Hospital, Barnawa Kaduna gave a letter of Ethical Approval (Appendix 3), after defending the research proposal before an Ethics Committee, to access their records, and interview health professionals and their patients. In Benue State, it was verbal approval from the Director of Primary Health Care at the Local Government service commission, who was also an IDI informant.

Further, permission was also obtained from respective LGA PHC coordinator/Medical Officers-in-charge of PHC facilities to collect data through a permission letter (Appendix 6) and individual respondents and key informants, and household heads in the community; individual informed consents were then sought from prospective respondents and informants, from the PHC workers (some signed the Consent Form – Appendix 7), PHC service users and household heads/members (some signed the Consent Form – Appendix 8) through social interaction and familiarities before the study instruments were applied on them including recording their voices on electronic devices. Some participants signed the consent form while others gave verbal approvals.

An initial rapport with communities/gate keepers, and other stakeholders such as my research assistants in each community was developed, in all cases, to facilitate access to the PHC centres and the communities.

3.9 Methodological Challenges/Limitations/Challenges on the field

During the study, the researcher encountered some challenges. These include difficulties with some respondents, such as respondent unavailability (as in the case of male discussant). The other was the security issue. For instance, the researcher's stay in Gombe State was cut short by bomb blasts in the State during the field work; the researcher was at Yamaltu-Deba LGA when this happened in Gombe State. He had to get back to Zaria; fortunately he had collected sufficient data by then. For most of the PHC service providers, the questionnaire was interviewer-administered, that

is, directly administered (or personally guided) due to the fact that the questionnaire was somewhat lengthy and most of respondents had poor understanding of English language. This was overcome by the use of more research assistants who had been trained for a week prior to the field work. The research assistants were proficient in both English and the respective local languages. The additional research assistants however increased the financial and logistic cost of the whole process.

In Benue State, for example, the researcher had to make several return visits after the initial 4-week data collection. This was because for most of the time, PHC service providers were either on strike or were "not willing to do anything" then, obviously from the protracted non-payment of their salaries (over six months, as at first week of February 2015).

In addition, the data for this study were deliberately huge because of the exploratory nature of the study, thus the need to include various dimensions to the analysis of the mental health services delivery in the three selected northern States that are geographically and culturally distant. This posed some logistic challenges such as accommodation and transport costs, but the researcher did not get any support for this work. However, researcher's monthly income sufficed.

Moreover, the Nvivo software proposed for qualitative data analysis was unaffordable. This created a serious challenge for the qualitative analysis. In summary, the major methodological challenges are:

i. Some case studies would have added to our understanding of the problems of mental health problems and services in the northern region in Nigeria;
ii. Most Community Health Workers especially the CHEWs (both the junior and senior) needed one-on-one support to fill questionnaires: most could not even write and/or read basic English;
iii. Data collection involved extensive travels, the use of so many research assistants (N=23 in the three States) and needed contacts, with their attendant cost implications;

iv. Out of the 47 PHC centres studied, only one (Sev-Sav Specialist Clinic, Vandeikya) had some male clients, who came for "special treatment" for whom interviews were not allowed to interview any of them;

These challenges were however overcome by elongating the proposed length of data collection from the proposed four months to six months (December 2014 to May 2015), and the involvement of additional research assistants for data collection. The cooperation, interest and support of the Health Administrators including the Executive Secretaries/Directors of the State Health Authorities and the various PHC coordinators and PHC workers at the centres were vital supportive components that aided the successful data collection for the study. Many of them became volunteer research assistants, as reflected in the Acknowledgements for this study. Two of them (one with MSc Sociology in Kaduna State, the one with BSc Sociology in Gombe State) were particularly helpful.

CHAPTER FOUR

THE CURRENT STATUS OF MENTAL HEALTH SERVICES AT PRIMARY HEALTH CARE CENTRES

4.0 Introduction

The chapter presents the state of mental health services (MHS) at the PHC level in the three selected States in northern Nigeria, as examined in this study, with particular reference to the availability of mental health information services, mental health referral services and psycho-education at the centre, among others. The MHS found in the areas vary from total absence in some centres to rudimentary to many others. Community acceptability of these services and burden of community mental health problems are also presented. These are presented in sections of the chapter. However, the survey respondents' socio-demographic characteristics will first be presented.

4.1 Respondents' Socio-demographic Characteristics

There are two sets of survey respondents, namely, the PHC workers and Community Household survey respondents. The PHC workers' socio-demographic variables assessed include the age, sex, ethnic groups, marital status and religion of respondents (see Table 4.1.1).

Table 4.1.1: PHC workers' Socio-demographic Characteristics

S/No	Variable	Frequency	Percentage
1	**Age category**		
	20-29 years	43	22.5
	30-39 years	90	47.1
	40-49 years	39	20.4
	50-59 years	15	7.9
	60-69 years	1	0.5
	No Response	3	1.6
	Total	**191**	**100.0**
2	Sex		
	Male	84	44.0
	Female	106	55.5
	No Response	1	0.5
	Total	**191**	**100.0**
3	Ethnic groups		
	Hausa	41	21.5
	Fulani	15	7.9
	Waja	5	2.6
	Tera	6	3.1
	Tangale	3	1.6
	Idoma	33	17.3
	Tiv	24	12.6
	Southern Ethnic Groups	27	14.1
	Others	35	18.3
	No Response	2	1.0
	Total	**191**	**100.0**
4	Religion		
	Christianity	118	61.8
	Islam	73	38.2
	Total	191	100.0
5	Marital status		
	Single	43	22.5
	Married	144	75.4
	Widow(er)	2	1.0
	No Response	2	1.0
	Total	**191**	**100.0**

Mean age: 35.5 years

As indicated in Table 4.1.1, many of them (47.1%) are within the age bracket of 30 – 39 years (age range: 23 to 62 years; mean age: 35.5 years), followed by those aged between 20 and 29 years (22.5%) and 40 and 49 years (20.4%). They are mostly female (55.6%) from mostly Hausa (21.5), Idoma (17.3) and Southern Kaduna tribal extractions (14.1%). Most of them are Christians (61.8%)

and married (75.4%). It is thus found that the PHC workers are predominantly married females within the age range of 30 to 49 years (mean age = 35.5 years), from diverse ethnic extractions reflected by the geographic spread of the study, most of them being Christians.

For the community survey (see Table 4.1.2), there were a total of 495 household members from 47 communities hosting the selected PHC centres in nine LGAs of the three States (27.5%, Kaduna 38.6%, and Benue 33.9%).

Table 4.1.2: Community Respondents' Socio-demographic Data

S/No	Variable	Frequency	Percentage
1	**State:**		
	Gombe	136	27.5
	Kaduna	191	38.6
	Benue	168	33.9
	Total	495	100.0
2	**LGA**		
	Gombe	72	14.5
	Yemeltu-Deba	33	6.7
	Kaltungo	31	6.3
	Giwa	62	12.5
	Kaduna South	91	18.4
	Kachia	38	7.7
	Makurdi	88	17.8
	Vandeikya	39	7.9
	Otukpo	41	8.3
	Total	495	100.0
3	**Age (in years)***		
	20-29	173	34.9
	30-39	142	28.7
	40-49	97	19.6
	50-59	26	5.3
	60-69	3	0.6
	NR	54	10.9
	Total	495	100
4	**Sex:**		
	Female	267	53.9
	Male	224	45.3
	NR	4	0.8
	Total	495	100

5	**Ethnic group (tribe):**		
	Southern Kaduna tribes	57	11.5
	Hausa	113	22.8
	Fulani	23	4.6
	Tangale	9	1.8
	Waja	9	1.8
	Tera	11	2.2
	Tula	10	2.0
	Idoma	87	17.6
	Tiv	66	13.3
	Others	104	21.0
	NR	6	1.2
	Total	**495**	**100**
6	**Religion:**		
	Christianity	322	65.1
	Islam	165	33.3
	NR	8	1.6
	Total	495	100
7	**Occupation**		
	House wife	57	11.5
	Business/trader	90	18.2
	Farmer/cattle rearer	52	10.5
	Civil servant	147	29.7
	Teacher	46	9.3
	clergy	3	0.6
	NR	79	16.0
	Total	495	100
8	**Highest formal educational attainment**		
	No formal education	32	6.5
	Primary	26	5.3
	Secondary	121	24.4
	NCE/Diploma	116	23.4
	HND/1ST degree	95	19.2
	Masters	21	4.2
	PhD	8	1.6
	NR	76	15.4
	Total	495	100
9	**Monthly income****		
	N10,000 and less	67	13.5
	N11,000-29,000	50	10.1
	N30,000-49,000	25	5.1
	N50,000-69,000	16	3.2
	N70,000-89,000	17	3.4
	N90,000-119,000	18	3.6
	N120,000 &above	28	5.7
	Not stated	274	55.4
	Total	495	100

**Mean age: 30.5 years **Mean monthly income: N21, 977.8 (Nigerian naira)*

As shown in Table 4.1.2, respondents' ages range from 21 to 62 years, with a mean of 30.5 years; those within 20 – 29 years constituted 34.9% and only few (n=3; 0.6%) were 60 years and or older. Women constitute the majority (53.9%) against men (45.3%). The Hausa constitute the single largest group (22.7%, n=57), then the Idoma (17.6%), Tivs (13.3%), and the Southern Kaduna tribes (11.5%). Other tribes from Gombe, apart from the Fulani, constitute 7.8% (n=39); a few (n=6; 1.2%) did not state their ethnic groups. The predominance of the Hausa may be explained by the widespread distribution of the ethnic group across the study areas especially in all LGAs in Gombe and Kaduna States. Christians form the bulk of the respondents (65.1%) of the sample. This may not be unconnected with the fact that Christianity is widespread across the study area – Gombe, Kaduna and Benue States. Most of the respondents had some form of formal education with secondary and diploma/NCE certificates (24.4% and 23.4% respectively) forming the majority. Only 221 (44.6%) of the respondents stated their monthly incomes, which range from N5, 000.00 (a farmer) to N350, 000.00 (a teacher with an MSc degree). Those earning N10, 000.00 or less were more (13.5%), a good number (5.7%) earned N120, 000.00 or above. The mean income is N21, 977.8.

4.2 Mental Health Services (MHS) at Primary Health Care (PHC) Centres

Data from health administrators, PHC workers, service users (clients and patients), and community members indicated the forms and status of mental health services. The services assessed include mental health information, mental health campaigns, mental health screening services (early detection services), general interventions and treatment services including the use of psychotropics (mental illnessdrugs), and community rehabilitative services. The acceptability of these services, and the forms of mental health problems prevslent in the study communities, are also presented in following sections below.

4.2.1 The Availability of Mental Health Services at the Primary Health Care level

Availability of MHS is presented here in terms of having general mental health services MHS) available at PHC centres such as mental health information like posters, the client-centred services, the 2-way referrals, among others.

4.2.1.1 Availability of Mental Health Information services

Mental health information includes all the materials such as posters, handbills and stickers as well as media resources for public enlightenment focused on sensitising the community on mental health. Posters and clinic health education are the commonest means used at PHC centres to provide health information. This is explored with particular reference to mental health

Data from physical observations of all the PHC centres visited revealed that only two PHC centres had some posters related to mental health displayed at their centres. Most of the health workers confirmed that there were no such posters in the centres. For instance, in Kaduna State, the Head of a PHC centre stated that "we don't have mental health posters. They are supposed to give us from the Ministry or Local Government but they have never mentioned it before". At Gangara in Giwa LGA in Kaduna State, the head of the centre was even angry about the situation of lack of mental health posters at his centre. When asked about them, he said with some suggestions:

> None, none at all, if for instance, if we request from LGA, and they don't have, they should request from state government, if they don't have them, they should request from Federal Government,…..that's how it should be.

Showing the researcher round the clinic, he pointed to other posters, saying:

> But we have posters on flaccid paralysis (polio) malaria, measles, yellow fever, cholera, meningitis, tetanus, Ebola, but none on mental health None! No one has ever been brought here.

On probing further what the workers have done about trying to get the posters he said:

> Truly, truly, no attempt to give or bring any (posters on mental health; But we will try and approach the local government, and we will hear what they (LGA administrator) will say – that is the only solution for now. We will request and we see whether they

> will look for some for us, maybe it is because the programme on mental health is not long that they brought it, maybe that's why.

Some health workers expressed surprise that the issue of posters came up. At Danmahawayi PHC centre in Giwa LGA, the Head of the Unit said:

> See posters on immunization, ANC etc but you are the first person to talk about mental health posters, to tell us that there should be posters for Mental Health. Even LGA has never mentioned it. You are the first person to come here to talk about it.

This suggests a major neglect of the mental health services especially that posters on other PHC services are lavishly displayed at every available space at PHC centres, including on fridges and cupboards in offices. In all other centres in Gombe and Kaduna, and most other parts of Benue State, similar complaints about the absence of these mental health information materials pervade the entire study areas apart from two centres in Otukpo and Vandeikya, in Benue State. The absence of these posters indicates that common forms of public mental health information services are lacking at PHC centres in the study States.

In one of these two centres (i.e. at Vandeikya and Otukpo LGAs), there were only three posters on mental health on their wall at the entrance of the centre. The posters were on psychosis, epilepsy and depression with the themes: *"people with psychosis need your support"; "people with epilepsy need your support"; and "people with depression... need your support"* (see Appendix 9). These posters, although relevant to the MHS, only focus solely on appeals for curative and rehabilitative services for patients suffering from the indicated mental disorders, without attention to primary mental health care ideals, which should be essentially promotive and preventive. This implies that generally, there were no posters on promotive and preventive mental health services in all 47 PHC centre visited in the three States. Thus, it is concluded that there were no promotive and preventive information for PHC attendees and the public – which are the primary domains of PHC.

Similarly, it was also discovered that mental health education is not usually part of the routine health education given to PHC clients, as revealed by PHC Coordinators and clinic attendees (as established earlier under Section on availability of MHS). Despite this obvious neglect, however, mental health information services are highly desired by community members, as expressed by both community members, community leaders and even the health workers. Their views will be presented under the section on Acceptability of Mental Health Services in the community.

4.2.1.2 Mental Health Services available at PHC centres

Many health workers attested to the poor state of mental health services in the three States. In Gombe State, a health worker at Gombe LGA started commenting on the availability of MHS by saying "Honestly mental health service is very very poor." Generally, PHC workers and even Directors at the State level decried the total neglect of mental health, and the lack of any "official structure for mental health care."

At Vandeikya in Benue State, the Deputy PHC coordinator (HOD PHC) at the LGA lamented that

> There is nothing official happening about mental health; my brother (facing the researcher). Nothing, perfectly nothing is happening about mental health. So to simply answer your question: perfect No, nothing.

All the PHC coordinators in the three states lamented that there are no provision for the treatment of mentally sick persons at their centres. There are no drugs for mental disorders neither are there 'Standing Orders' for the treatment of mental illness at PHC centres. At Kaduna South, the PHC coordinator at the Local Government Health office corroborated the fact that there are no formal mental health services in the LGA. She said that she had no idea why not, but she guessed that probably it was because there had been no directive from State Ministry of Health to start providing mental health services.

Findings show that mental health services are scarce at all the LGAs and in all States studied. Many coordinators and administrators admitted this. As the PHC Director in Benue State said:

> Nothing from the government; no specific attention directed to mental health. And I think the Federal Government is responsible for the non-existence of mental health programmes at the LGA level.

Therefore, from the statement above, PHC workers, who are the drivers of the PHC system, agree that they have failed to play their roles effectively and this is responsible for the lack of MHS at the primary care level, to some extent. In addition, some PHC coordinators and heads of centres said that they could not provide these services because of lack of staff and space for the services. These limiting factors were captured by the head of PHC centres in Kachia LGA of Kaduna State thus:

> I would like to provide mental health service but no staff or section of the clinic for that. Similar policy issues and political unwillingness were raised.

However, at Sev-AV Specialist Clinic, Vandeikya the doctor (in charge of the centre) said:

> The only mental health service here (at the clinic) is the one incorporated into the Assessment form for those on HIV treatment (i.e. the psychological care assessment of PLWHA).

This indicates that in this centre, some form of mental health screening is being undertaken, but only for patients attending HIV/AIDS clinics whose psychological status are constantly evaluated as part of the overall care for people living with HIV/AIDS.

Although, some PHC coordinators felt that they are responsible for lack of mental health services at the PHC level, and many of them have also vowed to commence these services no matter how rudimentary for the meantime, especially because of the awareness created by the researcher's study. For instance, the Kaltungo PHC coordinator in Gombe State said:

> Since you (he was referring to the researcher) have come, we will ginger up and create orientation. More of the PHC workers have forgotten what they were taught in

> their school, but we have to expose them to in service workshops so that we can start something.

Furthermore, he continued, apologetically:

> What we should do now is (he paused for some time and continued)…. since you have now come to ginger us, now we have to call all the in-charges (i.e. The Heads of PHC centres) , probably all the workers, we will go back to the villages, we orientate them, give them new mind set probably engage the community to create awareness; to tell them that it is not only when you are sick but any time we are to check ourselves psychologically from time to time. It is one of the services they need, let them know. I think we should go back and start reorienting ourselves and them.

From this statement, it is deduced that health workers seem to have been reluctant to provide mental health services for reasons bordering on the poor attitude of the health workers to PLWMI.

Apart from the attitude of the PHC coordinators, most health administrators, especially the PHC Directors at the State Ministries of Health also complained about government's unwillingness in providing mental health services. For instance when asked, the Benue State Director of PHC at the Local Government Service Commission, Makurdi said that Benue State Government:

> … has no mental health services in (the) LGAs. However, two years ago or so (this IDI was conducted in January 2015), an Australian NGO called CBM came to train nurses in mental health for the State. They opened up five LGAs but nurses trained have not been absorbed... no specific attention has directed to mental health. Any case noted is referred.

A PHC coordinator in Kaltungo in Gombe State on his part laughed, and said, still laughing:

> Yes, it (mental health) is part of the components (of PHC) quite alright but we are not offering it. I don't know why we are doing that! Why it has not been put in practice, I don't know what to say about it. But honestly to be frank, mental health has been in silence. The services have not been available. There is no directive from the Government to do such things.

In Benue State, the Director PHC at the Local government Service Commission presented a similar scenario. But in the case of the State, a non-governmental organisation is helping to initiate some community-based services. He identified Christofoel Blind Mission (CBM) as the only NGO providing community mental health services (CMHS) in form of community mental health

awareness. He added that NKST Church Mkar somewhat include MHS in their activities at the Rehabilitation Centre NKST, which focuses on leprosy primarily but that there is some MHS being provided, mainly in form of rehabilitation.

Even clients at PHC centres attest to the fact that mental services do not exist at most centres. FGD participants confirmed the lack of mental health services. For example, a pregnant woman in Shika PHC, when asked whether they are given mental health education as part of the ANC, said: "No, we have never been told or educated on mental health except, on care of our children, and the pregnancy." At Giwa PHC centre, in Kaduna State when asked about mental health services (looking surprised), another FGD participant said:

> Yes, we get the service like immunizations, drugs, care, attention, family planning. We are okay with the services they render here ...but No-o, we have never been told or educated on mental health except, on care of our children.

Most of the FGD participants were pregnant women who had come for ANC routine check ups. Expectant mothers are a particular vulnerable group to mental health challenges, but they all confirmed the absence of any of MHS for them when they attend antenatal clinics.

A consultant psychiatrist in Kaduna during an IDI sum up the woes of the PHC services, including the reasons for the non-provision of the services at the community level thus:

> ….aah….the MHS in the community is right now next to nothing. You go to the PHC most of their staff don't know what mental health is all about. A lot of them can't recognize symptoms of mental problems, because of that they can't diagnose and a lot of patients will go unrecognized or untreated…

The data presented in this section largely imply that MHS at PHC centres are scarce, and poorly and haphazardly rendered. This could generate the notion of whether these workers actually want to provide these services at that level, and whether in fact they think mental health services could be provided jointly with other PHC services. Related to this, the presence of any programmes on Mental Health Services at the centres was further explored. Out of the 191 health workers, only 22

(11.5%) of them reported having information on some form of mental health programme in their States. They identified the type and the organisations running such mental health programme. Table 4.2.3 indicates the identified programmes and the organisations providing the services.

Table 4.2.3: Mental health programmes and their sponsoring organisations

Identified programmes	**Frequency (%)**		**Org Running it**	**Provider State**
CCMHP*	7	31.8	CBM	NGO/Benue
Health Restoration Centre Agboke	1	4.5	LGA	LGA/Benue
Community mental service Day Care Centre	1	4.5	NKST Mkar	Faith-based/Benue
Community Public enlightenment on drugs	1	4.5	LGA	LGA/Gombe
Grass root Mental Organisation	2	9.0	LGA	Kaltungo/Gombe
None stated	10	45.5	Not applicable	Not applicable
Total	22	100.0		

*CCMHP = Comprehensive Community Mental Health programme Source: Field data, 2015

Table 4.2.3 reveals that of the three States being studied, Benue and Gombe States have some mental health programmes at the community level. However, unlike Gombe State where all the programmes are driven by the LGAs, NGO and faith-based health institutions are more involved in Benue State. Kaduna State did not appear to have any record of such services.

The researcher evaluated these claimed service programmes, during the visit and in-depth interviews at the respective communities. For example, in Kaltungo LGA in Gombe State, both the Grass root Mental Organisation and Community Public Enlightenment on Drugs were mentioned by respondents as services being provided. It was established that these two services were mentioned as mere ideas but they were undertaken or activated. In fact, the PHC Coordinator said, laughing:

> The Grassroot thing (referring to the Grass Root Mental Organisation) was presented at a seminar at the secretariat where the presenter just suggested the name. After that, I can't remember anybody ever talking about it again o. But we have things like that in mind.

He added that the community public enlightenment on drugs mentioned was carried out occasionally, in schools and some communities. But he said that it not a programme as such at the Local Government level or that any NGO was taking it up.

From the foregoing, it can be concluded these two programmes never actually existed in the LGA but have been mentioned at some fora. It was noted there are however adhoc public enlightenment events being undertaken on particular situations and circumstances, such as part of secondary school programmes. For the remaining programmes, such as Comprehensive Community Mental Health programme being provided by CBM, the researcher found out that some community mental health activities in form of public enlightenment were being carried out.

4.2.1.3 Referral Services and Database at PHC Level

The referral system for mental health care from the Primary Care level to secondary/tertiary levels is virtually absent in the study areas. PHC workers claimed that they refer clients suspected to be mental patients to the next level of care but there is usually no feedback. The PHC coordinator in Giwa lamented the lack of this two-way referral in PHC system, saying:

> In fact we have that problem. Anytime we refer up (i.e. to Secondary or tertiary level), they finish with the treatment and there is no feedback. They will not refer them (the patients) back (to PHC) again. That is not normal; at least, there should be a feedback to show us all they have done. But No, they don't.

The Kaltungo PHC coordinator said "We take psychiatric cases to Gombe specialist psychiatry unit, but after treatment, we don't hear from the hospital again. At one centre in Giwa LGA, the health workers claimed: "We referred a mental patient to ABU Teaching Hospital, Shika, but thereafter no feedback." This implies that the health workers expected a back referral after the patient was treated. During an IDI at Psychiatric Hospital in Kaduna, the Acting Head of Nursing, who was formerly in Jamaica, agreed that the two-way referral is a global practice standard in mental health. He Said:

> In Jamaica, patients that are even admitted in Psychiatric hospitals are discharged to their Primary Health Care centres, for follow up...this referral system prevents default of follow ups.

This is completely absent in all the areas studied. Data show that PHC workers claim to refer all mental health cases reported at their centres to the other levels of care, but no back referral to PHCs. This is a one-way referral, which is against the principles of PHC. However, the researcher probed into the claim of health workers that they usually referred patients to General and Teaching Hospital/Specialist Hospital, and the way the referral was said to be done.

From the in-depthinterviews, it is found that even those patients whom they claim to have referred from their PHC centres were neither properly referred (i.e. no referral letter but just verbally told to go to the Teaching Hospital) nor documented in any record book in their clinics. In fact, in all the PHC centres, there were no records of mental disorders. On further inquiry, the researcher was told that it is because the government did not make any provision for reporting cases of mental disorders. Some PHC coordinators and Heads of centres claimed that the Monthly Report Format from the Federal Ministry of Health has no provision for documenting mental illness.The researcher requested to see a copy of the said document from the Federal Ministry of Health. On content analysis of the document, it was found that there was no provision for documenting of mental health-related problems.However, the researcher probed further why they could not improvise other recording format for their own purpose, to which they said they are not being directed to do so. There is therefore a weak data base for mental health disorders at PHC level in almost all the centres studied. From the data on availability of MHS so far in this section, these services are quite scarce. The status of MHS at PHC centres in the three States is as summarised in Table 4.2.4.

Table 4.2.4: Availability of MHS at PHC centres by Location

S/No	Form of service	Available	Provider	Location
i.	Mental health posters/flyers	Scanty	CBM	Two PHCs In Benue
ii.	Psycho-education at PHC	Nil	-	-
iii.	Community mental health awareness	Scanty	CBM, FNPH	Benue, Kaduna
iv.	Counselling of PHC clients	Few	Individual PHC workers	All States
v.	ANC Mental health Assessment	Nil	-	-
vi.	Childhood Behaviour Checklist	Nil	-	-
vii.	Age-specific (Adolescent) psycho-education	Nil	-	-
viii.	Common psychotropics (drugs used in MHDs)	Nil	-	-
ix.	Referrals			
x.	Records of MHPs at PHC centres	Nil	-	-
xi.	Formal rehabilitation for PLWMI	Nil	-	-

4.2.2 Community Acceptability of and Desire for MHS

Data in this section reveal the level of communities' desire to accept MHS if available. This is measured by the expression of their desire to have these services in their communities. Community's interest in having MHS was assessed by eliciting desire for mental health information and whether they would be willing to accept modern treatments for community members who may have mental illness. Community members were thus asked whether they would wish to have mental health information provided for them on mental health-related issues. Most of them (90.5%, n=448) expressed needs for such information.

On their preferences for properly disseminating such information, out of the 448 (90.5%) of respondents who stated their desire that mental health information be provided in their communities, they were asked to choose from a set of information sources they would prefer the most or the least. Their preferences are presented in Table 4.2.5.

Table 4.2.5: Preferred ways of disseminating mental health information to community

S/No	Source of information (N=448)	Frequency (%)				
		Most preferred	**Preferred**	**Just preferred**	**Least preferred**	**NR (%)**
i.	School	267 (59.6)	133 (29.6)	24 (5.4)	12 (2.7)	12 (2.7)
ii.	TV advertisements	186(41.5)	164 (36.6)	55 (12.3)	18 (4.0)	25(5.6)
iii.	Radio	264 (59.0)	118(26.3)	51(11.4)	10 (2.2)	5(1.1)
iv.	Youth magazines	115 (25.6)	161(36.0)	94 (21.0)	40 (9.0)	38 (8.4)
v.	TV shows/programmes	183 (41.0)	159 (35.5)	61(13.6)	15(3.3)	30 (6.6)
vi.	Village meetings	200 (44.6)	124 (27.7)	66 (14.7)	30 (6.7)	28 (6.3)
vii.	Newspapers	128 (28.6)	169 (37.7)	76 (16.9)	39 (8.7)	36 (8.0)
viii.	Bus-stops	96 (21.4)	90 (20.1)	90 (20.1)	128(28.6)	44 (9.8)
ix.	Youth centres/ arcades	150(33.4)	152(34.0)	50 (11.2)	53 (11.8)	43(9.6)
x.	Text messages (sms)	88 (19.6)	119 (26.5)	116 (26.0)	81(18.1)	44 (9.8)
xi.	Talks by people with problems	173(38.6)	93 (21.0)	86 (19.1)	51(11.3)	45(10.0)
xii.	Churches/mosques	261(58.3)	107 (23.9)	22 (4.9)	32 (7.1)	26 (5.8)
xiii.	Health talks at centres	270 (60.3)	100 (22.3)	34 (7.6)	20 (4.5)	24(5.3)
xiv.	Online information	118 (26.3)	100 (22.3)	110 (24.6)	70(15.6)	50 (11.2)
xv.	Notice boards	125 (27.9)	98 (21.9)	110 (24.6)	69 (15.4)	46(10.2)

Table 4.2.5 reveals that the three most preferred means of disseminating mental health information to communities are PHC centres (60.3%), in schools (59.6%) and on radio (59.0%). Worship areas (churches and mosques) and at village meetings are also significantly preferred (58.3% and 44.6% respectively). The least preferred is through text messages (19.6%) and at bus parks (21.4%). This implies that PHC centres, schools and electronic media, together with village/community assemblies such as meetings and worship centres are considered veritable centres of information dissemination on mental health and other health matters, by extension.

However, apart from the sources chosen from the study tool, community members also enumerated other means that they would also prefer to have mental health information disseminated, as highlighted by State in the Figure 4.2.1.

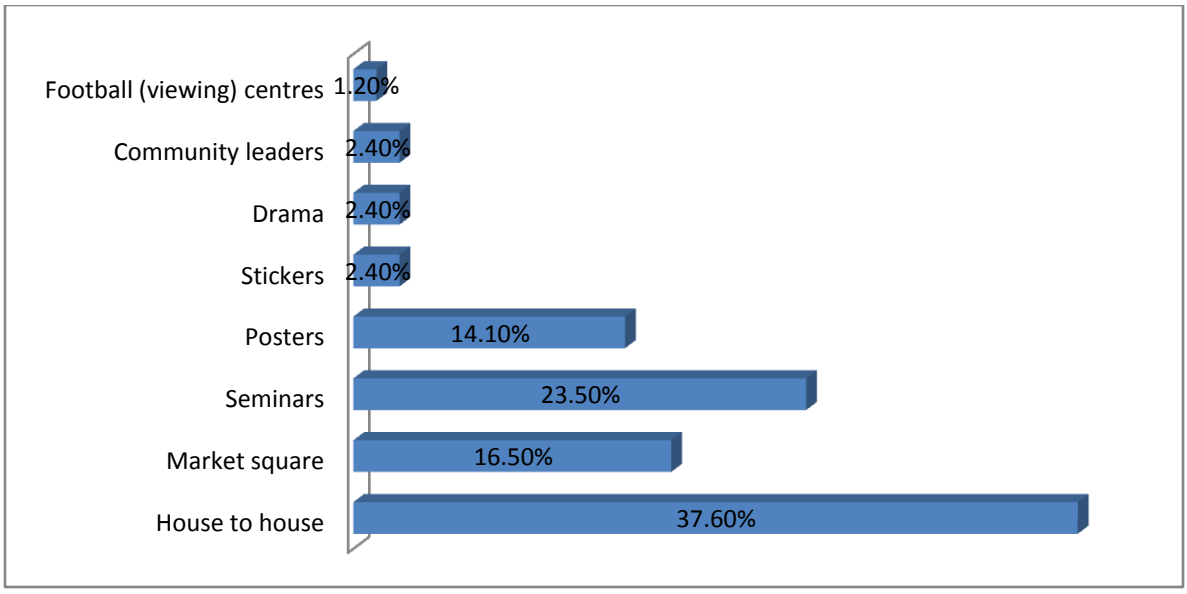


Figure 4.2.4: Other suggested ways of giving the Mental Health information by State

As shown in the Figure 4.2.4 (a), among the 85 (18.9%) community respondents who suggested other ways they would prefer to have mental health information, house to house and the use of pamphlets or posters and handbills are among the means to be adopted. Although mentioned by only few, market squares and the use of drama, among others as mentioned by some community members may be useful as well.

Further analysis of these means reveal that females tend to prefer the use of posters (nine of 12; 75.0%), market square (n=8 of 14, 57.1%) and stickers (all the two suggestions) while the males seem to prefer the house to house (26 out of 32; 81.3%) and use of community leaders (all two suggestions). Religion also seems to influence the choice of preferred means of passing mental health information. Data show that Christians would prefer the house to house (26 of 32 suggestions; 81.3%) and market square (11 out 14 suggestions; 78.6%) more than Muslims. From this deduction, in planning MHS delivery to communities, gender and religious affiliations are therefore social considerations that should be taken into account.

The desired sources of passing mental health information were also explored from health workers. Most of them want community mobilisation as the veritable means. A PHC coordinator summarised it: "*The Best way to disseminate information is by social mobilization."* The best ways to do the social mobilisation were further explored. It was found that both health workers and community members would prefer specific community-initiated means of passing such mental health information; some of these customized means agreed upon by both include involving community leaders, house to house and using the market squares. This implies that to provide effective mental health information, these media of communicating to community members should be incorporated into any plan for health information dissemination.

However, while many of the suggested and preferred means were similar in many respects to those already stated, some of the methods have been mismanaged in some other situations. For example, while the radio is seen by community leaders as the most far reaching and convenient; youth meeting (or arcades) are said to have been misused. Hear an IDI youth leader in Otukpo LGA:

> The best medium to reach youths and others is the radio, like use of JOY FM (a Radio Station) in Benue State) to enlighten people.

He regretted that the hitherto most effective means, which was using the Youth Forum has been bastardised. He said:

> Youth forum is no longer popular nor effective because of youths now always expect "brown envelopes" anytime they are called together (no thanks to political era).

This implies that disseminating mental health information is environment-sensitive, and this must be considered in the provision of MHS. Some suggestions were made by community leaders on the way forward for overcoming the burden of mental health problems which include involving "Law enforcement to focus on drugs, drinking should be restricted to certain times of the day, and to equip Rehabilitation Centres for psychiatric illness…"

Similarly, FGD participants attending antenatal clinics (i.e. PHC female attendees) during an FGD session also expressed strong desire for mental health services. One FGD participant in Gombe LGA said, wishfully: "Sir, I wish you will invite our families here, or visit families one by one. The society is not well... all families have serious problems; I tell you" (Female, 37 years). The informant was acknowledging the need for information on mental health even for an entire family. Her response implies that the community is aware of the enormous mental health challenges in the communities, but it appears that nothing is being done at the family level.

Other community informants corroborated her statement. In Kaduna South LGA, two FGD female participants at Kakuri PHC narrated how they encounter persistent psychological distress in their homes, and wished their spouses could be made to come for the mental health information that arose at the FGD session. To corroborate the community's strong desire and expressed acceptability of mental health services, PHC workers were asked to state if they think MHS should be provided together with other primary health care services at their PHC centres, majority (85.9%; n=154) of them think so; only 27 (14.1%) of them think otherwise. This indicates that most PHC service providers themselves desire that the mental health component of PHC become an integral part of the routine services at these centres. However, a few workers (14.1%) do not think so.

To further express such desires for mental health services, PHC coordinators said that in northern Nigeria, MHS are generally acceptable to the people. For example, a PHC coordinator said:

> Yes, mental health information is needed but our patients that come here are those that don't need the mental health information: these are women and children. The youths who need the information on drugs do not come.

The survey on community acceptability of mental health services shows the direction of respondents' views by State as shown in the Table 4.2.6.

Table 4.2.6: Community Acceptance of MHS at the PHC level by State

Community	**State**						**Total**	
	Gombe		Kaduna		Benue			
	Frequency	%	Frequency	%	Frequency	%	Frequency	%
No	14	24.1	16	23.9	26	39.4	56	29.3
Yes	29	50.0	35	52.2	29	44.0	93	48.7
Not sure	15	25.9	16	23.9	11	16.6	42	22.0
Total	**58**	**100.0**	**67**	**100.0**	**66**	**100.0**	**191**	**100.0**

From Table 4.2.6, it is indicated that more communities would accept MHS (48.7%), than they would reject it (29.3%). However, the acceptance is highest in Kaduna State (52.2%), compared to 50.0% and 44.0% in Gombe and Benue States respectively. On the other hand, the rejection is highest in Benue State (39.4%), compared to 24.1% and 23.9% for Gombe and Kaduna States respectively. It can be deduced that, on the whole, communities would accept MHS more than they would reject them. However, the level of rejection requires attention if the services are available.

Community members' attitudes towards service providers are also key determinants of service uptake or rejection at PHC centres. On whether the attitude of PHC workers could affect their level of acceptance or otherwise, an attitudinal assessment was necessary to prospectively determine patronage of the centres whenever MHS are to be delivered. Community members' feelings on the PHC workers' attitudes in their respective PHC centres, are presented in Table 4.2.7.

Table 4.2.7: Community Perception about PHC workers' General Attitudes at their PHC centres

S/No	The health workers here:	(N=495)						
		SA	**A**	**NS**	**D**	**SD**	**Mean, X**	**Remark**
i.	know their work very well	165 (33.3)	177 (35.8)	130 (26.3)	18 (3.6)	5 (1.0)	4.0	Positive
ii.	are really helpful	159 (32.1)	216 (43.6)	103 (20.8)	11 (2.2)	6 (1.2)	4.0	Positive
iii.	Make the PHC centre a comfortable to talk freely	121 (24.4)	185 (37.4)	151 (30.5)	25 (5.1)	13 (2.6)	3.8	Positive
iv.	waste a lot of clients' time	67 (13.5)	95 (19.2)	179 (36.2)	111 (22.4)	43 (8.7)	2.9	Positive
v.	are willing to listen and support	158 (32.0)	191 (38.6	117 (23.6)	26 (5.2)	3 (0.6)	4.0	Positive
vi.	can keep things confidential	138 (27.9)	147 (29.7)	159 (32.1)	36 (7.3)	15 (3.0)	3.7	Positive
vii.	Are friendly, easy-going	157 (31.7)	158 (31.9)	130 (26.3)	36 (7.3)	14 (2.8)	3.8	Positive

Overall mean = 3.8 (Positive towards health workers)
Decision rule: 1.0 – 2.9 = Negative attitude; 3.0 – 5.0 = Positive attitude

Table 4.2.7 shows that the general attitudes of community members to PHC workers is positive (mean =3.8 on a scale of 5), as reflected in the high rating of these workers and their activities at the centres. This range from 51.5% on being concerned with youth issues to 75.7% being helpful to clients who come to such centres. Most respondents rated the PHC workers as very willing to listen to their clients (70.6% strongly agree/agree), as being experts at their job (69.1% strongly agree/agree) and knowledgeable (68.0%), make the clinic acceptable to clients (68.5%), approachable and accessible (66.1%), being helpers to their clients (64.8%) and friendly (63.6%).

However, PHC workers were rated slightly low on confidentiality (44.0% for not allowing people know that you're going about a client's mental health problem; and 31.3% - the lowest rating – for not disclosing a client's problem to even significant others without client's consent) and time management, as respondents claimed that a lot of time is wasted in attending to them (32.7%).

Exploring the community views, prospectively, on the attitudes of health workers is important because their opinions on service providers have significant contribution to the overall

acceptability and the subsequent utilisation of such MHS at PHC centres. In planning a model for effective MHS, data on their attitudes is quite paramount.

The need for community MHS was also supported by many health administrators. For example, the Kaduna South PHC coordinator on whether community would accept MH services exclaimed:

> Yes! They will surely accept it; especially now that they are battling with their children at home now with cases of mental disturbances….who would want to see his/her child suffering from madness in the house?

She even gave a scenario that there was one day she was going to supervise one facility (a health centre) when she saw a woman crying following her child. That boy was seriously abusing substances. She said some commercial bike riders were trying to help her restrain her son to no avail.so she said "…to stay with somebody like that in a house is a problem, so she wanted to take him to the psychiatric hospital". Because she said that living with such a son or leaving him in community was seen dangerous. We call them "special cases" or "Government property". And according to her, there is a department in the LGA responsible for handling such cases: they hand them over to the psychiatric hospital.

From the foregoing, the PHC Coordinator seemed to point to the fact that because mental cases are public knowledge in the communities, they have no option than to accept services. However, a PHC Coordinator in Gombe anticipated some difficulties, when he said:

> With time they will, but it is not going to be easy. We have to tell them that it doesn't mean you are sick, let us tell them actually what mental health is, we give them mental health education based on the definition. I think they will listen.

This possible obstacle was confirmed when a community leader in Benue State expressed fears that mental health services might not be readily accepted by communities if there are "no circulars from above." He also said they do not need information when their children have no job. He said "but if government wants (to do that), they should first talk about jobs".

For the health workers who wished that mental health care services be provided together with other primary health care services in their centres, they were asked to agree or disagree, in varying degrees, with a set of stated reasons for such desired integration. Their responses are presented in the Figure 4.2.2.

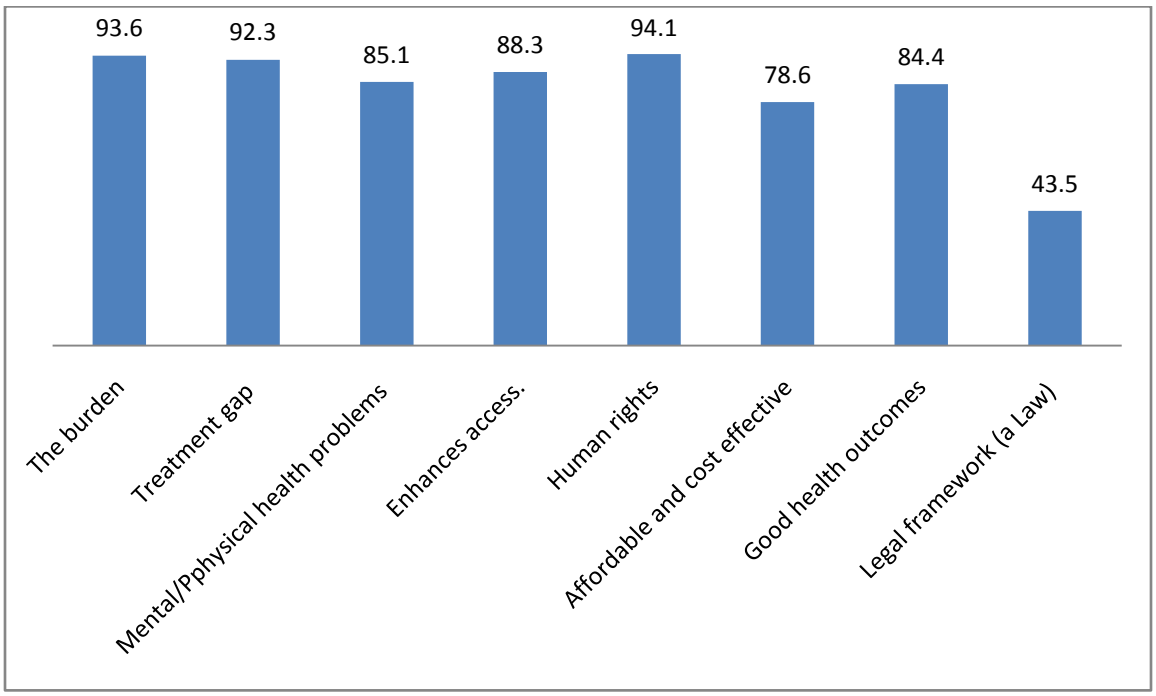


Fig.4.2.2: Reasons for desired mental health services

Figure 4.2.2 presents some reasons that necessitate the desire for MHS at the community level. Among other issues are the need to manage both physical and mental disorders simultaneously as these are interwoven, expressed by 92.3% of health workers. This implies that MHS should be provided along other PHC services, like maternal and child health services such as antenatal care, family planning and immunization of children. In addition, the data from the Figure 4.2.2 indicated other reasons which also should provide strong basis for desiring mental health services at the PHC community level.

4.2.3 Forms and Burden of Mental Health Problems in the Community

Both heath workers and household members consider mental health problems are quite prevalent in their communities. Most of health workers at the PHC centres in three northern States, (93.6%) think that the burden of mental disorders is great in the communities they serve. Responses of health workers agreed to the fact that mental health problems are much in their communities, as shown in the Table 4.2.8.

Table 4.2.8: The Perceived Burden of Mental Health problems in the Three Northern States

Burden high	Yes	%
Gombe	40	69.0
Kaduna	50	74.6
Benue	54	81.8

As shown in Table 4.2.8, most respondents in all the three States acknowledged the serious social and economic challenges created by community psychopathology. The burden is perceived to more (81.8%) in Benue State, compared to Gombe (69.0%) and Kaduna (74.6%) States, respectively.

