GENDER DIFFERENTIALS IN THE PERCEPTION AND TREATMENT OF MENTAL ILLNESS AMONG THE YORUBA OF OGUN STATE, NIGERIA

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Matriculation Number: CUGP100334

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A THESIS SUBMITTED TO THE DEPARTMENT OF SOCIOLOGY, COLLEGE OF BUSINESS AND SOCIAL SCIENCES, COVENANT UNIVERSITY, OTA, IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF DOCTOR OF PHILOSOPHY (Ph.D) DEGREE IN SOCIOLOGY

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ACCEPTANCE

This is to attest that this thesis is accepted in partial fulfilment of the requirements for the award of the degree of **Doctor of Philosophy in Sociology** in the Department of **Sociology,** College of Business and Social Sciences, Covenant University, Ota.

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DECLARATION

I, **OLAWANDE, TOMIKE IBIRONKE** (CUGP100334), declare that this Ph.D thesis titled "Gender Differentials in the Perception and Treatment of Mental Illness among the Yoruba of Ogun State, Nigeria" was carried out by me under the supervision of Prof. Ayodele S. Jegede of the Department of Sociology, University of Ibadan, Ibadan and Prof. Patrick A. Edewor of the Department of Sociology, Covenant University, Ota. I attest that this thesis has not been presented either wholly or partly for the award of any degree elsewhere. All sources of data and scholarly information used in this thesis are duly acknowledged.

OLAWANDE, TOMIKE IBIRONKE ……

Signature & Date

CERTIFICATION

We certify that the thesis titled "Gender Differentials in the Perception and Treatment of Mental Illness among the Yoruba of Ogun State, Nigeria" is an original work carried out by **OLAWANDE, TOMIKE IBIRONKE** with Matriculation Number CUGP100334**,** in the Department of Sociology, College of Business and Social Sciences, Covenant University, Ota, Ogun State, Nigeria, under the supervision of Prof. Ayodele S. Jegede and Prof. Patrick A. Edewor. We have examined the work and found it acceptable for the award of a degree of Doctor of Philosophy in Sociology.

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DEDICATION

This work is dedicated to the Almighty God, my saviour, defender and provider and to my lovely parents Elder and Mrs. S.S. Ojo who sacrificed their comfort for my education.

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LIST OF ABBREVIATIONS

APA	American Psychological Association
ANOVA	Analysis of Variance
BMI	Body Mass Index
CBT	Cognitive Behavioural Therapy
DALYs	Disability-Adjusted Life Years
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders-Text Revision
FGM	Female Genital Mutilation
FMC	Federal Medical Centre
FMD	Frequent Mental Disorder
GBV	Gender Based Violence
GD	Gender Differences
HERFON	Health Reform Foundation of Nigeria
ICD	International Classification of Diseases
IDI	In-Depth Interview
IPV	Intimate Partner Violence
KII	Key Informant Interview
LGAs	Local Government Areas
MDGs	Millennium Development Goals
MHLAP	Mental Health Leadership and Advocacy Programme
NGOs	Non-Governmental Organizations
NHIS	National Health Insurance Scheme
NICE	National Institute for Health and Clinical Excellence
NIMH	National Institute of Mental Health
OCD	Obsessive Compulsive Disorder
PPD	Post-Partum Disorder

PLWMI	People Living With Mental Illness
PRB	Population Reference Bureau
PTSD	Post Traumatic Stress Disorder
SDGs	Sustainable Development Goals
TBA	Traditional Birth Attendant
UN	United Nations
UNDP	United Nations Development Programme
USA	United States of America
USDHS	United States Department of Health Survey
VAG	Violence Against Women
WHO	World Health Organisation

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ABSTRACT

Mental health is an important and indispensable constituent of health which determines the capacity of an individual to consciously live a meaningful and stable life. Mental illness presents a lot of challenges especially in developing nations, Nigeria inclusive. There are various cultural factors that influence the perceptions of people about mental illness. Although studies exist on the perceptions and treatment of mental illness, little attention has been paid to gender differences. This study, therefore, examined gender differentials in the perception and treatment of mental illness among the Yoruba people of Ogun State, Nigeria. Labelling and African Feminist theories provided the theoretical framework. The research design was a cross-sectional survey of communities and four neuropsychiatric hospitals in Ogun State, purposively selected based on the location of the first generation psychiatric hospital in Nigeria. Qualitative and quantitative methods of data collection were triangulated. Multi-stage sampling technique was used to select three Local Government Areas (LGAs) in the study area based on the presence of psychiatric hospitals. Through proportionate sample size distribution to the LGAs, nine hundred and sixty seven (967) 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 analysed using descriptive and inferential statistics (Chi square at $p<\_0.05$ and F-test). Qualitative data were content analysed. Respondents' mean age was 22.2 years. Female respondents in the sample constituted 54.2% while male respondents constituted 45.8%. There were significant differences between men and women in the perception and treatment of mental illness. With regard to availability of modern mental healthcare facilities, 62.1% and 69.5% of male and female respondents respectively claimed that modern mental healthcare facilities were available. For accessibility of mental healthcare services, 60.7% and 39.1% of male and female respondents reported that they travelled more than 5km for mental healthcare services. On the utilisation of mental healthcare services, 26.4% and 73.6% of male and female respondents indicated that finance was major hindrance to the utilization of mental healthcare services. Gender was significantly related to preference of healthcare professionals (χ^2= 45.739). Household support was a significant factor in the effective treatment and rehabilitation of the mentally ill. Mothers (as caregivers) were more disposed (than fathers) to assume complete responsibility for the treatment of mental illness in their dependants. From the Study, one can conclude that women are more in touch with the reality of the disease condition in their dependants as they bear more of both the financial (73.6%) and emotional burden of managing People Living with Mental Illness (PLWMI). Stigmatisation and gender discrimination in the treatment of People Living with Mental Illness (PLWMI) should be eradicated through government actions, advocacy and education.

Keywords: Gender differentials, Mental illness, Treatment, Perception, Ogun State

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Globally, health is desirable by all. Good health has been recognised as one of the core life-sustaining needs that are crucial for building a nation (Smith, 2013 and World Health Organisation, 2015). The World Health Organisation conceptualises health as a complete state of physical, social and mental well-being and not just the non-existence of a disease or illness (World Health Organisation, 1948). Physical health refers to the biological aspect of health; it connotes functional and metabolic efficiency of an individual. Social health refers to the health of an individual as it relates to his or her ability to interact with others and thrive in social settings. Mental health is a term used to describe the level of emotional well-being or absence of mental disorder. The physical, social and mental health of a person are interrelated and interconnected (Elegbeleye, 2013).

Mental health is an integral part of an individual's capacity to live a life of fulfillment, including the ability to maintain social relationships and to make day-to-day decisions (World Health Organisation, 2005). However, mental illness explains the disorder generally characterised by deregulation of mood, and behavior of either male or female. The concept of gender is a structural determinant of mental health and mental illness. The relationship between gender and mental health is complex and it contains a core contradiction (Gelder, Lopez-Ibor, Andreasen, 2000; Gureje, 2010). Majority of the female-dominated cases are results of specific diagnoses (specifically depression, fear, nature and eating abnormalities). Patel, Kirkwood, and Pednekar (2006) identified the existence of societal effects in mental illness. They establish that poverty (characterised by poor earnings, inability to make ends meet), marital status and tobacco usage significantly contribute to greater proportions of psychological disorder.

For Kessler, McGonagle, Zhao, Nelson, Hughes, Eshleman, Wittchen and Kendler (1994), global rates of mental illness experienced by men are the same for women. However, remarkable gender differences (GD) occur in the forms of mental illness. Financial status, traditional expectations, and societal support vary by masculinity and femininity, and they influence on persons' susceptibility to mental illness. Epidemiological reviews propose that women in matrimony are

more affected by matrimonial conflict than married men and men are more expected to be affected by occupational-related stress. This development has much to do with masculinity and feminity roles and expectations in the world. Male and female differences in mental health will not be abridged until women's mental health is considered (Avotri and Walters, 1999). Male and female differences occur in form of help-seeking for mental illness. Masculinity and femininity prejudice also takes place in the management of mental illness (World Health Organisation, 2014). The interferences obtainable for averting and treating the psychological disorder in developing nations are quite limited (World Health Organisation, 2012).

Recognition of mental illness is by careful assessment of cultural customs, values, and beliefs within the individual's society. However, societal attitudes, beliefs and successful treatment of mental illness play a vital role in determining health-seeking behaviour. Kabir, Iliyasu, Abubakar, and Aliyu (2004) affirmed further that the role of the society in the prevention and treatment of patients with mental illness cannot be overemphasised.

On World Mental Health day in the year 2007, Ban ki-Moon, the Secretary-General of the United Nations stated that:

> *People living with mental illness consist of a vulnerable group. The rate of mental illness and the need for treatment is common among the deprived, yet, these are particularly the collection of people with the lowest access to proper mental health care services. People living with mental illness avoid seeking care because of fear of stigma. The effects are endless which include ill-health, human suffering, and financial loss. It is our responsibility to provide care and services for them while beefing up efforts to protect the human rights of people living with mental illness*.

Mental illness has gotten to an alarming rate globally. Approximately, 500 million people have a mental illness globally with the majority living in developing countries (World Health Organisation, 2013). World Health Organisation reported that 25 to 38 million people had schizophrenia and epilepsy respectively, over 90 million people suffered from drug and alcohol problem and over 150 million persons had depression at any point in time, and around one million persons commit suicide annually (World Health Organisation, 2013). This figure is projected to increase by 15 percent in the year 2030 (World Health Organisation 2014). However, the prevalence rate of mental illness in Nigeria is 20 percent. The high prevalence of mental illness has a significant emotional burden on individuals, families, and society (Mental Health Leadership and Advocacy Programme, 2012).

Culture influences the people's perception, attitudes, and behavior in the treatment of mental illness (World Health Organisation, 2007). In Somalia, there is the widespread belief that evil spirits cause mental illness and that hyenas are endowed with the ability to see them and thus can cure the mentally ill by scratching and piercing them (Hooper, 2013). This treatment is dissimilar to the ones available in Western countries as it is presumed that there can be some sources of mental illness, for instance, genetics which is often medically treated.

For instance, Ola-Aluko and Edewor (2002) argued that the society socialised a Nigerian woman into a culture of female subordination as in most other patriarchal (male-controlled) cultures of the world. In another study, Aniebue and Ekwueme (2009) revealed that socio-cultural practice such as male dominance (patriarchy) and the stigmatising nature of mental illness, in which women are possibly more susceptible than men could explain the observed gender differences in health-seeking behaviour of people living with the mental disorder. There is prevalent stigmatisation of mental disorder in Nigeria. However, attitudes to mental illness are driven by ideas of the stigma involved in seeking psychiatric help.

Studies also indicate that the mentally ill and their caregivers seek the assistance of faith healers to get rid of warning signs (Kulhara, Avasthi, and Sharma, 2000). Research findings also reveal that traditional therapeutic approaches are considered complementary to the conventional management of mental illness (Saravanan, Jacob, Deepak, Prince, David and Bhugra, 2008). This view of causation of mental illness and help-seeking behaviour is also similar to the perception and belief system in the Yoruba-speaking area of Nigeria. In Nigeria, efforts to raise consciousness among primary healthcare workers on the significance of treating mental illness have not advanced. Early and proper management minimises the adverse biological and psychosocial impact of mental illness (Lieberman, Hill and Fenton, 2000).

Mental illness encompasses short and long-term conditions which include anxiety disorder, affective or mood disorders (depression) and substance use disorder (hard drugs, marihuana, Indian hemp, and alcohol dependence). Among the Yoruba of Southwest Nigeria, mental illness is referred to as '*arun opolo*', psychosis as *'iwin or were*' and mental retardation as '*ode or odoyo'* (Jegede, 2005; Jegede, 2010). The Yoruba people attribute its causes to four sources, namely, natural sources (accident or drug-induced), supernatural or mystical (due to the wrath of the gods), preternatural source (due to witches) and hereditary sources (Jegede, 2010). There is the

categorisation of mental illness into three – '*were amutorunwa'* (the mental illness that is inborn); '*were iran'* (hereditary mental illness) and '*were afise'* (mental illness which is an affliction from someone).

In Nigeria, five kinds of traditional healers deliver healthcare services, viz, Traditional Birth Attendants (TBAs), witchdoctors, mind readers, spiritualists and herbalists (Jegede, 2010). Traditional Birth Attendants address pregnancy-related problems and management of women. Religious scriptures, supplications, and consecrated water are used by faith healers (mostly men) in their treatment approach. Diviners, typically women, focus on identifying illness through divination. The traditional healers act as an intermediate between individuals, their family tree, and God. Spiritualists employ the use of spiritual powers in diagnosis and treatment of mental illness. Herbalists mostly men, apply herbal medications in their therapeutic approach (Gureje, 2010).

Till date, there is not much research on gender differentials in the perceptions and treatment of mental illness in Ogun State, a culturally distinct part of the country and also a notable state as it houses one of the largest neuropsychiatric hospitals in Nigeria. It is against this background that this study attempts to examine the gender differentials in the perception and treatment of mental illness among the Yoruba of Ogun State to identify points of convergence or divergence

1.2 Statement of the Research Problem

Globally, mental health is the most neglected component of health. Mental illness presents lots of challenges in developing countries. Such problems include stigma and lack of information about mental health in the society. One in four will suffer a mental illness but will they get the care and treatment they need? (British Broadcasting Corporation, 2016). In spite of the encumbrance of dysfunctional behaviour and the resulting level of anguish for persons, efforts to address it continue to be disappointing. This poor effort is because of low budgetary resources, inadequate psychiatric professionals, the existence of competing and conflicting mental healthcare system needs and the stigma involved in seeking psychiatric assistance. Attitude to mental illness reflects the bias of societal interaction with people suffering from mental illness.

In Nigeria, existing mental health policy document which includes advocacy, promotion, prevention, management, and rehabilitation was formulated by the Nigerian government in 1991. Since its creation, no amendment has taken place, and there has been no formal evaluation of its application. Information about the level of mental healthcare services in Nigeria is hard to come by. It is, therefore, difficult to identify areas of need, to make informed decisions about policy direction and to monitor progress. Since there is no policy implementation, treatment of mental illness cannot be successfully achieved.

Holistically, what one culture may consider as a mental disease or abnormal behaviour may be seen as normal in another culture. This dissimilarity in conception shows bias in the definition, identification, and management of a mentally ill individual. There is often disagreement and lots of debate on how to understand mental illness in developing countries across different cultures. In most Yoruba communities, due to its patriarchal (male dominance) nature, when a man suffers mental illness, it is traced to the wicked people in his extended family who do not want him to succeed in life. A woman, on the other hand, due to her subjugated position is not seen in the same light when she suffers a mental illness. Her case is traced to her committing atrocities such as acts of promiscuity or witchcraft and other harmful activities such as wickedness against a rival wife or husband's concubine.

The care for individuals living with mental illness is an emergent public health and of immense sociological concern. In Nigeria, inadequate mental healthcare amenities and neediness make the care of people with emotional sickness a critical weight for individuals living with dysfunctional behaviour, families and the general public. Also, uniformity in standard care and treatment of People Living With Mental Illness (PLWMI) is inadequate. There is discrimination against women regarding perceived causes, labeling, choice of treatment and medical facilities and even medical professionals to handle women have been problematic in Ogun State.

However, Leighton, Lambo, Hughes, Leighton, Murphy and Mackiln (1963) investigated psychiatric disorder among the Yoruba of Ogun State, Abeokuta. The result revealed that the occurrence of mental illness in Nigeria might be reliable with the projection estimates of most developing nations by the World Health Organisation.

There is little focus on the interrogation of male and female differences particularly in Nigeria, where men and women differ in susceptibility to specific nature of mental illness. Therefore, this study differs from others because it identifies gender differentials in the perceptions, attitudes and cultural beliefs of adults (men and women), orthodox professionals (psychiatrists and social workers) and traditional healers regarding the causes and management of mental illness among the study population in Ogun State, Nigeria.

This study aimed to proffer answers based on the problem identified about gender differentials in the perception and treatment of mental illness among the Yoruba people of Ogun State, Southwestern, Nigeria.

1.3 Research Questions

i. How do Yoruba people of Ogun State perceive mental illness?
ii. How accessible is mental healthcare services in the study area?
iii. What are the determinants of mental health services utilisation in the study area?
iv. What is the influence of gender role in mental illness treatment?

1.4 Aim and Objectives of the Study

This study aimed at examining the gender differentials in the perception and treatment of mental illness among the Yoruba of Ogun State, Nigeria. The specific objectives are to:

i. examine how the Yoruba of Ogun State perceive mental illness;
ii. assess availability of mental health care services in the study area;
iii. examine respondents' perception about access to mental health care services;
iv. examine respondents' perception about utilisation of mental health care services;
v. examine respondents' perception about choice of mental health care therapy;
vi. assess gender preference of mental health care professionals for treatment; and
vii. determine how gender roles influence household decision-making about mental illness treatment.

1.5 Significance of the Study

This study has contributed to the field of medical sociology through valuable addition to the growing body of knowledge on mental illness. Specifically, it expands the scope of male and female variations in mental health, contributing most importantly to gender role in the treatment of mental illness in Nigeria with particular reference to the Yoruba people of Ogun State which has been neglected in most studies globally.

As regard policy implications, this study is a concrete evidence and documentation to policymakers in addressing the issue of mental illness in Nigeria which is characterised by patriarchy (male dominance) where the voice of women is seen but not heard. Sociologically, the study examined the social roles of women that have varied considerably among different cultures and issues related to the dangers of mental illness which are usually indicated by gender disadvantage. These issues predominantly include violence from the husband through sexual intercourse, being widowed or separated, having low independence in decision-making, and having low levels of care from one's household. The study addresses the attitude to mental illness especially the issue of stigmatisation, treatment, and prevention of mental illness.

A deep comprehension of the connection between gender and socio-cultural issues in the development of mental illness will lead to improved identification of warning signs and management of outcomes for both men and women. In addition, this study contributes to the area of marital stability as a panacea for preventing increased mental illness from marital problems.

The families of people living with mental illness (PLWMI) who often experience stigma will benefit from results obtained from this study. The relations of people living with mental illness will be able to understand the implications of negative attributes associated with mental illness. However, this study will also address the care of the mentally-ill regarding treatment options and the process of decision-making in the family. The study serves as an expansion to the practical knowledge of professionals such as social workers and health educators in the area of awareness and sensitisation about the myths associated with mental illness

At this period of world economic downturn, the struggle for survival has become very acute, and these have stimulated all faculties leading at times to tilted and disturbed physical and mental states. It is, therefore, a contemporary issue to learn how to maintain a balanced physical, mental

and social health. The need to comprehend the nature of mental and social health, the causes of psychological difficulties and the treatment of mental illness in this present age cannot be over-emphasised.

The culture of the people affects their health and social relationships. This typifies the situation among the Yoruba of Ogun State where perceptions, attitudes, and behaviour influence the management of mental illness. It will also help change general perceptions of the society and demeanours towards the mentally ill. Therefore, it is very imperative to study male and female differentials in the perception and treatment of mental illness among the Yoruba of Ogun State, Nigeria. The study will also make recommendations or policy that could help in changing the general perceptions of the society and attitudes towards people living with mental illness.

1.6 Scope of the Study

This study analysed the differences that exist between male and female participants in the perception and treatment of mental illness. The research paticipants were drawn from adults male and female aged 18 years and above who were of Yoruba ethnic group that resided in the selected Local Government Areas (LGAs) accessing Federal and State-owned psychiatric hospitals in Ogun state. The choice of the study area is influenced by the ease of use of health facilities for people living with mental illness. However, professional healthcare workers (psychiatrists and social workers), traditional healers, families or people who care for the individuals living with mental illness (those currently receiving treatment for mental illness or disoder and those who have recuperated) were not left out.

1.7 Operational Definition of Key Terms

For better understanding and simplicity, the key terms in this study have been given operational meanings as follows:

Caregiver: In this study, caregiver refers to someone who provides unpaid care and support to any member of the family or relative, acquaintance or neighbour who has been diagnosed with mental illness. The function of a caregiver has been recognised as vital, both functionally and economically. The caregiver remains in contact with professional healthcare workers and helps the mentally ill with decision-making and matters affecting their daily life. A fundamental part of caregiving is the ability to be an excellent communicator with a person living with mental illness (who has recovered or who is recovering).

Culture: This is a word used in defining the way and manner in which a group of people lives. Culture dictates the attitudes and behaviour of people in society. Culture is the characteristics and knowledge of a particular group of individuals. Culture is a shared pattern of conduct, interactions, and understanding that are learned by socialisation. Culture is either material or non-material culture. However, culture varies in relation to time and place.

Diagnosis: The identification of the nature of illness by the examination of symptoms is known as a diagnosis. The necessary information for diagnosis is usually collected through history and bodily investigation of people living with mental illness. Diagnosis defines the causes of symptoms, mitigations, and solutions. To treat a people living with mental illness, diagnosis (that is identifying the cause of mental illness) must be carried out before prescribing treatment. However, diagnosis takes various forms depending on the nature of mental illness.

Diagnostic and Statistical Manual of Mental Disorders (DSM): This implies the comprehensive summary of what is known as mental disorders. It is also the most careful and detailed scientific analysis of diagnoses ever conducted. DSMs are made up of three components, diagnostic classification, criteria sets and descriptive text. It also has various applications in research and clinical community. It is essential for collecting and communicating public health statistics. It is an essential tool for mental health and other health professionals.

Epidemiology: This refers to the distribution of diseases (mental illness) within a population both in space and in time and of the factors that influence this distribution.

Family: Is the collection of individuals that are related by consanguinity (birth), affinity (marriage) and adoption. The family consists of the nuclear and the extended family. The nuclear family includes a man, his wife and children while the extended family has in addition to this, cousins, nieces, grandparents, aunts, uncles, nephews and sibling-in-laws. However, it is the person seeking caregiving services who defines his or her 'family'.

Gender: This refers to the traditional and societal characteristics of men and women expressed in masculinity and femininity. Gender plays a key role in the ordering of group of life. Gender draws attention to the socially constructed aspect of differences into male and female. Gender issues are not similar to women's issues. Rather, comprehending men and women issues is the understanding of prospects, restrictions and the impact of change as they both have an emotional influence on men and women in the society. Gender is an aspect of the larger socio-cultural environment.

Gender **Differentials:** This referred to as the relative distinctions between individuals (male and female). It provides explanations for the wide range observations in the perception, causes, manifestations, and management of mental illness among males and females.

Mental Health: This refers to a state of well-being in which a person becomes aware of his or her potential and the ability to deal with the stress of life, work effectively and productively, and can make an impact to his or her community.

Mental Illness: It refers to disorders characterised by deregulation of mood, and behaviour that impairs a person's ability to function effectively. Mental illness refers to an emotional pattern that takes place in an individual and accompanied with distress or disability that is not expected as part of the culture in the society. Mental illness describes the health circumstances that are described by an alteration in thinking; mood or conduct connected to distress and weakened functioning

Perception: This refers to a belief or an opinion often held by people. It is the way and manner in which mental illness is regarded, understood or interpreted. It is also the ability to see, hear, or become aware of mental illness through the senses. Also, it is the act or faculty of perceiving, or apprehending using the senses or of mind, cognition and understanding.

Psychiatrist: This is a physician who specialises in the diagnosis and treatment of mental illness. He or She is a medical doctor, unlike a psychologist. Psychiatrists work in mental health hospitals. Psychiatrist evaluates patients to determine whether symptoms are the result of physical illness, a blend of physical and mental or specifically a psychiatric one.

Social Worker: A social worker is a professional who assists people. Most often he or she helps people manage their daily lives, understand and adapt to illness. His or her duty is to provide support for service users and to maintain the professional relationship by acting as a guide and advocate for people with mental illness. A social worker uses his professional judgment to make tough decisions that might not always be well received by all patients.

Stigmatisation: The word 'stigma' is derived from Greek which implies physical symbols, aimed to uncover some degrees of danger and something unusual about the moral position of the signifier. It is a negative approach based on bias and misrepresentation caused by an indicator of illness. Stigmatisation of psychological disorder occurs globally, though the form and nature differs across cultures. It refers to as the devaluing and disgracing of people living with mental illness.

Treatment: Treatment refers to care given to the mentally ill. This is the administration or application of remedies to a patient. It can be orthodox or traditional in nature depending on who is receiving the treatment. In this study, treatment was measured in terms of availability, access, utilisation, and choice of mental healthcare services in the study area. Specialists, who are mostly professional healthcare workers and the traditional healers, are the experts that treat people living with mental illness.

Traditional healers: This is a person who is known by the public as experienced in providing healthcare by using herbs, animals and inorganic materials and other specific ways and means. These techniques and methods are rooted in societal, traditional and spiritual contexts and on the awareness, qualities, and principles that are predominant in the community, regarding physical, psychological and social well-being and the causation of disease and infirmity.

1.8 Organisation of Chapters

The thesis is organised into six chapters with each covering a particular subject matter. Chapter one entails background to the study, statement of the research question, aim, and objectives of the study, significance of the study, the scope of the study and operational definition of key terms. Chapter two covers a comprehensive literature review of the subject matter under inquiry and a presentation of the conceptual and theoretical framework that the study adopted. Chapter three focuses on the research methods which consist of the study population, sample design, and procedure, instrument of data collection, method of data analysis, limitations of the study and ethical considerations. Chapter four focuses on data presentation, data analysis and interpretation of results. Chapter five presents the discussion of findings obtained from the study. Chapter six presents the summary, conclusion, recommendations, and contribution to knowledge.

CHAPTER TWO

LITERATURE REVIEW

2.1. Preamble

This aspect of the work focuses on the review of the literature as it relates to gender differentials and treatment of mental illness. A cursory search on literature aptly reveals that some of studies exist in the field of mental health, not only in Nigeria but across the globe. The second part of the review deals with the theoretical framework and conceptual framework adopted for the study. The theoretical framework employs the use of two related theories, which are: Labelling theory and Black/African feminist theory. It further adopts a model for its conceptual framework that shows the relationship between gender differentials in the perception and treatment of mental illness. In this regard, a predominantly mono-cultural setting of the Yoruba from Ogun State, Nigeria is used to understand the interwoven connections between gender differentials and mental illness. Therefore, the study focuses on gender analysis of mental illness, causes, treatment and the management of intervention in these cultural settings.

2.2 Conceptualising Health

The most famous definition of health is located in the preamble to the constitution of World Health Organisation (WHO). The holistic model of health, as conceptualised by WHO, is a condition of a comprehensive physical, social and mental well-being and not simply the non-existence of a disease or illness (World Health Organisation, 1946). This definition indicates that there is a fundamental relationship between the soundness of the body and the good of the self. The World Health Organisation's Ottawa Charter for Health Promotion (1986) views well-being as multidimensional and promotes a social prototype of health. It describes health as an affirmative notion highlighting social and personal assets in addition to physical capacities.

According to Last (1995), health is a state in which humans and other living creatures interact and co-exist indefinitely. Health is a state characterised by anatomic, physiologic integrity, ability to perform especially valued familial, work, and community roles, the capacity to deal with physical, biological, psychological and social stress (Strokes, 1982). Health is characterised by the capability of persons, families, groups, and communities to deal successfully with substantial misfortune or

risk (Vingilis and Sarkella, 1997; Lashan, Lacey, and Kenyatta, 2014). The measurement of the state of health of a population involves more than counting the individuals who, on checkup displayed unmistakable signs of disease and comparing their number with those who do not. No matter the variations in the definitions given by authors, the assessment of mental health is still subjective to the author's conceptualisation.

Social scientists in America discovered that psychosocial welfare may be a more precise construction of mental and social safety. Thus, they have interrogated the rationality of an explanation that entails complete health. Nevertheless, an expansion of the World Health Organisation's explanation may be essential to comprise a spiritual part of health if social scientists can come to an understanding that mysticism is a characteristic of health and not simply an effect (Larson, 1996; Jegede, 2010). The primary determinants of health, according to the World Health Organisation, are the societal, economic, physical setting and the individual characteristics and conduct of the person.

Environment and circumstances influence health. Gender must be counted as a determining factor of health due to its clarifying influence about variations in health consequences between men and women. These irregularities are demonstrated not only concerning variation in vulnerability and exposure to dangers – for instance, susceptibility to sexual violence, but likewise, basically, in the authority of males and females to cope with their lives, to adapt to such perils, safeguard their existence and impact the course of the process of health advancement. This poise of supremacy has benefited men and demoted women to an inferior, deprived status (Pan American Health Organisation, 1995). In Nigeria, there are different conceptions concerning health and disease. According to Omotosho (2010), socio-cultural factors which affect the perception of health include religion, ease of use of relatives in the hospital or link with hospital staff, family decision, marital status, position in the household, educational status and, very significantly, the nature of the disease.

2.3 Conceptualising Mental Health and Mental Illness

It is challenging to conceptualise health as no single definition is collectively recognised by scholars in the area of mental health. It is a socially generated and definite idea, that is, diverse cultures, groups, beliefs, and expertise have diverse means of conceptualising its environment of what is psychologically fit.

To most educated persons, the concept of mental health has been confused with the idea of mental illness. Mental health is more than the mere non-existence of mental illness. Mental health is an important and indispensable constituent of health. It is a condition of welfare in which a person recognises his or her capabilities, can deal with the typical pressures of life, can labour efficiently and is competent to contribute meaningfully to his or her society. In the optimistic view, mental health is the basis for individual well-being and the proper running of society (Oyewunmi, Olabode, Oluwole and Ayannike, 2015). The Canadian Mental Health Association (2014) argued that assessing mental health is not as simple to do as measuring physical health. The contributory factors to how well individuals can adapt in the society include their physical condition, genetic makeup, learning, reasoning, and socialisation. Others are culture, life experiences, drugs, diseases and psychological mechanisms (Akinade, 2008).

The variety of meanings presented can be challenged on some grounds, relating to their compatibility with one another and their internal reliability (Rogers and Pilgrim, 2005). However, a statistical norm can be used to define mental health, but what of a society which contains wrong and destructive standards? What is common in one culture may be strange in another society. It is not easy to draw a firm line between normal and abnormal mental states. Diverse scholarly works have focused on various scopes of mental health, used diverse meanings of mental illness and considered different populations, and a large portion of them have not measured for all the mystifying issues (Mukherjee, 2013). The characteristics of mental health include ability to enjoy life, self-actualisation, flexibility, balance, and resilience (Holmes, 2014).

Keyes (2002) further divides the concept of mental health into three independent domains, namely, emotional, psychological and social well-being. These domains are satisfied with the quality of life, and positive affect, self-acceptance and a sense of purpose in life, having a thriving social life

in local and broader societies respectively (Robitschek and Keyes, 2009). According to Akinade (2008), mental illness refers to a psychological form that takes place in persons and is connected with suffering or ill health that is not likely to be a feature of the ways of life in the society. It is used to describe the situations of health that is characterised by variations in philosophy, the frame of mind or conduct connected to suffering and weakened functioning (United States Department of Health and Human Services, 1999). For Goldstein, and Noel (2017), the expansion of the Diagnostic and Statistical Manual of Mental Disorders (DSM) helped concretise the concept of mental illness. Furthermore, Australia Bureau of Statistics (2003) defined mental illness as a clinically diagnosable illness that affects an individual's reasoning, emotional or societal abilities. For Olise (2010) and National Institute of Mental Health (2013), no one factor is responsible for mental illness. There are lots of factors responsible for mental illness which include genetic factors, environmental factors which may be physical or socio-cultural (living in poverty and lack of social support), psychological factors which include poor social skills, poor coping skills and the problem with communication.

Mental illness is a general term to describe psychological abnormalities and disorders. There are different categories of mental illness, and many different facets of human behaviour can become disordered (Ghalandari and Jamili, 2014). Other general medical problems, for example, maternal and child health and HIV/AIDS are associated with mental illness. Social factors such as poverty, low educationalal lovel, social exclusion, gender disadvantaged, conflict and disaster contribute to the onset of mental illness (Prasadarao, 2009).

2.4 Conceptualising Gender

Gender is a sociological word that refers to the traditional and societal characteristics of men and women that show in a suitable masculinity and femininity. It does a crucial part in the organisation of culture. It attracts consideration to the communally fashioned part of differentiation into male and female. Aina (2012) opined that gender matters are different from women's issues. Instead, understanding gender matters include understanding changes, limitations and the effect of variation as they both touch men and women.

Anytime gender is debated, numerous misunderstandings make some persons accept as true that there is either warfare or encounter to be battled and won by either male or female. All that is required is to provide females with equal opportunities in the social world. The term 'gender' was introduced into sociology by Oakley (1972). She defined gender as the similar and uneven societal partition into masculinity and femininity. According to Madu (2006), it is a psychosocial concept of masculinity and femininity. It is an aspect of the wider socio-cultural background. Additional significant conditions include race, time of life, cultural background, level of poverty, etc. It does not simply talk about nature and individuality. Gender can also be examined from representational and physical echelons. Information indicates that the characteristics of gender involve societal qualities, socio-culturally determined, and social concept imbibed through the course of socialisation.

The specificity of the normal bodily, behavioural, emotional and psychological features of masculinity and femininity that are being openly fashioned and cultured through differences can be denoted as gender (Ferrante, 2011). For Oyekanmi (2005), gender is a societal concept that creates roles acted by both females and males. It examines the position of women in contrast to men. In unindustrialised nations, women have access to less political and financial assets likened with men. Hence, the explanation of gender, that is, the condition of men and women should not be evaluated in isolation. It should be in association with each other.

In the world, masculinity and femininity development continues to lag behind human development (United Nations Development Programme, 2000; Aina, 2012). Women constitute over seventy percent of the population of the poor (United Nations Development Programme, 1995; World Health Organisation, 2015) and carry the threefold weight of industrious, procreative and caring effort. Women are at danger for deprived physical and mental health. Apparently, masculinity and femininity must be taken into consideration in ways gender roles impacts on mental health.

Gender differences vis-à-vis health results have been bedeviled by the usage of two diverse theoretical structures. Men are perceived mainly on the subject of their work-related part, with work hypothesised as a fundamental variable. On the other hand, women are mostly studied with respect to their domestic functions. Emphasis on the dominance of women's domestic functions

has resulted in their paid work being considered as an extra role instead of a fundamental inconstant in its right, hence, additional muddling and bewildering assessments made by masculinity and femininity (Arber, 1991). The stress on women's procreative well-being and women's functions as wives and mothers has been specifically obvious in the health programmes and investigation carried out in developing nations.

Conversely, in the discoveries of Avotri and Walters (1999) about Ghanaian women, the primary health worries women acknowledged were associated with psychosocial health difficulties connected to weighty assignments. It is perceived that the mental health of women in unindustrialised nations from a psycho-social multi-level viewpoint acknowledged minute consideration (Patel, Araya, de Lima, Ludermir and Todd, 1999). This perspective consists of the mental health implications of procreative, operative, and procreative healthcare as women's work-related health has likewise been a subject of the old fixation with women's procreative functioning (Loewenson, 1999).

