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Mental Health Awareness and Access: Challenges for Insurgence Victims in Nigeria Local Communities

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ABSTRACT

This study draws on the fieldwork in fifteen local communities at the early stages of stability from the violent actions of bandits, IPOB and boko-haram insurgence in Nigeria. It adopts an inter-sectional approach to interrogate the embodied experience of victims and their relations on mental health access and the point at which (dis)continuity and contradiction occur due to the social dynamics shaping accessibility barriers. The study finds the differences in the situatedness between men and women on the geographical and financial accessibility to mental health, but also with respect to the acceptability and availability of health services in local communities. Victims rely on their multiple and converging identities to creatively negotiate access to mental health, albeit within an overstretched health system. The socially imposed identity such as 'the weak' for women versus 'the powerful' for men, though constantly contested and mobilized at different point in time, present women with the privileged social positioning to negotiate access to health information and services than men. However, such a social positioning turns out to encamp the privileged women in that it creates a false sense of identity and immobility, which, in and of itself, constitutes barriers to mental health. The study argues that situatedness matters in the analysis of the victims' experience on mental health access in local communities. Overall, it contributes to the empirical and theoretical discussions on the rights to health and wellbeing among the Persons of Concern to the United Nations Commissioner for Victims (UNCHR) in local states.

Keywords: Insurgence, Victims, Mental Health, Awareness, Accessibility, Local Communities

INTRODUCTION

The recent wave of terrorism and political violence globally has re-ignited discussion on the welfare and health needs of insurgence victims (World Health Organization [WHO], 2017; UNHCR, 2015). Particularly, insurgence victims' direct exposure to physical violence, their loss of livelihood, and their separation from relatives have also been found to bring about psychosocial problems, such as stress disorders, depression, and anxiety (Malachi et al., 2022; Mölsä et al., 2017; Simich, Este, & Hamilton, 2010). Victims' mental health therefore becomes a public issue and a challenge for the provision of mental health services in many areas (Duarte-Gómez et al., 2018). However, it appears that Nigeria as a country has failed to develop a robust system that will facilitate access to mental health services that are available, accessible, culturally acceptable, and of good quality to insurgence victims. In response to this, the WHO (2017) has updated existing frameworks on the promotion of mental health to insurgence victims and has reiterated the need for countries to prioritise the mental health needs of

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individuals who have encountered any form of violence. This call is particularly relevant to Nigeria, which has been confronted with violent insurgences in the last decade.

In particular, the emergence of the Bandit and banditry terrorist group in Nigeria has led to high death tolls, fright, and forced displacement - about 2.7 million people have been forcibly impacted, which has led to a huge humanitarian crisis in the country (Mercy Corps, 2017). With the scale of insecurity and fright in the country, it is important to pay attention to how health services are made accessible to insurgence victims. In this paper, the term "insurgence victims" refers to victims and their relations who have been affected by violent activities of insurgences either in their community or when in search of a better life and safety. Many victims of insurgence violence who have lost their loved ones, homes, properties, or sources of livelihood may sought sanctuary in other parts of the country but are not necessarily displaced. (Duarte-Gómez et al., 2018).

Despite the importance of mental health to insurgence victims, there is a dearth of systematic studies on the situated experience of the victims on mental health access in the country. Previous studies have examined mental health situations in the aftermath of the violent conflict with armed opposition groups such as Bandit insurgency and banditry for victims in the IDPs camps (Omole, Welye, & Abimbola, 2015; Bigna, 2016; Awosusi, 2017; Sani et al., 2018; Chukwuma & Ekhator-Mobayode, 2019), the mental health access for victims living within local communities, who are necessary not displaced, has received little or no attention. A study conducted among IDPs in Borno state, Nigeria to assess their mental health burden showed that at least 60% of the Victims reported at least one mental health symptom (Kaiser et al., 2020). Many reports are prevalence of mental health symptoms among IDPs, most mental health studies focus on the general IDP population, neglecting the needs and peculiarities of the victims who do not made it to IDPs but lives in local communities. There is a dearth of research that focuses on the mental health challenges of Victims who live in towns and villages in Nigeria. In addition, an inter-sectional analysis, which highlights how the social dynamics and power relation shaping access to mental health is still missing. Some earlier studies have established there was limited funding supports to improve health services in many conflict-affected communities, especially mental health services in the country (Omole et al., 2015; Dechambenoit, 2016; Chukwuma et al., 2019).

