The Burden of Treatment among Adults with Mental Illness in Igboland: A Qualitative Exploration

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Abstract. The burden of treatment among adults with mental illness is a rarely discussed issue in health and social care professions because most healthcare research focuses on the cost of mental health disorders. Considering that it impacts one's capacity to follow the prescribed medical regimen, health and social care stakeholders must understand the importance of the burden of treatment on the provision of quality health and social care and the patient's overall well-being. Thus, this exploratory qualitative report examined the treatment burden among adults with mental illness in Igboland. This investigation revealed five core categories of treatment challenges and five main personal capacities that may influence the treatment burden among adults with mental illness using "Cumulative-complexity Model." This study shows that the treatment burden among adults with mental illness in Igboland is predominately the outcome of failed health and socio-economic policies at the local, state, and national levels of governments.

Keywords: Igboland; Mental health disorders; Treatment burden; Socio-economic policies

Introduction

The United Nations' Sustainable Development Goals (SDGs) are rooted in the global resolution to promote social inclusion. This goal explains why the theme of the World Health Day 2001 was "Stop exclusion- Dare to care (World Health Organization, 2000)." The mismanagement of the structural determinants of health has not only excluded the poor from participating in socio-economic activities; it has also denied them access to preventive health and social care. Consequently, the lack of timely access to care has exacerbated treatment burdens across the global populations. Economic globalisation has globalised both communicable and non-communicable diseases, and continually exposes marginalised individuals and groups to incessant illnesses, which increases their burden of treatment. For instance, in major Igbo cities, the incidence of adults with mental health disorders has become prevalent. This frequency raises some concerns on the ability of the families, communities, government and the mental health institutions to deal with it effectively.

This study provides valuable data on the intervention challenges faced by adults with mental illness in Igboland. This subject is rarely discussed in health and social care professions, as most healthcare research focuses on the burden of mental health disorders. Since it can adversely impact an individual's capacity to follow a prescribed medical regimen, health and social care stakeholders must acquire an informed knowledge on the importance of burden of treatment on the provision of quality health and social care, and the patient's overall well-being. This investigation revealed five main treatment burdens. It also indicated five primary personal capacities that may help reduce the burden of treatment among adults with mental illness. This study demonstrates that the burden of treatment among adults with mental illness in Igboland is predominately the outcome of failed public health and socio-economic policies at the local, state, and national levels of governments.

Literature Review

What is the Burden of Treatment?

According to Dobler et al. (2018), the burden of treatment is a less recognised and relatively newly invented phrase. It is the workload of healthcare experienced by those living with chronic illnesses and the impact that it has on their well-being (Gallacher, May, Langhorne & Mair, 2018). It can adversely impact the individual's ability to follow a prescribed therapeutic regimen (Gallacher, May, Langhorne & Mair, 2018). People may differ in their ability to manage their health problems and adhere to medical procedures and care due to several factors such as income, health literacy, social support, etc. Thus, the quality and structure of health and social care services have a significant influence on the burden of treatment and patients' capacities to adhere to the physician's orders (Gallacher, May, Langhorne & Mair, 2018). Gallacher, May, Langhorne and Mair (2018) assert that healthcare workload includes the acts of thinking, organising, executing, and reflecting that arise throughout the therapeutic encounter. For example, apart from overcoming the burden of the disease, the patients also struggle with the treatment problems or tasks such as medication management, family doctor's visits, laboratory tests, and maintaining a healthy lifestyle.

Worldwide, the existing healthcare systems and guidelines are not flexible enough to care for the large and rising number of patients with multifaceted care needs and those with multimorbidity (Spencer-Bonilla, Quiñones & Montori, 2017). With the case of mental illnesses, which are caused by several factors, minimally disruptive treatment could improve the lives of patients with complex needs while reducing their burden of treatment (Spencer-Bonilla, Quiñones & Montori, 2017). The reason for this approach is because of the enormity of the treatment burden. For instance, in the United States, the care for individuals with chronic conditions accounts for two-thirds of healthcare spending, and out-of-pocket costs are unevenly high for patients with lower income, poor health, and activity limitations (Anderson, 2010). Therefore, patients and caregivers must accomplish the workload of integrating treatments into their daily routines and of relating to healthcare systems over prolonged periods of their lives (Wolff & Boyd, 2015).

