



“Watching my family being killed by terrorists made me really depressed”: Mental health experiences, challenges and needed support of young internally displaced persons in northern Nigeria

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ABSTRACT

Background: Over 3.9 million people have been displaced in Nigeria as a result of the over one-decade-long Boko Haram insurgency and about 2.1 million of this population are internally displaced within the country. Young internally displaced persons (IDPs) are at higher risk of mental illness such as depression, anxiety, post-traumatic stress disorder (PTSD) among others, however, there are sparse studies on this population. Therefore, this study explored the mental health experiences, challenges, and needed support for young internally displaced persons in Durumi and New Kuchingoro Internally Displaced Persons Camps in Nigeria.

Methods: This qualitative study was conducted among young IDPs in Durumi and New Kuchingoro IDP camps in Northern Nigeria. Fourteen (14) focus group discussions comprising 89 participants and 30 in-depth interviews with 30 participants were conducted with young IDPs. The interviews were in Hausa and Pidgin English, audio-recorded, transcribed, translated into English, and applied thematic analysis was done using MAXQDA Analytics Pro 2020

Results: A total of 89 participants consisting of 47 males and 42 females participated in the FGDs and IDIs. Five key themes emerged from the FGDs and IDI: (1) knowledge about mental health, (2) mental Health Experiences, (3) coping strategies, (4) availability of mental health and other health Support, and (5) needed support. Young IDPs had fair knowledge about mental healthcare. Participants reported their experience before displacement as being peaceful with members of the family together in a good environment while they experienced stress, trauma, shock, sadness, and symptoms of anxiety, depression, and PTSD during and post displacement. Personal coping strategies such as listening to music, engaging in sports, reading books, farming, and other economic activities were reported by participants. Participants reported the absence of structured and specialized mental health support in the IDP camps and solicited mental health, physical health, economic and educational support. **Conclusion:** Young IDPs had negative experiences that led to symptoms of mental health disorders such as depression, anxiety disorders, PTSD among others with little or no access to quality mental healthcare. Hence, they require specialized and structured mental health support to lead healthy and productive lives. Policy and programs aimed at increasing access to mental health information and services for forced migrants are recommended.

Introduction

Over 3.9 million people have been displaced in Nigeria as a result of the over one decade long Boko Haram insurgency and about 2.1 million of this population are internally displaced within the country (UNHCR,

2021; IOM, 2021). According to the United Nations Guiding Principles on Internal Displacement, Internally Displaced Persons (IDPs) are defined as “persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict,

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situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized state border." The Boko Haram insurgency attacks are rife in Northern Nigeria, with states such as Borno, Yobe, and Adamawa considered to be directly affected by the Boko Haram insurgency attacks (Dunn et al., 2018). Due to these attacks, many of the survivors have fled to neighbouring states for their safety and source of livelihood; they often reside in formal camps, as internally displaced persons (UNHCR, 2021). According to UNHCR (2021), internally displaced persons (IDPs) are persons who have not crossed the border for their safety, they stay within their own country and are under the protection of its government. Several studies have shown that conflicts and violence significantly affect the mental well-being of the victims (Seidi and Jaff, 2019; Charlson et al., 2019; Adesina et al., 2020) as IDPs do not only experience displacement from their ancestral homes, they may also lose source of livelihood, properties, experience physical injuries and loss of loved ones.

Generally, young people have increased risks of acquiring mental health disorders due to environmental stressors and developmental factors (Addington et al., 2018) as 75% of mental illnesses occur before the age of 24 and 50% of mental disorders are established before age 14 (Kessler et al., 2005). Young persons living in IDP camps are even more predisposed to acquiring mental disorders as they not only face the above factors, but also experience the negative effects of the change of environment, loss of loved ones, and other debilitating effects of violence (Vossoughi et al., 2018). A systematic review and meta-analysis conducted by Blackmore et al. (2020) to determine the prevalence of mental illnesses among children and adolescents refugees and asylum seekers in five countries revealed that Post-traumatic Stress Disorder (PTSD), depression, and anxiety disorders were common occurrence in this population. A study conducted among IDPs in Borno state, Nigeria to assess their mental health burden showed that at least 60% of the IDPs reported at least one mental health symptom (Kaiser et al., 2020). Despite the reported prevalence of mental health symptoms among IDPs, most mental health studies focus on the general IDP population, neglecting the specific needs and peculiarities of the young IDPs as there is a dearth of research that focuses on the mental health challenges of young IDPs in Nigeria.

