



Barriers to the provision of community-based mental health services at primary healthcare level in northern Nigeria – A mixed methods study

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ABSTRACT

This study examined the barriers associated with the level of community-based mental health services in three selected States in northern Nigeria. Both quantitative and qualitative data were collected from a convenient sample of 191 primary healthcare (PHC) service providers and a purposive sample of 13 primary healthcare system administrators and managers at both State and Local government levels through a WHO/WFMH 10-factor questionnaire and literature-derived guide for in-depth interviews (IDIs). Quantitative data analysis was undertaken using simple descriptive measures (with the use of IBM Statistical Product and Service Solutions (SPSS) 23.0) while the qualitative data was thematically analysed to complement the quantitative data. Results show that in all the study States, poor funding, lack of skilled mental health human resource and inadequate training of available personnel were identified as the major barriers to provision of mental health services at the community level. Socio-cultural factors such as community rejection of the services, stigma and misconceptions were reported as second-grade barriers. It is concluded that PHC administrators, coordinators and service providers agree that fallouts of policy failure and lack of political will at Federal, State and Local government levels and socio-cultural dynamics constitute barriers to community based mental health services. Efforts towards improving the provision of these services need to focus more on healthcare policy issues and political machinery of the governments while motivating available service providers to increase community psycho-education in their respective centres and host communities. This should be done as short-, medium- and long-term measures.

1. Introduction

The availability of mental health services (MHS) in the community, like other healthcare services, is determined by a variety of factors (WHO, 2018; Jegede, 2010). The World Health Organisation (WHO, 2010) recognised and listed “five key barriers” that need to be overcome to increase the availability of mental health services at primary care level, namely: 1) the absence of mental health from the public health agenda and the implications for funding; 2) the current organization of mental health services; 3) lack of integration within primary care; 4) inadequate human resources for mental health; and 5) lack of public mental health leadership. These could be the combination of political,

physical and social barriers reported to hamper the provision of mental health services at primary healthcare (PHC) centres (WHO, 2008; WHO/WFMH, 2009).

Butler et al. (2008) and AHRQ (2012) identified barriers to mental health services as service provider factors, financial and funding challenges, cultural issues and organizational barriers, PHC workers unwilling to take additional responsibility, poor referral system and follow up against the recommended two-referral system, 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

Abbreviations: MHS, mental health services; WFMH, world federation of mental health; WHO, World Health Organisation; CMHS, Community Mental Health Service; PHC, Primary Health Care.

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include negative attitudes, negative 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 people living with mental illness and an absence of legislation that might otherwise provide an enabling framework. He further added that attitudinal barriers including stereotype of people living with mental illness, social stigma and other overt discriminations. [Wakida et al., \(2018\)](#) reported that there are five barriers to integration of mental health services into primary healthcare were (i) attitudes regarding program acceptability, appropriateness, and credibility; (ii) knowledge and skills; (iii) motivation to change; (iv) management and/or leadership; and (v) financial resources.

Recently, [Aryani et al. \(2019\)](#) identified barriers to mental health service provision as poor dissemination of the national policy to the local government and primary healthcare centres; low prioritization of mental health issues; organization workforce issues; funding concerns; poor coordination and supervision; poor management and recording system; scarcity of ancillary facilities and other resources such as psychotropic medicines.

Historically, the Federal Government of Nigeria had 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](#)). There are also human resource challenges, including serious knowledge gap due to deficient curricular content for the training of primary healthcare workers and lack of interest among health care professionals to undertake specialized courses in mental health.

Approximately, 71% of the Nigerian population are meant to have access to a primary healthcare facility located within five kilometres (5 km) radius of their house, in which community-based mental health services are expected to be provided ([FMOH, 2007](#)). However, many of these primary healthcare 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 mental health services ([Anyebe et al., 2019a; Anyebe et al., 2020](#)). This is in spite of the huge burden of mental health problems in Nigerian communities ([Gurje, 2015; Makanjuola, 2015](#)).

An estimated 20%–30% of individuals in the population (about 200million) is reported to suffer from mental illnesses with large portions remaining unnoticed, unattended and are likely to cause severe disability and heavy socioeconomic burden on families and communities ([Whiteford et al., 2013; Charlson et al., 2014; Onyemelukwe, 2016](#)). Many community mental health problems have also been reported in the study setting ([Anyebe et al., 2017](#)). A large proportion of these could have been detected at PHC centres but for the non-availability of the services.

