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Collaborating with the Community for Quality Community Roles of Mental Health Care in Northern Nigeria: Exploring the Nurses' Challenges and Opportunities

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Abstract

Providing community mental health care requires collaboration between the community and health workers. This study explored the community-Primary Health Care (PHC) system link in three purposively selected northern Nigerian States. Using a mixed-methods research, data were collected from 191 PHC workers and 18 community members and traditional medicine men (TrMM) through a questionnaire and in-depth interviews. Quantitative data were descriptively analysed using SPSS Version 23; thematic analysis was done for the qualitative data. The two were then triangulated. Nurse and midwives constituted 23.5% of the PHC workforce. Findings showed that Nurse and midwives constituted 23.5% of the PHC workforce and 55.0% of the workers said there is no collaboration between the primary health care systems with the community; 42.0% claimed that communities are involved. Another 33.0% reported some collaboration between the traditional and the modern health practitioners. Qualitative data supported these divergent views. Some TrMM narrated the involvement of some nurses in managing the physical health conditions of their patients with mental illness; other TrMM reported collaboration with a Neuro-psychiatric Hospital regarding occupational therapy. However, in many instances, some TrMM vehemently resisted even visits from modern mental health workers to their centres. Diverse challenges and opportunities for collaboration between the modern health system, the community and the community's traditional medical system abound. For effective community mental health care, this collaboration needs to be managed and continual enlightenment and advocacy are paramount. Primary Healthcare professionals especially nurse-midwives, should employ appropriate models and strategies to ensure a robust collaboration for the needed community mental health services.

Keywords: *Community Mental Health Care, Collaboration, Northern Nigeria, Primary Health Care*

Introduction

The prevalence of mental health disorders has been a source of concern over the years (Thornicroft & Tansella, 2003; Malvárez, 2008). Some empirical evidence in Nigeria and elsewhere establish that most mental health problems have their origins in the community and society and the prevalence continues to rise globally including Nigerian communities (Anyebe, Olisah, Ejidokun and Nuhu, 2017; WHO, 2008). The World Health Organization, WHO, (2008) stated the social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with (mental) illness. These circumstances breed illnesses including mental health problems. Consequently, providing effective and quality mental health care services at the community level should be a veritable means of achieving mental health for all (WHO, 2007), particularly for the over 70% of the Nigerian population in rural areas. This requires community participation and collaboration between the community health workers and the nursing workforce especially those at the Primary Health Care (PHC) level. According to WHO (2010; Fact 10), governments, donors and groups representing mental health workers, patients and their families need to work together to increase mental health services, especially in low- and middle-income countries.

This statement emphasises the role of multisectoral collaboration (Herrman, Saxena & Moodie, 2005). To address mental health services, the WHO-AIMS Report (2006) on Nigeria recommends that intersectoral collaboration be fostered to improve the quality of life. In *The National Mental Health Policy for Nigeria,* the FGN has emphasised that the logical and rational approach to reaching the population at large is through the incorporation of mental health into the Primary Health Care. In this way, the community shall have the opportunity to participate and determine the type of mental health care appropriate for it (FMOH, 1991:2). The emphases on universal coverage with community participation was reaffirmed by WHO Factsheet (2007), which stated that collaborations are required to promote mental health and effective mental health service (MHS) provision.

The issues of collaborations and community development are persistent and long-standing discourse. In 1991, Hellandendu reported the low community involvement in PHC services in northern Nigeria. Similarly, Jegede (2010), in his study of southern Nigeria communal effort in health care services established that modern health care programmes are designed and brought to communities without collaborating with the beneficiaries communities. According to him, the people are not involved at the planning stages and although it benefits the people, community members would consider arrangements as a mere government programme, rather than the people's programme (Jegede, 2010; p.96)
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Other socio-cultural determinants such as religion, which influence health care in general also impinge on the provision of mental health services at the PHC level (Oluwabamide & Umoh, 2011; Asuzu, 2009). Thus, the role that religious leaders, as community leaders, play in the mental health providers has been highlighted in studies elsewhere in Nigeria, pointing to their incorrect perceptions (Igbinomwanhia, James & Omoaregba, 2013).