While the few available mental health studies conducted in internally displaced persons' camps are mostly quantitative (Sheikh et al., 2014), our research takes a qualitative approach. Our study explored young IDPs' mental health experiences, psychosocial support, and challenges in accessing mental healthcare. The findings from this study will inform public mental health policy and programs especially in providing tailored mental health interventions to young IDPs in Nigeria and across the globe.

Methodology

Study design

This study utilizes qualitative data collected as part of a cross-sectional study conducted by researchers from Slum and Rural Health Initiative under a funded grant from the Global Challenges Canada and their Global Mental Health partners to investigate the mental health experiences and availability of mental health and psychosocial support services of young persons in two Internally Displaced Persons camps in Abuja. Qualitative interviews were conducted among young persons residing in two IDP camps in Abuja. This data was collected between June 1, 2021 and June 30, 2021. Structured interview guides were developed by a team of expert researchers at Slum and Rural Health Initiative to explore the mental health experiences and the need for mental health support in IDP camps in Abuja.

Study setting

Our study was conducted in two communities in Abuja, North Central, Nigeria; the Durumi IDP camp and the New Kuchingoro IDP camp which were chosen via simple random sampling. These camps were established in 2014, after people living in the Northeastern part of Nigeria, fled their villages and hometowns due to the incessant Boko Haram insurgency attacks. The majority of these persons flew to Abuja, one of the biggest cities in North Central, Nigeria, and the political capital of the country.

The Durumi IDP camp is located in Durumi District, Area 1, Abuja Municipal Area Council. This camp has an estimated population of about 4,500 internally displaced persons who have been living there since 2014, and do not have hope of returning to their hometowns and villages any time soon. This camp is reported to be the largest IDP camp in Abuja. Residents in this camp are majorly from Borno states, with some other inhabitants from Adamawa and Yobe. Children and youths (0 - 24 years) make up about half of this population (Mohammed, 2017). These people are predominantly Muslims and speak the Hausa language majorly. Some other languages spoken in this community include Pidgin English, Fulfude, and English.

Also, the New Kuchingoro IDP camp is located at New Kuchingoro, Lugbe Division, Games Village, AMAC Local Government Area, Abuja. This camp has an estimated population of about 2,700 internally displaced persons. About half of this population are children and young people aged 0 - 24 years. Residents in this camp are majorly from Adamawa and Yobe States, are predominantly Christians and speak Pidgin English language majorly. Some other languages spoken in this community include Glavda, Pidgin English, and Hausa.

Study participants and recruitment

This study applied a purposive sampling technique to recruit participants. Young internally displaced persons in the IDP camps were approached, and the aims and objectives of our study were explained to them. The eligibility criteria were young people aged 13-24 years and who could communicate effectively in the major local languages: Hausa and or Pidgin English Language.

Participants for the In-Depth Interviews (IDIs) were selected from the earlier conducted FGDs. This was done by identifying participants from the FGDs who seem to have more information to offer the research assistants.

Data collection procedure

Data was collected from participants through Focus Group Discussions (FGDs) and In-Depth Interview (IDIs). In-depth interviews (IDIs) were conducted after the Focus Group Discussions (FGDs) to provide an opportunity to elicit more information from participants who were outspoken and those who were quite reserved. Also, we took into cognisance the fact that the discussion of mental health is a sensitive topic, and certain participants would prefer a one-on-one interview to a group discussion. Prior to data collection, structured interview guides were developed by mental health experts, translated into the local languages (Hausa and Pidgin English), and tested for clarity to ensure they elicited the right response. The same interview guide was used for both FGDs and IDIs. Afterward, field researchers underwent a 3-day intensive research training program in Abuja on qualitative data methods and collection.

For the focus group discussions (FGDs), we conducted 14 FGDs across the two IDP camps, with each focus group consisting of at least 6 participants. We ensured a gender balance, as each FGD group had a male-female ratio of approximately 50:50. The participants for the FGD were divided into three groups based on their ages which included; 13-16 years, 17-20 years, and 21-24 years. The FGDs were led by a moderator (trained researcher) who was assisted by two other

researchers (note taker and timekeeper). Each FGD lasted for about 45–90 min. Interviews were conducted using a structured interview guide, and probes were also used to facilitate discussion among the participants. Also, a tape recorder was used to record the discussions from participants, with their permission, which was transcribed verbatim in the local language before being translated into the English language by professional translators.

