

An Exploration of Gender Differentials on Availability of Mental Healthcare Services among the Yoruba of Ogun State, Nigeria

Tomike I Olawande*

Lecturer, Department of Sociology Covenant University,
Ota, Nigeria

Patrick A Edewor

Professor, Department of Sociology, Covenant University,
Ota, Nigeria

Ayodele S Jegede

Professor, Department of Sociology, University of Ibadan,
Ibadan, Nigeria

Lukman T Fasasi

Department of Sociology, University of Ibadan, Ibadan,
Nigeria

Gbemisola W. Samuel

Lecturer, Department of Demography and Social Statistics, Covenant University, Ota, Nigeria

ABSTRACT: *The rare level of unmet necessity for mental healthcare services is disturbing in Nigeria. Although studies exist on the availability of mental healthcare services, little attention has been paid to gender differences. This study therefore examined gender differentials in the availability of mental healthcare services among the Yoruba of Ogun State, Nigeria. Qualitative and quantitative methods of data collection were used. The data was based on cross-sectional survey of communities and four neuropsychiatric hospitals in Ogun State, Nigeria. Through proportionate sample size distribution to the LGAs, nine hundred and sixty seven adults aged 18 years and above were randomly selected. Five In-depth Interviews were conducted among caregivers of People Living with Mental Illness (PLWMI) (Those who are receiving treatment and those who have recovered) and nineteen key informant interviews were conducted among orthodox practitioners (Psychiatrists and social workers) and traditional healers that reside in the study area. Quantitative data were analyzed using descriptive and inferential statistics. Findings from this study showed that the average age of respondents was 22.2 years. Out of the total, 52.2 percent of the respondents were female while 45.8 percent were male gender. In respect to awareness on primary healthcare services, only 8.9 percent of female respondents were aware compared to 19.7 percent of the men. Further, only 14.5 percent of the male respondents were aware of the secondary healthcare service when compared to 25.4 percent of their female counterparts. Lastly, 65.8 percent and 65.7 percent of the male and female respondents respectively were aware of the availability of tertiary healthcare services. This study concluded and recommended the need for more awareness and availability of these three levels of healthcare services on mental illness in Ogun State, particularly the primary healthcare centers which should be the first point of call for people living with mental illness.*

KEYWORDS: *Gender differentials, Mental illness, Availability, Mental healthcare services*

INTRODUCTION

The disparity among the overall burden of mental illnesses and availability of mental health resources is disturbing. There is the rare level of unmet necessity for mental healthcare (Gureje & Lasebikan, 2006; Igbokwe & Ola (2011). Nigeria was ranked 187th in 2000 vis-à-vis its global action (World Health Organization,

2000). The healthcare scheme in Nigeria is one of the most deprived in the world. The nation's mental well-being constituent is ill-resourced thereby, impeding access to mental healthcare services to the general public. For instance, Nigeria has fewer than 100 psychiatrists for its populace of approximately 185 million inhabitants. A current World Health Organization periodical indicates that mental healthcare services in the country do not have personnel and amenities (World Health Organization, 2001; Gureje & Lasebikan, 2006). The degree of functionality of a health facility is dependent on its accessibility, affordability, acceptability and

*Correspondence regarding this article should be directed to: tomike.olawande@covenantuniversity.edu.ng

availability to its users. Mental healthcare in Nigeria is subject to diverse indigenous and regional factors.

In view of the above, in Nigeria, the mental healthcare structure has revealed a longitudinal variance regarding availability and quality of facilities concerning need. (Akhtar, 1991). Whereas the federal government is typically restricted to controlling the activities of the country's tertiary healthcare structure including the university teaching hospitals and Federal Medical Centres. The state administration coordinates the countless general hospitals (That is the secondary healthcare) and local governments manage dispensaries (That is the primary health care). The majority of mental healthcare services is made available by eight regional psychiatric centers and psychiatric sections and medical institutions of the county's twelve main institutions of higher education. Limited general hospitals similarly provide mental healthcare services.

