



JOURNAL OF COMMUNITY MEDICINE AND PRIMARY HEALTH CARE

ORIGINAL ARTICLE

COMMUNITY-BASED SUPPORTS AND HEALTH OUTCOMES OF INTERNALLY DISPLACED CHILDREN IN BANDITRY-AFFECTED COMMUNITIES OF SOKOTO STATE, NIGERIA

Tarah UA,¹ Yunusa U.²

¹ Department of Nursing Services, Usman Danfodiyo University Teaching Hospital, Sokoto, Nigeria.

²Department of Nursing Sciences, Bayero University, Kano, Nigeria.

KEYWORDS

Banditry,

Caregivers,

Community-Based
Support,

Health Outcomes,

Internally Displaced
Children,

Nigeria.

ABSTRACT

Background Banditry-related insecurity in north-western Nigeria has resulted in widespread internal displacement, exposing children to malnutrition, communicable diseases, poor sanitation, psychological distress, and limited access to healthcare. This study explored caregivers' perspectives on community-based supports and health outcomes of internally displaced children in banditry-affected communities of Sokoto State, Nigeria.

Methods: A qualitative descriptive phenomenological study was conducted among caregivers of internally displaced children residing in five internally displaced persons (IDP) camps in Sokoto State between March and April 2023. Participants were purposively recruited, and in-depth semi-structured interviews were conducted until data saturation was achieved (n = 11). Interviews were audio-recorded, transcribed verbatim, translated where necessary, and analyzed inductively using Braun and Clarke's thematic analysis with NVivo 12. Trustworthiness was ensured through member checking, peer debriefing, reflexive journaling, and independent coding. Ethical approval was obtained for the study.

Results: Participants were female caregivers aged 18–51 years, most with little or no formal education. Four themes emerged: absence of structured community-based health programmes; severe resource constraints affecting child health; informal community coping and resilience; and priority needs for sustainable interventions. Caregivers relied on communal sanitation, mutual aid, food sharing, and spiritual coping; however, persistent shortages of food, water, sanitation, shelter, and healthcare services adversely affected child health outcomes.

Conclusion: Internally displaced children in banditry-affected communities face substantial health challenges compounded by inadequate community-based support systems. Strengthening sustainable, well-resourced community-based interventions integrated with formal healthcare services is essential to improve child health outcomes in displacement settings.

Correspondence to:
Usamatu Abubakar Tarah
usamatarah@gmail.com

Article History:

Date received:28/04/2026

Date accepted:30/06/2026

Date Published:01/08/2026

INTRODUCTION

Internal displacement remains a major humanitarian and public health challenge, particularly in conflict-affected low- and middle-income countries. In Nigeria, persistent banditry and armed violence in the north-west have displaced thousands of households, creating growing populations of internally displaced persons (IDPs), among whom children are especially vulnerable. Internally displaced children (IDCs) face heightened risks of malnutrition, communicable diseases, poor sanitation, psychological distress and inadequate access to essential healthcare, all of which threaten survival, growth and long-term development.^{3,5}

The health risks faced by displaced children are often worsened by overcrowded living conditions, food insecurity and inadequate water and sanitation facilities common in many IDP camps. These conditions increase exposure to preventable illnesses and further compromise child wellbeing. Studies have shown that conflict and displacement can worsen child morbidity and mortality, particularly where access to health services is limited.^{5,8}

In Nigeria, humanitarian responses to displacement are coordinated through agencies such as the National Emergency Management Agency (NEMA), State Emergency Management Agencies (SEMA) and the Federal Ministry of Health, often in collaboration with organizations including the United Nations Children's Fund (UNICEF), World Health Organization (WHO), International Organization for Migration (IOM), International Committee of the Red Cross (ICRC) and Médecins Sans Frontières (MSF).^{6,7,12}

While these efforts support emergency healthcare, nutrition and disease prevention, important gaps remain in the availability and sustainability of health services for displaced children, especially in underserved camps.

In many displacement settings, caregivers rely on informal community-based supports, such as mutual aid, communal sanitation and faith-based coping strategies, to meet children's health needs when formal support is inadequate. Community-based supports may influence health-seeking behaviour, nutrition practices and access to care, while also promoting resilience among displaced populations.^{8,9} However, evidence on how these supports function and contribute to child health outcomes, particularly from caregivers' perspectives in north-western Nigeria, remains limited.