The current study differs from the previous research in two ways: first, it adopts an intersectional approach to interrogate the situated experience of the insurgence victims on mental health access in local communities at the early stages of stability from violent encounter with insurgency terrorist. By doing so, the study aims to provide the nuanced understanding on how the insurgence victims navigate to access mental health in local communities and at which point do (dis)continuity and contradiction occur as a result of the social dynamics and power relations shaping accessibility barriers in the country. Second, the study contributes to the broader debate on accessibility barriers to mental health beyond a single social division, be it ethnicity, religion and nationality, but to include the analysis of the organisation of power shaping access to mental health at the individual level. The findings from this study will inform public mental health policy and programs especially in providing tailored mental health interventions to all victims of insurgence in Nigeria and across the globe.

The current study differs from the previous research in two ways: first, it adopts an inter-sectional approach to interrogate the situated experience of the insurgence victims on mental health access in local communities. Intersectionality lead the study to provide the nuanced understanding on how the insurgence victims navigate to access mental health in local communities and at which point do (dis)continuity and contradiction occur as a result of the social dynamics and power relations shaping accessibility barriers in the country. Second, the study contributes to the broader debate on accessibility barriers to mental health beyond a single social division, be it ethnicity, religion and nationality, but to include the analysis of the

organisation of power shaping access to mental health at the individual level. The findings from this study will inform public mental health policy and programs especially in providing tailored mental health interventions to all victims of insurgence in Nigeria and across the globe.

CONCEPTUAL FRAMEWORK

Complex factors have been found to influence access to health globally. In this study, access to mental health refers to the ability of individuals to access mental related health services (Agbenyo et al., 2017). This includes the possibility of individuals identifying, seeking and using mental health services (Rutherford et al., 2010). Indeed, Penchansky and Thomas's (1981) Theory of Access which provides broad lens to explore mental health access, guided this study. The theory is made up of five closely related components: geographical accessibility, availability, financial accessibility, acceptability and accommodation. To elaborate, geographical accessibility refers to the distance to and the location of mental health services in local communities. Availability here refers to the availability of mental health services, professionals and resources to support individuals seeking mental health. Financial accessibility means the affordability of mental health services and medication and the capacity of individuals to pay for them. Acceptability refers to characteristics of clients that might influence mental health access, including cultural and religious factors, which might influence mental health-seeking behaviour. Accommodation has been explained as the organisation of services to accommodate clients seeking mental health which includes quick response of specialist, hours spent to see a specialist and appropriateness of the infrastructure to the needs of clients.

In Nigeria, existing literature has reported that at every level of Penchansky and Thomas's (1981) Theory of Access, there are barriers encountered by individuals in their efforts to seek mental health. For instance, with respect to geographical accessibility, it has been reported that mental health services are not widely available to many people in communities (Peters et al., 2008; Yao et al., 2013). In most instances, people living in especially rural areas are the most affected, as they must cover long distances and spend more when seeking mental health (Agbenyo et al., 2017). This rural environment are yet prone to insecurity of all kinds Regarding availability, it has been found that many health services do not have the required personnel or resources to discharge mental health duties (Macha et al., 2012; Peters et al., 2008). In some situations, health professionals have preconceived notions regarding or negative attitudes towards patients, which discourages them from seeking mental health (Yao et al., 2013). One major barrier to mental health access consistently mentioned in the literature is poverty and the high cost of mental health services (Macha et al., 2012). In view of this, many victims of insecurity are unable to access mental health and are at high risk of deteriorating conditions. With respect to acceptability, mental health must be delivered in a culturally acceptable way. For instance, mental health-related information must be delivered in a language that is understandable to the displaced population (Peters et al., 2008; Rutherford et al., 2010). While the studies mentioned above have provided insight into areas to improve in efforts to achieve equitable access to mental health, the situation of insurgence victims in terms of equitable access to mental health in local communities in Nigeria remains unreported. Therefore, the study answered the question of how accessible are mental health services to insurgences victims in local communities? And what barriers affect insurgence victims in their efforts to access mental healthcare?