Quite recently, Green & Coluci (2020) in a systematic review noted that collaboration between western medical practitioners and traditional healers presents divergent feelings and realities. They noted that while both modern and traditional practitioners have fragile collaborative relationships, there are mutual scepticisms. In South Africa, similar delicate collaboration was reported some years before (Campbell-Hall, Petersen, Bhana, Mjadu, Hosegood & Flisher, 2010). This collaboration situation in northern Nigeria is empirically unsubstantiated.
This study explored the Community-Primary Health Care system link in an effort to explore possible areas of collaboration and the roles nurses (and other health workers) in northern Nigeria communities can play.

Methods and Materials
Setting: Forty-seven PHC centres and their host communities in nine Local Government Areas in three States in northern Nigeria

(Gombe, Kaduna and the Benue States) were purposively selected for the study.

Design: Both quantitative and qualitative designs are used for the study. Adopting convergent mixed-methods. This community-based exploratory and cross-sectional study adopted mixed methods to explore the level of collaboration between primary health care system and community members in providing community-based mental health care including the involvement of traditional healers in mental health activities.

It is exploratory as new dimensions of the phenomenon of collaboration were explored from the community and traditional medicine men (TrMM) while descriptively examining health workers perceptions and views. The study is part of a larger study in three purposively selected States from north-central, northwest, and northeast Nigeria on mental health services.

Sampling Procedure: The three states in northern Nigeria (Gombe, Kaduna and the Benue States) were purposively selected for the study, one State from each of the three geo-political entities of northern Nigeria. The Primary Healthcare Centres (and host communities) were randomly selected (Anyebe, *et al*., 2019: 45).

Sample population and Instruments for Data Collection: As shown in Table 1, a total of 209 participants were involved in the study. A convenient sample of 191 primary health care professionals from 47 randomly selected primary healthcare centres in three states was selected. They were selected from their centres based on their availability at the time of visit. They constituted the respondents for the survey questionnaire. Their representative number was selected using *Table for Determining Sample Size from a Given Population,* constructed based on the formula: $s = X\,2NP(1-P) \div d\,2\,(N-1) + X\,2P(1-P)$, for researchers (Krejcie and Morgan, 1970), and adding 10 – 20 % for incomplete answers or non-response rate (Araoye, 2004). They were selected from their centres based on their availability at the time of visit throughout the four-month study. They constituted the respondents for the survey questionnaire. The questionnaire was validated with a Cronbach' Reliability coefficient of 0.83

A purposive sample of 18 health care workers, community leaders including traditional medicine men (TrMM), was also selected from whom qualitative data were collected via in-depth interview (IDIs) Guide, which was validated to explore the phenomenon of study.

The participants were selected based on their strategic positions as community leaders and traditional mental health healers in the community who were deemed capable of giving reliable information on the phenomenon of community-based mental health care is explored.

Table 1: *Study Participants*

SN	Study participant category	Benue	Kaduna	Gombe	Total
1	Primary care professionals for survey	58	67	66	191
2	Community IDI participants	2	3	2	7
3	Health workers	3	3	2	7
4	Traditional medicine men	0	2	1	4
	Total	**63**	**75**	**71**	**209**

Procedure for Data Collection: The questionnaire was both self-administered and interviewer-administered for some PHC workers who could not comfortably fill in the questionnaire. Some of the PHC workers needed to be assisted in filing the questionnaire used as an interview schedule.

The IDIs for community members and PHC coordinators at the Local Government levels were conducted using audio-tape recorder.

Field notes were also taken. All the IDIs were conducted in local Nigerian language (Hausa). A total of 15 research assistants (in the three States) participated in the data collection process (this is part of a larger study).

Data Analysis: Quantitative data were coded and analysed using IBM Statistical Package for the Social Sciences (SPSS Version) 23. The qualitative data were translated, transcribed, thematically analysed and presented using narratives and verbatim quotes. Both quantitative and qualitative data were triangulated to meet the research objective (Babbie, 2010). The data generated two levels of results: 1) Collaboration of Traditional Medicine Men and 2) Collaboration with the community.