Sokoto State has experienced increasing displacement due to banditry-related violence, with many families residing in overcrowded camps characterized by poor shelter, food insecurity and inadequate water and sanitation. In these settings, caregivers, predominantly women, play central roles in child survival and well-being. Understanding their perspectives is important for designing culturally appropriate and sustainable interventions.

Therefore, this study explored caregivers' perspectives on community-based supports and health outcomes of internally displaced children in banditry-affected communities of Sokoto State, Nigeria. Specifically, the study sought to identify existing support mechanisms, examine perceived gaps and challenges, and generate context-specific recommendations to inform policy and community-based interventions for improving child health outcomes

METHODS

STUDY DESIGN

This study employed a descriptive phenomenological design grounded in Husserlian philosophy to explore caregivers' lived experiences of community-based supports aimed at enhancing the health outcomes of internally displaced children in banditry-affected communities. The phenomenological approach facilitated a deeper understanding of caregivers' lived experiences, perceptions, and interpretations of community-based support mechanisms and their role in influencing the health and wellbeing of internally displaced children. To enhance rigour and minimise researcher bias, bracketing was employed through reflexive journaling to reduce the influence of researchers' preconceptions during data collection and analysis.

STUDY AREA AND POPULATION

The study was conducted in selected IDP camps within Sokoto East Senatorial District, north-western Nigeria, an area affected by banditry, insecurity and forced displacement. The selected camps, Guiwa Eka, Guiwa Lowcost, Ramin Kura, Gidan Igwe and Shiyar Gagi, were chosen because of the presence of displaced populations and informal community support structures.

These camps are characterized by temporary shelters, overcrowding, inadequate sanitation, food insecurity and limited access to formal healthcare services. The study population comprised adult caregivers primarily responsible for the daily care

and health-related decision-making of internally displaced children residing in the selected camps.

SAMPLE SIZE AND SAMPLING TECHNIQUE

Purposive sampling was used to recruit 11 participants with direct experience and knowledge of community-based support systems for child health within the camps. Eligible participants were caregivers aged 18 years or older who had resided in the camps for at least 6 months and were directly responsible for one or more children. A total of 11 participants were interviewed. The sample size was considered adequate as data saturation was achieved, with no new themes emerging. This is consistent with recommendations for phenomenological research emphasizing depth over breadth^{19,20}

DATA COLLECTION

Data were collected using a semi-structured interview guide designed by the research team in line with the study objectives, relevant literature, and the Neuman Systems Model. The guide was reviewed and validated by experts in qualitative research and community health nursing to ensure content validity, relevance, and contextual appropriateness. It was subsequently translated into Hausa and reviewed by bilingual experts to ensure linguistic accuracy and cultural relevance.

A pilot interview was conducted among caregivers with characteristics similar to the study participants but outside the selected study camps to refine the interview guide. Following the pilot interview, minor modifications were made to improve clarity, sequencing, and contextual appropriateness of questions, including simplification of ambiguous wording and addition of probing questions to elicit deeper responses on community-based support experiences.

In-depth face-to-face interviews were conducted in secure locations within the camps and lasted approximately 30–35 minutes. Interviews explored caregivers' experiences and perceptions of community-based supports, including family networks, peer support, faith-based assistance, community volunteers, and informal health or nutrition initiatives. All interviews were audio-recorded with participants' permission, transcribed verbatim, and translated into English. Selected transcripts underwent back-translation to ensure semantic accuracy.

To enhance analytic rigour, coding was independently conducted by two researchers, and

inter-coder agreement was assessed using percentage agreement, with a minimum agreement threshold of 80% maintained before consensus discussions were held to resolve discrepancies.

DATA ANALYSIS

Data were analysed inductively using Braun and Clarke's six-phase thematic analysis approach: familiarization with data, coding, searching for themes, reviewing themes, defining and naming themes, and producing the report.¹⁷ Coding was conducted independently by two researchers and discrepancies were resolved through discussion. An inter-coder agreement of at least 80% was achieved.