What could be responsible for the lack of these services at the primary healthcare level in northern Nigeria despite the high prevalence of mental health challenges? Certain factors must be responsible for the scarce community mental health services found in the region. In 2009, the World Federation for Mental Health in collaboration with World Health Organisation identified 10 barriers as specific obstacles to providing mental health services at community-based settings globally ([WHO/WFMH, 2009](#)). The 10-factor barriers encompass other barriers found in many other studies ([Butler et al., 2008; AHRQ, 2012; Mulligan, 2013](#)). These barriers need to be examined as they may account for widespread limited or scarce mental health services reported in northern

Nigeria ([WHO/WFMH, 2009; Anyebe et al., 2019; Anyebe et al., 2020](#)) but have not been examined in any previous study in Nigeria, particularly in the northern part of Nigeria. Empirical evidence on these would be needed to inform policy on the delivery of these scarce community mental health services, especially in view of the current emphasis on community based mental healthcare. This study therefore aims to identify and explore the real and perceived barriers to the provision of community mental health service in three selected States in northern Nigeria.

2. Methods and materials

2.1. Design and setting

This study is part of a larger study conducted between October 2014 and June 2015. The study adopted the convergent mixed method (simultaneous quantitative and qualitative) design ([Creswell, 2012](#)), adopting the descriptive cross-sectional and exploratory designs to examine the barriers to the provision of mental health services in the community in three purposively selected States in northern Nigeria ([Fig. 1](#)).

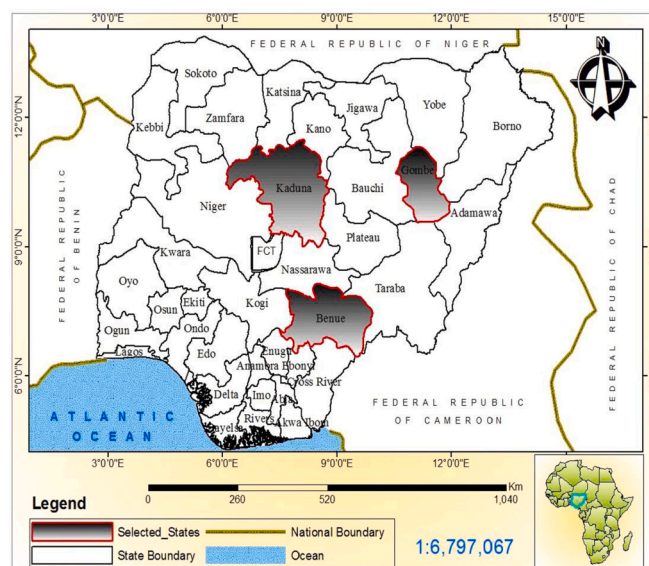


Fig. 1. Map of Nigeria showing the selected three States in northern Nigeria.

Table 1

The Sample of States, LGAs and their Populations.

State	LGA	LGA Hqrts	Population	Male	Female
Benue	Vandeikya	Vandeikya	230,120	114,811	115,309
	Makurdi	Makurdi	297,398	157,295	140,103
	Otukpo	Otukpo	176,647	91,563	85,084
Gombe	Gombe	Gombe (city)	268,000	141,947	126,053
	Yamaltu/Deba	Deba Habe	255,248	135,281	119,967
	Kaltungo	Kaltungo	149,805	144,746	110,502
Kaduna	Kachia	Kachia	244,274	124,655	119,619
	Kaduna South	Kakuri	402,390	210,486	191,904
	Giwa	Giwa	286,427	144,218	142,209

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

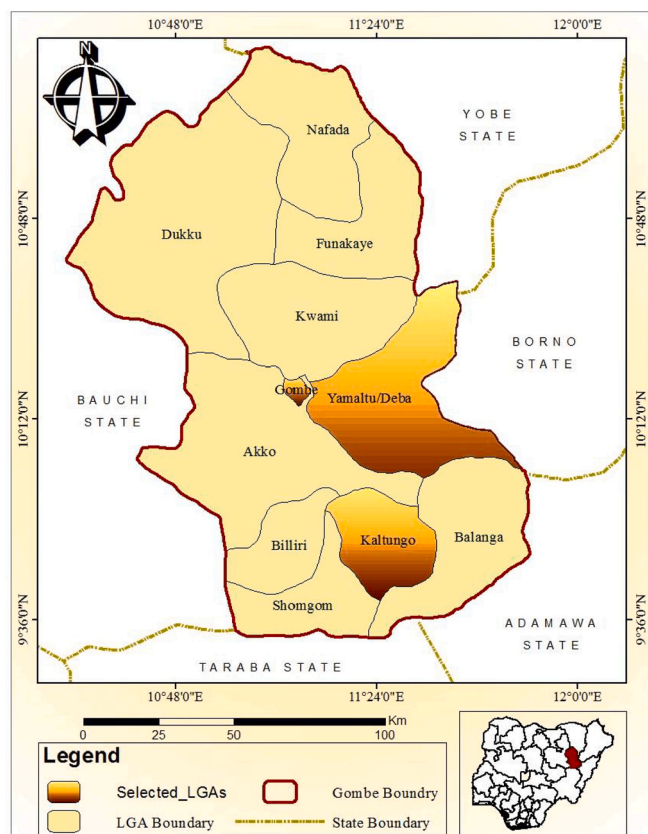


Fig. 2. Map of Gombe State showing the three selected LGAs.