METHODS

This study utilizes qualitative data collected to understand complex social problems of mental health accessibility among insurgence victims in local communities. It used intersectionality as an analytical tool. Using intersectionality as an analytic lens offers an

opportunity to interrogate the complex factors shaping the disparities in mental health access within an overstretched health system such as reported in the Nigeria. Intersectionality can be understood as what it does rather than what it is. By what it does, intersectionality has gained prominent use in the study of social inequality to shed light on the organisation of power influencing the rights of inclusion and exclusion (Anthias, 1998; Lutz, 2001; Lutz, 2015; Collins & Bilge, 2016). Regarding mental health accessibility in local communities, the unit of analysis is not only a single lens of social division, either as gender, nationality, ethnicity or class, but also other differences that are intertwined and mutually constituted by the differences (Lutz, 2015).

Study Participants

The study is an exploratory qualitative design, involving 35 in-depth interviews and 4 focus group discussions (FGDs) on the five components of mental health accessibility. The method was considered suitable to explore in detail the complex factors shaping mental health access among the insurgence victims. Whereas each of FDGs took about 1:00hrs, with an average of 4 participants, the in-depth interview took about 1hr on the average. Due to cultural sensitivity, the FDGs were conducted separately for men and women. The participants (*N*=84) were conveniently selected from eight local communities that have experienced banditry insurgences: Owo (Ondo State), Nafada, Akko and Funakaye (Gombe state), Omala (kogi state), Oke-Ako (Ekiti), and Maru, Kadaddada and Tsafe (Zamfara state). These communities were conveniently selected because they had the largest populations of insurgence victims in specific selected locations in Nigeria.

Table 1: Demographic characteristics of the participants

(N=84)	Frequency	Percentage (%)
Participants		
Direct Victims	21	25
Indirect Victims	54	64
Community health workers	9	11
Gender		
Female	53	63
Male	**31**	37
States		
Ondo	20	24
Ekiti	13	15
Gombe	21	25
Kogi	14	17
Zamfara	16	19
Education		
Primary level	11	13
Secondary level	24	28
University level	21	25
No education	**29**	34
Age		
18–30	13	16
31–40	23	27
41- 50	21	25
51–60	10	12
61–70	12	14

71–90	**5**	6
Religion		
Christian	24	29
Muslim	39	46
Traditionalist	8	10
None	13	15
State	FDG (avg = 4)	Interviews (KII)
Ondo	1(4)	15
Ekiti	1(4)	10
Zamfara	0	14
Kogi	1(4)	8
Gombe	1(4)	21
Participants (*N*)	16	68
	19%	81%

Instrument

The interviews were conducted using semi-structured interview guide, developed from review of literature (Metusela et al., 2017; Mölsä et al., 2017; Shtarkshall et al., 2009). The interview guide addressed the issues of geographical accessibility, availability, accommodation, financial accessibility and acceptability, which might impact on mental health access for insurgence victims. After two pilot interviews were conducted with interpreters to assess the interview schedule, the lack of security and the language barriers were identified as barriers and were added to the interview guide. For example, the shortage of mental health professionals in the communities was discussed during the FGDs and was then elaborated on during the one-on-one interviews with the participants.

Data Collection Procedure

The study was approved by the Center for Research Ethics Committee at Bamidele Olumilua University of Education, Science and Technology, and the participants willingly consented to participate in the study. 3 FGDs made up of an average of four participants were conducted in four of the five selected states. In addition, 68 participants were engaged in face-to-face interviews in the nine communities of the five selected states in Nigeria. Due to the tensed security situation in Zamfara State at the time of data collection, it was difficult to engage participants in focused group discussions. The data was collected by the first author who worked with one local research assistants and an interpreter due to language barrier in the local communities in 2022. The researchers paid visits to traditional authorities of each communities, inform the notable leaders about the study and gave them room to direct their people to volunteer to participate in the study. The copies of the letter of introduction were given to the local community health workers, who led us to the homes of insurgence's victim. They were informed about their right to withdraw from the study at any time without incurring any consequences. The participants were informed of the risk of participating, namely that they could be reminded of traumatic experiences and loss of loved ones. This prepared the participants psychologically, and they then passionately shared their stories. Both the FGDs and the interviews were audio-recorded, they were each about 45 minutes long, and notes were taken to allow for inclusion of emerging issues in the subsequent interviews.