Ethical consideration: Approval for the study was given by Health Research Ethics Committee, Ahmadu Bello University Teaching Hospital Zaria, northwest Nigeria (**ABUTH/HREC/K028/2014**) while individual States and study participants gave permissions.

Findings

Professional Characteristics of the PHC Workers

As shown in Fig. 1, nurses and midwives constitute 23.5% (n=45) of the PHC workforce (N=191).

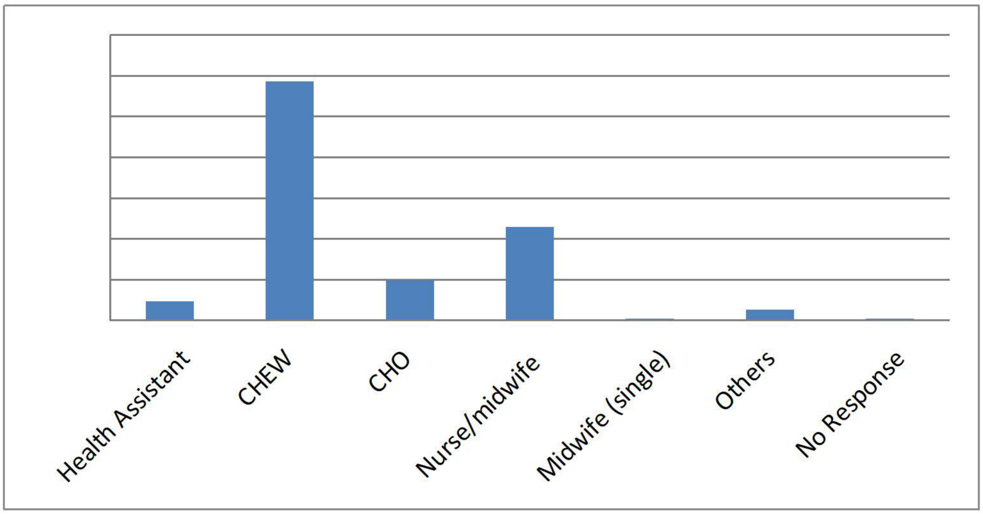

Figure.1: *PHC Workers' Professional Categories*

Collaboration with Traditional Medicine Men

On collaboration between the traditional and the modern health practitioners in providing mental health care services in their communities, only 53 (33.0%) answered in the affirmative; 84 (44.0%) said there is no such collaboration, while the remaining 44 (23.0%) expressed uncertainty (fig. 2).

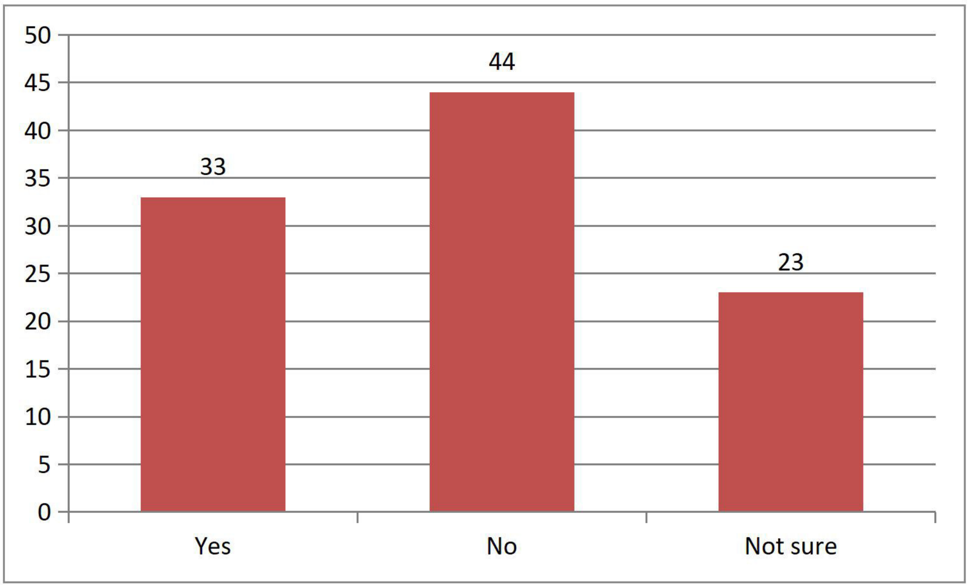

Figure. 2: *Health Workers' Opinions on Modern-traditional medicine collaboration in MHS*

