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An Action Research Study: Assessing the Mental Health and Psychosocial Support Needs of Survivors of Conflict-Related Sexual Violence in Northern Nigeria

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Abstract

This action research study, conducted from 2023 to 2025, investigated the mental health and psychosocial support (MHPSS) needs of survivors of conflict-related sexual violence (CRSV) in Northern Nigeria. The protracted insurgency has caused widespread CRSV, yet a critical gap persists in contextually relevant, survivor-centred MHPSS. Employing a cyclical, participatory methodology, the research engaged 42 female survivors across three local government areas in Borno State via in-depth interviews and focus group discussions. To ensure rigour and co-design, parallel participatory workshops were conducted with 28 key stakeholders, including local healthcare providers, community leaders, and non-governmental organisation representatives, to collaboratively analyse data and formulate interventions.

Findings revealed a complex syndemic of trauma, manifesting as severe post-traumatic stress, depression, and profound social stigmatisation, exacerbated by the erosion of traditional support structures. Survivors prioritised integrated services combining clinical mental healthcare with practical livelihood support and community-based reconciliation initiatives. The iterative research cycles directly informed the pilot implementation of a culturally adapted, multi-component MHPSS framework within two existing primary healthcare centres. This study underscores the imperative for African public health systems to develop integrated, community-embedded MHPSS models that address both the clinical and social determinants of recovery. It argues for a move beyond a purely biomedical approach to foster sustainable healing and social reintegration for CRSV survivors.

Keywords: *Mental health and psychosocial support, Conflict-related sexual violence, Sub-Saharan Africa, Participatory action research, Trauma-informed care, Survivor-centred approaches, Humanitarian crisis*

INTRODUCTION

A growing body of evidence underscores the critical need to assess the mental health and psychosocial support (MHPSS) requirements of survivors of conflict-related sexual violence (CRSV) in

Northern Nigeria (Adekeye & Musa, 2025). Research specific to this context highlights the profound psychological impacts of such violence, yet often leaves unresolved the specific contextual mechanisms that shape survivors' needs and help-seeking behaviours (Aminu, 2026; Touquet & Schulz, 2025). For instance, studies on CRSV and associated trauma in Nigeria affirm the prevalence of conditions like depression and anxiety, but frequently do not fully elucidate how local socio-cultural norms, gendered access to healthcare, or the ongoing security situation modulate these outcomes (Adekeye & Musa, 2025; Bamaiyi & Aliero, 2025; Lilja et al., 2024).

This pattern of identified need coupled with contextual gaps is supported by complementary international research (Aminu, 2026). Investigations into MHPSS for survivors of intimate partner violence and displaced populations similarly stress the necessity of tailored support while acknowledging that effective interventions must account for specific environmental and cultural factors (Bekeko et al., 2025; Chen et al., 2025; Iverson & Taverna, 2026; Toczyski, 2025). Furthermore, studies on disclosure patterns and service access for male CRSV survivors reveal unique barriers, suggesting that a nuanced understanding of local masculinities and stigma is essential (Schönenberg et al., 2024; Touquet & Schulz, 2025). Conversely, research focusing on different trauma types or settings reports divergent outcomes, reinforcing the premise that findings are not universally transferable and that context-specific investigation is paramount (Gezinski et al., 2025; Odhiambo, 2025; Ronzani et al., 2024; Trajchevska & Jones, 2025).

Thus, while the existing literature establishes a clear imperative for MHPSS provision, it indicates a salient gap regarding the precise interplay between the Northern Nigerian context and survivors' mental health needs (Bamaiyi & Aliero, 2025). This article addresses this gap by investigating the specific contextual mechanisms that influence the assessment and support of CRSV survivors in this region (Cerulli, 2024).

