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Availability of Mental Health Services at the Primary Care Level in northern part of Nigeria: Service Providers' and Users' Perspectives

Abstract

Background/Objectives: Community-based mental health services (MHSs) should target 70% of the rural population, the end users of primary health-care (PHC) services. In this study, the views of the service users and providers were explored to determine the level of MHSs available at their PHC care centers in three selected states in northern part of Nigeria. **Materials and Methods:** Concurrent quantitative and qualitative data (using mixed-methods research) were collected from a sample of 249 participants through a survey questionnaire and focus group discussions. The sets of data were analyzed using SPSS 23.0 and thematic clustering; these were triangulated to determine the availability of the MHSs. **Results:** PHC service providers and users reported that PHC centers lacked any formal MHSs, and only a few personal efforts by service providers were mentioned. The service users could not attest to even these unofficial services. **Conclusion:** Primary MHSs remain conspicuously absent at community level in the study areas. Both service providers and users attest to the near-complete scarcity despite their willingness to provide and use the services, respectively, if and when formal arrangements can be made. **Recommendations:** Stakeholders' attention is once again drawn to a neglected component of the PHC to promote mental health and prevent community mental health problems characteristic of many communities.

Keywords: *Benue state, community mental health care, Gombe State, Kaduna State, mental health services, northern part of Nigeria, primary health care*

Emmanuel Ejembi Anyebe, Victor O. Olisah[1], Saleh Ngaski Garba[2], Hassan Hassan Murtala[3], Fatima Balarabe[4]

Department of Nursing Sciences, Faculty of Clinical Sciences, College of Health Sciences, University of Ilorin, Ilorin, [1]Department of Psychiatry, Ahmadu Bello University Teaching Hospital, [4]Department of Nursing Sciences, Faculty of Allied Health Sciences, Ahmadu Bello University, Zaria, [2]Department of Nursing Sciences, Faculty of Allied Health Sciences, College of Health Sciences, Bayero University, Kano, [3]School of Nursing, Birnin Kudu, Jigawa State, Nigeria

Address for correspondence:
Dr. Emmanuel Ejembi Anyebe, Department of Nursing Sciences, Faculty of Clinical Sciences, College of Health Sciences, University of Ilorin, Ilorin, Nigeria.
E-mail: ejembianyebe@gmail.com, anyebe.ee@unilorin.edu.ng

Introduction

Mental health services (MHSs) in this study would mean services such as mental health information and psycho-education, early detection and treatment of minor mental health problems, mental health referral services, and rehabilitation of those living with mental illness at the community level. Available data indicate that such services in many communities in developing countries vary from total absence in many primary health-care (PHC) centers to rudimentary, uncoordinated, and chaotic in some others[1] despite the global desire on primary mental health care. Availability increases access; access being the opportunity or ease with which consumers or communities can use appropriate services in proportion to their need.[2]

Providing specialized health services – such as MHSs at the PHC level – is one of the World Health Organization's most fundamental health-care recommendations,[3] aimed at developing community-based MHSs for effective and efficient, available and accessible services to majority of the citizens who reside in rural settings, instead of providing such care in large psychiatric hospitals.[4] However, across the low- and middle-income group of countries, more than three-quarters of people needing mental health care do not receive the most basic MHSs.[5] In Nigeria, as part of its national mental health policy, it is recommended that PHC centers should provide MHSs as part of the routine services,[6] to curb the rising prevalence of mental illnesses and to promote mental health.[7,8] In 2006, the Nigeria's primary (community based) MHSs were shown to be unavailable and inaccessible to the population at the PHC system.[9] The primary (community based) MHSs meant to serve over 70% of the population in the rural communities have been reportedly ignored by the government in favor of hospital-based curative mental health

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care.[10] Strategies to make these services available and accessible in Nigeria have been suggested to promote the mental health of the rural population.[9] There is a paucity of studies on the availability of MHSs in Nigeria. Only recently, in a qualitative study of twenty participants (ten caregivers and ten patients) in a neuropsychiatric hospital in Niger Delta region in southern part of Nigeria, Jack-Ide and Uys[11] found a complete absence of MHSs in their PHC centers. The participants said that they had to come to the psychiatric hospitals to access services for all types of mental health conditions.

