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*The rare level of unmet necessity for mental healthcare services is disturbing in Nigeria. Although studies exist on the availability of mental healthcare services, little attention has been paid to gender differences. This study therefore examined gender differentials in the availability of mental healthcare services among the Yoruba of Ogun State, Nigeria. Qualitative and quantitative methods of data collection were used. The data was based on cross-sectional survey of communities and four neuropsychiatric hospitals in Ogun State, Nigeria. Through proportionate sample size distribution to the LGAs, nine hundred and sixty seven adults aged 18 years and above were randomly selected. Five In-depth Interviews were conducted among caregivers of People Living with Mental Illness (PLWMI) (Those who are receiving treatment and those who have recovered) and nineteen key informant interviews were conducted among orthodox practitioners (Psychiatrists and social workers) and traditional healers that reside in the study area. Quantitative data were analyzed using descriptive and inferential statistics. Findings from this study showed that the average age of respondents was 22.2 years. Out of the total, 52.2 percent of the respondents were female while 45.8 percent were male gender. In respect to awareness on primary healthcare services, only 8.9 percent of female respondents were aware compared to 19.7 percent of the men. Further, only 14.5 percent of the male respondents were aware of the secondary healthcare service when compared to 25.4 percent of their female counterparts. Lastly, 65.8 percent and 65.7 percent of the male and female respondents respectively were aware of the availability of tertiary healthcare services. This study concluded and recommended the need for more awareness and availability of these three levels of healthcare*

*point of call for people living with mental illness.*

*Gender differentials, Mental illness, Availability, Mental healthcare services*

The disparity among the overall burden of mental illnesses and availability of mental health resources is disturbing. There is the rare level of unmet necessity for mental healthcare (Gureje & Lasebikan, 2006; Igbokwe &

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availability to its users. Mental healthcare in Nigeria is subject to diverse indigenous and regional factors.

In view of the above, in Nigeria, the mental healthcare structure has revealed a longitudinal variance regarding availability and quality of facilities concerning need. (Akhtar, 1991). Whereas the federal government is typically restricted to controlling the activities of the country's tertiary healthcare structure including the university teaching hospitals and Federal Medical Centres. The state administration coordinates the countless general hospitals (That is the secondary healthcare) and local governments manage dispensaries (That is the primary health care). The majority of mental healthcare services is made available by eight regional psychiatric centers and psychiatric sections and medical institutions of the county's twelve main institutions of higher education. Limited general hospitals similarly provide mental healthcare services.

Internationally, only two out of a hundred of nationwide financial plans are dedicated to mental health (World Health Organization, 2005). Approximately 70 percent of African nations and 50 percent of south-east Asian nations spend 1 percent of their health financial plan on mental health (Jacob, Sharan, Mizra, Garrido, Seexat & Saxena, 2007). In countless unindustrialized nations, women lament the nonexistence of confidentiality, privacy and information in existing mental healthcare facilities. One of the greatest challenges in providing facilities for People Living with Mental Illness (PLWMI) in Nigeria is making available harmless and cheap treatments.

Studies conducted by Ngui, Lincoln, Ndtei & Roberts (2010); Jack-Ide & Uys (2013) & Elegbeleye (2013), show that the Nigeria populace is still vaguely aware of mental illness and the ease of use of mental healthcare services and effective treatment outcomes. Mental healthcare services in rural communities are unavailable and have left people living with mental illness and their relations with no option than to use whatever is available. According to Beaglehole, Epping-Jordan, Patel, Chopra, Ebrahim, Kidd & Haines (2008), the control of mental illness requires functioning, affordable and equal primary healthcare since it is through access to these services that those at a high risk of mental illness can be identified, advised and treated. The availability of mental health services in unindustrialized nations is pitiable owing to the shortage of resources, poor access to health facilities and the little importance given to mental health concerns.

According to Gureje & Lasebikan (2006), it is not all psychological disorders that require treatment (Regier, Narrow, Rupp & Kaelber, 2000; Gureje & Lasebikan, 2006). Likewise, not everybody with a need for treatment desires to see a professional. The primary healthcare system in Nigeria is poorly resourced and organized (Gupta, Gauri & Khemani, 2003; Gureje & Lasebikan, 2006). They are principally managed by nurses and community healthcare personnel with little or no training in mental healthcare concerns. It is uncertain if the specialists at the primary healthcare service can provide quality care and services people living with mental illness. Poor awareness and adverse approach to mental illness in Nigeria, which are common in some unindustrialized nations inhibit individuals from seeking medical assistance (Gureje, Lasebikan, Ephraim-Oluwanuga, Olley, & Kola, 2006; Gesinde,