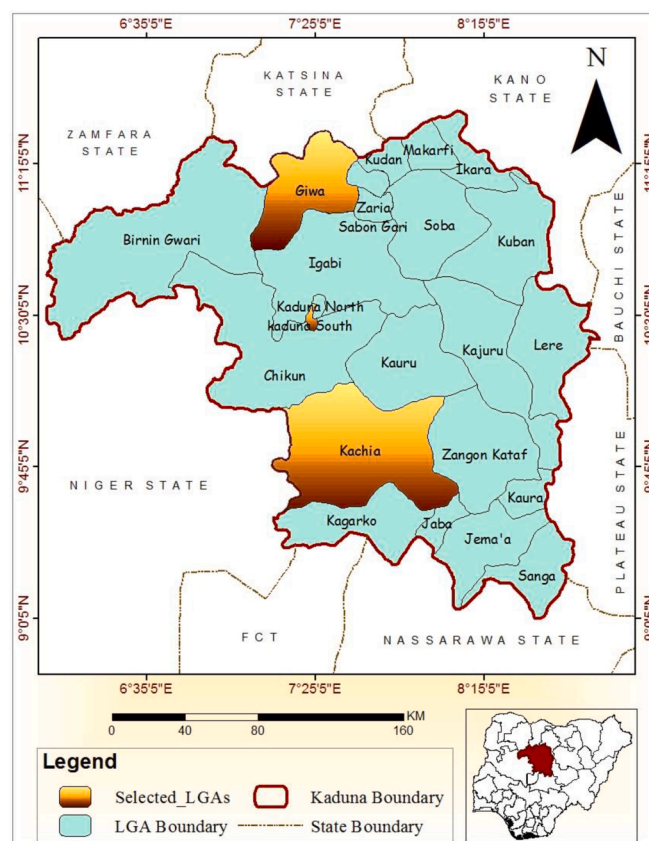


Fig. 3. Map of Kaduna State showing the three selected LGAs.

2.2. Sampling procedure and selection of study participants

Three States in northern Nigeria were selected based on geo-political representation and accessibility profile (safety due to Boko Haram insurgency) of the region at the time of data collection (Anyebe et al., 2020). The selected local government areas are shown in Table 1, and Figs. 2–4. The local governments are the third-tier of the government structure in Nigeria, similar to district government. They are responsible for the administration and delivery of primary healthcare in Nigeria, among other community development programmes (Fig. 5).

A comprehensive list of the primary healthcare workers in at the local government level in each of the States was not feasible. Thus from the 47 primary healthcare centres, between two and five primary healthcare service providers (average per centre is 3) were conveniently selected from the functional primary healthcare centres in the nine (9) Local Government Areas (i.e. three from each State). A total of 191 primary healthcare service providers in the three States (see Table 1) were thus conveniently selected to complete the questionnaire. A part of a large study, sample size was determined using *Table for Determining Sample Size from a Given Population*, constructed based on the formula: $s = X 2NP(1 - P) \div d 2(N - 1) + X 2P(1 - P)$, for researchers (Krejcie and Morgan, 1970).

A purposive sample of 13 participants, made up of selected heads of the nine Local Government Health Departments, two directors in the State Primary Healthcare Development Agencies in the three States, one consultant psychiatrist involved in community psychiatry and a provost of a College of Health technology, an institution training community health workers constituted the participants involved in the in-depth interviews.

2.3. Research instruments

A questionnaire based on the WHO/WFMH 10-factor tool, with a set

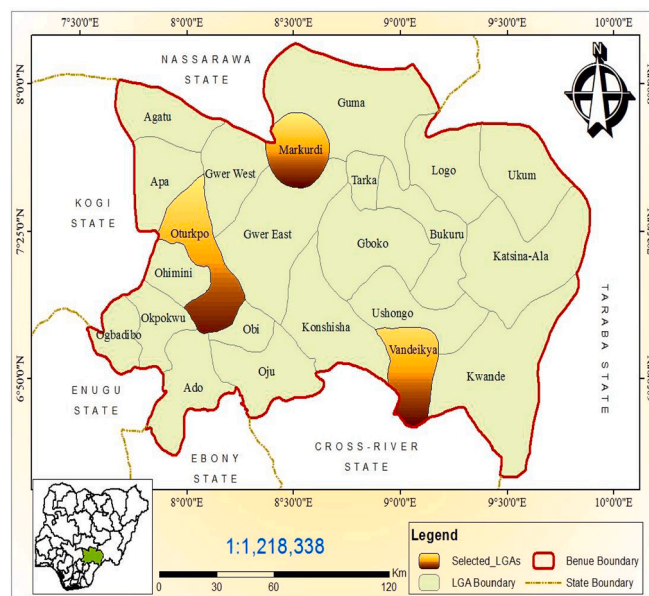


Fig. 4. Map of Benue State showing the three selected LGAs.

of primary healthcare service providers' characteristics and an In-depth Interview (IDI) guide were used to collect data. The questionnaire consisted of two sections: Section A and Section B. Section A included the name of primary healthcare centre, Local Government Area, the State, and socio-demographic profile of respondents (age, sex, ethnic group, religion, professional rank, marital status and highest educational attainment).

