THE CROSS CULTURAL CARE OF MENTALLY ILL IN NIGERIA: THE TRADITIONAL AND THE ORTHODOX METHODS

VICTOR EYO ASSI
Department of Sociology & Anthropology
University of Uyo, Uyo Akwa Ibom state.
Email: victorassi82@gmail.com
Tel: +2348037719495

MAJOR ITELMOWEI
Department of Sociology & Anthropology
Niger Delta University, Bayelsa State.

SUMMARY

Every community and society has its peculiar way of life and these practices and beliefs go a long way in influencing the people's perception, attitude and management of diseases and other health related problems that befall them. The mentally ill in Nigeria are faced with these health challenges which result in some isolating their families and loved ones (nuclear and extended families), while some are rejected due to their cultural beliefs system. Over the years there have been debates on the choice of care for the mentally ill persons because to some the orthodox is preferable to the traditional and vice versa. It's on this ground that this paper sought to examine the traditional medicine, Orthodox medicine, and the cross cultural care between the traditional and orthodox medicine in the care of the mentally ill persons in Nigeria. The paper also employed the Biopsychosocial model and Holistic model to explain

the cross cultural care of mentally ill person(s) in Nigeria. The paper finally justifies itself by employing cross – cultural care for treatment in the tradition and orthodox levels for the mentally ill, describing the psychological distress and associated factors of the attendees of traditional and orthodox healing practices; the prevalence and severity of mental disorders treated by traditional and orthodox practitioners

INTRODUCTION

Mental health has received little attention in Nigeria over the years. As a result, in order to achieve the Millennium Development Goals (MDGS) goal of health for everyone, the World Health Organization (WHO) endorsed mental health as a universal human right and a fundamental goal for health care systems of all countries (WHO, 2005). Integrating mental health services into primary care is the most viable way of closing the treatment gap for people with mental health problems and ensuring that they get the mental health care they need. (World Organization and Association of Family Doctors (WONCA, 2008). This will also reduce discrimination of the mentally ill and increase their right to access treatment and care within their own community in the least restrictive environment, with the least restrictive treatment. (World Health Organization, 2009).

According to Olson 2006, Mental health systems are generally a subsystem of the health care system, and how these services are organized, delivered and financed is significantly influenced by the way in which the overall health services system are run .The primary objective of a mental health system is to ensure that its

organizations, institutions, and resources improve service provision and, thus, the mental health of the population. The WHO conceptualizes optimal actions for improved service provision as establishing national policies, programmes, and legislation on mental health, providing services for mental disorders in primary care, ensuring accessibility to essential psychotropic medication, developing human resources, promoting public education and involving other sectors and promoting and supporting relevant research (WHO - AIMS, 2005).

The fact remains that, Nigeria is a country with 372 different ethnic backgrounds (Otite 1990) having their own beliefs and cultural practices with regard to health and disease. Each society or community has its peculiar way of doing their things and it is known that these practices and beliefs go a long way in influencing the people's perception, attitude and management of diseases and other health related problems that befall them. All over Nigeria, human life is seen as sacred and priceless and as such its protection and preservation is equaled to nothing and hence different societies have various ways and methods of protecting and preserving lives.

Some of these cultural practices, which have endured centuries of practice, have worked for the people who practice them. Unfortunately, it is not uncommon for our mind to think of something crude and bad whenever we talk about cultural practices as it concerns health. It must be said that not all cultural/traditional practices are bad. Some have stood the test of time and have positive

values, while others may be harmless, uncertain or negatively harmful. It is essential that we understand how and why each custom is practiced by any community if any meaningful impact is to be made towards implementing health programme. This is because the practices a community adopt fulfil certain purposes for them.

However the recent surge in the acknowledgement of the efficacy of traditional medicine by many people all over the world emanates from the dismal performance of the present health system. In its 2003 World Report, the World Health Organisation, scored many African countries very low and this was attributed to inadequate harnessing of all human resources in the health sector especially traditional medicine healers.

In spite of the continued growth of the Gross Domestic Product (GDP), the state of health care delivery in Nigeria remains abysmal due to poor funding and infrastructural development. The country has one of the lowest health practitioner-to-patient ratios in Sub-Saharan Africa with 0.3 Physicians per 1000 persons, 1.7 hospital beds per 1000 persons, 1.7 Nurses, 0.02 Dentists, 0.05 Pharmacists, 0.91 Community Health Workers and 1.7 Midwives, per 1000 persons (WHO,2006; Ogbolu 2007). Oyeneye, and Orubuloye, (1985) found out that the traditional doctor/patient ratio was 1:208, in the former Bendel State of Nigeria, (now Edo and Delta States) while in Benin-City, Edo State, there is one traditional healer to every 110 people (Onyekaba,2008). Unfortunately many of these skilled personnel (orthodox) have relocated to Europe, America

and the Middle- East, to ply their trade and thereby creating a brain drain costing many African countries especially Nigeria, about $2 billion annually and also a supply gap at home.