Data Analysis

The FGDs and the interviews were translated and transcribed by interpreters from Fulfulde, Hausa, Yoruba and Pidgin English to English. The translations were cross-checked to ascertain whether the views of the participants had been captured accurately. Thematic

analysis, as suggested by Braun and Clarke (Braun et al., 2006), was followed in the analysis of data collected since the study was guided by a conceptual framework. The method involved five interactive stages: reading, theme coding, identification, organisation and writing the draft. The components of the conceptual framework (geographical accessibility, availability, financial accessibility, accommodation and acceptability) were used as a priority themes. The authors extensively discussed the content of the transcribed texts to identify the core concepts, to which codes phrases were developed and assigned to the data. A coding framework was developed and shared among the authors, who reached consensus on the final content. The coding phrases were developed into categories and were subsequently organised under the priority themes. At this stage, the quotes linked to the codes were extracted from the transcriptions. The last stage was running commentaries through the extracts, which were shared among the authors for suggestions, and a final draft was agreed on by the authors.

RESULTS

Our study findings reveal that insurgence victims in Nigeria faced significant barriers in their efforts to seek mental health. Whereas there had been several barriers to mental health access in some of the communities before due to governance negligence, the situation got worse due to the influx of the bandits and rise in victims which have put much pressure on the limited mental health services in the country. The experience of victims, especially women who are widowed, pregnant and nursing mothers, were quite different from their male counterparts on accessibility to mental emergency services in remote areas. Thus, there were differences in the situatedness between men and women on awareness accessibility, geographical accessibility, financial accessibility, and acceptability of the need for mental health services. At different times and in different occasions, men and women deployed the multiple identities but also overlapping identities such as awareness, religion, ethnicity, gender, and social networks to overcome accessibility barriers. The implications on each component of the mental health accessibility are discussed in detail below.

Mental Health Awareness

The mental health services in the communities and around the community lacked the needed services to provide effective awareness to insurgence victims. In the communities, only few participants discussed the limited awareness/ information of mental health services. Some participants related that the mental health system in the country was unable to satisfy their mental health needs. Some participants particularly expressed discomfort with exposing what was meant to be a privately life issues to the public. Some elaborated that they preferred to talk to a religious leader or close family members because the conditions of mental health care can affect their privacy. “I prefer talking to my sister at home, she’s better than a total stranger because she understands and will never discuss me in the public” (female FDG 2 Oke-Ako, Ekiti). It emerged that mental health services lacked the necessary publicity and health awareness that will encourage victims participate in the process. In fact, community health workers in those communities indicated that the indigenes always denied their need to quality mental health when advised. This, according to some participants, was because of improper understanding of mental health and its benefits. Many do not understand how speaking to a professional could help deal with their pains, fear and cleansing of the mind and so believed they have they had to live with burdens in their heart:

> We only visit health people to treat malaria and typhoid, how can we go and tell them our problems, they didn’t cause it. How will they know what to do since they are not in our shoes? (FGD a male participant in Owo, Ondo)

> My family was once told in our clinic here to go to the city talk to some people, they said I needed it to determine the nature of the problem I complained of, but we don't believe in all that. We went to Alhaji [a spiritualist], who eventually did herbal treatments for me. (male participant from Omala, Kogi)

Two rural community health workers confirmed that there were rarely mental health professionals working at the health services in the surrounding communities. Most times the health professional had to play the role of psychologist even though they are not trained as such. The few available psychologists sometimes had to leave to attend to emergency cases in other communities. This puts the lives of many people at risk, as they have to wait for days to get attended to. This was also a source of frustration for clinic directors, who said they had lost some victims because of the movement of mental health professionals between services:

> All Health professionals don't want to come, not just psychologist, because of the social degraded and insecurity situation. When you go to the hospital, the health workers are very few, and they are always moving from place to place to treat patients. We have tried all means possible to get more specialists here, but we have been unsuccessful. (Community leader, Zamfara)

Religion as a barrier to awareness

The linkage of mental health to spirituality was very controversial, although people with records of higher levels of religious involvement report more favourable arguments of mental health. Many direct and indirect victims justified their decision on their strong belief in God's capability to heal and judge. "Our God is the only one who can comfort us, what can man do than to leave it all in God's hands and we pray to God every day for vengeance" (Female FDG 1, Kogi). Some were also of the opinion that their various religious denominations have been helpful in reinstating their mental health. However, some victims preferred receiving medical attention at the health centres provided the needed personnel and services are adequate. To them, it is highly risked relying on only God to fix their mind, especially when there is opportunity to access such health system. "It does not matter what religious we practice; We also care about the risk of not getting the needed professional attention, we just pray that government provide more of such health system for our community" (KII 23, Ekiti, KII 31, Kogi).