While there are treatments for various forms of mental disorders available, two-thirds of people with a diagnosed mental illness never seek care from a healthcare professional. Some of the reasons are due to stigma, discrimination and neglect (World Health Organisation, 2001). Therefore, the United Nations' health agency tries to promote mental health for all by encouraging governments to pursue solutions for mental health that are available and affordable (World Health Organisation, 2001). To accomplish this task, governments must move away from large mental institutions and focus more on community-based health care and incorporate mental health care into primary health care and the overall health care system (World Health Organisation, 2001). According to the Director-General of the World Health Organisation (2001), "mental illness is not a personal failure. If there is a failure, it is in the way we have responded to people with mental and brain disorders." Governments are not doing enough to lessen the burden of mental disorders. For instance, in 2001, over 40% of the countries worldwide have no national policy on mental health, and more than 30% have no mental health programme. Approximately 25% of countries have no mental health legislation (World Health Organisation, 2001).

Poorer nations like Nigeria spend a lower percentage of their health budget on mental health, and they also assign these limited budgets less efficiently, spending a large portion on psychiatric hospitals (Vigo, Kestel, Pendakur, Thornicroft & Atun, 2018). Consequently, there is an unreasonably high treatment gap for commonly treated mental disorders, like general depressive disorders, of 78% in high-income countries, and as high as 96% in low-income and lower-middle-income countries, can be decreased only with a substantially higher investment in community-based mental health services (Thornicroft, Chatterji & Evans-Lacko, 2017). Coincidentally, these countries must not wait for an improvement in their economic wealth

before increasing the percentage of their health budget to mental health and using the allocation more efficiently.

Igboland and Mental Illness

Understanding the Study Population

The Igbos have various subgroups that have been created based on their clan, lineage, village affiliation and dialect (Ekezie, Anyanwu, Danborno & Anthony, 2011). The traditional Igbo communities practice consensual rulership despite the seeming authoritarianism of some of the community chiefs and elders. For instance, the pre-colonial Igbo societies had a decentralised sociopolitical system, which ensured that people lived together in peace, love, oneness, justice, guaranteeing equity, fairness, and co-prosperity as they believe that togetherness is a strength (Oghojafor, Alaneme & Kuye, 2013). They had well-defined norms notwithstanding the absence of a hierarchical sovereign head. Also, every Igbo indigene had direct and productive participation in decision making, which promoted a democratic process (Oghojafor, Alaneme & Kuye, 2013).

Most of these changed after the unification of Northern and Southern Nigeria by the British colonial masters in 1914. The amalgamation of Nigeria and the subsequent colonisation of Nigeria fashioned a political class that has problems with reconciling itself with the long period of the historical development of the Nigerian peoples in forging a modern nation-state (Jega, 2000).

According to Ekeh (1983), the colonial rule in Nigerian promoted a new historical era. Ekeh (1983) states that one of the most notable outcomes of colonialism was the creation of two public authorities, the primordial and the civic, which related differentially with the private domain in terms of morality. The primordial public domain was based on the cultures and customs of the people and reflected a high standard of morals derived from the peoples' histories (Ekeh, 1983). The civic public realm, however, was associated with illicit and exploitative colonial rule and had no ethical connections with the private domain. It was the illegal or the unscrupulous public sector in which defrauding the system was considered a patriotic duty. Unfortunately, the unwritten law of the dialectics is that it is lawful to rob the civic public to strengthen the primordial public (Ekeh, 1975). Also, many people believe that the state and its organs are synonymous to alien rule and the perfect tools of plunder and they have not yet been reidentified fully as instruments for the promotion of common interests (Leys, 1965). Such conditions promote self-aggrandisement, social exclusion and the socio-economic milieu that breeds all forms of mental illnesses.