This was investigated in-depthly through qualitative data explored from other sources: the PHC coordinators, community leaders and PHC clinic attendees/clients. In fact health workers reported that virtually all categories of people are prone. Health workers consider all persons from birth to old age could be affected, but stating that the age groups of 20 to 29 years (77.5%) and 14 to 19 years (58.1%) are perceived more vulnerable while the least considered is the children from birth to 13 years (19.9%). Respondents perceived appreciable level of proneness to mental health problems for all age categories in all the States, although Kaduna State appears to have more for almost all age groups. Respondents however consider the age category 20 – 29 years as more vulnerable than others.

Hence, the burden of mental health disorders in the community (sometimes referred to as community psychopathology or social psychopathology) was explored further through IDIs. In

Kaduna State, one of the PHC coordinators said: "there is a big mental burden and challenge in this State." The PHC coordinator said she has witnessed many cases herself, which she personally referred to Federal Neuro-psychiatric Hospital, Kaduna, under special cases (i.e. treatment of such cases are free). A medical record from the Federal Neuro-psychiatric Hospital Kaduna indicates the hospital-based burden of mental illness (see Table 4.2.9).

Table 4.2.9: Records of Mental Illness at a Specialist Psychiatric Hospital Kaduna

Year	Inpatient admission	Outpatients
2012	618	2903
2013	609	3015
2014	308	2814
Total in 3 years	1535	8732

Source: Medical Records Department, Fed Neuropsy Hospital, Kaduna

This three-year record, as shown in Table 4.2.9, reveals a total of 10, 267 cases of mental illness and mental health problems including 529 in patient cases of substance-related disorders (i.e. mental and behavioural disorders related to single or multiple drug use disorders), suicidal attempts, and few cases of abnormal grief and adjustment disorders. Most cases of substance abuse were adolescents.

On further examination of mental cases in the community, the youths form the greatest vulnerable group. For instance, on adolescents featuring in the overall burden of mental challenges, a Child and Adolescent Consultant Psychiatrist in Federal Neuro-psychiatric Hospital Kaduna said:

> Well… adolescence period is a very challenging period. Adolescence is a transition from childhood to adulthood and a lot of things are peculiar to them. They feel they need their freedom. That is when we say adolescent crisis. They want to have their peers. They make friends, some influence them positively, some badly. They are already there, they want their independence. They don't want parental control...

The above statement indicates that the period of adolescence poses one of the most vulnerable life stage where mental health interventions such as psycho-education and public awareness campaigns

are most desirable. When these services are unavailable, adolescents are prone to social maladies. The Consultant Psychiatrist in Kaduna said:

> A lot of them go into hard drugs "psycho-active substances", and this causes a lot of problems to their mental health. It causes a lot of them to steal. They get involved in so many things...indiscriminate sexual behaviour, which will expose them to mental disorder if they get infected with sexually transmitted diseases. In addition to that, a lot of them run away from home, because they want freedom (independence); girls and boys running away from home, using substances, leaving school. These have negative effects on their mental health specifically young adult.

The doctor in the statement above expressed the high level of vulnerability of young people to substance-related mental health disorders due principally to maturational adolescent periods. He also implicated social vices in the statement including stealing and leaving homes (which are signs of conduct disorder). He advanced some reasons for engaging in substances and drugs, when he said:

> ...a lot of them believe they need substance to be bold, speak and some who don't go to school, who menial jobs believe they need substance to be strong to off-load truck and they are misled. A lot of them take Indian hemp 'cannabis'. In this clinic, I have seen an 11-year old (child) already addicted to cannabis (Indian hemp) and codeine. He probably started earlier to be dependent at this age (11 years). It's a lot of problem and burden for the community, even for parents and health workers. We need the services of everybody, including the government, parents, teachers and health workers.

This implies serious social and economic challenges for the communities and the nation at large. Similar mental health concerns were raised in other places as well. For example, in Gombe State, the Kaltungo LGA PHC Coordinator said that substance-related mental health burden gets to the extent that "Some children do something deliberately to implicate parents for punishment;" implying that young people may engage in social vices to intentionally distress their families. In addition, the Provost of College of Health Technology Kaltungo Gombe State said:

> Honestly, I live in Gombe, but am from here (Kaltungo). I was looking at drug abuse by teenage as so small, but kai!! It is increasing like fire in the desert. It is very bad, I personally look at it as an alarming situation we need to address.

In Makurdi, the PHC Director at the Ministry of Health observed steadily on drug abuse, said: "they abound, and I give you instances". He narrated various situations of mentally sick young people on the streets as a result of substance abuse. He said: "my brother, you will pity us (people in Benue State) because many of young people are now on the streets because of all sorts of things they drink and smoke." The researcher's attention was drawn to a few cases of some vagrant young men on the streets of Makurdi near the Benue State Local Government Service Commission, whom the PHC Director seeing the researcher off to the vehicle associated with what he had talked about (i.e. substance-related disorders) (*personal conversion).*

Community leaders, including a youth leader, interviewed corroborated the views of the health workers and administrators on the burden. Most of the problems highlighted on the mental health burden relate mainly to drugs (substances), as confirmed by community leaders. In Otukpo (Benue State), for instance, the use of a local mixture called *monkey tail* which is the most recent and current substances being abused by youths. According to a Youth Leader in an IDI, monkeytail is a mixture of 'ogogoro' (i.e. local gin), tramal (a strong killer), boiled hemp (marijuana) and cough syrup. And when they take it, "this turns their head".

The youth leader lamented that on the streets of Otukpo, there are many mentally sick young men seen at all corners. Mostly such illnesses are all caused by these combination drugs. But he added that the situation of number of mad people in Otukpo is made worse with "imported madmen." When asked what this meant, he narrated this story:

> ...mad men are brought into Otukpo at night from Ibo land and dumped secretly at night. They are too many in Iboland. We called them "imported madmen. "They bring them with night buses, all these Luxury buses you see, and drop them at parks in the night as if they are normal passengers. They dress them well, put a bag on their backs, drop them and go. So we wake every morning to see new mad men on our streets. But the community is now becoming vigilant to monitor such things now."

The researcher was shown some vagrant mentally sick persons believed to have been brought in this way (and he took some pictures of them lying on the street but most of these cannot be shown here for ethical reasons!) Only one which did not show the clear identity is shown (see Appendix 10).

The Provost of the College of Health Technology, Otukpo, during an IDI corroborated the Youth Leader's narrative of the heavy mental health challenges in the community. In her own case, she cited very many examples of situations where the effects of 'monkey tail' were manifest. Other informants also expressed concerns about the involvement of commercial bike riders (Okada 'going' syndrome) in drug abuse/substance, who use uncompleted building near some schools where they come to "refill" (to take their substances) three to four times a day as they work. A situation where after "refilling" some Okada riders could not ride the bike but kept talking to themselves, was cited.

When asked if the problem of substance abuse is exclusively male youth problem, the Provost said that "a few known ladies are involved but they do it secretly for fear of parents and other relatives – for the boys, it is a show of being a man (macho)."

At Otukpo, Benue State a PHC coordinator decried the pattern of substance use in the community; lamenting that alcohol consumption in Otukpo was not time-restricted, as many people are seen at drinking places which open as early as 8am. He said that some workers go to their offices already drunk, while many others take their breakfast along with palm wine or beer, and nobody (i.e. relevant authorities) seems to complain.

The community leaders further highlighted other problems associated with substance abuse such as poor eating but high drinking, indiscriminate guns use under the influence of drugs. One added that "cultism is very common because drugs are used by them and it turns their heads. It is the reigning thing now."

Some community leaders have even lost confidence in security agents and governments in the handling drug issue in the community, and have to give up in desperation because of the

difficulty arresting the substance and drug abuse problems. One community leader said in Otukpo: "A policeman once took this concoction, dropped his gun and ran off; here in Otukpo." The involvement of even law enforcement agents as culprits has implication for control. At Sabon Sarki, for instance, the community leader said: "in fact I had one tramal seller arrested by the police, selling it with Indian hemp but it is like the sellers are attached to the government", expressing frustrations over the control of these substances. Lamenting further the burden of multiple drug abuse, a community leader in Vandeikya in Benue State blamed the problems of unemployment, family disorganization, and poor eating habit.

There is a similar situation in other places within Kaduna and Gombe States. For instance, Tramadol (i.e. tramal) is considered the biggest abuse challenge in Kachia and other communities in Kaduna State as community leaders claimed. A psychiatric nurse in Kaduna Neuro-psychiatric Hospital narrated a scenario. He said that some long distance drivers were said to have taken as much as 30 tablets of tramadol (tramal) to stay awake on the their journeys while some young people take between 15 and 30 tablets of this drug to enhance their performance in their daily activities of living. Meanwhile, he added that, "as few as just two tablets of tramal caused convulsion in a patient, who even became unconscious but was treated; but this is what youths are taking freely now," he said.

At the Neuro-psychiatric Hospital, Kaduna, a psychiatric nurse practitioner narrated his experience of admitting a young man who took 15 tablets of Rohypnol (a sedative drug called flunitrazepam, often used as a date rape drug) and suddenly became over active and violent and was brought into the unit for management.

In Gombe State, substance abuse is also a problem. A PHC Coordinator in Gombe State said:

> Like in this Kaltungo now, most of the youths are into drugs. I think we should focus on that, it is something that we should focus. We have tried, government have tried, no improvement. Like this cough syrup tutolin, fortwin (pentazocine), they over dose themselves with that injection, even valium. You find somebody without smell of

> alcohol but he is dangerously tipsy. That's what they are doing; sometimes this valium.

It is thus revealed that in all selected three States, innovative cocktails of tranquilisers, alcohol and narcotics are taken by youths. Table 4.2.10 summarises some of the commonly abused drugs and substances by States.

Table 4.2.10: Summary of substances abused in the Study Areas

State	**Common substances abused**	**Source of information**
Gombe	Tramal, alcohol, tutolin, fortwin, valium, alcohol	Health workers/administrators, community leaders, FGD participants, Heads of Health Training Institution,
Kaduna	Tramal, cough syrup, tranquiliser, alcohol including fermented palm wine	Health workers/administrators, Heads of Health Training Institution, community leaders, FGD participants
Benue	Monkeytail (mixture of *ogogoro, Tramal, boiled Indian hemp, cough syrup*), ethanol in water, alcohol including palm wine	Health workers, Heads of Health Training Institution, community leaders, Youth leaders, FGD participants

Source: Field work: Qualitative Data, 2014-2015

Table 4.2.10 indicates the commonest substance of abuse is alcohol in various forms (gin, beer, local brews and palm wine), cough syrup and analgesics, like tramal (tramadol). These substances are addictive and psychoactive and traditionally known as addictive. Interestingly, some informants including some health workers and administrators do not consider alcohol as one of such problem substances. One PHC coordinator in Kaduna South LGA said: "Alcoholism is not seen as a problem, it only causes liver cirrhosis." Many community leaders also have such beliefs as captured by one of them, who said (shaking his head in disapproval that alcohol consumption could be responsible for mental health disorders):

> No, no, no... Drinking (alcohol consumption) cannot cause mental problems; ok is he the only one taking the drink; why are others who drink don't mad. My son, see! Any

> mental illness has what caused it- some are natural, some are juju, some are witches, some self-inflicted in our land, our fore parents say if you witch yourself, no one can undo the witchcraft for you (CL: Vandekeikya LGA).

This probably explains why many health workers claimed that communities are not doing much to curb the problem. An inquiry related to this burden of substance and mental disorders, and actions to curb such problems, one PHC coordinator in Yamaltu Deba in Gombe State said:

> No…as far as I am concern (sic), nothing is being done (about alcohol consumption). All this, is because, honestly mental health care is very, very poor. The suicide cases we see now is because no mental health (services). People drink out frustration and problems.

However, in Benue State it was gathered that there was an attempt by the State Government to ban the consumption of *ogogoro* but that this has not been successful, because of poor enforcement.

On the handling of such frustration other than drinking alcohol, he said some people even use more harmful methods of coping, while others cannot even manage their frustrations and would want to take their lives. A PHC coordinator in Gombe State narrated (an incident that took place in 2015), a case of suicidal attempt due to poor handling of frustration:

> **The case: Drank one bottle of Izal to die.**
> The victim was a 33-year old female, who had been married for 5 years but had had no child. She lives in Gombe, while her husband lives and works outside Gombe. She is a civil servant with the Gombe State Government and doubles as a focus person for an NGO (in Yobe). The lady had called the husband, one evening, informing him that she was going to die. Expectedly the husband laughed, and took it as a joke. In fact, the husband joking called "coward." Later same evening she went to visit an aunt living close by, to tell her that "she was not feeling fine" but met some visitors in the aunt's house. She then went back to her house. She wrote and left a letter in which, she asked for God's forgiveness for what she was going to do (to kill herself). She stated in the letter that she knew it was wrong to kill herself but that she had to do it.
> In the letter also, she distributed her savings plus the three months' outstanding salary owed her by employers; in the letter a total of N1, 100,000.00 was to be distributed to her relatives and creditors, then the remaining amount given to her mother. She then drank a whole bottle of Izal (a disinfectant), and subsequently became unconscious. Meanwhile, her aunt whom she visited tried calling her on phone but she was not picking her call. She (the aunt) decided to go and checked on her. On reaching her house, the aunt met the door open. On entering the house, the lady lay unconscious on the floor, with a knife by her side. The aunt raised alarm. The lady was quickly rushed to a nearby private hospital. The husband rushed to Gombe the next day. The

> lady was managed for three days and discharged home. After discharge, she did not give any plausible reason for attempting to take her life.

Her pre-morbid personality was described as paranoid: she was always suspicious of other people including friends and relatives. This narration indicates the poor coping strategies of some community members, an aspect that is a major promotive focus of mental health services at the primary care level. This is absent, from the health workers narrative.

A community leader also lamented on the burden with some of his families affected. At Juji, in Kaduna South LGA, the community leader shared similar experience of his sister who has mental illness but was treated at Barnawa Hospital. She was with her husband at the time of study. She was still attending the hospital but that

> If the services you (the researcher) are talking about were here, she will go there since it is closer home. My junior sister has been suffering from mental illness. This is over seven years now. From here, we took her to Barnawa (FNPH), where she received treatment and she is now doing very well. She is married with children, although she still goes to Barnawa every 3 months to receive medicines. But she is ok. This Christmas (December 25, 2014), all the tomatoes, onions and children wears used in my house here were brought by her (the researcher visited in January 2015).

Inclusive was also a community leader in Kaduna, he said that he lost a brother who had mental illness and currently houses a sister who has the illness. At Awon, a community leader said he has a sister and a brother with Mental illness. The brother died two years previously but the sister lives with him and shares everything except that she cooks herself for reasons best known to her.

The Gangara District head, in Kaduna State narrated his own story thus:

> My brother's son is suffering from mental illness. We have gone everywhere, no solution. His problem started as a child when he was about three years old. I think epilepsy… they have tried and tried but no way. Now he is 20 plus. He is still with me here. There was a time he fell inside fire and got burnt. You saw him when you entered. He cannot do anything. Did he greet you when he passed? …he will not greet except if he so chooses. I have lived with him like that throughout.

During IDIs, the traditional ruler disclosed that his 24-year old son's mental illness, started at age 3 years and how he was being taken to several places for treatment to no avail. His problem was said to have started when he fell off the back of his mother at about three years. Few weeks after, the

little boy started convulsing. They have been taking him for both traditional and modern health care but the boy remains mute most times, uninterested in people and does neither work nor goes to school. But he can take eat, bathe and groom himself, though awkwardly.

During the visit to the palace, the said boy passed by the researcher and two assistants while waiting for the Sarki's arrival, but he did not greet, answer greetings or even look in the direction of the visitors. During the IDI, the chief asked: "did you not see one young man pass here, did he greet you? He is the one". This community leader earnestly advocated for treatment for PLWMI, especially for those with similar challenges with his ward. To him, every person is useful, even if the mentally ill. In Makurdi, a community leader narrated a story he claimed to have witnessed at High Level (a place in Makurdi): The case story went like this:

> A mental patient was sitting on the street in Makurdi here near a drinking joint. Three friends were at the joint drinking, then one of the three friends excused himself to go and ease himself; two of the friends were left sitting, and one of them allegedly dropped a substance suspected to be poison in the other (excused) friend's cup. On his return, the unsuspecting friend picked the glass, and was to drink from the cup when the mentally sick person jumped up, came and stopped him from drinking it. This created a scene! The mentally sick man then asked and insisted; but everybody around, knowing him to be a mental patient, interpreted his behaviour as a sign of his sickness. At this point, the mentally ill man said, "Ok I am mad but let one of the other two friends drink from the cup". Then chaos started. It then dawned on the minds of the unsuspecting friend and the bystander the point the sick man was making. He (mentally sick man) said, "they dropped something in your cup, the remaining part in this one's pocket ……. check……" the second friend then ran away and the situation there turned sour.

He concluded that even if somebody is "mad" or is considered so, he is still useful at home.

Despite these serious social psychopathologies, there are no treatments or interventions for the maladies, leaving a wide treatment gap for mental disorders. This assertion is borne out by survey from both community members and health workers.As indicated in Fig. 4.2.3, in spite of huge mental health challenges, formal MHS are absent, thus leaving an enormous gap between the need

for the intervention/treatment of mental health problems and the existing treatments for the burden. This is expressed by most health workers (92.3%; n=142) in the three States.

With this level of mental health burden and the large treatment short falls for those that require the mental health care, fears that the link between mental illness and physical ailments usually referred to psychosomatic disorders would become more apparent was expressed by health workers. Data indicate that health workers believe that mental and physical health problems are interwoven (85.1%; n=131). Many cases of physical illnesses occasioned by mental disorders are cited. It is indicated that mental disorders are one of the most prominent and treatable causes of suicide (68.3% for strongly agree/agree; mean = 3.75), with the belief by 55.4% of the workers that all suicide cases are attributable to mental illness. Mental illness has also been viewed as contributing to both unintentional and intentional injuries, as expressed by 74.8% of health workers. This contributes to both communicable and non-communicable diseases (52.3%; mean = 3.40), indicating the body-mind interplay. This further helps to explain the mental-social-physical connection as emphasised in the WHO definition of health, justifying the WHO assertion that *there is no health without mental health, because mental health is total health; if you lose it, lose all!*

A Psychiatrist during an IDI, made an observation on about this link, with particular reference to the social effects of substance-related mental problems. To him, these effects cut across crime commission, truancy, sexual promiscuity and sexually transmissible diseases (STIs) including HIV/AIDS, to running away from home (i.e. self-imposed vagrancy/homelessness). This implies that substance-related mental problems usually accentuate social deviant behaviours, which usually lead to more physical, social and mental problems. Community members are aware of such association. For instance, a community in Gombe said that stories abound of people who constantly took ethanol diluted with water, and later vomited frank blood and died. Such stories thus indicate that the many

of mental health problems and challenges have implication for physical illness (morbidity) and mortality. A Gombe community leader believes that young people who:

> …smoke and drink all this nonsense (sic) don't even eat well. They drink 'ogogoro' (a locally produced gin) and these local brews ('burukutu') on empty stomachs. This addiction has many physical consequences, including deaths.

Another community leader in Otukpo Benue State buttressed the link between substance abuse and physical illness by narrating instances of death from heavy drinking and smoking thus:

> Just last week (IDI on 16/1/2015), a guy known for heavy drinking and misbehaving started vomiting, just at the roundabout here (near Ochobo roundabout), the blood could fill about one small paint rubber (i.e. about four litres) Before he reached the hospital, he gave up (died)....Another one, my wife's cousin died just before Christmas (December 2014). The drinking ate up his liver, and his stomach and blood was pouring from his mouth like water. We didn't bother to take him to the hospital because everybody was talking (warning him) but for where? He will even beat my (mother) in-law. Now, all is over. I don't know why somebody will be taking something that harm his body and sense but he says he is enjoying it.

It is thus indicated the desire of the community to accept MHS. Several reasons were also advanced for that desire, one of the obvious reasons being the enormous prevalence of mental health issues and challenges in the community. The need of the community for relevant information on mental health issues and sources of help when these problems occur were revelations.

In this chapter, the findings so far have revealed that mental health services at PHC centres are scarce in the three study States; and where available, they are insignificant, poorly organised and disjointed. However, the communities strongly and earnestly desire these services because various forms of preventive mental health problems are very prevalent in the study communities, as summarised in Table 4.2.11.

Table 4.2.11: Summary of Mental Health Challenges in the Study Communitites

S/No	Form of mental health problems	Communities	Group most involved
i.	Innovative multiple substance abuse and related disorders	Gombe, Kaduna, Benue	Adolescents/Youths, More males, few females
ii.	Suicide attempt	Gombe	One isolated case; female
iii.	Mental illness	Gombe, Kaduna, Benue	Family members; Males/females, young/adults
iv.	Emotional Problems at ANC	Gombe, Kaduna, Benue	Pregnant women
ix.	Unspecified disorders referred	Gombe, Kaduna, Benue	Males, females, young and adults

There is therefore a very wide treatment or intervention gap. This has been expressed by both health workers and community respondents. The absence of these services suggests there are some factors hindering MHS delivery at PHC centres.

CHAPTER FIVE

FACTORS RESPONSIBLE FOR THE OBSERVED STATE OF MENTAL HEALTH SERVICES, AND A SUGGESTED MODEL OF PROVIDING VIBRANT MHS AT PHC CENTRES

5.0 Introduction

It has been established in this study that mental health services are scarce in the three selected States in northern Nigeria. This chapter presents the several factors identified acting as barriers to providing MHS at the PHC level. These relate to policy failure and lack of political will (their fallouts) as well as socio-cultural issues. Suggested ways of improving the MHS at the community level are also presented in this chapter.

5.1 Barriers to Mental Health Services at PHC level

Many barriers responsible for the virtually non-existent mental health services have been identified in the study areas. These are presented under two main heading; namely, policy/political and socio-cultural barriers.

5.1.1 Lack of Policy and Political Commitment

In all the States studied, none has a State Mental Health Policy. In Kaduna State however, there is a document, which is a blueprint for the operation of all LGAs, called the *Kaduna State Primary Health Care Development Agency Local Government Area (KDSPHCDA LGA) Health Operational Plan Manual* published in March 2014. A content analysis of this document to determine the extent to which mental health is addressed in this operational document revealed that promotion of mental health not mentioned at all in all its pages. In the document, the Kaduna State Director PHC stressed the centrality of this document to the overall function of the State PHC activities thus:

> Effective and evidence-based planning is central to PHC system strengthening and delivery of affordable quality health care to the citizen. Introduction of LGA Health Operational Plan in the State has impacted positively on PHC system in areas of improved allocation efficiency, increased access to quality care (Waziri, 2014: 5).

The above statement indicates the emphasis placed on this LGA Health Operational Plan, for delivering effective health and other related services at the PHC level. Further analysis highlighted the need and relevance of the document, as expressed by the Executive Secretary, Kaduna State PHC Development Agency, who asserted that:

> ...the LGA health operational plan is a unique opportunity for achieving a functional integration of activities of all PHC MDAs in the state... to achieve the operation of PHCUOR (PHC under one Roof) in the state (Safiyanu, 2014:6).

Despite this emphasis, the analysis revealed that in the cost summary template (Annex 4; p.18), where specific allocations are made for all services to be provided to the people, mental health care allocation was absent. However, most of the PHC components or services are covered, each having budgetary allocations in percentages of the total budget allocated to PHC.

It is also discovered that, of the 17 highlighted the cost intentions of the Operational Plan, all other PHC services such as supply of essential drugs, safe child delivery, family planning, malaria prevention using insecticide treated nets (ITN)s, immunization, ANC visit, manpower development are all captured, but mental health services (MHS) was not even mentioned. This implies that despite the central relevance of this policy document to the provision of PHC services "under one roof", as Executive Secretary of the Kaduna State PHC Development Agency emphasised in the mission statement of the document, MHS is conspicuously omitted; implying that MHS is not sheltered by PHC Roof, and thus not even in the realm of the "the future planners for development and implementation" of LGAs in Kaduna State. This indicates policy gap with particular reference to MHS. During an IDI with Executive Secretary of the Agency, this omission could not be justified but he simply said: "it must have been a serious oversight."

Other data collected also point to policy gaps relating to mental health in the other States. For example, in Benue and Gombe States, all the State PHC Directors/Executive Secretary reported that their States had no specific policy on mental health. But they acknowledged that they were aware of

a Federal Government Mental Health Policy. However, PHC workers' trainers in all the three States, who are lecturers at Colleges of Health Technology, said they have never had access to such documents but have heard about. This is captured in this statement by the Provost, Gombe State College of Health Technology, Kaltungo: "On mental health policy, the lecturers including myself claimed to be aware of it but that it is not available to teachers of CHWs (community health workers) training for teaching students." This indicates that the National Mental Health Policy is only a remote document but there is no domesticated one for the State Governments of the three States.

For some health administrators, it is even a laughing matter because policy on mental health is remote. For example, the Kaltungo PHC coordinator in Gombe State said, laughing:

> … As far I know, oga (referring to the researcher)! have you seen one here Gombe (State), honestly mental health is very very very poor, very very very poor and no such policy here. I think that is the most serious problem we have, all these suicidal things (we see) are as a result of mental health problems and because there are no MHS. But government is doing virtually nothing.

At Yamaltu-Deba LGA, the PHC Director's interview highlighted thus "the Federal Government is responsible for the non-existence of mental health programmes at the LGA". On his part, a PHC Agency Executive Secretary, through his Representative in one of the State said admittedly that:

> ...well, you know the mistake the government/policy makers are making, I believe, is what you want to correct by your work (researcher's study). You see, there are structures but nobody to work, nothing is done. So there is urgent need to first of all focus on manpower. I mean the training of the community health workers, like we are doing. Therefore, my brother, I think you need to let them (i.e. governments) know that we urgently need upward review of curriculum, training and re-training and stepping down of such training to others, mobilizing the site, maybe a pioneer site for piloting. I think by those steps, we will achieve tremendously. And I think this your (referring to the researcher's work) will be a starting point for this.

The statement indicates the weak commitment of the government in implementing mental health as a component of the PHC. In addition, as part of his comment in the statement, he said:

> And I think this your work will be a starting point for this; indicate in your report that the health workers themselves seem not to be awake to the responsibilities until reminded.

On lack of policy at State level, some health workers however accuse the Local Government Chairmen as being responsible for the lack of MHS at PHC level. On asking about barriers to MHS in Giwa LGA (Yakawada), during an interaction with health workers, a health worker answered, angrily, saying: "it is the Local Government Chairman, he is the only barrier." On further probing this statement, many health workers saw the LGA bosses as focusing on issues such as immunisation, family planning and HIV/AIDS instead of MHS.

The data in this section so far indicate that lack of policy or its failure and political unwillingness are the major factors responsible for lack of MHS at the PHC centres in three selected States. The fallout of this is the emergence of other barriers reflected in lack of service area (Section) at PHC centre for MHS, lack of skilled health workers to provide MHS, lack of motivation for the available ones, lack of funds, and other resources including the lack of designated areas at PHC centres where MHS can be provided. These emerging barriers are presented below.

5.1.1.1 Mental Health Section/Room at PHC centres

All the Heads of PHC centres were asked whether there were any designated sections or rooms for mental health services at their respective PHC facilities. To this, allof them said no. Observations at the centres confirmed the absence at these centres, except at one centre in Otukpo LGA where an NGO, called CBM, organizes PHC attendees for mental health talk in one part of the General Outpatient Department. However, some pregnant women saidthat some staff provided some counselling services to those who had some psychological problems such as depressive episodes, anxiety disorders and violence-related issues, most times in their (staff's) private offices.This indicates that no PHC centres investigated had any formal arrangement, a room or a section of the (PHC) Clinic for the provision of MHS to any group of clients. This is a big barrier to MHS.

5.1.1.2 Shortage of Skilled PHC workers on Mental Health as barrier

PHC Professional categories

In the survey, the workers' professional grouping shows that Community Health Extension Workers (CHEWs) form the bulk of PHC service providers (58.6%; n=112), distantly followed by Nurse-midwives (RNM) (23.0%; n=44) and Community Health Officers (CHO) (9.9%; n=23), as shown in Fig. 5.1.1.

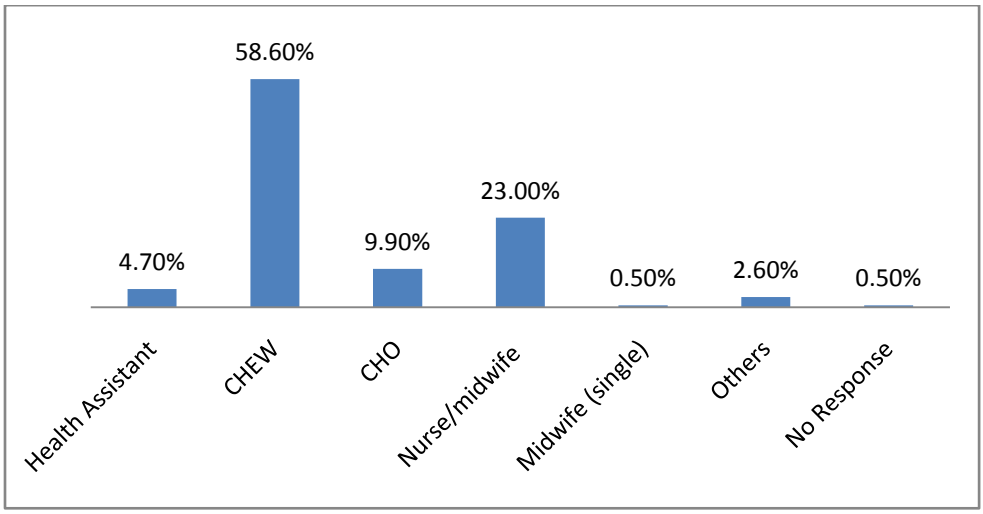


Fig 5.1.1: Proportions of PHC workers' professional designation at PHC centres in Study States

Fig 5.1.1 reveals however that service providers trained in Community Health (that is, CHEWs and CHOs) constitute the majority of the PHC workers. Out of the 112 CHEWs, 22 (19.6%) are in the junior category (with certificate in Community Health); the remaining are senior CHEWs. These senior CHEWs have diplomas in Community Health and they (the SCHEWs) constitute the majority (57.1%, n=109). No General Duty doctor or mental health nurse was found in any centre.

Further analysis of the positions of these health workers in their respective centres at the time of data collection is shown Table 5.1.1

Table 5.1.1: Respondents' Positions at PHC centres

Positions of respondents	Frequency	Percentage
Head of Centre	27	14.1
Deputy Head of centre/unit	6	3.1
Focal Person	1	.5
Other staff at centre	156	81.7
Not stated	1	0.5
Total	191	100.0

In Table 5.1.1, it is revealed that Heads of Unit constituted 14.1% (n=27) of the workers sample population, while the bulk (81.7%) were other service providers (n=156), made up of community health officers, nurses and midwives, community health extension workers, and environmental health officers. The heads of centre are the coordinators of the PHC centres who are in charge of the day to day running of the services at these centres. According to the PHC policy, such centres are to be headed by CHOs or senior nurses. The headship of these clinics is reflected in Table 5.1. 2.

Table 5.1.2: Profession and positions at PHC centres

Profession	Head of Centre	Percentage
CHEW	15	55.6
CHO	6	22.2
Nurse-midwife	5	18.5
Midwife (single)	1	3.7
Total	**27**	**100.0**

Source: cross tabulation: profession and position

On further analysis, as indicated in Table 5.1.2, it is found that out of the 27 Heads, 15 (55.6%) are CHEWS while CHO and Nurse-midwives constitute 18.5%; n=6) each. This implies that most of the Unit Heads are CHEWs. This shows that in all the centres, there is no mental health personnel heading any centre neither was any mental health coordinator found. CHOs and Senior nurses who

are supposed to head these units are few. This indicates poor manpower status of PHC centres to provide meaningful MHS.

These data were supported by other observation at the centre, where the number of PHC workers on the staff lists was explored presented in the following sections.

Number of Health workers at PHC

The staff strength (actual number of health workers) at the PHC centres was assessed for adequacy and quality. Throughout the records at the centres, it was confirmed that there is no mental health service coordinator in any centre in any of three States investigated neither are there specialists available at PHC centres to provide mental health services nor was there any general duty doctor found, except the CBM coordinated centre in Otukpo. As all PHC Coordinators lamented, there are no mental health nurses or doctors in their centres.And this category of professionals needs to be available to meet the minimum standard for MHS delivery. As one PHC coordinator in Gombe State acknowledged;

> In each facility or ward, there is supposed to be a Mental Health Coordinator (specialist or (Focal person).but you have to go to the Ministry to bring them out, we need to go and look for them. But if you wait for them, they won't come, because people who have (psychological) problems but most times they don't even know they have it. So it is better that in each ward, we have a mental health Focal Person to help create awareness.

The lack of mental health specialists of any cadre may be responsible for the poor state of MHS at the PHC centres.

Findings in this section have indicated that apart from the general duty CHEWs, CHOs and nurses, mental health specialists are lacking. This may explains why even the minimal available mental health services in few areas are poorly organised and are provided only as a matter of the choice and concern by the particular staff on duty.

Moreover, the general duty PHC workers available are few and already overburdened with other PHC services.For example, from the staff records made available to the researcher at the centres, the number per centre ranged from 2 (Awon PHC centre, Kachia LGA) to 13 (Yakawada CHC, Giwa), indicating that there is a serious shortage of skilled PHC workers in most centres. Many centres would not release the number of staff on their staff rosters due to some "official reasons", which is suggestive of inadequacies.

Confirming the inadequacy of the staff shortage at PHC centres, a health administrator in Gombe State summarised the staff situation at PHCs thus: "honestly, our staff is not enough. We will need additional staff, especially for mental health." Many others expressed similar concerns but said that most available staff are ready to commence the MHS if brought on board by the relevant authorities.

5.1.1.3 PHC Workers' Training Challenges as Barrier for MHS in PHC:

In this section, the PHC workers' educational attainment as against the recommended status for providing MHS and their training needs are presented, with particular reference to the content of the training curricula for the community health workers.

PHC workers' educational categories and Training Needs

The PHC workers' educational data are presented in Table 5.1.3. These data are important variables in assessing the quality of these workers who provide the mental health services. The Table and figure below indicate the educational attainment and professional qualification respectively.

Table 5.1.3: PHC workers' Educational Attainment

Educational attainment	Frequency	Percentage
Certificate	22	11.5
Diploma	109	57.1
HND	60	31.4
Total	**191**	**100.0**

As indicated in Table 5.1.3, most of the PHC workers hold diploma certificates (57.1%). Those with HND or its equivalent (31.4%, n=60) are made up of Community Health Officers and Nurse-Midwives. Thus, they are mostly community health extension workers with diploma in Community Health. This category of community health workers are trained to provide services at the PHC centres, and work under the supervision of the CHO or the senior nurse. PHC workers undergo various levels of training to qualify to provide PHC services and usually require additional training to deliver specialized services like MHS. The level of the relevant training they have received was assessed in a survey, and through IDIs.

A consultant psychiatrist in Kaduna during an IDI expressed serious concern about the level of preparedness of PHC workers in providing the services at the community level. He said:

> ….the mental health services in the community is right now next to nothing; because if you go to the PHCs (centres) most of their staff don't know what mental health is all about. A lot of them can't recognize symptoms of mental problems, because of that they can't diagnose and a lot of patient will go unrecognized or untreated. Sometimes a lot of mental health disorder also present (manifest) as the physical symptoms and are wrongly treated as malaria or typhoid without assessing the mental health.

The narrative from the mental health specialist indicates gap in the knowledge and skill of PHC workers to identify and intervene in mental health disorders. This need for more training is re-echoed even among the PHC Coordinators and the health workers themselves. Health workers' opinions during the survey on whether there is adequate training of primary health care workers to provide mental health services at the PHC level, health workers were divided in their views: 86 (45.0%) considered the training they have undergone as adequate, 78 (40.9%) disagreed, while 27 (14.1%) were not sure. This indicates that about equal numbers are on either side of the divide as to the adequacy or otherwise of the mental health content of their training.

To investigate and confirm this claim, the knowledge and training needs of Primary Health Care workers in mental health services provision was assessed. This is achieved through the health

workers' survey and administrators. The researcher, using WHO mhGAP training tool (Appendix B), assessed the knowledge of these workers on the services they are expected to know and provide at their centres. It is indicated that using the WHO mhGAP basic task performance tools for middle-level health workers as the PHC workers, there is a lack of knowledge of basic mental health care skills and interventions by PHC workers in the study area, as rated by the workers themselves. The result of the survey shows a very poor knowledge of the workers and very low skill level in handing the psychological problems of PHC clients.

During IDIs with some of the PHC workers, many of them acknowledged their inadequate knowledge and skills in detecting and managing mental health issues at the PHC level. A health worker at Danmahawayi in Giwa LGA admitted:

> We do not know how to assess mental problem n children and pregnant women. It was not captured in school also. We only had two weeks of psychiatric training while in school. We don't render mental health services. Nobody ever came to even talk about it.

Similarly, almost all PHC coordinators admitted the poor preparation of PHC workers to provide MHS. For instance, the PHC coordinator in Giwa LGA of Kaduna State said:

> Most of us, probably have done a little of mental health but have forgotten training we received. So what I will recommend is that all the PHC state…we have to put it to practice especially the clinic in-charges.

These data corroborated the survey of the PHC workers on their knowledge and skill, based on the WHO mhGAP questionnaire (Appendix B) for middle cadre health workers, namely, PHC workers such as Nurses, CHEWS and CHOs.

Another knowledge component of the barrier to MHS is the mistaken view of the mental health services that health workers displayed. It was established that most of the health professionals

exhibited a diverse understandings of mental health services. Health workers mistook mental health services, which is an umbrella term for all interventions for psychological problems for just psychiatric services (i.e. care for the mentally ill). During IDIs, to many health workers, when the term mental health is mentioned, it simply meant mental illness. Similarly, like many lay people, most health workers equated MHS to psychiatric care. A PHC coordinator in Giwa affirmed that:

> ….yes, people believe mental health is all about mental illness. Honestly when you mention mental health services most of us take our minds to psychiatric care...which is wrong.

This indicates that whenever MHS is mentioned, health workers think only of cases of mental health illness. This works to the detriment of promotive and preventive MHS. On the contrary, mental health services cover mental health information, positive mental health habits and other interventions to prevent psychological problems. But this has been misunderstood to mean psychiatric services. This is probably responsible for the poor MHS delivery in the study area.

In addition, even the target clientielle for mental health services is also found to be misunderstood by many health workers. Most of them believe that women and children, who constitute some of the vulnerable groups to psychological problems, do not require mental health services. For example, a CHO in charge of PHC centre in Vandekiya LGA of Benue State said:

> ...our patients that come here are those that don't need the mental health information: these are women and children. The youths who need the information on drugs do not come.

This indicates that some health workers do not consider pregnant women (ANC clients); children (who come for treatment of other ailments and immunization) and probably other community members, other than youths, as people that require any form of mental health services. However, during the survey of health workers, many others included the children and pregnant women as vulnerable to mental health disorders (as presented in the section on burden of mental health in

Chapter 4). In fact, a PHC Coordinator in Gombe State acknowledged that women and children face many psychological challenges, requiring MHS. He said:

> You know, why you see women more in the health centre, is because they have multiple problems and these children too. It is the women that will take the children, and women are the ones that go there for pregnancy care and family planning. Children also go there for immunization. All these have stresses.

This implies that women face more stresses related to child bearing and rearing, and suggest that they need psychological intervention to cope effectively. All these interventions fall within MHS,

Data analysed in this section so far reveal that the terms (mental health and mental illness) are poorly understood by many health workers, being narrowed down to only small aspect of the concept (psychiatric care). Mental health services, however, embraces care given to the physically and psychologically sick and the well. It is comprised of promotive, preventive, curative and rehabilitative components that improve mental wellbeing. This means that it covers mental health, mental health problems and mental illness, using various clues of symptoms for diagnosis and forms of interventions. The poor understanding displayed by the health workers will seriously hinder the provision of the required MHS.

Having identified the knowledge and skills gaps as obstacles to MHS delivery, PHC workers' views on their need for further training among other things were then inquired. Their responses are shown in Table 5.1.4.

Table 5.1.4: Responses of PHC workers on their training needs

Questions on Training Needs (N=191)	Yes	Percentage
Do you think you need further training to enable you provide mental health care at the PHC level?	172	90.1
Do you think your curriculum of training in the institution where you were trained need to be modified to meet the need for providing mental health care services in the community?	168	88.0
In Nigeria, do you think the mental health component of your training is adequate to provide functional mental health services at the PHC level?	70	41.4
Are sufficient credit hours allocated to this component to cover detection of mental illness early in life?	58	30.4
Have there been any new courses specifically related to training you for scaling up mental health services in the last five years?	18	9.4

From Table 5.1.4, it is shown that at least 90.1% of them think they need additional training to enable them provide MHS while 88.0% believe that the training curriculum for PHC workers especially for the CHEWs need to be modified. The data in Table 5.1.4 show that most PHC workers believe that there is an inadequate emphasis placed on the mental health aspect of the training, credit hours allocated to teaching mental health component is also inadequate, and that new courses to enhance delivery of MHS have not been introduced as emphasis is on the need for further training for health workers. It is also indicated that there is need to review their curriculum of training.

During IDIs, many of the workers indicated beliefs that there are areas of the professional practice that require improvement. At PHC Makera 1 in Kaduna South LGA, a Unit Head said:

> We wish they can arrange short courses for us but the government is not even concerned…4 to 6 weeks will be okay because we did little also in school except some Nurses who have post basic psychiatric certificate but we don't have any Nurse with that qualification.

Many other community health workers suggested between four and six weeks short courses for those interested, while some PHC coordinators suggested regular workshops for the community health workers. Findings also show that many staff are interested in undergoing the mental health training.

At the Township MCH centre in Gombe LGA, the researcher's interaction with staff and community members revealed that most of the CHEWS are interested in Community Mental Health (CMH) training. But like one CHEW in Gombe LGA said:

> Despite the high interest, no training programme for us to be trained (sic). We cannot provide Community Mental Health (CMH) care with our present certificate very well. I want to do the course but I am not a Nurse to do the post basic psychiatric training and there is no post CHO psychiatric training.

Many other CHEWs expressed similar zeal. A particular CHEW literally implored the researcher to include him in any upcoming programme of training of CMH, which he might organise. This goes to show the high level of interest by many community health workers to undergo the mental health training to help them provide services is high.

IDIs revealed the views of many health administrators, implying that there are no mental health services because government never made arrangement, and that staff are poorly trained to handle MHS. At Kaduna South, a PHC coordinator testified that,

> PHC workers are highly interested to be trained… I believe CHEWS and CHOs need short courses while the Nurses can go for specialised training as Registered Psychiatric Nurse.

The high interest in MH training permeates the Training Institutions as well. For example, the Provost of Gombe School of Health Technology in Kaltungo even solicited to the researcher to:

> Pilot MHS in Kaltungo (LGA) because we have willing workers to take it on, even me! I can leave the classroom for it. After all I was on the field for years before I left for the University in Delta State for my B.Sc Community Health.

In summarizing the staff situation, a PHC coordinator attested that "Training is not adequate too; and workers are few." But staff are willing to undergo planned courses on mental health to enable provide the services. However, these courses, in any form, are currently non-existent. Findings in this section also indicate that the training curricula of CHEWs and CHOs need review. This document was therefore analysed to ascertain the claims of the out-dated nature of the document.

