



MENTAL HEALTH PROBLEMS IN NORTHERN NIGERIAN COMMUNITIES – AN EXPLORATORY STUDY

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ABSTRACT

Community-based studies on mental health problems (MHPs) in developing countries are scanty; the few available statistics are mostly from hospital-based studies. The objective of the study was to explore the forms and burden of MHPs from the views of community members and Primary Healthcare (PHC) service providers, with a view to calling attention for urgent intervention to forestall further psychosocial deterioration in communities. This study conducted in three northern States of Nigeria adopted the mixed research methods (questionnaire, IDIs, FGDs) to collect data from PHC service providers and community members in 47 PHC centres, and their hosting communities. Data collected were translated and/or transcribed and triangulated to meet research objectives. There are worrying mental health challenges and disorders, under the following headings: (1) Unspecified mental health problems in families (2) Substance abuse and related disorders; (3) Suicidal attempts; (4) “Imported madmen” (trafficking of mentally sick persons), and (5) Psychological distress in expectant mothers. Many mental health problems are prevalent in most communities; the main challenge being the multiple psycho-active substances abuse, and emotional issues of expectant mothers. Attention is required from both governmental agencies including security operatives and the PHC system, and NGOs in curtailing dimensions of these phenomena, with the need to shift focus to community based mental health services

Key words: Northern Nigeria, burden, mental health problems, Primary Health Care

Mental health problems (MHPs) consist of all behaviours, activities, feelings and thoughts which significantly impair social, occupational and intellectual or cognitive functioning, encompassing but limited to mental health issues like substance-related disorders, psychological or emotional disturbances, and mental illness or disorders (Mental Health for Canada, 2008). Mental health problems including disorders, ranked as the leading cause of disability worldwide, are on the increase globally and in Nigeria (WHO, 2007; Saxena, *et al*; 2010; WHO, 2012), accounting for between 12% and 17% of global burden of disease (Thornicroft and Tansella, 2003; Malvárez, 2008; WHO, 2012). Mental health problems are among the risk factors for communicable diseases including sexually transmissible diseases and HIV/AIDS and non-communicable diseases, contributing to both unintentional and intentional injuries including suicide (WFMH, 2004; WHO, 2010).

Many community-based MHPs are linked to faulty life styles resulting in social episodes like substance abuse and its related mental health disorders among in- and out-of school youths (Abdul, *et al*; 2010) and can be addressed

at PHC settings (WHO/Wonca, 2007; WHO/Wonca, 2008). Factors, such as wars and other major disasters also, either facilitate poor mental health or worsen psychosocial well-being (WHO, 2010). In Nigeria, emergencies and disasters, increased levels of negative stress, images of war, terror, death and destruction have been attributed to the mental health challenges in recent times (Makanjuola, 2015), giving rise to a variety of mental health problems in communities. Unfortunately, statistics on mental health problems from community-based studies are quite scanty. Apart from the 1963 Leighton/Lambo study of the Yorubas, in Abeokuta, the Federal Ministry of Health (Nigeria) (FMOH, 1991:2) had acknowledged that “there is paucity of concrete nationally based data on the prevalence of various types of mental health problems and disorders in Nigeria, despite the apparent magnitude of the problem”. Recently, the same concern was again expressed by Makanjuola (2015) during a Webinar Online Conference on Mental Health Care in Nigeria, lamenting the poor national data on the burden

of mental health problems in Nigeria.

Available results of isolated hospital-based studies however indicate the incidence of mental disorders in Nigeria seem consistent with the projected estimates for developing countries (WHO, 2004). Over 63 million Nigerians are said to suffer from some form of mental disorder (one in every four Nigerian will suffer from a diagnosable mental health problem in his/her lifetime), with a rising trend in incidence of drug and alcohol abuse among youths and adults in Nigerian communities (PHFN, 2015; Makanjuola, 2015). There are also indications that vagrant psychotics are many on the streets of Nigeria but no accurate data on them (PHFN, 2015). These speculations have not been substantiated from the community members, especially in northern Nigeria. This study therefore explored the views and opinions of community members, PHC clinic attendees and Primary Health Care (PHC) workers in three States in northern Nigeria emerging and re-emerging mental health problems prevalent in their communities. This is with a view to advocating for an urgent action to forestall worsening mental health scenario in such communities.