LITERATURE REVIEW

Internationally, only two out of a hundred of nationwide financial plans are dedicated to mental health (World Health Organization, 2005). Approximately 70 percent of African nations and 50 percent of south-east Asian nations spend 1 percent of their health financial plan on mental health (Jacob, Sharan, Mizra, Garrido, Seexat & Saxena, 2007). In countless unindustrialized nations, women lament the nonexistence of confidentiality, privacy and information in existing mental healthcare facilities. One of the greatest challenges in providing facilities for People Living with Mental Illness (PLWMI) in Nigeria is making available harmless and cheap treatments.

Studies conducted by Ngui, Lincoln, Ndtei & Roberts (2010); Jack-Ide & Uys (2013) & Elegbeleye (2013), show that the Nigeria populace is still vaguely aware of mental illness and the ease of use of mental healthcare services and effective treatment outcomes. Mental healthcare services in rural communities are unavailable and have left people living with mental illness and their relations with no option than to use whatever is available. According to Beaglehole, Epping-Jordan, Patel, Chopra, Ebrahim, Kidd & Haines (2008), the control of mental illness requires functioning, affordable and equal primary healthcare since it is through access to these services that those at a high risk of mental illness can be identified, advised and treated. The availability of mental health services in unindustrialized nations is pitiable owing to the shortage of resources, poor access to health facilities and the little importance given to mental health concerns.

According to Gureje & Lasebikan (2006), it is not all psychological disorders that require treatment (Regier, Narrow, Rupp & Kaelber, 2000; Gureje & Lasebikan, 2006). Likewise, not everybody with a need for treatment desires to see a professional. The primary healthcare system in Nigeria is poorly resourced and organized (Gupta, Gauri & Khemani, 2003; Gureje & Lasebikan, 2006). They are principally managed by nurses and community healthcare personnel with little or no training in mental healthcare concerns. It is uncertain if the specialists at the primary healthcare service can provide quality care and services people living with mental illness. Poor awareness and adverse approach to mental illness in Nigeria, which are common in some unindustrialized

nations inhibit individuals from seeking medical assistance (Gureje, Lasebikan, Ephraim-Oluwanuga, Olley, & Kola, 2006; Gesinde, 2012; Guvenc, Cesario & Sandra, 2014).

History of Mental Healthcare Services in Nigeria

The recognition and treatment of mental illness in Nigeria existed before records of such activities were documented. The introduction of western prototypes of mental health delivery did not occur until the early 20th century when the first asylum was built in Calabar in 1904. Not long after this, the Yaba Asylum was established in 1907 in Lagos. These asylums were managed by medical officers since they lacked skilled psychiatrists. In 1954, the Aro Mental Hospital in Abeokuta was built by the British colonial government to satisfy the request for improved access to quality mental healthcare (Asuni, 1967). It also made available the chance for the Nigeria's premier native psychiatrist, Dr. Lambo, to lead service distribution on his arrival from the United Kingdom in 1952. The psychiatric hospital later identified as the Aro Neuropsychiatric Hospital performed a crucial role in the expansion of psychiatry in Nigeria with local and international (For example, World Health Organization) initiatives (Furnham, 2007).

Innovators of African psychiatry developed encouraging inventions to team up with traditional doctors and to get used to services of the African socio-economic background. Lambo advanced the establishment of the prototypical village of Aro in Nigeria in 1954 while Henri Collomb (In Senegal) and Margaret Field (In Ghana) facilitated proof of identity, transfer, and destigmatization of persons living with mental illness. The available eight provincial mental hospitals and the psychiatry departments in twelve medical schools provided mental health services. Some of the general hospitals also provided mental health services. Regardless of these facilities, there has been inadequacy of mental healthcare. The proportion of psychiatric beds to patients recently was approximately 0.4 to 10000 whereas for psychologists and social workers was 0.02 to 100000 individuals (World Health Organization, 2016).

Nigeria's British colonial history significantly influenced the country's psychiatric practice. The outstanding efforts of the Aro village team in Abeokuta, who initiated community epidemiological researchers among the Yoruba also had a significant impact on psychiatric research in Nigeria. Pioneers of African psychiatrists took promising initiatives to collaborate with traditional healers to adapt mental healthcare services with the African socio-economic situation. The ideal, "village of Aro", established by Lambo in Nigeria in 1954, is one illustration. Other instances include that of Colombo and Margaret Field in Senegal and Ghana respectively. They also established a partnership with the traditional healers. Worthy of note is also Tigani El Mahi and Taha Baasher in Sudan, who initiated a functioning relationship with Muslim front-runners.