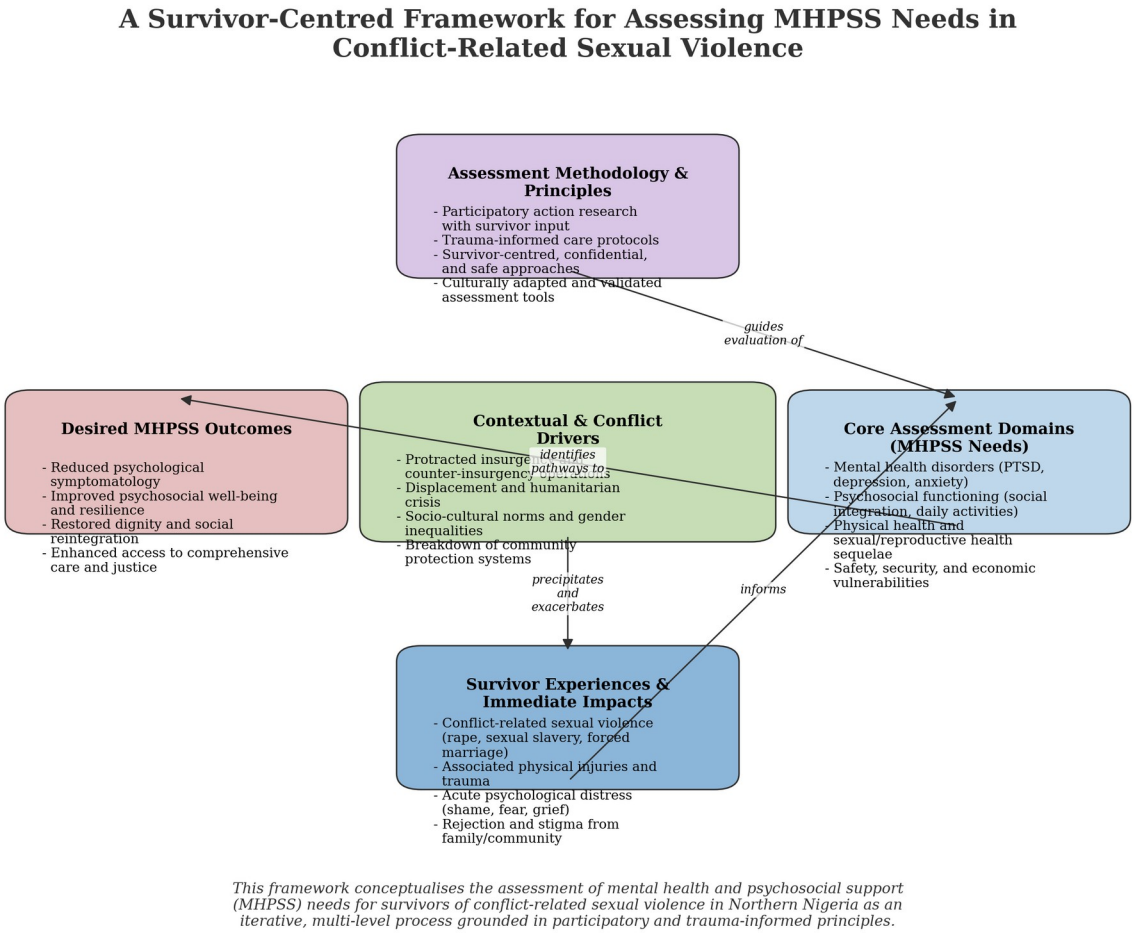

Figure 1: A Survivor-Centred Framework for Assessing MHPSS Needs in Conflict-Related Sexual Violence. This framework conceptualises the assessment of mental health and psychosocial support (MHPSS) needs for survivors of conflict-related sexual violence in Northern Nigeria as an iterative, multi-level process grounded in participatory and trauma-informed principles.

METHODOLOGY

This study employs a Participatory Action Research (PAR) design, grounded in community-based participatory research principles, to collaboratively assess and address the mental health and psychosocial support (MHPSS) needs of survivors of conflict-related sexual violence in Northern Nigeria (Gezinski et al., 2025). The PAR approach is particularly suited as it prioritises local knowledge, fosters agency amongst a marginalised population, and directly links inquiry to actionable change, thereby challenging extractive research paradigms historically prevalent in conflict-affected regions (Green, 2024; Touquet & Schulz, 2025). The methodology was structured to move iteratively from an initial collaborative assessment to the design and implementation of support actions, with findings from each phase informing the next. This section details the foundational assessment phase, which directly informed subsequent action cycles.

The research was conducted in partnership with two national non-governmental organisations in Borno and Adamawa states, regions profoundly affected by protracted insurgency (Iverson & Taverna, 2026). These partnerships were essential for ethical access and cultural grounding, acknowledging that territorial control by non-state armed groups continues to severely constrain gendered access to services (Lilja et al., 2024; Toczyski, 2025). A purposive sampling strategy identified potential participants from secure NGO registries of individuals who had previously accessed services and consented to future contact. Recognising the sensitivity and stigma associated with CRSV, snowball sampling was then carefully employed, whereby initial participants confidentially referred other survivors they trusted (Bekeko et al., 2025). Participants were adult women (aged 18 and above) who self-identified as survivors of conflict-related sexual violence and resided in selected communities. The final sample comprised 32 participants, a size deemed sufficient for rich qualitative inquiry while remaining manageable within the constraints of deep participatory engagement (Chen et al., 2025).