According to World Health Report (1998), globally, the health of women is intricately connected to their position. It gains from impartiality and is hurt with discrimination. At present, the position and welfare of numerous millions of women globally are unfortunately still low (World Health Organisation, 1998). According to Chandra, Raghunandan and Krishna (2008), the complex interaction of social, biological and cultural factors determine women's mental health. Women are susceptible to numerous mental health challenges due to their subordinate position in the society and the effect of stressors that are regularly gendered comprising poverty or paucity of financial resources, violence and deprived physical health. Depression, post-traumatic stress disorders are much more widespread among the female gender than in their male counterparts.

Mental health challenges including substance use disorders, anxiety disorders, and schizophrenia though not more prevalent in women have particular clinical and long-term repercussions among women. Sexual strain and intimate partner violence are also significant factors of mental health challenges in women during pregnancy and the postpartum periods are associated with mental illness due to a combination of hormonal, biological and psychosocial vulnerability. The

postpartum disorder has been identified as a significant cause of morbidity globally. Reproductive and sexual health disease also has an association with mental illness.

Men and women vary in the severity and occurrence of mental illness. The validity of this finding is undermined by the fact that diagnosis of mental illness is primarily based on reported symptoms and rarely on objective signs, biopsies, blood tests, or indices of structural abnormality of the brain (Seeman, 2007). However, men and women are vulnerable to diverse illnesses, situations, and physical involvement. For instance, childbearing, ovarian cancer and cervical cancer are experienced by women while men only experience prostate cancer and testicular cancer (African News Service, 2013). Adult women will probably be physically entangled as preys of domestic abuse when likened to adult men.

During the 19th century, the widely held assumptions were that there were no male and female differences in mental health/mental illness. There were also postulations that any evidence that submitted that women passed through psychological anguish than men was due to women being more disposed to mental disorder, being keener to look for treatment and sex prejudice on the part of skilled healthcare workers. However, there was wide recognition that most pointers of physical illness among women seemed to have greater rates of morbidity. There was the general postulation that the obvious rates of women did not reveal actual variations in disease but gender variations in illness activities.

A study of the current literature discloses that there is now a universal consensus among social scientists that women passed through more psychological pain than men and that this is largely due to features of their societal roles. Similarly, in the preceding few years, the combined evidence shows that women really do have advanced proportions of ailment than men and this possibly is as well primarily a consequence of their social role.

2.5 Gender Role and Mental Health

Women are habitually socialised to be sensitively profound, treasuring and to coordinate their success through a relationship with others, men are commonly socialised to be expressively reserved, confident, and autonomous (Kimberling and Ouimette, 2002). Through the examination of these labels, the conviction that women are regarded as inferior to men is not implausible. Women are confined to experience these conventional characters and anticipations of precision daily, irrespective of the number of functions they take on in their daily lives. The daily roles of a woman as a wife to the husband and, by extension, to the extended family, mother to her children, caretaker, and worker, add to the day-to-day stress. The content and potentials of each of these daily roles are seen differently by women and men. In marriage, it characteristically has worth, and importance provided the two partners are in love with each other. Nevertheless, the eminence of matrimony is more intensely associated with household fulfillment for the women than men (Denmark and Paludi, 1993). There may be the association of this dissimilarity to male and female differences in the psychological rationale for marriage. Men may have additional contributory benefits from the matrimony (for example, household tasks). On the other hand, females, who are faced with less option, may put in more emotionality in their matrimonial roles (Denmark and Paludi, 1993). From these arguments, it is apparent that these differences may lead to tension between the two partners. Thus, the stress may cause the depressing frame of mind for womenfolk that possibly will make them have the sensation as if they are maids to their spouses, not friends. Females recounted greater degrees of their spouses as less compassionate and as more probable to be a depression stressor (Wilhelm and Roy, 2002).

Another part that women participate in that is akin to matrimonial functions is the maternal roles. These parts are much intricately interconnected, as marriage could be the key foundation to nurture kids. Since women have been branded in the preceding as teen guardians, this tag has been problematic to halt. There are very limited family members in the world that have men as the main custodian of their offspring. Women, even if working, devote about seventy hours in seven days to taking care of their children. On the contrasting continuum, fathers' engrossment with the kids, about thirty hours in seven days, does not considerably differ with their work (Denmark and Paludi, 1993). The usual closeness of role straining for career mothers was not incredibly influenced. Nevertheless, employed women feel dissatisfied with the volume of time they allocate for their

kids and husband. Notwithstanding, due to labels and misconstructions, women are likely not to grumble about masculinity and feminity roles. Assessments by fathers demonstrated that the more time the mother spent with him, with childcare and rearing responsibilities, the greater his gratification with her work plan and her overall period apportionment (Denmark and Paludi, 1993). Correspondingly to that account, men's views over the allotment of tasks seemed to be influenced by simply on how gratified they were with a different responsibility. Hence, many men seem to be pleased as soon as they are not participating in house chores and the point that they see that their spouses are not satisfied with it does not diminish their matrimonial fulfillment (Denmark and Paludi, 1993). Over and done with the exploration of these dual gender roles, it is obvious that females are discontented with their gender duties. Women are confronted with the challenge of the way to make their existence significant. With declining household size, growing prolonged existence, and enhanced self-expectation, the period over which the connubial woman takes on additional roles, apart from being a mother, is getting extended (Weissman and Paykel, 1974).

Some scholars have submitted information regarding bodily look, and specifically, physical allure might be more vital to the impression of women compared to that of men (Denmark and Paludi, 1993). At the beginning of third grade, Hankin, and Abramson, 2001 reported that boys display pleasures on their physical look than girls. In contemporary times, the notion that "thin is beautiful" has turned out to be the socially acknowledged custom. The mass media broadcasts what is gorgeous frequently than what women do not appear to associate with these appearances. Hence, these causal features, if taken to the extreme, can end in an unsafe state of mind and behaviours. For instance, depression and eating syndromes. When it is about women, these dual syndromes are enormously comorbid with each other. Eating disorders will be assessed more in the subdivision of comorbidity.

Studies have indeed established that male and female role battle in men is adversely correlated with psychological health. Men who stressed achievement, supremacy, and rivalry as a degree of their individual assets or significance and men who constrained their emotional countenance to tend to have a tendency to be more nervous and down irrespective of the stage they are in life (and were also unlikely to seek mental help) than women. Such men also recounted greater worry and diminished societal familiarity. Restraining emotionality, as part of masculinity and feminity role

battle, was related with relational tactlessness, suspicion, psychoticism, and melancholy (Zamarripa, Wampold and Gregory, 2003).

The emphasis of masculinity and feminity role struggle in men revealed that causes, for example, constrained emotionality or struggle between labour and household are parts of personhood that are related to psychological well-being. There are, yet, elements of socialisation and hopes positioned on men by the general public. On the masculinity and feminity role conflict variables, mean differences came up as anticipated. Males displayed advanced stages of suitable achievement, unsuitable achievement, and restraining emotionality than women. This result is consistent with an assumption that submitted that men are socialised to stress success at the cost of emotionality. There were no differences between men and women about the struggle between work and family, an outcome that endorses discoveries in the management literature. The approaches for controlled emotion were grouped as anticipated, with men's warmth in the direction of other men are constrained, trailed by men's love toward women and women's regard toward other women, and women's warmth toward men are the least controlled (Zamarripa, Wampold, and Gregory, 2003).

However, the worth for the various masculinity and feminity role conflict variables revealed predictable gender differences, for the maximum portion, the link among these variables and dejection and anxiety showed few gender variations. For men, in line with prior studies, limited emotionality was associated with depression; however, controlled emotionality was not connected to stress. A related arrangement occurred for women, signifying that the harmful consequences of controlled feelings function alike in men and women (Zamarripa, Wampold, and Gregory, 2003).

It was assumed that only unsuitable accomplishment would result in depression and anxiety, but the outcomes slightly buttressed a substantial association between unsuitable achievement and dejection only for women. Nonetheless, suitable achievement resulted in a less amount of dejection and worry, while inappropriate achievement created more dejection and anxiety, as anticipated. The relationship amongst achievement, dejection, and anxiety did not vary by gender. These results opposed the idea advanced by some that parts of authority and rivalry are exclusively

harmful to men and recommended that there are constituents of success that cannot be thought to be dangerous in any way and may be defensive (Zamarripa, Wampold and Gregory, 2003).

The conflict between work and family was associated with depression and apprehension in men and women. Evidently, the upsurge in women in the labour force has altered women's role from assisting men's professional advancement to having to stabilise labour and domestic roles. There are indications, however, that women's experience of the struggle is challenging since they feel more accountable for household obligations and family responsibilities than do men (Zamarripa, Wampold, and Gregory, 2003).

2.6 Sustainable Development Goals (SDGs) and Mental Health

In the year 2000, world leaders implemented the United Nations Millennium Declaration and derived the Millennium Development Goals (MDGs) comprising eight internationally acknowledged development goals which were to be achieved by 2015. The goals focused on eradicating poverty, hunger, and inequality; achievement of Universal Primary Education; promoting equality between men and women and women empowerment; lessening the proportion of child mortality; improvement of the health of mothers; combating HIV/AIDS, malaria, and other deadly ailments; guaranteeing environment sustainability and development of a universal trust for development.

Recently, the MDGs have given ample devotion to international health and development. In its image for development, health and education are the points of focus. Three out of eight goals, eight of sixteen targets and eighteen of forty-eight indicators relate directly to health. Health is a significant contributor to some other goals. However, the health goals pay no attention to non-communicable diseases which include mental illness that is common in developing countries. Though disparities in mental health occur and are prevalent, they are habitually overlooked as demonstrated by the disregard of a focus on mental health in the Millennium Development Goals (United Nations, 2000). In the view of Patel (2005), mental health remains a neglected subject in universal health and its total nonexistence from the Millennium Development Goals strengthens the point that mental health has a minute role to play in primary development-related health programmes. Nevertheless, the World Health Organisation (2001) argued that in developing

countries mental health syndromes contribute to a noteworthy amount of disability-adjusted life years (DALYs).

According to the American Psychological Association (2016), the execution of the all-inclusive Mental Health Action Strategy in 2013 and the global initiative to decrease the damaging use of alcohol in 2010 by the World Health Assembly paved way for the enclosure of mental health and substance misuse in the Sustainable Development Goals (SDGs). Also, the ministerial pronouncement on executing the universally approved goals and obligations regarding universal public health, in the complex section of the essential assembly of the economic and social council in July 2009, emphasised the significance of incorporating mental health into the execution of the MDGs. It also focused on integrating mental health into other globally approved developmental goals and obligations, to decrease poverty, encourage improved health, and accomplish other advance results.

For Dogra, Omigbodun, Adedokun, Bella, and Adesokan (2012), there is a close connection between mental illness and social factors of health comprising poverty, gender shortcoming; poor physical health including HIV/AIDS and poor maternal and child health. For instance, there is a relationship between children who are unable to register in schools or complete primary education (MDGs 2) and developmental and mental disorders. Also, people who have HIV/AIDS (MDGs 6) are much more likely to suffer mental health problems, and these problems can have effects on their complete health results.

According to Frey (2015), the outcome document of the United Nations Conference on Sustainable Development entitled ‘The future we want’ set forth in order to institute a functioning group to advance a set of SDGs for deliberation and proper act by the General Assembly at its sixty-eighth session. The document gave the mandate that the sustainable development goals should be articulate with and assimilated into the United Nations development agenda further than 2015. Goal 3 target 4 states that by the year 2030, a third of the premature death from non-communicable diseases will be reduced through prevention, management, and promotion of mental health while goal 5 aims to accomplish equal opportunity for gender and empower all women and girls.

In the year 2015, Sustainable Development Goals have begun to give much attention to international health and development. In its vision for development, health and gender equality are squarely at the center; of which three of out of the seventeen goals relay directly to health and gender equality. Health is a significant contributor to several other goals. However, the World Health Organisation (2015) opined that in developing countries, mental health conditions contribute a substantial proportion of Disability Adjusted Life Years (DALYs**).**

2.7 Social Epidemiology of Mental Illness

People are passionately interested in every organ except the mind. Very few bother to know whether their minds are functioning well. Meanwhile, the mind is the most detrimental organ in the body. Behavioural attitudes such as social withdrawal, receiving phone calls from new friends, radical change in dress sense and unruly behaviour are all tales of mental issues. Psychiatric disorders are prevalent among people from lower socio-economic groups with a bi-directional pattern of socio-economic status and factors that influence health in a vicious cycle (World Health Organisation, 2013).

According to Essue, Kimman, Nina, Katharma and Tracey (2015), the United States of America epidemiological studies revealed that 2.5 percent of older adults meet the diagnostic standards for either primary gloomy disorder or dysthymic malady. In contrast, twenty-seven percent of the elderly participants in these same studies had some sub-diagnostic depressive symptoms. Research indicates that women's role may be demanding. Women are susceptible to experience childhood sexual abuse that results in psychological damage (Freeman and Freeman, 2013). Clinicians are of a diverse opinion that disorder rates differ by gender. A multi-country World Health Organisation Study on Psychological Problems in General Health Care found out that women predominate in anxiety attacks, panic disorder and depressive disorder which lead to higher rate of suicide (Lecrubier and Ustun, 1998).

A review of eight United States of America studies of prevalence estimates of personality disorder (all types) found a range of six to fifteen percent in the general population and up to fifty percent in clinical psychiatric populations (de Girolamo and Dotto, 2000). Much of this variation seems to reflect differences in diagnostic measures. According to Kessler *et al.* (1994), community samples suggest a one-year prevalence of seven out of a hundred for women and nine out of a hundred for

men in social phobia but clinical samples suggest no sex differences. When those with a diagnosis of schizophrenia were studied, the annual incidence was between 0.017 and 0.54 percent, with a one-year prevalence ranging from 0.14 to 0.46 percent (Jablensky, 2000). There is an absence of visible gender variations in the incidence of dangerous mental conditions like schizophrenia and bipolar disorder that have an impact on less than two percent of the population (World Health Organisation, 2014).

Population studies revealed that lifetime incidence and frequency rates of schizophrenia fall between 0.1 percent to 3 percent and 0.2 percent to 1.6 percent for bipolar disorders (World Health Organisation, 2012). However, there are no reports of significant gender differences. For better clarification on gender differences in mental health, the need to incorporate gender role exploration within a structural study of the factors of health cannot be over-emphasised. The incorporation is because gender roles interconnect with crucial structural factors of health which include earnings, educational and occupational status.

Bootzin and Accoella (2002) believed that psychological ills are the product of social ills. Disturbances faced by individuals are symptoms of the general disorders of the society. The economic recession encountered in the country is an evidence of this view. The higher the rate of unemployment, the higher the rate of admission into hospitals, suicide, and death from stress related ailments rose insignificant proportion as well (Adewuyi, 2000).

2.8 Gender Differences and Mental Illness

Kessler, Chiu, and Colpe (2004) opined that close to half of adults who are 18 years old and above in the USA are likely to have at least one mental disorder during their lifespan. Signs or indicators of mental disorder include stress, despair and emotional challenges (Centers for Disease Control and Prevention, 2004). Statistics from the United Kingdom National Morbidity Survey of 2000 shows the categories of demographic characteristics of mentally challenged people. It reveals that individuals who are separated or divorced or single are more prone to mental disorder (Singleton, Bumpstead, O'Brien, Lee and Meltzer, 2001). Scholars also sketched data from the National Comorbidity Survey of adults in the United States. They identified three key groups of childhood danger associated with children and adult disorder, sexual abuse, physical abuse, and neglect; family maladaptation and loss of a parent through separation, divorce or death (Green, McLaughlin and Berglund, 2010).

An evaluation of the association between marital status and mental health revealed that women in matrimony do experience an increased rate of mental illness than married men, although single women display rates of mental illness akin to or even less than the rates revealed for single men. Married individuals of both sexes experience improved physical health than the unmarried. It would seem that being married as likened with being single is connected to better physical health for both men and women. However, it is not related to better mental health for women except they are productively employed. Such employment under certain situations may have damaging effects.

Halgin and Whitbourne (2003) admit that some psychiatric conditions have strikingly diverse degrees of occurrence and frequency in women and men, but they are ambiguous about whether these variations are real or attributable to many partialities. Numerous bodies of literature show gender variations in help-seeking behaviour among people that are mentally ill. Women are more likely to seek help, whether professional or quack, than men (Clarrochi, Wilson, Deane, and Rickwood, 2003). In contradiction, another study in rural Australia showed that men would try to find assistance if they agonised from mental health challenges. The study observed male and female differences. For example, males have advanced preference signal for seeking assistance from psychologists than females do (Clarke, 2010). On the other hand, women had constantly higher proportions of suicidal efforts and post-traumatic stress condition compared to men.

Eaton, Keyes, Kruger, Balsis, Skodol, Markon, Grant and Hasin (2012) asserted that women are liable to mood and anxiety disorders while men are susceptible to anti-social nature, substance addiction/alcohol misuse syndromes. Dennerstein, Astbury, and Morse (1993) discovered that women in matrimony have higher admission rates in mental health amenities than married men. Also, Afifi (2007) submits that male and female and role differences have an emotional impact on women's health.

One main health problem for women is that of mental condition. A variety of studies revealed that women are excessively afflicted by mental health challenges and that their susceptibility is related to marital status, labour and roles in the world. Females are more likely to have a mental illness when compared to males. Major proposed reasons were: nurturing children and taking care of the house is frustrating; the role of housewife is somewhat amorphous and indiscernible; when a married woman works she is in a less pleasing position than the married man and expectations challenging women are vague and diffuse. Before World War II, more studies revealed an advanced rate of mental illness for men than women, signifying that social change has negatively affected women. Also, in nations experiencing economic holocaust, there was a higher occurrence of mental disorder, and the higher rates were in women than men.

Women living in the western world live longer than men and have less mortality rates for most reasons of death. There is a strong indication that these variations are because of women's constitutionally greater resistance to contagious and deteriorating disease. Gender-specific risk causes of mental illness that affect women comprise centre violence, socio-economic shortcoming, low returns and income disparity, low or subservient social status and position and incessant obligation for the care of others. The high pervasiveness of sexual violence to which women are open and the resultant high rate of Post-Traumatic Stress Disorder (PTSD) succeeding such viciousness make married women the leading single collection of women affected by mental illness.

2.9 Factors Influencing Gender Differences in the Treatment of Mental Illness

2.9.1 Cultural Factors

Mental disorder is seen as a cultural phenomenon and not a universal referent as popularly thought (Lambo, 1962). Man is a social being conditioned by cultural pressures. It is imperative to comprehend behaviour and mental health only within a cultural framework. Studies have shown that there are relationships between socio-cultural factors and causes of mental disorder and utilisation of modern health facilities in society (Jegede, 1995). In developing countries, culture plays a dynamic role in the health behaviour of the people because most people are traditionally inclined and superstitious.

From ancient times, individuals, through all cultures globally, have experienced indications of mental illness (Department of Health and Human Services, 2001; Prasadarao, 2009). Culture impacts the way an individual shows signs of illness relates them to others, deals with the emotional challenges attached to the illness, and his or her readiness to seek a cure. Sam and Moreira (2002) assert that culture and mental illness unseemly in each other and that knowledge of the part of beliefs in mental health is fundamental to the wide-ranging and precise diagnosis. Castillo (1997) acknowledged numerous dimensions that culture impacts mental health. They are the person's experience of the disorder and allied indications; the way the person articulates the symptoms within the socio-cultural milieu; the interpretations of the symptoms and thus, its diagnosis, management and finally the result.

The part of the culture in mental health report, diagnosis, treatment, and the prognosis is well summarised in a report by the United States physician on mental health. The report stated that the culture which a patient hails from forms their mental health and influences their health-seeking behaviour. Similarly, the clinician's culture and the healthcare system have impacts on diagnosis, management, and financing of services' (United States Department of Health and Human Services, 1999). The review by the Council of National Psychological Associations for the Advancement of Ethnic Minority Interests (2003) emphasised that psychiatric experts know and are sensitive to their cultural background and prejudices. Similarly, they know their cultural legacy with that of their patients. They recognise how these impact their views. Thus, they enthusiastically strive to

know themselves, their culture and other people's cultures with the aim of evolving essential services necessary to work with particular cultural groups.

Although Diagnostic and Statistical Manual of Mental Disorders-Text Revision (DSM-IV-TR) is the most acceptable culturally diagnostic tool to date, there is still a long way in understanding how culture shapes mental disorder. International Classification of Diseases (ICD) was developed by the World Health Organisation in thirty-nine countries around the world. Culture and language differences can limit the equivalency of diagnosis (Bourne and Russo, 2000; American Psychiatric Association, 2000). The ability of DSM-IV-TR to deal with cultural issues is a primary concern. It does not cover all mental disorders found in other cultures. In most cultures, men are seen as dominant, active and aggressive whereas women are viewed as affectionate, emotional and soft-hearted (Williams and Best, 2000). Many cultures and traditions have regarded mental illness as a type of religious penance or demonic possession. In early Egyptian, Indian, Greek and Roman literature, mental illness was considered a religious or personal problem.

A Dictionary of the Yoruba Language treats the concept of illness, translated as '*aisan*' as synonymous with concepts such as sickness and disease. For Giddens (2008), people in all societies do not share the same conceptions of illness as involving the physical malfunctioning of the body. Illness for the Yoruba people is a state that one is not well, irrespective of subjective or objective state. Jegede (2009) opined that illness has its biological, psychological, sociological and cultural dimensions. Also, certain cultural practices affect the health of the individual either physically or mentally or both. For example, practices which encourage undernutrition of the mother or child can cause mental illness in the child's life later. Female Genital Mutilation also has both physical and psychological complications.

2.9.2 Social Factors - Poor Parenting, Abuse, Neglect and Poverty

Poor parenting is also a causal risk factor for depression and anxiety (Pillemer, Suitor, Pardo and Henderson, 2010). The Schizophrenia Commission (2012) argued that family separation or bereavement and childhood ordeal have been discovered to be risk causes of psychosis and schizophrenia. Abandonment of children by the parents or caretakers mostly occurs during childhood. Most times, parents who indulge in this damaging attitude also suffered neglect as

children. The long-standing consequences of desertion are poor child's bodily, emotional, and mental health and in later life (Feldman and Papalia, 2012).

Issues in a relationship have continuously been connected to having mental disorders. There has been growing argument on the relative effect of the home or work environs, school and peer groups on child's mental health. Parenting expertise or parental melancholy or other complications may also be risk factors. Parental divorce seems to intensify risk, possibly if there is family disagreement or disorganisation, even though a real understanding bond with a single parent may recompense. According to Heinrich and Gullone (2006), there is an association between early social deprivation, or lack of continuing, cooperative, safe and dedicated relationships and the development of mental disorders.

Individual's interaction with other people as well as the worth of the relationships can considerably increase or reduce an individual's quality of living. An individual's constant fights with friends and family can result in an increased danger of developing a mental illness. A malfunctioning family often creates a harmful co-dependent bond on the part of the household head (usually to drugs). The loss of a loved one, most especially at an early age, can have long-lasting impacts on an individual. The person may experience anxiety, guilt, resentment or loneliness. These experiences can push people into loneliness and depression. They may result in alcohol and drug use to manage their feelings. Divorce is also another issue that can have damaging effects on both children and adults. Divorcees may undergo emotional fine-tuning problems because of the loss of intimacy and social relationships. Nevertheless, current statistics reveal that the adverse consequences of divorce have been significantly overstated.

Concerns about the security of the job and the monetary existence of the family can produce a massive burden on persons and this may possibly have implications on their mental health status (Omokhodion and Gureje, 2003). Studies have revealed that there is an uninterrupted connection between poverty and mental illness (Kondo, 2008). The lower the significant position of an individual in the society, the higher the risk of mental illness. Penurious people are two to three times more probable to have mental illness than people of a higher economic class. These impoverished families must deal with stressful variables such as unemployment and lack of affordable housing. These stressors can lead to mental health conditions. A person's socio-

economic class shapes the biomedical, environmental, behavioural and psychosocial risk factors that are connected to mental health.

2.9.3 Psychological and Biological Factors

Some clinicians believe that psychological features only lead to mental disorders. Others guess that unusual behaviour can be a combination of both social and psychological factors. Environmental and psychological factors complement one another causing emotional stress, which in turn triggers mental illness. Each is distinctive in how they will respond to psychological stressors because what may affect one person may have slight or no influence on another person. Psychological stressors, which can activate mental disorder, include expressive, bodily or sexual abuse, the death of a loved one, abandonment and inability to relate to other people. The failure to interact with others is also called emotional detachment. Emotional dispassion makes it challenging for people to commiserate with others or to share their thoughts and feelings. An emotionally disconnected individual may make an attempt to give a good reason for or apply rationality to a condition that has no logical justification. These persons tend to emphasise the significance of their freedom and maybe a bit neurotic. Often, the lack of ability to interact with others is because of a traumatic event.

The mental features of persons, as evaluated by both neurological and psychological studies, have been linked to the advancement and maintenance of mental disorders. These mental illnesses include cognitive and neurocognitive factors, pointing to how a person sees, deliberates or feels about some things; an individual's entire personality, temperament or surviving style or the degree of shielding factors or "optimistic illusions" including positivity, individual control and a sense of meaning. The extent to which biological variables have an impact on the serious vulnerability of melancholy in women over men is somewhat insignificant; nevertheless, it still makes available a probable account for the incidence. Hormonal and heredity causes are put into cognisance and make available a number of indications of fact when likening depression vulnerability between women and men. Hormonal fluctuation essentially has emotional impact on the depression level in women. Depletion of estrogen also referred to as menopausal indications, elucidates increased depressing rates and vasomotor insecurity (burning explosions). Formanek and Gurian (1987) argued that the inclusion of rates of vasomotor instability as a factor of depression increased the

depression rates from thirty-nine percent to fifty-five percent. The surge in depression occurrence among women can also be accredited to them having feelings of being un-womanly. These feelings can happen at menopausal phases as it is a stage of infertility. Thus, the sense of aging sets in. Also, it is factual that men have a tendency to value allure and youth in their companions much more than do women. "Men have a preference for youthfulness because it is likely to be associated with higher fertility, reproductive potential, and health" (Ben Hamida, Mineka and Bailey, 1998). In line with the principles of development, after a woman becomes unproductive, she is less preferred by men since the rationale for having sexual intercourse is to get pregnant and give birth to children.

Many pieces of evidence on hormones as well as the mindset about menopause led to doubt as to what precisely causes the depression. The unclearness remains unresolved because it is practically difficult to execute an experimentation of having women isolate their moods of depression from menopausal conditions. Nevertheless, "depression may be an antecedent rather than a result of emotional reactions connected to menopause" (Denmark and Paludi, 1993). To liken hormonal variances between men and women would be partial. It is definite that women experience much more hormonal fluctuations than men (because of childbearing, premenstrual symptom, menstruation, use of contraceptives, postnatal period and menopause). On the other hand, similar to women, men do have signs related to menopause but are relatively denoted as "mid-life" challenges or depression. It is nearly difficult to elucidate why women are vulnerable to depression than men when referring to biological inconsistencies. According to Nazroo and Edwards (1998), "such a particular variation cannot be described just as a consequence of biology, predominantly among women as rates of depression did not differ by parity".

When relating to heredity, the genetic transmission may make women more vulnerable to depression. There is rational confirmation from twin and family works that genetic influences are active in the origin of depression and emotional disorders that support the genetic transmission as a justification for the gender differences (Nazroo and Edwards, 1998). Two possible grounds were given to back up the hereditary theory and make available, the sign that makes females to be vulnerable to depression. A reasonable hereditary justification is X-linkage; that is, the location of the significant locus on the X chromosome. If the genetic factor for depression is positioned in the X chromosome and the trait is prevailing, women, who possess two X chromosomes, are likely to

suffer depression more frequently depressed when compared to men that possess only a single X chromosome (Nazroo and Edwards, 1998).

A second probable genetic justification is the phenotype of women. This clarification postulates that both genetics and ecological effects may lead to women's depression. For example, if the parent of a woman were depressed, she is more than probable to become depressed because of the environment and genetic predisposition. Therefore, having a relation who is depressed, turn out to be a long-lasting environmental strain, which denotes an ongoing "background" stressors that have a toll on one's coping capacities and means. The causes of prolonged pressure are countless; instances comprise an insecure or dangerous housing (Kimberling and Ouimette, 2002). Phenotypes affect men as well; though its effects are resilient in women. This effect happens since women have a greater penchant of consciousness of their environs and are characteristically narrowly connected to their relations. It is apparent that phenotypic qualities affect the rate of depression. Nevertheless, as indicated before, the phenotype theory is just a likely clarification for the vulnerability of women to depression. There cannot be certain assumptions grounded in theoretical propositions.

2.10 Perception and Attitude to Mental Illness

In the 1950s, social scientists started to address inquiries about how the public comprehend mental illness and the way they react to people suffering from such ailment. The findings were revealing (Phelan, Link, Stueve and Pescosolido, 2007). On the societal conceptualisations of mental illness, interviews were channeled with over 3,000 Americans. At the end of the research, there was the conclusion that there was a strong inclination for individuals to link mental illness with psychosis and to see other categories of emotional, behavioural, or personality glitches in non-mental health term as, "an emotional or character variance of a non-problematic sort" (Holmes, 2014). The definition of mental illness was in such constricted and extreme languages that the community dreaded, banned and undervalued people living with mental illnesses (Crocetti, Spiro, and Siassi, 2004). Irrespective of the cause of these damaging approaches, their existence was well recognised. Nunnally (2001), for instance, found that individuals were more probable to rub in a wide variety of deleterious adjectives such as dangerous, filthy, icy, useless, nauseating, frail, and uninformed in an individual seen as mentally unbalanced than to a normal person.

Majority of the articles on mental health published between 1990 and 2004 examined the approaches towards people living with mental illness (PLWMI) from European and other technologically advanced western countries. Fifteen out of a hundred of the reviewed studies were restricted to non-industralised nations and studies carried out in Africa were just a study from Ethiopia (Barke, Nyarko, and Klecha, 2011). There is little information about the understanding of an approach to mental illness in sub-Saharan Africa (Gureje, Lasebikan, Ephraim-Oluwanuga, Olley and Kola, 2005). A study conducted by Adewuya (2005) asserted that in Nigeria, studies on attitudes towards mental disorder and persons living with mental illness are scanty. Erinosho and Ayorinde had studied two communities in western Nigeria (Erinosho and Ayorinde, 1978). A more current study among residents of three states in Southwestern Nigeria revealed the widespread negative understandings and perception of mental disorder (Gureje *et al.*, 2005). Kabir *et al.* (2004) conducted a study in a rural community in the northern part of Nigeria. Adebowale and Ogunlesi (1999) assessed the views about causes and treatment of mental disorder in Nigeria. The study population includes people living with mental illness and their families. Ilechukwu (1988) also observed the inter-connections of opinions about the psychological disorder and its management while Abiodun (1999) evaluated the approach of hospital labour force towards psychological disorder. Since the behaviour of an individual is subject to the norms, philosophies, and customs of his or her ethnic background, multi-ethnic characterised nations similar to Nigeria will likely have a varied individual attitude towards persons suffering from mental illness.

Various studies on mental illness have revealed that there is a robust relationship amid people's perception of mental illness causation and stigmatising attitudes to people living with mental illness (Adewuya and Makanjuola, 2008). In Nigeria, the stigmatising attitude is pronounced as people constantly try to isolate themselves from individuals living with mental illnesses. This is because they are viewed as being dangerous, and capable of throwing themselves and their families into shame and dishonor. The Yoruba rank mental illness in the same category as leprosy and other stigmatising diseases. Mental illness is believed to be rooted in spiritual attacks. Thus, families with a history of madness may find it very difficult to give out their daughters out in marriage or to bring a bride into the family (Babalola, 2003).

The negative attitude and rejection of the society towards people living with mental illness hurts their earnings, job status and may add to the growth rate of their environmental stress and lessen their adaptability (Adewuya and Oguntade, 2007). There have been several assumptions about the stigmatising experiences of people who have a mental disorder. Previous studies had postulated that stigmatisation and discrimination were rare experiences of mentally ill individuals in Africa (Fabrega, 1991). However, current works carried out among university students and the communities in Nigeria had contrary findings (Adewuya and Makanjuola, 2005; Gureje *et al.*, 2005). Similarly, it was commonly assumed that skilled or professional mental health practitioners are less probable to endorse or indulge in stigmatising attitudes towards mentally ill patients (Corrigan, Green, Lundin, Kublak and Penn, 2001). Recent studies have also challenged this assumption. These studies did not show obvious variations in the attitude of health specialists and the society towards people living with a psychological disorder (Aydin, Yigit, Inandi and Kirpinar, 2003; Lauber, Anthony, Ajdacic-Gross and Rossler, 2004; Carlylee, 2010).

2.10.1 Stigmatisation

Stigmatisation of mental illness is an everyday and everywhere occurrence, though the form and nature of its presentation vary from one culture to another (Murthy, 2002; Carlylee, 2010). 'Stigma' as a concept is rooted in the Greek word that is focused at exposing abnormality about the signifier's morality. It is also defined as someone to be evaded particularly in public. Erving Goffman, in his final work on stigma, noted that the stigmatised person is more often not seen as someone less humane. Much of the mental health terms have been assimilated into the public dialogue in an explicit stigmatising manner. The use of such terms as 'psycho', 'nutter', 'maniac', 'schizo' and 'kolo' are employed to belittle the entire field of mental health (Adeoye, 2013). Stigmatising people living with mental illness is devaluing and disgracing (Abdullahi and Brown, 2011).

Most of the researchers on stigma were done in developed countries. There are scanty data on stigmatisation of people living with a psychological disorder in sub-Saharan Africa (Barke, Nyarko, and Klecha, 2011). The more mentally ill individuals feel stigmatised, the lower their self-confidence (Link, Struening, Neese-Todd, Asmussen and Phlelan, 2001). Stigmatising attitudes

towards psychiatric patients have direct consequences for the prevention, management, reintegration, and value of existence.

Stigma breeds bias or the unequal conduct towards individuals. It also leads to denial of their rights denials in the society (Stuart, 2005). Stigma and discrimination connected to being obese and overweight can lead to mental health consequences (Puhl and Brownell, 2001). According to United Nations (2008), eighty-five percent of the world's child and adolescent populace live in developing countries. Stigma hinders people with mental illness from seeking treatment, finding employment and residing in the society. The World Health Organisation (2001) has noted that there is the opinion that stigmatisation of the mentally ill is the most important barrier to overcome in the society. Also, World Health Organisation Global Action Programme advocacy for non-discriminatory attitudes and practices is one of its main tactics of enhancing the state of global mental health.