Also, 30 In-Depth Interviews(IDIs) were conducted from the different categories earlier described using the IDI guide. A tape recorder was used to record the discussions from the participants with their permission. The In-Depth Interviews lasted about 40 min to 75 min. The IDI guide had probes to further explore participants’ opinions about the specific issues. The recordings were transcribed directly into the local language and later translated into English by professionals.

Data analysis

After completion of the field data collection phase, recordings from the FGDs and IDIs were transcribed into the local language (Hausa and Pidgins) and afterward, translated into the English language. The interview transcripts were then sorted and grouped based on the mode of the interview which consisted of 14 Focus Group Discussions and 30 In-Depth Interviews among participants in different age groups. Also, the interview topic guide provided an early framework for the development of a codebook. The code system with 20 codes was developed using the themes developed.

Thematic analysis of the interview transcripts was conducted using a qualitative data analysis computer software package MAXQDA Analytics Pro 2020 (software program designed for computer-assisted qualitative and mixed methods data, text, and multimedia analysis in academic, scientific, and business institutions. It is developed and distributed by VERBI Software based in Berlin, Germany). This was done by reading through textual data, identifying themes in the data, coding those themes, and then interpreting the structure and content of the themes as explained by Guest et al. (2011). The transcripts were imported into the document system of the software. Data analysis involved an inductive and cyclical approach of closely reading and rereading each transcript, identifying patterns that emerged, coding the data with labels, and generating themes and sub-themes (Table 1). Finally, at the mapping and interpretation stage, the key contents were identified across and within the data and made preliminary explanations of associations with the data. Relevant data extracts were used to demonstrate key findings.

Ethical approval

Ethical approval was obtained from the Federal Capital Territory Health Research and Ethics Committee, Abuja with code no (FHREC/2021/01/04/18-01-21). In addition, we also met and sensitized the community stakeholders of both Durumi and New Kuchingoro IDP camp on the purpose of our study/intervention, and received approval from

Table 1
Themes and subthemes.

Theme	Sub-Themes
Knowledge about mental health	Knowledge about mental health disorders Knowledge about mental healthcare
Mental Health Experiences	Before displacement During Displacement At the IDP camp
Coping strategies	Personal Social/Group/Interpersonal Economic
Availability of Health Support	Non-Governmental Organization Religious Government
Needed support	

the community leaders. Afterward, we identified potential participants who met our eligibility criteria and explained our study aims and objectives for them to make an informed decision about participating in the study. Participants were assured of utmost confidentiality and informed consent was obtained from all participants before the commencement of the interviews. For participants aged 13–17 years, assent was obtained from their parents and/or guardians. In addition, caution was also taken when discussions became sensitive for members, as our researchers, who were trained mental health experts, offered counseling and support services for such participants.

Results

Characteristics of study participants

A total of 89 participants participated in the FGDs sessions, consisting of 47 males and 42 females. On the other hand, a total of 60 participants participated in the IDIs sessions. Majority of the participants had at least completed the Basic Primary School Certificate, were either Muslims or Christians and few of them were married (Table 2).

Knowledge about mental health

Knowledge about mental health disorders

Some interviewed participants had poor knowledge about mental health and mental health disorders. When asked about mental health, they could not give any clear definition or description. These young IDPs could not also associate the signs and symptoms of some specific mental health disorders such as anxiety disorders and depression. Some participants even confused physical health with mental health.

“Like physical health, mental health is like your head is painning you. Then you drink medicine and rest, and you will sleep for like three minutes to four minutes before you feel alright and the pain will go”

IDI 2, 13–16 years

However, a few participants associated mental health disorders as an illness being caused solely by violence, conflicts, and terrorism as many of them have experienced traumatic situations such as loss of loved ones, properties, and means of livelihood.

“Witnessing your brother getting killed can cause mental health disorder. Just like the Chibok girls incident, some of them were buried alive, and witnessing such can cause one to have mental health disorder”

FGD 5, 13–16 years.

Table 2
Socio-demographic Characteristics of study participants.

