PERCEPTION AND PRACTICES OF NURSES AND COMMUNITY HEALTH WORKERS REGARDING CHILD AND ADOLESCENT MENTAL HEALTH IN ADO AND IREPODUN/IFELODUN AREAS, EKITI STATE, NIGERIA

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A Project Submitted to the Centre for Child and Adolescent Mental Health,

In partial fulfilment of the requirements for the Degree of

MASTER OF SCIENCE

Of the

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DECLARATION

I declare that this study was carried out by me Elizabeth Olufisayo FADUMIYO in the child and adolescent mental health department, of the University of Ibadan.

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CERTIFICATION

I certify that this study was carried out by Elizabeth Olufisayo FADUMIYO in the child and adolescent mental health department, of the University of Ibadan under my supervision. This dissertation work was supervised by:

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DEDICATION

I dedicate this project to the glory and honour of God almighty who divinely helped me when I was helpless during the course and research work, my darling husband and my loving and caring parents Mr.&Mrs. Fadumiyo for their support.

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ACKNOWLEDGEMENT

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LIST OF ABBREVATIONS

ADHD	Attention Deficit Hyperactivity Disorder
AIDS	Acquired Immune Deficiency Syndrome
BHC	Basic Healthcare Centre
CAMH	Child and Adolescent Mental Health
CAMHS	Child and Adolescent Mental Health Service
CHEWS	Community Health Extension Officers
CHW	Community Health Workers
CHOS	Community health officers
DALY	Disability Adjusted Life Years
HIV	Human Immunodeficiency Virus
LCDA	Local Council Developmental Area
LGA	Local Government Area
LMIC	Low and Middle Income Countries
MH	Mental Health
PHC	Primary Healthcare
PHCPS	Primary Healthcare Providers
SPSS	Statistical Package for Social Science
UK	United Kingdom
USA	United State of America
W.H.O	World Health Organization

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ABSTRACT

There is a huge gap in the provision of mental health services for children and adolescents in Nigeria primary health centres, where over half of children in the community access the primary healthcare facilities under the care of nurses and the community health workers (CHEWs and CHOs). Information on the perception and practices of healthcare providers working in these settings could aid effective policy formulation and planning of interventions. Thus, this study was designed to assess the perception and practices regarding child and adolescent mental health among the primary healthcare providers in Ekiti State Nigeria.

A hospital based cross-sectional study was conducted in the selected local government areas using a three-stage sampling techniques to select two out of sixteen local government areas. Forty out of the 50 primary health centres in the two local governments were selected and 10 respondents from each of the centres making up to 400 respondents. Information on the socio-demographics, awareness and perception of mental illness in children and adolescents, knowledge on the possible causes of mental illness in children and adolescents, attitude and practices of child and adolescent mental illness were collected using a self- administered semi-structured questionnaire. Respondents who answered no or unsure to all seven questions were classified as having low social distance, respondents with only one affirmative (yes) answer was classified as having medium social distance while those with two or more affirmative responses were classified as having high social distance. Data were analysed using descriptive statistics, Chi- square test at p=0.05.

The respondents were made up of 76.0% females, nurses were 51.5%. About half of the primary healthcare workers have worked for a period of 1-5 years. Most of the PHCP said they first heard of CAMH from school (36.0%), followed closely by 32%

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of them who first heard about CAMH from home. About two thirds of the respondents thought that CAMH is somewhat important and a high proportion (92.7%) agreed that depression is a mental health problem in children while 68.5% of the respondents said that “divine punishment/God will are causes of mental illness in children. Nurses had better knowledge of CAMH compared to the community health workers. However, high proportion (73.5%) of the PCHP said they have limited confidence in themselves to recognize when a child or adolescent has a mental illness.

The good knowledge of CAMH care among the PHCPs did not translate to actual full involvement in good practice regarding child and adolescent mental health services but the level of practices were worse among the community health workers in Ado and Ifelodun/Irepodun LGAs in Ekiti state. Advocacy and training opportunities are needed to address the problem and regular training programmes in order to address specific needs such as prompt referral and correct treatment for CAMH.

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CHAPTER ONE

INTRODUCTION

1.1 Background

According to the World Health Organization (WHO, 2014), mental health can be defined as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. Thus, mental health disorders refer to any condition that affectsthe mood, thinking and behaviour of people. Examples of mental illness include: depression, anxiety disorders, schizophrenia, eating disorders and addictive behaviours. Mental health disorders account for about 15-30% of the disability-adjusted life year (DALYs) lost in the first three decade of life (Kieling, et al., 2010). It has been shown that mental illness inflicts a significant burden on individuals, their families and the society (Kalian, 2010; Zechmeister, 2008).

Healthcare is the responsibility of the three tiers of government in Nigeria. The first and lowest tier of government is the local governments which is majorly responsible for the delivery of primary care, the second tier is the State governments which focus on the various general hospitals (secondary care), while the third tier is the Federal government whose role is mostly in coordinating the affairs of the Federal Medical Centres and Teaching Hospitals (tertiary care). The primary healthcare providers (PHCPs) are first line of contact in health and related issues to the community including children and adolescents and act as a principal point of continuing of care within the healthcare system.

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In Nigeria, and in most developing countries, the primary healthcare facilities are the first place of seeking for health, partly because of their closeness to the people and relatively more accessibility to individuals and families in a community than secondary and tertiary healthcare facilities. Therefore, the primary healthcare providers play significant roles in providing "essential healthcare" to people in various communities, including some mental health–related cares. The primary healthcare providers attend to approximately all health and related issues in the developing countries, and in Nigeria these categories of health workers play important role in delivering services to the community.Majority of the people do not have access to tertiary health services as a result, they rely on the primary healthcare providers.

Globally, mental health disorders are common, but it rarely receives public attention. Mental healthcare services are poorly funded in public and private sectors (McDavid et al., 2008). Consequently, thepublic attention and poor funding of mental health-related issues leave affected individual and their caregivers to bear the burden of care of individuals with mental illness (Niyati et al., 2002). A study conducted by Okewole et al., (2011) showed that a major determinant of psychiatric morbidity among caregivers of children and adolescent with neuropsychiatric disorders is the burden of care. However, anecdotal observations showed that there are challenges to providing mental health services at primary health facilities in Nigeria.

One possible challenge to mental health is the attitude and perception of people, including healthcare workers, towards mental illness. Another is the deficiency in knowledge of mental health disorders. Thus a good understanding of the perception, attitude and practice of primary healthcare providers relating to child and adolescent mental health is necessary. This information may help policy makers in planning of

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services for adolescents with mental illness and identifying factors that may affect their help seeking behaviour (Fisher et al., 1997; Adewuya et al 2007; Heflinger and Hinshaw 2010).

A study conducted by Adewuya et al., (2007) shows that healthcare providers had higher level of social distance towards the mentally ill. Other studies in the UK and Germany indicated that patients experienced stigmatizing attitude by healthcare providers (Gaebel et al., 2002). There are widespread stigmatizing and discriminatory attitudes among primary health workers toward mental illness and those who suffer from it (Kapungweet el., 2011).

Omigbodun et al., (2007) found that most children and adolescents affected with mental health problems go unrecognized and untreated. Another study by Ayidin, et al., (2003), revealed that while academics in the university hospital, resident doctors and registered nurses have sufficient knowledge about mental illness, such as, schizophrenia, anxiety, and depression; they had higher negative attitude towards people with mental illness more than the less educated hospital employees.

1.2 Statement of the Problem

It is established that 12-20% of children seen in the primary healthcare setting are confronted with substantial psychosocial problems (Wolraich et al., 1996) and frequently use of healthcare services (Bernal et al, 2000; Murphy et al, 1999). Research findings also suggest that the cost for primary healthcare of children who have psychosocial symptoms far exceed the average patients cost (Bernal et al, 2000).

However, primary healthcare providers, who constitute the first in the line of health provision, appear not to be adequately empowered to address mental health challenges in Nigeria (Adewuya et al., 2007). There are obvious barrier to provision of mental

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healthcare to children and adolescents at the primary health facilities in most part of Nigeria, such as “high level of social distance” towards the mentally ill(Adewuya et al., 2007). This barrier and many others can be addressed through on-the-job training and retraining of primary healthcare providers on child and adolescent mental health issues. However, there is dearth of baseline data on the knowledge, attitude and existing practices of these health workers. This information is essential for planning effective and sustainable interventions directed towards improving the healthcare workers approach to mental health in children and adolescents. A lot of research relating to mental health had been done on stigma, focusing on the general population as the source and also on the consequence of stigma for patients and their families who provide care for them (Hinshaw et al., 2005). Not much importance has been placed on the people who are entrusted with the duties of providing care for the people with mental disorders. It is therefore expedient to generate data that can form the basis for designing programmes and interventions geared towards improving attitude and practices of key personnel in the primary health sector in Nigeria.

1.3 Research Questions

This study seeks to provide answers to the following questions:

1. What is the level of knowledge among primary healthcare providers regarding mental health disorders?
2. What are perceptionsof primary healthcare providers regarding mental health disorders?
3. What is the attitude of primary healthcare providers towards child and adolescent mental health?

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4. What are the common practices among primary healthcare workers when they suspect a child or adolescent with mental health problem?

1.4 General Objective

The general objective of this study is to describe theperceptions and practices of nurses and community health workers regarding child and adolescent mental health in Ado-Ekiti and Irepodun/Ifelodun Local Government Areas of Ekiti state, Nigeria.

1.4.1 Specific Objectives

1. To describe the level ofawareness and perceptions of nurses and community health workers towards child and adolescent mental health.
2. To assess the level of knowledge of nurses and community health workers about child and adolescent mental health.
3. To assess the attitudes of nurses and community health workers towards child and adolescent mental health
4. To describe the current practices of nurses and community health workers regarding the care child and adolescent mental health disorders.

1.5 Scope of study

This study was focused on investigating perception and practices of nurses and community health workers regarding child and adolescent mental health in Ado and Irepodun/Ifelodun areas, Ekiti state, Nigeria. A review of the register of the primary healthcare providers in the study area revealed that there are only four doctors playing supervisory roles while nurses and the community health workers constitute the main workforce providing care for patients at the primary health centres. Hence, the reason for focussing this research on the nurses and community health workers (CHOs and CHEWs).

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1.6 Significant of the study

Previous studies have shown that the health care providers' understanding of mental illness and related issues is a key factor in achieving effective preventing, diagnosis, referral and better outcome for individual with mental health problem (Adewuya2008; Ayindin2003). Given the prime roles played by healthcare providers, there is a need to integrate the activities of primary healthcare providers in prevention, recognition and treatment of mental health disorders (Glied 1998; Brauner et al. 2006; Eaton et al. 2011; Quiah 2014). One of the approaches to getting the health workers in the primary health facilities to become proactively engaged in provision of care for who have mental health disorders is to constantly enhance their knowledge and their improve perceptions. These aspects of needs are not currently being addressed in Ekiti state, especially among the nurses and the community health workers. This study is therefore needed in order to access and document different factors that influence nurses' and CHWs' perception, knowledge on possible causes of mental illness in children and adolescents, attitude and practices.) It is envisaged that the findings from this study will help to reveal aspects of mental health training and related issues which need attention.

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1.7 Operational Definition of terms

For the purpose of this research, the following terms or phrases were defined as follows:

1.7.1 Perception: The way in which nurses and community health workers regard, understand, or interpret child and adolescent mental health.

1.7.2 Mental health: A state of well-being in which every individual realises his or her own potential, can cope with the normal stress of life, can work productively and fruitfully, and is able to make a contribution to her community (W.H.O, 2014).

1.7.3 Practices: The primary healthcare provider's customs, habits, procedure or ways of carrying out child and adolescent mental health care.

1.7.4 Primary health care providers: Primary healthcare providers in this study are the Nurses and community health workers (CHOs, CHEWs) who deliver healthcare services in the healthcare centres.

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CHAPTER TWO

LITERATURE REVIEW

2.1 Preamble

Mental health disorders are a major burden of disease worldwide, often attended to by general psychiatrists in general hospital settings after referral from non- psychiatrists (Ndetei et al., 2011). However, child and adolescent mental health disorders are less often recognized by the non-psychiatrists, thereby reducing the likelihood of making referral to the psychiatrists for evaluation (Adewuya et al, 2007). The reasons may be either from total lack of knowledge or awareness that children have mental disorder or as a result of the general negative attribute (stigma) placed on mental illness and especially in child and adolescent mental health services (Bhugra, 1989)

2.2 Mental Health Problem in Children: Problem with Definition:

According to the World Health Organization (W.H.O), children and adolescents are uniquely positioned in the society as the pivot for the future (WHO, 2001). The problem of mental health disorders in children and adolescents can have their origins from both society and dysfunctional family settings (Omigbodun, 2004; Flisher et al., 1997). There are many socio-economic, political and cultural factors that have direct and indirect implications on the physical, mental and social health of children. The realities of poor resources in developing countries and coupled with other competing problems such as HIV/AIDS and malaria may reduce the attention of policy makers towards child mental health. However, there is good evidence such as from Ethiopia that where resources are put into the training of primary healthcare providers, conditions such as, depression, psychosis, anxiety and mania can be identified and treated (Tadesse et al.,1999).

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The knowledge about the treatment provided in the health care setting for child and adolescent mental illness by people in the community is limited, thus alternative places, such as, prayer houses, traditional herbalists, drugs stores, are being patronized by many families without any improvement in the health status of patient. This increases the burden of the illness on the patient, family and the larger society as well as leading to increase social distance by the relations or neighbours (Adewuya et al., 2011; Gureje et al, 2005).Social distance was seen to be higher in response to hypothetical scenarios proposing higher level of intimacy such as marrying someone with mental illness in South-western Nigeria.

Omigbodun (2004) reported that 62.2% of Nigerian children and adolescents that were referred to the clinic had significant psychosocial stressors. Another study conducted in western Ethiopia revealed childhood behavioural disorder prevalence of 17.7% (Tadesse et al., 1999). Moreover, Johnson et al (2008) conducted a survey in post-conflict Liberia and discovered that about 40% of adolescents met the criteria of major depressive disorder and 43% met symptoms criteria of post-traumatic stress disorder.

2.3 Epidemiology of Child and Adolescent Mental Disorders

The World Health Organization gave a report that indicated a large and disproportionate percentage of burdens of disease which falls in the preview of neuropsychiatric conditions in children and adolescents (W.H.O, 2001). Also, the disability-adjusted life years were underrepresented in children and adolescents with disorder such as attention-deficit/ hyperactivity disorders (ADHD), conduct disorder, learning disability, mood disorder, pervasive developmental disorder (Fayyad et al., 2001).