Globally, reasons for stigmatisation are not the same across cultures. For example, the World Mental Health surveys showed there is a close association between that stigma and anxiety; and mood conditions among adults with a significant disability. The statistics revealed that 22.1 percent and 11.7 percent of individuals who participate from developing and developed countries respectively got embarrassed and discriminated due to their mental health status (Alonso, Buron, Bruffaerts, He, Posada-Villa, Lepine, Angermeyer, Levinson, Girolamo, Tahimori, Mneimneh, Medina-Mora, Ormel, Scott, Gureje, Haro, Gluzman, Lee, Vilagut, Kessler and Von Korff, 2008). Research carried out by Crisp, Gelder, Rix, Meltzer and Rowards (2000) revealed that an individual's familiarity with someone with mental instability does not mean he or she will not utter derogatory statements about the victim.

Some psychologists believe that certain social and cultural factors can influence one to have mental disorders. Social ills such as discrimination, poverty, and crime might be at the roots of mental disturbance. Schizophrenia and alcoholism appear to be more prevalent among people in the low socio-economic levels. Such people may not have ready access to adequate professional treatment. Stigma has several components (Link and Phelan, 2001). The difference is labeled, and the meaning of the names is appraised in line with cultural beliefs. The stigma brings loss of status

and discrimination. There are studies in many parts of Africa which have found that mentally unstable people are often deprived of social support.

Stigma and discrimination connected with being obese and overweight can lead to mental health consequences (Carr and Friedman, 2005). According to research carried out by Mukherjee (2013), females were 1.4 times more likely to report Frequent Mental Disorder (FMD) compared to males. Present or perpetual tobacco users (minimum of hundred cigarettes in a lifetime) and spree drinkers were more likely to report FMD. Respondents involved in any form of physical activity outside regular work were significantly less likely to suffer from mental distress. The findings are similar to a pattern with people in both the lower and higher range of Body Mass Index (BMI) having poorer mental health (Zhao, Ford, Dhingra, Li, Strine and Mokdad 2009). There was a note that specific mental problem (For example, anxiety disorders are usually more common among underweight men (McLaren, Beck, Patten, Frick and Adairr, 2008). Underweight people often suffer from malnutrition and micronutrient deficiency which are biological risk factors for poor mental health. A 2005 report submitted that a women-specific association may exist between obesity and depression (Allison, Newcomer, Dunn, Blumenthal, Fabricatore, Daumit, Cope, Riley, Tvreeland, Hibbern and Alpert 2009). Mental health challenges that are rooted in violence are also not identified. At least one out of five women had experienced actual or attempted rape in their lives (World Health Organisation, 2014). The lifetime prevalence rate of violence against women falls between the ranges of sixteen and fifty percent. In Nigeria, information does not exist on the widespread negative approaches to mental illness despite the pervasive stigmatisation of the illness (Gureje *et al*., 2005).

2.11 Causes of Mental Illness

Although the precise factors of psychological disorders are unknown, it is becoming obvious through research that many of these conditions are the results of a combination of biological, cultural, and social factors. Studies have evaluated lay public views about the causation of psychiatric disorders (Adewuya and Makanjuola, 2008). In many societies, particularly in non-Western cultures, it is believed that mental illness affects people that are demonic-possessed. It is also said to be the results of evil-eye, curse, spells, the breaking of taboos of the culture (Gureje *et al.*, 1995, Erinosho, 1998; Olatawura, 2002; Mateus, dos Santos and de Jesus Mari, 2005; Aluko-Arowolo, 2006; and Jegede, 2009). In most cases, the ancestors or spiritual connection is invoked to determine the origin and type of treatment required. In Nigeria, people tend to believe and seek medical help from traditional healers, witch doctors, and prayer houses along with the orthodox type of religious activity (Erinosho, 1996; Health Reform Foundation of Nigeria, 2006).

The Yoruba believe that there is a linkage between the son and the deceased father. However, they do not believe that the dead father can cause mental illness. For Prince (1964), the Yoruba believe that the ancestors can bring about unrest of mind, lack of prosperity, and sometimes physical illness if they are not accorded proper burial and occasional sacrifices. There is the belief among the Yoruba that deceased fathers continue to aid their sons during their difficult times and even help them in knowing how to treat their clients through dreams. Central to the Yoruba conception of mental illness is the belief that individuals have a double (*Eleda or Ikeji*) in heaven. The one on earth agreed to stay for a period to do a particular kind of job, marry and have a certain number of children and later return to heaven to be with his double. This contract includes all the details of his future. If the individual fails to execute the contract, it is believed that the double may get angry and attack so that he becomes mentally ill (Morah, 2009). There is also the 'biological' or 'brain disease' explanation of mental illness. There is the belief that childbirth, poisoning (intentional poisoning or the consumption of dangerous herbs) could lead to mental illness.

2.11.1 Depression

The conceptualisation of depression varies from society to society. For some, depression means feelings of unhappiness but do not seem to affect daily activities. For some, depression connotes sickness characterised by depressive mood, loss of appetite, lack of concentration. Symptoms of depression vary according to an individual's age and culture.

The significance of male and female differences in mental health is exemplified in the various significant rates of depression that are commonly faced by women when compared to men's experiences. Piccinelli and Homen (1997) epidemiological review of gender variations in the experience of affective disorders and schizophrenia revealed that women experienced them more than men. Piccinelli and Wikinson (2000) argued that with few exemptions, females have a depressive abnormality (from mid-life through adulthood) than males. Women are more susceptible to mental illness than men while males are more vulnerable to alcohol disorder than females. People who were unemployed, on sick leave or disabled, and never married were prone to developing a mental disorder, and though with a fewer definite difference, living in a city had an association with mental illness.

It was reported that research conducted across racial groups revealed a lifelong pervasiveness of depression and anxiety in females than males (World Health Organisation and International Consortium of Psychiatric Epidemiology, 2000). Numerous studies have shown that single mothers who earn low income are more prone to the depressive disorder than other people (Salsberry, Nickel, Polivka, Kuthy, Slack and Shapiro, 1999). Depression is characterised by depressive disposition, displeasure in most activities, weight loss or gain. It also has indications such as sleep disturbance, low energy, poor concentration, a feeling of guilt or low self-worth, and recurring thoughts of death for more than two weeks (American Psychological Association, 2000; World Health Organisation, 2007). Depressive symptoms include continued somatic reports, such as aches, pains, or cramps that do not go away with appropriate medical treatment (National Institute of Mental Health, 2007). Depression is no respecter of age, gender, class or race. It usually involves acute episodes of overwhelming sadness of short duration. It affects all groups of people with anxiety syndromes. It is one of the most frequently experienced psychological syndromes. It yearly affects more than 19 million persons living in the United States of America (Akinade, 2008).

Indications of depression include severe sadness, loss of gratification in life, negative thoughts, feelings of worthlessness and excessive or inappropriate guilt and lack of motivation. Studies have revealed the existence of a direct link between depression and suicide in the United States of America. Possible causes of depression could be biological, cognitive, social or psychological factors. Depression is often caused by heavy drinking. Many large-scale population studies show that women tend to exhibit anxiety disorders more often than men do (American Psychological Association, 2000). Men are prone to developing substance abuse and social resistant problems while women are more likely to develop anxiety and depression. A current meta-analysis revealed that about 20 percent of mothers living in developing countries experience clinical depression after childbirth. This result is much higher than the previous figures on prevalence coming mostly from high-income countries. Suicide is one of the main factors of death among pregnant and post-partum women. Worldwide, mental health challenges of mothers are seen as a major public health issue, although maternal mortality is still central to maternal health indicators (World Health Organisation, 2017).

Depression accounts for the highest proportion of the burden related to psychological disorders (American Psychological Association, 2000). According to the World Health Organisation (2001), depressive disorders ranked fourth due to their global burden of disease and are expected to be ranked second by 2020. A report by the World Health Organisation opined that proportions of depression in mature life are three to four-fold advanced in women that have passed through sexual abuse during childhood or partner violence in adulthood. The National Institute of Mental Health approximated that three million and above adults who are between 18 and 68 years suffer from a severe mental disorder. The estimated unemployment rate among this group falls between 70 and 90 percent. Employment is acknowledged as an efficient path to enhancing their mental stability. The depression occurrence and prevalence increased the moment individuals became unemployed.

Reviews on the association between social support and depression experience in males and females revealed controversial findings. While some found out that social support equally predicts depression recovery for both gender, others showed differences for both genders (Bebbington, 1996). Dalgard, Dowrick and Lehtinen (2006) concluded that gender variations do not explain the higher rate of depression in women in adverse events, social assistance or susceptibility. Women

reported more anxiety-associated variables than men. These consist of panic disorder, Obsessive-Compulsive Disorder (OCD), Post-Traumatic Stress Disorder (PTSD) and others. (Robichaud, Daugas and Conway, 2003).

Male and female differences in depressive indications seem to arise in early puberty and at that point exist during the course of adult life expectancy (Nolen-Hoeksema, Larson and Grayson, 1999). Steady discoveries point out that pubescent teenager have depressive indication at an earlier stage of development than teenage boys. Emergent male and female differences can be instigated by an individual susceptibility, stress of lifespan, and the challenge of adolescent transition. Both male and female genders experience sexual maturity at almost the same age. However, it is argued that girls are more susceptible to depression than boys even before adolescence (Ge and Conger, 2003).

In a six-year longitudinal survey including 451 families, interviewers asked each family member to fill a set of questions on personal features and life experiences of family members. The research revealed that early depression signs are found in middle phase and the dawn of adolescence. The study further revealed that there is a relationship between gender-linked susceptibilities (diathesis) and risk of depression for young females than males (Ge and Conger, 2003). Similar scholarly works also supported these gender differentials findings on depressions (Nolen-Hoeksema and Girgus, 1994). Nevertheless, there are several criticisms against these studies. Firstly, these studies were experimental studies. Prior studies on adolescent depression did not submit similar findings.

2.11.2 Alcohol and Substance Misuse

Over the years, the role of alcohol in most cultures cannot be overemphasised. It has been an element central to religious observance and has usually been part of important social and cultural events as well. The wine has long been recommended to advance physical health, and indeed current scientific evidence shows a consistent relationship between moderate drinking and longevity although the reasons for this link are still poorly understood. The relationship between alcohol to health can thus be understood as a continuum. Warner (2000) suggests that marijuana provides something to do with friends, relieves boredom, and can help them with depression, anxiety, insomnia and physical discomfort which may explain its extensive use though at the same time it often worsens feelings of hallucinations.

Studies in developed countries show that 70-90 percent of adults drink alcohol and about five to ten percent of these have developed alcohol dependence. There are no figures available for developing countries, but there is evidence of a steady increase in the last ten years. In Nigeria, the consumption must be extremely high because alcoholic drinks are readily available all the time. It is known that any country with high alcohol consumption has a significant number of cases of alcohol-related psychosis, suicide, and murder (Akubue, 2009).

Gender differences were found in diagnosis with more male than the female that was diagnosed with an alcohol abuse abnormality and anti-social disorder (Unger and Crawford, 2002; Akubue, 2009). A study carried out in Nigeria between 1998 and 2008 revealed that marijuana use has continued to grow among commercial drivers, students, sex workers in brothels and musicians. The study of Gureje *et al*. (2005) in three Yoruba-speaking states revealed that substance misuse (alcohol or drugs) could result in mental illness.

2.11.3 Stress

Stress is a frequently heard term that appears to affect many people on a regular basis, yet it is poorly understood, commonly distorted and its implications are often taken for granted. The stress construct has suffered from a lack of clear definitional criteria arising from long-standing confusion over its use as both stimulus and response. Also, until recent years there have been few well-validated psychometric instruments to measure the subjective elements of this universal human experience. It is regarded as one of twenty-first century's most potent health hazards. Stress

makes people vulnerable to mental illness. Culture influences both the appraisal and experience of stress. Stress has direct psychological effects on the body, direct cognitive and behavioural effects and secondary effects by exacerbating illnesses, making them worse and delaying recovery (Dougall and Baum, 2002). In line with a study piloted by Ogunsemi, Oluwole, Abasiubong, Erinfolami, Amoran, Ariba, Alebiosu and Olatawura (2010), it was established that stress, depression, and anxiety are common among primary health care attendees.

There is nobody that is immune to stress. It can be beneficial and at the same time damaging. It can lead to tension, anxiety, and depression. In homes, women are known to be the caretakers; they also have a career outside the home and also combine traditional chores. Over seventy out of a hundred married women with offspring under the age of 18 years get employment outside the family environment. Individuals who study human interactions in the society label women as struggling to accomplish the 'male standard' at work while trying to sustain the excellent wife and mother standard at home. Stress occurs when individuals feel like they do not have the tools to accomplish all of the burdens in their lives. Stress can be temporary or permanent. Some of the most hectic life happenings are the passing away of a wife or husband or close relatives, separation, losing an occupation, marital separation or divorce, pregnancy, and marriage.

The stress response is a complex process for both men and women, but some differences between the sexes have been identified. There is the report that women respond with lesser levels of epinephrine than men. Nevertheless, the biased information of women's views of stress arousal can likely be greater regarding emotional distress and a dearth of self-assurance than the real level of circulating epinephrine would propose. Women are further intensely affected by the bodily and emotional impacts of stress than men. The reactions of women are embedded in their physique interaction. Men possess advanced androgen levels while women possess advanced estrogen levels. Women are likely to respond to stress in a different way than men. They do not react with the fight or flight response. They are more appropriate to discuss. Agreeing to National Women's Health Information Center, the effect of stress on women's bodily and emotional well-being ranges from a headache to ill-tempered bowel disorder. Particular stress effects consist of eating syndromes, emotional conditions, heart disease, cancer and mental illness.

The workplace is one of the key factors of mental illness. Job stress is the severe bodily and emotional reaction that happens when the work specifications do not equal the needs, skills, and

wealth of the worker (United States National Institute for Occupational Safety and Health, 2015). Job stress causes deprived health and can upsurge rates of occupational harms and accidents. A number of potential reasons for occupational-related stress are overburden, job uncertainty, secluded working conditions and insufficient child-care activities. Sexual harassment puts women under stress in their workplaces. Its effects consist of several physical infirmities as well as mental health difficulties such as depression and augmented rates of suicide. There is emergent global interest in the influence of occupational stress as well as subjects connected to gender, violence, sexual harassment, family, and underemployment. Job stress is one of the most common work-related health problem in European Union. The subsequent European assessment on working conditions showed that 28 out of a hundred of workforces stated that their job causes stress. In Japan, there is a drastic increase in the rate of employees who report severe concerns or stress about their working life.

2.11.4 Violence against Women

A few conducts of gender-based violence that lead to or are expected to produce bodily, sexual or emotional hurt to women constitute violence against women. Conducts include threats, pressure or subjective deprivation of a right, whether happening in public within a secluded domain. For the World Health Organisation, the occurrence of violence against women is alarmingly high. Women likened to men are in greater danger of being battered. Violent victimisation enhances women's risk of joblessness, reduced earnings and separation (Byrne, Resnick, Kilpatrick, Best and Saunders, 1999). For this purpose, gender-based violence is a predominantly significant cause of deprived mental health because it further deteriorates women's social status and at the same time, it upsurges susceptibility to depression and other mental illnesses.

Violence Against Women (VAW), mainly intimate partner violence and sexual violence are main public health difficulties and abuse of women's human rights. Lifetime incidence rate of violence against women falls between 16 and 50 percent. In domestic violence, women are normally the preys of the attack and the perpetrator may be well driven directly by the need to exhibit his masculinity to enforce his male supremacy and to control women. One in every three women globally has experienced both physical and sexual intimate partner violence in their lifetime (Heise, Pitanguy and Germain, 1998; World Health Organization, 2016; White, Jain, Orr, and Read, 2017).

The World Health Organisation's multi-country study on women's health and domestic violence against women (2005) in 10 principally low-and-middle-income nations establish that among women aged 15-49, 15 percent and 17 percent of women in Japan and Ethiopia respectively reported physical and/or sexual violence by an intimate partner in their lifespan. Between 0.3 to 11.5 percent of the women said they had been sexually violated by someone other apart from their partner since they were 15 years old. The main sexual involvement for lots of women was described as involuntary. Seventeen percent, 24 percent and 30 percent of women in rural Tanzania, rural Peru and rural Bangladesh respectively admitted to having forced first sexual experience. Globally, 38 percent of killings of women are committed by a male intimate partner. Nevertheless, dependable data on the magnitude of domestic violence are scarce, particularly in unindustrialised nations. A clarification could be that women are frequently exceptionally unwilling to report assaults for the panic of not being understood or being re-victimised. Furthermore, the evidence is frequently not documented in an organised way.

Violence can adversely have an emotional impact on women's physical, psychological, sexual and reproductive health and may intensify susceptibility to mental illness. Violence against women has disastrous consequences similar to homicides and suicide. It can lead to damages with 42 percent of women who experience intimate partner violence reporting an injury as a result of this violence. The depressive tendency of a victim, post-traumatic stress disorder, sleeping problems, eating abnormality, suicidal tendencies and efforts are also effects of this violence. The societal and financial costs of intimate and sexual abuse are enormous and have triple implications in the society. There is the tendency for women to suffer isolation, non-involvement in normal activities, inability to cater for themselves and their kids.

Intimate Partner violence is a particularly gendered issue. According to Wilson and Neil (2006), data collected from the National Violence Against Women Survey (NVAWS) established that women aged 18-65 are significantly and more likely than men to experience physical and sexual violence (Coker, Davis, Arias, Desai, Sanderson, Brandt and Smith, 2002). The survey revealed that physical intimate partner violence is linked to an increased susceptibility to depressive symptoms, depending on substance use and severe mental abnormality. Humphreys and Thiara (2003) assert that the body of existing research evidence shows a direct link between the

experience of Intimate Partner Violence (IPV) and higher rates of self-harm, depression and trauma symptoms.

2.11.5 Post-Traumatic Stress Disorder (PTSD)

Post-Traumatic Stress Disorder (PTSD) in people is an example of anxiety abnormality of disorder that occurs after experiencing a dangerous event. This event include: being a casualty of sexual or physical abuse or physical attack, fighting, plane crash, and demise or severe illness of an esteemed one. Women are two to three times more probable to develop PTSD than men. Also, individuals with on-going constant worry in their lives are more expected to develop PTSD after a hazardous occurrence. Globally, there is the view that maternal mental health problems are significant public health challenges. Virtually all women can develop a mental illness during pregnancy, and in the first year after delivery but poverty, migration, stress, exposure to domestic violence and small support increased risks for mental illness. Prolonged or severe mental illness disturbs the mother-infant attachment, breastfeeding, and infant care.

Globally, about ten out of a hundred of expectant women and thirteen out of a hundred of women who have just delivered experience mental illness. In developing countries this is even higher, that is, 15.6 percent of women experience mental illness during pregnancy, and 19.8 percent do experience mental disorder after childbirth. In severe cases, mothers' suffering might be so severe that they may even commit suicide. Also, the affected mothers cannot perform correctly. Due to the inability to function properly, the children's growth and development may be negatively affected as well. Maternal mental disorders especially depression are treatable. A current meta-analysis revealed that about twenty percent of mothers residing in developing countries experience depression after childbirth. This figure is much higher than the previous data on prevalence coming mostly from developed countries. Suicide constitutes one of the most important bases of death among pregnant and post-partum women. Depression creates tremendous suffering and disability and lessened response to the needs of the child. Evidence reveals that treating the mother's depression results to improved growth and development of the newborn.

Postpartum disorders denote psychological disturbances which take place in women of reproductive age within four weeks of childbearing (American Psychology Association, 2000). Prevalence rates for Post-Traumatic Stress Disorder differ extensively from place to place. Studies

in industrialised nations report prevalence rates of ten percent. In developing countries, the figures vary. The disorder occurs three times more commonly in unindustrialised than industrialised nations (Cooper, Tomlinson and Swartz, 1999) and represents substantial health difficulty affecting women and their relatives. In China, Lee, Yip and Chiu (1998) establish major depression to occur in 5.5 percent of women six weeks Post-Traumatic Stress Disorder. In Capetown, South Africa, the rate of prevalence of Diagnostic and Statistical Manual of Mental Disorders-Text Revision major depression was found out to be 34.7 percent at two months. Other African studies that have observed Post-Traumatic Stress Disorder in women have dealt with the occurrence or the prevalence of psychological disorder in general rather than focused on major depression (Aderibigbe, Gureje, and Omigbodun, 1993).

The prevalence of depression among expectant women varies from seven percent to twenty-six percent (Hobfoll, Ritter, Lavin, Hulsizer, and Cameron, 1995). Depression in prenatal period is a robust sign of postpartum depression (Graff, Dyck and Schallow, 1991) which is connected with contrary fetal advancement. Thus, the management of antepartum depression is serious (Moses-Kolko and Roth, 2004). Various factors have been discovered to be connected to postnatal depression. These include marital instability, insufficient social support and financial worries (Ballard, Davis, Cullen, Moran and Dean, 1994). There have also been reports of socio-cultural factors such as in-law relationship problems (Lee, Yip, Leung and Chung, 2004). The prevalence or occurrence of postpartum depression is between 10 percent and 15 percent in the first year after delivery. This experience might have severe effects on the women's interactions, her advantageous position and her capability to care for her child (Logsdon, Wisner, Billings and Shanahan, 2006). So far, data on postnatal depression are very limited in developing countries, including Nigeria. Also, the few available studies have been carried out in tertiary healthcare facilities (Abiodun, 2006). Countless women with postpartum depression would not take delivery of mental health services since primary care workers might be reluctant to monitor, manage and refer the women.

In the works of Agnes, Tuohy, Murphy, and Begley (2016), numerous women, prenatal period and maternity is an optimistic mental process. Nonetheless, for selected women, this ground-breaking experience can bring about the advancement of innovative mental health issues or the advent of a current issue. It is projected that fifteen to twenty-five percent of women will develop a mental health issue either for the period of prenatal or the first year post-pregnancy. Fifteen out of a

hundred women will encounter depression for the duration of prenatal period and between fifteen percent and twenty percent of women will encounter some form of depression in the first 12 months post-delivery. Post-traumatic stress disorder is projected to take place in three in a hundred women, and six out of a hundred resulting in emergency caesarian section (Ross and McLean, 2006). The amount of anxiety disorder is expected to be between fourteen out of a hundred and fifteen out of a hundred. This estimate also comes with an acknowledgment that anxiety disorder is frequently comorbid with depressive disorders, and one to two women per 1000 births experience the commencement of psychosis, often named postpartum or puerperal psychosis (Higgins, Tuohy, Murphy and Begley, 2016; Agnes, Tuohy, Murphy; Begley, 2016).

Few reviews have additionally focused on the possibility for re-occurrence and the deterioration of current mental health challenges. In specific, the stated re-occurrence proportions for bipolar disorder are moving towards 50 percent in the reproductive period and 70 percent in the post-delivery period (Viguera, Ross, Baldessarimi, Jeffrey, Zachary, Alison, Zurick, Lee and Cohen, 2007). Women with an identification of schizophrenia are at an augmented danger of psychosis (Munk-Olsen, Laursen, Pedersen, Mors and Mortensen, 2006; Munk-Olsen, Laursen, Mendelson, Pedersen, Mors and Mortensen, 2009). Although women with a history of depression are also at an augmented jeopardy of its reappearance, continuance, or exacerbation. A prenatal period can also deteriorate indications for women with pre-existing binge eating syndrome (Watson, van Wijngaarden, Love, McSorley, Bonham, Mulhern and Myers, 2013); therefore, the significance of mental health support throughout prenatal period, delivery and early maternity. Untreated maternal mental suffering, both in the prenatal or postnatal period, can have potentially undesirable consequences on the mother, fetus and newborn, as well as in the life-threatening case, maternal suicide (Oates and Cantwell, 2011). Maternal psychological distress can be linked with the augmented rate of miscarriage, pre-term birth, and postnatal expert care for the newborn and low-birth-weight babies (Kim, Evans, Angstadi, Ho, Sripada, Swain, Liberzon and Phan, 2013; Agnes, Tuohy, Murphy and Begley, 2016).

2.11.6 Women's Infertility and Mental Illness

The association of women's procreative functioning to their psychological health has received expanded and deep enquiry over several years especially in developing countries whereas other sections of women's health have been ignored. By contrast, there has been virtual neglect of involvement of men's reproductive functioning to their psychological well-being. There has been the conduct of a small number of studies that show that men are as passionately receptive to many of the similar happenings as women (Soliday, McCluskey-Faweett and O'Brien, 1999; World Health Organisation, 2014).

Infertility may cause physical, emotional and financial burden (Monga, Alexandrescu and Katz, 2004). Psychological complications of childless marriages have been documented in developed countries (Monga, Alexandrescu and Katz, 2004; King, 2003) and less developed nations (Dyer, Abrahams and Mokoena, 2005). In Africa, women with fertility problems may be despised, neglected and abused by their husband and her in-laws (Dyer, Abrahams and Mokoena, 2005). Their experience of exclusion from some important social events has been noted in some parts of Nigeria (Orji, Kuti and Fasubaa, 2002). Despite these observations, the implication of fertility experience on the mental health of women is an area that is currently under-researched in sub-Saharan Africa and Nigeria in particular,

Childbearing is often highly valued in African societies, and infertile couples suffer a lot of stigma. There is often intense pressure from relatives for the husband that is in a childless union to get another wife because more often than not family members tend to perceive the woman as the infertile partner. The intrusive nature of in-laws, therefore, constitutes potent sources of stress for these women.

2.12 Treatment of Mental Illness

Improvements in management and convalescence of people with mental illness have enhanced their health (Aina, Suleiman, Oshodi and Olorunshola, 2010). There is an effective treatment for mental illness as many studies have shown that general populace in developing countries believes in the effectiveness of conventional treatment (Lauber, Carlos and Wulf, 2005; Makanjuola, 2006). In spite of the assertion in the efficacy of orthodox treatment, professional healthcare workers maintain undesirable approaches towards people living with mental illness (PLWMI) (Glozier, Hough, Henderson and Holland-Elliot, 2006). The recognition of the early indicators of mental illness and access to prompt effective management is significant. The quicker the treatment procedure, the better the result.

Male and female differentials occur in forms of help-seeking for mental illness. Females are more prone to seeking assistance and disclosing a mental illness to physicians while males are more likely to find high-quality mental healthcare and are the primary users of inpatient care (World Health Organisation, 2017). In India, Banerjee and Banerjee, (1995) and Prasadaro, (2009) found out that patients that ascribed their epilepsy to mystical reasons at the outset turn to traditional doctors, while individuals that ascribed to biomedical causes hunt for contemporary medical treatment. The issue of rehabilitating the mentally ill in Nigeria has become increasingly important not only to the government but also to the generality of the people.

There is the report that forty-eight women out of a hundred are more expected than men to use psychotropic medications (Simoni-Wastila, 2000). According to a study carried out by Allen et al. (1998) and the World Health Organisation (2013), men are more expected than women to make known challenges with alcohol consumption to their health care provider. Regardless of the existence of gender differences, most mentally ill do not seek the help of competent doctors in industrialised nations, and the condition is possible to be much poorer in unindustrialised nations (World Health Organisation, 2014). In unindustrialised nations, men look for treatment more often at standard health services, although women are more prone to self-treat or utilise unconventional treatments. This attitude has been clarified through variables which include various roles of women which inhibit their actions primarily to the household domain and make it problematic for them to visit the hospitals in the course of opening periods. When poor women are ill, they have a tendency

to delay looking for contemporary treatment pending the time their warning signs are too severe to overlook. Hence, they yield elongated period to recuperate and frequently return to work before they have totally recovered (Vlassoff and Bonilla, 1994). When men are sick, others inspire them to pursue therapeutic assistance, and hereafter they are suitably diagnosed and cured earlier than women.

In women, management of mental illness centre on managing and cognitive expertise to assist in preventing rumination from evolving into a clinically imperative dejection or nervousness whereas in men, treatment centre on remunerating plan activities and forming violent predispositions into non-destructive deeds (Eaton *et al.,* 2011). Effective treatment includes medication, cognitive and behavioural psychological therapies. Efficient treatment also entails psycho-social attention, psychiatric ill health rehabilitation, the prevention of threat factors which include unsafe alcohol and other medication usages, and learning self-management services.

2.12.1 Psychotherapy

Psychotherapy is a typical kind of treatment method for various mental illnesses. Psychotherapy is a relational mediation, typically made available by mental health experts which include a medical psychologist that uses a few varieties of exact psychological methods. There are various kinds of psychotherapy. Cognitive behavioural therapy (CBT) is employed for a significant variance of syndromes. CBT is centred on changing the forms of thought and behaviour connected with a specific disease. Several types of CBT and side-shoots exist. Psychoanalysis addresses the underlying psychic conflicts and defenses. It has dominated psychotherapy before till now. Family therapy or systemic therapy is sometimes used, addressing a network of relationships as well as individuals themselves. Various forms of psychotherapy are built on a humanistic model. Several psychotherapies are designed for a particular abnormality or example, interpersonal and social rhythm therapy. Skilled mental health practitioners usually select treatment pathway by engaging in an integrating method designed for the specific syndrome and persons. Considerable decisions might hinge on the curative bond, and there may be problems of reliance, discretion, and commitment.

2.12.2 Medication

Psychiatric treatment is also extensively employed to cure psychological abnormalities. These are certified psychoactive medicines often recommended by a mental therapist or the household physician. There are numerous core groups. Anti-depressants are utilised for treating clinical-related depression as well as nervousness and other oddities. The treatment of anxiety abnormalities and associated problems, for example, insomnia employs Anxiolytics on a short-term basis. Mood stabilisers are utilised primarily for the treatment of bipolar disorder with a focus on mania instead of depression. There is also the use of antipsychotics in treating psychotic illnesses, for example, schizophrenia. Although, antipsychotics are used in less doses for the treatment of anxiety.

Notwithstanding the several familiar appellations of the drug categories, there can be a significant intersection in the types of conditions they are produced to treat. There may possibly be off-label usage. There can be difficulties with hazardous effects and adherence. An individual may often take part in diverse treatment methods and utilise numerous mental health facilities. There may be case treatment (recognised as "service coordination" at times), utilised inpatient or day-to-day treatment and employment of a psychosocial recuperation platform. The provision of optimum management earlier in the treatment of mental illness might avert more relapses and unending ill health which make a new and timely intervention available in mental illness treatment. Examples of mental healthcare services include clinics, hospitals or the community-based health centres. Several methods are centred on a recovery paradigm of psychological disorder and may centre on stimulating stigma and public segregation and creating empowerment and optimism.

Nearly 20 million Nigerians are living with one type of mental illness. Nonetheless, among those individuals, fewer than ten out of a hundred get any treatment, and less than one out of a hundred gets high-quality mental healthcare services (Gureje and Lasebikan, 2006). The treatment of illnesses in the Yoruba healing system occurs at two levels. The first is the diagnosis, in which the cause and the curing of the disease are ascertained. The second is the performance of any necessary rituals and medication through herbs and other means. The Yoruba believe very much in the medical potency of plants, their roots, and leaves in their natural state. According to Gureje and Lasebikan (2006), belief in the mystical causality of mental illness and panic of stigma hinders

people living with mental illness to look for a prescribed facility for mental illness. A mystical opinion of the origin of mental illness may suggest that conventional therapy would remain unsuccessful and assistance will perhaps be sought from spiritualists and traditional healers. In Nigeria, studies revealed that treatment for a mental ailment is usually gotten from these alternative providers (Gureje, Lasebikan, Ephraim-Oluwanuga, Olley and Kola, 2005) and they also believe in the mystical causality of mental illness.

Specifically, professional healthcare workers which include physicians attribute diverse connotations to indistinguishable indications for presenting male and female living with mental illness (Malterud and Okkes, 1998) or attribute women's disorders to mental disorders and recommend unsuitable treatment (World Health Organisation, 1998). However, stigma and negative views associated with mental illness, inadequate healthcare service, access to mental healthcare services and poverty are some of the many barriers experienced by people living with mental illness seeking care and sustaining treatment (Gureje, Lasebikan, Ephraim-Oluwanuga, Olley and Kola, 2005; Ngui, Lincoln, Ndetei and Roberts, 2010).

In Ogun State, there are peculiarities in establishing the causes, nature and management forms of illnesses. The "trado-medical" practice is used for diagnosis and treatment of mental illness. This method examines the totality of man about his genetic, divine and mental as well as societal make-up. In this society, traditional healers are community-based experts who are recognised as capable in the skill and practice of therapeutic medicine (Jegede, 2010).

2.13 Availability of Mental Healthcare Services

The disparity among the overall burden of mental illnesses and availability of mental health resources is disturbing. For Gureje and Lasebikan (2006), there is the rare level of unmet necessity for mental healthcare. These verdicts focus some of the dearth in the Nigerian healthcare structure. Nigeria was ranked 187th among the 11 member nations of the World Health Organisation in 2000 vis-à-vis its global action (World Health Organisation, 2000). The healthcare scheme in Nigeria is one of the most deprived in the world. The system's mental well-being constituent is ill-resourced, therefore, impeding access of 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 Organisation periodical indicates that mental healthcare services are deprived of exclusively scarce personnel and amenities (World Health Organisation, 2001; Gureje and Lasebikan, 2006). The extent may ascertain the degree of functionality of a health facility or service by its accessibility, affordability, acceptability and availability to its users. Mental healthcare in Nigeria is subjective by diverse indigenous and regional factors that influence the worth or magnitude existing in one setting.

In view of the above, in Nigeria, the mental healthcare structure has revealed longitudinal variance regarding availability and quality of facilities concerning need. (Akhtar, 1991). The function of 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. On the other hand, the state administration coordinates the countless general hospitals (secondary healthcare) while local governments manage dispensaries (primary health care) which are controlled by the federal government. The majority of mental healthcare services is made available by eight regional psychiatric centres and psychiatric sections and medical instituions of the county's twelve main institutions of higher education. Limited general hospitals similarly provide mental healthcare services.

According to Gureje and Lasebikan (2006), it is not all psychological disorders that require treatment (Regier, Narrow, Rupp and Kaelber, 2000; Gureje and Lasebikan, 2006). Likewise, not everybody with a necessity for treatment desires to see a professional. Without a doubt, given the authenticity of the dearth of dedicated mental healthcare experts, a sensible strategy to offer care for those in want in Nigeria will position primary healthcare workers at its central. The primary healthcare system in Nigeria is poorly resourced and organised (Gupta, Gauri and Khemani, 2003; Gureje and 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 seeking care.

Resources are also rare in unindustrialised nations. Nevertheless, issues other than resources may also define acknowledgment of treatment for mental illness. Consciousness that impairment is a medical difficulty and that real interference occurs for the problem may define whether persons

living with mental illness will seek treatment or not. Poor awareness and adverse approach to mental illness in Nigeria, which are frequently common in some unindustrialised nations, may inhibit individuals from seeking assistance (Gureje, Lasebikan, Ephraim-Oluwanuga, Olley, and Kola, 2006; Guvenc, Cesario and Sandra, 2014).

Studies conducted by Ngui, Lincoln, Ndtei and Roberts (2010) and Jack-Ide and Uys (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 and 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 unindustrialised nations is pitiable owing to the shortage of resources, poor access to health facilities and the little importance given to mental health concerns.