Socio-demographic characteristics	Number (n=89)	Frequency (%)
Gender		
Male	47	52.8
female	42	48.2
Age (years)		
13-16	33	37.1
17-20	24	27.0
21-24	32	35.9
Education		
Primary	42	47.2
Secondary	27	30.3
Tertiary	9	10.1
No formal education	11	12.4
Religion		
Christianity	31	34.8
Islam	38	42.7
Traditional	12	13.5
Others	8	9.0
Marital status		
Single	63	70.8
Married	26	29.2

Knowledge about mental healthcare

Young IDPs had fair knowledge about mental healthcare. While some interviewed participants had poor knowledge on mental healthcare, some had good knowledge as they described the social, spiritual and medical aspects of mental healthcare.

"I don't know ohhh ...maybe mental illness can be treated by stopping too much thinking."

FGD 9, 17–20 years

"It is just to forget about the thoughts that come to our mind and put efforts in encouraging one another to remember that what happened to us is permissible by God."

FGD 12, 17–20 years

The major care for mental illness mentioned by some participants across FGDs and IDIs was spiritual care. A few participants noted that mental healthcare requires the combination of medical and spiritual intervention.

"They can support themselves through prayers. According to my understanding they can be supported through education. They can be visited and taken to the hospital. the way that we can treat this mental health, at least we have to go to the health facilities in order for us to have treatment"

FGD 5, 13–16 years

Few participants reported that improved socio-economic status can also ensure good mental health. They reported that surviving family members and relatives lost their source of income and stated that this could negatively impact their mental health.

"Mental health can be restored if the financial needs are met and they are able to cater for the family and also put their children in school, seeing that they have no worries and everything is going fine with the children will give them peace of mind and they will not easily think of the past."

FGD 14, 13–16 years

Mental health experience

Before displacement

Young IDPs described their experience before displacement as peaceful with members of the family together in a good environment. They described having occasional family, community and social events which were usually fun and full of laughter and joy.

"You will constantly have thoughts because you had to flee from home and staying here is not completely peaceful like when you were in your hometown and all those thoughts can cause mental health disorder."

FGD 14, 13–16 years

"I truly am always thinking of home and when I was at home I had joy but presently there is no joy here in this rough environment."

FGD 4, 21–24 years

Most of the interviewed young forced migrants described a feeling of happiness attending school and religious centers in their previous community. Few participants also expressed the feeling of joy and satisfaction in engaging in menial jobs and trade to support their families.

"I used to think about what I left in my village because I used to hustle (do menial jobs) for myself and I used to do something good for my family and since I left my village everything has gone down so I always think about this and it is going to affect my mind"

FGD 4, 21–24 years.

During displacement

Majority of the interviewed young IDPs experienced trauma, shock and sadness as they witnessed the killing of their loved ones and destruction of their properties during their displacement from their ancestral homes.

"Some could have the mental health disorder especially us from Gwoza (in Borno State), some witnessed their houses being burnt after they were dragged out, and some were watching while their father, brother or younger one was killed. So you see, it is a must for an individual to get a mental health disorder and think too much."

IDI 18, 13–16 years

"They have killed our mothers and fathers. Leaving our villages to come here is not easy, they have killed our people, we had to run a long distance for three days before finding a place to hide".

FGD 9, 17–20 years

Participants described how they were forced to flee their homes. However, while seeking asylum and fleeing to save their lives, all of them found it uneasy that some got injured, few mentioned they had no food or water to sustain them and were exhausted and stressed from long hours or days of walking and running to a place of safety in another town or state.

One of the participants reported;

"... I had to walk barefoot for days during the time of war (the Boko Haram insurgency) and getting fatigued or exhausted from walking can cause a variety of diseases that are unknown and even depression and anxiety"

FGD 5, 13–16 years.

Young forced migrants also experienced anxiety and stress during this period. They were nervous, restless, tense and sleep-deprived for several days before they finally found a place to settle down.

"I have always been in a state of anxiety since we came here. During the war in my hometown, I fled long distances from Nigeria to Cameroon because of Boko Haram, and when I remembered that my mother was in the hands of Boko Haram, I used to think so much that I could not sleep. It was after two years that soldiers saved her from their hands. As a result of that, I was diagnosed with diseases such as high blood pressure, fibroids, ulcers and so on".

IDI 30, 20–24 years

An FGD participant described how he was anxious and terrified when he was kidnapped and wounded by the Boko Haram sect members while fleeing from his hometown before he managed to escape.

"I was kidnapped by Boko Haram when I was on my way to Abuja in 2015, I got wounded by a Boko Haram member.. they also killed my mom and my sister"

FGD 13, 21–24 years

After displacement (At the IDP camps)

Majority of the participants described their experiences with current events that sometimes trigger memories which made them frightened and on guard for danger. These participants discussed the symptoms they experience such as flashbacks, agitation, irritability, hypervigilance, hostility, faster heartbeats, among others.