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Omigbodun (2005) explained that up to 20% of children and adolescents suffer from disabling mental illness. Amongst these disabling mental illnessesFoster et al., (2002) found that suicide is the third leading cause of death among adolescents worldwide. Across diverse counties Weismann et al, (1999), also found that major depressive disorder often begin in adolescent which is associated with a huge psychosocial impairment resulting to suicide. Also conduct disorder is also a disorder found in children and adolescent and can continue into adulthood predisposing them to delinquency, crime, antisocial behaviours, marital problems, poor parenting, unemployment and poor physical health (Patterson, DeBaryshe& Ramsey, 1989).

In sub-Saharan African, the prevalence of mental health disorders in children and adolescents ranges from 18.8% to 20.7% (Cortina et al., 2012). In concordance to that, few small scale studies in the community and primary care in Nigeria, suggest that up to 20% of children and adolescents in this environment have mental health problems (Abiodun, 1992; Gureje et al, 1994; Jegede&Cederbald, 1990; Omigbodun et al, 2007). These findings suggest that most of these children and adolescents with mental health problems go unrecognized and untreated. However this could be as a problem on the poor knowledge about their mental health problems/ difficulties or negative attitude of healthcare providers towards child and adolescent mental health services. These problems are obstacles to successful treatment, rehabilitation and integration of mental health services for people in the society and the effect of all these is as a result of stigmatization, which has been described as a cluster of negative attitudes and beliefs that initiate the general public to fear, reject, avoid and discriminate against people with mental illness. (BRFSS Report in President's new freedom commission on mental health, 2003).

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2.4 Prevalence of Mental Health Disorders in Children

Numbers of observations in community surveys of children and adolescents have shown that one in every three to four teenagers is estimated to meet the criteria for diagnostic statistical manual of mental disorders (DSM) mental disorders (Castello, et al., 2004). Nevertheless, only a small proportion of these teens actually have sufficiently severe distress or impairment to warrant intervention. Brauner CB, et al., (2006) About 10% of teens is estimated to meet the substance abuse mental health service administration criteria for a severe emotional disturbance, (Costello, et al., 2005; Brauner, et al., 2006) defined as a mental health problem that has a drastic impact on a child's ability to function socially emotionally and academically. (US Department of Health and Human Services, Mental Health Report 1999)

Children and adolescents in the LMIC constitute about 35-50% of the population (Patel et al., 2008). Close to half of all lifetime mental disorders arise before the age of 14 years (Kessler et al., 2005; Patel, et al., 2007). A review by Sharan and Sagar (2007) revealed that worldwide prevalence rates for child and adolescent mental disorders are around 10-20%.

There has been a gap between the needs and services for mental healthcare and services especially in the LAMIC while most care is institutionally based with poor attention to community mental health (Saxena, et el., 2007). In the high income countries it is indicated that more than a quarter of children and adolescents meet a life time criteria for mental health disorder (Costello et al., 2004). The evidence base on the burden of child and adolescent mental disorders in the LMIC is relatively small due to some numbers of factors like inadequate number of skilled human resources,

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less awareness and low priority, high service load, greater concern for child mortality and morbidity, and journal acceptance biases against LAMIC research (Patel et al., 2013).

Mental health problems in children are common yet many people do not believe that it exits (Eaton et al., 2011). Child and adolescent mental health disorders prevalent rates vary across countries and the LMIC is said to have more children with mental health problems than it is believed to be in the community. Half of the populace is under the age of 18years old, it is estimated that about 20% of the children have a mental health problem and in Nigeria about 12% of the children are affected (Kessler et al., 2007)

Tehran, a country in the Middle East found an occurrence rate of 14.2% of psychiatry disorders among their adolescent with the prevalent rate of ADHD alone to be 8.2% (Mohammadi et al., 2008). In Indian,Malhotra et al., (2009), carried out a longitudinal study and found an incidence rate of 18/1000 years among children in Indian. Also a cross sectional study in Carolina shows that roughly 13.3% of the children in the study were initially identified with a psychiatric disorders, when these children were monitored for about 3 to7 years, 37.6% of them met the psychiatry diagnosis of the DSM IV classification (Costello, 2003). In Kwara state, Nigeria a study recorded 18.6% prevalence rate for psychiatric disorders among children in the community (Adelekan 1999). Also at the same region, Tunde et al., (2012) found 11.4% prevalence rate of psychiatric disorders among children attending a primary health centre.

Nigeria has a population of about 150 million with 50% of this consisting children and adolescents (Omigbodun et al., 2004). It can therefore be extrapolated from the findings in this study that about 8 to 16 million children and adolescents will develop a mental illness at some point in their lifetime. Result of the high figure for active case

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finding, early identification and appropriate psychiatric intervention for the affected children and adolescents.

2.5 **Epidemiological surveys on the perception and practices of child andadolescent mental health problems:**

The professionals and the general public perception about child and adolescent mental health disorders differs, studies shows that there is a need for advocacy to influence leaders towards the unmet need of child and adolescent mental health service in most region of the world (Burns et al., 2004). Despite the huge data and findings on the burden of mental health issues and its negative effect, the public perception has not changed about mental health disorders (Stevenson et al., 1994) instead an increase negative attitude is towards people with mental health disorders (Angermeyer and Dietrich, 2006; Hansen et al, 2011). The consequences of these negative attitudes can affect individuals with mental health illness by being unemployed, through loss of income (Sharec et al., 2010) it can cause these individuals not to seek care or delayed care (Andrews et al, 2001), it can also lead to limited social support network.

In Europe, report shows that mental health service for children are less developed as compared to adult (2005). The lack of adequate knowledge about child and adolescent mental illness would affect the practices of healthcare providers towards unmet need.Mubarak Abera, et al., (2014) conducted a research in Ethiopia and found out that most of the primary health care providers reported that mental health care was important and majorities expressed interest in actually delivering mental health care. Almost half of the PHC workers reported that supernatural factors were important causes of mental health disorders. he perception and attitude leading to stigmatization by the general public, health professionals, and other allied workers towards mental health issues across the globe have been highlighted in so many studies (Gureje 2006;

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Patrick and Amy 2002; Bhugra 1989) but few in child and adolescent mental health service. The stigma arises from ignorance, lack of knowledge and information that gives rise to the persistent negative attitude Aydin et al., (2003) and social rejection of people with mental illness (Corrigan, 2005; Vijay et al, 2012) leading into a vicious cycle. (Wahl, 1999; Craig &Hinshaw, 2010) documented that the health and mental health professionals such as medical doctors, psychologists, social workers, nurses and trainees/ students as well as research investigators held stigmatizing attitudes and practices towards mental illness and this is the same as what is found in the general public. The negative attitude and practices by health professional could influence their ability to make holistic decisions to help those with mental illness specially children and adolescents in the society.

Studies in the South-Western Nigeria on the level of knowledge and attitudes of the general public towards mental illness by (Gureje et al, 2005; Adewuya and Makanjuola 2008), found that there is a general good knowledge/ awareness (60 to 90% of respondents) on the causes of mental illness. But when the community or general hospitals' social distance (social stigma) scores was determined by the modified Bogardus social distance scale, a high level of negative attitudes (stigma) was found among people in the community/ general hospital towards those with mental illness. This was comparable to what is obtained in the Western world (Stuart and Arboleda-Florez, 2003). Dispelling the assumptions that stigma is more in the Western world than non-Western world. (Adewuya and Oguntade 2007), surprisingly, found a high negative attitude among doctors with about 64.1% of them scoring higher on social distance scale). There is an urgent need for advocacy for individuals especially children and adolescents with mental health problems to reduce stigma and improve the use of available mental health services.

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2.6 **The Need for Primary Care Providers' Perceptions of CAMH**

Generally, there is a paucity of mental health providers in LMIC. A recent study included data from 58 LMIC showing that 67% had insufficient number of psychiatrists and 79% had insufficient number of psychologists, occupational therapists and social workers (Bruckner, et al., 2011). As a result of this insufficient human resource, there is a need to scale up services at the primary care level. This is essential because the primary care is more accessible and usually the first contact for patients. They also reach a large proportion of the population and they are already utilized by children and adolescent for other type of health problems and preventive care (Paula et al., 2009). Child mental health problems are relatively common, associated with high levels of burden and high costs over a lifetime. (Kalian, 2010; Zechmeister, 2008).

Early intervention for children and adolescents with mental health problems has been shown to be cost effective and lead to improved quality of life in later life. The world health organization (W.H.O) identified that, the ultimate goal of primary healthcare is a better health for all. There is no complete health without mental health (Prince et al., 2007). Despite the significant implications of untreated mental illness during childhood and adolescence, and potential benefits from early treatment and preventive programs, government attention on child mental health care is insufficient, especially in the LMIC. In these countries, government spending on child mental health care is disproportionately smaller in comparison with investments in mental health care for older age groups and spending on physical health for all age group. (Saxena, 2007; Wang, et al, 2005).

Mental health problem remains highly stigmatized by the general populace in the community, often preventing individual living there to seek help for mental health

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problems (McDonald et al., 2005), the few individuals who seek help are likely to visit the primary healthcare centre. However, it has been reported that PHCPs are under-trained in identifying or treating MH problems (Geller, 1999). Studying this group of health providers' perspectives may prove to be beneficial. With a more detailed understanding of the perception of PHCPs, their perceived prevalence of mental health problem can be identified, and the findings from the current study can form the basis for an intervention program for these health providers in the state, the nation and the sub-Saharan Africa as a whole.

2.7Primary Health Care Delivery and Mental Health

The term primary healthcare was used initially to describe the first care given to a person poor in health, irrespective of where the care was given, however, primary health incorporates preventive, promotion, rehabilitation and curative care with emphasis on prevention (Olise,2007). However, in response to international calls following the Alma Ata conference in 1978 for the improvement of primary healthcare, paramedical schools was established to train scientifically oriented and multivalent health providers for the duration of 3years and thus regarded as community health workers.The level of sophistication at the primary healthcare level depends on the socioeconomic development of the people. Primary healthcare seeks to address then common health problems of the people. Healthcare facilities at the level include dispensaries, health post, clinics, health centres and comprehensive health centres.

A community health officer is an individual trained to manage health issues or problems in the community i.e. at the primary level of healthcare delivery. They are usually in the primary health centres. These facilities are staffed by Nurses and community health workers (CHOs, CHEWs,) environmental health officers and

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available doctors. Most private sector practitioners also provide healthcare at this level. The primary health centres supposed to serve about 5000-10000 and is usually headed by a community health officer, also they serve at the community health posts, maternal and child health post which are both usually located at smaller villages. They provide general preventive, curative, promote and pre-referral care to the population.

The world health organization (WHO) has postulated the treatment or management of some mental health problems at the community level, in these effects, it's of great importance to look out for competence's of community health officers in the diagnosis or identification for referral and management to reduce severity of outcomes. Efficient referrals to tertiary healthcare delivery centres are affected by so many factors, successful management of neonatal illness requires accurate assessment, supported by an effective clinical guidelines. Delay in the diagnosis and treatment of mental health problems, due to inadequate healthcare provider's recognition of mental illness in children and adolescents or lack of proper diagnostic equipment, is common in developing countries and lead to preventable cases of neurodevelopmental impairment, disability and sometimes death Narayanan et al.,(1990) currently, the world health organization (WHO) had introduced the MH gap Action plan for LMIC primary healthcare providers on how well to carry out mental health services in the primary healthcare centres with guild lines on providing services but no such training or guild line exist is Ekiti state among the primary health care providers . Hence there is a need for training primary healthcare providers using the MH gap Action plan in Ekiti state.

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CHAPTER THREE

METHODOLOGY

3.1 STUDY DESIGN

This is a cross sectional study involving the use of semi-structured questionnaire interview for nurses and community health workers at primary health facilities in two selected local government areas of Ekiti State, Nigeria.

3.2. STUDY AREA

The study was carried out in two out of the 16 local government areas in Ekiti state, namely; Ado-Ekitiand Ifelodun/Irepodun local government areas. These local government areas are homogenous,populated by Yoruba speaking people of the South west zone of Nigeria. The Religion of the people is mainly Christianity and Islamic religion while a few percentages of the people are Traditional religion worshippers.

According to the 2006 population census, Ado-Ekiti local government area has estimated population of 308,621.Ado -Ekiti is divided into 13 geo-political wardswhile Ifelodun/Irepodun local government area has 11 political wards. Ado local government has 33 primary health centreswhile Ifelodun/Irepodun has 17 primary health centres (Appendix 3). The major practices at the primary healthcare centres are majorly centre on mother and child's health, immunization for children, antenatal care for the mothers, counselling and services for prevention of communicable and non-communicable diseases. There is scarcely any provision for practices relating to mental health services.

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3.3 STUDY POPULATION

The study population comprises of primary healthcare providers practicing within the local government selected. The primary healthcare providers include the nurses and the community health workers (CHOs, CHEWs) in the primary healthcare centres.

3.3.1.*Inclusion Criteria*

Primary healthcare providers in Ado-Ekiti and Irepodun/Ifelodun local government area who gave consent to participate in the study (Community health workers and Nurses)

3.3.2.*Exclusion Criteria*

Primary healthcare workers who do not provide direct care and treatment (Laboratory attendants, X-ray technicians and workers at the health records) were not included.

3.4 SAMPLE SIZEDETERMINATION

The sample size was determined by the single proportion sample size formula:

$n = Z2\alpha \times p \times (1-p)/ d2$

Where:

n= sample size

Zα= value of the Standard normal distribution corresponding to a significant level α (1.96 for a 2- sided test at 0.05 level).

P= proportion (64.1%=0.641) of people with higher level of social distance and stigmatization of mental health illness as found by Adewuya et al, (2008).

d= degree of precision or absolute deviation from the true value (0.05), 95% CI.

Therefore, n= 1.962 x 0.641(1-0.641)/0.052

n= 353.60

The response rate = 353.6/100-10 = 353.6/0.9 = 392.9

This was rounded up to 395

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3.5 SAMPLING TECHNIQUE

The computed sample size was evenly shared among the health centres selected i.e. 10 per site. This consists of a sample size of 353 which was increased to 400 to allow for evenly distribution and non-response rate. Sampling method used in this study was the multi-stage random sampling.

First stage: Two local government areas were randomly selected from the 16 local government areas in Ekiti state (Ado-Ekiti and Irepodun/Ifelodun LGAs). Each of these local governments is divided into political wards. Ado-Ekiti has 13 political wards while Irepodun/Ifelodun has 11political wards as at the time of this study.

Second stage: The primary healthcare centres were used only for the purpose of this study. There are 33 primary healthcare centres in Ado-Ekiti while there are 17 in Irepodun/Ifelodun adding up 50 public healthcare centres. Out of these centres, a random selection was also made to select out 40 public healthcare centres.

Third stage – Random selection (Balloting) was also used to select 10 healthcare providers each from the 40 primary health centres. The list and phone numbers of nurses and the community health workers (CHEWs, CHOs) attached to the clinics were made available at the centres. Only the healthcare providers who gave their consent were enrolled. The primary healthcare providers who were not available as at the time of selection were contacted via telephone.