Understanding Mental Illness in Nigeria/ Igboland

In Igboland, mental illness or insanity describes behaviours that are not in harmony with the culturally acceptable conducts within the household or society (Iroegbu, 2005). Though both conventional and traditional conceptions of mental illness agree on the pathology of insanity, such as its manifestations; loss of rationality, substantial impairment of thought, emotional instability, distorted perception, wrong orientation and confused memory or the failure to meet the ordinary demands of life (Iroegbu, 2005). The notion of mental illness in traditional Igbo society transcended this. The Igbo tradition posits that an apparent irrationality is merely a physical or human understanding of the metaphysical interrelation between the casualty and the external force or entity that influenced people's action or behaviour. To most Igbo people this transcends the human rationality. Generally, the Igbos see sense in the madman's nonsense as they only assess the mad person in a state of keen, intimate receptivity with some personalities and forces invisible to human eyes and perception.

In the traditional Igbo society, mental illness is the worst sickness that could afflict an individual. The community treated such an individual as accursed, and an outcast and the object

of ridicule (Nwoko, 2009) due to the social construct on the causes associated with most mental illnesses. According to Nwoko (2009), the traditional Igbo society attributes mental illness to spiritual and, or physical issues. The conservative Igbo community sees mental illness as a punishment from ones' chi (personal god) for the abominable deeds which one had involved oneself in the distant past (Nwoko, 2009).

Suleiman (2016) states that mental health disorders are prevalent in Nigeria. Thus, the burden of mental health disorders is estimated at 15% by the year 2020 worldwide. Likewise, mental health professionals project that common mental health disorders such as depression, anxiety, and substance abuse- related conditions will incapacitate more people than complications caused by AIDS, heart disease, accidents, and wars (Ngui, Khasakhala, Ndetei & Roberts, 2010). According to Onyemelukwu (2016), about 20%–30% of people living in Nigeria suffer from mental disorders. Lamentably, Nigeria does not have long-term comprehensive mental health disorder policies or robust public mental health awareness programmes to dispel the misconceptions concerning mental health issues (Suleiman, 2016).

For instance, the World Health Organization Assessment Instrument for Mental Health Systems (2006) reported that there is substantial neglect of mental health issues in Nigeria. Suleiman (2016) supports this assertion by stating that Nigeria drafted its current mental health policy document in 1991 and that the policy has not undergone any revision or assessment since its inscription. Also, the Ministry of Health (2006) affirms that no desk exists in the ministries at any level to deal with mental health issues and that the government has assigned only four per cent of the national expenditures on health for mental health. Suleiman (2016) expanded on these issues by affirming that individuals with mental health disorders do not have access to essential medicines at primary health centres. Also, most of the primary health care facilities do not have enough physicians to manage primary health care centres. Furthermore, Suleiman (2016) alleges that most primary healthcare facilities in Nigeria lack access to psychotropic medications and that only a few non-governmental organisations provide counselling, housing or support group services to individuals living with mental health disorders. Iheanocho et al. (2015) conclude that only 10% of adults with mental illness in Nigeria receive any care.