The CHEWs and CHO Training Curricula

A content analysis of the Training Curricula of community health professionals (i.e. junior and Senior CHEW and CHOs), examining the training component of PHC workers as a barrier to the provision of MHS was undertaken. Health workers had lamented that they had only two weeks psychiatric training while in school that made rendering mental health services very difficult. The clause "we had only two weeks psychiatric training" is key to the analysis of the training documents of this group of health workers; the period allocated is too short. Similarly, the concern expressed by the Provost, Gombe State School of Health Technology during an IDI indicated the need to examine the curriculum of training. He had said:

> Everything on curriculum is "referral" but on the field "we are the alpha and omega", so there is need for review, in view of the dynamic nature of knowledge. Reproductive health curriculum has just been reviewed to enable students update e.g. MVA.

These documents were therefore analysed by the researcher to draw out the strengths and short comings, with particular reference to the mental health content of the curricula. This was combined with IDIs with three Provosts/Coordinators of CHW Training in Gombe, Kaduna and Benue States.

An examination of Community Health Training Curricula of SCHEWs and JCHEWs, showed that Mental Health Lecture is just one credit unit (only 15 Hours) throughout the training. The provost added that the content taught "does not include details of assessment of adult and child clients; that they are just to introduce them (i.e. the students) to it and the Standing Orders".

In critiquing of all the curricula for training (i.e. Curriculum for Certificate in Community Health, JCHEW; Diploma in Community Health SCHEW; and Higher Diploma in Community Health, CHO Training), Community Mental Health is coded JCH 137 with one credit unit (15hours). The course content has nothing on checklist for mental illness, the mhGap (WHO) is completely absent, and there is no section on gender- and age-specific disorders or developmental stage-focused disorders (infancy to old age). No hours were allocated for clinical experience, and the qualification of the teacher to teach the content was not specified No Teacher qualified. However, positive mental health

habits and community preventive measures have prominence including immunization but no ANC, PNC and occupation/age-specific services.

For the Diploma in Community Health, the Community Mental Health has two hour credit units (30 hours), focused on equipping students with the knowledge and skills to enable him/her promote positive mental health, recognised and manage mental illness in the community. Like the JCHEW curriculum, no hours allocated for skill acquisition (clinical experience), no assigned mental health professional to teach the course and others absent like the JCHEW. Community resources for MHS not appropriately stressed.

The Higher Diploma in Community Health (CHO Training) Community Mental Health is coded CHO 335 is allocated one credit hour (15hours) with the goal of "providing the student with the knowledge and skills to ensure the promotion of mental wellbeing, prevention of mental disorders, and early diagnosis and rehabilitation of the mentally ill in the community." But it is found that time allocated is grossly inadequate for a HND, the course content became far less than the Diploma, and other weaknesses are as in Certificate and Diploma curricula.

From the foregoing analysis, the curricula of training is insufficient to prepare CHEWs and CHOs with the required knowledge and skills to deliver quality MHS. The various views presented by heads of schools and CHW practitioners confirm the lacunae. The researcher further explored the PHC workers' opinions on the training needs in a survey.

They are only aware of the WHO mhGAP Training Manual but it is not available; they are not aware of the content of the Manual. The WHO mhGAP is the document for training the middle-level health workers (as those in PHCs) to provide specialized MHS.

Further on teachers' qualification, all the provosts in the three States said that none of their teachers is trained in the area of Mental Health or exposed to Community Mental Health seminars/workshops to equip them with adequate mental health course content. They added that the

major barrier to teaching mental health to the community health workers is inadequate training for PHC Tutors, and consequently the poor exposure of trainees to Mental Health problems. The provosts suggested improving the teaching of Mental Health to scale up the training for PHC tutors (who in turn impart knowledge on the CHEWS and CHOs), to make training materials available for teachers e.g. the WHO mhGAP curriculum, and to organise workshops on the recommended training modules/manual for middle level health workers.

At the College of Health Sciences, Otukpo, Benue State, the Provost mentioned the role CBM plays in the training of CHEWs in form of periodic lectures for the students, hoping this should increase the mental health content of their training especially that School of Nursing Benue State lost accreditation for over three years at the time of study (IDI in January, 2015). The CBM is however reluctant to do that since it is not part of their mandate. But she narrated the plans to set up a Community Mental Health Research Centre in Otukpo to keep a database for mental health problems, particularly the multiple drugs usage. Similarly, she confirmed that they only train SCHEWs and JCHEWs using Standing Orders (SO), though not meant to use specialist mental health assessment but tailored towards giving basic care when necessary and then refer.

This section therefore concludes that shortage of skilled PHC workers is a major barrier to the provision of MHS in the study area at PHC level, and because of the inadequate number, poor knowledge and skill of the personnel, and weak training system including lack of qualified teachers to groom the workers.

5.1.1.4 Lack of motivation and working tools

Data collected from PHC workers on motivation indicate that workers are not encouraged to provide MHS in the community. For example, PHC workers said that although they are trained to use ‘Standing Orders’ (a treatment protocol) to provide PHC clinical services, there are no such

protocols ('Standing Orders') for treating mental health disorders at their centres. Some claimed that they are not even aware that mental disorders fall under the purview of their job description. In addition, there are no drugs for treating mental disorders at the PHC centres. Some even claim that drugs for the mental illness are not part of the essential drug list.

IDIs further reveal many other damping factors for providing MHS by health workers like, in some PHCs, salaries are not paid, many staff are deprived of in-service training opportunities, and the work environment is described as hostile when workers cannot meet up with family expenses. A CHO informed the researcher that village health workers (VHWs) are involved in social mobilization but paid by the (Benue) State government but supervised by CHO. But the CHO said:

> We (CHOs, CHEWs) have not been paid our salary for 4months now, so I don't waste my time to follow them: they just bring their reports, I sign and submit to the desk officer of MDG at the (LGA) secretariat. For now, they are mainly involved in MCH services; they note the number of deliveries, deaths, etc. If the MHS are available, we will use them too.

Another CHO at the Vandeikya LGA Secretariat reaffirmed:

> You see the secretariat, at this time (it was 11:27am), nobody is in the office; How can they come; the government is not serious; they reduced our salaries by almost half then paid half of the halved salary. Even that have not been paid for four months now.

The PHC Director at the state corroborated by saying "….the State Government has (sic) not the entire health workers in this State for over six months now." This indicates that PHC workers are poorly motivated in some States. However, in some other States, workers' salaries were not a serious problem.

However, 43.5% of workers agreed that there is a "Standing Order" for managing mental disorders at PHC centres; another 27.8% of them said they are not aware of any document for mental illness in their centres. This has already been explored qualitatively.

The data in this section have indicated low motivation of workers, coupled with absence of intervention protocols, is a major barrier to MHS delivery. The strength that can be explored however is the high interest of the workers to undergo the specialized training to help them provide the desired MHS. The reason for the interest was mainly for professional fulfilment; they claim that they enjoy studying and providing psychological care.

5.1.1.5 Lack of funds to provide MHS at the PHC

During the IDIs, health workers at all the centres and administrators were unanimous in saying that mental health services are not funded by the government. For example, one of them in Gombe State said:

> No, we have never had any fund for mental health". But it seems money is not made available for anything... even in the standing order, there is provision for mental health, but it is stated to refer to next level of management. No money for drugs...no, no drugs available for mental health.

This is further supported by the views expressed by health workers' survey that lack of financial resources and funding even for mental health research has been a major barrier to MHS delivery in the three selected States in northern Nigeria. The poor funding and difficulty in mobilizing funds for MHS at PHC centres in the study area is an offshoot of the policy failure on MHS.

5.1.1.6 Lack of Intersectoral Collaboration between Formal and Non-formal sectors

In this section, collaboration between the PHC system and traditional healers, NGOs, and communities was explored. On traditional healers' involvement in MHS in the community, health workers' willing for any such collaboration between the traditional and the modern health practitioners assessed showed that only 53 (33.0%) answered in the affirmative; a large number of respondents, 84 (44.0%), said such collaboration would not be possible. The remaining 44 (23.0%) expressed uncertainty about the possibility of such collaboration. Opinion of Health Workers on Modern-traditional medicine collaboration has shown discrepancies in perception among both traditional and modern medical practitioners.

Similarly, in the treatment of mental illness, health workers were also divided; some believe that when traditional treatment combined with modern care, the efficacy rating of traditional treatment will slightly improve (19.9%), and will further improve when combined with modern and spiritual (36.2%). This is suggestive of some health workers being in favour of the traditional-modern collaboration in the treatment of the mental health problem. This is the only form of MHS most health workers discussed.

The opinions of community respondents however show that traditional healers are not considered important or useful in treating mental illness as no respondent indicated willingness to take any mentally sick person to the traditional healer. This is surprising because in illness behaviour, one of the first points of consultation is the traditional or folk medical practitioner. Some community members even claimed, when asked if they take the patients to traditional healers, that "Noo…., we don't have a traditional healer (for mental illness) here in our community." Thus, the collaboration between these two categories of mental health care was also further explored.

On the involvement of traditional healer in MHS, in Gombe State, a PHC coordinator said:

> …in those days yes, there is none now because some of them have died, they went away with their expertise; people no longer patronize them.

This implies, in his opinion, that traditional healers for mental illness were no longer available in the Gombe because as he said: "all our cases (mental illnesses) are taken to the Specialist Hospital (Gombe)." However, still in Gombe State, a medical practitioner identified some healers, and even went further to highlight what looked like an area of collaboration. He said:

> If you go the north (i.e. Gombe north), we have people that are caring for them (PLWMI). If you go to Tudunwada, Mallam Hassan, is a very popular person. In Jekadefari also we have a traditionalist. If he (healer) has any case (i.e. a psychiatric patient) with other medical problems, he calls me and I (the CHO) treat the medical problem while he (the healer) takes care of his psychiatric patient.

This shows that even traditional healers seek areas of collaboration with the modern medicine. However, the traditional healer did not disclose his art of healing the psychiatric patients to the informant, who is a modern medical practitioner.

This however implies that health worker even collaborates with the traditional health care providers on many fronts such as specialist group in hospitals where a psychiatrist calls the physician to manage other medical conditions like diabetes and hypertension in a psychiatric patient.

Unlike a view expressed by one IDI informant in Gombe State that no traditionalists exist these days, although countered by the views of the previous informant, Kaduna State has a number of traditional psychiatrists. On traditional healers/intervention a PHC coordinator in Kaduna State said:

> Baza'a rasa ba"! 'Baza'a rasa ba'… tunda (meaning: it is possible…since) the government are backing the traditional healers now. We have them but I don't know where they are. But we have them…except may be for the mental health, I don't know.

This informant is suggesting some government approval for collaboration in Kaduna. But while some of these healers truly exist and allow some form of working together with the modern therapists, many of them choose to be secretive about their activities. For example, in Kaduna State, a senior consultant in psychiatry informed the researcher about attempts made by the Federal Neuropsychiatric Hospital Kaduna to link up with a traditional psychiatrist in Mando Kaduna but to no avail. He said:

> The hospital has written him, officially, several times (for a visit to his treatment centre in Mando, Kaduna) but he would not welcome anyone. Even the psychiatric nurses in training at the hospital wrote to make an excursion there, again he refused.

He continued, on further inquiry on the purpose for the intended visit to the healer, that:

> All we needed to do was to see where we could work together with him…because we learnt that he has in-patients that are kept for months, some years, where he is said to be teaching various trades like carpentry, tailoring, etc. some of the inmates are taken

> to the farm. So we wanted to work with him, especially in terms of occupational therapy.

However, in Salanke in Giwa LGA, a traditional psychiatric healer who is now deceased, had transferred the art to his (male) children before his death. The children currently treat PLWMI. On a visit to the area by the researcher, it was found that they did not specialize in managing psychiatric patients, but treat them among other patients including those with fracture. On collaboration with modern medicine, one of them said: "truly, it will be a welcome idea, but no hospital has approached us for that." This indicates that the traditional healers are willing to collaborate, but he could not say, for the moment, what areas "the medical people (modern psychiatrists) would want us to work together."

In addition, in Makarfi (Tashan Yari community), another healer also operates his 'clinic', with 12 patients as at the time of the researcher's visit. At the time of the study, the Federal Neuropsychiatric hospital Kaduna was collaborating with the healer. The area of common interest for now is the activity therapy and occupational therapy. Both the healer and health professionals from the Psychiatric Hospital are willing, and in fact, are formalising the ways to do this. In-patients at the centre are taught various trades, and farming techniques. The Psychiatric Hospital now visits this centre often, as a consultant psychiatrist put it: "with the possibility of using the centre as a 'half-home'."

The findings in this section reveal that there is an opportunity for modern-traditional medicine collaboration whenever providing MHS, as expressed by some professionals and institutions. This desire for collaboration is obvious because some have actually started integrating some areas of common interests as shown at some minimal but deliberate levels. However, most traditional healers and health worlers alike still prefer to stay aloof from the modern-traditional

collaboration in mental health care system. This therefore remains a barrier that will require resolution if and when MHS in the community are available.

NGOs in Community Mental Health Services

More than half of the workers (53.4%) said NGOs are not being encouraged to participate in the provision of MHS at the PHC level. Only 13.6% (n=26) of them said they were aware of any form of collaboration. Among these (n=26), 18 (69.2%) identified the NGOs/CBO that they claimed were involved, as shown Table 5.1.5.

Table 5.1.5: Identified NGO/CBO on MHS by Centre and State

NGO/CBO	State	Frequency*	Percentage
CBM Otukpo	Benue	8	44.4
Health Rest Centre Agboke	Benue	6	33.3
WHO-initiated	Gombe	1	12.5
Psychiatric Unit Services	Gombe	1	5.6
FNPH Kaduna-initiated	Kaduna	2	11.1
Total		18	100.0

** None stated = 8*

From their responses shown in Table 5.1.5, only Benue State has NGOs involvement in the provision of mental health services. The other services mentioned are from formal organisations like the Federal Neuro-psychiatric Hospital Kaduna. The sole existence of mental health-related NGOs in Benue State was acknowledged by PHC administrators even outside Benue State, For instance, a PHC coordinator in Kaduna attested to this when she said:

> Benue State has started because the Benue State government sent people to Barnawa (i.e. School of Post basic Psychiatric Nursing, Federal Neuro-psychiatric Hospital) here in Kaduna for training. I learnt that one NGO is helping to train nurses there. I even assisted them (the trainees) by introducing to the community leaders here when they were doing the research project; but in Kaduna here, no such thing.

Even in Gombe State, the presence of a Mental Health NGO in Benue State is a common knowledge, as one of the PHC coordinators also affirmed that

> In the north, I am not aware of any organised NGO for mental health care apart from one in Benue State, called CBM; although I don't know the detailed activities of the organisation.

The researcher visited CBM (Appendix 11) when he was in Benue State. He elicited further information on the NGO from the PHC Director of Local Government Service Commission (LGSC) and from two of the nurses who benefitted from the training. The Director, LGSC, reaffirmed the existence of the CBM in Otukpo Benue State and the role the NGO was playing in helping the State to provide mental health services. He said:

> The Christofoel Blind Mission (CBM, is an NGO focused on comprehensive community mental health programme. They are located at Jesus College, Otukpo. The programme is implemented by the Methodist Church and sponsored by CBM, an Australian-based NGO. The CBM is only in Benue State for now to implement programme for now.

On the role of the CBM in the State, the informant said that:

> They are involved in the training of nurses in Mental Health for Comprehensive Community Mental Health Programme for Benue State. They train nurses for Benue State to employ. The essence is (that) they will come back and be engaged by the government. They signed MOU with the state government. Well, the CBM has also an understanding with the (Benue) State government to employ these nurses after training but the government cannot go against its policy which is embargo on employment.

He added that

> The NGO also periodically organises lectures for Community Health Extension Workers (the students in training at the College of Health Technology. They (CBM) also provide logistics for services (i.e. community mental health services).

The Director explained how the nurses for training are recruited and used after training:

> The CBM scouted for nurses who are qualified to be trained but it was difficult to get such because of the O'L requirements. However, some nurses were selected from some local government areas, and freshers from school. About 12 or so of them were trained but the Benue state government cannot absorb them because of embargo on employment….

> Apart from the challenges are getting suitably qualified (O'L science credits), there are interested Nurses who agree to do the Mental Health training; and there is lack of staff in the Benue State government generally.

Apart from these challenges, it was gathered that the State government has not been fulfilling its own part of the agreement, that is, to employ theses nurses that are trained to be deployed to the LGAs in the State. The PHC Director, and the two nurses trained by the CBM lamented this situation as unbelievable.

On what has been happening to those trained, he said:

> … well, some of them have complied (i.e. they reported back to the Government), some have not. Some of them are employed by other institutions, the remaining 12 are still not engaged. But I learnt some of them got appointment with the Teaching Hospital here in Makurdi. Some got jobs elsewhere; some staff of Local Governments went back to their stations

This shows that despite the manpower need and the magnanimity of the CBM in training the needed human resource for providing the much needed MHS, such resources lay waste, as far as MHS are concerned. The PHC Director Benue State LGSC complained bitterly that with an MOU between the Benue State Government and those who were trained by this NGO had not been employed by the State despite the need for them because of the general embargo on employment but to him, "this is regrettable...especially the mental health problems are too much in this State (Benue)", in view of the serious mental health challenges in the State.

The researcher was able to recruit two of the nurses trained by CBM for their experiences. One of them who was then working in a hospital in Makurdi said it was embarrassing to her for the Benue State Government "to rubbish a rare offer from a foreign-based initiative like the CBM," she said.

Another trained mental health nurse, a Benue State indigene working then in Kaduna in a private hospital was accessed to share her own experiences. She said:

> The agreement (with Benue State Government) was that the state will pay us and the (CBM) will provide everything. But the state did not employ us. But up till now we don't know how far, how they are doing. Presently, I am working in a private hospital, since, they didn't call us, I came back to Kaduna. I now work in a private hospital here in Kaduna, a Paediatric Hospital for that matter. Benue State did not absorb us, me and three others in Kaduna here, all working in private hospitals. We waited and waited (for Benue State to employ them) but we have to look for work. We went to the Local government Service Commission several times but they said there is embargo; so I came back to Kaduna. We are still waiting to be invited by Benue State government.

Having ascertained all this, the researcher visited the CBM Secretariat at Otukpo for their views on their services. The Head of the CBM at Otukpo narrated the modus operandi and challenges, similar to the narration of the Benue State Director for Primary Health Care and CBM trainees. But he added that "community mobilization, sensitization and education are our (CBM) main activities" but they lack qualified staff. He also said they have an understanding with the School of Post-basic Psychiatric Nursing, Federal Neuro-psychiatric Hospital in Kaduna to offer them at least five admission opportunities for selected nurses every year to train mental health nurses for Benue State.

From the foregoing, there is a semblance of some form of collaboration with NGOs in Benue State. However, such collaboration has failed to meet its goal of providing the necessary manpower for MHS. This is due to purposeful government policy (of embargo on employment).

In Kaduna State, the situation is quite different. There was no NGO identified for MHS, a similar scenario in Gombe State. In Kaduna, a senior consultant in psychiatry said:

> ……aah…not really… strictly speaking, no NGO dedicated to MH as such. We have very few. They are profit making, not strictly NGO. We have autism prevention group, religious group etc. There are some Reverend Sisters who have organized an NGO, they see children with special needs. But they are very very scanty and few. We have seen many organized NGOs like the ones on maternal mortality, HIV, family health, there is no such as far as mental health is concerned in children.

In fact, it was found that some health administrators (PHC Coordinators) in Kaduna State deliberately discouraged NGOs in mental health from operating, due to some past experiences (some

real and perceived reasons) of such health administrators. For instance, at one of the LGAs in Kaduna State (the Kaduna South LGA), PHC coordinator said that she discouraged attempts by some NGOs that approached the LGA to assist in providing some mental health services because "some fake NGOs extorting money from people once existed, so I refused to accept any now". But in Gombe State, the representative of Executive Secretary of the State PHC Development Agency said they are looking out for the NGOs. As he put it: "No NGO yet but we are ready to work with them." This means that in Gombe State, there is the willingness expressed about having an NGO to work with to provide MHS but there was none as the time of the study.

The data in this section has shown that apart from an NGO called CBM operating in Benue State, no other NGO working on any aspect of MHS was identified in the study areas. In Kaduna and Gombe States, health Administrators acknowledged the absence of NGOs focusing on mental health. The only State (Benue) that has such NGOs has not explored the opportunity maximally, resulting in poor collaborative efforts.

Community Participation

A CHO informed the researcher that village health workers are involved in social mobilization by services such as maternal and child health (MCH) services, paid by the (Benue) State government but supervised by CHO. But a CHO said:

> …they just bring their reports; we (CHOs, CHEWs) just sign (the reports) and submit to the desk officer of MDG at the (LGA) secretariat. For now, they are mainly involved in MCH services; they note the number of deliveries, death, etc. If the mental health services are available, we will use them too.

Community leaders are also made members of PHC committees in their domains now. Although not in all communities, in Sabon Sarki and Awon communities in Kachia LGA, the community leaders chair the PHC committees in the communities. In other places, like Awon in Kaduna States and Vandeikya in Benue State, retired health care workers are being made chiefs. Many of these are aware of the components of the PHC, and so aware of the need for MHS at PHCs.

But like one of them said, MHS is not available so there are collaborative activities in that area yet. "But like the Ebola case, we were completely involved. I hope when this one you are talking about comes, they (i.e. the government and PHC centres) will do the same", one of them said.

On family role, both community leaders and health administrators emphasise such need for collaboration. This is because some community leaders and health workers have associated mental health problems with poor parenting (as presented under the causes of mental illness of the study). The need for collaboration with the family was because,

> Probably this may be as a result of peer group or problem from the house; probably the parents are not giving adequate care; (so) he (the child) decides to go and misbehave so that the whole world will know about the neglect from family. A child will deliberately cause trouble and run away to put them (the family) in trouble.

Hence, informants advocate for families to be proactive. As the Gombe LGA PHC coordinator noted:

> The family has serious role to play. If everybody should at least provide parental care before the children come out, they might come from a home, so if we parents should be taking our responsibility counselling the child, they may not go to that extent.

In Giwa LGA, Kaduna State, the PHC director corroborated this by saying that

> Family have serious role. Parental care, every parent should be responsible for a child. At times, peer group. Everybody should talk to a child. At times because parents are not adequate

The section indicates the need for the community and its basic units to see the necessity of complementing government efforts. It is shown that communities are being incorporated into primary health administration only in a few places. Thus, lack of community involvement remains a factor to be improved prospectively to improve MHS at the community level.

The data so far in this section show that there are scanty and uncoordinated collaborations between modern PHC and traditional medicine men (TrMM), NGOs and the community in MHS delivery; another reflection of poor policy implementation. Similarly, only few identified areas for

collaboration between modern and traditional mental health care exist. These include management of concomitant medical problems with mental illnesses, and in some rehabilitative mental health therapies like occupational therapies. But at that, many practitioners (both modern and traditional) that are resistant to this synergy in MHS.

The data presented in this section has revealed that there is either a lack of policies and political unwillingness for mental health care at PHC level or their non-implementation where there is any. These have reflected lack of service area for MHS, non-availability of qualified human resources and training, lack of funding for MHS and mental health research, and problematic collaborations between traditional healers, NGOs and community resources.

5.1.2 Socio-cultural Barriers to Mental Health Services in the Study Areas

5.1.2.1 The Attitudes of PHC Professionals toward Mental Illness

Health workers' attitudes have significant influence in the overall services delivered to their clients. Hence, health workers' attitudes towards mental illness and the mentally ill person were assessed in the survey. The variables assessed include labelling, stereotyping and stigma as well as the perceived causes and treatment of mental illness, and the perceived consequences of mental illness on the mental patient. Perceptions of health workers in these domains have been found to influence the care for PLWMI and other related services. The workers' responses to labelling issues of PLWMI are presented in Table 5.1.6.

Table 5.1.6: Health workers' perceptions of the mentally ill and mental illness

S/No	Labelling (N=191)	SA (%)	A (%)	N (%)	D (%)	SD (%)	Mean, X	Remarks
	I dislike living with someone who has a mental illness	45 (23.6)	37 (19.4)	31 (16.2)	49 (25.7)	29 (15.2)	3.10	Negative
ii.	To avoid rejection, the mentally ill should hide obvious symptoms of their illness	37 (19.4)	25 (13.1)	40 (20.9)	56 (29.3)	33 (17.3)	2.93	Positive
iii.	I think I would not employ someone who has a history of mental illness	46 (24.1)	42 (22.0)	34 (17.8)	49 (25.7)	20 (10.5)	3.23	Negative
iv.	I think I would not marry someone who has a history of mental illness	54 (28.3)	53 (27.7)	41 (21.5)	27 (14.1)	16 (8.4)	3.53	Negative
v.	I think public attitudes to mental illness affects people with mental illness as citizen	82 (42.9)	56 (29.3)	31 (16.2)	16 (8.4)	6 (3.1)	4.00	Positive

Table 5.1.6 indicates the attitudinal predisposition of labelling to the mentally ill in terms of covering, employment, marriage and public attitudes to them. The data indicate that respondents' overall attitude to PLWMI is predominantly negative. Most of the health workers feel that public attitudes toward the people living with mental illness (PLWMI) influence them as citizens (72.2%), they would not marry a person who has ever had mental illness (56.0%), and neither would they like to employ PLWMI (46.1%). This presents the PLWMI with some degree of social disadvantages, including lack of desire to provide for the services meant for this category of patients.

Similarly Table 5.1.7 assesses the stereotypical component of the perception of workers. As shown, workers who are supposed to be knowledgeable about the mental illness situation expressed mixed feelings about the PLWMI as indicated in Table 5.1.7.

Table 5.1.7: Health workers' Stereotypical Predisposition about the Mentally ill

Stereotyping (N=191)	**SA (%)**	**A (%)**	**N (%)**	**D (%)**	**SD (%)**	**Mean**	**Remark**
I sometimes feel afraid to talk to someone who has a mental illness	54 (28.3)	75 (39.3)	26 (13.6)	25 (13.1)	11 (5.8)	3.71	Stereotyped
I think receiving care in a psychiatric hospital is a sign of personal weakness	34 (17.8)	37 (19.4)	30 (15.7)	53 (27.7)	37 (19.4)	2.88	Not stereotyped
I think that a person who has mental illness is dangerous to others	54 (28.3)	62 (32.5)	28 (14.7)	32 (16.8)	15 (7.9)	3.56	Stereotyped
I think I would feel ashamed if others knew someone in my family had mental illness	41 (21.5)	36 (18.8)	40 (20.9)	43 (22.5)	31 (16.2)	3.06	Stereotyped
I feel mentally ill people are potentially dangerous.	55 (28.8)	47 (24.6)	26 (13.6)	45 (23.6)	18 (9.4)	3.39	Stereotyped
Mentally ill people are violent	55 (28.8)	44 (23.0)	32 (16.8)	42 (22.0)	18 (9.4)	3.39	Stereotyped
I feel People with mental illness are irresponsible	42 (22.0)	38 (19.9)	28 (14.7)	49 (25.7)	34 (17.8)	3.02	Stereotyped

Overall mean=3.28
Decision rule: 1.0 – 2.9 = Not stereotyped; 3.0 – 5.0 = Stereotyped

Health workers reported fear of personal safety. Table 5.1.7 shows that health workers are afraid (strongly agree and agree) to communicate with PLWMI (67.6%) and consider them dangerous to others (60.8%). Some view PLWMI as potentially dangerous (53.4%) and violent (51.8%). This implies that most health workers are likely to avoid the mentally ill who are in need of care and other services. This tends to portend a hindrance to the provision of mental health services in general. The general tendency, from these data, indicates that PHC workers in the study area have stereotypical attitudes towards the PLWMI.

This is not however supported by IDIs with the health workers. Most health workers interviewed had expressed support for PLWMI. Virtually, all health workers interviewed held similar compassionate positions for them. For instance, at the Gangara, Giwa LGA, a PHC worker advocated full support for the mentally ill persons because he considers PLWMI as useful as other

people and believed the mentally sick person can even save people from some unpleasant situations. He presented a scenario to reflect his opinion:

> If there is a mad man on the road (street), and every day you give him N20 (twenty Nigerian Naira) to buy food, he will make sure he knows where you are staying (living) and will even protect you if you are being attacked by anyone.

From the short narrative, it is believed that when people show the mental patient some level of care, the patient is likely to recognise such gesture and would help the benefactor as the need arises.

The study also explores health workers' perception of the perceived risk factors or social causes and control of mental illness. Thus, health workers' perception of the (social) causes of mental illness was examined, and the main causes mentioned are as shown in Table 5.1.8.

Table 5.1.8: Health Workers' Perception of Social Causes of mental illness

S/No	Causes of mental illness (N=191)	Yes	%	NS	%	No	%
i.	Poor parenting causes mental illness	134	70.1	19	9.9	38	19.9
ii.	Mental illnesses are due to stress	109	57.0	38	19.9	44	23.1
iii.	Disasters/civil disturbances	151	79.1	17	8.9	23	12.0

Table5.1 indicates health workers' perceived social causes. They believe that civil disturbances constitute a major factor for mental illness (79.1%), followed by poor parenting practices and socio-economic stress. Only few mentioned preternatural (12.5%) causes.

However, during IDIs, many health practitioners associate community beliefs about causes of mental illness to such factors such as spiritual causes. For example, a psychiatrist in Benue State said:

> … most symptoms (of mental illness) are ascribed to some spiritual factors like witches and wizards, punishment for intergenerational sins their ancestors have committed and they don't think is a mental health issues. Sometimes a lot of mental health disorders also present the physical symptoms and are treated as malaria or typhoid without accessing the mental health.

A consultant psychiatrist in Kaduna during an IDI also said that many people believe that mental illness is caused by "witches, wizards, and punishment for sins of their parents."

The treatment options available to health workers were explored. These options include modern, traditional, and spiritual treatments or a combination or two or the three. Their responses are presented in Table 5.1.9.

Table 5.1.9: Health Workers' Perceptions on Treatment Preferences for Mental illness

S/No	Preferred Treatment (N=191)	SA (%)	A (%)	N (%)	D (%)	SD (%)	Mean
i.	Treatment for mental illness do not work	22 (11.5)	8 (4.2)	26 (13.6)	68 (35.6)	67 (35.1)	3.87
ii.	Modern medicine is the best for mental illness	64 (33.5)	51 (26.7)	48 (25.1)	20 (10.5)	8 (4.2)	3.74
iii.	Traditional treatment is the best for mental illness	8 (4.2)	22 (11.5)	74 (38.7)	48 (25.1)	39 (20.4)	2.53
v.	Spiritual healing by Imam/Priest/ religious leaders (clergy) is the best for mental illness	16 (8.4)	27 (14.1)	72 (37.7)	52 (27.2)	24 (12.6)	2.78
vi.	Combining modern treatment and traditional medicines is the best for mental illness	20 (10.5)	18 (9.4)	74 (38.7)	52 (27.2)	27 (14.1)	2.74
vii.	Combining orthodox and spiritual healing is the best treatment for mental illness	36 (18.9)	33 (17.3)	63 (33.0)	37 (19.4)	22 (11.5)	3.12
viii.	Combining orthodox, spiritual and traditional medicines is the best treatment for mental illness	49 (25.7)	33 (17.3)	41 (21.3)	48 (25.1)	20 (10.5)	3.22

Overall mean=3.1
Decision rule: 1.0 – 2.9 = Not recommended; 3.0 – 5.0 = Recommended treatment

Table 5.1.9 shows that health workers are weakly in favour of modern medical treatment for mental illness as reflected in the overall mean of 3.1. As shown in Table, most health workers (70.6%) believe that mental illness can be treated; a little less than these (i.e. 60.2%) believe that modern medicine is the best option. A few health workers (15.7%; n=30) do not believe that mental illness is treatable while the 13.0% (n=26) who remained neutral in their response seem to suggest that health workers have some reservations about treating mental illness. Further analysis (in Table 5.1.10)

shows that traditional treatment for mental illness is the least favoured (15.7%) compared to spiritual (22.5%), which is also rated low. However, these two seem to improve when combined with the modern treatment. For example, when combined with modern care, its rating slightly improved to19.9% compared to modern/spiritual which is 36.2%; when the three are combined, the rating again dropped to 33.0%. This shows that health workers are not in favour of the traditional treatment of the mental health problem. This may not be surprising because of the scientific orientation of the health workers' educational and training exposures.On their opinions on effects of delay in or not seeking treatment for mentally ill persons, Table 5.1.10 shows their responses.

Table 5.1.10: Health workers' perceptions on not seeking treatment for mental illness

S/No	When people delay or not treat mental illness, there will be: (N=191)	SA (%)	A (%)	N (%)	D (%)	SD (%)	Mean	Remarks
i.	Loss of productivity for the ill persons	93 (48.7)	80 (41.9)	9 (4.7)	7 (3.7)	2 (1.0)	4.33	Strong negative
Ii	Loss of productivity for their family members.	80 (41.9)	81 (42.4)	14 (7.3)	12 (6.3)	4 (2.1)	4.15	Strong negative
iii.	Higher health care costs.	77 (40.3)	76 (39.8)	16 (8.4)	20 (10.5)	2 (1.0)	4.07	Strong negative
iv.	Self-medication	71 (37.2)	72 (37.7)	25 (13.1)	13 (6.8)	10 (5.2)	3.94	Negative effect
v.	Marital crisis	73 (38.2)	88 (46.1)	15 (7.9)	7 (3.7)	8 (4.2)	4.10	Strong negative
vi.	Mental illness getting much worse.	94 (49.2)	79 (41.4)	10 (5.2)	4 (2.1)	4 (2.1)	4.33	Strong negative
vii.	Physical health getting much worse.	86 (45.0)	74 (38.7)	13 (6.8)	12 (6.3)	6 (3.1)	4.16	Strong negative
viii.	Frustration over unmet expectations at school.	73 (38.2)	88 (46.1)	16 (8.4)	10 (5.2)	4 (2.1)	4.13	Strong negative
ix.	Frustration over unmet expectations at work.	76 (39.8)	81 (42.4)	23 (12.0)	7 (3.7)	4 (2.1)	4.14	Strong negative
x.	Trouble with the law.	73 (38.2)	75 (39.3)	20 (10.5)	19 (9.9)	4 (2.1)	4.01	Strong negative
xi.	Social isolation.	85 (44.5)	87 (45.5)	9 (4.7)	7 (3.7)	3 (1.6)	4.27	Strong negative
xii.	Trouble getting a job	93 (48.7)	70 (36.6)	13 (6.8)	12 (6.3)	3 (1.6)	4.24	Strong negative
xiii.	Trouble finding a place to live.	81 (42.4)	71 (37.2)	23 (12.0)	10 (5.2)	6 (3.1)	4.10	Strong negative

Overall mean=***4.15***(strong negative consequences)
Decision rule: 1.0 – 2.9 = Weak Negative consequences; 3.0 – 5.0 = Strong Negative consequences

From the data in Table 5.1.10, the consequences of not seeking health care following mental illness can be described as grave (Overall mean=4.15), as indicated on a five-point scale of consequences expressed by health workers. These range from the least, self-medication (74.9%) to the worst, mental illness getting worse (90.6%). Other sequelae of ignoring mental illness episodes include loss of productivity for the patient (90.6%) and the family (84.3%), social isolation of both patient and family (90.0%), problems of employment i.e. difficulty getting a job, frustration at school, and marital crisis (84.3% each), physical illnesses getting worse (83.7%), frustration at work if employed (82.2%), and high cost of treatment (80.1%). Other consequences are PLWMI having problems getting where to live (79.6%) and often get into trouble in a community's justice system (the law).

The overall finding here is that prompt seeking of treatment as soon as mental illness is noticed otherwise there will be dare consequences. This suggests need for such services which are apparently non-existent in the research communities.

5.1.2.2 Community Members' Attitudes and Perceptions

In this subsection, perceptions of community respondents about the causes, and treatment of mental illness are assessed. Their views of the mentally ill person are also presented.

Perceived Causes of mental illness

These perceptions of factors causing mental illness as reported by community members reveals that accident and trauma (87.9%), brain disorder and drug abuse and addiction (86.7% each for strongly agree and agree), drug misuse (78.8%), and marital and family conflicts (78.2%), hereditary tendencies (73.3%) are perceived as the main causes of mental illness by community members. Most of these causes mentioned by the community respondents, fall within the biopsychosocial explanation of mental illness. However, some low rated causes mentioned such as sin (34.8%),

witchcraft (44.5%), demonic possession (58.0%), God's punishment (44.0%), and destiny (40.2%) are among the low rated causes, but are of sociological importance.

The perceived causes of mental illness by the community members are grouped into transgression, human malevolence, and preternatural factors. These perceptions have implications for accepting MHS if available, and may act as barriers to service utilization. These beliefs are widespread across the three States, as indicated in Table 5.1.11.

Table 5.1.11: Perceived causes of mental illness by States

State	**Witchcraft**	**Sin**	**Destiny**	**Demons**	**God's anger**
Gombe					
Yes (%)	53 (44.4)	48 (37.2)	86 (65.2)	78 (58.6)	61 (47.3)
Not sure (%)	35 (28.7)	24 (18.6)	29 (22.0)	36 (27.1)	28 (21.7)
No (%)	34 (27.9)	57 (44.2)	17 (12.8)	19 (14.3)	40 (31.0)
Total (%)	122 (100.0)	129 (100.0)	132 (100.0)	133 (100.0)	129 (100.0)
Kaduna					
Yes (%)	99 (53.8)	67 (37.2)	79 (43.1)	114 (62.0)	84 (45.5)
Not sure (%)	51 (27.7)	57 (31.7)	42 (23.0)	47 (25.5)	51 (27.5)
No (%)	34 (18.5)	56 (31.1)	62 (33.9)	23 (12.5)	50 (27)
Total (%)	184 (100.0)	180 (100.0)	183 (100.0)	184 (100.0)	185 (100.0)
Benue					
Yes (%)	58 (35.1)	57(35.2)	34 (21.4)	95 (57.6)	73 (44.8)
Not sure (%)	51 (31.0)	39(43.1)	52 (32.7)	38 (23.0)	40 (24.5)
No (%)	56 (33.9)	66 (40.7)	73 (45.9)	32 (19.4)	50 (30.7)
Total (%)	165 (100.0)	162(100.0)	159(100.0)	165 (100.0)	163 (100.0)

As shown in Table 5.1.11, in Gombe State, destiny is believed to cause mental illness more (65.2%), compared to beliefs in demonic possession in Kaduna (62.0%) and Benue (57.6%) States. For Benue State, destiny is the least attribution (21.4%) to mental illness. Furthermore, both Christians and Muslims implicate demons (58.8% and 61.7%) and witchcraft (41.5% and 53.4%) respectively, as the causes of mental illness.

However, Muslims believe in destiny (70.2%) as the aetiolgic explanation for mental illness more, compared to Christians (26.7%). This implies that religious affiliations are social factors that are likely to impede MHS delivery in the study communities.

IDIs with community leaders also revealed several factors believed to cause and sustain mental illness in an individual, which can be summarized as transgression, human malevolence, preternatural, socio-economic problems, self-inflicted factors or heredity. For example, a community leader in Benue State summarized these perceived causes when he said:

> My son, see, any mental illness has what caused it – some are natural, some are juju, some are witches, some self-inflicted in our land. Our fore parents say if you bewitch yourself, no one can undo the witchcraft for you except yourself. Any self-inflicted witch-craft that result in mental illness cannot be cured and the person does not have sense to undo it himself either.

Many community leaders particularly in Benue State believed that mental illness can be self-inflicted. As described by one of them self-inflicted causes when some people:

> Some insult elders, violate ancestral laws in the community like adultery, incest, steal from farms that has juju to protect the crops, and in fact those that go against community laid down rules as they relate to traditional belief.

When asked if things like smoking marijuana, drinking alcohol and 'monkey-tail' were part of the self-inflicted causes of mental illness, a community leader in Benue State answered in the affirmative but added that just drinking alcohol cannot lead to mental illness but drinking too much thereby forgetting one's work or family is a curse. By drinking too much is perceived as a family or hereditary problem. As explained by one community leader:

> If you watch, it runs in families- father drunkard, sons' drunkards, many in one family drunkards – it is a family problem. In this community, most indigenous people drink but as you go round you see big big houses, people dressing fine, their children are in school, etc but these people all drink. So it is not the drinking. It is curse! See some people take one or two measure and they misbehave, some take that 10 times, they are building houses, marrying wives, raising their children. So issue of drinking too much is about the family.

On smoking as a self-inflicted problem, community leaders distinguished between types of smoke, as captured by one leader who said that "for smoking, there is ordinary cigar and there is bad cigar, the Indian hemp; that one can turn somebody's head; so many young people have gone mental because of it".

On further inquiry on what they described as natural causes of mental illness, it is revealed that such causes are believed to be from God, "which the both living and our ancestors cannot control". Mental illnesses caused by natural means are thus believed to run its normal course, and no that remedy can be provided except if God himself decides to heal the sufferer. To them, the treatment required is just to keep the patient well, feed him, and bath him. It means if mental illness is adjudged to have been caused by God, community members are not likely to seek medical solution of any type. This perception has implications for providing MHS in such environment.

Many other community leaders in Benue, Gombe and Kaduna States mentioned other socio-economic problems as causes, such as unemployment, economic hardships, worries, orgies, marital problems, poor parenting and poor child care practices like "frequent hitting of children on the head" (Danmahawayi Community Leader). An FGD participant in Gombe State corroborated this when she said "hitting and knocking a baby on the head can make him have mental problems." On the issue of unemployment, one community cum religious leader in Kaduna State said that:

> Unemployment is a problem everywhere – even in 'oyibo' land (western countries). Young people go to school, finish and come back; no work, nothing to do!So they start to smoke without good food, and drink without food, their head will turn. Sometimes, it is not their fault…See my son, somebody who has not eaten (food), no job, no peace in his house, what education do you want to give him? Will you get him attention? Give him the basic things first.

Unemployment is overwhelmingly portrayed as a very serious issue. Community leaders do not believe that mental health education to communities would suffice in the presence of economic challenges like unemployment. For example, when asked if disseminating mental health information could help youths cope with the socio-economic stressors to reduce mental health challenges, oncommunity leader said, angrily:

> Help what? Government is not doing anything about people, so do you want us to listen to talk on how not to feel hungry, young men cannot marry but they impregnate our daughters or to cope with no job? Government should start with these first.

On if taking to farming could be a source of employment to help in improving mental health of the community youths, he laughed sarcastically, and said:

> Farm? As I chose to farm I didn't go to school. My sons and daughter – some want to school, some refused to go to school. These ones have their farms and in fact their families, so those that went to school should farm again? So, why did they go to school?

On further inquiry if it then meant those who did not get to school but are farming do not have mental health problem, he simply said "most problems are in those educated ones." This conversation confirms the pains of some communities about their socio-economic burdens, which contribute to poor mental health.

On methods to ascertain the causes of mental illness, community leaders agreed unanimously that the causes can be investigated. As one community leader in Kaduna State put it:

> If the mental illness is traced to juju or witchcraft from others, it is treated by first, consulting the ancestors and oracle, the traditional medicine man has the solutions whether it is mental illness or any other sickness, and provide family support as I mentioned earlier and keep him safe, feed him, bath him. You may have to restrain him so that he can remain in a place so that he does not harm anyone.
>
> You and I know what natural things are- from God which those living and our ancestors cannot control. God himself said it. That is that type that will run its normal course, then the person recovers even without any treatment - just keep the patient well, feed him, bath him.

Treatment of Mental illness

The treatment of mental illness was assessed from the perspectives of community and health workers. Table 5.1.13 shows the community perception on the treatment.