Internationally, only two out of a hundred of nationwide financial plans are dedicated to mental health (World Health Organisation, 2005). Approximately 70 out of a hundred of Africans and 50 out of a hundred of south-east Asian nations spent smaller amount of one out of a hundred of their health financial plan on mental health (Jacob, Sharan, Mizra, Garrido, Seexat and Saxena, 2007). In countless unindustrialised nations, women grumble about the nonexistence of confidentiality, privacy and information regarding mental healthcare facilities in existence. One of the greatest challenges to providing facilities for people living with mental illness (PLWMI) in Nigeria is making available, a steady, sufficient quantity of suitable, harmless and cheap treatments.

2.13.1 History of Mental Healthcare Services in Nigeria

Historically, in technologically advanced nations, mental healthcare service provision have been distributed into three epochs namely, traditional, that is, the growth of the asylum (from 1880-1955), transitional and modern. These times were characterised by the creation of huge shelters that remained isolated from the population they assisted. The periods were also identified by the decline of the asylum or 'deinstitutionalisation and the restructuring of mental health services agreeing to an evidenced-based method, harmonising and incorporating the basics of both community and hospital services.

The recognition and treatment of mental illness in Nigeria existed before records of such activities were written and kept. 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 founded 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 Organisation) initiatives (Furnham, 2007).

Ground-breaking policies for providing community-based mental healthcare in Africa have appeared and disappeared, with limited actions taken or proving possible to roll out on a broad basis. 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 de-stigmatisation 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 provide mental health services. Regardless of these facilities, there has been the 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 Organisation, 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.

2.13.2 Community-based Mental Healthcare Services

Community-based mental healthcare service is characterised by an emphasis on the populace and community health essentials; case discovery and uncovering in various communities; in the vicinity easy to get amenities; community involvement and policymaking in the design and setting up of mental healthcare structures. It also involves mutual support and facility user enablement for persons and relations and interfaces with non-profiting organisations about rehabilitation.

In developed nations, 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 Organisation is an advocate of community mental healthcare in both industrialised and unindustrialised nations (World Health Organisation, 2001). For Makanjuola (2011), in developed countries, the elements of community-based mental healthcare services are well-recognised and consist of closing down or downsizing mental clinics, the establishment of mental health components in general hospitals and the construction of mental health groups that are community-based. The latter include occupational therapies, 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 labour 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 Organisation recommended the expansion of community mental health services viz-a-viz the incorporation of mental health into the current primary healthcare system and the mobilisation 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) and Eaton (2008) recommends replacing large mental health 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 Organisation, 2000). World Health Organisation defined the necessity and validation for constructing community-based mental healthcare schemes and services (World Health Organisation, 2001). For Jacob et al., (2007) they recognised 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 comprise 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, Ndetei and Robert (2010), the few psychiatric hospitals that are present are usually bedeviled with inadequate personnel, jam-packed and may not make available the needed quality of care. Most hospitals for the provision of mental health are situated in metropolitan locations and isolated from household members and friends, which escalate the social segregation and financial budget for the relations. In selected nations, 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 industrialised countries, there is the de-institutionalisation 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 utilise and improve primary care in most unindustrialised nations of the world (Tejada de Rivero, 2003) should entail mental healthcare, as a serious character of populace well-being. Chan and 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 care consists of the massive societal and financial liability, the interlinked nature of bodily and recognised 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 constitutional rights of patients (WHO/WONCA, 2008). Community mental health services can assist diminish societal humiliation and discrimination by lessening the societal seclusion, lack of care, and institutionalisation of people suffering from psychological disorders. The efficient community treatment of mental illness will also assist society to realise that individuals with mental illness can live fruitful lives, donate to the public, and advance the community interests all over the world.

.2.13.3 Non-Governmental Organisations in Mental Healthcare

Countless nations indicate that they have several Non-Governmental Organisations functioning in the area of mental health. Spiritual health services were the first set of providers of care in several nations. It is just lately that NGOs came on board to perform significant functions. These organisations may be privately sponsored or accept sustenance from local government, external contributors or other NGOs. A number of NGOs may possibly perform important functions in training, resource delivery, and programme support.

Internationally, handpicking 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 organisations itemised on the website of the United Nations, only 46 out of a hundred focused on mental health policy and programmes. Forty-seven of these organisations had involved in a minimum of one lasting progressive plan. Still, merely 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.

There are three modes of mental healthcare delivery system namely; Orthodox medical care, Traditional/Alternative care and spiritual care.

Orthodox Medical Care: This mode uses the allopathic principle to treat mental illness. By this law, mental illness is treated by the use of drug/medicines that produce effects different from antithetical to those of the disease treated. Professional healthcare workers include psychiatrists, psychologists, social workers, occupational therapies, psychiatric nurses and medical doctors are the principal agents in the treatment of mental illness using the conventional medical care.

Traditional/Alternative Care: The second mode of healthcare delivery services identifiable in Nigeria is traditional medical care. It may be erroneous to believe that medical service came to Nigeria with the advent of the British colonisation. Before the arrival of the British Government and colonial administration, there existed traditional healers treating and healing the mentally ill in Nigeria. In essence, the traditional/Alternative care has still not varnished as it is statutory and forms part of overall healthcare delivery system. In Nigeria, traditional healers are the principal

agents in the treatment of mental illness. Traditional healers utilise ritual sacrifice, incantations, and charms to treat mental illness. However, the traditional/alternative care provides cheap, affordable and accessible healthcare services and it has been so recognised locally and internationally.

Spiritual Care: This refers to as spiritual healing through divine intervention from traditional religion, Islamic faith, and Christian faith. Every religion has a spiritual guide in the form of sources of power. The traditional religion has oracles through which they consult God for the solution to health problems. They rest their healing hope on oracles (ifa, Ogun, Oya, and others) as intermediaries between them and God. Christians have faith that Jesus Christ can heal their health problems if they call on the name of Jesus Christ and also if the pastor or religious leader can pray for them using the Holy Book called Bible. In Islam, Muslims believe in oneness sanctity of Allah. The Muslims believe that regular reading of the Holy Quran is a protection against all evils. When found in any predicament, they quickly resort to invocation by reciting chapters and verses of the Holy Quran that are cognate and relevant to the management of mental illness.

The efficacy and efficiency of spiritual healing is a function of the individual's belief in his or her religion. The professional healthcare workers (Psychiatrists and Social Workers) and the traditional healers are not also left out in the process of full recovery and rehabilitation of the mentally ill. However, the option to seeking medical or traditional help is entirely left to the family to decide which would be based on the belief system of the relatives of the mentally ill.

2.14 Access to Mental Healthcare Services

Access to healthcare services is a multi-dimensional process. It involves the worth of care, physical approachability and obtainability of the exact kind of care for those in necessity. It also entails monetary ease of access, and appropriateness of service (Peters, Garg, Bloom, Walker, Brieger and Rahman, 2008; Omonona, Obisesan and Aromolaran, 2015). Difficulties with accessibility to health service comprise assessment of the suitability of the quantities of healthcare amenities and the accurate dissemination of these establishments to permit stress-free and quick access to a medical facility for people living with mental illness in need of the affordability, and consequently the ease of access to excellent healthcare for all people living with mental illness.

According to Jacob *et al*. (2007), equitable access to mental healthcare is a fundamental objective of every healthcare system in both technologically advanced and unindustrialised nations. However, Gureje and Lasebikan (2006) asserted that access to both public and private health amenities is expanded through principally out-of-pocket disbursement, as there is no National Health Insurance (NHIS) scheme. The Economic limitation is a common obstacle to health service delivery (Kessler, Frank, Edlund, Steven, Katz, Elizabeth, Lin, and Phillip, 1997). Alongside with reduced resources, deprived understanding of an undesirable approach to mental illness in Nigeria institute supplementary obstacles to help-seeking (Jorm, 2000).

Mental healthcare is a subsystem of healthcare systems. Moreover, the manner in which these services are organised, distributed and funded is considerably subjective by the approach in which the total healthcare systems are managed (Jack-Ide, Uys and Middleton, 2012). In Nigeria, accessing mental healthcare is a serious challenge in ensuring optimal mental healthcare services. More than 75 out of a hundred of rural and peri-rural Nigerians have no access to mental healthcare services (Omigbodun, 2011). Individuals with severe mental illness have poor access to excellent overall healthcare compared to persons without mental illness (Horvitz-Lennon, Kilboure, and Pincus, 2006). The long waiting time at the psychiatric hospitals make access to mental healthcare service challenging. This situation makes people living with mental illness to give up without receiving the necessary treatment. Traditional cultural practices and beliefs prevalent in the Nigerian society are responsible for the unequal access to the healthcare delivery scheme. The notion of equity in mental healthcare services is predicated on the principle of social justice

underpinned by the view that access to mental healthcare should be based upon need while the determination of financing should be according to the ability to pay (Wagstaff and Van Doorslaer, 2000).

In Nigeria, modern psychiatric care is developing. Hence, people have no access to it because the treatments are unaffordable. Moreover, there is the main concentration of treatment facilities in the major urban centers (Kiecha, Barke and Gureje, 2004). Access to mental healthcare facilities is important for designing service distribution schemes and are beneficial techniques of reviewing help-seeking behaviour and accepting the pathways relations and persons of people living with mental illness discover before taking patients to a mental health service (Fujisawa, Hashimoto, Masamune-Koizumi, Otsuka, Tateno, Okugawa, Nakagawa, Sato. Kikuchi, Tonai, Yoshida, Mori, Takahashi, Sato, Igimi, Waseda, Ueno, Morokuma, Takahashi and Sartorius, 2008; Garter, Jordanova, Maric, Alikaj, Bajs, Cavic, Dimitrov, Hristro Dimitrov, Iosub, Milhai, Szalontay, Helmchen and Satorius, 2005; Omonona, Obisesan and Aromolaran, 2015). Curable illnesses frequently go untreated for the reason of nonexistence of access to healthcare.

Poor women are unable to access healthcare more frequently than men from similar social class, even in well-resourced nations, for instance, United States of America (Krieger and Zieler, 1995). The higher rate of women's mental and physical ill health has also remained imagined to be the result of gender differences in physical signals and the social appropriateness of sick roles for women (Sen, George, and Ostlin, 2002). Sensitive and reasoning capabilities of women may hinder their access to healthcare (Papanek, 1998). The few scholarly works from unindustrialised nations propose that the form and nature of access to service in unindustrialised nations vary from what is obtainable in technologically advanced nations and that access is worse (Abas and Broadhead, 1997; Cooper and Sartorius, 1996) and virtually non-existent in African nations. Information is scarce on met and unmet necessities for mental health services in Nigeria (Kohn, Saxena, Levav. and Saraceno, 2004; Alegria and Kessler, 2000).

2.15 Use of Mental Healthcare Services

In Nigeria, the condition of the health scheme is dysfunctional and exclusively under-financed with a per capita expenditure of US$9.44 (World Bank, 2010; Omononna, Obisesan, Aromolaran, 2015). The ease of access to health facilities has been presented to be a major factor in the utilisation of healthcare services in unindustrialised nations (Mekonnen and Mekonnen, 2002). The use of mental healthcare services is affected by many interacting factors which include, access, availability, referral practices and help-seeking preferences. However, there are very few studies on mental healthcare utilisation in developing countries. According to Zwi (2001), the under-utilisation of the health services in public division has been a global occurrence in unindustrialised nations. The utilisation of mental healthcare services is connected to the availability, excellence and fee of services, as well as the socio-economic arrangement and individual features of the handlers of the services (Chakraborty, Islam, Chowdhury, Bari and Akhter,, 2003; Onah, Ikeako and Ilobachie, 2009). The absence of female medical professionals is occasionally an obstacle for women to make use of healthcare services (Paolisso and Leslie, 1995).

Countries that account for additional two billion of the world's population spend as little amount as one percent of their entire public sub-division healthcare financial plan on mental health. The bulk of nations in Africa are in this group. Only 51 percent of the world's population in developing nations have access to community-based services. Indication on the utilisation of mental health services is restricted, but at least 85 percent of people living with mental illness do not obtain treatment within any 12-month epoch in developing nations. In Brazil, there is an estimate that over 70 percent do not utilise mental healthcare services. In Nigeria, a community-based study revealed that only nine out of a hundred of individuals with Diagnostic and Statistical Manual Disorder got certain treatment for mental illness for the period of one year (Gureje *et al*., 2005; Mcdaid, Martin, and Shoba, 2008)

According to Mcdaid, Knapp, and Raja (2008), the exceptionally restricted financial plan for mental health in developing countries means that access to numerous facilities is hooked on fee at the time of use. Forty out of a hundred of developing nations stated that out-of-pocket disbursement is the main technique of funding mental healthcare while only three percent of developed nations do so. The dependence on out-of-pocket disbursements is both unproductive and unbalanced, as it

dampens utilisation of mental healthcare services by those with inadequate earnings, which is particularly worrying given the close connections between poverty and mental illness. The service payment could result in poverty or obligation if relatives lend from moneylenders at stringent conditions. Thus, there are the lost chances to lessen a number of the externalities connected with deprived mental health.

Another important cause is the insufficient supply of available resources that are usually concentrated in large numbers in metropolitan areas. The distance to cover to get to a community-based mental health service can be significant. In some of the studies conducted in India, the primary motivation behind the absence in the continuous usage of antipsychotic medicines was the distance to cover which is more than ten kilometers to the nearest mental healthcare facility. The commitment of community-based services is similarly weak as a result of the applied difficulties of poverty, food insecurity, the dearth of transportation and monetary resources. No single reason has been held responsible for discrepancies between gender differences and healthcare utilisation patterns (Kandrack, 1991).

According to Gureje and Lasebikan (2006), revealed that technologically advanced nations recommend poor usage of mental healthcare services. No statistics exist in unindustrialised nations about met and unmet necessity for mental health service in the society. Suggestion resulting from developed nations recommends that unmet need for management of mental illness is a challenge in Nigeria. Research piloted in North America and Western Europe indicates that while noticeable dissimilarities occur in the form and correlate of service usage among nations, under-utilisation of services by persons with mental illness is prevalent (World Health Organisation, 2004; Alonso *et al*., 2004).

Studies have shown that only a negligible people living with mental illness take delivery of treatment in the healthcare system. The decision to utilise mental healthcare services is determined by factors including symptoms profile, severity, and duration. The determinants also include nature of mental illness, social network, and support, health beliefs, perceptions of the need for service, attitudes as regard etiology, stigma, difficulty in discussing mental illness and the perceived or actual reactions of caregivers and friends. In Nigeria, high level of unmet need for mental health services exists. Nevertheless, there is a paucity of knowledge about the extent to which social

network contributes to utilisation of mental healthcare services (Lasebikan, Owoaje, and Asuzu, 2012).

2.16 Choice of Mental Healthcare Services

The choice of mental healthcare service is critical to the modernisation of health and social care services. Increasing choice creates better alignment between people living with mental illness and what facilities are subsequently delivered. The selection of mental healthcare services aims to advance greater patient freedom, involvement and the empowerment in the treatment and attention received, to expand the range of available services and to improve the quality of care (Samele, Lawton-Smith, Warner and Mariathasan, 2007). Choice places treatment decisions with people living with mental illness. Essential elements of health and illness behaviour are belief systems. They impact the varieties that individuals make either when a persons living with mental illness fall ill or their relatives.

Women and men face various health issues and also have different connections to health providers. A fundamental question concerning the choice of the patient is the dilemma of taking care of people living with mental illness and at the same time guarding them and the public against destruction. However, options for people with mental illness become limited for those at jeopardy of harming themselves or others. The actual choice of mental health services is limited by the range of available services.

Furthermore, African societies believe supernatural forces are the causes of mental illness, and this affects the choice of mental illness healer. In general, the options of mental illness healer in Western countries sharply contrast with those in Nigeria where most psychiatric patients consult traditional healers. Also, religion plays a great role in African societies and entrenches the belief in an all-powerful creator and carer to whom one prays concerning one's health needs (Koenighg, 2008).

2.17 Gender Preference of Mental Healthcare Professionals

According to the World Health Organisation, less than one doctor of psychiatry for only 100,000 persons in most of south-east Asia exists, and fewer than one therapist available for only 1 million persons in sub-Saharan African countries (Jacob *et al.,* 2007; World Health Organisation, 2005). For instance, Nigeria has 100 psychiatrists for a population of 185 million (Gureje and Lasebikan, 2006). In Nigeria, doctors of psychiatry are a rare resource. There are 130 doctors of psychiatry to a populace that is more than 185 million resulting in a ratio of one psychiatrist to 1.1 million people (Gureje, Kola, and Fadahunsi, 2006). There is the concentration of most of the psychiatrists in the major cities. Gender preference is a clear and well-documented example of considerations of the attitude of people living with mental illness (PLWMI). Ninety-five out of a hundred specialists who are psychiatrists work in tertiary institutions and the remaining five percent work in other healthcare services in Nigeria (WHO-AIMS, 2006). The fraction of psychologists and social workers is 0.02 to 100,000 (Oyedeji, Gureje, and Lawal, 2004).

Professional healthcare workers have been identified as the key personnel to effective healthcare delivery system (Joint Learning Initiative, 2004; World Health Organisation, 2006). Nevertheless, the inadequate workforce is the most commonly reported staff-related problem in healthcare, especially in resource-constrained countries. Acute shortage of competent healthcare workers is a major challenge facing Nigeria's health system. As a consequence of insufficient facilities and poor incentive packages, there is the migration of a lot of medical doctors and other health specialists to technologically advanced nations (Muula, Panulo, and Maseko, 2006; Uneke, Ogbonna, Ezeoha, Oyibo, Onwe, Ngwu and Innovative Health Research Group, 2008).

In Nigeria, limited statistics on the availability, gender distribution and trends of human resources for health have been an obstacle to operational human resources for health planning (Ebuehi and Cambell, 2011; Uneke *et al*, 2008). Access to medical workforces may be freely accessible in metropolises; rural inhabitants frequently have to travel substantial distances to obtain treatment. The unavailability of professional healthcare workers in the countryside often leads to a delay in seeking healthcare until mental health disease has developed unbearable symptoms and is advanced. In Nigeria, negative attitude towards people living with mental illness by professional

healthcare workers were claimed to be embedded in harmful cultural views and traditional deeds that end in societal hatred (Ewhrudjakpor, 2009).

The public's negative orientations toward mental illnesses also extend to the professionals who treat them. For instance, Nunnally (2001) established that the public appraised specialists who treat mental illnesses significantly more adversely than those who treat physical illnesses. In fact, among the Yoruba, doctors of mentally-ill people are often regarded as being mentally ill themselves. Hence the saying that *were lo 'nwo were*, meaning "it is only an insane man that treats a madman" (Babalola, 2003).

2.18 Gender Role in Household Decision Making on Treatment of Mental Illness

Mental health help-seeking behaviour in a native African society usually in a household decision-making process, very often, is influenced by the society's concept of mental illness (Olenja, 2003). Usually, the relations of individuals with mental illness decide on their behalf on where to seek help. The belief system of the roots of mental illness impacts a family's opinion about the likely cause of mental disorders experienced by a family member in the society (Aghukwa, 2012).

First, the diagnosis of mental retardation occurs at a substantially earlier point in the family life than severe mental illness. Specifically, persons with mental retardation are typically diagnosed at birth or in the early childhood period. Consequently, most siblings of persons living with mental illness have always known their brother or sister to have significant disabilities. Their formative years included the satisfaction and difficulties of living with a visible "difference in the family" (Featherstone, 2006), and many siblings, especially sisters, were thrust into positions of surrogate parenting (Stoneman, Brody, Davis and Crapps, 2007; Wilson, Blacher and Baker, 2001).

Access to better treatment for people living with mental illness, comprising of prescriptions of drugs, psychosocial interferences and reintegration services are essential core fundamentals in easing the burden on caregivers. Additional dealings include the readiness of emergency management, delivery of lawfully delegated community treatment to prevent hospitalisation and knowledgeable balance support are also necessary (Awad and Voruganti, 2008). People living with mental illness are subject to episodic crises that may undermine the stability of the family and the household. Thus, the course of mental retardation is more accepted in society than are persons with

mental illness. Women are often the healthcare gatekeeper for the family. Women seek healthcare more often for their children and themselves.

The challenge of the family liability of helping people living with mental illness is a collective problem in technologically advanced and unindustrialised nations. Diverse healthcare and social schemes in the various nations may impact a family's obligation to care. Relatives may have to take all-encompassing responsibilities of taking the precaution of people living with mental illness to a convinced magnitude subject on the available facilities, resources, and care of the people living with the mental disease and their caregivers.

Household members or relatives with mental illness usually suffer from stigma (Larson and Corrigan, 2008; Corrigan and Miller, 2009). Mental illness is not merely stressful for people living with mental illness but also for their family members. Several studies have revealed that caregivers of individuals living with mental illness suffer from stress, experience a substantial level of burden and usually get inadequate assistance from mental healthcare professionals (Saunders, 2009). The most important predictors of burden are challenging behaviour, disability, and severity of symptoms. Effective treatment is thus the first step to reducing the burden. High expressed emotion may reflect the family's efforts to assist the patient and is mediated by controlling behaviour, stigma, burden and the caregiver's perception of the people living with mental illness's control over their behaviour (Ohaeri, 2003).

The bulk of household caregiving is commonly delivered by mothers and fathers, wife or husband, or relations. Scholarly works reveal that most caregivers of people living with mental illness especially adults are their parents. In Asian culture, the older inhabitants in a household are the 'heads of households' who have the key obligation to take care of other household members and are accountable for their health situation (Chien, Chan and Morrissey, 2007). Consequently, grown-up household members may notice an advanced level of the problem as they have to bear the bulk of the care. Globally, caregivers are more likely to be women. For instance, in the United Kingdom, approximately 58 out of a hundred of the caregivers are women (Nolan, 2001). Asian scholarly works establish approximately 70 out of a hundred of caregivers are females (Chan, Yip, Tso, Cheng and Tam, 2009). The World Federation of Mental Health (2010) gave an estimate that worldwide, women constitute about 80 percent of the caregivers. They are likely to be the daughter,

mother or wife of the person living with mental illness and are typical with little earnings. The influence of women's demanding caregiving can be significant. Evidence shows that middle-aged and elderly women who provided support for an ill husband or wife or a spouse with mental illness were virtually six times as expected to have depression and were likely not to have experience of caregiving accountabilities (World Federation of Mental Health, 2010). Consequently, the universal problem is the necessity to have a detailed understanding of the necessities and apprehensions of female caregivers and to cultivate techniques to help them.

Knowledge of the detailed way that the way of life could impact family caregivers' burden and the techniques that these problems are conveyed about caring for a family member with mental illness may show a significant portion in the growth of an all-inclusive ideal for family-centered care. According to Chan (2011), there is a consensus that the household is the principal lasting caregiver and a valuable supply for people living with mental illness. In spite of individual and ethnic variations in need and worries, studies in the United Kingdom reported that some collective needs arise from caregivers. They are expressive support, assistance from seclusion, acknowledgment of dependable and suitable services, evidence and acknowledgement of their role and impact can perform well in helping caregivers (Department of Health, 1999). Extended Arab families are responsible for an arrangement for their members that may occasionally avert or recompense for the effects of parental loss and psychological disorder (El-Islam, 2008).

Violent behaviour by people living with mental illness is most frequently towards family, caregivers, and acquaintances rather than towards unfamiliar persons. Regrettably, there are no statistics for Nigeria on Population Attributable Risk percentage (PAR %) that would have pointed out the proportion of violence linked to mental illness.

2.19 Care and Support for People Living with Mental Illness

Caregivers play a significant and ever-expanding function as development in medical care find new ways to help control mental illness. Caring for people with mental illness calls for untiring labour, vigour, understanding, and it unarguably significantly influences the caregivers' day-to-day lives. There are physical, social, emotional and financial effects of caregiving. Caregivers are at jeopardy of numerous diverse physical and mental health challenges. They suffer from the alarming level of constant worry, frustration, depression and sometimes exhibit harmful behaviours. They neglect their care and have higher death rates than non-caregivers of the equivalent age (American Psychological Association, 2013).

In Nigeria, the ill health resulting from mental illness is huge with a high load of attention on people living with mental illness, caregivers and the general public (Oluyomi, Kola, and Gureje, 2012). Societal support is seen to be of abundant worth for relations who experience the problem related to caring for people living with mental illness. More household support was definitely associated with advanced levels of household functioning (Saunders, 1999). Minor levels of societal care from other household members and associates of people living with mental illness have been established to be intensely related with advanced scores in basic valuations and additional unmet necessities (Caudie, 1993). Societal support was discovered to be the paramount specialist of care given to caregivers in an Asian study (Chien *et al*., 2007). Hence, empowering the kin's social system may stand for a beneficial approach to relieve family's care liability. There is the acknowledgment of caregiving as a severe stressor that places caregivers at risk of having emotional problems (Aneshensel, Pearlin, Mullan, Zarit and Whilach, 1995). Agreeing to National Caregiver Survey, the bulk of caregivers (71.5 percent) are daughters and wives (Pinquart and Sorensen, 2006). Numerous models have shown that masculinity and femininity differences in caregivers' consequences occur because when likened to male caregivers, female caregivers experience higher levels of caregiving stressors, possess less social resources and report lower levels of mental and physical health.

According to White, Jain, Orr, and Read (2017) by the introduction of de-institutionalisation, people living with mental illness are taken care of in the society by their families. Researchers revealed that in developed nations, about 225 percent to 50 percent of people living with mental

illness after discharge from the hospital reside with their family and are subject to the support and continuous participation of their relatives. In the Asian Tigers, the passage towards de-institutionalisation is restricted by traditional and societal elements, which is connected to accommodating people living with mental illness as members of the general public (Yip, 2000). Nevertheless, it was revealed that approximately 70 percent of people living with mental illness live with their relatives. They are dependent on the household for providing care (Chan and Yu, 2004). Marsh (2001) recommended that relatives were frequently assisted as an extension of the mental healthcare system. Globally, it has been recognised that caregivers will continually perform an essential and ever-increasing role since health and community services delivery structures are capital challenged (World Federation of Mental Health, 2010). Caregivers must have adequate knowledge and support to enable them to take up the responsibilities of taking care of people living with mental illness consequently leading to relapse or readmission (Ngui, Lincoln, Ndetei and Robert, 2010).

Many persons who have mental illness depend on friends and family for support and to help them in their daily activities. There is an increasing public knowledge that relatives are the main source of support for persons with mental retardation and severe mental illness (Francell, Conn, and Gray, 2008). In Nigeria, the problem of caring for individuals with mental illness rests mainly on families (Ohaeri, and Fido, 2001). The literature on the situation of parents who make available lifelong care to a family member with a disability is on the increase (Fisher, Benson, and Tessler, 2000). However, there is little knowledge about the consequences for adult siblings in these families. The power of spiritual conviction plays a significant role in assisting household members to survive with the pressure of caring for a mentally ill relative (Rao, Rammohn and Subbakrishna, 2002; Xuan-Yi, 2008).

2.20 Communication Issues and Mental Illness

Communication is an essential aspect of the human experience which most individuals engage in daily. The America Speech Language Hearing Association (ASHA) defines communication as the conduct of one person giving to or receiving from another person, information about that person's wishes, requests, sensitivities, understanding, or emotional state. Communication is a vital constituent of all curative interferences. Communication skills form the basis for every intervention. Stevenson (2008) opines that communication skills are the building blocks (nuts and bolts), that is, the basic techniques and principles which everyone engages in the therapeutic intervention process related to mental illness. The knowledge and interpersonal skills that a caregiver applies to communicate are important features of assisting the individual who is suffering from mental illness, as well as facilitating the development of a positive relationship.

There is the belief that people living with mental illness are difficult to dialogue with and feel different from the manner things are done; these inconsistencies may account for some of the public distance and segregation that those living with mental illness experience. Perceived difficulties in communication with people living with mental illness affect professional healthcare workers as well as members of the society.

Good communication with people living with mental illness requires that professional healthcare workers listen and learn about their patients as individuals with unique concerns and needs. To achieve this, professional healthcare workers need to have compassionate beliefs and to receive suitable training (Crisp, Gelder, Rix, Meltzer, and Rowards, 2000).

2.21 Gap in Knowledge

The gap this research is out to fill lies in adding valuable information to existing literature and filling existing policy recent disparities in the field of psychiatry practice in Nigeria. Also, its strength lies in addressing the specifics of mental health in Nigeria. Current research on the analytical interaction between gender differences and mental illness is limited in several ways as it relatively neglects the treatment options and gender preference of mental healthcare professionals in treating mental disease. In exploring the local environment, several types of research excluded male and female differences in their various analysis of mental disease. Most studies focus one-sidedly on the stigmatisation of people living with mental illness thereby neglecting the male and female role in the decision-making procedure in the treatment of mental illness particularly among the Yoruba. Many studies conducted on mental illness focused on knowledge, beliefs, and attitudes towards people living with the mental disease (Kabir *et al*., 2004; Gureje *et al*., 2005; Ukpong and Abasiubong, 2010; Audu *et al*., 2011). As a result of this, they neglect other aspects such as adherence to treatment and prevention of mental illness. Also, gaps in knowledge identified are that there are numerous foreign scholars in this field of research, but very few African scholars have done little work in this area. There is the dearth of knowledge in the research and situating it in the context of Nigerian society is required. Must we use a foreign approach to treating a local issue? The answer will be preferable no. For example, the death of a husband is often connected to his wife, thereby subjecting her to psychological trauma and lots of cultural inhibitions but in developed countries, it is not so. However, the current study analysed difficulties in the utilisation of mental health services and offer solutions to the lingering problem of mental health/illness.

2.22 Theoretical Framework

This study is anchored on two theories. These theories provide a firm basis upon which the reviews and findings of this research will stand. They will also give the basis for appropriate recommendations. These theories are:

a) Labelling theory
b) Black/African Feminist theory

2.22.1 Labelling theory

During the 1960s and 1970s and till date, labelling theory was very prominent. Labelling theory had its origin in the book 'suicide' written by French Sociologist, Emile Durkheim (1858-1957). Labelling theory proposes that individuals get labels based on the way others assess their propensities or behaviours. Furthermore, it is the theory of self-identification and conduct of persons may be prejudiced by concepts that are employed to describe or classify them. Labelling theory is concerned with social roles that the general public offers for abnormal behaviour termed social stigma. Social roles or functions are necessary for organisation and functioning of the society.

The term 'mentally ill' was applied to labeling theory in the year 1966 by Thomas J. Scheff. Scheff claimed that mental illness is a sole manifestation of social influence. He submitted that the world views certain activities as abnormal and to come to positions with and comprehend those activities frequently exacts the label of mental illness on those who display them. The label of 'mentally ill' may assist a person seeking help regarding medications. Studies have shown that expectations of labelling could have a substantial adverse effect. It can cause patients to withdraw from the general public. They come to forestall and recognise undesirable social responses to them, and this possibly damages the value of life (Bruce, 1987; Bruce, Francis, Elmer, Patrick and Bruce 1989; Bruce, Link, Jo and Phelan, 1999).

In relation to labelling theory, the purpose of the reactions of others to a specific group is deviance. Deviance does not insinuate the superiority of an action which an individual commits but the consequences of the presentation of the instructions and sanctions of the criminals. However, Durkheim emphasised mostly on the society than the individual. The world describes the person

in a specific manner, and it creates predictions about human attitudes. Given this, the Yoruba conceptualises mental disorder from a traditional viewpoint and tags the person as 'were' when his conduct is of non-conformity with the accepted culture, particularly when such attitude is on the extreme.

The world is continuously changing as a result of monetary, governmental and traditional forces. Just as the ultilisation of technical-know-how upsurges and the struggle for information and science become well-known; the societal prospects adapt to fit these needs associated with a technological increase. The nonconformity from the societal and traditional customs in the world is regarded as an idiosyncrasy, but as these standards in the world are always fluctuating; the meaning of abnormality is also changing. Mental illness is built by the world because when women do not conform to the norms and values of the society such as being good wives and mothers, they are regarded as being deviant as their attitude is a demonstration of abnormality.

The deviance can become the central feature of marked persons' identity, which has implications for their future conduct. People living with mental illness are stigmatised and can set in train a self-fulfilling prophecy. Once labelled and processed as a deviant, people living with mental illness are forced into certain situations where their behaviour is interpreted as confirming their abnormal status. Mental illness is not perceived as a condition lying within the individual, but as a social construct, a status conferred on a person by other members of society. Once labelled as a person with a mental health condition, they are stigmatised and treated differently.

The labelling theory is quite relevant in evaluating mental illness among the Yoruba especially as it affects women. Mental illness is mostly labelled as something that is profoundly spiritual, and for a woman, it must be that the gods are punishing her for some wrongdoing such as witchcraft or promiscuity including her refusal to engage in some cultural or traditional rites as may be demanded of her by her family members. This label invariably clearly explains why among the Yoruba, women are more likely to be assigned appropriate diagnosis due to how such mental illness may have been labelled which is also a reflection of the peoples' perception, attitudes, and cultural beliefs.

2.22.2 Black/African feminist theory

The theory of feminism examines the position of women in society and tries to further their interests. Feminism argues that sex is a fundamental and irreducible axis of social organisation that, to date, has subordinated women to men. Feminists have described the structural subordination of women as patriarchy with its secondary meanings of the male-headed family, mastery, and superiority.

It holds that the concern with gender question is primarily on the secondary standing of women in the society (Igenozah, 2004). Feminists see the secondary status of women in the scheme of things as a form of victimisation, especially the subordinate role women are made to play. Feminists believe that the position the woman finds herself today is not entirely her own doing. Rather, it is a situation imposed on her not by her feminine characteristics but by strong societal forces of education and tradition which are under the purposeful control of men.

There are different versions of feminism, but they mostly share similar features (Haralambos and Holborn, 2008). Varieties of feminists' theory include: (1) Radical feminism – it concerns itself with male and female oppression. Women are faced with oppression, not just different from or unequal to, but vigorously controlled, subordinated and maltreated by men. (2) Marxist/Socialist feminism – its focus is on physical domination. Here, women's experience of difference, disparity, and subjugation differs by their social location within male dominance, capitalism and racial discrimination. (3) Liberal feminism – its emphasis is on masculinity and femininity disparity. The position of women is not only different from that of men but also regarded as deprived and not equal to men. The result of male and female inequality is as a result of male dominance in the society and sexist arrangement of the division of labour. (4) Black/African feminism – the experience of women is at variance with that of men in terms of experience, location and the position they occupy. Emphasis is on gender differences. It assumes that women are inferior to men and that this natural inferiority explains their social subordination (Schaefer, 2008).

This study will only focus on the Black/African feminist. Feminists believe that patriarchy led to the oppression of women. The Black/African feminist affirms that other feminist theories emphasise on the conditions of white women and neglect what happens to women of colour.

According to Hill (2000), these differences are the legacy of slavery which have suppressed the ideas of black women and concentrated on the experiences and grievances of white and middle-class women. African feminists emphasise on the subjugation of women especially those in rural communities who suffer several cultural inhibitions. They are seen but not heard. They are mostly voiceless in society. This theory has claimed that black women are situated within structures of supremacy in basically diverse techniques from white women. African women are marginalised regarding race, class, gender, and sexuality. African feminism is vital for the empowerment of African women.