Section B consisted of the 10 factors: lack of advocacy, lack of practical implementation of service scale up, community rejection of the services, stigma about mental health disorders, lack of political commitment/will, lack of policy, lack of funds to provide services at the primary healthcare centre, misconception of the community about mental illness, shortage of skilled primary healthcare workers on mental health, lack of adequate training for few available primary healthcare workers adopted from the WHO/WFMH tool of Ten Barriers. As barriers, the questions were stated in negative forms to which respondents were asked to express their agreement (“Yes”) or disagreement (“No”) or “Not sure” to ten factors, namely: *mental health policy, advocacy, implementation of programmes, community rejection, stigma, training of PHC workers, misconceptions, status of skilled workers, funding, and misconception.*

The questionnaire was piloted and validated involving 20 primary healthcare workers at the two PHC centres in Zaria. Using the test retest, the 20 respondents completed the questionnaires and data entered into the SPSS version 23 and with Cronbach alpha coefficient (reliability) was determined. The analysis yielded a reliability coefficient of 0.82.

The IDI Guide was designed to elicit information from health administrators in each of the selected States in northern Nigeria and the primary health coordinators in the selected Local Government Areas in the study States. The guide consisted of Sections A and B. Section A is on informant’s socio-demographic data (centre, respondent’s position, age, sex, and category) while Section B focuses on exploring the factors affecting level of mental health services at the primary healthcare level, probing for: (i) the public health agenda and funding/financing/resource allocation for mental health, (ii) the current organization of mental health services at primary healthcare level, (iii) integration of mental healthcare within primary care system, (iv) human resources for mental health at that level, and (v) drugs availability, affordability and accessibility.

2.4. Data collection

Following the approval for the study from the Health Research Ethics Committee of Ahmadu Bello Teaching Hospital Zaria, and the individual permissions obtained from study participants, data collection commenced. In each of the selected three States, five (5) trained research assistants administered and retrieved the questionnaire at the primary healthcare centres. The workers filled the questionnaire at the centres, guided by the research assistants, and retrieved on the same day. Respondents took between 12 and 20 min to complete the questionnaire. A total of 191 questionnaires were distributed to a convenient sample of 191 primary healthcare workers from the 47 selected primary healthcare centres, through face to face interaction. A total of 15 trained research assistants across the three States were thus involved in the administration and retrieval of the questionnaire.

All the 13 in-depth interviews were personally conducted in English language by the first author. In-depth interviews (IDIs) conducted 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). Probing questions 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. The guide included probing questions like: *“As the State coordinator of Primary Healthcare Agency in the State, sir, what can tell us about mental health policy in relation to mental health services at the primary healthcare level?”* *“if you could, kindly, comment on presence of mental health coordinators at the PHC centres in your State?”* *“With the current status of mental health services at your primary healthcare system, as you just mentioned, can you give us a picture of the staff situation at these centres?”* *“To what extent are drugs in the Essential Drug List for minor mental health*

issues available in your facilities?” *In your opinion, what can you say about community’s beliefs about mental illness, with particular to accessing services at your centres?”* *“Often times, there are other challenges at this level of primary healthcare; could you discuss such challenges at the PHC centres here?”*

All the in-depth interviews were conducted in English language by the principal investigator/first author, and assisted by research assistants; the interviews were audiotaped. Each interview lasted between 20 and 30 min. The interviews were conducted in the offices of the informants. Field notes were also taken by both interviewer and research assistants.

2.5. Data analysis

The data collected were edited, coded and entered into the Microsoft Excel Spreadsheet and then loaded onto the Statistical Product and Service Solutions (SPSS) Version 23.0. A simple descriptive analysis for the data was undertaken, using relative measures such as simple percentages, modal distributions and means, and presented in Tables and charts.

For qualitative data, the interviews were transcribed. The transcripts were reviewed several times for accuracy; content and thematic analyses were then undertaken. The following themes emerged: policy and political barriers, attitudinal and socio-cultural barriers. Data were then presented using quoting informants’ opinions and views verbatim in relation to each thematic category to support or contrast the survey results. The triangulated data were presented to examine the participants’ views on perceived and real barriers to the availability of community mental healthcare services in the areas.