Table 5.1.12: Community Respondents' Perceptions on Preferred Treatments for mental illness

S/No	Treatment	SA	A	NS	D	SD	X	Remark
I	No need for treatment because mental illness cannot be treated, whatever the cause	12 (2.4)	14 (2.8)	81 (16.4)	117 (23.6)	271 (54.7)	1.74	Negative
Ii	People with mental illness need prayers from clergymen (religious leaders).	119 (24.0)	230 (46.5)	93 (18.7)	26 (5.3)	27 (5.5)	3.78	Positive
Iii	Talking with a professional therapist	235 (47.5)	155 (31.3)	82 (16.6)	16 (3.2)	7 (1.4)	4.20	Positive
Iv	Modern medicine	269 (54.3)	136 (27.5)	72 (14.5)	18 (3.6)	0 (0.0	4.32	Positive
V	Traditional medicine	28 (5.7)	105 (21.2)	205 (41.4)	85 (17.2)	72 (14.5)	2.69	Negative

Average mean=3.34

Table 5.1.12 shows that most respondents (78.3%) believe that mental illness requires treatment; only 5.2% stated that mental illnesses have no treatments; others (16.4%) were not sure whether or not it should be treated. Seventy-nine percent of the respondents stated that mentally ill persons need religious leaders to pray for them, while 78.8% believe in talking with a professional therapist. On the choice between traditional medical treatment and modern drugs, 81.8% of community members prefer modern medicine compared to 26.9% that opted for the traditional medicine. This means that modern treatment is preferred over the traditional medicine. There are many areas of conflict arising from these varied beliefs. These are in forms of treatment preferences and what some community members said they would do or would not do when their relations are mentally sick.

Although alternative treatments are not generally favoured, many respondents mentioned some alternative treatment preparations for mental illness. Among the alternative interventions mentioned, spiritual healing is the most preferred alternative treatment (60.0%), although some mentioned herbal preparations (28.9%), special cultural diets (18.9%) such as specially prepared foods and concoctions, and sacrifices (11.9%) and charms (6.6%).

These treatment options are further assessed through IDIs with some traditional healers and community leaders. Although many of the community leaders said in traditional care mental patients

are put in shackles but orthodox medical treatment most common as most people prefer modern treatment in hospitals. A Tiv community leader said:

> In Tiv land, we used to treat mental illness at home…in the immediate family. We use 'ide' (a wooden log; shackles) in which holes are made and the patients' legs are tied: he cannot move, he eats and does everything there.

The use of shackles is a common across the selected States studied. On how effective its use was, many believed that after several months some patients recover but usually with other problems, such as inability to walk. Such side effects were confirmed in Kaduna State. For example, At Sabon Sarkin, in Kachia LGA, the traditional and community leader during IDI confirmed the use of shackles in his community to restrain patients, but that most patients sustained injuries when trying to walk with the shackles. The leader does not support traditional treatment for mental illness, but also claims to have no mentally ill people in the community. An FGD participant in Gombe supported this assertion when she said:

> ...honestly, he should be taken to psychiatry for treatment until normal. In the hospital, most said He will get well. They can also be secluded until they are calm and peaceful. If secluded or restrained, he will be calm. Also he can be taken to traditional healer; there he will get well.

But many other participants disagreed with secluding mental patients, including shackles because they stated that the mentally ill would feel unloved, and can even commit suicide. A woman, an FGD participant even claimed that they can harm others by being restrained and secluded. However, many others believe that mental patients need drugs, injections, care and attention including good food, and prayers for him to get well. The prayer option seems to be widespread. For example, when the study explored how community respondents will handle the mental problem on your own when they said would not contact any health professional on noticing mental illness in a close relative or person, majority (86.0%; n=43) could not say how they would handle the problem on their own, only 4 (0.8%) and 3 (0.6%) admitted that "I will pray for him" and "I will take him to church"

respectively. This indicates offering prayers for such patients.This finding indicates that some community members believe that mental illness just needs divine intervention as it would normally run its 'natural' course, describing the course of mental illness as self-limiting. As claimed by community leader in Vandeikya in Benue State:

> Mental illness runs its natural course. It is like labour in women when they are pregnant-whether you are there or not, the woman will deliver. So also, mental illness, when you gave anything or not it will clear. You only need to keep him safe in one place during the course-that's why we use those words.

For such informants, seeking medical treatment for mental illness may be seen as unnecessary, expecting resolution spontaneous. This has implications for care seeking behaviours PLWMI.

These treatment and alternative options elicited in this section may be connected with what respondents believe to be the causes of the mental illness, and with the level of fear and interaction between community members and PLWMI as well as the mentally ill.

Related to the fear expressed by some respondents about PLWMI, the researcher evaluated the level of such fears and social distance that community members would maintain with PLWMI. Table 5.1.13 presents community attitude to the PLWMI.

Table 5.1.13: Attitudinal Predisposition of Community Respondents to the mentally sick

S/No	Attitude	SA=1	A=2	NS=3	D=4	SD=5	X
i	I fear anyone with mental illness	150 (30.3)	144 (29.1)	53 (10.7)	112 (22.6)	36 (7.3)	2.47
ii	I avoid anyone with mental illness	89 (18.0)	165 (33.3)	60 (12.1)	138 (27.9)	43 (8.7)	2.55
iii	I feel angry with anyone with mental illness	27 (5.5)	46 (9.3)	75 (15.1)	218 (44.0)	129 (26.1)	3.75
iv	I hate anyone with mental illness	19 (3.8)	28 (5.7)	71 (14.3)	191 (38.6)	186 (37.6)	1.99
v	I do not trust anyone with mental illness	71 (14.3)	166 (33.5)	80 (16.2)	117 (23.6)	61 (12.3)	3.13
vi	Indifferent about anyone with mental illness	20 (2.0)	40 (8.1)	105 (21.2)	205 (41.4)	125 (25.3)	2.24

Overall mean*=2.7 (Negative attitude)*

Table 5.1.13 indicates that fear of the mentally ill is the most prominent attitudinal predisposition of most respondents (54.4% for strongly agree/agree), followed by avoidance (51.3% for strongly agree/agree) and lack of trust (48.8% for strongly agree/agree). Respondents however being bothered about people with mental illness (66.7% for strongly disagree/disagree); however they do not seem to hate the mentally ill (9.5% for strongly agree/agree).

These data show that community members' perceived social interaction with the mentally ill is generally fair (mean=2.7) but there are some levels of fear, avoidance and doubt about entrusting issues to PLWMI's custody. Although it is shown that respondents do not show hatred towards the PLWMI, they get worried having the mentally ill around them. These have implications for their integration in community activities, with the increasing need to get the PLWMI involved in socially and economically productive interactions. This in turn may imply that community support and understanding may be threatened. Other data collected explain more on this finding further. For example, Table 5.1.14 (below) indicates the social distance with PLWMI ascommunity acceptance.

It (Table 5.1.14)reveals community respondents' willingness to engage in some social interactions with the PLWMI, ranging from distant to intimate social proximity. It is shown that respondents are most unwilling to marry an individual, who has had a mental illness (67.7%), or marry into their family (64.9%), or live in the same room (60.4%). This means that intimate closeness with person with mental illness could be a problem in the community and portend the rejection/isolation of the mentally sick. Other social interactions also suffer. For instance, respondents would not want a person who has had a mental illness to be a leader in any social group they belong (63.4%), be their children's teacher (63.0%) or even the person's own teacher (61.8%).

Table 5.1.14: Levels of acceptance of people living with mental illness (PLWMI):

S/No	Statement	SA (%)	A (%)	NS (%)	D (%)	SD (%)	X	Remark
i	People with mental illness should be given jobs.	40 (8.1)	157 (31.7)	117 (23.6)	133 (26.9)	48 (9.7)	3.01	Positive
ii	People with mental illness can be good workers.	43 (8.7)	139 (28.1)	154 (31.1)	111 (22.4)	48 (9.7)	3.03	Positive
iii	I will be willing to be in the same social group with anyone with mental illness.	30 (6.1)	139 (28.1)	157 (31.7)	115 (23.2)	54 (10.9)	2.95	Negative
iv	I will be willing to have someone with mental illness as my leader.	12 (2.4)	34 (6.9)	135 (27.2)	163 (32.9)	151 (30.5)	2.17	Negative
v	I will be willing to attend the same school with someone with mental illness.	29 (5.9)	153 (30.9)	127 (25.6)	128 (25.9)	58 (11.7)	2.93	Negative
vi	I will be willing to have a person with a mental illness to be my teacher.	15 (3.0)	29 (5.9)	145 (29.3)	155 (31.3)	151 (30.5)	2.16	Negative
vii	I will be willing to have a person with a mental illness to be your child's teacher.	17 (3.4)	37 (3.4)	129 (26.1)	151 (30.5)	161 (32.5)	2.18	Negative
viii	I will be willing to live in the same compound with someone with mental illness.	23 (4.6)	86 (17.4)	149 (30.1)	130 (26.3)	107 (21.6)	2.57	Negative
ix	I will be willing to share the same room with someone with mental illness.	16 (3.2)	74 (15.0)	106 (21.4)	121 (24.4)	178 (36.0)	2.25	Negative
x	People with mental illness can be good parents.	71 (14.3)	153 (31.0)	126 (25.4)	95 (19.2)	50 (10.1)	3.20	Positive
xi	I will be willing to have a person with a mental illness to marry into your family.	14 (2.8)	29 (5.8)	131 (26.5)	141 (28.5)	180 (36.4)	2.10	Negative
xii	I will be willing to marry person with a mental illness.	13 (2.6)	28 (5.7)	119 (24.0)	106 (21.4)	229 (46.3)	1.96	Negative

Average mean=2.54

On job opportunities for PLWMI, respondents are divided: 39.8% wish that jobs be offered to them while 36.6% said they should not be given. Similarly, respondents are also divided in considering PLWMI as good workers (36.8) and not good workers (32.1%); belonging to the same social group (34.2%) compared to 34.1% not willing to be in same social group; and attending the

same school (36.8%) against 37.1% who would not want to attend same school with anyone with mental illness. However, some respondents (45.3%) opined that mentally ill persons can be good parents but another 47.9% would not wish to live in the same compound with such clients.

From the foregoing analysis, it can be inferred that most respondents' social distance rating with mentally ill persons is similar to Bogardus scale; the more intimate interactions (like living in the same or marrying a mentally ill individual) are more disapproved than the more remote ones (like living in the same compound or belonging to same social group). This has implications for providing mental health services at the community level, as this further implies social stigma and discrimination against the PLWMI. Social stigma may be associated with refusal to seek public mental health care services, which in turn worsens both the mental and physical illness of the mentally sick person. This will then add more disease burdens to an already poorly and erratically provided mental health services, thus would act as barrier to MHS.

5.1.6 Social Stigma and Obligations to Care for Patients with mental health disorders

In the study area, many community members do not see mental illness as a mark for discrimination or a condition which may lead to discrimination. This perception is widespread in all the study areas. For example, a community leader at Otukpo (Benue State) said, "If you have a decayed tooth, do you remove it and throw it away. No. You find out that you even suck it more often than others." Similarly at Awon in Kachia LGA in Kaduna State, a community leader said that PLWMI are taken to hospital, and that there is no isolation or discrimination against mental patients, adding that after all, "all families have a mentally sick person in one way or the other."

Many health workers also argued in similar vein. For instance, the Provost of the School of Health Technology, Kaltungo agreed with these community members' assertion on stigma, saying:

> Here in this district, as the most socialized (enlightened) senatorial district, we don't have problem here in Gombe South; stigma is not too much of a problem. Where we have problem, is probably the Gombe Central and North.

This informant here is suggesting that stigma against PLWMI may be a problem in some parts of Gombe State, but not common in Gombe South district. From this insinuation, the researcher explored situation in the two areas (Gombe and Yamaltu Deba LGAs). At Gombe LGA, a PHC coordinator when asked about stigma of PLWMI in the area commented that;

> …yes, there is going to be this problem of stigmatization. But the truth is, it is either everybody is sick or no body is sick. It is not only in one family. So we have to give them mental health education so they will know that it is not all mental illnesses that is bad (dangerous).

In fact in Gombe LGA, a community leader told the researcher a story of a woman who assumed that her mentally sick husband to be as good as dead. Part of her story, according to the informant, was that:

> …In a gathering, all widows were asked to stand up. A woman whose husband was mentally ill also stood up. But people near her (who knew her husband) were trying to make her sit down but she insisted, saying they should leave her alone, saying her husband is as good as dead, that was there any difference between her and the rest?

Furthermore he said:

> So, you see, this is a serious mental health challenge; such a woman and family need mental intervention. Because the husband is not doing his responsibility, the children she is the one that is catering for them, she does everything, so you find out this type of need counselling, and they (such people) are many in this place.

Further findings show that although many community members dismissed stigma as a barrier, some likened mental illness to a state worse than death. A community leader from Benue State stressed that: "being dead is preferred to being mad; honestly, bereavement is better than having a mental patient in a family." but at Vandeikya, another community leader did not agree that mentally ill persons should be badly treated, when he said:

> We don't abandon or neglect PLWMI. Ah no…no, we don't. They are our blood and flesh but we here and other communities here we don't disown them. If you disown them and the cause is from God or ancestors they will be angry with the family and worse things may happen.

This indicates that some communities accept PLWMI based on beliefs about the perceived causes of the mental illness, for example, the fear of possible ancestral reprisals on the community if they abandon any community member that is mutually sick. Similarly, some PHC attendees, i.e. antenatal clients, also expressed their opinions on the stigma for PLWMI. Their opinions were a combination of fears and concerns. For instance, a FGD participant (a woman) at Gangara said: "Haah...it will not be easy o…I can only relate at a distance; interaction cannot be as usual, although, he will be cared for." Another participant said:

> ...because some of them are violent, they have to be restrained so that they don't go out and injure or destroy things. One has to take extra care in relating with him…Yes, he should be kept closed in door or restrained, since he is not in his right senses.

People are therefore cautious in dealing with PLWMI, by being clearly ambivalent. This indicates that the attitudes expressed seem to those of ambivalence. This disposition has the potential to affect the provision of MHS at the community.

Opinions of PHC workers on social stigma associated with the treatment of mental illness and access to care was also assessed through a survey, as presented in Table 5.1.15. The Table indicates a high level of stigma associated with mental illness in the study areas. It is found that respondents believe that because of this, many people would hide their illness to cover up shame.

Table 5.1.15: Health workers' perceptions about mental illness

	Stigma about mental illness:	SA	A	N	D	SD	**Mean**	Remark
i.	Because of the stigma associated with mental illness, people do not want to talk about the illness.	71 (37.2)	85 (44.5)	20 (10.5)	14 (7.3)	1 (0.5)	**4.10**	Strongly negative
ii.	Stigma about mental disorders and discrimination against patients prevent people from seeking mental health care.	77 (40.3)	67 (35.1)	23 (12.0)	22 (11.5)	2 (1.0)	**4.02**	Strongly Negative
iii	Stigma about mental disorders and discrimination against families prevent people from seeking mental health care for mentally sick members.	78 (40.8)	67 (35.1)	19 (9.9)	25 (13.1)	2 (1.0)	**4.01**	Strongly negative
iv.	Not talking about the disease can result in delays in diagnosis and treatment.	83 (43.5)	71 (37.2)	10 (5.2)	16 (8.4)	11 (5.8)	**4.04**	Strongly negative
v.	Families are often reluctant to talk about mental illness because they:							
	a. Feel guilty or ashamed.	75 (39.3)	69 (36.1)	11 (5.8)	27 (14.1)	9 (4.7)	**3.91**	Negative
	b. Have the added burden of trying to 'cover up' the illness.	65 (34.0)	73 (38.2)	34 (17.8)	15 (7.9)	4 (2.1)	**3.94**	Negative

Overall average mean= 4.00 (Strongly negative)

The Table further reveals that the stigma opinions for the issues raised range from why people do not want to talk about their mental illness (61.7%) to why treatments are delayed (80.7%). Other stigma-related problems include patients being deterred from seeking care (75.4%), families being discriminated against (75.9%), families feeling ashamed (75.4%), and their struggles to cover the problem (72.2%). This indicates that the health workers perceive a high stigma level associated with mental illness with its attendant consequences such as cover up of the illness and refusal to access care even if it is available. With an overall mean of 4.00, health workers accommodate a high level stigma on the mental patients.

This finding implies that the more the stigma attached to mental illnesses, the less the willingness to provide MHS. Similarly, the more mental illnesses are covered up or hidden from

public awareness, the less the utilization of the services even if they are made available. This would constitute a social barrier to MHS in the community.

From the foregoing therefore, stigma remains an issue to address in any effort at providing MHS in the selected States in northern Nigeria. It is clear that although, most health workers do not see stigma as a serious obstacle to the provision of MHS in northern Nigeria, it is still a significant social factor to consider when planning any MHS programme as reflected in the ambivalent reactions from the community members. This shows that many community members avoid PLWMI for fear of being harmed even when they would desire to provide care. This will affect the provision of the MHS, at least from the community perspectives. On having mental illness in the family or an in law or in the same school, most people stated that one will have to be careful with him, saying, "We will distant from him".

From the data in this chapter so far, barriers to MHS delivery are many. The major ones are the absence of any political commitment and mental health policy in all the three States. There are many emerging specific barriers from this, ranging from poor resource allocation, poor staffing and training to lack of data format for mental health problems. There are also socio-cultural obstacles related to beliefs about causes and treatment of mental disorders. Most of the barriers are similar to those speculated by WHO/WFMH (2009) as the reasons why MHS at PHC level have remained low. The researcher therefore used the WHO/WFMH tool on these barriers to elicit the views of health workers so that their views can be compared with the WHO/WFMH 10-factor tool recognized as global barriers to the provision of mental health at the PHC level. In the survey, the PHC workers responded to this set of barriers to mental health services, adapted from the 10-factor WFMH/WHO (2012) tool. Table 5.1.16 reveals the workers' views on these barriers by States.

Table 5.1.16: Barriers to Provision of MHS in Study Areas

BARRIERS	**STATE**			**TOTAL** (%)
	Gombe (%)	Kaduna (%)	Benue (%)	
No Advocacy				
Yes	53 (1.4)	59 (88.1)	58 (87.8)	170 (89.0)
No	3 (3.5)	1 (1.5)	5 (7.6)	9 (4.7)
Not sure	2 (3.4)	7 (10.4)	3 (4.5)	12 (6.3)
Total	58 (100.0)	67 (100.0)	66 (100.0)	191 (100.0)
No Implementation				
Yes	56 (96.6)			
No	0 (0.0)	59 (88.0)	56 (85.0)	171 (89.5)
Not sure	2 (3.4)	4 (6.0)	5 (7.5)	9 (4.5)
Total	58 (100.0)	4 (6.0)	5 (7.5)	11 (6.0)
		67 (100.0)	66 (100.0)	191 (100.0)
Comm. Rejection				
Yes	14 (24.2)	16 (23.8)	26 (39.4)	56 (29.3)
No	29 (50.0)	35 (52.2)	29 (43.9)	93 (48.7)
Not sure	15 (25.8)	16 (24.0)	11 (16.7)	42 (30.0)
Total	58 (100.0)	67 (100.0)	66 (100.0)	191 (100.0)
Stigma on MI				
Yes	30 (51.7)	37 (55.2)	32 (48.5)	99 (51.9)
No	15 (25.8)	19 (28.4)	23 (34.8)	57 (29.8)
Not sure	13 (22.4)	11 (16.4)	11 (16.7)	35 (18.3)
Total	58 (100.0)	67 (100.0)	66 (100.0)	191 (100.0)
No policy				
Yes	46 (79.3)	45 (67.1)	51 (77.3)	142 (74.3)
No	5 (8.6)	6 (9.1)	8 (12.1)	19 (10.0)
Not sure	7 (12.1)	16 (23.8)	7 (10.6)	30 (15.7)
Total	58 (100.0)	67 (100.)	66 (100.0)	191 (100.0)
No Funding				
Yes	49 (84.5)	47 (70.1)	52 (78.8)	148 (77.5)
No	5 (8.6)	7 (10.5)	6 (8.1)	18 (9.4)
Not sure	4 (6.9)	13 (19.4)	8 (12.1)	25 (13.1)
Total	58 (100.0)	67 (100.0)	66 (100.0)	191 (100.0)
Misconception				
Yes	39 (67.2)	51 (76.1)	51 (72.2)	141 (73.8)
No	7 (12.1)	6 (9.0)	9 (13.7)	22 (11.5)
Not sure	12 (20.7)	10 (14.9)	6 (9.1)	28 (14.7)
Total	58 (100.0)	67 (100.0)	66 (100.0)	191 (100.0)
Lack of skilled workers				
Yes	52 (89.6)	53 (79.1)	58 (87.9)	163 (85.3)
No	3 (5.2)	4 (6.0)	6 (9.1)	13 (6.8)
Not sure	3 (5.2)	10 (14.9)	2 (3.0)	15 (7.9)
Total	58 (100.0)	67 (100.0)	66 (100.0)	191 (100.0)
Poor Staff Training				
Yes	54 (93.2)	57 (85.1)	60 (91.0)	171 (89.5)
No	2 (3.4)	6 (9.0)	4 (6.0)	13 (6.8)
Not sure	2 (3.4)	4 (5.9)	2 (3.0)	7 (3.7)
Total	58 (100.0)	67 (100.0)	66 (100.0)	191 (100.0)

**The missing % accounts for 'Not Sure' responses*

Table 5.1.16 shows the health workers' responses to the 10-factor WFMH/WHO Assessment tool used, highlighting the barriers to the provision of mental health services at the PHC level. The Table shows that the health workers believe that lack of training for PHC workers (89.6%), absence of scaling up mental health services (89.4%), lack of advocacy (89.0%), and inadequate skilled workers (85.3%) are major barriers to providing mental health services at the PHC level. Other important barriers are lack of political will (78.4%), lack of funding (77.4%), lack of policy (74.3%) and misconceptions (73.8%) are other hindrances expressed by the workers. Community rejection of mental health services and stigma are the least identified barriers, 29.4% and 51.9% respectively.

From these data, barriers to the provision of MHS in the study areas are evident and many. They include, firstly, the absence of cogent government policy, lack of funding, inadequately trained and poorly motivated staff; and secondly, social hindrances like misconceptions, negative attitudes and some level of social stigma, as summarised in Table 5.1.17.

Table 5.1.17:Summary of Identified Barriers to MHS at PHC in the three States

S/No	Barriers	States
i.	Lack of State MH Policy/ Political unwillingness:	Gombe, Kaduna, Benue
	No provision for MHS at PHC centres	Gombe, Kaduna, Benue
	Low level of Staff knowledge of PMH care	Gombe, Kaduna, Benue
	Poor staffing and motivation	Gombe, Kaduna, Benue
	Deficient Curricula in PHC Training Schools	Gombe, Kaduna, Benue
	Lack of collaboration with communities/NGOs	Gombe, Kaduna, Benue; Benue has only one NGO with which State Government is not cooperating
ii.	Socio-cultural barriers:	Gombe, Kaduna, Benue
	Misconceptions about causes of mental illness by both community and health workers	Gombe, Kaduna, Benue
	Preference for alternative treatments for mental health disorders	Gombe, Kaduna, Benue
	Some level of social stigma	Gombe, Kaduna, Benue

The 10-barrier (factors) identified by WHO (2012) as expressed by PHC workers and presented in Table 5.1.16 are also prominent in this study areas. These factors and those highlighted by the study participants are responsible for the scarce mental health services at the PHC level in the study areas despite the zeal of the staff to provide the MHS. The way forward for improving and providing MHS to the communities in these States in northern Nigeria and attempts to develop a model for effective and efficient MHS delivery are key factors to this study. This is the focus of the next session.

5.2 Towards providing functional MHS at PHC Level: A Proposed Model

Having looked at literature on the various approaches at providing cost-effective mental health services (MHS) in other places, with a view to developing a socially acceptable model for the northern Nigerian situation as represented by the three selected States, a systematic examination of data and suggestions obtained in this study from health administrators, health workers, and community members vis-à-vis the content analysis of official documents is done in this section. These are analysed and harmonized to form the basis of a proposed model for the provision of effective and efficient mental health services at the PHC level in Gombe, Kaduna and BenueStates.

5.2.1 The Views of Health Workers and Health Administrators

The ways to address MHS in the States, as presented by health professionals, consist of improving the services, enhancing capacity of health personnel, and overcoming the identified hindrances, i.e. policy failure and social problems. Out of the 191 health workers, 42 (22.0%) made at least one suggestionon improving MHS in PHC centres in general as presented in Table 5.2.1.

Their suggestions as presented in Table 5.2.1 focus more on the need for human resource training (71.4%), public mental health education (42.9%) and improving funding and facilities for mental health care, 35.7% and 31.0% respectively, among other suggestions.

Table 5.2.1: Ways of Improving MHS at PHC level as Suggested by Health Workers

S/N	Suggestions (N = 42)	Frequency*	Percentage
i.	Provide skilled personnel	30	71.4
ii.	Mobilize community/youth sensitization	8	19.0
iii.	Mental Health education to the communities	18	42.9
iv.	Improve funding of MHS	15	35.7
v.	Provide free MHS	4	9.5
vi.	Build community MH centre	13	31.0
vii.	Political commitment/will	6	14.3
viii.	Linkage model	2	4.8
ix.	Have separate MH units at PHC centres	1	2.4
x.	Break specific barriers/identified barriers	1	2.4
xi.	Advocacy	6	14.3
xii.	Incorporate MHS in PHCs	4	9.5

***Multiple responses*

In another set of suggestions, health workers wish that stigma on mental illness and PLWMI should be addressed to improve services. The study therefore explored the possible ways of preventing stigma associated with mental illness. Out of the 191, most of the health workers (97.9%; n=187) felt that stigma must be reduced. Their responses are shown in Table 5.2.2.

Table 5.2.2: Health workers' Suggestions on Reducing Stigma of mental illness

Suggestions	Yes (%)	Not Sure (%)	No (%)	Total (%)
Incorporate anti stigma educational programmes into the mental health policies of my State	156 (81.6)	16 (8.4)	19 (10.0)	191 (100.0)
Anti-stigma programmes should focus on identifying the population at risk, and properly address the causes of mental illness	169 (88.4)	15 (7.9)	7 (3.7)	191 (100.0)
Effective stigma-reducing educational programmes through public enlightenment	167 (87.4)	12 (6.3)	12 (6.3)	191 (100.0)
There is need for more research in mental health.	176 (92.1)	8 (4.2)	7 (3.7)	191 (100.0)

Health workers' suggested ways of dealing with stigma associated with mental illness as shown in Table 5.2.2. Their suggestions focus more on the need for more research (92.2%) to identify specific beliefs and misconceptions, identifying vulnerable groups (those at risk) of mental illness so as to prevent its occurrence, and creating public awareness (88.5%) through psycho-education. They also suggested the need to make anti-stigma programmes as part of the mental health policies of respective States.In addition to these, out of the 191 health workers, 75 (39.3%) made other suggestions as shown in Table 5.2.3 (multiple responses).

Table 5.2.3: Other Suggestions on Stigma Reduction

S/No	Other Suggestions (N = 75)	Frequency *	Percentage
i.	Care for PLWMI/ Family support	10	13.3
ii.	Ensure a policy/law against stigma	12	16
iii.	Positive community attitudes/empathy	25	33.3
iv.	Carry out community diagnosis/mobilisation	6	8
v.	Create jobs for/involve PLWMI	6	8
vi.	Training/Seminars	3	4
vii.	Provide mental health facilities in PHC	5	6.7
viii.	Community leaders to create right environ	4	5.3
ix.	Involving NGOs	3	4
x.	Allow to specialise/train workers	9	12
xi.	Mass campaign/public awareness creation	59	78.7
xii.	Specific health education on drugs/substance	5	6.6
xiii.	Form support groups	3	4
xiv.	Avoid mocking PLWMI/Repercussions	1	1.3
xv.	Cooperation from PLWMI	3	4
xvi.	Increase Student community/ward posting period/more experience	2	2.7
xvii.	Religious leaders to preach against stigma	3	4.0
xviii.	Regular meeting with community leaders	18	24.0
xix.	Advocacy	1	1.3
xx.	Review psychiatric terminologies (language)	1	1.3
xxi.	Build village/community Mental Health homes	2	2.7

******Multiple responses*

As indicated in Table 5.2.3, out of the 75 health workers that suggested some other ways of reducing stigma associated with mental illness in the community, 59 (78.7%) of them believe that mass campaign and public awareness creation was the main avenue for stigma reduction, with five other respondents (6.6%) specifying the need to direct such education on drugs and substances of addiction; another 25 (33.3%) suggested changing community attitudes towards the mentally ill, with 18 others (24.0%) specifically suggesting regular meetings with community leaders, while 12 (16.0%) on the need for policy formulation against stigma, and 9 (12.0%) emphasising the need for health workers to be trained in mental health as a specialty area of community health. No support group was identified for PLWMI.

These data were supported with some qualitative responses from IDIs. A consultant psychiatrist feels the starting point should be community awareness creation, saying:

> First of all is awareness. People should know that mental health services exist, that treatment is effective. I have had cause to go and give lectures in some religious settings (NASFAT). They are youths. Some school in Kaduna too. Invited me to give lectures, we talk about mental issues.

He added:

> Some years back, I have done some talks on media. All these are geared towards letting people know what mental symptoms are and what they indicate and how people who have these symptoms be helped/assisted to get over it. Now, not every strange symptom is associated with the hand work of enemy or witch. They are so many misconceptions. I have also talked of epilepsy, enuresis in the past. Now, when these happen, there are effective and efficient ways of managing them. They only have to seek treatment in the right place, either within the community or in specialist hospitals.

So he believes that:

> …when all these are put in place, effective services will be delivered to people who are willing to receive the treatment. In Yoruba land, it is said ‘mio fe sa’gba mo bun e’ meaning so if you are going to give services and they say they don’t believe in you, there is nothing you can do. That is why you have to first enlighten them, if it works. If they are aware, they will access it a lot of them will not want to stop and even be the ones to even be advertising for you (i.e. the services). The MH professional that ooh I have taken my child, my neighbour has taken his child to MH professionals and

> they are doing well and a lot of them confess that they have been to a lot of places, spent a lot and you will even be surprised that the fee here is far less than a lot of them don't leave us again because it is cheaper and seem to be more effective.

It has been suggested that community beliefs and the training of PHC workers affect services at PHC centres must be addressed. As presented under the training needs in Chapter five of this study, the workers themselves acknowledged inadequate training and skill for virtually all of them to be able to handle MHS at the PHC system. This was confirmed from the poor knowledge demonstrated by poor scores on the mhGap Tool used to assess their knowledge and skills in the survey. They therefore suggested other ways by which the health workers' training on mental health care can be improved to meet the goals of providing these services. Out of the 191 respondents, 90 (47.1%) made suggestions on the need for improved knowledge and skills, as presented in Table 5.2.4.

'Table 5.2.4: Other Suggestions on Improving Health workers' training

S/No	Ways to improve PHCWs training	Frequency	Percentage
i.	Regular Staff training/seminars/workshops	66	73.3
ii.	Scholarships/sponsorships to higher institution	6	6.7
iii.	Motivation/incentives for PHC workers	8	8.9
iv.	Teach MHS models/psychology	4	4.4
v.	Short courses	3	3.3
vi.	Increase MH credit hours in Curriculum	3	3.3
	Total	90	100.0

As shown in Table 5.2.4, emphasis is on the need for them (health workers) to be introduced to further training, as stated by most of those who suggested some change (34.6%), incentives (4.2%), among others as shown in Table 5.2.4. The respondents also seem to suggest the specific direction in which the workers need this additional information to enhance the provision of mental health services at the PHC level. Majority (83.2%; n=159) of them believe that there is need to review the current curriculum being implemented by training institutions involved in preparing these workers

for service provision while 79.1% (n=151) of them think that anti-stigma campaigns should commence with the health workers. Thus, the workers themselves believe there are areas of the professional practice that require improvement.

All IDIs with PHC coordinators and Administrators at the Ministries agreed completely with need for additional training and review of existing curricula of training. They also discussed the form these should take. For instance, one senior psychiatrist doctor said:

> …Yes, first we educate them (the PHC workers) about signs and symptoms. Also, it is very good if we can have very very short instruments that are simple. In any case, they suspect a child; they can administer the instrument to their mothers or teachers. For the older children and adolescent, there are specific instrument we can use to determine presence of these mental symptoms.

He reiterated that:

> Yes!!.... there are things like "symptom check list", there is 'HATS' specific for children, then we have general health questionnaires for adolescents. They are so short, validated in Nigeria. We can train them on how to administer and interpret the responses.

However, other senior practitioners in psychiatry said that such training should not just be events but a process. A consultant psychiatrist put it thus: "However, we need to have plans to go for follow-up to see if they are doing what we trained them or not, but we have not". He even said that some health workers have already started this model of care delivery, when he added that:

> Some of the psychiatric nurses, who have come to the School for Training (Psychiatry) we meet one of them and we see that the presence of these people (psychiatric nurses) have made a lot of difference e.g. in Funtua, we have a psychiatric Nurse who is running a Psychiatric Clinic-outpatient clinic and his own is a very special thing. He is doing so very very fine. If we can get people like him, it will make our work much easier. Because our training in Funtua was very easy because of the presence of that man. We are planning to follow-up and see how much of these are they practising at the PHC level.

Another consultant also said the other activities they are doing, suggestive of training other categories of health workers other than mental health specialists to provide primary mental health services. He said, excitedly, that:

> We do linkage and enhancement. In an attempt to see how we can remove the burden of lack of access, we take mental health to their community. We train them. What we need to do is follow-up to see those we have trained, whether they can identify features of mental disorder, they will treat those minor ones and able to refer those they cannot treat to our centre here.
>
> In addition to helping to reduce the burden, it will also reduce burden on us. Where we will have to see only critical ones rather than see minors at our limited time.

Other linkage models are used and are being suggested for the region. A consultant psychiatrist in Kaduna said that they are presently involved in some of such training to enhance other primary and secondary level health workers to provide effective and efficient MHS. He narrated how According to him

> We started with Kastina state, Funtua and Kastina town. Presently, we are in Kaduna state; Kachia, Ikara, Birnin-Gwari. So, in addition to the one we do in Kaduna metropolis, in 44 Army barracks, we go there, access their patients and train their residents.

Although, the Ikara project just started with the first batch of 12 workers being trained at the FNPH Kaduna, the Kachia and Birnin Gwari trained personnel have not commenced the linkage services, as revealed during the researcher's visit to Kachia. This form of training is to improve PHC workers' knowledge and skills in providing MHS at the Secondary and PHC levels. Thus, the workers themselves believe there are areas of the professional practice that require improvement. One PHC worker suggested:

> We wish they can arrange short courses for us but the government is not even concerned…4 to 6 weeks will be okay because we did little in school except some Nurses who have post basic psychiatric certificate but we don't have any Nurse with that qualification.

When the researcher visited Kachia General Hospital to ascertain the linkage between the Federal Neuro-psychiatric Hospital Kaduna (FNPH), it was revealed that the hospital had established a

programme to train the staff of the General Hospital. These staff were in turn, expected to train PHC workers (at primary health care level). However, the Matron in charge of hospital said that although they have been taught by the FNPH as agreed, the staff at the Kachia General Hospital) had not started the stepping down to PHC as at time of study, over two years after commencement. The researcher also noted that the hospital had neither a Focal Person nor a coordinator for this enhancement programme. Detailed information on the linkage from a competent person who has been trained was therefore lacking.

However, the researcher attempted finding out about the status of the programme from other sources. He was finally directed to the Hospital Secretary of the Kachia Hospital. It was gathered that the programme had not properly taken off, because it was faced with challenges which according to him, are:

> no suitable room for doctors who come to consult, not even a suitable table and chair and space. Those who promised to assist, that is Agwom Kadara and PHC Unit Kachia, to repair consulting room, and residential places for visiting team from Barnawa, etc are not forthcoming. And the Hospital itself is financially down, no allocation, no renovation.

Therefore, from the short courses and enhancement-linkage programmes, as suggested, are the main desired ways to improve the knowledge and skills of health workers, who in turn, provide the desired MHS. But it seems even these are encountering problems already.

5.2.2 Community Factors

A lot of suggestions on addressing community factors were also put forward to improve services. The role of family was emphasized because of the neglect of children in the community by parents had been implicated in precipitating mental health problems. A youth leader also suggested the use of Law Enforcement agencies to control the abuse of drugs, the use of the Media such as use of JOY FM (Benue) as the best means to enlighten community on mental health problems and MHS.

In addition, community members suggested village meetings and community leaders as preferred means to creating awareness. Community members themselves suggested involving them, and disseminate mental information directed by their leaders through house to house campaigns as in the case of Ebola that was done recently. Other means like drama and youth forums were also suggested.

Unfortunately Youth Forums are no longer popular or effective because of youths now always expect "brown envelopes" for things anything they are called to do; "*no thanks to politicians",* according to a youth leader. It is also suggested that *"*drinking should be restricted to certain times of the day." A health worker said people in the community must be aware that there is mental health team that can access their patients and there are treatments, effective, efficient, readily available that will benefit those children. On the best way to close the wide treatment gap found in this study, and also supporting the suggestion on house to house means of creating awareness, a psychiatrist in Kaduna during an IDI said:

> We conducted a study years back on treatment gap among children with epilepsy in one LGA in Kaduna State. We got about 95% gap! About 95% of those children have never had access to anticonvulsants since the onset of their seizure disorders. They have been going to herbalist, religious home, traditional healers because they didn't know there is treatment for epilepsy. So, the awareness is, these people must know that effective treatment exists and they can access it. So that when we carry these services to their doorsteps, they will appreciate it and come out. If they know that it works, their children and adolescent can receive treatment. Still part of the linkage and enhancement, the community people can be reached. PHC workers can be trained on how to recognize mental health problems in children and adolescents.

In addition to that, he said:

> We can also start on the preventive aspect of it by giving Health education on those common factors that have been associated with development of MH problems in children and adolescents, things we can do to prevent them. These things start right from when ANC, prevention of mental disorders starts right from inside the womb. These things that can prevent an unborn child from mental disorders, mental retardation, and epilepsy are things that one can health educate the mother and workers. Good ANC, good delivery, good paediatric services. If these things are put in place, it's very, very likely that we will reduce the amount of mental health problems children and adolescents in the community can have.

Many health administrators advised that there should be a Mental Health Coordinator in each ward of the community, and that concerted efforts be made to incorporate mental health services into ANC and post-natal clinics, because according to him, "women are best channels to the youths; so focus more on women since PHC clients are mostly women."

Other suggestions include community involvement through participation in focused workshop, the need to combat harmful beliefs about mental illness and PLWMI. As suggested by a PHC Director in one of the States Ministry of Health, this can be done by the Government at the State and LGA levels through:

> Involvement of community at district, village and religious levels as (PHC) committee members; the committee members are then trained to go and motivate people to attend planned mental health information meetings at all levels.

Community mobilization and participation are therefore suggested as key elements to initiate, maintain and improve mental health services at the community level.

5.2.3 A suggested model of MHS delivery

The suggestions and information imply that MHS delivery through enhancement, linkage and social engineering. The ways forward for mental health services at PHC level in the selected States in northern Nigeria is therefore for the respective States to domesticate the Mental Health Policy. This will ensure having Mental Health Units/Sections in PHC centres and training health workers to provide MHS through different approaches (i.e. the enhancement). Short courses of four to six weeks, and regular seminars and workshops are novel. This will need the inclusion of socio-political dynamics such as community mobilization and participation, and governmental commitments (i.e. the linkage). The medium and long term methods should therefore include implementing and expanding the enhancement-linkage model of mental health services, incorporating the social contexts of the three States in northern Nigeria.

The findings of this study have provided sufficient rationale for a community-based intervention model that will have to be guided by principles of community participation in the provision of mental health services and grounded in culture-specific models of care that comprehensively provide the needs of the rural and urban populations (Appendix 14). This suggested model is based on the information provided by health workers, health administrators, community members and PHC service users. The suggestions cut across strategies based on the ideals of Donabedian Structure-Process-Outcome models of quality health, and enhancement-linkage. At the same time, the observed attitudinal predispositions relate to social dimensions of community to PLWMI and mental illness. The model also gives some credence to a model developed for primary eye care (Kyari, 2014). In this suggested model, the following five strategic steps are proposed:

i. Strengthening the Tertiary Mental Health Care Institutions to provide acceptable standard of mental health services in terms of facilities, adequate skilled human resource (personnel), and robust information management systems including reliable medical records management to ensure follow up and monitoring;

ii. Strengthening the secondary health facilities (State level) to manage less complex cases, with robust referral and feedback systems between the secondary and tertiary levels and between PHCs, workable protocols/guidelines (tools, inventories, checklist) for detecting and diagnosing common mental health problems should be in place, where non-complex cases can be managed at the secondary levels and complex ones referred to the tertiary levels. Patients with complex conditions be initially managed at tertiary level and referred back to secondary level and then to PHC for long-term care and follow-up (the Kachia and Ikara Experiences as cases in point);

iii. Developing mental health screening strategies at the secondary and primary levels, in form of age-grade and stage-appropriate and comprehensive mental health screenings

incorporated into routine PHC services including immunisations and antenatal care (ANC). This requires short trainings on primary mental health care;

iv. Providing treatment and community-based rehabilitation services as part of the mental health service being provided, with the full involvement of village health volunteer workers and other community groups interested in mental health services;

v. Increasing awareness and advocacy on mental health problems among policy makers and the public, in form of initiating and maintaining an excellent working relationship with people responsible for health policy at all levels, emphasizing the dangerous dimensions of mental health problems and their impact on socio-economic development of the society. Instituting a public mental health awareness campaign based on local beliefs, attitudes, and behaviours, using suitable communication channels as identified by respondents, for example, house to house visits, posters in public places, giving talks and handing out leaflets in clinics and other public places, working with local organisations (community information dissemination systems), and using the media.

This suggested model shares many ideals with the Enhancement-Linkage Model, but differs in the aspects and the means of disseminating information, community involvement and a strong nexus between the three levels of health care, where the tertiary, secondary and primary depend on each other for functioning. This interdependence can be anchored on the structure-process-outcome synergy grounded on the Donabedian Model for analysing health care delivery. This is, itself, premised on the structural-functionalist paradigm as the grand theory.

CHAPTER SIX

SUMMARY AND DISCUSSION OF FINDINGS

6.1 Summary of Key Findings

On availability of mental health services (MHS) at the PHC level, the study has established that there is scarce formal MHS at the Primary Health Care centres at the PHC level, as indicated by responses from the LGA and State Health administrators in all three States studies. It is found that virtually nothing is being done about MHS in the both the Local and State Government health programmes despite its presence at all levels of declaration and proposals(the Alma Ata declaration of PHC, Federal and StateGovernment of Nigeria proposals and in most PHC organograms). Only in Otukpo LGA in Benue State, that few organised community-based MHS, in form of community mental health campaigns and education, were found. These are initiated and provided by a faith-based International NGO, called Chistofoel Blind Mission (CBM). These psycho-educational services for the community are however being provided with the full approval of the Benue State Government. The State government had supposed to be partners in this arrangement, whereby the NGO would train mental health nurses for the government to employ for its community mental health care, but reneged. Also in Kaduna, mental health campaigns organised on Mental Health Days (October 1^{st} –7^{th}, 2014 and 2015) were found, as another form of community-targeted MHS. These were initiated and organised by the Federal Neuro-psychiatric Hospital Nurses. The programmes targeted secondary schools and the communities. Again, this was neither initiated nor facilitated by the LGA which should be responsible for PHC services. The PHC centre managed by a Teaching Hospital in Giwa LGA in Kaduna State did not reflect any advantage of having a Department of Psychiatry in the parent institution; no MHS were found in that PHC just like others.

It is thus found that although, there are virtually no official MHS at the PHC level in the selected States, the study revealed that there some services at some centres, which some PHC service

providers unofficially attempt to provide, at their own discretion. Some of the health workers reported that they provide some types of MHS like counselling and mental health education at their PHC centres for some specific clients based on some staff's concerns about psychological challenges they identified in clients/PHC attendees during PHC centre visits for other services. These services are however erratic, unorganised and uncoordinated, and often provided at the convenience and ingenuity of individual PHC workers. There is also no link between the lowest (PHC) and other level of health care (secondary and tertiary), as shown by the weak referral services for suspected mental health cases at the PHC centres in all the three States, despite the PHC stance of being a comprehensive service through claims of referrals from primary to tertiary levels of care.

