Social Context of Healthcare Utilization among People with Mental Illness in Southwestern, Nigeria

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Abstract
This study examined healthcare utilization among people with mental illness in Abeokuta and Ibadan, Southwest Nigeria as a way of understanding the context in which health seeking and treatment take place. The Health Belief Model and Rational Choice Theory were employed as theoretical framework. Data were collected using three qualitative methods. Twenty four In-depth Interviews (IDIs) were conducted among traditional healers, psychiatrist and significant others to patients. Four Key Informant Interviews (KIIs) were undertaken among mental healthcare providers. In addition, four FGDs were conducted among female and male participants in Ibadan. The findings revealed a strong perception that mental illness is caused mainly by supernatural forces. The notion that mental illness is incurable, transmissible and infectious accounts for harassment and stigmatization of victims and their families which often explains the withdrawal of patients from medical care. Most of the participants preferred the traditional pathway to treatment, irrespective of its perceived limitations.It is essential to put in place a policy to discourage stigmatization and discrimination against mentally ill patients in order to encourage healthcare utilization.

Keywords: mental-healthcare, mental illness, stigmatization, supernatural forces, integration of medical systems

Background

Psychiatric and neurological conditions accounted for 13 percent of the global disease burden and will likely rise to 15 percent by the year 2020 (WHO, 2011; 2008). Increasing cases of substance abuse, poorly equipped health facilities and dearth of specialists to treat established mental health disorders are among the most critical factors defining the dynamics of mental health conditions in relevant contexts (Odejide and Ohaeri, 1997; Aina, Ladapo, Lawal and Owoeye, 2007). Research shows that the global median number of facilities per 100,000 population to mental hospital is 0.04; there are 7.04 psychiatric beds per 100,000 population in mental hospitals; and 1.4 psychiatric beds per 100,000 population in general hospitals (Morris *et al*. 2012; WHO 2011). In Africa, the rate of psychiatrists per 100,000 population is 1 (Fournier, 2011). Indeed, the situation is more acute in low income countries where negligible proportions of budgets are allocated to the health sector generally (Nwokocha 2013; Bird, Omar, Doku, Lund, Nsereko and Mwanza, 2010).

The impact of poor funding of the health sector cannot be overstated. For instance, it has been observed that about 75 percent of people with mental, neurological and substance-use disorder in less developed countries were not receiving treatment or care for their conditions (WHO, 2001), a situation that has remained largely unchanged in most places. Studies in south-western Nigeria specifically reveal that mental healthcare delivery is undermined by inadequate facilities, lopsidedness and financial constraint (Adewuya and Makanjuola, 2005; Odejide and Ohaeri, 1997).

Mentally ill persons are mainly found in cities, especially in motor parks and market places and are viewed as suffering from the repercussions of their past evil deeds. (Odejide, Oyewumi and Ohaeri, 1989; Gureje, Lasebikan, Ephrahim-Oluwanuga & Jegede, 2005). Among the Yoruba of Nigeria, it is commonly believed that mental illness cannot be cured permanently (Jegede, 2005), since the victims are supposedly controlled by spirits. As a result of these perceptions, the mentally ill are classified as irresponsible, dangerous, unpredictable and, therefore, to be feared. Nwokocha (2008) identified two main causes of mental disorders among Nigerians, which are natural and induced; the former deriving from birth, while the latter occurs through conscious human actions to harm actual or potential enemies or individuals perceived as threats.

Consequently, priority is given to unorthodox therapy provided by traditional and faith-based healers conceived among many Nigerians to offer effective and sustainable treatment relative to what is obtainable from orthodox health practitioners (Nwokocha, 2008). Although Nwokocha has stressed the relevance of traditional psychiatry in most rural settings in Nigeria, the healers' methods of treatment which include long fasting, whipping, circumcision among others are implicated in patients' physical abuse and deterioration which often manifest as kwashiorkor and other physical abuses like body and stomach ulcer, whip-related marks and bed sores (Asuni, 1979). In spite of these, people still patronize the unorthodox mental health facilities. Thus, in order to understand the factors influencing mental healthcare delivery, this study specifically examined issues relating to utilization as a way of investigating the complex processes that characterize perception, choice of delivery system and health outcomes among people with mental illness in Southwest Nigeria.

Abeokuta and Ibadan were selected for the study due to their historical importance as cities with a major psychiatric hospital and the melting pot of the Yoruba culture respectively. Moreover, studies show that irrespective of educational level, a large number of people in these southwestern cities still seek recourse to traditional medicine (Odejide, Sanda, Olatawura and Oyeneye, 1978; Agara, Makanjuola and Morankinyo, 2008).