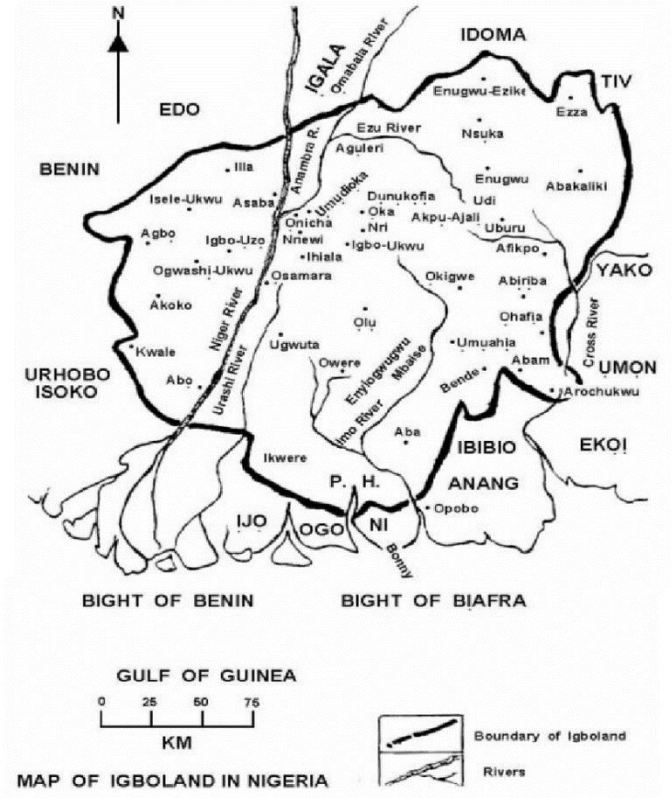

Figure 1. Map of Igboland in Nigeria

Source: Ebem, D.U (2009). https://www.researchgate.net/figure/Map-of-Igboland-in-Nigeria_fig2_27353122

Methods and Procedures

The Burman University Research Ethics Committee approved this study.

Recruitment of Participants

The group discussions focused on identifying the burden of treatment among adults with mental illnesses in Igboland. This objective of this study was to obtain data to develop affordable and accessible culturally appropriate education and intervention programmes for adults with mental illness in Igboland. The fieldwork took place in five batches through focus group discussions. The research subjects were purposively recruited to consist of a range of characteristics, including gender, age, length of the caregiving role, number of social supports, and the severity of mental illness(s). The focus group participants were recruited both from the churches and social community gatherings to ensure a reasonable inclusion of a wider population. Those who invited the participants received clear instructions on the required inclusion and exclusion conditions (see Table 1).

Table 1. Research participants inclusion and exclusion conditions

Inclusion	Exclusion
Must be 18 years and over	People who are less than 18 years/ or have a history of severe mental illness that would make them incapable of giving informed consent to participate in the study
An Igbo indigene/ or someone who has lived in Igboland for at least ten years.	Someone who is not an Igbo indigene/ or an individual who has not lived in Igboland for at least ten years.
Awareness of mental illness within the context of the Igbo tradition	Someone with a history of violence or disorderly conducts in a public gathering
An individual with personal experience with someone living with mental illness / or an individual living with "mild mental illness."	

Fieldworkers received training on how to conduct group discussions and documentation. Like the study participants, the fieldworkers agreed to respect the participants' confidentiality. The primary requirements were fluency in Igbo and English languages, expressed interest in mental health promotion, particularly in Igboland, interviewing, translating, and social skills. The principal researcher provided guidelines for the group discussions outlining the following areas: understanding of mental illness management and care plans; the level of social interactions; implementing treatment strategies, access to medications; and a personal-reflection on mental illness management in Igboland. Also, participants had a section, where they responded to questions on the perceived mental illness patients' or community capacity or resources- that is, factors outside of the health systems such as personal characteristics, income, support network, environment, individual' social responsibilities and conditions.

Participants responded either in Igbo or English language. The fieldworkers clarified the open-ended questions in various Igbo dialects while the principal researcher provided more explanations on the discussion questions and moderated proceedings to minimise groupthink and distractions. Altogether, 42 people participated in this study, with an average of 8.4 participants in each of the five focus group meetings.

Findings and Discussion

Participants

The average age of participants was 45. Twenty-five were males and 17 females. Participants represented the 19 major towns and cities in Igboland. Thirty-five per cent of the study subjects have at least one known mental illness, 25% stated that they deliver unpaid care to a family member living with either mild or severe mental illness. Ten per cent of the focus group members work as paid mental health professionals, while the remaining 30 per cent have friends and church members living with various mental health disorders. Fifty-five per cent of the participants indicated having some level of a college education.