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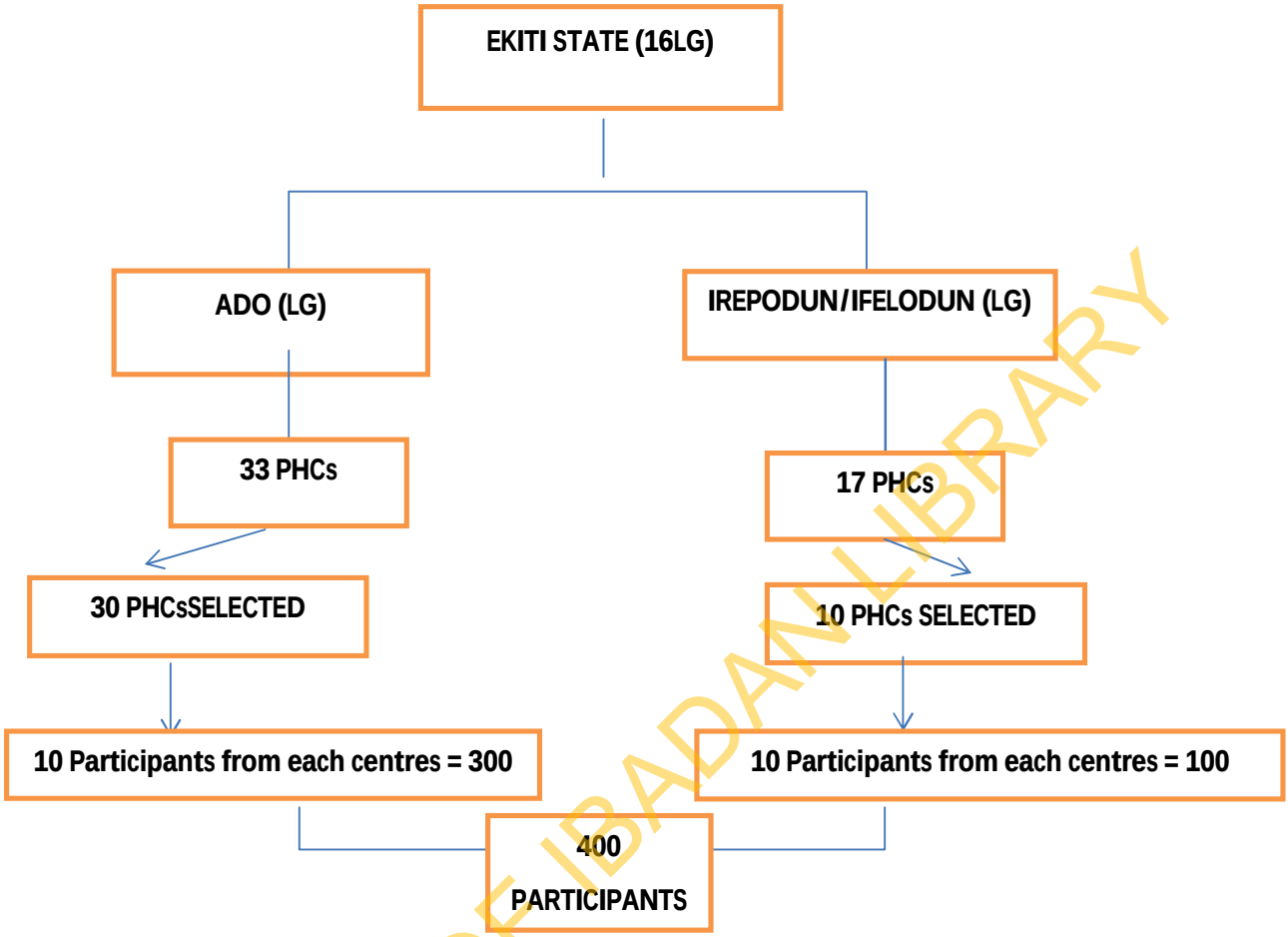
SAMPLING FRAME WORK



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3.6 STUDY INSTRUMENT FOR DATA COLLECTION

A self-administered questionnairewith items adapted from those used by Adewuya and Oguntade (2007) and Ani et al (2011) was used for data collection.

The questionnaire contained 5 main sections with open and closed–ended questions, namely;

A. Socio-demographic characteristics
B. Perception and awareness of child and adolescent mental health
C. Knowledge on the Possible causes of mental illness in child and adolescent
D. Healthcare providers' attitude towards children and adolescents with mental illness
E. Healthcare providers practice in relation to child and adolescent.

The administration of the questionnaire was coordinated and monitored by the researcher, assisted by two trained postgraduate students from the Ekiti State University.

The section of the questionnaire that explores respondent's perception and awareness of children and adolescents mental health problems consisted items on: where health workers first learn of mental illness in children and adolescents, their opinion on how important is mental health in children and adolescents, opinion on signs and symptoms of mental illness in children and adolescents, mental health problems in children and adolescents they have heard, were combined to create a composite perception scale.

The section of the questionnaire that explores respondent's knowledge of children and adolescents mental health problems consisted items on: signs and symptoms of mental illness in children and adolescents, types of mental disorders seen in children and adolescents, and possible causes of mental illness in children and adolescents. The 14

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items that assessed knowledge of causes of mental illness (Question 12-26 in the questionnaire) were combined to create a composite knowledge scale.

The respondent social distance towards children and adolescents with mental illness was assessed with seven questions modelled after Bogardus Social Distance Scale (Bogardus, 1933). The original Bogardus scale has been widely used in different parts of the world including Nigeria (Adewuya and Oguntade 2007; Ani et al 2011). The seven questions (27-33) in the questionnaire assessed how concerned the respondent would be in varying degrees of social interaction by themselves or close relatives with children adolescents with mental illness. Unlike previous studies, questions which portray very intimate associations were avoided (e.g. willingness to marry someone with a mental illness) as these may cause distress to respondents who may themselves have mental illness or have children with mental illness.

Also, the active verbs in some of the vignettes were positively framed (e.g. “would” instead of “would not”) for the same reason. The questions were coded as yes, no, and not sure. As in previous study by Adewuya&Oguntade (2007), the respondents were classified as having low, moderate or high social distance.

3.7 ETHICAL CONSIDERATION

Approval for the study was obtained from the Ekiti State Ministry of Health Ethical Review Committee.Participation in the study was completely voluntary and informed consent was obtained from each eligible respondents. Respondents were informed of their freedom to withdraw this consent at any time and two nurses and one CHW who did not give consent were left out of the study. During the course of this work and thereafter all information obtained about the subjects was kept strictly confidential.

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3.8 DATA MANAGEMENT AND ANALYSIS

The data were entered and analysed using the Statistical Package for Social Science (SPSS Inc., Chicago USA) Version 20.0 the main outcomes of the variables were perception, practices, knowledge on the possible causes of mental illness, signs and symptoms of mental illness in children and adolescents. Independent variables were demographic variables such as age of the primary healthcare providers, occupation, educational status, years of work experiences at the primary health facility and level of training.

Respondents who answered no or unsure to all seven questions (Q27-33) of the social distance scale were classified as having low social distance, respondents with only one affirmative (yes) answer was classified as having moderate social distance while those with two or more affirmative responses were classified as having high social distance.

In addition to the seven questions used to assess social distance, six other questions (Questions 34-39 in the study questionnaire) assessed respondents' negative attitudes and perception of their children and adolescents with mental illness (e.g. that they can be as intelligent or as beautiful as other children). After reverse coding some items, the six questions were combined with the seven social distance questions to create a stigma scale based on respondents percentages such that higher percentage indicate negative attitudes.

In addition, the questionnaire sought information on respondents training on mental health education, child and adolescent mental health, exposure to children or adolescents with mental illness in their practice, awareness and confidence in supporting children and adolescents with obvious features of mental illness such as

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depression, suicidal or hearing voices. Chi-square was used to test associations between two or more categorical variable. The level of significance was set at p = 0.05.

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CHAPTER FOUR

RESULTS

4.1 Demographic Characteristics of Study Participants

The study respondents comprised of 191 Nurses/midwives and 180 Community Health Workers (CHWs). Figure 4.1 displays the distribution of the respondents by age groups. The respondents' age ranged from 18 to 56years (mean age = 35.7 ±8.4 years). The modal age group was 28 – 32 years (27.8%).

Table 4.1 shows the distribution of respondents by socio-demographics characteristics and comparisons between nurses and CHWs. There were 89 (24.0%) males and 282 (76.0%) females. Of the 371 respondents, 22.2% of them were single, 58.4% were married, and 10.4% were married but separated from their spouses. Among the primary healthcare workers, 183 of them attended the school of health technology while 129 respondents attended the school of nursing and only 1 of the 371 respondents had a postgraduate degree as at the time of this study. There was a statistically significant difference between nurses and CHWs with respect to gender ($p = 0.008$), marital status ($p = 0.001$) and educational level ($p = 0.001$).

Table 4.2 shows the frequency distribution of healthcare providers by duration of practice. Over half of the respondents had worked for a period of 1-5 years.

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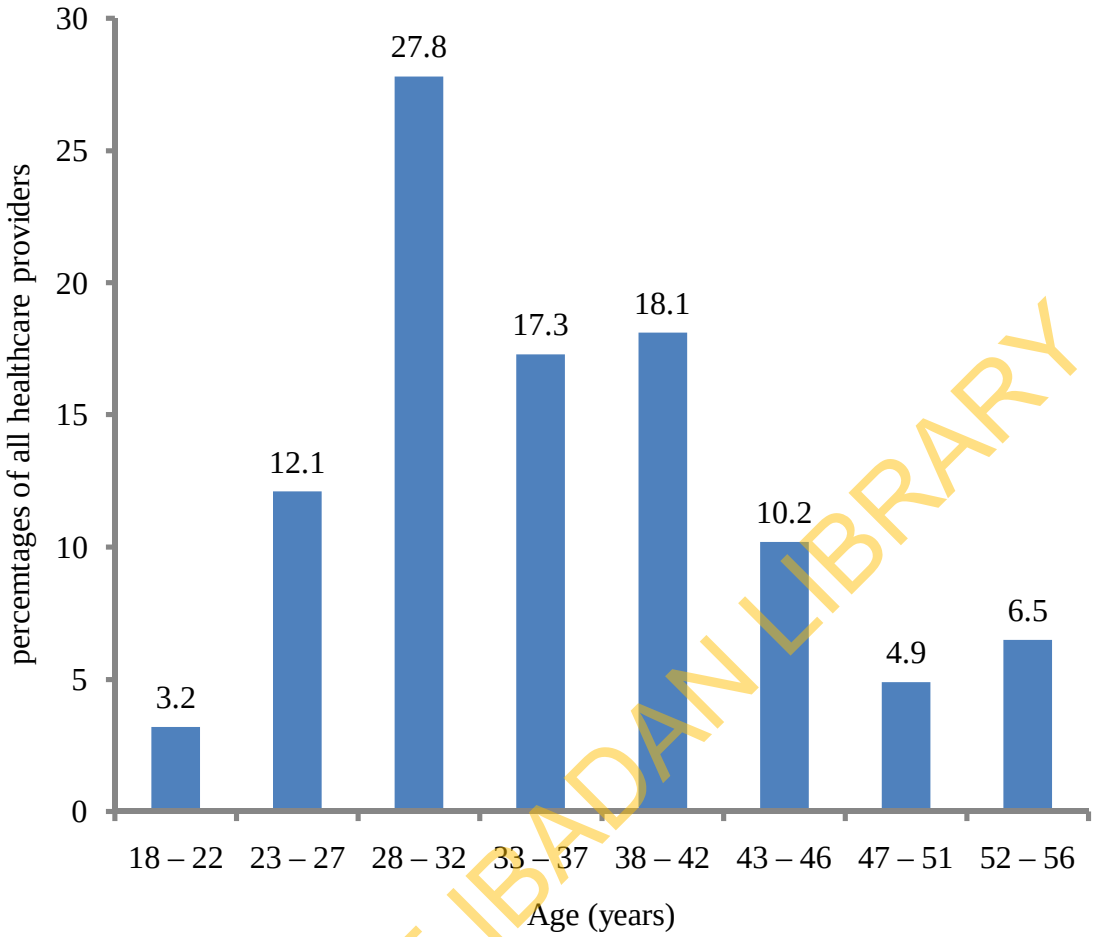

Figure 4.1: Distribution of Healthcare Providers by Age

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Table 4.1: Socio-Demographics Characteristics of Respondents

Demographics Variables	Nurses (N=191)		CHW (N=180)		Total (N=371)		P
	n	%	n	%	n	%	
Gender							
Male	35	39.3	54	60.7	89	100	0.008
Female	156	55.3	126	44.7	282	100	
Religion							
Christianity	147	51.2	140	48.8	287	100	0.851
Islam	44	52.4	40	47.6	84	100	
Marital status							
Single	18	22.2	63	77.8	81	100	0.001
Married	164	58.4	117	41.6	281	100	
Separated	9	10.4	0	0	9	100	
Educational level							
Post graduate	1	100	0	0	1	100	0.001
University	54	93.1	4	6.9	58	100	
Nursing school	110	85.3	19	14.7	129	100	
Health technology	26	14.2	157	85.8	183	100	

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Table 4.2: Frequency Distribution of Primary Health Care Providers Duration of Practice

years of experience	n	%
<1	4	1.1
1-5	209	56.3
6-10	69	18.6
11-15	54	14.6
16-20	6	1.6
>20	29	7.8
Total	371	100.0

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4.2 Awareness and Perception of Primary Healthcare Providers about Child and Adolescent Mental Health

Of the 371 primary healthcare providers, 135(36.%) reported that they first heard of CAMH from school, 6(2%) from media, 117(32.0 %) from home, 103(28%) from the community. Most of the PHCP said they first heard of CAMH from school followed closely by those of them who first heard of CAMH from home (Figure 4.3).

Over half (64.4%) of the PHCP taught that CAMH is somewhat important while 0.5% of them said it is not relevant only 29.1% of the respondent thought that child and adolescent mental health is very important (Table 4.3). More of the nurses (46.6%) found child and adolescent mental health very important compared to the community health workers (10.6%). Only among the community health workers (0.5%) was found child and adolescent mental health not to be relevant.