Male and female roles and expectations are enforced in the world as a form of informal social control and are portrayed through the agents of socialisation. It argues that the pressure that gender roles have on society may cause stress-related mental illness such as depression. Situating this in the context of the work, one can safely say that the Black/African feminist theory is very apt in explaining issues of mental illness among the Yoruba. This is because, with unyielding patriarchal structures among the people, women go through a process of socialisation that puts them at the receiving end and subjects them to widowhood rites. They are also denied inheritance rights at the death of a spouse as men often inherit wives.

Traditionally, in Nigeria, women remain subordinated via societal, spiritual, traditional practices and views in the society. They are seen as subordinate to men because of the cultural norm of maleness that is regarded as superior to femaleness. These behavioural patterns are underpinned by patriarchy and are reproduced in the form of sexist and discriminatory practices against women in the society. Women perform multiple roles as workers, housekeepers, and heads of households, among others. In the light of this, women face difficulties to adapt or develop coping strategies against the internal and external pressures from patriarchally structured society and gendered family domestic roles that were neither designed in conjunction with women nor the support of a family structure.

Women by their anatomy and societal expectations play essential functions in the propagation, survival, and development of the human race. For example, women carry pregnancies and take care of the new-born, manage the home, contribute economically to the family and nation and cope with unique problems of womanhood like menstruation, disorders of pregnancy, widowhood, and menopause. The lower social standing of women has an influence on how society responds to their

situation when they are affected by stigmatisation. Women are further marginalised by these health problems.

The resultant effects are poverty, extreme lack and want, suffering, deep thoughts and emotional pain which can lead to depression and even high blood pressure. The severity of this can make women begin to suffer from mental illness. The absence of care from family members can exacerbate their condition in such cases. In some cases, such an illness is attributable to the evil deeds of the woman especially if her husband died at a young age which in most communities is between 40 and 60 years.

2.23 CONCEPTUAL FRAMEWORK

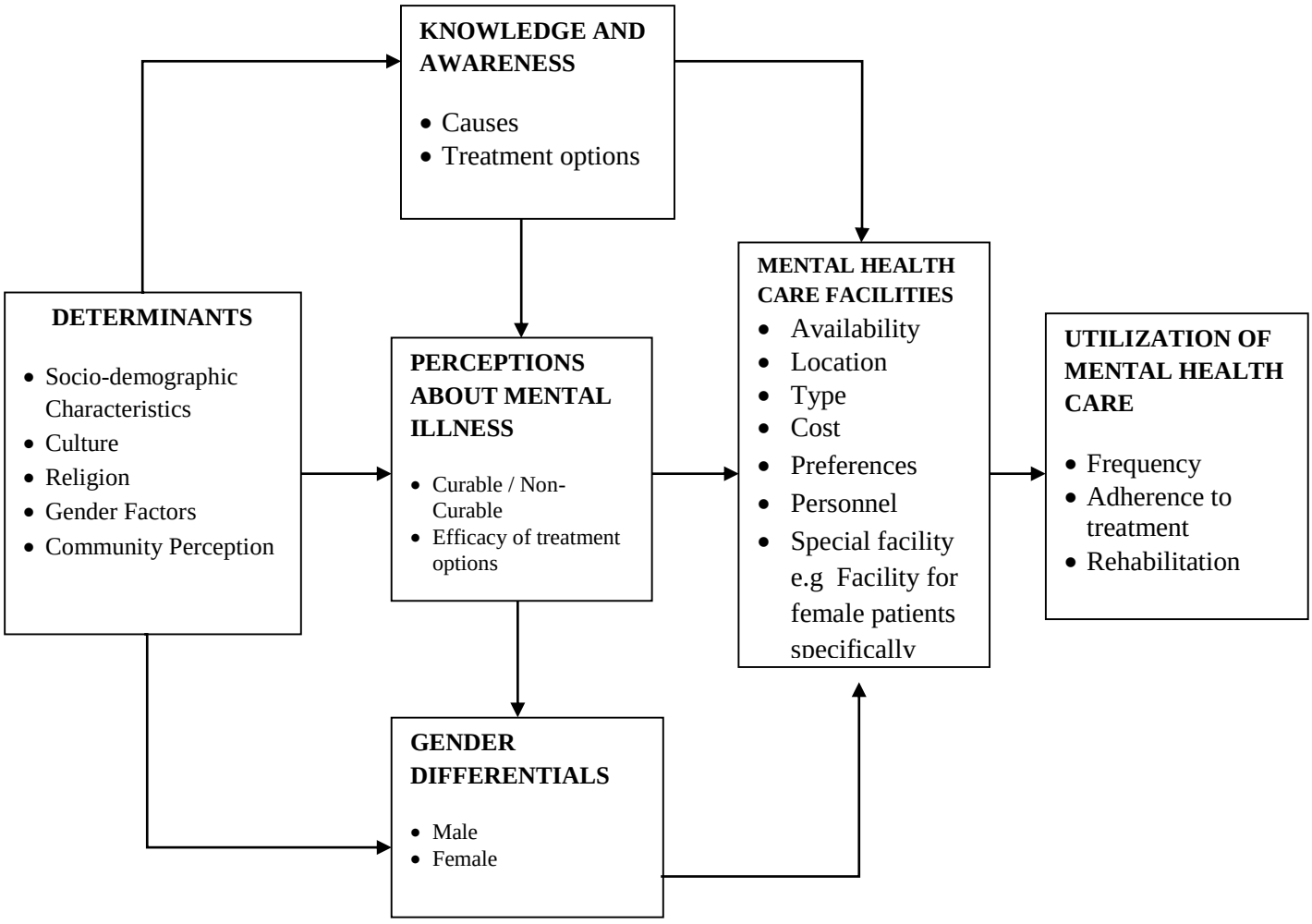

Figure 2.1: Conceptual Framework showing the relationship between determinants, perceptions, attitude to people living with mental illness and utilisation of mental health care facilities.

The conceptual framework as presented in figue 2.1 above shows that the people's perception about causes and treatment options of mental illness is often largely subjective by factors such as culture, religious belief, social status and fear of stigmatisation. These factors have influence the level of knowledge of respondents about mental illness. The level of knowledge thus determines the attitude of the people towards seeking the cure for mental illness. This influences their choice of treatment pattern, which may be orthodox or traditional, or combined therapy.

The conceptual frameworkdeveloped from the labelling theory guided the study of gender differentials, view and management of mental illness among the Yoruba people residing in Ogun State, Nigeria. The utilisation of healthcare facilities also depends on the perceived efficacy, the location, preferences and the socio-economic status of the family responsible for the treatment choice. Where there are special services for the treatment of female patients, this may influence the selection of therapy option, given the perception of the people that there is gender dimension to the causes of mental illness.

It begins with a description of the societal structure on which the study is conducted which is a patriarchal society where family lineage is traced through the male, and it is the man who has the final say with regard to family decisions on the issues relating to mental illness. Also, the religion practiced informs the decision-making process on the treatment options in the management of mental illness.

When a child in the family is mentally ill, men are known to play instrumental roles while the women play significant roles. Here, a husband only provides resources needed to make sure that health is being restored in the life of the child (be it male or female) while the woman (wife) ensures day-to-day management of resources and gives appropriate care and close monitoring to the child. Due to the patriarchal nature in Yorubaland of Ogun State, the responsibilities of caring for the child lie with the woman.

There is a strong interrelationship between all the issues presented in the conceptual framework which eventually culminate in the question of male and female differences in the management of mental illness experienced in Yorubaland of Ogun State, Nigeria. This is manifested in the level of adherence to treatment and rehabilitation.

CHAPTER THREE

METHODOLOGY

3.1 Preamble

This section describes the approaches used in data collection and analysis. It also describes the research design, study area, determination of sample size, sampling procedure, data collection instruments, analysis of data, data management, and ethical issues in research and limitation of the study.

3.2 The Research Design

This study utilised both cross-sectional and exploratory design. It is a cross-sectional research design because data was collected at a point in time from respondents that hailed from diverse socio-demographic backgrounds. It is an exploratory research design because it allowed for in-depth analysis on the factors that influence the gender differentials in the perception and treatment of mental illness. The triangulation of both quantitative and qualitative methods of data collection was adopted in order to get quality and robust information. Qualitative research tools were In-Depth Interview (IDI) and Key Informant Interview (KII) guides while quantitative research tool was a structured questionnaire.

3.3 Study Area

The study location was Ogun State in South-western Nigeria. It is known as the Gateway State. It was created on the 3rd of February, 1976. Ogun State borders Lagos State, to the South is the Atlantic Ocean, to the north are both Oyo and Osun States, to the east is Ondo State and to the west is the Republic of Benin (Ogun State Bulletin, 2009). Ogun State is predominantly a homogenous group of Yoruba extraction. It is made up of six Yoruba sub-ethnic groups which are the Egba people, the Ijebu people, the Remo dialectical group, the Egbado people, the Awori group and the Egun people. The majority of the inhabitants are Yoruba speaking people. The state capital is Abeokuta. The Yoruba tradition and beliefs about causes of mental illness to include witchcraft. This make Ogun State relevant as a traditional Yoruba state. Figure 3.1 is the map of Nigeria showing Ogun State.

Figure 3.1: Map of Nigeria

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According to National Bureau of Statistics (2016), the population of Nigeria is estimated at 183 million consisting of 92,387,474 and 90,989,254 males and females respectively. However, the figures showed that Ogun State had a population of 5,037,600 million comprising 2,533,913 men and 2,503,687 women.

The State has a range of cultural, traditional and historical attractions. Both monogamy and polygyny exist as forms of marriage with patriarchy (that is, there is male dominance) as the

authority structure. Being a patriarchal (male-controlled) society, men exercise domination in decision-making on most issues including health in the family. Traditionally, among the Yoruba of Ogun State, the male gender does not participate in domestic work including child rearing. Such tasks are exclusively the domain of women. Marriage takes the form of an agreement between the parents. After the completion of all necessary agreements and customs, the marriage is sealed in a manner reminiscent of a typical Yoruba marriage. There is a high regard for marriage because it is seen as a condition sine qua non for the survival of the society.

The extended family arrangement consists of close lineage other than a married couple and children who live in the same household or a familial and incessant association with one another governs the people of Ogun State. Surrounded by the background of family structure, series of childrearing practices are upheld. In Ogun State, a high value is placed on children and procreation is regarded as the essential purpose of marriage. Thus, every couple cares for children in a peculiar way. The traditional and modern child-rearing practices (a product of westernisation) are widely acknowledged. Meanwhile, a household extends mainly to many relatives in addition to parents and children living in the same compound. Within the extended family structure, traditional childrearing practices are communal.

People in the state practice Christianity, Islam and African Traditional Religion. Ogun State consists of twenty (20) LGAs divided into two hundred and thirty-six (236) political wards

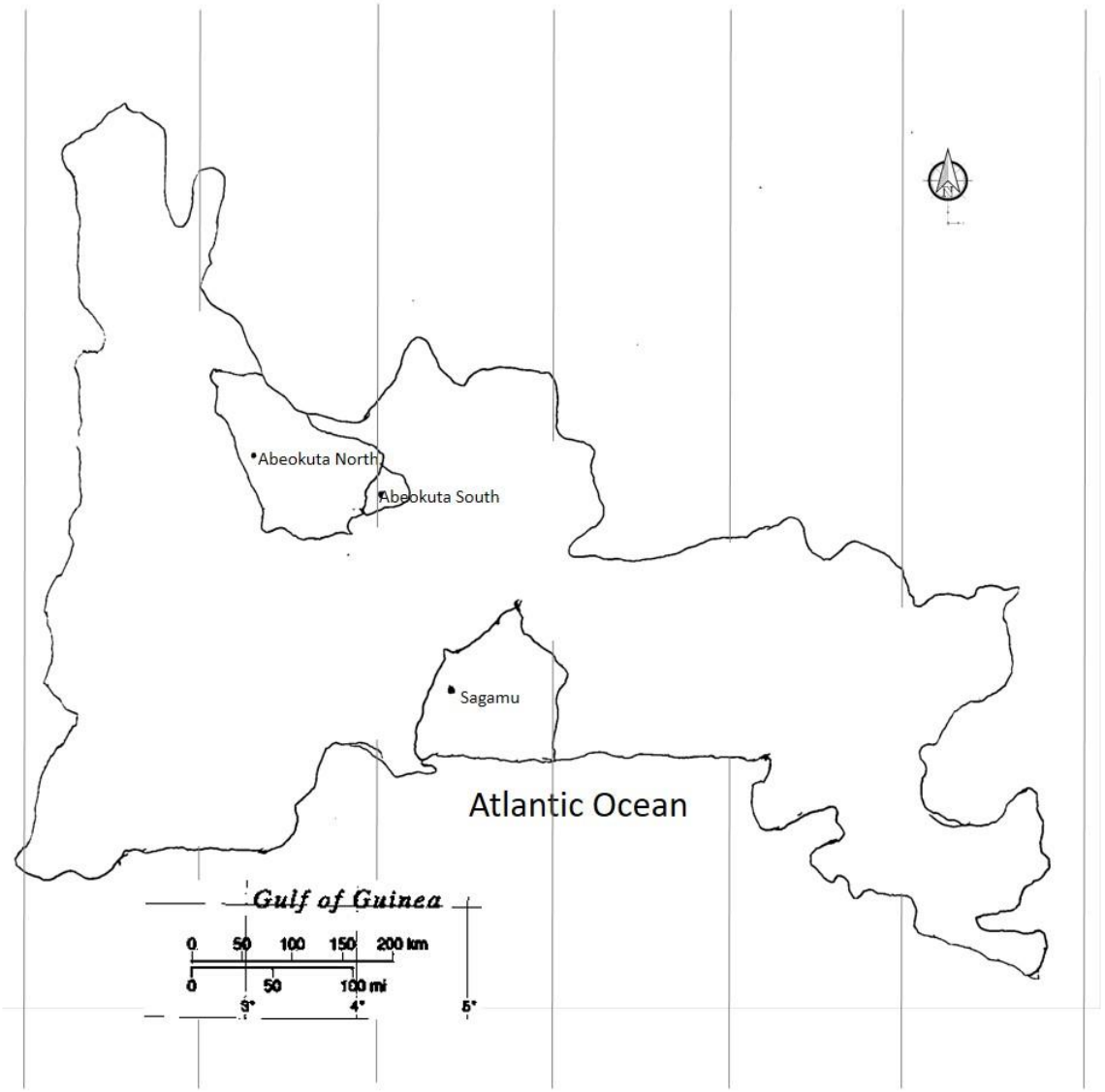

Figure 3.2: Map of Ogun state showing the selected Local Government Areas

The psychiatric hospitals and Local Government Areas (LGAs) selected for this study are:

1. **Department of Psychiatry, Federal Medical Centre, Abeokuta (Abeokuta South Local Government Area)**

The Federal Medical Centre Abeokuta is a 250-bedded regional specialist hospital which came into existence on 21st April 1993 with a philosophy of excellence in the provision of medical services to the gateway state of Ogun and other neighbouring states and nations. Over the recent years, the scope of this philosophy has gradually expanded to further encompass excellence in training and research, so that today we can rightly say that the hospital stands on a tripod of excellence in research, training and healthcare service delivery.

With very limited infrastructure and trained personnel inherited from the then State Hospital, Idi-Aba in its humble beginnings, the Federal Medical Centre Abeokuta has witnessed a phenomenal transformation in infrastructure and human resource development over the last two decades such that today the hospital has over 50 specialists in various fields of Medicine. The hospital has recorded feats such as separation of Siamese twins, performing the very first trans-oesophageal echocardiography in Nigeria and playing leading roles in a number of local and international collaborative research programmes.

The Department of Psychiatry, Federal Medical Centre Abeokuta offers preventive and curative mental health services through inpatient and outpatient services and in collaboration with other clinical departments. The staff consists of a consultant psychiatrist, a clinical psychologist, medical officer and four supportive administrative staff.

Its vision is to build a department that provides excellent psychiatric and psychological services and undertake high-impact research in adult psychiatric disorders. The services provided are In-patient and out-patient treatment, provision of psychotherapy, as well as a rehabilitation program. The hospital needs are an expansion of current space to cater for increased patient population, enhancement of consultation-liaison facilities to other specialties and facilities needed to rehabilitate mentally challenged adults and children. For example, occupational skills training. Training programmes are In-house seminars on current modes of psychiatric and psychological practice. However, the hospital collaborates with Neuro-psychiatric hospital, Aro, Abeokuta in areas of research and clinical experience. Is five-year targets are to improve evidenced-based

practice, expand in-patient care and to equip the department in the areas of forensic, geriatric and child psychiatry.

2. **Department of Psychiatry, Olabisi Onabanjo University Teaching Hospital, Sagamu (Sagamu Local Government Area)**

Olabisi Onabanjo University Teaching Hospital, Sagamu is designed to focus on providing high-quality healthcare services to Ogun in particular and Nigeria as a whole. Olabisi Onabanjo University Teaching Hospital is driven by the vision of providing excellent health to the people. Olabisi Onabanjo University Teaching Hospital is an epitome of a contemporary Teaching Hospital geared towards the mutual interaction between health workers and patients. Its strong emphasis is on emergency services with modern equipment at our disposal. Our professionals are disciplined vast with adequate knowledge of medical practice. At Olabisi Onabanjo University Teaching Hospital, efficient, affordable and accessible healthcare delivery is always within reach. OOUTH is redefining healthcare delivery in Ogun State Nigeria. The mission of the hospital is to achieve a client-friendly, efficient and effective tertiary health care services and to operate best practices through absolute dedication, discipline, and commitment to the well-being of the people of Ogun State.

3. Aro Neuropsychiatric Hospital, Abeokuta (Abeokuta North Local Government Area)

The Neuropsychiatric Hospital, Aro, Abeokuta, Nigeria, came into existence in 1954; but its progenitor, then an asylum, now called Lantoro Annex, came into existence on the 13th of April, 1944. This was when thirteen health attendants were transferred from the Yaba Asylum, Lagos, to open the Lantoro Institution with five mentally ill patients. These were Nigerian soldiers repatriated from the Burma war front during the Second World War.

In 1948, through an arrangement made by the late Dr. (Later Sir) Samuel Manuwa, Deputy Director of Medical Services, Western Provinces of Nigeria, the present site of Aro Neuropsychiatric Hospital, sitting on an expansive 732 acres of land was acquired with the assistance of the then Alake of Egbaland, Abeokuta, the late Oba (Sir) Oladapo Ademola II.

Though, as far back as the late 1930's, the present site of Aro Neuropsychiatric Hospital had been labeled "Site for Mental Hospital", it was not until 1954 that the Aro Complex, the main hospital

which is about 18 kilometers from Lantoro Annex, was begun by the doyen of psychiatry in Nigeria and Africa, the late Professor Thomas Adeoye Lambo (OFR), upon his return to Nigeria, having completed his course of study in psychiatry at the University of Birmingham.

The defunct Western Region of Nigeria managed the hospital until 1976 when the region was split into three, namely, Ogun, Ondo and Oyo States. The Federal Government took over the hospital and set up a board to oversee it, along with two other psychiatric hospitals at the time, namely: Psychiatric Hospital, Yaba, Lagos and Psychiatric Hospital, Uselu, Benin City. Decree 92 of 1979 was promulgated in October 1979 to back the Board. The same decree formally declared Aro Complex as an affiliate of the University College Hospital, the teaching hospital of the University of Ibadan, Ibadan.

The world recognition of the hospital came about during the pioneering efforts of the late Professor Thomas Adeoye Lambo (OFR), when he innovated, way back in the 1960s, the 'Aro Village System' of treating the mentally ill. The thrust of this system was a community participatory system of treatment of the mentally ill that involved psychiatric professionals, patients' relatives and co-tenants, neighbours and the community where the patients were admitted.

This treatment paradigm was achieved by creating the "Aro Village System" a few kilometers from Aro Hospital, where patients were admitted into "normal" houses with other tenants living alongside patients and their relatives. The principle of the village system was subsequently adapted all over the world and virtually opened the hitherto locked gates of psychiatric hospitals all over the world.

In 1978, a visiting team of the World Health Organization (WHO) Consultants recommended the development of the Aro Neuropsychiatric Hospital Complex as the headquarters of a national and regional center for research and training in mental health, neuro-psychiatry, psychiatric nursing, clinical psychology and related disciplines in bio-behavioural sciences. The premise for this recommendation was that there was a need for a focal strategy that will seek both African and external resources to permit the immediate development of the high-level facilities, necessary to make the accelerated impact on the training of health personnel, conduct of research and clinical service delivery.

The development of Aro as a national and regional mental health resource center was supported by the Federal Military Government headed by General Olusegun Obasanjo (GCFR), as being entirely consistent with national health priorities and Nigeria's policy to play a leadership role in Africa, the then focus on Nigerian's foreign policy.

In August 1979, following the consent of the Board and the Federal Ministry of Health, the WHO designated the Aro Complex as a Collaborating Centre for Research and Training in Mental Health. With assistance from the WHO, a team of expert consultants in neuro-psychiatry, psychology, sociology, anthropology and psychiatric nursing visited Nigeria in 1980 and, in collaboration with Nigerian colleagues, recommended a detailed plan of work for the Aro Complex.

This included the setting up of a national Neuro-Psychiatric Institute, which will initially serve as an integral part of the Aro Complex but eventually will serve as a structure to incorporate other centers of significance in the mental health specialty elsewhere in Nigeria, and in other African countries. The plan of work was accepted by the Federal Government which rapidly moved to initiate the development of the Aro Complex, especially the hospital part to provide high-level clinical services which are required in an institution designed for advanced training and research in mental health and related disciplines.

At present, there are still ongoing efforts to steadily and assiduously develop the planned "Institute" status of the complex. Aro hospital provides qualitative and innovative primary, secondary and specialised hospital and community-based mental health services, as well as training and research. The services are biased toward treatment and rehabilitative care of severe mental illness as a tertiary referral center to other psychiatric care facilities in the country. Specialised care provided include child and adolescent services, old age services, alcohol and drug treatment services, forensic services, and Rehabilitation services. Primary care mental health programme for Ogun State remains a model of functional mental health service Integration in the developing world.

4. **Lantoro Community Psychiatry, Abeokuta (Abeokuta South Local Government Area)**

Lantoro was a former Local Government Prison which was taken over, first by the Military, and later by the then Colonial Medical Department. In January 1946, the first civilian patients were admitted into Lantoro. Later on, in the same year, criminal patients who were adjudged to be mentally ill were also admitted into Lantoro, on the order of the courts in accord with the Lunacy Ordinance. The Lantoro Institution soon became overpopulated and a decision was taken to establish a well-equipped hospital for mental and nervous diseases.

The Lantoro Community Psychiatry, Abeokuta offers preventive and curative mental health services through inpatient and outpatient services. The staff consists of a consultant psychiatrist, a clinical psychologist, medical officer, social workers and supportive administrative staff.

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

i. The presence of amenities for psychiatric patients; and

ii. The availability of psychiatric patients

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

3.4 Study Population

The study population consist of two categories of participants. The first category were adults, male or female who are 18 years and above. They are Yoruba and reside in the selected LGAs. The selected LGAs have psychiatric facilities. Table 3.1 presents the distribution of adult population in the selected Local Government Areas (LGAs).

Table 3.1: Adult Population Distribution According to Selected Local Government Areas (LGAs)

Local Government Area	Male Population	Female Population	Total Population
Abeokuta North	80,235	83,930	164,165
Abeokuta South	109,619	122,324	231,943
Sagamu	80,874	87,098	167,972
Total	270,728	293,352	564,080

Source: National Population Commission, 2016

The second category of the study population consist of selected family members or caregivers of people living with mental illness (PLWMI) (presently receiving treatment and those who have recovered) who are of Yoruba descent, orthodox practitioners (psychiatrists and social workers) in the selected psychiatric hospitals and traditional healers in Ogun State.

3.5. Sample Size Determination

The sample size (represented by N) used in this study was derived from Fisher's formula for the proportion of the population of adults 18 years and above in the selected LGAs.

$N=Z^2PQ/d^2$

N stands for the required minimum sample size

P stands for the proportion of population (18 years and above)

Q = (1-P). This stands for the proportion of the population that is not up to 18 years old.

Z means the standard normal deviation for the 95 percent at the confidence level of 1.96.

d means precision, that is, the level of desired accuracy. This is put at 0.04

The sample size for the study locations was based on the last National Population Census figures and the estimated 2016 statistics released by the National Population Commission. The proportions of the adult population in the selected Local Government Areas are as indicated below:

i. Abeokuta North Local Government Area – 48.5 percent of adults,
ii. Abeokuta South Local Government Area – 59.7 percent of adults and
iii. Sagamu Local Government Area – 38.9 percent of adults.

The Fisher's formular was used for the determination of sample size using the prevalence rate of each LGA listed. The researcher allowed for an attrition rate of 5 percent for sampling error.

The sample size for quantitative data from the selected LGAs is as indicated below

Table 3.2: Sample Size for Quantitative data

S/N	Local Government Areas	Population of Adults (aged 18+)	*P* (%)	Sample Size
1.	Abeokuta North	164,165	48.5	403
2.	Abeokuta South	231,943	59.7	388
3.	Sagamu	167,972	38.9	383
	Total Sample Size			**1,174**

Source: National Population Commission, 2016 and Computation by Researcher

Thus, a total of 1,174 adults (18 years and above) were selected across the selected three (3) LGAs.

3.5.1 Inclusion criteria

The inclusion criteria were based on literature and past works on mental health. The criteria include:

i. Adult member of a household, either male or female that is 18 years and above, of Yoruba origin and residing in the Local Government Areas of the selected psychiatric hospitals in Ogun State;
ii. The members of family or individuals who care for mentally unstable individuals (presently suffering plus those who have recovered) who are of Yoruba descent in the selected psychiatric hospitals in Ogun State;
iii. Psychiatrists in selected hospitals in the State; and

iv. Selected traditional healers in the selected LGAs

3.5.2 Exclusion criteria

The exclusion criteria were based on literature on mental health. The criteria include:

i. Adult member of an household, either male or female that is below 18 years;
ii. Adults that are not of Yoruba origin, but are living in study locations;
iii. Family members or Caregivers of the mentally sick outside the selected hospitals;
iv. Psychiatrists that work outside the selected hospitals in Ogun State; and
v. The traditional healers who are operating outside the selected Local Government Areas.

3.6 Sampling Techniques

The respondents for the study were drawn from adults (male and female), 18 years and above, Yoruba and resident of the study location. The 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 sampling procedure entailed multi-stage sampling techniques in which there is a sampling of households and the selection of males and females who are at least 18 years old in the sampled households. The employment of each technique was due to the characteristics of the required sample. The respondents were sampled from two-fifths of the political wards. This was in line with the procedures contained in the WHO sampling manual. The researcher made the random selection of the political wards. Similarly, there was a random selection of respondents from households in the wards. Where there was no qualified respondent, the next houses occupied by qualified respondents were selected.

According to the sample calculated, a total of 1,174 adults (male and female), who are 18 years and above who are Yoruba were selected from the Local Government Areas.

The summary of the multi-stage sampling techniques is as indicated below.

Table 3.3: Multi-Stage Sampling Procedure

STAGES	SAMPLING TECHNIQUES
1st stage	Purposive sampling of Ogun State
2nd Stage	Stratification of the State into Local Government Areas of the selected Psychiatric hospitals in Ogun State (Abeokuta North, Abeokuta South and Sagamu)
3rdStage	Random selection of two-fifth of the wards in the each area of the study location (WHO sampling manual)
4th Stage	From the selected Local Government Areas to communities, compounds were selected

Source: Researcher's Compilation, 2016

3.7 Enrolment and Training of Research Assistants

The large sample size and the peculiarities of the study necessitated the engagement of the services of eight (8) research assistants consisting of four males and four females who are fluent in the Yoruba language. They were employed for the administration of the questionnaire. These research assistants were trained and remunerated. The research assistants were trained from 4 pm to 7 pm (3 hours) daily for one week discussing with them each of the items in the questionnaire and the places they should go to.

3.8 Description of Research Tools

The sources of data collection included primary and secondary sources. A structured questionnaire, In-depth Interview (IDI) and Key Informant Interview (KII) were used to obtain the needed primary data. On the other hand, the secondary sources for this study include the use of journals, textbooks, dictionary, internet sources and other research works. Also, the triangulation approach involving the use of quantitative and qualitative methods was adopted in this study.

3.9 Collection of Quantitative Data

The collection of quantitative data was basically with the use of a structured questionnaire.

3.9.1 Questionnaire

The structured questionnaire for this study was administered to household members who were either male or female, 18 years and above, Yoruba and residing in the selected LGAs. The structured questionnaire was divided into eight (8) sections. Section one contained questions on socio-demographic characteristics of the respondents. Section two contained questions about the respondents' perception of mental illness. The third part dealt with questions on the availability of psychiatric services. The fourth section contained questions on the ease of access in the utilisation of psychiatric services. The fifth section was on issues that dealt with the use of mental healthcare services. The sixth part was the choice of mental healthcare therapy. The seventh section contained questions on gender preference of mental healthcare professionals. Finally, questions on gender role in household decision-making and treatment of mental illness were in the eight section of the questionnaire. The questionnaire adopted for this study was a self-administered structured questionnaire containing both open and closed-ended questions. A total of 1,174 copies of the questionnaire were planned for distribution. However, respondents who accepted to be involved and participated in the study were 1,081 with only 967 copies retrieved. For the respondents' easy interpretation and proper understanding, research assistants asked the questions from the respondents in the Yoruba language where necessary (See Appendices II and III).

3.10 Collection of Qualitative Data

The collection of qualitative data was basically with the use of the Key-Informant Interview guide and In-depth Interview guide.

3.10.1 Key Informant Interviews (KIIs)

The key informants were selected through the purposive sampling method. The selection took into consideration relevant experience and knowledge of the subject matter. The key informants comprised six (6) Psychiatrists and eight (8) social workers in the selected psychiatric hospitals in Ogun State. Also, there was the conduct of five (5) Key Informant Interviews with traditional healers. Nineteen (19) KIIs were conducted (See Appendices IV and V). The KII guide was written in English Language and translated to theYoruba Language where applicable.

3.10.2 In-Depth Interviews (IDIs)

An In-depth interview guide was designed in simple language and translated into Yoruba for interviewees who could not speak and understand the English Language. In-depth interviews were conducted with caregivers of mentally ill people (presently suffering and those who have recovered). Five (5) caregivers from the three Local Government Areas were purposively selected (See Appendix VI to IX). Table 3.4 explains the data collection for qualitative and quantitative data in each of the selected Local Government Areas (LGAs):

Table 3.4: Respective Sample Size for Quantitative and Qualitative Data by Selected Local Government Areas

S/N	Local Govt Area	Wards	No of wards sampled	Quantitative sample size For HH	IDI For CG 18+	KII for TH	KII for Psychiatrist	KII for SW
1	Abeokuta North	15	6	403	2	2	3	2
2	Abeokuta South	15	6	388	1	2	2	4
3	Sagamu	15	6	383	2	1	1	2
	TOTAL	**45**	**18**	**1,174**	**5**	**5**	**6**	**8**

Source: Researcher's Compilation, 2016

Keys: IDI- In-depth Interview; KII- Key Informant Interview; HH- Household, CG - Caregivers, TH-Traditional Healer and SW- Social Worker.

An explicit explanation on how the data collection techniques answered the research objectives is as shown below.

Table 3.5: Data Collection Methods by Research Objectives

S/N	Objectives	Questionnaire	IDI	KII	
1	Examine how the Yoruba of Ogun State perceive mental illness	✓	✓		
2	Assess availability of mental healthcare services in the study area	✓	✓		
3	Examine respondents' view about access to mental healthcare services	✓	✓		
4	Examine respondents' view about utilisation of mental healthcare services	✓	✓	✓	
5	Examine respondents' view about choice of mental healthcare therapy	✓	✓	✓	
6	Assess gender preference of mental healthcare professionals for treatment	✓	✓		
7	Determine how gender roles influence household decision-making about mental illness treatment	✓	✓		

Source: Researcher's Compilation, 2016

3.11 Validity of Research Instrument

Data collection tools for any research need to be valid and reliable to have accurate and dependable data. This researcher took several measures to ensure that the research instruments were precise and reliable. The researcher got specialists that reviewed and edited the tools in English Language for content validity. A Yoruba linguist translated the protocol into the Yoruba language. The translation was for the benefits of the participants who do not understand the English Language.

3.12 Reliability of Research Instrument

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. It is worthy to note that each section of the instruments had diverse reliabilities. The section on the perception of mental illness was 0.756; availability of mental health care services was 0.924. Furthermore, access to mental healthcare facility was 0.821, use of mental health care services was 0.824, choice of mental health care therapy was 0.915, gender preference of mental health care professionals was 0.872 and gender role in household decision-making about the treatment of mental illness was 0.609**.**

3.13 Pre-test

There was a pre-test of the questionnaire in another location (Ado-Odo/Ota) Local Government Area, Ogun State with respondents that had same characteristics with the study population. The essence of pre-test of the questionnaire was to test the relevance, appropriateness, and adequacy of the questions to address the research objectives. The findings from the pre-test were used to address the shortcomings of the questionnaire. However, there was no conduct of pre-test on the Key Informant Interview guide and In-Depth Interview guide because of the non-availability of psychiatric hospitals in Ado-Odo/Ota Local Government Area.

3.14 Data Management

Data generated were collated, stored, and processed in a manner that nothing was lost in the process. The tape-recorded interviews and discussions were translated and also transcribed. Copies of the structured questionnaire administered were collated, labelled, screened and entered into the computer and analysed. The tape recordings and note taken were kept in a safe place. Also, backup files of data generated were stored on Google cloud, hard drive or flash drive to serve as backup.

3.15 Data Analysis Procedure

In any study, the type of data collected during the fieldwork will determine the type of analysis that will be carried out. This study utilised both quantitative and qualitative methods of data analysis as appropriate for each objective.

3.15.1 Quantitative Data Analysis

The quantitative data collected were coded, inputted into the laptop and analysed using the Statistical Package for Social Sciences (SPSS version 18). The type of scales of measurement and the questionnaire format (open and close-ended questions) necessitated the statistical analysis at univariate, bivariate and multivariate levels.

Univariate Analysis

The univariate analysis focused on examining variation in a single variable. Univariate analysis was carried out through descriptive statistics of frequency distribution and percentage. Univariate analysis showed the descriptive statistics (using frequency distribution tables, percentages, and graphs). It was used to analyse variables such as the socio-demographic characteristics of respondents. It also focused on examining variations in a single variable.

Bivariate Analysis

The bivariate analysis examined the relationship between an independent variable and a dependent variable in the study. Gender differentials are the dependent variable while perception and treatment of mental illness are the independent variables which can be manipulated and thus have an influence on household decision-making. Chi-Square was used to find out if a relationship exists between variables at the significant level of 0.05. The test was also used to examine the relationships between gender differentials and perception of mental illness; the relationship between gender differentials and access to mental healthcare facilities.