TRUSTWORTHINESS

Rigor was ensured using Lincoln and Guba's criteria.¹⁸ Credibility was enhanced through prolonged engagement, peer debriefing and member checking. Dependability was supported by maintaining an audit trail. Confirmability was ensured through reflexive journaling and independent coding, while transferability was enhanced through a detailed description of the study context and participants.

ETHICAL CONSIDERATIONS

Ethical approval was obtained from the Sokoto State Ministry of Health Research Ethics Committee (Ref: SMH/1580/V. IV). The study complied with the ethical principles of the Declaration of Helsinki.²² Participants were informed about the purpose of the study, voluntary participation and their right to withdraw at any stage without consequences. Verbal informed consent was obtained and audio-recorded due to low literacy levels. Confidentiality was maintained by assigning participant codes, removing identifiers from transcripts and storing data securely in password-protected files accessible only to the research team. Interviews were conducted privately to ensure participants' dignity, safety and privacy.

RESULTS

A total of 11 caregivers participated in the study. All participants were female and predominantly middle-aged, with the largest proportion aged 41–50 years (n=4). Most participants were Hausa (n=4) or Fulani (n=2), while five belonged to other minority ethnic groups. Educational attainment was generally low, with ten participants having no formal education. Four participants were unemployed, while seven were engaged in informal occupations such as petty trade and casual labour. Most participants had experienced displacement for more than one year (n=9).

Table 1: Socio-demographic Profile of Caregivers of Internally Displaced Children (n=11)

Variable	Category	Frequency (n)
Age (years)	18–30	2
	31–40	3
	41–50	4
	≥51	2
Gender	Female	11
Ethnicity	Hausa	4
	Fulani	2
	Other	5
Education	No formal education	10
	Primary	1
Occupation	Unemployed	4
	Informal/Other	7
Religion	Islam	11
Marital status	Married	6
	Divorced/Separated	3
	Widowed	2
Displacement duration	6 months–1 year	2
	≥1 year	9

THEMES AND SUB-THEMES

Four major themes emerged from the analysis:

1. Absence of structured community-based health programmes
2. Severe resource constraints affecting child health
3. Informal community coping and resilience
4. Priority needs for sustainable interventions

THEME 1: ABSENCE OF STRUCTURED COMMUNITY-BASED HEALTH PROGRAMMES

Caregivers consistently described a marked absence of structured and organized community-based health programmes within the camps. Participants reported that no formal child-focused health promotion, disease prevention, nutritional support, or coordinated healthcare initiatives existed to support internally displaced children. Although displacement had fostered a sense of shared hardship, participants emphasized that this had not translated into organized or sustainable community health systems.

Health-related decisions were described as largely individualized and dependent on each caregiver's limited capacity:

"There is no program here that is meant for children's health. Everyone is just managing their own child the way they can." (P1)

The lack of structured support was frequently linked to poverty, displacement-related instability, and competing survival priorities:

"We don't even have enough to eat, so how can we plan any health program for the children?" (P2)

Spiritual coping emerged as a common response to the absence of formal assistance:

"We mostly pray for the children because there is nothing else we can do as a community." (P3)

Although caregivers occasionally engaged in collective actions, participants emphasized that these were informal, inconsistent, and lacked institutional coordination or sustainability. These narratives highlighted substantial gaps between children's health needs and the availability of structured support systems.

THEME 2: SEVERE RESOURCE CONSTRAINTS AFFECTING CHILD HEALTH

Persistent shortages of food, potable water, shelter, sanitation facilities and financial resources emerged as major factors negatively affecting child health outcomes. Food insecurity was identified as the most pressing concern:

"Our major problem is the lack of food. When there is no food and nowhere to stay properly, sickness will surely come." (P2)

Poverty constrained both caregiving and collective action:

"What can we do when everybody here is facing their own problem? Everyone is just trying to survive." (P5)

Poor sanitation and inadequate water supply were repeatedly highlighted:

"Toilet facilities are our number one need. We don't even have a proper water source here." (P1)

Participants also described the economic burden of obtaining water:

"Even now, I bought just one jerrycan of water for 100 naira to wash my clothes and that of my children." (P1)

Although some adaptive strategies such as resource sharing and rationing existed, participants perceived them as insufficient to mitigate the effects of deprivation on child health.