Some participants had this to say:

"As for me, anywhere a fight is taking place reminds me of the past events and the things I left behind, my chest hurts and my heart beats faster."

FGD 14, 13–16 years

Yes, as long as I think a lot, I sit and begin to reminisce about what I experienced... You are standing there at the scene while your brother is killed; it can disturb you to the point of you dying.

FGD 11, 21–23 years

"you regularly think about things that are not reasonable enough, maybe on something, like for example, our siblings at home were killed and we always think of that and that can make us go crazy"

FGD 10, 21–24 years

Some of the young IDPs experienced grief due to the loss of their loved ones during the Boko Haram crisis. They associated this with their poor mental health status.

"...most of us here are suffering from mental illness because our parents or siblings were killed in our presence."

IDI 22, 13–16 years

"Due to the war we experienced, and fleeing we had to do, as well as watching my family being killed by terrorists made me depressed to the point of having high blood pressure."

IDI 14, 20–24 years

Some of the interviewed young IDPs reported feeling sad, loss of interest, sadness, excessive crying, which are symptoms associated with depression. Furthermore, they occasionally experience prolonged

sadness especially when they remember the horrific deaths of their family and friends. Few participants were the sole survivors in their families which have deprived them of social support and negatively impacted their mental health.

“Especially how they came and killed our people, like my own family were killed and some that lost their loved ones also had mental health disorder and some are depressed. Some had to flee rather than get killed and that alone can cause mental health disorder.”

FGD 13, 21–24 years

“I would say, for instance, my father’s family only has one survivor and that is my father’s younger sister. As the only survivor, she is always traumatized by the thoughts of the past, about her sad experiences. Despite her very young age, she is always thinking beyond her mental capacity because she lost her father and all her younger ones.”

IDI 14, 21–24 years

Symptoms of anxiety disorders such as anxiety, constant worrying, trembling, restlessness, trouble concentrating, feeling nervous or tense, panic and increased heart rate were reported by the FGD participants and IDI participants. Furthermore, some participants said that the sapping state of their current rough and untidy environment significantly contributes to their poor mental health status as they are deprived of the basic comfort they need. The lack of security in the IDP camps further heightens their anxiety. For instance, one respondent reported feeling anxious when security operatives were shooting in the air thinking they were thieves, bandits, kidnappers terrorists.

“Yes, it is still scary to live here, because where we are now is a desert and our rooms are made of tarpaulin. We are usually scared to hear that the guards from the game village are firing guns for security and that scares us.”

IDI 30, 20–24 years

A few interviewed young forced migrants also described the mental health experience of other surviving elderly community members which included sadness, depression, insomnia and grief of other community members as a result of their traumatic experiences.

“I lost my father and siblings and that made my grandmother cry all the time.”

IDI 23, 13–16 years

Coping strategy and internal support system

Personal

Participants talked about different ways of coping with the situation around them, in a personal attempt to find a way to cope with what happened to them, participants said they try not to think about the whole situation and the past, while other personal coping strategies mentioned by some of them include listening to music, playing musical instruments, reading books. However, few participants could not identify any coping strategies.

“...by the time I begin to feel or listen to music, it takes away that painful memory...I am the kind of person that reads books, by the time I read books that comfort me or I get whatever information that I want from it, it will begin to calm me.”

IDI 3, 13–16 years

Some participants reported that they avoided staying alone, some young internally displaced persons blame the Boko Haram terrorist group for their current state as a coping mechanism.

“I move on with my life by blaming the people responsible for this war and insurgency or blaming the government for not protecting us.”

IDI 30, 20–24 years

Many of them pray and involve themselves in religious activities as coping strategies. They stated that there were religious centers around them which they regularly attended for spiritual guidance and support.

“.... you can help yourself by praying to God because with God everything is possible”.

FGD 9, 17–20 years

Young IDPs tend to focus their energy and spend the bulk of their time on activities with financial gains such as farming, sewing, bead

making, shoemaking among others instead of idling and thinking about the traumatic experiences they have had. Some participants also engaged in farming and learning entrepreneurship skills as a means to stay mentally healthy. Attending school was reported as one of the coping strategies by some participants.