On the acceptability of MHS, the findings of this study have indicated that most community members strongly wish to have MHS in the communities, as indicated by most community leaders, survey respondents and health workers. This is clearly demonstrated by the high expectations for these services, as expressed by over 90% of the community respondents and narratives from both PHC coordinators, community leaders and service users during IDIs and FGDs. The reason behind this strong community desire for MHS arises from the fact that mental health problems are very prevalent, and have reached an epidemic proportion especially youths, in their domains, culminating into various social problems. Community members are likely to accept the MHS if available because of the many consequences of mental health problems such as loss of productivity (90.6%), worsening physical illness (83.7%) and co-morbidity with suicide (90.6%), as expressed by health workers. Community members therefore strongly desire public mental health awareness programmes in form of campaigns: house to house, in the market squares, and through community leaders, in addition to other conventional means. These suggested means are associated with gender and religious affiliations, as women preferred use of stickers and posters while male would want these

through their community leaders. However, the study found some level of community resistance to accepting MHS wholesome, as expressed by about 46% of community respondents. The reluctance to accept MHS fully is related to their socio-cultural beliefs about causes of mental health problems.

Some of the mental health challenges found in the communities include the abuse of newly formulated intoxicants and addictives like the "monkey tail," tramal, solution and glue sniffingmainly by youths in all the study areas, and attempted suicidal episodes. An innovative way of getting mentally sick people covered were identified as inter-state trafficking of mental patients (a practice whereby intractable psychotics are rounded up by unknown persons and dropped in public places like long distance bus parks in another State), and post traumatic experiences by community members are prevalent in the communities. Findings also revealed some socio-economic factors which respondents attributed to the burden of mental health challenges in their communities such as unemployment, poverty and family disorganisation.

On the factors influencing the availability and acceptability of MHS at the PHC level, the study identified a poor political will to domesticate and implement the National Mental Health Policy at State level. From the responses of State PHC Directors/Executive Secretaries and PHC coordinators in LGAs, none of the three States had any mental health policy on ground, where strategies for providing MHS at the PHC level are articulated. The fallouts of this policy lacuna are in the areas of lack of facilities,a lack of a section/room for mental health care, non-availability of essential drugs for mental health disorders, and even the lack of Standing Orders for managing mental health problems at the PHC centres in the study areas. Others include poor resources allocation, poor staff and training, and weak collaborative strategies were empirically established in this study.These must have accounted for the non-availability of MHS delivery in all centres in the States. In addition, this study also indentified lack of funding and supports for mental health research as majorbarriers to evidence-basedMHS delivery in the study areas. All the Local Government and State PHC

administrators reported the absence of any budget for mental health programmes. Offical documents, such as the LGA Operational Blueprint in Kaduna State which provided for annual budgetary allocations for most other components of PHC, confirm this: mental health care was not included in the document.

On the number of PHC workers, it was also found that there is shortage of trained PHC workers to handle MHS: PHC worker per PHC centre ranged from two to thirteen. In all the centres, findings revealed that there was no mental health specialist in any of the PHC centres to provide MHS. However, the study revealed that in Benue and Kaduna States, there are mental health nurses who are reported by some of the Health Administrators to have been posted to some General Hospitals where they remained redundant because there are no mental health units in their hospitals. In fact, in the case in Benue State, there are even trained specialists who are not even employed at all by State Government. The CBM (an NGO) had trained some mental health nurses for employment by the Benue State Government to work in community mental health programmes, but the State would not employ these mental health trained specialists. This is in spite of the signing of Memorandum of Understanding (MoU) between the State Government and the NGO. On the other hand, PHC Directors expressed frustration on the failure of their State Governments to post psychiatric trained nurses on the General Wards of secondary level health facilities.

On the knowledge of the workforce, investigations revealed that the available PHC workers had poor knowledge and inadequate skill in handling mental health problems at the PHC centres.Over 70% of the PHC workers displayed poor knowledge and skills required to provide effective and efficient mental health services at the PHC level. This was derived from the mhGAP tool used to determine knowledge on their roles at PHC centre. Most of the PHC workers are not even aware of activities related to MHS including some global Mental Health awareness programmes. It is also found that many others did not know that mental health is part of the routine

services at the PHC centres. Most of them (97.4%) did not know that a day (October 10th every year) is set aside every year as Mental Health Day for creating public awareness on promotion of mental health.

The findings further indicated that PHC workers, like the community laity, wrongly equate mental health services to psychiatric services. In addition, even some of the most vulnerable group to mental health problems, i.e. children and pregnant women, who are the major PHC service users and particularly prone to psychological problems, are considered as "not targets of mental health services" by most PHC workers. PHC workers mainly consider the youths as the only focus of MHS at the community level. This has implications for future mental health service design and implementation. Thus, the study found that there is lack of adequately trained mental health professionals and resources required to effectively and efficiently handle the mental health problems prevalent in the three northern Nigerian States studied.

Another major policy-related barrier to MHS found in this study is the lack of available mental health data base at the centres investigated. It is found that there is a complete absence of any records of mental health disorders in all the centres. According to the PHC workers at the centres, the *Monthly Report* format from the Federal Ministry of Health did not have any provision for reporting mental health disorders. Although, service providers claimed to have occasionally seen some mental cases at their centres, they also reported they usually referred such cases to other levels of care. However, it was found that no documentation of either the disorder or the referral process was seen in any centre. This leaves a data vacuum at the primary care level in all the centres.

Similarly, on collaboration, it was found that there is weak collaboration between the PHC system and other formal and non-formal health sectors. For instance, the findings revealed that no collaboration exists between any of the governments of the three States and any NGO in MHS

delivery. In Benue State where a resemblance of this was found, it turned that the State government reneged on its counterpart commitment of employing the trainees which should have been the only government-NGO collaboration found in this study. Likewise, no other governmental and partnership was found in an attempt to provide MHS in any other centre in the States.

Similarly, there is no formal existing colloboration with traditional psychiatric healers, although they provide disjointed services. A semblance of informal collaboration was found in Gombe State, where it a modern medical practitioner is usually invited by a traditional medicine man (TrMM) to treat any co-existing medical condition in a psychiatric patient in his care. Even this, is an isolated case. In Kaduna and Benue States no such situation of collaboration was found. However, in Kaduna State, the federal Neuro-psychiatric Hospital was advocating for such collaboration with some traditional healers without such success at the time of data collection.

The study identified various perceptual and attitudinal issues related to MHS delivery such as incorrect perceptions about mental illness, and social stigma and discriminatory tendencies against PLWMI. Findings revealed that most PHC workers and community members attribute the causes of mental illness to social issues such as civil disturbances (79.1%), poor parenting (70.1%), and stress (57.0%); while many others (61.4%)associated mental illness with evil spirits or as punishment for sins as causes. The study also identified many socio-cultural and economic factors believed to trigger mental health problems in the study areas. Many community leaders blamed social issues like lack of employment for youth and substance abuse as a major precipitating factors. Interestingly, however, the role of substance abuse including alcohol in the causation of mental problems was controversial. While many reported it as a major cause of mental disorder, others including some health personnel, believe that it is not an issue. Instead, most community members (over 60%) implicate transgressions, human malevolence and preternatural causes in the aetiology of mental

illness. The religious backgrounds of the communities are strongly tied to such beliefs. The availability and acceptability of MHS would be patterned along these diverse beliefs.

The findings of the study also indicate that most mental illnesses are hidden by both patients and families from public knowledge. This gives the illness the opportunity to develop into worse stages where it can become more difficult to remedy. By such time when the illness is inevitably made public, there will be stigma and the associated discrimination in terms of socio-economic states of the patient. Because of stigma against people living with mental illness, some survey respondents (37.4%) said they would not want to take their mentally ill relations to seek modern mental health care. They stated their preferences for religious and traditional healing interventions. Such stance would hinder their patronage of modern MHS at the PHC even if they are available.

However, many suggestions on how to overcome these barriers and improve the availability and acceptability of the MHS were elicited from both community members and PHC workers. It was suggested that a robust mental health policy at each State level, a synergy between the three levels of health care, with components of training for PHC workers and community participation in form of linkage-enhancement format. In the final analysis, to make MHS available, the suggestions focused on the fact that structural, process and outcome parameters in mental health care must be enhanced.

6.2 Discussion of Findings

The findings of this study on availability of MHS have shown that these services fall very short of the Nigerian minimum standards for MHS as spelt out in the in the *Minimum Standards Primary Health Care* by the Federal Ministry of Health, Nigeria (NPHCDA, 2007). Indicators of the availability of MHS at any PHC facility were listed as: there must be a section or room at all PHC centres designated for MHS, with either a general duty doctor, or a mental health specialist (a mental

health nurse or psychiatrist) to provide such services. In addition, the document emphasizes and specifies the need to have and provide modern drugs for common mental disorders at the centres. As reported by PHC workers and observed by the researcher, none of such provisions exists in all the 47 PHC centres investigated. Therefore, using this Federal Government *Minimum Standards* document as a tool for assessing the availability of these services, it can be said that MHS are actually non-existent in all the PHCs in the selected States.

Officially MHS are not formally provided for in the daily routines at PHC centres, although some individual PHC workers have demonstrated the desire and willingness to provide such services, but in a rather haphazard manner. Such chaotic nature of MHS in most countries was noted by other researchers and health authorities within and outside Nigeria (WHO, 2008; WFMH, 2009; Odejide *et al;* 2010). In 2006, the WHO-AIMS (2006) study conducted in Nigeria declared that the country lacked mental health services in the community but stated that curative psychiatric services are provided by the 12 regional psychiatric institutions in Nigeria.As pointed out by many other reports (WFMH, 2009; WHO 2009; 2012), most mental health patients and clients cannot access treatment and other-related services, creating a treatment gap as high as 80 – 90% in the developing countries, including Nigeria. From the findings of this study, this gap appears to fall within this range or even higher in view of the reported non-availability in almost all PHC centres. This has been complicated by the lack of knowledge and skills of PHC service providers. Findings by Omigbodun (2001) in Ibadan, South West Nigeria, pointed to the fact that despite training undertaken by some CHOs, they were still unable to implement mental health in PHC. As a result, virtually no mental health services were being provided at the PHC level in the two Local Government Areas studied in Oyo State, South West Nigeria. In the present study areas, it is found that no such training has ever been received by the health workers in Gombe, Kaduna and Benue States. This suggests that the MHS in these areas are expected to be quite remote. Despite this, the

level of mental health issues and disorders in the community is quite glaring. As found, mental health services in the community-based health level are lacking in the three States; only minimally and accidentally but haphazardly provided were found. Even the public mental health awareness activities adjourned to change negative attitudes of community towards PLWMI and correct misconception of mental illness (Eaton and Agomoroh, 2008), were unavailable.

In Nigerian communities, when modern health services are not available or inaccessible, community members usually resort to alternative pathways to health care, such as patronizing traditional healers and spiritualists (Jegede, 2010; Gureje, 2015). In this case, the non-availability of MHS at the community level would mean that traditional medical practitioners and other alternative treatment will be patronized. Glimpses of this were noted in this study where few traditional psychiatrists were found to have patients under their care.

The study established a clear concern for mental health challenges in the communities. There were cases of co-occurring disorders like substance-related disorders, and vagrant mentally ill persons, few reported cases of "imported madmen"and a case of suicidal attempt. Suicidal ideations or attempts suggest evidence of poor coping (both individual and family) with social and economic stressors of life as manifested by a reported case of suicidal attempt. Suicidal tendencies and families sending out their (mentally) sick members (as in the case of 'posting' them to other States) are suggestive of poor handling of everyday socio-economic (situational) crises, and possible break down of traditional social support network. People who maintain constant social contact with and enjoy social support from significant others are reported to have better mental wellbeing than those who are isolated and unsure of any support (Townsend, 2006). Similarly, the absence of a PHC system where people can visit when they need counselling or help can predispose them to suicides and other impaired social and economic functioning (WFMH, 2009). According to World Federation

for Mental Health (2009), knowing that people will have a place (like the suicide prevention clinic, as can be provided at POHC centres) to discuss distressing problems should the need arise is the active ingredient. This arrangement is also recommended (WHO, 2012) and the PHC centres are expected to provide that avenue. However, the findings of this study indicate that there are no such Counseling Units in the PHC centres, implying that conditions that would require basic professional counselling to resolve would eventually worsen, and could deteriorate to suicidal or even homicidal episodes. In some countries, there are even Suicide Prevention Clinics, where clients with suicidal or other-directed injuries ideations are managed. The efficacy of such arrangement varies across cultures. On contrary, also, perhaps the very referral to a suicide prevention clinic has designated the patient as being at high risk, alerting the individual's support network to the need to attend to the emergence of acute suicide risk. Whatever the active ingredients are, to identify them specifically will translate to more efficient, cost-effective preventive treatments. Only a few PHC workers reported providing such counselling services on their own when they felt a client needed. These are obviously inadequate and expectedly uncoordinated.

For the high rate of multiple substance abuses found in this study, concomitant disorders are common elsewhere. Substance abuse is a necessary and sufficient cause of mental health problems, and the relationship between substance abuse and mental illness, often referred to as co-occurring disorders, is well established (Harris & Edlund, 2005). In 2008, almost 2.5 million adults aged 18 years or older were affected by both a serious mental illness associated with substance dependence or abuse (Substance Abuse and Mental Health Services Administration [SAMHSA] 2009). Research in the field indicates that roughly 54% of clients in treatment settings have co-occurring disorders of substance abuse and mental health problems (Harris & Edlund, 2005). But less than one-half of those individuals received treatment for their mental illness or substance abuse disorder (SAMHSA,

2009), leaving a large intervention gap. Such enormous inaccessibility to MHS is also found in this study.

Effects of mental health challenges are reported to have impaired both the social and economic functioning of youth, families and communities, particularly substance-related disorders (Saddock and Saddock, 2006), which constitute the majority of all cases of mental and behavioural disorders, often associated with multiple substance abuses, as found in this study. This is usually reflected in the low productivity of the individual, and social maladjustment such as impaired social functioning resulting in crime commission and incarceration, failed role performance, academic and occupational underachievement, among others. Thus, the WHO reported that rather than reducing mental illness and other disabilities to medical problems and solutions, there is need for social approach such as how social arrangements, policies and practices can either "enable or disable" people in form school attendance, employment and other livelihood enhancements (WHO, 2011).

The cases of "imported madmen" are reported in only one of the three States studied but cases of trafficking of chronically sick people is not a new phenomenon. This finding will require further exploration to establish its true dimension and prevalence in States in northern Nigeria.

The scarce of MHS and the identified cases of mental health problems in the communities indicate that patients cannot access services and care. There is therefore a large treatment or intervention gap, as also expressed by most (68.5%) health workers and community respondents during IDIs. This wide gap in treatment and other interventions implies that while the existing mental problems will continue to worsen, many other community members might develop more disorders. Globally, and especially in developing countries like Nigeria, this wide intervention gulf has been acknowledged by world health authorities and experts such as WHO, 2008 and WFMH, 2009). In his analysis of south west Nigeria, Jegede (2000) had reported that due to the limited mental health care services in

most communities in Nigeria, traditional medicine men (TrMM) manage most cases of mental illness.

The barriers responsible for the absence of community-based MHS in the study areas are mainly issues of policy failure and political unwillingness. As pointed by Ityayar (1983), from inception of PHC programme in Nigeria, the problems of health care delivery in Nigeria, including MHS, are deeply rooted in the socio-political climate of the country. He had argued that rural PHC services are deliberately sub-optimally provided, and maldistributed in terms of funds allocation, health workforce, and related other resources. Similarly, Ayorinde, Gureje and Lawal (2004) had emphasised that the poor leverage and thwarting of mental health care delivery in Nigeria is mainly due to a lack of political will and poor policy-making. This, they believe, has resulted in the lack the appropriate staff and sufficient funds for PHC services, including MHS.These policy and political barriers are analyzable from the structural-functionalist perspective, exemplified here by the Donabedian *Structure-Process-Outcome* typology. The barriers are essentially structural, as manifested by the lack of mental Health facilities including Section in PHC centres to carry MHS, staffing problems and even lack of drugs and Standing Orders on mental health problems. This manifests as lack of referrals and coordination between the level three tiers of health care in the three States studied.

There are also the process factors, as identified by the Donabedian model, such as the beliefs of community members and health workers inhibiting prospectively acceptance of MHS. These social barriers including stigma and discrimination also fall within the purview of Social Interactionism, as part of the framework for this study. The barriers speculated by the WHO document, are essentially structural and process factors (Donabedian, 1980) and are predominantly present in the selected States in northern Nigeria. For example, in Zambia, Kenya and South Africa

the lack of political commitment of mental health care is identified as the fundamental issue in the absence of the services (Mwape *et al;* 2007). This is the similar finding in this study.

For the low funding of MHS at the PHC level found in the Study States, it is not an isolated case. Many other studies elsewhere have revealed the low investment in mental health care, despite the increasing burden of mental illness (WHO Report, 2011) y. Such low budgetary allocations have also previously been found in Southern Nigeria (Adefuye, 2011). To provide functional MHC in PHC systems, Smith, *et al;* (2008) had recommended proper financing. All these point to policy and advocacy issues. The fallouts of this policy failure include lack of specific services including absence of essential drugs for mental disorders, human resources and training challenges, problems of funding, collaboration, and research.

On the poor database at PHC centres in all three States found in this study, Boerma (2015) of the World Health Organisation had emphasized that a good data base has been adjourned as a very important parameter in the provision of MHS in any community. He captured this succinctly, saying that accurate and complete data is essential for good decision making and health planning. This has not been the case in the study area where information gathering and documentation on mental health issues is almost completely non-existent at all PHC centres investigated. Other empirical studies indicate these weal data bases. As observed by WHO-AIMS (2006); Odejide *et al;* (2010) and Mwape *et al;* (2010), most developing countries lack data to show how much mental health problems actually exist in the communities.

The findings of this study indicated that there is no collaboration of the PHC system with the different intersectoral partners. WH0 Factsheet (2007) had stressed the role of intersectoral partners, alongside mental health policies, in addressing the socio-economic and environmental factors related to mental health. Health care providers and community members involved in mental health care

services are required to be aware of these social, economic and other environmental factors contributing to mental health promotion. Even the Federal Ministry of Health (1991; 2007) had stressed the need for community participation, involvement of NGOs and the collaboration with traditional healers especially those treating mental illness. This has obviously been jettisoned by the lack of this synergy.

Studies have however shown that mental health promotion strategies are themselves ignored by health workers (WHO, 1978; WHO-AIMS, 2006; Odejide *et al;* 2010; WHO, 2007; WMHF, 2009) and community members alike (Abiodun, 1989; Asuzu, 2009). Herrman, Saxena and Moodie (2005) reported that government must partner with other stakeholders like NGOs, development partners and even other governmental non-health sectors as strategy for achieving effective PHC services, including MHS. Similarly, WHO (2001) in addressing the burden of global diseases of which mental disorders concstitute between 12 and 14%, recommended the multi-sectoral approach to make PHC services (including MHS) available, accessible and affordable. This has not been the case in the study; the level of such collaboration is weak or completely in the providing MHS in the three selected States for this study. Many other scholars and world heath authorities such as Herrman, Saxena and Moodie (2005) and WHO (2001) believe that functional MHS in PHC system should have activities based on multisectoral approach. This has not been the case in this study.

In the study population, investigation revealed many socio-cultural obstacles. The social barriers identified by the study include incorrect community perception of mental disorders and some level of stigma and discrimination and substance abuse and substance-related disorders among young people in the community (Abdul *et al*., 2009; Kabir, Iliyasu and Aliyu, 2004). Most community members and health workers alike share similar attitude and perception towards people living with mental illness, the causation, manifestations and treatment of mental illness.

On unemployment as a cause of mental illness, Tuke (2014) observed that "of all the modes by which the patients may be induced to restrain themselves, regular employment is perhaps the most generally efficacious". Being gainfully employed is a cherished goal of many people with mental disorders. Interventions such as individual placement and support can improve patients' chances of being employed.

In the study areas, it was revealed that the causes of mental illness are associated with various factors such as religio-magical causes, evil spirits and God's anger. Thus, beliefs in transgression, human malevolence and preternatural causes are common in the study areas. In 2015, Gureje, during a Webinar conferencing, stated that 40% of Nigerians believe that mental disorders are due to supernatural causes, possessed by evil spirits and punishment for gods/God. Al-Adawi, *et al;* (2002) also found that both medical students and the public considered mental illness as caused spirits, indicating that traditional beliefs about mental illness did not change despite exposure to a biomedical model of mental illness. This perception affects acceptance of MHS. As Gureje (2015) noted, over 30% of Nigerians believe in religio-magical cure for mental illness. Even in United States, Ward*et al.;* (2013), in their study ofAfrican American men and women's attitude toward mental illness, found primordial sentiments and stigma associated with mental illness, and they prefer recourse to religious intervention to modern medical treatment, despite good knowledge.

These barriers have been recognised by WHO (2012) and WFMH (2009) as very strong barriers to MHS in other communities. Addressing the barriers that prevent access to mental health care and campaigning for the full incorporation of MHS in global public health has been the focus of WHO (Herrman, Saxena and Moodie, 2005), becausein most developing countries, more than 75% of those requiring mental health do not access basicMHS (WHO, 2001). However, as indicated, some social barriers like community rejection and social stigma which pose serious hindrances to MHS elsewhere are not strong social factors that would negatively affect the provision of MHS in

the study communities, as affirmed by community members, if and whenever, MHS are made available to the communities in the region.

Data from the various sources in this study suggest that the ways forward in overcoming the identified barriers for MHS delivery at PHC in the three States in northern Nigeria. Firstly, the need for a strong link between the three tiers of health care in terms of training of personnel and service delivery is well established by the findings of this study. Findings clearly indicate that for health workers providing PHC services need to be properly trained through a variety of training sessions such as short courses of four to six weeks, and regular seminars and workshops as a short term measure. To improve the availability, and acceptability of mental health services, Osungbade and Siyanbade (2010) had suggested, that primary health care staff, among other things, need to be strengthened to take on additional tasks and bridge the treatment gap through primary care strategies. Similarly, collaboration between the modern and traditional health care systems has been advocated to further close the service gap. Jegede (2010) believes this is the key to efficient and effective PHC services including MHS. As also advocated by Ityavyar (1983), the community can contribute to significantly change the health care services in Nigeria. But to him, this had remained a mirage. Hellandendu (1991) had similarly emphasised the positive role the community could play to enhance PHC-community health care services, if they were involved promptly and appropriately.

These key components of mental health service delivery also need to be considered in the overall proposal for improved MHS. The medium and long term methods should therefore include implementing and expanding the enhancement-linkage model of mental health services, considering the inclusion of socio-political dynamics such as community mobilization and participation, and governmental commitments in terms of appropriate legislation and policy implementation within the social context of States in northern Nigeria. Attempts are made to crystalise these suggestions into

model; to construct a schematic presentation showing the linkages within socio-cultural environment with particular reference to community-based (PHC) mental health services.

CHAPTER SEVEN

CONCLUSION AND RECOMMENDATIONS

7.1 Conclusion

The aim of including the promotion of mental health in the PHC services is to reduce the incidence and prevalence of mental health problems in the community, and to minimise the disabilities arising from mental illnesses (i.e. to rehabilitate PLWMI). Where individuals with mental challenges are identified, such individuals should access the required services as close as possible to their abodes. In fact, the mental health component of PHC is meant to prevent such mental problems from occurring in the community. However, cases of the mental health disorders are rising in the community. The need to assess the available services to address these problems thus became paramount. This study therefore explored the erstwhile state of mental health services in PHC facilities in three selected States in Northern Nigeria. The study also identified factors affecting these services, including the attitudinal and social barriers. The findings of this study attempted to crystallise its data into proposing a model for improving mental health services in the study areas.

PHC facilities are very common health centres in all the three States, run by the LGAs Health Authorities. Most of the buildings of the PHC centres have recently been renovated by SURE-P and MDGs, and some corporate bodies such as Coca cola Company, and were in good state of repairs. Despite this renovation and new constructions in a few places, no facility has any section or room designated for Mental Health Services. The effect of this is the observed lack of these services in almost all the PHC facilities in the three States. Almost all the study areas are not able to provide any form of MHS to promote mental health, prevent and manage mental health problems and illnesses at

their PHCs. As shown, organised mental health services are limited in government-owned primary health care facilities in the study areas except for some disparate ones haphazardly provided by some primary health care workers in form of general counselling and antenatal and postnatal services.

The very scarce mental health services at the PHC centres in States in northern Nigeria are due largely to government weak policy implementation and lack of interest, despite the high demand for these services, among other barriers identified as responsible for this near total non-availability of these services. Weak political will and lack of policy were identified as the main obstacles to the provision and accessibility to MHS. The backlash of this includes shortage of adequately trained human resources, lack of informational materials and some misconceptions among health workers and community members. In addition to the shortage of trained mental health care professionals, almost all the available PHC workers lack the knowledge, skills and resources required to efficiently and effectively handle the mental health problems found all the over the communities.

Only an NGO focusing on community mental health services was found in one of the three States; even at that, the NGO primarily and initially focused on sight saving (common eye problems) but only expanded its services to address some aspects of the stark community mental health services expected as part of its rehabilitative mission. The implications of this non-availability of MHS is that those who need these services especially regular PHC attendees like the pregnant women and children for immunisations, and youths in the community who need psycho-education cannot access the services. This has created a wide treatment/intervention gap. The overall effect of this is the deterioration of those already having avoidable mental health problems, and the increasing prevalence of such problems and other new ones.

From the findings of this study, the abuse of newly fabricated, improvised additives and intoxicating substances found could mean the social symptoms of ineffective coping with daily

stresses of life. These have started manifesting in the community as attempted suicide. This is been associated with decreasing social support and cohesion among family and group members. The western lifestyle of nuclear family arrangement, and even the industrial tendency of less attention to traditional parenting styles, has been implicated in the increasing rate of mental problems among youths in the study areas. Many of the mental health problems prevalent in the community originate from failed family and other social interactions, due mainly to diminishing traditional social and economic safety systems, as suggested by reports of neglect of children (from health administrators) and the claim from the survey that poor parenting is making children vulnerable to mental health problem.

As can be deduced from the findings, accessibility failed to be an issue that could be sufficiently explored in the study, in view of the fact that MHS were virtually non-existent in the first place. The desirability and willingness to accept the services if made available was therefore assessed. Prospectively, communities were very willingly to accept mental health services, and in fact, strongly desire for the services because of the huge mental health issues and challenges pervading in their communities.

The attitudes and perceptions of health workers and community members show similar tendencies. The mix shows that socio-cultural orientation of the health workers and community members to mental illness and PLWMI are similar, and this should be responsible for the similar attitudes despite medical training of the health workers. This study indicated that stigma and discrimination against PLWMI is low but still constitutes a significant issue to address when the full provision of mental health services in the communities is embarked upon.

From the suggestions, observations and responses of participants from this study, a model for efficient mental health services leaning on the Donabedian Structure-Process-Outcome. This model

focuses on resurrecting the moribund Mental Health Policy of the Federal Government of Nigeria and challenging States to domesticate such policy at the secondary and primary levels of health care. The model if activated at the tertiary level and domesticated at other levels will provide for facilities at PHC centres such as having sections/rooms for MHS, policy on training of PHC staff on mental health, provision of essential drugs for mental disorders, and a deliberate collaborative strategy. The model thus adopts a structural-functionalist ideal where the interdependence of the three tiers of health care will have to interweave, and also link up the social infrastructure (such as community leaders, community-based groups) and the non-health sectors to provide a comprehensive mental health care package at the Primary Health Care level, where over 70% of the population should have access to comprehensive PHC.

This study thus confirms the speculation that political, policy and socio-cultural factors are barriers to the provision of community-based (PHC) mental health service in most communities including those in the three selected States. The role of policy formulation, political commitment, and social engineering including active community involvement at all levels of planning and implementation, are very important to ensure vibrant MHS at the PHC (community) level.

7.2 Implications of the Findings

The findings of this study have implications for mental health care provision, policy and research.

7.2.1 Implications for Provision of Mental Health Services in Nigeria: The study has awakened the consciousness of community members and health workers on the huge but unrecognized need for MHS in (northern) Nigerian communities, and should serve as a stimulus for advocacy programmes community-based MHS. The findings have provided some baseline evidence on the level of MHS at the PHC centres and range of obstacles to the provision of MHS in northern Nigeria. These hindrances cut across governmental lassitude and non-commitment, the PHC system complacency to

community ignorance, misconceptions and negative attitudes.The suggested model also has the potential of making the MHS available, accessible and acceptable in the study communities. This should reduce the burden of suffering for the mentally ill and PLWMI by providing basic treatment and restorative care, promoting mental health and preventing mental illness in the community.

7.2.2 Implications for Health Policies: The current mental health policy for Nigeria focuses on enhancemen-linkage as the model in which mental health can be successfully integrated into PHC; so far, this has not been successful. Results emerging from this model can be replicated in other parts of the country and used bypolicy makers. This could ultimately lead to a change in the mental health policy on training and resource allocation for mental health at the PHC level.

7.2.3 Implications for Further Research: This study provides baseline information on MHS, community-based mental health problems, and the problem-intervention gap. This should stimulate further researches in these vital areas, especially in northern Nigeria.

7.3 Recommendations

Based on the findings of this study, the following recommendations are made as measures to improve the current status of MHS in Gombe, Kaduna and Benue States:

i. Adequately equipped and staffed Mental Health Services Sections or at least a Room should be provided in all PHC centres in the three States. The need to build more PHC facilities with MHS Units thus requires urgent political and administrative attention;

ii. Training of PHC workers should be instituted as a matter of urgency to enable the service providers acquire basic MHS skills in psycho-educating members of the community on the promotion of mental health (through forming groups like Community Vanguard on Substance Abuse and related Disorders), and detecting and treating common mental

problems. Such trainings can, in the first instance, take the forms of short courses of between four to six weeks Primary Mental Health Care Training for community health workers and nurses/midwives who are interested in providing these services. State Ministries of Health (through their Agencies such as SPHCDAs) should also, as a matter of policy, support all LGAs to identify interested and willing PHC service providers to undertake specialised training in mental health, by granting sponsorships and scholarships. Such trained personnelcan be further motivated to act as mental health coordinators at PHC centres;

iii. There is need to insist on incorporatingthe mental health services at all routine (day to day) service delivery, alongside other services like antenatal care (ANC) clinics, immunisations and treatment of other common ailments, at the PHC level, in forms of "pluses" during other routine services like the clinics, immunisation of children, when treating childhood and other diseases at the PHC and health clinics. This can be achieved through health education, and quick mental status examination (MSE) (screening for both children and adults) using short and established check lists e.g. The Child Behaviour Checklist (CBC), Abuse Assessment Screen (AAS) for pregnant women, Psycho-social Risk Factors Checklist for pregnant women, Edinburg Postpartum Depression Scale, among others. This will improve the level and range of provision of mental health services at the PHC level and make more services accessible;

iv. State PHC Development Agencies should also insist on applying all the PHC principles, including insistence on the two-way referrals between levels of care; multi-sectoral collaboration between government, communities and NGOs; as well as advocacy for community-based mental health services to adequately pressurized elected legislative arm of government to come up with necessary policies and laws on mental health care. This

should be paramount in all subsequent health policy plans of government. In this regard, Desk Offices for Mental Health should be created at all State Ministries of Health. These Desk Offices in collaboration with Local Government Service Commission or State Primary Health Care Development Agencies in each State should then be mandated to ensure the implementation of mental health care in all PHCs at the LGAs, or assign at least one PHC in each LGA to commence MHS from where MHS can expand;

v. Research should be encouraged in basic mental health care to provide basic data that will guide Mental Health Policy and Legislation and evidence-based MHS delivery at the PHC level to monitor key mental health indicators in the community.

7.4 Suggested Areas for Further Studies

i. Case Studies will add to better understanding of the issues related to the provision of these services, including the forms and quantum of mental health problems in communities of the study areas, as well as the needed interventions and their total implementation and sustainability, alongside other primary care or services;

ii. There is need to develop models or to test the effectiveness of existing and proposed models for their suitability in the provision of MHS at the PHC in northern Nigerian States. Such models testing should focus on, firstly for service delivery, and another for the training of PHC workers that will provide these services. Such models need to be experimented at interventional phases to arrive at effective and efficient mental health service delivery to the highly expectant communities in the study areas.

GLOSSARY

1. *Mental health:*It consists of all behaviours, activities, feelings, and thoughts that enable an individual to be at peace with self and others, and allows the individual to carry out his social roles optimally, and live a productive functional life.
2. *Mental health problems:* These are any behaviours, activities, feelings and thoughts which impair the performance of these social activities, which may be subjective and objective. They also mean the absence of peace with self and with others, characterised by an individual's inability to adapt to the constantly changing physical and psychosocial environment of the individual. Mental health problems range from the worries individuals experience as part of everyday life to serious long-term conditions. Not all mental health problems are mental illnesses.
3. *Mental illness*: Mental illness occurs when an individual's impaired social interaction is concurrent with significant cognitive, affective and functional impairments.Mental illness is used interchangeably with mental health disorders. All mental disorders are mental health problems.
4. *Mental health services:*Mental health services are all the means by which effective interventions for mental health and mental health problems are delivered. Mental health services at the PHC level are all interventions, measures and plans directed towards the promotion of mental health, prevention of mental illnesses, treatment of mental health problems, and the rehabilitation of people living with mental illness (PLWMI) at the community level. They are called community-based mental health services.

5. *Psychiatric services:* these are services and measures to treat mental illness or disorders. They are mainly curative and rehabilitative measures for the institutional (usually hospital) management of the mentally ill.

REFERENCES

Abegunde, D. (2012). Nigeria Still Searching Right Formula. *WHO bulletin,* Geneva: WHO

Abiodun, O.A. (1989). Mental health and primary care in Africa. *International Journal of Mental Health*. 18(4), Pp. 48-56

Adefuye, D. (2011). Budgetary Allocation to Health, Shame of a Nation, Association of Nigerian Physicians in America Blog http://www.anpa.org/blog/2011/03/30/budgetary-allocation-to-health-shame-of-a-nation accessed on march 20, 2012

Abdul, A.J., Anyebe, E.E., Ajayi, D.A., Garba, S.N. and Yusuf, B. (2010). Prevalence of Use of Marijuana among Secondary School Students in Kaduna. *Journal of Educational Research and Development Vol.5, No.3;* pp. 48-56. ISSN: 0794-4667 (Dec)

Abegunde, D. (2013). Mental Health Care in Nigeria: Time for Change. The Nation Newspaper

Afro.who.int (2008). International Conference on Primary Health Care and Health Systems in Africa; accessed on 21/5/2013 from*http://www.afro.who.int/en/media centre/pressreleases/item/54-international-conference-on-primary-health-care-and health-systems-in-africa.html*.

Agency for Healthcare Research and Quality (AHRQ, 2012). Experts call for integrating mental health into primary care: Research Activities, Agency for Healthcare Research and Quality, Rockville, MD. January 2012, No. 377. Accessed on 24th May 2013 from http://www.ahrq.gov/news/newsletters/research-activities/jan12/0112RA1.html.

Aiken LH, Clarke SP, Sloane DM. 2012 Hospital staffing, organization, and quality of care: cross-national findings. International Journal of Quality in Health Care.14(1):5-13.

Al-Adawi S, Dorvlo AS, Al-Ismaily SS, Al-Ghafry DA, Al-Noobi BZ, Al-Salmi A, Burke DT, Shah MK, Ghassany H, Chand SP. (2002). Perception of and attitude towards mental illness in Oman. *International Journal of Social Psychiatry*.48(4):305-17 (Dec).Accessed on 11 June 2013 from http://www.ncbi.nlm.nih.gov/pubmed/12553410

Akhtar, Rais (1991). *Health Care Patterns and Planning in Developing Countries,* Greenwood Press, 1991. pp. 264

Amin S, Das J, Goldstein M. (2008) (Edrs.). Are you being served? New Tools for Measuring ServiceDelivery. Washington DC The International Bank for Reconstruction and Development / The World Bank; Cooperberg MR, Birkmeyer JD, Litwin MS. 2009 Defining high quality health care. Urol Oncol. 2009;27(4):411-6.

Anyebe, E.E., Abdul, A.J., Olisah, V.O. and Bitiyong, F.W. (2008). Perceptions of Mentally ill Patients and their Relatives in ABUTH Zaria about Mental Illness and Treatment. *African Journal of Medical Sciences. Vol.1, No.1;* pp. 68-73

Anyebe, E.E., Garba, S.N., Lawal, H. and Ukut, C. (2014). Assessment of level of Stress amongst Nurses in Zaria metropolis, northern Nigeria; *West African Journal of Nursing.* 23(1). 54

Aschbrenner, K., Carpenter-Song, E., Mueser, Kim, Kinney, Allison , Pratt Sarah , and Bartels Stephen (2013). A Qualitative Study of Social Facilitators and Barriers to Health Behaviour Change among Persons with Serious Mental Illness, *Community Mental Health Journal*, (49) 2, pp. 207-212

Asuzu, M. (2008). Nigeria still searching for right formula. *Bulletin of the World Health Organization.* 86 (9). 664-666 (September 2008).

Asuzu, J. (2009). The Necessity for a Health Systems Reform in Nigeria. *Journal of Community Medicine & Primary Health Care.* Vol. 16, No. 1. Pp.1-3

Babbie, E. (2010). *The Practice of Social Research. 12th Edition.* USA: Wadsworth Cencage Learning.

Bennet, F.J. (1985). Primary Health Care for Countries in Africa. In Sofoluwe, G.O. and Bennet, F.J. eds. *Principles and Practice of community health in Africa.* University Press Limited, Ibadan.

Bird DC, Lambert D, Hartley D, Beeson PG, Coburn AF (1998). Rural models for integrating primary care and mental health services. *Adm Policy Ment Health*.; **25**: 287-309

Bolton, Derek (2010, Aug). Conceptualisation of mental disorder and its personal meanings. *Journal of Mental Health.* Vol.19, No.4; pp.328-336. Retrieved on 23/4/2013 from http://www.

Boerma W.G.W. (2006). Coordination and integration in European primary care. In: Saltma RB, Rico A, Boerma WGW, eds. *Primary care in the driver's seat? Organizational reform in European primary care*. Maidenhead, Open University Press; retrieved 23 May, 2013 from (http://www.euro.who.int/Document/E87932_chapt1.pdf

Boerma, T. (2015): A Global Commitment to Improve Health Data. Available on WHO website: www.who.int/mediacentre/commentaries/improving-health-data/en/ Accessed on 9th June 2015.

Bornemann, Thomas H. (2009). Making mental health a global priority. World Mental Health Day. Geneva.

Bower, P. (2002). Primary care mental health workers: Models of working and evidence of effectiveness. *British Journal of General Practice*. 52 (484). Pp.926-933

Butler M., Kane R.L., McAlpine D., Kathol, R.G., Fu S/S., Hagedorn H., Wilt T.J. (2008). Integration of Mental Health/Substance Abuse and Primary Care No. 173 (Prepared by the Minnesota Evidence-based Practice Center under Contract No. 290-02-0009.) AHRQ Publication No. 09-E003. Rockville, MD. Agency for Healthcare Research and Quality.

Campbell, J. (2005). *Rebecca A. Donatelle Health-The Basic 6th Edition: Psychosocial Health: Being Mentally, Emotionally, Socially, and Spiritually Well.* Pearson Education Inc. Publishing as Benjamin Cunnings: USA

Chiejina, A. (2013). Mental health problems on the rise in Nigeria;*Entrepreneur*›*Health*Friday, 01 March. P17

Chuke, P. O. (1988.). Nigeria: In Saltman, R.B. Ed. The International Handbook of Health Care Systems. Greenwood Press, N.Y.Department of Health, DoH, (2011). *Mental Health Primary Health Care (PHC) Services*. Provincial Government of the Western Cape. Accessed 16 June 2012 from http://www.who.int/topics/primary_health_care/en/

Community Health Practitioners Registration Board of Nigeria (2006), Curriculum for Certificate/Diploma/HND in Community Health. NBTE

DHHS (US Department of health and human Services) (1999). Mental Health: Culture, Race and Ethniciy: A Report of Surgeon General. US Public services

Donabedian A. (1980). The Definition of Quality and Approaches to its Assessment Vol. 1 of Explorations in Quality Assessment and Monitoring: Ann Arbor, MI: Health Administration Press.

Drew, N., Funk, M., Tang, S. et al., (2011). Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis. *The Lancet*, 378 (9803); 1664

Eaton, J. and Agomoh A.O. (2008). Impact of a community-based mental health awareness programme. *Social Psychiatry and Psychiatric Epidemiology.* 20: 1-8

Eaton, J., McCay, L., Semrau, M., Chatterjee, S., Baingana, F., Araya, R., Ntulo, C., Thornicroft G., Saxena, S. (2011). Scale up of services for mental health in low-income and middle income countries (Review). *The Lancet*Volume 378, Issue 9802, 29; 1592-1603.

Eaton J, McCay L, Semrau M, *et al*.(Supplement to: 2011). Scale up of services for mental health in low-income and middle-income countries. *Lancet* 2011; published online Oct 17.DOI:10.1016/S0140-6736(11)60891-X.

Ekhoragbon (2013), National Trails (Saturday, June 29, 2013), Dankwambo worries: Too few doctors in Gombe State \

Federal Medical Centre Abeokuta, FMC, (2010): A Case Study in Hospital Management. Retrieved 06 June 2013 from http://www.docstoc.com/docs/21999635/Federal-Medical Centre_ Abeokuta_-A-Case-Study-in-Hospital-Management.

Federal Ministry of Health (FMOH) (1988). National Health Policy. Lagos; FG Press

Federal Ministry of Health (FMOH) (1991). National Mental Health Policy. Lagos; FG Press

Federal Ministry of Health (FMOH) (2010); National Sero-Prevalence Survey among Women Attending ANC. Abuja Nigeria

Federal Ministry of Health (FMOH) (2007). Integrated Maternal, Newborn, and child Health Strategy. Abuja: Government of Nigeria.

Feltz-Cornelis CM, Lyons JS, Huyse FJ, Camos R, Fink P, Slaets JPJ. (1997). Health services research on mental health in primary care. *International Journal Psychiatric Medicine*. 27: 1-21.

Fie, B. (2009). *Continuum of Mental Health Concept*, posted on 18 December 2009. Accessed June 14, 2013; available at http://www.jiwafifirosaline42.blogspot.com/

Foronda, M.Jr. (2012). *Results of Mental Health Study Published by Global Forum;*Social Development Research Center: Center for Local and Oral History (MFCLOH). Accessed on (30/11/12) from http://www.dlsu.edu.ph/research/centers/sdrc/mentalhealth global.asp

Gabel, Stewart (2010, Nov). The Integration of mental Health into Paediatric Practice: Paediatricians and Child and adolescent Psychiatrists Working together in New Models of care. *Journal of Paediatrics.* Vol. 157, No.5. pp.848-851. Retrieved on 23/4/2013 from http://www.jpeds.com

Giddens, A. and Suttons, P.W. (2010): *Sociology*. 6th edition: Polity: Wily Indiaa Pvt. Ltd

Gillam, S. (2007). The declaration of Alma Ata: Still Relevant after all these Years? *Institute of Public Health, Cambridge.*

Goffman, E. (1961): Asylums: Essays on the Social Situation of Mental Patients and Other Inmates. Doubleday Anchor, New York.

Gureje, O.A. (2013). Community Study of Knowledge and Attitude to Mental Illness in Nigeria. *British Journal of Psychiatry;* available at http://bjp.rcpysch.org/content/185/436.full. Accessed 5 Feb 2012

Gureje, O. (2015). Challenges of Mental Health Care in Nigeria. A Webinar Internet Conference held on 15th December 2015 .

