UNIDIR

MANAGING EXITS
FROM ARMED CONFLICT

MEAC FINDINGS REPORT 46

Addressing Silent Burdens: Effective Responses to Psychological Distress in the North East of Nigeria

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October 2025

Contents

This report, and the research that supported it, were undertaken as part of UNIDIR's Managing Exits from Armed Conflict (MEAC) project. MEAC is a multi-donor, multi-partner initiative to develop a unified, rigorous approach to examining how and why individuals exit armed conflict and evaluating the efficacy of interventions meant to support their transitions. While the report benefited from feedback from MEAC's donors and institutional partners, it does not necessarily represent their official policies or positions.

Citation: Moritz Hoene, Francesca Batault, Kato van Broeckhoven, Siobhan O'Neil, Mohammed Bukar, and Fatima Yetcha Ajimi Badu, "Addressing Silent Burdens: Effective Responses to Psychological Distress in the North East of Nigeria", *Findings Report 46,* UNIDIR, Geneva, 2025, https://doi.org/10.37559/MEAC/25/09.

Key Findings

- Psychological distress is widespread among the population in the North East of Nigeria. Former associates of Boko Haram, affiliates of Community Security Actors, and unaffiliated community members all report similar levels of distress.
- Women and girls report higher distress and face specific challenges. Children may also be particularly vulnerable, as the long-term impacts of early trauma often emerge later in life. This underscores the importance of gender- and age-appropriate interventions.
- Conflict experiences are a relevant risk factor, with both victimization and perpetration linked to higher levels of psychological distress. Sexual violence, though likely underreported, emerges as a particular risk factor.
- Daily stressors such as displacement and insecurity, are consistently associated with higher levels of psychological distress. Food insecurity was both the most reported stressor (73 per cent of respondents did not get enough food to eat) and strongly correlated with distress, emphasizing the importance of addressing basic needs as priorities for potential support.
- Support remains limited, leaving many needs unaddressed and pointing to the importance of safe, supportive spaces where people can process their experiences and access psychosocial care.

Background

About MEAC

How and why do individuals exit armed groups, and how do they do so sustainably without falling back into conflict cycles? These questions are at the core of UNIDIR's Managing Exits from Armed Conflict (MEAC) initiative. MEAC is a multi-year, multi-partner collaboration that aims to develop a unified, rigorous approach to examining how and why individuals exit armed conflict and evaluating the efficacy of interventions meant to support their transition to civilian life. MEAC seeks to inform evidence-based programme design and implementation in real time to improve efficacy. At the strategic level, the cross-programme, cross-agency lessons that will emerge from the growing MEAC evidence base will support more effective conflict resolution and peacebuilding efforts. The MEAC project benefits from generous support by the German Federal Foreign Office (GFFO); the Government of Norway; Global Affairs Canada (GAC); the Swiss Federal Department of Foreign Affairs (FDFA); and the Irish Department of Foreign

Affairs; and is run in partnership with the International Organization for Migration (IOM); UNICEF; the UN Development Programme (UNDP); the UN Department of Peace Operations (DPO); the World Bank; the Secretariat of the Regional Strategy for Stabilization, Recovery and Resilience in the Lake Chad Basin; and United Nations University Centre for Policy Research (UNU-CPR).

About this Series

The MEAC findings report series seeks to put evidence about conflict transitions and related programming into the hands of policymakers and practitioners in real time. The reports present overviews of findings (or emerging findings) across a wide range of thematic areas and include analyses of their political or practical implications for the United Nations and its partners.

About this Report

This report provides insights on drivers of poor mental health and psychosocial well-being in conflict-affected populations in the specific context of the North East of Nigeria and identifies key needs and priority areas for effective mental health and psycho-social support (MHPSS) programming. By analyzing survey data collected in 2024 in the Borno, Adamawa, and Yobe States, this report highlights risk factors faced by respondents related to their self-reported levels of psychological distress and in doing so contributes to filling the knowledge gap around the topic in the North East of Nigeria.

Given this is a setting with limited resources for MHPSS services, a broad approach to the topic is taken, considering programming beyond strict psychological activities with possible benefits for mental health and psychosocial well-being. By collecting data in the region, from community members, current and former affiliates of community security actors (CSAs) – like militias (e.g., the Civilian Joint Task Force (CJTF)) – and former associates of Boko Haram, MEAC research provides unique insights into the MHPSS needs of the population in the North East.

Introduction

In recent years, mental health and psychosocial well-being amongst conflict-affected populations has gained increased attention from policy makers, practitioners, and academics. Recognizing the importance of addressing mental health needs, views of mental health and psychosocial support (MHPSS) – "any type of local or outside support that aims to protect or promote psychosocial well-being or prevent or treat mental disorder"[1] – have evolved from an optional add-on to an essential part of humanitarian programming. Recent UN guidelines on the topic highlight the growing attention being paid to MHPSS and the need for such activities.[2]

Conflict presents various risk factors for poor mental health and psychosocial well-being. According to a study supported by the World Health Organization (WHO), mental disorders such as depression, anxiety, PTSD, bipolar disorder, or schizophrenia are highly prevalent in conflict settings with roughly twenty-two per cent of people living in conflict-affected areas estimated to display such mental health issues.[3] In addition to undermining individuals' access to key services, full participation in society, and long-term physical health,[4] poor mental and psychosocial well-being have been shown to have a negative impact on social capital and a society's capacity for peaceful conflict resolution.[5] Mental health and psychosocial well-being thus constitute a key issue to address in achieving sustainable peace.

A wide range of contributing or risk factors for poor mental health in the context of conflicts or humanitarian emergencies have been studied. These include adverse conflict experiences, such as exposure to violence, or the loss of family and community members.[6] Further, conditions which provide challenges in daily life, such as not having one's basic needs met,

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[1] Inter-Agency Standing Committee, "IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings," (Geneva, IASC, 2007).
[2] Inter-Agency Standing Committee, "IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings," (Geneva, IASC, 2007); United Nations Children's Fund, "Operational Guidelines on Community-Based Mental Health and Psychosocial Support in Humanitarian Settings: Three-tiered support for children and families," (New York, UNICEF, 2018); Paige Arthur and Céline Monnier. "Mental Health and Psychosocial Support to Sustain Peace: Four Areas to Explore for Improving Practice," (New York, New York University Center on International Cooperation, 2021); United Nations Development Programme, "Guidance Note: Integrating Mental Health and Psychosocial Support into Peacebuilding," (New York, UNDP, 2022); International Organization for Migration, "Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement – Second Edition," (Geneva, IOM, 2022).
[3] Fiona Charlson et al., "New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis," *Lancet*, vol. 394, No. 10194 (June 2019).
[4] Michelle Funk et al., "Mental Health and Development: Targeting people with mental health conditions as a vulnerable group," (Geneva, WHO, 2010); William V. Bobo et al., "Association of Depression and Anxiety With the Accumulation of Chronic Conditions," *JAMA Network Open*, vol. 5, No. 5 (May 2022).
[5] Roos Haer, Florian Scharpf, and Tobias Hecker, "The Social Legacies of Conflict: The Mediating Role of Mental Health With Regard to the Association Between War Exposure and Social Capital of Burundian Refugees," *Psychology of Violence*, vol. 11, No. 1 (September 2020); United Nations Development Programme, "Guidance Note: Integrating Mental Health and Psychosocial Support into Peacebuilding," (New York, UNDP, 2022).
[6] Pål Kristensen, Lars Weisæth, and Trond Heir, "Bereavement and Mental Health after Sudden and Violent Loss: A Review," *Psychiatry: Interpersonal and Biological Processes*, vol. 75, No. 1 (March 2012); Sandra Trujillo et al., "Mental health outcomes in communities exposed to Armed Conflict Experiences," *BMC Psychology*, vol.9, No. 127 (August 2021); Bernardo Carpiniello, "The Mental Health Costs of Armed Conflicts—A Review of Systematic Reviews Conducted on Refugees, Asylum-Seekers and People Living in War Zones," *International Journal of Environmental Research and Public Health*, vol. 20, No. 4 (February 2023).

health issues, poor living conditions, or a lack of safety, are frequent subjects of research.[7] These daily stressors (e.g., social and material conditions acting as sources of severe stress in a person's daily life[8]) can both be a result of the conflict or pre-existing factors that coincide with the conflict. Different studies identified former combatants or associates of armed groups, women, displaced persons, and children as being especially vulnerable due to additional risk factors regarding their mental health (even more so for people at the intersection of multiple of these groups).[9] Looking at children for instance, the loss of a parent to conflict violence, disruptions in education, or neglect by caregivers provide additional, unique risk factors for their mental well-being.[10]

Mental Health in the Context of the Boko Haram Conflict in the North East of Nigeria

Since 2009, the Boko Haram conflict has wreaked havoc in Nigeria's North East, leading to widespread insecurity and a devastating humanitarian crisis. Millions have been internally displaced across Borno, Adamawa, and Yobe (BAY) states. The 2025 Humanitarian Needs and Response Plan identified 7.8 million people across the BAY states requiring assistance.[11] While humanitarian efforts have primarily focused on immediate needs such as food, shelter and water and sanitation (WASH), the mental health and psychosocial needs of these populations have remained largely unaddressed, in part due to insufficient resources and a lack of mental health professionals.[12] A lack of humanitarian access to zones outside garrison towns and limited financial resources have complicated the delivery of much-needed support services, including MHPSS services.[13] Poor awareness of mental health issues among the general population has also resulted in widespread misconceptions and stigma towards those suffering from mental health afflictions.[14] Mental health issues are understood through a range