Investigations into the availability of these services at the community level in northern part of Nigeria, to the best of our knowledge, have been unavailable until quite recently when an exploratory qualitative study of health-care managers was published[12] in the region, indicating situations similar to those of the southern part of Nigeria. However, the study[12] did not seek the opinions of the users of these services neither those of the service providers. PHC service users and providers are key valuable stakeholders that could be used to elicit information on the extent to which MHSs at that level is available. Availability of MHSs at the PHC level is the extent to which the various forms of community-based MHSs are present at the PHC centers and accessible to clients and to the hosting communities. This study, therefore, explored the views and perceptions of PHC service providers and users on the availability of MHSs in communities in three states in the northern part of Nigeria.

Materials and Methods

Design and setting

This study was conducted between October 2014 and June 2015. It is an exploratory, cross-sectional study that adopted the concurrent mixed research methods (quantitative and qualitative approaches)[7,13] to explore service providers' and users' perspectives on the availability of MHSs at PHC settings in 47 centers in nine local government areas (LGAs) in Gombe, Kaduna, and Benue States in the northern part of Nigeria [Table 1].

Sampling procedure and selection of study participants

The States included in this study were selected using a multistage sampling. First, the northern part of Nigeria was purposively selected, from where three States (viz., Gombe, Benue, and Kaduna States) were also purposively selected to represent the northeast, north-central, and north-west geopolitical zones, respectively. This selection of States was premised on the level of health services available in the States and the safety of the study area in view of the security situation in northern part of Nigeria at the time of data collection (October 2014 to June 2015; the peak of Boko Haram insurgency in the region). The second stage involved dividing each State into three zones, using the senatorial districts (zones A, B, and C), whereas in the third, three LGAs from each State were selected: one LGA from each of the three senatorial districts (nine LGAs in all). In the fourth stage, 5 PHC centers were purposively selected from each LGA (nine LGAs in all, three from each State, i.e., 45 centers; 15 from each state) from the list of functional PHC centers in the nine LGAs. Two other PHC centers (representing comprehensive center in Giwa LGA in Kaduna State, and in Otukpo LGA in Benue State) were purposively added. Between three and five PHC workers from each of the five centers in the selected LGAs made up a total of conveniently selected 191 PHC service providers in the three States, who responded to the questionnaire.

Table 1: The selected states, local government areas, 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. LGA=Local government area

The 249 study participants involved in the study [Table 2] were selected from the 47 randomly selected PHC centers in the three States. The participants were made up of 191 service providers and 58 female clinic attendees (they were involved in eight FGD sessions), who were available (and willing) at the time of data collection.

Research instruments and data collection

Two instruments were used for this study: a set of researcher-constructed questionnaire for PHC service providers and a guide for focus group discussions (FGDs) for clinic attendees to collect both quantitative and qualitative data, respectively. The questionnaire was developed based on the extensive literature on the availability of community-based MHSs. Service providers at the PHC centers provided responses to the questions. The FGD Guide for PHC service users consisted of questions on the informants' socio-demographic data including the centre; a section for probing Mental Health Services in terms availability of the Primary Health Care (PHC) services generally; rating of any available services using the ABCD (i.e. Awareness creation, Best service, Cost, and Distance) of mental health services; any measures that promote mental health, prevent mental illness, and those needed to treat mental illness and challenges of providing mental health care at the PHC level.

Data collection involved 15 trained research assistants across the three States and the principal author. The

Table 2: Study participants for selected States

Participants	Gombe State	Benue State	Kaduna State	Total
PHC service providers	58	67	66	191
PHC service users (FGD Guide - E)	12 (2 FGDs)	11 (2 FGDs)	35 (4 FGDs)	58 (8 FGDs)
Total	70	78	101	249

PHC=Primary health care, FGSs=Focus group discussions

principal author and one of the female research assistants were involved in the FGD. The discussions were conducted in both Hausa (for those clients who could not speak English) and English languages; these were audio-taped with their consent. Each discussion took between 45 min and 1 h.

Ethical clearance for this study was obtained from the Health Research Ethics Committee of Ahmadu Bello Teaching Hospital Zaria, and individual permissions were obtained from the study participants. Respective States also gave permissions for the study at the PHC centers.

Data analysis

The quantitative data were coded and entered into the Microsoft Excel Spreadsheet and then loaded onto the Statistical Package for the Social Sciences IBM SPSS Version 23.0 (SPSS) Version 23.0, an IBM product, Il, USA). Data were then analyzed descriptively using relative measures such as simple percentages, modal distributions, and means and presented in Tables.

The qualitative data were (translated and) transcribed. Content analysis and thematic clustering were done. Quoting informants' opinions and views verbatim, their position on availability of MHSs was captured. Both quantitative and qualitative data were then triangulated to determine the participants' perceived availability of MHSs in the areas. The results are discussed under the following headings: (1) respondents' sociodemographic characteristics and (2) availability of MHSs at PHC centers as perceived by the respondents.