Grange, Adenike (2007). UCL Lancet Lecture: Health Reform in Nigeria (12 November). Retrieved on March 03, 2013 from http://www.ucl.ac.uk/news/news articles/0711/07111203

Han, C. Voils, C. I., and Williams, J.W. (2013). Uptake of Web-Based Clinical Resources from the MacArthur Initiative on Depression and Primary Care, *Community Mental Health Journal*, 49(2): 166-171

Haralambos, M. & Holborn, M. (2004). Sociology themes and perspectives. 6th edition. London: HarperCollos Publication Ltd. 291-292

Hellandendu, J.M. (1991). Community Participation in PHC: A Case Study of Ekklesiya Yan Uwa – A Nigerian Rural Health Programme Gar Kida. Unpublished PhD Thesis, Department of Sociology, ABU Zaria-Nigeria

Hudson, C.G. (2005). Socio-economic Status and Mental Illness: Tests of the Social Causation and Selection Hypotheses; *American journal of Orthopsychiatry.* 75(1): 3-18

Harris, M.F., Harris, E. and Roland,M. (2004). Access to primary health care: three challenges to equity; *Australian Journal of Primary Health* 10(3) 21 – 29; accessed on 8/3/2014 from http://www.publish.csiro.au/paper/PY04043.htm

Health Evidence Network, HEN, (2004). What are the arguments for community-based mental health care? Annex 2. Key principles for balanced community-based mental health services [web site]. Copenhagen, WHO Regional Office for Europe, (http://www.euro.who.int/HEN/Syntheses/mentalhealth/20030903_1).

Herrman, H., Saxena, S and Moodie,R. (2005) ed. *Promoting Mental Health: Concepts, Emerging Evidence,Practice*: A Report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and The University of Melbourne: WHO Publication

Hogan, M.O (2006). *A Dictionary of Sociology*: Nig: EPP BOOKS

Ihekweazu, Ckike. and Anya, Ike. (2006). Nigerian Health "Reforms": Rhetoric Or Real? *On behalf of the Nigerian Public Health Network*. Accessed on Jan 23, 2013 from http://nigeriaworld.com/articles/2006/jun/224.html

Igbinomwanhia, N.G., James, B.O., Omoaregba, J.O. (2013). The attitudes of clergy in Benin City, Nigeria towards persons with mental illness. African Journal of Psychiatry, 16; 160 200

International Children Centre (ICC) (1981). *Primary Health care: Children in the Tropics.* International Children's centre, Paris.

Ityavyar, D.A. (1983). Political Economy of Health Care Problems in Nigeria. *Journal of African Studies.* 13 (1); 45-62; available at http://www.escholarship.org/help_copyright.htm/#reuse. Accessed on 8 Jan 2015.

Jack-Ide, I.O. and Uys, L. (2012). Barriers to mental health services utilization in Niger Delta region of Nigeria: service users' perspectives. *The Pan African Medical Journal.* 13(3): 15.19

Jack-Ide, I.O. and Uys, L. (2012). Barriers to mental health services utilization in Niger Delta region of Nigeria: service users' perspectives. *The Pan African Medical Journal.* 13(3): 15.19

Jack-Ide,.I.O., Uys, L.R. and Middleton, L.E. (2012). A Comparative Study of Mental Health Services in two African Countries: South Africa and Nigeria. *International Journal of Nursing and Midwifery;* 4(4). 50-57

Jegede, A.S. (1996). Social epidemiology. In Oke, EA and Owumi, B.E. (eds). Readings in Medical Sociology. Ibadan:RDMS Books. 52-71.

Jegede, A.S. (2001). "Asian as a social term"in Nigeria Perspective of Illness. *Journal of the Nigeria Anthropological and Sociological Association;* 3(2).p.1-8.

Jegede, A.S (2002). The Yoruba cultural construction of health and illness. *Nordic journal of African studies*. 11(3); 322-335.

Jegede, A.S. (2010). "Mental Health." In *African Culture and Health*, enlarged edition. Ibadan: Bookwright Publishers (Nigeria)

Johnson, R. B., Onwuegbuzie, A. J. and Turner, Lisa A. (2007). Toward a Definition of Mixed Methods Research *Journal of Mixed Methods Research* 2007; 1; 112; accessed on June 20, 2012 from http://mmr.sagepub.com/cgi/content/abstract/1/2/112

Kabir, M., Iliyasu, Z. and Aliyu, M.H. (2004). Perception and beliefs about mental illness among adults in Karfi village, northern Nigeria;*BMC International Health Human Rights.*4: 3; Accessed 19th Nov 2013 from http://www.biomedcentral.com/1472-698X/4/3/prepub Published online 2004 August 20. doi: 10.1186/1472-698X-4-3

Kelley E, Hurst J. *Health care quality indicators project. Conceptual framework paper*. Paris, Organisation for Economic Co-operation and Development, 2006 (OECD Health Working papers no. 23) (http://www.oecd.org/dataoecd/1/36/36262363.pdf).

Kessler, Rodger (2012). Mental Health Care Treatment Initiation When Mental Health Services Are Incorporated into Primary Care Practice. *JABFM.* Vol. 25, No.2: pp. 255-259; available onhttp://www.jabfm.org, retrieved on Feb. 25, 2013.

Kissekka, M.N. (1982). Psychocultural Stress and African Women; *African Journal of Mental Health;* 1(1). 44-59

Kwong, Kenny, Chung Henry, Cheal Karen, Chou Jolene C. and Chen Teddy (April 2013). Depression Care Management for Chinese Americans in Primary Care: A Feasibility Pilot Study,*Community Mental Health Journal* volume 49, Issue 2, pp. 157-165

Kyari, F. (2014). An Ideal Service for glaucoma would…'. *Community Eye Health Journal;* Vol. 27, No. 87. P. 52

Lancet Global Mental Health Group (2007). Scale up services for mental disorders: a call for action. *Lancet*; 370: 1241–52.

Makanjuola, R. (2015). "The Burden of Mental Health Problems," Mental Health Care in Nigeria. A Webinar Internet Conference in December 2015.

Malvárez, Silvina (2008). *Global Perspectives on Mental Health:* Tenth Annual Conference. Pan American Health Organization (Louisville, USA, April)

Mauer, B.J. (2009). *Behavioural Health/Primary Care Integration and the Person-Centred Healthcare Home.* Washington DC: National Council for Community Behavioural Healthcare; retrieved on Jan 23, 2013 from http://www.TheNationalCouncil.org

Mauer, B., and Reynolds, K. (2008) Getting started with collaborative care: Working all aspects of the four quadrant model. Presented to National Council for Community Behavioral Healthcare conference, May 2008.

Mulligan, D. (2013). Barriers faced by people with Disabilities*; Community Eye Health Journal;* 26 (81). P.8

Multiple Cluster Indicator Survey, Nigeria (2011). Accessed on May 16, 1013 from http://www.mamaye.org.ng/evidence/multiple-cluster-indicator-survey-nigeria-2011,.

Murray C, and Frenk J. (2000). World Health report: a step towards evidence-based health policy. *Lancet*, 2001, 357:1698-1700.

Murray C.J.L. and Lopez, A.D. (1996). "The Global Burden of Disease", World Health Organization, Geneva Table 5.4 page 270

Mwape, L., Sikwese, A., Kapungwe, A.Mwanza, J.Flisher, A.Lund, C.and Cooper, S. (2010). Integrating mental health into primary health care in Zambia: a care provider's perspective, *International Journal of Mental Health Systems* 2010, 4:21,Accessed 23/1/12 from http://www.ijmhs.com/content/4/1/21

Nairaland (2011). What really are the major problems with primary health care in Nigeria? Retrieved on 09 May, 2013 from http://www.nairaland.com/nigeria/topic-471320.0.html

National Coalition for the Homeless [NCH] (2004). *Who is Homeless?* Retrieved May 2013 from http://www.nationalhomeless.org/who.html

National Population Commission (NPC) and ICF international (2014): *Nigeria Demographic and Health Survey 2013* Abuja: Nigeria, and Rockville, Maryland USA: NPC and ICF international.

National Population Commission (NPC) 2010; National Population Census. Abuja Nigeria

National Council for Community Behavioural Healthcare (2009). Behavioral Health / Primary Care Integration and the Person-Centered Healthcare Home; available at www.TheNationalCouncil.org/ResourceCenter; accessed Aug 12, 2012

National Strategic Health Development Plan (NSHDP) 2010-2015

NPHCDA (2007). Minimum Standards for Primary Health Care in Nigeria:PATHS2/FMOH/UKaid

Odejide, A.O., Morakinyo, J.J., Oshiname, F.O., Omigbodun, O., Ajuwon, A.J. and Kola, L. (2010) *Integrating mental health into primary health care in Nigeria: management of depression in a local government (district) area as a paradigm.* Accessed on Jan 23, 2013 from http://www.ncbi.nlm.nih.gov/pubmed/12607921

Oke, E.A. (1995). Traditional Health Services: An Investigation of Providers and the Level and Pattern of Utilization among the Yoruba. *Ibadan: Ibadan Sociological Series, No. 1*

Olayinka, A. and Olutayo, A.O. (2013). The Macro-sociological Theories, in Olutayo, A.O. and Olayinka, A.(ed) *Sociological Theory for African Students.* First edition. Ibadan: Ibadan University Press. Pp.25-69

Olusegun, A. P. (2010). Nigerian Health Care System – A ticking time bomb. Retrieved on 23 Jan 2013 from (http://www.nigeriaplus.com/nigerian-health-care-system-a-ticking time bomb-1-by-adepoju-paul-olusegun/

Oluwabamide, A. J. and Umoh, J.O., (2011). An Assessment of the Relevance of Religion to Health Care Delivery in Nigeria: Case of Akwa Ibom State. *Journal of Sociology and Social Anthropology*, 2(1): 47-52

Omigbodun, Olayinka O. (2001). A Cost-Effective Model for Increasing Access to Mental Health Care at the Primary Care Level in Nigeria, *The Journal of Mental Health Policy and Economics* No.4, 133-139

OSMH (Orilla Solders' Memorial Hospital)/WHO (2003).*Community Mental Health Services*; available at www.osmh.on.ca/programs; accessed Jun 4, 2014.

Otani K, Waterman B, Faulkner KM, Boslaugh S, Dunagan WC. 2010 How patient reactions to hospital care attributes affect the evaluation of overall quality of care, willingness to recommend, and willingness to return. Journal of Healthcare Management. 2010;55(1):25-37.

Osungbade, K.O. andSiyanbade S.L. (2010). Myths, misconceptions, and misunderstandings about epilepsy in a Nigerian rural community: implications for community health intervention

Padula WV, Mishra MK, Makic MB, Sullivan PW. (2011). Improving the quality of pressure ulcer care with prevention: A cost-effectiveness analysis. Medical Care. 2011;49(4):385-92.

Patkai, Istvan (2009). Conceptual Changes in Mental Health and CBR;- An oral presentation at the Workshop on Community Based Rehabilitation (CBR) and Mental Health – Hotel Prince Palace Mahanak, 18-20 February, 2009

Pastore, P., Griswold, S., Homish, G.G., and Watkins, R. (2013). Family Practice Enhancements for Patients with Severe Mental Illness, *Community Mental Health Journal*, Volume 49, Issue 2, pp. 172-177

Polit *et al:* (2007). Understanding the value of Qualitative Research. *Nursing Times;* 103(8): 32 33; available at www.nursingtimes.net/02/m/f. accessed Feb 19, 2014

Public Health Foundation of Nigeria, PHFN, (2015). Mental Health Care in Nigeria. A Webinar Internet Conference in December 2015.

Project Launch (2013). Making the Case for Integrating Behavioural health into Primary care.

Reid R, Haggerty J, McKendry R. (2002). *Defusing the confusion: concepts and measures of continuity of healthcare*. Ottawa, Canadian Health Services Research Foundation. Retrieved on May 23, 2013; available at (http://www.chsrf.ca/funding_opportunities/commissioned_research/projects/pdf/def

Rademakers J, Delnoij D, de Boer D. (2011). Structure, process or outcome: which contributes most to patients' overall assessment of healthcare quality? BMJ Qual Saf;20:326-31.

Read, M. (1966). *Culture, Health and Disease: Social and Culture Influence in Health Programs in Developing Countries*. London: Tavisk publications J.B. Lippincot company.

Ritzer, G. (2012). *Sociological Theory*, 8th edition. New York: Mc Graw Hill.

Rochefort CM, Clarke SP. Nurses' work environments, care rationing, job outcomes, and quality of care on neonatal units. Journal of Advanced Nursing. 2010;66(10):2213-24

Royal College of Obstetrics and Gynaecology (2011). *Management Mental Health Issues during Pregnancy and Postnatal Period.* Good Practice No.14. RCO&G

Safaei, J. (2012). Socio-economic and Demographic Determinants of Mental Health across Canadian Communities. *The Internet Journal of Mental Health.* 8(1): available at http://ispub.com/IJMH/8/1/14282, accessed Aug. 9, 2014.

Safiyanu, 2014). *Kaduna State Primary Health Care Development Agency Local Government Area (KDSPHCDA LGA) Health Operational Plan Manual* published in March 2014. (p.6)

Saultz JW (2003). Defining and measuring interpersonal continuity of care. *Annals of Family Medicine*, 1:134–143. (http://www.annfammed.org/cgi/content/full/1/3/134).

Saving Newborn lives in Nigeria (2009).Newborn health in the Onset of the Integrated Maternal, Newborn and Child Health Strategy: Abuja: FMOH, the children, Access

Saxena S, Thornicroft G, Knapp M, Whiteford H. (2007). Resources for mental health: scarcity, inequity, and inefficiency. *Lancet*; 370: 878–89.

Scheff, T. (1966). *Being Mentally Ill.* 2nd Edition. Piscataway: Aldine Transaction

Shekhar Saxena, Michelle Funk, Dan Chisholm (2013). Department of Mental Health and Substance Abuse, World Health Organization, CH-1211, Geneva, Switzerland saxenas@who.int

Simmons R, Fajans P, Ghiron L. (2007). Introduction. In: Simmons R, Fajans P, Ghiron L, eds. Scaling up health service delivery: from pilot innovations to policies and programmes. World Health Organization, Geneva: vii–xvii.

Smith, PC, Mossialos E, Papanicolas I. (2008). *Performance measurement for health system improvement: experiences, challenges and prospects*. Copenhagen, WHO Regional Office for Europe. Retrieved on 23May 2013; available at http://www.euro.who.int/document/hsm/2_hsc08_ebd2.pdf.

Starfield B et al. Continuity and coordination in primary care: their achievement and utility. *Medical Care*, 1976, 14:625–636.

Thornicroft, G. and Tansella, M. (2003) *What are the arguments for community-based mental health care?* Copenhagen, WHO Regional Office for Europe (Health Evidence Network report;http://www.euro.who.int/document/E82976.pdf, accessed 29 May 2013).

Tope-Ajayi, F. (2004). *A Guide to Primary Health Care Practice in Developing Countries, 4th Edition.* Rotimi Excels Production, Akure.

Townsend, J.M. (1978). *Cultural Conceptions and Mental Illness: The Comparison of Germany and America.* Chicago: The University of Chicago Press.

Townsend, M.C. (2006). Community Mental Health Nursing; In *Psychiatric-Mental Health Nursing. 4th edition.* Philadelphia: F.A. Davis (pp. 835 – 861).

UCLAISAP.org (2013). What is Health Care Reform? Primary Care/Behavioral Health Integration. Accessed on 24th May 2013 from http://www.uclaisap.org/Affordable-Care Act/index.html *and* http://www.uclaisap.org/Affordable-Care-Act/html/performance measurement.html

VanCleve, S.N., Hawkins-Walsh, E. and Shafer, S. (2013). Integrating Mental Health in Pediatric Primary Care; *Journal for Nurse Practitioners.* 2013;9(4):243-248. Accessed 24 May 2013 from http://www.medscape.com/viewarticle/782535_1

Vogel, Ronald J. (1993); Financing Health Care in Sub-Saharan Africa Greenwood Press. pp 18.

Ward, E.C, Wiltshire J.C., Detry M.A. and Brown R.L. (2013). African American Men and Women's Attitude Toward Mental Illness, Perceptions of Stigma, and Preferred Coping Behaviors. *Nursing Research*. 62(3):185-94 (May-Jun). Accessed on 11 June 2013 from http://www.ncbi.nlm.nih.gov/pubmed/23328705

Wakerma, J., Humphreys, J.S., Wella, R., Kuipers, P., Entwistle, P., and Jones, J. (2008). Primary health care delivery models in rural and remote Australia – a systematic review. *BMC Health Sciences Research.* 8:278 doi:10.1186/1472-6963-8-276 available online at: http://www.biomedcentral.com/1472-6963/276. Accessed 23/6/2015

Waziri, 2014). *Kaduna State Primary Health Care Development Agency Local Government Area (KDSPHCDA LGA) Health Operational Plan Manual* published in March 2014. (p.5).

WHO (1978). *Alma-Ata 1978: Primary Health Care.* Report of the International Conference on Primary Health Care Alma-Ata, USSR, 6-12 September 1978. World Health Organisation, Geneva.

WHO (1978). Primary Health Care. Report of the International Conference on Primary Health Care, Alma-Ata, USSR. Geneva, World Health Organisation.

WHO (2001). Health systems performance: glossary [web site]. Geneva, World Health Organization, 2001 (http://www.who.int/health systemsperformance/docs/glossary.htm).

WHO/World Bank (2004). The Cost-Effectiveness of Primary Care Services in Developing Countries: A Review of the International Literature. Working Paper No. 37. Disease Control Priorities Project.

WHO (2006). Constitution of the World Health Organization. Basic documents, forty-fifth edition, supplement, October, 2006. Geneva: World Health Organization.

WHO (2006). How can the human rights of people with mental disorders be promoted and protected? Available at http://www.who.int/features/qa/43/en/index.html May 28, 2012.

WHO (2007).Developing Community Mental Health Service *Report of the Regional Workshop Bangkok, Thailand, 11-14 December 2006:* World Health OrganizationRegional Office for South-East Asia New Delhi, August 2007.

WHO (2007). What is mental health? Acessed on May 28, 2012 from http://www.who.int/features/qa/62/en/index.html.

WHO (2007). Developing Community Mental Health Service *Report of the Regional Workshop Bangkok, Thailand, 11-14 December 2006:* World Health Organization: WHO Regional Office for South-East Asia New Delhi, August 2007

WHO (2008). WHO calls for urgent scaling up of services for mental disorders, especially in the developing world at http://www.who.int/mediacentre/news/releases/2008/pr37/en/index.html

WHO (2008). mhGAP Mental Health Gap Action Programme: scaling up care for mental, neurological and substance use disorders. Geneva: World Health Organization.

WHO (2008).Bulletin of the World Health Organization | September 2008, 86 (9)

World Health Report (2008). Primary Health Care: now more than ever.Geneva: WHO

WHO (2010). Mental Health and Development report. Accessed May 3, 2013 from http://whqlibdoc.who.int/publications/2010/9789241563949_eng.pdf

WHO 2009. Need to address mental disorders in children: WHO calls for action on World AutismAwareness Day: accessed on May 16, 2013 from http://www.who.int/mediacentre/news/releases/2009/autism_children_20090402/nnde.html

WHO (2010). Mental health: strengthening our response Fact sheet No. 220 available at http://www.who.int/mediacentre/factsheets/fs220/en/index.html. accessed May 28, 2012.

WHO (2010). WHO simplifies treatment of mental and neurological disorders: New *Intervention guide* to facilitate the management of depression, alcohol use disorders, epilepsy and other common mental disorders in the primary health-care setting, available at http://www.who.int/mediacentre/news/releases/2010/mental_health_20101007/enidex. tml

WHO (2010). People with mental disabilities cannot be forgotten. WHO urges development programmes to include people with mental and psychosocial disabilities AT http://www.who.int/mediacentre/news/releases/2010/mental_disabilities_2010091/ n/index.html

WHO (2010) *International Statistical Classification of Diseases and Related Health Problems* 10th Revision Version for 2010) (ICD-10). Geneva; WHO Publications.

WHO (2011).New psychological first aid guide to strengthen humanitarian relief: Improving the mental health of disaster affected populations, at http://www.who.int/mediacentre/news/releases/2011/humanitarian_relief_2011089 en/index.html

WHO (2012). Depression: *a global crisis World Mental Health Day, October 10, 2012* UNESCA/MoH, 2004

WHO (2012). Dementia cases set to triple by 2050 but still largely ignored available at http://www.who.int/mediacentre/news/releases/2012/dementia_20120411/en/indx html.

WHO 2012. New WHO report: *Dementia: a public health priority*

WHO (2012). Dementia. Retrieved on May 02, 2013, from http://www.who.int/mediacentre/news/releases/2012/dementia.

WHO (2013). Mental disorders. Retrieved on May 02, 2013 from http://www.who.int/topics/mental_disorders/en/2013

WHO (2013). Draft comprehensive mental health action plan 2013–2020. Accessed on May 16, 2013 from http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_10Rev1-en. pdf.

WHO (2013). Health Topics: Mental Health and Mental Disorders, available at *(http://www.who.int/topics/mental_disorders/en/, 2*013. Accessed on 21/5/2013

WHO-AIMS Report (2006). Mental Health System in Nigeria: *A report of the assessment of the mental health system in Nigeria using the World Health Organization – Assessment Instrument for Mental Health Systems (WHO-AIMS).* Ibadan, Nigeria.

WHO/Europe (2005). *WHO Regional Committee for Europe resolution EUR/RC55/R8 on strengthening health systems as a continuation of the WHO Regional Office for Europe's Country Strategy "Matching services to new needs"*. Copenhagen, WHO Regional Officefor Europe,2005.Retrieved:23/5/2013;from(http://www.euro.who.int/Governance/resolutions).

WHO/Europe (2012). *Primary Care Evaluation Tool.* Retrieved from http:// euro.who.int/document/ on 23 April 2013

WHO/Europe (2012). *WHO Regional Office for Europe meeting on strengthening primary care contribution to the prevention and control of non-communicable diseases*. Retrieved 2 April 2013 from (http://www.euro.who.int/pubrequest)

WHO Report (2011). WHO highlights global underinvestment in mental health care; accessed on 21/5/2013:http://www.who.int/mediacentre/news/notes/2011/mental_health: Geneva

World Mental Health Day [WMHD] (2004). *The Relationship Between Physical and Mental Health: Co-Occurring Disorder:* World Federation for Mental Health. Retrieved on Jan. 23, 2013 from http://www.wmhday.net

World Mental Health Day [WMHD] (2009): *Mental Health in Primary Care: Enhancing Treatment and Promoting Mental Health.* World Federation for Mental Health. Retrieved on Jan. 23, 2013 from http://www.wmhday.net

World Mental Health Day (2010). Retrieved on May 02, 2013 from http://www.wfmh.org/00WorldMentalHealthDay.htm 2010

World Mental Health Day [WMHD] (2011): *The great Push: Investing in Mental Health.* World Federation for Mental Health. Retrieved on Jan. 23, 2013 from http://www.wmhday.net

WHO Report (2010). *Health System Financing: The Path to Universal Coverage.* Geneva:WHO.

WHO/WFMH (2009). Integrating mental health into primary care: *A global perspective.* Geneva: WHO

WHO/Wonca (2007). Integrating mental health services into primary health care: Mental Health Policy, Planning and Service Development Information Sheet, Sheet3.Geneva, World Health Organization; accessed on 21/05/2013 from http://www.who.int/mental_health/policy/services/en/index.html,

WHO/Wonca (2008). *Integrating Mental Health into Primary Care: A Global Perspective*. Geneva: WHO. pp. 21-55.

www.improvingchroniccare.org (2014). Chronic Care Model.

www.onlinenigeria.com (2013). Social Infrastructure; accessed on 18?03/2014 from Http://Www.Onlinenigeria.Com/Links/Benueadv.Asp?Blurb=214#Ixzz2wisz9b7i: PostedTo The Web: 1/29/2003 12:59:23

APPENDICES

Appendix A:

Survey Questionnaire for Primary Health Care (PHC) Workers

I am a postgraduate student of the Department of Sociology, Ahmadu Bello University Zaria, undertaking a study, ***Analysis of the Provision of Mental Health Care Services at the Primary Health Care Level in Northern Nigeria,*** aimed at investigating efficiency and effectiveness of mental health care services at the primary health care level in Northern Nigeria. Information is required from the relevant primary healthcare professionals to enable me achieve this. You are one of such required professionals. Kindly provide sincere responses to the questions in this questionnaire to assist me gather valid information. The information is strictly for academic purposes and will be treated with utmost confidentiality please.

Thank you for anticipated cooperation.

Anyebe, EE

Section A: Respondent's Socio-demographic Data

1. Name of PHC centre: .....
2. LGA/State: ……..……
3. What is your age (in years)? .....
4. What is your sex? a) Female [ ] b) Male [ ]
5. Ethnic group: .....……
6. Religion: …….....……..
7. Rank/Position: .....
8. Profession (occupational specialty): …….
9. Highest educational attainment: ……

Marital status: a) Single [ ] b) Married [ ] c) Widow(er) [ ] d) Divorced [ ]

Section B: Mental health services in the Primary Health Care centres

Objective 1a: To assess the Availability of Mental Health Care Services at the Primary Health Care level

10. Do have you a section or room at your centre used for mental health care services? a. Yes [ ] b. No [ ]
11. Are you aware of any new mental health programmes implemented in PHC or community settings (either Government, NGO or combined)? a. Yes [ ] b. No [ ]. *If No,* skip Questions 12 – 16.
12. If Yes, Please list these: ……
13. For each new programme, please state if it is at a local, State or national level or international NGO: …….
14. What is the main organization running them: ……
15. State the focus of the service: ……
16. Do you have any of these services (either as pilots or scaled) been formally evaluated? Yes [ ] No[ ]
17. In your opinion, over the years, how can you rate mobilizing funding for mental health-related activities in your community/PHC? (***Tick one***): a. Much harder [ ] b. Harder [ ] c. Equally hard [ ] d. Easier [ ] e. Much easier [ ]
18. Have any funds/funding being made available specifically for mental health services in your Centre? (a) Yes [ ] (b) No [ ]. ***If No, go to Question 21***

19. If yes, which body provided the funding? (please tick as many as applicable) (a) International organizations (NGOs, donor agencies, UN agencies, foreign government funds etc) [ ] (b) The Federal Government [ ] (c) state government [ ] (d) Local Government [ ] (e) Local NGO [ ]
20. Please list new funds/funding streams made available for research related to mental health in your State if any: ……
21. Have there been any new information resources to guide mental health practice (e.g. intervention guidelines/packages, training materials in the last five years that you are aware of? (a) Yes [ ] (b) No [ ]. ***If no, go to Question 23***
22. If yes, please list any of these. ……
23. In your community, how will you rate the progress that has been made towards scaling up mental health services at your centre (***tick one***): a. Very Poor [ ] b. Poor [ ] c. No change [ ] d. Good [ ] d. Very Good [ ]
24. In your opinion, for the past five (5) years, how will you rate attempt to provide mental health services in your centre by nongovernmental organisations (NGOs)/civil sector (tick one): a. Very Poor [ ] b. Poor [ ] c. Fair [ ] d. Good [ ] e. Very Good [ ]
25. In your opinion, for the past five (5) years, how will you rate attempt to provide mental health services in your centre by government? (Tick one): a. Very Poor [ ] b. Poor [ ] c. Fair [ ] d. Good [ ] e. Very Good [ ]

Objective 1b: To Assess the Accessibility of Mental Health Care Services at PHC centres

26. Are you aware of any new organisations (whether local, State, national, or global) that have been established within the past five (5) years which have as one of their aims to improve access to mental health services in your State? (a) Yes [ ] (b) No [ ]. ***If No, go to Question 28***
27. If yes, mention them: .....
28. Are there any major new initiatives by any organisations aimed at promoting improved mental health care services in your State? (a) Yes [ ] (b) No [ ]. ***If No, go to Question 30***
29. If Yes, please list any of these. ……
30. In your opinion, what has been the level of awareness of health planners about the need to scale up mental health services? a. Very low [ ] b. Low [ ] c. Fair [ ] d. Good [ ] e. Very Good [ ]
31. Are you aware of Mental Health Day celebration? (a) Yes [ ] (b) No [ ], *If No, go to Question37*
32. If Yes, what date is it celebrated? ……
33. To what extent has the celebration of this (mental health awareness) day met its goals and the content in your State/community. a. Not at all [ ] b. Just few mentioned [ ] c. Fair [ ] d. Well [ ] e. Very well [ ]
34. What has been the committment of your local health authority to this day? a. Not at all [ ] b. Just mentioned [ ] c. Fair [ ] d. Well [ ] e. Very well [ ]
35. Do communities participate in the awareness celebration? (a) Yes [ ] (b) No [ ]
36. What is the extent of the community participation? a. Just mentioned [ ] b. Fair [ ] c. Well [ ] d. Very well [ ]
37. Are there any comprehensive mental health service focused on any particular group in your centre? a. Yes [ ] b. No [ ]
38. Which group(s) of people do you consider vulnerable to mental illness? *(Tick as many as you consider correct)*

i. Children from birth to 13 years [ ]
ii. Adolescents aged 14 to 19 years [ ]
iii. Young people aged 20 to 29 years [ ]
iv. Middle age 30 to 45 years [ ]
v. Adults aged 45 to 60 years [ ]
vi. Elderly aged 61and above [ ]

37. Kindly indicate your sincere opinions on the availability and adequacy of the following mental health care services for the indicated categories of patients in your centre in the Table below.

S/No	Client category	Services			
		Available?		If yes	
		Yes	No	Adequate	Not adequate
i	Children of 13 years and below				
ii	Adolescents aged 14 to 19 years				
iii	Young people aged 20 to 29 years				
iv	Middle age 30 to 45 years				
v	Adults aged 45 to 60 years				
vi	Elderly aged 61and above				

Objective 1c: To Assess the Desirability and Acceptability of Mental Health Care Services alongside other components of Primary Health Care centres

38. Do you think mental health care services should be provided together with other primary health care services in your PHC centre? a) Yes [ ] b) No [ ] *If No, go to Question 40*
39. If yes, state your reasons for wishing that mental health care services should be provided together with other primary health care services in your centre in the Table below, by kindly ticking **strongly agree (SA), agree (A), neutral (N), disagree (D)** and **strongly disagree (SD)** in the following statements according to your opinion.

S/no	Statement	SA	A	N	D	SD
i.	The burden of mental disorders is great					
Ii	Mental and physical health problems are interwoven					
Iii	The treatment gap for mental disorders is enormous					
Iv	Primary care for mental health enhances access.					
V	Primary care for mental health promotes respect for human rights					
Vi	Primary care for mental health is affordable and cost effective					
Vii	Primary care for mental health generates good health outcomes					
Viii	Your State has a legal framework (a Law) that adequately protects the rights of people with mental disorders.					

40. Which of the plans and services in the Table below do you think are ***available in your centre*** that support providing mental health care at the primary health care level? Kindly tick: **Strongly agree (SA), Agree (A), Neutral (N), Disagree (D)** and **Strongly Disagree (SD)** in the following statements to indicate your opinion.

S/no	Statement	SA	A	N	D	SD
i	Government policy and plans incorporate primary care for mental health.					
ii	There is advocacy to change attitudes and behaviour toward mental illness					
iii	There is adequate training of primary health care workers					
iv	Primary care tasks are limited					
v	Specialist mental health professionals are available to support primary care					
vi	Specialist mental health facilities (e.g. specialist psychiatric hospitals/departments) are available to support primary care					
vii	Patients have access to essential psychotropic medications (drugs used to treat mental illnesses) in primary care					
viii	Providing mental health services has been a continuous process in my centre					
ix	There is a mental health service coordinator in my centre					
x	There is collaboration with other government non-health sectors					
xi	There is collaboration with non-governmental organizations					
xii	There is collaboration with village and community health workers, and					

	volunteers in my centre					
xiii	Financial resources for mental health care are adequately provided					
xiv	Human resources for mental health care are adequately provided in my centre					
xv	Mental health experts are available by Phone consultation (i.e. telephone to provide consultation on medication management and referral to local mental health specialists)					
xvi	Mental health experts have direct mental health consultation to clients					
xvii	Mental health experts are available by internet consultation (i.e. videoconferencing to provide mental health consultation to children and families and referral to local mental health specialists)					
xviii	There is collaboration between the traditional and the modern health practitioners					
xix	Primary care and mental health clinicians are physically located in the same treatment setting (i.e. co-location)					
xx	Primary care practice operates a collaborative and integrated service (i.e. has mental health clinicians or staff who assess and treat children and families, and facilitate case conferences)					
xx	Persons living with mental disorders have the same rights to treatment as individuals with physical illnesses;					
xxi	Comprehensive delivery of mental health services through primary health care is ensured in my centre					
xxii	There is a programme promoting healthy attitudes particularly among youth towards mental health and illness					
xxiii	There is a programme promoting positive socio-cultural attributes particularly among youth towards mental health and illness					
xxiv	There is a programme or measures to reduce the problems of alcohol and drug abuse					
xxv	Special care are provided to different disadvantaged minority groups in the community;					
xxvi	NGOs are encouraged in the provision of mental health care services in my centre;					
xxvii	There is an encouragement for mental health related research.					
xxviii	There is funding for mental health related research.					
xxix	There is a list of essential medicines (drugs) for mental health disorders in my centre					
xxx	There is a standing orders for treating mental health disorders					

Objective 2: To identify the Barriers to the Provision of Mental Health Care Services at Primary Health Care centres

41. In the Table below, identify what you consider as the barriers to implementing mental health services at the primary health care level in your centre. ***Please tick according to your opinions from options SA to SD, where SA=5, A=4, N=3, D=2; SD=1)*.**

S/no	Statement	SA	A	N	D	SD
i.	Lack of advocacy					
ii	Lack of practical implementation of service scale up					
iii	Community rejection of the services					
iv	Stigma about mental health disorders					
v	Lack of political commitment/will					
vi	Lack of policy					
vii	Lack of funds to provide MHS at the PHC					
viii	Misconception of the community about mental illness					

xix	Shortage of skilled PHC workers on mental health					
x	Lack of adequate training for available PHC workers					

42. Indicate any other barrier(s) to providing mental health care services at your PHC centre: .....
...
43. Suggest ways of improving mental health care services in PHC centres generally:.....
.....
.....

PHC Workers' Knowledge of Mental Health and Assessment of their Education/Training Needs

44. In Nigeria, do you think the mental health component of your training is adequate to provide functional mental health services at the PHC level? a. Yes [ ] b. No [ ]
45. Are sufficient credit hours allocated to this component to cover detection of mental illness early in life? a. Yes [ ] b. No [ ]
46. Do you think you need further training to enable you provide mental health care at the PHC level? a. Yes [ ] b. No [ ]
47. List the category(ies) of health workers you think should be trained to provide mental health care services at the PHC centres ***(please list them in order of importance):***
    a. .....
    b. .....
    c. .....
48. Do you think your curriculum of training in the institution where you were trained need to be modified to meet the need for providing mental health care services in the community? a. Yes [ ] b. No [ ]
49. Have there been any new courses specifically related to training you for scaling up mental health services in the last five years? (a) Yes [ ] (b) No [ ]. *If No, go to Question 51*
50. If yes, please list all these. ……
51. Which of these suggestions would you recommend for the mental health curriculum for health workers:
    a. Review the curriculum of health professionals to combat the cultural beliefs prevalent among Nigerian health workers. (a) Yes [ ] (b) No [ ]
    b. Anti-stigma campaigns should start from health workers. (a) Yes [ ] (b) No [ ]
52. Suggest other ways by which the health workers' training on mental health care can be improved to meet the goals of providing these services:.....
.....
53. In the Table below, state **Yes** for the activities you do (and how well you carry out such activities by tciking either ***very well, well or just fair)*** or **No** for the ones you do not do:

S/No	**ITEM**	**Yes**	**No**	**Not sure**	**If Yes, how well?**		
					Very well	Well	Just Fair
i	I know how to communicate with mentally ill people.						
ii	I know how to carry out mental health Assessment on adult patients						
iii	I know how to carry out mental health Assessment on children						
iv	I can treat a mentally ill person adequately						
v	I can devise a plan for treatment continuation and follow-up, in consultation with the person.						
vi	I can address the person's questions and concerns about treatment						
vii	I can communicate realistic hope for better functioning and recovery.						

viii	I can continually monitor for treatment for mental illness						
ix	I can facilitate referral to specialists, where available and as required.						
x	I make efforts to link the mentally ill person to community support.						
xi	I can encourage self-monitoring of mental illness symptom to enable patient seek care immediately.						
xii	I can document key aspects of interactions with the mentally ill person and the family in the case notes.						
xiii	I can use family and community resources to contact clients who have not returned for regular follow-up.						
xiv	I can ensure that the mentally ill people are treated to meet their mental health needs at the same time						
xv	I can mobilize possible sources of social and community support in the local area.						
xvi	I provide social support for social challenges that a mentally ill person may face						
xvii	I encourage involvement in self-help support groups.						
xviii	Icoordinate schools to mobilize educational support for children and adolescents						
xix	Icoordinate schools to mobilize social support for children and adolescents						
xx	I know how to keep the mentally ill persons' confidentiality						
xxi	I know how to promote the social inclusion of people with mental disorders						
xxii	I know how to educate people about harmful substance abuse						
xxiii	I know how to provide education about other risky behaviours						
xxiv	I know how to prepare people for developmental life changes						
xxv	I know how to support people for developmental life changes						
xxvi	I know how to prevent stigma associated with mental illness						

Section C: Health Workers' Perceptions about mental illness

Objective 3: The perceptions and attitudes of PHC professionals toward mental illness

54. ***Instruction:*** for each of the following, please indicate the answer that best describes how you ***perceive***mental illness and the mentally ill person, by ticking the relevant spaces provided.

S/N	Item	SA	A	N	D	SD
A	**Labelling**					
	i. I dislike living with someone who has a mental illness					
	ii. To avoid rejection, the mentally ill should hide obvious symptoms of their illness					
	iii. I think I would not employ someone who has a history of mental illness					
	iv. I think I would not marry someone who has a history of mental					

		illness					
	v.	I think public attitudes to mental illness affects people with mental illness as citizen					
B	**Stereotyping**						
	i.	I sometimes feel afraid to talk to someone who has a mental illness					
	ii.	I think receiving care in a psychiatric hospital is a sign of personal weakness					
	iii.	I think that a person who has mental illness is dangerous to others					
	iv.	I think I would feel ashamed if others knew someone in my family had mental illness					
	v.	I feel mentally ill people are potentially dangerous.					
	vi.	Mentally ill people are violent					
	vii.	I feel People with mental illness are irresponsible					
C	**Perceptions about mental illness**						
	i.	Children (13 years and below) are affected by mental illness					
	ii.	Adolescents (from 14 – 19) are affected by mental illness					
	iii.	All people who kill themselves have mental illness					
	iv.	Mental disorders are one of the most prominent and treatable causes of suicide.					
	v.	War, civil disturbances and other major disasters increase the rates of mental disorders tend to double after emergencies.					
	vi.	Mental disorders are among the risk factors for communicable and non-communicable diseases.					
	vii.	Mental disorders can also contribute to unintentional and intentional injury					
	viii.	Poor parenting causes mental illness					
	ix.	Mental illnesses are due to stress					
	x.	Mental illnesses are due to a lack of willpower					
	xi.	In our community mentally ill patients are chained or have the limbs tied with ropes or other materials (physical restraint).					
	xii.	In our community mentally ill patients are locked up alone in a separate apartment.					
	xiii.	In our community mentally ill patients are denied of basic needs					
	xiv.	In our community mentally ill patients are denied of privacy.					
	xv.	In our community mentally ill patients' right are protected by the law					
	xvi.	Mentally ill people have a weak character.					
D	**Preferred Treatment for mental illness:**						
	i.	Treatment for mental illness do not work					
	ii.	Orthodox (modern) medicine is the best treatment for mental illness					
	iii.	Traditional treatment is the best treatment for mental illness					
	iv.	Religious (spiritual) healing by Imam/Priest/religious leaders (clergy) is the best treatment for mental illness					
	v.	Combining orthodox and traditional medicines is the best treatment for mental illness					
	vi.	Combining orthodox and spiritual healing is the best treatment for mental illness					
	vii.	Combining orthodox, spiritual and traditional medicines is the best treatment for mental illness					
E	**Stigma about mental illness:**						

	i.	Because of the stigma associated with mental illness, people do not want to talk about the illness.					
	ii.	Stigma about mental disorders and discrimination against patients prevent people from seeking mental health care.					
	iii.	Stigma about mental disorders and discrimination against families prevent people from seeking mental health care for mentally sick members.					
	iv.	Not talking about the disease can result in delays in diagnosis and treatment.					
	v.	Families are often reluctant to talk about mental illness because they:					
	b.	Feel guilty or ashamed.					
	c.	Have the added burden of trying to 'cover up' the illness.					
F	**(Consequences) When people do not address mental illness, there will be:**						
	i.	Loss of productivity for the ill persons					
	ii.	Loss of productivity for their family members.					
	iii.	Higher health care costs.					
	iv.	Self-medication					
	v.	Marital crisis					
	vi.	Mental illness getting much worse.					
	vii.	Physical health getting much worse.					
	viii.	Frustration over unmet expectations at school.					
	ix.	Frustration over unmet expectations at work.					
	x.	Trouble with the law.					
	xi.	Social isolation.					
	xii.	Trouble getting a job					
	xiii.	Trouble finding a place to live.					
G	**Suggestions on Eliminating/Reducing Stigma of mental illness:**						
	i.	Incorporate anti stigma educational programmes into the mental health policies of my State					
	ii.	Anti-stigma programmes should focus on identifying the population at risk, and properly address the causes of mental illness					
	iii.	There is need for intensive public awareness, effective stigma-reducing educational programmes					
	iv.	There is need for more research in this area.					

55. State any other suggestion (s) to reduce stigma associated with mental illness in the community:

i. .....

ii. .....

Thank you for taking the time to complete the survey. I appreciate your assistance.

Appendix B: Household survey Questionnaire

Dear respondent
I am a postgraduate student in the Department of Sociology, Ahmadu Bello University, Zaria conducting a study on: ***Analysis of the Provision of Mental Health Care Services at the Primary Health Care Level in Northern Nigeria,*** aimed atinvestigating efficiency and effectiveness of mental health care services at the primary health care level in Northern Nigeria. This questionnaire has been designed for the purpose of data collection.

The researcher will appreciate your honest responses to make this study worthwhile.

Information provided will help to enhance the provision of mental health services especially at the primary level in Nigeria particularly in the northern region with its peculiarities.

Be assured that the information provided will be used for the purpose of this research only: no part of the information will be linked to any person as strict confidentiality is assured.

Thank you.
Anyebe, EE

INSTRUCTION:
Please answer the questions that follow and return the completed questionnaires.

Section A: Respondent's Socio-demographic Data

Name of Community: ……..
LGA/State: …….