In developed nations, on the other hand, community-based mental health services are currently the most desired ideal for the provision of psychiatric care, in comparison to the traditional psychiatric hospital built services. The World Health Organization is an advocate of community mental healthcare in both industrialized and unindustrialized nations (World Health Organization, 2001). For Makanjuola (2011), in developed countries, the elements of community-based mental healthcare services are well-recognized and they consist of the establishment of mental health components in general hospitals and the construction of mental health groups that are community-based. The latter include occupational therapies, nurses, psychiatrists, social workers, psychologists, and other mental health experts. They provide outpatient services with an emphasis on supporting people living with mental illness in their homes and anywhere imaginable. Primary healthcare works in collaboration with the specific community-based mental healthcare services with the expectation that there would be the management of mental illness in this location by health labor force who enjoyed elementary mental health training.

In Africa, community mental healthcare services are not functional because there is a paucity of skilled mental health specialists and practically there is no societal provision, and where relatives of people living with mental illness are not available, traditional healers and spiritual front-runners frequently perform the leading role in dealing with mental illness. The World Health Organization recommended the expansion of community mental health services viz-a-viz the incorporation of mental health into the current primary healthcare system and the mobilization of community resources. The structure of the primary healthcare scheme in sub-Saharan Africa is sensibly deep-rooted, even though variable analysis and excellence of services are limited. According to Eaton (2008), the advantages of community-based services are properly documented and have robust research indication of efficiency. World Health Report (2001) & Eaton (2008) recommends replacing large mental health services with community psychosocial rehabilitation services, which can make available better and earlier care, are more respectful of human rights and can help limit the stigma of mental health treatment.

Health structures are central to the provision of evidence-based mental healthcare (World Health Organization, 2000). World Health Organization defined the necessity and validation for constructing community-based mental healthcare schemes and services (World Health Organization, 2001). Jacob et al., (2007) recognized the vital mechanisms for improving mental health services such as making available the treatment for mental abnormality in primary care and guaranteeing that there is an augmented access to a crucial psychotropic drug. The components also entail the provision of medical care in the society, enlightenment of the public (Including the people, consumers and families); development of nationwide strategies, programs, and regulations on issues about mental health; improvement of social resources; connection with other regions; observation of community mental health; and funding of significant research. Hence, a mental health scheme comprises all organization and resources with the emphasis on advancing mental health and covers the following areas: policy and legislative framework, mental health in primary mental healthcare, community education, community mental health services, human resources, relations with other regions, observation and enquiries.

According to Ngui, Lincoln, Ndetei & Robert (2010), the few psychiatric hospitals are usually bedeviled with inadequate personnel, crowded and may not make available the needed care. Most hospitals for the provision of mental health are situated in cities. In some cases, these clinics are just ‘storerooms’ that serve the purpose of keeping patients away from the rest of the general public due to inadequate resources and capability to cope with their situations effectively. In industrialized countries, there is the de-institutionalization of people living with mental illness. This habit is common in numerous people living with mental illness, who are, imprisoned because of inadequate access and availability of particular psychiatric amenities in the society. One important method for addressing the disparities in mental healthcare is to

Internationally, identifying NGOs with particular emphasis on mental illness is challenging. A current review looked at NGOs that offer crisis mental health services resulting in tragedies as well as developing facilities. Of 119 English language-speaking organizations itemized on the website of the United Nations, only 46 percent focused on mental health policy and programmes. Forty-seven of these organizations had involved in a minimum

As shown in Table 1 the availability of mental healthcare services matter for the treatment of people living with mental

buy. The psychiatric hospital has qualified professional healthcare workers who take care of my daughter. I am impressed by the services rendered (Caregiver, Abeokuta South Local Government Area, IDI).

With regard to secondary healthcare services, for male respondents, 28.6%, 35.7%, 16.7% and 19% reported that cheap drugs; available services; qualified professional healthcare workers and all of the items indicated were available in the secondary healthcare services respectively. Conversely, for female respondents, 31.3%, 31.3%, 21.3% and 16.3% reported that cheap drugs; available services; qualified professional healthcare workers and all of the items indicated were available in the secondary healthcare services respectively. On primary healthcare services, for male respondents, 2.8%, 8.3%, 25% and 64% reported that cheap drugs; available services; qualified professional healthcare workers and all of the items indicated were available in the primary healthcare services respectively. Conversely, for female respondents, 6.9(wor2 )TJ0.2350 Tw 00.235ed that cheap drugs; available services; qualified professional healthcare worseco3D(for male respo0.5 (all )0.8 e )0.7 6items were a1e in the sec,

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