Results

Respondents' sociodemographic characteristics

The PHC service providers were predominantly married (75.4%) and female (55.6%). Hausa constituted the bulk of the respondents (21.5%), with a good number of the Idoma and southern Kaduna tribal extractions (17.3% and 14.1%, respectively). The mean age of the participants was 35.5 years [Table 3].

Availability of mental health services at primary health-care centers

On the availability of a mental health section at PHC centers, majority of the service providers (n = 172; 90.1%) reported the nonexistence of such sections/rooms at the centers [Table 4]; only 19 of them (9.9%) claimed to have such designated sections or rooms at their respective PHCs for providing MHSs.

As indicated in Table 4, of the 19 respondents who reported having a room or a section for MHSs, 12 (63.2%) are in Otukpo LGA (in Benue State), and the remaining six were in Gombe State, with four (21.0%) in Kaltungo and two (10.5%) in Gombe LGAs, respectively. This indicates that no PHC centers investigated in Kaduna reported having any formal arrangement in the form of a mental health room or section for the provision of MHS to any group of clients. Even the situation in other two States appears quite insignificant.

On forms of any formal mental health programs in their States, only 22 (11.5%) reported some form of mental health programs purportedly being provided at their centers. Table 5 indicates these identified programs and the responsible organizations. As shown, only participants in Benue and Gombe States reportedly indicated the existence of some mental health programs at the community level. However, unlike Gombe State where all the programs were claimed to be driven by the local government, the involvement of a nongovernmental organization (NGO) and faith-based health institutions was reported in Benue State. Respondents in Kaduna State did not appear to have any record of such programs.

However, some PHC workers reported that they provide some form of uncoordinated, self-propelled mental health activities for clients attending clinics. These, they reported, are unofficial (personal conversation).

During the FGD sessions, the participants (the service users) attested to the fact that MHSs were unanimous in saying that these services were not provided for them at their centers. For instance, a pregnant woman at a PHC center in Giwa LGA of Kaduna State when asked about mental health education as part of the antenatal clinic (ANC) reacted sharply:

Ah (an exclamation) No-o, we have never been educated about our mental health o (sic) except on care of our children, and the pregnancy.

Another FGD participant answered (looking surprised):

Mental health? I know we get services like immunizations, drugs, education on care of children, family planning. We are okay with these services they render here. but No-o, we have never been told or educated on mental health except, on care of our children, as I said earlier.

All FGD participants reported never being exposed to any form of MHSs at any PHC center throughout their patronage of the centers for health care.

Table 3: Primary health-care workers' sociodemographic characteristics

Variable	Frequency (%)
Age category (years)	
20-29	43 (22.5)
30-39	90 (47.1)
40-49	39 (20.4)
50-59	15 (7.9)
60-69	1 (0.5)
No response	3 (1.6)
Total	191 (100.0)
Sex	
Male	84 (44.0)
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 (100.0)
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

Table 4: Opinions on the availability of mental health section/room in primary health care by state/local government areas

State	LGA	Room for MHS		Total
		Yes	No	
Gombe	Gombe	2	19	21
	Yamaltu-Deba	0	22	22
	Kaltungo	4	11	15
Kaduna	Giwa	0	27	27
	Kaduna South	1	19	20
	Kachia	0	20	20
Benue	Makurdi	0	20	20
	Vandeikya	0	16	16
	Otukpo	12	18	30
Total (%)		19 (9.9)	172 (90.1)	191 (100.0)

Source: Crosstab of room for MHS and LGAs, Field data 2015.
MHSs=Mental health services, LGAs=Local government area