As shown Fig. 2, in the treatment of mental illness, health workers were divided; some believe that when traditional treatment combined with modern care, the efficacy rating of traditional treatment will slightly improve and will further improve when combined with modern and spiritual. This is suggestive of some health workers being in favour of the traditional-modern collaboration in the treatment of the mental health problem while others do not believe so.

Qualitative data support these diverse opinions, indicating there are mixed feelings about collaboration with modern mental health institutions. These views and opinions are presented below:

The opinions of community respondents in one community indicate that traditional healers are not considered important or useful in treating mental illness as no respondent indicated a willingness to take any mentally sick person to the traditional healer – a surprising finding because, in illness behaviour, one of the first points of consultation is the traditional or folk medical practitioner. As one of the community members claimed, when asked if they take the patients to traditional healers, he said: *"No…., we don't have a traditional healer (for mental illness) here in our community."* Thus, the collaboration between these two categories of mental health care was also further explored. Some health workers in most communities corroborated the non-existence, traditional healers, in mental health services (MHS) in their communities. For example, in Gombe State, a PHC coordinator said:

> *…in those days, yes; there is none now because some of them have died, they went away with their expertise; people no longer patronize them.*

This implies, in his opinion, that traditional healers for mental illness were no longer available in the Gombe because as he said: *"all our cases (mental illnesses) are taken to the Specialist Hospital (Gombe)."*

However, still in Gombe State, a healthcare practitioner was able to identify some healers and even went further to highlight what looked like an area of collaboration. He said:

> *If you go the north (i.e. Gombe north), we have people that are caring for them (PLWMI). If you go to Tudunwada, Mallam Hassan is a very popular person. In Jekadefari also we have a traditionalist. If he (healer) has any case (i.e. a*

> *psychiatric patient) with other medical problems, he calls me and I (a CHO) will go and treat the medical problem while he (the healer) takes care of his psychiatric patient.*

This even shows that traditional healers do not only exist but seek areas of collaboration with modern healthcare practitioners. However, health workers complained that the existing traditional healers were not willing to disclose their art of healing administered on psychiatric patients to modern medical practitioners.

In another situation, Kaduna State reportedly has a number of traditional psychiatrists. When asked about the existence of traditional healers and their interventions in mental health problems in the community, a PHC coordinator in Kaduna said:

> *Baza'a rasa ba"! 'Baza'a rasa ba'… tunda (meaning: it is possible…since) the government are backing (sic) the traditional healers now. We have them but I don't know where they are. But we have them.*

This informant is suggesting some government approval for collaboration in Kaduna.

Some level of collaboration is expected from the healers in other parts of Kaduna State as well, where there is an expressed willingness to collaborate in certain aspects of care. One traditional healer in Tashan Yari when asked if they would be willing to work with the healthcare system, he said:

> *Truly, it will be a welcome idea, but no hospital has approached us for that…the medical people (i.e. modern psychiatrists) would want us to work together."*

In addition, in Kaduna State, another healer also operates his 'clinic', with 12 patients as at the time of the researcher's visit, narrated how he was already working with the Federal Neuropsychiatric hospital Kaduna in areas of activity therapy and occupational therapy. According to him,

> *Both of us* (the healer and health professionals from the Psychiatric Hospital) *are willing to make the collaboration official …in-patients here (at the centre) are taught various trades, and farming techniques.*

Some staff of the Psychiatric Hospital were said to be visiting the centre from time to time.

