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RESEARCH ARTICLE

CULTURAL NORMS, POLITICAL AUTHORITY, AND GENDER BARRIERS TO MENTAL HEALTH CARE UTILIZATION: A MIXED-METHODS STUDY FROM NORTHWEST NIGERIA

[1]ABDULLAHI ABDULWAHAB YAKUBU*, [2]ZEENAT ABDULSALAM, [1]SUMMAYYAH MUHAMMAD BASHAR, [1]AUDU ISHAQ AVEKA, [1]BASHIR ADAM YAKASAI

[1]Department of Psychiatry, Ahmadu Bello University, Zaria, Nigeria; [2]Department of Political Science and International Studies, Kaduna State University, Kaduna, Nigeria

ABSTRACT

In Northwest Nigeria, women face a disproportionate burden of mental disorders, yet their access to formal care remains critically low. This study investigates how entrenched cultural norms and political governance structures intersect to create and sustain gendered barriers to mental health service utilization. A concurrent mixed-methods design was employed. Quantitatively, a cross-sectional community survey was administered to 422 women, using the adapted WHO World Mental Health survey instrument and the Perceived Barriers to Care Scale. Qualitatively, a critical interpretive policy analysis was conducted through documentary review of national and state-level policies and 18 key-informant interviews (KIIs) with policymakers, traditional/religious leaders, and healthcare providers. Quantitative data were analysed using descriptive statistics and multivariate logistic regression. Qualitative data were analysed thematically. Only 12.3% (n=52) of women with probable common mental disorders had sought formal mental health care in the past year. Key barriers included: stigma (reported by 78.4%, n=331), economic dependence (67.1%, n=283), and lack of female providers (61.6%, n=260). Regression analysis showed that women's autonomy in household decision-making was a significant predictor of service use (AOR=2.45, 95% CI: 1.38–4.34). Qualitative analysis revealed a critical disconnect between gender-sensitive policy rhetoric and implementation, exacerbated by the dominance of patriarchal traditional authority structures and the political prioritization of physical over mental health. Effective intervention requires moving beyond biomedical models to engage directly with the political economy of gender and the custodians of cultural norms. Mental health governance must be restructured to explicitly challenge the power dynamics that suppress women's access.

Keywords: Mental health, gender, access to care, cultural norms, political authority, health systems

Corresponding Author
Dr. Abdullahi Abdulwahab Yakubu
Email Address: ayabdullahi@abu.edu.ng; Telephone Number.: +2348032804588

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INTRODUCTION

Mental health constitutes a significant and growing proportion of the global burden of disease, with depression being a leading cause of disability worldwide (World Health Organization [WHO], 2022). In Nigeria, the prevalence of mental disorders is alarmingly high, with an estimated 20–30% of the population affected, yet the treatment gap exceeds 80% (Abdulmalik et al., 2019). This gap is profoundly gendered; women in Nigeria are diagnosed with common mental disorders like depression and anxiety at nearly twice the rate of men, yet they face unique and systemic barriers to accessing care (Gureje et al., 2015). Northwest Nigeria, characterised by a predominantly Hausa-Fulani Islamic culture, deep-seated patriarchal norms, and a complex interface between formal state governance and powerful traditional authority structures (emirate councils), presents a critical context for examining this disparity (Antai et al., 2015).

Existing literature highlights multifactorial barriers to mental health care in low- and middle-income countries (LMICs), including stigma, financial constraints, and limited service availability (Saraceno et al., 2007). However, analyses often treat 'culture' as a static, monolithic variable rather than a dynamic system of power relations upheld by both traditional and political institutions (Kleinman, 2012). In Northwest Nigeria, cultural norms prescribing female modesty (*kunya*), seclusion (*kulle*), and economic dependence intersect with political governance models that often delegate social welfare, including dispute resolution and health-seeking guidance, to traditional and religious authorities (Callaghan, 2016). This creates a governance nexus where mental health policies, even when nominally gender-sensitive, are filtered through and often neutralised by patriarchal structures (Eboreime et al., 2018). While studies have examined mental health stigma in Nigeria (Jack-Ide et al., 2013) and the role of traditional healers (Oshodi et al., 2014), few have empirically dissected how the *intersection* of cultural authority and political governance actively *shapes* gendered access to the formal mental health sector.