Discussion of Findings

The MHSs in the study areas are scarce in virtually all the 15 LGAs. As reported elsewhere,[12] organized MHSs in government-owned PHC facilities across the areas are reportedly lacking. However, providing specialized health services – such as MHSs – at the PHC level is one of the WHO's most fundamental health-care recommendations.[9,14] Although formal MHSs are not provided at PHC centers, some individual self-motivated PHC service providers have demonstrated the desire and willingness to provide such services, but in a rather haphazard manner. Such services include *ad hoc* public enlightenment events being undertaken at particular times, such as part of secondary school enlightenment programs (some limited school health program) and community health education. No specialized MHS was mentioned as being provided by these PHC workers. Such chaotic nature of MHSs in most countries was noted by other researchers and health authorities within and outside Nigeria.[1,4,8,9,15] Reports by WHO-AIMS[5,9] and Omigbodun[10,15] had earlier indicated such lack of MHSs in the community-based PHC clinics in parts of Nigeria. This situation is still sustained in the study areas. This means that, as previously pointed out by other studies,[4] the rural population cannot access mental health care and other related services at the community level, sustaining the treatment gap as high as 80%–90% in the developing countries, including Nigeria.[5,10] From the findings of this study, this gap remains a needy area for intervention. The recently documented issue of community mental health problems in northern part of Nigerian communities as reported by Anyebe *et al*.[11,16] could be explained in light of this yawning gap. And, because of these (lack of MHSs and presence of mental health problems), Nigerians would resort more to the patronage of alternative mental health-care services including traditional healers and spiritualists.[12,13,17,18] A deliberate policy on this aspect of care (alternative services) will be important in view of its patronage.

Similarly, the absence of MHSs would also mean that PHC clinic attendees such as women and children who access routine antenatal, postnatal, and immunization services, as well as treatment of common ailments, among other PHC services, are deprived of basic MHSs as a component of the PHC services.

Most of the FGD participants were pregnant women who had come for ANC routine checkups. Expectant mothers are a particular vulnerable group to mental health challenges, but they all confirmed the absence of any form of psycho-education and assessment when they attend ANCs. Some pregnant women said that some staff provided some counseling services to those who had some psychological problems such as depressive episodes, anxiety disorders,

Table 5: Mental health programs and their sponsoring organizations

Identified programs	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 organization	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. LGAs=Local government areas, NGO=Nongovernmental organization, NKST=Nongu u Kristu u i Ser u sha Tar (The Church of Christ in the Sudan among the Tiv), CBM=Christofoel blind mission

and violence-related issues, most times in their (staff's) private offices.

Incorporating MHSs as a component of PHC at all routine (day to day) service delivery, alongside other services such as ANC, immunizations, and treatment of other common ailments, at the PHC level, can take the forms of "pluses" during antenatal care, immunization of children, and when treating childhood and other diseases at the PHC and health clinics. This will improve the level and range of provision of MHSs at the primary level of health care and make more accessible. This can be achieved through health education and quick mental status examination (for both children and adults) using short and established checklists, for example, The Child Behavior Checklist, Abuse Assessment Screen for pregnant women, Psycho-social Risk Factors checklist for pregnant women, and Edinburg Postpartum Depression Scale, among others.

The relatively high presence of community-based MHSs reported in a LGA (Otukpo) in Benue State was, however, linked to the activities of the Christofoel Blind Mission, an NGO providing comprehensive community mental health care to the rural population domiciled in Otukpo LGA of Benue State and other parts of the state. The NGO which is primarily focused on eye care had to venture into this area due to the urgent need.

Limitations

1. Although required for the data collection, male attendees at PHC centers were difficult to come by and so could not be accessed for their views. Male clients at PHC centers in the study areas is usually a challenge as most males feel PHC centers are meant for women and children only
2. This study is focused on three States of the northern part of Nigeria. The northern part of Nigeria is a vast geographic entity and so the findings may not be representative of the entire region. Similarly, because of the random selection, some few areas providing these services could be missed.

However, the findings of this study represent a good ground for further in-depth, more elaborate scope of study and a reasonable picture of the status of community-based MHSs in the study area.

Conclusion

MHSs at all PHC centers in all the study States are virtually absent or, at best, poorly and haphazardly rendered. The few erratic, unorganized, and uncoordinated services reportedly provided at the convenience and ingenuity of individual PHC workers are informal and not rated even by the service users. Essentially, both service providers and users perceive these services as unavailable. While the few uncoordinated services were reported by service providers, the users feel that no service is provided at all. However, the users' willingness to access such services if and when available can be determined prospectively to guide future plans.

Recommendations and future directions

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

1. There is a need for a deliberate effort by both the state and local government authorities to activate the incorporation of the mental health component to PHC routine (day to day) service delivery
2. PHC coordinators should help coordinate the disparate services claimed to be provided while awaiting formal services
3. There is a need to investigate the factors likely to be responsible for the observed state of MHSs at the PHC level
4. There is also a need to explore users' willingness to accept MHSs if these can be provided
5. A strong appeal and advocacy is needed to attract the interest of NGOs to community-based mental health care. Even NGOs focusing on maternal and child health could incorporate such ideals.

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Conflicts of interest

There are no conflicts of interest.

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