Burden of Treatment

The research subjects asserted that the burden of treatment comes either from the workload of healthcare or as a result of coping with care shortages. For instance, 71.4 per cent of (30 of the 42) the participants said that either they or people they know who are living with mental illness find it difficult to understand mental illness management and care plans, which makes it a burden for one to manage the disorder. For instance, Mr CJ stated that:

'One *does not know where to start! In this country is there is no information on this type of sickness. Even those who come to our churches to educate us on it, do not go into many details. Some of them don't even know what they are saying.'*

Caroline K. supported this by stating that:

'Yes*! They always confuse me! They call every brain problem madness, but I know that my brother is not mad; the only issue with him is that he has a problem controlling his emotions. The hospital keeps on giving him crazy people's medications, which keeps him in bed all day.'*

Mr Nkume prolonged the discussions on this item by stating that:

"I have been trying to help my uncle to cope with some of his mental health problems for some time now, but my biggest problem is that I don't have any support coordinating his care. Imagine that he has to see many doctors in different locations and at different times and days. I honestly wish we can attend to all his medical needs in one place at the same time. It will make life easier for everyone."

Another participant suggested that life for many individuals and families would be much easier if there were a team or an organisation that can help someone with mental illness to develop and maintain coping strategies. 'One doesn't have an immediate helpline or someone to talk to in time of crisis, and it takes a while to see a specialist.,' she responded.

Only ten out of the 42 (24%) participants were satisfied with the level of social interactions. However, the majority of the participants agreed that most people with mental health disorders could seek medical assistance from health and social care professionals as long as they have the resources. However, Mr Nkume alleged that this "*is not always so with an average person in Igboland."*

Similarly, 10% of the respondents affirmed that most people with mental health issues obtain support from friends and family members. Nevertheless, 90% of the participants blamed social stigma and the fear of losing one's employment as some of the reasons why it is difficult for individuals with mental health disorders to seek medical advice from health and social care professionals, and support from friends, family, fellow patients. According to Mary Bell:

'It *is a taboo in this city to tell someone that you have a mental health issue. You can even lose a potential husband or wife by telling him or her that one of your family members is living with schizophrenia for an example. People keep most of these issues to themselves and hope for the best, which makes treatment a big burden.'*

Another participant added: *'I know someone who recently lost her job because of manic depression. Her boss saw her taking a tablet; he googled it and gave her a sack letter two days later.'*

Most of the participants mentioned the poor implementation of mental illness management plans as one of the leading sources of treatment burdens in Igboland. For instance, 80% of the participants stated that the lack of transportation makes it burdensome for most mental illness patients to access the sparsely available medical facilities. According to Bobloko:

"*As a psychiatric nurse, I can confirm that transportation is one of the major problems facing most patients in this region. People which chronic illness, mainly individuals with mental health issues grapple with this issue. For instance, 70% of the no-show in hospital appointments are due to lack of transportation."* Another respondent added: *'My friend and I got stuck in the traffic on our way to the Federal Medical Centre Umuahia last week due to the poor road conditions. A trip that usually takes us 40 minutes lasted for about 2 hours, costing my friend his appointment with his physician."*

Lack of access to medications is another notable healthcare workload highlighted by the research participants. Forty per cent of the female participants claimed that either they or someone they know could not afford to buy the medications as they do not have family medical insurance plans. On the other hand, 60 per cent of the female participants alleged that their

primary health centres do not have enough effective medications. Interestingly, 10 per cent of the participants blamed the mental health physicians or psychiatrists for their plights. According to Elder Aguata:

"There are no drugs, and the few available are so expensive. I learned that some of the doctors are diverting them to their privately-owned clinics or pharmacies, which makes so difficult for an average person to buy."

Linus stated: 'Apart *from the drugs being scarce and expensive, they affect one physically and mentally. I noticed that my friend is getting fatter and fatter since he started taking that tiny medication. All he does is to sleep even at work.'*

Elder Aguata: '*Yes, someone nearly died yesterday in my compound. His wife said he combined his antidepressant medication with some native herbs. I guess nobody educated him on how to coordinate his treatment regimen.'*

Reflecting on the overall performance of the mental health practice in Igboland, 90 % of the participants agreed that things are improving in comparison to what was obtainable ten years ago. For instance, they stated that presently, most primary health centres had qualified mental health professionals who are eager to help patients lead more meaningful lives. However, they want a more person-centred approach to patient care as this would enhance patients' adherence to the treatment plans.