In 2009, government's investment in the health sector as a percentage of GDP was a paltry 5.8 per cent. This is against the 15 per cent of national budgetary provisions recommended by the African Union in what is now referred to as 'Abuja Declaration'. Nigeria also has fifty-nine (59) Teaching hospitals and Federal Medical Centres, 3,303 General Hospitals and 20,275 Primary Health Centres, for a population of 170 million people (July, 2012 estimates).

Orubuloye, and Ajakaiye, (2002), noted that out of the 101,041 communities in Nigeria only 14,474 or 14.3 percent have access to some form of modern health care facility and most of these facilities are concentrated in urban areas. It goes to show that only about 14 per cent of Nigerians have access to conventional medical care leaving the remaining population to look elsewhere, notably traditional medicine. To Dr Agan, Chief Medical Director, University of Calabar Teaching Hospital, Calabar, "health care delivery in Nigeria is dead". In fact lack of basic health personnel and infrastructures has led many government officials and other rich Nigerians to go abroad for medical care. According to the Nigerian Medical Association (NMA), 5000 Nigerians seek overseas treatment on a monthly basis at a cost of over $500 million in India and other countries, with India alone raking $260 million.

Its on this background that this paper seeks to examine and investigate the care given to mentally sick both at the traditional and orthodox levels.

CONCEPTUAL CLARIFICATIONS

For proper understanding of the cross cultural care of mentally ill persons at the traditional as well as orthodox levels in Nigeria, it is pertinent to clarify some of the terms such as traditional medicine and orthodox medicine in Nigeria.

2.1. Traditional Medicine/ Care

The various societies that make up the Nigerian State have for long relied on the indigenous health system which was developed as a response to their environment and it involves the use of locally available resources to prevent and cure diseases. It is a natural health care system which many generations of Nigerians have used. The practice transcends the maintenance of good health of the people as it also protects them from the menace of wild animals, evil spirits, accidents, provide bountiful harvest, good luck and other human activities (Roan,1999, Osborne, 2007). Nigerians therefore, have a deep belief and reliance on traditional medicine, hence about 80 per cent of the population uses it almost exclusively while about 95 per cent use it concurrently with western medicine. This is because, to the Nigerian, traditional medicine treats the entire individual rather than one aspect of him or just his disease. According to the World Health Organization, traditional medicine is:

*The total combination of knowledge and practices, whether explicable or not, used in diagnosing, preventing or eliminating physical, mental or social diseases and which may rely exclusively on past experience and observation handed down from generation to generation, verbally or in writing (*WHO, (2008).

At the centre of this practice are health professionals variously called Babalawo (Yoruba), Dibia (Igbo), Boka (Hausa), and among whom different expertise in healing has emerged. These include herbalists, bone-setters, traditional birth attendants, and psychiatrists among several others. They usually rely on vegetables, mineral substances, animal parts and certain other methods such as prayers, divinations, and incantations. (Mbiti, 1976, Owumi, and Jerome, 2008).

Traditional medicine exists in four major categories viz: Nature healing (bone setting, hydrotherapy, use of air, fire and hypnotism etc.), Natural healing (telepathy prayers, incantations, hypnotism etc.), Herbal healing (use of leaves, branches, fruits, stem back, roots, whole plants); Spiritual healing (involving spirits such as demons, witchcraft, water mermaid etc.) (Nigerian Tribune, 2010). The practitioners acquire herbal knowledge either through inheritance or apprenticeship or as a call and the training period is usually long and expensive, even starting the preliminary preparations at the age of five in some cases. Part of the training involves some apprenticeship where candidates acquire knowledge pertaining to medicinal value, quality and use of different herbs, the causes, cure and prevention of diseases, among others. Overtime, they have created

lasting impressions on the minds of the people and are given due recognition as competent health care providers. (Erinoso, and Ayomide, 1985). The typical medicine-man devotes much time and personal attention to the patient and this enables him to penetrate deep into the psychological state of the patient. According to Mbiti, (1976), traditional health practitioners symbolize the hopes of society, hopes of good health, protection and security from evil forces, prosperity and good fortune, and ritual cleansing when harm or impurities have been contracted.