Theoretical/Conceptual Framework

This study is anchored on the Health Belief Model (HBM) by Rosenstock and Becker, and the Rational Choice Theory by Coleman. The HBM systematically

explains and predicts behavioural response(s) to health seeking and treatment of acute and chronic illnesses through the perception of prospective actors. The model has been adopted to explain variations in mental healthcare utilisation on the basis of four main constructs that find expression in perception – susceptibility, severity, benefits and barriers. We note that for the purposes of this analysis, little emphasis will be placed on perceived susceptibility considering that people not only hardly conceive their proneness to mental illness but also rarely seek precautionary mental healthcare on the basis of perceived vulnerability.

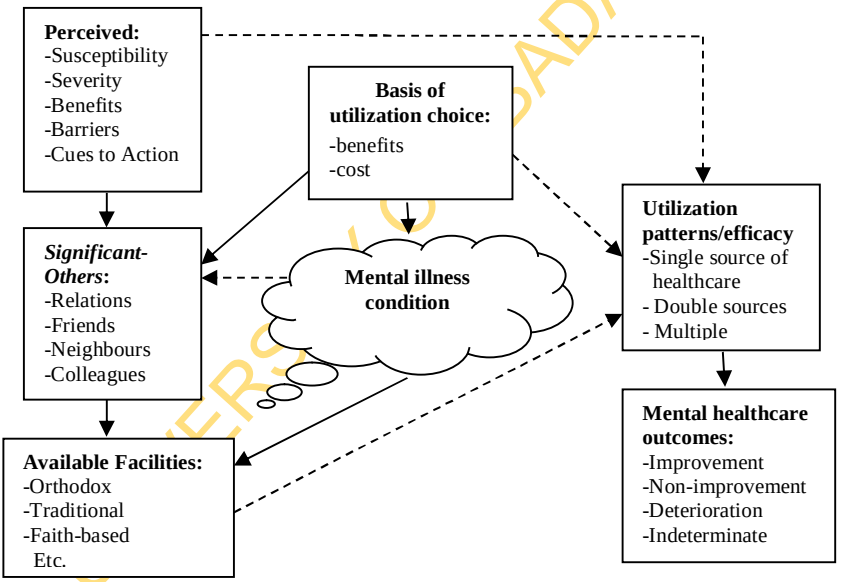
Perceived severity is examined on the premise that a prospective health-seeker would more likely undertake a health-related action convinced that it is a better choice compared to non-perception of seriousness when a disease occurs. An individual who perceives mental illness as either non-serious or incurable will not likely undertake health related action. However, perception of severity will depend largely on the extent to which the assessor has knowledge of a particular illness and its potential effects. Thus, *Significant-Others* who perceive the severity of mental illness when it occurs and the concomitant implications such as low productivity, loss of job, emotional instability, and stigma among others are likely to assist a victim with regard to seeking mental healthcare aimed at ameliorating the illness condition and in turn reduce the potential effects that would likely arise from such a condition. The perception of severity among actors, ordinarily, motivates them to undertake health related action which is directed at a positive goal.

Perceived benefits of seeking healthcare services for mental illness supposes that not doing so translates to consequences on the victim and family members. However, even when that perception drives the quest for utilization of mental healthcare facility, the dilemma of choice between orthodox and unorthodox systems of healthcare delivery still presents itself among potential health-seekers. The HBM recognizes that an actor may be discouraged by perceived likely inhibitions that could undermine utilization of mental healthcare services as and when necessary. Perceived barriers to utilization may include stigma, distance to facility, bureaucracy, cost of services, belief system, attitude of healthcare providers and poorly equipped facilities among others (Makanjuola, 2003).

Cues to Action which is an important HBM construct deals with sources of information that could assist a health seeker in identifying facilities, therapies and their perceived efficacy. Such cues may include positive reports, supportive government policies, location of facilities, subsidization of medication costs among others through awareness creation and advocacy messages disseminated through jingles, adverts and other communication materials. To be sure, perceptions about issues related to health seeking would make little meaning if the perceiver does not go beyond that level. Cues to Action concretize other HBM constructs by directing the views of a prospective health-seeker and/or *Significant-Other* to specific information that may translate perception into action. Thus, irrespective of how strong an

actor's perception of vulnerability, severity and treatment-efficacy may seem, cues are essential and give credence to health seeking behavior.