Trustworthiness of the qualitative data was ensured as suggested by Lincoln and Guba (1985) using credibility, dependability, transferability and confirmability. Credibility as confidence in the truth of the data and in the researchers’ interpretations of the data through in-depth engagement and subject triangulation, eliciting information from health administrators and primary healthcare coordinators across 47 centres. For dependability, each day after field work, data collected and field notes were reviewed to ensure that the findings and interpretations were adequately supported and connected. In addition, researchers constantly had various individual reviews and then discussions on the processes of data collection and data analysis to ensure continuous scrutiny of the data as well as the processes applied for collection, analysis and reporting. This often generated areas for further exploration in subsequent interviews. Transferability was ensured through description of the contexts and methodology. The detailed description of the process has the potential of facilitating replication, and hence transferability. The reflective processes on all data collected and their triangulation adopted by the researchers ensured good level of confirmability.

2.6. Ethical approval

Ethical clearance for this study was obtained from the Health Research Ethics Committee (HREC) of Ahmadu Bello Teaching Hospital Zaria (Ethical Clearance Certificate No: ABUTH/HREC/K028/2014) and individual permissions from study participants. Respective States also gave permissions for the study at the PHC centres.

To ensure anonymity, autonomy and confidentiality of the study participants, both instruments (the questionnaire and interview guide) were devoid of information on personal identities of the participants. They were also assured of the confidentiality and protection of their identities in case personal identity filtered into the information being shared during the interviews. In addition, they were also informed of the freedom to choose to participate or decline or even withdraw their

Table 2
PHC workers' Socio-demographic characteristics.

Variable	Frequency	Percentage
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
Sex		
Male	84	44
Female	106	55.5
No Response	1	0.5
Total	191	100.0
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
Religion		
Christianity	118	61.8
Islam	73	38.2
Total	191	100
Marital status		
Single	43	22.5
Married	144	75.4
Widow (er)	2	1.0
No Response	2	1.0
Total	191	100.0

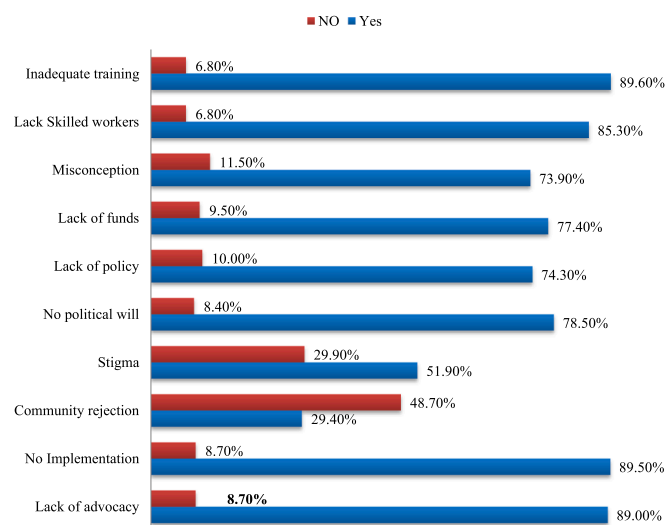


Fig. 5. Barrier responsible for Level of MHS in PHC.

participation at any stage of the study.

3. Results

3.1. Socio-demographic characteristics of PHC workers

The 191 survey participants are from Gombe (58), Kaduna (67) and Benue (66) States. Their socio-demographic variables included age, sex, ethnic groups, marital status and religion of respondents. The 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 (Table 2).

3.2. Barriers to the provision of community-based mental health services

In the survey, the PHC workers responded to a set of stated barriers adapted from the 10-factor WFMH/WHO (2012) Tool on barriers to mental health services. The Fig. 1 reveals the extent to which the 191 primary healthcare service providers perceived these barriers in the practice areas by agreeing (Yes), disagreeing (No) or are unsure of the stated barriers.

As shown in Fig. 1, lack of training for primary healthcare workers (89.6%), absence of scaling up mental health services (89.4%), lack of advocacy (89.0%) and inadequate skilled workers (85.3%) are perceived as the major barriers to providing mental health services at the primary healthcare level. Others 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 (29.4%) and stigma (51.9%) are the least mentioned barriers. This indicates that in northern Nigeria communities neither

Table 3
Barriers to Provision of MHS by States in the Study Area.

BARRIERS	STATE			TOTAL (%)
	Gombe (%)	Kaduna (%)	Benue (%)	
No Advocacy				
Yes	53 (91.4)	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				
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 (100.0)	66 (100.0)	191 (100.0)
No Fund				
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)
Inadequate 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)

reject mental health services nor attach much stigma to mental illness.

These opinions of healthcare service providers are disaggregated by States (see Table 3).

These were further explored quantitatively through in-depth interviews conducted with State primary healthcare Health Administrators, and Local Government primary healthcare coordinators.

On lack of training for primary healthcare service providers, all the service providers in three States believe that lack of training of the workers as a major hindrance to the delivery of community-based mental health services. This was supported with in-depth interviews conducted.