1. What is your age (in years)? **.....**
2. Sex: a) Female [ ] b) Male [ ]
3. Ethnic group (tribe): ……
4. Religion: ……..
5. Profession (occupational specialty): …….
6. Highest formal educational attainment: ……
7. Monthly income: ……

Objective: Assessing availability, accessibility, acceptability of mental health care services:

8. Are you aware of any Primary Health Care (PHC) centre in your community? a. Yes [ ] b. No [ ]. ***If No, go to Question 18.***
9. Is the PHC centre too far from your house? a. Yes [ ] b. No [ ]
10. Are health workers readily available at the centre to attend to you? a. Yes [ ] b. No [ ]c. Don't know [ ]
11. Are drugs readily available? a. Yes [ ] b. No [ ] c. Don't know [ ]
12. Are you aware of mental health care services in your PHC centre? a. Yes [ ] b. No [ ] c. Don't know [ ]. ***If NO, skip Questions 13 to 17***
13. If yes, is there a service area (a place) for mental health services in the centre? a. Yes [ ] b. No [ ] c. Don't know [ ]
14. Are these services easy to get? a. Yes [ ] b. No [ ]c. Don't know [ ]
15. Are the services free? a. Yes [ ] b. No [ ]c. Don't know [ ]
16. Do you think these services are acceptable by community members a. Yes [ ] b. No [ ]
17. Do you think these services are available for all groups in the community? a. Yes [ ] b. No [ ]

Awareness of mental health programmes in the community

18. Have you heard of mental health awareness campaign before? a. Yes [ ] b. No [ ]
19. Have you witnessed any in your community? a. Yes [ ] b. No [ ]
20. Have you participated in any? a. Yes [ ] b. No [ ]
21. What were the activities? ……..……
22. Do you think there is need to get more information on mental health issues a. Yes [ ] b. No [ ] *If No, skip Question 23.*
23. If Yes, what do you think are the best ways of doing that? *Please tick as appropriate*

S/No	Source of information	Most preferred	Preferred	Just preferred	Least preferred
i	School				
ii	TV advertisements				
iii	Radio				
iv	Youth magazines				
v	TV shows/series/programmes				
vi	Village meetings				
vii	Newspapers				
viii	Bus-stops				
ix	Youth centres/ arcades				
x	Text messages (sms)				
xi	Talks by people with problems				
xii	Churches/mosques				
xiii	Health talks in PHC centres				
xiv	Online information				
xv	Notice boards				

24. Do you think there is need to get more information about ways of getting help on mental health in the community? a. Yes [ ] b. No [ ]. *If No, skip Question 25*
25. If Yes, what do you think are the best ways of doing that? *Please tick as appropriate*

S/No	Source of information	Most preferred	Preferred	Just preferred	Least preferred
i	School				
ii	TV advertisements				
iii	Radio				
iv	Youth magazines				
v	TV shows/series/programmes				
vi	Village meetings				
vii	Newspapers				
viii	Bus-stops				
ix	Youth centres/ arcades				
x	Text messages (sms)				
xi	Talks by people with problems				
xii	Churches/mosques				
xiii	Health talks in PHC centres				
xiv	Online information				
xv	Notice boards				

26. What other ways will you want the information? ….....
27. How do you feel about the PHC workers in the PHC centre in your community? *Kindly indicate your sincere responses in the Table below*

Attitude towards PHC service providers

	The health workers here:	SA	A	NS	D	SD

i	are experts in their work (know their work very well)					
ii	are really helpful					
iii	won't allow people know you're going about a mental health problem					
iv	won't allow even significant others know					
v	don't insist on appointment before being seen					
vi	Make the PHC centre a comfortable to talk freely					
vii	Make the clinic acceptable					
viii	Is a helper to all patients					
ix	waste a lot of time					
x	Ask too many questions					
xi	Willing to listen and support					
xii	In touch with youth issues					
xiii	Can keep things confidential					
xiv	Good at sorting out problems					
xv	Approachable, accessible					
xvi	Knowledgeable					
xvii	Friendly, easy-going					

28. Have you talked to any health worker at a PHC centre for a professional help in mental health problem before? a. Yes [ ] b. No [ ]. ***If No, skip Question 29***
29. If yes, indicate who you talked to, in the Table below.

S/No	Health worker to contact	Yes	No
i	A community health officer		
ii	A community Health extension Worker		
iii	A nurse		
iv	A medical doctor in the locality		
v	Psychologist		
vi	Social worker		
vii	Psychiatrist		
viii	Don't know the type of personnel		

Objective: To evaluate the perceptions and attitudes of community members toward mental health problems and mental illness, and their roles in the provision of such services at the community level

30. Which of these signs indicate poor mental health? *State your agreement or disagreement on which of these measures promote mental health* by stating SA = Strongly Agree, A = Agree, NS = Not sure, D = Disagree, SD = Strongly disagree)

S/No	Perception	SA	A	NS	D	SD
i	Excessive worrying and thinking					
ii	Lack of concentration.					
iii	Continuous unhappiness without a cause.					
iv	Easy loss of temper/ irritability.					
v	Lack or inadequate sleep.					
vi	Withdrawal (mostly prefer staying alone and keeping to self).					
vii	Upset when the normal routine of life is disturbed.					
viii	People easily get on one's nerves.					
ix	Fear without a cause.					
x	Claiming to be always right					
xi	Others are always wrong					

xii	Suspiciousness.					
xiii	Feelings of numerous aches and pains					
xiv	Lack of control					
xv	Difficulty relating to people					
xvi	Breakdowns					
xvii	Strange thoughts.					
xviii	Inability to plan ahead					
xix	Always boosting beyond what one can actually do/achieve					
xx	Refusing assigned responsibilities/tasks most times					

31. Which of these do you think are signs of mental illness?

S/No	Manifestation	Yes	No
i	Aggression		
ii	Destructiveness		
iii	Talkative		
iv	Eccentric behaviour		
v	Wandering		
vi	Self-neglect		
vii	Nudity/naked		
viii	Restlessness		
ix	Anxiety		
x	Insomnia		
xi	Loss of consciousness		

32. Promotion of Mental Health:State your agreement or disagreement on which of these measures promote mental health by stating**SA = Strongly Agree, A = Agree, N = Neutral, D = Disagree, SD = Strongly disagree)**

S/No	Factor for mental health	SA	A	NS	D	SD
i	Good nutrition.					
ii	Good housing condition.					
iii	Personal hygiene					
iv	Environmental hygiene.					
v	Exercise and recreation.					
vi	Rest and sleep.					
vii	Avoiding conflicts					
viii	Resolving conflicts amicably.					
ix	Stress management.					
x	Suitable jobs.					
xi	Good family support.					
xii	Peaceful at home					
xiii	Peaceful work place.					
xiv	Peaceful school.					
xv	Avoid drug abuse.					
xvi	Accident prevention.					
xvii	Being with family members					

xviii	Being with friends and colleagues					

33. **Perceived causes of mental illness:**State your agreement or disagreement on which of these measures to promote mental health: **SA = Strongly Agree, A = Agree, N = Not sure, D = Disagree, SD = Strongly disagree** in the Table below:

S/No	Causes	SA	A	NS	D	SD
	Mental illness can be caused by:					
i	Sin					
ii	Brain disorder					
iii	Witchcraft/ Magic					
iv	Destiny					
v	Heredity					
vi	Demonic/ spirit possession					
vii	Drug abuse/addiction.					
viii	Making fun of a person with mental illness					
ix	Misuse of drugs					
x	Divine punishment/God's anger					
xi	Accident/trauma					
xii	Family conflict/marital disharmony					
xiii	Poverty					
xiv	Someone is to blame for mental illness					
xv						

34. **Respondents' Perceptions about mental illness**:State your agreement or disagreement on which of these measures promote mental health.

S/No	Perceptions	SA	A	NS	D	SD
i	People who have a mental illness are considered mad					
ii	People with a severe mental illness are dangerous.					
iii	People with a severe mental illness are violent.					
iv	People with a mental illness are shy and quiet					
v	Mental illness is the result of bad parenting.					
vi	Mental illnesses cannot be controlled.					
vii	Depression is a normal part of the aging process.					
viii	Mental illness does not affect children or adolescents					
ix	Anyone with a mental illness can ignore it, because being treated for a psychiatric disorder means an individual is weak.					
x	Mentally-ill persons should be locked up					
xi	Mentally-ill persons just lack will-power					
xii	People should sort out their own mental health problems					
xiii	Teenagers are more likely to attempt suicide than older people					
xiv	Mental illness cannot be cured					
xv	Females are more likely to have a mental illness than males					
xvi	Mental illness usually goes away by itself naturally					
xvii	Mental illness is a sign of weakness					
xviii	Adults are more likely than teenagers to have a mental illness					
xix	You can tell by looking at someone whether they have a mental illness					
xx	Mental illness can happen to anybody					
xxi	I have someone with mental illness in my family.					
xxii	I have a relative who I feel may have mental illness					

35. **Attitude towards the mentally ill:** State your agreement or disagreement on which of these measures promote mental health: **SA = Strongly Agree, A = Agree, N = Not sure, D = Disagree, SD = Strongly disagree)**

S/No	Attitude	SA	A	NS	D	SD
i	I fear anyone with mental illness					
ii	I avoid anyone with mental illness					
iii	I feel angry with anyone with mental illness					
iv	I hate anyone with mental illness					
v	I do not trust anyone with mental illness					
vi	I don't bother (indifferent to) about anyone with mental illness					

36. If you notice mental illness in a person close to you, will you contact someone for assistance? a. Yes [ ] b. No [ ]. ***If NO, go to question 39***
37. If Yes, indicate who will be the first person you will contact from the table below (but ***Skip Questions 39 and 40)***.

S/No	Contact	First Person to contact
i	A family member	
ii	A partner/spouse	
iii	A friend own age	
iv	A Counsellor	
v	An older friend	
vi	A doctor in the locality	
vii	A nurse	
viii	A psychiatrist	
ix	A Community health worker	
x	A psychologist	
xi	A social worker	
xii	A school teacher	
xiii	A clergyman (Pastor/Imam)	
xiv	A traditional healer	
xv	A traditional ruler	

38. Why would you want to contact the person mentioned above first? ***Tick as many as applicable***

a. The person is more likely to be sympathetic or accepting [ ]
b. This person is likely to be able to understand the situation better [ ]
c. This person would know what to do [ ]
d. This person will keep the issue confidential (will not expose the problem) [ ]
e. State any other reason: .....

39. Why would you not contact any one? ***Tick as many as applicable***
a. The person may no longer relate well because of the mental illness [ ]
b. It may upset the person [ ]
c. The person may not keep it as a secret [ ]
d. They may not know how to help me [ ]
e. State any other reason:.....

40. If you will not contact anybody when you notice mental illness in a person close to you (that is, If No to Question 36 above), state how you will handle the mental problem on your own?

.....
……

41. **Preferred Treatments:** State your agreement or disagreement on which of these measures to treat mental health problems: **SA = Strongly Agree, A = Agree, N = Not sure, D = Disagree, SD = Strongly disagree.**

S/No	Treatment	SA	A	NS	D	SD
i	No need for treatment because mental illness cannot be treated, whatever the cause					
ii	People with mental illness need prayers from clergymen (religious leaders).					
iii	Talking with a professional therapist					
iv	Modern medicine using drugs					
v	Traditional medicine					

42. Indicate how much you agree or disagree with the following treatment options ***(please tick as many as applicable).***

S/No	Types	SA	A	NS	D	SD
I	Herbal preparations					
Ii	Spiritual healing					
Iii	Special cultural diets					
Iv	Charms					
v	Sacrificial offerings					

43. **Levels of acceptance of people living with a mental illness (PLWMI)**: State your agreement or disagreement on which of these measures promote mental health*:* **SA = Strongly Agree, A = Agree, N = Not sure, D = Disagree, SD = Strongly disagree**

S/No	Statement	SA	A	NS	D	SD
i	People with mental illness can be good parents					
ii	People with mental illness should be given jobs					
iii	People with mental illness can be good workers					
iv	Would you be willing to be in the same social group with anyone with mental illness?					
v	Would you be willing to have someone with mental illness as your leader?					
vi	Would you be willing to attend the same school with anyone with mental illness?					
vii	Would you be willing to have a person with a mental illness to be your teacher?					
viii	Would you be willing to have a person with a mental illness to be your child's teacher?					
ix	Would you be willing to live in the same compound with anyone with mental illness?					
x	Would you be willing to share the same room with anyone with mental illness?					
xi	Would you be willing to have a person with a mental illness to marry into your family?					
xii	Would you be willing to marry person with a mental illness?					

Suggestions on fighting stigma associated with mental illness

44. Do you think excluding the mentally ill people from social activities and other privileges should be discouraged? Yes [ ] No [ ]. *If No, skip Question 45 (skip the Table below).*

45. **If yes,** indicate your opinions in the Table below.

S/No	Anti-stigma strategies	SA	A	NS	D	SD
i	Incorporate anti stigma educational programmes into the mental health policies					
ii	Focus anti-stigma programmes on identifying the population at risk, and properly address the causes of mental illness.					
iii	Start anti-stigma campaigns from health workers.					
iv	Do intensive public awareness, in form of effective stigma- reducing educational programmes					
v	Enforce change of attitudes toward mental illness in the society					
vi	Improve human rights in mental health facilities.					
vii	Empower mental health service users (i.e. patients) and families.					
viii	Replace psychiatric institutions with community mental health care.					
ix	Increase investment in mental health care.					
x	Adopt policies, laws and services that promote human rights.					
xi	Include traditional treatment in managing mental illness in communities					

Thank you for taking the time to complete the survey. I appreciate your assistance.

Appendix B: Household survey Questionnaire (Hausa Translation)

Sashen Nazarin Zamantakewar Ɗan Adam,
Jami'ar Ahmadu Bello, Zariya.

Rataye na B: Tambayoyin Bincike Domin Al'umma.

Barka da warhaka,

Ni ɗalibi ne mai neman Shaidar Digiri na Uku (Phd) a wannan Sashes (Sashen Nazarin Zamantakewar ɗan Adam) da ke Jami'ar Ahmadu Bello, Zariya. Ina gabatar da nazari mai taken ***"Nazarin Yadda Ake Kula da Masu Taɓin Hankali a Cibiyoyin Kiwon Lafiya na Matakin Farko, a Arewacin Nijeriya".*** Ina neman haɗin kanka/kanki na amincewa a amsa tambayoyin wannan bincike. Ana tabbatar da mai cika tambayoyin bincike cewa an yi tambayoyin ne kawai domin nazari, ba domin muzanta wani ko wasu ba. Saboda haka, dukkan bayanan da aka bayar, za su kasance na sirri. Da fatan za a amsa bil haqqi da gaskiya, domin cika burin nazarin.

Bayanan da aka samu, ana sa ran su taimaka wajen ci gaban samar da kulawa a cibiyoyin da aka tanada domin kula da masu taɓin hankali, musamman a matakin farko na kula da marasa lafiya a Arewacin Nijeriya.

Na gode **Anyebe, EE**

UMARNI:

A amsa waɗannan tambayoyin sannan a dawo da takardar (tambayoyin binciken).

Sashe na A: Yanayin Zamantakewa da Shiyyar Mai Amsa Tambayoyin Bincike

Sunan Anguwan:.....

Ƙaramar Hukuma/Gari:.....

1. Shekarun haihuwa:.....
2. Jinsi: a. Mace [ ] b. Namiji [ ]
3. Sunan ƙabila: .....
4. Addini: .....
5. Sana'a ko aikin da ake yi:.....
6. Ƙololuwar (matakin) ilimin da ake da shi: .....
7. Albashin da ake samu (in dashi) ko yankin kuɗin da ake samu a sana'a a wata daya:.....

Manufa: Gano Tabbacin Dama da Yarda da Samar da Kulawa a Wuraren Kula da Masu Taɓin Hankali:

8. Ko ka san cibiyar kula da kiwon lafiya a matakin farko ta al'ummarku? a. Eh [ ] b. A'a [ ]. ***Idan A'a, a je tambaya ta sha takwas (18)***
9. Ko cibiyar na nesa da gidanka? A. Eh [ ] b. A'a [ ]
10. Ko ma'aikatan kiwon lafiya a cibiyar shirye suke su kula da ku? a. Eh [ ] b. A'a [ ] c. Ba a sani ba [ ]
11. Akwai isassun magaunguna da suka dace nan take? a. Eh [ ] b. A'a [ ] c. Ba a sani ba [ ]
12. Ko kana da masaniya a kan wuraren da aka keɓe a cibiyoyin kula da lafiya a matakin farko domin kula da masu taɓin hankali? a. Eh [ ] b. A'a [ ]c. Ba a sani ba. (Idan a'a, a tsallake tambaya ta 13 har zuwa ta 17)
13. Idan eh, ko akwai wurin da aka tanada domin kula da masu taɓin hankali a cibiyar? a. Eh [ ] b. A'a [ ] c. Ba a sani ba [ ]
14. Ko ana samun sauƙin kulawa a wurin? a.Eh [ ] b. A'a [ ] c. Ba a sani ba [ ]

15. Ko kulawar kyauta ce? a. Eh [ ] b. A'a [ ] c. Ba a sani ba [ ]
16. Ko jama'ar hukumar ku sun yarda da wannan kulawar? a. Eh [ ] b. A'a [ ]
17. Ko kulawar ta ratsa dukkan jama'a a al'ummarku? a. Eh [ ] b. A'a [ ]

Wayewar Al'umma kan Shirin Kula da Masu Taɓin Hankali

18. Ko kana da masaniya game da shirin wayar da kan jama'a a kan cutar taɓin hankali? a. Eh [ ] b. A'a [ ]
19. Ko ka taɓa shaida ko kaga shirin (na wayar da kan al'umma) a al'ummarku? a. Eh [ ] b. A'a [ ]
20. Ko ka taɓa shiga shirin? a. Eh [ ] b. A'a [ ]
21. Kamar waɗanne abubuwa aka gudanar?.....
22. Kana jin akwai buƙatar samun ƙarin bayani kan cututtukan da suka shafi taɓin hankali? a. Eh [ ] b. A'a [ ]. ***Idan A'a, a tsaleke tambaya ta ashirin da uku (23)***
23. Idan an amsa'eh' a tambaya ta 22, waɗanne hanyoyi kake ganin za a iya samun bayani? *A yi da'ira [√] ga amsoshin da ta dace*

Lambar batu	**Hanyar samar da bayani**	**Wanda aka fi so**	**Wanda ake so**	**Wanda kawai dai aka so**	**Wanda ake so a ƙarshe**
i	Makaranta				
ii	Tallace-tallace a gidajen talabijin				
iii	Radiyo				
iv	Mujallun matasa				
v	Shirye-shiryen gidajen talabijin				
vi	Tarurrukan al'umma				
vii	Jaridu				
viii	Wuraren shiga motocin haya				
ix	Majalisun matasa				
x	Saƙonnin kar ta kwana na waya (sms)				
xi	Ganawa/tattaunawa da masu matsalar				
xii	Wuraren ibada (coci-coci/masallatai)				
xiii	Tattaunawa a cibiyoyin kula da marasa lafiya				
xiv	Hanyoyin sadarwa na zamani				
xv	Allunan bango				

24. Ko akwai buƙatar ƙarin neman bayani akan inda za'a iya samun taimako akan kula da lafiyar ƙwaƙwalwa. a. Eh [ ] b. A'a [ ]. *Idan A'a, a tsallake tambaya ta 25*
25. Idan Eh a tambaya ta 24, Waɗanne hanyoyi kake ganin za su taimaka wajen samar da bayanai akan neman taimako? *A yi da'ira [√] ga amsoshin da ta dace*

Lambar batu	**Hanyar samar da bayani akan neman taimako**	**Wanda aka fi so**	**Wanda ake so**	**Wanda kawai dai aka so**	**Wanda ake so a ƙarshe**
i	Makaranta				
ii	Tallace-tallace a gidajen talabijin				
iii	Radiyo				
iv	Mujallun matasa				
v	Shirye-shiryen gidajen talabijin				
vi	Tarurrukan al'umma				
vii	Jaridu				
viii	Wuraren shiga motocin haya				

ix	Majalisun matasa				
x	Saƙonnin kar ta kwana na waya (sms)				
xi	Ganawa/tattaunawa da masu matsalar				
xii	Wuraren ibada (coci-coci/masallatai)				
xiii	Tattaunawa a cibiyoyin kula da marasa lafiya				
xiv	Hanyoyin sadarwa na zamani				
x	Allunan bango				

26. Waɗanne ƙarin hanyoyin kake gani za su taimaka wajen samar da bayanai? ....
27. Yaya ka auna/ kake ganin ɗabi'un jami'an kiwon lafiya a cibiyoyin kula da lafiya a matakin farko na al'ummarku? *A amsa tambayoyin da ke tafe da gaskiya:*

Ɗabi'un jami'an kiwon lafiya

Lambar batu	**Jami'an kiwon lafiya a nan:**	**Matuƙar gaske**	**Matuƙa**	**Ana shakku**	**Ba a amince ba**	**Ko kaɗan ba a amince ba**
i	Sun san aikinsu					
ii	Suna taimakawa matuƙa					
iii	Ba sa barin sauran jama'a su san kana da matsalar taɓin hankali					
iv	Ba sa barin makusantarka su san halin da kake ciki					
v	Ba sa damuwa da ƙai'dajjen lokacin da suka bayar domin a dawo ganisu					
vi	Sun bada dama mutun yai Magana yadda take a zuciyar sa					
vii	Sun samar da yanayin amincewa a wurin (kula da masu taɓin hankali)					
viii	Masu taimako ne ga dukkan marasa lafiya					
ix	Suna ɓata lokacin marasa lafiya					
x	Sun cika yin tambayoyi barkatai/da yawa					
xi	A shirye suke su saurare mu kuma su taimaka mana					
xii	Suna da masaniya ga rayuwar ga al'umma da ta shafi matasa					
xiii	Suna ɓoye sirri					
xiv	Sun ƙware wajen gano mafitar matsalolinmu					
xv	A shirye suke su taimaka					
xvi	Sun san aikinsu					
Xvii	Suna da kyakkyawar mu'amula da jama'a					

28. Ko ka taɓa yi wa wani jami'in kiwon lafiya a matakin farko magana a kan taimakonsa wajen ciwon taɓin hankali? a. Eh [ ] b. A'a [ ]. ***Idan A'a, a tsaleke tambaya ta 29***

29. Idan eh, waka fada mawa? *A yi da'ira [√] ga amsoshin da ta dace*

Lambar Batu	**Jami'an kiwon lafiya da za a nemi taimakonsu**	**Eh**	**A'a**
i	Jami'in kiwon lafiya na al'umma		
ii	Nas/Jami'a/jami'i mai kula da marasa lafiya		
iii	Likitan wannan al'umma		
iv	Jami'an kiwon lafiya na wucin gadi na al'umma		
v	masanin mutuntakar ɗan Adam		
vi	Jami'in kula da zamantakewar al'umma		
vii	Likitan taɓaɓɓu/masu taɓin hankali		
viii	Ba a san nau'in jami'in ba		

Manufa: auna fahimta da ɗabi'un jami'an kiwon lafiya ga masu taɓin hankali da irin gudunmuwar da yake bayarwa

30. Waɗanne daga cikin waxannan alamomi ke nuni da tavuwar hankali alama?

Lambar Batu	**Fahimtar alamomin**	**Matuƙarg aske**	**Matuƙa**	**Ana shakku**	**Ba a amince ba**	**Ko kaɗan ba a amince ba**
i	Damuwa mai tsanani da yawan tunani					
ii	Rashin mayar da hankali					
iii	Ɓacin rai na babu gaira babu dalili					
iv	Saurin fushi					
v	Rashin isasshen barci					
vi	Janyewa (daga hulɗa da jama'a son/kaɗaici)					
vii	Ɓacin rai alokacin da harkokin rayuwa sukatafi ba daidai ba					
viii	Jama'a masu tsokanarka da fitina/tashin hankali					
ix	Tsoro na babu gaira babu dalili					
x	Kullum a gaskiyarka kake					
xi	Sauran jama'a a kullum ba daidai suke ba					
xii	Yawan zato					
xiii	Jin ciwo/raɗaɗin ciwo a kodayaushe					
xiv	Rashin mallakar zuciya					
xv	Matsalar iya hulɗa da jama'a					
xvi	Saurin mutuwar zuci					
xvii	Tunani mara amfani					
xviii	Rashin iya tsari					
xix	Yawan yin alfahari					
xx	Kin yin aikin da aka sa shi					

31. Wanne daga cikin alamomin nan ke nuni da taɓin hankali?

Lambar batu	Alamomin taɓin hankali	**Eh**	**A'a**
i	Saurin kai hari/neman faɗa/fitina		
ii	Ɗarna		
iii	Yawan magana/ maganganu na babu gaira babu dalili		
iv	Ɗabi'a ta daban cikin jama'a		
v	Matu ƙar shau ƙi (da wani abu)		
vi	Rashin kula da kai		
vii	Tsiraci		
viii	Rashin aikin yi		
ix	Ƙosawa (matuƙa)		
x	Rashin isasshen barci da dare		
xi	Fitar hankali		

32. Ci gaban (tabbatar) da kiwon lafiyar taɓaɓɓu. Amsa tambayar da amsoshin da suka gamshe ka.

Lambar Batu	**Sinadaran da za su taimakawa lafiyar masu taɓin hankali (kwakwalwa)**	**Matuƙargaske**	**Matuƙa**	**Ana shakku**	**Ba a amince ba**	**Ko kaɗan ba a amince ba**
i	Abinci mai amfani a jiki/inganci					
ii	Muhalli mai inganci					
iii	Tsaftar jiki					
iv	Tsaftar muhalli					
v	Motsa jiki					
vi	Samun isasshen barci					
vii	Kiyayewa					
viii	Sasansatawa cikin sauƙi					
ix	Iya magance al'amura					
x	Aikin yi mai inganci					
xi	Samun haɗin kai daga iyali					
xii	Kwanciyar hankali a gida					
xiii	Kwanciyar hankali a wurin aiki					
xiv	Kwanciyar hankali a makaranta					
xv	Kare kai daga shan ƙwayoyin maye					
xvi	Karoya daga hatsari					
xvii	Kasancewa da iyali (‘yanuwa)					
xviii	Kasancewa da abokanan aiki/makaranta					

33. Fahimtar dalilan da ke haifar da ciwon kwakwalwa/taɓin hankali. Zaɓi amsan da da ya gamshe ka.

Lambar Batu	Cutar taɓin hankali za ta kasance dalilin:	Matuƙargaske	Matuƙa	Ana shakku	Ba a amince ba	Ko kaƈan ba a amince ba
i	Zunubi					
ii	Taɓuwar kwakwalwa					
iii	Asiri					
iv	Ƙaddara					
v	Gado					
vi	Daga iska (iskokai)					
vii	Shaye-sheyen magungunan maye					
viii	Tsokanar wanda ya taɓu daga cutar					
ix	Yin amfani da magunguna babu ƙa'ida					
x	Fushin ubangiji/mahalicci					
xi	Hatsari/shiga wata matsala					
xii	Rashin kwanciyar hankali daga iyali/'yanuwa					
xiii	Talauci					
xiv	Mutum ke jawo wa kansa cutar (taɓin hankali)					

34. Fahimtar mai amsa tambayoyin taɓuwar hankali. A amsa da zaɓin da ya fi gamshe ka.

Lambar Batu	Fahimta	Matuƙargaske	Matuƙa	Ana shakku	Ba a amince ba	Ko kaƈan ba a amince ba
i	Duk mai ciwon kwakwalwa ana ganinsa taɓaɓɓe					
ii	Duk masu tsananin ciwon taɓuwa hatsari ne ga sauran jama'a					
iii	Duk masu cutar taɓin hankali masu neman fitina ne					
iv	Duk masu cutar taɓin hankali suna da kunya kuma ba su cika magana ba					
v	Rashin kulawar iyaye na haifar da cutar taɓin hankali					
vi	Ba za a iya warkar da cutar taɓin hankali ba					
vii	Matsanancin damuwa sinadari ne da kan haifar da tsufa da wuri					
viii	Cutar taɓin hankali ba ta					

	shafar yara da matasa					
ix	Mai cutar taɓin hankali na iya ganin neman waraka daga jami'an kiwon lafiya gazawace a gare shi					
x	Ya kamata a tsare duk mai cutar taɓin hankali a wuri na musamman					
xi	Mai cutar taɓin hankali bai mallaki hankalinsa ba					
xii	Jama'a/al'umma su nemi warakar cutar taɓin hankali da kansu					
xiii	Yara da matasa sun fi shiga haɗarin kashe kansu					
xiv	Cutar taɓin hankali ba ta da magani					
xv	Mata sun fi maza yawan kamuwa da cutar taɓin hankali					
xvi	Cutar taɓin hankali tana warkewa da kanta ba tare da an yi magani ba					
xvii	Cutar taɓin hankali alama ce ta kasala					
xviii	Manya sun fi yara haɗarin kamuwa da cutar taɓin hankali					
xix	Za ka iya gane mai ciwon taɓin hankali daga kallonsa/ganinsa					
xx	Cutar taɓin hankali za ta iya kama kowa					
Xxi	Akwai mai cutar taɓin hankali a zuri'armu					
xxii	Ina da ɗanuwa da nake ji yana da cutar taɓin hankali					

35. Ɗabi'u game da cutar taɓin hankali

Lambar Batu	**Ɗabi'a**	**Matuƙarg aske**	**Matuƙa**	**Ana shakku**	**Ba a amince ba**	**Ko kaɗan ba a amince ba**
i	Ina tsoron duk mai ciwon taɓin hankali					
ii	Nakan kiyaye duk wani mai cutar taɓin hankali					
iii	Nakan ji haushin duk wani mai cutar taɓin hankali					
iv	Na tsani duk wani mai cutar taɓin hankali					
v	Ban amince da duk wani mai cutar taɓin hankali ba					

vi	Ban damu da duk wani mai cutar taɓin hankali ba					

36. Idan ka ga alamun cutar taɓin hankali ga wani ɗan uwa ko aboki, za ka sanar da wani domin samun taimako? a. Eh [ ] b. A'a [ ]. ***Idan a'a, aje tambaya ta 39***

37. Idan eh, za ka sanar da wani, wane ne na farko da za ka sanar? ***(amma a tsalake tambaya ta 39 da 40).*** *A yi da'ira [√] ga amsan da ta dace akan wanda za a sanar a farko*

Lambar batu	**Wanda za a sanar**	**Na farko**
i	Danuwa (mace ko namiji)	
ii	Miji ko mata	
iii	Aboki (sa'an mai fama da cutar)	
iv	Jami'an bada shawara	
v	Abokin mai fama da cuta (wanda ya girme shi)	
vi	Likita mafi kusa da al'umma	
vii	Nas (jami'i mai kula da marasa lafiya	
viii	Likitan taɓaɓɓu	
ix	Jami'in kula da kiwon lafiya na al'umma	
x	Masanin mutuntakar ɗan Adam	
xi	Jami'in zamantakewar ɗan Adam	
xii	Malamain makaranta	
xiii	Shugabanin addini (fasto ko malam)	
xiv	Mai maganin gargajiya	
xv	Shugaban al'umma	

38. Wane buri za a cimma idan an sanar da wannan mutum na farko a sama? *Za a iya amsa fiye da ɗaya*

a. Ƙila ya tausayawa mai cutar [ ]
b. Ƙila ya taimaka a magance matsalar [ ]
c. Ƙila ba zai rasa abin da zai yi ba [ ]
d. Zai rufa asiri, ba zai tozarta mai cutar ba [ ]
e. Ko akwai wani dalili:……..……..

39. Me ya sa ba za a sanar da wani? ***Za a iya amsa fiye da ɗaya***.

a. Zai yi wu ya sauya zamantakewarsa saboda cutar
b. Ransu zai iya ɓaci [ ]
c. Ba za su rufa mini asiri ba [ ]
d. Babu wani taimakon da za su ba ni saboda rashin sani (jahilci) [ ]
e. Ko akwai wani dalili:……..……..

40. Idan an amsa tambaya ta 36 da a'a, (ba za a sanar da kowa ba), yaya za a magance wannan matsalar taɓin hankali?.....
……

41. Magungunan da za a fi so a yi amfani da su:

Lambar Batu	**Maganin da ya dace**	**Matuƙar gaske**	**Matuƙa**	**Ana shakku**	**Ba a amince ba**	**Ko kaɗan ba a amince ba**
i	Babu buƙatar yin magani saboda cutar ba ta warkewa ba ce					
ii	Masu fama da cutar (ta taɓin hankali) suna buƙatar					

	addu'a daga shugabannin addi'ni					
iii	Ganawa da masani (likitan taɓaɓɓu)					
iv	Amfani da maganin asibiti (na Bature)					
v	Amfani da maganin gargajiya					

42. Tabbatar da amincewarka ko rashin amincewarka

Lambar Batu	**Ire-iren magunguna**	**Matuƙargaske**	**Matuƙa**	**Ana shakku**	**Ba a amince ba**	**Ko kaƈan ba a amince ba**
i	Haƈe-haƈe magungunan gargajiya					
ii	Addu'ar shugabannin addi'ni					
iii	Jiƙe-jiƙen sauyoyi da ire-irensu					
iv	Surukulle					
v	Sadaka ga abin bauta					

43. Matakan yarda da masu fama da cutar taɓin hankali

Lambar Batu	**Matakan yarda da masu fama da cutar**	**Matuƙargaske**	**Matuƙa**	**Ana shakku**	**Ba a amince ba**	**Ko kaƈan ba a amince ba**
i	Masu fama da cutar taɓin hankali za su iya zama iyaye na gari					
ii	A ba masu fama da cutar taɓin hankali aikin yi					
iii	Masu fama da cutar taɓin hankali za su iya kasancewa ma'aikata na gari					
iv	Za ka yarda ka kasance cikin ƙungiya ƈaya da masu fama da cutar taɓin hankali?					
v	Za ka so shugabanka ya kasance mai fama da taɓin hankali?					
vi	Za ka so ka halarci makaranta ƈaya da mai fama da cutar taɓin hankali?					
vii	Za ka so malaminka ya kasance mai fama da cutar taɓin hankali?					
viii	Za ka so malamin ƈanka ya kasance mai fama da cutar taɓin hankali?					
ix	Za ka so maƙwabtaka da mai fama da cutar taɓin hankali?					

x	Za ka so ka zauna ɗaki ɗaya da wanda yake fama da cutar taɓin hankali?					
xi	Za ka so ka haɗa auratayya da mai fama da cutar taɓin hankali?					
xii	Za ka so ka auri mai cutar taɓin hankali					

Magance Ƙyamar da ake yi wa masu fama da cutar taɓin hankali.

44. A ra'ayinka, kana ganin ya kamata ayi zamantakewar yau da kullum da mai fama da cutar taɓin hankali? a. Eh [ ] b. A'a [ ]. *Idan a'a, kada a amsa tambaya ta 45*

45. Idan an amsa da 'eh', bayyana ra'ayinka daga bayanan da ke ƙasa.

Lambar Batu	**Hanyoyin magance ƙyama**	**Matuƙargaske**	**Matuƙa**	**Ana shakku**	**Ba a amince ba**	**Ko kaɗan ba a amince ba**
i	Gabatar da shirye-shirye domin faɗakar da jama'a kan illar nuna ƙyamar					
ii	Gano hanyoyin magance ƙyamar saboda lahanin da take haifarwa mai cutar					
iii	Magance ƙyama daga jami'an kiwon lafiya					
iv	Gabatar da shiri na musamman domin rage ƙyamar					
v	Sauya ɗabi'un al'umma kan ƙyamar masu fama da cutar taɓin hankali					
vi	A kula da 'yancin mai cutar taɓin hankali a asibitoci					
vii	Taimakawa masu fama da cutar (ta hanyar samun abun yi)					
viii	Sauya asibitocin masu taɓin hankali zuwa ga na al'ummomi (cibiyoyin kula da masu taɓin hankali na al'umma)					
ix	A ƙara kuɗaɗen da ake kashewa a fannin kula da masu taɓin hankali					
x	A tsara hanyoyin kula da kare 'yancin masu fama da cutar					
xi	A sa magungunan gargajiya cikin hanyoyin					

	kula da masu taɓin hankali					

Na gode ƙwarai da haɗin kan da aka ba ni na cika tambayoyin binciken.

Appendix C:

IDI Guide for Health Administrators/PHC Coordinators on:

Analysis of the Provision of Mental Health Care Services at the Primary Health Care Level in Northern Nigeria

Section A: Informant's socio-demographic data

1. Centre: ……

2. Position: ……...

3. Age: ……. ……..

4. Sex: …….

5. Category of staff: ……

6. Position/post: ……..

Section B: Mental health care in PHC system

Facts of mental health/illness burden and Mental Health Policy

Probe for:Policy/political will:

i. Explore Health Policy and Mental Health Care Reform/policy in the State – what is the focus of the policy, Healthcare Reform bill is expected to produce a shift in the delivery of alcohol and drug prevention, treatment and recovery services in the State.
ii. It is anticipated that HCR will result in (among other things) modifications in how services will be funded, the type of services delivered, the venues where they are delivered, the individuals who will receive the services, the work force that delivers the services, how services are measured, and how service benefits are evaluated. a substantially different service system will provide alcohol and other drug care (prevention, treatment and recovery services)
iii. Periodic review of legislation governing the care of the mentally ill is carried out?

Probe for:

i. Mental health problems as a burden in the society.
ii. What constitutes mental health and mental illness
iii. Distribution of mental health problems in society and who are more affected and why.

iv. Explore mental disorders burden in childhood and adolescents (before the age of 14 years compared across cultures and those under the age of 19).
v. The common mental disorders in the state
vi. Cases of substance/alcohol abuse
vii. Rate of cause of disability in the area
viii. Explore the incidence of suicide (how common, why (not), and whether mental disorders are one of the most prominent and treatable causes of suicide).
ix. Civil disorders and other major disasters have a large impact on the mental health and psychosocial well-being. **(Rates of mental disorder tendency to double after emergencies.)**

ix. Stigma about mental disorders and discrimination against patients and families as preventing people from seeking mental health care.

x. Human rights violations of psychiatric patients routinely reported/practiced: these include physical restraints, seclusion and denial of basic needs and privacy. Probe for: Any legal framework that adequately protects the rights of people with mental disorders?

xi. The distribution of skilled human resources for mental health across the state. Explore the shortages of psychiatrists, psychiatric nurses, psychologists and social workers as main barriers to providing treatment and care in primary care levels.

xii. Explore how governments, donors and groups representing mental health workers, patients and their families work together to increase mental health services in the state.

xiii. Any funds/funding being made available specifically for mental health services in your State and LGA.

Probe for: Burden versus Budget

xiv. Physical environment: ***Probe for:*** waiting areas, reception, sanitation, queues, etc

Mental Health Services in the State

Performance Measurements: Explore how the process of defining accurate and appropriate performance measures will likely need to consider the future environment of the mental health treatment field where services will no longer function as isolated care unit separated from other parts but also of the overall health care system.

Probe for:Nature of services and Integration into PHC

i. Explore for the nature of services
ii. Advocacy
iii. The need/necessity/benefits integrating MHS into PHC from the perspectives of primary Health Workers, community members and services users
iv. Community mapping

Probe for: Mental Promotion – Mental Health day celebration awareness, etc:

i. The extent to which this day has celebrated in terms of its goals and the content in northen Nigeria requires has not been ascertained.
ii. What has been the committment of the local and state health authorities in the region to this day?
iii. Do communities participate in the awareness celebration?

iv. Primary Care/Behavioral Health Integration: substance abuse screening, brief intervention, and treatment, to be co-located or integrated with primary care and mental health services.
v. Means of communicating MH information.

Probe for:Screening services

i. Knowledge of screening scales
ii. Availability of the screening tools
iii. Which category of clients, and for what conditions

Probe for:Curative services:

i. Knowledge and competence of staff
ii. Adequacy and distribution of staff
iii. Co-location or consultation
iv. If consultation, frequency of consultation: weekly, forth nightly, monthly, etc
v. Availability and affordability of the mental health drugs
vi. Acceptance by service users/community members
vii. Village system/
viii. Spiritual and traditional healers' homes
ix. Referral system

Probe for: Rehabilitative services
i. Day-hospitals
ii. Half way homes
iii. Community/family care
iv. Any partnership
v. Local DPOs

Probe for: The Role of Health Information Technology:

i. Explore the need for Healthcare Reform to dramatically shift the nature of substance problems (addiction) service delivery – to understand how prevention, treatment and recovery services have changed and to document who is receiving services State,
ii. What the services are and how well the services meet the needs of patients and communities, new data systems will be required in State/LGA.
iii. Any data systems to provide Substance/Drug Programs, and State and LGA policy makers with the data they need to monitor prevention, treatment and recovery systems

Probe for: The barriers to availability of mental health services that need to be overcome. Explore:

a. The absence of mental health from the public health agenda and the implications for funding/financing and resource allocation
b. The current organization of mental health services;
c. Lack of integration within primary care;
d. Inadequate human resources for mental health; and
e. Lack of public mental health leadership.

Mental Health Workers' Strength, Training and Motivation:

Explore workforce development & training: the environment of the health and mental health system, and mental healthcare personnel. **NOTE: Training Curricula and Products**

Probe for:

i. How many psychiatirsts, psychiatric nurses, etc in State employment; their distribution, and their utilisation
ii. Training their primary health care personnel to identify and treat priority mental disorders.
iii. The Ministries of Health of both countries have committed to sustain the programme for lasting impact. In Nigeria, what is the content of this training?
iv. Can they be a modified based on identified community and social realities?
v. Are anti stigma educational programmes incorporated into the mental health policies of countries in this State/LGA.
vi. Do the Anti-stigma programmes focus on identifying the population at risk, and properly address the causes of mental illness.
vii. Will suggest the need to review the medical curriculum to combat the cultural beliefs prevalent among Nigeria doctors. Anti-stigma campaigns should start from health workers.
viii. How are they motivated.

5. The perceptions of primary health care workers on the role of PHC system in the provision of mental health services. Probe for:

- Mental health care as a component of PHC
- Its policy on provision of mental health at the primary care level
- Perceptions on the inclusion of mental health at the primary care level

6. The level of mental health care at the Primary Health Care system. ***Probe for:***

- Types of mental health services provided at the PHC level
- Target age groups for the services
- Adequacy and quality of services provided
- Consultation, co-location, and/or collaborative service
- Referral system (one or two-way?)

7. The factors responsible for the level of MHC services. ***Probe for:***

- Mental health coordinator
- Staff strength (quality and quantity)
- Drugs availability, affordability and accessibility
- Beliefs about mental illness
- The challenges as observed from the community they serve.

8. Mental Health day celebration awareness: ***Probe for:***

- The extent to which this day has celebrated in terms of its goals and the content in northern Nigeria
- The committment of the local and state health authorities in the region to this day?
- The needs for intensive public awareness
- Effective stigma- reducing educational programmes and more research in this area?

- How much do co mmunities participate in the awareness celebration?

Appendix D: In-depth Interview (IDI) for Community leaders

Analysis of the Provision of Mental Health Services at the PHC Level in Northern Nigeria

Section A: Informant's socio-demographic data

Probe for:

1. Centre: ……
2. Position: ……...
3. Age: …….
4. Sex: ….....
6. Position/post:……..

Mental Health Services: *Probe for:*

i. Primary Health Care (PHC) services generally
ii. Need/necessity/benefits for providing mental health care services at the Primary Health Care (PHC) level: health workers, community members and service users (i.e. the patients (or clients).
iii. Rating of any available services using the ABCD (i.e. Awareness creation, Best service, Cost, and Distance) of mental health services
iv. Any barriers to providing mental health care services at the Primary Health Care (PHC) level:
v. Policy/political will from Primary Health Care (PHC) coordinator, Community Health Workers
vi. Financing and resource allocation from government or Non-governmental organisation (NGO)

Community perception about mental health and illness: *Probe for:*

- Community leaders/ people's knowledge, attitudes and perceptions relating to mental health and mental illness; Questions asked will include:
  - When you hear the phrase 'mental health,' what sorts of things come to mind for you?
  - When you hear the phrase 'mental illness' what sorts of things come to mind?