Mental Health Professionals Availability

There were limited health professionals in the communities and communities to care for the participants. In three communities where health services were available, participants mentioned that there was a lack of mental health professionals and resources in those services. Some participants said that the services were there, but there were no mental professionals available to treat insurgence victims. The few health professionals who were available in some of the communities were unable to attend to or treat the insurgence victims whose cases were mental health related. The following quotations summarise the experiences of participants:

> We are dealing with many people, and we can't easily say this is the number of people with mental health challenges. It is already stressful to attend to all the health needs of the community, due to shortage of medical personnel. The greatest challenge is access to mental health specialists that can cater to the people mental health needs, but we will keep trying our best. (Principal Officer, health center 1, Owo, Ondo)

Mental Health Accessibility

Most of the participants mentioned that they were unable to access mental health due to lack of mental health services, equipment, and health professionals in their community. Many

participants mentioned that there was no health facility in their rural communities, thus their inability to access mental health. Some participants also said that the mental health provided to them in the communities were very inadequate and had to rely on services in the neighbouring communities. However, some participants, such as community health workers, mentioned that the services are located far from the community, which makes it difficult for victims to access mental health:

> I have not been myself, people said I should see a doctor, I did but I can hardly sleep without remembering the horrible death of my husband and what they did to me and other women that day on the farm. Now that you've talked of mental health, I am 48 years old, even if I am to try mental health, we don't have the services here, how do I travel for hours (female participant, Akko, Gombe)

Geographical distance as barrier to accessibility

It also emerged that there were transportation challenges for them to travel to other communities to access mental health. Due to the insurgency, commercial transport operators had deserted some of the communities, which, according to some participants, made it difficult for them to travel for mental health services. The victims elaborated that they were scared to leave their home and access mental health in the neighbouring communities. Indeed, some community health workers said that Bandit attacked and killed drivers on the roads, thus making travelling a risky venture. The only means of transport was the military trucks that patrolled the communities. However, the trucks were few and unreliable, as the military had to patrol several communities. Some participants shared their perceptions as follows:

> Sometimes the armed forces help with their vehicles to carry the sick among the victims to the hospital in the neighbouring town, but they are not always there for emergencies. We have witnessed attacks along the Maradun–Magamin Tandu road. So, many would prefer to stay behind, despite the severity of their illness. (Leader of the community, Maru, Zamfara)

> Our people are afraid to travel. When you are sick, you must stay at home and pray that a miracle happens. Everyone lives in fear, because Bandit has recruited people from this community, and we don't know when they are coming back to attack us. (KII 10, Akko, Gombe)

Societal construct as a barrier to mental health accessibility

Women particularly had trouble in facing their fears and believed there are scars they must hide. Some stated traveling some distance to access mental health services is another mental stress on its own. Women noted lost of their husbands and the difficulty to travel a long distance alone while leaving their children who also need parental attention is frown at by the community (FDG 2, Omala, Kogi). The stigma that comes with being a victim (mostly sexually abused victims) and the lack of supports from their spouse and male relatives constituted inability to move freely and has thus constituted geographical barriers to mental health access. Although few other women who needed urgent medical attention were forced by family members to seek for the such assistance in nearest mental health care centres, while the family members support and protect their interest.

> It is difficult to travel some distance to access mental health care. We have to think about how to get there safely. Some of our community members have been sexually abused while trying to do that alone, and it is always difficult to explain this situation to people. How do one tell her husband you were raped and need mental assistance, where do we put our children? (FDG 4, female victims in Nafada, Gombe).