African concept of disease and medicine is the foundation of medical treatment in Africa. In Nigeria, medicine (unlike in the West) has personality and potent living force (Little, 1954). Hence, the management of neurosis by Nigeria traditional healers should be expected to be radically different from what obtains in western therapies and procedures. Nigeria traditional healers make use of divination to unearth the mental and psychological problems of their patients. In fact, psychotherapy is an integral part of African traditional medicine. This is done by trying to investigate the inner being of their patients, even when patients have not manifested physical signs of neurosis. The feat of African traditional healers in mental health care has been acknowledged in several scientific fora. According to Dopamu (1979) with reference to African medicine amongst the Yoruba of Nigeria, Dopamu wrote that: "...psychotherapy has always formed an essential and dynamic basis for effective methods of treatment. It enables us to know the relationship between the patient and the medicine. The medicine-man as a diagnostician

must first of all look into the social, cultural and intellectual environment and background of the patient. He can then evaluate and interpret the cause of the disease, and give the necessary help. This attitude can be described as "medical psychology". In diagnosis and treatment of diseases therefore, the Yoruba medicine man usually maintains "psychological homeopathy" in order to promote the well-being of his patient." Oracles and divination play significant roles in the treatment of neurosis in African traditional medicine. This is because in Africa, life is traced back to its metaphysical past which interplays with the present and future (Dime, 1995).

Idowu (1973) also highlighted the feat of African traditional healers in the treatment of psychiatric and psychological problems as: "...it does not infrequently happen that African doctors trained in the European methods advise relatives or patients in hospitals, this is not a case for this place, or this case as I see it, cannot be treated successfully in this hospital; why don't you take the patient home and try "the native way" It is thus not any wonder that most governments in Africa engage the services of traditional psychiatrists in the management of mental health.

Causes of neurosis and psychological ill-health are sometimes unknown. In such situations, African traditional healers resort to positive witchcraft (if the cause of ailment defies divination). Witchcraft could be positive or negative. Positive, if used for the good of community and humanity, but negative if used for evil. Positive witchcraft is often used to unravel the cause(s) and treatment of mental ill-health. According to Mume

(1976) “Many years of association with Jeje Karuwa, the wizard of Igbinse has afforded me the opportunity to see him perform wonderful feats which I believe an ordinary person cannot do. Many diseases, whose causes cannot be traced through scientific diagnosis, which also defy ordinary treatment, had been treated by him with resounding success". This type of therapy and similar kinds maybe difficult for non-Africans and Africans in Diasporas to appreciate and understand.

Traditional medicine has endeared itself to the people especially in the rural areas who lack access to western medical practice. Furthermore the prohibitive cost of western medications present another attraction for traditional medicine. Throughout Nigeria, traditional medicine is very popular because the practice takes full account of the socio-cultural background of the people. This is viewed against its western counterpart that engages patients in a “distant” and “disconnected” way from the spiritual elements of the human body. Moreover the efficacy of western drugs has been questioned. The Voice of America recently reported that 60 per cent of drugs circulating in Africa are fake just as ‘orthodox medical practitioners look forward to only between 30 and 35 per cent success rate for the efficacy of their drugs (Nigerian Tribune, 2012). Dr Azugbo, President-General of Herbs and Leaves Traditional Medicines Practitioners’ Association of Nigeria, opines that ‘in the ancient days, our forefathers did not take modern medicines. They used to take herbs and leaves and that was why they lived longer and stronger’ (Vanguard, 2012). Traditional medicine, as is well known, is a cultural gem of various communities

around the world and encompasses all kinds of folk medicine, unconventional medicine and indeed any kind of therapeutically method that had been handed down by the tradition of a community or ethnic group.

By the World Health Organisation (W.H.O 1976) definition, traditional medicine is the sum total of all knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental or social imbalance and relying exclusively on practical experience and observations handed down from generation to generation, whether verbally or in writing. With these descriptions, various forms of medicines and therapies such as herbal medicine, massage, homeopathy, mud bath, music therapy, wax bath, reflexology, dance therapy, hydrotherapy, mind and spirit therapies, self-exercise therapies radiation and vibration, osteopathy, chiropractice, aromatherapy, preventive medicine, radiant heat therapy, therapeutic fasting and dieting spinal manipulation, psychotherapy, etc. are a few elements of traditional medicine. It does show that a large country of the size of Nigeria, with diverse cultures and traditions, should be rich in traditional medicine and should have eminent and respected traditional healers to take care of the teeming population.

The traditional healer, as defined by the W.H.O (1976), is a person who is recognized by the community in which he lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious background, as well as on the knowledge, attributes and beliefs that are prevalent in the

community, regarding physical, mental and social well-being and the causation of disease and disability.

The pride of place of traditional medicine in the care for the mentally ill in many developing countries including Nigeria prompted the interest of the World Health Organisation (WHO), which acknowledged the central role traditional medicine plays in the 21st century in the areas of prevention and management of diseases such as Tuberculosis, Malaria, HIV/AIDS, and the care for the mentally ill, etc.

2.2. Categories of Traditional Healers

For most countries of the world, just as we have in Nigeria, a traditional healer may be able to perform many functions thereby becoming more versa tile as a healer. The various categories of tradition al healers, perhaps specialists known in traditional medicine today in the cure of the mentally ill include according to Tella, 1986; lwu, 1986.