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[7] Kenneth Miller et al., "Daily Stressors, War Experiences, and Mental Health in Afghanistan," *Transcultural Psychiatry*, vol. 45, No. 4 (February 2008); Fiona McEwen et al., "Prevalence and predictors of mental health problems in refugee children living in informal settlements in Lebanon" *Nature Mental Health*, vol. 1 (February 2023).
[8] Kenneth Miller and Andrew Rasmussen, "War Exposure, Daily Stressors, and Mental Health in Conflict and Post-Conflict Settings: Bridging the Divide between Trauma-Focused and Psychosocial Frameworks," Social Science and Medicine, vol. 70, Issue 1 (2010)
[9] Brandon A. Kohrt et al., "Comparison of Mental Health Between Former Child Soldiers and Children Never Conscripted by Armed Groups in Nepal," *Journal of the American Medical Association*, vol. 300, No. 6 (August 2008); Fiona Samuels, Nicola Jones, and Bassam Abu Hamad, "Psychosocial support for adolescent girls in post-conflict settings: beyond a health system approach," *Health Policy and Planning*, vol. 32, Suppl. 5 (December 2017); Bernardo Carpiniello, "The Mental Health Costs of Armed Conflicts—A Review of Systematic Reviews Conducted on Refugees, Asylum-Seekers and People Living in War Zones," *International Journal of Environmental Research and Public Health*, vol. 20, No. 4 (February 2023); David Cantor et al. "Understanding the health needs of internally displaced persons: A scoping review," *Journal of Migration and Health*, vol. 4 (October 2021).
[10] Christian Kieling et al., "Child and adolescent mental health worldwide: evidence for action," *Lancet*, vol. 22, No. 378 (October 2011); United Nations Development Programme, "Guidance Note: Integrating Mental Health and Psychosocial Support into Peacebuilding," UNPD, (New York, 2022).
[11] United Nations Office for the Coordination of Humanitarian Affairs, "Nigeria: 2025 Humanitarian Needs and Response Plan," OCHA, (January 2025).
[12] Adewale Olusola Adeboye. "Addressing the Boko Haram-Induced Mental Health Burden in Nigeria," *Health and Human Rights Journal*, vol. 23, No. 1 (June 2021).
[13] United Nations Office for the Coordination of Humanitarian Affairs, "Nigeria: 2025 Humanitarian Needs and Response Plan," OCHA, (January 2025).
[14] Temitope Labinjo et al., "Perceptions, attitudes and cultural understandings of mental health in Nigeria: a scoping review of published literature," *Mental Health Religion and Culture,* vol 23. No. 7 (September 2020).

of cultural and spiritual frameworks in Nigeria, with previous research showing that causes are often attributed to factors such as drug abuse, possession by jinns (evil spirits) and "punishment by God."[15] While these interpretations reflect deeply rooted beliefs and social contexts, they can make it challenging to identify and address mental health issues without further stigmatizing those affected, since they place much of the blame on the people suffering from mental health issues.

So far, the limited existing research and interventions on mental health and psychosocial well-being in the context of the Boko Haram conflict in the North East of Nigeria have focussed on victims of the conflict or those who were displaced by it.[16] Former associates of armed groups – Boko Haram, but also community security groups and militias (e.g., CJTF) – have only received limited attention and support.[17] Individuals exiting these groups (or in the case of the CJTF, often still associated with them) are not only coping with conflict-related trauma such as exposure to violence, displacement, and in some cases, participation in acts of violence, but they also return to environments where insecurity persists. Many continue to be displaced from their communities and face significant daily stressors, including food insecurity, lack of employment opportunities, and limited access to services. Beyond conflict exposure, these compounding stressors can exacerbate existing mental health challenges and further complicate reintegration efforts.

This MEAC findings report replicates the approach taken in previous research in other contexts[18] using original data collected with former armed group associates and conflict affected populations to address the knowledge gap and inform future MHPSS planning in the North East of Nigeria. The following section will provide an overview of the survey sample and methodology implemented in the data analysis in this report.

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[15] Africa Polling Institute and EpiAFRIC "Mental Health in Nigeria Survey: Report," January 2020.
[16] Bonnie Kaiser et al., "Mental health and psychosocial support needs among people displaced by Boko Haram in Nigeria," *Global Public Health*, vol. 15, No. 3 (September 2019); Miracle Adesina, Ruth Oladele, and Isaac Iyinoluwa Olufadewa, "Mental Health and Psychosocial Support in Conflicting Nigeria," *Yenagoa Medical Journal*, Vol. 2, No. 4 (October 2020); Santiago Martínez Torre et al., "Severity, symptomatology, and treatment duration for mental health disorders: a retrospective analysis from a conflict-affected region of northern Nigeria," *Conflict and Health*, vol. 16, No. 41 (July 2022); Sharli Paphitis et al., "Toward an integrated approach for mental health and psychosocial support and peacebuilding in North-East Nigeria: programme description and preliminary outcomes from 'Counselling on Wheels'," *BJPsych Open*, vol. 9, No. 6 (October 2023).
[17] Tarela Juliet Ike et al., "Reintegration of former Boko Haram members and combatants in Nigeria: an interpretative phenomenological analysis of community members' experiences of trauma," *Third World Quarterly*, vol. 43, No. 12 (August 2022); Sharli Paphitis et al., "Toward an integrated approach for mental health and psychosocial support and peacebuilding in North-East Nigeria: programme description and preliminary outcomes from 'Counselling on Wheels'," *BJPsych Open*, vol. 9, No. 6 (October 2023).
[18] Kenneth Miller et al., "Daily Stressors, War Experiences, and Mental Health in Afghanistan," *Transcultural Psychiatry*, vol. 45, No. 4 (December 2008); Touraj Ayazi et al., "Perceived current needs, psychological distress and functional impairment in a war-affected setting: a cross-sectional study in South Sudan," *BMJ Open*, vol. 5, No. 8 (August 2015); Andrew Riley et al., "Daily stressors, trauma exposure, and mental health among stateless Rohingya refugees in Bangladesh," *Transcultural Psychiatry*, vol. 54, No. 3 (May 2017).

Methodology and Sample

The data examined in this report stems from the baseline wave of a panel survey conducted in the North East of Nigeria between April and June 2024. An overview of key demographics in the sample are displayed in figure 1. The sample includes a total of 3,609 respondents, most of which live in the Adamawa, Borno, and Yobe (BAY) states.[19] Forty per cent of respondents are women and girls, while men and boys make up 60 per cent.[20] Eighty-four per cent of the sample are adults, and 16 per cent are children.[21]

Within the sample, 62 per cent (2,223 respondents) were never with any non-state armed group.[22] Additionally, 25 per cent of the total sample (896 respondents) reported having been associated with Boko Haram, of which 34 per cent (303 respondents) were women and girls, and 66 per cent (593 respondents) men and boys. The third group were 14 per cent of the total sample (508 respondents) who reported having been with at least one CSA.[23] Out of those affiliated with CSAs, only 11 per cent were former CSA affiliates, while most (89 per cent) reported currently being affiliated. Both former and current CSA affiliates were analysed together, unless otherwise explicitly mentioned in the findings section.

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[19] Originally, a total of 3,632 respondents completed the survey. However, for the purpose of this report, 23 respondents were dropped from the sample. Four of these were dropped since they did not answer the questions on their mental well-being, which is the analytical focus in this report. Another eight respondents were dropped due to not answering the question on association or due to a coding inconsistency regarding their association. The remaining eleven respondents were dropped since they did not answer the questions on either injury, food security or displacement. This was necessary since association, injury, food security, and displacement are included as relevant factors throughout the analysis.

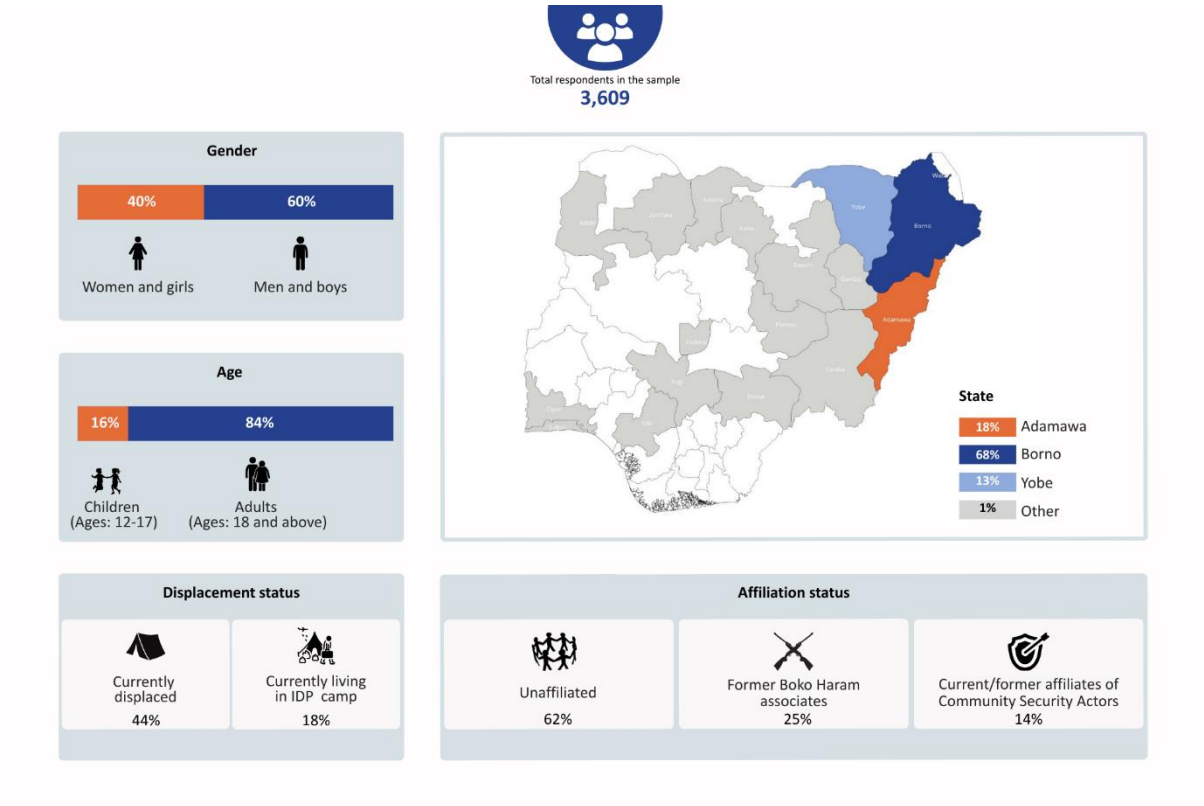
[20] While MEAC strives for a 50-50 gender split, it proved challenging to reach certain sub-populations, especially women affiliated with non-state armed groups. Furthermore, some sub-populations of interest were inherently unbalanced, such as the CSAs (where 17 women and girls were interviewed relative to 491 men and boys).
MEAC strives to conduct gender-sensitive and gender-responsive research and assessments in line with evolving best practice. MEAC collects data that can be disaggregated by gender (amongst other demographic features) to compare the experiences of men, boys, women, and girls. MEAC also uses targeted and responsive questions to examine the particular experiences of certain groups. Local variation requires that MEAC adapt its approach to gender to each of the local contexts where it works. Due to cultural sensitivity around asking a person about their gender in this socially conservative context, enumerators were asked to make an assumption about a respondent's gender based on visual, audio, and social identity indicators. Although self-identified data on gender would be preferable and would allow for the inclusion of non-binary answer options, the practical limitations imposed by the need to conduct culturally sensitive, ethical, and safe research necessitated this trade-off. Ultimately, the intent is not to oversimplify the complexities of gender but rather to present an analysis grounded in the information available and consistent with the limitations imposed by the data collection process.