The Rational Choice Theory (RCT) further elucidates the ability of individuals to make important health decisions by weighing the benefits and costs of a contemplated action (Ritzer 2008). Although the perspective presumes that taking a health-related action derives from the goal which an actor sets out to pursue, after a careful calculation of derivable benefits and costs, such decision is hinged on individual and community values. For instance, the choice of a mental health treatment option among traditional, orthodox and faith-based facilities by *Significant-others* may depend on factors such as availability and accessible, beliefs and practices, attitude of care providers, environmental hygiene, post-treatment therapies, rehabilitative care components (Adeneye *et al.*, 2014) among others. As Odejide *et al.* (1978) and Agara *et al.* (2008) observed, several people irrespective of educational status subscribe to the supernatural and preternatural explanation of mental illness. The conceptual framework that follows synthesizes HBM and RCT to indicate their separate and combined influences on the activities of a prospective mental health seeker.

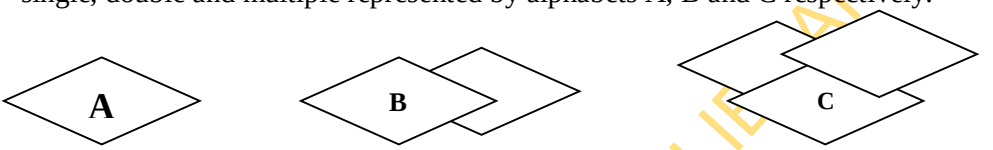


Framework Synthesizing Health Belief and Rational Choice Models

Figure 1shows that mental illness condition, which is represented by a brain-shaped structure with some disjointed tissues, necessitates health-seeking action from *Significant-others* who may include but not limited to relations, close friends, good neighbours and, at times, colleagues. Due to the state of mind of several mental health patients, utilization of facilities depends almost entirely on the decision of *Significant-others*. Therefore, the latter's perception of susceptibility, severity, benefits and cues to action is a critical factor in

arriving at conclusions regarding the type of facility to patronize, utilization patterns and post-treatment activities.

The framework also reveals that issues related to perception, assessment of available mental healthcare facilities and choices that are considered rational and appropriate depend on events around and the level of exposure of the health seeker. The arrows with broken lines suggest that HBM and RCT components, as well as perception about available facilities do not have direct relationship with utilization but mainly expressed by the *Significant-other* whose psychosocial disposition and level of awareness are central to use of these facilities. Figure 1 further indicates three likely patterns of utilization – single, double and multiple represented by alphabets A, B and C respectively.



Single source of mental healthcare could be any of the three (orthodox or traditional or faith-based) shown in the conceptual framework. Sticking with only the orthodox or any other, for instance, may either be a restatement of trust in the efficacy of that healthcare delivery system or due to lack of awareness about the existence of any other. Perhaps, individuals who patronize two sources of mental healthcare do so in the belief that each of the systems will provide at least a modicum of solution to the problem. Multiple healthcare sourcing may be a reflection of the uncertainty that pervades the perceived etiology of mental illness among several Nigerians (Nwokocha, 2008; Jegede, 2005). Therefore, many people are likely to adopt the eclectic approach in order to take the advantage that each of these systems could offer.

Methods

This study adopted a descriptive research design employing the qualitative method of data collection. Abeokuta and Ibadan cities of Southwest Nigeria were purposively chosen for the research. The *Aro* Neuropsychiatric hospital Abeokuta established in 1954, though preceded by those of Yaba and Calabar, is famous for its very high level of patronage (Ayorinde, Gureje and Lawal, 2004; Asuni, 1967) by people not only in Southwest Nigeria but other parts of the country and beyond. Ibadan on the other hand was chosen due to the existence of orthodox and traditional facilities in the city including psychiatric units at the University College Hospital and Oyo State General Hospital as well as a number of traditional mental healthcare homes. The study targeted mainly *Significant-others* to mentally ill patients, orthodox and non-orthodox care providers.

The intra-method triangulation of In-depth Interviews (IDIs), Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) was employed in collecting data. Twenty-four IDIs were conducted among 14 *significant others*, 2 traditional healers, 2 faith-based healers and 6 psychiatric

health personnel in the two study sites. Four KIIs were undertaken among experienced orthodox and traditional mental health care providers; in addition, four FGD sessions were organized among different categories of persons.

Ethical principles guiding social science research were followed including seeking informed consent from respondents/participants, guaranteeing their anonymity and ensuring that they did not suffer any form of harm arising from the study. Data were content analyzed beginning with the translation and transcription of tape-recorded information generated in the course of fieldwork. Thereafter, responses were organized along important themes reflecting the objectives of the research.