They also believed that the non-Implementation of the primary healthcare components despite domesticated policy, identified by primary healthcare service providers constituting a hindrance to the provision of the mental health services in the community is related to the lack of training. This was captured by one the primary healthcare coordinators, saying:

Related to the above barrier, human resource issues were also explored. Majority (65.5%) of workers agreed that the skilled human resources to run primary healthcare centres was also lacking; and repeated that even the few available ones (workers) lack the required training (40.9%) and facilities (43.0%) to work with. The workers further stated that experts to consult clients are absent (67.5%), especially experts for direct consultation (48.2%) and internet consultation (56.0%). Respondents also said that there is no mental health service coordinator in any centre in all the States neither investigated nor are specialists are available at primary healthcare centres to provide mental health services, except the Christofel Blind Mission (CBM) coordinated centre in Otukpo, Benue State. This means that the minimal, available mental health services in all other areas are unorganised and are provided as a matter of the choice and suitability to the particular staff on duty.

Similarly, the number of health workers at the primary healthcare centres was reported to be low, as presented by one primary healthcare coordinator in Kaduna:

There is a serious shortage in most centres. The number per centre range from 2 (Awon PHC centre, Kachia LGA) to 13 (Yakawa Comprehensive healthcare Centre, Giwa).

Another Health administrator in Gombe State summarised the staff situation at primary healthcare centres thus: *Honestly, our staff is not enough. We seriously are in need of additional staff.*

Readiness and willingness of staff for mental health services, a coordinator emphasized that:

...They (the staff) are very ready but there must be government commitment. We can use churches and mosques, religious organizations, for a start.

3.3. Lack of funds to provide mental health services at the primary healthcare centres

On whether financial resources allocated for mental health care are adequately provided, only 32 (16.7%) respondents out of 191 stated the affirmative; the remaining 83.3% said no.

On interview, both State administrators and the primary healthcare coordinators state that there is poor funding of mental health care at both State level and at their (primary healthcare) centres.

Some mentioned that research in mental health is not being encouraged at that level no funds have ever been allocated for research in mental health. One State Primary Healthcare Development Agency director said that *"research is seen as a neglected aspect of mental health care."*

A primary healthcare coordinator in Gombe State when asked about whether any type of funding was being given to his unit, said vehemently:

No, we have never ever had any fund for mental health" 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...nothing, no drugs available for mental health.

This further supported by the views expressed by State administrators on lack of financial resources and funding for mental health research and service. This must be a major barrier to MHS delivery at community.

However, in Benue State, a few stated some level of funding for comprehensive community mental health services. But it was reported that the funding came from a non-governmental organisation (NGO) called CBM (Christofel Blind Mission) which is providing some community services for promotive mental health in Benue State. No funding was reported from the state government.

3.4. Lack of policy and political will

As shown in Fig. 1 and Table 2, lack of mental health policy (74.3%) and political will (78.5%) by the State and Federal governments are seen as strong barriers in providing mental health services at the community level.

During in-depth interviews, most health workers reported policy neglect relating to mental health. Most claimed they are not even aware of the existence of any such policy in their States. Only few trainers of primary healthcare workers in Health Training Institutions (HTIs) that claim to be aware, even that they reported never sighting such document. This is captured in this statement by a Provost in Gombe State College of Health Technology, Kaltungo:

"On mental health policy, the lecturers claimed to be aware of it but not available to teachers of community health workers training for teaching students."

For some health administrators, it is even a laughing matter to talk about mental health in the States because policy on mental health is "remote". Like a primary healthcare coordinator in Gombe State, when asked about a mental health policy in Gombe State, said:

... Oga (a Nigerian version of 'Sir', referring to the researcher)! Have you seen one here in Gombe (State) since you came or in your literature search?...as far I know, no such policy here. (The) Government is doing virtually nothing.

Some even blamed the central Federal Government, as presented by another primary healthcare Director in Gombe State, saying, angrily:

"The Federal Government is responsible for the non-existence of Mental Health programmes at the LGA (Local Government Area)".

A primary healthcare coordinators in Benue State expressed fears that mental health services might not be readily favour at the community healthcare level because *"there are no circulars from above."* By this, the government (State or Federal) had not mandated the local government health system to commence provision of such services as part of primary healthcare services.

In Kaduna State, still on the general issue on mental health policy at the primary healthcare level, a consultant psychiatrist during an in-depth interview rather exclaimed:

"Aah (an exclamation), the mental health services in the community is right next to nothing."

Some insinuated that the government policy on mental health services only exists on paper but without implementation. It was stated that many health workers are not aware of it or are aware of but never had access to it, as captured in this statement:

“On mental health policy, the lecturers claimed to be aware of it but not available to teachers of community health workers’ training for teaching students” (a Provost, School of Health Technology).