[21] In line with the international norms for defining childhood, any respondent reporting their age as 18 or above at the time of the survey qualifies as an adult. Anyone who reported their age as 17 or below at the time of survey is considered a child. Children below the age of 12 years were not allowed to participate. Children could only participate if a parent or guardian provided consent on their behalf. The authors recognize, however, that the international norm for defining childhood up to the age of 18 might not always reflect local perceptions about child- and adulthood.

[22] This group of unaffiliated community members included 1,123 women and girls, and 1,100 men and boys.

[23] Respondents in MEAC's sample formed part of various community security groups, including the Civilian Joint Task Force (CJTF), the Yan Gora and the Hunters and Charmers. For more on these groups, see Kato Van Broeckhoven, Zoe Marks, Siobhan O'Neil, Mohammed Bukar, and Fatima Yetcha Ajimi Badu (2022) "Community Security Actors and the Prospects for Demobilization in the North East of Nigeria," *MEAC Findings Report 18,* United Nations University, New York.

FIGURE 1 – SAMPLE OVERVIEW



Survey respondents were sampled using a range of methods. Unaffiliated community members were recruited through random sampling from communities and IDP camps across the BAY states, with the aim of being demographically representative (and within the constraints of access and security). Some respondents presently or formerly affiliated with CSAs as well as those formerly associated with Boko Haram were also recruited in this sample. However, most respondents affiliated with CSAs or formerly associated with Boko Haram were recruited through UN-supported programmes, within interim transit centres or through snowball sampling.

Quantitative Analysis

The quantitative findings presented in this report include both summary statistics and multiple linear regression models.[24] Specific details on each model are provided in footnotes throughout the report.[25] Previous quantitative research on the topic of mental health in conflict contexts typically employ checklists of PTSD, depression, anxiety, other mental health issues, or

[24] Multiple linear regression allows to estimate relationships between multiple possible explanatory variables and self-reported levels of psychological distress.
[25] Interactions between different explanatory variables were also tested. As these did not provide relevant additional insights and did not have a significant effect on the results of the regressions, these interactions are not included.

general psychological distress, to measure their outcome of interest.[26] Commonly used mental health checklists ask respondents a number of questions, the answers to which are then combined into an indicator of the specific issue studied.[27] This research replicates this established statistical approach in part to test to what extent findings from existing literature on MHPSS are present in the context of the North East of Nigeria.

An inherent difficulty in researching mental health within the context of the North East is the lack of local vocabulary on the topic. Local languages such as Hausa, Kanuri and Shuwa Arabic rarely have words to describe mental health afflictions such as 'anxiety', 'depression' or 'post-traumatic stress'. MEAC worked closely with local researchers to develop questions that could be translated into local languages and appropriately reflected the mental health issues in ways that the respondents could easily understand.

Ultimately, MEAC's baseline survey included five questions on respondents' mental well-being. These five mental health questions are a subset of those used on common mental health checklists, adapted to the local context. They cover different manifestations of poor mental well-being, asking about a mix of symptoms and syndromes. Combined, they make up the psychological distress indicator which is used throughout this report, in line with the approach taken in previous research.[28] The questions included in the indicator are as follows:[29]

- "In your life now, how often do you feel a lot of anxiety?". Answer options: Most times, Sometimes, Never.
- "In your life now, how often do thoughts about the bad things that happened to you keep bothering you?". Answer options: Most times, Sometimes, Never.
- "In your life now, when you think about the bad things that happened, how often do you instantly feel something in your mind or your body, like you feel very sad, you start to sweat, or your heart start to beat fast?". Answer options: Most times, Sometimes, Never.
- "In your life now, how often do you stay away from things that remind you of the bad things that happened?". Answer options: Most times, Sometimes, Never.

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[26] Kenneth Miller et al., "Daily Stressors, War Experiences, and Mental Health in Afghanistan," *Transcultural Psychiatry*, vol. 45, No. 4 (December 2008); Touraj Ayazi et al., "Perceived current needs, psychological distress and functional impairment in a war-affected setting: a cross-sectional study in South Sudan," *BMJ Open*, vol. 5, No. 8 (August 2015); Andrew Riley et al., "Daily stressors, trauma exposure, and mental health among stateless Rohingya refugees in Bangladesh," *Transcultural Psychiatry*, vol. 54, No. 3 (May 2017); Wai Kai Hou et al., "Everyday life experiences and mental health among conflict-affected forced migrants: A meta-analysis," *Journal of Affective Disorders*, Vol. 264 (March 2020).

[27] This approach is taken since mental health cannot be directly measured but is derived through a combination of indicators. Such concepts are referred to in statistical research as latent variables.

[28] Throughout the report, psychological distress is used as an umbrella term for the different types of mental health issues covered by MEAC surveys. The individual components of the indicator are not assessed.

[29] Respondents always have the option to refuse to answer (i.e. skip) a survey question, which could happen for various reasons (e.g. lack of knowledge or not wanting to answer). In this report, unless explicitly mentioned, 'refused to answer' rates below 5 per cent are excluded from the calculation and analysis of summary statistics. All statistics reported are rounded to the nearest whole number. Disaggregations by percentage thus do not always add up to 100 per cent.

- "In your life now, how often do you feel sad or uninterested in life?". Answer options: Most times, Sometimes, Never.

The psychological distress score was calculated by assigning points for each response and adding these together for the five questions feeding into the indicator. Answering 'Sometimes' to a question was equivalent to one point in the indicator, 'Most times' answers were assigned two points, and 'Never' answers were assigned zero points.[30]

It is important to note here that respondents are self-reporting their mental health in response to the five different questions. While these responses do not constitute a medical diagnosis of a specific mental health condition, they do provide some insight into the general mental and psychosocial well-being of respondents as well as the population in general and allow an analysis of the relationships with possible explanatory factors.

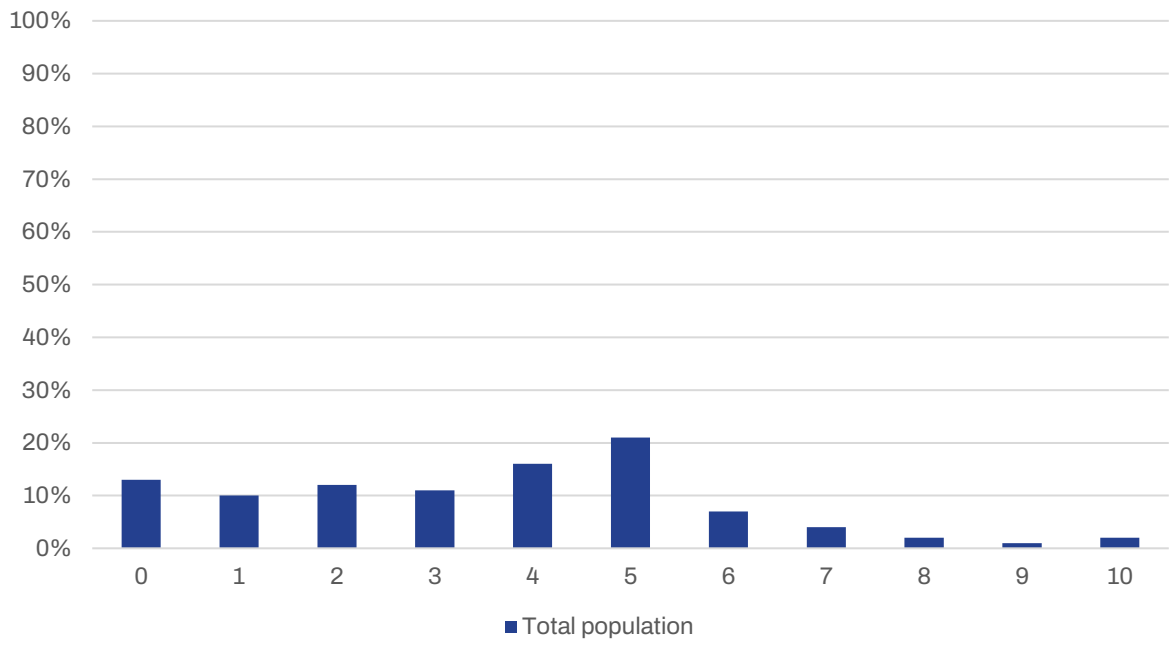
Findings

In this part of the report, different potential drivers of poor mental health and psychological well-being are investigated. To begin, it takes a brief look at levels of psychological distress in the sampled population. The distribution of psychological distress scores among the survey sample is displayed in Figure 2 and shows that most respondents reported at least some level of difficulty.[31] Approximately 87 per cent of all respondents reported a score other than zero, indicating they experience at least one element of the psychological distress indicator based on the questions outlined earlier in this report.

The following sections investigate potential explanations for the variation in psychological distress levels found among conflict-affected populations in the North East of Nigeria. First, in response to practitioner concerns, the impact of armed group association on psychological distress is explored. The report then examines the outcomes for particular sub-populations, including child soldiers and women and girl ex-associates. The next section looks alternatively at the impact of conflict experiences, while the third section discusses the effects of daily stressors on psychological distress. The report concludes with potential entry points to target and scale MHPSS programming in the region, a setting with limited existing resources.

[30] After creating the aggregated psychological distress indicator, its internal validity, meaning how reliable the indicator is, was tested. This was done by calculating Cronbach's alpha, which is commonly used when testing the internal validity of indicators measuring latent variables. Cronbach's alpha takes a value between 0 and 1, with a higher value indicating higher internal validity. Typically, a score above 0.7 is seen as acceptable. The aggregated psychological distress indicator has a Cronbach's alpha of 0.79 and thus passes this threshold, giving confidence in its use for statistical analysis. This indicator is the dependent variable, or outcome of interest, for all regression analysis conducted in this report.
[31] Keeping in mind that these scores do not equal to a medical diagnosis.

FIGURE 2 – DISTRIBUTION OF SCORES ON THE PSYCHOLOGICAL DISTRESS INDICATOR



Association with an Armed Group

In this section, the report focuses on the effect of association with an armed group on an individual's mental health.[32] Former associates of armed groups are at the centre of MEAC's research and thus a group of special interest in this report. Further, according to the literature, they are expected to display higher levels of psychosocial distress possibly due to their proximity to the conflict, either as witnesses to violence or as perpetrators.[33] Association with a violent group alone, even without witnessing or perpetrating violence, may already cause distress or trauma by being part of a group which possibly contradicts one's moral values, known as moral injury.[34] While moral injury constitutes a distinct mental health issue on its own, it is, for instance, often related to PTSD and functioning.[35] Thus, the assumption is that association with an armed group increases the likelihood that an individual will report higher levels of psychological distress.