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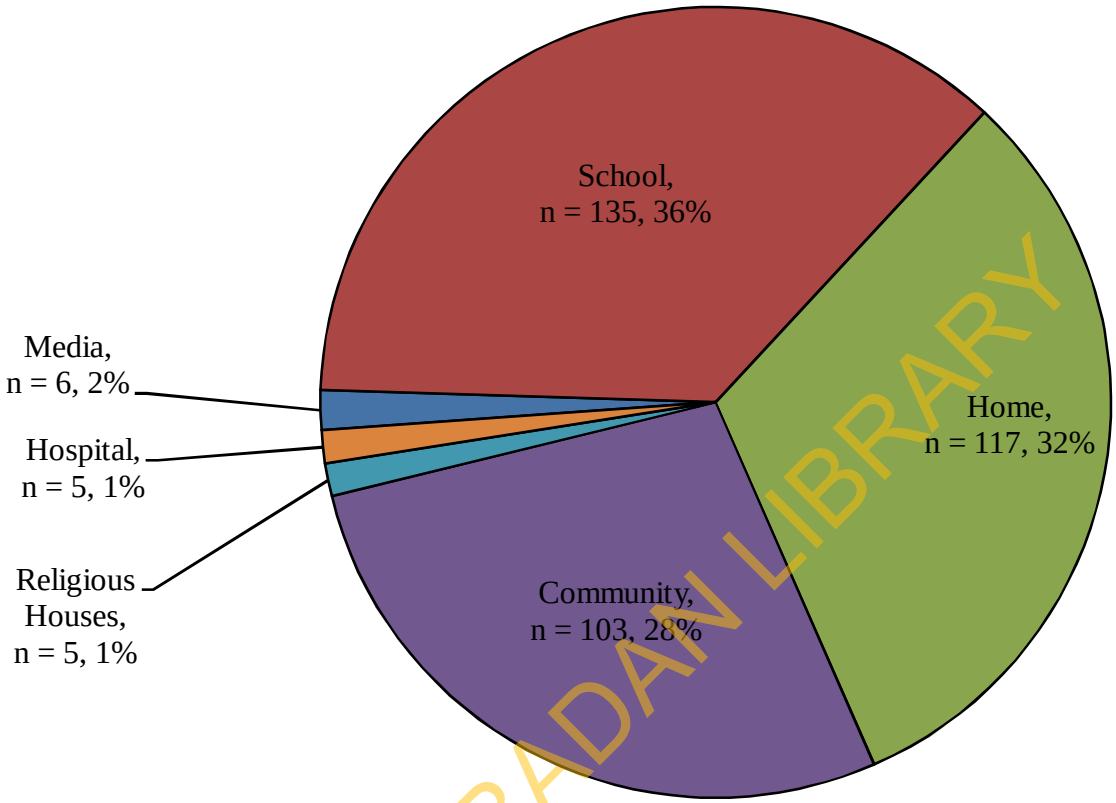

Figure 4.2: Distribution of Respondents by where they first learnt about mental illness in children and adolescents

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Table 4.3: Distribution of Respondents by Perceived Importance of Mental Health in Children and adolescents

Responses	Nurses		CHWs		Total	
	n	%	n	%	n	%
Very Important	89	46.6	19	10.6	108	29.1
Somewhat Important	97	50.8	142	78.9	239	64.4
Not Very Important	5	2.6	17	9.4	22	5.9
Not Relevant	0	0	2	1.1	2	0.5
Total	191	100.0	180	100.0	371	100.0

$\chi^2 = 6.117$, df = 3; p <0.0001

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4.2.1 Respondents' Awareness of Different Types of Mental Health Disorders in Children and Adolescents

Table 4.4 shows the distributions of respondents by their Awareness of different types of mental health disorders In Children andAdolescents. Most of the primary healthcare providers are aware about the following mental health conditions in children and adolescents. Importantly, drug addiction 368 (99.2%), depression 344 (92.7%), autism254(68.5%), as well as eating disorders 231 (62.3%) were the respondents most aware of (n>200). Among the primary health care providers the nurses had higher percentages compare to the community health workers.

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Table 4.4: Distributions of Respondents by their Awareness of Different Types of Mental Health Disorders in Children and Adolescents

Mental health problems	Nurses (N = 191)				CHW (N = 180)				Total (N = 371)				P
	Yes		No		Yes		No		Yes		No		
	N	%	N	%	n	%	n	%	N	%	N	%	
Conduct disorders	113	59.2	78	40.8	24	13.3	156	86.7	137	36.9	234	63.1	0.001
Attention deficit hyperactivity disorders	72	37.7	119	62.3	17	9.4	163	90.6	89	24.0	382	76.0	0.001
Autism	173	90.6	18	9.4	81	45.0	99	55.0	254	68.5	117	31.5	0.001
Anxiety	143	74.9	48	25.1	55	30.6	125	69.4	198	53.4	173	46.6	0.001
Phobia	154	80.6	37	19.4	97	53.9	83	46.1	251	67.7	120	32.3	0.001
Schizophrenia	68	35.6	123	64.4	15	8.3	165	91.7	83	22.4	288	77.6	0.001
Bipolar disorder	63	33.2	127	66.8	10	5.6	170	94.4	73	19.7	297	80.3	0.001
Depression	189	99.0	2	1.0	155	86.1	25	13.9	344	92.7	27	7.3	0.001
Post-traumatic stress disorders	131	68.6	60	31.4	60	33.3	120	66.7	191	51.5	180	48.5	0.001
Drug addiction	189	99.0	2	1.0	179	99.4	1	.6	368	99.2	3	.8	0.597
Eating disorders	159	83.2	32	16.8	72	40.0	108	60.0	231	62.3	140	37.7	0.001
Attachment disorder	103	54.5	17	9.4	17	9.4	163	90.6	120	32.5	249	67.5	0.001

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4.3 Knowledge of primary healthcare providers (Nurses and CHWs) Regarding Causes, Symptoms and Signs of Mental Health in Children and Adolescents

Table 4.5 shows a high proportion of the respondents answered “yes” to loneliness (97.0%), hereditary (98.4%) and abuse (80.6%) as causes of mental illness in children and adolescents. However, above average (57.0%) of the respondents agreed that “destiny/bad luck” and “evil spirit/witchcraft/sorcery’’ (85.7%) are causes of mental illness in children and adolescents.

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Table 4.5: Distributions of Respondents by their Responses to Suggested Causes of Mental Health in Children and Adolescents

Symptoms and Signs	Nurses (N = 191)				CHW (N = 180)				Total (N = 371)				P
	Yes		No		Yes		No		Yes		No		
	N	%	N	%	n	%	N	%	N	%	n	%	
Loneliness	188	98.4	3	1.6	172	95.6	8	4.4	360	97.0	11	3.0	0.103
Stress-personal, financial	168	82.7	33	17.3	83	46.1	97	63.9	241	65.0	130	35.0	0.001
Difficulty at school or work	137	71.7	64	28.3	57	31.7	123	68.3	194	52.3	177	47.7	0.001
Drugs, marijuana, alcohol abuse	191	100	0	0	180	100	0	0	371	100	0	0	-
Shaking hands with another child with mental illness	6	5	190	99.5	2	1.1	178	98.9	3	.8	368	99.2	0.528
Failure in school/life	147	77.0	44	23.0	62	34.4	118	65.6	209	56.3	162	43.7	0.001
Lack of will power	130	68.1	61	31.9	82	45.6	98	54.4	212	57.1	159	42.9	0.001
Divine punishment/God will	107	56.0	84	44.0	147	81.7	33	18.3	254	68.5	117	31.5	0.001
Evil spirit/witchcraft/sorcery	148	77.5	43	22.5	170	94.4	10	5.6	318	85.7	53	14.3	0.001
Sharing cutlery with another child with mental illness	0	0	191	100	0	0	180	100	0	0	371	100	
Destiny/bad luck	78	41.1	112	58.9	133	73.9	47	26.1	211	57.0	159	43.0	0.001
Hereditary (from parents, grandparents or relatives)	189	99.0	2	1.0	176	97.8	4	2.2	365	98.4	6	1.6	0.370
Brain injury/infection of the brain	191	100	0	0	180	100	0	0	371	100	0	0	
Abuse (sexual, physical)	175	91.6	16	8.4	124	68.9	56	31.1	229	80.6	72	19.4	0.001

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Table 4.6 shows that a high proportion of the respondents answered “yes” that the signs and symptoms of children and adolescents Includes ‘talking aloud to self’ (53.9% of nurses and 46.1% of the CHW), ‘thought of killing or harming self’ (100%), ‘school drop-out’(62.8 % of nurses and 37.2% of the CHW). More of the nurses had good percentages on the suggested symptoms of mental illness in children and adolescent compare to the community health workers.

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Table 4.6: Distributions of Respondents by their Responses to Suggested Symptoms and Signs of Mental Health in Children and Adolescents

Symptoms and Signs	Nurses (N = 191)				CHW (N = 180)				Total (N = 371)				P
	Yes		No		Yes		No		Yes		No		
	N	%	N	%	n	%	N	%	N	%	n	%	
Crawling sensation	132	73.3	59	30.9	48	26.7	132	69.1	180	100	191	100	0.001
Talking aloud to self	186	53.9	5	19.2	159	46.1	21	80.6	345	100	26	100	0.001
Sitting quietly in the corner of the room	185	57.1	6	12.8	139	42.9	41	87.2	324	100	47	100	0.001
Crying to self	178	52.7	13	39.4	160	47.3	20	60.6	338	100	33	100	0.145
Toileting on self	130	55.8	61	44.2	103	44.2	77	55.8	223	100	138	100	0.031
Lack of concentration	171	55.0	20	33.3	140	45.0	40	66.7	311	100	60	100	0.002
Aggression	182	53.2	9	31.0	160	46.8	20	69.0	342	100	29	100	0.22
Poor eye contact	142	67.9	49	30.2	67	32.1	113	69.8	209	100	162	100	0.001
Lack of sleep	167	58.9	24	28.9	121	42.0	59	71.1	288	100	83	100	0.001
Running away from home	155	61.3	36	30.5	98	38.7	82	69.5	253	100	118	100	0.001
School drop-out	130	62.8	61	37.2	77	37.2	103	62.8	207	100	164	100	0.001
Thought of killing or harming self	191	51.5	0	0	180	48.5	0	0	371	100	0	0	-

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4.4 Attitudes of Primary Healthcare Providers (Nurses, CHWs) to Children with Mental Illness (Modified Bogardus Social Distance Score)

Table 4.7 outlined the social distance and attitude scale with most of the respondents endorsing the fear that children and adolescents with mental illness are dangerous and could be unpredictable (95.1%). All the respondents (100%) answered yes that "I will be ashamed if people knew a child or adolescent in my family has mental illness", however, 63.1% of them agreed that "Children and adolescents with mental health disorders can be as handsome or beautiful like other children". Most of the respondents (65.8%) answered yes to the question that "I would be concerned if my child or relative receives a gift or birthday card from a child or adolescent with mental illness"

Table 4.8 showing respondents been classified as having low, moderate and high scores in the social distance scale. There is a significant difference in the attitude of nurses and the community health workers, reflecting that the nurses have higher negative attitude scores compared to the CHWs. (Figure 4.4)

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Table 4.7 ; Distribution of Respondents' Attitude towards Children and adolescents with Mental Illness.

Statements on social distance and stigma	Nurses (n = 191)				CHWs (n = 180)				Total (n = 371)				P
	Yes		No		Yes		No		Yes		No		
	N	%	n	%	n	%	n	%	n	%	n	%	
I will be ashamed if people knew a child or adolescent in my family has mental illness	191	100	-	-	180	100	-	-	371	100	-	-	
I would not approve of my child or relatives to maintain close friend with or date a child/ adolescent who has mental illness	185	96.9	6	3.1	176	97.8	4	2.2	361	97.3	10	2.7	0.585
I would be concerned about my child or relative sitting in class next to a child/adolescent who has mental illness	177	92.7	14	7.3	174	96.7	6	3.3	351	94.6	20	5.4	0.088
I would be concerned about my child or relative inviting a child or adolescent with mental illness to their birthday party	102	53.4	89	46.6	142	76.9	38	21.1	244	65.8	127	34.2	0.001
I would be concerned about my child or relative doing homework together with a child or adolescent with mental illness	127	66.5	64	33.5	148	82.2	32	17.8	275	74.1	96	25.9	0.001
I would be concerned if I find my child or relative walking home together with a child or adolescent with mental illness	172	90.1	19	9.9	172	95.6	8	4.4	344	92.7	27	7.3	0.041
I would be concerned if my child or relative receives a gift or birthday card from a child or adolescent with mental illness	77	40.3	114	59.7	114	63.3	66	36.7	191	51.5	180	48.5	0.001
Children and adolescent with mental health disorders can be as handsome or beautiful like other children	149	78.0	42	22.0	85	47.2	95	52.8	234	63.1	137	36.9	0.001
Children and adolescent with mental illness can be as intelligent as other children	33	17.3	158	82.7	8	4.4	172	95.6	41	11.1	330	88.9	0.001
Children and adolescent with mental illness can be as trustworthy as other children	48	25.1	143	74.9	22	12.2	158	57.8	70	18.9	301	81.1	0.001
Children and adolescent with mental illness are unpredictable and dangerous	179	93.7	12	6.3	174	96.7	6	3.3	353	95.1	18	4.9	0.186
I would be concerned if I found out that my child or relatives current teacher had mental illness when they were a child or adolescent	184	96.3	7	3.7	176	97.8	4	2.2	360	97.0	11	3.0	0.413
I will be afraid to have conversation with a child/adolescent who has mental illness	58	30.4	133	69.6	125	69.4	55	30.6	183	49.3	188	50.7	0.001

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Table 4.8 Distribution of Respondents' on the Social Distance Scale