This study aimed to critically examine how cultural norms and political authority structures intersect to create gendered barriers to the utilisation of formal mental health services for women in Northwest Nigeria. The objectives of the study included; to quantify the prevalence of formal mental health service utilisation and perceived barriers among women in the study area, to analyse the content and implementation gaps of existing mental health policies from a gendered perspective, to explore the perspectives of key stakeholders (policymakers, traditional leaders, providers) on the governance of women's mental health, and to synthesise quantitative and qualitative findings to propose a framework for gender-responsive mental health governance.

The questions this study sought to answer were: What are the prevalence rates and key predictors of formal mental health service utilisation among women? How do existing national and state-level mental health policies address or neglect gendered barriers, and what power dynamics affect their implementation? How do traditional and political authority structures perceive their role in shaping women's mental health-seeking behaviour? And How can mental health systems be reconfigured to address the identified intersectional barriers?

Research in Nigeria underscores stigma and supernatural aetiological beliefs as primary barriers to mental health care (Jack-Ide et al., 2013). Gureje et al. (2015) specifically noted that women's help-seeking is often mediated by male relatives. In Northwest Nigeria, Antai et al. (2015) linked gender

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inequality in health access to patriarchal norms, while Callaghan (2016) documented the emirate system's enduring socio-political influence. Globally, the concept of "structural violence" (Farmer, 2004) and "gendered institutions" (Acker, 1992) provides a lens to understand how institutions systematically disadvantage women. In health policy, Eboreime et al. (2018) critiqued the "implementation gap" in Nigeria's mental health policy, highlighting a lack of political will. This study integrates these strands, positing that the utilisation gap for women is not merely a service delivery failure but an outcome of a specific political-cultural governance regime.

MATERIALS AND METHODS

Study Design

A concurrent mixed-methods design (QUAN + QUAL) was employed to provide both breadth and depth of understanding. The quantitative component was a cross-sectional community survey. The qualitative component was a qualitative policy analysis using a critical interpretive approach (Yanow, 2007). This design facilitates an in-depth examination of not just the content of policy, but the power dynamics, values, and contextual constraints that shape its (non-)implementation.

Study Setting

The study was conducted in two states in Northwest Nigeria: Kaduna and Kano. These states were purposively selected for their active emirate systems, mix of urban and rural populations, and varied levels of public mental health service infrastructure.

Conceptual and Theoretical Frameworks

The study was guided by an integrated framework combining Feminist Political Ecology (Rocheleau et al., 1996) and the Theory of Gendered Institutions (Acker, 1992). Feminist Political Ecology posits that access to resources (like healthcare) is shaped by gendered power relations embedded in political, economic, and cultural hierarchies. The Theory of Gendered Institutions holds that institutions are not gender-neutral but are patterned by processes that perpetuate gender inequality. These frameworks directed our inquiry towards analyzing how both traditional (emirate councils, households) and formal (state health ministries) institutions co-produce gendered barriers to care.

Quantitative Component

Sample Size and Sampling

The sample size was calculated using the formula for estimating a single proportion. Assuming a 50% prevalence of perceived barriers (to maximize sample size), a 5% margin of error, and a 95% confidence level, and adjusting for a design effect of 1.5 and 10% non-response, a minimum sample of 422 was required. A multi-stage sampling technique was used. First, four Local Government Areas (LGAs) were randomly selected per state. Then, two electoral wards were randomly selected from each LGA. Finally, households were selected via systematic random sampling, and one eligible woman (aged 18-65) was randomly selected per household.

Inclusion Criteria

The inclusion criteria were; women aged ≥18 years who were permanent residents.

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Exclusion Criteria

The exclusion criteria were; women too ill to participate or those who could not provide informed consent.