95% per cent of the research subjects stated that positive personal characteristics such as resilience, independence, patience, humour and determination might help to reduce the burden of treatment and improve the quality of one's mental health. However, one of the respondents noted that:

"This is only applicable for a short period and not in a situation where one faces ongoing unpleasant life events. Our present economic situations take away from one's joy and the ability to forge ahead."

Also, most of them stated that one's financial strength or struggles might determine the extent of the treatment burdens, which an individual with mental illness faces. For instance, Elder Aguata stated that many wealthy Igbo families go to *"high-quality private medical facilities for their medical care while the poor ones often delay seeing a doctor. Some even die while waiting for financial assistance.*

Another respondent added:

"Yes, our governments have let us down because of their greed. Our leaders are only interested in stealing our resources. We do not have funds for hospitals, no money to pay our doctors. This is because most of our leaders and their cohorts are all going to India, Canada, United Kingdom, the United States, and Saudi Arabia for their medical treatments leaving us the poor ones to suffer and die."

Another major cause for the burden of treatment highlighted in this section was an individual's life workload or challenges such as the presences of other chronic diseases such as diabetes, arthritis, and high blood pressure, etc. Also, one's employment status, number of dependents, marital status and housing conditions were other variables that the participants listed as factors that might influence one's burden of treatment (see Table 2).

Table 2. Summary of research participants' notable burden of treatment and personal features that may either reduce or exacerbate them

Health and Social Care Workload: Interaction with the healthcare system	Potential burdens	Patient's Capacity or Life Workload	Potential Impacts

Complex mental illness management and care plans	• May make it a burden for one to manage the disorder ➢ May lead to patients receiving inconsistent medical advice ➢ May make it difficult for patients to relate to their health and social care providers ➢ May lead to poorly coordinated care plans resulting in ✓ Multiple appointments ✓ Unnecessary paperwork ✓ Patients are left confused	*Presence of co-occurring diseases*	It may exacerbate the patient's mental health problems and increases the burden of treatment as it reduces the patient's capacity to maintain a balanced lifestyle
Medication Burden	➢ Lack of access to effective medications ➢ Feeling stigmatised because of medication ➢ May interfere with the patient's daily activities ➢ Side effects may be deadly ➢ Possibility of a drug overdose ➢ Changes one's physically and mentally	*Employment status or income*	➢ Lack of adequate income may make it more difficult for the patient to receive a timely treatment, which exacerbates the treatment burden
Transportation Burden	➢ Patients may miss urgent psychiatric appointments, which hinders recovery ➢ Being stuck in traffic for hours promotes stress ➢ May lead to unplanned expenses	*Poor housing conditions*	➢ Overcrowded environment/ and unsafe living space may increase one's anxiety, create insecurity and depression, which make it more difficult for one to adhere to treatment plans
Social interactions/ The burden of social exclusion	➢ One may face stigmatisation ➢ Limited social supports ➢ One may lose his or her spouse or partner ➢ Possibility of losing one's employment	*Number of dependants*	All the participants agreed that the size of a patient's dependents might affect his or ability to cope depending on the person's resources. While children are the source of great joy, they may also exacerbate one's mental health issues in situations where one does not have the resources to cater for their needs adequately.
Inadequate/or lack of government social policies on mental health disorders	• May lead to the poor implementation of mental illness management plans ➢ May create a financial burden for an average Igbo person with mental illness ✓ Lack of money to paying for medication or consultation fees ✓ No government' social assistance for lost employment, transportation or family relocation.	*Marital status*	All the participants agreed that married individuals cope better than single men and women with mental health challenges as they have the support to negotiate the complex Nigerian mental health system. However, there must be love and understanding.