Results and Analysis

Findings of this study are presented along four specific objectives relating to perceived causes of mental illness, choice of healthcare system, access and use of facilities and the feasibility of integrating the different healthcare systems. Each of these perceptual components has implications for healthcare utilization in relevant contexts.

Perceived Causes of Mental Illness

Perception of causes of mental illness is a product of several interacting individual, ideational, environmental and socio-cultural factors. As one traditional healer noted in and IDI: 'mental illness may be inflicted by witches and wizards, which begins to manifest mainly after terrible nightmares'. An FGD participant corroborated the supernatural conception of mental disorder adduced by the earlier respondent by stating:

> *…mental disorder is a mysterious illness. This is one reason why it is commonly believed in our society today that mental illness is caused by spiritual forces. It could be that a victim may have committed one taboo or the other such as attempting to be involved in money ritual or seeking spiritual power… some are even bewitched out of envy. What is certain though is that a mentally ill person is directed by evil spirits. So in treating the person, there may be rituals and sacrifices to appease the gods.* (Female FGD/ Ibadan)

The above statement implicated several likely causes which can be classified along two major factors – unconscious victim precipitated mental disorders and activities of other individuals to harm enviable persons. The strong view that evil spirits direct the actions of mentally ill persons, as well as the perceived role of rituals and sacrifices in addressing the health needs of victims would largely determine healthcare utilization pathways and patterns. To be sure, in places where a large majority of people canvass the above opinion, recourse to orthodox healthcare delivery system would be less emphasized compared to traditional and/or faith-based therapies. Another cause of mental illness

identified by FGD participants is that it is genetically defined; as one of them stated:

> *…mental illness is genetically caused. I mean most mental illness is in the blood. It can be something that is in one's lineage. That is the reason why couples that want to get married first seek to know the family history of their intended partner in order to be sure that madness is not something that runs in such family, before the final consent is given.* (Male FGD/ Ibadan)

Again, the implication of locating the cause of mental illness in genetics is that *Significant-others* may not likely exhibit commendable level of zeal in seeking solution to the problem many of whom would have concluded that cure is not achievable in the circumstance. A similar view was expressed by an orthodox healthcare practitioner who noted:

> *Another cause of mental illness is congenital abnormalities. At times, children are born premature. I had a patient like that; his brain was not properly formed. The patient was initially doing very well; he was even in 300- Level in the university when the problem started. It was through the CT-scan that it was discovered that the brain was not properly formed.* (Psychiatric nurse/IDI)

Unlike the immediate preceding position that links mental disorders to genetics, the victim may be the only one in the family experiencing such a mental related challenge due to prematurity at birth. Yet, for persons who classify all cases of mental disorder as related to supernatural cause, such genetic-explanation would make little or no meaning.

Choice of Treatment for Mental Illness

Respondents/participants reported their preferred source of mental illness treatment based on the three main sources identified earlier. Several reasons may explain why such preferences are made. For instance, duration of treatment and/or perceived effect of treatment on the illness condition may define the attitude of prospective healthcare users. In the words of one FGD participant that seem to reflect the opinion of others:

> *Traditional treatment is always faster compared to other pathways, the traditional healers use sacrifices to appease the spirit so that the patient can respond to treatment quickly.* (Female FGD/Ibadan)

The above statement is embedded in an assumption that mental disorders derive from supernatural causes and also require concomitant solution. Thus, appeasing the gods is not expected in cases of congenital or drug abuse related instances even though such a distinction is never emphasized by some

individuals. Another reason for preferring the traditional system of mental healthcare delivery was expressed by an IDI respondent who noted:

> *We would have preferred Aro, but for the distance. Moreover, if one does not pay all the money for treatment as prescribed by doctors or other health personnel, the patient is unattended to and may never be admitted. In this place (Home of traditional healer), we paid only Ten Thousand Naira, at first, and she was admitted. But at Aro, if we were asked to pay Forty Thousand Naira, they would expect us to pay all the money before admission and still buy lots of things. Honestly, Aro is far and expensive... Although the University College Hospital (UCH) is closer, taking a patient there will require at least a deposit of between one and two hundred thousand naira. Where do we raise such huge amount.* (Relative IDI/Ibadan)