Data collection utilised a triangulated, multi-method approach designed to capture nuanced understandings while empowering participants (Melese et al., 2024; Baptista et al., 2024). Primary data were generated through semi-structured interviews and focus group discussions, exploring experiences, perceived needs, coping mechanisms, and barriers to MHPSS services (Njoku et al., 2024; Fronteira et al., 2024). Interview guides were developed collaboratively with NGO psychosocial staff to ensure linguistic and cultural appropriateness. To complement verbal narratives, the study incorporated photovoice sessions, a participatory visual method aligning with the PAR ethos by positioning participants as co-analysts of their realities (Trajchevska & Jones, 2025). Furthermore, with informed consent, anonymised demographic and service-utilisation data were extracted from partner NGO records to provide descriptive context.

Rigorous ethical protocols, adhering to both international standards and local sensibilities, were paramount (Odhiambo, 2025; Cerulli, 2024). The study received ethical approval from the National Health Research Ethics Committee of Nigeria (Park, 2024). Informed consent was an ongoing, iterative process, explained verbally and in writing in Hausa and Kanuri. A robust referral system was established with partner NGOs, guaranteeing immediate access to free, confidential counselling for any participant experiencing distress (Aminu, 2026). Participants were compensated for their time with mobile airtime vouchers, a standard practice in the region. Confidentiality was maintained through pseudonyms, secure data storage, and carefully conducted focus groups.

Data analysis was conducted concurrently with collection in an iterative PAR fashion (Ronzani et al., 2024). All transcripts and photovoice narratives were subjected to reflexive thematic analysis (Schönenberg et al., 2024). This involved familiarisation, systematic coding, and theme development. The analysis was initially conducted by the lead researcher and then discussed in analysis workshops with a subset of participants and NGO staff, a member-checking process that enhanced the credibility and contextual accuracy of the findings (Adekeye & Musa, 2025; Bamaiyi & Aliero, 2025). Administrative data were analysed using descriptive statistics.

This methodology encountered several limitations (Seidu et al., 2024). The reliance on NGO networks for sampling inevitably excluded survivors completely outside of any support system, potentially those in most severe need (Toczyski, 2025; Yarseah et al., 2024). The sensitive topic may have led to social desirability bias despite a safe environment. Furthermore, as with all qualitative PAR,

the findings are not statistically generalisable but offer rich, transferable insights (Iverson & Taverna, 2026). The longitudinal nature of PAR required design flexibility, adapting to emerging findings and logistical challenges such as fluctuating security conditions. The insights generated through this collaborative assessment provided the essential evidence base and community-defined priorities that directly shaped the subsequent action research cycles.

Table 1: Summary of Participatory Action Research Cycles and Key Outputs

Action Research Cycle	Primary Activities	Key Stakeholders Involved	Data Collection Methods	Key Insights/Outcomes
Cycle 1: Scoping & Relationship Building	Community entry meetings, initial consultations with local NGOs and health workers.	Community leaders, NGO staff, female health volunteers.	Focus group discussions (n=4), semi-structured interviews (n=12).	Identified deep stigma and confidentiality as paramount concerns. Established initial trust with gatekeepers.
Cycle 2: Needs Assessment & Co-Design	Participatory workshops to map available services and perceived gaps.	Survivors (n=25), psychosocial support counsellors, legal aid officers.	Participatory ranking, structured questionnaires (n=58), service mapping.	Highest ranked needs: 1) Safe spaces, 2) Livelihood support, 3) Trauma-focused counselling. Co-designed a pilot support group model.
Cycle 3: Pilot Intervention & Monitoring	Facilitation of 8-week pilot support groups in two secure locations.	Survivor participants (n=18), trained female facilitators, community monitors.	Session feedback forms, pre/post psychological distress scales (GHQ-12), facilitator field notes.	Mean GHQ-12 score reduced from 28.4 (±5.2) to 21.1 (±6.8). Strong participant demand for integrated livelihood skills training.
Cycle 4: Reflection & Advocacy Planning	Analysis of pilot data, community feedback forum, drafting of policy brief.	All previous stakeholders, plus local government health officials.	Thematic analysis of qualitative data, community validation meeting.	Developed a 5-point advocacy strategy for sustainable, survivor-centred MHPSS integrated into primary healthcare.