Herbalists: Herbalists use mainly herbs, that is, medicinal plants or parts of such plants-whole root, stem, leaves, stem bark or root bark, flowers, fruits, seeds, but sometimes animal parts, small whole animal — snails, snakes, chameleons, tortoises, lizards, etc; inorganic residues - alum, camphor, salt, etc — and insects, bees, black ants etc. are added.

Such herbal preparations may be offered in the form of (i) powder, which could be swallowed or taken with pap (cold or hot) or any drink, (ii) powder, rubbed into cuts made on any part of the body with a sharp knife, (iii) preparation, soaked for some time in water or local gin, decanted as required before drinking; the materials could also be boiled in water, cooled and strained (iv)

preparation pounded with native soap and used for bathing; such "medicated soaps" are commonly used for skin diseases, (v)pastes, pomades or ointments, in a medium of palm oil or shea butter, or (vi) soup which is consumed by the patient. Herbal preparations may also be administered as enema.

The herbalist cures mainly with plants which he gathers fresh. When seasonal plants have to be used, these plants are collected when available and are preserved usually by drying to eliminate moisture. Herbs were the first medicines used by pre historic man. They are, therefore, part of every cultural tradition and have helped the development and growth of herbalism in Nigeria.

2.3. Orthodox Medicine / Care

Orthodox medicine was introduced to the Africa continent in the wake of colonialism through missionaries of the Christian faith (Mbiti, 1976). This new medicine prepared people psychologically to become more receptive to western culture and education. This led to the relegation of traditional medicine to the background and the practitioners were derided and tagged ‘witch-doctors’. In Nigeria, traditional medical practice suffered a decline during the era of British colonization which virtually out-lawed it. (Mbiti, 1976). This is coupled with the rise of Christian ideology especially of the Pentecostal genre which considered most aspects of the practice as un-Christian and therefore ‘evil’ (Nigerian Tribune, September, 8, 2010. Pp. 42-43). The rejection and derision of the indigenous healing practice has continued till present time, leading to government’s unwillingness to

recognize and harmonize it with the global system of health care delivery

Orthodox medicine is principally the province of doctors/nurses/consultants et. al. and the primary philosophy of orthodox medicine is exemplified in the magic bullet concept. Thus, a diseased part will be targeted with a specific treatment aimed at 'fixing' that diseased part, such as a drug that destroys cancer cells, or a drug that dilates the bronchi to relax spasm in the lungs to enable proper breathing. Alternatively if a diseased part cannot be fixed then perhaps it will be cut off and removed, such as removal of the womb in cases of dysmenorrhea.

The specialty of orthodox Medicine is to look closer and closer at the diseased part in an attempt to understand the nature of the problem. Cancerous parts have been looked at in greater and greater detail and there are myriad names for different sorts of cancers in different sections of the body. Infections are examined closely to determine the nature of the invading organism. Blood is analyzed to measure the amount of hormones being produced by the ovaries or by the thyroid. There are X-rays, cat scans, ultra-sound scans, blood tests, urine tests, stool tests, sputum tests, smears, swabs, scrapings, samples, cameras into every orifice, or if there is not an orifice, why! just cut a hole, more and more detailed analysis. The purpose of all this is to arrive at a DIAGNOSIS - it is a 'staph' infection, there is an ulcer, you have gall-stones/kidney stones, your cholesterol is too high, your oestrogen is too low, you have MS/cancer/diabetes etc.

When there is a DIAGNOSIS, then and only then can a treatment be applied. It reminds me of primitive magic, once you know the REAL name of a person/demon/deity, then you have power over him/her/it. You have colitis, an inflamed colon - try an anti-inflammatory, or you have an infection - take an antibiotic, maybe you have hypertension - try a diuretic to squeeze fluid out of the system. In some circumstances the information from a diagnosis is very useful, an infection - is it viral, fungal, or bacterial, the pain is because there are gallstones, but many diagnoses are fairly pointless in reality, but because at least there is a DIAGNOSIS, the pointlessness is passed over. Consider, syndromes, a good translation for the word syndrome is "we don't know the what, the how or the why of this particular problem" and there are a lot of syndromes out there, it's a bit worrying. Any kind of ".....itis" is fairly weak also, '.Itis' means inflammation, inflammation is a term that embraces a multitude of causes.