This situation was confirmed by a consultant psychiatrist who was also interviewed. As he put it, *"the hospital is collaborating with this healer in Tashan Yari with the possibility of using the centre as a 'half-home'.*"

But while some of these healers truly exist and allow some form of working together with the modern mental health therapists, some of them would rather choose to be secretive about their activities and refuse any form of interaction with the modern health care system. For example, in Kaduna State, a senior consultant in psychiatry informed the researcher about attempts made by a Neuropsychiatric Hospital in Kaduna to link up with a traditional psychiatrist in Mando Kaduna but to no avail. He said:

> *The hospital has written to him, officially, several times* (for a visit to his treatment centre in Mando, Kaduna) *but he would not welcome anyone. Even the psychiatric nurses in training at the hospital wrote to make an excursion there, again he refused.*

He continued, on the further inquiry on the purpose for the intended visit to the healer:

> *some of the inmates are taken to the farm. So we wanted to work with him, especially in terms of occupational therapy.*

Collaboration with Community

Apart from the traditional healers, collaboration with the community itself was explored. During the survey, nearly half

(49.2%) of the study participants stated that there is a collaboration between the governments and the community members, while slightly over half (50.8%) could not say whether or not there is such collaboration. On the other hand, another 42.0% of the survey participants claimed that many communities are involved and collaboratively organize mental health education, although in very limited forms, through village health workers.

Qualitative data seem to support the need for collaboration. In prospectively supporting community involvement in the provision of mental health services, a Community Health Officer (CHO) during an in-depth interview reported that village health workers are always involved in the social mobilization for services such as maternal and child health (MCH) services, paid by the (Benue) State government, supervised by CHO. But for the mental health services, he said:

> *"For now, they (*village health workers*) are mainly involved in MCH services; they note the number of deliveries, death, etc. If the mental health services are available, we will use them too"*

IDIs with community leaders in parts of Kaduna and Benue States revealed that community leaders are incorporated in the primary healthcare system. It was reported that some community leaders were even made chairmen of PHC committees in their domains. Although not in all communities, in Sabon Sarki and Awon communities in Kachia LGA, the community leaders reportedly chair the PHC committees in the communities.

At Awon community in Kaduna State and Vandeikya in Benue State, retired health care workers were being made traditional chiefs, many of whom were aware of the components of the PHC, and so aware of the need for mental health services at PHC centres. But like one of them said, mental health care is not available at the PHC centres so there are no collaborative activities in that area yet. He hopefully said:

> *"But like the Ebola case, we were completely involved. I hope when this one you are talking about comes (*i.e. mental health services*), they* (i.e. the government and PHC centres) *will do the same."*

This expression of the willingness of the community to collaborate with government health agencies to provide the mental health services indicates anticipatory collaboration when the mental health services are provided by the PHC system.

Similarly, during the IDIs, the need for the community and its basic units (the families) to complement government efforts was emphasised. On the family role, both community leaders and health workers associated mental health problems with poor parenting. The need for collaboration with the family was also advocated. As a Local Government Area PHC coordinator in Gombe State noted:

> *"The family has a serious role to play. If everybody should at least provide parental care before the children come out, by having parents who counsel their children regularly, they* (the children) *may not go to that extent of having psychological or emotional breakdowns".*

In Kaduna State, a PHC director corroborated this by saying that

> *"Families have serious roles to play. Every parent should be responsible for his/her child. At times, peer group takes over. Parents should talk to their children but at times even the parents are not adequately prepared to even counsel their children".*

In all these, it is believed that the family as a primary socialising agent should be the first line of providing psychological upbringing for its offsprings. The family's collaboration is therefore critical in any effort at providing mental health services at the community level.

Discussion of Findings

The findings of this study indicated the collaboration between health care professionals in some areas of mental health services. Traditional health care providers appear to engage with some health workers in the treatment of patients with mental illness on many fronts. Although, this is quite limited. A study by Campbell-Hall, Petersen, Bhana, Mjadu, Hosegood & Flisher (2010) had reported in a South African study that traditional healers scarcely welcomed institutional collaboration with modern health care practitioners; however, they were ready for additional training in modern health care and establishing a collaborative relationship in the interests of improving patient care.