Multivariable Analysis

Multivariate analysis was used to determine the strength of the relationship between a dependent variable and several independent variables. Analysis of Variance (ANOVA) and F-test identified the nature of any relationship between the gender differentials and the use of mental healthcare facilities and further to determine the strength of the relationship between the gender differentials and gender preference of professional healthcare workers.

3.15.2 Qualitative Data Analysis

Data generated through In-depth Interview, Key Informant Interview with the aid of a tape-recorder were translated and transcribed while the notes taken during the interviews were organised and analysed thematically into important themes based on the study objectives. The

qualitative data was analysed using the Nvivo software version 8. The organised data were subjected to content and narrative analyses which guided the interpretation of the data. The first stage of the analysis involved grouping data into issues that dealt directly with general and specific research objectives raised in the study. In the second stage, a further content analysis was done to explore sub-themes and unanticipated issues. The third stage entailed a critical and reflexive review of interviews and case histories in constructing a holistic picture of gender differentials in the perception and treatment of mental illness among the Yoruba of Ogun State, Nigeria. Issues considered relevant but which were not anticipated from the outset were teased out in ways that aligned with the general focus of the study and at the same time represented the specific details that embedded in the experiences of individual participants.

3.16 Problems Encountered during the Fieldwork

Some problems were encountered in the conduct of this research. The first had to do with the issue of seeking and obtaining ethical approval from Aro Neuropsychiatric Hospital and Federal Medical Centre, Abeokuta. The Ethical Review Committee took time (three months) to approve the research. This delay was an obstacle to the promptness necessary for the commencement of the fieldwork.

Secondly, the need to supply relevant information or answers from the respondents who could not read and also write hindered the time of completion of the fieldwork because the research team had to start reading to them and selecting their choice of answers. Even for those with some level of education, their attitude showed that they placed little value on research.

Thirdly, there were difficulties in obtaining a response from the respondents. This challenge occurred because some vital information was considered to be personal or secret to them. The respondents were more focused on how the research team could be of medical assistance to them, and the absence of such services provoked displeasure and disengagement of the respondents.

Fourthly, it was also difficult securing appointments for key-informant interviews and the In-depth interviews. Several dates were taken to have the in-depth interviews and Key-informant interviews. Getting traditional healers in Ogun State was tough. ‘Gatekeepers’ were engaged to book appointments with the traditional healers. The researcher had to look for someone who is fluent in speaking the Yoruba language who could assist in the interpretation.

Furthermore, logistic was a fundamental problem encountered. Bad road network and poor transportation system in the state was not encouraging. The farthest Local Government Area is Sagamu Local Government Area. The movement up and down the location was challenging and stressful. Hence, the researcher had to sleep over for three days to ensure that the copies of questionnaire were duly filled.

Finally, lots of expenses were incurred which included the cost of printing the copies of the questionnaire, transportation of the research assistants, feeding and sometimes, incentives which were given to the respondents to get information. However, despite all these challenges, the field experience was meaningful and gave the researcher more experience and exposure.

3.17 Limitations of the Study

There was a limited literature which focused directly on gender dimensions to mental disorder. The gender differential dimension in the treatment of mental illness had been a gray area in many local and national studies. Therefore the bulk of references emerged only from developed countries. However, this challenge provided the study with the launch pad to add to existing literature on mental health and close the knowledge gap in mental disorder. One major setback of the research was that the respondents responded to questions with a mindset of a particular mental illness since they seemed to endorse non-biological contributory factors. Furthermore, the research was among just one ethnic group in Nigeria. It is possible that other ethnic groups may 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.

3.18 Ethical Considerations

Written and oral consents of the respondents were sought before the commencement of the interview process through the 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. The right to withdrawal of respondents/interviewees was emphasised. The study respected the rights, integrity, confidentiality, and secrecy of all the participants before, during and after the study. The anonymity of participants was also maintained by guarding against identifying participants with interview sessions. The following ethical issues were addressed.

Confidentiality of Data: The study participants were assured of the safety of their identity prior to the start of the interview sessions. Confidentiality of all information obtained from respondents was maintained by collecting anonymous responses. The interviewees were given pseudo labels. Copies of the questionnaire were given anonymous codes; filled in private and secured places. The data collected were kept under lock and key. All the research instruments and data collected will be stored for 5 years before they are safely discarded.

Voluntariness: In this study, there was no coercion, either from the researcher or any of the trained field assistants to participate in the study. Participation was voluntary, and participants were allowed to decide on whether to participate in the interview process, continue or withdraw from the process.

Beneficence to participants: Participants were told that the information obtained from the research will help to make available recommendations for policymakers on the control of mental illness especially among women.

Non-maleficence to participants: The study caused no harm of any degree. All necessary precautions were taken during questionnaire administration, Key Informant Interview and In-Depth Interview interactions to ask questions in such a way that, no social or psychological harm was caused.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.0 Preamble

The study made use of both qualitative and quantitative data. In the utilisation of quantitative methods, the study proposed a sample of 1,174, being the estimated number calculated for sample size. However, 967 respondents representing about 82% of the estimated sample size eventually participated in the study. Thus, the results presented are from the data gathered from the sample of 967 respondents. The study objectives formed the basis of presentation of the results. The first part is the socio-demographic characteristics of the respondents while the other parts are related to the seven objectives. In the qualitative methods, there were Nineteen (19) participants in the Key Informant Interview which comprised six (6) Psychiatrists and eight (8) Social workers in the selected psychiatric hospitals in Ogun State and Five (5) traditional healers. The qualitative methods equally employed the use of In-depth Interview with five (5) caregivers from the three selected Local Government Areas**.**

4.1 Socio-Demographic Characteristics

In this section, the results of respondents' socio-demographic characteristics are presented. Information presented in this subsection is intended to facilitate the interpretation of the main variables relating to the perception and treatment of mental illness which are presented in the latter part of the chapter. Table 4.1 shows the distribution of respondents by their socio-demographic characteristics in the study area.

Findings on gender showed that a bulk of the respondents (54.2%) were females while male respondents accounted for 45.8%. The mean age of the respondents was 22.2±18 years, with age range from 18 to 64 years. Age in group denotes ten years interval. Findings also indicated that 17.2% were under the age of 20, the highest proportion was between 20-29 years old with 41.9%; those in age categories 30-39 years were 27.7%; similarly, 8.2% represented those in age group 40-49 years. In addition, age groups of 50 years and above accounted for the least respondents (5%). This finding corroborates the report of United Nations Department of Economic and Social Affairs Population Division (2016), where it was argued that adults constitute the bulk of the

Nigerian population. The distribution of respondents' marital status showed that 40.4% were single, 57.4% were married, 1% were separated, 0.3% were divorced, and 0.8% were widowed. From this statistics, it is evident that the highest proportions of the respondents were married.

The religious distribution showed that the respondents practiced the three major religions in Nigeria. The study revealed that the larger percentage of the respondents practiced Christianity (45%), followed by Islam (39%) and only 15.8% practiced some forms of African Traditional Religion. Respondents' education presents the following information; respondents with no education were 11.7%. The majority of the respondents have junior and secondary school certificate (55.9%). In addition, respondents with the primary level education were 18.2%; while 14.2% of the respondents had a post-secondary education which includes polytechnic and university degrees. Occupation of the respondents had a close margin. Artisans accounted for 19.1%; traders were 17.8%; a larger percentage of the respondents were civil servants (25.6%). Furthermore, farmers made up 17.3%; pensioner accounted for 8.4% while the least percentages were cleric/spiritualist (4.9%) and unemployed (6.9%) respectively.

Respondents' number of years lived in the community indicated that 12.5% of the respondents had lived in the community within one to three years. 23.4% accounted for four to six years of stay. Moreover, respondents that had lived seven to nine years were 38.7% while ten years above accounted for 25.4%. This number of years could have contributed to their knowledge of mental healthcare services and assessment thereof regarding availability, access, choice and uses. Distribution of respondents by family type indicated that 47.7% were from nuclear family while 52.3% were extended family. The study also reported that 53.1% of the respondents practiced monogamy while 46.9% practiced polygyny.

Table 4.1: Distribution of Respondents by Socio-Demographic Characteristics

Characteristics	Categories	Frequency	Percentage
Gender	Male	443	45.8
	Female	524	54.2
	Total	**967**	**100**
Age In Group	Less than 20	168	17.2
	20-29	405	41.9
	30-39	268	27.7
	40-49	79	8.2
	50+	49	5
	Total	**967**	**100**
Marital Status	Single	391	40.4
	Married	555	57.4
	Separated	10	1.0
	Divorced	3	0.3
	Widowed	8	0.8
	Total	**967**	**100**
Religion	Christianity	436	45.1
	Islam	378	39.1
	AfricanTraditional Religion	153	15.8
	Total	**967**	**100**
Education	No education	113	11.7
	Primary education	176	18.2
	Junior/Senior Secondary	570	55.9
	Tertiary	138	14.2
	Total	**967**	**100**
Occupation	Artisan	185	19.1
	Trader	172	17.8
	Civil Servant	248	25.6
	Farmer	167	17.3
	Pensioner	81	8.4
	Clergy / Spiritualist	47	4.9
	Unemployed	67	6.9
	Total	**967**	**100**
Years lived in the Community	1-3	121	12.5
	4-6	226	23.4
	7-9	374	38.7
	10 and above	246	25.4
	Total	**967**	**100**
Family Type	Nuclear	461	47.7
	Extended	506	52.3
	Total	**967**	**100**
Marriage Form	Monogamy	454	53.1
	Polygyny	513	46.9
	Total	**967**	**100**

Source: Field Survey, 2016

Table 4.2: Demographic Profile of Key Informant Interview Participants in the Selected Local Government Areas (LGAs)

Categories	**Occupation**			
Variables	**Psychiatrist**	**Social Worker**	**Traditional healer**	**Total**
Gender				
Male	4	5	5	14
Female	2	3	0	5
Marital Status				
Single	2	3	1	6
Married	4	5	4	13
Educational Level				
No Education	-	-	3	3
Primary Education	-	-	2	2
Secondary Education	-	-	-	-
Tertiary Education	6	8	-	14
Religion				
Christianity	4	5	-	9
Islam	2	3	-	5
Traditional	-	-	5	5
Local Government Areas				
Abeokuta North	3	2	2	7
Abeokuta South	2	4	2	8
Sagamu	1	2	1	4
Total Number of Participants	**6**	**8**	**5**	**19**

Source: Field Survey, 2016

Apart from the community members, professional healthcare workers and traditional healers were interviewed to seek their opinions on the perception and treatment of people living with mental illness (PLWMI). Table 4.2 reveals the socio-economic features of the participants in the qualitative study. The study had more male participants in the KII; conversely, more female participated in the IDI compared to their male counterparts (see Table 4.2 and Table 4.3 respectively). Qualitative findings revealed that the educational status of the participants presents a close dynamics. For example, professional healthcare workers had the highest level of education, that is, tertiary education while the traditional healers had no formal education. However, the IDI for caregivers presents a different outlook; four caregivers had a secondary education while one caregiver had tertiary education. Furthermore, the qualitative data explored the marital status of the participants. Most of the participants were married. Most of the participants practiced Christianity except the five traditional healers who practiced African Traditional Religion.

Table 4.3: Demographic Profile of In-Depth Interview Participants in the Selected Local Government Areas (LGAs)

Variables	Caregivers
Gender	
Male	1
Female	4
Marital Status	
Single	-
Married	3
Separated	2
Educational Level	
No Education	-
Primary Education	-
Secondary Education	4
Tertiary Education	1
Religion	
Christianity	3
Islam	2
Traditional	-
Local Government Areas	
Abeokuta North	2
Abeokuta South	1
Sagamu	2
Total Number of Participants	**5**

Source: Field Survey, 2016

4.2 Perception of Mental Illness

The study sought to assess the perception of the respondents about mental illness. However, it was first of all necessary to evaluate the knowledge, awareness, attitude, and perception of mental illness of the study participants. Participants include community members (18 years and above), professional healthcare workers (social workers and psychiatrists), traditional healers and the caregivers of people living with mental illness (those who have recovered and those who are suffering from mental illness).

Table 4.4: Perception of Mental Illness by Gender

Characteristics	Gender Differentials		Total	$\chi 2$	Df	P-value	
Knowledge of mental illness	Male	Female		248.172	1	< 0.00001	P<0.05 SIGNIFICANT
Has knowledge	179(55.8%)	494(99%)	673(82%)				
Does not have knowledge	142(44.2%)	5(1%)	147(18%)				
Sources of knowledge about mental illness				11.439	6	0.0757	P>0.05 NOT SIGNIFICANT
Friends	59(18.4%)	88(17.6%)	147(17.9%)				
Parents/Relatives	60(18.7%)	105(21%)	165(20.1%)				
The media	101(31.5%)	112(22.4%)	213(26%)				
Hospitals	62(19.3%)	134(26.9%)	196(24%)				
Christian faith healing centre	11(3.4%)	16(3.2%)	27(3.3%)				
Islamic faith healing centre	7(2.2%)	10(2%)	17(2.1%)				
Traditional healers	21(6.5%)	34(6.8%)	55(6.7%)				
Causes of Mental illness				16.8585	3	0.0008	P<0.05 SIGNIFICANT
Natural	102(27.6%)	122(24.4%)	224(27%)				
Supernatural	109(44.7%)	219 (43.9%)	328(40%)				
Hereditary	87(18.6%)	100(20%)	187(22.8%)				
Preternatural	23(9.2%)	58(11.6%)	81(9.9%)				
Perceptions about whether mental illness affects males more than females				15.996	2	0.0003	P<0.05 SIGNIFICANT
More males are affected	110(34.2%)	241 (48.2%)	351(42.8%)				
More females are affected	160(50%)	201(40.2%)	361(44%)				
Can't say	51(15.9%)	57(11.4%)	108(13.2%)				
Commonness of Mental illness				32.368	3	<0.00001	P<0.05 SIGNIFICANT
Childhood	5 (1.6%)	9(1.8%)	14(1.7%)				
Adolescence	78 (24.3%)	73(14.6%)	151(18.4%)				
Adulthood	67(20.9%)	193(38.7%)	260(31.7%)				
Any age	171(53.2%)	224(44.9%)	395(48.2%)				
Curability of Mental illness				43.340	1	<0.00001	P<0.05 SIGNIFICANT
Curable	237(72%)	454(91%)	691(81.8%)				
Not Curable	84(28%)	45(9%)	129(18.2%)				
Where Mental illness can be cured				39.243	3	<0.00001	P<0.05 SIGNIFICANT
Psychiatric hospitals	160(50%)	349 (70%)	509(62%)				
Traditional healers	87(27.1%)	63(12.6%)	150(18.3%)				
Church	51(15.9%)	66(13.2%)	117(14.3%)				
Mosque	23(7.2%)	21(4.2%)	44(5.4%)				
Mental illness as a stigmatized condition				6.882	2	0.0320	P<0.05 SIGNIFICANT
Stigmatised disease	157(48.9%)	269(54%)	426(57.6%)				
Not a Stigmatised disease	120(37.3%)	144(28.9%)	264(17.8%)				
Can't say	44(13.7%)	86(17.2%)	130(24.6%)				
Total	**100.0**	**100.0**					
Number	**321(39.1%)**	**499(60.9%)**	**820**				

Source: Field Survey, 2016

Here we examine the opinion or perception of the interviewees about mental illness. This includes their knowledge and source of knowledge of mental illness, possible causes, gender more commonly affected, the stage of development in which it more commonly occurs that is, whether childhood, adolescence, adulthood or any age), the curability of mental illness, where mental illness can be cured and whether mental illness is a stigmatized condition.

Eight hundred and twenty respondents gave their opinion on perception of mental illness. Thirty nine pecent of this numbe were males while 61% wee females. As Table 4.4 shows, while 99% of female espondents wee awae of mental illness only 55.8% of the males were aware of it. That only 55.8% of the males were aware of it was quite unexpected.

The qualitative data collected indicated the perception of mental illness in a more robust way. Participants' perceptions about mental illness were generated from their being cognizant of the illness. The qualitative data on the perception of mental illness was mainly sub-divided into four parts which included the definition, causes, gender differentials and attitude towards people living with mental illness (PLWMI).

Definition of Mental Illness

Noticeably, participants did not explain or describe their awareness in the same manner. Highlighted here are excerpts that clearly illustrate by definition the consciousness of participants about mental illness:

> *As Yoruba people, we know mental illness as 'were'. It is also called ''Alaaganna'' . As for me, mental illness means to misbehave in the society* **(Traditional healer, Sagamu Local Government Area, KII).**

Another Traditional healer had a different opinion on the definition of mental illness. This was his position:

> *From experience what we call mental illness is 'Arun opolo'. In this case, the person has run mad (***Traditional healer, Abeokuta North Local Government Area, KII).**

However, a Psychiatrist had a different view of mental illness. He said:

> *Mental illness is a health condition that is characterised by changes in thinking, mood or behaviour associated with impaired functioning (***Psychiatrist, Abeokuta South Local Government Area, KII).**

A Social Worker also gave the definition of mental illness as follows:

> *Mental illness is when an individual is not in conformity with the norms and values of society regarding behaviour (***Social Worker, Sagamu Local Government Area, KII)**

Another position on mental illness as given by a caregiver is as follows:

> *Mental illness is called disability of the mind. In Yorubaland, mental illness is called "were"* **(Caregiver, Abeokuta South Local Government Area, IDI).**

Another position on the definition of mental illness revealed that:

> *Mental illness is an abnormality of the brain. Mental illness in Yorubaland is called "were"* **(Caregiver, Sagamu Local Government Area, IDI).**

Although all the participants in the study areas are knowledgeable about mental illness, they gave different definitions. This is a reflection of the saying that no single definition is accepted universally by scholars in the field.

Perception of mental illness by participants was not only found on the meaning they attributed to the disease. Occasionally this meaning could be an outcome of the perceived causes. There was no restriction of the local name to the familiar '*were*' as it is known. Others have re-conceptualised the local name by the causes and described it as '*Arun opolo*'.

With regard to the sources of knowledge of mental illness, for the male respondents, 18.4%; 18.7%; 31.5%; 19.3%; 3.4%; 2.2% and 6.5% got their information on mental illness from friends; parents/relatives; media; hospitals; christain faith healing centre; Islamic faith healing centre and traditional healers respectively. In contrast, for the female respondents, 17.6%; 21%; 22.4%; 26.9%; 3.2%; 2% and 6.8% got their information of mental illness from friends; parents/relatives; media; hospitals; christain faith healing centre; Islamic faith healing centre and traditional healers respectively. While the males were more likely to get information on mental illness from the media, the females were likely to get information on mental illness from hospitals.

Causes of Mental Illness

With regards to the causes of mental illness, for the male respondents, 27.6%; 44.7%; 18.6% and 9.2% attributed the causes of mental illness to natural; supernatural; hereditary and preternatural respectively. On the other hand, 24.4%; 43.9%; 20% and 11.6% of the female respondents attributed the causes of mental illness to natural; supernatural; hereditary and preternatural respectively.

The exact cause of mental illness is unknown. Causes of mental illness among the Yoruba include natural, supernatural, spiritual, environmental, heredity and offences committed and attacks from enemies (Aluko, 2006). These causes substantiate the opinions of the Key Informant Interviews (KII) and In-depth Interview (IDI) respondents. Here are the opinions of some of the respondents regarding the causes of mental illness:

> *'Were' in Yoruba is caused by 'were' 'amutorunwa' (mental illness that one is born with), 'were' 'iran' (mental illness that is hereditary) and 'were' 'afise' (mental illness due to affliction)* **(Traditional healer, Abeokuta South Local Government Area, KII).**

Another participant stated that:

> *The primary cause of mental illness is the breaking of a taboo in the family. In Yorubaland, it is called 'ewo idile'* **(Traditional healer, Abeokuta North Local Government Area, KII).**

A Psychiatrist stated that:

> *Mental illness is due to poor rehabilitative measure, finance, poor family support and poor drug compliance* **(Psychiatrist, Sagamu Local Government Area, KII)**

However, a Social Worker described the causes of mental illness as follows:

> *Mental illness is hereditary; it runs in the family. It is also has a spiritual cause that is, by evil machinations, the spell of insanity, offence against the gods, breaking of taboos and environmental causes, which are as a result of pressure from family, in-laws, children, and spouses* **(Social worker, Abeokuta North Local Government Area, KII).**

A respondent stated that:

> *"Omo odun mejo ko'gbodo ya were bi koni taye ninun" (Translated thus; "A child of eight years or less must not be affected by mental illness without supernatural causes"). Mental*

> *illness is not meant for children except adults* **(Caregiver, Abeokuta North Local Government Area, IDI).**

Despite the differences that exist among the participants on the meaning of mental illness, they all seem to agree on causes of mental illness. In view of the above explanations, it is clear that the precise cause of mental illness is not known. Also, it is clear that mental illness is as a result of the combination of biological, cultural, and social factors.

Gender Differences in Mental Illness

With regard to perceptions whether mental illness affects males more than female respondents, 34.2% of male respondents reported that more males are affected than females while 48.2% of female respondents reported that more males are affected than females. Conversely, 50% of male respondents reported that more females are affected than males while 40.2% of female respondents reported that more females are affected than males.

There are different opinions on gender differences in mental illness. The following excerpts from KIIs attest to such differing opinions on mental illness.

> *Concerning drug abuse, we have 95% men and 5% women. Women are also prone to depression* **(Psychiatrist, Abeokuta North Local Government Area, KII).**

Another participant stated that:

> *Mental illness is more common in females than males. The ratio is 15:5. The age range is between 18 and 35 years which is as a result of a loss of loved ones, separation or divorce* **(Social Worker, Abeokuta North Local Government Area, KII).**

On the other hand, a Traditional healer stated his belief thus:

> *As Yoruba, males, and females are being affected by mental illness* **(Traditional healer, Abeokuta North Local Government Area, KII).**

Thus, it is believed that male and female are affected by mental illness in one way or the other. However, the proportion of females to males influenced by mental illness varies.

Women are more likely to be in psychotherapy than men (American Psychological Association, 2013). Over the years, findings have shown that females have a significantly higher risk of frequent mental distress.

According to the male respondents towards commonness of mental illness, 1.6%; 24.3%; 20.9% and 5.3% reported that mental illness is common to childhood; adolescence; older adulthood and any age respectively. On the contrary, 1.8%; 14.6%; 38.7% and 44.9% reported that mental illness is common to childhood; adolescence; older adulthood and any age respectively.

Findings revealed that in curability of mental illness, 72% of male respondents indicated that mental illness is curable while 28% do not accept that mental illness is curable. However, for female respondents, 91% indicated that mental illness is curable while 9% do not support that mental illness is curable.

In consideration of where mental illness can be cured for male respondents, 50%; 27.1%; 15.9% and 7.2% reported that mental illness could be cured in psychiatric hospitals; traditional homes; church and mosque respectively. On the other hand, for female respondents, 70%; 12.6%; 13.2% and 4.2% reported that mental illness could be cured in psychiatric hospitals; traditional homes; church and mosque respectively.

Attitude to Mental Illness

With regard to mental illness as a stigmatized condition, for male respondents, 50%; 27.1%; 15.9% and 7.2% reported that mental illness could be cured in psychiatric hospitals; traditional homes; church and mosque respectively. In contrast, for female respondents, 70%; 12.6%; 13.2% and 4.2% reported that mental illness could be cured in psychiatric hospitals; traditional homes; church and mosque respectively.

The rate of response by respondents on the attitude to mental illness was moderately impressive particularly among the caregivers/families of people living with mental illness. The following excerpts from KIIs and IDIs attest to this.

> *When my daughter committed homicide that was when I brought her to the psychiatric hospital where we eventually discovered that she has a mental illness. She is getting better, but I am scared of taking her home so that she won't kill another person in the family* ***(Caregiver, Abeokuta South Local Government Area, IDI).***

Another participant stated her reaction thus:

> *Mental illness runs in my family. No man is ready to take the hand of my daughter in marriage because they all believe that it is hereditary. In short, I am going to Mountain of*

*Fire and Miracles Ministries for deliverance (**Caregiver, Abeokuta North Local Government Area, IDI).***

On the other hand, a Psychiatrist expressed the following view:

*Three to four of our patients in this hospital have been neglected here. When we contacted their families, we were told that they were no more members of the family. Mental illness has brought a big shame to the family. We have been rehabilitating them for some time now **(Psychiatrist, Abeokuta North Local Government Area, KII).***

Another added that:

*The stigma attached to the illness is what makes it humiliating. The psychiatric hospital is a kind of label because it is secluded (***Caregiver, Sagamu Local Government Area, IDI)**

All the participants reported stigma as an example of the reaction of people towards them. There is the belief that stigmatisation and discrimination are the most critical challenges they face. These attitudes are the most fundamental problems people living with mental illness (PLWMI) often go through.

The gender differentials on the perception of mental illness significantly related with awareness of mental illness ($\chi 2$= 248.172), sources of knowledge ($\chi 2$= 11.439), causes of mental illness ($\chi 2$= 16.8585) and that it affects more males than females ($\chi 2$= 15.996). It is also significantly related with the commonness of mental illness ($\chi 2$= 32.368), curability of mental illness ($\chi 2$= 43.340), where mental illness can be cured ($\chi 2$= 39.243) and mental illness as a stigmatized condition ($\chi 2$= 6.882). This shows that there was a significant relationship between the gender differentials and perception of mental illness.

4.3 Availability of Mental HealthCare Services

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 centre and Islamic faith healing centre 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; christaian faith healing centre and Islamic faith healing centre respectively.

Another 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.

Table 4.5: Availability of Mental Healthcare Services by Gender

Characteristics	Gender Differentials		Total	$\chi 2$	Df	P-value	
Type of Mental Health Care Services Available	Male	Female		71.0474	3	< 0.00001	P<0.05 SIGNIFICANT
Modern medicine	200(62.1%)	346(69.5%)	546(66.6%)				
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				16.6934	2	0.000237	P<0.05
Primary healthcare services	30(19.7%)	35(8.9%)	65(11.9%)				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				11.1208	4	0.01109	P<0.05 SIGNIFICANT
Cheap Drugs	12(8.1%)	29(13.8%)	41(11.4%)				
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				0.6519	3	0.884457	P>0.05 NOT SIGNIFICANT
Cheap Drugs	12(28.6%)	25(31.3%)	37(30.3%)				
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**				
Primry Healthcare Services				4.799	3	0.197122	P>005 NOT SIGNIFICANT
Cheap Drugs	1(2.8%)	2(6.9%)	3(4.6%)				
Avoidable Services	3(8.3%)	5(17.2%)	8(12.3%)				
Qualified Professional Healthcare workers	9(25%)	2(6.9%)	11(17%)				
All of the above	23(64%)	20(69%)	43(66.2%)				
Total	**36**	**29**	**65**				

Source: Field Survey, 2016

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 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.

With regard to 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 to mental health care services are significantly influenced at $p \leq 0.05$ except for secondary health care services and primary healthcare services.

Thus, the qualitative data show that mental healthcare services are readily available in the community.

4.4 Access to Mental Healthcare Services

Just as the production of a commodity is not complete until when it gets to the final consumer/user, the availability of mental healthcare facilities is just-for-show until they are accessible to the users. This segment of the analysis presents the extent of accessibility of the available mental health facilities to the respondents.

With regards to the closeness of mental healthcare service, for male respondents, 39.3% reported that they travelled less than 5km to the mental healthcare services while 60.9% of female respondents reported that they travelled less than 5km to mental healthcare service. However, for male respondents, 60.7% reported that they travelled more than 5km to the mental healthcare services while 39.1% of female respondents reported that they travelled more than 5km to mental healthcare service.

With regards to how cheap the services rendered, for male respondents, 39.9% reported that the services rendered are cheap while 44.3% of female respondents reported that the services rendered are cheap. However, for male respondents, 25.2% reported that the services rendered are not cheap while 32.5% of female respondents reported that the services rendered are not cheap.

Table 4.6: Access to Mental HealthCare Services by Gender

Characteristics	Gender Differentials		Total	$\chi 2$	Df	P-value	
How close is the mental healthcare service to you?	Male	Female		36.7777	1	< 0.00001	P<0.05 SIGNIFICANT
Less than 5km	126(39.3%)	304(60.9%)	430(52.4%)				
More than 5km	195(60.7%)	195 (39.1%)	390(47.6%)				
The Services rendered are they cheap?				13.867	2	0.000975	P<0.05 SIGNIFICANT
Services rendered are cheap	128(39.9%)	221(44.3%)	349(42.6%)				
Services rendered are not cheap	81(25.2%)	162(32.5%)	243(29.6%)				
Can't Say	112(34.9%)	116(23.2%)	228(27.8%)				
Who pays for the service rendered in mental care service?				8.3216	2	0.015595	P<0.05 SIGNIFICANT
You	131 (40.8%)	162(32.5%)	293(35.7%)				
Family/ Relative friends	178(55.5%)	302(60.5%)	480(58.5%)				
Government	12(37.4%)	35(7%)	47(5.7%)				
What is the major means of transportation in your locality?				20.7796		0.00035	P<0.05 SIGNIFICANT
Car/Bus	284(88.5%)	477(95.6%)	761(92.8%)				
Motorcycle	20(6.2%)	15(3%)	35(4.3%)				
Bicycle	1(0.3%)	2(0.4%)	3(0.4%)				
Canoe	5(1.6%)	4(0.8%)	9(1.1%)				
Foot	11(3.4%)	1(0.2%)	12(1.5%)				
Total	**100.0**	**100.0**	**820**				
Number	**321(39.1%)**	**499(60.9%)**					

Source: Field Survey, 2016

Qualitative data buttress the points on access to mental health care services. The following excerpts from IDIs attest to different views on the access to mental health care services.

> *This child is my third child that will be visiting this psychiatric hospital. The hospital is very far away from where I live. The reason I came here despite the fact that it is far away from my community is that the services are very expensive. However, I want the government to subsidise them (***Caregiver, Abeokuta North Local Government Area, IDI).**

Another participant stated his opinion that:

> *Despite the fact the psychiatric hospital is far away, the services rendered are too expensive. I had to borrow money before I could bring my daughter here for treatment.* **(Caregiver, Sagamu Local Government Area, IDI).**

In relation to who pays for the services rendered in mental healthcare services, for male respondents, 40.8%; 55.5% and 34.9% reported that the respondents; family / relatives and

government respectively. On the other hand, 32.5%; 60.5% and 7% of female respondents reported that the respondents; family / relatives and government respectively.

In relation major means of transportation, for male respondents, 88.5%; 6.2%; 0.3%; 1.6% and 3.4% reported that car/bus; motorcycle; bicycle; canoe and foot respectively. On the other hand, 95.6%; 3%; 0.4%; 0.8% and 0.2% of female respondents reported that car/bus; motorcycle; bicycle; canoe and foot respectively.

The gender differentials by access to mental healthcare services with closeness to mental healthcare services ($\chi 2$= 36.7777), services rendered ($\chi 2$= 15.8117), who pays for the services provided ($\chi 2$= 26.618), principal means of transportation ($\chi 2$= 693.0848). The gender differentials by access to mental health care are significantly influenced at $p \leq 0.05$.

However, a participant has this to say:

> *The psychiatric hospital is very close to my house. But due to the critical condition of my son I was referred to this psychiatric hospital. The drugs and services are very cheap* **(Caregiver, Abeokuta South Local Government Area, IDI).**

Another added:

> *The traditional home is very far away from where I live (***Caregiver, Sagamu Local Government Area, IDI)**

The distance covered to access mental healthcare service was of extraordinary concern to all the participants. Some of the participants could not keep to clinic appointments because of the distance traveled. The importance of mental healthcare services is known to the participants. They expressed their opinions that there were no supportive mechanisms outside the hospital to manage their illness.

4.5 Use of Mental Healthcare Facilities

The section presents the discussion on the use of the available mental healthcare facilities.

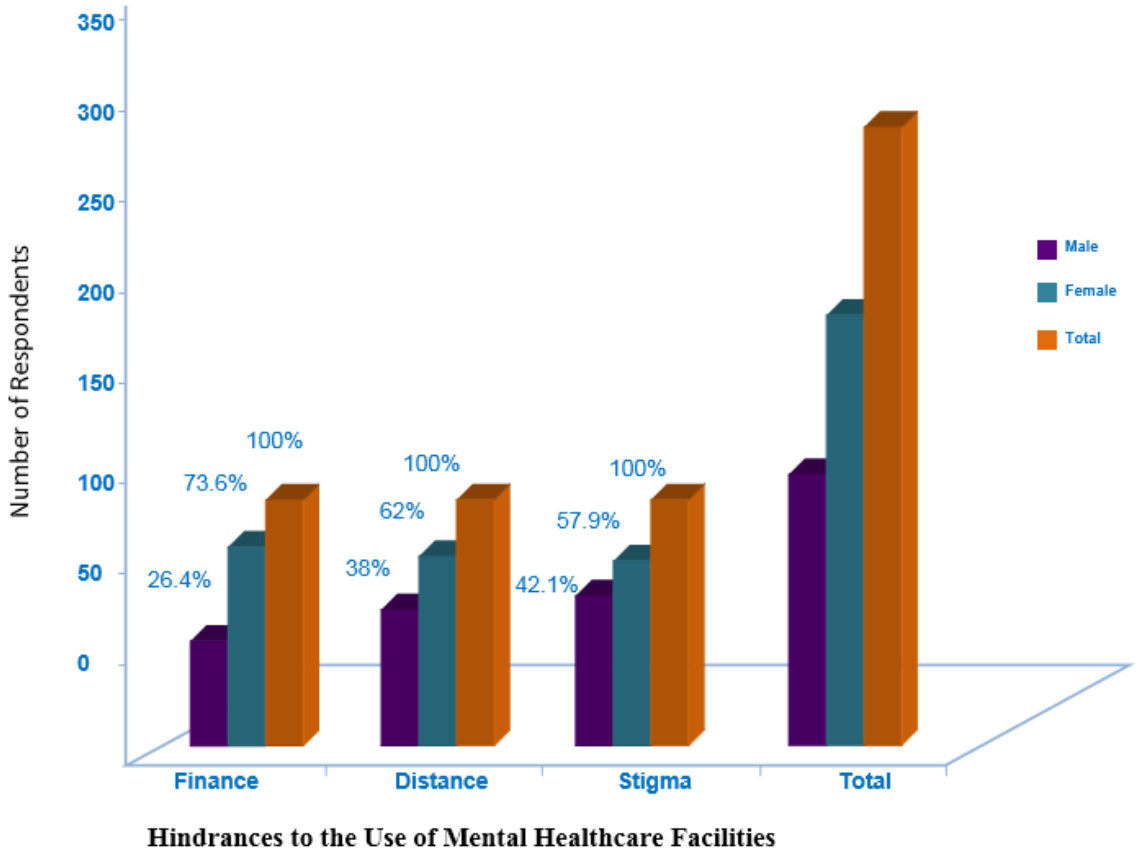

Figure 4.1: Hindrances to the Use of Mental Healthcare Facilities by Gender

Source: Field Survey, 2016

Here we examine the utilization of mental healthcare services in the study area. For male respondents, 26.4%; 38%; 28%; and 42.1% indicated that the hindrances to the utilization of mental healthcare services were finance; distance and stigma respectively while for female respondents, 73.6%; 62%; and 57.9% indicated that the hindrances to the utilization of mental healthcare services were finance; distance and stigma respectively.