Discussion

This exploratory qualitative study has provided a brief description of the lived experiences of adults with mental health disorders in Igboland, Nigeria. Although many health

and social care experts focus on the burden of mental illness, this research provides a rare scientific data on the challenges of treating mental illness. While the setting of this study is in Igboland, Nigeria, it seems plausible to suggest that the outcomes of this study may apply to other major ethnic groups in Nigeria, Ghana, Liberia, Sierra Leon, and The Gambia.

One of the notable qualities of this study is that the literature review collaborated the context of the participants' responses. The stagnant Nigerian healthcare system may be the immediate cause of the burden of treatment in Igboland. Still, the chronic ineffective federal government social and health policies are the root of these problems. The Nigerian Ministry of Health (2006) states that adults with mental health disorders in Igboland do not have access to essential medicines at primary health centres. Also, Suleiman (2018) alleges that most primary healthcare facilities in Nigeria lack access to psychotropic medications and that only a few non-governmental organisations provide counselling, housing or support group services to individuals living with mental health disorders. Iheanacho et al. (2015) conclude that only 10% of adults with mental illness in Nigeria receive any care.

The lived experience of the study population provides practical examples of some of the adverse outcomes of socio-politico-economic marginalisation. Even though most of the Nigerian economic resources come from the states within Igboland, the federal leadership has chronically starved Igboland of the necessities that promote good health. According to the Cumulative Complexity Model (CuCoM), accessing and using health and social care, as well as practising self-care, require adequate capacity (time, energy, and resources) to accomplish the treatment workload (See Figures 2 and 3 below). Unfortunately, this is not obtainable by many adults with mental health disorders in Igboland as most of them do not have the capacity due to chronic neglect by the local, state and federal governments. The general impression of the study population indicates people who have resigned to fate and without any faith in their selfish and corrupt leaders who prefer to embark on medical tourism in Western countries instead of investing in the health and social well-being of the masses. Most of The research participants asserted that the failure of their local, state and national governments to provide adequate resources compounds the clinical workload, increases the individuals' workload and reduces their capacity to manage their mental health issues (see Figures 2 and 3).