From this statement, it is difficult to know whether the respondent's perception and preference would likely change with notable improvement in socioeconomic status. Indeed, although poverty is a critical factor in choice of healthcare facilities, perception of efficacy is more important for some individuals especially those that can afford the cost of mental healthcare treatment in any of these systems. However, a Traditional Healer stated that some cases are better treated with orthodox medicine:

> *Not all mental illness can be treated in traditional way. For instance, a patient with head injury needs surgery and given that we do not undertake surgical activities in the traditional healing, we refer such patients to the hospital where that can be performed. This is because supernatural or herbs cannot remove blood from the brain; surgery is the only remedy for such a condition.* (Traditional Healer/KII)

The point here is whether each of these traditional healers will be honest enough to refer such patients to orthodox facilities for surgical procedures which for the most part are complex. Another interviewee corroborated the likelihood of referrals from traditional to orthodox and vice-versa by stating:

> *It is only mental illness that is not caused by the supernatural that can be treated in the hospital. For instance, mental cases related to smoking of India hemp or cocaine would get well without sacrifices…However, if the mental illness has supernatural undertone, the patient will never get better unless sacrifices are made.* (Traditional Healer/ IDI)

Access and Use of Mental Health Facilities

Respondents identified different factors that affect access to mental healthcare services in Southwest Nigeria, which may also be same in other parts of the country. A Key informant stated for instance that:

> *…the major problem facing treatment of mentally sick people is unavailability of psychiatric hospitals. We do not have enough health or rehabilitation centers to cater for mentally ill patients in a place like Ibadan, not to talk of other locations in Southwest Nigeria. The shortage of these facilities has resulted to available facilities being stretched to elastic limits... bed spaces, staff strength are not adequate to ensure standard care for patients. Inadequacies in facilities such as treatment centers, necessary equipment and personnel all negatively influence attitude towards taking health action. This is the major reason why people patronize traditional and spiritual healing centers.* (Psychiatric Nurse/KII)

In the same vein, another respondent corroborated the challenges that the orthodox facilities are facing in the study area by stating:

> *…we have had cases like that before, we had seriously ill patients to admit but our beds were filled… We have just twenty-four bed spaces for admitting psychiatric patients… to worsen the matter, this is the only state-owned hospital that treats psychiatric cases in the whole of Oyo State. So, people come from Saki, Igboho, Moniya and Eruwa, which are very far distances to this place for treatment.* (Psychiatric Nurse/IDI)

The import of this statement is unmistakable and suggests that these limitations serve as disincentive to prospective patrons to seek for an alternative. As such, the perception of efficacy of an orthodox mental health facility may not necessarily translate to use by individuals on the basis of non-readiness of the latter to accept patients.

> *…I pity families that have a member that is mentally ill. Using my own family as an example, the level of stigma that we suffer in our community is terrible. People assume that all of us are prone to madness because of the perception that it flows in the blood. This is the reason why we prefer this place (UCH); we came all the way from Ebonyi state. Although we have a nearby psychiatric hospital in our state, we decided to come here so that people would not likely identify us. It is terrible and painful to be so stigmatized.* (Relative of a patient/IDI)

Thus even when people have access to a facility as in the above instance, utilization is withheld on the basis of perceived or actual stigmatization of patients and *Significant-others*. Indeed, such fear and skepticism may discourage patronage of a perceived efficient and effective facility just in order to avoid such stigma. Among physicians, stigma and discrimination were also reported. A psychiatric doctor stated in an interview that:

> *Fellow medical doctors and even nurses also exhibit stigma towards our mentally ill patients, especially from the accident and emergency unit. Once they notice psychiatric history in any patient, they call us immediately claiming that they cannot attend to such patient. I think that that attitude is discriminatory.* (Psychiatric Doctor/KII)

Poverty is a critical factor in determining access and use of health facilities. As a respondent narrated:

> *…if there was enough money, she would not have stopped taking the drugs that Aro (Psychiatric hospital) prescribed for her. She would not have even come here (traditional healer's home)… The drugs worked, but when she stopped taking these drugs due to our inability to buy them she relapsed.* (Relative to a patient/IDI)

As further expressed by a caregiver, people who cannot afford the cost of newer and more effective drugs are not likely to initiate the process of orthodox mental healthcare utilization. Those already patronizing the system may decline. A healthcare provider gave a vivid account of a situation, thus:

> *Most of the conventional drugs are obsolete… There are some drugs we would like to use but relatives cannot afford them; so most relatives decline. I have a patient who is on twice a month injection (Respiderconsta) which costs Forty-five Thousand Naira per dose. That translates to Ninety Thousand Naira monthly, aside other drugs… certainly most people cannot afford that in Nigeria where the minimum wage is just Eighteen Thousand Naira only (about $120).* (Psychiatric Nurses/IDI)