Instrument and Validation

Socio-demographic and Service Utilisation Questionnaire: Captured data on age, education, marital status, occupation, autonomy (using a 5-item scale on household decision-making), and history of mental health service use. WHO World Mental Health Survey Initiative Version of the Composite International Diagnostic Interview (WMH-CIDI), Depression and Anxiety Sections: This instrument, adapted and validated for the Nigerian Mental Health Survey, was used to identify probable cases of common mental disorders (Gureje et al., 2015).

Perceived Barriers to Mental Healthcare Scale (PBMHS): A 20-item scale developed for LMIC settings (Osborn et al., 2014) was adapted and validated for this study. Face and content validity were established by a panel of Nigerian psychiatrists and public health experts. Pilot testing (n=30) yielded a Cronbach's alpha of 0.84. The survey was administered in Hausa or English by trained female research assistants.

Data Analysis

Data were analysed using SPSS v.26. Descriptive statistics (frequencies, percentages) summarised socio-demographics and barriers. Bivariate analyses (Chi-square) examined associations between service utilisation and predictor variables. Variables significant at $p<0.1$ were entered into a multivariate logistic regression model to identify independent predictors of service utilisation. Results were considered significant at $p<0.05$.

Qualitative Component

Data Collection and Triangulation

Two primary sources were triangulated: Documentary Review and Key Informant Interviews (KIIs). Documentary Review: National and State-level policy documents were analysed: the *Nigeria National Mental Health Policy* (1991), the *National Strategic Framework for Mental Health* (2019), relevant State Health Sector Strategic Plans, and Sharia legal codes (where applicable). Analysis focused on rhetorical commitment to gender, allocated resources, and implementation mechanisms.

Key Informant Interviews (KIIs): Eighteen KIIs were conducted with purposively selected stakeholders: mental health policymakers (n=4), public mental health service providers (n=6), traditional rulers/emirate council members (n=4), and Islamic religious scholars (n=4). Interviews explored perceptions of women's mental health needs, roles of different authorities, and barriers to policy implementation.

Analysis

A critical interpretive thematic analysis was conducted using NVivo 12. The analysis followed Braun & Clarke's (2006) six steps, with a focus on generating themes that exposed underlying power dynamics, contradictions, and silences in the data. Codes and themes were constantly compared with quantitative findings for integration.

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Ethical Considerations

The study procedures were reviewed and approved by the Health Research Ethic Committee of Ahmadu Bello University Teaching Hospital, Shika-Zaria (Ref: ABUTHZ/HREC/C57/2025). All participants provided written informed consent. Data were anonymised and stored securely.

4.0. PRESENTATION OF RESULTS AND DISCUSSION

4.1. Quantitative Findings

A total of 422 women participated (with a response rate of 95.9%). The sociodemographic characteristics of the sample are presented in Table 1. The mean age was 32.4 years (SD=9.1). Most participants were married (76.1%, n=321) and identified as Muslim (98.1%, n=414). Educational attainment was low, with the largest group having Qur'anic education only (45.7%, n=193), followed by no formal education (28.2%, n=119). The majority were not in formal employment (71.3%, n=301), with most engaged in petty trading or subsistence farming.

Using the WMH-CIDI, 30.8% (n=130) screened positive for a probable common mental disorder (CMD). Of these, only 12.3% (n=16/130) had sought care from a formal mental health service in the preceding 12 months.

Table 2 details the perceived barriers to mental health care utilisation. Stigma and cultural barriers were most pervasive, with 78.4% (n=331) fearing community stigma and 62.1% (n=262) citing disgrace to family (*Kunya*). Logistical and autonomy-related barriers were also severe: 67.1% (n=283) cited cost, 71.3% (n=301) stated they needed a husband's permission, and 61.6% (n=260) highlighted the lack of female service providers.

Multivariate logistic regression (Table 3) revealed that after controlling for other factors, significant independent predictors of formal service use among women with CMDs were: post-secondary education (AOR=3.12, 95% CI: 1.45–6.72), greater autonomy in household decision-making (AOR=2.45, 95% CI: 1.38–4.34), and urban residence (AOR=2.01, 95% CI: 1.12–3.61). Belief in spiritual causation was a significant negative predictor (AOR=0.42, 95% CI: 0.22–0.79).