It was deduced that the majority of the respondents who used the mental health services had a financial challenge in the utilization of mental healthcare services. The financial challenge suggests that the funding/subsidising of mental health care services may be required to ease the financial burden of the users of mental health care services in Ogun State.

The respondents expressed their views on the use of mental healthcare services. See the quote below:

> *My daughter makes use of the psychiatric hospital available in this community. She also use her drugs as prescribed by professional healthcare workers in the hospital. However, the major hindrance is finance. The drugs are too expensive* **(Caregiver, Abeokuta South Local Government Area, IDI).**

Another participant stated her reaction thus:

> *The major hindrance to the use of the hospital is distance. I had to lodge in a hotel so that my son can receive adequate treatment as at when due (***Caregiver, Sagamu Local Government Area, IDI).**

Another participant stated her reaction thus:

> *The major hindrance to the use of the hospital is finance. I had to borrow money from friends and relatives to ensure that my daughter is treated (***Caregiver, Abeokuta North Local Government Area, IDI).**

4.6 Choice of Mental Healthcare Facilities

With regard to the choice of mental healthcare threapy, for male respondents, 40.4%; 49.4%; 49.2%; 35% and 28.3% reported that the choice of mental healthcare therapy are spriritual; traditional; medical practictioner; traditional/ spiritual and psychiatrist respectively. On the other hand, 59.6%; 50.6%; 50.8%; 65% and 70.7% of female respondents reported that the choice of mental healthcare therapy are spriritual; traditional; medical practictioner; traditional/ spiritual and psychiatrist respectively.

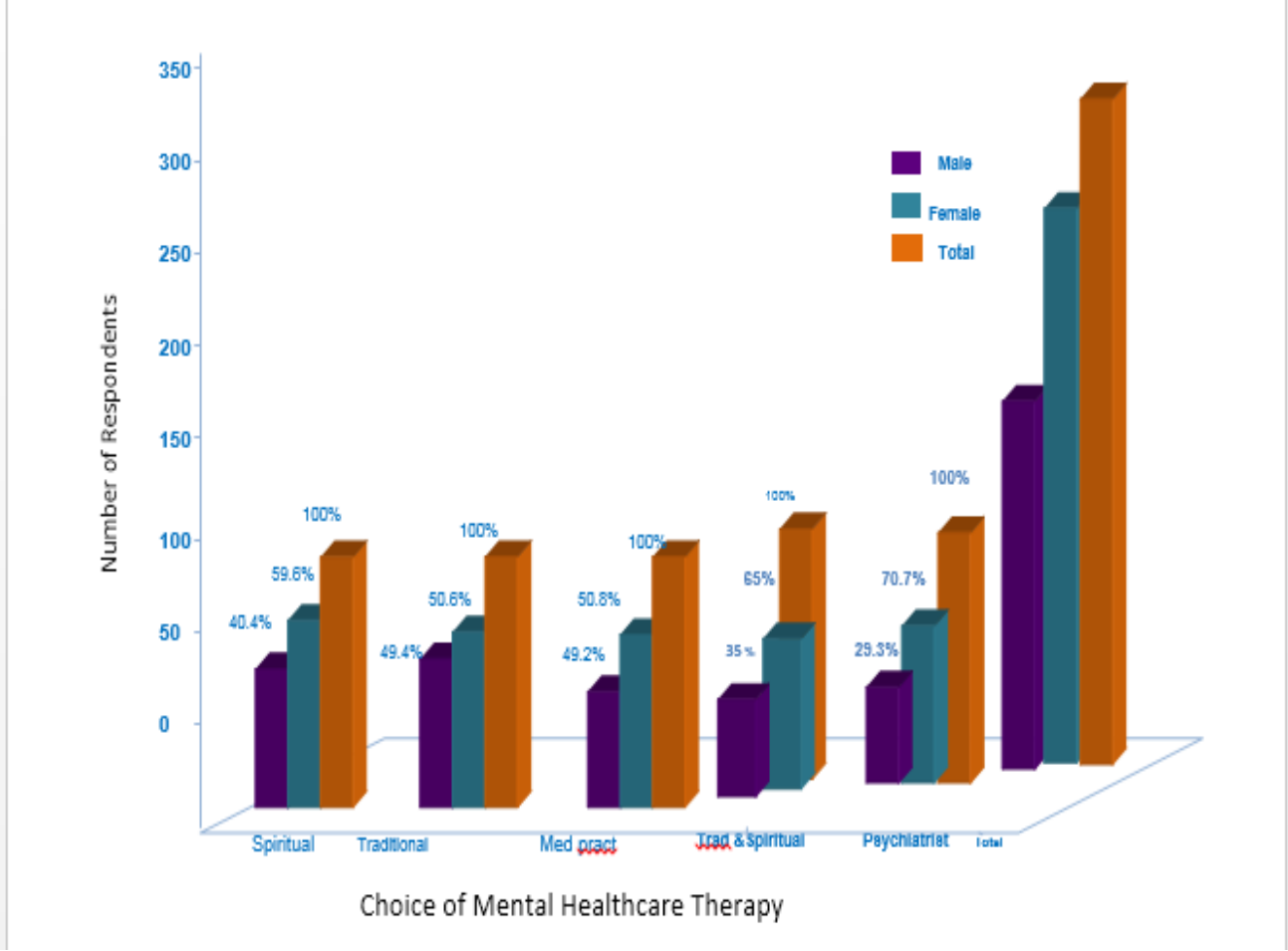

Figure 4.2: Choice of Mental Healthcare Facilities by Gender

Source: Field Survey, 2016

The Indepth interview participants expressed their views on the preferred treatment mental healthcare facilities available in the community. See the quote below:

> *I prefer to bring my son to the psychiatric hospital for treatment where prompt attention will be given to him. Also, the hospital has qualified professional healthcare workers. So with that am satisfied.* ***(Caregiver, Abeokuta South Local Government Area, IDI).***

Another participant stated her reaction thus:

> *I like the services rendered in psychiatric hospital. I have gone to traditional homes, but I don't like the way my daughter was chained to the tree. The traditional healer gave my daughter concoction to drink. Instead of the situation to improve it got worse. But since I brought her here, she has improved* ***(Caregiver, Sagamu Local Government Area, IDI).***

However, a participant has this to say:

> *I used both psychiatric hospital and spiritual. I believe that whatever happens in the physical has been settled in the spiritual. I was always going to church to pray for the healing of my cousin. In a nutshell, I used both psychiatric hospital and spiritual just for me to make sure that my cousin gets well as soon as possible* ***(*****Caregiver, Abeokuta North Local Government Area, IDI***).*

From the above, it could be deduced that respondents preferred pschyiatic hospitals despite the fact that it is believed that mental illness is caused by supernatural factors.

4.7 Gender Preference of Mental Healthcare Professionals

In the treatment of people living with mental illness, finding the preferred mental health professional(s) may serve as a first-aid therapy for people living with mental illness (PLWMI). This segment of this study reports the gender preference of mental healthcare professionals.

Table 4.7 shows the respondents' choice for the treatment of people living with mental illness (PLWMI). The respondents were not gender-biased as the respondents preferred both male and female health workers to treat people living with mental illness (PLWMI). Although, about 10% preferred male healthcare workers while 14% preferred female healthcare workers. About 20% have no preference, the emphasis of the majority is both male and female health worker.

Table 4.7: Gender Preference of Mental Healthcare Professionals

Preference of healthcare worker	**Gender**		**Total**	**X^2**	**Df**	**F**	**p-value**
	Male	Female				0.653	<0.00001
Male health worker	45(10.3%)	54(14.2%)	99(12.1%)	45.7392	3		
Female health worker	29(6.6%)	71(18.6%)	100(12.1%)				
Male and Female health worker	286(65.1%)	168(44.1%)	454(55.4%)				
No preference	79(18%)	88(23.1%)	167(20.4%)				
Total	**439**	**381**	**820**				

Source: Field Survey, 2016

***** Chi-Square Tests Result

Table 4.7 revealed the chi-square test of a relationship. It shows that there is significant difference between males and females in the gender differences of mental healthcare professionals (P-value is 0.00001). Male overwhelming have no gender preference in who teat them unlike female.

Below are excerpts that clearly describe gender preference of mental healthcare professionals:

> *As for me, I prefer both male and female healthcare workers to take care of my son. Remember that there is a saying that 'we care but God heals' irrespective of the gender, all I want is that my son should be healthy.* ***(Caregiver, Abeokuta North Local Government Area, IDI)***

Another position on gender preference of mental healthcare professional is as follows:

> *I prefer a male healthcare worker. The reason is simply because of the experience of the healthcare workers involved.* **(Caregiver, *Sagamu Local Government Area, IDI).***

Another Caregiver has a different opinion on gender preference of mental healthcare professionals;

> *I prefer a female healthcare worker to take care of my daughter. The reason for my preference is that female healthcare worker has sympathy than male counterpart* **(*Caregiver, Abeokuta South Local Government Area, IDI*).**

Another position on gender preference of mental healthcare professional as given by a female respondents is as follows:

> *I prefer a female healthcare worker. The reason is that women are naturally caring and emotional than male healthcare workers.* **(Caregiver, *Abeokuta North Local Government Area, IDI).***

4.8: Gender Roles in Household Decision making on the Treatment of Mental Illness

The role of gender in the household decision making concerning the healthcare of people living with mental illness (PLWMI) is analysed and discussed below.

Table 4.8: Gender Roles in Household Decision making on the Treatment of Mental Illness

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	0.325	2	0.162	0.653	0.521
Within Groups	203.682	818	0.249		
Total	204.007	820			

Source: Field Survey, 2016

***** ANOVA Result

Analysis of Variance (ANOVA) was done and the results presented in Table 4.8. The table showed that there is no significant relationship between males and females in the expected roles of family members in the treatment of mental illness.

The respondents expressed their views on gender role in decision-making for the treatment of mental illness quoted below:

> *The government should provide for the needs of anyone who is mentally ill just like what is obtainable in the United States. I also believe that in taking care of the mentally ill, everyone is involved. It is everyone's business.* ***(Caregiver, Abeokuta South Local Government Area, IDI).***

Another participant responded as follows:

> *The government should cater for needs of the mentally ill. National Health Insurance Scheme (NHIS) can help out if the government cannot take full responsibility. However, parents (mother and father) should take care of their children when sick especially in this kind of situation* ***(Caregiver, Sagamu Local Government Area, IDI).***

Another female participant stated as follows:

> *The mother should cater for needs of the mentally ill. Mothers are emotional and are naturally caring.* ***(Caregiver, Sagamu Local Government Area, IDI).***

Another added that:

> *The need of the mentally ill should be provided by the government. Family members should take care of the mentally ill* ***(Caregiver, Abeokuta North Local Government Area, IDI).***

Another participant stated thus:

> *The mother should cater for needs of the mentally ill. Fathers don't have time in the family. Their responsibility is to provide money* ***(Caregiver, Abeokuta South Local Government Area, IDI).***

CHAPTER FIVE

DISCUSSION

5.1 Discussion of Findings

The discussion of the research findings shows the aspect of the data collected that are unique, supported by literature and contribute to knowledge by extending the literature. This discussion covers other sub-themes such as perception, definition, and causes of mental illness, availability, access, choice, ultilisation of mental healthcare services in the study area, gender preference of mental healthcare professionals and gender role in decision-making in the management of mental illness.

The Yoruba terminology for mental illness is a vast knowledge; the term '*were*' was used by Jegede (2002), Erinosho (2010) and Olugbile, Zachariah, Kuyinu, Coker, Ojo and Isichei (2009). As earlier observed by Jegede (2005, 2010) and Erinosho (2010), indigenous knowledge of the illness informed the local name, based on the causes of the illness. Similarly, the Yoruba people also viewed '*were*' as '*Àrun Opolo'* symbolising 'brain syndrome'. Another local name ascribed to the illness among the Yoruba in Nigeria is '*Alaaganna*'. However, there has not been any comprehensive sociological investigation of the etiology of the illness in this study area.

The results obtained and analysed in this study showed that there was a significant association between perception of mental illness and gender. Available data revealed that mental illness is known widely among the Yoruba of Ogun State, Nigeria, with the majority of the respondents (82%) being aware of the illness. The perception of mental illness varies by gender. Invariably, gender differences exist in the study area. Knowledge is very vital to practice. What you are not aware of, you may never practice except by mistake. The statistical analysis demonstrates that knowledge of mental illness is significantly associated with gender.

Sources of mental illness had a significant association with gender. Respondents' knowledge of mental illness emanates from seven sources, which include friends, parents/relatives, media, hospital, Christian faith healing centers, Islamic faith healing centers and traditional healers. For male respondents, 18.4%; 18.7%; 31.5%; 19.3%; 3.4%; 2.2% and 6.5% got their information of mental illness from friends; parents/relatives; media; hospitals; christain faith healing centre; Islamic faith healing centre and traditional healers respectively. In contrast, female respondents,

17.6%; 21%; 22.4%; 26.9%; 3.2%; 2% and 6.8% got their information of mental illness from friends; parents/relatives; media; hospitals; christain faith healing centre; Islamic faith healing centre and traditional healers respectively. The media had the highest percentage of sources of information on mental illness. Invariably, the media have put a lot of effort towards the creation of awareness about mental illness.

Further findings from this study revealed that causes of mental illness had a significant association with gender. Most females (43.9%) and males (44.7%) believed in mystical factors as one of the leading causes of mental illness. This result is in line with the findings by Adewuya and Makanjuola (2008) and Adewuya and Oguntade (2007). This finding is contrary to the apriori expectation, as found in Gureje, Lasebikan, Ephraim-Oluwanuga, Olley, and Kola (2005) who posted that poor knowledge of causation of mental illness was common in Ogun, Osun and Oyo States in Nigeria. According to a study carried out by Ahmed, Sun, and Nazar (2015), people all over the world have diverse explanatory viewpoints concerning the nature, sources, and interventions for mental illness. The belief in the mystical forces is strengthened in day-to-day cosmology in Nigeria. Health is observed as being underpinned by spiritual dimensions (Oluwole, 1995; Gureje do, 2005; Ojua and Omono, 2012). This view is similar to the findings of Ukpong and Abasiubong (2010) and Ani, (2004) that the ascription of mental illness to mystical causality is not limited to the illiterates.

Results show that 34.2% of male respondents reported that more males are affected than females while 48.2% of female respondents reported that more males are affected than females. Conversely, 50% of male respondents reported that more females are affected than males while 40.2% of female respondents reported that more females are affected than males. However, the result showed that gender differences exist in the perception and treatment of mental illness. Traditionally, people are not interested in discussing mental illness in Nigeria (Bakare, 2014).

Findings from this study revealed that there are significant gender differences in the commonness of mental illness. Results also suggest that mental illness affects anyone irrespective of age and gender. This result is similar to the findings by Steel, Marnane, Iranpour, Chey, Jackson, Patel and Silove (2014). According to Patel, Flisher, Hetrik and McGorry (2007), mental illness affects persons at any phase of life. The result further showed that there are significant gender differences

with regard to the perceived curability of mental illness. This result is in line with the findings of Oyewunmi, Olabode, Oluwole, and Ayannike (2015) and World Health Organisation (2003). Qualitative data corroborated this position.

There were differences between men and women with regard to where mental illness can be cured. Male (50%) and female (70%) believed that mental illness could be cured effectively in psychiatric hospitals. However, this is contrary to the findings of Hailemariam (2015); Adewuya and Makanjuola, (2009); Aneibu and Ekwueme (2009) and Kabir *et. al.*, (2004) who observed that the most preferred treatment of mental illness is spiritual/traditional healers. In Nigeria, it is evident that religious conviction demonstrates an imperative role in the health belief system of the people. The study conducted by Jack-Ide, Makoro and Azibiri (2013), revealed that sacred/spiritual mode of care provide the trust with God being 'in charge' and having the supremacy to defeat every single underhandedness spell from an adversary. Due to the perceived causes (supernatural) of mental illness, the traditional experts and spiritual therapists are the single persons to assist the patients getting respite from the disorder (Ganesh and Udoh, 2012).

Further findings from this study revealed that there are significant gender differences in the perception of mental illness as a stigmatised condition ($P<0.05$). There has been the association of mental illness with several misconceptions such as the false impression that people living with mental illness are unsafe and fierce. Stigmatisation and prejudices against people living with mental illness are prevalent in the world. For decades, people living with mental illness (PLWMI) are seen with a feeling of a doubt (Porter, 2002). This assertion is in line with the findings of Barke, Nyarko, and Klecha, (2011); Botha, Koen, and Niehaus (2006) and Crabbb, Stewart, Kokota, Masson, Chabunya, and Krishnadas (2012). It also corroborated the findings of Sadik, Bradley, Al-Hasoon, and Jenkins, (2010); Ukpong and Abasiubong (2010) and Gureje, Lasebikan, Ephraim-Oluwanuga, Olley and Kola (2005; 2006). This position was corroborated by qualitative data. This trend confirmed that in Nigeria, stigmatisation of mental illness is widespread.

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 centre and Islamic faith healing centre 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;

christaian faith healing centre and Islamic faith healing centre respectively. However, this is contrary to preceding studies in Nigeria that revealed that numerous semi-urban and rural societies are assisted by a massive number of traditional healers (Odejide and Morakinyo, 2003). Also, in the work by Westbrook (2011), roughly 70 percent of mental health treatment is delivered viz-a-viz non-orthodox approaches. In Nigeria, modern medicine exists and plays a noteworthy part in the management of mental illness.

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. This result is in line with the findings of Jack-Ide, Azibiri, and Igoni, (2014) which posited that there is no provision of mental health services. The qualitative data also corroborated this finding. The results obtained and analysed 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.

Numerous scholarly works have discovered male and female disparities in health care services. The results obtained and analysed in this study showed that there is a significant association between access to mental healthcare services and gender. This finding is at variance with the work by Omonona, Obisesan, and Aromolaran (2015) which posited that uneven access to contemporary healthcare is evident in Ogun State. However, in the work by Rhodes, Goering, To, and Williams (2002), women access mental health care facilities more frequently, receive treatment more often, and have higher rates of hospitalisation for psychiatric problems than men. These variations may have repercussions for the diagnosis and therapy women receive. Findings from the study confirm previous work by Omonona, Obisesan, and Aromolaran (2015) which showed that utilisation of the possibility of gaining access to mental healthcare amenities upsurges with closeness to the health centers. This proximity is required to diminish their rate of transportation and thoroughness of approachability to distant modern healthcare services. However, the statistical analysis showed that there were significant gender differences with regard to closeness to mental healthcare services.

The result showed that for male respondents, 39.3% reported that they travelled less than 5km to the mental healthcare services while 60.9% of female respondents reported that they travelled less than 5km to mental healthcare service. However, for male respondents, 60.7% reported that they travelled more than 5km to the mental healthcare services while 39.1% of female respondents reported that they travelled more than 5km to mental healthcare service. This result shows that the majority of the respondents were females. Male-headed households had more access to mental health care services than female-headed households. This result is in line with the findings by Omonona, Obisesan, and Aromolaran (2015) who posited that males headed family units had greater access to mental healthcare services than a female headed family units. Further findings from this study revealed that there were significant gender differences with regards to services rendered. The results obtained and analysed showed that there were significant gender differences with regard to who pays for the services provided.

The results obtained and analysed in this study showed that there was a significant association between the use of mental healthcare facilities and gender. The result showed that 33.3% of male respondents had used mental health care services while 66.7% of the female respondents had used mental health care services. This finding corroborated the works of Oliver, Pearson, Coe and Gunnel (2005) which reported that men were less likely to seek help. 43% of the male respondents had never used mental health services while 57% of the female respondents had never used mental health care services. In the findings by Bertakis, Azari, Helms, Callahan and Robbins (2000) women have higher medical care service utilisation. For Bebbington, Meltzer and Brugha. (2000) people who have mental illness often do not seek professional help. Not ever married, separated and legally separated men have higher general admission proportions to mental health amenities than women in similar marital status categories. Interestingly, women in matrimony have greater hospital admission rates than men in matrimony (Dennerstein, Astbury, and Morse, 1993).

Further findings revealed that the significant barrier in the use of mental healthcare services was finance. This finding is contrary to apriori expectation, as found in Stuart (2008), Levin, (2001), Shibre, Nagash and Kullgren, (2001), Audu *et al*., (2011) all of whom posted that people living with mental illness fail to use medical care because of stigmatisation. A crucial part in the effective use of mental health care service is funding. Financing of mental healthcare services in developing countries has a tendency to be low. This slow funding pace might be because of the stigmatising

attitudes towards mental illness (Horvitz-Lennon *et al*., 2006). The results obtained and analysed in this study indicated that most of the female respondents preferred psychiatrist to the spiritual/traditional healers. This finding confirms the assertion of Gureje, Lasebikan, Kola, and Makanjuola (2006) that general medical practitioners mostly provided treatment of people living with mental illness; just a couple were cured by alternative practitioners such as traditional healers. However, in the findings by Omoleke (2010), Yoruba people prefer the traditional mode of treating mental illness to the modern method. Perhaps, this is because the traditional medicine employs the use of diabolical forms in the treatment of people living with mental illness. Qualitative data also corroborated this position.

The results showed that the reason for the determinants of respondent's preference in the treatment choice of mental illness was the belief that mental illness was as a result of supernatural factors. Qualitative data collected also corroborated this position. The four determinants of mental illness identified in this study are the belief that the illness is due to supernatural factors (35.7%); influences of relatives and neighbours (22.8%); stigma related with mental illness (26.6%) and deficiency of funds (14.9%). Out of these four, the prominent determinant is the belief that the illness is due to supernatural factors. The implication from this is that natural means or factors might not have caused mental illness, but that the reason is natural human occurrences. The results obtained and analysed in this study showed that the mother of the mentally ill should be the last option in the choice of who should take care of people living with mental illness (PLWMI) among the Yoruba. There were significant associations between gender and attitude to people living with mental illness. The female held more hostile attitude than male respondents (Chikaodiri, 2009). These findings buttressed the fact that mother may be more affected psychologically than any other member of the household.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Summary

In the last decade, there has been the conduct of substantial amount of research in gender and mental health. Human beings react differently when ill, in the acknowledgment of illness and time of recovery, and the way their families and society treat women and men.

Taking gender into consideration is essential for understanding a mental health condition. The existence of gender differences in the demographic characteristics and mental health conditions has been well established in the study area. The issue of gender cannot be separated from the concept of mental health as practiced in Nigeria, Africa, and other Third World countries. A major health problem area for women is that of mental health. Series of studies point out that females are excessively pretentious by mental illnesses. In addition, there is a close association between their vulnerability and marital status, work, and roles in the society. Women's mental health status is determined by economic views, environmental factors, community, socio-cultural, social support, stressors, life happenings, individual behaviour, availability and access to health services.

In order to differentiate females' mental health-related issues from that of males, it might be said that definitions may possibly include, but not restricted to disorder, diseases, and illnesses, which occur more commonly in females. Females' psychological well-being also extends beyond exact conditions or difficulties; they include the arrangements that oversee the healthcare delivery system, the procedures that influence females' dealings with the healthcare structure and the factors that determine whether the treatment received is gender sensitive. There can be the compromise of the quality of care if there is no understanding of gendered, social model of health.

The study examined the gender differentials in the perception and treatment of mental illness among the Yoruba of Ogun State, Nigeria. The study identified the perception of male and female on mental illness which include; knowledge, attitude, causes and where to get cure or treatment for mental illness. The study also examined the availability, access, utilisation, and choices of mental health care services. There was also the investigation into the gender preferences of mental

health care professionals in the treatment of mental illness. Also, there was the examination of gender role in the treatment of mental illness.

The study identified various variables that affected the perception of mental illness. It also examined male and female differences in the perception and treatment of mental illness amongst 967 respondents in carefully chosen Local Government Areas in Ogun State. Awareness of mental illness among the respondents was quite impressive and the perception of mental illness varied by gender. Discoveries from the study showed that more females than males had knowledge of mental illness. Chi-square revealed that the perception of mental illness by gender significantly influenced at $p \leq 0.05$. The majority (82%) of the respondents had a high awareness of mental illness. Female respondents that were aware of mental illness were 73.4% while male stood at 79.6%. Most males got sources of information on mental illness from the media while most of the females got information on mental illness from the psychiatric hospital. Both males and females believed that the primary cause of mental illness is supernatural. The female respondents also believed that mental illness affects more males than females. Both male and female respondents opined that mental illness occurs at any age. It is not surprising that males and females are of the opinion that mental illness has cure despite the fact that supernatural factor was the most mentioned primary cause of mental illness. Female respondents (43.9%) attributed the causes of mental illness to be mystical sources while the male counterpart (34%) attested to it. Males and females believed that the cure for the treatment of mental illness is in psychiatric hospitals. The findings revealed that large proportion of female respondents (26.9%) got to know about mental illness from the hospital while a large percentage of male respondents (31.5%) got to know about mental illness from the media. A higher proportion of female than male respondents believed that mental illness could be cured in psychiatric hospitals. Findings from the qualitative study show that people living with mental illness are stigmatised in the society.

Findings from the study also revealed that there are significant gender differences by availability to mental healthcare except for secondary healthcare services and primary health care 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 patronised tertiary services more than other pathways to mental illness treatment.

The perception of mental illness differs across gender and this, in turn, affects the utilisation of mental health care facilities in the study area. The treatment of mental illness is influenced by the access, availability, use, and choice of mental health care amenities. A nation that has access and ultilisation of decent healthcare services will probably appreciate preferred health (well-being) over one that doesn't. For instance, industrialised nations have a universal healthcare system, have elongated lifespan compared to developing nations. The study revealed respondents adherence to treatment and rehabilitative measures of mental illness. Entrée Qualitative findings substantiated the validity of the quantitative data. However, treatment options, that is, availability, access, use and choice of mental health care services affect male and female.

The study also examined the choice of mental health care services. Most of the respondents preferred psychiatrists to any other treatment options. This is surprising because most of the respondents believed that the main cause of mental illness is supernatural. One of the significant findings of the study was the preference of mental health care professionals by male and female differences. The chi-square result showed that the gender differentials by the preference of mental health care professionals are significantly influenced at $p \leq 0.05$. This means that both male and female preferred male and female health care professionals because of their knowledge in the treatment of mental illness. The study also revealed that mothers (as caregivers) take full responsibility for the treatment of mental illness. This is solely as a result of the psychological and emotional attachment women have in the family.

6.2 Conclusion

This study concludes that gender differences largely influenced the perception and the treatment of mental illness. The availability and choice of mental healthcare services towards improving the mental health of adults were key factors that could impact the mental health status of adults.

Variations in perception of mental illness by gender also take place in the study area. In addition, there was a high level of awareness which also translates to adequate knowledge of the illness. This is because of the traditional norms related with the causality of mental illness in the study area varies from the systematic clarification of the illness, which in turn impacts the behavior of the people.

Female professionals were perceived better to appreciate peculiar nature and health challenges of women. They were also considered as more empathic and tolerant in the handling of mental illness affecting the female gender. The household support remains significant towards effective treatment and rehabilitation of the mentally ill. There is a need for availability of more facilities and health personnel for the special care of the mentally ill.

6.3 Recommendations

The following recommendations were made based on the findings of the study:

1. The government should improve the quality of mental healthcare facilities: Mental health facilities have an imperative role to perform by relieving the suffering that is associated with mental illness, such as behavioural pathology, distress, emotional and psychological disorders. Women abused, those disturbed by political viciousness, suicide attempters are hooked to sedatives and alcohol, and specifically, those who undergo severe mental illness can be assisted considerably by experienced mental healthcare professionals. Despite this, mental health care service professionals are scarce in the selected study area. Well-trained specialists are limited, drugs and psychosocial interventions are either inaccessible or of pitiable quality, and even where proficiency and means exist, they rarely spread to the communities where they are greatly needed.

2. There should be the mainstreaming of male and female viewpoints in the mental healthcare sector. Mainstreaming can be done by enlightening womenfolk of the society regarding the likelihood of the intervention available for mental health and probable services and programme that is significant to accomplish the improvement of emotional well-being. The expansion of community-based development platforms may work on the commitment of women to their indigenous societies and their dedication to community health of members of the family. Formal mental healthcare amenities which comprise balanced treatment strategies for psychotropic prescriptions and the trustworthy delivery of sufficient goods at convincing prices (carefully chosen all-purpose antidepressants, antipsychotic and anticonvulsant medications) must be supplemented by non-medical interest and backing groups, consumer groups and therapeutic establishments that make available vital care in societies.

3. The government should subsidise the cost of treating mental illness. This subsidy is to enable the proper management of People Living with Mental Illness (PLWMI). There is a need for financial investment to have sustainable programmes, and creativity is required to figure out policies and programmes that link local resources with expert knowledge.

4. Stakeholders should encourage efforts to develop gender policies and to make females essential in planning, formulation, and implementation of policies on mental healthcare services: Women comprise the huge bulk of caretakers of first and last option for adults who have a mental illness. Negligibly, it is in a community's long-term social interest to support with this encumbrance through formal health services. Also, since women are central to the attainment of health policies, their involvement in formulating mental health policies should be encouraged. Governments, international organisations and NGOs should outline ways for women to exercise leadership roles. There may be the assessment of policies by women's groups not only concerning how they support women's mental health but also regarding the quality of services provided to women, children and men.

5. The Populace should be enlightened and educated on the effect of stigmatisation of the People Living with Mental Illness (PLWMI) irrespective of the gender. Anti-stigma efforts should include interventions for People Living with Mental Illness (PLWMI) and not completely giving attention to public attitudes. There should be the conduct of awareness creation programmes through the

media, colloquiums, seminars, Government and Non-Government Organisations (NGOs) about nature and management attitudes to mental illness on the general public.

6.4 Contributions to Knowledge

This research work contributed to existing knowledge in the following ways:

1. This study has succeeded in widening knowledge about perceived causes of mental illness.

2. The study expanded the scope between male and female differences in mental health, by contributing significantly to gender role and the treatment of mental illness in Nigeria with particular reference to the Yoruba people of Ogun State which has been neglected in most studies globally.

3. Academically, the study contributed significantly to the field of medical sociology

4. Academically, the study widened the frontiers of gender studies to include interest in mental healthcare

5. As regard policy implication, the study serves as a pointer for policymakers in addressing the issue of mental illness in Nigeria which is characterised by patriarchal nature (male dominance) where the voice of women is seen but not heard.

6. The study also contributed in addressing the attitude to mental illness especially the issue of stigmatisation.

7. The study also serves as an addition to the practical knowledge of healthcare experts such as health educators and social workers in the area of awareness and sensitisation about the myths associated with mental illness.

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APPENDIX I

INFORMED CONSENT FORM

Title of Research: Gender Differentials in the Perception and Treatment of Mental illness among Yoruba of Ogun State, Nigeria.

Name of Researcher: Olawande, Tomike Ibironke of Covenant University, Ota, Ogun State.

Sponsor of research: This study is sponsored by Olawande, Tomike ibironke

Purpose of the research: The study is purely for academic purpose

Procedures: You are encouraged to take part in this research and kindly fill the questionnaire which will be given to you. If you do not wish to answer any of the questions asked in the questionnaire, you may say so and can move on to the next question. Also, the information recorded is considered confidential, and no one else except the researcher will have access to the information documented during the research.

Expected duration of research and of participant (s) involvement: Filling the questionnaire will last for approximately 30 minutes. The possible duration for the In-depth Interview and Key Informant Interview for specific participants will last for about twenty minutes while expected duration for the whole study will last for about four hours.

Discomforts and risks: As with any research, the only possible discomfort you might experience from participation in this study is that you could be uncomfortable answering certain questions. The participants may suffer emotional distress because of some personal significance of the study to them. For this reason, you may decline to answer any or all of the questions, or you may stop participating at any time.

Costs to the participants, if any, of joining the research: Your participation in this research will not cost you anything. However, an adage says, 'Time is money'. In view of this, time is a factor for consideration.

Benefits: There will be no direct benefits to you but the information obtained from this study will help to provide suggestions that will enable the researcher develop appropriate programmes for policy makers on gender differential in the perception and treatment of mental illness in Nigeria.

Statement of Confidentiality*:* Your participation in this research is confidential. The researcher, Supervisors and Ethnic Review Committee will have access to the tape recorder (if permitted) and transcription of your interview along with any information that discloses your identity in this research. All this information and materials will be in care of *Olawande Tomike.* Also, in the event

of publication of this research, no personally identifying information will be disclosed. Pictures taken in the course of this interview will be used for academic purpose alone and with your permission alone which is taken as granted through appendage of your signature to this inform consent form.

Voluntariness: Your participation in this research is entirely voluntary.

Alternatives to participation: You do not have to take part in this research if you do not wish to. You may end your participation at any time without penalty by telling the researcher.

Due inducement(s): You will be compensated for lost wages; cost of transport to and from the research site but you will not be paid any fees for participating in this research.

Consequences of participants' decision to withdraw from research and procedure for orderly termination of participation: You can also choose to withdraw from the research at anytime. Please note that some of the information that has been obtained about you before you chose to withdraw may have been modified or used in reports and publications. These cannot be removed anymore. However the researcher promise to make good faith effort to comply with your wishes as much as is practicable.

Modality of providing treatments and action(s) to be taken in case of injury or adverse event(s): If you suffer any injury as a result of your participation in this research, you will be treated at the NHIS Clinic, Neuropsychiatric Hospital, Aro and also at a centre nearer to their place of residence probably at the Hospital's designated primary health care at the various Local Government Areas.

What happens to research participants and communities when the research is over:

The researcher will inform you of the outcome of the research through a news bulletin. During the course of this research, you will be informed about any information that may affect your continued participation or your health.

Statement about sharing of benefits among researchers and whether this includes or exclude research participants: There is no plan to contact any participant now or in future about such commercial benefits.

Any apparent or potential conflict of interest: Not aware of any other information that may cause the researcher not to do their work with fear or favour.

Statement of person obtaining informed consent:

I have fully explained this research to _____ and have given sufficient information, including about risks and benefits, to make an informed decision.

DATE: _____ SIGNATURE: _____

NAME: _____

Statement of person giving consent:

I have read the description of the research or have had it translated into language I understand. I have also talked it over with the doctor to my satisfaction. I understand that my participation is voluntary. I know enough about the purpose, methods, risks and benefits of the research study to judge that I want to take part in it. I understand that I may freely stop being part of this study at any time. I have received a copy of this consent form and additional information sheet to keep for myself.

DATE: _____ SIGNATURE: _____

NAME: _____

WITNESS' SIGNATURE (if applicable): _____

WITNESS' NAME (if applicable): _____

Detailed contact information including contact address, telephone, fax, e-mail and any other contact information of researcher(s), institutional HREC and head of the institution: This research has been approved by the Ethics Committee of the Neuropsychiatric Hospital, Aro and the Chairman of this Committee can be contacted at DRT's Office, Postgraduate Building, Neuropsychiatric Hospital, Aro.