Although both male and female insurgence victims in rural communities could not access health services at their doorsteps, the rural communities leveraged their family members and relations to access support from family members. Whilst women could connect easily to neighbours and shared their health challenges, it was difficult for men to do the same. This is because the society has been constructed in such a way that makes men burden bearer and shouldn't be weak no matter what. "It is always difficult for men to seek for mental health assistance because they may be considered weak. How do you sit and tell people that your wife was sexually abused in your presence or that your kids were killed while you watch helplessly" (Male community health workers 2, Oke-Ako, Ekiti). A male Participant in Akko Gombe recounted that he would rather prefer to relocate and abandon all than admitting to an abuse or acceptance of being a victim to the atrocities of a man like him. (Male participant 2, Akko, Gombe).

Finances as barrier to accessibility

Many participants were dissatisfied the few availabilities of mental health services in the country. For the few communities that have such access, it emerged that the mental health is not free for insurgence victims, and without money, they were not given the necessary attention. Some participants said that they did not have money to pay for transportation and mental health services. They mentioned that they earn low income, and therefore could not raise money to pay for mental health services. Similarly, some community health workers added that people in the communities are poor, and that they struggle to cover the cost of any form of medical care. Some participants shared their experiences as follows:

> I was once very down and decided to reach out through a friend to a mental health professional. My friend said I may have to travel down to Lokoja or pay for the personnel traveling expenses. I got tired and I had to engage a friend who has experience same situation, although the problem is still unresolved. (Omala, Kogi)

> I was given the opportunity of talking to a mental health professional via telephone three times a week, but I can't afford the airtime costs of regular call, as suggested by the professional. My situation has not improved and has affe cted my ability to work. Somethings I just want it all to end. (Nafada, Gombe)

Besides the different experience of mental health access among the insurgence victims living in and out of the camps, men and women also had different levels of financial barriers. Most women have lost their spouse who used to be the breadwinner of their families. So, it was extremely difficult for some women to cope the demands from their children while still nurturing the loss of livelihood from the violent conflicts. "The first thing is to take care of our children, which is already putting some pressure on us. We can hardly afford to pay for medical bills" (Female FDG 4, Tsafe, Zamfara).

Language barrier to mental health accessibility

Some participants mentioned that they had difficulty communicating with health professionals. The health professionals were mostly from other parts of the country to provide health care to the community. It emerged that most of the available few mental health professionals were not indigenes of the community, and as such, they were not proficient in the local dialect. Although community health workers who took part in this study said that the locals were reluctant to communicate with the mental health professionals because the feel their mental challenges is their secret to keep and thus unsafe to share.

> I have encountered many challenges in accessing mental health here. I don't speak English, and most health professionals brought here speak English, we most times look

> for interpreters. How do I then tell them about my secret through others. (Nafada, Gombe)

> It is a small community here, if we must speak to health people through an interpreter, everyone will get to know our story sooner or later. I speak little English but it is easier telling my story in my local language so that I can go deep. (Kadaddada, Zamfara)

Mental Health Acceptability

Participants were asked if they needed permission from other close relatives or partners to access mental health. Mostly all male participants responses were negative but 85% of female participants said they did need permission from close relatives before deciding to access mental health. It emerged that some participants, especially women, had lost their partners, leading them to seeking such approval from distance relatives or keeping to themselves. Some said that they discussed their mental health needs with the community health workers so that they can be helped to access mental health. In addition, four community health workers mentioned that many women did need permission from their husbands to access mental health.

> My husband most know I have a problem and agree to me seeing and talk to other people about it, even my widowed sister will always let me know her problem before sharing with people at the hospital (KII 28, Akko, Gombe)

> My wife has her own problems, and I have my personal problems, I can't burden her with mine, if I need to see a health professional, I will do so without her knowing (KII 8, Oke-Ako, Ekiti)

DISCUSSION

The study reported here adopted Penchansky and Thomas's (1981) Theory of Access to explore the experiences of insurgence victims in their efforts to access mental health. It is apparent that the deplorable living conditions among the people and the lack of health infrastructure in the NIGERIA have affected insurgence victims in exercising their right to mental health services that are available, accessible, acceptable and culturally responsive. However, Social makers (such as religion, language, gender, and ethnicity) and power differentials (embedded in the prevailing cultural norms, i.e. Patriarchy system) created deeply contested social positionings that define the rights and access to health services. The social positionings enabled 'privileged' and 'less privileged' access to mental health between men and women in the study areas. This created different experience among the victims on geographical accessibility, availability and acceptability of health services.