Participants reported;

“If we are asked what we do for ourselves, I can beat my chest to say it is farming. We have walked far distances like Nasarawa state just to farm. I also use my handwork to support myself through sewing and bead making”

FGD 4, 21–24 years

Family and social support

Some of the forced Migrants have lost their immediate families due to the insurgency, they, however, found support from social interactions with fellow forced migrants. They engaged in an interpersonal coping strategy. They looked out for themselves, they took care of themselves by taking any sick person to the hospital, providing the person with food, accommodation, and clothing, counseling the individual, and support in any other means possible. Some young IDPs also engaged in sporting activities and games with other young people living in the IDP camps. Participants also reported having found support through attending social and religious gatherings in the IDP camps.

A participant also reported:

“...brothers and sisters can bring any amount and we join them together and take the person to the hospital and if it isn’t enough then we look for an alternative to help the situation at hand”

FGD 10, 21–24 years

Availability of mental health and other health support

Generally, interviewed young IDPs stated that they had not received any specialized and structured mental health support. However, they reported receiving community mental health sensitization from few organizations such as Slum and Rural Health Initiative.

“...no one came here to talk to us about mental health or supported us mentally, except you (Slum and Rural Health Initiative)”

IDI 19, 20–24 years

FGD participants and IDI participants reported receiving other forms of health support by non-governmental organizations and religious bodies which were usually one-day programs, one-off events and short term.

Non-governmental organization

Most of the physical health support according to them was from non-governmental organizations as well as support from a few religious institutions. Several supports were provided which included physical health support, economic empowerment, and vocational training. The physical health support provided to them included the provision of medications, food provision, water through boreholes, the building of a pharmacy store but few also mentioned supply of facemasks, sanitary pad and gloves, enrollment of children in schools, financial support, and economic support involving entrepreneurial skill acquisition training such as shoemaking and tailoring. However, no participant reported receiving any mental health support from either the government or any organization.

Participants reported that:

As for me I witnessed those that brought us food and also clothing. The support that I prefer most is the support through skill acquisition training we received. There are those that will come with food and it gets to finish but if we can get support in skill acquisition it will be preferable”

FGD 4, 21–24 years

Religious

Also, the religious institutions were also able to help with some relief materials. Many of these programs were focused on physical health

outreaches which involved free medications, medical health professionals and water supply. Many of these programs also involved feeding IDPs. Some religious institutions gave educational support through the provision of educational materials, the building of a primary school and the supply of volunteer teachers.

A participant had this to say:

“It has helped me a lot, especially those who come from the church. They advise us to calm down because this thing has happened to people in the past and by the power of God, it has passed. We didn't know about running water except for the river, but we were given water to drink, I was very impressed.”

IDI 30, 20–24 years

Needed Support

Mental health support

Some of the participants and participants reported that they needed mental health support both for themselves and their children. Some participants also reported that they needed a periodic mental health screening to identify those with mental health disorders and effectively treat and manage such conditions for a more productive and healthy life. Some participants also mentioned the need for mental health educational programs to further enlighten young people about mental health. A few participants also expressed their need for an expert psychologist at the camp for regular mental health screening and counseling for the IDPs. Participants and participants stated that they needed rehabilitation especially for those with severe mental disorders and that necessary assistance should be provided to such persons as may be required.

“Just like the government is supporting the rehabilitation of former Boko Haram members, we also need such support to help people who are in distress by giving them advice and all the necessities they need for the sake of others because some have mental health conditions and high blood pressure already.”

IDI 30, 20–24 years

“We need, let me say, an organization that will come and teach those with mental health disorder on control measures and have a constant check session and screening for them as well as those who are yet to be affected by mental health disorder on how to stay mentally healthy.”

IDI 1, 17–20 years

“What we really want is to have mental stability and no problem, and we want to go to school. A mental health specialist should be provided so as to always check on those with mental disorders”

FGD 12, 17–20 years

Economic support

Most of the participants and participants reported that they needed economic support especially through the provision of jobs to address the rate of unemployment among young persons living in the IDP camps especially for the graduates. Some participants decried the rate of stealing and other crimes which they attributed to the high unemployment rate at the IDP camps. Some participants also stated that they needed financial empowerment such as start-up capital to gainfully engage the skills they have acquired through various skills acquisition programs and to establish small-scale businesses that will cater to their needs and that of their immediate family members. As the practice of early marriage is still common in Northern Nigeria and among internally displaced persons, some participants stated that they needed financial assistance to support their children's education and pay for other charges.