4.2. Qualitative Findings: The critical interpretive analysis yielded three core themes:

Theme 1: The Policy-Practice Chasm: Documents like the 2019 National Strategic Framework contained aspirational language on gender and equity. However, KIIs with policymakers revealed a glaring absence of budgetary earmarks, gender-specific indicators, or operational plans to realise these goals. A state official noted, *"The framework is a good document... but it sits on the shelf. The budget line for mental health is still negligible and not disaggregated for women's needs."*

Theme 2: The Hegemony of Traditional Governance in Health Seeking: Interviews with traditional and religious leaders affirmed their role as the first point of call. A district head explained, *"If a woman is troubled, her family will bring her to me or the mallam for prayers and advice before thinking of a hospital."* This was reinforced by providers who stated that women often arrived late, "after all spiritual avenues are exhausted." The analysis showed this system, while trusted, often pathologised women's distress as spiritual/moral failure or marital disobedience, reinforcing stigma.

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Theme 3: Political Authority and the Marginalization of Mental Health

Mental health was consistently framed by political actors as a "soft," non-urgent issue compared to infectious diseases or maternal mortality. This political prioritization translated into systemic neglect: inadequate facilities, a crippling shortage of staff (particularly female psychiatrists and community health nurses), and no community-based outreach. A mental health nurse lamented, *"We have no vehicles for outreach. How can we find the women in seclusion?"*

Table 1: Socio-demographic Characteristics of Participants (N = 422)

Characteristic	Category	Frequency (n)	Percentage (%)
Age (Years)	18–25	118	28.0
	26–35	157	37.2
	36–45	108	25.6
	46–65	39	9.2
Mean (SD)	32.4 (9.1)		
Marital Status	Married	321	76.1
	Never Married	56	13.3
	Divorced/Separated/Widowed	45	10.7
Religion	Islam	414	98.1
	Christianity	8	1.9
Highest Education	No Formal Education	119	28.2
	Qur'anic Only	193	45.7
	Primary	62	14.7
	Secondary	32	7.6
	Post-Secondary	16	3.8
Occupation	Unemployed/Housewife	214	50.7
	Petty Trading/Artisan	87	20.6
	Subsistence Farming	131	31.0
	Formal Employment	21	5.0
Residence	Urban	178	42.2
	Rural	244	57.8
Household Decision-Making Autonomy (Score)	Low (0–2)	254	60.2
	Medium (3)	113	26.8
	High (4–5)	55	13.0

Source: Authors' Analysis (2025).

Table 2: Perceived Barriers to Mental Health Care Utilisation (N = 422)

Barrier Category	Specific Barrier	Frequency (n)	Percentage (%)
Stigma & Culture	Fear of community stigma	331	78.4
	Belief in spiritual causation	287	68.0
	Disgrace to family (*Kunya*)	262	62.1
Access & Logistics	Lack of female service providers	260	61.6
	Distance to facility	195	46.2
	Cost of treatment/transport	283	67.1
Autonomy & Agency	Requires husband's permission	301	71.3
	Lack of personal income	283	67.1

Source: Authors' Analysis (2025).

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Table 3: Predictors of Formal Mental Health Service Utilization among Women with Probable CMDs (n = 130)

Variable	Adjusted Odds Ratio (AOR)	95% Confidence Interval	p-value
Post-secondary Education	3.12	1.45 – 6.72	0.004
High Autonomy Score	2.45	1.38 – 4.34	0.002
Urban Residence	2.01	1.12 – 3.61	0.019
Belief in Spiritual Causation	0.42	0.22 – 0.79	0.008

Source: Authors' Analysis (2025).

Table 4: Synthesis of Key Barriers to Implementing Gender-Responsive Mental Health Care

Level	Barrier	Manifestation
Cultural/Normative	Patriarchal gender norms	*Kulle* (seclusion), economic dependence, need for male permission
	Stigma & explanatory models	Attribution to spirit possession/witchcraft, shame on family
Governance/Political	Policy implementation gap	Lack of budgetary commitment, gender-blind planning
	Political economy of health	Mental health deprioritized, leading to infrastructure and human resource deficits
	Delegation to traditional systems	Formal state cedes social welfare authority, undermining public health system
Service Delivery	Non-gender-sensitive services	Lack of female providers, no privacy protocols, distant facilities
	Fragmented care	No linkage between traditional/spiritual systems and formal health system

Source: Authors' Analysis (2025).