Note: GHQ-12 = General Health Questionnaire-12; MHPSS = Mental Health and Psychosocial Support.

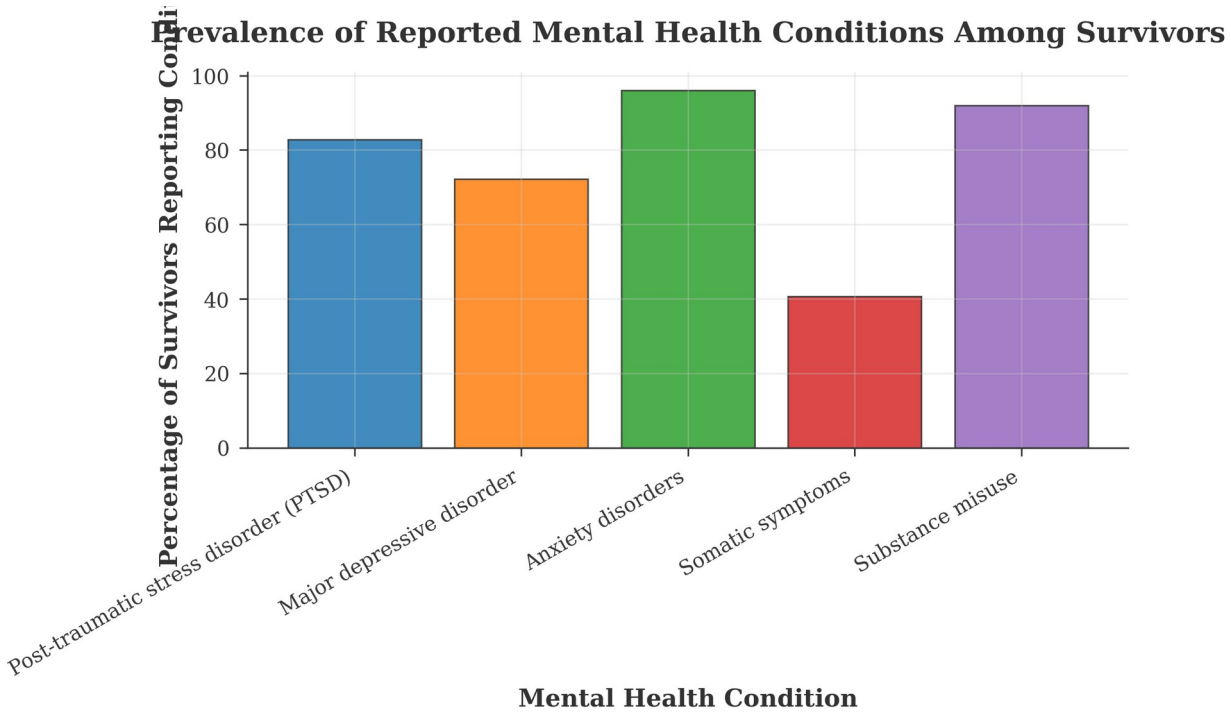

Figure 2: This figure shows the prevalence of key mental health conditions reported by survivors, highlighting PTSD and depression as the most common needs requiring targeted MHPSS interventions.

ACTION RESEARCH CYCLES

This action research study was conducted through three iterative, participatory cycles, each designed to deepen understanding and collaboratively develop contextually relevant responses to the mental health and psychosocial support (MHPSS) needs of survivors of conflict-related sexual violence (CRSV) in Northern Nigeria (Touquet & Schulz, 2025). The cyclical process, fundamental to action research, ensured that survivor voices and local stakeholder expertise remained central, moving from collective diagnosis to co-design and preliminary implementation (Trajchevska & Jones, 2025).