“We are suffering here that you will be suffering there but if they can support us, especially Non-Governmental Organizations (NGO), we are talking about, if they can support and empower our youth and provide them with something good, especially, there are some whose education has stopped, their school, they have stopped along the process here, so if they can take those our youths and especially our graduates, there are graduates here that are idle. Okay, if they, especially if you empower a graduate, he can support

the remaining ones. And all this type of support can help.”

FGD 4, 21–24 years

“What we want is work to do like tailoring and also to learn different types of skills so that we can be able to cater for ourselves and also for others; and for us to trade that for money. Secondly, a lot of people are idle in this place with nothing to do, so we need jobs to do. Not having what to do is what prompts some people to steal and it is not that they don't have the ability to do other businesses, that is why we need support through skill acquisition programs here and other forms of support.”

FGD 14, 13–16 years

Other support

Some of the participants, when asked about the support they needed in the camp mentioned, the provision of food and shelter, enrollment or improvement of existing schools, and increased the number of teachers in the school. Some participants stated that they needed support in returning back to their ancestral homes. Some other participants mentioned that they needed support through the supply of various medications and drugs to aid their wellbeing. Some participants also mentioned that they needed vocational training in order to enhance their economic status. However, a few participants needed educational support through the payment of school fees.

“We need good accommodation with good food, our body has become tough due to lack of care, and if only we can get back to our houses we will be fine.”

IDI 5, 13–16 years

“We need food, medication, borehole is not enough, toilets too are not enough with clothing too; we need our children to get education, all those are our problems. Some groups came and did their best but there are still shortages in the camp, and we learnt skills but there is no capital to start, I can bake cake.”

FGD 13, 21–24 years

Discussion

Our study explored the mental health experiences, coping strategies, and needed psychological support among young IDPs. It is not surprising that the majority of the participants in our study have experienced at least one mental health symptom ranging from anxiety, sadness, worry, and symptoms of PTSD following displacement from their homes. This tallies with observations from previous studies where mental health symptoms are reportedly prevalent among refugees, asylum seekers, migrants, and IDPs globally (Na et al., 2016; Kaiser et al., 2018; Blackmore et al., 2020; Charlson et al., 2019; Adesina et al., 2020). Major risk factors for poor mental health among participants in this study were attributed to the experience of watching their loved ones killed, the destruction of their lands and properties, and physical injuries sustained during displacement. This is similar to a report from a study conducted among IDPs in Kaduna, North Eastern Nigeria, where the chances of having PTSD was reported to be 3.7 times higher among individuals who had witnessed the killings of a relative (Sheikh et al., 2014). Also, Okeke-Ihejirika et al. (2020) noted that physical injuries sustained by persons while fleeing from their communities to seek safety in neighbouring communities, affected the mental well-being of IDPs.

Some of the participants in our study were able to describe mental health and mental disorders. This is in contrast to previous research where vulnerable population groups such as IDPs, refugees, and asylum seekers have little or no knowledge about mental health and mental disorders (Goodkind et al., 2014; Siewa et al., 2014; Wei et al., 2016; May et al., 2014). This knowledge about mental health and mental disorders may have been made possible by the mental health awareness programs held occasionally in the community by volunteers from non-governmental organizations. Despite the knowledge about mental health and mental disorders among this population, most of them could not access medical and professional help, as this was reportedly not

available.

The common coping strategies utilized by participants included dependency on family and social ties for support, involvement in religious activities, and provision of financial support. Coping strategies as defined by Geuken (2013) are ways by which individuals deal with anticipated or actual problems. It is also worthy of note that many participants in this study utilized positive coping strategies. Similar studies conducted among persons in conflict-affected situations showed that involvement in religious activity and dependency on social networks were common positive coping mechanisms, which has been associated with good mental health outcomes (Sousa, 2013; Seguin and Roberts, 2017; Saxon et al., 2017; Collado, 2020; Samuel and Ezeah, 2020). In contrast, some studies have shown that migrants, refugees, asylum seekers and IDP engage in negative coping mechanism, such as alcohol and substance abuse, which further worsened their mental health outcomes (Weaver and Roberts, 2010; Ezard, 2012; Roberts et al., 2014). The predominance of positive coping strategies among participants in our study may be attributed to their religious and cultural beliefs, which may have forbidden alcohol usage.