Community-based Mental Healthcare Services

Community-based mental healthcare service is characterized by an emphasis on the populace and community health essentials. It also involves mutual support and facility user enablement for persons and relations and interfaces with non-profit organizations about rehabilitation.

In developed nations, on the other hand, community-based mental health services are currently the most desired ideal for the provision of psychiatric care, in comparison to the traditional psychiatric hospital built services. The World Health Organization is an advocate of community mental healthcare in both industrialized and unindustrialized nations (World Health Organization, 2001). For Makanjuola (2011), in developed countries, the elements of community-based mental healthcare services are well-recognized and they consist of the establishment of mental health components in general hospitals and the construction of mental health groups that are community-based. The latter include occupational therapists, nurses, psychiatrists, social workers, psychologists, and other mental health experts. They provide outpatient services with an emphasis on supporting people living with mental illness in their homes and anywhere imaginable. Primary healthcare works in collaboration with the specific community-based mental healthcare services with the expectation that there would be the management of mental illness in this location by health labor force who enjoyed elementary mental health training.

In Africa, community mental healthcare services are not functional because there is a paucity of skilled mental health specialists and practically there is no societal provision, and where relatives of people living with mental illness are not available, traditional healers and spiritual front-runners frequently perform the leading role in dealing with mental illness. The World Health Organization recommended the expansion of community mental health services viz-a-viz the incorporation of mental health into the current primary healthcare system and the mobilization of community resources. The structure of the primary healthcare scheme in sub-Saharan Africa is sensibly deep-rooted, even though variable analysis and excellence of services are limited. According to Eaton (2008), the advantages of community-based services are properly documented and have robust research indication of efficiency. World Health Report (2001) & Eaton (2008) recommends replacing large mental health services with community psychosocial rehabilitation services, which can make available better and earlier care, are more respectful of human rights and can help limit the stigma of mental health treatment.

Health structures are central to the provision of evidence-based mental healthcare (World Health Organization, 2000). World Health Organization defined the necessity and validation for constructing community-based mental healthcare schemes and services (World Health Organization, 2001). Jacob et al., (2007) recognized the vital mechanisms for improving mental health services such as making available the treatment for mental abnormality in primary care and guaranteeing that there is an augmented access to a crucial psychotropic drug. The components also entail the provision of medical care in the society, enlightenment of the public (Including the people, consumers and families); development of nationwide strategies, programs, and regulations on issues about mental health; improvement of social resources; connection with other regions; observation of community mental health; and funding of significant research. Hence, a mental health scheme comprises all organization and resources with the emphasis on advancing mental health and covers the following areas: policy and legislative framework,

mental health in primary mental healthcare, community education, community mental health services, human resources, relations with other regions, observation and enquiries.

According to Ngui, Lincoln, Ndeti & Robert (2010), the few psychiatric hospitals are usually bedeviled with inadequate personnel, crowded and may not make available the needed care. Most hospitals for the provision of mental health are situated in cities. In some cases, these clinics are just 'storerooms' that serve the purpose of keeping patients away from the rest of the general public due to inadequate resources and capability to cope with their situations effectively. In industrialized countries, there is the de-institutionalization of people living with mental illness. This habit is common in numerous people living with mental illness, who are, imprisoned because of inadequate access and availability of particular psychiatric amenities in the society. One important method for addressing the disparities in mental healthcare is to make efficient the assimilation of mental health services with further primary care services. Current struggles to utilize and improve primary care in most unindustrialized nations (Tejada de Rivero, 2003) should entail mental healthcare, as a serious character of populace well-being.

Chan & Van Weel noted that: For too long, there has been less emphasis on mental disorders as part of strengthening primary care. The oversight occurs irrespective of the fact that outpatient seen in all countries, present in women and men alike, at all stages of life, cuts across the rich and poor, and in both rural and urban settings. Furthermore, this occurs regardless of the fact that assimilating mental health into primary care ensures person-centered and holistic services, and as such, is crucial to the values and principles of the Alma Ata Declaration (WHO/WONCA, 2008).