1.0. THEORETICAL FRAMEWORK.

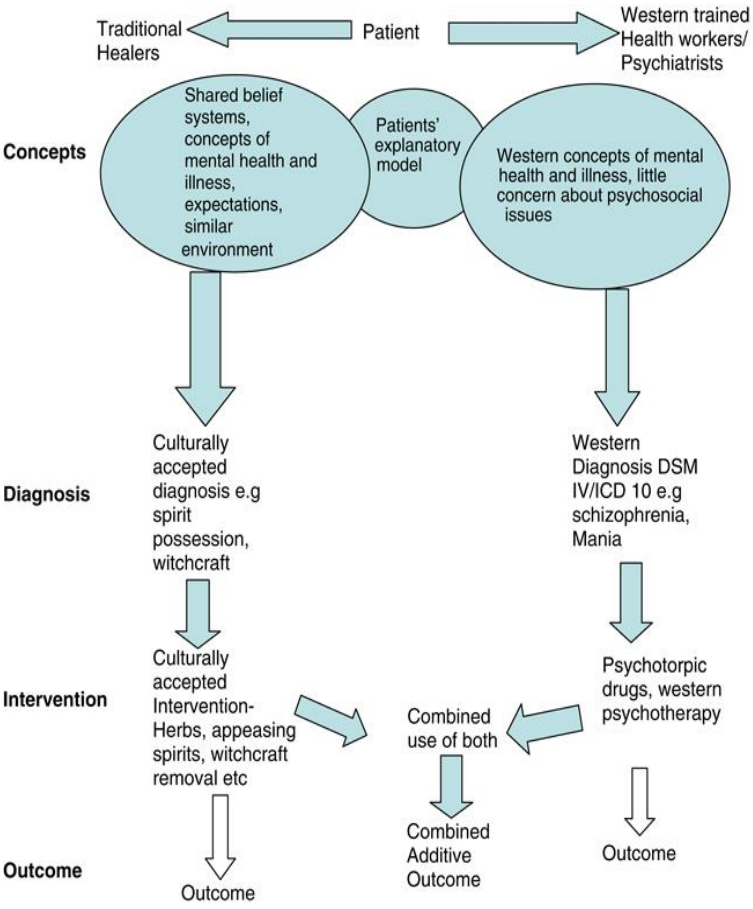
This study has explored a lay concept of cross cultural care in the traditional and the orthodox levels for the care of the mentally ill. On the bases of that, it shall draw its theoretical ideas from various models of health care. For the purpose of this work, we shall use two namely: Biopsychosocial model and Holistic model

3.1. Biopsychosocial model

The Biopsychosocial model is a general model or approach that posits that biological, psychological (entailing thoughts, emotions, and behaviors), and

social factors all play a significant role in human functioning in the context of disease or illness (Engel, 1977). Health is best understood in terms of a combination of biological, psychological, and social factors rather than purely in biological terms (Engel, 1977). According to the Biopsychosocial model, factors that potentially influence any health outcome exist at many levels of organization, and scientific scrutiny is required at all those levels to detect which factors indeed play a significant role. The Biopsychosocial model as described by Engel (1977) has been criticized by Richter (Richter, 1999) who argued that this model cannot depict the system of psychiatric care and its related problems faithfully. Although it is generally acknowledged that psychiatry should orientate toward the Biopsychosocial paradigm, in practice, real changes toward this model cannot be found because the biological approach in etiology and treatment has become more and more important in recent decades (Richter, 1999).

Figure I: The Conceptual Framework of the Study



Source: Catherine Abbo. (2011) *Fig. 1.*Theoretical framework

3.2. Holistic model

The **holistic approach** is a **model** that addresses this issue and how it can be useful in explaining the experience of mental health. The **holistic model** is made up of five dimensions, emotional, physical, spiritual, psychological and social. At the center of

the **model** is the person, the service user/survivor. This model combines many health modalities and models of health care with the goal of helping the patient or client achieve optimal physical, mental, emotional, social, and spiritual health (Klinghardt, 2005). The ultimate goal of holistic medicine is to use all the available diagnostic and treatment modalities to optimize the health of the person on all levels of well-being, without doing harm to the person. The premise of holistic medicine is to attempt to treat the patient as opposed to the illness. Traditional healing and complementary and alternative medicine (CAM) use the holistic approach or model to health care. However, some critiques of this model argue that not all components of traditional healing and CAM are holistic (Klinghardt, 2005). In this regard, no single model of health care is capable of meeting the entire range of human needs at the time of illness and disease (Sewell, 2008). Hence the need for this paper is to be based on all the three models in order to achieve a comprehensive view.

The objectives of these studies were to document the lay cross – cultural care for treatment in the tradition and orthodox level for the mentally ill, describe the psychological distress and associated factors of the attendees of traditional and orthodox healing practices; the prevalence and severity of mental disorders treated by traditional and orthodox practitioners.

As illustrated from Figure 1 above, the concept of mental care can be view from two stand point: the traditional healers and the western trained health workers/ psychiatrists. The method of diagnosis is

different, the traditional healers belief in culturally accepted diagnosis by spirit possession and consulting the gods of the land, while the western diagnosed using the DSM IV/ICD 10. The traditional healer intervention method is culturally based, through the use of herbs, appeasing the spirits and witchcraft removal. Because to the traditional healer mental illness is culturally influence by strange powers. But on the other hand, psychotropic drugs/ western psychotherapy is used and recommended for the cure of the mentally ill. The combination of the two methods of healing will bring about a Combined Additive Outcome.