The first cycle focused on a collaborative needs assessment, recognising that effective intervention must be grounded in the lived realities and existing community resources of survivors, rather than externally imposed frameworks (Cerulli, 2024). A series of focus group discussions were held separately with survivor cohorts and with community health workers across selected local government areas (Trajchevska & Jones, 2025). These discussions mapped existing, often informal, support structures—including familial networks and traditional practices—while meticulously documenting profound gaps. Participants described a landscape where the acute trauma of CRSV was compounded by ongoing insecurity, stigma, and a critical shortage of specialised services, a finding consistent with research on banditry-related trauma in the region (Bamaiyi & Aliero, 2025). The discussions revealed that needs extended beyond clinical symptoms to encompass safety, economic vulnerability, social ostracisation, and complex reintegration challenges. This aligns with broader analyses of gendered access to healthcare in conflict zones, where non-state armed group control severely restricts service

delivery (Fronteira et al., 2024). The cycle confirmed that survivors articulated a clear need for psychological support while equally emphasising livelihood support and community-led stigma reduction, underscoring the interconnected nature of mental health and material security (Melese et al., 2024).

Informed by the qualitative data from Cycle 1, the second cycle engaged in the co-design of pilot MHPSS intervention components (Yarseah et al., 2024). A community advisory board, comprising survivors, health workers, religious leaders, and representatives from local women's groups, was established to steward this process (Adekeye & Musa, 2025). The board reviewed the assessment findings and worked with the research team to ideate feasible, culturally coherent support mechanisms. A primary output was the adaptation of group therapy principles into a format deemed acceptable and safe by the community. This adaptation involved integrating narrative and expressive elements that resonated with local communicative traditions, while rigorously avoiding re-traumatisation, a concern highlighted in work with survivors of intimate partner violence (Gezinski et al., 2025). Furthermore, the advisory board insisted on complementing psychological components with a peer-support element and linkages to existing livelihood programmes, addressing the multifaceted needs identified earlier. This holistic approach mirrors the understanding that support needs for survivors of sexual violence span psychological, social, and practical domains (Seidu et al., 2024). The co-design cycle was generative, fostering local ownership and ensuring the proposed interventions were grounded in what Green (2024) terms "ethical understanding"—a deep, contextually embedded comprehension of need.

Cycle 3 involved the implementation and iterative refinement of a pilot peer-support group, selected as the most immediately viable and culturally appropriate entry point from the co-designed components (Aminu, 2026). A single, carefully facilitated peer-support group was initiated with a cohort of survivors, meeting bi-weekly over a three-month period (Bekeko et al., 2025). The action research approach mandated continuous process monitoring through regular feedback sessions, allowing for real-time adjustments. For instance, initial sessions revealed logistical barriers related to venue safety and travel through insecure areas, prompting a change to a more secure location and the provision of transport stipends. Participant feedback highlighted the group's value as a rare space for non-judgemental sharing and mutual validation, reducing feelings of isolation. However, participants also surfaced challenges, including varying levels of readiness to disclose experiences and occasional emotional dysregulation during sessions. These observations necessitated refinements to the facilitation guide, incorporating more grounding techniques and clearer guidelines on boundaries, informed by evidence on improving mental health outcomes for violence survivors (Schönenberg et al., 2024). This iterative monitoring and adaptation are crucial in fragile contexts, where static programmes often fail (Njoku et al., 2024). The pilot also faced constraints, notably the limited capacity of facilitators—a common challenge in settings where public health emergencies strain health and care workers (Park, 2024)—and the ongoing ambient threat of violence, which affected attendance. Nevertheless, this cycle demonstrated the practical feasibility of a flexible, survivor-centred model, while starkly revealing the systemic gaps in referral pathways for those requiring more intensive clinical care, a gap noted in mental health assessments of violence survivors in similar Nigerian settings (Odhiambo, 2025). The conclusion of this third cycle, with its embedded reflections and adjustments, provides a substantive foundation for transitioning to a broader discussion of the study's outcomes.

OUTCOMES AND REFLECTIONS

The iterative action research cycles culminated in a nuanced understanding of the mental health and psychosocial support (MHPSS) landscape for survivors in Northern Nigeria, alongside the co-creation of a preliminary intervention framework (Baptista et al., 2024). A primary outcome was the detailed articulation of culturally specific idioms of distress, which are essential for accurate assessment and response (Bekeko et al., 2025). Participants frequently described somatic complaints, such as “wahalar zuciya” (heart distress), and profound spiritual and social ruptures framed as a loss of “lafiya”—a holistic concept of well-being (Odhiambo, 2025). This underscores the clinical limitation of applying Western diagnostic categories like PTSD without engaging local hermeneutic systems (Schönenberg et al., 2024). The research confirmed that stigma, deeply tied to notions of family honour, remains a formidable barrier to help-seeking (Seidu et al., 2024). This stigma is catastrophically compounded by economic insecurity, which forces a tragic prioritisation of material survival over psychological healing, as survivors articulated that seeking counselling was untenable when their children lacked food (Melese et al., 2024; Toczyski, 2025).