METHODS AND MATERIALS

Design and setting: an exploratory study conducted in 47 PHCs and their hosting communities in nine Local Government Areas (LGAs) in three purposively selected northern States of Nigeria (Gombe, Kaduna and Benue), using the mixed research methods.

Data collection: Both quantitative and qualitative data were collected through a set of questionnaires, in-depth interviews (IDIs) and Focus Group Discussions (FGDs) from PHC service providers and community members in 47 PHC centres, and their hosting communities.

Study Participants: The questionnaire was administered to 191 PHC service providers and 495 household members, while the qualitative data were derived from IDIs involving 11 PHC service providers, 15 community members and 58 FGDs (in eight sessions). They were selected through a combination of multi-stage and purposive sampling methods.

Data analysis: Quantitative data were analysed descriptively

Supported by the qualitative data which were first (translated and)

transcribed, and then thematically analysed quoting informants' opinions and views verbatim, thus triangulated. The analysis reveal the following categories of mental health burden in the selected communities: (1) Unspecified mental health problems (2) Substance abuse and related disorders; (3) Suicidal attempts; (4) "Imported madmen", and (5) Psychological distress in expectant mothers.

Ethical clearance: Ethical approval was obtained from a University Teaching Health Research Ethical Committee. Community leaders, Heads of PHCs equally approved the use of their facilities while individual study participants also gave their written or verbal informed consent.

RESULTS

Unspecified Mental Health problems and Mental Illness in Households and Communities

Both health workers and household members believe that mental health problems are quite prevalent in their communities. Out of the 191 PHC service providers, 178 (93.6%) of them believe that there are numerous and worrisome mental health problems and disorders in the communities in which they serve. They also believe these problems have attendant perceived and real serious social and economic challenges created by community psychopathology. Among the selected States, the burden is perceived to be more in Benue State (81.8%), compared to Kaduna (74.6%) and Gombe (69.0%) States respectively, as shown in the Fig.1.

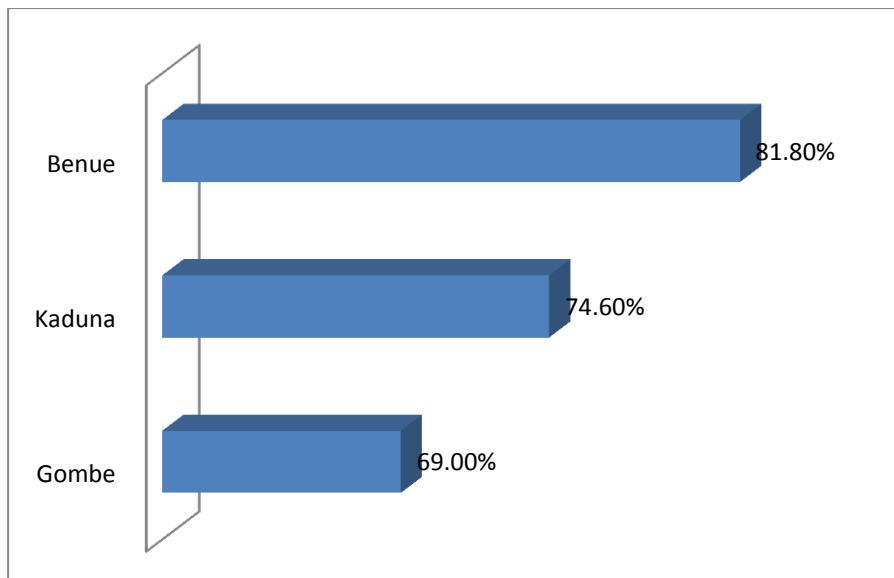


Figure 1: Perceived burden of community mental health problems in three States in Northern Nigeria

Health workers reported that virtually all categories of people in the community are prone, from birth to old age could be affected. However, they believe that the age groups of 20 to 29 years (77.5%) and 14 to 19 years (58.1%) are perceived more vulnerable.