Social Distance Score	Nurses		CHWs		Total	
	n	%	n	%	n	%
Low	57	38.5	91	61.5	148	100
Moderate	34	42.0	47	58.0	81	100
High	100	70.4	42	29.6	142	100

x^2 =33.29, df =2, p>0.001

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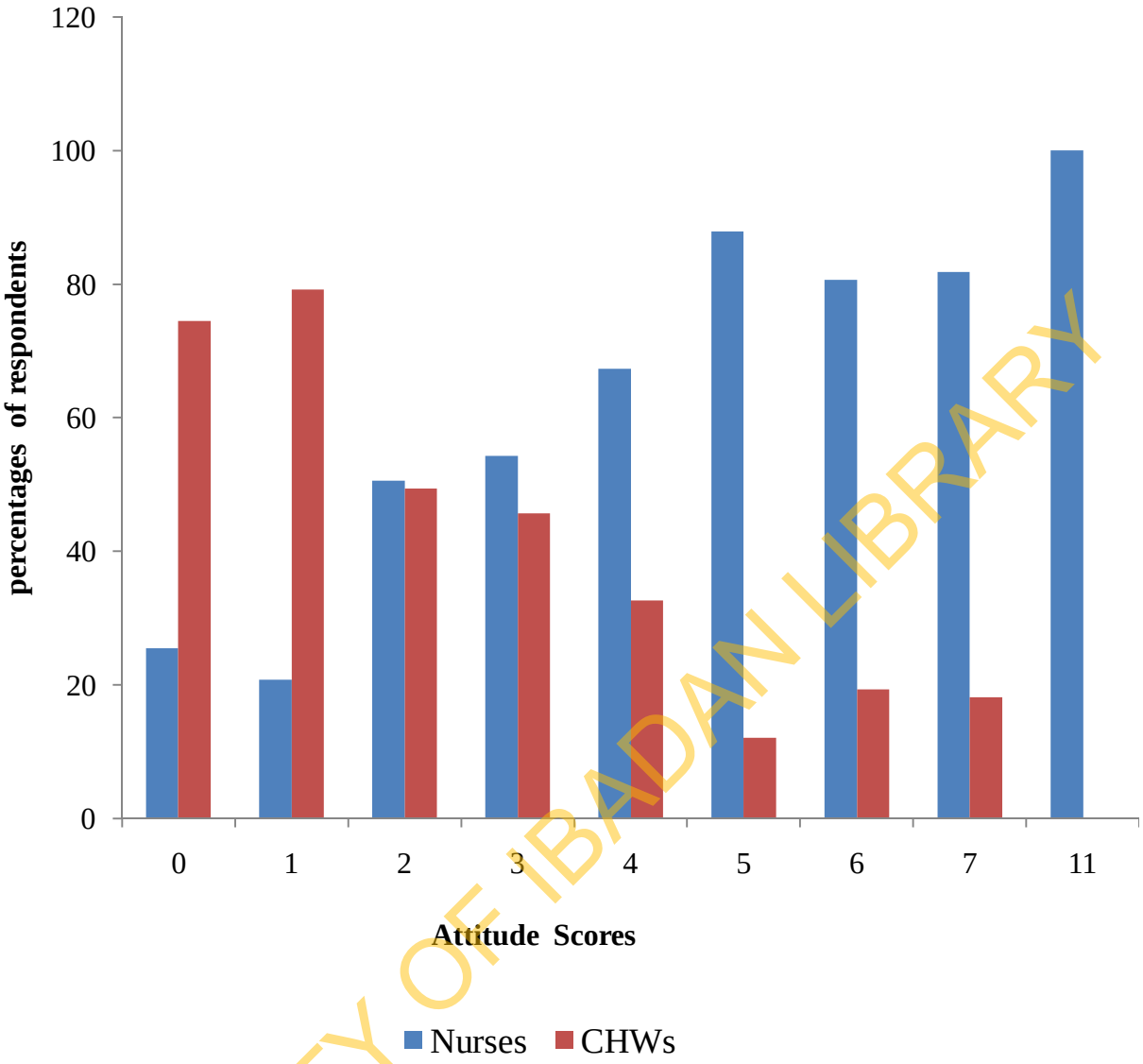

Figure 4.3 Distribution of Respondents scores on the attitude scale.

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4.5 Primary Healthcare Providers Practices in Relation to Child and Adolescent Mental Health

Nearly all the respondents said 'yes' that providing health education was part of their duty only and only one respondent answered 'no' showing that there is no significant difference between the nurses and the community health workers on providing health education. "Have you ever received training on providing mental health education"? Almost all the nurses (72.3%) said yes while 70.6% of the community health workers said no. Of all the respondents only 9 (nurses) said they have had training on child and adolescent mental health (Table 4.9).

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Table 4:9 Frequency Distributions of Respondents Practices on Child and Adolescent Mental Health

Questions on practices relating to child and adolescent mental health.	Nurses (N = 191)				CHWs (N = 180)				Total (N = 371)				P
	Yes		No		Yes		No		Yes		No		
	N	%	n	%	n	%	N	%	N	%	n	%	
Have u ever received training on providing mental health education?	138	72.3	53	29.4	53	27.7	127	70.6	191	100	180	100	0.001
Is providing health education part of your duty?	191	51.6	0	0	179	48.4	1	100	1	100	370	100	0.302
Have you ever receive training on child and adolescent mental health?	9	100	182	50.3	0	100	180	49.7	9	100	362	100	0.002
Have you ever seen a child or adolescent in your clinic that appears to have a mental illness?	104	74.8	87	37.5	35	25.2	145	62.5	139	100	232	100	0.001
Do you know of any hospital that takes care of children?	117	75.5	74	34.3	38	24.5	142	65.7	155	100	216	100	0.001
Do you know of any medication that can be used to treat children with mental illness?	12	85.7	179	50.1	2	14.3	178	49.9	14	100	357	100	0.009
If you come across a child or adolescent in your clinic who is tearful and feeling very sad and depressed, would you know how to assist the child to get help?	133	71.5	58	31.4	53	28.5	127	68.6	186	100	185	100	0.001
If you saw a child in your centre who is talking about killing himself/herself, would you know what to do to assist the child to get help?	115	73.7	76	35.3	41	26.3	139	64.7	156	100	215	100	0.001

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Table 4.10 shows the respondents Confidence in relation to practice child and adolescent mental health. Among the nurses, 44.3% had limited confidence in recognizing children/ adolescents with mental illness while 60.2% of the community health workers had limited confidence to help children and adolescents with mental illness.

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Table 4.10 Respondents Responses to their Confidence to Practice Child and Adolescent Mental Health

Primary healthcare provider's confidence in practicing child and adolescent mental health.	Nurses (N = 191)						CHWs (N = 180)						Total (N = 371)						p
	Very good		Good		Limited		Very good		Good		Limited		Very good		Good		Limited		
	n	%	n	%	N	%	N	%	n	%	n	%	n	%	n	%	n	%	
How would you rate your confidence in recognizing when a child and adolescent has mental illness	2	100	69	70.4	120	44.3	0	0	29	29.6	151	55.7	2	100	96	100	271	100	0.001
Over all how would you rate your confidence in being able to help a C/A who has mental illness	4	100	90	73.2	97	39.8	0	0	33	26.8	147	60.2	4	100	23	100	244	100	0.001
Over all do u believe all primary healthcare providers have a responsibility to identify and or treat C/A with mental illness to be best of their ability	3	75.0	76	71.0	112	43	1	25.0	31	29.0	148	56.9	4	100	107	100	260	100	0.001

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Table 4.11 shows the primary health care providers abilities in assisting a child in their centre who is talking about killing himself/herself. Majority, 126 (34.0%) of the primary health care providers who said they could assist a child with suicidal ideation said they would refer such a child to the hospital to see a psychiatrist/psychologist while some respondents, 16 (4.4%) said they would advise the parents of the said child to seek for spiritual assistance such as prayers, deliverance and traditional medicine. Few of them said they would engage in counselling session with parents and child with the said mental health problem.

Of all the total respondents (371) only 13 of them was able to mention a particular type of medication that could be used to treat a child or adolescent with mental health problem. Among the 13 respondents that mentioned a particular type of drug 5 of them mentioned largactil followed by 2 of them who said antidepressants even if they did not mention the particular type of antidepressant. (Table 4.12)

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Table 4.11; Respondents' forms of assistance to children or adolescents with suicidal ideation

Primary healthcare providers' Practices to help a child with suicidal ideation	n	%
No response	220	59.2
Counseling	9	2.4
Advice parents to seek spiritual help (Deliverance/prayer /traditional medicine)	16	4.4
Refer (psychiatrist/psychologist/general and teaching hospitals)	126	34.0
Total	371	100

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Table 4.12 Respondents Suggested Medications used In the Treatment of Mental Illness In Children and Adolescents

Primary health care providers known medication that can be used to treat children with mental illness?	n	%
No response	358	96.5
Amitriptyline	1	0.3
Antidepressant	3	0.7
Carbamazepine	1	0.3
Haldol	1	0.3
Largactil	5	1.3
Risperidone	1	0.3
Tegretol	1	0.3
Total	371	100.0

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CHAPTER FIVE

Discussion, Conclusion, Recommendations

5.1 Discussion

Perception and Awareness of CAMH among PHCP's

Despite the compelling evidence on the need for early intervention in support of the effectiveness of child and adolescent mental healthcare on the reduction of adulthood mental health related problems (Omigbodun, 2005; Adewuya & Oguntade 2007, ;Quiah, 2014), This study revealed that the importance of child and adolescent mental health has not been grasped by the nurses and community health workers. Less than half of the respondents 108 (29.1%) found child and adolescent mental health very important, 62.3%somewhat important while 1.5% of them said it is not relevant in their opinion. Among the primary health care providers, the nurses had higher percentages compared to the community health workers about the signs of mental illnesses in children and adolescents like 'talking aloud to self', 'thought of killing or harming self', 'aggression'. These findings are in keeping with findings from previous studies (Kapungwe et al, 2011;Ndetei et al 2011;Quiah 2014). For example, a qualitative study that investigated primary health care professionals' perception of mental health among young people in Nicaragua found that most of the professionals had adequate information on mental illness among young people (Medina et al, 2014). Other studies have reported similar findings (Urada et al, 2012; Kapungwe et al, 2011; Winer et al, 2013). Comparing the nurses and the community health workers, more nurses were aware of the signs of mental illness in children and adolescents compared to community health workers. However, this might be due to the clinical exposure and experiences the nurses had during their training in the nursing school. A lot has to be done regarding awareness training and information

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dissemination among the primary healthcare providers especially among the community health workersin Ekiti state, before child and adolescent mental health service could be introduced. In-service training is an integral part of the step that must be taken before new health policy or practice can be introduced into the primary healthcare system.

Attitude of PHCP's towards Children and Adolescent with Mental illness

One of the goals of this study was to identify the attitude of primary healthcare providers towards children and adolescents with mental illness. This study revealed that all respondents said they will be ashamed if people knew a child or adolescent in their family has mental illness. However, over half of them agreed that "Children and adolescents with mental health disorders can be as handsome or beautiful like other children". Half of the respondents said that "I would be concerned if my child or relative receives a gift or birthday card from a child or adolescent with mental illness". These findings are similar to what was reported by Adewuya and Oguntade (2007) among doctors in western Nigeria. Adewuya and Oguntade (2007)showed that 65% of the doctors had negative attitude towards individuals with mental health problems. Also astudy that was conducted in Zambia found a widespread stigmatizing and discriminatory attitude towards mental illness and people suffering from it(Kapungwe et al, 2011). Other studies have also found high level of negative attitudes towards mental illness (Lauber and Rossler, 2007; Gask, 2005). In this study the nurses had a high proportion of those with high negative attitudes toward children and adolescents with mental illness compared to the community health workers. This finding is similar to a previous study by Ayidin et al., (2003) which reported that academics, resident doctors and nurses with sufficient knowledge about mental illness had high negative attitudes than less educated hospital staff. The reason for the high negative attitudes among the higher cadres of healthcare providers despite their high knowledge is yet unclear.

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However, poor attitude could negatively affect the ability and willingness of the healthcare providers in providing services to children and adolescents in their clinics more so that the primary healthcare centres are largely utilized by the people in the community.A study conducted in Zambia, Kapungwe et al.,(2011) also gave a report that negative attitude of healthcare providers on mental health was a major hindrance to preventing mental health problems and primary healthcare integration. The attitude regarding mental illness in general by most people around the world is stigmatizing in the academic setting, hospital setting and the community setting (Ayidin et al 2003; Gureje et al 2005; Adewuya et al 2007; Fernando et al 2010). Therefore intervention is needed to reduce the negative attitude of primary healthcare providers towards these vulnerable children and adolescents. The intervention could start with including modules on child and adolescent mental health in the training curricula of the health workers (nursing school and the health technology colleges).

Knowledge of CAMH among the PHCP's

In this study, most of the respondents were able to recognize some signs and symptoms of mental health disorders in children and adolescents like talking out loud, sitting quietly, lack of concentration, aggression, lack of sleep, thoughts of killing self. A high proportion of the respondents answered "yes" to loneliness, hereditary and physical/sexual abuse as causes of mental illness in children and adolescents. However, some of the respondents still answered yes that "divine punishment/God's will" and "destiny/bad luck"and "evil spirit/witchcraft/sorceryare causes of mental illness in children.Other studies (Adewuya & Oguntade 2007; Ani et al 2011) also reported that evil spirits and bad luck were commonly stated causes of mental illness. However, it is important to note that some respondents endorsed that mental illness can be caused by shaking hands with a mentally

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ill person. Some of the primary healthcare providers still don't have knowledge of the causes of mental illness. These findings emphasise the importance of more education regarding myths and beliefs about child and adolescent mental health among the primary health care providers especially the community health workers, this will also reduce stigmatization. While the level of knowledge about causation is good, some of the healthcare providers would benefit from being provided with more accurate information through training specifically addressing the myths about causes of mental illness. It is well recognized that improving knowledge and awareness about stigmatizing conditions are generally helpful in reducing negative attitudes toward these conditions (Hebel et al.,2002). However, more of the nurses had good percentages on the suggested symptoms of mental illness in children and adolescent compare to the community health workers.

Practices in relation to Mental illness in Children

This study revealed that majority of the respondents said that providing health education is part of their duty. Good percentage of the nurses answered yes to 'have you ever received training on providing mental health education' and majority of the respondents answered no to ever received training on child and adolescent mental health. With regards to clinical practice, less than half of the respondents said yes to "If you come across a child or adolescent in your clinic that is tearful and feeling very sad and depressed, would you know how to assist the Child to get help" of those who said yes majority of them stated that they will counsel, or referchild. In response to the practice question "If you saw a child in your centre who is talking about killing himself/herself, would you know what to do to assist the child to get help", one third of the respondent said yes. Of those who said yes good number of the respondents stated that they will refer to a

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psychiatrist/psychologist, refer to a psychiatric hospital followed by advising parents of the child to seek for spiritual help such as prayers, deliverance and traditional medicine. This study also revealed that majority of the primary health care providers said they had limited confidence in themselves to recognize when a child or adolescent has a mental illness. Few of the respondents had confidence in their ability to help a child or adolescent with mental illness. Only (9) of the nurses said they have had training on child and adolescent mental health while none of the community health workers have had such training. "Have you ever seen a child or adolescent in your clinic that appears to have a mental illness?" half of nurse/midwife said yes while most of the community health workers said no. However early intervention for children and adolescents with mental health problems has shown to be cost effective and lead to improved quality of life in later life. The world health organization (W.H.O) identified that, the ultimate goal of primary healthcare is a better health for all. There is no complete health without mental health (Prince et al, 2007). A lot of children and adolescents would have passed through this primary healthcare providers without been recognized.