On the one hand, the prevailing social and cultural norms areas across the country prioritized women over men in areas of mental health. This enabled female victims have the privileged access to mental health during an emergency. On the other hand, there was the discontinuity of the privileged position: it was extremely difficult for women to travel some distance alone to access mental health without the fear of being sexually harassed. Even though female victims had preferential mental health treatments, it was never easy for them to move freely and hence, could not access mental health services. Thus, it appears that women had the trouble accessing mental health not only because of the lack of mental health services and an absence of specialised professionals at the doorsteps but also their immobility due to the same privileged positions they derived from the prevailing social and cultural norms.

The finding above confirms the previous studies, which have reported that a lack of health services and an absence of medical specialist affect mental health access of the insurgence victims (Omole et al., 2015; Chukwuma et al., 2019; Awosusi et al., 2019). It also corroborates the earlier research, which have reported women having trouble accessing health

services in volatile communities (Samari, 2017). However, there is the disagreement on how geographical barriers affect access to mental health. Whereas in the previous studies, the impact of geographical barriers has only been reported negative on women mental health access (Awosusi et al., 2019; Dominic, Ogundipe & Ogundipe, 2019; Meyer-Weitz & Akintola, 2017), our study finding indicates that geographical barriers to mental health access created advantageous and disadvantageous positionings among the insurgence victims. Our study confirms the existing study which have reported that mental awareness is a capital that could bridge the disparity in mental health access because it accounts for the systematic interactions between social status and mental health (Awosusi et al., 2019, Samari, 2017).

The insurgence victims who have built enough social networks are likely to be satisfied with the mental health delivery (Meyer-Weitz et al., 2018). In the current study, it appears that victims, especially women, could easily integrated into the local communities because they were considered as 'weaker' than men who have been stereotyped as powerful and should not been seen as weak. As it has previously been reported in Nwogwugwu (2020), the women's social privileged position helped build trust with the rural communities and access the local support networks to overcome some barriers to mental health access. One of the importance of the local support networks is the encouragements and reassurances of healing by past survivors, who were mostly women. The lack of access to health information has previously been reported as a potential source of health disparities (Dominic et al., 2019; Meyer-Weitz et al., 2018). Our study finding indicates the stereotyping of victims had a negative impact on mental health access. It was extremely difficult for them to gain trust from the rural communities, which affected how the local network supports and built the needed avenue to access health information (Samari, 2017; Awosuyi, 2019).

The emergence of Boko Haram, bandits and IPOB insurgencies in Nigeria has been linked to limited economic activity and failure of governments to provide essential services, such as hospitals, to communities (Agbiboa 2017). The prevailing barrier to mental health in the country has compounded the plight of victims. While participants maybe reeling their loses and loved ones due to the insurgency, they appear not to have avenue where their health needs could be addressed. This may compound the vulnerability of participants and possibly, their integration in the communities. Our study findings suggest that victims who in the rural communities could not afford bills for the routine sessions and mental illness. However, those living in more developed environment could afford theraphy session, drug bills for complicated mental health challenges, albeit they were still unable to access the proper mental health services. This finding confirms the previous studies on the situation of the insurgence victims' experiences on mental health access (Dechambenoit, 2016; Samari, 2017; Meyer-Weitz et al., 2018; Dominic et al., 2019). Whereas it was easy for the male victims to engage in economic activities in the rural communities to pay medical bills, it was extremely difficult for the female counterparts, especially the women that automatically assume the role of breadwinners of the family due to an encounter with the insurgents' actions.