A director of a State Primary Healthcare Agency 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 no body 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 primary healthcare.

In addition, as part of his comment in the statement, he said *“And I think this your work will a starting point for this”* indicate the health workers themselves seem not to be awake to the responsibilities until reminded.

In spite of this though, some health workers accuse the Local Government Chairmen as being responsible for the lack of mental health services at primary healthcare level. On asking about barriers in Giwa Local Government Area, during an interaction with health workers, a health worker answered, angrily, saying:

“it is the chairman, the Local Government Chairman, he is the only barrier.”

On further exploration of this statement, many health workers see the local government administrators as being focused only on issues other than mental health service because *“mental health is not lucrative.”* By this they mean that NGOs are not showing interest in mental health service, and thereby not financially rewarding.

From the foregoing, policy and political will constitute major barriers to mental health services delivery in the study.

3.5. Community rejection of mental health services (29.4%) and stigma (51.9%)

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. As one coordinator opined:

“all families have a mentally sick person in one way or the other.”

A Provost of the School of Health Technology, Gombe State agreed with this’ 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 other two local government areas.

This position on stigma against people living with mental illness was therefore explored at Gombe Local Government Area, where a primary healthcare coordinator when asked about stigma of people living with mental illness in the area commented that;

...yes, there is 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 are dangerous.

4. Discussion of findings

From the data presented, all the study participants from all the States

involved in this study have identified similar barriers to the provision of mental health services in the community. The absence of a clear mental health policy at both federal and state levels is unanimously presented by both healthcare service providers and administrators. This study identified barriers to mental health service delivery at the primary healthcare level in northern Nigeria. Among the several barriers to providing mental health services at the primary health care level at primary healthcare centres, political and policy issues are said to have acted as major determinants, similar to previous assertions by some global health authorities (WFMH/WHO, 2012). A mental health policy captures the three fundamental issues in organizing mental health service at the community level: 1) deinstitutionalise mental health care; 2) integrate mental health into general health care; and 3) develop community mental health services (WHO, 2010).

As presented, Nigeria’s mental health services especially at the primary healthcare level is crippled due to lack of policy, weakly implemented mental health policies and political inattention and unwillingness (Jack-Ide, Uys & Middleton, 2012; Mental health Atlas, 2011). Poor policy implementation in Nigeria has specifically reported as the major factor against the effective provision of MHS (WHO-AIMS Report, 2006). Similarly barriers have been identified in Zambia, where Mwape et al. (2010) also found a weak political will in their attempt to integrate MHS into the PHC. Similar findings by Sarikhani, Bastani, Rafiee, Kavosi and Ravangard (2020) reported that weakness of evidence-based policy making, inappropriate legislation on mental health services, inappropriate professionals’ training, imperfect mental health information system, insufficient resources and geographical imbalance in resource allocation were the key the barriers to the provision and utilization of mental health services in low and middle income countries. Providing effective mental health care at the primary healthcare would need political commitment. This appears to be a long standing issue in Nigeria as previously identified in many studies in Nigeria (Jack-Ide & Uys, 2012; Gureje, 2015).

The study therefore shows a failure of policy thrusts and deliberate neglect (lack of political will) in the study area to create a unified system to address structural and process issues for community-based mental health services. The fallouts of these are unarticulated plans, human resource challenges, and legislations and poor resource allocation, (services lacking and sufficient funds) are specific barriers to mental health services in Nigeria and Ghana (Ayorinde, Gureje, & Lawal 2004; Ihekweazu & Anya, 2006; Abegunde, 2013; Awenva et al., 2010). Gureje (2015) lamented that Nigeria allocates only 4% of her health budget to mental health as a whole, which is far below the recommended mental health budget (WHO-AIMS Report, 2006). The assertion indicates that the budgetary allocations for mental health are diverted to the few Psychiatric Hospitals and Departments of Psychiatry in Nigerian Medical Schools while virtually no allocation goes to mental health services at the primary healthcare level. This is in spite of the global emphasis to invest more resources at the primary care level to scale up mental care services especially at the primary care level (WFMH, 2010).

There are shortage of primary healthcare workers with the appropriate skills to carry out community-based MHS services, as found elsewhere (WHO-AIMS Report, 2006; Van-Cleve et al.; 2013; Mental Health Leadership and Advocacy Programme, mhLAP, 2014). To address this shortages, short-term and continuing professional training programmes have been suggested (mhLAP, 2014; WHO/Mental Health Atlas, 2014). Many countries such as Jordan, Ethiopia, Panama and Zambia have adopted this strategy in training the operators of their PHC systems and the primary care providers. This approach has helped to integrate mental health services into the PHC (WHO/WFMH, 2009; Mwape et al., 2010), thus making community mental mental services a priority. In other parts of Africa, such as Zambia, Kenya, and South Africa, few isolated studies have shown the role of primary healthcare 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. (2010) identified a

strong support from primary health care workers in Zambia. In Uganda, lack of capacity, opportunity and motivation are identified as major barriers to the integration of mental health at the primary healthcare level (Wakida, Obua et al., 2018). These barriers have reflected in poor mental health facilities and lack of structures for mental health services (Anyebe et al., 2019; Anyebe et al., 2020).