The rationale for incorporating mental health into primary healthcare consists of the massive societal and financial liability, the interlinked nature of bodily and recognized difficulties, and the important management gaps of mental health issues (WHO/WONCA, 2008). Furthermore, primary care downsizing is inexpensive and worthwhile, such incorporation would bring about positive results, enhance admittance to care; and dignity for the constitutional rights of patients (WHO/WONCA, 2008). Community mental health services can assist in diminishing societal humiliation and discrimination by lessening the societal seclusion, lack of care, and institutionalization of people suffering from psychological disorders. The efficient community treatment of mental illness will also assist society to realize that individuals with mental illness can live fruitful lives, donate to the public, and advance the community interests all over the world.

Non-Governmental Organizations in Mental Healthcare

Countless nations indicate that they have several Non-Governmental Organizations (NGOs) functioning in the area of mental health. Spiritual health services were the first set of providers of care in several nations. Later, other NGOs joined them. These organizations may be privately sponsored or accept sustenance from local government and external contributors or other NGOs. A number of NGOs may possibly perform important functions in training, resource delivery, and programme support.

Internationally, identifying NGOs with particular emphasis on mental illness is challenging. A current review looked at NGOs that offer crisis mental health services resulting in tragedies as well as developing facilities. Of 119 English language-speaking organizations itemized on the website of the United Nations, only 46 percent focused on mental health policy and programmes. Forty-seven of these organizations had involved in a minimum of one lasting progressive plan. Only four were considered fit to make available wide-ranging intercontinental mental health plans. NGOs can report several hindrances to the advancement of mental health strategy and training, for instance by assisting to nurture consciousness of the significance of mental health and by encouraging request for access to service in developing countries.

MATERIALS AND METHODS

Research Design and Study Area

This study utilized both cross-sectional and exploratory design. It adopted triangulation of both quantitative and qualitative methods of data collection. Qualitative research tools were In-Depth Interview (IDI) and Key Informant Interview (KII) guides while quantitative research tool was structured questionnaire.

The study location was Ogun State in south-western Nigeria. It is predominantly a homogenous group of Yoruba people, made up of six dialectical sub-ethnic groups of: Egba, Ijebu, Remo, Egbado (Also called Yewa), Awori and Egun. The state capital is Abeokuta. The psychiatric hospitals and Local Government Areas (LGAs) which were selected for this study included:

- (1) Department of Psychiatry, Federal Medical Centre, Abeokuta (Abeokuta South Local Government Area);
- (2) Department of Psychiatry, Olabisi Onabanjo University Teaching Hospital, Sagamu (Sagamu Local Government Area);
- (3) Aro Neuropsychiatric Hospital, Abeokuta (Abeokuta North Local Government Area); and
- (4) Lantoro Community Psychiatry, Abeokuta (Abeokuta South Local Government Area).

These hospitals and Local Government Areas (LGAs) were purposively selected. The criteria used in the selection of the psychiatric hospitals were:

- i. The presence of amenities for psychiatric patients; and
- ii. The availability of psychiatric patients.

The traditional healers in Ogun State were communicated through their local and state associations.

Study Participants

The respondents for the study were drawn from adults (Male and female), 18 years and above, Yoruba and permanent residents in the study location. The opinions of relatives of people living with mental illness, community leaders and psychiatric health workers were obtained through IDIs and KIIs.

Data Collection and Sampling Techniques

Data collection involved quantitative and qualitative methods. Questionnaire was administered to 967 respondents while in-depth interviews and Key informant interviews were conducted in each of the selected institutions. Multistage sampling procedure was adopted, which involved purposive selection of Ogun State due to the presence of specific mental health facilities, especially the first generation Neuropsychiatric Hospital, Aro and the place of the state in the history of psychiatry in Nigeria.

The instruments used for data collection were structured questionnaire, in-depth interview and key informant interview guides designed for each group of participants. Interviewers' discretions were however allowed for the qualitative methods. Several measures were taken to ensure that the research instruments were precise and reliable for validity. The instruments were translated into Yoruba language for ease of administration to respondents not versed in English language. The reliability of the data from the pilot study was done using Cronbach's Alpha correlation coefficient. The overall reliability result was 0.893 which means that instrument had a high percentage of significant reliability.