THEME 3: INFORMAL COMMUNITY COPING AND RESILIENCE

Despite the absence of formal community-based health programmes, caregivers demonstrated resilience through informal collective coping mechanisms aimed at protecting children's health and wellbeing. Participants described self-organized sanitation activities as a routine communal practice intended to reduce illness risks within the camps:

"We sweep the camp every day. Even yesterday, we swept the whole place very well." (P1)

Collective participation in maintaining environmental hygiene was commonly reported:

"When it is time to sweep the camp, everybody comes out and we do it together." (P4)

Mutual support through food sharing also emerged as an important coping strategy:

"We assist one another with food so that no child will sleep hungry." (P4)

Participants further described informal pooling of small financial contributions during medical emergencies to facilitate healthcare access for sick children:

"If a child is seriously sick, we try to contribute small money to help take the child to the hospital." (P4)

While these informal coping mechanisms fostered solidarity and offered temporary relief, caregivers acknowledged that they remained fragile, inconsistent, and insufficient to sustainably address child health challenges in the absence of structured interventions.

THEME 4: PRIORITY NEEDS FOR SUSTAINABLE INTERVENTIONS

Participants clearly articulated priority needs for interventions that can sustainably improve child health outcomes. Frequently mentioned needs included food, shelter, clean water, sanitation facilities, healthcare services, clothing and livelihood support. Participants appealed for government assistance:

"We are calling on the government to assist us with food to eat and rooms to live in." (P2)

Others prioritized children's immediate material needs:

"Honestly, our major expectation is food, followed by clothes for our children." (P10)

Livelihood support was also emphasized:

"If we are given financial support for business and food, we will be able to take care of ourselves and our children." (P6)

Access to child-focused healthcare services was considered critical:

"There should be serious attention to their health, their living conditions, and the food they eat." (P11)

Participants expressed a strong desire for coordinated, well-resourced and sustainable interventions involving government and humanitarian actors.

SUMMARY OF FINDINGS

The findings indicate that internally displaced children in the study setting face major health challenges linked to the absence of structured support systems and severe resource shortages. Although informal community coping mechanisms provide some resilience, participants perceived them as insufficient, emphasizing the

urgent need for sustainable community-based interventions.

DISCUSSION

This study explored caregivers' perspectives on community-based supports and their implications for the health outcomes of internally displaced children in banditry-affected communities of Sokoto State. Findings revealed substantial gaps in structured support systems, severe resource constraints, reliance on informal coping mechanisms, and an urgent need for sustainable interventions.

A major finding of this study was the absence of formal, organized community-based health programmes within the IDP camps. Although community support existed informally, it rarely translated into structured health promotion, disease prevention or coordinated child health services. Caregivers largely relied on personal coping strategies and informal assistance rather than institutional mechanisms.

This finding reflects broader systemic weaknesses in humanitarian coordination and local governance. Similar gaps in organized support for displaced populations have been reported in Nigeria and other humanitarian settings, where service delivery often remains fragmented and inadequate.^{6,7} The absence of coordinated community-level health programmes undermines disease prevention, continuity of care and equitable access to services, thereby negatively affecting child health outcomes.⁸

Resource scarcity also emerged as a central determinant of both caregiving capacity and child health outcomes. Persistent shortages of food, water, shelter, sanitation facilities and financial resources were perceived as major drivers of childhood illness, malnutrition and vulnerability. These findings are consistent with reports documenting inadequate nutrition, poor healthcare access and insufficient basic services among internally displaced children.^{3,9} WHO similarly identifies inadequate water, sanitation and hygiene as major contributors to disease burden in displacement settings.¹⁰

Beyond direct health effects, resource shortages constrained the ability of communities to organize preventive and promotive activities, reinforcing dependence on humanitarian support. These

findings highlight the importance of addressing structural determinants of health in displacement contexts.