[32] Both former and current association is included in this analysis. This is particularly relevant for affiliates of community security actors, as many in the MEAC sample reported being currently affiliated.
[33] Kirsten Johnson et al., "Association of Combatant Status and Sexual Violence With Health and Mental Health Outcomes in Postconflict Liberia," *Journal of the American Medical Association*, Vol. 300, No. 6 (August 2008); Brandon A. Kohrt et al., "Comparison of Mental Health Between Former Child Soldiers and Children Never Conscripted by Armed Groups in Nepal," *Journal of the American Medical Association*, Vol. 300, No. 6 (August 2008).
[34] Edward D. Barker and Heidi Riley, "The role of trauma and mental health in violent extremism," *XCEPT*, (2022).
[35] Victoria Williamson, Sharon A M Stevelink and Neil Greenberg, "Occupational Moral Injury and Mental Health: Systematic Review and Meta-Analysis," *The British Journal of Psychiatry,* vol. 212, No.6 (June 2018).

To statistically test whether association is in fact a relevant contributing factor for poor mental health in the North East of Nigeria, a regression was run, controlling for additional explanatory factors (e.g., age, gender, conflict experiences, and daily stressors).[36] It was found that association with an armed group, whether it is a faction of Boko Haram or a CSA such as the CJTF, does not have a significant effect on the psychological distress indicator, suggesting that association alone does not sufficiently explain poor mental health outcomes.[37] This does not mean that association does not matter for mental health. Rather, it points to the diverse experiences of former associates of Boko Haram, CSA affiliates, as well as unaffiliated community members.

Generally, respondents reported similar levels of psychological distress across different association categories, making it difficult to establish differences between subgroups of the population. Again, this suggests that former Boko Haram associates, CSA affiliates, and unaffiliated community members are diverse groups with complex and varied experiences within (or outside of) armed groups that contribute to their psychological well-being. The experiences of former associates of Boko Haram vary largely and will likely depend on several factors, including which faction of Boko Haram they lived under (Islamic State West Africa Province – ISWAP or Jamā'at Ahl as-Sunnah lid-Da'wah wa'l-Jihād – JAS), when they were associated and exited the group, the territory they lived in, their status in the group and their gender. For example, the experience of a military-age man associated with ISWAP cannot be likened to that of a young girl living in JAS territory. While both – for the purpose of this report – are considered associates of armed group, their time with the group is each shaped by a confluence of specific experiences and other factors that may impact their mental well-being. Another factor that differs within the group of former Boko Haram associates is their post-exit experience. For example, while most former associates said they were not detained by security forces, seven per cent said they were put in detention.[38] There have been concerns regarding the conditions and treatment of detainees in detention facilities, which could potentially impact mental health and psychosocial well-being.[39] Other key differences could include whether individuals are displaced after exiting, how they are received by their families and communities upon return, whether they exited with or without spouses or children, and whether they have

[36] MEAC has a limited range of variables available on these topics. As mentioned in this report both conflict experiences and daily stressors are highly relevant factors. Out of the possible measurements for conflict experiences, being injured was chosen as the control in this model. For daily stressors, food security and current displacement were selected. This was done taking into account data limitations and after checking for correlations with other possible control variables.

[37] A regression was run to test this relationship. Association with Boko Haram resulted in a coefficient of 0.033 and association with a CSA resulted in a coefficient of 0.126. Neither of these coefficients were statistically significant at the 95 per cent confidence level. The control variables gender (0.210), adult (0.946), injury (0.837), food security (-0.383), and current displacement (0.304) were all statistically significant. This regression model has an adjusted R^2 value of 0.059, meaning that 5.9 per cent of the variation in the psychological distress indicator can be explained by the factors included in the model. N = 3,609.

[38] "Were you ever detained by the security forces because they suspected you of being with Boko Haram or another armed group, even if it's not true?". Answer options: Yes, No. Filtered for former Boko Haram associates.

[39] Amnesty International, '"Help Us Build Our Lives": Girl Survivors of Boko Haram and Military Abuses in North-East Nigeria," AFR 44/7883/2024, 2024; Human Rights Watch, "They Didn't Know if I Was Alive or Dead" Military Detention of Children for Suspected Boko Haram Involvement in Northeast Nigeria," 2019.

access to reintegration support and basic services thereafter – all of which may shape their mental health outcomes in important ways.

Thus, association with an armed group on its own cannot effectively identify target groups for MHPSS activities, which is further complicated by the limited clinical expertise and funding for such interventions in the region. Rather, based on the results for the controls included in the model, the past and current experiences and current living conditions of individuals seem to be relevant factors to consider regarding the mental health of conflict affected populations. This is not surprising, as these factors have frequently been studied in previous literature as relevant predictors of mental health outcomes. Although some studies found a significant effect of association with an armed group on its own when controlling for conflict exposure,[40] association has mostly been studied in combination with past or current experiences. Conflict experiences as well as daily stressors will be investigated further in later parts of the report. To reiterate, this does not mean that association in and of itself does not matter, but that it needs to be considered in combination with other factors. Further, it points to complex conflict experiences of former associates, which are not captured in this particular regression model. It also does not mean that former associates of Boko Haram or CSA affiliates should be disregarded from MHPSS programming but require additional screening to identify those in need of specialized assistance.

Age of Association

Another focus of the literature on the mental health impacts of conflict has been on child soldiers.[41] To test for the effect of the age of first association with Boko Haram on mental health, a regression was run on a subset of former Boko Haram associates who became associated with the group as children (under 18 years old). Like their adult counterparts, children in armed groups are exposed to various sources of trauma.[42] Considering the relevance of childhood trauma for mental health outcomes in adulthood,[43] association with Boko Haram during childhood is assumed to pose an additional long-term risk factor.

Among former associates of Boko Haram, psychological distress scores were distributed similarly for both those who were children when they first came to be with the group as well as those who were adults when they joined. The regression did not provide a clear indication that

[40] Brandon A. Kohrt et al., "Comparison of Mental Health Between Former Child Soldiers and Children Never Conscripted by Armed Groups in Nepal," *Journal of the American Medical Association*, vol. 300, No. 6 (August 2008).
[41] Theresa S. Betancourt et al., "Research Review: Psychosocial adjustment and mental health in former child soldiers – a systematic review of the literature and recommendations for future research," *The Journal of Child Psychology and Psychiatry*, vol. 54, No. 1,(October 2012).
[42] Ibid.
[43] Hyu Jung Huh et al., "The relationship between childhood trauma and the severity of adulthood depression and anxiety symptoms in a clinical sample: The mediating role of cognitive emotion regulation strategies," *Journal of Affective Disorders*, vol. 213 (April 2017).

becoming associated with Boko Haram as a child had inverse impacts on *current* mental health outcomes for those respondents who became associated as children.

Yet is clear that those who were associated with Boko Haram as children face extreme difficulties, both while with the group and upon exit. Past MEAC research has illustrated the plight of children while associated with Boko Haram: many described primitive and isolated conditions, being cut off from wider society and being unable to socialise with others.[44] Others detailed the extensive fear and trauma experienced during their time with the group, including being bombed by fighter jets, constantly being on the run and an overwhelming sense of fear and unpredictability, in addition to the daily hardships such as acquiring enough food.[45] Other research has highlighted that such violence and deprivations can result in persistent impairments in physical well-being, mental-health outcomes and developmental potential.[46] While the psychological toll may not always be immediately visible, the effects of trauma in childhood often surface more clearly during adolescence or adulthood.[47] This is particularly important to consider as children frequently struggle to articulate their inner distress and mental health conditions such as depression, anxiety or PTSD may only become diagnosable years after exposure to traumatic events.[48] Thus, the analysis presented herein should not be interpreted as children facing fewer mental health burdens as consequences of the conflict. Rather, children formerly associated with Boko Haram do not appear to report worse outcomes at the time of the survey, although this may change over time. Considering that children often have difficulties answering mental health questionnaires and mental health issues often manifest later in life, children formerly associated with armed groups such as Boko Haram may begin to express adverse mental health effects years after exit, which would have implications for how MHPSS interventions are adapted for young people who may be at risk of exhibiting symptoms or developing syndromes later in life and relatedly, on long-term MHPSS planning.

Gender

Regression analysis found that women and girls who were associated with Boko Haram are found to report higher levels of psychological distress than men and boys who were with the

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[44] Kato Van Broeckhoven, Anamika Madhuraj, Francesca Batault, Jessica Caus, Fatima Ajimi Badu, Mohammed Bukar, Siobhan O'Neil, "Picturing Conflict: Child Perspectives From Their Time With Boko Haram and Their Exit Journeys," UNIDIR, Geneva, 2024.
[45] Ibid.
[46] Jonathan Hall et al., "Child development and resilience in war, conflict and displacement," *SIPRI*, 9 May 2022.
[47] Ronald C. Kessler et al., "Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative," *World Psychiatry*, vol. 6, No. 3 (October 2007); Hyu Jung Huh et al., "The relationship between childhood trauma and the severity of adulthood depression and anxiety symptoms in a clinical sample: The mediating role of cognitive emotion regulation strategies," *Journal of Affective Disorders*, vol. 213 (April 2017).
[48] Ronald C. Kessler et al., "Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative," *World Psychiatry*, vol. 6, No. 3 (October 2007); Jerica Radez et al., "Adolescents' perceived barriers and facilitators to seeking and accessing professional help for anxiety and depressive disorders: a qualitative interview study," *European Child & Adolescent Psychiatry*, vol. 31, No. 6 (June 2022).

group.[49] This is in line with existing literature, which suggests women in conflict contexts are generally more vulnerable to certain mental health issues such as depression.[50] Women's mental health appears to suffer more with conflict exposure and is often associated with gender-based violence.[51]

It is possible that women and girls do not experience higher rates of psychological distress, but rather they are more willing to admit to mental distress than men and boys. Gender norms together with the stigma around mental health in Nigeria may make it even more difficult for men and boys to report certain mental health problems, resulting in underreporting. However, women and girls who were associated with Boko Haram also have considerably different experiences in the group and with reintegration than men and boys which might contribute to additional and specific psychological distress. Within Boko Haram, strict gender norms dictate the lives of those living under its occupation. For instance, women and girls' movement was often highly restricted (making escape more challenging).[52] They experienced forced marriages – often multiple – while with Boko Haram and frequently remained dependent on their husbands even after exiting the group.[53] Even after exiting, rigid gender norms often continue to be enforced, and women and girls' movement and ability to engage in economic activities to support their families or go to school may continue to be limited. Further, reintegration programming is typically targeted at men (and boys), and as women and girls are not seen as threats they often bypass programming, making the return to their communities even more challenging.[54] This lack of support and the challenges they face back in the community can have long-term effects on their daily lives, potentially adding to insecurities and stress experienced by women and girls. Considering these challenges, along with the finding that women and girls report higher levels of psychological distress than men and boys, further research is needed to identify gender differences in psychosocial needs which may require tailored MHPSS interventions given the unique experiences and vulnerabilities discussed.