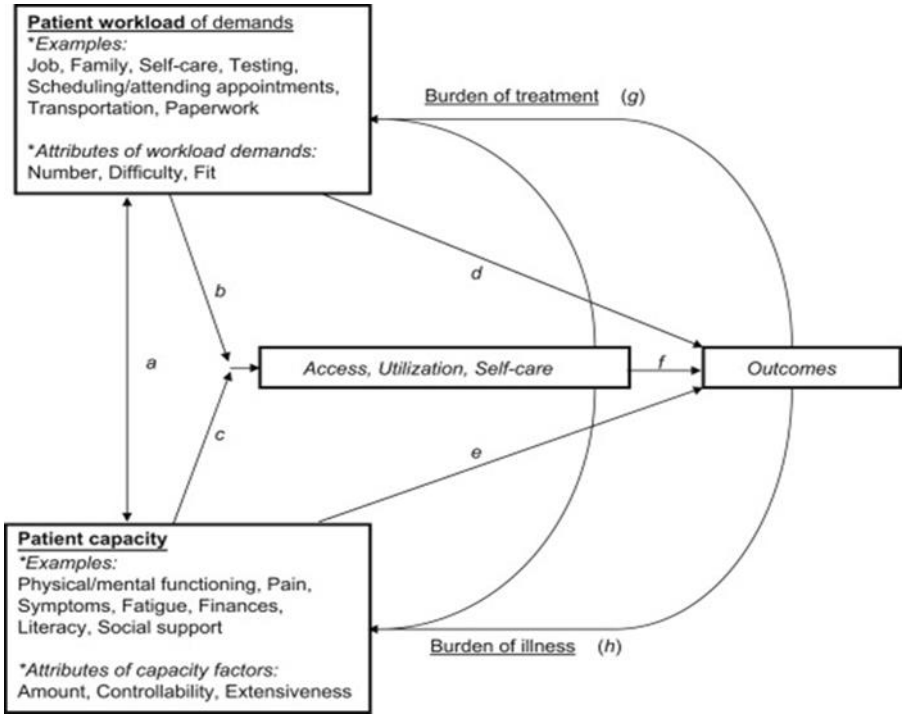

Figure 2

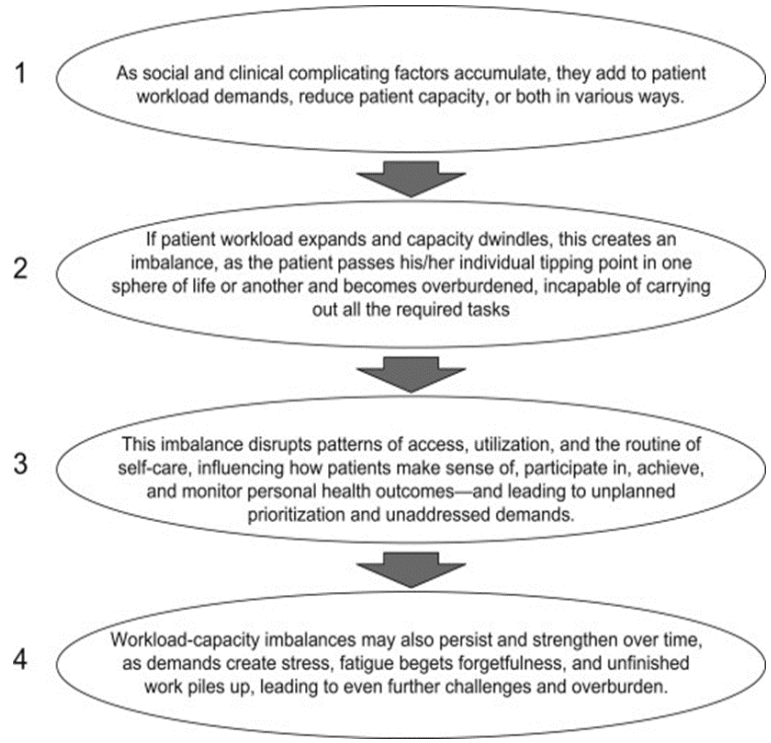

Figure 3

Figures 2 and 3. The cumulative-complexity model
Source: Shippee et al. (2012)

Conclusion

This explorative qualitative study identified five main treatment burdens and five individual capacities that may decrease or increase the problems of treatment among adults

with mental illness in Igboland. It also revealed that these impediments are predominately the outcome of failed public health and socio-economic policies at the municipal, state, and national levels of governments. For instance, while there are no social welfare programmes to mitigate against abject poverty in this region, the few available medical and social care facilities do not have the resources to cater to those in need. These compound the issues and add to the workload demands on the sick, the frail and the vulnerable, reducing their capacity to manage their mental health problems.

One of the trends in the population studied is their inability to access timely information regarding their specific mental illness. Majority of the participants state that this makes it harder for them to make informed decisions or know which mental health services to access. Thus, one of the plausible solutions to this problem is for health, and social care providers in Igboland to provide adequate information on mental health issues, which they can disseminate through the local churches, mosques, national mobile phone networks, and social media. Specifically, the creation of a freely accessible mental health database, which highlights the costs and locations and categories of available resources on mental illnesses in layman's language will go a long way in providing public health education on this matter.

Another notable trend is the culture of medical tourism by the Nigerian political and social elites. Given the present currency exchange rate in Nigeria, people travelling outside of the country for medical care may end up spending their entire savings to access care abroad, thereby depriving themselves and their families the necessities of life, thus creating or increasing inequities. Also, this trend seems to encourage a culture of negligence and misappropriation of public funds by the political elites, which leave the entire region with little or no means of developing and implementing sustainable health and social care plans for the masses. Consequently, this paper recommends that all the mental health stakeholders in Igboland in particular and Nigeria in general work together to promote a culture of public service accountability, which supports the development and patronage of health and social services in Nigeria.

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