Despite limited formal support, caregivers demonstrated resilience through communal sanitation, food sharing and informal pooling of resources for healthcare emergencies. These practices reflected social cohesion and community solidarity as protective factors for child wellbeing. This finding aligns with evidence that community support networks mitigate health vulnerabilities among displaced populations.^{12,13} Community participation has also been recognized as enhancing the ownership and sustainability of interventions.¹⁴

However, while these informal coping mechanisms provided short-term relief, participants acknowledged their fragility and inability to address long-term and complex child health needs without structured support.

Caregivers emphasized food security, adequate shelter, clean water, sanitation facilities, accessible healthcare services and livelihood support as priorities for improving child health outcomes. These needs underscore the interconnected social, economic and environmental determinants shaping child health in displacement settings.

This finding supports previous studies advocating multi-sectoral responses that integrate emergency humanitarian assistance with long-term development strategies.^{15,16} The emphasis on economic empowerment also suggests that sustainable interventions should move beyond relief provision to include livelihood strengthening and social protection.

The findings reveal a mismatch between the complex health needs of internally displaced children and the limited availability of structured support systems. While informal resilience mechanisms offer partial protection, they cannot substitute for coordinated institutional interventions. Strengthening formal support structures while building on existing community coping systems may improve sustainable child health outcomes.^{17,18} This study has some limitations. The qualitative design and relatively small sample size limit generalizability of findings beyond the study setting.

The exclusively female participant sample may have limited representation of male caregiver perspectives.

In addition, reliance on self-reported experiences may have introduced recall or social desirability bias. However, use of member checking, reflexive journaling, peer debriefing and independent coding strengthened credibility and trustworthiness of findings.

CONCLUSION

Internally displaced children in banditry-affected communities of Sokoto State face profound health challenges, including malnutrition, poor hygiene, limited healthcare access and increased vulnerability to communicable diseases. These challenges are compounded by scarcity of basic resources and the absence of structured community-based health programmes. Although caregivers rely on informal collective coping strategies such as communal sanitation, mutual aid, food sharing and spiritual coping to support children's wellbeing, these mechanisms are insufficient to address the complex and ongoing health needs of displaced children.

The study highlights a substantial mismatch between the health needs of internally displaced children and the limited availability of organized, adequately resourced support systems. Strengthening sustainable, culturally appropriate and coordinated community-based interventions that integrate formal healthcare services with existing informal support mechanisms is essential for improving child health outcomes in displacement settings.

Strengthening structured child-focused health programmes, improving access to essential services such as food, water, sanitation and healthcare, and supporting existing community-led coping systems

through coordinated multi-sectoral interventions are critical to improving health outcomes among internally displaced children. Future research should focus on scalable, context-specific and culturally appropriate strategies for strengthening child health support systems in humanitarian settings.

ACKNOWLEDGEMENTS

The authors wish to express sincere gratitude to all caregivers who participated in this study for sharing their experiences and insights. The authors also acknowledge the support and guidance of colleagues and mentors whose expertise contributed to this study.

FUNDING

This study received no external funding.

CONFLICT OF INTEREST

The authors declare no competing interests.

AUTHOR CONTRIBUTIONS

UAT: Conceptualization, Methodology, Investigation, Data Curation, Writing – Original Draft, Project Administration.

UY: Methodology, Formal Analysis, Validation, Supervision, Writing – Review & Editing.

All authors reviewed and approved the final version of the manuscript.

DATA AVAILABILITY STATEMENT

The datasets generated and analysed during this study are available from the corresponding author upon reasonable request, subject to ethical approval and protection of participants' confidentiality.

ETHICAL APPROVAL

Ethical approval was obtained from the Sokoto State Ministry of Health Research Ethics Committee (Ref: SMH/1580/V. IV). Verbal informed consent was obtained from all participants prior to data collection.