During IDIs, PHC coordinators also perceived the burden of mental health problems in their communities to be high, as captured here: *“there is a big mental burden and challenge in this State just like other States”* (PHC coordinator Kaduna). Another PHC coordinator in the State buttressing the problem,

claimed to have personally witnessed many cases in the course of her duty, which she had to refer to the Federal Neuropsychiatric Hospital, Kaduna.

Among the community (household) members (N=495), many respondents (19.6%; n=97) reported having at least a family member with diagnosable mental disorder but not receiving any formal treatment. Similarly, the same number (19.6%) reported to be having a relation with mental illness or disorder.

During IDIs, all community leaders also acknowledged and lamented on the burden in their

families. In Kaduna South LGA, a community leader shared the experience of his sister who has mental illness was treated at a Psychiatric Hospital and was living with her husband at the time of study:

My younger sister has been suffering from mental illness. This is over seven years now. She received treatment and she is now doing very well. She is married with children, although she still goes to Barnawa every three months to receive medicines. But she is okay. This Christmas (December 25, 2014), all the tomatoes, onions and children's clothes we used in my house were brought by her (the researcher visited in January 2015, Juji village).

Another community leader in Kaduna said that he lost a brother who had mental illness and still had a sister who has the illness. At Awon, a community leader said he had a sister and a brother with Mental illness, although the brother died two years ago (at the time of data collection). The sister was still living with him and shared everything except that she preferred to cook for herself. A traditional ruler also disclosed how his 24-year old son's mental illness started at age 3 years. His story was that:

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

During the visit to the palace, the Principal researcher and two assistants encountered while waiting for the informants arrival for interview, but the boy ignored all courtesies from the visitors. During the IDI, the chief asked: "did you not see one young man pass here, did he greet you? He is the one". In Makurdi, a community leader also acknowledged the presence of mentally ill persons in his community and in virtually every village in his community, appealing that "*even if somebody is mad or he is labelled so, he is still useful at home.*"

Many community leaders, including a youth leader, interviewed all corroborated the views of the health workers and PHC administrators on the burden. Most of the problems highlighted on the mental health burden relate mainly to drugs

(substances), as confirmed by community leaders.

Abuse of Innovative Substances

From the various IDIs with community members and Primary Healthcare personnel, substance abuse is another challenge in the community. The commonest substances of abuse found are alcohol in various forms (gin, beer, local brews and palm wine) or in combination, cough syrups

(mainly tutolin) and analgesics like fortwin, pentazocine, tramadol (i.e. tramal) and Rohypnol (a sedative drug called flunitrazepam, often used as a date rape drug). These substances are psychoactive and traditionally addictive, and have been linked with mental health problems. Table 1 summarises the commonly abused drugs and substances found by States.

Table 1: Summary of substances abused in the Study Areas

State	Common substances abused	Source of information
Gombe	Tramal, alcohol, tutolin, fortwin, valium, alcohol, solution (solvent)	Primary Healthcare workers and administrators; community leaders; Heads of Health Training Institution; FGD Participants
Kaduna	Tramal, cough syrup, tranquiliser, alcohol including fermented palm wine	Primary Healthcare /administrators, Heads of Health Training Institution, community leaders; FGD Participants
Benue	Monkey-tail (mixture of <i>ogogoro</i> , <i>Tramal</i> , <i>boiled Indian hemp</i> , <i>cough syrup</i>), alcohol,	Health workers, Heads of Health Training Institution, community leaders, Youth leaders; FGD Participants

Source: Field work: Qualitative Data, 2014-2015

Suicidal Attempts

A PHC source in one of the States narrated a typical case of suicidal attempt. The uncompleted mishap was associated, according to the informant, with “poor handling of marital and economic frustrations.” In his narrative, he said: *The victim was a 33-year old female, who had been*

married for 5 years but had had no child, drank one bottle of Izal with the intention to kill herself, fortunately she was brought to an hospital and treated. She lives here in the State (The name withheld by researcher), while her husband lives and works outside the state. Although this was an isolated case, some community leaders narrated other

scenarios in their respective communities where some young people had attempted killing themselves, for lack of jobs, inability to get admission into higher institutions of learning or even because of failing Senior Secondary School final examinations. According to a PHC coordinator in one State, “cases of attempted suicide are becoming commonplace these days, having managed or received reports of several cases in recent times for our centres (i.e. PHC centres).”