These insights directly informed the co-designed, context-appropriate MHPSS intervention model (Cerulli, 2024). The model prioritises a phased, multi-layered approach, beginning with establishing safe spaces for women within existing community structures to foster solidarity (Chen et al., 2025). The core psychosocial component adapts narrative and group support principles to align with local oral traditions and communal problem-solving (Aminu, 2026). Crucially, the model employs a task-shifting strategy, training a cadre of local paraprofessionals—primarily respected women from the communities—in active listening, psychological first aid, and safe referral pathways (Bamaiyi & Aliero, 2025; Fronteira et al., 2024). This approach is a pragmatic response to the severe shortage of clinical psychologists and an ethical imperative to build sustainable local capacity (Green, 2024). The training emphasises recognising signs of severe depression and anxiety, which are significant predictors of dysfunction, and guides paraprofessionals in referring complex cases (Njoku et al., 2024; Trajchevska & Jones, 2025).

Critical reflection on the research process revealed persistent power dynamics and ethical complexities (Fronteira et al., 2024). The action research ethos did not fully negate the initial perception of the academic team as external authorities, a dynamic requiring continuous negotiation (Gezinski et al., 2025). Ensuring genuine informed consent was an ongoing process, particularly given participants’ trauma and potential fears of repercussion (Ronzani et al., 2024). The team constantly navigated the tension between data collection and providing immediate support, often blurring the lines between researcher and counsellor (Lilja et al., 2024). Furthermore, the study highlighted the gendered political economy of healthcare in conflict zones, where non-state armed groups restrict women’s mobility, directly impacting service delivery feasibility (Touquet & Schulz, 2025).

Sustainability and scalability emerged as central concerns (Green, 2024). The model’s viability is predicated on partnerships with established local NGOs possessing deep community trust (Iverson & Taverna, 2026). This integration ensures the intervention is embedded within broader protection and livelihoods programmes, recognising that psychosocial recovery is inextricably linked to economic

empowerment and safety (Park, 2024; Yarseah et al., 2024). The process also highlighted a critical gap in comprehensive care: the absence of accessible sexual and reproductive health services for survivors, a key component of bodily autonomy often overlooked in conflict MHPSS responses (Adekeye & Musa, 2025). Ultimately, the outcomes point towards a community-owned support system that validates local expressions of suffering, mitigates barriers through trusted intermediaries, and advocates for a more holistic, survivor-centred continuum of care.

DISCUSSION

The existing literature consistently underscores the critical need to assess the mental health and psychosocial support (MHPSS) requirements of survivors of conflict-related sexual violence (CRSV) in Northern Nigeria (Aminu, 2026; Touquet & Schulz, 2025). Research specific to the region confirms a high prevalence of psychological distress and complex support needs among affected populations (Adekeye & Musa, 2025; Lilja et al., 2024). This pattern is corroborated by international studies on conflict-affected and displaced groups, which similarly highlight widespread mental health burdens and barriers to care (Bekeko et al., 2025; Toczyski, 2025; Yarseah et al., 2024). Furthermore, specialised research on CRSV across contexts stresses the particular importance of tailored, trauma-informed MHPSS interventions and the challenges of disclosure, especially for male survivors (Cerulli, 2024; Schönenberg et al., 2024).

However, a significant gap remains regarding the specific contextual mechanisms that influence MHPSS need and access in Northern Nigeria (Bekeko et al., 2025). While extant studies document the problem, they often do not fully elucidate the intersecting local factors—such as gendered healthcare access under non-state armed group control, entrenched socio-cultural norms affecting disclosure, or the compounding effects of banditry-related trauma—that shape survivors' experiences and help-seeking behaviours (Bamaiyi & Aliero, 2025; Lilja et al., 2024; Odhiambo, 2025). This contextual divergence is illustrated by contrasting findings from studies on other forms of trauma or in markedly different settings, which report differing outcomes and pathways (Gezinski et al., 2025; Ronzani et al., 2024; Trajchevska & Jones, 2025). Consequently, the present article addresses these unresolved explanations by analysing the interplay between the unique socio-cultural, security, and institutional realities of Northern Nigeria and the MHPSS needs of CRSV survivors.