Integration of Mental Healthcare Systems

In this session we present the views of respondents on the possibility of integrating traditional and orthodox systems of mental healthcare delivery. As a Relative to a mentally ill patient opined:

> *I think it is possible for the systems to converge; it can be a classic case of division of labour whereby the strength of each is emphasized. I even heard that some years back traditional healers were encouraged to present their medication to orthodox doctors for harmonization, and later work together.* (Relative/IDI)

Another respondent who had a contrary opinion to the effect that such convergence is not feasible stated that:

> *I do not think there could be a situation whereby the orthodox and non-orthodox can work together. I say that because the two systems are completely different with a wide variation in their*

> *approaches. For instance, while the orthodox is explicit, precise and scientific, the other systems are embedded in mystery. They offer incantations and sacrifices to gods; often people become traditional healers through inheritance and succession not necessarily on the basis of expertise as is the case with the orthodox. Depending on what the gods say, the traditional system may direct that a particular concoction should only be handled by a female or by a particular family… In faith based too, whoever is going to apply their method should be someone who is also "faithful". If not, whatever he does may not be effective.* (Psychiatric Nurse/IDI)

Although the divergence of orthodox and unorthodox systems of healthcare delivery is the common notion, a caregiver stated:

> *I heard that in India, they have reached the level of working together. We believe in the patient's faith. In fact, there are cases we ask the "Alfa" or Pastor to come and pray, as the case may be, but we do not allow them to administer substances on patients given that we do not know the content; not restricting them on that basis would be interpreted as professional misconduct which is a serious medical offence. Even food has to be tested before we allow it to be given to our patients. The herbalist may also come and pray, but we do not allow them circumcise or give the patient any concoction. And sacrifice can be done on behalf of the patient, but not within the hospital premises.* (Psychiatric Nurse/IDI)

However, the level of integration described above will not likely lead to drug counteraction since what the unorthodox contributes in the process are not physical things but rather prayers, incantations and sacrifices which could have been performed elsewhere other than the hospital environment.

Discussion

Cases of mental disorders are on the increase in Southwest Nigeria as in most other parts of the world for various reasons ranging from substance abuse, congenital abnormalities and brain injuries resulting from accidents and shock. In most African communities, the basis of mental illness is located in the supernatural (Jegede, 2005; Tshotsho, 1994) and therefore to be treated with unorthodox therapies that may include but not limited to sacrifices, incantations and witchcraft to de-communicated the patient from evil spirits. The implication of strong conviction about the supernatural cause of such disorders is that classifications are hardly made on various types of mental conditions. Thus, perceived benefits of patronizing the unorthodox system may in the long run prove erroneous as a result of inadequate analysis of the situation prior to the decision on the healthcare delivery option to choose.

Our view is that the unorthodox can be contemplated only in circumstances where it is established that the cause is related to genetics. In which case, previous attempts to seek solution from effective and functional orthodox facilities proved abortive. As some respondents pointed out, mental disorders in some instances run in families; this aligns with the observation of Kessler (1999) that most mental illnesses are found among family members. As Jegede (2005) noted, some medicine men/women, witches, priests among others are endowed with the knowledge and power to manipulate situations including the one related to healing strange and tough health conditions. Ayorinde, Gurueje and Lawal (2004) buttressed this when they stated that most mental health services in Nigeria are sought through unorthodox means, which may involve nocturnal sacrifices and rituals (Nwoko, 2009). Thus, notwithstanding the level of efficacy ascribed to traditional mental health therapy several individuals, for religious reasons are discouraged by the fetishism inherent in it.

Generally, however, choice of treatment facility is influenced by several considerations such as availability of and distance to facilities, perceived duration of treatment, efficacy, cost of treatment, attitude of healthcare providers, and payment options among others (Aina *et al.*, 2007; Mental Health Literacy, 2007; Odejide & Ohaeri, 1997; Katz *et al*,. 1997). Several individuals would prefer facilities that are nearer their homes for healthcare services for reasons such as reduction in cost of transportation and close monitoring of relatives especially the mentally ill. Yet others would rather prefer a distant facility to avoid stigmatization as was reported in this study. We posit here that stigmatizing the mentally ill is inappropriate and should be discouraged in the strongest terms as antithetical to the African mentality of hospitality and being one's brother's/sister's keeper. However, it should not be sufficient justification for deciding to forgo an efficient and effective mental health facility close to someone's domain for a less acclaimed facility.