The statement: “there are no circulars from above” indicates that governments (State or Federal) need to mandate the local government health system to commence provision of such services as part of primary healthcare services. In a study on utilization of posters for mental health services, Anyebe et al. (2019b) reported primary healthcare system expect State governments to initiate and mandate mental health services before they could use posters for mental health education.

On the other hand, socio-cultural factors such as incorrect perceptions and misconceptions of communities about mental illness and the persons living with mental illness have been reported (WHO, 2006). However, of all the factors believed to be hindering the provision of community-based mental health services in this study area, these socio-cultural factors issues including stigma and community rejection of services are the least mentioned. This indicates that in northern Nigeria communities neither reject mental health services nor attach so many stigmas to mental illness. Compared to other studies in Nigeria and elsewhere stigma on mental illness is not pronounced, although it does exist (Subramaniam et al., 2017; Ahmed & Baruah, 2017; Ukpong & Abasiubong, 2010). Studies had indicated that northern Nigeria communities accept mentally ill persons more easily than those in other regions (AbdulMalik & Sale, 2012; Yusuf, Nuhu & Olisah, 2013).

Barriers to the provision of mental health services are evident and many in the study areas. They include the absence of active government policy, lack of funding, inadequate and poorly trained and motivated but willing staff, and social hindrances like stigma. The 10-barrier (factors) identified by WHO (2012) 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 primary healthcare level in the study areas. The barriers speculated by the WHO document, and empirically assessed in this study and discussed in this chapter are predominantly present in northern Nigeria. They are barriers to mental health service delivery in the region. However, some of the barriers do not appear significant in the study areas. For example, community rejection of mental health services and stigma against people living with mental illness in the region, though present, are the weakest social factors that would affect mental health illness, if and whenever, they are made available to the communities in the region. Apart from these WHO-recognised barriers to the provision of mental health services in the primary healthcare system, respondents and informants enumerated many other factors that may affect mental health services in their communities. Barriers such as these have also been suggested by other authors (Peritogiannis & Nikolaou, 2019).

4.1. Implications for mental health services in the community

Barriers identified in this study should inform policy makers to take a holistic look at the mental health policy in Nigeria which has been under consideration at the National Assembly since 2003. This could ultimately lead to a change in the mental health policy on training for mental health at the primary healthcare level. This study provides baseline information on community-based mental health problems, and the problem-intervention gap. This should stimulate further research in these vital areas, especially in the selected States in northern Nigeria.

4.2. Limitations of the study

The purposive selection of the study sites and participants makes generalisation of the findings limited to only the study areas. However, replication of the study in other parts of the country will be worthwhile. Literature review from other parts of southern Nigeria still point to the

issues of mental health policy, lack of political will and mental health human resource issues. The findings are therefore clear pointers to the absence of scarcity and uncoordinated mental health services in communities in northern (Anyebe et al., 2019; Anyebe et al., 2020).

5. Conclusion

The findings have provided some baseline evidence on the range of obstacles to the provision of mental health services in northern Nigeria, which hinge mainly on policy, political, attitudinal and social dimensions. The fallouts of these policy gaps and insipid political commitments account for lack of legislative framework for mental healthcare, structural issues such as 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 poor budgetary allocation. Although minor, some socio-cultural barriers like stigma, community rejection of service and misconceptions are also barriers.

5.1. Recommendations and suggestions for further studies

Based on the findings of this study, the following recommendations are made:

There is need to address the acute shortage of skilled (mental health) service providers by initiating short courses for primary healthcare workers to acquire basic skills in detecting, and treating common mental problems and providing community psycho-education and counselling to vulnerable members of the population. In addition, facilitating and granting sponsorships and scholarships to Primary Healthcare providers and other healthcare professionals interested in providing community mental health care to undertake specialist training in mental health will ensure provision of community mental health services.

Trained mental health specialists (personnel) should be motivated to provide mental health services. They can be used as the needed mental health coordinators at primary healthcare centres.

There is need for State Ministries of Health to create Desk Offices for Mental Health in all the States to ensure the implementation of community-based mental health care in all Primary Healthcare in all the Local Government Areas. This should be done in collaboration with Local Government Service Commission. Mental Health Policy and Legislation should be made a priority of governments. The elected legislative arm of government should see this as a top priority. This should along with advocacy visits paid to all relevant stakeholders, including political and community leaders.

Because of the limited scope of the study (only northern Nigeria), larger and randomized studies in Nigeria can be undertaken with a view to developing culture-sensitive and competent models to enhance service delivery.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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