Psychological Problems among Pregnant Women

At the PHC centres, many antenatal clinic (ANC) attendees who participated in the Focus Group Discussions (FGDs) complained about numerous psychological distresses they experience during pregnancy. According to them, PHC personnel attending to the pregnant women hardly talk about their psychological wellbeing. During one of the FGDs, many of them express lack of mental health education and care during ANC, as captured by two FGD participants:

...we get the services like immunizations, drugs, checking, and family planning and others. 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, even though we have many family issues bothering us (Makera PHC).

Many of us here (pregnant women at clinic) have (emotional) problems in our homes but nobody talks about such problems here o; they just check our weight, BP whether it is high oho, they just give us sleeping tablets; that is all. Like me, my BP (meaning High Blood Pressure) is because of my husband's wahala (Kaltungu PHC).

Data show that these pregnant women who came for ANC routine check-ups also had various levels of emotional and psychological challenges which are never explored by care providers at the PHC centres. Two of these women also narrated similar scenarios, though at separate IDIs, how they were always beaten or locked out of the house by their husbands each time they went for ANC. They had to come for the ANC without the knowledge of the husbands.

DISCUSSION

This exploratory study presents existing community-based mental health issues, establishing a clear concern for mental health

challenges in the communities. Various forms of mental health problems (MHPs) can be detected and managed (or referred) at PHC settings (WFMH, 2009). Despite the cases of mental health problems prevalent in families and communities, there are wide intervention gaps in northern Nigeria (Anyebe, 2015) as in many other communities (WHO, 2008; WFMH, 2009). In his analysis of south west Nigeria, Jegede (2000) had reported that due to the limited mental health care services in most communities in Nigeria, traditional medicine men (TrMM) manage most cases of mental health issues.

Abuse of multiple substance mix is found in this study. The relationship between poly-substance abuse and mental health problems, often referred to as co-occurring disorders or concomitant disorders are common and well established (Harris & Edlund, 2005; SAMHSA] 2009) but less than one-half have access to treatment . These seriously impair both the social and economic functioning of youth, families and communities (Saddock and Saddock, 2003), thus the need for social approach to these problems (WHO, 2011; 2012a). Some States in Nigeria such as Benue State Government attempted to ban the consumption of the local

gin, *ogogoro*, but that this has not been successful.

The isolated case and the several narratives of attempted suicide identified in this study are suggestive of another ineffective and tragic coping strategy considered by psychologically decompensated individuals at times of distress, as typified by the marital frustration found in the study. The phenomenon of “imported madmen” identified in one of the three States studied. Although it was an isolated scenario, it points to a probably an unexplored area of trafficking chronically sick people, which is not a new phenomenon.

Suicidal attempts and families sending out their mentally sick members (as in the case of ‘posting’ them to other States) may also be suggestive of poor handling of everyday socio-economic (situational) crises, and possible break down of traditional social safety net. People who maintain constant social contact with and enjoy social support from significant and general others are reported to have better mental wellbeing than those who are isolated and unsure of any such support (Townsend, 2006). Similarly, the absence of a PHC system where people can visit when they need counselling or help can predispose them to suicides and other impaired social and economic functioning

(WFMH, 2009). According to World Federation for Mental Health (2009), knowing that people will have a place (like the suicide prevention clinic, as can be provided at POHC centres) to discuss distressing problems should the need arise is the active ingredient. This arrangement is also recommended (WHO, 2012) and the PHC centres are expected to provide that avenue. In some countries, there are even Suicide Prevention Clinics, where clients with suicidal or other-directed injuries ideations are managed. The efficacy of such arrangement varies across cultures. On contrary, also, perhaps the very referral to a suicide prevention clinic has designated the patient as being at high risk, alerting the individual's support network to the need to attend to the emergence of acute suicide risk. The study also identified real emotional and psychological challenges among pregnant PHC clinic attendees. The issue of mental health challenges of expectant mothers found in this study has been a neglected area of maternal and child health (MCH) globally. However, several reports such as Royal College of Obstetrics and Gynaecology, RCOG, (2012), WHO (2010) and Atlas (2014) show that during pregnancy, expectant mothers and families face many psychological problems which can be detected and managed during ANC at PHC

clinics to prevent pregnancy-induced mental health disorders or post-partum mental health challenges such as puerperal depression (WHO, 2012b). These are often ignored or go undetected at primary care settings. WHO (2010) reported that about half of mental disorders in adulthood begin prenatally and before the age of 14, which could have been prevented or detected early at PHC settings.