- How they would expect someone with a mental illness to look or behave:
- Willingness to have a person with a mental illness as a close friend; to marry into their family; and to attend their school or to be employed with them.
  Preferred sources of information on awareness about mental health and illness
- Potential sources of help for someone with a problem
- Advantages and disadvantages of help-seeking behaviours

- Advantages and disadvantages of other approaches
- Desired characteristics of professional help services
- Sources of referral to professional help Groups at particular risk
- Experience of mental health hospitals or clinics if any
- People committing suicide in the community or neighbouring community
- War and other major disasters have a large impact on the mental health and psychosocial well-being
- Mental disorders risk as factors for other (communicable/non-communicable) diseases.
- Stigma and discrimination affecting access or seeking mental health care.
- Human rights violations (physical restraint, seclusion and denial of basic needs and privacy)

Others: (a) ***Probe for:***

- Measures that promote mental health
- Measures that prevent mental illness.
- Measures taken to treat mental illness
- Measures to rehabilitate mentally ill patients

(b) Probe for:

- Treatment options and reasons for preferring specific treatment options
- Any history of a mental patient known to responsent from onset and its progression (trajectory of):
- Details of the onset, treatments received and recovery,
- Challenges of the illness, and
- Suggestions on the services preferred.

Challenges on Provision of Mental Health Care at the Primary Health Care (PHC) level

Probe for:

- Community Factors: participation or otherwise, the distance of treatment health facility from the community
- Service factors: Availability of health personnel to provide the required treatments, availability of Drugs for mental health problems
- Other barriers: information, communication, etc

Appendix D: Community leaders (Hausa Translation)

Sashe na A: Yanayn zamantakewar mai amsa bincike. Yi binciken

1. Hukuma----------
2. Matsayi/kujera ----------
3. Shekarun haihuwa----------
4. Jinsi----------

Kulawa da lafiyan ƙwakwalwa. Binciki:

i. Kwon lafiya a mataki na farko gaba daya
ii. Bukatar/amfanin samun kulawar lafyan ƙwakwalwa a kwon lafiya ta mataki na farko

iii. Kamanta samun byan bukata (kulawa) ta fanin wayewa, samun cikaken kulawar lafiyan ƙwakwalwa, lada ko yanayn yadda ake biya da nisan wurin kulawar
iv. Akwa wani hani ko Katanga game da badawa ko samun kulawa da lafiyan kwakwalwa a kwon lafiya a mataki na farko
v. Akwai talafi da goyan baya(kudi) daga gwamnati ko gungiyoyi masu zaman kansu

Wayewa da fahimtar al'umma akan lafiayr ƙwakwalwa da tabin hankali. Binciki:

-sani, halaiya da wayewar shuwagabannn unguwa da al'umma akan al'amura da suka shafi lafiyar ƙwakwalwa da tabin ƙwakwalwa. Yi tambayoyi kamar:

- Idan aka ce lafiyar ƙwakwalwa , me ake nufi ko ma kake tunani ta kunsa
- Inkuwa aka ce tabn ƙwakwalwa, me kef ado zuciyar ka
- Mai ake ganin mai tabin ƙwakwalwa ke kama , hallaiyar sa.
- Idan ka kasance aboki, sirriki ko abokin aiki ko ma'aikacin mai tabin ƙwakwalwa, ya zaka kasance
- Mafi son hanyar fadakarwar tabin ƙwakwalwa da kiyaye lafiyan ƙwakwalwa ga al'umma
- Wuraren neman taimako ga mai tabin ƙwakwalwa
- Amfani da illar yin neman tamako
- Amfani da illar bin wasu hanyoyi
- Yadda a ke son jami'an kiwon lafiya su kasance (wato halin su)
- Hanyoyin samun kurrarun jami'an kiwon lafiya a lokacin da aka fuskanci matsalla
- Masaniyan yadda abubuwa suka kasance ko suka faru a asibitin kiwon lafyar ƙwakwalwa a baya
- Faruwan kisan kai a anguwan ku ko kewaye
- Illar yaki da bala'I akan lafiyar ƙwakwalwa da zamantakewan rayuwa
- Cututtukan da za'a iya samu ta dallin tabin hankali
- Illar nuna kiyyaya da banbanci ko kebe mai tabin hankali (wurn neman lafiyar sa)
- Keta yancin dan adam (kamar dauri, kebewa, hana su abubuwan mo re rayuwa, sutura da sauran su)

Binciki:

-Abubuwa mai kara lafyar ƙwakwalwa

-Abubuwa mai kare tabin ƙwakwalwa

-yadda za a magance tabin hankali

-yadda za a samar wa maitabin hankali rayuwar mutunci

Binciki:

-samu ko nemar wa mai tabin hankali lafya da dalillan daukar matakin ko yin hakan

-akwai tarihi ko labarin wanda ya samu tabin hankali da yadda hakan ta kasance

Binciki:

-yadda ta faru, neman waraka da samun waraka

-matsalolin da aka fuskanta

-ma ake ganiin za a iya yi ko magance matsallolin

Matsalloln da ake uskanta wurin samun lafiyar ƙwakwalwa a kwon lafiya ta mataki na farko

Binciki: Matsallan unguwan: kamar fahimta, nisan asibitin; Jami'an asibitin: kamar samun su, dabi'un su, kurewan su da samun magunguna; Sauran matsallolin kamar: samun bayyani da sadarwa

Appendix E: FGD Guide for PHC service users (patients/clients)

Section A: Informant's socio-demographic data

Probe for:

1. Centre: ……

2. Group characteristics:

- Number.....
- Age: …….....
- Gender: …….....
- Marital Status: ……..

3. Mental Health Services – *Probe for:*

vii. Accessibility of the Primary Health Care (PHC) services generally
viii. Any mental health services that they know of
ix. Any physical area or space in the centre they know of
x. Need, necessity, and benefits for providing mental health care services at the Primary Health Care (PHC) level
xi. Rating of any available services using the ABCD (i.e. Awareness creation, Best service, Cost, and Distance) of mental health services
xii. Any barriers to providing mental health care services at the Primary Health Care (PHC) level: such as physical barriers, social barriers, communication barriers, etc

4. Community perception about mental health and illness – *Probe for:*

- User's knowledge, attitudes and perceptions relating to mental health and mental illness; Questions asked will include:
- Meaning of 'mental health,' and 'mental illness'
- Who is termed mentally ill (characteristics)
- Social interaction with a person with a mental illness as a close friend; to marry into their family; and to attend their school or to be employed with them, etc.
- Potential sources of help for someone with a problem
- Advantages and disadvantages of help-seeking behaviours
- Advantages and disadvantages of other approaches
- Desired characteristics of professional help services
- Sources of referral to professional help Groups at particular risk
- Experience of mental health hospitals or clinics if any
- People committing suicide in the community or neighbouring community

- War and other major disasters have a large impact on the mental health and psychosocial well-being?
- Mental disorders risk factors for other (communicable and non-communicable) diseases.
- Stigma and discrimination affecting access or seeking mental health care.Human rights violations (physical restraint, seclusion and denial of basic needs and privacy)?

5. Others – ***Probe for:***

- Measures that promote mental health
- Measures that prevent mental illness.
- Measures taken to treat mental illness
- Measures to rehabilitate

6. Treatment options and reasons for preferring specific treatment options –*Probe for:*

- The health facility being too far
- Health personnel not being readily available
- Drugs not being readily available

7. Challenges of providing mental health care at the PHC level – *Probe for:*

- Community Factors
- Service factors
- Other barriers

8. Preferred Sources of Information/Awareness about mental health and illness – *Probe for:*

- Awareness campaigns; would they like to participate or be involved
- Posters, leaflet
- Media: Radio, TV
- Village meetings
- Town criers, etc

Appendix E: FGD for PHC Users (Hausa Translation)

Sashin A: Sanni masu amsa tambaya

Bincki:

1. Hukuma----------
2. Yanayin sawun
    - Addadin sawun----------
    - Jinsi su----------
    - Matsayin su (wato aure)----------

3. Yanayin kulawa da lafiyan ƙwakwalwa :- Binciki
    i. Amfani da kiwon lafya a mataki na farko
    ii. Sannin inda ake kulawa da lafiyan ƙwakwalwa

iii. Akwai wurin da aka kebe na kulawa da lafiyan ƙwakwalwa a asibitin kwon lafiya ta matak na farko
iv. Bukata/amfann samun wurin kula da lafiyan ƙwakwalwa a matak na farko
v. Kamanta samun biyan bukatar (kulawa) tafanin wayewa, samun cikkakken kulawa, lada ko yanayn biya da nisan asbitin
vi. Akwai wan hank o katanga da ke hana ssamun kulawan? Kamar:- nisan asibitin, abin hawa, kudi, sadarwa da makamancin su

4. Fahimtar yan anguwa game da kwon lafiyar ƙwakwalwa da tabin hankali:- yi bincken:
-fahimtar ɗabi'u da nazarin masu amfani da asibtn kwon lafya a matak na farko akan lafiyan ƙwakwalwa da tabn hankali. Y tamboy kamar:
i. Ma'anan lafiyar ƙwakwalwa da tabin hankali
ii. Wanene ma tabin hankali (yanayin sa)
iii. hulɗa da mai tabin hankal. Kamar abokantaka, sirriki, ko kasance wa a makaranta daya, ko wurn aik daya
iv. Wuraren neman taimako ko samun taimako
v. Amfani da illar neman taimako
vi. Yadda ya kamata jami'an kiwon lafya su kasance
vii. Inda ko wanda ya kamata a tuntuba dan akwa matsala
viii. Yadda asibitin kula da tabin hankali ya kasance a baya
ix. Illar yaki da bala'I akan lafiyar ƙwakwalwa da zamantakewa da halin rayuwa
x. Cuttutukan da za a ya samu ta dalilin tabin hankali
xi. Illar nuna kiyyaya a kebewa akan neman lafiyan mai tabin hankali
xii. Keta yancin dan adam (dauri, kebewa, hana abubuwan jindadin rayuwa da makamancan haka)

5. Sauran abubuwan bincike
i. Abubuwa da ke kara lafyan ƙwakwalwa
ii. Abubuwan dake hana tabin ƙwakwalwa
iii. Yadda za a kulak o magance tabin ƙwakwalwa
iv. Yadda za a samar wa mai tabin ƙwakwalwa rayuwa mai inganci

6. Hanyoyin neman lafiya da dalilan dake tattare da hanyan da a ka zaba. Bincki:-
i. inda wurin kwon lafiaya ta ke (ma'ana nisan wurin)
ii. hallayen jam'an kiwon lafiyan
iii. samun magunguna

7. matsallolin da ake fuskanta wajen neman lafiyan ƙwakwalwa a mataki na farko

i. matsallolin yankin ko anguwan
ii. matsallolin wurin kiwon lafiyan
iii. sauran Katanga

8. mafi son faggen fadakarwan lafiyan ƙwakwalwa da tabin hankali. Bnciki:

i. Samun bayanai: zaia so a so a shiga cikin fadakarwan(wato ayi tare daku)
ii. Allunan bango da takardu
iii. Gidan telebijin da radiyo
iv. Tarrukan al'umma

APPENDIX F:

CHECK LIST FOR OBSERVATION OF FACILITIES AND SERVICES AT PHC CENTRES

i. State/LGA:
ii. Centre/Community:

STAFF SITUATION:

i. Number of trained health workers at the centre
ii. Category of the workers: CHW, Nurse, Midwife, Doctor, etc

THE CASES:

i. Note any record of mental illness: Scan through general disease conditions seen and recorded to note any mental illness documented.
ii. Treatments available for mental health problems
iii. Treatments given for mental health problems

PHYSICAL ENVIRONMENT: Others: notes on physical facilities, centre arrangement, etc

iv. Facilities available:
    a. Does your facility have a roof that does not leak?
    b. Does your facility have windows or shutters that open and close to ensure ventilation, warmth and protection from rain?
    c. Any section or room at your centre used for mental health care services
    d. An area with provision for privacy for counselling? If available, equipped?
    e. Is there a waiting room?
    f. Is a wall chart displayed indicating mental health services provided are available?
    g. Are mental health posters on the walls?
    h. Are health educational materials on the wall in good (not dirty or torn) condition and displayed where your clients can see them?
    i. Do you maintain a supply of educational materials on different topics including family planning, safe motherhood, neonatal care, prevention and treatment of malaria, sexually transmitted infections, HIV and immunization for your clients?
    j. Standing orders on mental illness ***(content analysis)?***
    k. Are there drugs available for treating mental health problems?

Appendix G:

Guide for Content Analysis of Training Curricula of PHC Workers

39. Name of the training programme: .....
40. Training Institution: ……..……....
41. Category of PHC staff being trained:.....
42. Contact Hours/Credit units for Mental health lectures:.....
43. Content of curricula being taught:
    a. Common MH problems and illnesses: for example, ability to identify MH problems and disorders, ways of supporting people that require care, common screening tools for children, pregnant women, substance abuse, etc).
    b. **WHO Recommended Training Manual For Middle Level Health Workers For Mental Health Care Services**
44. Discussion (FGD or Interview) with Coordinators of Training Institutions:
    a. Awareness of WHO Recommended Training Manual For Middle Level Health Workers For Mental Health Care Services.
    b. Any plan or policy of implementing the Manual.
    c. The qualification(s) of the teachers: (are they trained in MH?)
    d. Any barriers to teaching mental health.
    e. Exposure of trainees to community-based clinical practice.
    f. Suggestions on improving the teaching of Mental Health at the Institution.
45. Other issues:
    a. ……
    b. ……
    c. ……
    d. ……

Appendix 1: A Copy of Full Ethical Approval from ABU/ABU Teaching Hospital, Zaria

HEALTH RESEARCH ETHICS COMMITTEE

AHMADU BELLO UNIVERSITY TEACHING HOSPITAL

SHIKA - ZARIA, NIGERIA.

E-mail: abuth@yahoo.com Website: www.abuth.org

Chairman of Board: Chief. Shualb Oyedokun Afolabi *Fnil*
Chief Medical Director: Prof. Lawal Khalid, *MBBS, FMCS, FWACS, FRCS(ED) mnl*
Chairman, Medical Advisory Committee: Prof. Abdullahi Mohammed, *MBBS, FWACP, FICS*
Director of Administration: Barr. Ishak Bello, *LL.B, BL., LL.M, PGDM, AHAN, FCAI*

Our Ref: ABUTH/HREC/TRG /36

Your Ref: _____

Date: 18th June, 2014

ABUTH HREC FULL ETHICAL CLEARANCE CERTIFICATE

Re: **"The provision of Mental Health Care in Nigeria: A sociological Examination of the Integration of Mental Health Services into the Primary Health Care in Northern Nigeria."**

ABUTH Ethics Committee assigned number:	-	**ABUTH/HREC/K028/2014**
Name of the principal Investigator:	-	**Mr. Emmanuel Ejembi Anyebe,**
Address of the Principal Investigator:	-	**Faculty of Social Sciences, ABU-Zaria**
Date of receipt of valid application:	-	**5th Feb, 2014**
Date of meeting when final determination on ethical approval was made:	-	**20th & 21st of May, 2014**

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

Please note: this approval dates from **19th June, 2014– 19th June, 2015**.

No participant recruitment into this research may be conducted outside these dates.

All informed consent forms in this study must carry the ABUTH HREC number assigned to this research and the duration of ABUTH HREC approval of the study.

This HREC expects that you submit your application as well as an annual report for ethical clearance renewal 3 months prior to expiration of study dates. This is to enable you obtain renewal of your approval and avoid interruption of your research.

If there is delay in starting the research, please inform the ABUTH HREC so that starting dates can be adjusted accordingly.

No changes are permitted in the research without prior approval by ABUTH HREC, except in circumstances outlined in national code for Health Research Ethics: http://www.nhrec.net.

ABUTH HREC reserves the right to conduct compliance assessment visits to your research site without prior notification.

Prof. A. I. Mamman
Chairman, ABUTH HREC

Appendix 2: Letter of Introduction from Department of Sociology, ABU, Zaria

DEPARTMENT OF SOCIOLOGY

Faculty of Social Sciences

AHMADU BELLO UNIVERSITY, ZARIA, NIGERIA

Vice-Chancellor: Professor Abdullahi Mustapha, B.Sc. (Hons) Pharm. (A.B.U), Ph.D. (London), FPSN
Head of Department: Dr. Yohanna Kagoro Gandu, B.Sc., M.Sc (A.B.U.), Ph.D. (Rhodes)
Telephone: 08173917192
Telegram: UNIBELLO
Fax: 069-50891

SF/STM/12

Date: 18/12/2014

.....

.....

.....

.....

Dear Sir/Madam,

LETTER OF INTRODUCTION

Name of Student: ANYEBE, Emmanuel E. (PhD/Soc.Sci/16647/2011-12

The above named person is a postgraduate student of this Department conducting research in the area of Analysis of the Provision of Mental Health Care Services at the Primary Health Care Level in Northern Nigeria

Any assistance you give will be much appreciated.

Thank you.

Dr. Y.K. Gandu
Head of Department

DEPARTMENT OF SOCIOLOGY
Ahmadu Bello University
Zaria — Nigeria

Appendix 3: Copy of Full Ethical Approval from Federal Neuro-psychiatric Hospital, Kaduna

FEDERAL NEURO-PSYCHIATRIC HOSPITAL, KADUNA

BARNAWA, KADUNA NIGERIA.

OFFICE:
Opposite Shagari Low Cost
P.M.B. 2187,
Barnawa Kaduna.
☎:062-230001-3, 237308-10
e-mail: fnphkaduna@yahoo.com

Date: January 12, 2015

Medical Director
DR. T. L. SHEIKH
MBBS (ABU) M.Sc., FWACP
Cert. Gmh (Harvard)

Head of Clinical Services
DR. EBITI W.N.
MBBCH (CAL) FWACP

Deputy Director of Administration/
Secretary to Board
ALHAJI MAHMUD ALHASSAN
B.Sc. MPA, CHPM, AHAN, MNIM, MNIPR

HEALTH RESEARCH ETHICS COMMITTEE

Notice of Full Approval

RE: **Provision of Mental Health Care Services at the Primary Healthcare Level in Northern Nigeria.**
Name of Principal Investigator: **Emmanuel Ejembi Anyebe**
Address of Principal Investigator: **Dept. of Sociology, A.B.U. Zaria.**
Date of receipt of valid application: **December 22, 2014**
Date of meeting when final determination of research was made: **January 8, 2015.**

This is to inform you that the research described in the submitted protocol, the consent procedure, and other participant information materials have been reviewed and *given full approval by the Health Research Ethics Commitee.*

This approval dates from **January 8, 2013** to **June 8, 2015** If there is delay in starting the research, please inform the HREC so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates.

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

Dr. Ebiti. William N.
Chairman, HREC

Dr. Mohammed Abdulaziz
Secretary, HREC

THE BOARD OF MANAGEMENT
Chairman: ALHAJI RAMALAN A. YERO (Turakin Dawakin Zazzau)
Members: DR. T.L. SHEIKH, DR. EBITI W. N., ALHAJI MAHMUD ALHASSAN, MRS. ZAINAB TATARI MAHMOOD, HON. DEPO OYEDOKUN, GBENGA AWOYALE, DR. JAMES I. BALAMI, DR. PIWUNA C.G.

Appendix 4: A Copy of Letter of Introduction LGA Chairmen (Gombe State)

GOMBE STATE GOVERNMENT OF NIGERIA
GOMBE STATE PRIMARY HEALTH CARE DEVELOPMENT AGENCY (GSPHCDA)

GSPHCDA/OFF//78/VOL.I/9 19th January, 2015

To:

The Chairmmen
Gombe,Kaltungo and Y/DebeLGA.
Gombe State.

Attention: *PHC Coordinator.*

LETTER OF INTRODUCTION

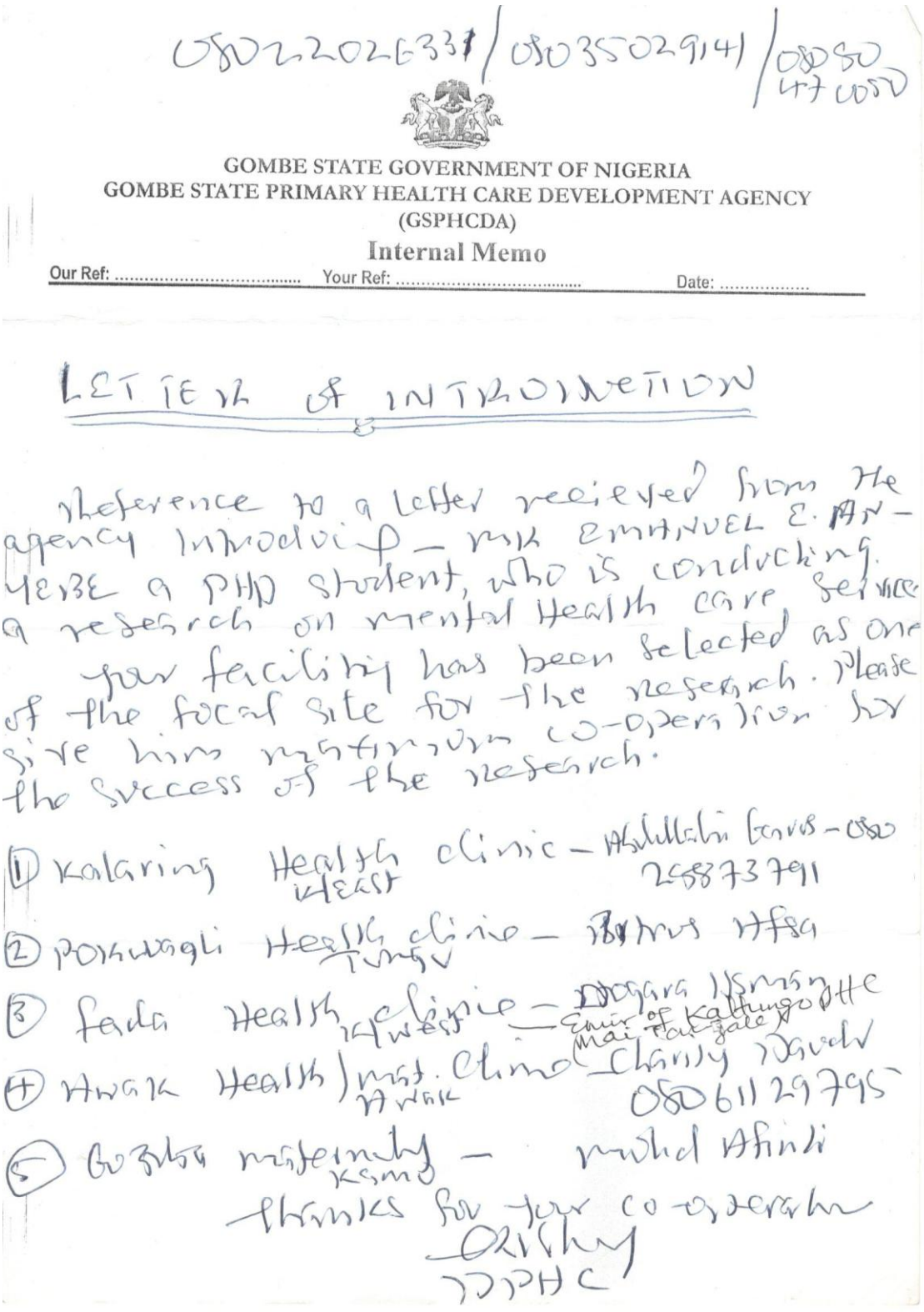
The bearer of this letter MR. EMMANUELEJ EJEMBI ANYEBE is a Phd. student from the Department of Sociology ABU Zaria.

2. He is currently conducting research on MENTAL HEALTHCARE SERVICE AT THE PHC LEVEL and is here to collect Data in 5 PHC Facilities (in 5 Wards) in your LGA

3. Details of his requirements will be heard from him, while you are expected to give him every possible support to facilitate his work, please.

Haruna Ali Dadinkowa
For: Executive Secretary

Appendix 5: A Copy of Letter Introducing Researcher to Kaltungo LGA PHCs and Communities



GOMBE STATE GOVERNMENT OF NIGERIA
GOMBE STATE PRIMARY HEALTH CARE DEVELOPMENT AGENCY
(GSPHCDA)
Internal Memo

Our Ref: ..... Your Ref: ..... Date: .....

LETTER OF INTRODUCTION

Reference to a letter received from the agency introducing MR EMMANUEL E. AN-YEBE a PHD student, who is conducting a research on mental Health care service your facility has been selected as one of the focal site for the research. Please give him maximum co-operation for the success of the research.

1. Kalaring Health clinic – Abdullahi Idris – 080 25887 3791
2. Pokwangli Health clinic – [illegible]
3. Tada Health clinic – [illegible] Emir of Kaltungo the Mai Tafarfate
4. Awak Health / mat. clinic – Charity David 080 611 29795
5. Gubata maternity – Rashid Afindi

Thanks for your co-operation

Dr Chy
DDPHC

Appendix 6: Copy of Researcher's Letter of seeking Permission for Data Collection

Department of Sociology
Ahmadu Bello University Zaria
22nd December 2014.

.....

.....

.....

Dear Sir/Madam,

REQUEST FOR PERMISSION TO COLLECT DATA ON MENTAL HEALTH CARE SERVICES AT THE PRIMARY HEALTH CARE LEVEL

I am a postgraduate student of the Department of Sociology, Ahmadu Bello University Zaria, undertaking a study to investigate the ***Provision of Mental Health Care Services at the Primary Health Care level in Northern Nigeria*** (the approved study locations are Gombe, Kaduna and Benue States) with Ethical Clearance Certificate No: **ABUTH/HREC/K028/2014**.

To enable me achieve this, I hereby request your permission to allow me access to get some relevant information from your:

[ ] Records and Observations at selected Primary Health Care centres in your community

[ ] Primary Health Care service providers/workers in your community/facility

[ ] Primary Health Care service users (clients) in your facility

[ ] Staff (Doctors/Nurses/psychologists/Social workers/administrators, etc) in your facility

[ ] People living with mental illness in your facility/community

[ ] People affected by mental illness in your facility/community

[ ] Family/household heads or the representatives in your facility/community

[ ] Community/religious leaders in your community

[ ] Traditional healers in your community

[ ] Other information (specify): .....

I shall be grateful for your approval and assistance to ensure a smooth data collection. Thank you.

Yours sincerely,

Emmanuel Ejembi ANYEBE (PhD/SOC-SCI/16647/2011-2012)

Att'd: LETTER OF INTRODUCTION from Department of Sociology, ABU Zaria

Appendix 7: Consent Form for State and LGA Health Administrators

Consent to participate in research project on

Analysis of the Provision of Mental Health Care Services at the Primary Health Care Level in Northern Nigeria.

The approved study locations are Gombe, Kaduna and Benue States, with Ethical Clearance Certificate No: **ABUTH/HREC/K028/2014**.

Only to be completed if you are a Primary Health Care Service Provider

I (please write your name).....agree to participate in this research project.

I understand that:

- The research is being conducted by a post graduate student on Primary Health Care workers' views on the true situation of the provision of mental health care services in primary health care settings and factors affecting the efficiency and effectiveness of the services; the objectives of which have been explained to me;
- As part of the research I will be asked my attitudes, knowledge and experiences of mental health, mental illness and mental health care services in my community;
- I will have complete control about what I choose to talk or not talk about in relation to the research. However, I recognise there is a chance that discussion of these topics may raise some of my own concerns about myself or someone else;
- The researcher will offer additional support, information and referral should discussion of these topics raise any personal concern;
- Any personal information I give to the researcher will be confidential.

Signed.....Date.....

Appendix 8: Consent Form for Community Participants

Consent to participate in research project on community people's perception about mental health, mental illness and mental health services

Title of the Study: ***Analysis of the Provision of Mental Health Care Services at the Primary Health Care Level in Northern Nigeria.***

Study areas: The approved study locations are Gombe, Kaduna and Benue States, with Ethical Clearance Certificate No: **ABUTH/HREC/K028/2014**.

Only to be completed if you are 18 years or older

I (please write your name), ..., agree to participate in this research project.

I understand that:

- The research is being conducted by a post graduate student on community people's perception about mental health, mental illness and mental health services as part of a study on analysis of the provision of mental health care services in primary health care settings; the objectives of which have been explained to me;
- As part of the research I will be asked my attitudes, knowledge and experiences of mental health, mental illness and mental health care services in my community;
- I will have complete control about what I choose to talk or not talk about in relation to the research. However, I recognise there is a chance that discussion of these topics may raise some of my own concerns about myself or someone else;
- The researcher will offer additional support, information and referral should discussion of these topics raise any personal concern; and
- Any personal information I give to researchers will be confidential.

Signed..... Date.....

Appendix 9: The only Mental Health Information posters found (in one Study LGA, Benue State)





Appendix 10: Example of Trafficking of PLWMI from other States to Benue States (Otukpo town)

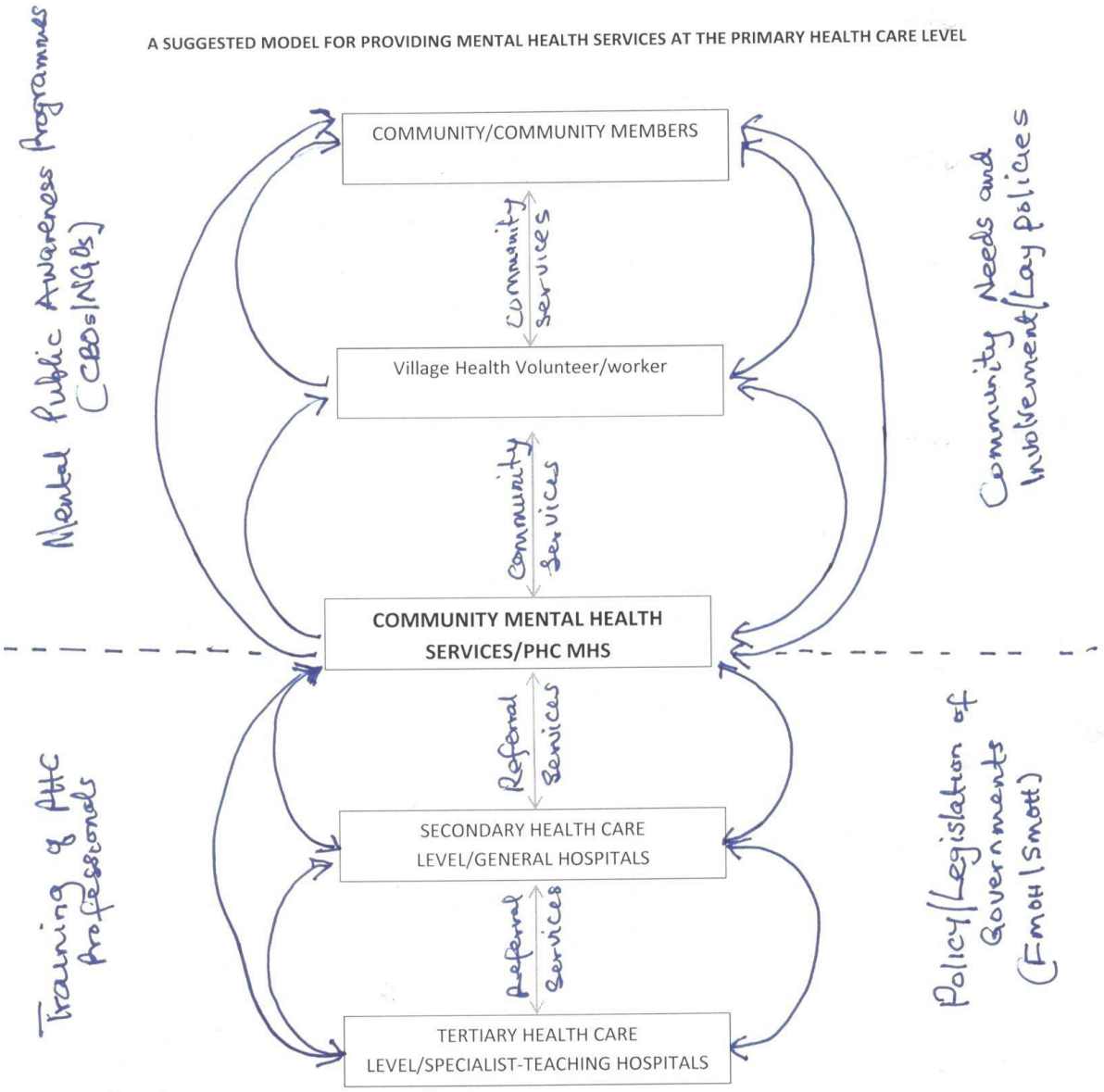


Appendix 11: The only Community-based NGO (CBM) on mental health found (in Otukpo LGA, Benue)





Appendix 12: The Schema of the Proposed Model for MHS

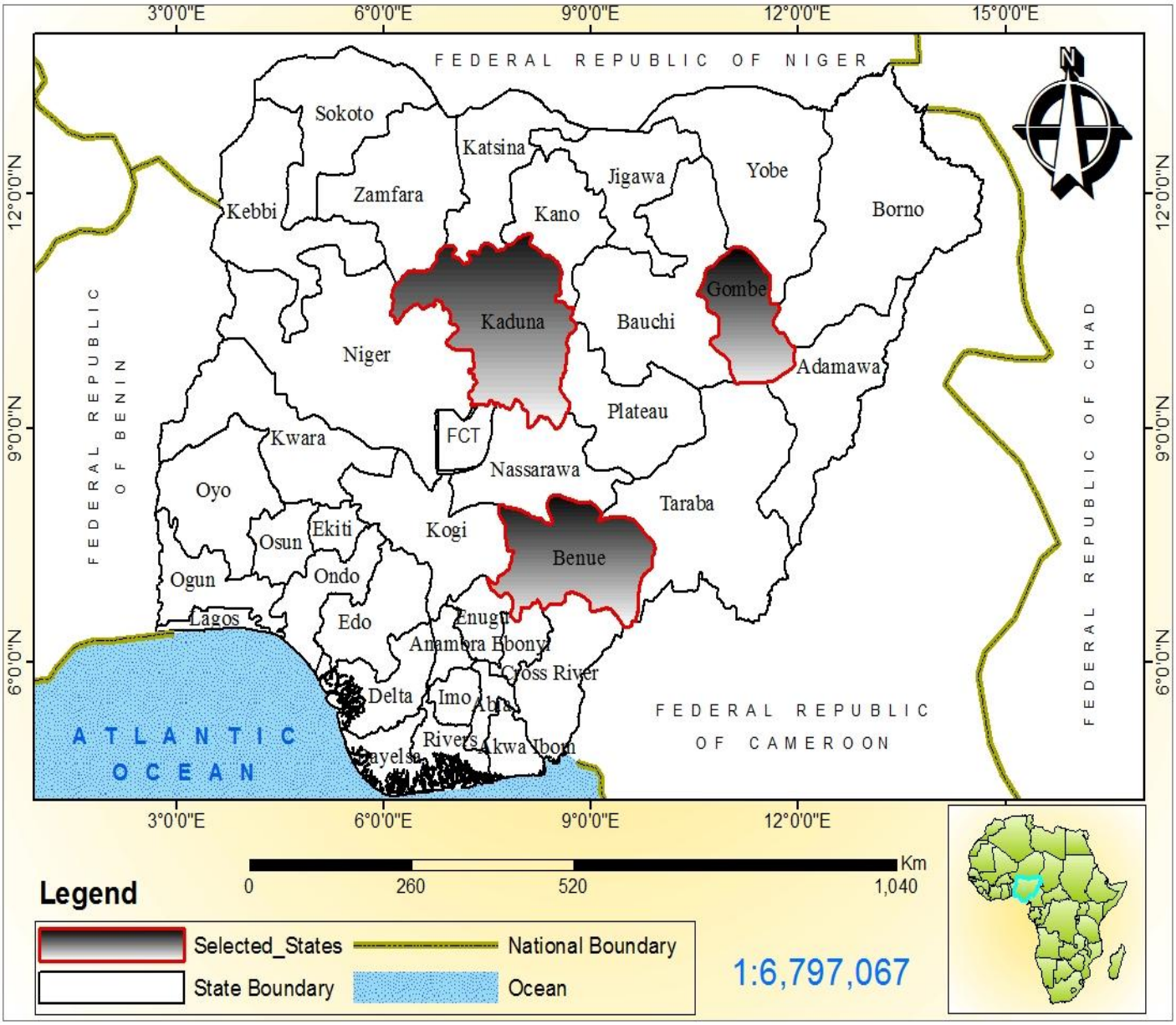


Key steps:

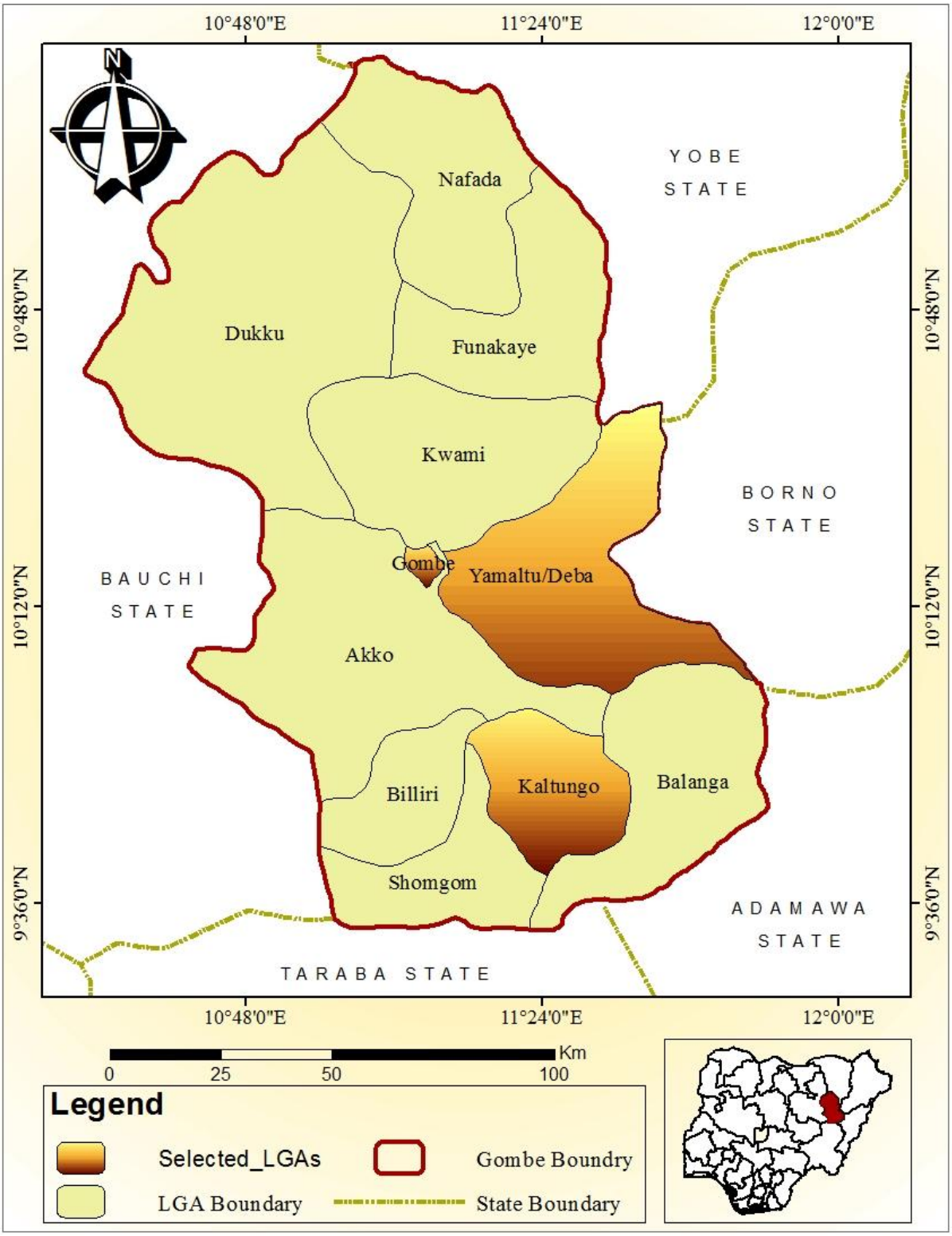
- Strengthening existing but dormant collaborations/referral systems between levels of health care, community-based organisations/NGOs, and communities
- Legislation and Advocacy at Federal and State Government levels (National and State Assemblies)
- Training of PHC professionals and Public Mental Health Awareness Programmes

288

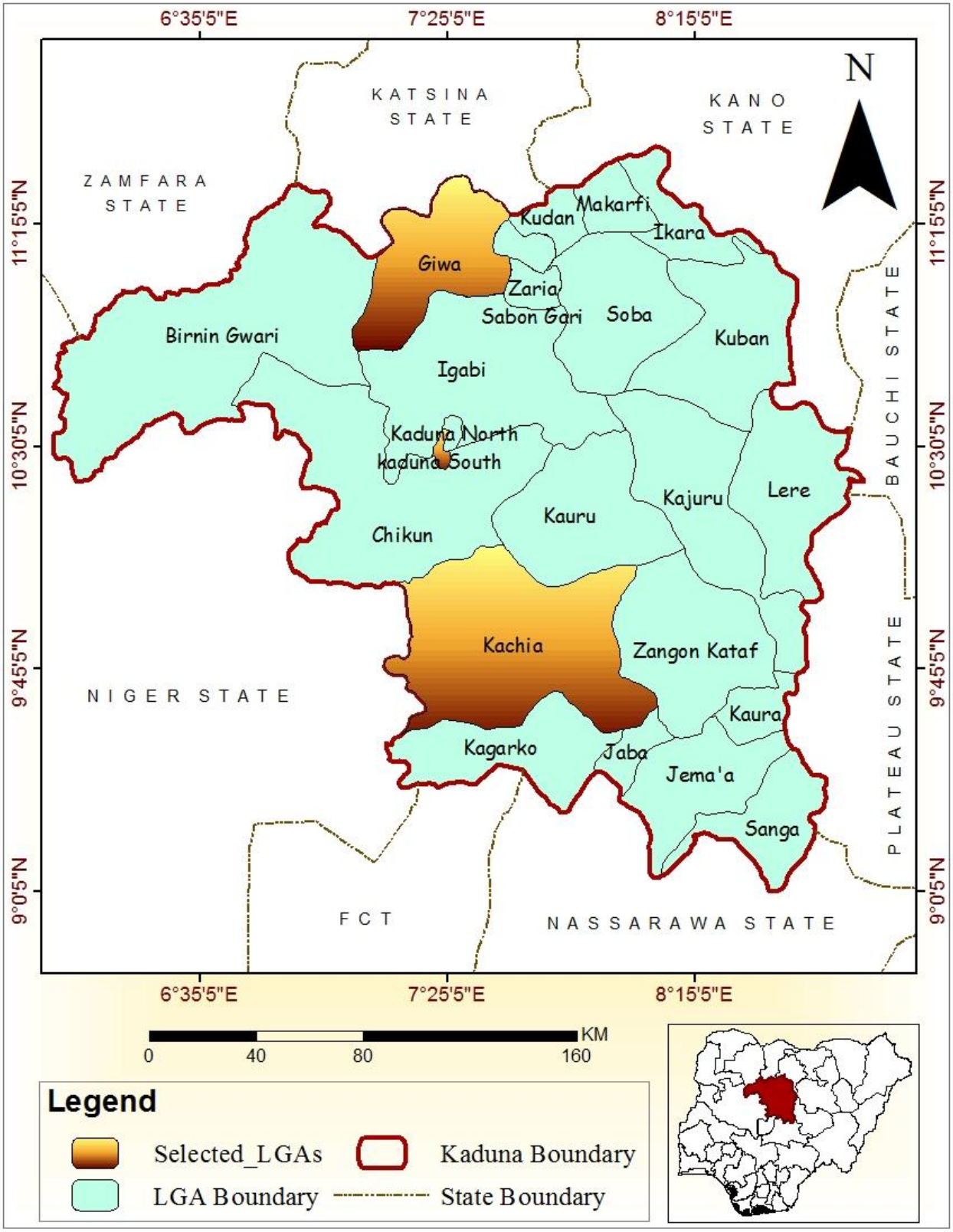
Map of Nigeria showing the three States in northern Nigeria



Map of Gombe State showing the three selected LGAs



Map of Kaduna State showing the three selected LGAs



Map of Benue State showing the three selected LGAs