More than half of the nurses said yes to "Do you know of any hospital that takes care of children with mental illness?" compared to majority of the community health workers who said no. This shows the importance of providing training and exposure to primary healthcare providers on child and adolescent mental health given that they may come across children with more serious mental health problems irrespective of their actual clinical roles. This finding partly agrees with another study that reported that higher cadres of professionals between the ages of 40 years and above felt the responsibility of caring for the individual with mental illness as compared individuals of lower cadres whose proportion decreased with age (Ndetei et al., 2011). The lower cadres could be said to be under trained on mental health related issues. In a study conducted among primary

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care providers in Idaho it shows that these primary care providers are highly utilized yet majority of them are undertrainedotherwise lacking in their ability to identify and treat mental health and related problems and or misdiagnose these problems in their patients (Alexander A. Theiler, 2011). However, despite the significant implications of untreated mental illness during childhood and adolescence, and potential benefits from early treatment and preventive programs, government attention on child mental health care is insufficient, especially in the LMIC (Patel et al., 2008). Findings from this study about the primary healthcare providers' practices show that at the moment no known national or state guidelines exist on child and adolescent mental health services in the state. More studies are needed on what should constitute the content and mode of delivery of child and adolescent mental health in the state. In addition there is need to send primary healthcare providers for in-service training that focuses on CAMH and encourage more teachings on CAMH services at nursing schools and at the health technology school where the primary healthcare workers are being trained.

Many researchers have proven the efficacy of the healthcare providers, providing better mental healthcare for all including women and children in managing pre-existing medical and psycho-social conditions which is also a form of health promotion. However, this important service is still not well established in Nigeria, more especially in states like Ekiti with minimal resources (Akerele and Adewuyi, 2011) in comparison with other states of the Federation. Engaging the health workers in the implementation of child and adolescent mental health services may be challenging if the key players and stakeholders do not have adequate knowledge and correct perceived benefit of the interventions.

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5.1 CONCLUSIONS

The good knowledge of mental illness among the primary healthcare providers especially the nurses did not translate to actual full involvement and correct practices of CAMH services and also having high social distance towards children and adolescents with mental health problems. The primary healthcare providers had little/no training on CAMH. Therefore, there is a need for further trainings to reduce the negative attitudes towards children and adolescents with mental illness among the primary healthcare providers. These interventions should include accurate information to correct myths about causes of mental illness and good awareness programs.

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5.2 LIMITATIONS OF THE STUDY

Limitation of this study is that the participants were limited to the nurses and community health workers working at the primary health centres in the two selected local government areas of the 16 local governments in Ekiti state. Also, the data might not completely represent the actual situation and opinions of all health workers in the state.

5.3 RECOMMENDATIONS

Based on the findings from this study, the followings are recommended:

1. Inclusion of courses on CAMH in nursing training curriculum and the health technology colleges.
2. Organisation of refresher courses on CAMH for the primary healthcare providers (nurses and community health workers) in Ekiti state.
3. Provision of guidelines for carrying out Child and Adolescent Mental Health at the various health facilities in Ekiti State.
4. There is need to encourage the PHCP to improve on their health information seeking habits through the internet and journals.
5. Further studies on training needed, acceptability, advocacy and impacts of CAMH in the health facilities in Ekiti state.

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AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

REFERENCES

Abiodun O. A. 1992. Emotional illness in a pediatric population in Nigeria.*East Afr Med J* 10: 557-559.

Adewuya, A., Efinfolami A.R., Ola B.A., 2011. Correlates of self-stigma among out-patients with mental Illness in Lagos, Nigeria.*Int. J. Social Psychiatry*, 57: 418-227.

Adewuya, A.O., 2008. Social distance towards people with mental illness in southwestern Nigeria.*Australian and New Zealand journal of psychiatry* 42: 389-395.

Adewuya A. O., Makanjuola R.O 2005. Social distance toward people with mental illness among Nigerian university student.*Soc psychiatry Epidemiol* 40: 862-868.

Adewuya A. O., Oguntade, A.A., 2007. Doctors' Attitude towards people with mental illness in western Nigeria.*SocPsychiatriEpidemiol* 42: 931-936.

Akerele, D., Adewuyi, S. A. 2011 "Analysis of Poverty Profiles and Socioeconomic Determinants of Welfare among Urban Households of Ekiti State, Nigeria" Current Research *Journal of Social Sciences* 3(1): 1-7

Ayindin, N. 2003. Attitudes of hospital staff towards mentally ill patients in a teaching hospital turkey. *International Journal of Social Psychiatry* 49: 17-26.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Bernal P., Estroff, D., Aboudarham, J. 2000. Psychosocial Morbidity: The economic burden in a pediatric health maintenance organization sample. *Archives of Pediatrics& Adolescent Medicine* 154: 261-266.

Bhugra D. 1989. Attitudes toward mental illness: a review of the literature. *ActaPsychiatr Scand.* 80: 1-12.

Bogardus E. S. 1933. Social distance scale.*Sociology and Social Research* 17: 265-271

Brauner, C., Stephens, CB., 2006. Estimating the prevalence of early childhood serious emotional/behavioral disorders: challenges and recommendations.121: 303-310.

Bruckner T., Scheffler, RM., Shen, G., Yoon, J., Chisholm, D., Morris, J., Fulton, BD., Dal Poz, MR., Saxena, S. 2011. The mental health workforce gap in low- and middle-income countries: a needs-based approach. *Bull World Health Organ* 89: 184-194.

Burns B., et al., 2004. Mental health need and access to mental health service by youths Involved with child welfare.*J.AmAcad child Adolescpsychiatr* 43: 960-970.

Corrigan 2012. Stigma of mental illness: practical strategies for research and social change. Washington DC. *American psychological association press.*

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Cortina M. A., Shodha, A., Fazel, M., Ramchandani, P.G. 2012. Prevalence of child mental health problems in sub-Saharan Africa: a systematic review. *Arch pediatrAdolesc Med* 166: 276-281.

Costello E., Mustillo, S., Keller G., Angold, A. 2004. Prevalence of psychiatric disorders in childhood and adolescence In: Levin BL, Petrila J, And Hennessy KD, eds. Mental Health Services: a Public Health Perspective. Second Edition. Oxford, UK: Oxford University Press: 111-128.

Costello E., Egger H., Angold, A. (2005). 10-year research update review: the epidemiology of child and adolescent psychiatric disorders: I. Methods and public health burden. *J Am Acad Child Adol Psychiatry*. 44: 972–986.

David, M., Matins, K., Sohba, R, (2008). Barriers in the mind: promoting an economic case for mental health in low- and middle-income countries. *Journal of the world psychiatry* 7 79-86.

Eaton, J., McCay, L., Semrau, M., Chatterjee, S., Baingana, F., Araya, R. 2011. Scale up of services for mental health in low-income and middle-income countries. . *Lancet* 14: 3-12.

Fayyad J. A., Jahshan, C.S., and Karam, E.G. 2001.Systems development of child mental service in developing countries.*Child AdolescPsychiarClin North Am* 10: 745-762.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Flisher A., Kramer, R.A., Grosser, R.C., Alegria, m., Bird,H.R., Bourdon, K.H. 1997. Correlates of unmet need for mental services by children and adolescents .*Psychol Med* 25: 1145-1154.

Gaebel, W B., 2002. Public attitude towards people with mental illness in six German cities: results of a public survey under special consideration of schizophrenia. *Eur Arch Psychiatry ClinNeurosci*; 252:278-288.

Glied S. 1998. Too little time?The recognition and treatment of mental health problems in prim ary care.*Health Services Research* 33: 891-910.

Gureje O., 2005. Community study of knowledge and attitude to mental illness in Nigeria.*British Journal of Psychiatry* 186: 436-441.

Gureje O., Olley, BO., Ephraim-Oluwanuga, O. 2006. Do beliefs about causation influence attitudes to mental illness? *Journal of the world psychiatry* 5: 104-107.

Gureje O. O., O., Gater, R., Aha, R. A., Ikuesan, B. A., Morris J. 1994.Psychiatric disorders in a pediatric primary care clinic. . *British Journal of Psychiatry* 165: 527-530.

Heflinger. A. C., Stephen, P., Hinshaw. 2010. Stigma in Child and Adolescent mental Health Services Research: understanding professional and institutional

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Stigmatization of youth with mental health problem and their families. *Adm Policy Mental Health* 37: 61-70.

Hinshaw S. P. 2005. The stigmatization mental illness in children and parents: Developmental issues, family concern and research needs. . *Journal of child Psychology and psychiatry* 46: 714-734.

Johnson, K. 2008. Association of combatant status and sexual violence with health and mental health outcomes in post-conflict Liberia.*JAMA* 300: 676-690.

Kapungwe A., Cooper, S., Mayeya, J, Mwanza, J. 2011. Mental Health and poverty project research program consortium. Attitude of primary health care provider towards people with mental illness: evidence from two districts in Zambia. *African journal of psychiatry (Johannesburg)* 14: 290-297.

Kessler, R., Berglund, P., Demler, O., Jin, R., Merikangas, KR., Walters, EE. 2005. Lifetime prevalence distributions of DSM-IV disorders in the National Comorbidity Study Replication. Arch Gen Psychiatry 62: 593-602.

Kieling C., 2010. Global mental health 2. Child and adolescent mental health worldwide: evidence of action. *The lancet series* S0140-6736: 6827-6821;6820-6830.

Kilian R., Losert, C., Park, A., McDaid, D., Knapp M. 2010. Cost-effectiveness analysis in child and adolescent mental health problems: an updated review of literature. *Int J Ment Health Promot.* 12: 45-57.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Medina C.O' Kullgren G., Dahlblom K. 2014.A qualitative study on the primary healthcare professionals' perceptions of mental health, suicidal problems and help seeking among young people in Nicaragua.*BMC Family Practice*,**15**:129.doi:10.1186/1471-2296-15-129

Ndetei D. M., Khasakhala L.I., Mutiso, V., Mbwayo, A.W. 2011. Knowledge, attitude and practices (KAP) on mental illness among staffs in general medical facilities in Kenya: practices and policy implication. *African journal of psychiatry* 14: 225-235.

Nyati, Z., Sebit, MB. 2002. Burden of mental illness on family members, care-givers and the community. *East Afr Med J* 79: 206-209.

Okewole A., Dada, MU., Ogun, O., Bello-Mojeed, M., Usoh, T. 2011. Prevalence and correlates of psychiatric morbidity among caregivers of children and adolescents with neuropsychiatric disorders in Nigeria.*African journal of psychiatry*.

Omigbodun O. 2004. Psychological issues in child and adolescent psychiatric clinic population in Nigeria. *SocPsychiatrEpidemiol* 39: 667-672.

Quiah A. G., 2014. Knowledge, attitude and practice in relation to child and adolescent mental health among health workers in, Monrovia, Liberia. *Center for child and adolescent mental health.* University of Ibadan, Nigeria M.Sc. Camh.

AFRICAN DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Urada D., Schaper E., Alvarez L., Reilly C., Dawar M., Field R., Antonni V., Oeser B.,Crèvecoeur-MacPhailD., Rawson R.A. 2012. Perceptions of Mental Health and Substance use Disorder Services Integration among the Workforce in Primary Care Settings. Vol 44, Issue 4: 292-298.

Winer R.A, Morris-Patterson A., Smart Y., Bijan I., Katz C.L., 2013.Knowledge of and Attitudes toward Mental Illness among Primary Care Providers in Saint Vincent and the Grenadines.*Psychiatric Quarterly,Vol* 84: 395-406

World health Organization 2001.Mental health; new understanding new hope.The W.H.O report.Geneva Switzerland.

World Health Organization 2003.Caring for children and adolescent with mental disorders.World Health Organization W. H.O Geneva.

Patel V., Flisher, AJ.,Hetrick, S., McGorry, P. 2007. Mental health of young people: a global public-health challenge. *Lancet* 369: 1302-1313.

Patel V., Flisher, AJ.,Nikapota, A., Malhotra, S., 2008. Promoting child and adolescent mental health in low and middle income countries.*J Child Psychol Psychiatry* 49: 313-334.

Patel V., Kieling, C., Pallab K., Maulik, Gauri, D. 2013. Improving access to care for children with mental disorders: A Global Perspective.*Arch Dis Child* 98: 323-327.

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Patterson G. R., DeBaryshe,BD., Ramsey, E 1981. A developmental perspective on antisocial behaviour. . *ampsychol* 44: 329-335.

Paula C., Nakamura, E., Wissow, L., Bordin, I .A.,Nascimento. R., Leite, A., Cunha, A., Martin, D. 2009. Primary care and children's mental health in Brazil.*AcadPediatr*9: 249-255.

Prince M., Patel, V., Saxena, S. 2007. No health without mental health. *Lancet.* 370: 859-877.

Saxena S., Thornicroft, G., Knapp, M., Whiteford, H. 2007. Resources for mental health: scarcity, inequity, and inefficiency. *Lancet* 370: 878-889.

Sharan P., Sagar, R. 2007. Mental health policy for children and adolescents in developing countries.*J Indian Assoc Child Adolesc Mental Health* 3: 1-4.

Singh S., Kamal, P. 1981. Drug abuse among school and college students in Punjab.*Child Psychiatry Q* 14: 5-11.

Tadesse, B., kebede, DT., and Alem, A., 1999. Childhood behavioral disorders in Ambo district western Ethiopia. Prevalence estimate.*ActaPsychiatrScandSuppl,* 397: 92-97.

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Theiler, AA. 2011. Primary care providers' perception of mental and behavioral health problems in frontier areas of Idaho. Master of Health Science, General Research.Idaho, Boise State University.

US Department of Health and Human Services. 1999. Mental Health: A Report of the Surgeon General Rockville, MD.

Wang P., Berglund, P., Olfson, M., Pincus, HA., Wells, KB., Kessler, RC. 2005. Failure and delay in initial treatment contact after first onset of mental disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiat.* 62: 603-613.

Zechmeister, I., Kilian, R., McDaid, D. 2008. Is it worth investing in mental health promotion and prevention of mental illness? A systematic review of the evidence from economic evaluations. *BMC Public Health* 8: 20.

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APPENDICES

Appendix 1

INFORMED CONSCENT FORM

This study is being conducted by Fadumiyo Elizabeth Olufisayo, a master of child and adolescent mental health (CAMH) student at the Centre for Child and Adolescent Mental Health, College of Medicine, University of Ibadan. The study is self-sponsored as part fulfilment of the award of M.Sc. CAMH. The study is going to be for a period of 6 months.

I am conducting a research to explore perception, attitude and practices regarding child and adolescent mental health/illness among primary health care providers in Ekiti state. The information you provide for us will help us understand your perception, attitudes, and practices and be useful in providing mental health services in EKITI-STATE especially for children and adolescent. Please note that your answers will be confidential and NOT release to anyone else. Result obtained from this result will be made available to authorities for prompt intervention.

Your participation in this study will not cost you anything. Your honest answers will be highly appreciated. You are free to refuse and withdraw at any given time if you choose to. We will greatly appreciate your help in responding to the questions and also taking part in the study.

Consent: now that the study has been well explained to me and I fully understand the consent of the study process. I will be willing to take part in the study.

…….. ……

Signature/thumbprint of participant/date signature of interviewer/date

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Appendix 2

INSTRUMENT FOR DATA COLLECTION

INSTRUCTIONS: Please tick(X) or circle as appropriate for the selected answer(s) that best apply.