The unavailability of mental health professionals was related by participants as being a barrier to mental health access. This finding is partly consistent with previous studies, which have found that a lack of health professionals in communities is a barrier to mental health access in Nigeria (Meyer-Weitz, Asante & Lukobek, 2018; Zihindula et al., 2017; Dechambenoit, 2016; Damari, 2017). In this study, due to insecurity and constant attacks, health professionals had fled communities, leaving only a few, who lacked expertise in some areas. This has put the lives of indigenes and insurgence victims in danger, as they may not get the required medical attention of good quality. Bandit has been on the rampage in the country, which seems to have informed the departure of health professionals. Although they had fled for their lives, their absence has created a lacuna in the health system, as participants were unable to access their services. While Bandit maybe inflicting pain and engaging outright

killing of ordinally citizens (Weeraratne, 2017), it is possible that the absence of mental health professionals could lead to a high death rate and untreatable conditions. This could push individuals to adopt 'crude' and risky method of mental health. As emerged in the study and a previous study, in the absence of proper mental health and professionals, some participants relied on traditional medicine for treatment, which has negative consequences when it is not administered properly (Ramathal & Ngassapa, 2001).

A peculiar finding reported under the component of financial accessibility was the inability of participants to enjoy free mental health. This finding is consistent with previous studies which reported poverty as a barrier to mental health to vulnerable and insurgence victims (Zihindula et al., 2017; Macha et al., 2012; Rutherford et al., 2010).

STUDY LIMITATIONS

The results of the study should be interpreted with extreme caution due to some limitations. Firstly, the study was conducted in fifteen communities in Nigeria, and as such, the findings may not be representative of the views of all the insurgence victims in Nigeria. It is important to state here that there were representatives from all fifteen communities, and the study may therefore provide a snapshot of developments in the country. Secondly, the study was a qualitative study, which did not allow the researchers to include the perceptions of many insurgence victims in the country. The researchers aimed to explore this phenomenon, and the study could serve as the basis for future large-scale research. The study relied on the accounts of insurgence victims, victims' relations and community health workers, with inputs from few health professionals. It is important for future research to explore the perceptions of more mental health professionals regarding their experiences providing mental health to insurgence victims. Despite these limitations, this was the first attempt in terms of empirical research to analyse the accessibility of mental health to insurgence victims in an African setting.

CONCLUSION AND POLICY IMPLICATIONS

This study was situated in Penchansky and Thomas' (1981) Theory of Access, to fill a scholarly gap, through exploration of the situated experience of the insurgent's victims on mental health access in the Nigeria country. It adopted an inter-sectional approach to unravel the everyday experiences of insurgence victims and how the organisation of power engendering the disparities in mental health access between displaced men and women in the country. This study confirmed the findings of previous studies, which found that complex factors influence mental health-seeking behaviour of insurgence victims (Kalengayi et al., 2012; Mengesha et al., 2017; Shtarkshall et al., 2009). Unique findings that emerged from this study are fleeing of mental health professionals from communities, insecurity, which has caused fear among participants, and denial of mental health access because lack of identity documents. It is apparent that there are systemic barriers in Nigeria, as there is an absence of basic services, such as hospitals, in the communities (Mercy Corps, 2017). It is a dilemma for participants, as they have been victimized by insurgents, but they are now unable to access mental health. Although Bandit may be on a killing spree in Nigeria, barriers to mental health could contribute significantly to the death tolls and slow the integration of insurgence victims in the country. Therefore, there is an urgent need for policymakers to work towards addressing barriers to mental health in the country, to enable all participants to access mental health. Particular attention should be paid to the disparities in mental health access between men and women in the Nigeria country, including the gender dynamics of health professionals, the design of accommodation facility and geographical proximity of mental health services. Education for the victims and the rural communities through awareness programmes can help foster local integration, increase social and cultural capital and remove barriers to mental health information.

The findings of this study could have implication for policymaking in terms of ways to improve mental health access to insurgence victims. Due to the complexity of barriers related by participants, a system-wide approach could be adopted by policymakers to promote better mental health for all. For instance, government and international organisations could prioritise the creation of employment opportunities and invest in infrastructure development in Nigeria, to enable indigenes and insurgence victims to enjoy their fundamental right to quality mental health. This approach could prevent Bandits from staging future terrorist attacks in the country, and it could enable people in the Nigeria to enjoy their right to quality mental health. Also, the steady investment in mental health access could be complemented with deployment of mental health professionals to Nigeria. This could enable insurgence victims to receive mental health services from qualified professionals trained to provide mental health. Furthermore, there is the need for governments to reduce, if not total removal of, the cost of mental health services to insurgence victims. In this way, victims would be relieved of financial burden and be empowered to seek mental health when the need arises.

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