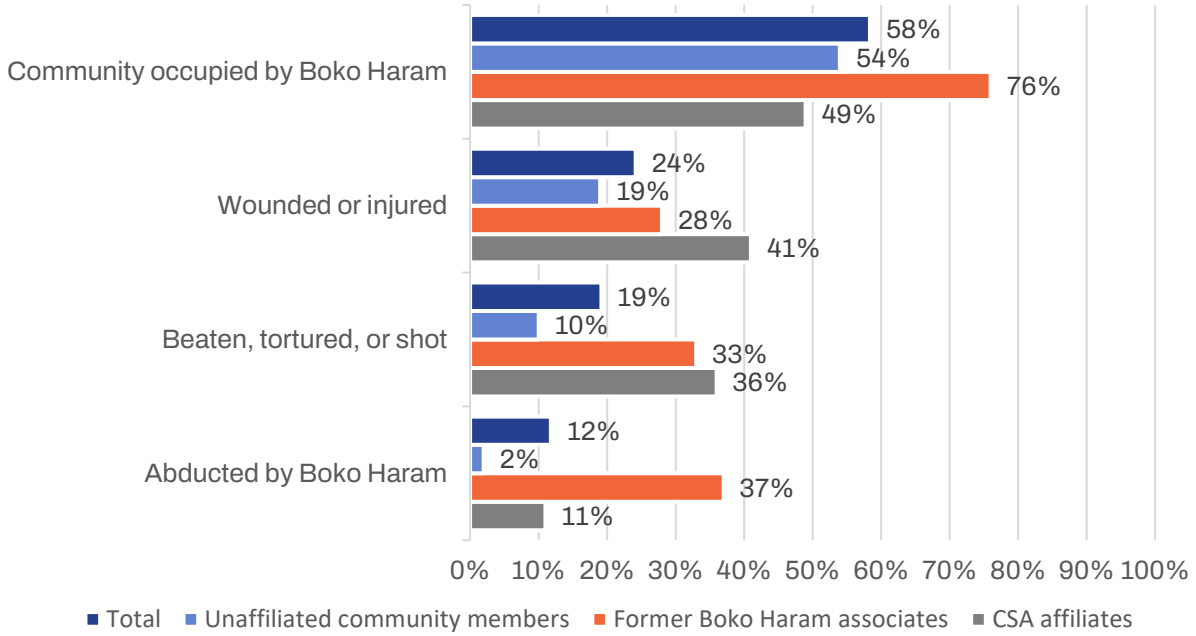
Other Conflict Experiences

Given that association itself does not appear to explain mental health outcomes in the North East of Nigeria, the question remains – what factors are driving mental health and psychosocial well-being in the region? In line with the literature on the influence of conflict experiences on

[49] The regression model for former Boko Haram associates resulted in a coefficient of 0.528 for respondents' gender. The result was statistically significant at the 99 per cent confidence level. The regression controlled for age, injury, food security, and current displacement. The model had an adjusted R^2 value of 0.051, meaning 5.1 per cent of the variation in the psychological distress indicator is explained by the variables in the model.
[50] Fiona Charlson et al., "New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis," *Lancet*, vol. 394, No. 10194 (July 2019).
[51] Eran Bendavid et al., "The effects of armed conflict on the health of women and children," *Lancet*, vol. 397, No. 10273 (February 2021).
[52] Chitra Nagarajan, Francesca Batault, Siobhan O'Neil, and Fatima Yetcha Ajimi Badu, "From Survival to Struggle: Women and Girl's Experiences with and After Boko Haram," Findings Report 39, UNIDIR, Geneva, 2024.
[53] Ibid.
[54] Ibid.

mental health, the report will now examine the effect of conflict exposure and victimization. Research has found that traumatic experiences such as loss of family members and forced displacement due to conflict increase the likelihood of poor mental health outcomes.[55] Thus, a similar relationship would be expected between conflict experiences and mental and psychosocial well-being in MEAC's data from the North East of Nigeria. Figure 3 displays an overview of some conflict-related experiences of the surveyed population and highlights the considerable share of the population directly affected by the conflict.

FIGURE 3 – OVERVIEW OF COMMON VICTIMIZATION EXPERIENCES BY ASSOCIATION[56]



Large portions of the population in the North East were impacted by conflict violence. As shown in Figure 3, 58 per cent reported that their community had been occupied by Boko Haram and 24 per cent of respondents said they injured as a result of the conflict. These specific questions were included in the regression model testing the effect of conflict experiences on

[55] Bernardo Carpiniello, "The Mental Health Costs of Armed Conflicts—A Review of Systematic Reviews Conducted on Refugees, Asylum-Seekers and People Living in War Zones," *International Journal of Environmental Research and Public Health*, vol. 20, No. 4 (February 2023).

[56] This figure presents a summary of multiple survey questions. Percentages refer to the percentage of respondents answering Yes to each question.
"Did Boko Haram ever occupy your community?". Answer options: Yes, No;
"Have you ever been seriously wounded or injured as a result of the Boko Haram conflict?". Answer options: Yes, No;
"Were you ever beaten, tortured, or shot as a result of the Boko Haram conflict?". Answer options: Yes, No;
"Were you ever abducted by Boko Haram?". Answer options: Yes, No.

psychological distress since they were most frequently reported by the overall population and cover a variety of conflict experiences for different sub-populations.[57]

The regression results showed an increased likelihood of psychological distress for those who had been injured during the conflict. Similarly, respondents whose community was occupied by Boko Haram were more likely to report psychological distress.[58] Although not tested in the regression model due to conceptual overlap between the questions, it can be expected that similar conflict experiences, such as being beaten, tortured, or shot, or being abducted by Boko Haram will have similar negative effects on mental health outcomes.

The results confirm previous findings in the literature that conflict violence exposure is associated with psychological distress. Considering how widespread victimization is in the region, this finding demonstrates a widespread need to integrate MHPSS components and referral options throughout interventions even if they are not specific to peacebuilding or reintegration (e.g., medical care for physical injuries caused by the conflict). This need extends beyond interventions narrowly targeted at those classified as 'victims' or formerly associated.

Sexual Violence

There is concern that certain types of victimization may have greater impacts on mental health than others. This is particularly true regarding sexual violence. Previous research found that sexual violence generally increases the risk of mental health issues,[59] which is confirmed by MEAC data from the North East of Nigeria. The regression analysis found that respondents who reported experiencing sexual violence are significantly more likely to report higher levels of psychological distress.[60] Some caution should be applied when interpreting these results, since only a small share of respondents reported experiencing sexual violence. Out of all adults in the survey, less than one per cent or 23 respondents in total (16 women and seven men), said they experienced sexual violence.[61]

Sexual violence is thought to be grossly underreported due to stigma and local perceptions about sexual violence in the context of marriage (including forced marriages by Boko Haram). Although the number of respondents who answered 'Yes' to the question is very small, the significant effect of this variable in the model indicates that there is indeed a clear negative

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[57] Further, the correlations between all potential variables were tested, showing low correlations between these two measures, to ensure they are not overlapping measurements of the same aspect.
[58] The regression run to test this relationship resulted in coefficients of 0.798 for injury and 0.417 for occupation by Boko Haram. Both results were significant at the 99 per cent confidence level. Controls were included for age, gender, association, and food security. This model has an adjusted R^2 value of 0.061, meaning that it can explain 6.1 per cent of variation within the psychological distress indicator. N = 3,578.
[59] Kirsten Johnson et al., "Association of Combatant Status and Sexual Violence With Health and Mental Health Outcomes in Postconflict Liberia," *Journal of the American Medical Association*, vol. 300, No. 6 (August 2008).
[60] The regression model resulted in a coefficient of 1.230 for sexual violence, which was statistically significant at the 95 per cent confidence level. Controls were included for injury, occupation by Boko Haram, gender, association, and food security. The regression has an adjusted R^2 value of 0.039, therefore 3.9 per cent of the variation within the psychological distress indicator is explained by the variables included in the model. N = 3,009.
[61] "Has anyone ever forced you to have sex, or touched you in any way, without your consent?". Answer options: Yes, No. Posed only to adults.

relationship between sexual violence and mental health. This finding highlights the need for MHPSS services for survivors of sexual violence. Such support requires careful, ethical, and contextually grounded screening that acknowledges the complex nature of experiences (e.g., forced marriage) to inform tailored care. This process needs to be conducted in a way that is sensitive to potential stigma, ensuring people feel comfortable accessing support.

Violence Perpetration

Previous literature on the mental health outcomes of those who had been with an armed group or state military has also identified experiences of, or proximity to, violence, including perpetration, as possible explanations of poor psychological well-being. While most studies find witnessing or perpetrating violence, including killing, to have a negative impact on the perpetrator's mental health, others do not find the same clear results or find varying results for different sub-groups.[62] We thus expect former associates of Boko Haram or a CSA who committed violence to be more at risk of reporting psychological distress. Out of those adults who were with Boko Haram, ten per cent admitted to committing violence while with the group.[63] For those adults who were or currently are with a CSA, five per cent reported having committed violence while with the group.[64]

To test whether the perpetration of violence during association affects these respondents' mental health, a further regression model was run. Since questions about violence perpetration were only asked of adults, these results only apply to adult former (and current CSA) associates.[65] The results show that those who perpetrated violence are more likely to report higher psychological distress indicator scores, in line with previous research. This is true for both former Boko Haram associates and former and current CSA affiliates.[66]

Within the context of the Boko Haram conflict, it is important to note that perpetration of violence occurred along a spectrum of coercion. That is to say, some former associates of Boko

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[62] Rachel M. MacNair, "Perpetration-Induced Traumatic Stress in Combat Veterans," *Peace and Conflict: Journal of Peace Psychology*, vol. 8, No. 1 (March 2002); Tobias Hecker et al., "Does Perpetrating Violence Damage Mental Health? Differences Between Forcibly Recruited and Voluntary Combatants in DR Congo," *Journal of Traumatic Stress*, vol. 26 (January 2013); Alexander H. Jordan et al., "Distinguishing War-Related PTSD Resulting From Perpetration- and Betrayal-Based Morally Injurious Events," *Psychological Trauma: Theory, Research, Practice, and Policy*, vol. 9, No. 6 (November 2017); Brandon J. Griffin et al., "Moral Injury: An Integrative Review," *Journal of Traumatic Stress*, vol. 32, No. 3 (December 2019).