Section A-PERSONAL INFORMATION

Q1. How old were you as at last birthday? Age (in complete years)……

Q2. Your gender?1 [ ] Male. 2[ ] Female

Q3. Your religion?1 [ ] Christian.2 [ ] Islam.3[ ] Traditional 4 [ ] Other.

Q4. Your marital status?1 [ ] Single. 2 [ ] Married. 3 [ ] Separated. 4 [ ] Divorced.

Q5. What is the highest level of education you have completed?

1 [ ] Primary school. 2 [ ] Secondary school 3 [ ] Health Technology 4 [ ] nursing school

5 [ ] University.6 [ ] postgraduate 7 [ ] others.

Q6. Your occupation?1 [ ] Medical doctor. 2 [ ] Nurse/midwife. 3 [ ] CHEW. 4 [ ] CHO. 5 [ ] others (specify)

Q7. How many years or months have you been working as a primary health care provider? .....

Section B -CHILD AND ADOLESCENT MENTAL HEALTH PERCEPTION AND AWARENESS

Q8. Where did you first learn about mental illness in children and adolescent?

1 [ ] Media.2 [ ] school.3 [ ] Home.4 [ ] community.5 [ ] religious house. 6 [ ] others (specify)

Q9. In your opinion, how important is mental health in children and adolescent?(CHECK ONE)

1 [ ] very important.2 [ ] somewhat important.3 [ ] Not very important.4 [ ] Not relevant.

Q10. Which of the following do you think might be signs and symptoms of mental illness in children and adolescent? (PLEASE CHECK ALL THAT APPLY)

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1. Crawling sensations [ ]
2. Talking aloud to self [ ]
3. Sitting quietly in the corner of the room [ ]
4. Crying to self [ ]
5. Toileting on self [ ]
6. Lack of concentration [ ]
7. Aggression [ ]
8. Poor eye contact[ ]
9. Lack of sleep [ ]
10. Running away from home [ ]
11. School drop- out [ ]
12. Thought of killing or harming self [ ]

Q11. What mental health problems in children and adolescent have you heard about? (CHECK ALL THAT APPLY)

1. Conduct disorders [ ]
2. Attention deficit hyperactivity disorders [ ]
3. Autism [ ]
4. Anxiety [ ]
5. Phobia [ ]
6. Schizophrenia [ ]
7. Bipolar disorder [ ]
8. Depression [ ]
9. Post-traumatic stress disorders[ ]
10. Drug addiction [ ]
11. Eating disorders [ ]
12. Attachment disorder [ ]

Section C. Question 12-26

KNOWLEDGE ON POSSIBLE CAUSES OF MENTAL ILLNESS IN CHILDREN AND ADOLESCENTS.

(Please tick(X) or circle as appropriate for the selected answer(s) that best apply).

Q12. Loneliness [ ]

Q13. Stress, personal/financial [ ]

Q15. Difficulty at school or work [ ]

Q16. Drug, marijuana, alcohol abuse [ ]

Q17. Shaking hands with another child with mental illness [ ]

Q18. Failure in school life [ ]

Q19. Lack of will/power [ ]

Q20. Divine punishment/ God will [ ]

Q21. Evil spirit/witchcraft/sorcery [ ]

Q22. Sharing cutlery with another child with mental illness [ ]

Q23. Destiny /bad luck [ ]

Q24.Hereditary (parent, grandparent or relatives [ ]

Q25. Brain injury/ infection of the brain [ ]

Q26. Abuse (sexual, physical) [ ]

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SECTION D

Please tick(X) or circle as appropriate for the selected answer(s) that best apply.

Q27. I will be ashamed if people knew a child or adolescent in my family has mental illness. Yes [ ]. No [ ]. Not sure [ ]

Q28. I will not approve of my or relatives to maintain close friend with or date a child/adolescent who has mental illness. Yes [ ]. No [ ]. Not sure [ ]

Q29. I would be concerned about my child or relatives sitting in class next to a child/adolescent who has mental illness. Yes [ ]. No [ ]. Not sure [ ]

Q30. I would be concerned about my child or relative inviting a child/ adolescent with mental illness to their birthday party. Yes [ ]. No [ ]. Not sure [ ]

Q31. I would be concerned about my child / relative doing homework with a child/adolescent with mental illness. Yes [ ]. No [ ]. Not sure [ ]

Q32. I would be concerned if I find my child or relative walking home together with a child or adolescent with mental illness. Yes [ ]. No [ ]. Not sure [ ]

Q33. I would be concerned if my child or relative receives a gift or birthday card from a child or adolescent with mental illness. Yes [ ]. No [ ]. Not sure [ ]

Q34. Children and adolescent with mental health disorders can be as handsome or beautiful like other children. Yes [ ]. No [ ]. Not sure [ ]

Q35. Children and adolescent with mental illness can be as intelligent as other children. Yes [ ]. No [ ]. Not sure [ ].

Q36. Children and adolescent with mental illness can be as trustworthy as other children. Yes [ ]. No [ ]. Not sure [ ]

Q37. Children and adolescent with mental illness care unpredictable and dangerous.

Yes [ ]. No [ ]. Not sure [ ]

Q38. I would be concerned if I found out that my child or relatives current teacher had mental illness when they were a child or adolescent. Yes [ ]. No [ ]. Not sure [ ]

Q39. I will be afraid to have conversation with a child/adolescent who has mental illness. Yes [ ]. No [ ]. Not sure [ ]

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SECTION E

PRACTICES IN RELATION TO CHILD AND ADOLESCENT MENTAL HEALTH

: Please tick(X) or circle as appropriate for the selected answer(s) that best apply.

Q40. Have you ever received training on providing mental health education? 1. Yes [ ] 2.No [ ]

Q41. Is providing health education part of your duty? 1. Yes [ ]. 2. No [ ]

Q42. Have you ever received training on child and adolescent mental health? 1. Yes [ ] 2. No [ ]

Q43. Have you ever seen a child /adolescent in your clinic that appears to have mental illness?

1. Yes [ ]. 2. No [ ]

Q44. Do you know of any hospital that takes care of children with mental illness? 1. Yes [ ]. 2. No [ ]. If yes? Please write down the name (s)
……

Q45. Do you know of any medication that can be used to treat children with mental illness? 1. Yes [ ]. 2. No [ ]

Q46. If you come across a child /adolescent in your clinic who is tearful and feeling very sad and depressed, would you know how to assist the child to get help? 1. Yes [ ]. 2. No [ ]

If yes, please write down what you would do……

Q47. If you saw a child in your centre who is talking about killing himself /herself would you know what to do to assist the child to get help? 1. Yes [ ]. 2. No [ ]. If yes please write down what you would do……..

Q48. If you saw a child in your unit who says he is hearing voices telling him to kill his parents, would you know what to do to assist the child to get help? 1. Yes [ ]. 2. No [ ]. If yes, write down what you would do.
……

Q49. Over all, how would you rate your confidence in recognizing when a child /adolescent have a mental illness? 1. Very good [ ] 2. Good [ ] 3. Limited [ ]

Q50. Over all, how would you rate your confidence in being able to help a child /adolescent who has mental illness? 1. Very good [ ] 2. Good [ ] 3. Limited [ ]

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Q51. Over all do you believe all primary healthcare providers have a responsibility to identify and or treat children /adolescent with mental illness to be best of their ability? 1. Very good [ ] 2. Good [ ] 3. Limited [ ]

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Appendix 3

List of public and private primary and health care centres in the two LGAs

(Ado and Ifelodun / Irepodun)

NAMES OF LGA	**POLITICAL WARD**	**NAMES OF HEALTH FACILITIES**	**OWNERSHIP**	**CODE**	
ADO EKITI	OKESA	PRISON CLINIC	PUBLIC	13/001/001/001	1
		POLICE CLINIC	PUBLIC	13/001/001/002	2
		XTS SCH CLINIC	PUBLIC	13/001/001/003	3
		XTS GIRLS CLINIC	PUBLIC	13/001/001/004	4
		JOE JANE MEDICAL CENTRE	PRIVATE	13/001/002/001	
		ADEDOYIN HOSPITAL	PRIVATE	13/001/002/002	
	ODO ADO	BASIC HEALTH CENTRE ODO ADO	PUBLIC	13/001/001/005	5
		GRACE OF HOPE HOSP	PRIVATE	13/001/002/003	
		SUPREME FAITH HOSP	PRIVATE	13/001/002/004	
		ADETOYE HOSP	PRIVATE	13/001/002/005	
		FOUNTAIN OF HOPE	PRIVATE	13/001/001/006	
		IDOFIN B H C	PRIVATE	13/001/001/007	
	AGO ADULOJU	BHC AGO ADULOJU	PUBLIC	13/001/001/008	6
		ERINFUN HEALTH CENTRE	PUBLIC	13/001/001/009	7
		FED POLY HEALTH CENTRE	PUBLIC	13/001/001/010	8
		NPHC TEMIDIRE/ESUNMO	PUBLIC	13/001/001/011	9
		EMINRIN HEALTH CENTER	PUBLIC	13/001/001/012	10
		UNITY SCHOOL CLINIC	PUBLIC	13/001/001/013	11
		DAMOLA HEALTH	PRIVATE	13/001/00	

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		CLINIC		1/014	
	IGIRIGIRI	BHC IGIRIGIRI	PUBLIC	13/001/001/015	12
	UREJE	MOFERERE HEALTH CENTER	PUBLIC	13/001/001/016	13
		MARY ASSUMTA HOSP	MISSION	13/001/002/006	
		IBUKUNOLU MATERNITY	PRIVATE	13/001/001/017	
		ABEGUNDE MEMORIAL HOSP	PRIVATE	13/001/002/007	
		SANYA CLINIC	PRIVATE	13/001/001/018	
		MERCY CLINIC	PRIVATE	13/001/001/019	
		DE MARK CLINIC	PRIVATE	13/001/001/020	
		RCCG MATERNITY	MISSION	13/001/001/021	
		DIVINE CITADEL HOSP	PRIVATE	13/001/002/008	
		MAKINDE CLINIC	PRIVATE	13/001/001/022	
	OKE ILA	OKE ILA HEALTH CENTER	PUBLIC	13/001/001/023	14
		HOUSING HEALTH CENTER	PUBLIC	13/001/001/024	15
		ILAMUO HEALTH CENTER	PUBLIC	13/001/001/025	16
		GOD MERCY HOSP	PRIVATE	13/001/001/026	
	OKE IYINMI	CHC OKEYINMI	PUBLIC	13/001/002/009	17
		FSP OKEYINMI	PUBLIC	13/001/001/027	18
		OBA'S MARKET CLINIC	PUBLIC	13/001/001/028	19
		TOKUNBO CLINIC	PRIVATE	13/001/001/029	
		LIVING SPRING CLINIC	PRIVATE	13/001/001/030	
	IJIGBO	IDOLOFIN HEALTH CENTRE	PUBLIC	13/001/001/031	20
	BASIRI	BHC BASIRI	PUBLIC	13/001/001/032	21
		LGSC STAFF CLINIV	PUBLIC	13/001/001/033	22
		STAFF CLINI SECRETARIAT	PUBLIC	13/001/001/034	23

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		ADELUSI CLINIC	PRIVATE	13/001/00 1/035	
		ORE OFE CLINIC	PRIVATE	13/001/00 1/036	
		ST.GREGORY HOSP	PRIVATE	13/001/00 2/010	
		OLUBUNMI MEDICAL CENTRE	PRIVATE	13/001/00 1/037	
	EKUTE	OKE ONIYO HEALTH CENTRE	PUBLIC	13/001/00 1/038	24
		ADETADE HOSP	PRIVATE	13/001/00 2/011	
	ODO	BHC ODO	PUBLIC	13/001/00 1/039	25
		GILEAD HOSP	PRIVATE	13/001/00 2/012	
	OPOPO	HEALTH CENTRE OPOPO	PUBLIC	13/001/00 1/040	26
		ILOKUN/IRASA HEALTH CLINIC	PUBLIC	13/001/00 1/041	27
		OLORUNDA HEALTH CENTRE	PUBLIC	13/001/00 1/042	28
		UNAD HEALTH CENTRE	PUBLIC	13/001/00 1/043	29
		UNIVERSITY TEACHING HOSP	PUBLIC	13/001/00 3/001	30
		ALAFIA HOSPITAL	PRIVATE	13/001/00 2/013	
		THRINITY HOSPITAL	PRIVATE	13/001/00 2/014	
		ORIRE HOSP	PRIVATE	13/001/00 2/015	
		FASANMADE HOSP	PRIVATE	13/001/00 2/016	
		BENVIC MEDICAL CLINIC	PRIVATE	13/001/00 1/044	
		AFOLABI MEDICAL CLINIC	PRIVATE	13/001/00 1/045	
		OLUMORIN HOSP	PRIVATE	13/001/00 2/017	
		SHALOM HOSP	PRIVATE	13/001/00 2/018	
		MOTHER & CHILD CLINIC	PRIVATE	13/001/00 1/046	
		GOD'S OWN CLINIC	PRIVATE	13/001/00 1/047	
		FAMILY CLINIC	PRIVATE	13/001/00 1/048	
	IRONA	BHC IRONA	PUBLIC	13/001/00	31

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				1/049	
		ILE ABIYE GENERAL HOSP	PRIVATE	13/001/002/019	
		OGUNTOYE HOSP	PRIVATE	13/001/002/020	
		ILERI OLUWA CLINIC	PRIVATE	13/001/001/050	
		GOD GRACE HOSP	PRIVATE	13/001/002/021	
		LIBERTY CLINIC	PRIVATE	13/001/001/051	
		OKE ASO HEALTH POST	PUBLIC	13/001/001/052	32
		OKE OSUN HEALTH POST	PUBLIC	13/001/002/022	33
		TUKAD CLINIC	PRIVATE	13/001/001/053	
IREP/IFELO	IGEDE A	IGEDE CHC	PUBLIC	13/013	
		CAC OKE IGBALA MISSION CLINIC	MISSION		1
	IGEDE B	IGEDE BASIC HEALTH CENTRE	PUBLIC		2
	IGEDE C	ILAMOYE BASIC HEALTH CENTRE	PUBLIC		3
		IRETIAYO CLINIC	PRIVATE		
		CAC OKE-AYO MISSION CLINIC	MISSION		
	IYIN A	IYIN BASIC HEALTH CENTRE	PUBLIC		4
		ADEOLA NURSING HOME	PRIVATE		
		AROTO BASIC HEALTH CENTRE	PUBLIC		5
		K & S MISSION CLINIC IYIN EKITI	MISSION		
	IYIN B	IYIN GENERAL HOSPITAL	PUBLIC		6
		IYIN HEALTH POST	PUBLIC		7
		AGBARAJESU CLINIC	MISSION		
		OKESEGUN CAC MISSION CLINIC	MISSION		
		OKE IRAPADA CAC MISSION CLINIC	MISSION		
	AWO WARD	AWO BASIC HEALTH CENTRE	PUBLIC		8
	IWOROKO WARD	IWOROKO BASIC HEALTH CENTRE	PUBLIC		9
		DOCTOR'S CLNIC	PUBLIC		10