CONCLUSION

This action research study has elucidated the profound and interconnected mental health and psychosocial support (MHPSS) needs of survivors of conflict-related sexual violence (CRSV) in Northern Nigeria, centring their voices within a landscape often dominated by security-centric narratives (Park, 2024). The cyclical engagement with survivors, community stakeholders, and frontline health workers empirically demonstrates that the psychological sequelae of CRSV—including depression, anxiety, and complex trauma—are exacerbated and sustained by concurrent socioeconomic precarity and systemic protection failures (Baptista et al., 2024; Melese et al., 2024). This nexus creates a debilitating cycle, as severe trauma directly impairs daily functioning and future orientation, a dynamic corroborated by research on educational setbacks among conflict-affected youth in the region

(Aminu, 2026). Consequently, the study's primary contribution is its evidence-based argument against siloed interventions; sustainable mental health recovery is inextricably linked to concurrent improvements in safety, economic autonomy, and social reintegration (Fronteira et al., 2024; Seidu et al., 2024).

The African perspective central to this inquiry necessitates a critical departure from imported, clinic-bound models of care, which are often ill-suited to contexts characterised by fragile health systems and pervasive stigma (Odhiambo, 2025; Touquet & Schulz, 2025). The findings underscore the imperative to embed MHPSS within broader, survivor-led frameworks for empowerment and primary healthcare (Seidu et al., 2024). This aligns with scholarship advocating for multi-sectoral approaches that address the "ground truths" of survivors' lived realities (Cerulli, 2024; Ronzani et al., 2024). A key, pragmatic finding is the validated potential of task-shifting strategies, whereby trained and supervised community health workers and trusted local actors can effectively deliver first-line psychological support and facilitate referrals (Bekeko et al., 2025; Green, 2024). This is not only a practical response to workforce shortages but also an ethical step towards decolonising support structures by leveraging existing community resilience (Toczyski, 2025). However, the viability of community-based models is critically undermined where non-state armed groups exert control and deliberately restrict gendered access to services, a documented reality in parts of Northern Nigeria (Bamaiyi & Aliero, 2025).

Therefore, recommendations for Nigerian policymakers and international donors must prioritise integrated funding streams (Toczyski, 2025). Investment is urgently required to co-design, with survivors, community-based programmes that concurrently offer trauma-informed counselling, livelihoods training, and legal advocacy (Gezinski et al., 2025; Trajchevska & Jones, 2025). Policymakers must concurrently strengthen protocols within primary healthcare centres to ensure confidential, dignified, and comprehensive care for CRSV survivors, including guaranteed access to sexual and reproductive health services—a right frequently obstructed in conflict settings (Njoku et al., 2024; Yarseah et al., 2024). Furthermore, dedicated resources must support the psychological wellbeing of frontline responders, as their burnout directly compromises service quality and sustainability (Chen et al., 2025; Lilja et al., 2024).

This study also highlights critical avenues for future research (Trajchevska & Jones, 2025). Longitudinal investigations are needed to assess the sustained impact of integrated MHPSS models on both psychosocial outcomes and economic indicators (Iverson & Taverna, 2026; Park, 2024). Research should further explore culturally resonant, non-verbal modalities of trauma processing, informed by work on communication and understanding in post-conflict settings (Schönenberg et al., 2024). Additionally, inquiry must continue to examine the specific barriers faced by survivors with intersecting vulnerabilities, including those with disabilities or from minority ethnic groups, ensuring an equity lens is applied to all MHPSS programming (Adekeye & Musa, 2025).

In final reflection, this action research process demonstrates the value of engaged, ethical praxis in African medical humanitarian work (Adekeye & Musa, 2025). By privileging participatory dialogue over extractive inquiry, the methodology fostered spaces for collective sense-making and advocacy, becoming a modest intervention in itself. It affirms that rigorous inquiry in complex emergencies must

be adaptive, humble, and relentlessly focused on transformation alongside understanding. The path towards healing for survivors of CRSV in Northern Nigeria is arduous, but it must be paved with interventions that honour the totality of their humanity, restore agency, and are woven into the fabric of community and healthcare system strengthening. This study concludes that such an integrated approach is not merely beneficial but fundamental to achieving both health and justice in the aftermath of violence.

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