4.3. DISCUSSION OF FINDINGS

This study elucidates the potent intersection of culture and politics in structuring a nearly insurmountable barrier to mental health care for women in Northwest Nigeria. The abysmal 12.3% service utilisation rate among women with CMDs is lower than the already dire national average, underscoring the region's acute disparity (Gureje et al., 2015). The quantitative findings affirm the centrality of women's autonomy and education, aligning with global evidence on gender and health access (Moser, 2007). The powerful negative predictor of spiritual belief corroborates studies from across Africa on the primacy of traditional explanatory models (Oshodi et al., 2014).

Our qualitative findings, however, deepen this understanding by exposing the *governance mechanisms* that sustain these barriers. The identified policy-practice chasm resonates with Eboreime et al.'s (2018) analysis of Nigeria's health policies, where progressive content is systematically undermined by a lack of political will and financial commitment. This study extends that critique by showing how this gap is *gendered*; the absence of specific budgetary lines for women's mental health is a political choice that perpetuates inequality.

The hegemony of traditional governance highlights a critical, often overlooked dynamic. While other studies note the role of traditional healers (Oshodi et al., 2014), our analysis through a political

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ecology lens reveals a more structured delegation of authority. The formal state's tacit or active reliance on emirate and religious systems for social order, as described by Callaghan (2016), creates a parallel, often contradictory, system of care that funnels women away from formal services. This is not merely a 'cultural preference' but a function of a pluralistic governance landscape where the state has vacated its welfare role.

The political marginalization of mental health reflects a global pattern of neglect in LMICs (Saraceno et al., 2007), but is exacerbated in this context by the competition for scarce resources and a political calculus that undervalues the needs of a disenfranchised group; women with mental illness. The resulting lack of female providers and outreach capacity is both a cause and a consequence of this marginalization, creating a vicious cycle of exclusion.

The synthesis in Table 4 demonstrates that barriers are not isolated but interact across levels. For instance, cultural stigma (normative level) is legitimised by traditional authorities (governance level) and is unaddressed by a health service lacking sensitivity (service delivery level). This interdependent system effectively "governs" women's behaviour away from formal care.

This study is not without some limitations. The cross-sectional design limits causal inference. The sensitive nature of the topic may have introduced social desirability bias in both survey and interview responses. While KIIs provided depth, the perspectives of women who exclusively use traditional care and their male gatekeepers require further exploration.

5.0. CONCLUSION AND RECOMMENDATIONS

This study argues that improving women's mental health access in Northwest Nigeria requires transformative, not just technical, interventions. Our recommendations include: 1). Policy-Level: Develop and fund a Gender-Responsive Mental Health Action Plan with clear budgets, female-specific targets, and accountability mechanisms tied to state health ministries, 2). Governance-Level: Initiate structured dialogue and partnership frameworks between the formal health sector and traditional/religious institutions to foster referral pathways and challenge stigma, without co-opting patriarchal norms, 3). Service Delivery: Mandate gender-sensitivity training for all health workers and invest in recruiting, training, and deploying female mental health professionals to community primary healthcare centres, and 4). Research: Implement community-based participatory action research to co-design interventions with women, challenging the power dynamics that this study has uncovered.

Addressing gendered barriers to mental health care necessitates confronting the political and cultural authority structures that sustain gender inequality. It is ultimately a task of governance reform and political courage.

AUTHORS' CONTRIBUTIONS

AAY, ZA, SMB, AIA, and BAY conceptualized and designed the study. AAY, ZA, SMB, AIA, and BAY were involved in data collection and analysis. AAY, ZA, SMB, AIA, and BAY drafted and revised the manuscript. All authors critically reviewed for intellectual content, approved the final version, and agreed to be accountable for all aspects of the work.

AVAILABILITY OF RESEARCH DATA

Data are available upon reasonable request from the corresponding author.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

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