A major limitation of the study was that no depression, anxiety or body dysmorphic disorder scales were used to measure the mental health profile of the pregnant women, due largely to the qualitative nature of their involvement (FGD and IDIs). Neither could be the substance abuse cannot be ascertained quantitatively because of the focus narratives and opinions of community members and PHC service providers. Therefore the magnitude of the problem cannot be quantified. The study has however drawn attention to the mental health challenges and distresses of different strata of the community population particularly the youth and innovative intoxicants being used, the neglected aspect of ANC (i.e. mental health of pregnant women), family acknowledgement of mental disorders, and the re-emergence

of trafficking of people with stigmatised diseases (in this case, mentally sick persons) being relocated to new environments.

From the findings of this study, the abuse of newly fabricated, improvised additives and intoxicating substances found could mean the social symptoms of ineffective coping with daily stresses of life. These have started manifesting in the community as attempted suicide. This is been associated with decreasing social support and cohesion among family and group members. The western lifestyle of nuclear family arrangement, and even the industrial tendency of less attention to traditional parenting styles, has been implicated in the increasing rate of mental problems among youths in the study areas. Many of the mental health problems prevalent in the community originate from failed family and other social interactions, due mainly to diminishing traditional social and economic safety systems, as suggested by reports of neglect of children (from health administrators) and the claim from the survey that poor parenting is making children vulnerable to mental health problem.

CONCLUSION

Various forms of mental health problems and disorders including

unspecified disorders in families, suicide attempts, and emotional problems at ANC, and vagrant psychotics are prevalent in the study communities in the three States in northern Nigeria. These problems are found among the youth, adults in both males and females including pregnant women. There are also cases of abuse of newly formulated intoxicants and additives like the “monkey-tail,” tramal, solution and glue sniffing associated with co-occurring disorders mainly by youths is found in all the study.

RECOMMENDATIONS

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

- i. Advocacy about mental health problems should be undertaken to sensitise and mobilise communities in the study areas on the burden of mental health problems, ways of preventing them and to promptly and adequately access these services, where available (advocacy is arguing on behalf of mental health problems so that these problems and people with these problems get the attention they deserve, based on evidence). Advocacy visits to

- community leaders and relevant government parastatals to influence policies in favour of mental health a regular task by PHC workers and other stakeholders, like partners in mental health care will help;
- ii. The traditional social support system should be strengthened and maintained as a veritable psycho-social tonic to enhance mental wellbeing of individuals and families. This can be achieved by encouraging families and significant others on the need to spend time together, and provide social support each other to improve their mental health especially at times of (psychological and social) crises.
- iii. There is need to shift focus from hospital-based to community-based mental health services to address common mental health problems in the community;
- iv. There is also the need to incorporate mental health assessment into routine ANC services at PHCs. This should address these pregnancy- and childbirth-related mental health problems alongside other routine antenatal and postnatal physical health care.
- v. Involve governmental and non-governmental agencies including security operatives to curtail the ravaging dimensions of this menace.
- vi. These findings will require further exploration to establish its true dimension and prevalence in States in northern Nigeria.