2.0. CROSS- CULTURAL VARIATIONS OF MENTALILLNESS.

In many parts of Nigeria, mental illness is attributable to various causative factors. Nevertheless, all seem to explain mental illness as an affliction on man from the spirit world. In the Yoruba culture people who suffer from mental disorder are called “were”, and they believe that the pregnancy of such people were possessed by spirit pranksters most often referred to as “emere”. Surviving children manifest various forms of mental illness ranging from manipulative stereotyped histrionic dissociative disorder to real schizophrenia. In other parts of the country, people suffering from mental illness are seen as being the architect of their own misfortune. They are seen as being serving the consequences of one evil or the other they have committed in the time past. As such, when someone is mentally ill it is unusual for his people to seek orthodox medical care. They rather would consult the native medicine man since the cause of the problem, for them certainly is from the spirit

world. This practice will affect both the prognosis and the overall outcome of the illness because in most cases, these medicine men do abuse the power and trust bestowed on them by their people.

Apart from in the conceptualization of the etiology of mental disorders, it has been noted that cultural practices affect the manifestations of the symptoms and signs of mental disorders, as some mental disorders occur exclusively in one location and do not occur at all in others. This led Yap in 1962 to coin the word culture-bound syndromes to explain this phenomenon.11

The type of cultural belief that an individual holds on to, determines the type of care to patronize. And this cultural belief can affect: Which deviant behaviours are considered to be **illness,** Notions of etiology (causation**),** Notions of appropriate treatment**,** Ideas about who is an appropriate healer**,** How people seek help**,** How people receive care

4.1. TYPES OF CULTURAL BELIEF SYSTEM

Cultural belief system in the care of the mentally ill can be divided into four :

- ✓ Western vs. non-western.
- ✓ Individualistic orientation: places high value on personal autonomy.
- ✓ Collectivist orientation: places high value on interdependence.
- ✓ Modern vs. traditional

The following can be attributed on an individual's mental health:

- ✓ People in cultures that are individualistically oriented tend to attribute cause of mental illness to something within themselves—personal responsibility
- ✓ People in cultures that have a collectivist orientation tend to attribute cause of mental illness to something outside the self—the responsibility of forces beyond their control.

4.2. ORTHODOX CARE / MENTAL HEALTH SERVICE

This domain deals with how mental health services are organized and delivered at various levels of care either for promotion, prevention or treatment of mental disorders, as well as for the rehabilitation of persons with mental illnesses. In Nigeria however, no posts have been created in the Ministries of Health at state or national levels for mental health, and these services are often supervised by officials with other primary duties (WHO-AIMS, 2006).

Nigeria's mental health facilities consist of eight federally funded psychiatric hospitals and six state-owned mental hospitals financed and managed by various state governments, for a population of over 150 million people. Given the limited number of these hospitals, their catchment areas often go beyond their immediate location in terms of city or even state. None of the facilities have beds for children and adolescents. There is only one private community residential facility available with 10 beds in Lagos State and it is administered by a religious organization for rehabilitation of persons with drug problems (WHO-AIMS, 2006). As compared to South Africa that has

3,460 outpatient mental health facilities; 1.4% of those are for children and adolescents. These facilities serve 1,660 persons per 100,000 of the general population in a year. There are 80-day treatment facilities and 41 psychiatric inpatient units in general hospitals with a total of 2.8 beds per 100,000 population; 3.8% of these beds are reserved for children and adolescents. Sixty-three community residential facilities provide a total of 3.6 beds per 100,000 population; 23 mental hospitals provide a total of 18 beds per 100,000 population. Children and adolescents have 1% of beds reserved for their care in mental institutions across South Africa (WHO-AIMS, 2007; Lund et al., 2008).

Historically, Nigerian mental health care service dates back to 1904, when the first asylum was opened in the southern city of Calabar. In 1907, Yaba Asylum in Lagos opened, and another facility followed in 1914 at Lantoro, Abeokuta (Ayonrinde.,Gureje., and Lawal, 2004). The first Nigerian psychiatrist, Dr. Thomas Adeoye Lambo, spearheaded service delivery on his return from the United Kingdom in 1952, when the Neuropsychiatric Hospital in Aro, Abeokuta, was still under construction. Lambo had just completed his training in psychiatry at the Maudsley Hospital, London, which played a central part in the development of psychiatry in Nigeria, with community practice been developed in collaboration with WHO initiatives (Boroffka, 2006). In spite of a strong academic history in psychiatry, mental health care is still institutionalized and inadequate.