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		ARE BASIC HEALTH CENTRE	PUBLIC		11
	AFAO WARD	AFAO BASIC HEATLH	PUBLIC		12
		AROMI PHC	PUBLIC		13
	IGBEMO WARD	IGBEMO BASIC HEATLH CENTRE	PUBLIC		14
		IGBEMO CHC	PUBLIC		15
		ST. JOSEPH MATERNITY HOME	PRIVATE		
		OLA OLUWA CLINIC	PRIVATE		
	TROPORA WARD	TROPORA BASIC HEATLH CENTRE	PUBLIC		16
	EYIO WARD	EYIO BASIC HEATLH CENTRE	PUBLIC		17

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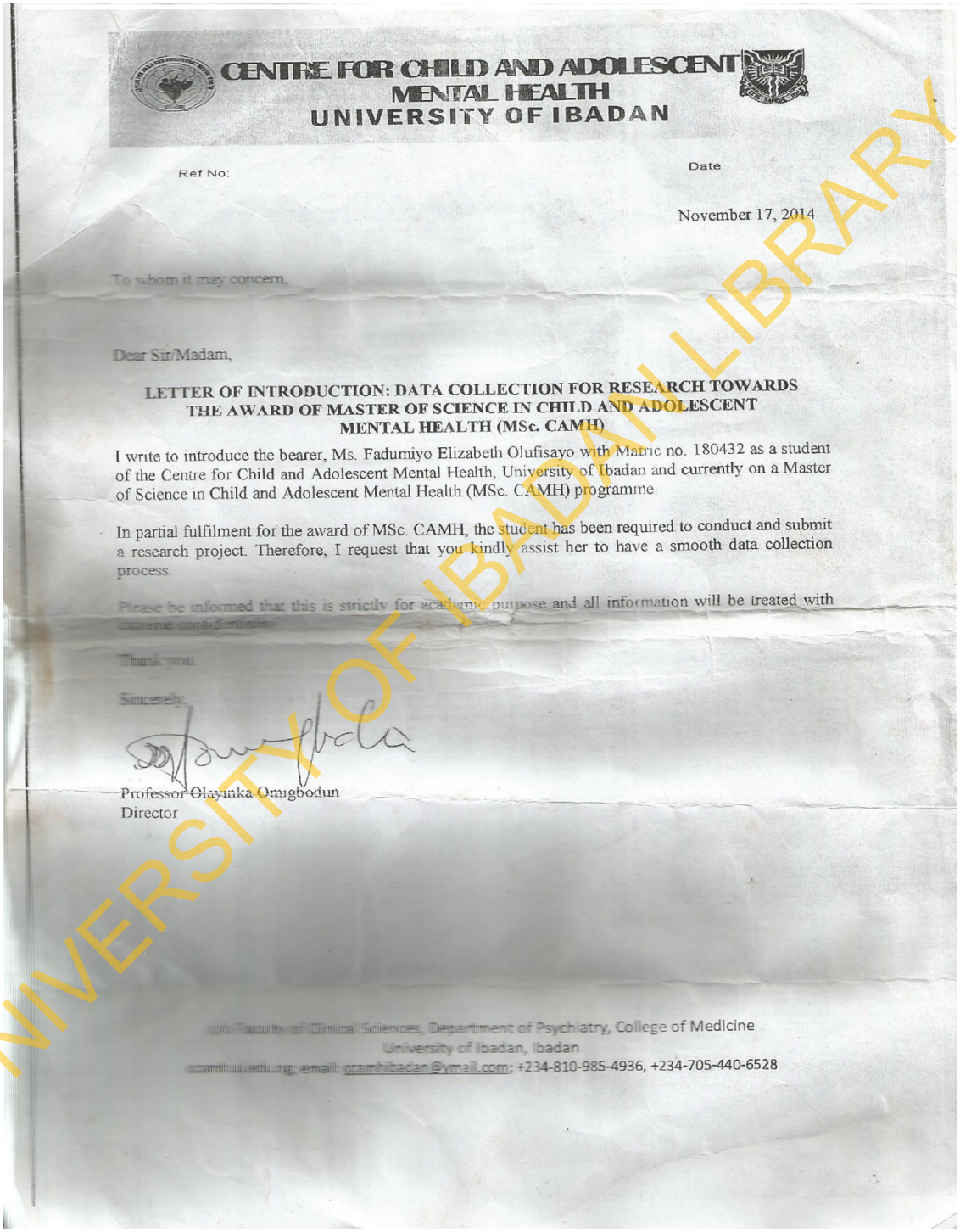
Appendix 4

Introduction letter



CENTRE FOR CHILD AND ADOLESCENT MENTAL HEALTH
UNIVERSITY OF IBADAN

Ref No:

Date

November 17, 2014

To whom it may concern,

Dear Sir/Madam,

LETTER OF INTRODUCTION: DATA COLLECTION FOR RESEARCH TOWARDS THE AWARD OF MASTER OF SCIENCE IN CHILD AND ADOLESCENT MENTAL HEALTH (MSc. CAMH)

I write to introduce the bearer, Ms. Fadumiyo Elizabeth Olufisayo with Matric no. 180432 as a student of the Centre for Child and Adolescent Mental Health, University of Ibadan and currently on a Master of Science in Child and Adolescent Mental Health (MSc. CAMH) programme.

In partial fulfilment for the award of MSc. CAMH, the student has been required to conduct and submit a research project. Therefore, I request that you kindly assist her to have a smooth data collection process.

Please be informed that this is strictly for academic purpose and all information will be treated with extreme confidentiality.

Thank you.

Sincerely,

Professor Olayinka Omigbodun
Director

Faculty of Clinical Sciences, Department of Psychiatry, College of Medicine
University of Ibadan, Ibadan
email: ccamhibadan@ymail.com; +234-810-985-4936, +234-705-440-6528

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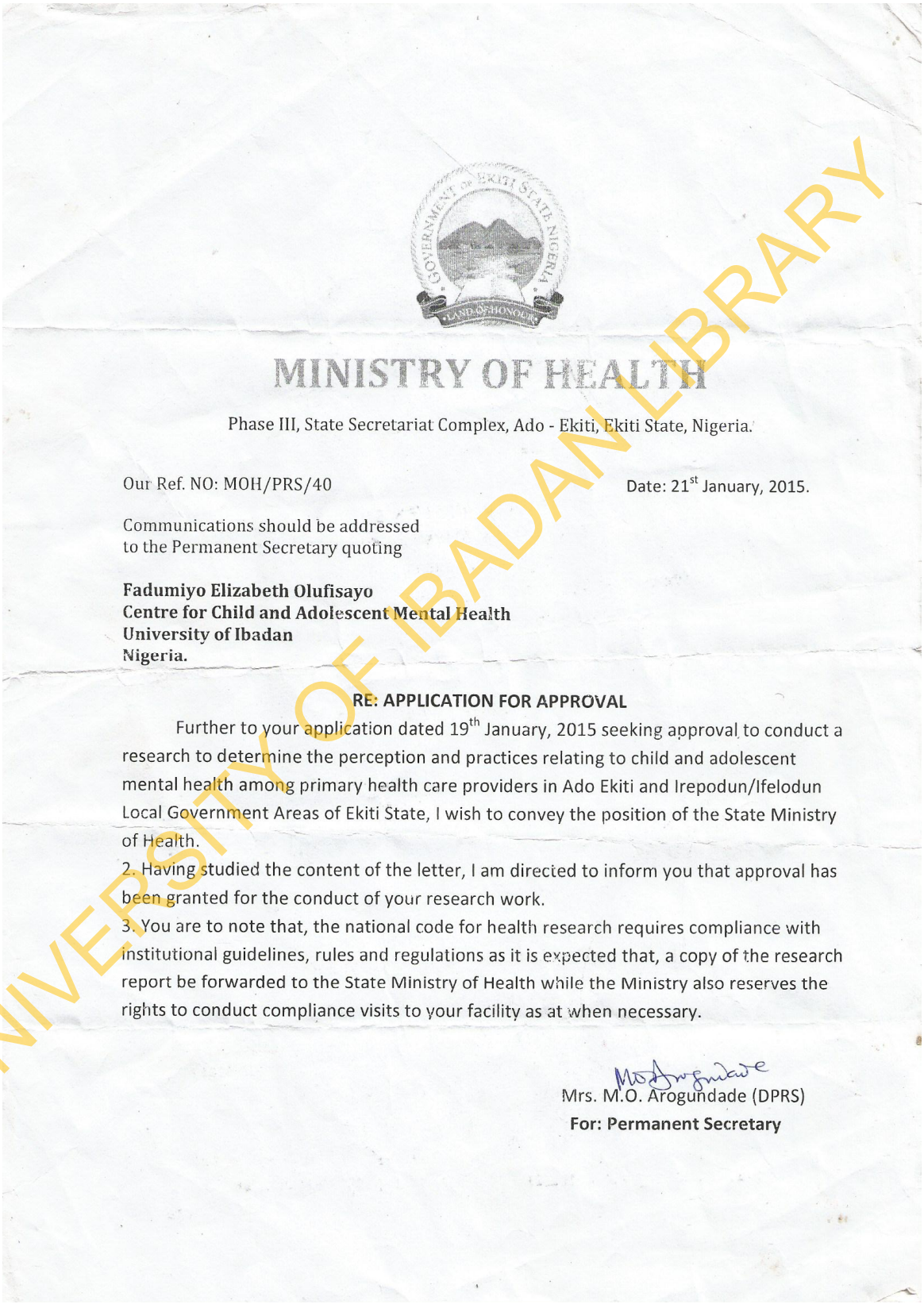
Appendix 5

Ethical approval



MINISTRY OF HEALTH

Phase III, State Secretariat Complex, Ado - Ekiti, Ekiti State, Nigeria.

Our Ref. NO: MOH/PRS/40

Date: 21st January, 2015.

Communications should be addressed
to the Permanent Secretary quoting

Fadumiyo Elizabeth Olufisayo
Centre for Child and Adolescent Mental Health
University of Ibadan
Nigeria.

RE: APPLICATION FOR APPROVAL

Further to your application dated 19th January, 2015 seeking approval to conduct a research to determine the perception and practices relating to child and adolescent mental health among primary health care providers in Ado Ekiti and Irepodun/Ifelodun Local Government Areas of Ekiti State, I wish to convey the position of the State Ministry of Health.

2. Having studied the content of the letter, I am directed to inform you that approval has been granted for the conduct of your research work.

3. You are to note that, the national code for health research requires compliance with institutional guidelines, rules and regulations as it is expected that, a copy of the research report be forwarded to the State Ministry of Health while the Ministry also reserves the rights to conduct compliance visits to your facility as at when necessary.

Mrs. M.O. Arogundade (DPRS)
For: Permanent Secretary

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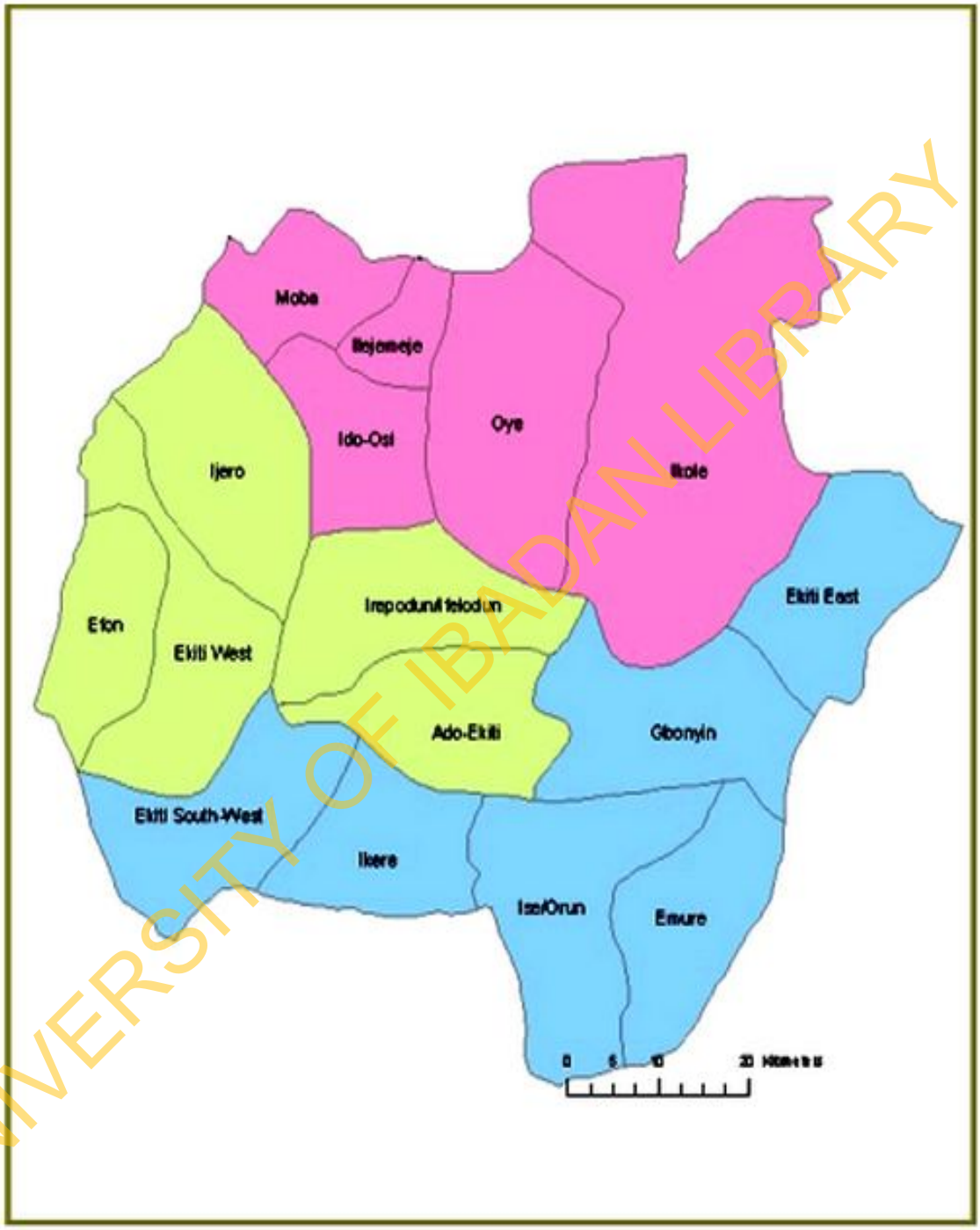
Appendix 6

EKITI STATE – SENATORIAL DISTRICTS



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