ALVAN JOURNAL OF SOCIAL SCIENCES (AJSS)
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ALVAN IKOKU FEDERAL UNIVERSITY OF EDUCATION, OWERRI
https://www-ajsspub-org.b12sites,com https://www.ajsspub2.org
E- ISSN: 3043 – 5463 ISSN: 1595 – 5842 VOLUME 3, ISSUE 2, 2026

RESEARCH ARTICLE

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT (MHPSS) SYSTEMS FOR YOUTH IN CONFLICT AREAS: GAPS, EQUITY, AND POLICY IMPLICATIONS FROM NORTHWEST NIGERIA

[1]ABDULLAHI ABDULWAHAB YAKUBU, [2]ZEENAT ABDULSALAM, [1]SUMMAYYAH MUHAMMAD BASHAR, [1]AUDU ISHAQ AVEKA, [3]MIVANYI MUSA MURINYI, [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; [3]Department of Child and Adolescent Mental Health Services, Lincolnshire Partnership NHS Foundation Trust (LPFT), Galaxy Suite, Boston Archway Centre, United Kingdom

ABSTRACT

Youth in protracted conflict zones face severe mental health and psychosocial challenges, yet MHPSS systems in these settings are often fragmented and understudied. This mixed-methods study assessed the availability, accessibility, and equity of MHPSS for youth (15-24 years) in Northwest Nigeria, a region severely affected by banditry, kidnapping, and farmer-herder conflicts. A cross-sectional survey was administered to 412 youth across three states (Kaduna, Katsina, Zamfara), complemented by 24 in-depth interviews with youth, caregivers, and 15 key informant interviews with policymakers, health workers, and NGO staff. Quantitative data were analysed using descriptive statistics and chi-square tests, while qualitative data underwent critical interpretive policy analysis. Results revealed critical gaps: only 18.2% of youth with self-reported significant distress accessed any formal MHPSS service. Key barriers included stigma (67.0%), cost (58.3%), and lack of awareness (61.4%). Significant inequities were observed by location (urban vs. rural), gender, and displacement status. Qualitative findings highlighted a disjointed, crisis-driven policy landscape dominated by non-state actors, with minimal government stewardship or youth participation. The study concludes that the MHPSS system in Northwest Nigeria is inadequately resourced, inequitably distributed, and poorly integrated into broader health and social protection frameworks. Urgent policy actions are required to strengthen public-sector leadership, fund community-based interventions, mainstream MHPSS into primary healthcare and education, and actively engage youth in programme design, with particular attention to marginalized subgroups.

Keywords: Conflict, Equity, Mental Health, Policy, Psychosocial Support, Youth

Corresponding Author

Abdullahi Abdulwahab Yakubu
Email Address: ayabdullahi@abu.edu.ng

Received: 22/4/2026; **Revised:** 27/6/2026; **Accepted:** 12/7/2026; **Published:** 17/7/2026

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1.0. INTRODUCTION

Protracted armed conflict constitutes a profound public health emergency, with devastating consequences for the mental health and psychosocial wellbeing of civilian populations, particularly youth (Charlson, van Ommeren, Flaxman, Cornett, Whiteford, & Saxena 2019). The United Nations defines youth as individuals aged 15-24 years, a developmental period where exposure to trauma and adversity can disrupt key transitions in education, relationships, and identity formation, with long-term sequelae (World Health Organization (WHO, 2021)).

In conflict-affected settings globally, the prevalence of common mental disorders such as depression, anxiety, and post-traumatic stress disorder (PTSD) among youth is estimated to be double that of non-affected peers (Dückers, Alisic, & Brewin, 2017). Northwest Nigeria, encompassing states like Kaduna, Katsina, and Zamfara, has been entrapped in a complex, multi-layered security crisis marked by rampant banditry, kidnapping for ransom, and violent farmer-herder clashes. This has resulted in thousands of deaths, widespread internal displacement, the destruction of livelihoods and schools, and a pervasive climate of fear (Higazi, 2021).

In response, Mental Health and Psychosocial Support (MHPSS) systems; a multi-layered framework of services spanning from community-based social support to specialized clinical care, are deemed essential (IASC, 2007). However, in low-resource, conflict-affected regions like Northwest Nigeria, these systems are often weak, underfunded, and heavily reliant on international non-governmental organisations (INGOs), raising critical questions about sustainability, equity, and cultural appropriateness (Tol, Le, Harrison, Galappatti, Annan, Baingana, Betancourt, …. Onmerem, 2023).