In the context of pervasive poverty, high cost of treatment discourages individuals from patronizing orthodox facilities which many respondents had described as expensive. Yet, hospitals being formal bureaucratic organizations with led down rules and regulations provide very limited options for defraying the cost of healthcare. For instance, while the unorthodox systems may allow payment in installments and/or quid pro quo in materials and services, the orthodox would insist on cash payment. Hence, these perceived bottlenecks undermine recourse to hospitals irrespective of the competences and expertise that may be available in them. Inability to readily finance healthcare, among individuals and families, accounts for unnecessary delays in seeking medical attention even in the context of perceived severity and derivable benefits. As Adewuya and Makanjuola (2005) observed, sub-Saharan Africa is reputed for its deficiency in providing prompt and effective professional mental health services necessary to forestall degeneration of an illness to a chronic condition. Such inadequacy is arguably an offshoot of a poorly financed health system; for instance, Morris *et al.* (2012) stated that the median mental health

expenditures per capita range from about US$ 0.20 in poor countries to US$ 45 in high income areas.

Issues related to integration of orthodox and unorthodox systems of healthcare delivery have been in the front burner for over three and half decades when the World Health Organization appealed to governments to accord traditional medicine some degree of support and development in the promotion of health services (WHO, 1978). The mixed reaction expressed by respondents/participants in this study about possible integration of the two systems is also evident in the literature. For instance, while Nwoko (2009) argued that such integration cannot be overemphasized and should possibly be undertaken through either assimilation or collaboration, Offiong (1999) pointed out that the opinion in certain quarters is that outright integration of the methods would not only be overambitious but practically impossible given their level of divergence. In this study, we found that referral from traditional to orthodox is recommended in a situation requiring head-surgery; a reverse scenario on any form of mental health situation was not recorded probably due to high degree of skepticism about traditional medicine among formal health providers (Nwokocha, 2008).

Conclusion

This study has revealed that mental health delivery in Southwest Nigeria is fraught with many challenges just like the overall health sector. As a result, health systems are characterized by inconsistencies, unpredictability and skepticism among users and prospective patrons. This apparent lack of trust in the system particularly the orthodox perhaps explains issues related to low level of utilization. Socio-individualistic factors that find expression in perception, attitude and ability to defray the cost of mental healthcare services are central to arriving at decisions about utilization of facilities.

It is strongly recommended that efforts should be made by relevant stakeholders to reduce to the barest minimum the incidence of mental disorders on one hand by inculcating the right values in family and community members. On the other, rehabilitating established cases should be prioritized through the provision of enabling environment that encourages prompt and sustained access and use of mental health facilities as and when necessary. In addition, government should enact legislation to discourage stigmatization and discrimination against mentally ill persons and their *significant-others* and that way encourage unfettered utilization of facilities. For a society like Nigeria to maximally exploit its inherent potentials, every individual needs to be given the opportunity for self-expression. Unattended or poorly treated mental disorders alienate victims from self, family and society. Thus, the chain of psychosocial consequences arising from this condition is antithetical to socioeconomic development.

References

Adeneye A.K., Jegede A.S., Mafe M.A. and Nwokocha E.E. 2014. Awareness of antimalrial policy and use of artemisin-based combination therapy for malaria treatment in communities of two selected Local Government Areas of Ogun State, Nigeria. *World Health and Population.* 15(1): 45-60.

Adewuya, A.O. and Makanjuola, R.O.A. 2005. Social distance Towards people with mental illness amongst Nigerian University Students. *Social Psychiatry and Psychiatric Epidemiology*. 40: 865–868.

Agara A.J., Makanjuola A.B. and Morakinyo O. 2008. Management of Perceived mental Health Problems by Spiritual healer: A Nigerian Study. *African Journal of Psychiatry*. 11: 113-118.

Aina O.F., Ladapo H.T.O, Lawal R.A. and Owoeye O.A. 2007. Community-oriented services in a psychiatric hospital: Efforts to reduce stigmatization. Niger. *J. Psychiatry*. 5(1): 19-25.

Asuni, T. 1979. The Dilemma of Traditional Healing with Special Reference to Nigeria. *Social Science and Medicine*. 13B: 33-39.

Ayorinde O., Gureje O. and Rahman L. 2004. Psychiatric Research in Nigeria: bridging tradition and modernization. *British Journal of Psychiatry*. 184: 536-538.