CONCLUSION

Without doubt our health conditions affect others especially our loved ones, thus treatment refusal for our conditions have consequences for others (relations and community). This is because family members are usually saddened by the unwillingness of their loved ones to receive proper health care especially if such conditions are psychiatric in nature. However, non-consensual treatment of the harmless neurotic cannot be justified, since community members are not directly at risk. The harmless neurotic is neither destructive nor contagious. Compulsory treatment of the mentally ill (especially if harmless) breaches the right of the patient, this is because."...every touching of the patient is potentially a battery on that patient. It is the patient's consent-either implied or expressed- which makes the touching legally innocuous" (Mason, and Smith,1983)

RECOMMENDATIONS

Consequently, the respect of autonomy and the opportunity for decision-making in health care usually available to other patients should be extended to the mentally ill. According to Mill (1974) no one should be compelled to do anything even if it was in the person's interest and that should also apply to the mentally ill. Even the notion of caring control, be it by medical personnel or community should be resisted. This is more so in mental health care which sometimes involve behaviour and mental modification. In African traditional setting and ATM, the community must gradually come to term with the fact that health and health care is more of a subjective affair than community affair, hence the

need to uphold patient decisions and respect their unique individuality.

REFERENCES

Abbo, C. (2011). Profiles and outcomes of traditional healing practices for severe mental illnesses in two districts of Eastern Uganda. Global Health Action, Vol.4: 7117. Available on online at : www. ncbi.nim.nih.gov/pmc/articles/PMC315016/pdf/GHA-4- 7117. Accessed on 30th November, 2016

African Union, (2009).Progress Report on the AU Decade of Traditional Medicine (2001-2010).4th Session of the AU Conference of Ministers of Health, Addis Ababa, Ethiopia.

Alem, A., Jacobsson, L., Hanlon, C. (2008). Community-Based Mental Health Care in Africa: Mental health workers' views. World Psychiatry, 7: 54-57.

Ayonrinde, O., Gureje, O., Lawal, R. (2004). Psychiatric Research in Nigeria: Bridging Tradition and Modernization. British Journal of Psychiatry, 184: 536-538.

Owumi, B.E., and Jerome, P.A. (2008) Traditional Medicine and National Healthcare Reforms in Nigeria: Which Way? In Proceedings of National Conference on Social Dimensions of Reforms and Development. NASA. Sokoto. August 20-22. Pp 149-160.

Boroffka, A. (2006). Psychiatry in Nigeria a partly annotated Bibliography. Enugu: Chuka. Available online at http://psychiatrie.de/data/pdf/7a/03/00/boroffka_nigeria.pdf Accessed on 28th November, 2016.

Burns, J., King, H., Saloojee, S. (2007).KZN Treatment Protocol for Mental Disorders. KwaZulu Natal Provincial Directorate for Health. www.kznhealth.gov.za/townhill/protocol.pdf.

Burns JK (2008). Implementation of the Mental Health Care Act (2002) at district hospitals in South Africa: Translating principles into practice. South African Medical Journal. 98: 46-49.

Declaration of Alma-Ata (1978).Primary health care. Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September, 1978. World Health Organization, Geneva. Available at http://whqlibdoc.who.int/publications/ 9241800011.pdf.Accessed on 12th December, 2016.

Dime, C.A. (1995). African Traditional Medicine: Peculiarities. Ekpoma: Edo State University Press.

Dopamu, P.A. (1979) Yoruba magic and Medicine and Relevance for Today. In Religious Journal of the Nigerian Association for the Study of

Religions (NASR), 4: 96.

Downess, R.M. (1977).TIV Religion. Ibadan: University of Ibadan Press.

Edge, R.S. (1999). Ethics of Health Care: A Guide for Clinical Practice, Philippines. Delmar Publishers.

Engel, L. (1977). The need for a new medical model: A challenge to biomedicine. Science, 196: 129–36.

Erinoso. O. A. and A. Ayomide (1985). Traditional Medicine in Nigeria: A study prepared for all Nigerians. Abuja. FMOH.

Erinoso. O. A. (2005). Sociology for Medical, Nursing, and Allied Professions in Nigeria. Ijebu-Ode Bulwark Consult.

Erinoso. O. A, (2012). Some Thoughts on Accountability in and Responsibility for Health in Nigeria. Quarterly Newsletter of the Health Reform Foundation of Nigeria, 1. No. 1. 1-5.

Frankl, V. (1962): Man's Search for Meaning, London, King's English Book Printers Ltd.

Freud, S. (1962): An Outline of Psycho-Analysis, New York, Norton Press.

Orubuloye, I. O. and Ajakaiye, O. (2002).Health Seeking Behaviour in Nigeria. Ibadan. Nigeria Institute of Social and Economic Research.

Iroegbu, P. (1994). Enwisdomization and African Philosophy. Owerri: International Universities Press Ltd.

Iroegbu, P. (1995). Metaphysics: The Kpim of Philosophy. Owerri: International Universities PressLtd.

Iwundu, C. (1991). Guidance and Counselling, Owerri, New-Day Publications

Klinghardt, D. (2005). The five levels of healing. Explore. 14: 1–5.