The Nigerian national mental health policy, last revised in 2013, suffers from chronic under-implementation, with less than 3% of the health budget allocated to mental health and severe shortages of specialised human resources (Abdulmalik et al., 2019). This policy-practice gap is likely exacerbated in conflict zones, where infrastructure is damaged and population needs are acute. Furthermore, emerging literature highlights that access to MHPSS is not uniform, with inequities often perpetuated along lines of gender, geography, disability, and displacement status (Tol, Ager, A., Bizouerne, Bryant, El Chammay, Colebunders, ... & Ventevogel, 2015).

This study aimed to comprehensively assess the MHPSS system for conflict-affected youth in Northwest Nigeria, with a specific focus on identifying service gaps, analysing equity of access, and deriving evidence-based policy implications. The specific objectives of the study were; to map the existing MHPSS service landscape for youth in Northwest Nigeria, to assess the accessibility and utilisation of MHPSS services among youth, to analyse equity in access to MHPSS across key demographic and social stratifiers (gender, location, displacement status), and to critically examine the policy and governance environment shaping MHPSS provision.

The questions this study sought to answer included: What types of MHPSS services are available, and who are the main providers? What are the patterns of MHPSS utilisation, and what are the perceived barriers and facilitators to access? Are there significant disparities in access to MHPSS based on gender, rural/urban location, or displacement status? How do existing policies, funding flows, and coordination mechanisms influence the provision and equity of MHPSS for youth?

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Existing research on MHPSS in Nigeria has largely focused on the general population in relatively stable settings or on specific disorders (Ozota et al., 2024). Studies in the conflict-ridden Northeast have documented high mental health burden but paid limited attention to systemic analysis of the support structures (Duke et al., 2025).

In context of the Northwest Nigeria, nascent research highlights community coping mechanisms but lacks a rigorous examination of the formal and informal support system architecture (Ejiofor, 2022). Globally, studies in similar contexts, such as the Democratic Republic of Congo and South Sudan, underscore the critical role of integrated, community-based models and the perils of fragmented, donor-driven interventions (Greene et al., 2017; Tol et al., 2020). This study addresses a critical gap by applying a health systems and equity lens to the under-researched Northwest Nigerian context, generating actionable evidence for policy and programming.

2.0. CONCEPTUAL AND THEORETICAL FRAMEWORKS

Quantitative: The study was guided by the Inter-Agency Standing Committee (IASC) MHPSS intervention pyramid, which conceptualises support on a continuum from basic services and community support to specialised care (IASC, 2007). The analysis of equity was informed by the Commission on Social Determinants of Health framework, focusing on the conditions that create or mitigate health inequities (WHO, 2008). The policy analysis was situated within a critical interpretive framework, which seeks to understand how power, resources, and discourse shape policy processes and outcomes (Yanow, 2007).

3.0. MATERIALS AND METHODS

3.1. Study Design

A concurrent mixed-methods design was employed, integrating a cross-sectional community-based survey with a qualitative critical policy analysis. This allowed for the triangulation of data on service availability, utilisation patterns, and the underlying policy landscape (Creswell & Plano Clark, 2017).

3.2. Study Setting and Period

The study was conducted between March and July 2025 in three purposively selected states in Northwest Nigeria: Kaduna, Katsina, and Zamfara. These states represent the epicentre of the banditry and kidnapping crisis. One urban and two rural local government areas (LGAs) were selected per state.

3.3. Study Population and Sample Size Determination

The target population was youth aged 15-24 years residing in the selected LGAs. The sample size was calculated using the formula for estimating a single proportion: $n = (Z^2 \times P(1 - P)) / d^2$. Assuming a 50% prevalence of unmet MHPSS need (P=0.5) for maximum variability, a 95% confidence level (Z=1.96), and a 5% margin of error (d=0.05), the initial sample was 384. Adjusting for a 10% non-response rate yielded a minimum sample of 422. A total of 412 completed surveys were analysed (response rate: 97.6%).

3.4. Sampling Method

A multi-stage cluster sampling technique was used. In each state, LGAs were stratified into urban/rural. Clusters (wards) were randomly selected from each stratum, and households were selected via random walk. In each household, one eligible youth was randomly selected.

Inclusion and Exclusion Criteria

Inclusion Criteria: Aged 15-24, resident in the selected LGA for ≥6 months, and provided assent/consent.