Mental health disorders due to internal displacement can persist for decades, even after the conflict has been resolved (Daoud et al., 2012; Flink et al., 2013; Makhshvili et al., 2014; Comtesse et al., 2019). This emphasizes the need for regular and available mental healthcare information and services for young IDPs (Ekezie et al., 2020). Participants in our study were not only able to recognize their mental health symptoms, but also identified the need for mental health services. These services highlighted were the provision of mental educational programs, periodic mental health screening, and the availability of a mental health professional within their community. Participants also highlighted economic support as some of the mental health services they had received from non-governmental organizations. This was also reported in studies conducted among IDPs in Africa and Syria where economic empowerment and entrepreneurial skills training were a part of mental health services (Amodu et al., 2020; Falb et al., 2020). According to UNICEF (2021), mental health and psychosocial support (MHPSS) is essential for improving the well-being of adolescents and young persons in emergencies. The Inter-Agency Standing Committee (IASC) guideline pyramid for MHPSS in humanitarian emergencies recognizes specialized services at the apex of the pyramid (IASC, 2007). A systematic review of mental health interventions available for IDPs showed that the majority of these interventions were not youth-specific and have also not been carried out in Nigeria (Uphoff et al., 2020).

Policy and programmes recommendations

Conflicts and displacement impact the mental health of young people living in internally displaced person camps through multiple pathways and further expose them to other health risks. Having recognized that in Nigeria, IDPs are amongst the most vulnerable populations for obvious reasons, this research provides an insight into the psychological problems of internally displaced persons, which are generally ignored while researching this vulnerable population. From the findings of this study, we have the following five recommendations:

First, Government, funding agencies, international organizations and NGOs should fund and/or implement research and advocacy projects that are aimed at providing accessible mental health services to young persons in IDP camps

Second, there is a need for holistic and supportive mental health policies and programs to help IDPs cope with displacement challenges. A more concerted effort toward mental health promotion of IDP is required. Mental health policies and strategies must be context-specific and involve youth in all aspects of the formulation

Also, the government should identify key health problems including mental health issues faced by IDPs, and formulate/revise national policies, strategies and plans to improve the mental health and wellbeing of IDPs (especially young IDPs) by initiating international collaboration,

dialogues with host states to improve the health protection and promotion of IDPs.

While there is a visibly large number of IDPs in Nigeria scattered across various states arising from a multiplicity of causes, there is no reliable database providing a comprehensive profile of IDPs in Nigeria. It is of utmost importance that an accurate database of IDPs in Nigeria should be created for effective planning purposes.

In addition, Mental health information and services should be made available in local languages and implemented by trained community mental health champions (lay-persons) to ensure constant availability of mental health services in IDP camps.

Strengths and limitations

Our study focused on young IDPs living in Nigeria. This is a vulnerable group living in a humanitarian crisis in a low-resource setting. Hence, our focus on this hard-to-reach population presents a unique strength for this study. Our study is also the first-of-its-kind to use a qualitative approach to explore the mental health experiences, coping strategies, and mental health needs of young IDPs in Nigeria. The large sample size of this study also bolsters our evidence. A limitation is that our study used qualitative methods with a specific population group in Nigeria which limits its generalisability, but we hope that the finding are useful for work with young IDPs in other settings."

Conclusion

Young IDPs had negative experiences that led to symptoms of mental health disorders such as depression, anxiety disorders, PTSD among others with little or no access to quality mental healthcare. Available mental health information and services are usually one-time services and are delivered by volunteers and individuals from non-governmental organizations, religious institutions etc. Furthermore, mental health tertiary centers are distant and expensive and cannot cater for the high rates of mental disorders among young persons in IDP camps. Hence, they require specialized and structured mental health support to lead healthy and productive lives. It is therefore imperative that a community-led and community participatory approach should be used in ensuring the availability and accessibility of mental health information and services to young persons in IDP communities. Policy and programs aimed at increasing access to mental health information and services through family and community support for forced migrants in humanitarian settings are recommended.

Authors' contributions

IIO and MAA conceptualized and designed the study. IIO, MAA, RIO was involved in the data collection and the implementation of the study on the field. MAA, RIO, IIO, and TAA were involved in the data analysis. All authors were involved in the writing of the manuscript draft. All authors also read and approved the final manuscript.

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Availability of data and materials

The datasets used for this study are available from the corresponding author on reasonable request.

Declaration of Competing Interest

The authors declare that they have no competing interests.

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