In our present study, modern mental health practitioners sought ways of collaborating with the traditional system. This is contrary to Campbell *et al.,* (2010) study where modern healthcare practitioners were less interested in an arrangement for collaboration.

In another recent systematic review study, Green & Coluci (2020) concluded that both traditional healers and biomedical practitioners recognise that patients can benefit from a combination of both practices and demonstrate a clear willingness to work together. Some healers are sceptical about the effectiveness of the Western psychiatric medication.

The low level of collaboration of the PHC system with community apparatus in relation to mental health care is in contrast to the expectations of many health authorities on the role of intersectoral partners. The WHO and Federal Ministry of Health Nigeria had stressed the need for community participation, the involvement of NGOs and the collaboration with traditional healers especially those treating mental illness (WH0 Factsheet, 2007; Federal Ministry of Health, 1991; 2007). Many other authors also emphasised that functional mental health services in the PHC system should have activities based on a multisectoral approach (WHO, 2001; Herrman, Saxena and Moodie, 2005).

Delicate collaboration within the mental health service provision is not new. Previous studies have however shown that mental health promotion strategies are generally ignored by health workers (WHO, 1978; WHO-AIMS, 2006; Odejide *et al;* 2010; WHO, 2007; WMHF, 2009) and community members alike (Asuzu, 2009). It is clear that up till now, this synergy between PHC workers and community members in collaborating to provide mental health services at the basic level has not been well established as found in this study.

The findings have however revealed that there is an opportunity for modern health-traditional medicine collaboration whenever providing mental health services, as expressed by some professionals and institutions. This desire for collaboration is obvious because some have actually started integrating some areas of common interests as shown at some minimal but deliberate levels. However, most traditional healers and health workers alike still prefer to stay aloof from the modern-traditional collaboration in the mental health care system. This, therefore, remains a barrier that will require resolution if and when mental health services in the community are available.

Implications for the Nurse as An Advocate

The nurse is a health care provider found at all levels of the health care delivery systems, uniquely placed in relation to the community, service users and the health care system. As found in this study, nurses in some communities interface with traditional medical practitioners to alleviate suffering and foster care. In the PHC system, nurses and midwives constitute a good number of the service providers, as indicated in this study. This creates an avenue for the nurse-midwife to foster collaboration between the different categories of health care providers, traditional and modern to ensure the quality of care provided. This vantage position of the nurse must be explored empirically and practically to enhance the provision of mental health services at the community level.

Limitations of the Study

The small sample size of this study and the few traditional medicine men accessed and interviewed limit generalizing the findings of this study to other areas. In addition, the instruments used were self-constructed, which have not been standardized. As an exploratory study, the available data constitute some primary data for researchers and mental health policy designers to explore, in their efforts toward seeking areas of collaboration with the traditional medical system in the provision of mental health services in the community, especially the ways families can be incorporated effectively and efficiently

Conclusion

It is concluded that nurses/midwives (and other PHC workers) are presented with challenges of collaborating with non-formal sectors like the community and traditional medical system, and such challenges must be overcome to achieve effective and efficient quality mental health care. It is shown that communities are been incorporated into primary health administration in a few places, although this is not widespread, however. The family, parents/guardians, community leaders and the community through the village health system are important to bridge this gap. Thus, these factors remain to be improved for the overall functioning of the PHC system, and particularly to bring on board, sustain and improve community-based mental health services.

Recommendations

Based on the findings of the study, it is recommended that:

i. Community apparatuses including families and their traditional medical systems and modern health workers need to be adequately sensitized through continual enlightenment and advocacy (by the nurse and other health care practitioners) in the community on the critical role of collaboration in providing and improving community mental health care.

ii. Areas of effective promotive, preventive and therapeutic synergies can and should be further explored and identified by researchers and policy formulators to enhance holistic collaborative mental health services for the community.

iii. Health care professionals should also continue to brainstorm in all appropriate forums, such as in scientific articles, conferences and workshops, to chart a way forward for the scarce community-based mental health services to reduce the mental health burden in the community.

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