E-mail: **hrec@neuroaro.com**.

In addition, if you have any question about your participation in this research, you can contact the principal investigator, Name……..Department……... Phone…….. and Email…….You can also contact the Head of the Neuropsychiatric Hospital, Aro at …..……..

PLEASE KEEP A COPY OF THE SIGNED INFORMED CONSENT.

APPENDIX II

Questionnaire

Department of Sociology

College of Business and Social Sciences

Covenant University, Ota, Ogun State

Questionnaire No……

Dear Respondent,

I am a Postgraduate student of Covenant University and I am conducting a research on **GENDER DIFFERENTIALS IN THE PERCEPTION AND TREATMENT OF MENTAL ILLNESS AMONG THE YORUBA OF OGUN STATE, NIGERIA** in partial fulfilment of the requirements for the award of a doctorate degree in the Department of Sociology. I want to seek your permission to respond to interview that will take a little minute of your time. The interview will last for about one hour and you are free not to answer any question that you are not comfortable to answer. You are also free to withdraw your participation in the study without any consequence on you benefiting from any benefit that the result of the study may provide now or in the future. I assure you that the information provided will be used solely for academic purposes without any record of your identity.

Thank you for your anticipated cooperation.

Olawande Tomike

If you accept to participate in this study, please tick the box ☐

Date of interview: Day ☐ Month ☐ Year ☐

Local Government Area: _____

Ward: _____

Town/ Village: _____

INSTRUCTION: Tick corresponding codes to your choice of answer, provide answers to the open ended questions and where necessary, tick or provide multiple answers.

SECTION ONE: SOCIO-DEMOGRAPHIC CHARACTERISTICS

S/N	QUESTION	RESPONSES	CODES
1	What is your gender?	Male Female	1 2
2	How old were you as at your last birthday?	……. (In years)	
3	What is your marital status?	Single Married Separated Divorced Widowed	1 2 3 4 5
4	What is your religion?	Christianity Islam Traditional	1 2 3
5	What is your highest level of education?	No education Primary education Junior /Senior Secondary Education Post Secondary Education	1 2 3 4
6	Occupation	Artisan Trader Civil servant Farmer Pensioner Cleric/Spiritualist Unemployed	1 2 3 4 5 6 7
7	How long have you been living in this community?		
8	What is your current family type?	Nuclear Extended	1 2
9	What is your current form of marriage?	Monogamy Polygyny	1 2

SECTION TWO: PERCEPTION OF MENTAL ILLNESS

S/N	QUESTION	RESPONSES	CODES
10	Do you know about mental illness	Yes No	1 2
11	How did you know about mental illness?	Friends Parents/Relatives The media Hospitals Christian faith healing centre Islamic faith healing centre Traditional healers Other (Please Specify)	1 2 3 4 5 6 7 8
12	What are the causes of mental illness?	Natural Supernatural Hereditary Preternatural Other (Please Specify) ……	1 2 3 4 5
13	Does mental illness affect the male gender more than female?	Yes No Can't say	1 2 3
14	Mental illness is common among which of the following?	In childhood In adolescence In older adulthood At any age	1 2 3 4
15	Do you think mental illness is curable?	Curable Not Curable	1 2
16	If yes, where can it be cured?	Psychiatric hospitals Traditional healers Church Mosque Other (Please Specify)	1 2 3 4 5

17	If answer to question 15 is No, why do you think it can't be cured?		
18	Is mental illness is a stigmatized health condition?	Stigmatized disease Not a stigmatized disease Can't say	1 2 3

SECTION THREE: AVAILABILITY OF MENTAL HEALTHCARE SERVICES

S/N	QUESTION	RESPONSES	CODES
19	What type of mental health care service is available in this community?	Modern medicine Traditional medicine Christian Faith healing centre Islamic faith healing centre Other (please specify)	1 2 3 4 5
20	If answer to question 19 is modern medicine, specify?	Tertiary healthcare services Secondary healthcare services Primary healthcare services	1 2 3
21	Which of the following is made available in options chosen in question 20?	Cheap drugs Affordable services Qualified professional Healthcare workers All of the above None of the above	1 2 3 4 5

SECTION FOUR: ACCESS TO MENTAL HEALTHCARE SERVICES

S/N	QUESTION	RESPONSES	CODES
22	How close is the mental healthcare service to you?	Less than 5km More than 5km Other (please specify)	1 2 3
23	Are the services rendered cheap?	Yes No Can't say	1 2 3
24	If yes, how much is the cost of services rendered		
25	Who pays for the service rendered in mental care service	You Family/ Relative friends Government Other (Please Specify)	1 2 3 4
26	What is the major means of transportation in your locality?	Car/Bus Motorcycle Bicycle Canoe Foot	1 2 3 4 5

SECTION FIVE: USE OF MENTAL HEALTH CARE SERVICES

S/N	QUESTION	RESPONSES	CODES
27	Have you ever made use of mental health services?	Yes No	1 2
28	How often are you expected to come to the mental health clinic or traditional homes for treatment?	Daily Once a week More than once Once a month Twice in a month Never Other (specify)……	1 2 3 4 5 6 7
29	How often do you use your medications (drugs or herbal)?	Every day as prescribed When I remember When it is convenient Occasionally	1 2 3 4
30	What hinders you from using mental health services?	Finance Distance Stigma Other (Please Specify)	1 2 3 4

SECTION SIX: CHOICE OF MENTAL HEALTHCARE THERAPY

S/N	QUESTION	RESPONSES	CODES
31	What is the preferred treatment choice of mental illness?	Spiritual Traditional GP/Medical practitioner Traditional and spiritual Psychiatrist Other (Please Specify) …….	1 2 3 4 5 6
32	What are the reasons for choosing the option in question 32?	Belief that the illness is due to supernatural factors Influence of relatives and neighbours Stigma associated with mental illness Lack of funds All of the above None of the above	1 2 3 4 5 6

SECTION SEVEN: GENDER PREFERENCE OF MENTAL HEALTHCARE PROFESSIONALS

S/N	QUESTION	RESPONSES	CODES
33	Which health worker will you prefer to treat you?	Male health worker Female health worker Both male and female health worker No preference	1 2 3
34	Why do you prefer your choice in question 33?	Ease of communication Religion Knowledge of mental health issue Experience Technical expertise Sympathy Other Please specify) All of the above None of the above	1 2 3 4 5 6

SECTION EIGHT: INFLUENCE OF GENDER ROLE IN HOUSEHOLD DECISION MAKING ABOUT THE TREATMENT OF MENTAL ILLNESS

S/N	QUESTION	RESPONSES	CODES
35	Who should provide for the health care needs of the mentally ill?	Household head Husband for wife Wife for husband Children Friends and Relatives Government Other (Please Specify)	1 2 3 4 5 6 7
36	Who do you think should take care of the mentally ill in the household?	Mother only Father only Father and mother Male siblings Female siblings All of the above None of the above	1 2 3 4 5 6 7

IFIKUN III

IWE IBEERE (YORUBA VERSION)

Department of Sociology

College of Business and Social Sciences

Covenant University, Ota, Ogun State.

Oludahun mi owon,

Mo je akekoo-agba ni ile-iwe Covenant University ti o n se iwadii lori **IYATO LAARIN ERO ATI ITOJU AWON ALARUN OPOLO LOKUNRIN ATI LOBINRIN NI AARIN AWON YORUBA IPINLE OGUN NI ORILE-EDE NAIJIRIA** Iwadii yii wa fun afikun imo eko ati okan lara ohun amuye fun gbigba Oye Omowe (Dokita) ni Eka Sosioloji. Mo fe toro aye lowo re lati le dahun iforo-wani-lenu-wo ti yoo gba die ninu akoko re. iforo-wani-lenu wo yii yoo to bi I wakati kan eyi ti e so ni eto lati sai dahun awon ibeere ti ko ba te yin lorun. O tun no ominira lati yo ara re kuro ninu iwadii yii lai si atubotan Kankan lori ere ti iwadii yii yoo mu wa yala nisisiyi tabi ni ojo-iwaju. Mo fi da o loju pe awon imo ti fi sile ni a o lo fun imo eko lai si eni ti yoo mo o.

E seun fun ifowosowo-po yin.

Olawande Tomike

Bi o ba gba lati kopa ninu iwadii yii, fi owo si apoti yii ☐

Ojo iforo-wani-lenu-wo: Ojo ☐ Osu Odun ☐ ☐

Ijoba Ibile _____

Ekun _____

Ilu / Abule _____

IMORAN: *Mu ami to ba idahun re mu ki o si so idahun si awon ibeere ti idahun re ye ni kiko ki o si mu idahun si ibeere ewo-nidahun to wa nibe.*

IPIN KINNI: ISESI AWON TO WA NI AGBEGBE

NOMBA	IBEERE	IDAHUN	AMI
1	Ako tabi abo?	Ako Abo	1 2
2	Omo odun meloo ni o?	---------- (ni odun)	
3	Kin ni ipo igbeyawo re?	Apon Gbeyawo Pinya Dalemosu Opo Omiran (bi o ba wa) _____	1 2 3 4 5 6
4	Kin ni esin re?	Kirisitieni Musulumi Iborisa Omiran (bi o ba wa) _____	1 2 3 4
5	Ipele wo lo kawe de?	Ko kawe rara Eko Kurani Iwe-Eri Alakobere Iwe-Eri Sekondiri Onipele meta akoko Iwe-Eri Sekondiri Onipele meta keji OND HND/Yunifasiti Postgraduate degree	1 2 3 4 5 6 7 8
6	Ise	Ko ni ise Omo ile-iwe Omo ekose Osise Ijoba Oluko Onisowo Oniworobo Agbe Onise-owo	1 2 3 4 5 6 7 8 9
7	Eelo ni o n gba lapapo losu?	_____	
8	Igba wo lo ti n gbe ni agbegbe yii?	_____	
9	Iru ebi wo ni ebi re?	Oko, aya ati awon omo Oko, aya, awon ebi ati awon omo Omiran (ko o bi o ba wa)	1 2 3
10	Iru igbeyawo wo ni o wa lowolowo bayii?	Oko kan, aya kan Oko kan, aya pupo Omiran (ko o bi o ba wa)	1 2 3

IPIN KEJI: ERO OLUDAHUN NIPA ARUN OPOLO.

NOMBA	IBEERE	IDAHUN	AMI
11	Se o mo nipa arun opolo	Bee ni Bee ko	1 2
12	Bawo ni o se mo nipa arun opolo?	Ore Obi /Ebi Lori iroyin Ile iwosan Ile iwosan ti Kirisitieni Ile iwosan ti Musulumi Onisegun Ibile Omiran (ko o bi o ba wa_____	1 2 3 4 5 6 7 8
13	Kin ni awon okunfa arun opolo?	Oju lasan Emi airi Ajogunba Koja oju lasan Omiran (ko o bi o ba wa)_____	1 2 3 4 5
14	Nje arun opolo wopo laarin awon okunrin ju awon obinrin lo?	Bee ni Bee ko N ko le e so	1 2 3
15	Laarin awon wo ninu awon wonyii ni arun opolo ti wopo julo?	Omode Odo Arugbo Ko mo ojo-ori	1 2 3 4
16	Se o ro pe arun opolo gboogun?	Bee ni Bee ko	1 2
17	Bi o ba je bee ni, nibo ni a ti le wo o san?	Ile iwosan alarun opolo Onisegun Ibile Soosi Mosalasi Omiran (ko o bi o ba wa) _____	1 2 3 4 5

18	Bi idahun si ibeere (15) ba je bee ko, kin ni idi ti o fi so pe ko gboogun?		
19	Nje arun opolo je aisan ti awon eniyan maa n year fun?	Bee ni Bee ko N ko le e so	1 2 3

IPIN KETA: WIWA NI AROWOTO AWON ETO ITOJU ARUN OPOLO

NOMBA	IBEERE	IDAHUN	AMI
20	Iru eto itoju arun opolo wo lo wa ni agbegbe yii?	Oogun igbalode Oogun Ibile Ile-iwosan igbagbo Kirisitieni Ile-iwosan igbagbo ti Musulumi Omiran (ko o bi o ba wa) _____	1 2 3 4 5
21	Bi idahun si ibeere (19) ba je oogun igbalode, ewo ni?	Eto itoju onipo keta Eto itoju onipo keji Eto itoju onipo kinni	1 2 3
22	Ewo ninu awon wonyii ni o wa ni arowoto lara awon idahun ti o mu ninu ibeere (20)?	Eto oogun ti ko won Olutoju to pegede Osise eleto iwosan Gbogbo awon ti oke yii Ko si ninu awon ti oke yii	1 2 3 4 5
23	Bawo ni eto itoju arun opolo yii se sunmo o to?	Ko to kilomita marun un O ju kilomita marun un Omiran (ko o bi o ba wa) _____	1 2 3
24	N je eto itoju ti won n se ko won?	Bee ni Bee ko N ko le e so	1 2 3
25	Bi o ba je bee ni, eelo ni owo ise won?		

26	Ta ni o n san owo itoju ti won se ni ile-iwosan alarun opolo?	Emi Ebi / Ara / Ore Ijoba Omiran (ko o bi o ba wa) _____	1 2 3 4
27	Kin ni ohun irinse ti o wopo julo ni agbegbe re?	Oko ayokele Boosi elero Oko oju-omi Alupupu (Okada) Omiran (ko o bi o ba wa) _____	1 2 3 4 5
28	Kin ni awon idena ti o wa fun riri itoju arun opolo gba ni agbegbe re?	O ti won ju Itiju Yiyera fun ati eleya-meya Ona jinjin Omiran (ko o, bi o ba wa)	1 2 3 4 5

IPIN KARUN UN: BI OLUDAHUN SE N LO AWON ETO ITOJU ARUN OPOLO WONYII SI

NOMBA	IBEERE	IDAHUN	AMI
29	N je o ti lo eto itoju arun opolo ri?	Bee ni Bee ko	1 2
30	Igba melo o lo ye ki o lo fun itoju ni ile-iwosan arun opolo ti Ibile?	Ojoojumo Eekan lose O ju eekan lo Eekan losu Eemeji losu Laelae Omiran (ko o bi o ba wa) _____	1 2 3 4 5 6 7
31	Igba melo o ni o maa n lo oogun re (oogun oyinbo tabi agbo)?	Ojoojumo gege bi won se so Igba ti mo bar anti Igba ti o ba rorun Eekookan	1 2 3 4
32	Kin ni o da o duro lati lo eto itoju arun opolo?	Owo Ona jinjin Yiyera fun	1 2 3

		Omiran (ko o, bi o ba wa) _____	4

IPIN KEFA: ETO ITOJU ARUN OPOLO TI OLUDAHUN YAN

NOMBA	IBEERE	IDAHUN	AMI
33	Iru itoju wo lo yan laayo fun titoju arun opolo?	Ti emi Ti ibile Akose-mose onisegun Ti ibile ati ti emi Onimo arun opolo Omiran (ko o, bi o ba wa) _____	1 2 3 4 5 6
34	Kin ni idi ti o fi mu idahun ti o mu fun ibeere 32?	Igbagbo pe arun yii ni owo aye/airi ninu Ipa ti awon ebi ati ara n ko Ikorira tabi yiyera ti won n year fun alarun opolo Aini owo Gbogbo ti oke wonyii Ko si ninu ti oke wonyii	1 2 3 4 5 6

IPIN KEJE: OLUTOJU ARUN OPOLO TO PEGEDE TI OLUDAHUN FE YALA OKUNRIN TABI OBINRIN

NOMBA	IBEERE	IDAHUN	AMI
35	Osise eleto ilera wo ni iwo yoo fe ki o toju re?	Okunrin Obinrin Ati okunrin ati obinrin Eyikeyi	1 2 3 4
36	Kin ni idi ti o fi yan idahun ti o yan ni ibeere (30)?	Tori ibanisoro to muna doko Esin Imo nipa arun opolo Imo kikun nipa ise naa Idaniloju ise won Ibanikedun Omiran (ko o, bi o ba wa) _____ Gbogbo ti oke yii Ko si ninu awon ti oke yii	1 2 3 4 5 6

APPENDIX IV

KEY INFORMANT INTERVIEW GUIDE FOR PROFESSIONAL HEALTH CARE WORKERS (PSYCHIATRIST AND SOCIAL WORKER)

Introduction: I am OLAWANDE Tomike conducting a research on **Gender Differentials in the perception and treatment of Mental Illness among the Yoruba of Ogun State, Nigeria**. This research is purely for academic purpose and part of the requirements for the award of a doctorate degree in Sociology. The information that will be given by you will go a long way in achieving the aim of this study.

Confidentiality and Informed Consent: Please note that all information generated from this discussion is purely for academic purposes and will be treated with utmost confidentiality.
I would like to tape the discussions so that I can make sure I capture the thoughts, opinions and ideas I hear from you. The tapes will be destroyed as soon as they are transcribed. This Interview session will take a few minutes of your time. Do I have your permission to continue?
Yes ( ) No ( )
Thanks for your anticipated

1. **Socio-demographic characteristics of Respondent**

Name of Organization:	**Length of service:**
Age:	**Present Rank:**
Education:	**Position:**
Religion:	**Length of stay in present position:**
Ethnic Group:	
Sex:	

2. Orthodox healing practice in Ogun State

Probe for: - * Causes of mental illness

- Diagnosis of mental illness
- Treatment of mental illness
- Gender differences in the causes and treatment of mental illness

3. As a healthcare worker, what are the challenges you face with the mentally ill and how can they be resolved?

4. Are mental healthcare services available to the mentally ill?

Probe for: - Availability in terms of drugs, facilities and professional healthcare workers

Date and Place of Interview:

IFIKUN V

YORUBA VERSION

ILANA IFORO-WANI-LENU-WO FUN AWON OSISE ELETO IWOSAN TO PEGEDE (OGA AGBA AWON ELETO IWOSAN, DOKITA ALARUN OPOLO, OGA AWON NOOSI).

IFAARA: Emi OLAWANDE Tomike n se iwadii lori **Iyato laarin Ero ati Itoju awon Alarun Opolo lokunrin ati lobinrin ni aarin awon Yoruba Ipinle Ogun ni Orile Ede Naijiria.** Iwadii yii wa fun afikun imo eko ati okan lara ohun amuye fun gbigba Oye Omowe (Dokita) ni eko Sosioloji. Awon oro ti o wa ninu iwe yii yoo je ki eredi iwadii yii o kese jari.

Ifitoni-leti ati asiri pipamo:

E jowo gbogbo awon oro ti a o gba jade lati inu ijiroro yii wa fun eko, a o si je ki o je ajomo laarin wa. N o fe lati ka ijiroro wa yii sori fonran ki n le ni idaniloju pe mo gba ero, ariwisi ati imo ti mo gbo lati enu re sile. A o ba fonran yii je ni kete ti a ba ti ko o jade. Iforo-wani-lenu-wo yii yoo gba akoko die ninu akoko yin. Nje mo le e te siwaju. Bee ni ( ) Bee ko ( )

E seun fun ifowo-sowo-po yin.

1. **Iwa ati ise oludahun**

Oruko ile-ise:	**Odun to o ti lo lenu ise:**
Ojo-ori:	**Ipele to o wa lowolowo:**
Imo eko:	**Ipo re:**
Esin:	**Odun to o ti wa ni ipele yii:**
Eya:	
Ako tabi abo:	

2. Ise Isegun Ibile ni Ipinle Ogun.

Iwanilenu-wo:- *Okunfa arun opolo
*Ayewo arun opolo
*Itoju arun opolo
*iyato laarin okunfa ati itoju arun opolo laarin okunrin ati obinrin

3. Gege bi olutoju alaisan, kin ni awon idojuko ti a ni pelu awon alarun opolo ati pe bawo ni a se le yanju re?

4. Nje itoju wa fun awon alarun opolo?

Iwalenu-wo:- Wiwa ni arowo-to awon oogun, ohun elo ati olutoju alaisan to pegede.

Ojo ati Ibi Iforo-wani-lenu-wo:

APPENDIX VI

KEY INFORMANT INTERVIEW GUIDE FOR TRADITIONAL HEALERS

Introduction: I am OLAWANDE Tomike conducting a research on **Gender Differentials in the perception and treatment of Mental Illness among the Yoruba of Ogun State, Nigeria**. This research is purely for academic purpose and part of the requirements for the award of doctorate degree in Sociology. The information that will be given by you will go a long way in achieving the aim of this study.

Confidentiality and Informed Consent: Please note that all information generated from this discussion is purely for academic purposes and will be treated with utmost confidentiality.
I would like to tape the discussions so that I can make sure I capture the thoughts, opinions and ideas I hear from you. The tapes will be destroyed as soon as they are transcribed. This Interview session will take a few minutes of your time. Do I have your permission to continue?

Yes ( ) No ( )

Thanks for your anticipated

Bio Data of Respondents

Name of Traditional healer:	**Years of Experience:**
Age:	**Level of Education:**
Religion:	**Ethnic Group:**
Sex:	**Local Government Area:**

QUESTIONS

1. What do you know about mental health and mental illness?

Probe for: - * Causes of mental illness

- Diagnosis of mental illness
- Treatment of mental illness
- Gender differences in the causes and treatment of mental illness

2. What are your involvements in the treatment of mental illness?
3. Explain the social and cultural factors on the treatment of mental illness?

Probe for: - cultural beliefs in the causes and treatment of mental illness

4. As a traditional healer, what are the challenges that you face with the mentally ill in Ogun State?

Date and Place of Interview:

IFIKUN VII

YORUBA VERSION

AWON KOKO IFORO-WANI-LENU-WO FUN AWON ONISEGUN IBILE.

Ifaara: Emi OLAWANDE Tomike n se iwadii lori **Iyato laarin Ero ati Itoju awon Alarun Opolo lokunrin ati lobinrin ni aarin awon Yoruba Ipinle Ogun ni Orile Ede Naijiria.** Iwadii yii wa fun afikun imo eko ati okan lara ohun amuye fun gbigba Oye Omowe (Dokita) ni eko Sosioloji. Awon oro ti o wa ninu iwe yii yoo je ki eredi iwadii yii o kese jari.

Ifitoni-leti ati asiri pipamo: E jowo gbogbo awon oro ti a o gba jade lati inu ijiroro yii wa fun eko, a o si je ki o je ajomo laarin wa. N o fe lati ka ijiroro wa yii sori fonran ki n le ni idaniloju pe mo gba ero, ariwisi ati imo ti mo gbo lati enu re sile. A o ba fonran yii je ni kete ti a ba ti ko o jade. Iforo-wani-lenu-wo yii yoo gba akoko die ninu akoko yin. Nje mo le e te siwaju? Bee ni ( ) Bee ko ( )

E seun fun ifowo-sowo-po yin.

Koko Imo nipa awon Oludahun

Oruko Onisegun Ibile:	**Iye odun to o ti n sise:**
Ojo-ori:	**Ipele Eko:**
Esin:	**Eya:**
Ako tabi abo:	**Ijoba Ibile:**

IBEERE:

1. Kin ni o mo nipa Opolo pipe ati arun opolo?

Iwanilenu-wo:- *Okunfa arun opolo
*Ayewo arun opolo
*Itoju arun opolo
*iyato laarin okunfa ati itoju arun opolo laarin okunrin ati obinrin

2. ki ni ikopa re ninu itoju arun opolo?
3. Salaye awon koko lona ibile ati ti igbalode lori itoju arun opolo.

Iwalenu-wo:- Igbagbo ninu nnkan ibile fun itoju arun opolo.

4. Gege bi Onisegun Ibile, kin ni awon idojuko ti e ni pelu awon alarun opolo ni Ipinle Ogun.

Ojo ati Ibi Iforo-wani-lenu-wo:

APPENDIX VIII

ENGLISH VERSION

IN-DEPTH INTERVIEW GUIDE FOR CAREGIVERS OF PEOPLE WITH MENTAL ILLNESS

Introduction

This is a study that seeks to investigate the gender role in the treatment of mental illness among the Yoruba of Ogun State, Nigeria. I am Olawande Tomike. The research is purely for academic purpose and part of the requirements for the award of a doctorate degree in Sociology. The information that will be given to you will go a long way in achieving the aim of this study. Please, note that whatever information you provide will be treated with utmost confidentiality.

I would like to tape the discussions so that I can make sure I capture the thoughts, opinions and ideas I hear from you. The tapes will be destroyed as soon as they are transcribed.

Confidentiality and Informed Consent

Please note that all information generated from this discussion is purely for academic purposes and will be treated with utmost confidentiality. This Interview session will take a few minutes of your time. Do I have your permission to continue? Yes ( ) No ( )

Thanks for your anticipated

Bio Data of Respondents

Sex:	**Occupation:**
Age:	**Relationship with the mentally-ill:**
Education:	**Years of Illness:**
Religion:	
Ethnic Group:	

QUESTIONS

1. Which of the mental health services do you prefer in the treatment of mental illness? Traditional or orthodox or both? Why do you prefer any one of them?
2. What are the barriers in accessing mental health services?
3. As a family member, what are the challenges that you face?
4. Kindly explain gender role in household decision making on treatment of mental illness
    - Also probe further on the household decision making process in terms resource allocation and care of the mentally ill
    - Further information on the role of religion, patriarchy, gender, headship of household, family composition, living arrangement and social network on treatment of mental illness in determining the roles of members of the household.
    - Probe for information on how the household build up sustain the health of members.

Date and Place of Interview:

IFIKUN IX

YORUBA VERSION

IFORO-WANI-LENU-WO TO JINLE FUN AWON OLUTOJU AWON TO NI ARUN OPOLO.

Ifaara:

Ise yii wa fun wiwadii ipa ti imo ako tabi abo n ko ninu itoju arun opolo laarin awon Yoruba ni Ipinle Ogun ni Orile-Ede Naijiria. Oruko mi ni Olawande Tomike. Iwadii yii wa fun afikun imo eko ati okan lara ohun amuye fun gbigba Oye Omowe (Dokita) ni eko Sosioloji. Awon oro ti o wa ninu iwe yii yoo je ki eredi iwadii yii o kese jari.

Ifitoni-leti ati asiri pipamo: E jowo gbogbo awon oro ti a o gba jade lati inu ijiroro yii wa fun eko, a o si je ki o je ajomo laarin wa. N o fe lati ka ijiroro wa yii sori fonran ki n le ni idaniloju pe mo gba ero, ariwisi ati imo ti mo gbo lati enu re sile. A o ba fonran yii je ni kete ti a ba ti ko o jade. Iforo-wani-lenu-wo yii yoo gba akoko die ninu akoko yin. Nje mo le e te siwaju? Bee ni ( ) Bee ko ( )

E seun fun ifowo-sowo-po yin.

Koko Imo nipa awon Oludahun

Ako tabi abo:	**Ise:**
Ojo-ori:	**Ibatan re pelu alarun opolo:**
Imo Eko:	**Odun ti arun yii ti bere:**
Esin:	
Eya:	

IBEERE

1. Ewo ninu awon eto itoju arun opolo yii ni o yan laayo fun itoju arun opolo? Ibile, Ode-oni tabi mejeeji. Kinni idi ti o fi yan okan ninu won laayo?
2. Kin ni awon idena to wa ninu eto itoju arun opolo?
3. Kin ni awon ipenija ti o ni gege bii molebi?
4. Salaye ipa ti imo ako ati abo n ko ninu ipinnu lori itoju arun opolo.

* Salaye siwaju sii lori ipinnu agboole lori eto isuna ati itoju alarun opolo naa.
* Afikun imo lori ipa ti esin, agbara okunrin, imo ako ati abo, olori-ebi, eto ebi, ibagbe-po ati ibase-po lori itoju arun opolo ninu mimo ise awon molebi kookan ninu agboole.
* Iwalenu-wo lori bi agboole yoo se je ki ilera pipe wa fun awon molebi.

Ojo ati Ibi Iforo-wani-lenu-wo:

APPENDIX X

ANALYSIS PROCEDURE

The table below shows measurement of variables and the analysis procedure for measuring the variables in the study.

Problems Matrix – Measurement of variables

Objective	Variables	Indicators	Analysis Proceedure
1	Respondents' perceptions of mental illness	Gender Religion Belief/Culture Knowledge of mental illness Awareness of mental illness Attitude to mental illness Perception of mental illness Causes of mental illness *Natural *Supernatural *Pretenatural *Inheritable	Descriptive statistics: frequency distribution and percentages to describe gender differentials that influence treatment of mental illness among respondents Content and thematic analysis of the qualitative responses will be coded and summarized using Invivo.8 to compliment the result from the quantitative analysis.
2	Availability of mental health care services in the study area	Prescriptions Medications Traditional methods Orthodox methods Religion and beliefs /Culture Adherence to treatment Care of the mentally ill	Descriptive statistics: frequency distribution and percentages Chisquare Content and thematic analysis of the qualitative responses will be coded and summarized using Invivo.8 to compliment the results from the quantitative analysis.
3	Respondents' access to mental	Distance	Chisquare

	health care services	Means of transportation Social support and Networking family support Perceptions Religion Type of services rendered Means of payment for services rendered	Content and thematic analysis of the qualitative responses will be coded and summarized using Invivo.8 to compliment the results from the quantitative analysis.
4	Respondents' use of mental health care services	Nature of illnesses – depression, stress, anxiety Frequency of visits to hospitals Prescriptions Medications Traditional methods Orthodox methods Barriers in service delivery Poverty Social network / Neighbourhood	Descriptive statistics: frequency distribution and percentages to describe the utilization of mental healthcare facilities among respondents Content and thematic analysis of the qualitative responses will be coded and summarized using Invivo.8 to compliment the results from the quantitative analysis.
5	Respondents' choice of mental health care therapy	Preferred treatment Culture / belief system Religion	Descriptive statistics: frequency distribution and percentages to describe the choice of mental healthcare therapy among respondents Content and thematic analysis of the qualitative responses will be coded and summarized using Invivo.8 to compliment the results from the quantitative analysis.

6	Respondents' gender preference of mental health care professionals to treat them	Gender Culture/belief system Patriarchy communication Social/family support Government programmes for mentally ill Gender support Others e.g. NGO Cultural practices	Chisquare Content and thematic analysis of the qualitative responses will be coded and summarized using Invivo.8 to compliment the results from the quantitative analysis.
7	Influence of gender role in household decision making about the treatment of mental illness	Household relationship Household Head Household decision making process Family possessions Gender role Culture Patriarchy Communication Social support Care of the mentally sick Child rearing practices	Analysis of Variance Content and thematic analysis of the qualitative responses will be coded and summarized using Invivo.8 to compliment the results from the quantitative analysis.

APPENDIX XI

MENTALLY ILL PERSON AT ABEOKUTA SOUTH LOCAL GOVERNMENT AREA

APPENDIX XII

A MENTALLY ILL PERSON AT ABEOKUTA NORTH LOCAL GOVERNMENT AREA

NEUROPSYCHIATRIC HOSPITAL, ARO.
RESEARCH ETHICS COMMITTEE
P.M.B. 2002, ABEOKUTA, OGUN STATE, NIGERIA.

Ref No. NPHA/276/VOL.II/870 Date: 16th June, 2016

NPHAHREC Registration Number: NHREC/24/07/2013

NOTICE OF FULL APPROVAL AFTER FULL COMMITTEE REVIEW

RE: Gender differential in the perception and treatment of mental illness among the yorubas of Ogun State, Nigeria.

NPHA Ethics Committee assigned number:	**PR003/16**
Name of Principal Investigator:	**Olawande Tomike Ibironke**
Address of Principal Investigator:	**Department of Sociology, Covenant University, Ota, Ogun State, Nigeria.**
Date of receipt of valid application:	**4th March, 2016**

Date of meeting when final determination on ethical approval was made **14th June, 2016.**

This is to inform you that the research described in the submitted protocol, the consent forms, and other participant information materials have been reviewed and given full approval by the NPHA Ethics Committee.

This approval dates from **14th June, 2016** to **13th June, 2017**. If there is delay in starting the research, please inform the NPHA Ethics Committee so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. *All informed consent forms used in this study must carry the NPHA HREC assigned number and duration of NPHA HREC approval of the study.* It is expected that you submit your annual report as well as an annual request for the project renewal to the NPHA HREC early in order to obtain renewal of your approval to avoid disruption of your research.

The National Code of Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the NPHA REC. No changes are permitted in the research without prior approval by the NPHA HREC except in circumstances outlined in the Code. The NPHA HREC reserves the right to conduct compliance visit to your research site without previous notification.

You are to submit a copy of your report to the committee for vetting before any peer review or examination defense upon completion of your research.

Dr. G. Amoo
Chairman, NPHA Ethics Committee

E-mail: hrec@neuroaro.com Phone No: +234 - 8133970504

FEDERAL MEDICAL CENTRE

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Deputy Director of Administration & Secretary to the Board
Mr. A.O. Vaughan
B.Ed (Eng) Cert. Health Planning & Mgt MPA; AHAN

Our Ref: FMCA/470/ Your Ref: Date 31st May, 2016

FMCA: NREC REG. NUMBER: NIREC/04/08/2010-2015

FMCA: FEDERAL WIDE ASSURANCE: U.S./REG NO: FWA/00018660/02/28/2017

NAME OF PRINCIPAL INVESTIGATOR: OLAWANDE TOMIKE IBIRONKE

PROTOCOL TITLE: GENDER DIFFERENTIAL IN THE PERCEPTION AND TREATMENT OF MENTAL ILLNESS AMONG THE YORUBAS OF OGUN STATE, NIGERIA

FEDERAL MEDICAL CENTRE 37 MAY 2016 APPROVED ABK. HREC

ETHICS ASSIGNED NUMBER: FMCA/470/HERC/05/2016

NOTIFICATION OF FULL MEMBER APPROVAL OF RESEARCH PROTOCOL

This is to inform you that the Federal Medical Centre, Abeokuta Health Research Ethics Committee (HREC) at its sitting on 19th May, 2016 decided to give full membership approval to your research proposal, after necessary reviews and corrections, under the regulations guiding experiments in human subjects.

This approval is for a period of one year from 31st May, 2016 to 30th May, 2017. If there is delay in starting this research, please inform the HERC so that dates of approval can be adjusted accordingly. Note that no activity related to this research may be conducted outside these dates. No changes are permitted in the research without prior approval by HERC.

All forms and questionnaires used in this study must carry the HERC assigned number and the duration of HERC Approval.

You are to note further that, the National Code of Health Research Ethics requires you to comply with all institutional guidelines, rules and regulation, to follow trends of the code. Please ensure that any adverse effect from your study is promptly reported to the HERC Federal Medical Centre, Abeokuta.

You are expected to submit a progress report to this Committee every three (3) months from the date of approval. The HERC reserves the right to conduct compliance visits on your research sites without previous notification.

Thank you.

FEDERAL MEDICAL CENTRE 37 MAY 2016 APPROVED ABK. HREC

Dr. A. I. Rasaki
For: Chairman, Hospital Research Ethics Committee