[63] N = 861 "During your time with [Boko Haram], did you ever commit violence against someone?". Answer options: Most times, Sometimes, Never. Posed only to adults who were associated with an armed group. Filtered for Boko Haram only.

[64] Most respondents who reported being with a CSA said they were currently still with the group; N = 505 "During your time with [CSA], did you ever commit violence against someone?". Answer options: Most times, Sometimes, Never. Posed only to adults who were associated with an armed group. Filtered for CSA only.

[65] Meaning those who were adults when taking the survey. Some respondents who answered the question may have been children when they were associated with Boko Haram (and perpetrated violence).

[66] The regression model for former Boko Haram associates resulted in a coefficient of 0.751 for the perpetration of violence during association (N = 848). The regression model for CSA associates (former and current) resulted in a coefficient of 1.396 for the perpetration of violence during association (N = 498). Both results were statistically significant at the 99 per cent confidence level. The regressions controlled for gender, injury, food security, and current displacement. The Boko Haram model has an adjusted R^2 value of 0.067, meaning 6.7 per cent of the variation in the psychological distress indicator is explained by the variables in the model. The CSA model has an adjusted R^2 value of 0.029, explaining 2.9 per cent of variation in the indicator.

Haram and CSAs may have been forced to perpetrate violence and engage in violent acts against their will while others engaged in violence willingly. The lines between victims and perpetrators can often be blurry in conflict, as many may have experienced both throughout their involvement. While these nuances do not absolve harmful actions, they complicate the psychological impact on individuals, making it essential to understand the full context of their experiences. This is also the case for CSA affiliates. While CSAs like the CJTF are often viewed as hometown heroes and protectors of their communities, past MEAC research has highlighted the coercive nature of these groups, not least when it comes to committing violence and abuses.[67] While MHPSS services, when provided, are typically focused on victims of violence, these results show the need of expanded support that also addresses the complex mental health needs of those who perpetrated violence, sometimes in the name of defending the State and its people. Recognizing the implications for the professionalization of CSAs and/or the successful transition to civilian life of former armed group associates – regardless of group – is crucial so that interventions can be provided to address the trauma, moral conflict, and psychological challenges these individuals face, ensuring accountability, community reconciliation, and healing in parallel.

Daily Stressors

Conflict experiences are the most frequently studied aspect regarding mental health outcomes in conflict-affected populations. In Western psychology, research with returning American soldiers from Vietnam led to an "assumption that war exposure represented the critical determinant of distress among survivors of political violence" including for populations like refugees, internally displaced persons and other conflict affected populations who were still facing indirect challenges related to conflict.[68] Over time, scholars have moved beyond this "trauma-focused" framework and considered daily stressors – social and material conditions acting as sources of stress in a person's daily life – as potential explanatory factors for adverse mental health outcomes beyond PTSD symptoms. Indeed, recent research has found a strong effect of daily stressors on the mental health and psychosocial well-being of conflict affected populations.[69] These trends have also been observed in other MEAC research, including in-depth focus group discussions and key informant interviews with hundreds of former

[67] Some affiliates have described the inevitability of engaging in violence once affiliated with a CSA as they were equipped with weapons, while others cited the lack of oversight over the group as contributing to their indiscriminate violence. Kato Van Broeckhoven, Zoe Marks, Siobhan O'Neil, Mohammed Bukar, and Fatima Yetcha Ajimi Badu (2022) "Community Security Actors and the Prospects for Demobilization in the North East of Nigeria," MEAC Findings Report 18, United Nations University, New York, p. 21.

[68] Kenneth Miller and Andrew Rasmussen, "War Exposure, Daily Stressors, and Mental Health in Conflict and Post-Conflict Settings: Bridging the Divide between Trauma-Focused and Psychosocial Frameworks," Social Science and Medicine, Vol. 70, Issue 1 (2010), p. 10.

[69] Kenneth Miller et al., "Daily Stressors, War Experiences, and Mental Health in Afghanistan," *Transcultural Psychiatry*, (2008); Andrew Riley et al., "Daily stressors, trauma exposure, and mental health among stateless Rohingya refugees in Bangladesh," *Transcultural Psychiatry*, vol. 54, No. 3 (May 2017); Fiona McEwen et al. "Prevalence and predictors of mental health problems in refugee children living in informal settlements in Lebanon," *Nature Mental Health*, vol. 1 (May 2023).

associates of Boko Haram and conflict-affected community members. While many participants have experienced extreme and devastating violence, including the loss of family members, kidnappings, sexual violence and forced marriages, it is often daily hardships that they identify as their greatest challenges. The inability to feed themselves (and their children), ongoing insecurity by Boko Haram and the loss of their homes, belongings, and livelihoods are sources of persistent and daily stress and remain major obstacles in rebuilding their lives.

In this section, the report analyses the effect of such stressors on the mental health of respondents in the North East of Nigeria. Out of the wide range of potential daily stressors, current displacement, food security, physical insecurity, and stigmatization were selected.[70] Each of these variables covers a different source of daily stress, allowing for a more nuanced analysis of the effect of daily stressors.[71] Although many of these factors are also linked to conflict experiences, they are considered separately here due to their ongoing impact on individuals' daily lives amidst an ongoing humanitarian crisis. For example, while displacement is also a conflict experience, it is included as a daily stressor in this analysis since it can persist long after conflict or armed group exit, and current displacement is likely to be a source of stress in people's day-to-day lives.

A regression analysis of MEAC's data finds that currently being displaced increases the likelihood of reporting higher psychological distress scores, in line with existing research findings.[72] Having access to sufficient food reduces the likelihood of psychological distress, while conversely, food insecurity poses a risk factor for mental health issues. Respondents who reported feeling in danger of being hurt or killed are also significantly more likely to report higher psychological distress scores. Additionally, those respondents who experienced stigmatization reported higher psychological distress.[73]

A key point to note is that current daily stressors can have more immediate implications for mental health than past conflict experiences and past traumatic events. As discussed in existing research, when people are facing different struggles and insecurity in their daily lives, they often do not have the capacity to deal with past trauma, suggesting that effects of past

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[70] "Are you currently displaced?". Answer options: Yes, No;
"Over the last week, did you get enough food to eat?". Answer options: Yes, No;
"As a result of the Boko Haram conflict, how often do you feel like you are in danger of being hurt or killed?". Answer options: Most times, Sometimes, Never (Most times and Sometimes were combined for regression purposes);
"In the last month, how often did people like they did not trust you?". Answer options: Most times, Sometimes, Never (Most times and Sometimes were combined for regression purposes).
[71] Correlation between the different variables was checked to ensure minimal overlap between their measurements.
[72] David Cantor et al. "Understanding the health needs of internally displaced persons: A scoping review," *Journal of Migration and Health*, vol. 4 (October 2021).
[73] This regression model resulted in the following coefficients: 0.236 for current displacement, -0.363 for food security, 0.887 for danger, and 1.366 for stigmatization. All these results were statistically significant at the 99 per cent confidence level. Controls were included for age, gender, association, and injury. This model has an adjusted R^2 value of 0.106, meaning that 10.6 per cent of the variation in the psychological distress indicator can be explained by variation in the variables included in this model. N = 3,602.

trauma may only become fully visible once daily stress has subsided.[74] It is important to note that assessments of PTSD and other mental health issues are often developed in Western countries and may not fully capture mental health in other contexts. Some researchers have highlighted the need for culturally adapted and validated mental health assessments and identified additional symptoms beyond those used in the West.[75] Further, in areas affected by conflict or widespread poverty, there is also a question of whether certain symptoms may not be present due to the context. For instance, not getting out of bed may not be an option if it results in someone not having food to eat, thus making it a matter of survival and rendering the metric problematic for assessing daily functioning in certain contexts.

Displacement

The regression analysis confirms that being displaced increases the risk of higher levels of psychological distress. A considerable share of survey respondents said they were displaced at the time of participating in the survey (44 per cent). Displacement is connected to (and can exacerbate) numerous insecurities and stressors in people's daily lives including crowded and unsafe conditions; the disruption of community support networks; and difficulties in accessing employment, public services or aid.[76] Displaced children specifically also face additional difficulties in accessing education and face protection risks that can impact their well-being.[77] Given the detrimental impact of displacement, activities that contribute to better living conditions for displaced people in the region – or support in their return to their areas of origin, when it is safe to do so – could benefit their mental health.

Food Security

Having sufficient food to eat is closely linked with psychological well-being in the North East of Nigeria. Food security reduces the likelihood of psychological distress, whereas food insecurity increases the risk of poor mental health. This effect of food (in)security on mental health is notable given that only 27 per cent of respondents said they had enough food to eat in the previous week. The 2025 Humanitarian Needs and Response Plan estimates 5.1 million

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[74] Kenneth Miller et al., "Daily Stressors, War Experiences, and Mental Health in Afghanistan," *Transcultural Psychiatry*, vol. 45, No. 4 (December 2008); Fiona McEwen et al., "Prevalence and predictors of mental health problems in refugee children living in informal settlements in Lebanon," *Nature Mental Health*, vol. 1 (February 2023).

[75] Brandon A. Kohrt et al., "Validation of cross-cultural child mental health and psychosocial research instruments: adapting the Depression Self-Rating Scale and Child PTSD Symptom Scale in Nepal," *BMC Psychiatry*, vol. 11, No. 1 (August 2011); Lynn Murphy Michalopoulos et al., "Global Posttrauma Symptoms: A Systematic Review of Qualitative Literature,", *Trauma, Violence & Abuse*, vol. 21, No. 2 (April 2020); Anushka R. Patel and Brian J. Hall, "Beyond the *DSM-5* Diagnoses: A Cross-Cultural Approach to Assessing Trauma Reactions," *Focus*, vol. 19, No. 2 (June 2021).

[76] Kenneth Miller and Andrew Rasmussen, "The mental health of civilians displaced by armed conflict: an ecological model of refugee distress," *Epidemiology and Psychiatric Sciences*, vol. 26, No. 2 (April 2016); United Nations Office for the Coordination of Humanitarian Affairs, "Nigeria: 2025 Humanitarian Needs and Response Plan," OCHA, January 2025.