Exclusion Criteria: Severe cognitive impairment or acute distress that precluded participation.

Qualitative: Purposive and snowball sampling was used to select 24 youth (balanced for gender and displacement status), 10 caregivers, and 15 key informants (KIs) from State Ministries of Health, Education, the Primary Health Care Development Agency, UN agencies, and local and international NGOs.

3.5. Data Collection Instruments

Quantitative Survey: A structured, interviewer-administered questionnaire was used. It comprised:

Socio-demographic and Conflict Exposure Section: Captured age, gender, displacement status, education, and exposure to conflict events.

MHPSS Need and Utilisation: Adapted from the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) and used in Nigerian studies (WHO, 2005). It assessed self-reported distress (via a 0-10 visual analogue scale), help-seeking behaviour, and types of services used.

Barriers to Access Scale: A 15-item scale developed from literature, assessing stigma, financial, knowledge, and geographical barriers. It showed good internal consistency in this study (Cronbach's $\alpha = 0.82$).

The Kessler Psychological Distress Scale (K6): A validated 6-item scale screening for non-specific psychological distress (Kessler et al., 2002). It has been used and validated in several Nigerian studies, showing good psychometric properties (Abdulmalik et al., 2016). In this sample, $\alpha = 0.78$.

Qualitative: Semi-structured interview guides were used for youth/caregivers and KIs. Topics included lived experiences, perceptions of available support, decision-making processes, and policy challenges.

3.6. Data Analysis:

Quantitative: Data were analysed using SPSS v.29. Descriptive statistics (frequencies, percentages, means) summarised variables. Chi-square tests examined associations between access (dependent variable) and independent variables (gender, location, displacement). Statistical significance was set at $p < 0.05$.

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Qualitative: Interviews were audio-recorded, transcribed, and translated. Data were analysed using a critical interpretive policy analysis approach, involving iterative coding, thematic analysis, and interrogation of underlying assumptions, power dynamics, and policy silences (Yanow, 2007).

4.0. PRESENTATION OF RESULTS AND DISCUSSION

4.1. Presentation of Results

Quantitative Findings

The mean age of respondents was 19.5 years (SD=2.8). Slightly over half were male (52.9 percent, n=218). A significant proportion were internally displaced (28.2%, n=116). Most had witnessed or directly experienced a conflict event (85.4 percent, n=352). Over one-third (36.2 percent, n=149) screened positive for significant psychological distress (K6 score ≥13).

Formal MHPSS services (e.g., primary healthcare with mental health, NGO-run counselling centres) were reported only in urban centres. Traditional and religious healing systems were ubiquitous. As shown in Table 1, only 18.2 percent (n=27) of the 149 youth with significant distress had accessed any formal MHPSS service in the past year.

The most frequently cited barriers were stigma (67.0 percent, n=276), lack of awareness of where to get help (61.4 percent, n=253), and cost (58.3 percent, n=240). Transportation difficulties were more pronounced for rural youth (72.1 percent vs. 33.5 percent urban, $p<0.001$). Significant inequities in formal service access were found (Table 2). Urban youth, males, and non-displaced youth were significantly more likely to have accessed formal MHPSS.

Qualitative Findings: A Critical Policy Analysis

Thematic analysis revealed a disjointed MHPSS ecosystem. Policymakers described a "policy vacuum" for youth-specific MHPSS in conflict, with mental health perceived as a low-priority, clinical issue. Funding was overwhelmingly external, project-based, and short-term, leading to what one KI termed "parachute programming"; brief interventions that end with donor cycles. Coordination between government and NGOs was described as ad hoc.

Table 1: MHPSS Service Utilisation among Youth with Significant Psychological Distress (K6 ≥ 13) (n = 149)

Source of Support Sought	Frequency (n)	Percentage (%)
Formal Services		
Primary Health Centre	12	8.1
NGO Counselling Centre	15	10.1
Subtotal Formal	**27**	**18.2**
Informal Services		
Religious Leader/Place	89	59.7
Traditional Healer	45	30.2
Family/Friends Only	112	75.2
No Help Sought	22	14.8

Note: Categories are not mutually exclusive.

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Youth narratives highlighted a profound sense of exclusion: "They design programmes for us, never with us." The dominance of biomedical models was critiqued by community leaders, who felt indigenous support systems were sidelined rather than strengthened.