REFERENCES

1. International Committee of the Red Cross. Root Causes and Prevention of Internal Displacement: The ICRC Perspective. Geneva: ICRC; 2023. Available online: <https://www.icrc.org> (accessed 13/06/2026).
2. Rieder M, Choonara I. Armed Conflict and Child Health. *Arch Dis Child*. 2012, 97 (1), 59–62. <https://doi.org/10.1136/adc.2009.178186>
3. United Nations Children’s Fund. Humanitarian Action for Children: Nigeria. New York: UNICEF; 2023. Available online: <https://www.unicef.org/media/131976/file/2023-HAC-Nigeria.pdf> (accessed 13/06/2026).
4. Nidzvetska S, Rodriguez-Llanes JM, Aujoulat I, Gil Cuesta J, Tappis H, van Loenhout JAF, et al. Maternal and Child Health of Internally Displaced Persons in Ukraine: A Qualitative Study. *Int J Environ Res Public Health*. 2017, 14 (1), 54. <https://doi.org/10.3390/ijerph14010054>
5. Bendavid E, Boerma T, Akseer N, Langer A, Malembaka EB, Okiro EA, et al. The Effects of Armed Conflict on the Health of Women and Children. *Lancet*. 2021, 397 (10273), 522–532. [https://doi.org/10.1016/S0140-6736\(21\)00131-8](https://doi.org/10.1016/S0140-6736(21)00131-8)
6. Nmadu A, Nmadu CP, Abba KA, Bello-Muhammad BF. Caregiver Perspectives on Health Challenges of Internally Displaced Children in Sokoto, Nigeria. *Int J Health Care*. 2022, 8 (1), 1–12.
7. Akuto GW. Challenges of Internally Displaced Persons in Nigeria: Implications for Counselling and the Role of Key Stakeholders. *Int J Innov Psychol Soc Dev*. 2017, 5 (2), 21–27.
8. World Health Organization. Water, Sanitation and Hygiene (WASH) [Internet]. Geneva: World Health Organization; 2024 [cited 2026 Jun 13]. Available online: https://www.who.int/health-topics/water-sanitation-and-hygiene-wash#tab=tab_1
9. United Nations Children’s Fund. Protecting the Rights of Internally Displaced Children [Internet]. New York: UNICEF; 2019. Available online: <https://www.unicef.org/media/56191/file/Protecting%20the%20rights%20of%20internally%20displaced%20children.pdf> (accessed 13/06/2026).
10. Salami B, Iwuagwu S, Amodu O, Tulli M, Ndikom C, Gomaa H, et al. The Health of Internally Displaced Children in Sub-Saharan Africa: A Scoping Review. *BMJ Glob Health*. 2020, 5 (8), e002584. <https://doi.org/10.1136/bmjgh-2020-002584>
11. Médecins Sans Frontières. Forced From Home: The Health and Humanitarian Consequences of Internal Displacement [Internet]. Geneva: Médecins Sans Frontières; 2018. Available online: <https://www.msf.org> (accessed 13/06/2026).
12. Mohammed H. Internal Displacement in Nigeria: A Case Study of Borno State. Berlin: Stiftung Wissenschaft und Politik; 2017. Available online: https://www.swp-berlin.org/publications/products/arbeitspapiere/Mohammed_2017_Internal_Displacement_Nigeria.pdf (accessed 13/06/2026).
13. United Nations. Guiding Principles on Internal Displacement. New York: United Nations; 1998.
14. African Union. Convention for the Protection and Assistance of Internally Displaced Persons in Africa (Kampala Convention). Addis Ababa: African Union; 2009.
15. Federal Government of Nigeria. National Policy on Internally Displaced Persons in Nigeria. Abuja: Federal Government of Nigeria; 2021.
16. Braun V, Clarke V. Using Thematic Analysis in Psychology. *Qual Res Psychol*. 2006, 3 (2), 77–101. <https://doi.org/10.1191/1478088706qp0630a>
17. Lincoln YS, Guba EG. Naturalistic Inquiry. Newbury Park (CA): Sage Publications; 1985.
18. Creswell JW. Qualitative Inquiry and Research Design: Choosing Among Five Approaches. 4th ed. Thousand Oaks (CA): Sage Publications; 2018.
19. Guest G, Bunce A, Johnson L. How Many Interviews Are Enough? An Experiment with Data Saturation and Variability. *Field Methods*. 2006, 18 (1), 59–82. <https://doi.org/10.1177/1525822X05279903>

20. Neuman B, Fawcett J. The Neuman Systems Model. 5th ed. Upper Saddle River (NJ): Pearson; 2011.
21. World Medical Association. World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects. JAMA. 2013, 310 (20), 2191–2194.
<https://doi.org/10.1001/jama.2013.281053>