[77] Paramjit T. Joshi and John A. Fayyad, "Displaced Children: The Psychological Implications," *Child & Adolescent Psychiatric Clinics*, vol. 24, No. 4 (October 2015); David Bürgin et al., "Impact of war and forced displacement on children's mental health—multilevel, needs-oriented, and trauma-informed approaches," *European Child & Adolescent Psychiatry*, vol. 31, No. 6 (June 2022).

people in the North East of Nigeria (out of 33 million in the entire country) will experience food insecurity in the lean season (typically from June through September).[78] The scale of food insecurity was echoed in the MEAC survey data, in which 75 per cent of survey respondents named a lack of sufficient food as one of the three biggest problems in their community, the most frequently cited issue.[79] Addressing widespread food insecurity thus presents a potential entry point for programming to positively affect mental and psychosocial well-being while simultaneously dealing with other problems faced by conflict-affected communities in the North East of Nigeria. Programming addressing such concrete aspects, like food insecurity or potentially income generating activities, which should contribute to better food access, might also be more positively received by the population than activities explicitly and narrowly focussed on mental health, such as counselling sessions, since they address their immediate and articulated needs.

Physical Insecurity

Physical insecurity is also found to contribute to psychological distress. In the survey, 46 per cent of respondents reported insecurity – feeling in danger of being hurt or killed – highlighting how even though the number of civilian fatalities linked to the conflict has generally declined since its peak in 2014-2015 (although the number of violent incidents has not),[80] physical violence persists. Insecurity not only contributes to psychological distress but can further increase the risks associated with livelihood activities or accessing services, thus exacerbating other daily stressors like food insecurity.[81] In addition to MHPSS targeted programming, providing security and protecting the population from Boko Haram and other armed actors is essential to prevent further psychological distress and to address existing mental health needs.

Social Acceptance

Negative social perceptions, including stigmatization (measured in distrust experienced by respondents in the last month), have adverse effects on mental health, as found in the regression analysis, and reflect broader social cohesion challenges to peacebuilding and reconciliation within conflict-affected communities. Stigma acts as a source of stress in people's daily lives by associating them with negative characteristics and placing them at a considerable social disadvantage, which can have implications for access to support and

[78] United Nations Office for the Coordination of Humanitarian Affairs, "Nigeria: 2025 Humanitarian Needs and Response Plan," OCHA, January 2025.
[79] "What are the three biggest problems in your community?". Answer options (multiple select): Poverty, Lack of sufficient food, Lack of sufficient water, Bad infrastructure, Presence of Boko Haram, Presence of Jamā'at Ahl as-Sunnah, Presence of the Mamman Nur faction, Unemployment, Illicit drug sale and abuse, Criminality, Corruption, Misbehaviour of community security groups, Banditry, Military attack, raids, or arrests, Not enough presence of security actors, Physical health concerns, Lack of education, Land access, Changes in climate or extreme weather events, Forced sex, Social stigma, Other, None.
[80] Kehinde Ogunyale, "Examining fifteen years of the Boko Haram Insurgency," Dataphyte, 26 February 2025.
[81] United Nations Office for the Coordination of Humanitarian Affairs, "Nigeria: 2025 Humanitarian Needs and Response Plan," OCHA, January 2025.

economic integration.[82] Especially in conflict contexts, where such support is key to secure housing, livelihoods, or medical care, stigmatization and social acceptance are also linked with other highly relevant daily stressors.

In the MEAC survey, four per cent of respondents said that in the last month people had acted as if they did not trust them. This low share of respondents reporting this form of potential stigmatization, as well as the high share of respondents (90 per cent) saying they feel fully accepted by their community,[83] is a positive sign for community cohesion. Former associates of Boko Haram reported higher levels, with eight per cent saying they experienced being mistrusted by others. Previous MEAC research also shows that community willingness to accept Boko Haram returnees is high and community members typically view reintegration positively.[84] Community acceptance and stigma are not uniform, with gender differences in acceptance and negative feelings towards former Boko Haram associates, possible stemming from gendered information gaps.[85] Nonetheless, community acceptance is high among both women and girls and men and boys.[86]

While the low rates of stigmatization, and the high rates of community acceptance, are promising, it is important to continue monitoring these dynamics since changes could occur depending on future conflict developments. The results show that experiencing stigma has a considerable impact on mental and psychosocial well-being, and should these dynamics shift, it will be essential to address them in order to maintain and support psychosocial well-being.

While the discussions around MHPSS are often focused on those formerly associated with an armed group or those victimized in conflict, the results suggest that it is essential to address the daily stressors – whether social stigma or food insecurity – that are having significant impacts on the mental health of affected populations. Thus, clinical resources and MHPSS specific programming may not be needed – or needed alone – to improve psychological outcomes for many, which could improve if basic, persistent stressors are addressed (e.g., lack of food or shelter, insecurity).

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[82] Bruce G. Link and Jo C. Phelan, "Stigma and its public health implications," *Lancet*, vol. 367, No. 9509 (February 2006); Theresa S. Betancourt et al., "Past horrors, present struggles: The role of stigma in the association between war experiences and psychosocial adjustment among former child soldiers in Sierra Leone," *Social Science & Medicine*, vo. 70, No. 1 (January 2010).
[83] "How accepted do you feel in your community?". Answer options: Fully accepted, Mostly accepted, Neutral, A little bit accepted, Not at all accepted.
[84] Rebecca Littman, Siobhan O'Neil, Kato Van Broeckhoven, Mohammed Bukar and Zoe Marks (2021) "Community Acceptance of Former Boko Haram Affiliates," MEAC Findings Report 7, United Nations University, New York; Zoe Marks, Fatima Yetcha Ajimi Badu, and Rebecca Littman (2023). "Understanding Receptivity to Returning Former Boko Haram Associates Through a Gender Lens," Findings Report 30, UNIDIR, Geneva.
[85] Zoe Marks, Fatima Yetcha Ajimi Badu, and Rebecca Littman (2023). "Understanding Receptivity to Returning Former Boko Haram Associates Through a Gender Lens," Findings Report 30, UNIDIR, Geneva.
[86] Ibid.

Addressing Basic Needs and the Demand for Psychosocial Support

The needs far outstrip the limited MHPSS services available for conflict affected populations in the North East of Nigeria. Most respondents said they did not have access to any type of support.[87] For those who did have access, food or water was most frequently reported. Psychosocial support was rarely mentioned by MEAC survey respondents. The current availability of support suggests that an expansion of services to a wider population is essential to address both the humanitarian and psychosocial needs in the region.

This is reflected by the recommendations of survey respondents themselves. When asked what services they would give to others 'like them', respondents frequently mentioned food or water (81 per cent), cash (42 per cent), shelter (31 per cent), and medical care (27 per cent).[88] Further, services aimed at improving economic opportunities were also frequently mentioned, which could help address stressors like food insecurity.[89] When respondents list the biggest problems in their community, the most frequent responses all speak to the prevalence of daily stressors for the population: A lack of food (75 per cent), poverty (53 per cent), a lack of water (52 per cent), and unemployment (48 per cent). As discussed, daily stressors can have a more acute impact than traumatic past experiences and a high prevalence of daily stressors reduces the capacity to focus on psychological well-being and healing. As comprehensive treatment of psychological trauma requires a safe and stable environment,[90] addressing daily stressors may therefore be a necessary first step for comprehensive trauma treatment in the North East of Nigeria.

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[87] 54 per cent of respondents who were not associated with Boko Haram said they never received any services. 4 per cent of former Boko Haram associates said they did not receive any services while staying in a transit or rehabilitation centre and 66 per cent of those who did not pass through a centre said they did not receive any services.
N = 2,712 "Since the Boko Haram conflict began, did you receive any of the following things from the government, international organizations or NGOs?". Answer options (multiple select): Medical care, Food or water, Shelter, Formal education, Reorientation or reconciliation programming, Cash, Material goods, Skills training, Support to start a business, Family tracing, Sport or art activities, Psychological support, Religious counseling or education, Support to get married, Other, Nothing. Posed only to those not formerly associated with Boko Haram;
N = 788 "Did you receive any of the following while you were at [centre]?". Answer options (multiple select): Medical care, Food or water, Shelter, Formal education, Reorientation or reconciliation programming, Cash, Material goods, Skills training, Support to start a business, Family tracing, Sport or art activities, Psychological support, Religious counseling or education, Support to get married, Other, Nothing. Posed only to those who had stayed at a transit or rehabilitation centre. Filtered for former Boko Haram associates;
N = 115 "Did you receive any of the following after leaving [Boko Haram]?". Answer options (multiple select): Medical care, Food or water, Shelter, Formal education, Reorientation or reconciliation programming, Cash, Material goods, Skills training, Support to start a business, Family tracing, Sport or art activities, Psychological support, Religious counseling or education, Support to get married, Other, Nothing. Posed only to those whose last group of association was Boko Haram and who never passed through a transit or rehabilitation centre.
[88] "If you could decide, what type of support would you make sure to give people like you?". Answer options (multiple select): Medical care, Food or water, Shelter, Formal education, Reorientation or reconciliation programming, Cash, Material goods, Skills training, Support to start a business, Family tracing, Sport or art activities, Psychological support, Religious counseling or education, Support to get married, Other, Nothing.
[89] Including support to start a business (33 per cent), skills training (31 per cent), and formal education (25 per cent).
[90] Brigitte Khoury and Sariah Daouk, "Healing the Scars Within: Psychological Support for the War-Injured", in *Reconstructing the War Injured Patient*, Ghassan Soleiman Abu-Sittah, Jamal J. Hoballah, and Joseph Bakhach, eds. (Cham: Springer International Publishing, 2017).

At the same time, survey participation itself has revealed another dimension of unmet need: safe opportunities to share and process experiences. To monitor potential distress related to participation, MEAC surveys include a series of anxiety metrics. For example, respondents are asked about their level of worry before and after the survey is completed.[91] When comparing self-reported levels of worry before and after the survey, a slight decrease is observed. Although this by no means indicates a clinically significant or lasting reduction, there are indications that talking about their experiences – even when difficult – can be cathartic in this context, when approached in a sensitive manner. In the North East of Nigeria, it is typically not within the culture to discuss private matters and struggles beyond one's immediate family. There is further a general reticence in discussing conflict-related experiences and trauma for concerns that this may retraumatize or impede people's healing. Since the start of MEAC's surveys and qualitative research in Nigeria in 2020, it has become evident that, for many respondents, their participation in research interviews is a rare – or sometimes their first – opportunity to speak about their conflict experiences. For instance, one respondent expressed "I was happy that I got a chance to talk about our problems with you because speaking about my problems had become a therapy for me," while another noted that "she was happy to talk with me [the enumerator] because nobody listen[ed] to her before but now that she was able to share her experiences, she felt relaxed and relieved." Other respondents have gone insofar as requesting to participate in future surveys.