Bird P., Omar M., Doku V., Lund C., Nsereko J.R. and Mwanza J. 2010. The MHAPP Research Programme Consortium. Increasing the Priority of Mental Health in Africa: Findings from Qualitative Research in Ghana, South Africa, Uganda and Zambia. *Health Policy Plan*. 26: 357-365.

Fournier, O.A. 2011. The Status of Mental Healthcare in Ghana, West Africa and Signs of Progress in the Greater Accra Region. *Berkeley Undergraduate Journal*. 24(3): 1-17.

Gureje O., Lasebikan V.O., Ephraim-Oluwanuga O., Olley B.O. and Kola L. 2005. Community study of knowledge and attitude to mental illness in Nigeria. British. *J. Psychiatry*. 186: 436–441.

Jegede, A.S. 2005. The Notion of Were in Yoruba Conception of Mental Illness. *Nordic Journal of African Studies.* 14(1): 117-126.

Katz S.J., Kessler R.C., Frank R.G., Leaf P., Lin E. and Edlund M. 1997. The Use of Outpatient Mental Health Services in the United States and Ontario: The Impact of Mental Morbidity and Perceived Need for Care. *Am J Public Health*. 87(7): 1136-1143.

Kessler, R.C. 1999. The Prevalence, Distribution and Mental Health Correlates of Perceived Discrimination in the United States. *Journal of Health and Social Behaviour*. 40: 208-230.

Makanjuola, A.B. 2003. A Cost Comparison of Traditional and Orthodox Mental Healthcare. *The Nigerian Postgraduate Medicine Journal*. 10(3): 155-161.

Mental Health Literacy. 2007. *A Review of the Literature. Bourget Management Consulting for the Canadian Alliance on Mental Illness and Mental Health* November, 2007.

Morris J, Lora A, McBain R, Saxena S. 2012. Global Mental Health Resources and Services: a WHO Survey of 184 Countries. *Public Health Reviews.* 34. epub ahead of print.

Nwoko, K.C. 2009. Traditional Psychiatric Healing in Igbo land, Southeastern Nigeria. *African Journal of History and Culture.* 1(2): 036-043.

Nwokocha, E.E. 2013. Implications of Gender Inequity for achieving the Millennium Development Goals by 2015: Is Nigeria really making Progress? *The Nigerian Journal of Sociology and Anthropology.* 11(2): 1-22.

Nwokocha, E.E. 2008. Traditional Healthcare Delivery Systems in the 21st Century Nigeria: Moving beyond Misconceptions. *World Health and Population.* 10(1): 23-32.

Odejide, A.O. and Ohaeri, J.U. 1997. The existing mental health facilities in Nigeria. *Nigeria. J. Psychiatry.* 1(4): 235-248.

Odejide A.O, Oyewumi K. and Ohaeri J.U. 1989. Psychiatry in Africa: An overview. *Am. J. Psychiatry.* 146: 708-716.

Odejide A.O., Sanda A.O., Olatawura M.O. and Oyeneye A.O. 1978. Some Socio-Psychiatric Attributes of Patients Utilizing the Facilities of Traditional healers in the city of Ibadan. *Tropical and Geographical Medicine.* 30: 115-119.

Offiong, D.A. 1999. Traditional Healers in the Nigerian Health Care Delivery System and the Debate over Integrating Traditional and Scientific Medicine. *Anthropological Quarterly.* 72: 3-118.

Ritzer, G. 2008. *Sociological Theory, Seventh Edition.* Boston: McGraw-Hill.

Rosenstock. 1974. The Health Belief Model and Preventive Health Model, In: *The Health Belief Model and Personal Health Behaviour*. Marshal Backer, Charles. R. Stalker in New Jersey. Digest of Current Information.

Tshotsho, N.M.S. 1994. Assessment of a psychiatric patient using the transcultural approach. United Nations Nigeria Country Report, 2001.

World Health Organization. 1978. Primary Health Care: Report of the International Conference on Primary Healthcare. Alma-Ata, U.S.S.R. WHO, Geneva.

World Health Organization. 2001. *Atlas: Country Profiles on Mental Health Resources. Geneva: WHO. World Health Organization. Mental Health: a call for action by world ministers.* Geneva: World Health Organization; 2001. Available from http://www5.who.int/mental_health/.

World Health Organization. 2008. *The Burden of Disease-2004 Update*. WHO, Geneva.

World Health Organization. 2011. *Atlas: Mental Health Atlas.* Geneva.