Little, K. (1954).The Mende in Sierra Leone.In African Worlds. London: Oxford University Press.

Lund C, Kleintjes S, Bird, P., Green, A., Omar, M., Flisher, A., Funk, M., Faydi, E., Bhana, A. (2008). Mental health policy development and implementation in South Africa: A situation analysis. Phase 1 Country Report. Cape Town: Mental Health and Poverty Project.

Lund C, Stein DJ.Funk, M., Draper, C., Bhana, E. (2007). Challenges faced by South African health services in implementing the Mental Health Care Act. South African Medical Journal 97(5): 352- 353.

M. S. Onyekaba, (2008) Conference of Healers: Traditional African Medicine: Minnesota Dept. of Health. Minnesota.

Mason, J.K. and Smith, R.A.M. (1983) Law and Medical Ethics, London, Butterworths & Co. Ltd.

Mbiti, J. S. (1969). African Religions and Philosophy, London, Heinemann Pub.

J. S. Mbiti, (1976). African Religions and Philosophy. London. Heinemann.

Mume, J.O. (1976): Tradomedicalism: What it is, Agbarho, Jom Nature Cure Centre?

Nigerian Tribune, September, 8, 2010. Pp. 42-43.

Nigerian Tribune, September, 13, 2012. P.23

Nursing Act (Act 33 of 2005).Republic of South Africa. Available at http://www.info.gov.za/view/DownloadFileAction?id=67887 (Accessed 19 March 2012). Olson PR (2006). Mental Health Systems Compared: Great Britain, Norway, Canada, and United States. Illinois: Charles Thomas.

Ogbolu.Y, (2007). Neonatal Mortality: A Critical Global Issue. Neonatal Network, 26(6): 357-360.

Otite, O (1990) Ethnic Pluralism and Ethnicity in Nigeria Ibadan: Shaleson

Oyeneye, O. A. and Orubuloye, I.O. (1985). Some Aspects of Traditional Medicine In Bendel State Of Nigeria. Ibadan. Nigeria Institute of Social And Economic Research

Omosede, A. (2004): Oral Interview on African Traditional Medicine.

Orubuloye. I. O. and Ajakaiye. O. (2002).Health Seeking Behaviour in Nigeria. Ibadan. Nigeria Institute of Social and Economic Research.

Oyeneye. O. A. And Orubuloye.I.O. (1985). Some Aspects Of Traditional Medicine In Bendel State Of Nigeria. Ibadan. Nigeria Institute Of Social And Economic Research.

Ozekhome, F. (1990).The Theory and Practice of Traditional Medicine in Nigeria, Lagos. Okey Okwechime & Co Ltd. M News, September, 11, 2012. P. 18.

Sewell, R. (2008). Holism–remembering what it is to be human. Complement Their Clinical Practice, 14: 75–6.

S. Roan, (1999). Alternative Medicine. Encarta Yearbook, November. The Nation, August, 28, 2008. P. 44.The Nation, August, 7, 2012. P. 28

Vanguard, May, 17, 2012, P.7.Vanguard, May, 2, 2012, P.17.

WHO fact sheet. www.who.int/mediaactive/factsheet/culturalpractices and health/ en/ 2007-07 06

World Health Organization (2008). Mental Health Gap Action Programme: Scaling up care for mental, neurological and substance use disorders. Geneva. Available at http://whqlibdoc.who.int/publications/2008/9789241596206_eng.pdf (Accessed 18 April 2016).

World Health Organization (2009).Improving Health Systems and Services for Mental Health (Mental Health Policy and Service Guidance Package). Geneva.

WHO (2005). World Health Organization-Assessment Instrument for Mental Health Service (WHO-

AIMS) Version 2:2. Geneva: World Health Organization, Available at http://www.who.int/mental_health/evidence/ AIMS_WHO_2_2.pdf Accessed 5 November, 2016.

WHO (2006).World Health Organization-Assessment Instrument for Mental Health Service. WHO-AIMS Report on Mental Health in Nigeria. World Health Organization and Ministry of Health Ibadan, Nigeria. Available at http://www.who.int/mental_health/evidence/ nigeria_who_aims_report.pdf .Accessed 5 October 2016.

WHO (2007).World Health Organization-Assessment Instrument for Mental Health Service. WHO AIMS Report on Mental Health System in South Africa. WHO and Department of Psychiatry and Mental Health, University of Cape Town, Cape Town, South Africa. Available at: http://www.who.int/mental_health/evidence/ south_africa_who_aims_report.pdf Accessed 5 December 2016.

WONCA (2008).Integrating Mental Health into Primary Care: A Global Perspective. Geneva. Available online at http://www.who.int/mental_health/policy/ Integratingmhintoprimarycare2008_ lastversio pdf (Accessed 26 May 2016).