These findings underscore that while respondents continue to prioritize food, water, shelter and livelihood needs, there is also recognition of the value of supportive spaces to share experiences and reduce distress. Together, these needs highlight the importance of designing policy and programming that not only addresses urgent daily stressors driving poor mental health outcomes but also builds in accessible, community-based psychosocial support to deal with traumatic conflict experiences and talk about ongoing problems. The following section sets out policy recommendations based on the findings presented in this report.

Policy Recommendations

The findings presented in this report point to varied experiences and needs of the population in the North East of Nigeria. Due to these diverse experiences, simplistic assumptions about certain groups, such as former associates of armed groups, do not hold. Mental health support thus needs to be provided for both associated individuals and those who have never been associated with an armed group. This report identified several risk factors present in the

[91] "How worried are you feeling right now?". Answer options: Not at all worried, A little worried, Very worried; "How worried are you feeling right now, compared to before we started talking?". Answer options: Not at all worried, a little worried, Very worried.

surveyed population, which should be taken into account when assessing people's MHPSS needs.

The results confirm previous research findings from other conflict contexts that highlight the impact of both traumatic conflict experiences as well as daily stressors on mental and psychosocial well-being. Generally, conflict experiences and daily stressors are both widespread in the North East of Nigeria given the pervasiveness of the conflict over the last fifteen years, ongoing insecurity and widespread needs. Thus, activities which are easily scalable to support a much wider population than previously targeted in the region should be prioritized. As some previous research suggests, people may not be able to fully deal with the psychological distress caused by traumatic experiences if they are facing considerable stress in their daily lives. Nonetheless support addressing trauma from past experiences should be provided in a tailored and context-sensitive manner. While many people may respond to basic needs and non-healthcare interventions (e.g., livelihoods support, education, or recreational activities), additional clinical referral support will likely be needed for some who require assistance from mental health professionals. The basic needs and non-healthcare interventions are more easily scalable for a wider population, whereas specialised psychological treatment is more costly. Identifying and referring those who require this specialised support to professionals could therefore be done as part of non-specialised interventions. When designing any interventions, including MHPSS programming, it is important to include the affected communities in the design and implementation. By actively including communities, interventions are better tailored to the local context and needs, allowing for more effective and targeted support.

- **Providing inclusive basic support for broad parts of the population through low-cost and scalable activities.** Considering how widespread psychological distress was reported by the population, a need for MHPSS services is highlighted across all parts of the population. While certain groups may require more targeted interventions, a general minimum of support should be provided to everyone. Considering the context, low cost and scalable activities will allow to reach larger parts of the population. Although psychological support is not explicitly mentioned as a priority by most survey respondents, considering that most respondents did report some signs of psychological distress, services addressing mental health concerns need to be expanded. Previous findings that trauma reduces community members' trust in the reintegration process add to the importance of providing adequate MHPSS as part of broader reintegration programming.[92] These do not necessarily need to take the form of specialised medical care, which is difficult to provide at a larger scale in the specific

[92] Tarela Juliet Ike et al., "Reintegration of former Boko Haram members and combatants in Nigeria: an interpretative phenomenological analysis of community members' experiences of trauma," *Third World Quarterly*, vol. 43, No. 12 (August 2022).

context of the North East of Nigeria due to a lack of capacity in the health system.[93] Creating peer-led mental health support opportunities, for instance by training community members in basic mental health support and creating community safe spaces, can have a positive impact on mental well-being.[94] Allowing people to share their experiences and worries may already provide mental health relief, at least temporarily. Such scalable activities could also integrate livelihood and food security components, given the close link between daily stressors (such as hunger and unemployment) and psychological distress.

- **Expanding community-based mental health and tapping into existing local structures for support opportunities, and allowing people to share their experiences in safe settings.** While survey participation revealed that many respondents valued the rare opportunity to share their experiences, this points to a broader unmet need for safe and supportive spaces beyond research settings. Practitioners should therefore work with local communities to develop accessible, culturally appropriate, and low-cost opportunities for individuals to talk, share concerns, and receive basic psychosocial support such as community safe spaces and peer-to-peer support networks. In developing such opportunities, practitioners can also tap into existing community structures, for instance through religious clerics or traditional healers, who people already turn to when dealing with mental health issues. Such interventions should be designed to avoid re-traumatization, reduce stigma and encourage participation from women, men, and children, recognizing that cultural norms and gender dynamics influence who can access such spaces and who feels able to speak openly. Importantly, such spaces can serve as an entry point for referrals to more specialized services when needed.

  Further, considering the stigma around mental health and frequent blame placed on those suffering from different mental health issues, there needs to be safe guards in place to ensure that support does not end up harming participants. Wider community-level efforts to reduce mental health stigma should also be considered. These could include campaigns to raise awareness and counter misconceptions of mental health through trusted channels (e.g., radio broadcasts) and with trusted community leaders (e.g., traditional leaders and religious clerics). Such efforts will likely increase community buy-in to MHPSS programming.

[93] Adewale Olusola Adeboye. "Addressing the Boko Haram-Induced Mental Health Burden in Nigeria," *Health and Human Rights Journal*, vol. 23, No. 1 (June 2021).
[94] Médecins Sans Frontières (MSF) delivered MHPSS programming in Borno State with community mental health workers and lay counselors trained and supervised by MSF psychologists: Santiago Martínez Torre et al., "Severity, symptomatology, and treatment duration for mental health disorders: a retrospective analysis from a conflict-affected region of northern Nigeria," *Conflict and Health*, vol. 16, No. 41 (July 2022), p. 2; Saleh Adel G. A. Al-Tamimi and Gerard Leavey, "Community-Based Interventions for the Treatment and Management of Conflict-Related Trauma in Low-Middle Income, Conflict-Affected Countries: A Realist Review," *Journal of Child & Adolescent Trauma*, vol. 15, No. 2 (June 2022).

- **Addressing daily stressors and basic needs is a key step in improving mental health outcomes in conflict affected populations and needs to be done in concert with MHPSS programming.** In line with existing UN guidelines and psychological practice, ensuring people have a safe and stable environment, in which their basic needs are met is a key requisite for improving mental well-being. For example, in its guidelines on MHPSS in emergency settings, the UN Inter-Agency Standing Committee developed a four-tiered intervention pyramid to support multilayered approaches to MHPSS, which places basic services and security need at the base of the pyramid towards better mental health.[95] Only for the smaller group of people who require additional help beyond basic needs (1st tier) and community and family supports (2nd tier) does IASC guidance suggest the provision of focused psychosocial support delivered by non-specialised staff (3rd tier) and then clinical mental health and psychosocial services for those with severe mental health needs (4th tier). The guidelines suggest all four layers to be implemented concurrently as they are equally important.[96]

  Considering the current lack of MHPSS and basic services in the North East of Nigeria and taking into account capacity and funding constraints, an initial focus on the IASC first layer, ensuring all people have their basic needs met in a responsible way, may be the most cost efficient way to support mental well-being for most of the impacted population in this context. The second and third layer of the intervention pyramid also highlights the opportunities for more focused support without highly specialised staff. Based on the research presented here, daily stress caused by an insufficient coverage of basic needs is a key driver of poor mental health in the North East of Nigeria. Therefore, the expansion of basic needs and security services while integrating mental health components and specialist referrals will likely have positive effects in communities.[97] Special consideration should be given to displaced populations, who reported higher levels of psychological distress, likely due to a combination of factors such as unsafe living conditions, food insecurity, and disruption of community networks.

- **Recognizing a need for MHPSS services for victims (and perpetrators) of conflict violence.** As discussed in the findings, those who experienced (and may continue to experience) certain traumatic events related to the conflict, including different types of victimization, are more likely to report higher levels of distress. The high levels of

[95] Inter-Agency Standing Committee, "IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings," (Geneva, IASC, 2007).
[96] Ibid.
[97] An example of integrating mental health and food security support is currently being studied in Uganda. In the study, a home gardening initiative is coupled with the Self-Help Plus psychological intervention: Jonathan Hall et al. "Combining mental health and climate-smart agricultural interventions to improve food security in humanitarian settings: study protocol for the THRIVE cluster-randomized controlled trial with mothers in Nakivale refugee settlement, Uganda," *Trials*, vol. 26, No. 331 (September 2025).

victimization – including sexual violence – due to the conflict support the need for an expansion of MHPSS services. MHPSS components should be integrated into existing interventions that is accessed by victims (e.g., targeted medical support for survivors of sexual violence). Not only are those who experienced violence especially in need of psychosocial support, but special attention should also be paid to those who perpetrated violence during the conflict as part of broader efforts for reconciliation and rehabilitation. Considering the coerciveness of recruitment into armed groups as well as the perpetration of violence, people were often forced to go against their own morals, which likely explains the increased levels of psychological distress reported by these individuals. Even among those who joined state-affiliated militias and community security groups for self-defence reasons, perpetration of violence may have adverse and long-term impacts on personal- and community-level relations, thus impacting affiliates' capacity to effectively address conflict. Therefore, it is key to pay special attention to both victims and perpetrators of violence in designing targeted MHPSS interventions in order to prevent further violence and support their transition to civilian life. These interventions must also be gender- and age-sensitive, recognizing the unique vulnerabilities of women, girls, and children formerly associated with armed groups.

- **Conduct further research and monitoring of mental health and psychosocial well-being in the population in a tailored and culturally sensitive way.** While this report identified several relevant risk factors for mental well-being, more remains to be discovered, for instance regarding the specific needs of certain sub-populations (such as former associates). Additionally, the implementation of mental health interventions should be accompanied by regular follow up of their impacts on the population to ensure participants' well-being. Although the various regression models discussed in the findings section show the relevance of conflict experiences and daily stressors, they also suggest that additional factors play a role for the mental health of the population in the North East of Nigeria. While conflict experiences and daily stressors are key risk factors, they do not fully reflect the complex realities on the ground. Thus, more research is needed to explore further risk factors beyond the ones covered in this report. Potential areas for future research and monitoring could include gender differences in psychosocial well-being (including willingness to admit or seek help for mental health problems) or address late onset of mental health challenges faced by children to better understand the specific needs of key demographics. In addition, longitudinal research is recommended to track how daily stressors (e.g., displacement and stigma) and trauma interact over time, and to inform more adaptive, evidence-based interventions. Other avenues for future research should continue to explore the population's programming preferences to ensure effective and successful delivery of MHPSS.

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