Table 2: Equity in Access to Formal MHPSS Services (n = 412)

Characteristic	Accessed Formal MHPSS (n = 41)	Did Not Access (n = 371)	χ^2 (p-value)
Gender			5.12 (0.024)*
Male	28 (12.8%)	190 (87.2%)	
Female	13 (6.7%)	181 (93.3%)	
Location			22.41 (< .001)**
Urban	32 (19.3%)	134 (80.7%)	
Rural	9 (3.7%)	237 (96.3%)	
Displacement Status			4.87 (0.027)*
IDP	6 (5.2%)	110 (94.8%)	
Non-IDP	35 (11.8%)	261 (88.2%)	

Note: *p < .05, **p < .001.

4.2. Discussion of Findings

This study reveals a critically deficient MHPSS system for conflict-affected youth in Northwest Nigeria, characterised by severe availability gaps, profound access barriers, and entrenched inequities. The finding that only 18.2 percent of distressed youth accessed formal care is alarming, though consistent with reports from Northeast Nigeria, where service coverage remains below 20 percent for mental health conditions (Duke et al., 2025). The heavy reliance on informal supports, particularly religious leaders, echoes findings across Africa, where faith-based and traditional systems are often the first and only line of response (Ventevogel, 2014). However, our critical analysis extends beyond mere description to reveal how systemic and policy failures perpetuate this crisis.

The identified barriers; stigma, cost, and awareness, are pervasive in global mental health, but their intersection with conflict dynamics intensifies their impact (Charlson et al., 2019). The stark urban-rural and gender disparities mirror inequities documented in MHPSS access in post-conflict settings like Liberia and Sierra Leone, where centralised services fail to reach peripheral and female populations (Tol et al., 2015). The lower access among internally displaced youth is particularly concerning and aligns with studies from the Lake Chad basin, highlighting IDPs as a uniquely vulnerable subgroup within an already vulnerable population (Greene et al., 2017).

Our qualitative findings on policy fragmentation and donor dependency resonate with critiques of the humanitarian MHPSS architecture globally, where vertical, NGO-driven projects can undermine sustainable public system building (Tol et al., 2020). The "policy vacuum" described in Northwest Nigeria reflects a broader Nigerian challenge of weak mental health governance, as noted by Abdulmalik et al. (2019), but is exacerbated by the securitisation of the state response, which sidelines psychosocial concerns. The marginalisation of youth voices in programme design contradicts the principle of participation central to both the IASC guidelines and global youth mental health advocacy (IASC, 2007; WHO, 2021).

This study is not without some limitations. The cross-sectional design limits causal inference. Self-reported measures may be subject to bias. The focus on three states may not capture all nuances of the Northwest region. Nevertheless, this study provides a crucial evidence base for urgent action.

5.0. CONCLUSION AND POLICY IMPLICATIONS

The MHPSS system for youth in Northwest Nigeria is insufficient, inequitable, and unsustainable. To address this, evidence-based policy actions are imperative:

1. Government must lead in integrating MHPSS into primary healthcare and education platforms, using task-sharing strategies to extend services to rural areas.
2. Domestic resource allocation for mental health must increase. Donors should align with government priorities and fund longer-term system strengthening over short-term projects.
3. Governments and services providers should provide targeted outreach, subsidised services, and community mobilisation to reach displaced, rural, and female youth.
4. Authorities must establish robust, government-led MHPSS coordination mechanisms for the Northwest conflict response, ensuring synergy between state and non-state actors.
5. Mental health and psychosocial services providers must actively engage youth, caregivers, and indigenous healers in all stages of MHPSS policy and programme design, implementation, and evaluation.

Ethical Considerations
Ethical approval was obtained from the Health Research Ethic Committee of Ahmadu Bello University Teaching Hospital, Shika-Zaria. Informed consent/assent was obtained. Participants in distress were referred to available services. Anonymity and confidentiality were maintained.

Authors' Contributions

AAY, ZA, SMB, AIA, MMM, and BAY conceptualised and designed the study. AAY, ZA, SMB, AIA, MMM, and BAY were involved in data collection and analysis. AAY, ZA, SMB, AIA, MMM, 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.

Funding
No funding received.

Conflict of Interest
The authors declare that no conflict of interest exist in this manuscript.

Acknowledgement
We thank the study participants, research assistants, and the community leaders of all the participating communities for their support and cooperation throughout the study.

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