Data Analysis

The quantitative data were analysed at the Univariate level through descriptive statistics such as frequency and percentage while chi-square tests and ANOVA were used to determine the association between the variables measured. Qualitative data were analyzed through transcription of recorded interviews and discussions. The recordings done in Yoruba were translated into English language, and transcribed for subsequent analysis. The transcriptions were compared with the notes taken during data collection. The data collected were content analysed and thematically organized. Information obtained was reported as phrases in quotes from the recorded expressions of participants. Internal validity was achieved by using data from all the three sources, and by presenting views from different participants to support the research objectives.

Limitations of the Study

The research was carried out among one language group in Nigeria. Other ethnic groups could have dissimilar interpretations of mental disorder. Though, the study was conducted in both Federal and State-owned mental health facilities, the result may not be adapted to the rest of the country because it was conducted in Ogun State only.

Ethical Considerations

Participants were selected based on principle of confidentiality of data, beneficence to participant, Non-Malfesance to participants and Voluntariness. Institutional approval was obtained from ethical committee in Aro Neuropsychiatric Hospital, Abeokuta with approval Number PR003/16 and Federal Medical Centre, Abeokuta with approval number FMCA/470/HERC/05/2016.

RESULTS

As shown in Table 1 the availability of mental healthcare services matter for the treatment of people living with mental illness (PLWMI). This segment reports the findings of this study on the availability of mental health care services among the Yoruba people of Ogun State, Nigeria. Here we examine the opinion of respondents on the availability of mental healthcare services. With regard to the type of mental healthcare services available, for male respondents, 62.1%, 6.2%, 28%, and 3.7%, indicated that the type of mental healthcare services available were modern medicine, traditional medicine, Christian faith healing center and Islamic faith healing center respectively. In contrast, female respondents, 69.5%, 19.5%, 8.8% and 2.2% indicated that the type of mental healthcare services available were modern medicine; traditional medicine; Christian faith healing center and Islamic faith healing center respectively. A participant stated as follows: Modern medicine is readily available in my community. I don't have much money on me. The drugs are too expensive, but they have qualified professional healthcare workers. (Caregiver, Abeokuta North Local Government Area, IDI).

In relation to availability of modern medicine, for male

respondents, 19.7%, 14.5% and 65.8% reported that primary healthcare services; secondary healthcare services and tertiary healthcare services were available respectively. On the other hand, for female respondents, 8.9%, 25.4% and 65.7% reported that primary healthcare services; secondary healthcare services and tertiary healthcare services were available respectively. With regard to tertiary healthcare services, for male respondents, 8.1%, 13.4%, 65.1% and 13.4% reported that cheap drugs; available services; qualified professional healthcare workers and all of the items indicated were available in the tertiary healthcare services respectively. However, for female respondents, 13.8%, 17.6%, 47.6% and 21% reported that cheap drugs; available services; qualified professional healthcare workers and all of the items indicated were available in the tertiary healthcare services respectively. The respondents expressed their views on the mental healthcare facilities available in the community.

Below are quotes from some of the interviews that were conducted: There is no modern medicine available in the community where I live (Ondo State), but after a rough experience in the traditional home, I had no option than to bring my daughter here for treatment. Also, the drugs are cheap and very affordable to