REFERENCES

- Abdul, A.J., Anyebe, E.E., Ajayi, D.A., Garba, S.N. and Yusuf, B. (2010).** Prevalence of Use of Marijuana among Secondary School Students in Kaduna. *Journal of Educational Research and Development* Vol.5, No.3; pp. 48-56. ISSN: 0794-4667 (Dec)
- Atlas (2014).** *Mental Health Atlas*. WHO Publications: Geneva
- Anyebe, E.E. (2016).** *Mental Health Care Services at the Primary Health Care Level in Three States in Northern Nigeria*; a PhD thesis submitted to the School of Postgraduate Studies, Ahmadu Bello University, Zaria (Unpublished).
- Federal Ministry of Health (FMOH) (1991).** National Mental Health Policy. Lagos; FG Press
- Harris, M.F., Harris, E. and Roland, M. (2004).** Access to primary health care: three challenges to equity; *Australian Journal of Primary Health* 10(3) 21 – 29.
- Jegede, A.S. (2010).** “Mental Health.” In *African Culture and Health*, enlarged edition. Ibadan: Bookwright Publishers (Nigeria)
- Makanjuola, R. (2015).** “The Burden of Mental Health Problems,” Mental Health Care in Nigeria. A Webinar Internet Conference in December 2015.
- Malvárez, Silvina (2008).** *Global Perspectives on Mental Health: Tenth Annual Conference*. PanAmerican Health Organization (Louisville, USA, April)
- Public Health Foundation of Nigeria, PHFN, (2015).** Mental Health Care in Nigeria. A Webinar Internet Conference in December 2015.
- Royal College of Obstetrics and Gynaecology (2011).** *Management Mental Health Issues during Pregnancy and Postnatal Period*. Good Practice No.14. RCO&G
- Substance Abuse and Mental Health Services Administration, SAMHA, (2009).**
- Saxena S, Thornicroft G, Knapp M, Whiteford H. (2007).** Resources for mental health: scarcity, inequity, and inefficiency. *Lancet*; 370: 878–89.
- Sadock BJ and Sadock, AS (2003).** *Synopsis of Psychiatry , Behavioral Sciences/ Clinical Psychiatry* . 10th ed.

Hong Kong :William and
Wilkinson Publishers

Townsend M C (2005).
Psychiatric mental health nursing-
concepts of care. 5th edn.
Philadelphia: F.A Dais company.

**World Federation for Mental
Health [WFMH] (2004).** *The
Relationship Between Physical
and Mental Health: Co-
Occurring Disorder: Mental
Health Day: World Federation for
Mental Health.* Retrieved on Jan.
23, 2013 from
<http://www.wmhday.net>

WFMH (2009). Integrating
mental health into primary care: *A
global perspective.* Geneva

WHO (2007). Developing
Community Mental Health
Service *Report of the Regional
Workshop Bangkok,
Thailand, 11-14 December 2006:*
World Health Organization:
WHO Regional Office for South-
East Asia New Delhi, August
2007

WHO (2008). mhGAP Mental
Health Gap Action Programme:
scaling up care for mental,
neurological and substance use
disorders. Geneva: World Health
Organization.

WHO (2010). Mental Health and
Development report. Accessed
May 3, 2013 from
[http://whqlibdoc.who.int/publicati
ons/2010/9789241563949_eng.pd
f](http://whqlibdoc.who.int/publications/2010/9789241563949_eng.pdf)

WHO (2011). New psychological
first aid guide to strengthen
humanitarian relief: Improving
the mental health of disaster
affected populations, at
[http://www.who.int/mediacentre/
news/releases/2011/humanitarian
_relief_2011089](http://www.who.int/mediacentre/news/releases/2011/humanitarian_relief_2011089)

WHO (2012a). New WHO
report: *Dementia: a public health
priority*

WHO (2012b). Depression: *a
global crisis World Mental
Health Day, October 10, 2012*
UNESCA/MoH, 2004

WHO/WFMH (2009).
Integrating mental health into
primary care: *A global
perspective.* Geneva

WHO/World Bank (2004). The
Cost-Effectiveness of Primary
Care Services in Developing
Countries: A Review of the
International Literature. Working
Paper No. 37.

WHO/Wonca (2007). Integrating
mental health services into
primary health care: Mental
Health Policy, Planning and
Service Development Information

Sheet, Sheet3.Geneva,
WorldHealth Organization;
accessed on 21/05/2013
from <http://www.who.int/mental>

[health/policy/services/en/index.html](http://www.who.int/health/policy/services/en/index.html),

WHO/Wonca (2008).
*Integrating Mental Health into
Primary Care: A Global
Perspective.* Geneva: WHO. pp.
21-55