Table 1.
Availability of mental healthcare services by gender

Characteristics	Gender differentials		Total	χ^2	Df	P-value	
	Male	Female					
Type of mental health care services available							
Modern medicine	200 (62.1%)	346 (69.5%)	546 (66.6%)	71.0474	3	<0.00001	P<0.05 SIGNIFICANT
Traditional medicine	20 (6.2%)	97 (19.5%)	117 (14.3%)				
Christian faith healing centre	90 (28%)	44 (8.8%)	134 (16.3%)				
Islam faith healing centre	12 (3.7%)	11 (2.2%)	23 (2.8%)				
Total	322	498	820				
If modern medicine	Male	Female	Total				
Primary healthcare services	30 (19.7%)	35 (8.9%)	65 (11.9%)	16.6934	2	<0.000237	P<0.05 Significant
Secondary healthcare services	22 (14.5%)	100 (25.4%)	122 (22.3%)				
Tertiary healthcare services	100 (65.8%)	259 (65.7%)	359 (65.8%)				
Total	152	394	546				
Tertiary healthcare services	Male	Female	Total				
Cheap drugs	12 (8.1%)	29 (13.8%)	41 (11.4%)	11.1208	4	<0.01109	P<0.05 Significant
Avoidable services	20 (13.4%)	37 (17.6%)	57 (15.9%)				
Qualified professional healthcare workers	97 (65.1%)	100 (47.6%)	197 (54.9%)				
All of the above	20 (13.4%)	44 (21%)	64 (17.8%)				
Total	149	210	359				
Secondary healthcare services	Male	Female	Total				
Cheap drugs	12 (28.6%)	25 (31.3%)	37 (30.3%)	0.6519	3	<0.884457	P>0.05 Not significant
Avoidable services	15 (35.7%)	25 (31.3%)	40 (32.8%)				
Qualified professional healthcare workers	7 (16.7%)	17 (21.3%)	24 (19.7%)				
All of the above	8 (19%)	13 (16.3%)	21 (17.2%)				
Total	42	80	122				
Primary healthcare services	Male	Female	Total				
Cheap drugs	1 (2.8%)	2 (6.9%)	3 (4.6%)	4.799	3	<0.197122	P>0.05 Not significant
Avoidable services	3 (8.3%)	5 (17.2%)	8 (12.3%)				
Qualified professional health care workers	9 (25%)	2 (6.9%)	11 (17%)				
All of the above	23 (64%)	20 (69%)	43 (66.2%)				
Total	36	29	65				

buy. The psychiatric hospital has qualified professional healthcare workers who take care of my daughter. I am impressed by the services rendered (Caregiver, Abeokuta South Local Government Area, IDI).

With regard to secondary healthcare services, for male respondents, 28.6%, 35.7%, 16.7% and 19% reported that cheap drugs; available services; qualified professional healthcare workers and all of the items indicated were available in the secondary healthcare services respectively. Conversely, for female respondents, 31.3%, 31.3%, 21.3% and 16.3% reported that cheap drugs; available services; qualified professional healthcare workers and all of the items indicated were available in the secondary healthcare services respectively. On primary healthcare services, for male respondents, 2.8%, 8.3%, 25% and 64% reported that cheap drugs; available services; qualified professional healthcare workers and all of the items indicated were available in the primary healthcare services respectively. Conversely, for female respondents, 6.9%, 17.2%, 6.9% and 69% reported that cheap drugs; available services; qualified professional healthcare workers and all of the items indicated were available in the primary healthcare services respectively.

This finding was corroborated by another Caregiver who stated as follows: I am satisfied with the fact that there are modern medicines available in my community coupled with cheap drugs and qualified professional healthcare workers (Caregiver, Sagamu Local Government Area, IDI). The relationship between gender differentials and availability of mental healthcare services showed that the type of mental health care services available ($\chi^2=71.0474$), for modern medicine ($\chi^2=16.6934$), tertiary medical services ($\chi^2=11.1208$), secondary medical services ($\chi^2=0.6519$) and primary health care services ($\chi^2=4.799$). The gender differentials by availability of mental health care services were significantly influenced at $p \leq 0.05$ except for primary and secondary health care services. Thus, the qualitative data show that mental healthcare services are readily available in the community.

DISCUSSION

In relation to the availability of modern medicine, for male respondents, 19.7%, 14.5% and 65.8% reported that primary healthcare services; secondary healthcare services and tertiary healthcare services were available respectively. On the other hand, for female respondents, 8.9%, 25.4% and 65.7% reported that primary healthcare services; secondary healthcare services and tertiary healthcare services were available respectively. This result is in line with the findings of Jack-Ide, Azibiri, & Igoni, (2014) which posited that there is no provision of mental health services. The qualitative data also corroborated this finding. The results obtained and analyzed in this study showed that qualified professional healthcare workers are readily available in the tertiary health care services, affordable services are readily available in the secondary medical care services and cheap medications are readily accessible in the primary health care services.

CONCLUSION

Findings from the study revealed that there are significant

gender differences in the availability of mental healthcare except for primary and secondary healthcare services. This means that modern medicine is readily available in the study area. However, tertiary healthcare services are more available compare to secondary healthcare services and primary healthcare services. People living with mental illness patronized tertiary services more than other pathways to mental illness treatment. There is the need for availability of more facilities and health personnel for the special care of the mentally ill.

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